Side effects and discontinuation rate of depot medroxyprogesterone acetate in a tertiary hospital, southern Nigeria

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Received: 04 September 2020
Accepted: 07 October 2020

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ABSTRACT

Background: Depot medroxyprogesterone acetate (DMPA) also known as depo provera is a highly effective, safe and long-lasting reversible contraceptive with side effects that may cause discontinuation amongst acceptors. Objective was to determine the prevalence rate, side effects, discontinuation rate and indications for discontinuation of DMPA at Rivers State University Teaching Hospital (RSUTH), Port Harcourt.

Methods: This was a retrospective study of 874 clients attending family planning clinic at the RSUTH from 1st January, 2015 to 31st December, 2019. Their records were retrieved from the clinic and reviewed. Data was extracted, coded and analyzed using the statistical package for social sciences (SPSS) IBM version 25.0 (Armonk, NY).

Results: One hundred and one clients accepted DMPA out of 874 acceptors of contraceptives within the study period giving a prevalence rate of 11.6%. The modal age group was 25-29 years accounting for 31 (30.7%). Age range was 19-47 years and the modal parity was para 2. Majority of the clients had formal education, 100 (99%), married, 94 (93.1%) and multipara 61 (60.4%). The discontinuation rate was 32.7% and the commonest reasons for discontinuation were secondary amenorrhoea and irregular vaginal bleeding with each contributing 24.2%.

Conclusions: The prevalence and discontinuation rates of Depo provera were low. Secondary amenorrhoea and irregular vaginal bleeding were the commonest side effects and reasons for discontinuation.

Keywords: Depo provera, Discontinuation rate, RSUTH, Side effects

INTRODUCTION

Depo provera is a synthetic derivative of progesterone given at a dose of 150 mg intramuscularly every 3 months. It is one of the widely used forms of contraception worldwide.1-3 The minimal service provider user attention, low Pearl index, long duration of action, simple storage and non contraceptive benefits make it suitable to use in the developing countries.2,4,5 Depo provera acts by primarily inhibiting gonadotrophin secretion thereby inhibiting follicular maturation and ovulation. It thickens the cervical mucus thus preventing ascent of spermatozoa into the uterine cavity. It also causes changes in the endometrium leading to endometrial atrophy thereby making implantation of fertilized ovum difficult.5-8

Depot medroxyprogesterone acetate (DMPA) like other contraceptive methods has side effects and complications which may not be acceptable to the women therefore leading to the discontinuation.2,3,5 It is notably known to cause menstrual abnormalities including secondary amenorrhoea which has a negative socio-cultural perception in our environment, irregular vaginal bleeding.
menorrhagia and metrorrhagia. Other reported side effects are accidental pregnancies, weight gain, reduced libido, abdominal and chest pains, headaches, loss of bone mineral density, delay in return of fertility following its use, psychological and vasomotor disturbances.4,10

In view of this very effective and safe method of contraception, it becomes important to know the side effects and discontinuation rates with the reasons for the discontinuation at the Rivers State University Teaching Hospital (RSUTH), Port Harcourt. The findings will help in counselling and re-counselling of these women to encourage them not to discontinue the contraceptive in order to maximally gain from these contraceptives.

METHODS

This five year retrospective study was carried out at the family planning clinic of the Rivers State University Teaching Hospital (RSUTH) Port Harcourt, the capital of Rivers State in South-South geopolitical zone of Nigeria. The clinic gets its clients from within and outside the hospital. It has its own records section different from the hospital records and this makes it easy to retrieve the clients’ case notes. The clinic is headed by a consultant family physician with the support of trained family planning nurses. Resident doctors, medical students and student nurses rotate through the clinic in batches. At presentation, the clients were warmly welcomed by trained family planning nurses and physicians who also counseled them. The clients were allowed to make informed choice based on their needs and available contraceptives suitable for them. Thereafter medical history and clinical examination were done. Urine analysis and pregnancy test were also done for the clients and informed consent obtained. During the study period, the only available progesterone-only injectables were intramuscular injections of DMPA and Noristerat. The nurses injected 150 mg of DMPA into the deltoid or gluteal muscle within 7 days of normal menstrual period after excluding pregnancy. It was also given six weeks post-partum in lactating mothers. Follow up observations and repeat injections were done every 90 days. At each follow up visit, every complaint is documented in their case files. The body weight, blood pressure and result of urinalysis are recorded too. A client is lost to follow up if she defaulted more than twice from the scheduled visit.

