BARRIERS AND FACILITATORS TO EXPANSION OF AT HOME USE OF INJECTABLE CONTRACEPTIVES

Center for Health Policy and Research (CHPR), UC Davis

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Public Health: Health Services Research Seminar - Barriers and facilitators to expansion of at home use of injectable contraceptives

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DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS

Public Health: Health Services Research Seminar - Barriers and facilitators to expansion of at home use of injectable contraceptives

The following person(s) have disclosed a relevant financial relationship with an ineligible company related to this CME activity, which has been mitigated through UC Davis, Health Office of Continuing Medical Education procedures to meet ACCME standards:

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The following person(s) have disclosed no relevant financial relationship with ineligible companies related to this CME activity:

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OBJECTIVES

1.To describe how ensuring access to at home injectable contraception can contribute to patient-centered reproductive and sexual healthcare

2.To identify patient, provider, clinic, and systems-level factors that affect provider awareness and provision of at home use of injectable contraceptives

3.To label barriers and facilitators to expansion of injectable contraceptives for at home use

BACKGROUND

Evidence about Injectable Contraception

DEPOT MEDROXYPROGESTERONE ACETATE (DMPA)

Also known as “”depo-provera” “depo”, “the shot”

Progestin-only injectable contraception

In addition to pregnancy prevention, benefits include reduction of endometriosis pain and a lower risk of uterine cancer (when used long-term).

Comes in two formulations

- Intramuscular (IM)
- Subcutaneous (SC)

DMPA USE IN THE U.S.

- **Introduced in the US in 1959 for management of menstruation and in 1969 was approved for endometrial cancer treatment**
- **It was tested between 1967-1978 on 14,000 women in the US**
- **50% of the research subjects were African-American, low-income and rural women without clear consent for participation in the trial**
- **DMPA-IM approved for use as menstrual regulation in the US by the FDA in 1992**
- **DMPA-SC developed for self-administration and approved by FDA for provider-administration only in 2004**
- **CDC has provided guidance via the US MEC and SPR since 2016 that recommendations for DMPA-IM and SC are the same**

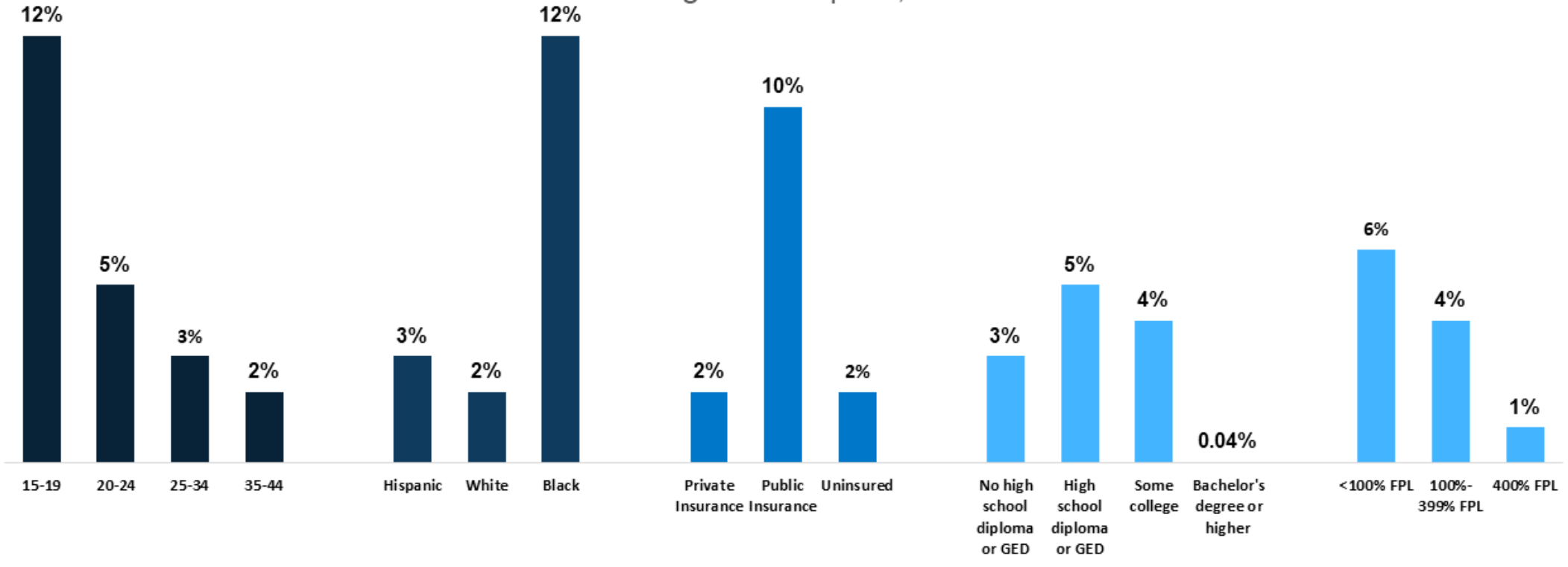
Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051

https://pubmed.ncbi.nlm.nih.gov/12344620/

WHO USES DMPA IN THE US?

The Contraceptive Injection Is Most Frequently Used by Black Women and Teenage Women

Overall Birth Control Injection Use in the Past Month, Among Women Ages 15-44 Currently Using Contraception, 2015-2017

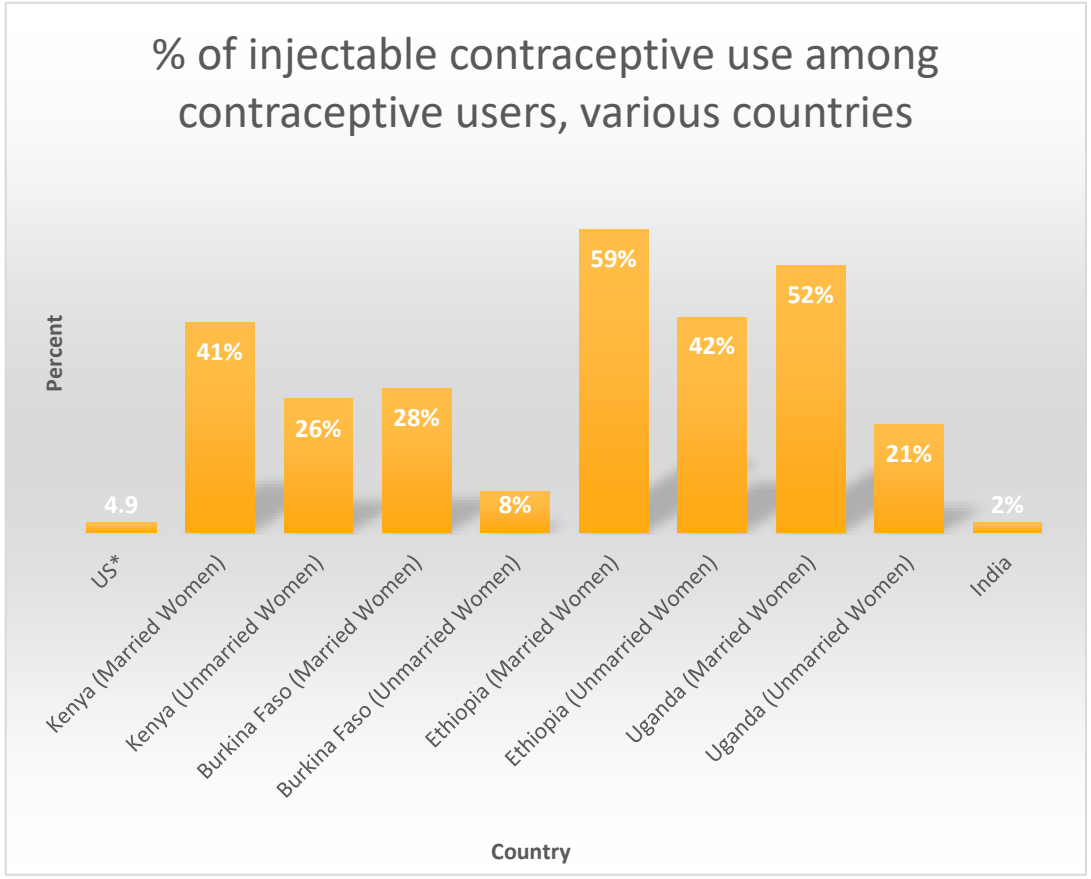


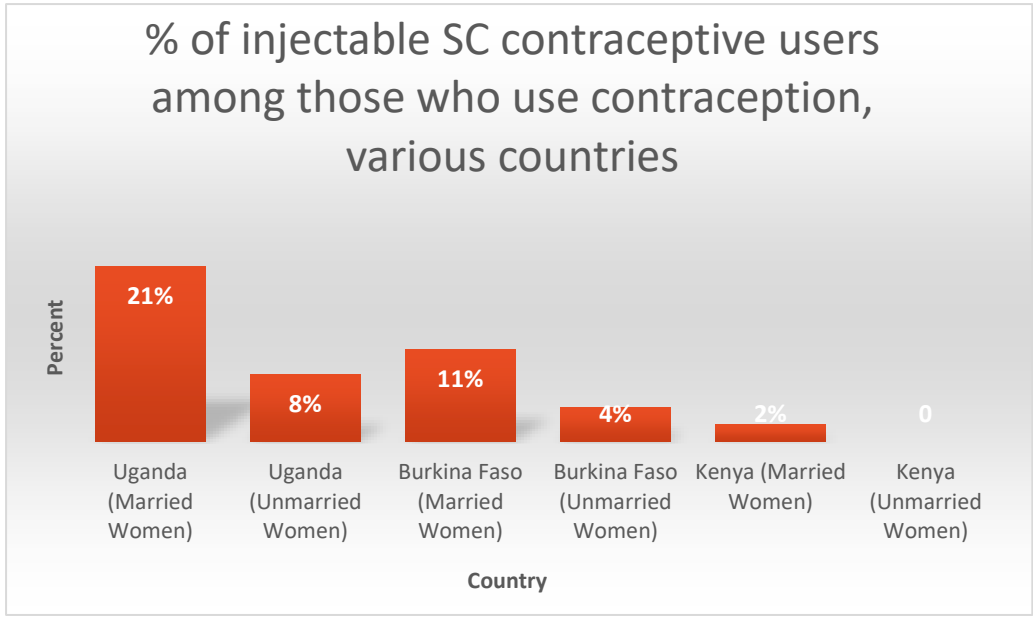
NOTES: Methods of contraception included are oral contraceptive pills, sterilization, condoms, intrauterine devices (IUDs), contraceptive implants, contraceptive rings or patches, injectables, withdrawal, and natural family planning.

The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $19,078 in 2015, $19,318 in 2016, and $19,730 in 2017.

KFF
HENRY J KAISER FAMILY FOUNDATION

IN COMPARISON WITH INTERNATIONAL SETTINGS…





-Kaiser Family Foundation, 2020; DMPA Contraceptive Injection: Use and Coverage | KFF

-Daniels K, Abma JC. Current contraceptive status among women aged 15–49: United States, 2015–2017. NCHS Data Brief, no. 327. National Center for Health Statistics; 2018

-The Performance Monitoring for Action Project, 2020; https://www.pmadata.org/data

CLINICAL EVIDENCE ABOUT USER-ADMINISTERED DMPA

Continuation of DMPA-SC at 12 months:

- **Overall, higher continuation rates for self-administered versus provider-administered DMPA-SC**
- **Self-administered or provider-administered DMPA-SC among young (18-24 years) vs older (≥25 years) women**
  - **Self-administered: no significant difference among young (79%) vs older (69%) women**
  - **Provider-administered: lower among young (39%) vs older (49%) women (p=0.047)**

Unintended pregnancy:

- **No differences in unintended pregnancy rates, and no significant difference among young (n=3) vs older (n=4) women**

Side effects or adverse events:

- **Low rates of adverse events and no differences in rates of side effects**
- **No differences by age group in self-administered or provider groups**

Kennedy, Caitlin E., et al. "Self-administration of injectable contraception: a systematic review and meta-analysis." *BMJ global health* 4.2 (2019): e001350.

Burke et al., J Adolesc Health, 2020;67(5):700-707. Burke et al., Lancet Glob Health, 2018:6(5):e568-e578.

INTEREST OF USER-ADMINISTRATION OF DMPA IN THE US

- **Upadhyay et al., reported 21% interested in self-administration (survey of 1592 individuals at 13 family planning clinics and 6 abortion clinics in US)**
  - **Previous DMPA users were more likely to have interest (AOR= 1.71, 95% CI: 1.26-2.32, p<0.001)**
  - **Those reporting difficulty obtaining or refilling prescription were almost twice as likely to have interest than nose reporting no difficulty (AOR= 1.99, 95% CI: 1.43-2.77, p<0.001)**
  - **Interest for DMPA-SC primarily driven by desire to eliminate unnecessary return visit to a facility for repeat injections**

Upadhyay, Ushma D., Vera M. Zlidar, and Diana Greene Foster. "Interest in self-administration of subcutaneous depot medroxyprogesterone acetate in the United States." *Contraception* 94.4 (2016): 303-313.

FEASIBILITY:

SELF-ADMINISTERED DMPA-SC USE DURING COVID-19 PANDEMIC IN THE U.S.

Contraception 102 (2020) 392–395

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/con

ELSEVIER

An implementation project to expand access to self-administered depot medroxyprogesterone acetate (DMPA) ☆,☆☆

Micah Katz [a], Rebecca L. Newmark [a], Alison Aronstam [a], Niamh O'Grady [b], Sara Strome [b], Sally Rafie [c], Jennifer Karlin [d,*]

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ELSEVIER

Contraception

Volume 112, August 2022, Pages 116-119

Brief Research Article

Would you be interested in DMPA-SC? An implementation project in two urban primary care clinics ☆, ☆☆

Christina Miles [a], Deepthi Ennamuri [a], Jaquelyn Yeh [b], Grace Shih [a]

Evaluating a Depo provera self-administration pilot program

PDF

Description

Title Evaluating a Depo provera self-administration pilot program

Name Fernandes, Sonia (author); Vitale, Tracy (chair); Rutgers University; RBHS School of Nursing

Date Created 2021-11-19

Other Date 2022-01 (degree)

Subject Health sciences, Depo-Provera, Depot medroxyprogesterone acetate, DMPA, Program evaluation, Self-administration, Self-injection

Extent 118 pages : illustrations

JOURNAL OF ADOLESCENT HEALTH

SAHM

Improving the Lives of Adolescents and Young Adults

ABSTRACT | VOLUME 70, ISSUE 4, SUPPLEMENT , S53-S54, APRIL 2022

101. Adolescent and Young Adult Satisfaction and Preference for Subcutaneous Depot Medroxyprogesterone Acetate

Hunter Wernick, DO, MS • Evelyn Wentzel • Kenneth Jackson • ... Olivia Valenti, MPH, CHES • Andrea Bonny, MD • Elise Berlan, MD, MPH • Show all authors

DOI: https://doi.org/10.1016/j.jadohealth.2022.01.196

CDC RECOMMENDATION (2020)

Morbidity and Mortality Weekly Report

Update to U.S. Selected Practice Recommendations for Contraceptive Use: Self-Administration of Subcutaneous Depot Medroxyprogesterone Acetate

Kathryn M. Curtis, PhD[1]; Antoinette Nguyen, MD[1]; Jennifer A. Reeves, MD[1]; Elizabeth A. Clark, MD[1]; Suzanne G. Folger, PhD[1]; Maura K. Whiteman, PhD[1]

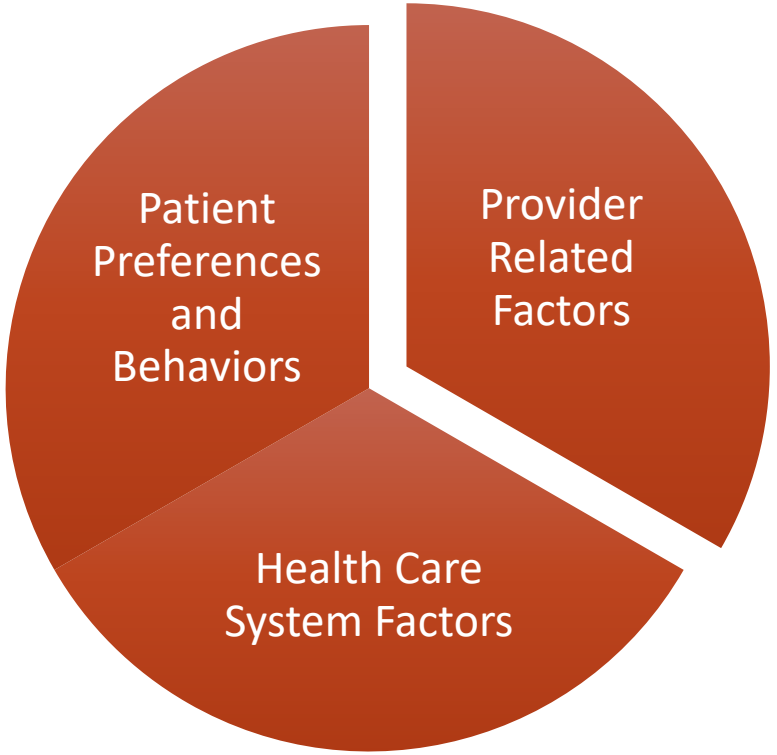
Self-administered subcutaneous depot medroxyprogesterone acetate (DMPA-SC) should be made available as an *additional* approach to deliver injectable contraception.

CENTERING EQUITY AND REPRODUCTIVE JUSTICE IN CONTRACEPTIVE IMPLEMENTATION

-Burlando AM, Flynn AN, Gutman S, McAllister A, Roe AH, Schreiber CA, Sonalkar S. The Role of Subcutaneous Depot Medroxyprogesterone Acetate in Equitable Contraceptive Care: A Lesson From the Coronavirus Disease 2019 (COVID-19) Pandemic. Obstet Gynecol. 2021 Oct 1;138(4):574-577.

-Dehlendorf C, Ruskin R, Grumbach K, Vittinghoff E, Bibbins-Domingo K, Schillinger D, Steinauer J. Recommendations for intrauterine contraception: a randomized trial of the effects of patients' race/ethnicity and socioeconomic status. Am J Obstet Gynecol. 2010;203(4):319.e1-8.

WHAT FACTORS CONTRIBUTE TO FAMILY PLANNING OUTCOMES?



-Dehlendorf et al, Disparities in Family Planning, 2010 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835625/

-Burlando AM, Flynn AN, Gutman S, McAllister A, Roe AH, Schreiber CA, Sonalkar S. The Role of Subcutaneous Depot Medroxyprogesterone Acetate in Equitable Contraceptive Care: A Lesson From the Coronavirus Disease 2019 (COVID-19) Pandemic. Obstet Gynecol. 2021 Oct 1;138(4):574-577.

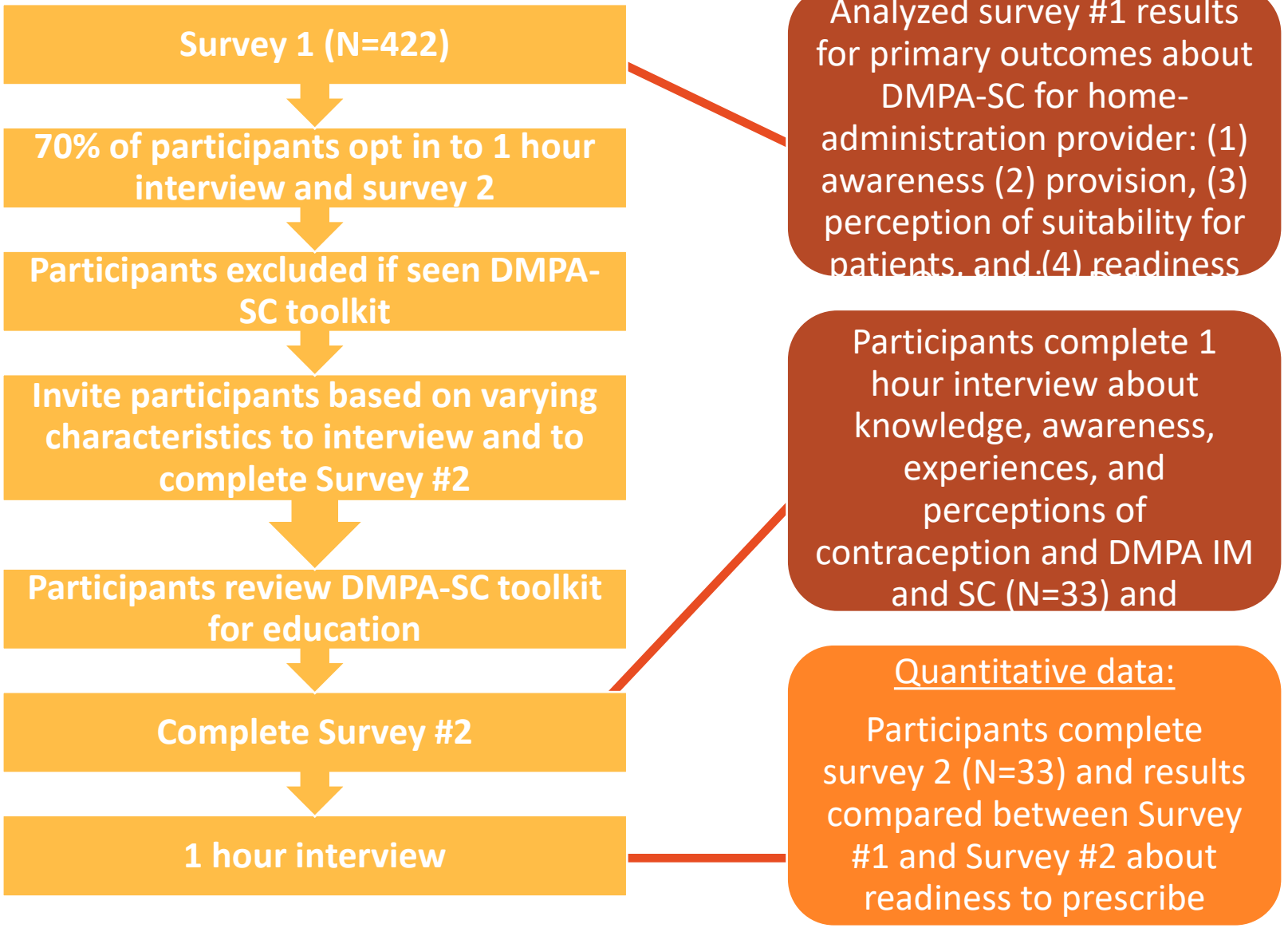
BARRIERS AND FACILITATORS TO EXPANSION OF AT HOME USE OF DMPA-SC

Preliminary Results From a Mixed-Method Study of Providers' Perspectives and Experiences

