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INSIDE

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Intrauterine contraception: What will it take to shift provider practice?

OB/GYNs see IUD as effective option, but few are inserting them

Another in her late 20s comes in your office. She says she is seeking reliable, long-term birth control as she balances the demands of a hectic work and family life. Is the intrauterine device (IUD) one of the options you offer her?

If it is not, you may be among the number of U.S. providers who do not include IUD insertions in their regular practice. According to a just-published survey of U.S. OB/GYNs, 20% of OB/GYNs had not inserted an IUD in the previous year, and of those that had, 79% had inserted 10 or fewer.[1]

Fear of litigation and a belief that IUDs cause pelvic inflammatory disease were associated with lower IUD use, according to the survey results. However, scientific evidence does not support these beliefs, say family planning experts.

"Many clinicians in the U.S. are unaware that the IUD is the most widely used and effective reversible method of contraception in the world today, exceeding even oral contraceptives," asserts **David Grimes**, MD, vice president of biomedical affairs at Family Health International in Research Triangle Park, NC. "IUDs not only provide protection against pregnancy tantamount to that achieved with tubal sterilization, but they have a range of noncontraceptive health benefits

EXECUTIVE SUMMARY

While most U.S. providers consider today's intrauterine device (IUD) to be safe and effective, results of a recent survey of OB/GYNs show few are routinely recommending or inserting them.

- The survey said 20% of providers had not inserted an IUD in the previous year, and of those that had, 79% had inserted 10 or fewer.
- Those providers who believe the IUD increases the risk of pelvic inflammatory disease, and those who fear being sued, inserted fewer IUDs. Scientific evidence does not support either concern, say experts.

that are just beginning to be appreciated."

An estimated 106 million women worldwide use an IUD for contraception;[2] however, fewer than 1% of American women at risk for pregnancy choose the method.[3] What factors might influence these decisions?

To examine the "physician piece" of the U.S. puzzle, researchers mailed surveys to assess use of and attitudes toward the IUD to 811 practicing members of the Washington, DC-based American College of Obstetricians and Gynecologists. The survey response rate was 50%.

According to lead researcher **Nancy Stanwood**, MD, MPH, an assistant professor in the department of obstetrics and gynecology at the University of Rochester (NY) Medical Center, physicians had not been surveyed on IUD use since the 1988 introduction of the Copper T380A IUD (marketed in the United States as ParaGard Intrauterine Copper Contraceptive by Ortho-McNeil Pharmaceutical, Raritan, NJ). Stanwood conducted the research, funded by the Robert Wood Johnson Clinical Scholars Program, while completing a fellowship at the University of North Carolina at Chapel Hill.

Survey results show respondents were most restrictive about patient monogamy in their selection of IUD candidates; having less conservative criteria for selecting IUD candidates was associated with greater IUD use. Respondents with liberal criteria inserted a mean of nine IUDs in the past year, whereas those with conservative criteria inserted four.

New era dawning?

Because most OB/GYNs are inserting few IUDs, educational programs should target these physicians to expand their IUD use, the researchers conclude. Such programs should highlight modern IUD safety and the rarity of litigation, say the researchers.

The risk of liability is out of proportion to actual experience with modern IUDs, says **Susan Wysocki**, RNC, NP, president and chief executive officer of the Washington, DC-based National Association of Nurse Practitioners in Women's Health. Only one lawsuit has been filed against the manufacturer of ParaGard since 1988, with the lawsuit ending in a defense verdict, she states.

The tide may be turning in provider resistance to the method, says Stanwood. Younger providers are not as influenced by the negative image of the IUD cast by the Dalkon Shield controversy three decades earlier, she notes. (Numerous lawsuits forced Dalkon Shield manufacturer A.H. Robins Co. of Richmond, VA, to declare bankruptcy in 1985 after more than 4,000 product liability cases had been filed against it.) Younger survey respondents were found to insert more IUDs than their senior counterparts, even when results were controlled for activity level of practice, survey results indicate.

