**(insert AGENCY name)**

Reproductive Health Program

Clinical Practice Standard

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| **Subject:** Depo Medroxyprogesterone Acetate (DMPA) | **No.** |
| **Approved by:**  |  | **Effective Date:**  |
| **Revised Date:** January 2018, January 2019, January 2021, **October 2022** |
| **References:** U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC), 2016; U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR), 2016; Contraceptive Technology, 21st Ed |

**POLICY:** This Clinical Practice Standard follows the recommendations of the U.S. MEC, 2016; U.S. SPR, 2016; and Contraceptive Technology, 21st Ed.

**PURPOSE:** This Clinical Practice Standard provides direction for reproductive health clinics to assist clients in their use of DMPA. DMPA is an injectable progestin, similar to the naturally occurring hormone progesterone, which can be used to provide long-acting contraception. It is a microcrystalline suspension made for slow release. There are two FDA-approved formularies available for administration by healthcare providers, DMPA IM and DMPA SQ. A large body of evidence supports the safety and efficacy of clients self-administering DMPA SQ and offering this option may reduce barriers to access by eliminating the need for in-person visits. User-administered DMPA-SC has higher continuation rates and comparable rates of pregnancy and side effects/adverse events versus provider-administered DMPA While DMPA SQ is not labeled by the FDA for self-injection, several studies have demonstrated the safety and feasibility of self-administered DMPA SQ. Both the WHO and the CDC recommend that user-administered injectable contraception should be made available as an additional approach to deliver injectable contraception to persons of reproductive age. DMPA has a direct effect upon the reproductive organs and other cells with hormone receptors. DMPA inhibits ovulation by suppression of the pituitary release of follicle stimulating hormone (FSH) and luteinizing hormone (LH). Cervical mucus is changed to inhibit sperm capacitation and penetration. The endometrium becomes thin and atrophic due to decreased estrogen.

With typical use, approximately 6 out of 100 people who use DMPA will become pregnant in the first year of use. DMPA injections must be given every 3 months.

DMPA does not protect against sexually transmitted infections (STIs).

**STANDARD:**

1. (**insert AGENCY name**) MDs, NPs, PAs, DOs, and NDs may prescribe DMPA to any client who requests this method and has no U.S. MEC category 4 risk conditions.
2. (**insert AGENCY name**) RNs may administer DMPA (or dispense for self-administration) to any client who requests this method and has no U.S. MEC category 3 or 4 risk conditions. RNs may administer or dispense DMPA to clients with U.S. MEC category 3 conditions only under a current written or verbal order from a prescribing provider.

**PROCEDURE:**

1. Follow [*Core Reproductive Health Services Clinical Practice Standard*.](https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/Clinical-Practice-Standards/CPS-Core_RH.docx)
2. Follow the [U.S. MEC](https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/appendixc.html) guidelines to determine client eligibility for use of DMPA:
3. RNs may initiate the client’s contraceptive method of choice as long as the client has no U.S. MEC category 3 or 4 risk conditions for its use.
4. If client has any MEC category 3 conditions, an NP, PA, DO, ND or MD *may* prescribe the method according to their clinical judgement, if requested by the client. Documentation must show that the client understands the risks of the method and finds other, lower-risk methods unacceptable. RNs may not dispense the method unless under explicit verbal order after discussing the client's case with the prescribing provider.
5. Clients requesting a method for which they have a category 4 risk condition will be offered lower risk methods and referred to an OB/GYN or specialist provider.
6. DMPA is available in two formularies.
7. DMPA-IM injection dose is 150 mg/1ml in either 1 cc vials or prefilled syringes.
The vial and the syringe should be vigorously shaken prior to use. Administer it as a deep IM injection using a 21-23-gauge needle in the deltoid (using at least a 1-inch needle) or upper outer quadrant of the buttocks (use a 1.5 inch or longer needle at this site). Do not massage the area.
8. DMPA-SQ dose is 104mg/0.65ml in pre-filled, single-use syringes to be administered in the anterior thigh or abdominal wall. This formulary may be self-administered by the client or administered by the client’s friend, partner, or family member. Prior to a client choosing this method, the client and provider should discuss and consider the client’s willingness to learn the technique, prior experience with injections, and a history of vasovagal syncope with injections.
9. Each client will receive client instructions regarding warning signs, common side effects, risks, use of method, alternative methods, use of secondary method, and clinic follow-up schedule. Document the client’s education and understanding of the method of choice.
10. Provide the client with a reminder card for when the next injection (for user-administered) or injection appointment is due.

**PLAN:**

1. Initiating DMPA IM and SQ:
2. The first DMPA injection can be given at any time if it is reasonably certain that the client is not pregnant.
* If DMPA is started within 7 days since menstrual bleeding started, no additional contraceptive protection is needed.
* If DMPA is started > 7 days since menstrual bleeding started, the client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.
1. RNs may administer/dispense up to a 12-month supply (4 injections) of DMPA under a standing order/protocol when initiating a contraceptive method. RNs are allowed to administer/dispense DMPA beyond the initial 12 months only if under a current written prescription from the clinic’s prescribing provider.
	1. When the initial start of the method occurs within a visit with a prescribing provider, the provider will write a prescription for up to 1-year supply and may dispense this amount depending on the client’s preference and anticipated use.
	2. Evidence supports that an extended supply of contraception prevents breaks in use and unintended pregnancy. When dispensing DMPA for self-administration, RNs and providers are encouraged to dispense a 12-month supply whenever possible.
2. Special considerations:

Use of Ella®:

The administration of DMPA simultaneously with Ella may reduce the effectiveness of Ella for emergency contraception. Ideally, DMPA should be delayed for 5 days after use of Ella® to prevent the reduction of contraceptive effects of either. However, shared-decision making may be used considering the risks and benefits of delaying DMPA vs starting DMPA at the time of visit.

A reliable barrier method of contraception should be used with subsequent acts of intercourse for the next 7 days.

Amenorrhea (not postpartum):

The first DMPA injection can be given at any time if it reasonably certain that the client is not pregnant.

The client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

 Postpartum (breastfeeding):

The first DMPA injection can be given at any time, including immediately postpartum (U.S. MEC 2 if < 1 month postpartum and U.S. MEC 1 if ≥ 1 month postpartum) if it is reasonably certain that the client is not pregnant.

If the client is < 6 months postpartum, amenorrheic, and fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [85%] of feeds are breastfeeding), no additional contraceptive protection is needed.

A client, who is ≥ 21 days postpartum and has not experienced the return of their menstrual cycle, needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

If the client’s menstrual cycles have returned and it has been > 7 days since menstrual bleeding started, the client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Postpartum (not breastfeeding):

The first DMPA injection can be given at any time, including immediately postpartum (U.S. MEC 1), if it reasonably certain the client is not pregnant.

A client who is < 21 days postpartum needs no additional contraceptive protection.

A client, who is ≥ 21 days postpartum and has not experienced the return of their menstrual cycle, needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

If a client’s menstrual cycles have returned and it has been > 7 days since menstrual bleeding started, the client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Post abortion:

The first DMPA injection can be given within the first 7 days, including immediately post-abortion.

The client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days unless the injection is given at the time of a surgical abortion.

1. Switching from another method:

The first DMPA injection can be given immediately if it is reasonably certain that the client is not pregnant. Waiting for the next menstrual cycle is unnecessary.

If it has been > 7 days since menstrual bleeding started, the client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

Switching from an IUD/IUS:

If the client is switching from an IUD/IUS and has had sexual intercourse since the start of the current menstrual cycle and it has been > 5 days since menstrual bleeding started, residual sperm might be in the genital tract, a healthcare provider may consider any of the following options:

1. Advise client to retain the IUD/IUS for at least 7 days after the injection and return for IUD removal;
2. Advise the client to abstain from sexual intercourse or use barrier contraception for 7 days before removing the IUD/IUS and switching to the new method; advise the client to use ECPs, with the exception of Ella®, at the time of IUD removal.

Switching from combined hormonal contraceptives:

Administer the first injection within 7 days after the last day of using the combined hormonal contraceptive method (i.e., within seven days after taking the last active pill).

1. Switching from contraceptive implant:

Administer the first injection on the day of implant removal.

1. Switching from the vaginal ring or contraceptive patch:

Administer the first injection on the day the patient would have inserted the next ring or applied the next patch.

1. If uncertain whether the client might be pregnant, the benefits of starting DMPA likely exceed any risk; therefore, starting DMPA should be considered at any time, with a follow-up pregnancy test in 2-4 weeks.
2. If a client needs to use additional contraceptive protection when switching to DMPA from another contraceptive method, consider continuing their previous method for 7 days after DMPA injection.
3. Continuing DMPA:
4. Repeat injections every 3 months (12-14 weeks):

The repeat DMPA injection can be given early when necessary (there are no time limits on early injections).

The repeat DMPA injection can be given up to 2 weeks late (15 weeks from the last injection) without requiring additional contraceptive protection.

If the client is > 2 weeks late (>15 weeks from the last injection) for a repeat DMPA injection, the client can have the injection if it is reasonably certain that the client is not pregnant. The client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days. Consider the use of EC if appropriate.

**ROUTINE FOLLOW-UP:**

1. The recommendations listed below address when routine follow-up is recommended for safe and effective continued use of contraception for healthy clients. Although routine follow-up is not necessary for the use of DMPA, recommendations might vary for different users and different situations. Specific populations such as adolescents, those with certain medical conditions or characteristics, and those with multiple conditions may benefit from more frequent follow-up visits.
2. Advise the client to return at any time to discuss side effects or other problems, if the client wants to change the method being used, and when it is time for reinjection.
3. At other routine visits healthcare providers, should do the following:

Assess the client’s satisfaction with the contraceptive method and whether the client has any concerns about the method use;

Assess any changes in health status, including medications that would change the appropriateness of the injectable for safe and effective continued use based on U.S. MEC;

Consider assessing weight changes and counsel clients who are concerned about weight changes perceived to be associated with their contraceptive method; and

Consider continuing to administer DMPA every 3 months with a current prescription from (**insert AGENCY name**)’s prescribing provider.

Management of DMPA Side Effects:

1. Prior to initiation provide counseling about potential changes in bleeding patterns:
2. Amenorrhea;
3. Unscheduled spotting;
4. Light bleeding; and
5. Heavy or prolonged bleeding.
6. These irregularities are not harmful and may decrease with continued use.
7. Unscheduled Spotting or Light Bleeding:
8. If clinically indicated, consider an underlying gynecological problem (e.g., STI, pregnancy or new pathologic uterine conditions). Schedule with prescribing provider/primary care provider for evaluation.
9. If an underlying condition is not found, consider nonsteroidal anti-inflammatory drugs (NSAIDs) for short term treatment (5-7 days) during the days of bleeding.
10. If unscheduled spotting or light bleeding persists and the client finds it unacceptable, counsel the client on alternative contraceptive methods, and offer another method if desired.
11. Heavy or Prolonged Bleeding:
12. If clinically indicated, consider an underlying gynecological problem (e.g. STI, pregnancy or new pathologic uterine conditions). Refer to the prescribing provider/ primary care provider for evaluation
13. If an underlying condition is not found, consider the following treatment option during the days of bleeding:

NSAIDs for short term treatment (5-7 days); or

Hormonal treatment (if medically eligible) with low dose combined oral contraceptives or estrogen for short-term treatment (10-20 days) (U.S. SPR, 2013).

1. If heavy or prolonged bleeding persists and the client finds it unacceptable, counsel the client on alternative contraceptive methods, and offer another method if it is desired.

**STOPPING DMPA:**

1. DMPA may be stopped at any time.
2. If the client does not want to become pregnant, advise the client to start using a new contraceptive 13 week after their last injection. The client may start another contraceptive *before* it is time for the next injection.
3. If the client desires to be pregnant:
4. Advise client that pregnancy may not occur for up to 6-12 months after stopping DMPA;
5. Provide the client with preconception counseling; and
6. Advise the client to begin taking a daily prenatal vitamin with 0.4 to 0.8 milligrams of folic acid at least 30 days before trying to become pregnant.

**CLIENT EDUCATION ON INJECTION TECHNIQUE:**

1. Ideally, provide client instruction in self-administration technique in-person or via audio/video telehealth visit. If that is not possible, provide education material with step-by-step instructions for self-administration, as well as guidance on the disposal of needles. See Attachment 1 for patient resources.
2. Clients should store the medication at room temperature.
3. Simple step-by-step instructions:

Wash hands.

Remove syringe from package and shake it for one minute until mixed.

Hold needle pointing up and tap syringe to shake air bubbles to the top.

Push syringe until air bubble are out.

Choose injection site (abdomen or anterior thigh), wipe with alcohol pad, and let area dry.

Take cap off of needle and hold syringe in dominant hand.

Grab the skin around injection site with non-dominate hand and insert needle all the way into skin at a 45-degree angle.

Press syringe all the way in and keep needle in place while counting to give.

Remove needle and dispose of into a sharps disposal container.

Apply light pressure to prevent bleeding without massaging.

**CLIENT EDUCATION:**

1. Advise the client there may be changes in periods (e.g., irregular bleeding, spotting, heavy bleeding, or no periods).
2. Advise the client that prolonged use of DMPA may put them at risk for osteoporosis but it is temporary and reversible when DMPA is discontinued.
3. Advise the client using DMPA to have adequate intake of calcium and vitamin D, engage in regular exercise, and avoid cigarette smoking and excessive alcohol consumption in order to maximize bone health.
4. Inform the client to call the clinic if they have any questions or concerns regarding the contraceptive method.
5. Inform the clients that any signs or symptoms of complications should be reported to the clinic; if the clinic is not open, clients should call 911 or go to the emergency room.
6. Discuss DMPA warning signs that indicate the need for medical evaluation (client should be informed to seek immediate care if any warning signs are noted):
7. Repeated, very painful headaches;
8. Heavy bleeding;
9. Depression;
10. Severe, lower abdominal pain (may be sign of pregnancy); and/or
11. Pus, prolonged pain, redness, itching or bleeding at injection site (may be sign of infection).

**REFERENCES:**

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**ATTACHMENT 1: Patient Resources for Self-Administered DMPA SQ**

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| **Resource**  | **Website**  |
| Reproductive Health Access Project, Depo SubQ User Guide (PDF)  | [www.reproductiveaccess.org/resource/de po-subq-user-guide/](http://www.reproductiveaccess.org/resource/depo-subq-user-guide/)  |
| RheumInfo, How to Give a Subcutaneous Injection Using a Pre-filled Syringe (video)  | [www.youtube.com/watch?v=arcr1wjun6c](http://www.youtube.com/watch?v=arcr1wjun6c)   |
| SafeNeedleDisposal.org, Educational Materials  | [safeneedledisposal.org/resourcecenter/online-brochures/](https://safeneedledisposal.org/resource-center/online-brochures/)  |
| Bedsider Provider Perspectives, Depo SubQ  | [www.bedsider.org/features/789-deposubq-the-do-it-yourself-birth-control-shot](http://www.bedsider.org/features/789-depo-subq-the-do-it-yourself-birth-control-shot)  |
| PATH, DMPA SQ Self-Injection Resources (webpage)  | [www.path.org/programs/reproductivehealth/dmpa-sc-self-injection/](http://www.path.org/programs/reproductive-health/dmpa-sc-self-injection/)  |
| Pfizer, Depo SQ Provera 104 Prescribing Information (webpage)  | [www.pfizermedicalinformation.com/enus/depo-subq-provera-104#S3](http://www.pfizermedicalinformation.com/en-us/depo-subq-provera-104#S3)  |