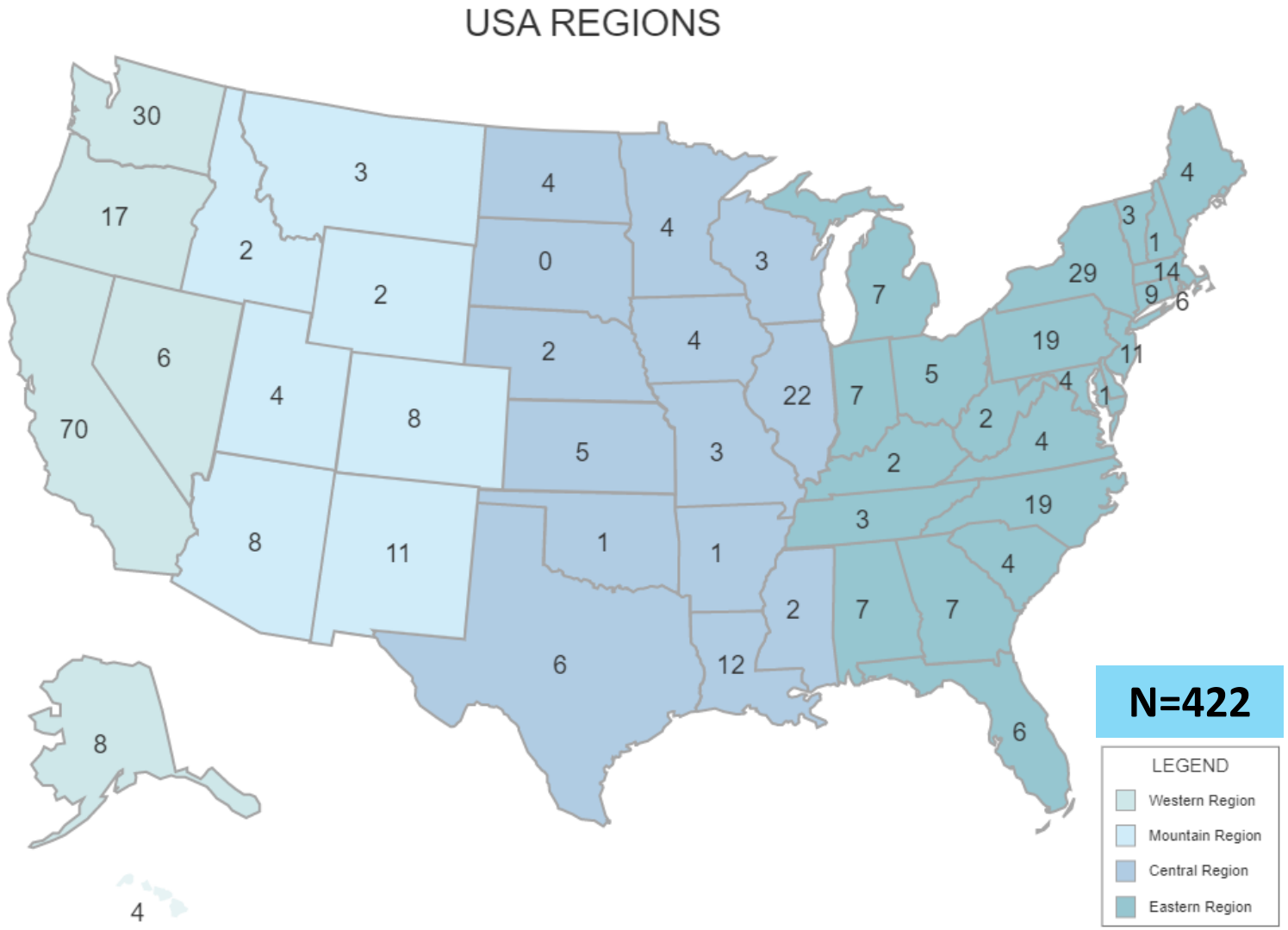
METHODS

- Convenience sample of contraception providers (including ACP, RN, pharmacists, MD/DO)
- Targeted sampling for geographic diversity
- Exclude those with less than 3 contraceptive visits/month
- Survey Administered by Qualtrics

MIXED-METHODS DESCRIPTIVE STUDY



DEMOGRAPHICS: PROVIDER GEOGRAPHIC LOCATION



DEMOGRAPHICS: PROVIDER CHARACTERISTICS

Gender	N (422)	%
Cis-gender Female	355	84.1
Cis-gender Male	44	10.4
Genderqueer or Genderfluid	10	2.4
Transgender Male	5	1.2
Transgender Female	2	0.5
Other /prefer not to say	6	1.4

Age	N (422)	%
Under 35	114	27
35-44	184	43.6
45-54	75	17.8
55+	49	11.6

Race/Ethnicity	N*	%
White	315	70
Asian	52	11.6
Black or African American	36	8
Hispanic or Latino	25	5.6
Other /prefer not to say	14	3.1
American Indian or Alaska Native	6	1.3
Native Hawaiian or Pacific Islander	2	0.4
* 26 participants selected multiple choices (total n of choices= 450		

DEMOGRAPHICS: PROVIDER TRAINING

Degree	N (422)	%
MD/DO	233	55.2
NP/PA/DNP*	107*	25.3

Fellowship	N (233)	%
No	157	67.4
Yes	76	32.6

Specialty	N*	%
Family Practice/Family Medicine	156	44.6
Ob/Gyn	89	25.4
Women's Health	54	15.4
Adult Medicine/Internal Medicine/ID	24	6.9
Other (please specify)	16	4.6
Midwifery	8	2.3
Pediatrics	3	0.9

DEMOGRAPHICS: PROVIDER SETTING

Setting	N*	%
Urban	294	49.2
Suburban	141	23.6
Telemedicine	82	13.8
Rural	77	12.9
Frontier	3	0.5
*120 participants selected more than one setting (n=597 total choices)		

Title X Family Planning Funding	N (422)	%
Yes	166	39.3
No	172	40.8
Not sure	84	19.9

Institution	N*	%
Academic	137	21.5
Primary care clinic	113	17.8
Planned Parenthood	112	17.6
Federally Qualified Health Center (FQHC)	64	10.1
Pharmacy	47	7.5
Other	165	25.5
*148 selected more than one institution (n=638 total choices)		

PRIMARY OUTCOMES

(1) Awareness of DMPA-SC for home-administration *

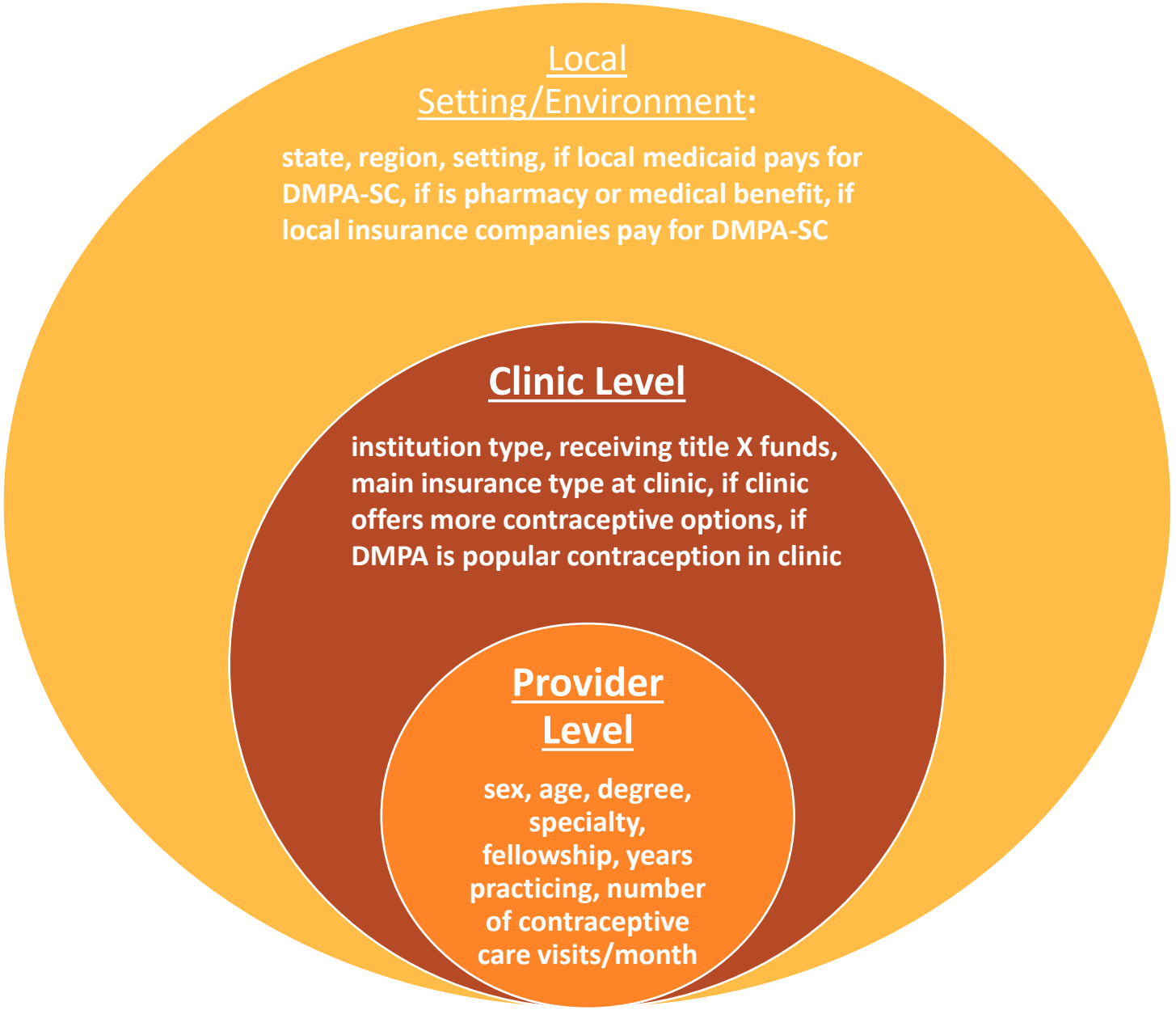
(2) Provision of DMPA-SC for home-administration *

(3) Perception of suitability for patients of DMPA-SC for home-administration

(4) Readiness to prescribe DMPA-SC for home-administration

* Will discuss today

HYPOTHESIZED COVARIATES



PRIMARY OUTCOME 1: PROVIDER AWARENESS OF DMPA-SC

- 79% of our sample was aware of DMPA-SC for user administration and 21 % were not aware

Among those:

- 2/3 thought DMPA-SC was only available in the US
- 50% learned about it between 2020-2022 due to changes due to the COVID-19 pandemic

PROVIDER PERCEPTION OF INTEREST AND SUITABILITY

- On average, providers thought 17.3% (95% CI [15.2, 19.3]) of patients not on any contraception would be interested in DMPA-SC for at home administration
- On average, providers thought 43.68% (95% CI [40.92, 46.45]) of DMPA-IM users would be interested in home administration

DMPA-SC for at home administration is a suitable and/or promising option for your patients	N	%
Yes	362	85.8
No	19	4.5
I don't know	41	9.7

RESULTS FROM BIVARIATE ANALYSES- PROVIDER LEVEL FACTORS

- Non-significant factors: Age, gender, degree, years practicing, mean score of knowledge questions, or if provider is FM or womens health, or date when provider learned about SMPA-SC. Also, km q's except lateness

Covariate	Not aware n (%) or mean (SD)	Aware n (%) or mean (SD)	P value
Mean number of patients seen that can become pregnant	**55.8 (26.7)**	**68.4 (26.6)**	**<0.001**
Fellowship completed	**no: 43 (49.4)** **yes: 3 (3.4)**	**103 (30.7)** **84 (25.1)**	**<0.001**
Mean number of contraceptive visits/month	**2.4 (1.6)**	**3.5 (2.1)**	**<0.001**
Specialty IM	**no: 62 (71.3)** **yes:10 (11.5)**	**267 (79.7)** **11 (3.3)**	**0.004**
Specialty OB/Gyn	**no: 61 (70.1)** **yes: 11 (12.6)**	**200 (59.7)** **78 (23.3)**	**0.039**

RESULTS FROM BIVARIATE ANALYSES- CLINIC LEVEL

- Non-significant factors: If other contraceptive options are the most popular (except OCP and IUD), if other type of clinical institution besides planned parenthood, payor mix in clinic

Covariate	Not aware n (%) or mean (SD)	Aware n (%) or mean (SD)	P value
If institution is a pharmacy	No: 71 (81.6) Yes: 16 (18.4)	304 (90.7) 31 (9.3)	0.023
If institution is a planned parenthood	No: 80 (92.0) Yes: 7 (8.0)	230 (68.7) 105 (31.3)	<0.0001
If clinic receives Title X funding	No or don't know: 65 (74.7) Yes: 22 (25.3)	184 (54.9) 150 (44.8)	0.0009
Clinic status in supporting providers	Workflows/education in place: 3 (3.4) Pro find own wf and education: 4 (18.4)) No workflows/unsupportive: 68 (78.2)	64 (19.1) 56 (44.8) 121 (36.2)	0.0004 0.0039 <0.0001

