Training and Reference Guide for a Screening Checklist to Initiate DMPA (or NET-EN)
This Training and Reference Guide for a Screening Checklist to Initiate DMPA (or NET-EN) was developed by Family Health International (FHI), a nonprofit organization working to improve lives worldwide through research, education, and services in family health. Similar guides, providing training and reference materials on other FHI provider checklists, are also being published.

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Introduction

This training and reference guide was developed for family planning service providers interested in using the Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN), commonly referred to as the “DMPA Checklist”. Designed to serve as both a training and reference tool, the guide is composed of two parts: a training module and a collection of essential, up-to-date reference materials. The guide is part of a series to train on other checklists, including the Checklist for Screening Clients Who Want to Initiate COCs, the Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD, and the checklist entitled How to Be Reasonably Sure a Client is Not Pregnant.

The DMPA Checklist was developed to assist service providers in screening clients who have already been counseled about contraceptive options and who have made an informed decision to use either of two popular injectable contraceptive methods: depot-medroxyprogesterone acetate (DMPA) or norethisterone acetate (NET-EN). This simple job aid is based on guidance provided in the Medical Eligibility Criteria for Contraceptive Use (WHO 2004) and supports the application of these guidelines into service delivery practice.

For the sake of simplicity, this guide focuses solely on DMPA. However, the information contained herein is equally applicable to NET-EN. Users of this guide should feel free to substitute NET-EN for any mention of DMPA and to adapt the training accordingly.

Research findings have established that DMPA is 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. However, for some women with certain medical conditions — such as breast cancer, ischemic heart disease, or stroke — use of these injectables is not recommended. The DMPA Checklist provides a series of questions designed to screen for such medical conditions and thereby determine whether a woman is medically eligible to begin using DMPA.

The DMPA Checklist also provides a series of questions to rule out pregnancy. Health care providers are generally required to rule out pregnancy before providing contraceptives, such as DMPA, because women who are pregnant do not require contraception. Also, it is considered good practice to avoid all unnecessary drugs during pregnancy. There is, however, no evidence that DMPA can harm pregnancy or a developing fetus. Pregnancy can be reliably determined with pregnancy tests, but in many areas of the world these tests often are either unavailable or unaffordable. In such cases, clients who are not menstruating at the time of their visit (occasionally referred to in this guide as “nonmenstruating women”, for the sake of simplicity) are often denied contraception by providers who rely on the presence of menses as an indicator that a woman is not pregnant. Usually, these women are required to wait for their menses to return before they can initiate a contraceptive method, thus putting them at risk of an unwanted pregnancy. The pregnancy-related questions on the DMPA Checklist are taken directly from the checklist entitled How to Be Reasonably Sure a Client is Not Pregnant. This checklist, referred to as the “Pregnancy Checklist”, has been shown to be 99 percent effective in ruling out pregnancy.
Purpose of the Training and Reference Guide
This publication is intended to provide program managers, administrators, trainers, and service providers with:

- a training module on how to use the DMPA Checklist;
- an overview of the DMPA Checklist and guidance for adapting it for local use;
- information on the most current research regarding the validity, effectiveness and use of the DMPA Checklist; and
- current, essential, evidence-based information on DMPA.

Intended Users of this Guide
This guide can be used by:

- trainers, facilitators, program managers and administrators responsible for training service providers to use the DMPA Checklist;
- service providers who need to apply the DMPA Checklist in their practice and are responsible for teaching themselves how to use it;
- policy-makers and program managers interested in introducing the DMPA Checklist for use in their community.

Intended Participants of the Training
Training on the DMPA Checklist would benefit both clinical and non-clinical service providers who provide clients with DMPA, including:

- facility-based family planning counselors and service providers;
- community-based health workers;
- pharmacists and others who sell drugs and are authorized to screen clients and provide DMPA;
- health care providers who integrate family planning services into HIV/AIDS prevention and care services, such as voluntary counseling and testing (VCT) counselors and health staff at antiretroviral treatment sites;
- health care providers in resource-constrained settings, such as refugee camps.

Note: This guide focuses exclusively on how to use the DMPA Checklist. In order to provide quality services, providers who offer or plan to offer DMPA to their clients may also need training or information on additional topics, such as various contraceptive methods and family planning counseling techniques.
How to Use this Guide

Using the guide as a training tool
This guide provides a curriculum for training service providers to use the DMPA Checklist. Training on the DMPA Checklist can be completed in approximately five hours. Facilitators are free to adapt the training to better serve the needs of their particular audience and may add or delete activities or use the information provided to create their own training. Additional tools that may assist the facilitator in adapting the training include a CD-ROM and training schedules for different types of audiences. The CD-ROM is located in the pocket inside the back cover, and the training schedules may be found in the section entitled Supplementary Training Schedules, page 73.

Using the guide as a reference tool
This guide also provides reference information that supplements the training. This information includes recommendations on adapting the checklist to the local context, basic evidence-based information on DMPA, and an annotated bibliography.
Learning Objectives
By the end of the training, participants will have learned or become familiar with:

- the rationale, purpose, and design of the DMPA Checklist;
- the medical eligibility criteria to screen clients for DMPA initiation; and
- proper use of the checklist.

Number of participants
No more than 30 people are recommended per training.

Time
A minimum of five hours is required to complete all four sessions. This includes the Optional Session but does not include breaks.

Structure of the Module

<table>
<thead>
<tr>
<th>Session</th>
<th>Time</th>
<th>Topic</th>
<th>Training Method</th>
</tr>
</thead>
</table>
| 1       | 30 minutes | Welcome and introductions  
**Exercise A: Peel the Cabbage** | Large group activity; group discussion |
| 2       | 20 minutes | Rationale and purpose of the DMPA Checklist | Facilitator presentation |
|         | 30 minutes | **Exercise B: Review of the WHO Medical Eligibility Criteria** | Small group activity |
|         | 10 minutes | **Exercise C: Demonstrating the Benefits of Using the Pregnancy Checklist** | Large group activity |
| 3       | 40 minutes | Design of and instructions for using the DMPA Checklist | Facilitator presentation |
|         | 140 minutes | **Exercise D: Practice Using the DMPA Checklist** | Small group activity |
| 4       | 15 minutes | Wrap-up | Group discussion |
| Optional Session | 15 minutes | Summary of Research Findings | Facilitator presentation |

Each training session has four components:

- **Objective** — a short description of the purpose and learning objective(s) for the session
- **Time** — anticipated length of the session
- **Training Steps** — basic steps that guide the trainer through the activities
- **Facilitator's Resource** — detailed information to convey to participants, as indicated in the training steps
Training Materials
Facilitators will need the following materials:
- flip chart paper
- tape
- markers
- colored pencils for all participants (red and green are recommended)
- training handouts, found on pages 35-50 and on the CD-ROM, including:
  - the Checklist for Screening Clients Who Want to Initiate Use of DMPA (or NET-EN)
  - two versions of the Quick Reference Chart (one with the categories colored in and one with no color)
  - Scenario Exercises for Participants
  - Answer Guide to Scenarios

Advance Preparation for Trainers
In order to understand the purpose, content, and approach of the training, we recommend that facilitators master the information in this guide, as well as the materials on the CD-ROM. Facilitators should also be very familiar with the training handouts used in conjunction with the participant exercises. Some sessions require advance preparation, such as photocopying, preparing flip charts, or preparing components for exercises. Facilitators should know their audience and adapt the training accordingly.

Due to the technical nature of the subject matter, it is highly likely that questions on DMPA will arise that are beyond the scope of the information provided in the training portion of this guide. The information provided in the reference guide or on the CD-ROM may help facilitators to address some of these questions. Because this guide is not intended to comprehensively answer all questions around DMPA provision, additional training may be required.

Key information for the facilitator is noted throughout the training module with the following symbol.
The CD-ROM

The CD-ROM accompanying this module provides information on all four screening checklists to enhance the training for a variety of participant groups. The CD-ROM contains the following materials.

1. Suggested schedule for a combined training on all four checklists

2. PowerPoint presentations for orienting different audiences on the checklists:
   - *PowerPoint* presentation A: How to Use Screening Checklists to Initiate Use of Contraceptives (for facilitators)
   - *PowerPoint* presentation B: Screening Checklists to Initiate Use of Contraceptives — Tools for Service Providers (for policy-makers and program managers)

3. Handouts for participants:
   - Scenario Exercises for Participants
   - Answer Guide to Scenarios
   - Quick Reference Charts
   - Four Screening Checklists
   - Certificate of Attendance (sample)

4. Electronic versions of all four Training and Reference Guides

5. Basic, essential, evidence-based information on COCs, DMPA, and IUDs:
   - *Medical Eligibility Criteria for Contraceptive Use*, WHO 2004
   - *Selected Practice Recommendations for Contraceptive Use*, WHO 2004
   - *PowerPoint* presentation C: Overview of COCs
   - *PowerPoint* presentation D: Overview of Injectables — DMPA and NET-EN
   - *PowerPoint* presentation E: Overview of the IUD
   - *PowerPoint* presentation F: Hormonal Contraceptives — Considerations for Women with HIV and AIDS
Session One: Welcome and Introductions

Objectives: To present the learning objectives of the training.

To facilitate introductions among participants and facilitator(s).

To develop a common understanding of training expectations and group norms.

To “break the ice” and help participants become engaged in the training.

Training Steps:

1. Welcome the participants and introduce yourself and any other facilitators. Provide an opportunity for participants to also introduce themselves. You may choose to have participants do this by stating their name and area of expertise or by using the icebreaker activity in the shaded box below. The icebreaker activity will also help you to better understand your audience.

2. Ask participants to state what they expect to learn from the workshop. Write their expectations on flip chart paper and save them until the end of the workshop. These expectations will be valuable at the end of the workshop as an evaluation tool.

3. Ask participants to suggest guidelines, or norms, to be followed by the group during the training session. Group norms could include: switching off mobile phones, respecting others’ right to speak, etc.

4. Launch the training by discussing the title of the DMPA Checklist and the learning objectives of the training. Highlight any relevant expectations that were previously expressed by participants.

5. Conduct Exercise A (page 12) to engage participants in an introductory discussion of their current practices for screening women who wish to start using DMPA.

Icebreaker Activity

Each participant talks to the person next to them for five minutes to find out: a) their name, b) the name of their organization and the nature of their work, and c) why they are attending the training today. Participants should then present this information back to the group.
6. Explain that the Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN), which we will often refer to as the “DMPA Checklist”, was developed to help providers correctly determine that a woman has no conditions which would prevent her from safely initiating DMPA.

7. Explain that participants will review the DMPA Checklist and will practice using it later in the training. In so doing, they will discover the answers to the following questions.
   • Why was the DMPA Checklist developed?
   • How should service providers use the DMPA Checklist?
   • What is the basis for the DMPA Checklist?
   • How does the DMPA Checklist work?
Exercise A: Peel the Cabbage

Advance Preparation
Prior to the training, write the following three questions at least four times, each on a different piece of paper. You should have at least 12 pieces of paper. Mix the pages up and then layer and crumple them so that they resemble a cabbage. Include additional questions on additional pieces of paper, as appropriate. Also write these three questions on the flip chart, each on a different page, and tape them up for all to see.

Name one practice that you follow to determine if a woman can safely initiate DMPA.

Name one approach to ruling out pregnancy prior to DMPA initiation.

Name one health condition that prevents women from using DMPA.

Objective: Participants will discuss their current practices for screening women who wish to start using DMPA.

1. Toss “the cabbage” to one of the participants. The person holding the cabbage must peel off the top layer and answer the question. After answering the question, the participant “tosses the cabbage” to another participant to answer the next question. If this question has already been asked, the participant cannot repeat the same answer. Continue tossing the cabbage until all the questions are answered. Possible answers are given below.

Name one practice that you follow to determine if a woman can safely initiate DMPA.

Answers could include: medical histories, questions about the presence of certain symptoms, laboratory tests, the DMPA Checklist, etc.

Name one approach to ruling out pregnancy prior to DMPA initiation.

Answers could include: a pregnancy test, presence of menses, pelvic exam, Pregnancy Checklist, etc.

Name one health condition that prevents women from using DMPA.

Answers could include: heart disease, high blood pressure, breast cancer, etc.

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2. If appropriate for your audience, you may choose to make the exercise fun by having the group give some form of mild “penalty” to participants who cannot answer their question. This might include such things as raising one hand, bending their head to one side or standing on one foot until the cabbage is completely peeled. Let the participants be creative.

3. Conclude the exercise by telling participants that they will have the opportunity to see whether their answers were correct or not at the end of Exercises B and C in Session Two.

Remember that participants may already have extensive knowledge and practical experience in family planning. Make an effort to incorporate participants’ questions, knowledge, and experiences into your training session, as appropriate.
**Objective:** To learn why and how the checklist was developed.

**Training Steps:**

1. **Hold up a copy of the DMPA Checklist to show participants, but do not distribute it until later in the session, at the end of Exercise B.** Check to see if they are already familiar with the checklist, by asking the following questions.
   - How many of you currently use this checklist to decide if a woman can safely use DMPA?
   - For those who use the checklist, do you find it useful in your work? How?

2. **Explain what the DMPA Checklist is and why it was developed.** If appropriate for your audience and if needed, you may also choose to discuss the research on the rationale for the Pregnancy Checklist, located in the Optional Session, page 32.

3. **Engage participants in a discussion on how service providers should use the DMPA Checklist.** Ask participants the following question to emphasize the use of this job aid to improve efficiency in their daily work.
   - In your daily work, how easy is it to use your national guidelines/protocols to determine if a woman can safely use DMPA?

4. **Discuss the basis for the two sets of questions on the DMPA Checklist.**
   - First, introduce the WHO Medical Eligibility Criteria and explain its purpose.
   - Then perform Exercise B (page 15) to help participants better understand how the categories work in relation to the use of DMPA.
   - Next, introduce the concept of Pregnancy Checklist questions, what they are, and why they were developed.
   - Perform Exercise C (page 17) to help participants understand the usefulness of the Pregnancy Checklist questions for ruling out pregnancy among women who are not menstruating at the time of their visit.

*If there are national guidelines or protocols for family planning provision, it is important to link the checklists to these documents to promote utilization of the checklist.*
Advance Preparation

- Prior to the training, make sufficient photocopies of both Quick Reference Charts (pages 45-46) and the DMPA Checklist (pages 47-50) to distribute to each participant.

- You will also need green and red pens or markers for each participant.

- In addition, you may want to prepare a flip chart page containing the information in the box below.

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>No restrictions for use.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 2:</td>
<td>Generally use; some follow-up may be needed.</td>
</tr>
<tr>
<td>Category 3:</td>
<td>Usually not recommended; clinical judgment and continuing access to clinical services are required for use.</td>
</tr>
<tr>
<td>Category 4:</td>
<td>Should not be used.</td>
</tr>
</tbody>
</table>

Objective: Participants will review the Quick Reference Chart to become familiar with relevant conditions that have been studied and determined to either be safe or not safe for DMPA initiation and use.

1. Give each participant a blank copy of the Quick Reference Chart, along with a green and a red pen marker.

2. Present the information in the box above and explain how the categories are grouped into two colors: GREEN — representing categories 1 and 2, and RED — representing categories 3 and 4.

3. Ask participants to use the green or red pens/markers to color in the rectangles to the right of the conditions listed on the chart. Choose a maximum of four conditions, such as diabetes, high blood pressure, HIV/AIDS, and endometrial cancer. Have them use GREEN if they think the condition falls under category 1 or 2 and RED if they believe the condition falls under category 3 or 4. They should choose the color based on their knowledge, assumptions or best guess. At your discretion, participants can work individually, in pairs, or as a group. Allow them 10 minutes to complete this task. (If no colored pencils or markers are available, have participants write a “G” for green or an “R” for red in the rectangles.)
4. Now, give each participant a copy of the color version of the Quick Reference Chart and ask them to compare their own answers to it. Allow about 10 minutes for them to assess whether their answers were correct or incorrect. **Note that the color version has four colors, one for each category. To make this activity simpler, only two colors are being used instead of four. Clarify to participants that light red/pink is red and light green is green.**

5. Ask volunteers to share which color or category they assigned to each condition. Correct any misinformation as you go along.

6. Distribute a copy of the DMPA Checklist. Ask participants to compare the first seven questions of the DMPA Checklist with the conditions colored in red on the Quick Reference Chart. Participants will quickly see that the checklist questions only ask about category 3 and 4 conditions (red categories). Explain that these questions were written to identify women who should not use DMPA or who will require additional evaluation by a higher level provider before initiating DMPA. Category 1 and 2 conditions (green categories) are not addressed on the checklist because research shows that women with these conditions can use DMPA safely.
Exercise C: Demonstrating the Benefits of Using the Pregnancy Checklist

Advance Preparation
In advance of the training, write each of the following statements on a separate piece of paper. The statements represent six circumstances that prevent a woman from becoming pregnant and one that does not.

- **Client 1:** “I've not had sexual intercourse since my last menstrual period.”
- **Client 2:** “I always use condoms during intercourse, but I want to start using something else.”
- **Client 3:** “I just started my menses six days ago.”
- **Client 4:** “I have a 3-week-old baby.”
- **Client 5:** “Five days ago, I had a miscarriage.”
- **Client 6:** “I am fully breastfeeding my 5-month-old baby. Since having my baby, I have not had my menstrual period.”
- **Client 7:** “It has been two weeks since I had my last menstrual period.”

Objective: Participants will gain a better understanding of the benefits of using the Pregnancy Checklist by visually comparing the number of women who would potentially receive contraception at the time of their visit when providers do and do not use the checklist. This exercise is based on studies of the Pregnancy Checklist done in Kenya, Guatemala, Mali, Senegal, and Egypt.

1. Ask 7 participants to come to the front of the room. They will represent 7 female clients seeking DMPA who are not menstruating at the time of their visit.

2. Tell the rest of the participants they will act as providers and will be asked to determine as they would usually do (i.e., based on their current practices) if these women are not pregnant. For example, participants might suggest that the client would be:
   - sent home with condoms and asked to return when they are menstruating, or to return four weeks later for an exam if they are not menstruating, whichever comes first;
   - given a pregnancy test;
   - given a pelvic or abdominal exam; or
   - asked more questions.
3. Distribute the above statements, one to each client. Have the first volunteer “client” read their statement out loud, then ask the group acting as providers if pregnancy can be ruled out for this client — Yes or No, and why. Require participants to explain their answers and correct any mistakes as you go along.

4. Repeat the exercise for all seven clients.

5. Conclude the exercise by stating that clients 1-6 represent the six questions on the Pregnancy Checklist that allow pregnancy to be ruled out. Emphasize that if these questions were not asked, these clients would not be able to receive DMPA right away. Point out that the Pregnancy Checklist prompts providers to inquire about all six of these conditions when facing a client. Explain that for client 7 pregnancy has not been ruled out. Since it has been two weeks since her last menstrual period, there is a possibility she might be pregnant. However, the Pregnancy Checklist cannot determine that this woman is, in fact, pregnant.
Facilitator’s Resource:

Why was the DMPA Checklist developed?

- The DMPA Checklist was developed to help family planning providers determine quickly and with confidence whether a client may safely use DMPA as their contraceptive method of choice by screening women for certain medical conditions.

- Screening is necessary because some medical conditions can prevent safe and effective DMPA use. Most women who want to initiate use of DMPA can safely and effectively do so. Some women need further evaluation and/or treatment before starting to use DMPA. For example, a woman who has diabetes should not be given DMPA unless further evaluation shows that she has no vascular complications. A few women should not use DMPA under any circumstances, such as those who have breast cancer or serious liver disease.

- Screening for DMPA initiation should also include ruling out pregnancy, because women who are already pregnant do not require contraception.

- The DMPA Checklist can be used in many settings by both clinical and non-clinical family planning service providers, including:
  - facility-based family planning counselors and service providers;
  - community-based health workers trained to safely provide DMPA;
  - pharmacists and others who sell drugs and are authorized to screen clients and provide DMPA;
  - health care providers who integrate family planning services into HIV/AIDS prevention and care services, such as voluntary counseling and testing (VCT) counselors and health care staff at antiretroviral treatment sites;
  - health care providers in resource-constrained settings, such as refugee camps.

How should service providers use the DMPA Checklist?

- As a screening/decision-making tool
  - The DMPA Checklist can be used as a screening tool to help a provider determine whether a woman (1) is a good candidate for DMPA use, (2) will need further evaluation, or (3) should choose another family planning method. It is not a diagnostic tool, such as a blood test, which can determine whether a woman has a particular disease or condition.
• The DMPA Checklist should only be used with women who have made an informed decision to use DMPA. In order to make an informed decision, all women should be counseled about their contraceptive options by providers who are properly trained in counseling techniques and in providing information on various contraceptive methods. The checklist itself is not a counseling tool, but may be used after counseling has been completed.

As a job aid for using resources more efficiently
• The DMPA Checklist can save time for both providers and clients by asking simple questions to rule out pregnancy and eliminating the need for most nonmenstruating clients to make another appointment.
• Evidence-based practice guidelines can be lengthy and sometimes complicated. Use of the DMPA Checklist provides a way to apply these same guidelines in a simple, efficient, and timely manner.

What is the basis for the DMPA Checklist?
• The DMPA Checklist is composed of two sets of questions: questions 1-7 for determining if the client is medically eligible to use DMPA and questions 8-13 to be reasonably sure that the client is not pregnant. First we will discuss the questions related to medical eligibility, and then we will discuss the questions designed to rule out pregnancy.

Medical Eligibility Questions (Questions 1-7)
• The first set of questions on the DMPA checklist is based on the WHO Medical Eligibility Criteria for Contraceptive Use (MEC). The WHO MEC is a set of recommendations to support the development of guidelines for providing contraceptives. It is updated by a WHO expert working group every three to four years (or as needed), in order to reflect the latest clinical and epidemiological data. The Quick Reference Chart on page 46 is a condensed version of the information contained in the WHO MEC (2004).
• The WHO MEC takes various individual characteristics (e.g., age, breastfeeding status) or health conditions (e.g., diabetes, hypertension) that may or may not affect eligibility for the use of each contraceptive method and classifies them into four categories.
<table>
<thead>
<tr>
<th>Category</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No restriction for use of method</td>
</tr>
<tr>
<td>2</td>
<td>Advantage of using method outweighs theoretical or proven risk: method generally can be used, but follow-up may be required</td>
</tr>
<tr>
<td>3</td>
<td>Theoretical or proven risk outweighs the advantages of using method: method not recommended except if other more appropriate methods are not available/acceptable</td>
</tr>
<tr>
<td>4</td>
<td>Method should not be used</td>
</tr>
</tbody>
</table>

- The DMPA checklist includes questions related to categories 3 and 4 only. These two categories include conditions for which the method is either not recommended or should not be used. Category 1 and 2 conditions are not addressed on the checklist because research shows that women with these conditions can use DMPA safely.

**Pregnancy-Related Questions (Questions 8-13)**

- The second set of questions on the DMPA Checklist is taken directly from another checklist entitled *How to Be Reasonably Sure a Client is Not Pregnant* (Pregnancy Checklist). The pregnancy-related questions were added to the DMPA Checklist in order to address a medical barrier that women often encounter when seeking DMPA at a time when they are not menstruating. In countries where resources are limited and pregnancy tests are often unavailable or unaffordable, many providers worry that these women may be pregnant (unless they are within four weeks postpartum). Many of these clients are sent home, often without contraception, to await menses. Those who are unable to return — often because of time and money constraints — risk unintended pregnancy.

- The questions from the Pregnancy Checklist help providers to be reasonably sure a woman is not pregnant or to decide that another approach is required to rule out pregnancy. Each question describes a situation that effectively prevents a woman from getting pregnant. **The checklist is not a diagnostic tool for determining if a woman is pregnant.** (Note that women in whom pregnancy was not ruled out by questions 8-13 are not necessarily pregnant.)
Objectives: To understand the design of the DMPA Checklist.

To practice using the DMPA Checklist in different scenarios to ensure that participants are comfortable using it.

Training Steps:
1. Discuss the checklist’s design and explain how to use the checklist. Then ask participants if they have any questions, and clarify anything they did not understand.

2. Conduct Exercise D to allow everyone in the group to practice administering the checklist.
**Advance Preparation**

Prior to the training:

- photocopy the Scenario Exercises for Participants (page 35-36);
- make sure you are familiar with the information provided in the Answer Guide to Scenarios (page 37-44);
- make photocopies, if desired, of the Answer Guide to distribute at the end of the session;
- prepare a flip chart page containing the following questions:
  - Is this client a good candidate for receiving DMPA during today’s visit?
  - Why or why not?
  - What course of action would you take next? (For example: counsel, refer, provide DMPA, send client home with condoms to await menses, administer a pregnancy test, etc.)
  - Did you experience any problems applying the checklist to your scenarios?

**Objective:** To help participants become comfortable using the DMPA Checklist.

1. Introduce the scenario exercises and explain that participants will be grouped into pairs. Each pair will receive two scenarios. Within each pair, one participant will play the role of the client and the other will play the provider administering the checklist. Participants will then switch roles for the second scenario and repeat the process. This way, everyone will have a chance to practice using the checklist and to experience both roles.

2. Explain that after they role-play their scenarios, each pair should discuss and be able to answer the questions on the flip chart.

3. Divide the participants into pairs and distribute two scenarios to each pair. Participants will have 10 minutes to role-play each scenario and 10 minutes to answer the questions on the flip chart (40 minutes total). Give the following instructions, according to the role the participants will play:

   **For participants acting as providers**
   
   - Make sure you have read and understood the checklist questions and explanations before administering the checklist to the client.
   - Ask the client the checklist questions and follow instructions to determine if the client can initiate DMPA.
   - Trust the client’s response.
• Base your decisions on the DMPA Checklist questions only, and not on any assumptions about the client. Doing so could lead you to the wrong conclusion and cause you to unnecessarily deny your client access to contraception.

• You may answer questions or define terms, if necessary. However, do not make substantive changes to the checklist questions; for example, do not separate one question into two questions or combine two questions into one.

For participants acting as clients

• Read the scenario carefully and answer the checklist questions based on the situations outlined in the scenario.

• If a situation is not specifically described in the scenario, you should answer “NO”. For example, if the scenario does not specify that the woman’s last menstrual period started within the past seven days, you, as a client, should answer NO to that question.

4. Reconvene the group and discuss each scenario with the whole group. Depending on the number of participant pairs, this part of the exercise may take between one and a half to two hours. For each scenario, ask a participant pair to share their answers to the questions on the flip chart. If they do not answer questions 1 or 2 correctly, or if additional possibilities exist in answer to question 3, solicit responses from the other participants, or provide it from the answer guide.

5. For each checklist question, discuss any concerns participants have about its phrasing or clarity. Help the group find ways to explain or rephrase the question without changing its meaning. Be familiar with the information in the Adapting the Checklist to the Local Context section of this guide, page 53.

6. When discussing a scenario in which pregnancy cannot be ruled out, emphasize that the client should be told she is not necessarily pregnant, but that, due to her responses, another approach will be needed to rule out pregnancy (either a pregnancy test, a pelvic exam, or awaiting her next menses). If she has to wait to rule out pregnancy, always provide her with some form of protection against pregnancy, such as condoms.

7. After all the scenarios have been discussed, the Answer Guide to Scenarios (page 37) may be distributed to the participants for their future reference.
8. A course of action has been outlined for each scenario. However, if any adaptations are made to the scenarios and/or checklist, it should be recognized that the course of action may change somewhat as well.

9. The scenarios have been designed to work with any provider training group. To further adapt the training to meet the needs of a specific audience, scenarios may be modified by the facilitator or by another qualified person. Additional scenarios may also be created.

Optional approaches for conducting scenarios

- Ask one or more of the participant pairs to role-play in front of the larger group. Have the whole group discuss each scenario before going on to the next one.
- Instead of role-playing in pairs, ask participants to work individually, each one developing a response to their scenario(s). Then have some participants present their response to the larger group.
- Ask participants to work individually and then find two or three people who had the same scenario. They should discuss their responses and see how they differ. These small groups could then share with the larger group.
Facilitator's Resource:

How does the DMPA Checklist work?

The DMPA checklist is designed to use the provider’s time as efficiently as possible. Notice that instructions for both sets of questions on the checklist state: “As soon as the client answers YES to any question, stop, and follow the instructions below.” This means that if the client answers “YES” to any question, the provider is finished with that set of questions. Therefore, depending on the client’s responses, the questioning may proceed question by question, OR the provider may discover the woman is not a good candidate early in the questioning.

The DMPA Checklist consists of 13 questions, as well as instructions for providers based on a woman’s responses. The first set of questions is meant to determine if the woman can use DMPA (questions 1-7, related to medical eligibility). The second set of questions is meant to identify women who are not pregnant and to determine if they can start using DMPA right away (questions 8-13, related to pregnancy). Each of the checklist questions is explained in more detail on the reverse side of the checklist. Providers should refer to these explanations to understand the intent of the questions.

Medical Eligibility Questions

- **“Yes” response** — If a woman answers “YES” to any one of these questions, she is not medically eligible to receive DMPA; however, some of these women may become medically eligible after further evaluation. See the instruction box at the bottom of this set of questions and follow the guidance provided there.

- **“No” response** — If a woman answers “NO” to all questions, the client is medically eligible to receive DMPA. However, pregnancy must be ruled out first. Proceed to the pregnancy-related questions.

Pregnancy-Related Questions

- **“Yes” response** — If a woman answers “YES” to any one question and is free from signs and symptoms of pregnancy, providers can be 99 percent sure she is not pregnant. Provide DMPA according to the instructions.

- **“No” response** — If a woman answers “NO” to all questions, she has not been protected from pregnancy. To rule out pregnancy in these women, the provider will need to do a pregnancy test, conduct a pelvic exam, or have the woman return when she is menstruating. If the client is sent home to await her menses, always provide her with condoms to use in the meantime.
When asking women questions from the checklist, providers should not confuse or replace diseases and conditions with signs and symptoms.

- One symptom can indicate several possible conditions. Also, many symptoms are not accurate indicators, so their presence could unnecessarily prevent a woman from using DMPA. For example, if the original question asks a woman if she has ever had a heart attack, it should not be changed to instead ask if she has ever had chest pain or shortness of breath. These symptoms may have many causes and do not necessarily indicate a history of heart attack. (Shortness in breath may indicate poor physical condition, asthma, common cold, bronchitis, heart disease, heart attack, etc.)

Generally, the conditions asked about on the checklist are serious enough that a woman would know if she has them because she would have had to seek medical attention for them. This is why several of the questions begin with “Have you ever been told…”, “Do you have…”, and “Have you ever had…”. If a woman has not been told she has a condition, providers should assume she does not have it.

Providers should make an effort to build trusting relationships with clients before administering the DMPA Checklist. For example, the provider might wish to convey to the client the necessity of answering as accurately and as honestly as possible, in order to avoid possible complications which may develop when DMPA is initiated in women with certain medical conditions. The majority of women will answer honestly to the best of their ability.
### Example for medical eligibility questions

A woman answers “NO” to questions 1 and 2, but then she answers “YES” to question 3 because she has been told she has jaundice. The provider should stop asking questions and read the instructions in the red box under the set of questions. The instruction is that this woman is not a good candidate for DMPA. She should be counseled about other available methods and, if needed, be referred for evaluation or treatment of her medical condition.

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.

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

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 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.
Example for pregnancy-related questions
A woman answers “NO” to questions 8 and 9, but then answers “YES” to question 10 because she has abstained from sexual intercourse since her last menstrual period. The provider should now stop asking questions, because a “YES” response to any of the questions indicates a circumstance under which it is highly unlikely that a woman could be pregnant.

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.

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

If the client answered YES to at least one of the questions 8–13, and she is free from 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.
Optional information: If participants are curious and asking questions about the design elements of the checklist, such as arrows and colors, an explanation is provided below for your use in addressing these questions. It is important to note that while these design elements provide visual cues, they are secondary to the main instructions on the checklist, which participants must follow.

- The arrows next to the “YES” responses and the straight lines next to the “NO” responses offer cues as to how to proceed through the questions. The arrows indicate the provider should end the questioning and jump directly to the instruction box below that set of questions. The straight lines indicate the provider must proceed to the next question.

- Generally, if the client’s response falls in the GREEN boxes, she is a good candidate, and if her response falls in the RED box, she is probably not a good candidate. However, for the eligibility questions, ALL of the client’s answers must fall in the green boxes for the woman to be a good candidate, whereas for the pregnancy questions ONE answer in the green boxes is sufficient for her to be a good candidate.
Objectives: To summarize what was accomplished during the training session.
To address any remaining issues.
To thank participants for their attention and participation.

Training Steps:
1. Briefly summarize the objectives and accomplishments of the training.

2. Show participants the flip chart page containing the expectations they expressed at the beginning of the training. Ask participants if these expectations have been met.

3. Engage participants in a wrap-up discussion, by asking the following questions:
   - Was the DMPA Checklist easy to use?
   - Was it easy to explain questions to the client?
   - What problems did you encounter while using the checklist?
   - Do you foresee any barriers to using the checklist in your work? How could these barriers be overcome?
   - What would help you to use the checklist in your work?
   - Do you have any suggestions for improving the checklist or for getting more providers to use it?
   - What did you find helpful about the training?
   - Could the training be improved in any way? If so, how?

This is a good way to end the training, because it allows you to address any issues or concerns that participants may have. Also, FHI requests that you compile these responses and forward them to our staff at publications@fhi.org for future improvements to this guide.

4. Thank the participants for their time and energy. Tell them whom they should contact for more information or materials.

5. Distribute certificates of attendance to each participant.
Training and Reference Guide for a Screening Checklist to Initiate DMPA

**Objective:** To understand the research surrounding the need for and the effectiveness of the Pregnancy Checklist.

**Training Steps:**
1. Summarize the research on the rationale for the Pregnancy Checklist.
2. Summarize the research validating the Pregnancy Checklist.

**Facilitator’s Resource:**

**Research on the rationale for the Pregnancy Checklist**
- The checklist was developed to reduce barriers to contraception for women who are not menstruating at the time of their visit. Research on menstruation requirements has been done in several countries.
  - Kenya — an estimated one-third of all new clients were sent home without a contraceptive method because of a menstruation requirement (Stanback et al. 1999).
  - Ghana — 76 percent of health care providers said they would send a client home if she was not menstruating at the time of her visit (Twum-Baah and Stanback 1995).
  - Cameroon — only one-third of nonmenstruating clients received hormonal contraceptive methods because providers were unsure of clients’ pregnancy status (Nkwi et al. 1995).
  - Jamaica — 92 percent of clients were required to be menstruating or to have a negative pregnancy test at the time contraceptives were provided (McFarlane et al. 1996).

- Additional research evaluated whether using the checklist reduced the number of women denied contraceptives because they were not menstruating at the time of their visits.
  - In Guatemala, 16 percent of nonmenstruating women were denied their contraceptive choice when no checklist was used. After providers began using the checklist, only 2 percent of women were denied (Stanback et al. 2005).
  - In Senegal, the situation was similar; fewer women were denied their contraceptive method of choice after providers were introduced to the checklist — 11 percent were denied without the checklist versus 6 percent when the checklist was available (Stanback et al. 2005).
Research on the validity of the Pregnancy Checklist

The Pregnancy Checklist has been extensively tested to ensure that it is valid and that women identified by the checklist as not pregnant truly are not pregnant. Research has been done in Kenya, Guatemala, Mali, Senegal, and Egypt. Those studies posed several questions to determine the checklist’s validity.

Does the checklist accurately predict that a woman is not pregnant?
Yes — Researchers compared the checklist results with a pregnancy test and found that more than 99 percent of the time the checklist was correct in ruling out pregnancy. In the very rare cases where the checklist ruled out pregnancy but the client was actually pregnant, the reasons included contraceptive failure or inaccurate answers given by the client.

Does the checklist accurately predict that a woman is pregnant?
No — Most women who are identified as possibly pregnant are, in fact, not pregnant. Researchers gave pregnancy tests to women who answered no to all questions and found that less than 15 percent were actually pregnant. If pregnancy is not ruled out by the checklist, the woman should be referred for additional evaluation or a pregnancy test, or should await menses.

Optional information: At the end of the Pregnancy Checklist, it states that “If the client answered YES to at least one of the questions and she is free of signs or symptoms of pregnancy, provide client with desired method.” Research shows that the six questions are much more reliable in determining whether a woman is not pregnant than are signs and symptoms. If a provider is trained to do so, signs and symptoms should be assessed in addition to, but not instead of, administering the checklist. If a provider is not trained to assess signs and symptoms of pregnancy, the provider should feel confident that pregnancy has been ruled out based on the questions alone. (Symptoms may include nausea, mood changes, and missed menstrual period(s), and signs may be uterine softness and breast tenderness.)

Emphasize that the checklist was developed to RULE OUT pregnancy and to minimize barriers women face in seeking contraception. The checklist CANNOT be used to diagnose pregnancy.
1. **DMPA Scenario**
   You had a heart attack a year ago that you saw a doctor for.

2. **DMPA Scenario**
   You are a 42-year-old woman and are healthy. Three years ago you had surgery to remove an abnormal breast lump, which was confirmed to be cancer.

3. **DMPA Scenario**
   You are currently seeing a doctor for a liver problem because you had noticed that your eyes had become yellow. (You have active viral hepatitis.)

4. **DMPA Scenario**
   A provider told you that you have high blood sugar.

5. **DMPA Scenario**
   You were told you had high blood pressure when you went to the clinic two years ago.

6. **DMPA Scenario**
   You have been experiencing light vaginal bleeding/spotting at different times throughout the month for about two months. You never had this happen before.

7. **DMPA Scenario**
   You had a baby two weeks ago and are breastfeeding.

8. **DMPA Scenario**
   You are a healthy woman who started your menses five days ago.

9. **DMPA Scenario**
   You are a healthy woman who answers “NO” to all the checklist questions.

10. **DMPA Scenario**
    You are a 37-year-old woman with four children and are requesting DMPA. Your doctor told you on two occasions that you had an elevated blood pressure (140/85 Hg) but that you don’t need to take any medication yet to control it. (If the provider wants to take your blood pressure, tell them that it is 140/85 Hg.) Your husband has been away from home for the past two weeks and you haven’t had sex since your last menstrual period.
11 DMPA Scenario
You are a 28-year-old woman with three children. You and your husband consider your family complete (you do not want any more children) and would like to use an effective contraceptive method. After a counseling session, you decided that you want to initiate DMPA. You are healthy, but for the past two months you have noticed light bleeding/spotting every time you’ve had intercourse. You meant to go to the doctor, but hadn’t gotten around to it yet.

12 DMPA Scenario
You are a 31-year-old woman who gave birth seven weeks ago and want to prevent another pregnancy by using DMPA as your method of choice. You are breastfeeding your baby, but sometimes you have to be away from home for work. When that happens, your mother-in-law gives the baby formula. Your husband uses a condom every time you have sex.

13 DMPA Scenario
You were just diagnosed with a blood clot in your leg and are currently being treated for it.

14 DMPA Scenario
You are a 26-year-old woman planning to initiate DMPA as your method of choice. You are healthy; the only time you had a health problem was during your last pregnancy when a doctor registered elevated blood pressure. However, your blood pressure returned to normal after delivery. Among other things:

You are in the middle of your menstrual cycle,
Your youngest baby is one year old,
You and your husband have intercourse at least twice a week,
You have never had a spontaneous or induced abortion,
You are trying to use the calendar method for family planning, but are having trouble calculating safe days.
DMPA Scenario 1

You had a heart attack a year ago that you saw a doctor for.

1. *Is this client a good candidate for receiving DMPA during today’s visit?*
   No.

2. *Why or why not?*
   She is not medically eligible because she should answer “YES” to question 1 — *Have you ever had a stroke or heart attack, or do you currently have a blood clot in your legs or lungs?* Women with these conditions may be at somewhat increased risk of blood clots if they take 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.

3. *What course of action would you take next?*
   She should be counseled on other available contraceptive options, such as IUDs, implants, condoms or sterilization, for which a history of heart attack is not a contraindication.

DMPA Scenario 2

You are a 42-year-old woman and are healthy. Three years ago you had surgery to remove an abnormal breast lump, which was confirmed to be cancer.

1. *Is this client a good candidate for receiving DMPA during today’s visit?*
   No.

2. *Why or why not?*
   She is not medically eligible because she should answer “YES” to question 2 — *Have you ever been told you 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. *What course of action would you take next?*
   She should be counseled on other available contraceptive options, such as IUDs, condoms or sterilization, for which breast cancer is not a contraindication.
DMPA Scenario 3

You are currently seeing a doctor for a liver problem because you had noticed that your eyes had become yellow. (You have active viral hepatitis.)

1. **Is this client a good candidate for receiving DMPA during today’s visit?**
   No.

2. **Why or why not?**
   She is not medically eligible because she should answer “YES” to question 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, liver tumors or active hepatitis) and past liver problems (such as history of hepatitis). Women with serious liver disease should not use DMPA, because DMPA is processed by the liver and its use may adversely affect women whose liver function is already weakened by the disease.

3. **What course of action would you take next?**
   She should be counseled on other available contraceptive options, such as IUDs, condoms or sterilization, for which active viral hepatitis is not a contraindication. As part of her counseling, she should be guided to talk with her provider about her liver condition and the possibility of beginning DMPA after treatment is completed.

DMPA Scenario 4

A provider told you that you have high blood sugar.

1. **Is this client a good candidate for receiving DMPA during today’s visit?**
   No.

2. **Why or why not?**
   She is not medically eligible because she should answer “YES” to question 4 — *Have you ever been told you have diabetes (high sugar in your blood)?* Among women with diabetes, those who have had the disease for 20 years or longer, or those with vascular complications should not be using DMPA because of the increased risk of blood clots.
3. **What course of action would you take next?**

Evaluate or refer the client to a higher-level provider for evaluation. If she has no complications, the woman may still be a good candidate for DMPA. Provide her with condoms to use in the meantime.

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**DMPA Scenario 5**

You were told you had high blood pressure when you went to the clinic two years ago.

1. **Is this client a good candidate for receiving DMPA during today's visit?**
   
   No.

2. **Why or why not?**
   
   She is not medically eligible because she should answer “YES” to question 5 — *Have you ever been told you have high blood pressure?* Women with blood pressure of 160/100 or higher should not use DMPA because they may be at increased risk of stroke or heart attack.

3. **What course of action would you take next?**

   Evaluate or refer the client to a higher-level provider for evaluation. If her blood pressure is below 160/100, she may still be eligible to receive DMPA. Provide her with condoms to use in the meantime.

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**DMPA Scenario 6**

You have been experiencing light vaginal bleeding/spotting at different times throughout the month for about two months. You never had this happen before.

1. **Is this client a good candidate for receiving DMPA during today's visit?**
   
   No.

2. **Why or why not?**

   She is not medically eligible because she should answer “YES” to question 6 — *Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?* This client 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 or treated by a higher-level health care provider. DMPA use should be delayed.
3. **What course of action would you take next?**
Evaluate or refer the client to a higher-level provider for evaluation. She may still be a good candidate for DMPA after the cause of the unusual bleeding is established. Provide her with condoms to use in the meantime.

**DMPA Scenario 7**

You had a baby two weeks ago and are breastfeeding.

1. **Is this client a good candidate for receiving DMPA during today’s visit?**
   No.

2. **Why or why not?**
   She is not medically eligible because she should answer “YES” to question 7 — *Are you currently breastfeeding a baby less than six weeks old?* There is some concern that the hormones in breast milk could have an adverse effect on a newborn during the first six weeks after birth.

3. **What course of action would you take next?**
   The provider should ask the client to return for her DMPA injection in four weeks. Note that if the woman says she cannot return in four weeks, it is a policy in some countries to give the first postpartum injection at the time she requests it (or even in some cases at discharge from the hospital). The facilitator will need to be aware of the national guidelines and adapt this answer accordingly.

**DMPA Scenario 8**

You are a healthy woman who started your menses five days ago.

1. **Is this client a good candidate for receiving DMPA during today’s visit?**
   Yes.

2. **Why or why not?**
   She is medically eligible because she answered “YES” to question 8 — *Did your last menstrual period start within the past 7 days?* — which means she is not pregnant. Each of the pregnancy-related questions (8-13) describes a condition
which effectively prevents a woman from getting pregnant. Thus, there is practically no chance a woman may be pregnant if she has any one of these conditions present.

3. **What course of action would you take next?**
The provider should provide the client with DMPA. No additional contraceptive protection is needed.

### DMPA Scenario 9

You are a healthy woman who answers “NO” to all the checklist questions.

1. **Is this client a good candidate for receiving DMPA during today’s visit?**
   No.

2. **Why or why not?**
   She is not eligible because pregnancy has not been ruled out (since she answered “NO” to questions 8-13). Although she is medically eligible to use DMPA, if she is pregnant, she does not need a contraceptive. (Accidentally initiating DMPA will not harm a developing fetus.)

3. **What course of action would you take next?**
The provider should let the client know that she is not necessarily pregnant, but that another approach will be needed to rule out pregnancy (either a pregnancy test, awaiting her next menses, or a pelvic exam). Stress to providers that they should not lead the client to believe that she is pregnant and always provide her with some form of protection against pregnancy, such as condoms, until pregnancy can be confirmed or ruled out.

### DMPA Scenario 10

You are a 37-year-old woman with four children and are requesting DMPA. Your doctor told you on two occasions that you had an elevated blood pressure (140/85 Hg) but that you don’t need to take any medication yet to control it. (If the provider wants to take your blood pressure, tell them that it is 140/85 Hg.) Your husband has been away from home for the past two weeks and you haven’t had sex since your last menstrual period.

1. **Is this client a good candidate for receiving DMPA during today’s visit?**
   Yes.
2. **Why or why not?**
   She is medically eligible because although she answered “YES” to question 5, her blood pressure is low enough. The explanation for question 5 states that women with blood pressure levels of 160/100 Hg or more should not initiate DMPA. Because the client’s blood pressure is somewhat elevated, but still below 160/100, she can be an appropriate candidate for DMPA use.

3. **What course of action would you take next?**
   Proceed with DMPA initiation. The facilitator may point out that some follow-up may be required after she initiates DMPA to make sure that her blood pressure remains the same. (This is true for all conditions in category 2.)

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**DMPA Scenario 11**

You are a 28-year-old woman with three children. You and your husband consider your family complete (you do not want any more children) and would like to use an effective contraceptive method. After a counseling session, you decided that you want to initiate DMPA. You are healthy, but for the past two months you have noticed light bleeding/spotting every time you’ve had intercourse. You meant to go to the doctor, but hadn’t gotten around to it yet.

1. **Is this client a good candidate for receiving DMPA during today’s visit?**
   No.

2. **Why or why not?**
   The explanation for question 6 suggests that unusual bleeding after intercourse may indicate an underlying pathological condition. While DMPA use won’t make this condition worse, it may change bleeding patterns and mask symptoms, making timely diagnosis more difficult.

3. **What course of action would you take next?**
   DMPA use should be delayed until the condition can be evaluated. Provide her with condoms to use in the meantime.
**DMPA Scenario 12**

You are a 31-year-old woman who gave birth seven weeks ago and want to prevent another pregnancy by using DMPA as your method of choice. You are breastfeeding your baby, but sometimes you have to be away from home for work. When that happens, your mother-in-law gives the baby formula. Your husband uses a condom every time you have sex.

1. **Is this client a good candidate for receiving DMPA during today’s visit?**
   Yes.

2. **Why or why not?**
   According to the explanation for question 7, a breastfeeding woman can initiate DMPA six weeks after her baby is born. Because this client gave birth seven weeks ago she is medically eligible to start DMPA. Also, because condoms are used at every sex act, she would answer “YES” to question 13 — *Have you been using a reliable contraceptive method consistently and correctly?* Therefore, pregnancy is ruled out.

3. **What course of action would you take next?**
   Proceed with initiation of DMPA.

**DMPA Scenario 13**

You were just diagnosed with a blood clot in your leg and are currently being treated for it.

1. **Is this client a good candidate for receiving DMPA during today’s visit?**
   No.

2. **Why or why not?**
   She should answer “YES” to question 1 — *Have you ever had a stroke or heart attack, or do you currently have a blood clot in your legs or lungs?* Women with a blood clot in their leg may be at risk of making their condition worse if they take DMPA. Women who have this condition usually seek medical attention, are told that they have this condition and will answer “YES”.

3. **What course of action would you take next?**
   Counsel the woman about other available contraceptive options, such as an IUD, condoms or sterilization, for which deep venous thrombosis (blood clot) is not a contraindication.
DMPA Scenario 14

You are a 26-year-old woman planning to initiate DMPA as your method of choice. You are healthy; the only time you had a health problem was during your last pregnancy when a doctor registered elevated blood pressure. However, your blood pressure returned to normal after delivery. Among other things:

You are in the middle of your menstrual cycle,
Your youngest baby is one year old,
You and your husband have intercourse at least twice a week,
You have never had a spontaneous or induced abortion,
You are trying to use the calendar method for family planning, but are having trouble calculating safe days.

1. **Is this client a good candidate for receiving DMPA during today’s visit?**
   No.

2. **Why or why not?**
   According to the instructions for questions 8-13, women who answered “NO” to all six questions are not protected from pregnancy and the provider cannot be reasonably sure that such women are not pregnant at the time of their visit.

3. **What course of action would you take next?**
   Depending on available resources, either pregnancy can be ruled out by a pregnancy test or the woman should wait until her next menstrual period begins before starting DMPA. She should be given condoms to use in the meantime.
**Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use**

To initiate use of combined oral contraceptives (DMPAs), depot-medroxyprogesterone acetate (DMPA), norethisterone enantate (NET-EN), copper intrauterine device (Cu-IUD)

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>DMPA</th>
<th>DMPA/NET-EN</th>
<th>CU-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menarche to 39 years</td>
<td></td>
<td></td>
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<tr>
<td>40 years or more</td>
<td></td>
<td></td>
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<tr>
<td>Menarche to 17 years</td>
<td></td>
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<tr>
<td>18 years to 45 years</td>
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<tr>
<td>More than 45 years</td>
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<tr>
<td>Menarche to 19 years</td>
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<tr>
<td>20 years or more</td>
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<td></td>
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</tr>
<tr>
<td>Nulliparous</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Less than 6 weeks postpartum</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>6 weeks to 6 months postpartum</td>
<td></td>
<td></td>
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<tr>
<td>6 months postpartum or more</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>Age &lt; 35 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age ≥ 35 years, &lt; 15 cigarettes/day</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Hypertension</td>
<td>History of hypertension where blood pressure:</td>
<td></td>
<td></td>
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<tr>
<td>Systolic 140 - 159 or diastolic 90 - 99</td>
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<tr>
<td>Headaches</td>
<td>Non-migrainous (mild or severe)</td>
<td></td>
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<tr>
<td>Migraine without aura (age &lt; 35 years)</td>
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<td>Migraines with aura</td>
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<tr>
<td>History of deep venous thrombosis</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Diabetes</td>
<td>Non-vascular disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vascular disease or diabetes of ≥ 20 years</td>
<td></td>
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<tr>
<td>Sickle cell anemia</td>
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</tbody>
</table>

**Category 1** There are no restrictions for use.

**Category 2** Generally use; some follow-up may be needed.

**Category 3** Usually not recommended; clinical judgment and continuing access to clinical services are required for use.

**Category 4** The method should not be used.

* Breastfeeding does not affect initiation and use of the IUD. Regardless of breastfeeding status, postpartum insertion of the IUD is Category 2 up to 48 hours postpartum, Category 3 from 48 hours to four weeks, and Category 1 four weeks and after.

** Evaluation should be pursued as soon as possible.

Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use –
to initiate or continue use of combined oral contraceptives (DMPAs), depot-medroxyprogesterone acetate (DMPA), norethisterone enantate (NET-EN), copper intrauterine device (Cu-IUD)

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<tr>
<td>Sickle cell anemia</td>
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<tr>
<td>Known hyperlipidemias</td>
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<tr>
<td>Cancers</td>
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<tr>
<td>Cervical</td>
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<tr>
<td>Endometrial</td>
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<tr>
<td>Ovarian</td>
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<tr>
<td>Cervical ectropion</td>
<td>Undiagnosed mass</td>
<td></td>
<td>** **</td>
</tr>
<tr>
<td>Family history of cancer</td>
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<tr>
<td>Current cancer</td>
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<tr>
<td>Uterine fibroids without cavity distortion</td>
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<tr>
<td>Endometriosis</td>
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<td></td>
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<tr>
<td>Trophoblast disease (malignant gestational)</td>
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<tr>
<td>Vaginal bleeding patterns</td>
<td></td>
<td></td>
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<tr>
<td>Irregular without heavy bleeding</td>
<td></td>
<td></td>
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<tr>
<td>Heavy or prolonged, regular and irregular</td>
<td></td>
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<tr>
<td>Unexplained bleeding</td>
<td></td>
<td></td>
<td>I C</td>
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<tr>
<td>Cirrhosis</td>
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<tr>
<td>Mild</td>
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<td></td>
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<tr>
<td>Severe</td>
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<td></td>
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<tr>
<td>Current symptomatic gall bladder disease</td>
<td></td>
<td></td>
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<tr>
<td>Cholestasis</td>
<td></td>
<td></td>
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<tr>
<td>Related to the pregnancy</td>
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<tr>
<td>Related to oral contraceptives</td>
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<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
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<tr>
<td>Active</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Client is a carrier</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Liver tumors</td>
<td></td>
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<tr>
<td>STIs/PID</td>
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<td></td>
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<tr>
<td>Current purulent cervicitis, chlamydia, gonorrhea</td>
<td></td>
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<td>I C</td>
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<tr>
<td>Vaginitis</td>
<td></td>
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<tr>
<td>Current pelvic inflammatory disease (PID)</td>
<td></td>
<td></td>
<td>I C</td>
</tr>
<tr>
<td>Other STIs (excluding HIV/hepatitis)</td>
<td></td>
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<tr>
<td>Increased risk of STIs</td>
<td></td>
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<tr>
<td>Very high individual risk of exposure to STIs</td>
<td></td>
<td></td>
<td>I C</td>
</tr>
<tr>
<td>HIV</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>High risk of HIV or HIV-infected</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No antiretroviral therapy (ART)</td>
<td></td>
<td></td>
<td>I C</td>
</tr>
<tr>
<td>Not clinically well on ART therapy</td>
<td></td>
<td></td>
<td>I C</td>
</tr>
<tr>
<td>Clinically well on ART therapy</td>
<td></td>
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<tr>
<td>Use of:</td>
<td></td>
<td></td>
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<tr>
<td>Griseofulvin</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Rifampicin</td>
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<td></td>
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<tr>
<td>Other antibiotics</td>
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</tbody>
</table>

I/C (Initiation/Continuation): A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method. For example, a client with current PID who wants to initiate IUD use would be considered as Category 4, and should not have an IUD inserted. However, if she develops PID while using the IUD, she would be considered as Category 2. This means she could generally continue using the IUD and be treated for PID with the IUD in place. Where I/C is not marked, a woman with that condition falls in the category indicated – whether or not she is initiating or continuing use of the method.

Breastfeeding does not affect initiation and use of the IUD. Regardless of breastfeeding status, postpartum insertion of the IUD is Category 2 up to 48 hours postpartum, Category 3 from 48 hours to four weeks, and Category 1 four weeks and after.

Evaluation should be pursued as soon as possible.
Assessing Medical Eligibility for DMPA

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

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 the condition and will answer “yes.” Answering “yes” to any part of the question means that the woman is not a good candidate for DMPA.

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...
### 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.

<table>
<thead>
<tr>
<th>Question</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever had a stroke or heart attack, or do you currently have a blood clot in your legs or lungs?</td>
<td><strong>NO</strong> Proceed to questions 8–13. <strong>YES</strong> Stop, follow the instructions below.</td>
</tr>
<tr>
<td>2. Have you ever been told you have breast cancer?</td>
<td><strong>NO</strong> Proceed to question 8. <strong>YES</strong> Refer.</td>
</tr>
<tr>
<td>3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?</td>
<td><strong>NO</strong> Proceed to question 8. <strong>YES</strong> Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.</td>
</tr>
<tr>
<td>4. Have you ever been told you have diabetes (high sugar in your blood)?</td>
<td><strong>NO</strong> Proceed to question 8. <strong>YES</strong> Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.</td>
</tr>
<tr>
<td>5. Have you ever been told you have high blood pressure?</td>
<td><strong>NO</strong> Proceed to question 8. <strong>YES</strong> Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.</td>
</tr>
<tr>
<td>6. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?</td>
<td><strong>NO</strong> Proceed to question 8. <strong>YES</strong> Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.</td>
</tr>
<tr>
<td>7. Are you currently breastfeeding a baby less than 6 weeks old?</td>
<td><strong>NO</strong> Proceed to question 8. <strong>YES</strong> Instruct her to return for DMPA as soon as possible after the baby is six weeks old.</td>
</tr>
</tbody>
</table>

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 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.

<table>
<thead>
<tr>
<th>YES</th>
<th>8. Did your last menstrual period start within the past 7 days?</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>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?</td>
<td>NO</td>
</tr>
<tr>
<td>YES</td>
<td>10. Have you abstained from sexual intercourse since your last menstrual period or delivery?</td>
<td>NO</td>
</tr>
<tr>
<td>YES</td>
<td>11. Have you had a baby in the last 4 weeks?</td>
<td>NO</td>
</tr>
<tr>
<td>YES</td>
<td>12. Have you had a miscarriage or abortion in the last 7 days?</td>
<td>NO</td>
</tr>
<tr>
<td>YES</td>
<td>13. Have you been using a reliable contraceptive method consistently and correctly?</td>
<td>NO</td>
</tr>
</tbody>
</table>

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.
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 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 breast milk 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.

**Determining Current Pregnancy**
Questions 8–13 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.
The purpose of this reference guide is to provide essential information that supplements the training module. This information includes:

- recommendations on adapting the checklist to the local context;
- basic evidence-based information on DMPA; and
- an annotated bibliography.

The facilitator should anticipate — and be well prepared to answer — questions that are likely to arise and that are beyond the scope of the DMPA Checklist. The checklist is intended solely to help providers decide if clients may or may not safely initiate DMPA. However, participants may well inquire about such issues as DMPA side effects or DMPA use by specific client populations, such as women who are at risk of HIV or who are living with AIDS, etc. This guide does not attempt to provide comprehensive information about DMPA, and trainers should consult other resources as needed.
The DMPA Checklist can be adapted to meet the specific needs of a local area or program, or to align with national guidelines that may apply. However, before the adapted version is finalized and put into use, we strongly recommend that any changes be reviewed by an expert who understands the medical basis for the provision of DMPA. Likewise, the corresponding training module should be adjusted to reflect any changes. The intent of each question is explained on the reverse side of the checklist to help with these adaptations. The following are examples of situations in which adaptation may be needed.

- **Adapting the checklist to the local language and style**
  Whenever necessary, the checklist should be translated and the style adapted to meet the cultural and linguistic needs of the intended users of the checklists and their clients. In addition to English, the checklist has been produced in French, Spanish, Kiswahili and several other languages. These checklists are available on FHI’s web site, www.fhi.org.

- **Adapting for local culture**
  Some of the questions on the checklist deal with personal issues and may need to be asked in a sensitive manner. For example, question 12 asks about miscarriage and abortion. To help ensure that the client feels safe and comfortable answering honestly, it may be useful to rephrase the question to “Have you lost a pregnancy in the last seven days?”.

- **Adapting the checklist for comprehension**
  Adaptations may also be made if the questions are too technical to be understood. Be careful, however, not to inadvertently change the intent of the question, because even small changes in wording can cause significant changes in meaning. For audiences with low literacy levels, it may be helpful to develop materials that convey key messages through illustrations with simple captions. Illustrations also should be appropriate for the local target audience.
The purpose of the DMPA Checklist is to safely allow more women to receive this contraceptive method. Poor adaptations could prevent eligible women from receiving DMPA. The following are examples of poorly adapted checklist questions.

<table>
<thead>
<tr>
<th>Original Question</th>
<th>Poorly Adapted Question</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had a stroke or heart attack, or do you currently have a blood clot in your legs or lungs?</td>
<td>Do you suffer from chest pain or unusual shortness of breath?</td>
<td>The original question intends to identify women who know they have a history of cardiovascular disease or current cardiovascular disease. It is not intended to identify or diagnose new conditions that may be contraindications for DMPA use. By listing symptoms, the adaptation turns the question into a diagnostic one and therefore changes its intention.</td>
</tr>
<tr>
<td>Have you ever been told you have breast cancer?</td>
<td>Do you have or have you ever had a breast lump?</td>
<td>The original question intends to identify women with a history of breast cancer or with current breast cancer. It does not intend to diagnose breast cancer. DMPA use is contraindicated for women with past or current breast cancer, but not for women who have an undiagnosed mass or benign breast disease (although evaluation is recommended after these women initiate DMPA).</td>
</tr>
<tr>
<td>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?</td>
<td>Are you fully or nearly fully breastfeeding and have you had no menstrual period since you gave birth?</td>
<td>The structure of the question is changed in this example. The original question identifies women who are experiencing lactational amenorrhea, which is defined by the three criteria in the question, and can be used to effectively prevent unintended pregnancy. Removing “Did you have a baby less than 6 months ago?” removes one of the criteria, so this question can no longer be used to identify women with lactational amenorrhea.</td>
</tr>
<tr>
<td>Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?</td>
<td>Do you have bleeding between menstrual periods or bleeding after intercourse (sex)?</td>
<td>This question is intended to identify women who may have an underlying pathological condition. Some women always have an irregular bleeding pattern (which is considered normal for them), and these women can use DMPA safely. Determining if the bleeding is unusual is essential, because it serves to differentiate between these women and those who experience a sudden change from regular to irregular bleeding. Such a change in a woman's bleeding pattern may suggest she has developed a pathological condition (e.g., tumor or pregnancy complication). By removing from the question the phrase “which is unusual for you”, providers may prevent many women with irregular cycles from using DMPA when, in fact, they are good candidates for the method.</td>
</tr>
</tbody>
</table>
FACT SHEET: Progestin-Only Injectables

Progestin-only injectable contraceptives (e.g., Depo-Provera, Noristerat) contain no estrogen. To prevent pregnancy, a shot is given every two or three months, depending on the type of injectable.

Primary mechanisms of action
- Prevent ovulation (release of eggs from the ovaries)
- Thicken cervical mucus (make it difficult for sperm to penetrate)

Characteristics of progestin-only injectables
- Highly effective
- Easy to use
- Reversible, with some delay in return to fertility (pregnancy occurs on average four months later than other modern methods)
- Do not interfere with intercourse, private
- Have no affect on quality or quantity of breast milk
- Have beneficial non-contraceptive effects (protection from endometrial cancer, uterine fibroids, ectopic pregnancy, and symptomatic pelvic inflammatory disease; may reduce sickle crises in women with sickle cell anemia)
- Have common side effects
- Provide no protection from sexually transmitted infections, including HIV

Possible side effects (generally not signs of a health problem)
- Irregular menstrual bleeding or spotting or heavy bleeding (more common during the first few months of use)
- Amenorrhea (common, especially after the first year of use)
- Weight gain
- Headaches and dizziness (less common than with combined oral contraceptives)
- Changes in mood and sex drive

Who can use progestin-only injectables
Women of any parity or reproductive age who:
- want to use this method of contraception
- have no contraindications
Who should not use progestin-only injectables (for a complete list, see WHO eligibility criteria)

Women who have the following conditions (contraindications):
- breastfeeding while less than six weeks postpartum
- multiple risk factors for cardiovascular disease
- blood pressure more than 160/100 mmHg
- current deep venous thrombosis
- current or history of ischemic heart disease or stroke
- unexplained vaginal bleeding (before evaluation)
- history of or current breast cancer
- diabetes with vascular complications
- active viral hepatitis, severe cirrhosis, or liver tumors

Use of progestin-only injectables by women with HIV and AIDS
- Women with HIV and AIDS can use progestin-only injectables without restrictions.
- Women with AIDS on antiretroviral drugs (ARVs) generally can use progestin-only injectables but follow-up may be required. Because contraceptive effectiveness of injectables may be somewhat reduced by ARVs, it is important to counsel women to come for their next injection on time (without any delay).
- Women with HIV who choose to use progestin-only injectables should be counseled about dual method use and consider using condoms in addition to injectable contraceptives.

Provide follow-up and counseling for
- Any client concerns or questions
- Common side effects, especially irregular bleeding or spotting or amenorrhea
- Importance of timely injections

Dispelling myths regarding progestin-only injectables
Progestin-only injectables do not:
- cause birth defects
- cause permanent infertility
Community-Based Distribution Of Depo-Provera: Evidence Of Success in the African Context

Summary
In collaboration with Save the Children USA and the Uganda Ministry of Health, Family Health International (FHI) conducted a cohort study demonstrating the safety, feasibility, and acceptability of community-based distribution (CBD) of depot-medroxyprogesterone acetate (DMPA or Depo-Provera) in a rural Ugandan district. Though paramedical provision of injectables has become routine in regions such as Asia and South America, the findings from this study are relevant because concerns about safety have rendered the practice highly controversial in sub-Saharan Africa. Study results reinforce the wealth of successful experiences from other regions and affirm that well trained community health workers can safely provide injectable contraception in the African context.

Introduction
In much of sub-Saharan Africa, a significant portion of the population lives in rural areas, leaving many women with limited access to clinic-based family planning services. Thus CBD of contraceptives remains an important service delivery mechanism in this region. Most CBD programs, however, typically only provide a limited selection of contraceptive methods, including condoms, pills, and spermicides. Despite the fact that community-based health workers in Asia and Latin America routinely provide Depo-Provera, safety concerns preclude paramedical provision of injectables in sub-Saharan Africa. Thus, women who prefer Depo-Provera are faced with the choice to travel to distant clinics to obtain it, use a less preferred method, or forego contraception altogether. Demonstrating the safety, feasibility, and acceptability of CBD of Depo-Provera in the African context, the findings from this study provide compelling evidence for programmatic and policy change that could improve women’s access to needed family planning services.

Methodology
The study took place in Nakasongola, a rural district two hours north of Uganda’s capital, Kampala. The primary aim was to assess the safety, quality, and feasibility of Depo-Provera provision by community reproductive health workers (CRHWs).

Key Points
Recent study results demonstrate the safety, feasibility, and acceptability of community-based distribution of Depo-Provera in the African context.

Depo-Provera clients of CRHWs were equally satisfied with the quality of care received and with their method as were clients of clinic-based providers.

Clients of CRHWs continued use of Depo-Provera as long as their clinic-going counterparts.

CBD provision of Depo-Provera appears to be as safe as provision by nurses.

Community-based family planning programs in Uganda and other sub-Saharan African countries should consider making programmatic and policy changes that would allow paramedical provision of injectable contraception by appropriately trained cadres.
This was accomplished by comparing the Depo-Provera clients of CRHWs with those of clinic-based providers on the following four outcomes: three-month acceptance rates (i.e., acceptance of second Depo-Provera injection), user satisfaction, client knowledge of key information about Depo-Provera (a proxy for the quality of counseling received), and reported incidence of injection site morbidities.

Clinic staff and CRHWs enrolled a total of 945 clients. Participants included new and re-starting clients accepting Depo-Provera either in 10 designated health clinics or from the trained CRHWs. Eighty-two percent (777) of study participants were followed up by local MOH health assistants who attempted to contact each client 13 weeks after the first injection.

The CRHWs underwent intensive classroom training as well as a two-stage clinic practicum, including supervised patient screenings and provision of contraceptive injections. To ensure safety, CRHWs only used auto-disable syringes and were trained in the proper use and disposal of sharps containers. During the study, all CRHWs were supervised by staff from Save the Children and also maintained contact with staff from nearby health centers. District health officials further ensured quality control by making periodic visits to the CRHWs.

**Results**
The following results illustrate how well CRHWs provided Depo-Provera services in comparison to clinic-based nurses.

**Continuation**
After controlling for relevant covariates, statistical tests showed no significant difference in the proportion of clinic and CRHW clients receiving a second injection. Furthermore, 94% of each cohort received their second injections within the MOH-approved “grace period” after the due date.

**Client Satisfaction**
Clients of CRHWs reported being at least as satisfied with services and with Depo-Provera as clinic clients (and more often reported being “very satisfied”).

**Quality of Care**
Quality of care was measured using client reporting on whether or not the provider explained that Depo-Provera does not protect against HIV, offered condoms, discussed STI/HIV/AIDS, discussed side effects, and provided a written appointment slip. On all measures, there was little difference between client reports of care received from nurses and from CRHWs.

Findings about client counseling showed that clinic-based clients were informed about a broader range of family planning methods than CRHW clients were. In addition, clients in both cohorts demonstrated a substantially low level of knowledge about potential side effects.
Side Effects
Clients in both cohorts exhibited the normal range of side effects, with only minor differences in rates between the two groups.

Injection Safety
To measure injection safety, researchers asked CRWHs to report needle sticks (there were none) and also asked clients about any problems resulting from the first injection. Of the total 748 clients questioned about this, only 4% reported problems, many of which appeared to be minor upon further investigation (i.e., “felt dizzy,” “little pain”).

Discussion
The findings from this research reinforce the wealth of experience from other regions suggesting that well trained community health workers can safely provide contraceptive injections. Specifically, the findings demonstrate that Depo-Provera clients of community-based health workers were equally satisfied with the care given and with their method as clients of clinic-based providers. They also continued use as long as their clinic-going counterparts and received care that was, in most respects, comparable in quality. Most importantly, CBD provision of Depo-Provera appears to be as safe as provision by nurses.

While the findings were generally positive, the data also suggest that CRHWs could improve upon their injection techniques and that both CRHWs and nurses could improve upon client counseling.

Recommendations
Given the results of this research and the growing popularity of Depo-Provera in sub-Saharan Africa, it is recommended that:

- Community-based family planning programs in Uganda and other sub-Saharan African countries should consider making programmatic and policy changes that would allow paramedical provision of injectable contraception by appropriately-trained cadres.
- Ministries of Health and donors such as USAID should ensure trained CRHWs a continuing, routine supply of both Depo-Provera and auto-disable syringes.
No More Waiting!

*Using a Checklist to Rule out Pregnancy is an Effective Way to Increase Access to Contraceptives*

**Summary**

Nonmenstruating women need not wait for the onset of their menses to initiate their contraceptive method of choice. Several research studies conducted in various countries show that a simple checklist developed to help providers rule out pregnancy among such clients is correct 99 percent of the time and is effective in reducing the proportion of clients denied contraceptive services. Using this checklist offers an effective and inexpensive alternative to laboratory tests and increases women’s access to essential family planning services.

Family planning providers are required to determine whether a woman might already be pregnant before initiating use of her contraceptive method of choice. When pregnancy tests are unavailable or unaffordable, health providers often rely on the presence of menstruation as an indicator to rule out pregnancy. When women do not present with menses at the time of their visit, they are sent home — often without any contraception — to await the onset of menses. This is because providers fear that contraception can harm an unrecognized pregnancy. Data analyzed from family planning programs in Cameroon, Ghana, Jamaica, Kenya and Senegal have found that a significant proportion of new, non-menstruating clients (25% to 50%) are denied their desired method as a result of their menstrual status.¹

Clients sent home because of such menstruation requirements risk unplanned pregnancies, if they are unable to return due to time and financial constraints.

**How to be Reasonably Sure a Client is Not Pregnant**

Ask the client questions 1-6. As soon as the client answers YES to *any question*, stop, and follow the instructions.

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>1. 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?</td>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
<td>2. Have you abstained from sexual intercourse since your last menstrual period or delivery?</td>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
<td>3. Have you had a baby in the last 4 weeks?</td>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
<td>4. Did your last menstrual period start within the past 7 days (or within the past 12 days if you are planning to use an IUD)?</td>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
<td>5. Have you had a miscarriage or abortion in the past 7 days (or within the past 12 days if you are planning to use an IUD)?</td>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
<td>6. Have you been using a reliable contraceptive method consistently and correctly?</td>
<td>YES</td>
</tr>
</tbody>
</table>

If the client answered NO to *all of the questions*, pregnancy cannot be ruled out. Client should await menses or use a pregnancy test.

If the client answered YES to *at least one of the questions* and she is free of signs or symptoms of pregnancy, provide client with desired method.
Family Health International (FHI) developed a simple checklist to rule out pregnancy among such clients with a reasonable degree of certainty. The checklist consists of six questions that providers ask clients while taking their medical history. If the client answers “yes” to any of these questions, and there are no signs or symptoms of pregnancy, then a provider can be reasonably sure that the woman is not pregnant. (See Figure 1.) The six questions are based on criteria established by the World Health Organization (WHO) that indicate conditions that effectively prevent a woman from getting pregnant.

**Checklist Correctly Rules Out Pregnancy**
A study to test the validity of the checklist against a standard pregnancy test was first conducted in Kenya in 1999 and later repeated in Egypt in 2005. In both studies, the checklist correctly ruled out pregnancy 99% of the time. In addition, each of the six individual questions indicated a high predictive value in ruling out pregnancy. As a result, both studies concluded that in low resource settings, where pregnancy tests are not available, nonmenstruating women should not leave a family planning clinic without an effective method, given that providers can be reasonably sure a woman is not pregnant as determined by a “yes” response to any of the six questions on the checklist.

**Checklist Allows Significantly More Women Access to Contraceptives**
An operations research study was conducted in Guatemala, Mali, and Senegal from 2001 to 2003 to determine the impact of the checklist on family planning services. The study results showed that where denial of services to nonmenstruating family planning clients was a problem, introduction of the pregnancy checklist significantly reduced denial rates and improved access to contraceptive services.

Among new family planning clients, denial of the desired method due to menstrual status decreased significantly — from 16 percent to 2 percent in Guatemala and from 11 percent to 6 percent in Senegal. In Mali, denial rates were essentially unchanged, but were low from the start. (See Figure 2.)

**Uses of the Pregnancy Checklist Beyond Family Planning**
Although originally developed as a tool for family planning providers, the pregnancy checklist may prove useful to other health providers in low-resource settings who also need to rule out pregnancy. For example, providers who prescribe and pharmacists who dispense medications that should be avoided during pregnancy, including certain antibiotics or anti-seizure drugs, can adapt the pregnancy checklist for use in their settings.
Hormonal Contraception and HIV: More Research Needed; No Changes in Family Planning Practices Currently Warranted

- No conclusive evidence exists that hormonal contraceptive use increases the risk of HIV acquisition, transmission, or disease progression.
- Current knowledge does not indicate a need to change existing recommendations that women at risk of HIV infection or those who are HIV-infected may safely use hormonal contraception.
- Hormonal contraceptive users at elevated risk of HIV infection should also use condoms consistently and correctly.

Background on Topic
Scientists seeking to identify factors that could contribute to the spread of HIV have raised the possibility of an association between hormonal contraceptive use and HIV acquisition. Research on the topic has been conflicting and inconclusive. Recently, however, data from the largest prospective study ever conducted specifically on hormonal contraceptive use and HIV acquisition has helped clarify this issue. These findings, as well as the current knowledge concerning a potential relationship between hormonal contraception and HIV transmission or HIV disease progression, do not warrant changing current family planning recommendations stating that women at risk of HIV infection or those whom are HIV-infected may safely use hormonal contraception.1

Hormonal Contraception Use and HIV Acquisition
Numerous studies have investigated a possible relationship between hormonal contraceptive use and HIV acquisition, but understanding of this matter has remained poor. Study results have been inconsistent, in part because nearly all these studies have been designed to investigate other research questions and have had important methodological shortcomings.

A study, published in the January 2, 2007 issue of the journal AIDS, clarifies this issue. It found no overall statistically significant association between the use of either combined oral contraceptive (DMPA) pills or depot medroxyprogesterone acetate (DMPA) and HIV acquisition. This four-year, prospective study, funded by National Institute of Child Health and Human Development, was conducted among some 6,100 HIV-negative women in Uganda, Zimbabwe, and Thailand. The primary finding of this study provides the best reassurance to date for women in need of highly effective contraception in settings of high HIV risk. The results from the study do not indicate that any changes should be made in the provision or use of DMPA or DMPAs. Neither the WHO nor the International Planned Parenthood Federation, which have reviewed the study results, plans at this time to change its guidelines for hormonal contraceptive use. Notably, this study was conducted among family planning clients, who are considered to be at low risk of HIV infection and are similar to most women worldwide who use hormonal contraception. In contrast, while results of other studies have been conflicting, those that have indicated an increased HIV risk associated with hormonal contraception were generally conducted among high-risk populations of women, such as sex workers.
Hormonal Contraceptive Use and HIV Transmission
Whether hormonal contraceptive use by HIV-infected women increases their risk of infecting sexual partners remains unknown. Only two studies of this issue have been prospective, and the results of four cross-sectional studies of HIV shedding from the genital tract (thought to be a marker of increased infectiousness) are conflicting, perhaps due to relatively small study samples.

Hormonal Contraceptive Use and HIV Disease Progression
The association between hormonal contraceptive use and clinical progression of HIV has not been studied directly. The only evidence so far that hormonal contraceptive use might affect HIV disease progression comes from a prospective study conducted among sex workers in Mombasa, Kenya. In a subset of 156 HIV-infected sex workers, use of either oral contraceptives or DMPA at the time of HIV infection was associated with acquiring genetically diverse virus populations from a single partner. The women who acquired these genetically diverse virus populations also had significantly higher viral set points and significantly lower CD4 cell counts four to 24 months after infection than did those with only one strain of the virus. Both low CD4 cell counts and high viral set points are predictors of HIV disease progression. More research is needed to confirm this finding.

Interactions between Hormonal Contraceptives and Antiretroviral (ARV) Drugs
Limited evidence suggests that certain antiretroviral (ARV) drugs can either raise or lower concentrations of contraceptive hormones in the blood of HIV-infected women using combined oral contraceptives (DMPAs). Theoretically, lower contraceptive hormone levels could reduce contraceptive efficacy and increase pregnancy risk, while higher levels could increase hormone-related side effects. One of the concerns is a relatively modest reduction in blood hormone levels of 20 percent to 30 percent among women on DMPAs taking the commonly-used ARV nevirapine. However, no studies have looked at actual clinical outcomes of these interactions, such as occurrence of ovulation and actual pregnancies. Few studies have looked at the question of how hormonal contraceptive use affects response to ARV therapy. But in the largest prospective study of the impact of HIV infection on U.S. women, hormonal contraceptive use did not reduce the effectiveness of the combinations of three or more different antiretroviral drugs known as highly active antiretroviral therapy (HAART).

Programmatic Considerations
No conclusive evidence exists that hormonal contraceptive use increases risk of either HIV acquisition or transmission. However, because hormonal contraception does not protect against HIV, uninfected hormonal contraceptive users at elevated risk of acquiring HIV should also use condoms consistently and correctly with each sexual act if they are not in a mutually monogamous relationship with an uninfected partner. HIV-infected women (regardless of contraceptive method they use) should also use condoms consistently and correctly to reduce any possible risk of HIV transmission to their partners.
Hormonal contraceptive users who are HIV-infected and who — in the absence of definitive data about disease progression and hormonal contraceptive/ARV drug interactions — wish to continue hormonal contraceptive use can be counseled to do so. However, unanswered questions about the effects of ARVs on oral contraceptive effectiveness have led the World Health Organization to caution that, although women on ARV therapy generally may use oral contraceptives, medical follow-up may be appropriate.4

HIV-positive hormonal contraceptive users who wish to switch methods should be counseled about all other available contraceptive methods. Some of these women may prefer using a contraceptive method that is highly effective since the prevention of pregnancy by HIV-positive women plays a critical role in the prevention of mother-to-child transmission of the virus. In such cases, the intrauterine device and sterilization may be important contraceptive options from which to choose. Finally, the use of HIV voluntary counseling and testing (VCT) services should be encouraged so more individuals can determine their HIV status.


4 WHO.

Source: The preceding Global Health Technical Brief is reprinted from the MAQ Website (Maximizing Access and Quality), a USAID initiative.
How Family Planning Programs Can Meet Rising Demand for Injectable Contraceptives

- As demand for injectable contraceptives continues to rise rapidly, programs are challenged to expand access and to improve the quality of care.
- To expand access, programs need to keep injectables in stock, train more providers, and find ways to offer injectables in rural and isolated areas.
- Good-quality services ensure that providers counsel clients well, give injections safely, and properly dispose of used needles and syringes.

What programs can do to plan for expanded services

**Maintain adequate supplies.** Family planning programs generally offer a progestin-only injectable — DMPA (depot-medroxyprogesterone acetate) injected every three months, or NET-EN (norethisterone enanthate) injected every two months. Some programs offer a combined hormonal injectable (progestin + estrogen) administered monthly. Stockouts of injectables are a common problem, however. Better forecasting has enabled some programs to anticipate increases in demand and place timely orders to manufacturers, donors, or procurement agents. To respond quickly to unexpected demand, emergency shipments are available from the United Nations Population Fund (UNFPA) and from USAID for USAID-funded programs.

**Train providers to offer injectables.** Training health care workers who are unfamiliar with injectables requires a comprehensive approach — covering screening, counseling, giving safe injections, conducting return visits, and managing side effects. Training a range of providers to offer injectables can increase access. In Honduras in the 1990s, for example, auxiliary nurses were trained to give injections, which enabled rural clinics where the nurses were posted to offer injectable contraception.1

**Give safe injections.** Of the 16 billion injections given for all purposes in developing countries each year, nearly two in every five are thought to be unsafe. The spread of infection can be avoided by ensuring that all injections are given with sterile equipment, that disposable syringes are placed in sharps disposal containers immediately after use, and that waste is safely buried or burned. Disposable syringes (ideally auto-disable syringes) are recommended. Reusable equipment must be sterilized above 121°C (250°F) in high-pressure steam for at least 20 minutes.
**Increase efficiency.** Programs can hold down the costs of expanding services by increasing efficiency. To increase efficiency, programs can shorten client waiting times, buy supplies in bulk to get low prices, and encourage clinic staff to decrease unproductive time on the job. Programs can also recover some costs from users who can afford to pay and are willing to pay for injectables. Computer software, such as the COPE® (Client Oriented, Provider Efficient) process and the CORE (Cost Revenue Analysis) tool, have helped programs model how client flow, prices, and staff time affect efficiency and cost recovery.2

**Consider community distribution.** Community provision has given access to injectables to women in Bangladesh, Ghana, Mexico, Thailand, and other countries. Programs offer injectables from mobile clinics or community clinics, or at clients’ or providers’ homes. A trial in Uganda found that community services for injectables can be comparable in quality to clinic services.3 As more programs try community distribution of injectables or scale up existing programs, attention to hiring and retaining providers, screening for medical eligibility, counseling, and waste disposal can help ensure good-quality services.

**Develop communication messages.** Communication programs can reach people who know about injectables but hesitate to try them. Many people need to see satisfied users among their peers or be encouraged by opinion leaders before they try something new. Interacting with a trusted source of information via a telephone hotline or in face-to-face discussions has helped potential and current users of injectables get accurate information.

**Help women make informed choices and be informed users.** Good counseling helps women decide whether injectables will suit them, and it can help them return on time for injections and cope with side effects if they occur. Good counseling will enable more women to make informed choices and to continue using injectables successfully.

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**Source:** The preceding Global Health Technical Brief is reprinted from the MAQ website (Maximizing Access and Quality), a USAID initiative.

While well-intentioned and based partly on medical rationale, some service delivery practices are unnecessary and can prevent access to family planning services for women and men who could safely use methods. There are six types of medical barriers: inappropriate or out-of-date contraindications; too-stringent eligibility criteria; unnecessary physical exams and laboratory tests; provider biases; limiting contraception provision to physicians only; and government regulations that limit the types of contraceptives available. To reduce medical barriers, providers must work as a group to assess all service delivery practices, to determine whether they are essential to provision of contraception. The medical community should develop standard guidelines on contraceptive use. Family planning should be viewed as less medical: Women and men should be seen as clients, not patients, and increased emphasis should be placed on delivery of methods through community-based, over-the-counter and social marketing outlets. Additional research should be conducted to assess contraceptive risks and benefits, to evaluate ways to reduce unnecessary restrictions and to understand clients’ perceptions of family planning methods and services.


Women in many countries are often denied vital family planning services if they are not menstruating when they present at clinics, for fear that they might be pregnant. A simple checklist based on criteria approved by WHO has been developed to help providers rule out pregnancy among such clients, but its use is not yet widespread. Researchers in Guatemala, Mali, and Senegal conducted operations research to determine whether a simple, replicable introduction of this checklist improved access to contraceptive services by reducing the proportion of clients denied services. From 2001 to 2003, sociodemographic and service data were collected from 4,823 women from 16 clinics in the three countries. In each clinic, data were collected prior to introduction of the checklist and again three to six weeks after the intervention. Among new family planning clients, denial of the desired method due to menstrual status decreased significantly — from 16 percent to 2 percent in Guatemala and from 11 percent to 6 percent in Senegal. Multivariate analyses and bivariate analyses of changes within subgroups of nonmenstruating clients confirmed and reinforced these statistically significant findings. In Mali, denial rates were essentially unchanged, but they were low from
the start. Where denial of services to nonmenstruating family planning clients was a problem, introduction of the pregnancy checklist significantly reduced denial rates. This simple, inexpensive job aid improves women’s access to essential family planning services.


A WHO-endorsed ‘pregnancy checklist’ has become a popular tool for ruling out pregnancy among family planning clients in developing countries. The checklist consists of six criteria excluding pregnancy, all conditional upon a seventh ‘master criterion’ relating to signs or symptoms of pregnancy. Few data exist on the specificity of long-accepted signs and symptoms of pregnancy among family planning clients. A study based on a previous observational study in Kenya (n=1,852) found that signs and symptoms of pregnancy were rare (1.5 percent), as was pregnancy (1 percent). Signs and symptoms were more common (18.2 percent) among the 22 clients who tested positive for pregnancy than among the 1,830 clients (1.3 percent) who tested negative, but did not add significantly to their predictive value. Although the ‘signs and symptoms’ criterion did not substantially improve the ability of the checklist to exclude pregnant clients, several reasons (including use of the checklist for IUD clients) render it unlikely that the checklist will be changed.


A study was conducted in Kenya in 1996 to determine whether menstruation requirements pose a barrier to new clients seeking family planning services. Data were collected from eight public-sector health centers and one hospital in two provinces. Health providers tracked the menstrual status of women using a simple tally sheet. Forty-five percent of the women seeking services were not menstruating. Among the 345 nonmenstruating women, 51 percent were breastfeeding and amenorrheic, while 49 percent were between menstrual periods. Providers considered nonmenstruating women pregnant unless they were within six weeks postpartum. Women were told to go home and await the onset of menses or to have a pregnancy test at another facility. Researchers estimated that 78 percent of nonmenstruating women were sent home without their chosen method, and that up to one-third of all women were turned away. In most cases, pregnancy could have been ruled out with a simple checklist. Policy-makers should consider adopting national guidelines that remove the unnecessary menstruation requirement.

Where pregnancy tests are unavailable, health providers, fearing possible harm to fetuses, often deny contraception to nonmenstruating clients. In Kenya, a trial (n=1,852) of a simple checklist to exclude pregnancy showed a negative predictive value of more than 99 percent. Use of this simple tool could improve access to services and reduce unwanted pregnancies and their sequelae.


Some family planning clinics require women seeking hormonal contraception or IUDs to be menstruating before they can receive their chosen method. Studies in Ghana, Kenya, Cameroon, Senegal, and Jamaica have found that menstruation requirements negatively affect access to services for clients who could safely use contraceptives. As many as one-fourth to one-half of new clients seeking contraceptive services are sent home to await the onset of menses. These clients risk an unplanned pregnancy, and many are unable to return to the clinic because of time and money constraints. Because pregnancy is a contraindication to contraceptive use, health providers have used menstruation as a proxy for expensive pregnancy tests. Another rationale for menstruation requirements is timing — hormonal methods are usually initiated and IUDs typically inserted during menses. In addition, some providers believe pregnant women may use contraceptives to induce abortion. While many providers believe that women know about menstruation requirements, data from Kenya and Cameroon show that clients do not. Denial of contraceptive methods to nonmenstruating women is a serious obstacle to services that could be reduced by using a simple checklist to rule out pregnancy.


Community-based services (CBS) have long used checklists to determine eligibility for contraceptive method use, in particular for combined oral contraceptives (COCs) and the three-month injectable contraceptive depot-medroxyprogesterone acetate (DMPA). As safety information changes, however, checklists can quickly become outdated. Inconsistent checklists and eligibility criteria often cause uneven
access to contraceptives. In 1996, WHO produced updated eligibility criteria for the use of all contraceptive methods. Based on these criteria, new checklists for DMPAs and DMPA were developed. This article describes the new checklists and their development. Several rounds of expert review produced checklists that were correct, comprehensible and consistent with the eligibility requirements. Nevertheless, field-testing of the checklists revealed that approximately half (48 percent) of the respondents felt that one or more questions still needed greater comprehensibility. These findings indicated the need for a checklist guide. In March 2000, WHO convened a meeting of experts to review the medical eligibility criteria for contraceptive use. The article also reflects the development of the resulting updated checklists.


This document was developed by the WHO expert working group which brought together participants from 18 countries, including representatives of many agencies and organizations. The document is important for improving access to quality care in family planning, as it reviews the medical eligibility criteria used for selecting appropriate methods of contraception for a variety of clients. The document provides recommendations for appropriate medical eligibility criteria based on the latest clinical and epidemiological data and is intended to be used by policy-makers, family planning program managers and the scientific community. It aims to provide guidance to national family planning and reproductive health programs in preparing guidelines for the service delivery of contraceptive methods.

World Health Organization. *Selected Practice Recommendations for Contraceptive Use. Second Edition.* Geneva, Switzerland: Reproductive Health and Research, Family and Community Health, 2004. *Selected Practice Recommendations for Contraceptive Use* is one of two evidence-based guidelines on contraceptive use published by WHO. This document provides guidance for using contraceptive methods safely and effectively once they are deemed to be medically appropriate. It is the companion guideline to WHO's *Medical Eligibility Criteria for Contraceptive Use*. The document is intended to be used by policy-makers, program managers, and the scientific community. It aims to support national programs in preparing service delivery guidelines.
Supplementary Training Schedules

A. Combined Training Schedule for All Four Provider Checklists

FHI has produced a series of four easy-to-use checklists designed to assist clinical and non-clinical family planning service providers in screening women who want to initiate use of COCs, DMPA/NET-EN, or the IUD. The fourth checklist helps providers rule out pregnancy among nonmenstruating women seeking to initiate the contraceptive method of their choice. It is recommended that service providers be trained on how to use all four checklists, unless a particular checklist is not applicable to their scope of work.

A training and reference guide has also been produced for each checklist. Familiarity with all four guides is necessary for conducting a combined training. The schedule on pages 74 and 75 is recommended for a combined training and follows the same structure used in the individual training guides. The Notes section of the outline will assist facilitators in determining what to include and how to adapt a section. Facilitators should carefully consider the training needs of participants when adapting the training.
## Session Overview and Schedule (Combined Training)

**Time:** 9 hours

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<th>Topic</th>
<th>Notes</th>
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| 1 | 40 minutes | Welcome and Introductions | Adapt from any of the checklist trainings. Use the questions:  
• What practice is currently used to determine if a woman is medically eligible to receive contraception? (Consider COCs, DMPA and IUD.)  
• How is pregnancy ruled out?  
• Can you name some conditions that prevent women from using COCs, DMPA or an IUD? (Create a separate list of conditions for each contraceptive method.) |
| 1 | 20 minutes | Rationale and Purpose | Adapt from the COC, DMPA or IUD Checklist trainings.  
• Show all four checklists but do not distribute them to participants at this time.  
• Emphasize that all checklists were designed to assist providers in safely screening women for contraceptive eligibility and, therefore, to reduce barriers to contraceptive use. The Pregnancy Checklist may have other purposes as well.  
• Note that the checklists were designed for a variety of providers and can be used in a variety of settings. The IUD Checklist differs from the others in that it requires that some of the questions be administered by a provider trained to conduct a pelvic exam. |
| 1 | 60 minutes | Exercise B: Review of the WHO Medical Eligibility Criteria | • Follow steps 1-6 under Exercise B for COCs, DMPA and IUDs, with the following exceptions:  
  **Step 3:** Choose a maximum of four conditions for each of the three contraceptive methods and allow a total of 20 minutes to complete the task. The following conditions are suggested for the exercise.  
  - **COCs and DMPA:** diabetes, high blood pressure, HIV/AIDS, and endometrial cancer.  
  - **IUDs:** nulliparous, STI, PID, and HIV and AIDS.  
  **Step 4:** Allow 20 minutes for participants to assess whether their answers were correct or incorrect.  
  **Step 6:** Distribute a copy of the COC, DMPA, and IUD checklists and complete the step.  
• Additional IUD discussion points should be brought up at this point (see Significant Issues Affecting Medical Eligibility in Facilitator’s Resource for Session 2 of the IUD Guide). |
<p>| 1 | 10 minutes | Exercise C: Demonstrating the Benefits of Using the Pregnancy Checklist | Additional detail on the research related to the Pregnancy Checklist can be found in the Optional Session. |</p>
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| 3       | 30 minutes | Design of and Instructions for Using the Checklists | All the checklists have the same basic design and instructions for use. Therefore, the training presented in this guide can be easily adapted to apply to all the checklists. Some notes:  
- The Pregnancy Checklist contains one set of questions, the COC and DMPA Checklists contain two sets, and the IUD Checklist contains three sets.  
- The Pregnancy Checklist contains no questions related to medical eligibility.                                                                                                                                 |
| 3-6 hours | Exercise D: Practice Using the four checklists | Provide participants the opportunity to use the COC, DMPA and IUD Checklists. The time will vary depending on the number of scenarios selected. To save time, do not independently practice the Pregnancy Checklist, since it is incorporated into the other checklists. Review the optional approaches for conducting the scenarios as potential time-saving tools. The option chosen should be the most appropriate for the needs of the participants. |                                                                                                                                                                                                                                                                         |
| 4       | 20 minutes | Wrap-up                                    | Modify as needed from this or any of the trainings.                                                                                                                                                                                                                     |
B. Training Para-Professionals on the DMPA Checklist

The term “para-professional” is used here to designate service providers who have not received formal training in clinical health care delivery. Para-professionals could include auxiliary health care workers, community health workers, paramedics, pharmacists and others who sell drugs, and social workers. They may have limited training in screening clients and/or in providing DMPA. Facilitators training para-professionals in the use of the DMPA Checklist should simplify the training content for this audience. Lecture sessions should generally be avoided, and the training should be practical in nature to ensure that para-professionals understand the checklist tool and are comfortable using it correctly. The outline below, which follows the same structure used in the individual training guides, is intended as a suggestion only. The Notes section of the outline will assist facilitators in determining what to include and how to adapt the different sections. Facilitators should carefully consider the training needs of participants when adapting the training.

Session Overview and Schedule (Para-professionals)

**Time:** 2 hours

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<th>Time</th>
<th>Topic</th>
<th>Notes</th>
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<tr>
<td>1</td>
<td>15 minutes</td>
<td>Welcome and Introductions</td>
<td>Use Session 1 from this guide. Do not perform Exercise A: Peel the Cabbage.</td>
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| 2       | 20 minutes | Rationale and Purpose Exercise C: Demonstrating the Benefits of Using the Pregnancy Checklist | Training Steps:  
• Distribute copies of the DMPA Checklist and the Quick Reference Chart to each participant.  
• Briefly and in simple language explain what the DMPA Checklist is and why it was developed.  
• Use the Quick Reference Chart to illustrate that many women, even those with certain medical conditions, can use DMPA. Allow five minutes for participants to familiarize themselves with the Quick Reference Chart. Do not perform Exercise B: Review of the WHO Medical Eligibility Criteria.  
• Perform Exercise C: Demonstrating the Benefits of Using the Pregnancy Checklist to illustrate how the checklist can be effective in ruling out the possibility of pregnancy in women who are not menstruating at the time they are seen by the para-professional. |
| 3       | 20 minutes | Design of and Instructions for Using the DMPA Checklist             | Briefly and simply explain the design of the DMPA Checklist and go over instructions for using it. Then ask participants if they have any questions or need any items clarified. |
| 4       | 45 minutes | Exercise D: Practice Using the DMPA Checklist                       | Review the optional approaches for conducting the scenarios as potential time-saving tools. The option chosen should be the most appropriate for the needs of the participants. |
| 4       | 15 minutes | Wrap-up                                                             | Modify as needed from this training. |
C. Introducing Provider Checklists to Policy-makers and Program Managers

A slide presentation (*Powerpoint* presentation B) with expanded notes can be found on the CD-ROM that accompanies this training and reference guide. This presentation is targeted to policy-makers and program managers who may be interested in introducing the checklists in their service delivery settings.

The presentation focuses on introducing all four checklists and includes an explanation of their rationale and a discussion of general issues regarding their use. It does not go into details on how to use the checklists. Also included is a section that can be adapted to issues specific to local areas, such as checklist dissemination and resources.
Sample Energizers

Energizers* are highly recommended during training sessions, in particular during trainings involving lectures. In this training, an energizer is recommended between sessions two and three.

- Coconut
  The facilitator shows the group how to spell out C-O-C-O-N-U-T by using full movements of the arms and the body. All participants then try this together.

- The sun shines on...
  Participants sit or stand in a tight circle with one person in the middle. The person in the middle shouts out “the sun shines on...” and names a color or articles of clothing that some in the group are wearing. For example, “the sun shines on all those wearing blue” or “the sun shines on all those wearing socks” or “the sun shines on all those with brown eyes”. All the participants who have that attribute must change places with one another. The person in the middle tries to take one of their places as they move, so that there is another person left in the middle without a place. The new person in the middle shouts out “the sun shines on...” and names a different color or type of clothing.

- Body writing
  Ask participants to write their name in the air with a part of their body. They may choose to use an elbow, for example, or a leg. Continue in this way, until everyone has written his or her name with several body parts.

- Football cheering
  The group pretends that they are attending a football game. The facilitator assigns specific cheers to various sections of the circle, such as ‘Pass’, ‘Kick’, ‘Dribble’ or ‘Header’. When the facilitator points at a section, that section shouts their cheer. When the facilitator raises his/her hands in the air, everyone shouts “Goal!”

Sample Certificate of Attendance

Name of Sponsoring Organization certifies that Name of Participant has successfully completed training on the Checklist for Screening Clients Who Want to Initiate DMPA at (Place) on (Date).

Name of Person issuing certificate
Title

Name of Person issuing certificate
Title

Sponsoring Organization

Appendix 79