INTRODUCTION

Access to safe and effective contraception is an important human right, and is vital in protecting the reproductive health of women. During the postnatal period (the 8-week period following a birth) the need for reliable contraception is especially important, in view of the considerable risks to mothers and babies associated with rapid repeat pregnancy. However, evidence suggests that many new mothers struggle to have their postnatal contraception (PNC) needs adequately met, and that opportunities to empower women to take control of their post-pregnancy fertility are often unfulfilled.

It is estimated that 45% of pregnancies and one-third of births in England are unplanned or associated with...
feelings of ambivalence.\textsuperscript{6} A 2016 quality statement from the National Institute for Health and Care Excellence (NICE) recommends that ‘women who give birth [should be] given information about, and offered a choice of, all contraceptive methods by their midwife within 7 days of delivery.’\textsuperscript{7} The Faculty of Sexual and Reproductive Health (FSRH) goes further, advising that ‘maternity service providers should ensure that all women after pregnancy have access to the full range of contraceptives, including the most effective LARC [long-acting reversible contraception] methods, to start immediately after childbirth.’\textsuperscript{8} More recently, the All Party Parliamentary Group (APPG) on Sexual and Reproductive Health in the UK has recommended that the full range of immediate postpregnancy contraception should be made available in abortion, maternity and early pregnancy settings.\textsuperscript{9}

The North East and North Cumbria (NENC) Integrated Care System (ICS) is the largest ICS in England, with 3 million inhabitants and an annual birth population of 25,000. An ICS is a partnership of healthcare organisations that is responsible for planning and delivering healthcare services across geographical areas in England. The NENC ICS has the highest rate of conceptions to those aged under 18 years in England, and one of the highest rates of abortions occurring after a recent birth among individuals under 25 years of age.\textsuperscript{10,11} In 2022, the Women’s Health Strategy For England identified access to contraception as a priority area for immediate action, including contraception after childbirth.\textsuperscript{12} In a fragmented commissioner-provider system, with multiple organisations responsible for delivering different elements of reproductive health care, providing comprehensive contraception care can be challenging.

The purpose of this cross-sectional study was to explore the current PNC offer in the NENC ICS by means of an online survey of a convenience sample of women who had completed a pregnancy in the preceding 3 years and had used regional healthcare services during and after their pregnancy.

## 2 Methods

During the period from 1 December 2022 to 3 April 2023, women aged 16 years or above who had completed a pregnancy in the preceding 3 years in the NENC region were invited to complete an anonymous online survey. The survey was developed by a multidisciplinary steering group of academic and practice partners and piloted by recently pregnant members of a public and patient involvement (PPI) panel, with changes made to the survey prior to launch in response to service-user feedback. The survey collected demographic data describing personal characteristics and individual- and area-level measures of socio-economic status, reproductive history, postnatal contraception use and access to preferred PNC methods during the respondents’ most recent pregnancies. Several elements of the survey were modelled on questions and response options included in a validated reproductive health survey launched by Public Health England in 2021, including questions that listed the contraceptive methods available. The present study is part of a larger project – the North East and North Cumbria Postnatal Contraception (PoCo) Study – that also examined wider experiences of antenatal, intrapartum and postpartum care, in addition to its primary focus on PNC. Participants were required to respond positively to a series of consent statements before being able to proceed to the main survey questions. Respondents who completed the survey were given the option to be included in a prize draw, with the opportunity to win a £50 shopping voucher. The survey was hosted on the Jisc online surveys platform (https://app.onlinesurveys.jisc.ac.uk).

