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INSIDE

FEBRUARY 2016 Vol. 37, No. 2; p. 13-24

Survey results show use of LARC continues to rise

About 46% of participants in the 2015 *Contraceptive Technology Update* Contraception Survey say they have seen "dramatically more" women choosing long-acting reversible contraceptive (LARC) methods such as the intrauterine device (IUD) and contraceptive implant in the last year.

"We have been offering IUDs to women for many years, and, yes, we have definitely seen an increase in requests and insertions of these methods," says **Corinne Rovetti,** APRN-BC, nurse practitioner at the Knoxville (TN) Center for Reproductive Health. "I believe the most significant reason being the Affordable Care Act coverage. Also, there has been huge increased marketing of these methods."

According to a recently published study that looked at data from the National Survey of Family Growth from 2009 to 2012, women's use of LARC methods has been steadily increasing for about a decade.[1] (*See infographic at http://bit.ly/1PjKFoO.)* During 2009-2012, use of LARC methods, particularly IUDs, increased almost uniformly across the national population of users, with significant increases documented among some of the groups of females who are typically at highest risk for unintended pregnancy, such as young adults and disadvantaged females. (Contraceptive Technology Update *reported on the research. See "More women reported to be moving to long acting reversible contraceptives," January 2016.)*

The American College of Obstetricians and Gynecologists

Review results of 2015 *CTU* Contraception Survey

This issue includes the results of the 2015 *Contraceptive Technology Update* Contraception Survey. Gain perspective from this overview of current clinician practice, and obtain updated information on how to use such long-acting reversible contraceptives as intrauterine devices and the contraceptive implant. We hope you enjoy this special edition of *CTU*.

Financial Disclosure: Consulting Editor **Robert A. Hatcher**, MD, MPH, Nurse Reviewer **Melanie Deal**, Editor **Rebecca Bowers**, Executive Editor **Joy Dickinson,** and guest columnists Anita Brakman and Taylor Rose Ellsworth report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Melanie A. Gold, guest columnist, discloses that she is a clinical advisory board member for Afaxys.

AHC Media

CONTRACEPTIVE TECHNOLOGY UPDATE®

Contraceptive Technology Update®
ISSN 0274-726X, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices

POSTMASTER: Send address changes to:
Contraceptive Technology Update
P.O. Box 550669
Atlanta, GA 30355

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421
customerservice@AHCMedia.com
AHCMedia.com
Hours of operation: 8:30 a.m. - 6 p.m. Monday-Thursday; 8:30 a.m. - 4:30 p.m. Friday, EST

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Back issues: $75. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

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CONTINUING EDUCATION & EDITORIAL DIRECTOR: Lee Landenberger

(ACOG) recently strengthened its recommendation regarding use of LARC methods as the most effective and safe forms of reversible contraception.[2]

The recommendation, released by ACOG's Committee on Gynecologic Practice and its Long-Acting Reversible Contraception Working Group, urges providers to encourage patient consideration of implants and intrauterine devices, to educate patients on LARC options, and to advocate for insurance coverage and appropriate payment and reimbursement for every type of contraceptive method.

The Committee Opinion guides clinicians to increase access to LARC methods by encouraging best practices in provision of LARC methods, including removing barriers to LARC insertion, says **Eve Espey**, MD, MPH, chair of the College's LARC Working Group. A few best practices include the following:

• Create same-day protocols for IUD and implant insertion. If pregnancy can reasonably be ruled out, insert the IUD or implant on the same day the woman comes in for contraception.

• Strike requirements for an additional visit prior to IUD insertion for sexually transmitted infection (STI) screening. If screening test results are positive, infections may be treated with the IUD in place.

• Offer LARC methods at the time of delivery, abortion, or dilation and curettage for miscarriage.

• Offer the copper IUD for emergency contraception.