The growing impact of evidence-based medicine also may influence providers' practices when it comes to the IUD, states Stanwood. Over the long run, the levonorgestrel IUD (marketed in the United States as the Mirena Levonorgestrel-Releasing Intrauterine System by Berlex Laboratories in Montville, NJ) is the single most effective method of reversible contraception available in the world today, closely followed by the Copper T380A.[4] Over seven years of wear, the cumulative probability of pregnancy is only 1.1% for the levonorgestrel IUD; for the Copper T380A, it is 1.7%.[4]

"With the whole push toward evidence-based medicine, I think obstetrician/gynecologists are looking at contraceptive counseling more from an evidence-based perspective and, hopefully, comparing effectiveness of one method to another," says Stanwood.

Get training in 2002

The Washington, DC-based Association of Reproductive Health Professionals (ARHP) plans 20 additional sessions in 2002 for its *New Developments in Contraception: Counseling and Insertion Training Featuring the Levonorgestrel Intrauterine System.* **(Check the resource box on p. 39 for enrollment information.)** The program, sponsored with the Ithaca (NY) Center for Postgraduate Medical

COMING IN FUTURE MONTHS

- Examine data on hormone therapy and breast cancer
- Stem the number of undiagnosed STDs
- Teen birthrate drops in the states — Why the decline?
- Provide reproductive care services at the work site
- Raise EC awareness on college campuses

RESOURCE

For more information on the **New Developments in Contraception** continuing medical education program, visit the Association of Reproductive Health Professionals web site, www.arhp.org, or write to 2401 Pennsylvania Ave., N.W., Suite 350, Washington, DC 20037-1718. Telephone: (202) 466-3825, or e-mail: arhp@arhp.org. Participants may enroll on-line; click on "New Developments in Contraception," then "Sign Up Here." Participants also may print out the on-line enrollment form and fax it to (202) 466-3826.

Education, was presented in 153 accredited continuing medical education sessions in 2001. More than 4,300 health care providers participated in the program, which has won two national awards. The program is made possible by an unrestricted educational grant from Berlex Laboratories.

In addition to provider educational sessions, the program features a patient education brochure, *Birth Control: Comparing the Choices,* a clinician's handbook, videotape, and a special issue of ARHP's monograph, *Clinical Proceedings*. Many of the program's educational materials are are available for purchase on ARHP's web site at www.arhp.org/newdev.htm.

"This program has been a highly effective tool, educating thousands of health care providers about today's new contraceptive options," says **Wayne Shields**, association president and CEO. "The associated training sessions also helped clinicians fine-tune their insertion skills, a key step toward ensuring a successful experience for women who choose this new method."

Keys to successful use

The success of any new IUD is going to be based on selection of appropriate candidates, appropriate consent and teaching, and appropriate insertion, says **Kirtly Parker Jones**, MD, associate professor in the department of obstetrics and gynecology at the University of Utah Health Sciences Center in Salt Lake City and co-chair of the ARHP program. Since the levonorgestrel IUD represents a new method as to its side effects and insertion techniques, it was imperative that ARHP get the message out on its proper use, she says.

Women who are well informed about the benefits and disadvantages of the method are satisfied users, says Parker Jones. Patients who have been using the levonorgestrel IUD for more than a year now report light periods with decreased cramping and bleeding, she notes. Again, she stresses that its success is based on "picking the right people, doing the right counseling, and putting it in right."

Given the IUD's history in the United States, providers need to recognize that a clinician who is passive about IUDs will insert few, if any devices, says **Andrew Kaunitz**, MD, professor and assistant chair in the obstetrics and gynecology department at the University of Florida Health Science Center/Jacksonville. In contrast, clinicians who are IUD advocates continue to actively insert IUDs in their practices, he reports.

A common example of why this proactive approach is important is the scenario in which a patient referred by her primary care provider for tubal sterilization ends up choosing an IUD, says Kaunitz.

Using an illustration from his own practice, Kaunitz talks about sterilization at the initial consultation, including surgical and efficacy issues. The two also discuss reversible options, including the IUD. A staff member in Kaunitz' office, a well-educated IUD user, also has volunteered to talk with potential candidates. This firsthand counseling sometimes makes a difference, he says.

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Research looks at new uses for mifepristone

With mifepristone now approved in the United States for use in early medical abortion, researchers are moving forward in investigating the drug for other areas of women's health, including contraception and treatment of

EXECUTIVE SUMMARY

Mifepristone, approved in the United States for medical abortion, is being examined for other indications, including contraception and treatment of endometrial cancer.

- Women are being recruited for a study that is designed to examine the drug's potential cancer-fighting capabilities.
- Research reports on use as a possible estrogen-free contraceptive. The drug's anti-progesterone effect completely prevented ovulation in most participants. Further investigation is needed to confirm the drug's safety and efficacy as a birth control method.

endometrial cancer.

The Houston-based University of Texas M.D. Anderson Cancer Center has opened the first clinical trial to study the drug's potential endometrial cancer-fighting capabilities. The Phase II clinical trial is recruiting 37 women whose tumors are progesterone-receptor positive with recurrent and/or advanced endometrioid carcinomas or low-grade endometrial stromal sarcoma.

On the other side of the globe, a just-published preliminary report of a trial indicates the drug's potential as an estrogen-free oral contraceptive.[1] The study, which involved 98 women in Edinburgh, Scotland, and Shanghai, China, shows that mifepristone in low daily doses inhibited ovulation and induces amenorrhea in most of the study population.

Marketed in the United States as Mifeprex by Danco Laboratories of New York City, mifepristone offers several potential avenues for exploration, says **Eric Schaff**, MD, professor of family medicine at the University of Rochester (NY). Developed in 1980, the drug's ability to block the action of progesterone places it as the first of its kind in the class of anti-progestins.

"I have been working with it since 1996 in different trials, and it is just a tremendous drug," Schaff observes. "There are many potential uses for it, as emergency contraception, contraception, as an anticancer medication, anti-stress medication, and treatment for fibroids and endometriosis."

Researchers at the Houston Cancer Center see mifepristone as a promising weapon in the war against endometrial cancer, the most common type of cancer of the gynecological tract. According to the Atlanta-based American Cancer Society, 36,000 new cases were reported in the United States in 2000, and 6,500 women died from the disease.

Recurrent and advanced endometrial cancer is very difficult to treat and even more challenging to cure, states **Lois Ramondetta**, MD, assistant professor in the center's department of gynecologic oncology. The center, which has been using the drug for the last few years through a compassionate use agreement, has seen encouraging results.

What does Ramondetta see as the three most encouraging aspects of mifepristone for treatment of this deadly cancer?

- Mifepristone appears to bind the progesterone receptor more strongly than progesterone, and in certain instances, it can act as a progesterone or anti-progesterone.
- The drug has been shown to have promising anti-angiogenesis properties.
- Mifepristone appears to be easier to tolerate than Megace (megestrol acetate, Bristol-Myers Squibb, Princeton, NJ), one of the current hormonal treatments for the cancer.

Early research indicates in vitro cell growth suppression using mifepristone in endometrial cancer cell lines, says Ramondetta.[2] Studies performed in France in the 1980s in patients with breast cancer (whose tumors are also hormone-responsive) showed encouraging response rates with mifepristone treatment; however, they were not prolonged responses.[3]

"What was noted, however, is that those patients whose tumors were progesterone receptor-positive had better responses," Ramondetta says.

Center researchers are recruiting 37 women of all ages and ethnicities for the mifepristone trial, which will last at least eight weeks. Since the trial is restricted to patients with progesterone receptor positive tumors, only a few of those evaluated are eligible, says Ramondetta. **(See the resource box on p. 41 for candidate criteria.)** Women will take a daily 200-mg pill dose of mifepristone. (In comparison, the U.S. medical abortion regimen calls for 600 mg of the drug, provided in three 200-mg tablets, followed two days later by two 200-mcg tablets of misoprostol.) Drug cost to participants is $500 per month.

A double-blind, parallel group study in Edinburgh and Shanghai examined the use of mifepristone as a potential contraceptive in healthy female volunteers ages 18-40. Participants were randomized to receive 2- or 5-mg mifepristone daily for 120 days. Ovarian activity was monitored by measuring urinary steroids, and participants kept a daily diary of menstrual bleeding throughout the study. Ninety women completed the study.

RESOURCE

For more information on Mifeprex, call the Mifeprex hotline, (877) 4-Early Option [(877) 432-7596], or visit the web site, www.earlyoptionpill.com.

The drug's anti-progesterone effect completely prevented ovulation in most women. In Edinburgh, 65% of the 2-mg group were amenorrheic throughout the 120 days of treatment, as were 88% of the 5-mg group. In Shanghai, 90% of women in both groups were amenorrheic. Women who did bleed reported a reduction in the amount of bleeding compared to their normal menstrual period, state the researchers.

Larger clinical studies are need to confirm the safety and effectiveness of this as a potential method of contraception. Research indicates the drug also holds promise as a emergency postcoital contraceptive,[4] notes Schaff. Its low number of side effects would make it an attractive option, he says.

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Check candidates for mifepristone trial

Women who wish to participate in the mifepristone trial at the University of Texas M.D. Anderson Cancer Center must fit the following criteria:

- must have a diagnosis of advanced or recurrent endometrioid adenocarcinoma or low-grade endometrial stromal sarcoma (LGESS);
- should have had a minimum of a total abdominal hysterectomy and bilateral salpingoophorectomy (removal of uterus, ovaries and fallopian tubes), or definitive radiation therapy;
- the recurrent tumor must be progesterone receptor (PR) positive;
- prior chemotherapy for recurrent or metastatic endometrial cancer or LGESS is permitted;
- must have measurable disease by X-ray or physical examination;
- must be able to return to M.D. Anderson periodically for follow-up;
- should not be on medications to control seizure activity;
- if taking estrogen, progestin, or antiprogestins, must discontinue their use at least three weeks prior to beginning treatment with mifepristone;
- should not have a history of another malignancy other than nonmelanoma skin cancer, unless they are in complete remission and have not been on therapy for that disease for a minimum of five years;
- should not have another serious medical illness.

Patients will undergo a physical exam and laboratory work once a month. At the end of eight weeks, a computed tomography scan will be done to see if mifepristone is helping shrink endometrial tumors. Participants with stable disease or improvement may take the drug for as long as it benefits them. Patients who experience significant side effects may have treatment interrupted until the side effects resolve.

Study participants are responsible for the cost of the trial drug. Women are advised to check with their health insurance carrier for possible coverage.

For more information or to register for the trials, contact Jacalyn Gano, RN, telephone (713) 794-1422, or e-mail jgano@mdanderson.org. Further information on the trial is available at the following web site: www.mdanderson.org/mifepristone. ■

2 trials will examine capability of microbicide

Can a new microbicide offer effective protection against pregnancy? How does it perform when it comes to prevention of HIV? Two trials of a polymeric gel are in the works to shed further light on these reproductive health questions.

BufferGel is a spermicidal and microbicidal gel

EXECUTIVE SUMMARY

Progress is reported on the microbicide front, as a polymeric gel enters two trials to evaluate its contraceptive and HIV-prevention capabilities.

- Ten U.S. sites are participating in the contraceptive efficacy trial of BufferGel, a spermicidal and microbicidal gel formulated to maintain the natural protective acidity of the vagina. The gel is a joint development of researchers at Johns Hopkins University and ReProtect LLC.
- BufferGel and another microbicide, PRO 2000 from Interneuron, will be the focus of an upcoming multicenter investigation in Africa and Asia that is designed to test their effectiveness against HIV transmission.

formulated to maintain the natural protective acidity of the vagina. Investigators at 10 U.S. sites began enrolling women in October 2001 for a contraceptive efficacy trial of the gel formulation, reports **Richard Cone**, PhD, professor of biophysics at Johns Hopkins University and managing director of ReProtect LLC, both in Baltimore. The polymeric gel was developed jointly by researchers at the university and the private firm.

The microbicide will be the focus of another trial this summer to determine its efficacy in preventing HIV transmission, says **Thomas Moench**, MD, medical director for ReProtect LLC. The trial, a multicenter investigation in Africa and Asia, will look at BufferGel and another microbicide, PRO 2000 from Interneuron of Lexington, MA. The investigation is part of the HIV Prevention Trials Network coordinated by the Bethesda, MD-based National Institutes of Health. ***(Contraceptive Technology Update* reported on BufferGel, PRO 2000, and other microbicides in an April 1999 article, p. 37, "Get Ready: Women to Have More Options for Preventing Disease.")**

Birth control option?

