

COLLEGE OF MIDWIVES OF BRITISH COLUMBIA

STANDARDS, LIMITS and CONDITIONS for PRESCRIBING, ORDERING and ADMINISTERING HORMONAL CONTRACEPTIVES

The following are the standards for midwives to independently prescribe, order and administer hormonal contraceptives in the community, hospital or other sites of midwifery practice for clients in care, as designated under specialized practice certification. ***Midwives without Specialized Practice Certification in Hormonal Contraceptive Therapy are required to refer their clients to an appropriate health care practitioner for treatment.***

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Standards, Limits and Conditions for Prescribing, Ordering and Administering Hormonal Contraceptives in Midwifery Practice

The standards below provide midwifery indications, routes of administration and upper dosage limits where appropriate, adverse effects and contraindications for the use of contraceptives approved for use in midwifery practice for midwives with specialized practice certification. Midwives may only prescribe, order or administer the following contraceptives within the standards set out in this document and to a client under their professional care where the contraceptive is required for the purposes outlined below.

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Systemic contraceptives^{1,2}

Systemic hormonal contraceptives are available in two basic preparations: 1) combined estrogen and progesterone and 2) progestin only. Condoms continue to be additionally recommended where protection against sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) is required. The SOGC makes the following recommendations in their consensus document:

Combined Hormonal Contraception

1. A range of hormonal contraceptives should be available to ensure that the individual receives the preparation most suited for their needs. (Grade C)
2. Information that antibiotic use does not appear to affect combined OC efficacy (except for griseofulvin and rifampicin). (Grade B) should be provided.

Progestin-Only Hormonal Contraception

1. Progestin-only methods should be considered as contraceptive options during the postpartum period, regardless of breastfeeding status, and may be introduced immediately after birth. (Grade B)
2. Progestin-only methods should be considered as contraceptive options if there is a history of venous thromboembolism (VTE), or if at a higher risk of myocardial infarction or stroke. If there is a proven thrombophilia, progestin-only preparations should be used with caution. (Grade B)
3. If using depot medroxyprogesterone acetate (DMPA) counselling should be provided about dietary and lifestyle factors that will affect peak bone mass, such as smoking, exercise, and calcium intake. (Grade A)

Special Considerations for Hormonal Contraception

If smoking, cessation counselling should be provided. If over 35 and smoking, advice not to use combined oral contraceptives (OCs) should be provided. (Grade A)

Combined Hormonal Contraception:

(Note: prescribing contraceptives requires certification in specialized practice)

The main mechanism of action of systemic combination contraceptives is to suppress gonadotropin secretion which inhibits ovulation. In addition, they 1) lead to endometrial atrophy making implantation less likely, 2) increase the viscosity of cervical mucus thus impeding sperm transport and 3) may impair secretion and peristalsis within the fallopian tube, interfering with ovum and sperm transport. They are available in monophasic, biphasic and triphasic combinations and include: 1) Desogestrel and Ethinyl Estradiol; 2) Ethynodiol

¹ SOGC. (2004). *Canadian Contraception Consensus*. Retrieved from <http://sogc.org/wp-content/uploads/2013/01/143E-CPG1-February2004.pdf>

² Systemic contraceptives should be available when seeking a reliable, reversible, method of contraception.

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Diacetate and Ethinyl Estradiol; 3) Levonorgestrel and Ethinyl Estradiol; 4) Norethindrone and Ethinyl Estradiol; 5) Norethindrone and Mestranol; 6) Norethindrone Acetate and Ethinyl Estradiol; 7) Norgestimate and Ethinyl Estradiol; and 8) Norgestrel and Ethinyl Estradiol. They are available in preparations that are delivered orally, by transdermal patch and intravaginal ring.

Prescribing:

Note: Prescribing contraceptives requires certification as a specialized practice. (See *Framework for Certification in Prescribing Contraceptives*).

The lowest dose preparation (35 mcg of ethinyl estradiol) that can achieve effective contraception, cycle control and minimal side effects should be prescribed. A variety of start dates for the combined OC can be considered: 1) Start during the first 5 days of the menstrual cycle or on the first Sunday after menses begin. No backup method of contraception is necessary to prevent pregnancy when all pills are taken; 2) Take first pill immediately upon ruling out pregnancy (regardless of timing in cycle). Backup contraception must be used for first 7 days.

Users of the 21-day regime should not exceed the 7 day pill-free interval between packs. The health-care provider should provide counselling about emergency contraception (EC) and provide a prescription for it. Dual protection with condoms is indicated if at risk of STIs and HIV transmission. Follow-up visit should be arranged to evaluate user experience and take blood pressure.

If prescriptive contraceptives are not affordable, there is the National Compassionate Oral Contraceptive Program SOGC at (800) 561-2416.

Instructions Regarding Missed Pills – from the SOGC:

- If you miss 1 pill, take it as soon as you remember. This may mean taking 2 pills in 1 day.
- If you miss 2 pills in a row during the first 2 weeks of the pack, take 2 pills on the day you remember and 2 on the following day. Use a backup method of contraception if you have sex in the 7 days after you miss the pills.
- If you have had unprotected intercourse after missing a pill, use emergency contraception.
- If you miss 2 pills in a row in the third week of the pack, throw out the remainder of the pack and start a new pack on the day you remember. You may not have a period this month. If you had unprotected intercourse after missing a pill, use emergency contraception.
- If you miss 3 pills in a row, throw out the remainder of the pack and start a new pack on the day you remember.
- If you had unprotected intercourse after missing a pill, use emergency contraception. Use a backup method of contraception if you have intercourse in the first 7 days of the new pack. You may not have a period this month.

