

Progesterin-Only Injectables

Key Points for Providers and Clients

- **Bleeding changes are common but not harmful.** Typically, irregular bleeding for the first several months and then no monthly bleeding.
- **Return for injections regularly.** Coming back every 3 months (13 weeks) for DMPA or every 2 months for NET-EN is important for greatest effectiveness.
- **Injection can be as much as 4 weeks late for DMPA or 2 weeks late for NET-EN.** Even if later, she may still be able to have the injection.
- **Gradual weight gain is common,** averaging 1–2 kg per year.
- **Return of fertility is often delayed.** It takes several months longer on average to become pregnant after stopping progestin-only injectables than after stopping other methods.

What Are Progesterin-Only Injectables?

- The injectable contraceptives depot medroxyprogesterone acetate (DMPA) and norethisterone enanthate (NET-EN) each contain a progestin like the natural hormone progesterone in a woman's body. (In contrast, monthly injectables contain both estrogen and progestin. See Monthly Injectables, p. 97.)
- Do not contain estrogen, and so can be used throughout breastfeeding, starting 6 weeks after giving birth, and by women who cannot use methods with estrogen.
- Given by injection into the muscle (intramuscular injection) or, with a new formulation of DMPA, just under the skin (subcutaneous injection). The hormone is then released slowly into the bloodstream. (See DMPA for Subcutaneous Injection, p. 68.)



- DMPA, the most widely used progestin-only injectable, is also known in its intramuscular form as “the shot,” “the jab,” the injection, Depo, Depo-Provera, and Petogen. The subcutaneous version in the Uniject injection system is currently marketed under the name Sayana Press and in prefilled single-dose disposable hypodermic syringes as depo-subQ provera 104.
- NET-EN is also known as norethindrone enanthate, Noristerat, Norigest, and Syngestal. (See Comparing Injectables, p. 427, for differences between DMPA and NET-EN.)
- Work primarily by preventing the release of eggs from the ovaries (ovulation).

How Effective?

Effectiveness depends on getting injections regularly: Risk of pregnancy is greatest when a woman misses an injection.

- As commonly used, about 4 pregnancies per 100 women using progestin-only injectables over the first year. This means that 96 of every 100 women using injectables will not become pregnant.
- When women have injections on time, less than 1 pregnancy per 100 women using progestin-only injectables over the first year (2 per 1,000 women).

Return of fertility after injections are stopped: An average of about 4 months longer for DMPA and 1 month longer for NET-EN than with most other methods (see Question 8, p. 94).

Protection against sexually transmitted infections (STIs): None



Side Effects, Health Benefits, and Health Risks

Side Effects (see also Managing Any Problems, p. 89)

Most users report some changes in monthly bleeding.[†]

- Typically, these include, with DMPA:

First 3 months:

- Irregular bleeding
- Prolonged bleeding

At one year:

- No monthly bleeding
- Infrequent bleeding
- Irregular bleeding

- NET-EN affects bleeding patterns less than DMPA. NET-EN users have fewer days of bleeding in the first 6 months and are less likely than DMPA users to have no monthly bleeding after one year.

Some users report the following:

- Weight gain (see Question 5, p. 93)
- Headaches
- Dizziness
- Abdominal bloating and discomfort
- Mood changes
- Less sex drive

Other possible physical changes:

- Loss of bone density (see Question 11, p. 95)

Bleeding changes are normal and not harmful. If a woman finds them bothersome, counseling and support can help.



Why Some Women Say They Like Progesterin-Only Injectables

- Requires action only every 2 or 3 months. No daily pill-taking.
- Do not interfere with sex
- Are private: No one else can tell that a woman is using contraception
- Stop monthly bleeding (for many women)
- May help women to gain weight

[†] For definitions of bleeding patterns, see “vaginal bleeding,” p. 407.

Known Health Benefits	Known Health Risks
DMPA	
Helps protect against:	None
<ul style="list-style-type: none"> • Risks of pregnancy • Cancer of the lining of the uterus (endometrial cancer) • Uterine fibroids 	
May help protect against:	
<ul style="list-style-type: none"> • Symptomatic pelvic inflammatory disease • Iron-deficiency anemia 	
Reduces:	
<ul style="list-style-type: none"> • Sickle cell crises among women with sickle cell anemia • Symptoms of endometriosis (pelvic pain, irregular bleeding) 	
NET-EN	
Helps protect against:	None
<ul style="list-style-type: none"> • Risks of pregnancy • Iron-deficiency anemia 	

NET-EN may offer many of the same health benefits as DMPA, but this list of benefits includes only those for which there is available research evidence.

DMPA for Subcutaneous Injection

DMPA is now available in a special formulation, called DMPA-SC, that is meant only for subcutaneous injection (just under the skin) and not for injection into muscle. Subcutaneous injection is easier to learn than intramuscular injection.

DMPA-SC is available in two injection systems—in the Uniject device and in prefilled, single-dose, conventional syringes. Both have short needles meant for injection just below the skin.

With the Uniject system, the user squeezes a flexible reservoir that pushes the fluid through the needle. DMPA-SC in the Uniject system is marketed under the brand name Sayana Press. This product may be particularly useful for community-based programs (see box, next page). Also, women can easily learn to give themselves subcutaneous injections with this system (see instructions on p. 84–85).

Correcting Misunderstandings (see also Questions and Answers, p. 92)

Progesterin-only injectables:

- Can stop monthly bleeding, but this is not harmful and could help prevent anemia. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman. Effectiveness is high regardless of the bleeding pattern.
- Do not disrupt an existing pregnancy.
- Do not make women infertile.

Delivering Injectable Contraception in the Community

Injectable contraceptives are popular with many women. This method can be more widely available when it is offered in the community as well as in clinics.