• On the advocacy side, work to allow Medicaid and private insurance to reimburse for immediate postpartum IUDs and implants.[2]

Educate and inform

Providers should encourage consideration of implants and IUDs for all appropriate candidates, including nulliparous women and adolescents, states the new committee opinion.[2] Educating providers about LARC and encouraging them to offer these methods to their patients might increase uptake. Research indicates that women who have heard of the IUD from their providers are more likely to be interested in it than women who have not.[3]

The Association of Reproductive Health Professionals offers a free webinar, *Comparative Contraception: Reversible and Permanent Options,* to help providers discuss LARC and

EXECUTIVE SUMMARY

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• The American College of Obstetricians and Gynecologists recently strengthened its recommendation regarding use of LARC methods as the most effective and safe forms of reversible contraception.

• Educating providers about LARC and encouraging them to offer these methods to their patients might increase uptake. Research indicates that women who have heard of the IUD from their providers are more likely to be interested in it than women who have not.

permanent birth control methods. *(Access the webinar at http://bit.ly/1O9NvK0.)* After viewing the webinar, providers should be able to do the following:

- describe the benefits, risks, and side effects of long-acting reversible and permanent contraceptive methods;
- identify potential candidates for long-acting reversible and permanent contraception;
- discuss myths and other potential barriers to the use of long-acting reversible and permanent contraception;
- describe shared decision-making that helps women choose a contraceptive method;
- identify sources of evidence-based information for patients on long-term and permanent contraception.

Pencil in Awareness Week

Want to promote awareness about LARC methods? Consider participating in the 2016 LARC Awareness Week, Nov. 13-19.

The annual event, coordinated by the California Family Health Council with other women's health advocacy groups, seeks to increase awareness about LARCs as a safe, effective, low-maintenance, and long-acting birth control method. The event website, www.love-my-larc.org, offers resources, such as a *Why LARCs* information sheet and a media kit for promoting the event.

The California Family Health Council also has developed the website www.safeandeffective.org to help patients and providers understand the benefits and disadvantages of LARC methods. At the website, providers can obtain information on training staff to counsel on LARC methods. There also are training videos and a facilitator's guide that will help provide a 30-minute in-service training for staff of reproductive health and family planning clinics who provide contraceptive counseling to adolescents and young women. The material is appropriate for physicians, nurse practitioners, nurses, health educators, and others. Also available on the website is patient information on LARC methods and resources to help providers develop a LARC clinic at their facilities.

What's the next step?

What can providers expect when it comes to increasing access to LARC methods?

"I think the next great step forward will come when postpartum women can routinely count on getting their implants and IUDs before they are discharged home from delivery," says **Anita Nelson**, MD, professor emeritus in the Obstetrics and Gynecology Department at the David Geffen School of Medicine at the University of California in Los Angeles.

Postpartum women are in need of effective contraception. Results from a recent national study indicate that at three months postpartum, 72% of women were using some type of contraceptive; 6% used LARCs, and 0.5% of these women became pregnant within 18 months of delivery. In comparison, 28% of women relied on hormonal methods, and 25% used less-effective forms of contraception. Data indicate 13-18% of these women became pregnant within 18 months, as did 23% of women using no contraception.[4] At least 70% of pregnancies among U.S. women in the first year after delivery of a child were unintended, data indicate.[4] *(Read more on the research. See "Long-acting reversible contraceptives used by few women after delivery,"* Contraceptive Technology Update*, September 2015.)*

The *U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC)* classifies immediate postpartum copper IUD insertion as Category 1 and immediate postpartum levonorgestrel intrauterine system insertion in nonbreastfeeding and breastfeeding women as Category 2. Insertion of the implant is safe at any time in nonbreastfeeding women after childbirth (Category 1 rating). The *US MEC* classifies the placement of an implant in breastfeeding women less than four weeks after childbirth as Category 2 because of theoretic concerns regarding milk production and infant growth and development. Implants may be offered to women who are breastfeeding and more than four weeks after childbirth because the *US MEC* classifies delayed insertion as Category 1.[5]