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Side Effects:

Include abnormal menstrual bleeding (breakthrough bleeding), nausea, weight gain, mood changes, breast tenderness, and headache.

Contraindications:

Absolute:

- <6 weeks postpartum if breastfeeding
- smoker over the age of 35 (≥ 15 cigarettes per day)
- hypertension (systolic ≥ 160 mm Hg or diastolic ≥ 100 mm Hg)
- current or past history of venous thromboembolism (VTE)
- ischemic heart disease
- history of cerebrovascular accident
- complicated valvular heart disease (pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)
- migraine headache with focal neurological symptoms
- breast cancer (current)
- diabetes with retinopathy/nephropathy/neuropathy
- severe cirrhosis
- liver tumour (adenoma or hepatoma)

Contraindications:

Relative:

- smoker >35 years old (<15 cigarettes per day)
- adequately controlled hypertension
- hypertension (systolic 140-159 mm Hg, diastolic 90-99 mm Hg)
- migraine headache over the age of 35
- currently symptomatic gallbladder disease
- mild cirrhosis
- history of combined OC-related cholestasis
- users of medications that may interfere with combined OC metabolism

Warnings and Precautions:

VTE; myocardial infarct; stroke; gall bladder disease; breast cancer and cervical cancer; estrogen component may reduce milk volume.

Adverse Reactions:

Include abnormal menstrual bleeding (breakthrough bleeding), nausea, weight gain, mood changes, breast tenderness, and headache.

Progestin Only Contraceptives

(Note: prescribing contraceptives requires certification in specialized practice)

In Canada, the progestin-only contraception is available as an injectable depot medroxyprogesterone acetate (DMPA) or oral norethindrone (progestin only pill or POP).

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Depot Medroxyprogesterone (DMPA)

DMPA is highly effective form of contraception, with a failure rate of less than 0.3% per year. It inhibits the secretion of pituitary gonadotropins which suppresses ovulation, increases the viscosity of cervical mucus and induces endometrial atrophy. As DMPA is estrogen free, those with known contraindications or sensitivity to estrogen can take it, including those who: 1) smoke and are >35; 2) have frequent migraine headaches; 3) are breastfeeding, 4) have endometriosis or 5) sickle cell disease, or 6) take anti-convulsant medications.

The use of condoms is still recommended in DMPA users for protection against sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) infection. As it is delivered by injection and lasts 12 weeks it is also very helpful for those who may not be able to be compliant with a daily pill regime.

Dosage and Administration:

150 mg intramuscular injection every 12 weeks. The IM injection can be given in the deltoid or gluteus maximus muscles. Initial dose can be given at any time when pregnancy can definitely be ruled out; however, ideally it is given within first 5 days of menses.

Contraception is assured within 24 hours of injection. However, if given after the first 5 days of the menstrual cycle, advice should be provided on use of a backup method of birth control for at least 1 week. If switching from using a combined oral contraceptive (OC) to DMPA, DMPA should be given within the first 5 days of stopping the combined OC.

Contraindications:

Absolute:

- pregnancy (known or suspected),
- unexplained vaginal bleeding,
- current diagnosis of breast cancer.

Contraindications:

Relative:

- severe cirrhosis,
- active viral hepatitis,
- benign hepatic adenoma.

Warnings and Precautions:

Delayed return to fertility, loss of bone density.

Those with a history of depression may be at greater risk of mood disorders. With severe depression, the use of Depot Medroxyprogesterone (DMPA) needs to be discontinued, depression may take longer to resolve.

Adverse Reactions:

Menstrual cycle disturbance, hormonal (headache, acne, decreased libido, nausea, and breast tenderness), weight gain, and mood disturbances.

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Prescribing:

As noted above, prescribing contraceptives requires certification as a specialized practice. (See *Framework for Certification in Prescribing Contraceptives*).

Oral Progestin: Progestin-only pill

(Note: prescribing contraceptives requires certification in specialized practice)

Norethindrone (Micronor®):

Also known as the “mini pill”, this is a very safe and effective when used as directed. It prevents pregnancy through changing the molecular structure of cervical mucous, including reduction in volume and increase in viscosity, so that little or no sperm can penetrate. It also impairs sperm motility. Ovulation may be suppressed or partially suppressed although forty percent of those using progestin-only contraceptives will continue to ovulate. Endometrial changes that reduce the potential for implantation may occur.

Dosage and Administration:

Supplied in packages of 28 tablets, each containing 0.35 mg of norethindrone (Micronor®). It should be started on the first day of the menstrual cycle, although it may be started at any time during the menstrual cycle as long as pregnancy can be excluded. *There is no pill-free interval.* A backup method of birth control should be used for the first 7 days. It is very important that pills are taken at the same time each day within 3 hours.

If a pill is missed outside of the 3 hour window, it should be taken as soon as possible and a backup method of birth control should be used for the next 48 hours. The next pill should be taken at the regular time even when it coincides with the taking of the missed pill. If 2 or more pills in a row have been missed, then the individual must take 2 pills per day for 2 days and use a backup method of birth control for 48 hours. Emergency contraception may be considered if appropriate. An advance prescription for emergency contraception for use can be provided.

Contraindications:

Absolute:

- pregnancy and current breast cancer

Contraindications:

Relative:

- active viral hepatitis
- liver tumours

Adverse Reactions:

Irregular bleeding and hormonal effects including headaches, acne, bloating, and breast tenderness.

Follow up:

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A follow-up visit should assess bleeding patterns, satisfaction, and provides an opportunity for health assessment and counselling around condom use for protection against STIs and HIV.