The record cards of all the clients that accepted DMPA between 1st January, 2015 and 31st December, 2019 were retrieved and studied. The information extracted from the cards included the socio-demographic characteristics of the clients, previous contraceptive methods used and their sources, side effects and complications of the current contraceptive, discontinuation and the reasons for discontinuation. The data was analyzed with the statistical package for social sciences (SPSS) IBM version 25.0 (Armonk, NY) using frequency counts and percentages.

RESULTS

One hundred and one clients chose DMPA out of 874 contraceptive acceptors during the study period giving the acceptance rate of 11.6%. It is the 4th most accepted contraceptive after implanton, intrauterine contraceptive device (IUCD) and jadelle. The ages of the clients ranged from 19 to 47 years. Majority of the clients, 60 (59.4%) were between 25-34 years. The mean age was 31.2±6.0 years. Majority of the clients were multiparous women, 61 (60.4%) and Christians 99 (98%). The parity range was 1 to 7 and modal parity was para 2. Four (3.9%) nullipara and 24 (23.8%) grandmultipara accepted and used DMPA during the study period. One hundred (99%) women had formal education out of which 57 (56.4%) had tertiary level of education while 37 (36.6%) and 6 (6%) had secondary and primary levels of education respectively. Majority of the clients were married 94 (93.1%) while 7 (6.9%) were single. The socio-demographic characteristics of the DMPA acceptors are shown in (Table 1).

Table 1: Socio-demographic characteristics of the clients.

<table>
<thead>
<tr>
<th>Variable</th>
<th>No.</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>20-24</td>
<td>11</td>
<td>10.9</td>
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<tr>
<td>25-29</td>
<td>31</td>
<td>30.7</td>
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<td>28.7</td>
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<td>35-39</td>
<td>19</td>
<td>18.8</td>
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<tr>
<td>40-44</td>
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<td>8.9</td>
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<td>45-49</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Educational status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No formal education</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>Primary</td>
<td>6</td>
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</tr>
<tr>
<td>Secondary</td>
<td>37</td>
<td>36.6</td>
</tr>
<tr>
<td>Tertiary</td>
<td>57</td>
<td>56.4</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christianity</td>
<td>2</td>
<td>2.0</td>
</tr>
<tr>
<td>Islam</td>
<td>99</td>
<td>98.0</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nullipara</td>
<td>4</td>
<td>3.9</td>
</tr>
<tr>
<td>Primipara</td>
<td>12</td>
<td>11.9</td>
</tr>
<tr>
<td>Multipara</td>
<td>61</td>
<td>60.4</td>
</tr>
<tr>
<td>Grand multipara</td>
<td>24</td>
<td>23.8</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>7</td>
<td>6.9</td>
</tr>
<tr>
<td>Married</td>
<td>94</td>
<td>93.1</td>
</tr>
</tbody>
</table>

Figure 1 shows the yearly trend of acceptors of DMPA. In 2015, 2016 and 2017; 28 (12.3%), 25 (12.4%) and 21 (12.6%) women accepted and used DMPA respectively. Subsequently the use continued to drop further to 13 (9.6%) in 2018 and 14 (9.9%) in 2019.
Figure 1: Yearly trend of acceptors of DMPA.

Figure 2: Sources of previous contraceptives used by clients.

Figure 3: Continuation and discontinuation rates of DMPA.

Table 2: Previously used contraceptives by the clients.

Table 3: Side effects and reasons for discontinuation of DMPA (n=33).