Insurance-related barriers might prevent many women from obtaining LARCs before being discharged from the hospital. In many states, intrauterine devices or the contraceptive implant are not included in the "global" obstetric fee, which means hospitals will incur a financial loss if a postpartum patient receives a LARC method prior to discharge. Advocacy is needed to help remove such financial barriers to effective contraception.[6]

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Survey profile

The 2015 *Contraceptive Technology Update (CTU)* Contraception Survey monitors contraceptive trends and family planning issues among readers. Results were tallied and analyzed by AHC Media in Atlanta, which publishes *CTU* and dozens of other healthcare newsletters and sourcebooks and presents webinars and conferences. The survey was mailed in November 2015 to subscribers and attendees at the 2015 *Contraceptive Technology* conference in Atlanta.

About 89% of respondents identified themselves as care providers, with 7% involved in administration and about 3% identifying themselves as faculty/teacher/student. About 46% said they worked in public health facilities, with about 14% working in student health centers. About 14% reported working in hospitals, with 11% in private practice. The remaining percentage listed other healthcare professional settings. When it comes to location of their employment, more than half (53%) said they worked in a rural area location. About 11% said they were employed in a suburban area, with about 36% listing an urban setting. ■

Focus on the contraceptive implant — Insert it in your family planning practice

Where does the contraceptive implant (etonogestrel subdermal implant Nexplanon, Merck, Whitehouse Station, NJ) fit in your practice? About 30% of participants in the 2015 *Contraceptive Technology Update* Contraception Survey reported 25 or more implant insertions in the past year, with 14% saying they inserted 11 to 24 devices in that time period.

The implant represents the most effective form of reversible contraception available, with a failure rate of 0.05 in the first year among typical users.[1] Data indicate the device provides effective use past its approved duration. Three studies in which 275 women used the etonogestrel implant Implanon for longer than three years found no pregnancies during the fourth year of use.[2] A recent study of women using the implant and intrauterine device indicates both methods remain highly effective one year beyond their approved duration of use.[3] (Contraceptive Technology Update *reported on the research. See "Intrauterine device and implant are effective beyond use approved by the FDA," May 2015.)*

"The growth in the use of implants

EXECUTIVE SUMMARY

About 30% of participants in the 2015 *Contraceptive Technology Update* Contraception Survey reported 25 or more implant insertions in the past year, with 14% saying they inserted 11 to 24 devices.

- The implant represents one of the most effective forms of reversible contraception available, with a failure rate of less than 1% over its three-year use approved by the Food and Drug Administration.
- A review of data from 11 clinical trials indicates that implant use is associated with an unpredictable bleeding pattern, which includes amenorrhea and infrequent, frequent, and/or prolonged bleeding. The bleeding pattern experienced during the first three months is broadly predictive of future bleeding patterns for many women.

is very important," observes **Anita Nelson**, MD, professor emeritus in the Obstetrics and Gynecology Department at the David Geffen School of Medicine at the University of California in Los Angeles. "This is a method that can be used by virtually all women and can be placed by virtually every clinician, even very busy primary care providers."

Look closer at method

The progestin-only implant measures 4 cm long and 2 mm in diameter, and it is inserted just under the skin at the inner side of the non-dominant upper arm. The drug release rate is 60-70 mcg per day in weeks 5-6; it decreases to approximately 35-45 mcg/day at the end of the first year, to approximately 30-40 mcg/day at the end of the second year, and then to approximately 25-30 mcg/day at the end of the third year.[4] It provides contraception through ovulation suppression and thickening of cervical mucous.

In a multicenter safety and efficacy clinical trial of the implant, the most common bleeding pattern observed throughout the study was infrequent bleeding, defined as less than three episodes of bleeding in a reference period (excluding amenorrhea).[5] The return to normal menstrual cycles and fertility is rapid after removal, according to trial results.

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The bleeding pattern experienced during the first three months is broadly predictive of future bleeding patterns for many women. Effective preinsertion counseling on the possible changes in bleeding patterns might improve continuation rates, the review states.

Check other benefits

In addition to its contraceptive efficacy, the implant offers non-contraceptive benefits as well. **Anne Burk**e, MD, MPH, associate professor in the Department of Gynecology and Obstetrics at the Johns Hopkins University of School of Medicine in Baltimore, spoke on such benefits at the 2015 *Contraceptive Technology* Quest for Excellence conference in Atlanta.[7]

Researchers conducted a small pilot study designed to evaluate the beneficial effects of Implanon on pelvic pain in women with pelvic congestion syndrome (PCS). The efficacy of pain control, amount and frequency of menstrual loss, degree of patient's satisfaction, and objective pelvic venography scores were analyzed. According to study results, Implanon appears to be an effective hormonal alternative for long-term treatment of properly selected patients with pure PCS-related pelvic pain.[8]

Another small study looked at use of the implant compared to the contraceptive injection depot medroxyprogesterone acetate (DMPA) for relief of pain associated with endometriosis, During a one-year follow-up period, researchers recorded a clear improvement in pain intensity for both treatment options. After six months, the average decrease in pain was 68% in the Implanon group and 53% in the DMPA group. The side-effects profile and the overall degree of satisfaction after study termination were comparable for both treatment options, researchers report.[9]

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Should oral contraceptives move over the counter? Readers speak out

When it comes to moving oral contraceptives over the counter (OTC), most participants in the *Contraceptive Technology Update* Contraception Survey say they support such a move. Almost 50% say they would support OTC availability of progestin-only pills, while 32% say they would support similar availability of combined hormonal pills.

A variety of factors contribute to nonuse of contraception, gaps in use, and early discontinuation, all of which put women at risk of unintended pregnancy, states a just-published article on OTC access to pills.[1] For some women, difficulties accessing contraception, including challenges obtaining a prescription or a method and problems paying for a method, lead to nonuse, the article notes.

In one study that looked at gaps in use, 40% reported problems accessing or using methods.[2] Results from a nationally representative sample indicate 30% of women who had ever tried to obtain a prescription for hormonal contraception reported difficulties obtaining the prescription or refills.[3]

Momentum is growing in the move toward putting pills within women's reach. Support for OTC access has been voiced by medical groups such as the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists.[4,5]

"Free the Pill"

In December 2014, Ibis Reproductive Health and the Oral Contraceptives (OCs) Over the Counter Working Group launched Free the Pill, a website (www.freethepill.org) and social media resource (on Facebook and Twitter) to provide information and updates on making a birth control pill available without a prescription in the United States, says **Kate Grindlay**, MSPH, senior project manager at Ibis Reproductive Health. Ibis, based in Oakland, CA, is an international nonprofit organization with a mission to improve women's reproductive autonomy, choices, and health worldwide. Ibis convenes the OCs OTC Working Group. It was formed in 2004 by researchers, advocates, and healthcare providers to work toward moving a pill over the counter to improve access to safe and highly effective contraception.

The website contains frequently asked questions and answers; information about the pill; and a "Voices" page, featuring quotes from women and men around the country on their opinions on making a birth control pill available over the counter. It also offers such resources as information on the full range of birth control options and where people can access them, how women can tell if the pill is right for them, and a map of countries around the world where the pill already is available OTC, says Grindlay. The Facebook and Twitter pages are regularly maintained with the latest news articles and updates on moving a pill OTC, as well as infographics and other materials designed to educate and engage, she states.

"Together, these resources aim to provide accessible, evidence-based information to a general audience in the U.S. that may have heard about the issue and wants to learn more, as well as to new audiences being reached for the first time," Grindlay observes.

The Free the Pill campaign is rooted in the philosophy that an over-the-counter birth control pill should be available at a low cost, covered by insurance, and accessible to people of all ages, says Grindlay. To date, more than 5,300 people have "liked" the Facebook page, and nearly 550 people have followed Free the Pill on Twitter,

EXECUTIVE SUMMARY

Most participants in the *Contraceptive Technology Update* Contraception Survey say they support moving oral contraceptives over the counter (OTC). Almost 50% say they would support OTC availability of progestin-only pills, while 32% say they would support similar availability of combined hormonal pills.

