# With smart strategies, immediate postpartum LARC is possible

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The need to provide immediate postpartum access to intrauterine contraceptives and contraceptive implants for those who desire them is now widely acknowledged among leading healthcare organisations. The most recently updated versions of the UK, US, and World Health Organization (WHO) Medical Eligibility Criteria for Contraceptive Use (MEC) all support the placement of the progestin implant, copper intrauterine device (IUD), and levonorgestrel intrauterine system (IUS) following the delivery of the placenta, and before hospital discharge. Postpartum placement has been recognised as safe, effective, and acceptable by the Royal College of Obstetricians and Gynaecologists (RCOG) and the American College of Obstetricians and Gynecologists (ACOG).

In the APPLES study (Access to Post Partum LARC in Edinburgh South), Cameron et al. (*BJOG* 2017: https://doi.org/10.1111/1471-0528.14674) describe the acceptability of prenatal contraceptive counselling among their patient population, and demonstrate considerable demand for immediate postpartum IUCs and implants. Yet the logistics of implementing the service remained challenging.

The authors discovered barriers, including hospital staff workloads, competing clinical demands, stocking issues, and staff training. Indeed, findings from other settings indicate that the APPLES pilot is not alone in experiencing these logistical challenges. In the US, the inclusion of immediate postpartum IUCs and implants under Medicaid reimbursement for delivery continues to become standard policy across many states (http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Immediate-Postpartum-LARC-Medicaid-Reimbursement); however, for many hospitals, the billing process is unclear and does not align well with systems for absorbing the upfront costs of the devices, meaning that postpartum access is available in theory but not in practice (Tocce et al. *Contraception* 2015;4:378). In many countries, prenatal contraceptive counselling is not part of standard practice, and the opportunity is missed to meet contraceptive desires before hospital discharge (Cameron *Best Pract Res Clin Obstet Gynaecol* 2014;28:871-80). In the developing world, stocking issues, provider training, and outdated service delivery policy have all been identified as barriers to service provision (http://www.care.org/sites/default/files/documents/FP-2012-IUD-Factsheet_FINAL.pdf).

Cameron et al. also found, however, that the community midwives participating in the project were able to establish a routine, integrated system for contraceptive counselling and assessing the desire for postpartum contraception. This finding is very encouraging and provides a model for other services in the UK and in other settings where community midwives are involved in prenatal care.

The barriers to implementing the in-hospital component of the provision system could also be overcome. Practical suggestions include expanding the range of healthcare professionals who are trained to provide methods, including midwives and nurses, developing dedicated postpartum contraception teams, and providing concrete estimates of stocking needs through the assessment of patient demand. Developing guidelines to integrate immediate postpartum contraception provision into best practices would also provide a policy framework to support new services.

Finally, addressing current research gaps could also help to reduce service delivery barriers, including examining patient preferences regarding the timing of informed consent once on the labour and delivery unit, and assessing outcomes of intrauterine contraceptive (IUC) placement beyond 10 minutes post-placental delivery.

## Disclosure of interests

None declared. Completed disclosure of interests form available to view online as supporting information. ■