Injectable Contraceptives: Tools for Providers

INFO REPORTS

JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

INFO Project
Center for Communication Programs

More than twice as many women are using injectable contraceptives today as a decade ago, and the numbers keep growing. Women choose injectables because they are highly effective, long-acting, reversible, and private. At the same time many women do not choose injectables or stop using them because of side effects—particularly irregular bleeding, no monthly bleeding, and weight gain—or because they have trouble returning for injections (13, 70, *135*, 168). Family planning programs are meeting increasing demand while helping providers to maintain good quality of care. Attention to quality, and to counseling especially, can be the difference between successful and unsuccessful efforts to expand access to injectables (77, 78). Using the tools in this *INFO Reports*, providers can inform women about injectables and help them be satisfied users.

Coming Soon: "Injectables Toolkit" Web site. Go to www.injectablestoolkit.org for job aids and information about injectable contraceptives

From INFO's Toolbox

Table 1. Formulations and Injection Schedules of Injectable Contraceptives

Common Trade Names	Formulation	Injection Type and Schedule
Progestin-Only Injectables		
Depo-Provera®, Megestron®, Contracep®, Depo-Prodasone®	Depot medroxyprogesterone acetate (DMPA) 150 mg	One intramuscular (IM) injection every 3 months
depo-subQ provera 104® (DMPA-SC)	DMPA 104 mg	One subcutaneous injection every 3 months
Noristerat®, Norigest®, Doryxas®	Norethisterone enanthate (NET-EN) 200 mg	One IM injection every 2 months
Combined Injectables (progestin + estrogen)[1]		
Cyclofem®, Ciclofeminina®, Lunelle®[2]	Medroxyprogesterone acetate 25 mg + Estradiol cypionate 5 mg (MPA/E_2C)	One IM injection every month
Mesigyna®, Norigynon®	NET-EN 50 mg + Estradiol valerate 5 mg ($NET\text{-}EN/E_2V$)	One IM injection every month
Deladroxate®, Perlutal®, Topasel®, Patectro®, Deproxone®, Nomagest®	Dihydroxyprogesterone (algestone) acetophenide 150 mg + Estradiol enanthate 10 mg	One IM injection every month
Anafertin®, Yectames®	Dihydroxyprogesterone (algestone) acetophenide 75 mg + Estradiol enanthate 5 mg	One IM injection every month
Chinese Injectable No. 1®	17α-hydroxyprogesterone caproate 250 mg + Estradiol valerate 5 mg	One IM injection every month, except 2 injections in first month

Sources: International Planned Parenthood Federation 2005 *(83)*, Lande 1995 *(99)*, Liggeri 2006 (103), WHO 1990 (204), WHO 1993 (205)
[1]Also called monthly injectables.
[2]The U.S. Food and Drug Administration approved *Lunelle*, but it is currently not available in the United States.

From INFO's Toolbox

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See companion *Population Reports*, "Expanding Services for Injectables"

Checklist for Giving Intramuscular Contraceptive Injections

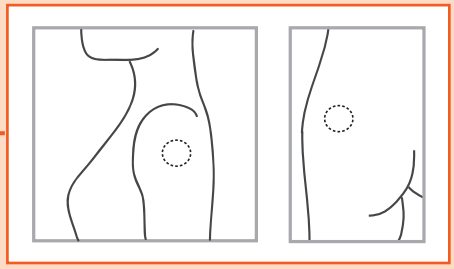
From INFO's Toolbox

Family planning providers can use this checklist to help ensure that injections are safe.

Prepare equipment and supplies

- ❑ In advance, assemble the supplies and materials needed
  - *Single-dose vial*
  - *Sterile needle and syringe* (If auto-disable (AD) or conventional disposable syringes and needles are not available, use sterile equipment designed for steam sterilization. Do not reuse disposable equipment.)
  - *Cotton wool*
- ❑ Wash hands with soap and water before giving the injection, if possible. Gloves are not needed unless there is a chance of direct contact with blood or other body fluids.
- ❑ Inspect the vial and check expiry date. Discard any with visible cracks or leaks.
- ❑ With injectables containing DMPA, roll the vial back and forth or gently shake to mix contents. If the vial of NET-EN is cold, warm to skin temperature before giving the injection.

Intramuscular injections can be given in the deltoid muscle of either arm or the left or right buttock (gluteal muscle, upper outer portion), whichever the woman prefers.[1] To minimize the risk of injury, providers should take care to deliver the injection in the proper site.



Give the injection safely

- ❑ Explain the injection procedure to the client and point out that the syringe and needle are sterile.
- ❑ Ask the client her preferred site for injection: upper arm (deltoid muscle) or buttocks (gluteal muscle). To decrease discomfort, position her so that her muscles are relaxed.
- ❑ Wash the injection site with soap and water if it is visibly dirty. Swabbing clean skin or wiping the skin with antiseptic before giving an injection is not necessary.
- ❑ Pierce the top of the vial with the sterile needle and fill syringe with the proper dose.
- ❑ With a smooth, steady motion, insert the needle deep into the muscle at a right angle (90°) and inject the contents of the syringe.
- ❑ After the injection ask the client to hold cotton wool on the injection site. Instruct the client not to massage the injection site.
- ❑ Wash hands with soap and water after giving the injection, if possible.

Dispose of waste appropriately

- ❑ Do not recap, bend, cut, or break needles after use. Discard the used disposable needle and syringe immediately in an enclosed sharps container.
- ❑ If reusable syringes and needles are used, they must be sterilized again after each use.
- ❑ Seal and dispose of sharps containers when they are three-fourths full. Follow program or clinic guidelines for proper waste management.

Adapted from: Hutin 2003 (*80*)

[1]Intramuscular injection of the combined injectable *Cyclofem* can also be given in the thigh (lateral muscle of the quadriceps).

How to Use This Report

Family planning providers can use the checklists and tables in this report to:

- Counsel about injectables or answer clients' questions (see Table 2, pp. 3–4),
- Identify women who may not be able to use DMPA or NET-EN for medical reasons (see Checklist, pp. 5–6),
- Be reasonably sure that a woman is not pregnant before giving the first injection (see Checklist, p. 6, questions 8–13),
- Review the steps required to give an injection safely (see Checklist, this page), and
- Help women be informed and satisfied continuing users of injectables (see Table 3, p. 7).

This report accompanies *Population Reports*, "Expanding Services for Injectables". See also *Population Reports*, "When Contraceptives Change Monthly Bleeding," Series J, No. 54, August 2006.

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Table 2. Helping Clients Make a Well-Informed Choice of Injectable Contraceptives

Effectiveness, side effects, and safety are the factors that women consider most important when they choose a contraceptive method (27, 55, 227). When they seek family planning services, most women already have a method in mind that interests them *(198)*. Increasingly, that method is an injectable contraceptive. Good-quality programs ensure that a woman interested in an injectable understands its effectiveness and side effects, is assured of its safety, and knows how it is used. Counseling also helps a woman decide if the method suits her needs, preferences, and current situation. This table offers information to help women with their decision-making.

	Progestin-Only Injectables[1]	Combined Injectables
KEY POINTS: Give women this information		
Women need this information to make an informed choice about injectables	• One of the most effective contraceptive methods. • Women have an injection every 3 months for DMPA or every 2 months for NET-EN. Important to try to be on time for the next injection. • Most women have frequent or irregular bleeding at first and then little or no monthly bleeding. This is not harmful. Gradual weight gain is common and not harmful. • Women take 4 months longer on average to become pregnant after stopping DMPA than after stopping methods other than injectables.[2]	• One of the most effective contraceptive methods. • Women have an injection once a month. Important to try to be on time for the next injection. • Likely to change bleeding patterns unpredictably during the first 3 months of use. This is not harmful. After 3 months most women have regular patterns (around 28 days from start of a monthly bleeding to the next).
Effectiveness: Depends on having injections on time		
Effectiveness	• Typically, about 3 pregnancies per 100 women in the first year of use if users do not return on time. • Less than 1 pregnancy per 100 women in the first year of use (3 per 1,000 women) if users return on time *(190)*.	
How often to return for injections	• DMPA: Every 3 months (4 times a year). NET-EN: Every 2 months (6 times a year). • Can come up to 2 weeks early or 2 weeks late and still have injection.	• Every month (12 times a year). Can come up to 7 days early or 7 days late and still have injection.
Counseling guidance	• Discuss whether returning to the clinic for injections will be convenient and easy to remember. • If the client may return late, discuss using a backup method[3] or oral contraceptives or emergency contraceptive pills.	
Many women can have first injection immediately	No need to ask the woman to return during her next monthly bleeding if provider can be reasonably sure she is not pregnant (see the *Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)*, pp. 5–6, questions 8–13. These questions also apply to combined injectables). If starting after day 7 of her monthly bleeding, she will need a backup method[3] for the first 7 days after the injection.	
Side Effects: Changes in monthly bleeding and weight gain are common		
Clear and honest information on side effects, especially changes in monthly bleeding, helps clients avoid surprise and concern if side effects occur. Women who are well-informed when they start injectables are more likely to continue using them than women who are not well-informed (*30*, *75*, *100*).		
Bleeding changes	• DMPA: At first, irregular bleeding and prolonged bleeding, then no bleeding or infrequent bleeding.[4] After 1 year 40%–60% of users have no monthly bleeding (*7,* 205). No monthly bleeding is more likely with DMPA than with NET-EN (*48*). • NET-EN: Irregular and prolonged bleeding in the first 6 months, but bleeding episodes are shorter than for DMPA users. After 1 year about 30% of users have no monthly bleeding (*202*).	• Irregular, frequent, or prolonged bleeding in first 3 months.[4] Mostly regular bleeding patterns (around 28-day intervals) by 1 year. After 1 year about 2% of users have no monthly bleeding (205).
Counseling guidance	Discuss with each client how important regular monthly bleeding is to her and how changes due to an injectable would affect her daily life. Some women consider regular monthly bleeding very important. Others like having no monthly bleeding (*62*). Point out that: • Bleeding changes due to an injectable are not harmful and not a sign of illness. • Having no monthly bleeding does not mean that a woman is infertile or that she is pregnant. • Monthly bleeding eventually returns after injections stop. • After an injection, bleeding changes cannot be stopped and may continue until the injection wears off—at least 3 months for DMPA, 2 months for NET-EN, and 1 month for combined injectables. • Heavy bleeding[4] is not common but, if it happens, short-term treatment is available.	
Weight change	• Average gain of 1 to 2 kilograms (2 to 4 pounds) per year (*87*,*220*). Some women, particularly overweight adolescents, have gained much more (22, *23*). Some users lose weight or have no significant change in weight (40, 120, 188).	• Average gain of 1 kilogram (2 pounds) per year (68). Some users lose weight or have no significant change in weight (67).
Counseling guidance	• Some of the weight gain may be the usual increase as people age (179). Ask if moderate weight gain would bother the client or her partner. Appropriate dieting and exercise sometimes can control weight gain.	

(continued on p. 4)

Table 2 (continued)

	Progestin-Only Injectables[1]	Combined Injectables
Return to fertility (among women who stop injections to become pregnant)	• DMPA: On average 4 months longer than for women who used methods other than injectables—10 months from the last injection, or 7 months from when the next injection would have been given (*130*, 171, *212*). These are averages so a woman should not be worried if she has not become pregnant after 12 months. • NET-EN: On average 1 month longer than for women using methods other than injectables (*212*).	• On average 1 month longer than for women who used methods other than injectables (153).
Counseling guidance	• It may take a few months after a woman stops using DMPA, but monthly bleeding eventually returns, and she will be able to get pregnant as before. • The length of the delay in becoming pregnant is the same for short-term and long-term users (57, *130*). • Injectables do not cause permanent infertility or spontaneous abortions.	
Other side effects[5]	• Headache, dizziness, abdominal discomfort, mood changes, less sex drive (174, *202*).	• Headache, dizziness, breast tenderness (153, 167, 221).
Counseling guidance	• Tell women that these may occur but are not common.	
Other possible physical change: Bone density	• DMPA: Small loss of bone density during use. Usually regained after use stops (*216*). • NET-EN: May have no effect on women age 40–49 (*15*). Little evidence available.	• Little evidence available but not a concern with combined methods (12, *216*).
Counseling guidance	• Programs need to decide if providers should mention loss of bone density with DMPA.[6]	
Safety: Injectables are safe for most women		
Programs should try to give each client the family planning method she wants and to avoid denying women their choice of a method arbitrarily or for reasons that lack a basis in evidence. For example, women can safely use injectables even if they have not had children, are not married, are adolescents, are over 40 years old, or have HIV/AIDS (*212*).[7]		
Medical eligibility criteria: Consult a handbook for guidance on screening women for conditions that may make use of injectables less safe[8]	Women usually should not start using a progestin-only injectable if they have very high blood pressure (systolic ≥160 mm Hg or diastolic ≥100), history of breast cancer, unexplained vaginal bleeding that suggests an underlying medical condition (until diagnosed), and certain conditions of the heart, blood vessels, or liver including history of stroke or heart attack and current deep vein thrombosis. Also, a woman breastfeeding a baby less than 6 weeks old should not use progestin-only injectables (see Checklist, pp. 5–6).	Women usually should not start using a combined injectable if they have high blood pressure (systolic ≥140 mm Hg or diastolic ≥90), migraine headache with aura,[9] migraine headache without aura and age 35 or older, history of breast cancer, heavy smoking and age 35 or older, and certain conditions of the heart, blood vessels, or liver including history of stroke or heart attack and current deep vein thrombosis. A woman breastfeeding a baby less than 6 months old should not use combined injectables. Women not breastfeeding should not use combined injectables less than 3 weeks after giving birth.
Tests	• None necessary (*215*). Providers can use a checklist to be reasonably sure that a woman is not pregnant (see Checklist, p. 6, questions 8–13).	
Sexually transmitted infections (STIs)	• Do not prevent transmission of STIs, including HIV. Women at risk for STIs should also use condoms to prevent STI transmission.	
Counseling guidance	• Help the woman decide if she might be at risk of STIs. If she might be at risk, help her decide how she will protect herself and others.	
Health Benefits: Injectables help protect against some health conditions		
	• DMPA helps protect against cancer of the lining of the uterus (endometrial cancer) (*25*). • DMPA helps protect against uterine fibroids (106). • DMPA may help protect against symptomatic pelvic inflammatory disease (*10*, 64). • For women with sickle cell disease, DMPA reduces the frequency and pain of sickle cell crises (43). • For women with endometriosis, DMPA reduces pain during menstrual periods, pain during intercourse, and pelvic pain and tenderness (37, 170, 199). • Both DMPA and NET-EN may help protect against iron-deficiency anemia (73, 222).	Long-term studies of combined injectables are limited, but most researchers expect that health benefits and risks are similar to those of combined oral contraceptives. For more information, consult a handbook of family planning.[8]

[1]Includes intramuscular and subcutaneous injection of DMPA. Among health benefits, only reduced symptoms of endometriosis are reported for subcutaneous DMPA (37,170).
[2]Programs can decide whether women need to know about the one-month delay to become pregnant after stopping NET-EN and combined injectables.
[3]Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptives. If possible, give her condoms.
[4]Irregular bleeding is at unexpected times; prolonged bleeding is longer than 8 days; frequent bleeding is more than 4 bleeding or spotting episodes in 3 months; infrequent bleeding is fewer than 2 bleeding episodes in 3 months; heavy bleeding is twice the usual amount (*16, 17, 219*).
[5]Reported by at least 5% of users.
[6]For more information about bone loss, see Questions and Answers About Injectables, p. 21 in the companion issue of *Population Reports*, "Expanding Services for Injectables."
[7]See box, Women With HIV/AIDS Can Use Injectables, p. 21 in the companion issue of *Population Reports*.
[8]See Table 3, Key Resources for Program Managers and Providers, p. 22 in the companion issue of *Population Reports*.
[9]An aura is usually a bright area of lost vision in the eye, often before a migraine headache begins.

Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)

Research findings have established that depot medroxyprogesterone acetate (DMPA) and norethisterone enantate (NET-EN) are safe and effective for use by most women, including those who are at risk of sexually transmitted infections (STIs) and those living with or at risk of HIV infection. For some women, DMPA and NET-EN are usually not recommended or are contraindicated because of the presence of certain medical conditions such as liver tumors and breast cancer.

This checklist (see next page) is designed for use by both clinical and nonclinical health care providers, including community health workers, to help screen clients who were counseled about contraceptive options and made an informed decision to use DMPA. It consists of 13 questions designed to identify medical conditions that would prevent safe DMPA use or require further screening, as well as to provide further guidance and directions based on clients' responses. Clients who are ruled out because of their response to some of the medical eligibility or pregnancy questions may still be good candidates for DMPA after the suspected condition is excluded through appropriate evaluation. The checklist is based on recommendations by the World Health Organization in the *Medical Eligibility Criteria for Contraceptive Use (212)*.

This checklist is part of a series of provider checklists developed by Family Health International (FHI), with support from the U.S. Agency for International Development (USAID). The checklist is included in this issue of *INFO Reports* as a collaborative distribution service of the INFO Project. For more information, please visit www.fhi.org.

Assessing Medical Eligibility for DMPA

1. Have you ever had a stroke, blood clot in your legs or lungs, or heart attack?

This question is intended to identify women with already known serious vascular disease, not to determine whether women might have an undiagnosed condition. Women with these conditions may be at somewhat increased risk of blood clots if they use DMPA. Women who have had any of these conditions will commonly have been told that they have had this condition and will answer "yes," if appropriate.

2. Have you ever been told you have breast cancer?

This question is intended to identify women who know they have had or currently have breast cancer. These women are not good candidates for DMPA because breast cancer is a hormone-sensitive tumor, and DMPA use may adversely affect the course of the disease.

3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?

This question is intended to identify women who know that they currently have a serious liver disease and to distinguish between current severe liver disease (such as severe cirrhosis or liver tumors) and past liver problems (such as treated hepatitis). Women with serious liver disease should not generally use DMPA because it is processed by the liver and hence its use may adversely affect women whose liver function is already weakened by the disease.

4. Have you ever been told you have diabetes (high sugar in your blood)?

This question is intended to identify women who know that they have diabetes, not to assess whether they may have an undiagnosed condition. Women who have had diabetes for 20 years or longer or those with vascular complications should generally not use DMPA because of the increased risk of blood clots. Evaluate or refer for evaluation as appropriate and, if these complications are absent, the woman may still be a good candidate for DMPA.

5. Have you ever been told you have high blood pressure?

This question is intended to identify women who may have high blood pressure. These women should be evaluated or referred for evaluation as appropriate. Based on evaluation, women with blood pressure levels of 160/100 mm Hg or more should not initiate DMPA.

6. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?

This question is intended to identify women who may have an underlying pathological condition. While DMPA use does not make these conditions worse, it may change the bleeding pattern and mask a serious underlying condition. Unusual bleeding changes may indicate pregnancy or tumor that should be evaluated soon or treated by a higher-level health care provider. DMPA use should be delayed until the condition can be evaluated. In contrast, women for whom it is not unusual to have heavy or prolonged bleeding, or irregular bleeding patterns, may safely initiate DMPA use.

7. Are you currently breastfeeding a baby less than six weeks old?

This question is included because of the theoretical concern that hormones in breastmilk can have an adverse effect on a newborn during the first six weeks after birth. A breastfeeding woman can initiate DMPA six weeks after her baby is born.

Note: Clients with multiple risk factors for cardiovascular disease (e.g., a combination of older age, smoking, and diabetes even without complications) generally are not good candidates for DMPA.

Determining Current Pregnancy

Questions 8–13 of the checklist are intended to help a provider determine, with reasonable certainty, whether a client is not pregnant. If a client answers "yes" to any of these questions and there are no signs or symptoms of pregnancy, it is highly likely that she is not pregnant. The client can start DMPA now.

If the client is within 7 days of the start of her menstrual bleeding, she can start the method immediately. No back-up method is needed.

If it has been more than 7 days since her first day of bleeding, she can start DMPA immediately but must use a back-up method (i.e., using a condom or abstaining from sex) for 7 days to ensure adequate time for the DMPA to become effective.

If you cannot determine with reasonable certainty that your client is not pregnant (using the checklist) and if you do not have access to a pregnancy test, then she needs to wait until her next menstrual period begins before starting DMPA. She should be given condoms to use in the meantime.

Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)

To determine if the client is medically eligible to use DMPA, ask questions 1–7. As soon as the client answers **YES** to any question, stop, and follow the instructions below.

NO	1. Have you ever had a stroke, blood clot in your legs or lungs, or heart attack?	YES
NO	2. Have you ever been told you have breast cancer?	YES
NO	3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?	YES
NO	4. Have you ever been told you have diabetes (high sugar in your blood)?	YES
NO	5. Have you ever been told you have high blood pressure?	YES
NO	6. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?	YES
NO	7. Are you currently breastfeeding a baby less than 6 weeks old?	YES

If the client answered **NO** to all of questions 1–7, the client can use DMPA. Proceed to questions 8–13.

If the client answered **YES** to any of questions 1–3, she is not a good candidate for DMPA. Counsel about other available methods or refer.

If the client answered **YES** to any of questions 4–6, DMPA cannot be initiated without further evaluation. Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations on p. 5 for more instructions.

If the client answered **YES** to question 7, instruct her to return for DMPA as soon as possible after the baby is six weeks old.

Ask questions 8–13 to be reasonably sure that the client is not pregnant. As soon as the client answers **YES** to any question, stop, and follow the instructions below.

YES	8. Did your last menstrual period start within the past 7 days?	NO
YES	9. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	NO
YES	10. Have you abstained from sexual intercourse since your last menstrual period or delivery?	NO
YES	11. Have you had a baby in the last 4 weeks?	NO
YES	12. Have you had a miscarriage or abortion in the last 7 days?	NO
YES	13. Have you been using a reliable contraceptive method consistently and correctly?	NO

If the client answered **YES** to at least one of questions 8–13 and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. The client can start DMPA now.

If the client began her last menstrual period within the past 7 days, she can start DMPA immediately. No additional contraceptive protection is needed.

If the client began her last menstrual period more than 7 days ago, she can be given DMPA now, but instruct her that she must use condoms or abstain from sex for the next 7 days. Give her condoms to use for the next 7 days.

If the client answered **NO** to all of questions 8–13, pregnancy cannot be ruled out.

She must use a pregnancy test or wait until her next menstrual period to be given DMPA.

Give her condoms to use in the meantime.

Table 3. Helping Clients Be Informed Users of Injectable Contraceptives

Women who make an informed choice of injectables need to be informed users as well. In particular, they need to know when to return for their next injection, what to do if they are late, and that side effects are usually not harmful. Providers can help women manage some bothersome side effects.

	Progestin-Only Injectables[1]	Combined Injectables
Key Points		
Support clients using injectables	• Give the injection safely and safely dispose of used equipment (see Checklist, p. 2). • Tell the client the name of the injection and when she needs to have her next injection. Give her an appointment card or reminder card, if possible. • Help her manage any side effects and continue with the injectable if she wishes, or, if she is not satisfied, help her choose a different method.[2]	
"Come on time for the next injection"		
Help the client choose a date for the next injection	• In 3 months for DMPA or in 2 months for NET-EN. • Discuss how to remember the date, perhaps tying it to a holiday or other event. Suggest that her partner help her remember the date. • Remind the client that she can come up to 2 weeks early or 2 weeks late. She should return even if she is more than 2 weeks late. She still may be able to have her injection. • Discuss using a backup method[3] or oral contraceptives (OCs) or emergency contraceptive pills when more than 2 weeks late. • Invite her to come back any time she has problems or questions.	• In 4 weeks for combined injectables. • Discuss how to remember the date, perhaps tying it to a holiday or other event. Suggest that her partner help her remember the date. • Remind the client that she can come up to 7 days early or 7 days late. She should come back even if she is more than 7 days late. She still may be able to have her injection. • Discuss using a backup method[3] or oral contraceptives (OCs) or emergency contraceptive pills when more than 7 days late. • Invite her to come back any time she has problems or questions.
Counsel the client when she returns for injections		
"How are you doing?"	• Ask if she has any questions or anything to discuss. Ask especially about bleeding changes. Give her any information, help, or reassurance she needs. • If she is having problems, let her know that you may be able to help. If she does not want to continue injectables, help her choose another method.	
"Any trouble returning on time?"	• If she has trouble returning on time, discuss reasons and solutions and discuss using a backup method[3] or OCs or emergency contraceptive pills when late. • If she often returns later than the grace period permits (2 weeks for progestin-only injectables and 7 days for combined injectables), help her consider whether another method would better suit her—perhaps implants or an IUD or, if she does not want more children, female sterilization (or vasectomy for her partner).	
If the client is early or late for the injection	• If she is 2 weeks early or less, she can receive her injection. • If she is 2 weeks late or less, she can receive her injection. No need for tests, evaluation, or a backup method. • If she is more than 2 weeks late, she can receive her injection if (1) she has not had sex since the day she would have been two weeks late, (2) she has used a backup method during this period, or she has taken emergency contraceptive pills within 5 days after any unprotected sex, or (3) she is fully or nearly fully breastfeeding and she gave birth less than 6 months ago. She will need a backup method[3] for the first 7 days after the injection. • If the client is more than 2 weeks late and does not meet these criteria, consult a family planning handbook for ways to be reasonably sure she is not pregnant.[2]	• If she is 7 days early or less, she can receive her injection. • If she is 7 days late or less, she can receive her injection. No need for tests, evaluation, or a backup method. • If she is more than 7 days late, she can receive her injection if (1) she has not had sex since the day she would have been 7 days late, or (2) she has used a backup method during this period, or she has taken emergency contraceptive pills within 5 days after any unprotected sex. She will need a backup method[3] for the first 7 days after the injection. • If the client is more than 7 days late and she does not meet these criteria, she can receive her next injection anytime it is reasonably certain she is not pregnant (see Checklist, p. 6, questions 8–13).
Plan the next injection	• Agree on a date for her next injection. Remind her that she should try to come on time, but she should come back no matter how late she is. • Give her condoms or emergency contraceptive pills if needed.	
Check for major life changes once a year		
Every year, at a routine re-injection visit, ask about changes that could affect her use of contraception	• Ask if she has had any new health conditions. Check whether any of these conditions would make use of injectables less safe (see Checklist, pp. 5–6). • Ask about major life changes that may affect her needs—particularly plans for having children and her STI/HIV risk. If a DMPA user plans to have a baby, remind her that she may need a few more months to become pregnant than women who have stopped other contraceptives. • Check blood pressure, if possible. She may need to choose another method: - If she is using a progestin-only injectable and systolic blood pressure is 160 mm Hg or more, or diastolic blood pressure is 100 or more. - If she is using a combined injectable and systolic blood pressure is 140 mm Hg or more, or diastolic blood pressure is 90 or more (*212*).	

[1]Guidance is for both intramuscular and subcutaneous injection of DMPA.
[2]For help, see Table 3, Key Resources for Program Managers and Providers, p. 22 in the companion issue of *Population Reports.*
[3]Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.

Sources

This bibliography includes citations to the materials most helpful in the preparation of this report. In the text, reference numbers for these citations appear in italics. The complete bibliography for this report and the companion *Population Reports* issue can be found at: http://www.populationreports.org/k6/. The links included in this report were up-to-date at the time of publication.

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