- Support for OTC access has been voiced by medical groups such as the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists.
- Ibis Reproductive Health and the Oral Contraceptives Over the Counter Working Group have launched Free the Pill, a website (www.freethepill.org) and social media resource (on Facebook and Twitter) to provide information and updates on making a birth control pill available without a prescription in the United States.

she reports.

"Free the Pill serves an important role as a platform for raising awareness around this issue and creating a space for dialogue in which people can engage with each other and expert resources to learn more, ask questions, and push the conversation forward," says Grindlay. "And the conversation has just begun."

Which pill will be first?

What will it take to move a pill over the counter?

At first glance, it seems likely that oral contraceptives meet the Food and Drug Administration (FDA) criteria to be accessed without a prescription.[1] Birth control pills have no significant toxicity if overdosed and are not addictive. Women themselves determine if they are at risk of unintended pregnancy, which means they essentially self-diagnose the condition for appropriate use of the product.

The FDA also will want to see that women can safely take the medication without a clinician's screening and take the medication as indicated over time without a clinician's explanation.[1]

Progestin-only pills (POPs) meet the criteria for over-the-counter status, states **Susan Wysocki**, WHNP-BC, FAANP, president and chief executive officer of iWomansHealth in Washington, DC, which focuses on information on women's health issues for clinicians and consumers.

"First, they are safe for most women. The conditions in which POPs are not ideal are identifiable to the user since, in most cases, that individual would be receiving medical care for that condition," states Wysocki. "Other OTC products, such as cold products, list conditions in which use of those products should be avoided."

By moving POPs to over-the-counter status, it would give women an opportunity to obtain an effective method of contraception easily, notes Wysocki. It might be a continued method or a bridge method to a longer-acting method, she states.

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Where do pills fit in the family planning picture?

How are oral contraceptives (OCs) being used in today's family practice picture? Results of the *Contraceptive Technology Update* Contraception Survey give insight on how providers are using this form of birth control in their daily practice.

There has been a "slight decrease" in the use of OCs as more women are wanting a longer-term method, along with the availability of coverage of such methods from the Affordable Care Act, says **Corinne Rovetti**, APRN-BC, nurse practitioner at the Knoxville Center for Reproductive Health in Knoxville, TN.

According to national statistics, among women using contraception, the pill continues to lead the pack, with 25.9% of contracepting women (9.7 million women) reporting its use.[1] Female sterilization was listed by 25.1% (9.4 million women), followed by the male condom (15.3%, 5.8 million women), and long-acting reversible contraception (LARC) (11.6%, 4.4 million women).[1] *(*Contraceptive Technology Update *reported on the trends. See "More women reported to be moving to long-acting reversible contraceptives," January 2016.)*

Other benefits seen

Most women who use OCs do so to prevent pregnancy; however, more than half also identify noncontraceptive health benefits, such as treatment for excessive menstrual bleeding, menstrual pain, and acne, as reasons for use.[2]

Oral contraceptives help relieve or reduce dysmenorrhea, which is experienced by up to 40% of all adult women and can lead to absences from work and school.[3] Use of OCs also can aid in treating menorrhagia, which can lead to anemia; pills also can reduce acne and excess hair growth.[4] Other noncontraceptive uses include prevention of menstrual-related migraines and treatment of pelvic pain that accompanies endometriosis and of bleeding due to uterine fibroids.

Menstrual regulation is cited by many women who choose to use oral

EXECUTIVE SUMMARY

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- About 14% of *Contraceptive Technology Update* Contraception Survey participants said more than half of their patients using pills choose extended or continuous regimens, with 25% saying 11-25% of patients use such regimens.
- When it comes to use of pills in older women who smoke, 75% of survey participants say they would not prescribe pills to healthy women ages 35-39 who smoke 10 cigarettes a day, with 93% reluctant to write prescriptions for women older than 40 with similar smoking habits.

contraceptives. In a national analysis of pill users, 28% said they used the method for this purpose.[2] About 14% of *CTU* survey participants said more than half of their patients using pills choose extended or continuous regimens, with 25% saying 11-25% of patients use such regimens.

When to offer options

When it comes to use of pills in older women who smoke, most *CTU* survey respondents vote thumbs down.

Three-quarters of participants say they would not prescribe pills to healthy women ages 35-39 who smoke 10 cigarettes a day, with 93% reluctant to write prescriptions for women older than 40 with similar smoking habits.

What does the *U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC)* say about use of combined pills and smoking?[5] For women age 35 or above who smoke 15 cigarettes or fewer per day, combined pills are classed as Category 3 (theoretical or proven risks usually outweigh the advantages of using the method). For women ages 35 and older who smoke more than 15 cigarettes a day, the MEC classes pill use as Category 4 (unacceptable risk).

Picking Quick Start

Same-day initiation of contraception, known as Quick Start, is an accepted practice among family planners.

Almost 90% of *CTU* survey respondents say their facilities do Quick Start for combined hormonal methods. That statistic compares favorably with the 45% of adolescent health providers who reported Quick Start use in 51 health centers throughout the United States with high rates of teen pregnancy.[6]

About three-quarter of *CTU* survey respondents say they will prescribe combined OCs to nonbreastfeeding mothers 4-6 weeks postpartum.

According to the *US MEC*, in women who are less than 21 days postpartum, use of combined hormonal contraceptives represents an unacceptable health risk (Category 4). In women who are 21-42 days postpartum and have other risk factors for venous thromboembolism (VTE) in addition to being postpartum, the risks for combined hormonal contraceptives usually outweigh the advantages and therefore, generally, should not be used (Category 3). In the absence of other risk factors for VTE, the advantages of combined hormonal contraceptives generally outweigh the risks, and they usually can be used (Category 2).[7]

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Chlamydia, gonorrhea, and syphilis cases are up for first time since 2006

Reported cases of chlamydia, gonorrhea, and syphilis have increased for the first time since 2006, according to just-published data by the Centers for Disease Control and Prevention (CDC).[1]

The approximately 1.4 million cases of chlamydia (456.1 cases per 100,000 population) represent the highest number of annual cases of any condition ever reported to CDC. The number of reported cases of chlamydia rose 2.8% since 2013. Rates of primary and secondary (P&S) syphilis, which are the most infectious stages of syphilis, and gonorrhea grew as well: 15.1% and 5.1%, respectively. In 2014, there were 350,062 reported cases of gonorrhea (110.7 per 100,000) and 19,999 reported cases of P&S syphilis (6.3 per 100,000), the CDC data reflects.[1]

"The recent sexually transmitted disease [STD] data should be a clarion call that there is a major STD problem on our hands in the United States, one that is grounds for declaring a sexual health crisis," states **William Smith**, executive director of the National Coalition of STD Directors in Washington, DC.

CDC surveillance data indicate the numbers and rates of reported cases of chlamydia and gonorrhea continues to be highest among young people ages 15-24. While young men and women are heavily affected by STDs, young women face the most serious long-term health consequences. The CDC estimates that undiagnosed STDs cause more than 20,000 women to become infertile each year.[2]

According to the *2014 STD Surveillance Report*, young people are still at the highest risk of acquiring an STD and most vulnerable to their damaging effects, notes **Eloisa Llata**, MD, MPH, a medical epidemiologist at the CDC. Young people ages 15-24 continue to represent half of the 20 million new infections each year, though they are only 25% of the sexually experienced population, states Llata. Many STDs go untreated because they often have no symptoms, she says. Individuals who are unaware they're infected might unknowingly infect others, Llata says.

What are some of the ways the CDC is promoting STD prevention among youth, given the high numbers of STDs found in this age group?

"To break the cycle, it is critical to increase screening and awareness, especially among young people," states Llata. "Our efforts include recommending the most effective treatments and encouraging expedited partner therapy where appropriate; advancing sound health policy, such as developing disease screening and treatment recommendations that help the most-affected populations gain access to prevention services and overcome barriers; and providing resources to state/local health departments to support on-the-ground STD prevention efforts."

Greater awareness and action is needed at all levels, says Llata. Individuals, healthcare providers, parents, and community leaders all have a role to plan in protecting the health of America's youth, she states. To reduce STDs, Americans must take steps to protect themselves, states the CDC.

Testing and treatment, using condoms consistently and correctly, and limiting the number of sex partners, are all effective strategies for reducing the risk of infection in sexually active individuals.

The National Coalition of STD Directors launched "Condoms (STILL) Work!" in October 2014 to raise awareness that in the midst of this crisis, clinicians have a great prevention tool that far from being passé, is "critical" to current and future efforts to prevent infections and create better sexual health, says Smith. The campaign, propelled by a donation of one million condoms from the makers of Trojan brand condoms, allowed the Coalition to award condoms to STD programs across the nation.

"Providers, through underscoring that condoms are important for patients engaging in sex with partners whose STD status is unknown or is known and necessary to prevent infection, must be part of the solution," says Smith.

Robert Hatcher, MD, MPH, professor emeritus of gynecology and obstetrics at Emory University School of Medicine in Atlanta, made the following comment: "The dramatic increase in STDs reminds all providers of LARC methods that in spite of their effectiveness, it remains important that all young women be offered and encouraged to use condoms, because over half of the time, an uninfected woman is infected by a male partner who is totally asymptomatic."

The new CDC data also that show rates of syphilis are increasing at fast pace: 15.1% in 2014.[1] While rates have risen in men and women, men account for more than 90% of all primary and secondary syphilis cases, the CDC states.

Men who have sex with men (MSM) represent 83% of male cases where the sex of the sex partner is known.[1] Syphilis infection can place a

person at increased risk for acquiring or transmitting HIV infection; available surveillance data indicate that an average of half of MSM who have syphilis also are infected with HIV.[1]

In a statement, **Jonathan Mermin**, MD, director of CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention, said, "STDs affect people in all walks of life, particularly young women and men, but these data suggest an increasing burden among gay and bisexual men."

To better identify and address specific challenges facing gay and bisexual men, CDC is concentrating research efforts to better identify and address such challenges facing gay and bisexual men, as well as developing educational resources for providers and improving efforts to offer more culturally relevant care.

The National Coalition of STD Directors, along with the National Alliance of State and Territorial AIDS Directors (NASTAD), has developed information for working with black and Latino MSM, who are at particular risk for STDs, as well as an optimal care overview for providing care to MSM patients. *(Download information at http://bit.ly/1qu4ZFd and the overview from http://bit.ly/1Yg2fdL.)*

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TEEN TOPICS

HPV vaccine update: Get up to speed

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Healthcare professionals need to be familiar with all of the indications for the human papillomavirus (HPV) vaccine, make strong recommendations for receiving vaccine at ages 11 or 12, and be aware of systems that can improve practice vaccination rates.

In 2014, the Food and Drug Administration (FDA) approved a vaccine designed to prevent nine high-risk strains of human papillomavirus.[1] In 2015, the Advisory Committee on Immunization Practices (ACIP) added the new 9-valent HPV vaccine (9vHPV or Gardasil 9) to its recommendations for the routine vaccination of adolescents.[2]

HPV is the most common U.S. sexually transmitted infection, so much so that nearly all sexually active people who aren't vaccinated will contract it at some point.[3] An estimated 79 million Americans are infected with HPV, with 14 million new cases each year, and the highest burden falls on adolescents and young adults under age 25.[4]

Most HPV infections are asymptomatic, transient, and resolve on their own. However, those infections that don't resolve can lead to cancers, as well as genital warts. An estimated 27,000 people are diagnosed annually with cancer attributed to HPV. Most are cervical cancers, but cancer of the vagina, vulva, penis, or anus, and oropharyngeal cancers also are caused by oncogenic strains of HPV.[5]