DISCUSSION

Depo provera is the fourth most frequently accepted and used contraceptive method among women attending the family planning clinic of Rivers State University Teaching Hospital (RSUTH) following implanon, intrauterine contraceptive device (IUCD) and jadelle. In a previous study done by Nonye-Enyidah et al, it was the third frequently used contraceptive following IUCD and implanon. This result probably means that the use of DMPA is on the decline as seen in the chart or this is a smaller study compared to the previous study.

The uptake rate of DMPA during the study period was 11.6%. This is lower than 15% contraceptive prevalence rate among Nigerian women in the reproductive age group.12 It is also lower than 21.4%, 15.7% and 15.35% seen in similar studies done by Ezegwui et al, Abassiattai et al and Oranu et al respectively.4,13,14 The national survey...
had suggested that injectable contraceptives were the most popular and commonly accepted contraceptive method among Nigerian women. This is contrary to the findings in this study where DMPA was the fourth commonly accepted and used contraceptive following implantan, IUCD and Jadelle. With the advent of more modern contraceptives, the uptake of DMPA in our centre has drastically reduced over the years. This is due to the long term coverage of these contraceptives like IUCD and subdermal implants which can last for five years and more. This decline in the use of DMPA is similar to findings in other centres.

The mean age of the acceptors was 31.2 years. This is similar to those from previous study in southern Nigeria. Majority of the clients, 60 (59.4%) were within the age range of 25 and 34 years which is in keeping with the findings from other centres. In this study, only one unmarried adolescent used DMPA. This might be due to the stigma attached to premartial and adolescent sex in our environment. Also adolescents prefer to patronize the chemist shop in our environment to government owned family planning clinics in other not to be seen and by the service providers. Adolescents are not advised to use progesterone-only contraceptives due to its effect on bone mineral density causing osteoporosis. They are also unlikely to be married and would benefit from abstinence or barrier methods to prevent sexually transmitted infections (STIs) as well as the contraception effects.

Most of the clients that accepted DMPA were multipara which is in keeping with previous studies. This is because it is usually the multiparous women who seek for contraception to limit the family size and space the childbirths. This is not in keeping with studies done in southern Nigeria where most of the acceptors were grandmultipara who preferred to use DMPA for terminal contraception. Majority of the clients in this study had formal education. Several studies have confirmed the fact that contraception is more readily accepted and used by educated women.

It is important to state that more than 60% of the clients had no side effects indicating a good safety profile of the contraceptive. Menstrual disorders were the commonest complications experienced by the clients with most of them having secondary amenorrhoea and irregular vaginal bleeding. This is in keeping with results of several studies. In this study secondary amenorrhoea and irregular vaginal bleeding were the commonest reasons for discontinuation of DMPA. These menstrual disorders are due to the effect on ovarian function. Fluctuating endogenous production from irregular follicular growth leads to irregular bleeding whereas secondary amenorrhoea has been attributed to ovarian suppression and endometrial atrophy. Secondary amenorrhoea may be beneficial to some women especially those that require reduced menstrual flow and those with sickle cell anaemia. Actual discontinuation rates of contraceptives vary by region, country and method of contraception. The discontinuation rate of DMPA in this study is 32.7%. This is similar to 32.7% seen in a study done in Senegal, less than 51.5% and slightly higher than 27.1% recorded by Ezegwu at al and Danli et al respectively. Since Depo provera like the other contraceptives has side effects that can lead to discontinuation of the drug, it is important that health care providers should counsel the clients adequately on the benefits and side effects before and during use to reduce the discontinuation rate caused by the side effects. There was no report of accidental pregnancy while the women were on DMPA hence indicating how effective this method of contraception is. This finding is also similar to other studies.

CONCLUSION

The acceptance rate of DMPA is low and its use is on the decline. Menstrual disorders remain the major side effects of this contraceptive and could lead to discontinuation. Therefore adequate counselling before and during follow up visits will go a long way in reducing the discontinuation rate of this very effective contraceptive.

ACKNOWLEDGMENTS

We wish to express our gratitude to the staff of the family planning clinic for the assistance rendered for this study.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES


