New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

Consensus Statement: **Long Acting Reversible Contraception**

The New Zealand College of Midwives recognises that it is within a midwife's scope of practice to provide advice, access to, and prescription of contraception up to 6 weeks following birth. Long acting reversible contraceptives (LARC) include sub-cutaneous hormonal implants and intrauterine contraceptive devices (IUCDs) including hormone and non-hormone containing devices.

Midwives may refer women to a GP or Family Planning clinic for LARC or may choose to insert them themselves after undertaking an appropriate education programme which enables them to have the appropriate knowledge and skills to provide this service. They also need to have sufficient clinical experience so that they can maintain these skills and have access to the necessary equipment to ensure safe insertion.

Rationale:

- Women have a right to determine and plan their pregnancy, and to make informed decisions about their preferred contraceptive method/s. Obtaining a breastfeeding history plays a part in contraceptive counselling.
- Some women experience barriers to accessing timely contraception after the birth of their babies.
- Women's demand for and ability to access LARC services will vary greatly throughout New Zealand. Consequently it is the individual midwife's decision as to whether or not she provides her clients with an insertion service.

Guidelines/Recommendations:

- The midwife needs to be fully conversant with the effects, effectiveness [9], side effects [8], contraindications and cautions for the use of any contraceptive device or medication that she is prescribing or administering. It is important to share this information with women to support informed decision-making (verbal and written information is recommended [1, 6].
- For LARC implants and hormonal IUCDs there is a need to share information about the potential effects on breastfeeding, menstruation and bleeding patterns [8], and the potential adverse effects from the removal of subcutaneous implants[2]. Those with continued irregular bleeding should be referred to their GP for follow-up investigations and treatment [6, 7].
- The choice of contraceptive method and the timing of initiation is a consideration for the breastfeeding woman.
- Women initiating lactation who are separated from their infants, women with diabetes, and women with a history of low milk supply, for example, may require individual assessment, information, counselling and support. However progestogen-only contraception does not appear to adversely affect infant growth, health, or development when used by breastfeeding women [6, 7].

The Medsafe datasheet states:

- that breastfeeding women should be advised not to start using subcutaneous implants earlier than six weeks after birth [2], however in some cases it may be appropriate.
- If LARC is inserted later than 21 days after childbirth, pregnancy should reliably be excluded and additional non-hormonal contraceptive precautions taken for a minimum of 7 days after insertion[3].

Medsafe also advises that:

- Postpartum insertions of IUCDs should be postponed until the uterus is fully involuted, however not earlier than six weeks after birth.
- If involution is substantially delayed, consider waiting until 12 weeks postpartum [4].
- There is an increased risk of uterine perforation if a woman is < 36 weeks post partum and breastfeeding [6].

References:

1. Contraceptives. http://nzf.org.nz/nzf_4163

2. Removal Difficulties with Jadelle and Implanon (2013) Medsafe publications http://www.medsafe.govt.nz/profs/PUArticles/Sept2013JadelleandImplanon.htm

3. Levonorgestrel 2 x 75mg (Jadelle) data sheet http://www.medsafe.govt.nz/profs/Datasheet/j/Jadelleimplant.pdf

4. MIRENA® levonorgestrel-releasing intrauterine delivery system (IUS) data sheet http://www.medsafe.govt.nz/profs/datasheet/m/Mirenaius.pdf

5. Heinemann K, Westhoff CL, Grimes DA, Moehner S. (2014). Intrauterine Devices and the Risk of Uterine Perforations: Final Results from the EURAS-IUD Study. *Obstetrics and Gynecology* 123 Supplement 1:3S reported in Prescriber Update September.

6. Berry-Bibee EN, Tepper NK, Jatlaoui TC et al. (2016). Safety of intrauterine devices in breastfeeding women: A systematic Review. *Contraception*.94:725-38.

7. Kapp, N., Curtis, K.,Nanda, K. (2010). Progestogen-only contraceptive use among breastfeeding women: a systematic review. *Contraception*. (82), 17-37.

8. Roke, C., Roberts, H., Whitehead, A. (2016). New Zealand women's experiences during the first year of Jadelle® contraceptive implant. *J. Prim Health Care.* 8(1), 13-19.

9. Lopez LM, Bernholc A, Chen M, Grey TW, Otterness C, Westhoff C, Edelman A, Helmerhorst FM. (2016). Hormonal contraceptives for contraception in overweight or obese women. *Cochrane Database of Systematic Reviews* Issue 8. Art. No.: CD008452. DOI: 10.1002/14651858.CD008452.pub4.

Resources:

See www.Familyplanning.org.nz for free downloadable information leaflets regarding implants and hormonal intrauterine devices.

See also Lactnet toxnet for additional information: https://toxnet.nlm.nih.gov/cgi-bin/sis/search2

Ratification:

This statement was ratified at the New Zealand College of Midwives AGM on 23/8/18

The purpose of New Zealand College of Midwives Consensus Statements is to provide women, midwives and the maternity services with the profession's position on any given situation. The guidelines are designed to educate and support best practice. All position statements are regularly reviewed and updated in line with evidence-based practice.