The bivalent and quadrivalent HPV vaccines that were FDA approved in 2006 and 2009, respectively, already offered protection against two strains, types 16 and 18, which cause 64% of HPV-associated cancers. The quadrivalent vaccine also protects against two strains that cause genital warts: types 6 and 11. The 9vHPV shot protects against all of these, plus five additional strains (HPV 31, 33, 45, 52, and 58). These additional strains cause about 10% of HPV-associated cancers, including about 15% of cervical cancers.[5]

The recommendation from ACIP is that HPV vaccines should be routinely given for females and males at ages 11 or 12, though it can be given as early as age 9. Vaccination for females ages 13-26 and males ages 13-21 also are recommended if they have not completed the three-dose series. Also, vaccination is recommended up to age 26 for men who have sex with men, as well as immunocompromised males.[2]

The availability of the new 9HPV vaccine might cause confusion about which vaccine to use, especially if patients have started and not yet finished the complete three-dose

series. If a female patient has started the series, she can complete it with the 9vHPV or with the bivalent or quadrivalent versions. Males also can start the series with the quadrivalent and finish with 9vHPV, or vice versa, but the bivalent vaccine is not approved for use in males. For all, the benefit of vaccinating in a timely way with any of the three options outweighs the risk of delaying vaccination to obtain 9vHPV.[6]

If a patient has completed the series, it is not recommended that they obtain a dose of 9-valent vaccine.

In 2014, 87.6% of adolescents ages 13-17 were vaccinated with tetanus, diphtheria, and acellular pertussis (Tdap), and 79.3% were vaccinated with meningococcal conjugate (MenACWY). In contrast, only 60% of females and 42% of males received one dose of an HPV vaccine series. Only 40% of females and 22% of males received the complete three-dose series. Although HPV vaccination rates have increased since the vaccine was introduced, they still lag far behind the other routine adolescent vaccines.[7]

Studies consistently show that a provider's recommendation is the single best predictor of vaccination.[8] Yet, in a recent study of family physicians and pediatricians, 25% failed to make a timely recommendation for girls; 40% failed to recommend it for boys. Sixty percent of the providers polled used a risk-based approach to decide when to recommend the HPV vaccination, rather than offering it routinely as per ACIP guidelines.[9]

After conducting focus groups with parents, the Centers for Disease Control and Prevention (CDC) has created materials for providers to help them discuss HPV vaccination with parents. They recommend bundling the HPV vaccination with other adolescent vaccines on the same day and giving them equal weight and importance. The CDC also recommends that providers emphasize that HPV vaccination is cancer prevention and one's personal belief in the benefit of their son or daughter receiving the vaccine.[10] Integrating routine recommendations for the HPV vaccine in practice can significantly impact parental and patient decisions and improve vaccine rates to be more in line with other routine adolescent vaccines.

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COMING IN FUTURE MONTHS

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CONTRACEPTIVE TECHNOLOGY UPDATE®

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1. What classification does the *U.S. Medical Eligibility Criteria for Contraceptive Use* use for immediate postpartum insertion of a copper intrauterine device?

A. Category 1
B. Category 2
C. Category 3
D. Category 4

2. What is the approved duration of use for the contraceptive implant?

A. One year
B. Two years
C. Three years
D. Five years

3. What classification does the U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC) use for women age 35 or above who smoke 15 cigarettes or less per day who wish to use combined pills?

A. Category 1
B. Category 2
C. Category 3
D. Category 4

4. Young people in the U.S. ages 15-24 continue to represent what percentage of the 20 million new sexually transmitted infections each year?

A. 25%
B. 50%
C. 75%
D. 85%

CNE/CME OBJECTIVES

After reading *Contraceptive Technology Update*, the participant will be able to:

1. identify clinical, legal, or scientific issues related to development and provisions of contraceptive technology or other reproductive services;
2. describe how those issues affect services and patient care;
3. integrate practical solutions to problems and information into daily practices, according to advice from nationally recognized family planning experts;
4. provide practical information that is evidence-based to help clinicians deliver contraceptives sensitively and effectively.