RESULTS FROM BIVARIATE ANALYSES- LOCAL/NATIONAL

- Non-significant factors: If setting is suburban, rural, frontier or telemedicine
- Left to review: State and region (US Census and Guttmacher)

Covariate	Not aware n (%) or mean (CI)	Aware n (%) or mean (CI)	P value
If setting is urban	No: 38 (43.7) Yes: 49 (56.3)	90 (26.9) 245 (73.1)	0.004
If local Medicaid covers DMPA-SC	No: 0; Don't know: 74 (86.1) Yes: 12 (13.8)	No: 13; Don't know: 195 (62.1) 127 (37.9)	<0.0001
If local insurance covers DMPA-SC	No: 2; Don't know: 74 (85.1) Yes: 10 (11.5)	No: 11; Don't know 231 (69) 92 (24.2)	0.021

PRIMARY OUTCOME 2: PROVISION OF DMPA-SC

- Less than half (47.4%) of the total sample (N=422) prescribe some form of at-home administration of DMPA (n=200)
  - 58% of those prescribing any formulation of DMPA for at home-administration said their prescriptions increased during the COVID-19 pandemic
- 42% (n=142) of those who are aware of at home-administration of DMPA-SC (n=335), prescribe DMPA-SC for at home administration
  - 77% of those prescribing DMPA-SC for at home administration started in 2019 or later

RESULTS FROM BIVARIATE ANALYSES- PROVIDER LEVEL FACTORS

- Non-significant factors: Age, degree, specialty, years practicing, suitability, mean score of knowledge questions or the efficacy, htn, or inj count kn questions, if FM or Women's Health

Covariate	Don't Prescribe (n, %) or mean (CI)	Prescribe DMPA for user administration (either formulation) (n, %) or mean (CI) N=200	P value
Gender	**cis-F: 148 (74.0) cis-M: 34 (17.0) other: 18 (9)**	**206 (93.2) 10 (4.5) 5 (2.3)**	**<0.0001**
Mean number of patients seen that can become pregnant	**62.6 (27.5)**	**69.2 (26.2)**	**0.013**
Fellowship completed	**no: 91 (41.2) yes: 36 (16.3)**	**55 (27.5) 51 (25.5)**	**0.008**
Mean number of contraceptive visits/month	**3.0 (2.0)**	**3.6 (2.1)**	**<0.0001**

RESULTS FROM BIVARIATE ANALYSES- CLINIC LEVEL FACTORS

- Non-significant factors: If other contraceptive options are the most popular, and if DMPA provider administered is most popular, if other type of clinical institution besides planned parenthood

Covariate	Don't Prescribe (n, %) or mean (CI)	Prescribe DMPA for user administration (either formulation) (n, %) or mean (CI), n=200	P value or mean (CI)
If institution is a planned parenthood	No: 175 (79.2) Yes: 46 (20.8)	135 (67.5) 65 (32.5)	0.009
If clinic receives Title X funding	No or don't know: 146 (66.0) Yes: 75 (33.9)	103 (51.5) 96 (48.0)	0.0029
Clinic status in supporting providers	Workflows/education in place: 6 (2.7) Only workflows/no education: 6 (2.7) No workflows/unsupportive: 209 (94.5)	61 (30.5) 54 (27.0) 85 (42.5)	<0..0001 <0.0001 <0.0001

RESULTS FROM BIVARIATE ANALYSES- LOCAL/NATIONAL LEVEL FACTORS

- Non-significant factors: If setting is urban, suburban, rural, frontier or telemedicine
- Left to review: State and region (US Census and Guttmacher)

Covariate	Don't Prescribe (n, %) or mean (CI)	Prescribe DMPA for user administration (either formulation) (n, %) or mean (CI) n=200	P value or mean (CI)
If local Medicaid covers DMPA-SC	No: 5; Don't know: 177 (82.3) Yes: 39 (17.6)	No: 8; Don't know: 91 (49.75) 100 (50.0)	<0.0001
If local insurance covers DMPA-SC	No: 6 (2.7); Don't know: 198 (89.6) Yes: 17 (7.7)	No: 7 (3.5); Don't know 107 (53.5) 84 (42.0)	<0.0001

PRESCRIBERS' PRACTICES

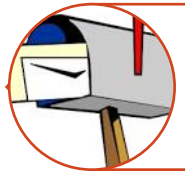
40% of those who prescribe DMPA-SC for home administration talk about at every contraceptive counseling visit

When initiating DMPA-SC, 62% allow patients to report pregnancy test results,

21% say their clinics requires review of results, and 17% want to see the results themselves (n=198)

1% provide telehealth support for at-home DMPA-SC (n=143)

69% do not send follow up reminders for those who home administer (n=162)



61% use a mail order pharmacy (n=162)

PROVIDER EDUCATION

Out of those that prescribe, 1/3 received direct training from their clinic organization, 10% received training from an external organization, and then over half sought out their own educational material

Education for DMPA-SC	N (422)	%
I already have the information I need and prescribe DMPA-SC for user administration	115	27.2
I am interested in receiving more information, so I can decide if it is a suitable option	93	22
I am interested in receiving more information so that I can counsel and prescribe DMPA-SC for user administration	187	44.3
I am not interested in receiving more information	27	6.4

BARRIERS & FACILITATORS FOR PRESCRIBING (SURVEY DATA)

Barriers to prescribing DMPA-SC among all participants

- Patients not interested/low demand
- Unaware of how to order/prescribe/not in our EHR
- Lack of provider education material

Barriers to prescribing DMPA-SC among prescribers

- Patients not interested/low demand
- Lack of patient support for reminders and ability to follow up
- Financial barriers

Facilitators for prescribing user administered DMPA-SC

- Insurance pays for it
- Resources for patients easily accessible
- Patient engagement

BARRIERS & FACILITATORS FOR PRESCRIBING (QUALITATIVE DATA TEASER)

Barriers to expanding at-home use of DMPA-SC: Bureaucracy and Time

- **Interviewer: "Now that you viewed the toolkit, do you think you will change your practices?"**
- **Fellowship-trained OB/Gyn: "Hard to say. I think I might try to ask and maybe make an effort to reach out to our pharmacy and ask if it's available. Because if I knew it was, then I certainly would start offering it and discussing it with patients…. Learning about it is making me think that maybe I should just confirm that its not available or ask if it can be available. Because that way, its an additional option."**

Facilitators to expanding at-home use of DMPA-SC:

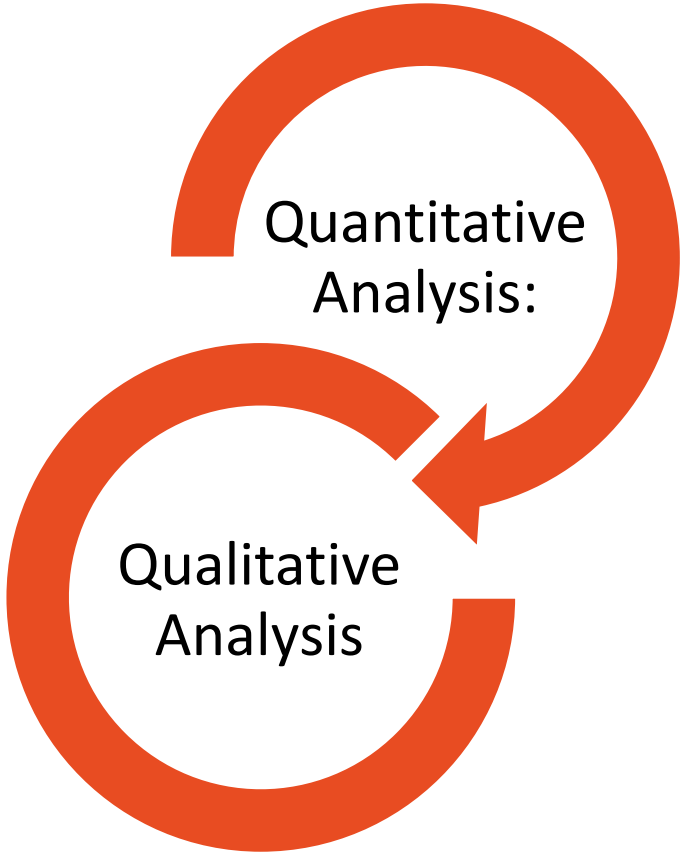
Clinic champion

- Interviewer: "Based on her [your daughter's] experiences and how you've helped her with that [teaching her how to self-administer medications], do you feel like your patients would be able to self-administer with little to no problems?"
- Respondent: "Yes, and I think that's one of the reasons why I've been a big fan and adopter of patient administered sub Q depo in my practice, because I saw that my 12-year-old daughter could do it all by herself, so I think that most people can be taught to do it by themselves. And it's just so freeing to be able to do it by yourself."

CONCLUSIONS

- 80% are aware of DMPA-SC for at home administration, yet only 42% of those aware provide DMPA-SC for at home administration
- 85% think it is a suitable/promising option; however, they have the perception that interest among patients is low (17% among patient of reproductive age and 40% among DMPA-IM users)
- More likely to be aware of the option if you are an OB/Gyn, not IM doctor, have completed fellowship, see more contraceptive visits a month and have more patients in your panel that can become pregnant, work at a clinic X, don't work at a pharmacy or planned parenthood, if MA and local insurance covers DMPA-SC, and if workflows are in place
- More likely to provide if you have completed a SRH fellowship, are cis-F, have a higher mean # of visits/patients in panel, work at title X clinic, don't work at PP, if MA and local insurance covers it., and if workflows are in place at the clinic.
- Barriers and facilitators are not likely provider awareness, but about provision and clinic workflows/toolkits including insurance navigation

NEXT STEPS: MIXING THE METHODS



- Bivariate outcomes for two additional primary outcomes:
  - (1) perception of suitability
  - (2) readiness to prescribe
- Multiple regression modeling controlling for confounders
- Analysis of secondary outcomes
- Comparison of Likert scales of readiness to provide before and after viewing Toolkit (survey 1 and 2)
- Coding of interviews

QUESTIONS?

ADDITIONAL SLIDES

SAME CONTRAINDICATIONS AS DMPA-IM

The contraindications and precautions for DMPA-SC are the same DMPA-IM. The Centers for Disease Control and Prevention's (CDC) Medical Eligibility Criteria for Contraceptive Use lists DMPA categorization as follows:

CATEGORY 3:

- Multiple risk factors for atherosclerotic cardiovascular disease (e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels)
- Systolic ≥160 mm Hg or diastolic ≥100 mm Hg
- Hypertension with vascular disease
- Current and history of ischemic heart disease
- History of stroke
- Unexplained vaginal bleeding (suspicious for serious condition before evaluation)
- History of benign or malignant liver tumor
- Systemic lupus erythematosus:
  - Positive (or unknown) antiphospholipid antibodies (initiation and continuation of the method)
  - Severe thrombocytopenia (initiation of the method only; continuation of DMPA is Category 2)
- Breast cancer in the past; no evidence of recurrent disease for 5 years
- Diabetes with nephropathy, retinopathy, or neuropathy or other vascular disease
- Diabetes of >20 years' duration
- Cirrhosis; severe, decompensated

SAME CONTRAINDICATIONS AS DMPA-IM

The contraindications and precautions for DMPA-SC are the same DMPA-IM. The Centers for Disease Control and Prevention's (CDC) Medical Eligibility Criteria for Contraceptive Use lists DMPA

CATEGORY 4:

Breast cancer treated within the past 5 years

DMPA-SC ADVANTAGES OVER DMPA-IM

Contains 30% less hormone and **may reduce common side effects**.

Uses shorter, smaller 26-gauge X 3/8 inch needle and smaller volume of liquid to inject into skin instead of muscle so that **may mean less pain at injection site.**

It comes pre-filled and ready to use at home, so client is **in control**.

DMPA-SC DISADVANTAGES OVER DMPA-IM

Takes time to learn how to use, so some clients experienced local site irritation and soreness on first and second self-injection.

- This improves over time.

According to the label, 1/100 experience dimpling at injection site.

Pfizer. Depo-subQ provera 104® medroxyprogesterone acetate injectable suspension 104 mg/0.65 mL. Retrieved from https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/021583s031lbl.pdf.