**(insert AGENCY name)**

Reproductive Health Program

Clinical Practice Standard

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| **Subject:** Progestin-Only Pills (POP) | | **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, 20th Ed | | |

**POLICY:** This Clinical Practice Standard follows the recommendations of the U.S. MEC, 2016; U.S. SPR, 2016; and Contraceptive Technology, 20th Ed.

**PURPOSE:** This Clinical Practice Standard provides direction for reproductive health clinics to assist clients in their use of the progestin-only pills.

Progestin-only pills (POPs) contain only a progestin and no estrogen. Approximately 9 out of 100 people who use POPs become pregnant in the first year with typical use. POPs are reversible and can be used by clients of all ages.

POPs do not protect against sexually transmitted infections (STIs).

**STANDARD:**

1. (**insert AGENCY name**) MDs, NPs, PAs, DOs, and NDs may prescribe POPs to any client who requests this method and has no U.S. MEC category 4 risk conditions.
2. (**insert AGENCY name**) RNs may dispense POPs to any client who requests this method and has no U.S. MEC category 3 or 4 risk conditions. RNs may dispense COCs 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/appendixd.html) guidelines to determine client eligibility for use of POPs:
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. Each client will receive client instructions regarding warning signs, common side effects, risks, method of use, alternative methods, use of secondary method, and clinic follow-up schedule. Document client education and understanding of the method of choice.

**PLAN:**

1. Initiation of POPs:
2. POPs can be started at any time if it is reasonably certain that the client is not pregnant:

* If POPs are started within the first 5 days since menstrual bleeding started, no additional contraceptive protection is needed.
* If POPs are started > 5 days since menstrual bleeding started, the client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days.

1. RNs may provide up to a 12-month supply of contraception under a standing order/protocol when initiating a method. RNs are allowed to dispense beyond the initial 12 months only if under a current prescription from the clinic’s prescribing provider.
   1. When the initial start of the method occurs within a visit with the NP, PA, or MD, 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. RNs and providers are encouraged to dispense a 12-month supply whenever possible.
2. Special Considerations
3. Amenorrhea (not postpartum):

* POPs can be started at any time 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 2 days.

1. Postpartum (breastfeeding):

* POPs can be started at any time, including immediately postpartum (U.S. MEC risk category 2 if < 1 month postpartum and U.S. MEC risk category1 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 breast feeding (exclusively breastfeeding or the vast majority [85%] of feeds are breastfeeds), no additional contraceptive protection is needed.
* A client, who is ≥ 21 days postpartum and has not experienced return of their menstrual cycles, needs to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days.
* If a client’s menstrual cycles have returned and it has been >5 days since menstrual bleeding started, they need to abstain or use additional contraceptive protection for the next 2 days.

1. Postpartum (not breastfeeding):

* POPs can be started at any time, including immediately postpartum (U.S. MEC 1), if it is reasonably certain that the client is not pregnant.
* Clients who are < 21 days postpartum, no additional contraceptive protection is needed.
* Clients, who are ≥ 21 days postpartum and whose menstrual cycles have not returned, need to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days.
* If a client’s menstrual cycles have returned and it has been >5 days since menstrual bleeding started, they need to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days.

1. Post abortion (spontaneous or induced):

* POPs can be started within the first 7 days, including immediately post abortion (U.S. MEC 1).
* The client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days unless POPs are started at the time of a surgical abortion.

1. Switching from another contraceptive method:
2. POPs can be started immediately if it is reasonably certain that the client is not pregnant. Waiting for the next menstrual period is unnecessary.

* If it has been > 5 days since menstrual bleeding started, the client needs to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days.

1. Switching from an IUD/IUS:

* If the client has had sexual intercourse since the start of their current menstrual cycle and it has been > 5 days since menstrual bleeding started, theoretically, residual sperm might be in the genital tract. A healthcare provider may consider any of the following options:

1. Advise the client to retain the IUD/IUS for at least 2 days after the POPs are initiated and return for IUD/IUS removal;
2. Advise the client to abstain from sexual intercourse or use a barrier method for 7 days before removing the IUD/IUS and switching to the new method; or
3. Advise the client to use EC pills at the time of IUD/IUS removal.
4. POPs can be started immediately after use of ECPs (with the exception of Ella®)
5. POPs can be started no sooner than 5 days after using Ella
6. If uncertain whether the client might be pregnant, the benefits of starting POPs likely exceed any risk; therefore, starting POPs should be considered at anytime, with a follow-up pregnancy test in 2-4 weeks.

**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 POPs, 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 client to return at any time to discuss side effects or other problems, or if they want to change the method being used. No routine follow-up visit is required.
3. At other routine visits, healthcare providers seeing POP users should do the following:

* Assess the client’s satisfaction with their contraceptive method and whether there are any concerns about method use.
* Assess any changes in health status, including medications that would change the appropriateness of POPs 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.
* Provide up to the maximum number of refills of the contraceptive method under a current prescription from (**insert AGENCY name**) prescribing provider.

Missed POPs:

1. For the following recommendations, a dose is considered missed if it has been >3 hours since it should have been taken.
2. Take one pill as soon as possible.
3. Continue taking pills daily, one each day, at the same time each day, even if it means taking two pills on the same day.
4. Use back-up contraception (e.g. condoms) or avoid sexual intercourse until pills have been taken correctly, on time, for 2 consecutive days.
5. Emergency contraception should be considered (with the exception of Ella®) if the client has had unprotected sexual intercourse.
6. Clients who frequently miss taking POPs may wish to consider an alternative contraceptive method that is less dependent on the user to be effective.

Vomiting or Severe Diarrhea:

1. If vomiting or severe diarrhea occurs within 3 hours after taking a pill:
2. Take another pill as soon as possible (if possible, despite discomfort);
3. Continue taking pills daily, one each day, at the same time each day;
4. Use back-up contraception (e.g. condoms) or avoid sexual intercourse until 2 days after vomiting or diarrhea has resolved; and
5. Emergency contraception should be considered (with the exception of Ella®) if the client has had unprotected sexual intercourse.

**STOPPING THE PROGESTIN ONLY PILL:**

1. POPs can be stopped at any time.
2. Fertility will return quickly.
3. If client does not want to be pregnant, advise the client to begin a new contraceptive method immediately.
4. If client desires pregnancy:
5. Provide 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:**

1. Advise the client of the importance of taking POPs at the same time each day.
2. Advise the client POPs may cause bleeding changes in many or most users. The abnormal menstrual patterns are unpredictable and may include:
3. Short cycles;
4. Irregular periods;
5. Intermenstrual bleeding and spotting; or
6. Less common: prolonged bleeding or amenorrhea.
7. Advise client to call the clinic if they have any questions or concerns regarding the contraceptive method.
8. Clients shall be informed 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.

**REFERENCES:**

Centers for Disease Control and Prevention. 2016. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. Retrieved from <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf>

Centers for Disease Control and Prevention. 2016. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. Retrieved from <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6504.pdf>

Hatcher, R., Trussell, J., Nelson, A., Cates, W., Kowal, D., Policar, M. 2011. Progestin-Only Pills. In Deborah Kowal (Ed) *Contraceptive Technology*, (20th Ed) Pg 237-245. Ardent Media: Atlanta, GA