In 2012 WHO noted that using lay health workers to give injectable contraceptives may increase access to injectables and does not appear to raise safety concerns. WHO suggested that provision of injectables could be added to well-functioning programs that employ lay health workers.

These recommendations are part of a global movement known as task-sharing—empowering more types of health care workers to provide various health services. The goal of task-sharing is to serve more people, especially where there are few highly trained health care providers (see Who Provides Family Planning?, p. 372).

Lay health workers, auxiliary nurses, and other community-based providers of injectables should be trained and able to give injections safely. Also, they should be able to screen clients for pregnancy and for medical eligibility. They can inform women about delayed return of fertility and common side effects, including irregular bleeding, no monthly bleeding, and weight gain, and explain the importance of dual protection if a woman is at risk for sexually transmitted infections, including HIV. They also can inform women about the range of methods available, including methods available at the clinic. All providers of injectables need specific competency-based training and supportive supervision to carry out these tasks. WHO recommends specific monitoring and evaluation of the provision of injectables by lay health workers.

(Continued on next page)

Prefilled syringes aid community-based programs

Prefilled single-dose, single-use injection devices make community and home delivery easier because providers do not have to draw a measured dose into the syringe from a vial. Also, these devices cannot be reused. DMPA is available in a number of prefilled single-dose injection systems: The older formulation for intramuscular injection (DMPA-IM) is available in auto-disable syringes. The newer subcutaneous formulation (DMPA-SC), which is suitable only for injection just under the skin, comes in the Uniject injection system under the brand name Sayana Press and in single-use conventional syringes (see DMPA for Subcutaneous Injection, p. 68).

The new subcutaneous formulation, particularly in the Uniject system, is likely to make delivery of DMPA injections in the community and the home easier. In fact, women can learn to inject themselves with this formulation (see p. 83).

Working together, in communities and clinics

For success, clinic-based providers and community-based providers need to work together closely. Programs vary, but these are some ways that clinic-based providers can support community-based providers:

- Managing side effects (see pp. 89–90)
- Using clinical judgment concerning medical eligibility in special cases (see p. 74)
- Ruling out pregnancy in women who are more than 4 weeks late for an injection of DMPA or 2 weeks late for NET-EN (see Managing Late Injections, p. 88)
- Responding to concerns of clients referred by the community-based providers

The clinic also can serve as “home” for the community-based providers, where they go for resupply, for supervision, training, and advice, and to turn in their records.



Who Can and Cannot Use Progestin-Only Injectables

Safe and Suitable for Nearly All Women

Nearly all women can use progestin-only injectables safely and effectively, including women who:

- Have or have not had children
- Are married or are not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion or miscarriage
- Smoke cigarettes, regardless of woman's age or number of cigarettes smoked
- Are breastfeeding, starting as soon as 6 weeks after childbirth
- Are living with HIV, whether or not on antiretroviral therapy (see Progestin-Only Injectables for Women With HIV, p. 74)

Avoid Unnecessary Procedures

(see Importance of Procedures, p. 368)

Women can begin using progestin-only injectables:

- Without a pelvic examination
- Without any blood tests or other routine laboratory tests
- Without cervical cancer screening
- Without a breast examination
- Without a pregnancy test. A woman can begin using a progestin-only injectable at any time, even when she is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant (see Pregnancy Checklist, inside back cover).

Blood pressure measurement is desirable before starting a hormonal method. However, where the risks of pregnancy are high and few methods are available, a woman should not be denied a hormonal method simply because her blood pressure cannot be measured. If possible, she can have her blood pressure measured later at a time and place convenient for her.

Medical Eligibility Criteria for Progestin-Only Injectables

Ask the client the questions below about known medical conditions. Examinations and tests are not necessary. If she answers “no” to all of the questions, then she can start progestin-only injectables if she wants. If she answers “yes” to a question, follow the instructions. In some cases she can still start progestin-only injectables.

1. Are you breastfeeding a baby less than 6 weeks old?

- NO YES She can start using progestin-only injectables as soon as 6 weeks after childbirth (see Fully or nearly fully breastfeeding or Partially breastfeeding, p. 76).

2. Do you have severe cirrhosis of the liver or severe liver tumor?

- NO YES If she reports severe cirrhosis or severe liver tumor, such as liver cancer, do not provide progestin-only injectables. Help her choose a method without hormones.

3. Do you have high blood pressure?

- NO YES

Check her blood pressure if possible:

- If she is currently being treated for high blood pressure and it is adequately controlled, or her blood pressure is below 160/100 mm Hg, provide progestin-only injectables.
- If systolic blood pressure is 160 mm Hg or higher or diastolic blood pressure is 100 or higher, do not provide progestin-only injectables. Help her choose another method, one without estrogen.
- If she reports having high blood pressure in the past, and you cannot check blood pressure, provide progestin-only injectables.

4. Have you had diabetes for more than 20 years or damage to your arteries, vision, kidneys, or nervous system caused by diabetes?

- NO YES Do not provide progestin-only injectables. Help her choose another method, one without estrogen.

5. Have you ever had a stroke, blood clot in your leg or lungs, heart attack, or other serious heart problems?

- NO YES If she reports heart attack, heart disease due to blocked or narrowed arteries, or stroke, do not provide progestin-only injectables. Help her choose another method, one without estrogen. If she reports a current blood clot in legs (affecting deep veins, not superficial veins) or in a lung and she is not on anticoagulant therapy, help her choose a method without hormones.

6. Are you having vaginal bleeding that is unusual for you?

- NO YES If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, progestin-only injectables could make diagnosis and monitoring of any treatment more difficult. Help her choose another method to use while being evaluated and treated (but not implants or a copper-bearing or hormonal IUD). After treatment, re-evaluate for use of progestin-only injectables.

7. Do you have or have you ever had breast cancer?

- NO YES Do not provide progestin-only injectables. Help her choose a method without hormones.

8. Do you have several conditions that could increase your chances of heart disease (coronary artery disease) or stroke, such as high blood pressure and diabetes?

- NO YES Do not provide progestin-only injectables. Help her choose another method, one without estrogen.

Also, women should not use progestin-only injectables if they report having lupus with positive (or unknown) antiphospholipid antibodies and not on immunosuppressive treatment, or severe thrombocytopenia. For complete classifications, see Medical Eligibility Criteria for Contraceptive Use, p. 388.

Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable, when relevant to the client.

Using Clinical Judgment in Special Cases

Usually, a woman with any of the conditions listed below should not use progestin-only injectables. In special circumstances, however, when other, more appropriate methods are not available or acceptable to her, a qualified provider who can carefully assess a specific woman's condition and situation may decide that she can use progestin-only injectables. The provider needs to consider the severity of her condition and, for most conditions, whether she will have access to follow-up.

- Breastfeeding and less than 6 weeks since giving birth (considering the risks of another pregnancy and that a woman may have limited further access to injectables)
- Severe high blood pressure (systolic 160 mm Hg or higher or diastolic 100 mm Hg or higher)
- Acute blood clot in deep veins of legs or lungs
- History of heart disease or current heart disease due to blocked or narrowed arteries (ischemic heart disease)
- History of stroke
- Multiple risk factors for arterial cardiovascular disease such as diabetes and high blood pressure
- Unexplained vaginal bleeding before evaluation for possible serious underlying condition
- Had breast cancer more than 5 years ago, and it has not returned
- Diabetes for more than 20 years or damage to arteries, vision, kidneys, or nervous system caused by diabetes
- Severe cirrhosis or liver tumor
- Systemic lupus erythematosus with positive (or unknown) antiphospholipid antibodies and not on immunosuppressive treatment, or severe thrombocytopenia.

Progestin-Only Injectables for Women With HIV

- Women who are living with HIV or are on antiretroviral (ARV) therapy can safely use progestin-only injectables.
- The time between injections does not need to be shortened for women taking ARVs.
- Urge these women to use condoms as well. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.

Counseling Women Who Want a Progestin-Only Injectable Where HIV Risk Is High

Some research has found that women who use a progestin-only injectable and are exposed to HIV are more likely than other women to get HIV infection (see Question 2, p. 92). It is not clear whether this is due to the progestin-only injectable or to the way that the research was conducted.

In countries and programs where many family planning clients are at high risk of HIV, providers should discuss this finding with women interested in a progestin-only injectable. For counseling tips see Considering Progestin-Only Injectables Where HIV Risk Is High, p. 438. Women who are at high risk for HIV can still choose a progestin-only injectable if they wish (MEC Category 2).

Providing Progestin-Only Injectables

When to Start

IMPORTANT: A woman can start injectables any time she wants if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist (see inside back cover).

Woman's situation	When to start
Having menstrual cycles or switching from a nonhormonal method	<p>Any time of the month</p> <ul style="list-style-type: none"> If she is starting within 7 days after the start of her monthly bleeding, no need for a backup method. If it is more than 7 days after the start of her monthly bleeding, she can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method* for the first 7 days after the injection. If she is switching from an IUD, she can start injectables immediately (see Copper-Bearing IUD, Switching From an IUD to Another Method, p. 172).

* 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.

Woman's situation	When to start
Switching from a hormonal method	<ul style="list-style-type: none"> Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. If she is switching from another injectable, she can have the new injectable when the repeat injection would have been given. No need for a backup method.
Fully or nearly fully breastfeeding	
Less than 6 months after giving birth	<ul style="list-style-type: none"> If she gave birth less than 6 weeks ago, delay her first injection until at least 6 weeks after giving birth. If her monthly bleeding has not returned, she can start injectables any time between 6 weeks and 6 months. No need for a backup method. If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles (see previous page).
More than 6 months after giving birth	<ul style="list-style-type: none"> If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection. If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles (see previous page).
Partially breastfeeding	
Less than 6 weeks after giving birth	<ul style="list-style-type: none"> Delay her first injection until at least 6 weeks after giving birth.

Woman's situation When to start

Partially breastfeeding (continued)

More than 6 weeks
after giving birth

- If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant.[†] She will need a backup method for the first 7 days after the injection.
- If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles (see p. 75).

Not breastfeeding

Less than 4 weeks
after giving birth

- She can start injectables at any time. No need for a backup method.

More than 4 weeks
after giving birth

- If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant.[†] She will need a backup method for the first 7 days after the injection.
- If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles (see p. 75).

No monthly bleeding (not related to childbirth or breastfeeding)

- She can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.

After miscarriage or abortion

- Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method.
- If it is more than 7 days after first- or second-trimester miscarriage or abortion, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.

[†] Where a visit 6 weeks after childbirth is routinely recommended and other opportunities to obtain contraception are limited, some providers and programs may give the first injection at the 6-week visit, without further evidence that the woman is not pregnant, if her monthly bleeding has not yet returned.

Woman's situation	When to start
After taking emergency contraceptive pills (ECPs)	<p>After taking progestin-only or combined ECPs:</p> <ul style="list-style-type: none"> She can start or restart injectables on the same day as taking the ECPs. <i>No need to wait for her next monthly bleeding to have the injection.</i> <ul style="list-style-type: none"> – She will need to use a backup method for the first 7 days after the injection. If she does not start immediately but returns for injectables, she can start at any time if it is reasonably certain she is not pregnant.
	<p>After taking ulipristal acetate (UPA) ECPs:</p> <ul style="list-style-type: none"> She can start or restart injectables on the 6th day after taking UPA-ECPs. <i>No need to wait for her next monthly bleeding to have the injection.</i> Injectables and UPA interact. If an injectable is started sooner, and thus both are present in the body, one or both may be less effective. Make an appointment for her to return for the injection on the 6th day after taking UPA-ECPs, or as soon as possible after that. She will need to use a backup method from the time she takes UPA-ECPs until 7 days after the injection. If she does not start on the 6th day but returns later for injectables, she may start at any time if it is reasonably certain she is not pregnant.

Giving Advice on Side Effects

IMPORTANT: Thorough counseling about bleeding changes and other side effects must come before giving the injection. Counseling about bleeding changes may be the most important help a woman needs to keep using the method without concern.

Describe the most common side effects

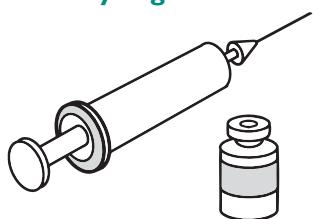
- For the first several months, irregular bleeding, prolonged bleeding, frequent bleeding. Later, no monthly bleeding.
- Weight gain (about 1–2 kg per year), headaches, dizziness, and possibly other side effects.

Explain about these side effects

- Side effects are not signs of illness.
- Common, but some women do not have them.
- The client can come back for help if side effects bother her.

Giving Intermuscular Injection with a Conventional Syringe

1. Obtain one dose of injectable, needle, and syringe



- DMPA: 150 mg for injections into the muscle (intramuscular injection). NET-EN: 200 mg for injections into the muscle.
- For each injection use a prefilled single-use syringe and needle from a new, sealed package (within expiration date and not damaged), if available.
- If a single-dose prefilled syringe is not available, use single-dose vials. Check expiration date. If using an open multidose vial, check that the vial is not leaking.
 - DMPA: A 2 ml syringe and a 21–23 gauge intramuscular needle.
 - NET-EN: A 2 or 5 ml syringe and a 19-gauge intramuscular needle. A narrower needle (21–23 gauge) also can be used.

2. Wash

- Wash hands with soap and water, if possible. Let your hands dry in the air.
- If injection site is dirty, wash it with soap and water.
- No need to wipe site with antiseptic.

If using a prefilled syringe, skip to step 5.

3. Prepare vial

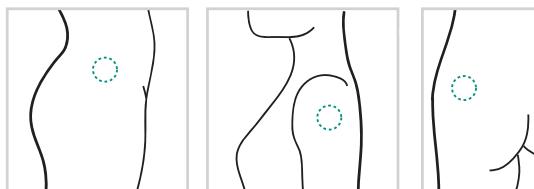
- DMPA: Gently shake the vial.
 - NET-EN: Shaking the vial is not necessary.
 - No need to wipe top of vial with antiseptic.
 - If vial is cold, warm to skin temperature before giving the injection.
-

4. Fill syringe

- Pierce top of vial with sterile needle and fill syringe with proper dose.
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5. Inject formula

- Insert sterile needle deep into the hip (ventrogluteal muscle), the upper arm (deltoid muscle), or the buttocks (gluteal muscle, upper outer portion), whichever the woman prefers. Inject the contents of the syringe.
- Do not massage injection site.



6. Dispose of disposable syringes and needles safely

- Do not recap, bend, or break needles before disposal.
- Place in a puncture-proof sharps container.
 - Do not reuse disposable syringes and needles. They are meant to be destroyed after a single use. Because of their shape, they are very difficult to disinfect. Therefore, reuse might transmit diseases such as HIV and hepatitis.
 - If reusable syringe and needle are used, they must be sterilized again after each use (see Infection Prevention in the Clinic, p. 376).



Giving the Injection with Subcutaneous DMPA in Unijet (Sayana Press)

1. Gather the supplies

Supplies include:

- Unijet prefilled injection device at room temperature that has not passed its expiration date
- Soap and clean water
- Cotton swabs or cotton balls, if available
- Safe puncture-proof container for sharps disposal

2. Wash

Wash hands with soap and water, if possible.

- Let your hands dry in the air.
- If injection site is dirty, wash it with soap and water.
- No need to wipe site with antiseptic.

3. Ask where the client wants the injection

You can give the injection just under the skin:

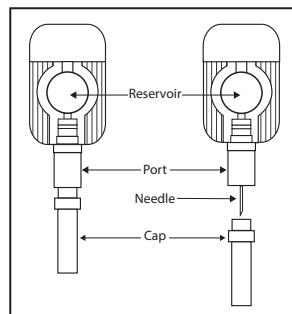
- in the back of the upper arm
- in the abdomen (but not at the navel)
- on the front of the thigh.

4. Open the pouch

- Open the foil pouch and remove the device.

5. Mix the solution

- Hold the device by the port (see picture I).
- Shake it hard for 30 seconds.
- Check that the solution is mixed (granules distributed throughout the solution) and there is no damage or leaking.

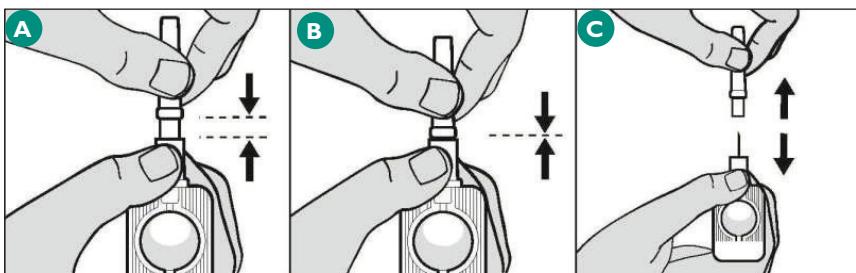


I. Parts of Unijet device

(Continued on next page)

6. Close the gap

- Hold the device by the port.
- Take care not to squeeze the reservoir during this step.
- Hold the device with the needle pointed upward to avoid spilling the drug.
- Push the cap into the port (see part A of picture 2, below).
- Continue to push firmly until the gap between the cap and port is closed (see part B of picture 2, below).
- Take off the cap (see part C of picture 2, below).



2. Close the gap and take off the cap

7. Give the injection



3. Pinch the skin and inject

- Gently pinch the skin at the injection site (see picture 3). This helps to make sure that the drug is injected into fatty tissue just under the skin and not into muscle.
- Hold the port. Gently push the needle straight into the skin with the needle pointing down (never upward) until the port touches the skin.
- Squeeze the reservoir slowly. Take 5 to 7 seconds.
- Pull out the needle and then release the skin.
- Do not clean or massage the site after injecting.

8. Discard the used device

- Do not replace the cap.
- Place the device in a safety box.

Supporting the User

Give specific instructions

- Tell her not to massage the injection site.
- Tell the client the name of the injection.
- Agree on a date for her next injection and give her a paper with the date written on it.

Self-injection Can Be an Option

Women can learn to inject themselves with the new subcutaneous formulation of DMPA. Some women like self-injection better than injections by health workers. Self-injection may save women time and money.

Research finds that 3 months after one-on-one training most women can competently give themselves their next injection. Women who inject themselves seem to be as likely to keep using injectable contraceptives as women who get their injections in clinics.

WHO recommends making self-injection an option where appropriate information and training are made available, referral links to a health care provider are strong, and women who self-inject are monitored and followed up. In addition, safe storage of injection devices at home and their safe disposal are important.

Teaching Clients to Self-Inject

Some clients will want to give themselves the injections. You can teach them how to do this. The following steps apply to self-injection with DMPA-SC in the Uniject injection system (Sayana Press).

1. Discuss plan for storage and disposal

Storage. Discuss where the client can store the devices for many months that is out of the reach of children and animals and in moderate temperatures (not in direct sunlight or in a refrigerator).

Disposal. Discuss how the client can dispose of the device in a container that has a lid and cannot be punctured and can be kept away from children. (Local programs should decide how to help women dispose of used needles.)

Note: The instructions on the next 2 pages can be copied and given to a client.

Steps in teaching clients to self-inject continue on p. 86.

How to give yourself an injection with Sayana Press

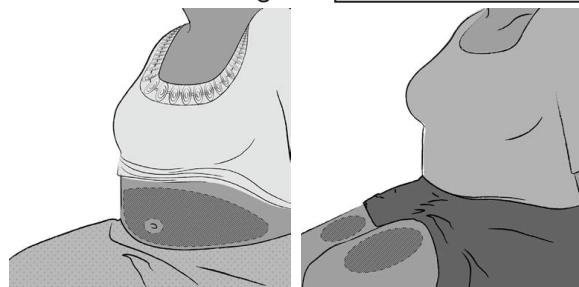
Important steps

How to do it

1. Choose a correct injection site

Choose either:

- the belly (but not the navel) OR
- the front of the thigh.

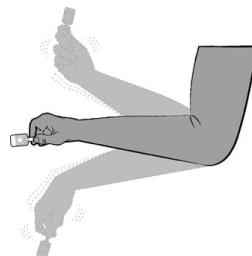


Parts of the Sayana Press injection device

1. Where to give yourself the injection

2. Mix the solution

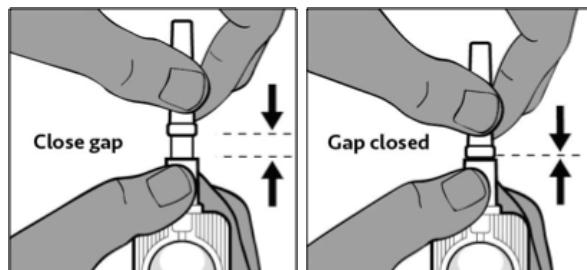
- After washing hands, open the pouch and take out the injection device.
- Hold the device by the port (not the cap) and shake it hard for about 30 seconds. Make sure the solution is completely mixed.



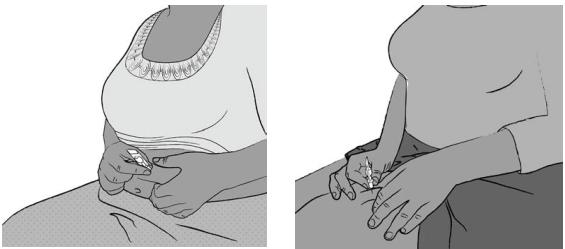
2. Mix the solution

3. Push the cap and the port together to close the gap

- Point the needle upward.
- Hold the cap with one hand and the port with the other hand.
- Press the cap down firmly until the gap is closed.



3. Close the gap

Important steps	How to do it
4. Pinch your skin into a “tent”	<ul style="list-style-type: none"> Take the cap off the needle. Hold the device by the port. With the other hand pinch about 4 cm (1½ inches) of skin.
5. Put the needle into the skin, and squeeze the reservoir slowly	<ul style="list-style-type: none"> Press the needle straight into the skin with the needle pointing downward. Press the needle in until the port touches the skin completely. Squeeze the reservoir slowly, for 5 to 7 seconds.
	
	4 & 5. Pinch the skin and press in the needle
6. Dispose of the needle safely	<ul style="list-style-type: none"> Pull the needle out and then let go of the skin. Put the device in a container that can be closed and cannot be punctured.
7. Plan for your next injection	<ul style="list-style-type: none"> Mark a calendar or other reminder for the same day of the month 3 months from today. You can give yourself the next injection as early as 2 weeks before that date or as late as 4 weeks after. If more than 4 weeks late, use another contraceptive method and see a health worker. Make sure you have another device for the next injection and that it will not expire before then.

If you need help or more injection devices, contact:

at

Teaching Clients To Self-Inject (continued from p. 83)

- 2. Explain and show how to self-inject.** Show the device and describe its parts. (See picture in instructions, p. 84.) Give the client a copy of the instructions and pictures on the previous 2 pages, a similar instruction sheet, or a booklet of more detailed instructions. Explain the important steps.

Use an injection model to explain and show the client how to do each step while helping the client follow along on the instruction sheet. (If an injection model is not available, you can use a condom filled with salt or sugar. Or you can use fruit or bread.)

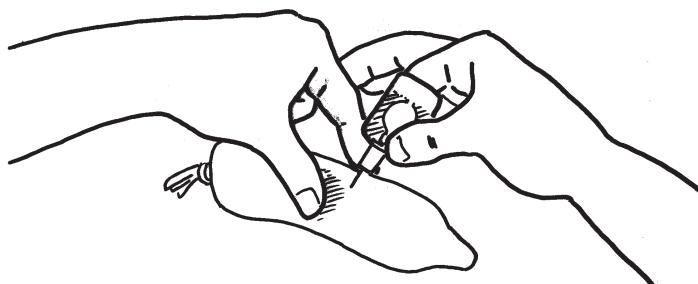
- 3. Ask the client to try it.** After you have used the injection model to show self-injection, ask the client to practice injecting the model. Watch her and then discuss what went well and what did not. Answer her questions.

Invite the client to keep trying to inject the model until she can do all the steps correctly and feels ready to inject herself.

- 4. Ask the woman to inject herself while you are watching.** Then give her injection devices to take home so that she can inject herself in the future. Make sure that she understands when her future injection dates are, and how to calculate those dates by noting the same day of the month every 3 months.

If she is unable to inject herself, give her the injection. When she returns for her next injection, ask if she wants to try self-injection again. If so, repeat the training.

- 5. Tell the client where to get more injection devices.** Invite her to contact you if she has any questions or problems with self-injection or getting more injection devices.



How Can a Partner Help?

The client's partner is welcome to participate in counseling and learn about the method and what support he can give to his partner. A male partner can:

- Support a woman's choice of a progestin-only injectable
- Show understanding and support if she has side effects
- Help her to remember to get her next injection on time
- Help to make sure she has ECPs on hand in case she is late for an injection by more than 4 weeks for DMPA or more than 2 weeks for NET-EN
- Use condoms consistently in addition to the progestin-only injectable if he has an STI/HIV or thinks he may be at risk of an STI/HIV

“Come Back Any Time”: Reasons to Return Before the Next Injection

Assure every client that she is welcome to come back any time—for example, if she has problems, questions, or wants another method; she has a major change in health status; or she thinks she might be pregnant.

General health advice: Anyone who suddenly feels that something is seriously wrong with her health should immediately seek medical care from a nurse or doctor. Her contraceptive method is most likely not the cause of the condition, but she should tell the nurse or doctor what method she is using.

Planning the Next Injection

1. Agree on a date for her next injection in 3 months (13 weeks) for DMPA, or in 2 months (8 weeks) for NET-EN. Give her a paper with the date written on it (or dates, if she is self-injecting and taking home more than one injection device). Discuss how to remember the date, perhaps tying it to a holiday or other event or circling a date on a calendar.
2. Ask her to try to come on time. With DMPA she may come up to 4 weeks after the scheduled injection date and still get an injection. With NET-EN she may come up to 2 weeks after the scheduled injection date and still get an injection. With either DMPA or NET-EN, she can come up to 2 weeks before the scheduled injection date.
3. She should come back no matter how late she is for her next injection. If more than 4 weeks late for DMPA or 2 weeks late for NET-EN, she should abstain from sex or use condoms, spermicides, or withdrawal until she can get an injection. Also, if she has had sex in the past 5 days without using another contraceptive method, she can consider emergency contraceptive pills (see Emergency Contraceptive Pills, p. 49).

Helping Continuing Users

Repeat Injection Visits

1. Ask how the client is doing with the method and whether she is satisfied. Ask if she has any questions or anything to discuss.
2. Ask especially if she is concerned about bleeding changes. Give her any information or help that she needs (see Managing Any Problems, next page).
3. Give her the injection. **Injection of DMPA can be given up to 4 weeks late. Injection of NET-EN can be given up to 2 weeks late.**
4. Plan for her next injection. Agree on a date for her next injection (in 3 months or 13 weeks for DMPA, 2 months for NET-EN). Remind her that she should try to come on time, but she should come back no matter how late she is. (See Managing Late Injections, below.)
5. Every year or so, check her blood pressure if possible (see Medical Eligibility Criteria, Question 3, p. 72).
6. Ask a long-term client if she has had any new health problems. Address problems as appropriate. For new health problems that may require switching methods, see p. 91.
7. Ask a long-term client about major life changes that may affect her needs—particularly plans for having children and STI/HIV risk. Follow up as needed.

Managing Late Injections

- If the client is less than 4 weeks late for a repeat injection of DMPA, or less than 2 weeks late for a repeat injection of NET-EN, she can receive her next injection. No need for tests, evaluation, or a backup method.
 - A client who is more than 4 weeks late for DMPA, or more than 2 weeks late for NET-EN, can receive her next injection if:
 - She has not had sex since 2 weeks *after* the scheduled date of her injection, or
 - She has used a backup method or has taken emergency contraceptive pills (ECPs) after any unprotected sex since 2 weeks *after* the scheduled date of her injection, or
 - She is fully or nearly fully breastfeeding and she gave birth less than 6 months ago.
- She will need a backup method for the first 7 days after the injection.
- If the client is more than 4 weeks late for DMPA, or more than 2 weeks late for NET-EN, and she does not meet these criteria, additional steps can be taken to be reasonably certain she is not pregnant (see Ruling Out

Pregnancy, p. 439). These steps are helpful because many women who have been using progestin-only injectables will have no monthly bleeding for at least a few months, even after discontinuation. Thus, asking her to come back during her next monthly bleeding means her next injection could be unnecessarily delayed. She may be left without contraceptive protection.

- Discuss why the client was late and solutions. Remind her that she should keep trying to come back every 3 months for DMPA, or every 2 months for NET-EN. If coming back on time is often a problem, discuss using a backup method when she is late for her next injection, taking ECPs, or choosing another method, such as an implant or IUD.

Managing Any Problems

Problems Reported as Side Effects

May or may not be due to the method.

- Problems with side effects affect women's satisfaction and use of injectables. They deserve the provider's attention. If the client reports side effects, listen to her concerns, give her advice and support, and, if appropriate, treat. Make sure she understands the advice and agrees.
- Offer to help the client choose another method—now, if she wishes, or if problems cannot be overcome.

No monthly bleeding

- Reassure her that most women using progestin-only injectables stop having monthly bleeding over time, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding.)
- If not having monthly bleeding bothers her, she may want to switch to monthly injectables, if available.

Irregular bleeding (bleeding at unexpected times that bothers the client)

- Reassure her that many women using progestin-only injectables experience irregular bleeding. It is not harmful and usually becomes less or stops after the first few months of use.
- For modest short-term relief, she can take 500 mg mefenamic acid 2 times daily after meals for 5 days or 40 mg of valdecoxib daily for 5 days, beginning when irregular bleeding starts.
- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see Unexplained vaginal bleeding, p. 91).

Weight gain

- Review diet and counsel as needed.

Abdominal bloating and discomfort

- Consider locally available remedies.

Heavy or prolonged bleeding (twice as much as usual or longer than 8 days)

- Reassure her that some women using progestin-only injectables experience heavy or prolonged bleeding. It is not harmful and usually becomes less or stops after a few months.
- For modest short-term relief she can try (one at a time), beginning when heavy bleeding starts:
 - 500 mg of mefenamic acid twice daily after meals for 5 days
 - 40 mg of valdecoxib daily for 5 days
 - 50 µg of ethinyl estradiol daily for 21 days
- If bleeding becomes a health threat or if the woman wants, help her choose another method. In the meantime, she can use one of the treatments listed above to help reduce bleeding.
- To help prevent anemia, suggest she take iron tablets and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).
- If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see Unexplained vaginal bleeding, next page).

Ordinary headaches (nonmigrainous)

- Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
- Any headaches that get worse or occur more often during use of injectables should be evaluated.

Mood changes or changes in sex drive

- Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner. Give support as appropriate.
- Clients who have serious mood changes such as major depression should be referred for care.
- Consider locally available remedies.

Dizziness

- Consider locally available remedies.

New Problems That May Require Switching Methods

May or may not be due to the method.

Migraine headaches (see Identifying Migraine Headaches and Auras, p. 436)

- If she has migraine headaches without aura, she can continue to use the method if she wishes.
- If she has migraine aura, do not give the injection. Help her choose a method without hormones.

Unexplained vaginal bleeding (that suggests a medical condition not related to the method)

- Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.
- If no cause of bleeding can be found, consider stopping progestin-only injectables to make diagnosis easier. Provide another method of her choice to use until the condition is evaluated and treated (not implants or a copper-bearing or LNG-IUD).
- If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using progestin-only injectables during treatment.

Certain serious health conditions (suspected blocked or narrowed arteries, serious liver disease, severe high blood pressure, blood clots in deep veins of legs or lungs, stroke, breast cancer, or damage to arteries, vision, kidneys, or nervous system caused by diabetes). See Signs and Symptoms of Serious Health Conditions, p. 384.

- Do not give next injection.
- Give her a backup method to use until the condition is evaluated.
- Refer for diagnosis and care if not already under care.

Suspected pregnancy

- Assess for pregnancy.
- Stop injections if pregnancy is confirmed.
- There are no known risks to a fetus conceived while a woman is using injectables (see Question 12, p. 95) or to a woman who receives an injection while pregnant.

Questions and Answers About Progestin-Only Injectables

I. Can women who could get sexually transmitted infections (STIs) use progestin-only injectables?

Yes. Women at risk for STIs can use progestin-only injectables. The few studies available have found that women using DMPA were more likely to acquire chlamydia than women not using hormonal contraception. The reason for this difference is not known. There are few studies available on use of NET-EN and STIs. Like anyone else at risk for STIs, a user of progestin-only injectables who may be at risk for STIs should be advised to use condoms correctly every time she has sex. Consistent and correct condom use will reduce her risk of becoming infected with an STI.

2. Can women at high risk for HIV use progestin-only injectables?

Yes. Women at high risk of HIV infection can use any contraceptive method, including progestin-only injectables, except spermicide or diaphragm with spermicide (see Spermicides and Diaphragms, p. 271).

In late 2016 a WHO assessment observed that some research finds that women who are at high risk of HIV infection and use a progestin-only injectable are slightly more likely to get HIV. It is not clear why studies find this. The injectable may or may not be responsible for increasing a woman's chances of becoming infected if exposed to HIV.

An expert group convened by WHO concluded, "Women should not be denied the use of progestogen-only injectables because of concerns about the possible increased risk" of HIV infection. WHO classified progestin-only injectables, such as DMPA (including Sayana Press) and NET EN, as Medical Eligibility Criteria (MEC) category 2 for high risk of HIV. This classification means that women at high risk of HIV can generally use the method.

WHO advises that, in countries and populations where HIV is common, providers should clearly inform women interested in progestin-only injectables about these research findings and their uncertainty, as well as how to protect themselves from HIV, so that each woman can make a fully informed choice (see Considering Progestin-Only Injectables Where HIV Risk Is High, p. 438, for counseling tips). In keeping with the MEC 2 classification, women

should be told clearly that they can choose and use a progestin-only injectable if they wish. Women also should be told that other long-acting and effective methods are available if they would like to consider a different method.

3. If a woman does not have monthly bleeding while using progestin-only injectables, does this mean that she is pregnant?

Probably not, especially if she is breastfeeding. Eventually, most women using progestin-only injectables will not have monthly bleeding. If a woman has been getting her injections on time, she is probably not pregnant and can keep using injectables. If she is still worried after being reassured, she can be offered a pregnancy test, if available, or referred for one. If not having monthly bleeding bothers her, switching to another method may help.

4. Can a woman who is breastfeeding safely use progestin-only injectables?

Yes. This is a good choice for a breastfeeding mother who wants a hormonal method. Progestin-only injectables are safe for both the mother and the baby starting as early as 6 weeks after childbirth. They do not affect milk production.

5. How much weight do women gain when they use progestin-only injectables?

Women gain an average of 1–2 kg per year when using DMPA. Some of the weight increase may be the usual weight gain as people age. Some women, particularly overweight adolescents, have gained much more than 1–2 kg per year. At the same time, some users of progestin-only injectables lose weight or have no significant change in weight. Asian women in particular do not tend to gain weight when using DMPA.

6. Do DMPA and NET-EN cause abortion?

No. Research on progestin-only injectables finds that they do not disrupt an existing pregnancy. They should not be used to try to cause an abortion. They will not do so.

7. Do progestin-only injectables make a woman infertile?

No. There may be a delay in regaining fertility after stopping progestin-only injectables, but in time the woman will be able to become pregnant as before, although fertility decreases as women get older. The bleeding pattern a woman had before she used progestin-only injectables generally returns several months after the last injection even if she had no monthly bleeding while using injectables.

8. How long does it take to become pregnant after stopping DMPA or NET-EN?

Women who stop using DMPA wait about 4 months longer on average to become pregnant than women who have used other methods. This means they become pregnant on average 10 months after their last injection. Women who stop using NET-EN wait about one month longer on average to become pregnant than women who have used other methods, or 6 months after their last injection. These are averages. A woman should not be worried if she has not become pregnant even as much as 12 months after stopping use. The length of time a woman has used injectables makes no difference to how quickly she becomes pregnant once she stops having injections.

After stopping progestin-only injectables, a woman may ovulate before her monthly bleeding returns—and thus can become pregnant. If she wants to continue avoiding pregnancy, she should start another method before monthly bleeding returns.

9. Does DMPA cause cancer?

Many studies show that DMPA does not cause cancer. DMPA use helps protect against cancer of the lining of the uterus (endometrial cancer). Findings of the few studies on DMPA use and breast cancer are similar to findings with combined oral contraceptives: Women using DMPA were slightly more likely to be diagnosed with breast cancer while using DMPA or within 10 years after they stopped. It is unclear whether these findings are explained by earlier detection of existing breast cancers among DMPA users or by a biologic effect of DMPA on breast cancer.

A few studies on DMPA use and cervical cancer suggest that there may be a slightly increased risk of cervical cancer among women using DMPA for 5 years or more. Cervical cancer cannot develop because of DMPA alone, however. It is caused by persistent infection with human papillomavirus (see Cervical Cancer, p. 340). Little information is available about NET-EN. It is assumed to be as safe as DMPA and other contraceptive methods containing only a progestin, such as progestin-only pills and implants.

10. Can a woman switch from one progestin-only injectable to another?

Switching injectables is safe, and it does not decrease effectiveness. If switching is necessary due to shortages of supplies, the first injection of the new injectable should be given when the next injection of the old formulation would have been given. Clients need to be told that they are switching, the name of the new injectable, and its injection schedule.

11. How does DMPA affect bone density?

During use, DMPA decreases bone mineral density slightly. This may increase the risk of developing osteoporosis and possibly having bone fractures later, after menopause. WHO has concluded that this decrease in bone mineral density does not place age or time limits on use of DMPA.

12. Do progestin-only injectables cause birth defects? Will the fetus be harmed if a woman accidentally uses progestin-only injectables while she is pregnant?

No. Good evidence shows that progestin-only injectables will not cause birth defects and will not otherwise harm the fetus if a woman becomes pregnant while using progestin-only injectables or accidentally starts injectables when she is already pregnant.

13. Do progestin-only injectables lower women's mood or sex drive?

Generally, no. Some women using injectables report these complaints. The great majority of injectables users do not report any such changes, however. It is difficult to tell whether such changes are due to progestin-only injectables or to other reasons. Providers can help a client with these problems (see Mood changes or changes in sex drive, p. 90). There is no evidence that progestin-only injectables affect women's sexual behavior.

14. What if a woman returns for her next injection late?

A woman can have her next DMPA injection even if she is up to 4 weeks late, without the need for further evidence that she is not pregnant. A woman can receive her next NET-EN injection if she is up to 2 weeks late. Some women return even later for their repeat injection, however. In such cases providers can use the instructions on p. 439, Ruling Out Pregnancy. Whether a woman is late for reinjection or not, her next injection of DMPA should be planned for 3 months later, or her next injection of NET-EN should be planned for 2 months later, as usual.

When a Woman Can Have Her Next Injection of DMPA or NET-EN

