**Progestin-Only Contraceptives (POC's)**

| DEFINITION | A client who desires to start, continue, or restart progestin-only contraceptives. Progestin-only methods do not contain estrogen; therefore offer effective options to women who cannot use a method that contains estrogen. Progestin-only contraception has a range of delivery systems which include: Progestin-only pills (minipills, POPs); subcutaneous progestin-only implant, medroxyprogesterone acetate (MPA). Most progestin-only methods act by increasing the viscosity of cervical mucus to impede sperm production, reducing the activity of the cilia in the fallopian tubes, changing the endometrium making it less likely for implantation, and a variable effect on ovarian suppression. The exception is with MPA, which suppresses the hypothalamic-pituitary-ovarian axis resulting in total suppression of ovulation. (Refer to IUD candidate protocol for all IUD’s including progestin bearing IUD’s) |
| SUBJECTIVE | Should include: 1. LMP 2. Medical, sexual, and contraceptive use history (initial or update) as appropriate. |
| OBJECTIVE | Should include: 1. B/P 2. Age-appropriate physical exam as indicated. May include: 1. Height, weight, and BMI |
| LABORATORY | May include: 1. Hemoglobin 2. Pap smear 3. STI screening 4. Sensitive urine pregnancy test 5. Other lab work |
| ASSESSMENT | Candidate for Progestin-only contraceptives. |
| PLAN | 1. Evaluate history and physical for Progestin-only contraceptive use. (See CDC U.S. medical eligibility criteria for contraceptive use) 2. Prescribe Progestin-only contraceptive pill, including dosage, # cycles, and direction for use. a. If LMP is < 5 days, start today with no back up method needed. b. If LMP is > 5 days, start today and use back up method or abstinence for 2 days. (If any unprotected coitus in the last 5 days, offer Emergency Contraception) c. Consider pregnancy test in 3 weeks if starting after the administration of ECP, or Quick/random start method (See Contraceptives: Quick Start) 3. If prescribing MPA (injectable method), include dose, length of time and schedule injections at 12-16 week intervals. It can be given up to 16 week intervals and earlier than 12 weeks as appropriate. a. If LMP < 5 days or switching from an effective method, start injection today with no back up method needed. b. If LMP > 5 days and not switching from an effective method and unprotected intercourse in the last 72-120 hours: offer Emergency Contraception. (See Contraceptives: Emergency Contraception) Options: 1. If negative pregnancy test, “Quick Start” injectable method. Advise back-up method or abstinence for 2 days. 2. If declining ECP, recommend abstinence, provide barrier method for 14 days, repeat urine pregnancy test and if negative, administer MPA and have patient use abstinence or back-up method for 2 days. (If menses returns before the 14 days, administer MPA and use back-up method or abstinence for 2 days.) |
4. If contraceptive implant is selected, place only if confident the patient is not pregnant.
   a. No backup method is needed if implant is placed at any of the following times:
      1. First five days of menses.
      2. Any time if switching from combined hormonal contraception.
      3. Switching immediately from progestin-only method, including POP, MPA injection.
      4. Within 5 days of first trimester pregnancy loss.
      5. Within 28 days after second or third trimester pregnancy loss of delivery.
   b. Counseling must include:
      1. Explain risks and benefits of the implant, including unscheduled bleeding.
      2. Watch for warning signs and seeking medical attention if bleeding is from placement site, pain, redness, drainage, chills or fever.
   5. Consider pregnancy test in 3 weeks, if indicated.

**CLIENT EDUCATION**

2. Reinforce pill instructions: taking the pill the same time each day (within a 3 hour window), there are no placebos in pill pack, will need to take pills during menses, and may have changes in bleeding pattern.
3. Advise breastfeeding clients if using POP to return when planning to discontinue breastfeeding, if she desires to use combined hormonal method.
4. Review with client the “Black Box” warning on prescribing information for Contraceptive Injections.
5. ECP reviewed.
6. Review safer sex education, if appropriate.
7. Recommend to RTC annually, prn for problems or as indicated per individual plan.

**CONSULT/ REFER TO PHYSICIAN**

1. Any client with prescribing precautions in Category 3 or 4, for Progestin-only contraceptives. (Review Medical Eligibility Criteria for Contraceptive Use, 2016)

References: