Models of care for intrauterine device provision in Australian general practice

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Background

IUDs are a safe and effective form of long-acting reversible contraception\(^1\).

They are associated with:

- high satisfaction\(^2\),
- high contraceptive continuation rates\(^2\); and
- low risks\(^2\).

Uptake of IUD in Australia is low!

- Only 6.3% of heterosexually active Australian women use an IUD\(^3\)

In Australia, general practice plays a vital role in managing contraception.

Rationale and Aim

To understand low IUD uptake we need to look at its model of care

In Australia, a clear model is yet to be defined implemented

Understanding GP IUD models of care can help to improve service delivery and therefore increase uptake

Aim
To describe the models of care that are used by current GP IUD providers.

Primary research question
How do GPs deliver IUD insertions in a general practice setting?

Secondary research question
How do GP IUD providers perceive GP IUD provision can be improved?
Methods

Population: GP IUD providers who work in a general practice setting.

Recruitment strategies:
- Email invitations
- Social media - GP circles
- SPHERE Working Group and Department of General Practice Presentations
- Monash University newsletters
- Snowballing
Methods

Data Collection

Qualitative semi-structured interviews were:
- Conducted in July and August 2021;
- Audio-recorded and conducted via telephone;
- Transcribed verbatim; and
- De-identified.

Data Analysis

Transcribed interviews were stored in NVivo 20 (a qualitative analysis software).

Transcripts were thematically analysed, which was guided by Braun et al.1:
- Codes and subcodes generated.
- These were then collated into potential themes.

Results

Mean interview duration was 40 minutes (range 27-60 minutes).

Twenty participants:
- 17 women and 3 men;
- Average age was 38 years;
- Worked as GP for a mean of 6.7 years;
- Had been providing IUDs for a mean of 5.4 years; and
- 12 metro, 6 inner regional and 2 outer regional.

Models of care were identified:
- Commonalities lead to four recognisable models;
- Each participant generally used one model of IUD provision; and
- Participants adapted and crafted to suit practice and patient needs.
Model 1: Common – 3 or 4 appointments

- Model one was used by most participants.

“So, it’s one consultation, insertion, one follow-up. Some people need two if they have questions or unsure and that’s fine. So, it’s a long consult for the counselling, it’s a long consult for the insertion and a short consult for follow up.” – GP3
Model 2: Streamlined

- Model two was the second most operated model.

“\(\text{If the other doctors have already spoken to them, then I will just see them for the procedure... As a follow up, I want to see them. I prefer them to see me rather than their regular doctor.}\) – GP9
Model 3: Same day insertion

- Only ¼ of participants followed this model.

“So, if it’s appropriate I’m happy to do that, it doesn’t take all that long so if I can guarantee that we’re not doing it at a bad timing for conceiving then I’m happy to do that.” – GP3
Model 4: Task-sharing

- Sharing arrangements varied:
  - Most common: nurses assisting throughout the patient IUD journey.
  - Rarest: nurse-led IUD models.

- Nurse task-sharing varied between clinics:
  - Ranging between “squeezing the patient’s hand, and that’s it” to the insertion being “a team effort.”

GP perceived nurse scope of practice in IUD services:
- Pap smears, pregnancy testing and cervical screens
- Observations and continuous monitoring
- Administering local anaesthetic
- Insertion set up and clean up
Adaptable models

Variations discussed by participants:
• Pre-insertion consultation with non-provider;
• Telehealth for pre-insertion consultation and/or follow up;
• No follow up appointment; and
• Referrals.

Adaptations were due to:
- The COVID-19 pandemic;
- Newly available research evidence;
- Geographic location; and
- Patients’ needs and preferences.

“The most common time I refer to a gynae is when someone wants sedation or anaesthetic.” – GP20
Improving GP IUD services in Australia

Respecting providers and valuing IUD services

Improving GP IUD services in Australia

Improving IUD service delivery and training pathways for GPs

Improving women’s health literacy on sexual and reproductive health

“Often GPs pay out-of-pocket a couple of $1000 to get the IUD training. I think it would be good if there was some funding for them.”— GP20
Implications

• Common model was more acceptable for GPs, as it is well suited to general practice. However, it may not necessarily be the best model for patients.

• Other models that are safe and adapt to patients’ and providers’ needs may be better, for example:
Conclusions and future directions

• This is the first study in Australia to describe GP IUD models of care.

• We identified four IUD models used in Australian general practice.

• Current models can be improved in quality by:
  Decreasing appointments numbers;
  Providers following current evidence on best practice; and
  Providers prioritising patients’ choices, needs and lifestyles.

Improving GP IUD services can increase access to quality contraceptive care
Thank you

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