Recruitment to the survey was achieved via multiple routes. A link to the survey was shared on Facebook, Instagram and X (formerly Twitter) social media platforms and by means of targeted online advertising. Posters and business cards were placed in public spaces across the region. Although the aim of the survey was to reach a large convenience sample of participants, efforts were also made to recruit from population groups of particular interest by means of engagement with support organisations and special interest groups. The survey was available in non-English language versions and in paper versions for participants without digital access. With support from the National Institute for Health and Care Research (NIHR) clinical research network (CRN) NENC, ten GP practices in North Cumbria and rural North Northumberland responded to a call to participate as participant identification centres (PICs), running database searches on their practice lists and inviting eligible patients to consider completing the survey by means of a text, email or postal invitation. All eight National Health Service (NHS) Foundation Trusts in the NENC region also participated as PICs and provided current and former service users with written and verbal information about the study.

Statistical analyses were undertaken using SPSS27 (IBM, Armonk, NY, USA). Descriptive statistics were generated to describe PNC uptake and the availability of preferred PNC method across the whole eligible sample by individual contraceptive type and by grouped methods of interest where applicable (Table 1). Proposed associations between demographic and pregnancy-related characteristics and PNC uptake/satisfaction were explored using odds ratios (ORs), and multivariate logistic regression was used to generate adjusted odds ratios (aORs) that controlled for the other demographic and pregnancy-related variables measured (see footnote to Tables 2–4). Potentially confounding variables used in the adjusted analyses were selected if a significant association was observed with that variable in the unadjusted analysis. Statistical significance was set at $P < 0.05$. Ethical approval for this study was granted by the Newcastle and North Tyneside 1 Research Ethics Committee (22/NE/0212).
TABLE 1  Survey respondents’ reported contraceptive use during the 8-week postnatal period.

<table>
<thead>
<tr>
<th>Resumption of sexual activity following delivery</th>
<th>Percentage (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 week later</td>
<td>0.2% (4)</td>
</tr>
<tr>
<td>1–4 weeks later</td>
<td>12.1% (302)</td>
</tr>
<tr>
<td>5–8 weeks later</td>
<td>34.9% (872)</td>
</tr>
<tr>
<td>More than 8 weeks later</td>
<td>47.5% (1188)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>5.3% (133)</td>
</tr>
<tr>
<td>Any sexual activity during 8 week postnatal period</td>
<td>47.1% (1178)</td>
</tr>
</tbody>
</table>

Contraceptive methods utilised during 8-week postnatal period

- Male condom: 29.7% (742)
- None: 28.9% (722)
- Progestogen-only contraceptive pill (POP): 10.1% (252)
- Contraceptive injection: 7.2% (179)
- Withdrawal method: 6.4% (161)
- Combined oral contraceptive pill (COCP): 6.0% (151)
- Contraceptive pill (type unknown): 5.8% (144)
- Contraceptive implant: 4.8% (121)
- Lactational amenorrhoea method (LAM): 4.1% (103)
- Avoiding penetrative sex: 3.4% (86)
- Hormonal coil (intrauterine system, IUS): 2.3% (57)
- Safe period/calendar method/rhythm method: 1.6% (39)
- Copper coil (intrauterine device, IUD): 1.4% (36)
- Fertility awareness apps: 1.4% (35)
- Emergency contraception (morning after pill or IUD): 1.3% (34)
- Tubal ligation: 0.9% (23)
- Male partner vasectomy: 0.8% (20)
- Contraceptive patch: 0.3% (7)
- Female condom: 0.2% (4)
- Vaginal ring: 0.1% (2)
- Reported using one method of PNC: 57.2% (1432)
- Reported using two methods of PNC: 12.2% (306)
- Reported using three or more methods of PNC: 1.9% (49)

Any contraceptive method medically prescribed/administered during 8-week postnatal period: 38.7% (969)

Any long-acting reversible contraception (LARC) method medically prescribed/administered during 8-week postnatal period: 15.5% (389)

Able to access preferred contraceptive method during 8-week postnatal period

- Yes: 51.7% (1238)
- No: 18.8% (451)
- Not applicable (no preferred method/did not want PNC): 29.5% (706)

*Note that total is >100% because respondents were able to select more than one option.
*Includes all oral contraceptives, patches, rings, permanent contraceptive methods, intrauterine contraception, injections and implants.
*Includes all intrauterine contraception, implants and contraceptive injections.

TABLE 2  Significant predictors of uptake of medically prescribed or administered PNC methods.

<table>
<thead>
<tr>
<th>Variable name/description</th>
<th>aOR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at time of pregnancy</td>
<td></td>
</tr>
<tr>
<td>≤19 years</td>
<td>Ref.</td>
</tr>
<tr>
<td>20–24 years</td>
<td>0.354* (0.164–0.764)</td>
</tr>
<tr>
<td>25–29 years</td>
<td>0.302* (0.143–0.636)</td>
</tr>
<tr>
<td>30–34 years</td>
<td>0.216* (0.102–0.454)</td>
</tr>
<tr>
<td>35–39 years</td>
<td>0.182* (0.084–0.393)</td>
</tr>
<tr>
<td>≥40 years</td>
<td>0.097* (0.032–0.291)</td>
</tr>
<tr>
<td>Household income</td>
<td></td>
</tr>
<tr>
<td>£39,999 or less</td>
<td>Ref.</td>
</tr>
<tr>
<td>£40,000–£69,000</td>
<td>0.784* (0.622–0.988)</td>
</tr>
<tr>
<td>£70,000 and above</td>
<td>0.889 (0.663–1.191)</td>
</tr>
<tr>
<td>Self-reported mental health</td>
<td></td>
</tr>
<tr>
<td>Very good</td>
<td>Ref.</td>
</tr>
<tr>
<td>Good</td>
<td>0.687* (0.525–0.898)</td>
</tr>
<tr>
<td>Fair</td>
<td>0.761 (0.556–1.041)</td>
</tr>
<tr>
<td>Bad</td>
<td>0.647 (0.391–1.070)</td>
</tr>
<tr>
<td>Very bad</td>
<td>1.155 (0.359–3.714)</td>
</tr>
<tr>
<td>Parity</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Ref.</td>
</tr>
<tr>
<td>2</td>
<td>1.059 (0.861–1.302)</td>
</tr>
<tr>
<td>3</td>
<td>0.931 (0.658–1.318)</td>
</tr>
<tr>
<td>4+</td>
<td>1.877* (1.095–3.221)</td>
</tr>
<tr>
<td>Mode of delivery</td>
<td></td>
</tr>
<tr>
<td>Vaginal delivery</td>
<td>Ref.</td>
</tr>
<tr>
<td>Assisted delivery (forceps/ventouse delivery)</td>
<td>1.341* (1.014–1.775)</td>
</tr>
<tr>
<td>Planned caesarean section</td>
<td>1.356* (1.035–1.778)</td>
</tr>
<tr>
<td>Emergency caesarean section</td>
<td>1.410* (1.082–1.837)</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td></td>
</tr>
<tr>
<td>Any duration of breastfeeding</td>
<td>Ref.</td>
</tr>
<tr>
<td>No breastfeeding</td>
<td>1.505* (1.222–1.852)</td>
</tr>
</tbody>
</table>

* Adjusted for age, relationship status, ethnicity, place of birth, postcode IMD quintile, education, household income, physical health, parity, pregnancy intention, breastfeeding status, gestational diabetes and postnatal depression.
* P < 0.05.

**Bold values are statistically significant.**

3 | RESULTS

A total of 3088 survey responses were received, with 2509 responses eligible for inclusion in analyses after ineligible submissions were excluded. Most exclusions were made for participants submitting non-UK postcodes and/or returning internally inconsistent responses. Sample demographic
characteristics are summarised in Table 2: 73.1% (n = 1810) of respondents were aged between 25 and 34 years at the time of their most recent pregnancy, and 51.1% (n = 1128) lived in postcodes in Index of Multiple Deprivation (IMD) quintiles 1 and 2, representing the 40% most deprived postcode areas in England. The English IMD score is a relative measure of area-level deprivation based on several deprivation domains. Respondents were mostly straight/heterosexual (95.2%, n = 2375), mostly white British (96.1%, n = 2399) and around half were married at the time of their most recent pregnancy (52.8%, n = 1316). Survey sample demographic characteristics in relation to population characteristics are summarised in Table S1. Although broadly aligned in relation to age and IMD postcode quintile, it is noted that the survey sample did not fully reflect the ethnic diversity of the background population, or the disability or educational attainment population profile for the region. All logistic regression analyses are reported in Tables S2–S4.

### 3.1 Postnatal contraceptive uptake

In all, 47.1% (n = 1178) of survey respondents indicated that they resumed sexual activity within 8 weeks of completing their most recent pregnancy (Table 1). However, although 71.1% of respondents reported using one or more contraceptive methods during this period, only 38.7% (n = 969) used a more effective contraceptive method that was medically prescribed/administered, and only 15.5% (n = 389) used a LARC (for a description of method groupings, see the footnote to Table 1). Almost a third (29.7%, n = 742) of respondents reported using condoms during the postnatal period, 21.9% (n = 547) used oral contraceptives, 4.1% (n = 103) practised the lactational amenorrhoea method (LAM) and 1.7% (n = 43) accessed permanent contraception methods (tubal ligation or male partner vasectomy). Notably, only 43.6% (n = 514) of the 1178 participants who indicated that they resumed sexual activity within 8 weeks of delivery reported using some form of medically prescribed or administered contraception during that period.

Just over half (51.7%, n = 1238) of participants indicated that they were able to access their preferred contraceptive...
method within 8 weeks of completing their most recent pregnancy, but 18.8% \( (n=451) \) said that they were unable to do so. The remaining 29.5% \( (n=706) \) indicated that they did not want PNC or did not have a preferred method.

### 3.2 | Demographic predictors of PNC uptake

Younger women in this sample were significantly more likely to access any medically prescribed contraception or LARC during the postnatal period than women in older age categories (Tables 1 and 2). The uptake of any medically prescribed contraceptive method ranged from 71.4% \( (n=25) \) in women aged 19 years or under to 19.4% \( (n=7) \) among women aged 40 years or above, and the uptake of LARC ranged from 51.4% \( (n=18) \) to 5.6% \( (n=2) \) in the same age categories. These associations were statistically significant, followed a clear trend (with uptake decreasing with increasing age), and persisted after adjusting for other variables.

Across four measures of socio-economic status (SES; household income, educational attainment, employment status and home postcode IMD quintile), women in lower SES groups were consistently more likely to access any medically prescribed contraception and/or LARC postnatally than women in higher SES groups, with clear evidence of a trend in uptake decreasing with increasing SES. However, after adjusting for potential confounding factors, the only statistically significant association that persisted was in relation to the lower uptake of any medically prescribed contraception among women with an annual household income of £40,000–£69,000, compared with women with a household income of less than £40,000.

Patterns of uptake in relation to self-reported physical and mental health were, for the most part, not significant, but differences in some individual categories were significant without following any clear trend.

### 3.3 | Demographic predictors of accessing preferred PNC

Women who identified as lesbian/bisexual/queer were significantly less likely to have been able to access their preferred PNC method than women who described themselves as straight/heterosexual (63.1%, \( n=53 \), vs 73.7%, \( n=1179 \)); this association persisted following adjustment for potential confounding factors (Table 4). Women who were non-white British were significantly more likely to indicate that they had been able to access their preferred PNC method than white British women (82.8%, \( n=53 \), vs 72.9%, \( n=1182 \)). Some evidence emerged of lower access to preferred PNC method among respondents who self-reported their mental health as less than ‘very good’, but this was not consistent for all mental health categories.

### 3.4 | Pregnancy-related predictors of PNC uptake

Women who had had four or more viable pregnancies were found to be significantly more likely to access any medically prescribed PNC or LARC than women with lower parities (Tables 2 and 3). For any medically prescribed PNC, this association persisted after adjusting for potential confounding factors. Women who delivered their most recent pregnancy by caesarean section (planned and emergency) or with forceps/ventouse were also found to be significantly more likely to access any medically prescribed PNC method than women who had an unassisted vaginal delivery.

Pregnancy intention, wherein the respondent’s most recent pregnancy was described as unplanned or ambivalent, was a significant predictor of PNC uptake, but only the higher uptake of postnatal LARC following an unplanned pregnancy remained significant after adjusting for other variables.

Women who did not breastfeed following their most recent pregnancy were more likely to access any medically prescribed PNC method or LARC than breastfeeding mothers (48.6%, \( n=372 \), vs 34.4%, \( n=596 \); 19.3%, \( n=148 \), vs 13.9%, \( n=241 \)), but these associations were only robust to multivariate logistic regression in the case of any medically prescribed PNC.

### 3.5 | Pregnancy-related predictors of accessing preferred PNC

Pregnancy-related characteristics were not significant predictors of women accessing their preferred PNC method, with the exception of breastfeeding status: non-breastfeeding women were more likely to report being able to access their preferred PNC method compared with women who breastfed (Table 4).

### 4 | DISCUSSION

#### 4.1 | Main findings

This study found that the uptake of the most effective forms of PNC was low in the NENC ICS, and that almost one-fifth of respondents were unable to access their preferred method of PNC. Although many demographic and pregnancy-related characteristics were not significantly associated with PNC uptake, women in this sample who were younger, had a lower household income, did not breastfeed, delivered by caesarean section, had three or more previous viable pregnancies and/or whose most recent pregnancy was unplanned were more likely to access reliable PNC methods. Women who identified as lesbian/bisexual/queer, were white British and who breastfed were more likely to say that they had been unable to access their preferred PNC.
4.2 | Strengths and limitations

The large sample size and extensive geographical reach of the survey (largely reflecting the demographic diversity of the background population in relation to age and SES, but not in relation to ethnicity) are key strengths of this study. As an online survey, the ability to describe sensitive topics anonymously may also have facilitated participation for some respondents. However, the small number of respondents from some subgroups is a weakness, and this precluded a more granular appraisal of the impact of ethnicity and gender identity on PNC uptake/satisfaction. Some of the associations in relation to these subgroups may have proven significant with a larger sample. That the data were self-reported is also a potential weakness: more than 500 ineligible responses were excluded and, given that the data were asked to describe events that may have occurred up to 3 years ago, there was the potential for recall bias.

4.3 | Interpretation

The association between younger age and higher uptake of PNC in this cohort is noteworthy, as research in other settings has found that teenage mothers are less likely to access postnatal care following discharge from hospital. The finding that women in older age categories are significantly less likely to access PNC care is also important. There may be a perception among healthcare providers that PNC is less valued and desired among older, potentially perimenopausal women. However, a US study estimated that as many as 75% of pregnancies to women aged over 40 years are unplanned, and qualitative research has reported that the PNC care of women who have in vitro fertilisation (IVF) pregnancies is often suboptimal.

The finding that women in lower SES groups were more likely to access PNC is in keeping with research in other high-income settings. Given that low income has been identified as an important risk factor for unplanned pregnancy, targeting PNC services at more socio-economically disadvantaged women may be beneficial. However, this approach may be ethically contentious, and it is incumbent on providers to avoid the risks of contraceptive coercion. Although LARC methods may reduce the risk of rapid repeat and unplanned pregnancy, they will not, on their own at least, meaningfully address the social phenomena that make these outcomes more likely among women from lower SES groups.

The significant association between a small number of pregnancy-related/reproductive characteristics and PNC uptake highlights opportunities for maternity care providers to consider how they might look to deliver PNC care in response to patient profiles. In this sample, women with higher parities (parity 5+) may be associated with an increased risk of some adverse maternal outcomes. The observation that women in this sample who had a caesarean section were more likely to access any medically prescribed PNC method but not more likely to access LARC methods is intriguing, and suggests that opportunities to site intrauterine contraception at the time of caesarean section are not currently widely offered or accessed. Work remains to be done to utilise the opportunities associated with an operative delivery to deliver more comprehensive PNC options.

The finding that women who do not breastfeed are more likely to access more effective PNC is intuitive. However, although LAM may be an effective approach to family planning for up to 6 months postpartum for many women, it is user-dependent and does not provide longer-term protection of the type afforded by LARC methods. As such, FSRH recommends that PNC should be initiated by breastfeeding and non-breastfeeding mothers as soon as possible following delivery.

Women who identified as gay/bisexual/queer were less likely to indicate that they were able to access their preferred PNC method than heterosexual women. Although there was not a significant difference between these two groups in terms of PNC uptake, this finding suggests that providers are falling short of meeting the needs of LGBTQ+ women in regard to their PNC preferences. Research in other settings has shown that women from a sexual minority group often experience higher rates of unintended pregnancy than heterosexual women, and has described queer-specific barriers to accessing effective contraception. The finding reported here suggests that these barriers persist in the postnatal period. The observation that respondents from ethnic minorities were more likely to have been able to access their preferred PNC method, but not more likely to access effective methods of PNC, is intriguing. This low PNC uptake but relatively high PNC ‘satisfaction’ seen in the non-white UK group may reflect diverse sociocultural attitudes towards contraception. Ultimately, qualitative research is required to understand the nuance of these findings. The finding that women whose self-reported mental health was less than ‘very good’ were less likely to be able to access their preferred PNC method is potentially noteworthy, but the inconsistency of this finding across mental health categories suggests that this finding should be interpreted with caution. However, PND has been cited as a risk factor for rapid repeat pregnancy, and unplanned pregnancy may perpetuate mental health symptoms.

The relatively low uptake of PNC in this UK-based high-income cohort reflects some of the challenges of providing comprehensive postnatal family planning care in global settings. Despite family planning provision being identified as a key element of antenatal care, a previous systematic review proposed that the unmet need for PNC may be as high as 59.4% across some parts of the low- and middle-income world, and another study has highlighted shortcomings in PNC services in these settings. The LOWE (LARC ForWard counselling) trial in Sweden has identified the
potential impact for structured contraceptive counselling to increase LARC uptake and reduce the risk of short inter-pregnancy intervals. In global settings, where maternal mortality and morbidity remains a serious threat, the need for effective evidence-based approaches to PNC provision is more urgent still.

5 | CONCLUSION

This study sheds light on the characteristics of PNC users in a large English region/ICS and identifies unmet need in the provision of PNC care. However, there is evidence that some of the women at greatest risk of rapid repeat pregnancy are more likely to access the most effective PNC methods. This challenges the assumption of the inverse care law, and may signify targeted activities on the part of provider organisations to reach those with greatest need. Ultimately, a policy of proportionate universalism that delivers targeted activities with ‘high risk’ subgroups proportionate to their need, while also being universally accessible, is likely to be the most effective means of achieving the public health and patient benefits offered by comprehensive PNC coverage.

AUTHOR CONTRIBUTIONS

MM, CS and JR acquired the funding for the study. All authors conceptualised and designed the study. MM, RJ, CM-C and JR curated the data and were responsible for formal analysis, investigation and methodology. All authors were responsible for project administration and management of resources. MM wrote the original draft of this article, and all authors were responsible for reviewing and editing it. All authors accept responsibility for the paper as published.

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CONFLICT OF INTEREST STATEMENT

The authors declare that they have no competing interests associated with this work.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author, upon reasonable request.

ETHICS APPROVAL

Ethical approval for this study was granted by the Newcastle and North Tyneside 1 Research Ethics Committee (22/NE/0212).

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REFERENCES


SUPPORTING INFORMATION
Additional supporting information can be found online in the Supporting Information section at the end of this article.

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