The contraceptive study is designed to test whether women using BufferGel and a diaphragm can reduce the risk of pregnancy as effectively as women using a conventional spermicidal detergent and a diaphragm. Investigators plan to enroll 1,000 women, who must be in a sexually active and monogamous relationship and at low risk for infection by sexually transmitted diseases. They must agree not to use other forms of contraception beyond that supplied by the study and be willing to risk getting pregnant.

The clinical sites are Eastern Virginia Medical School in Norfolk; Women's Health Institute in New Brunswick, NJ; University of Pennsylvania Medical Center in Philadelphia; Magee-Womens Hospital in Pittsburgh; University of Florida in Jacksonville; California Family Health Council in Los Angeles; University of Colorado Health Sciences Center in Aurora; University of Cincinnati; New York University and the College of Physicians and Surgeons of Columbia University, both in New York City.

Early research found the formulation effective in animal models,[1] and standard postcoital testing determined BufferGel to have in vivo spermicidal action.[2] The research under way will further examine the polymeric gel's contraceptive effectiveness in a clinical trial.

Check safety profile

Two small studies have been published on the safety of BufferGel. One investigation was focused in the United States;[3] the other was conducted at four international sites: Pune, India; Chiang-Mai, Thailand; Blantyre, Malawi; and Harare, Zimbabwe.[4]

In the U.S. study, 27 participants initially used the product once daily for 14 days and then twice daily for 14 days. They underwent colposcopy before and after product exposure. The formulation was well tolerated, although two-thirds of the participants reported at least one mild or moderate adverse experience. The most common adverse events were irritative genitourinary symptoms, according to the study. The majority of the study participants said they would use the product if it were commercially available.

In the international study, BufferGel was evaluated by 98 women for vaginal use twice daily. The formulation was found to be safe and well tolerated by the cervicovaginal epithelium. Irritation was generally mild and of short duration, study results indicate.

No detergent activity

BufferGel is applied vaginally before intercourse, like conventional spermicides; however, it does not use detergent activity to inactivate sperm. It simply reinforces the mild acidity that occurs naturally in the vagina, says Cone. Developers wanted to avoid detergent activity since it can irritate the vaginal lining after frequent use.

The formulation must be able to provide "sperm

and germ" protection, as well as maintain the vaginal flora, all in an acceptable product that women will use, notes Cone. BufferGel has met those standards in animal trials and in extensive clinical safety trials, he believes.

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Examine genital wart treatment options

Does your treatment approach for genital warts *(condyloma acuminata)* include at least one patient-applied therapy in addition to your provider-administered options? While no one treatment is superior to the other when it comes to the removal of symptomatic warts, the Atlanta-based Centers for Disease Control and Prevention (CDC) recommends the availability of at least one patient-applied option for genital warts in addition to provider-administered therapies.[1]

Providers need a selection of weapons in their arsenal against external genital warts, which are caused by several of the many types of human papilloma virus (HPV), the most common sexually transmitted disease in the United States.[2] Visible genital warts are usually caused by HPV types 6 or 11. Depending on their size, genital warts can be painful, friable, and/or pruritic.

HPV infection is a chronic condition, even when it is asymptomatic. No therapy has been shown to eradicate the virus.

EXECUTIVE SUMMARY

Providers should consider adding patient-applied therapies in their treatment arsenal for external genital warts.

- External genital warts are caused by several of the human papilloma viruses (HPVs). Visible genital warts usually are caused by HPV types 6 or 11.
- Two patient-applied therapies are available in the United States: imiquimod and podofilox. The U.S. Food and Drug Administration approved both in 1997.

Make the diagnosis

According to the CDC, genital warts may present as single or multiple growths or bumps that appear in the genital area, sometimes forming a cauliflowerlike shape. The warts usually appear as soft, moist, pink or red swellings. The shapes may be raised or flat, in single or multiple growths, and vary in size from small to large. Look for the warts on the vulva, in or around the vagina or anus, on the cervix, and on the penis, scrotum, groin, or thigh.

When choosing the proper therapeutic approach, consider the size, location, and number of warts; changes in the warts; patient preference; cost of treatment; convenience; adverse effects; and your own experience with the treatments, advises the CDC.

If you administer the therapy, provider options include cryotherapy; podophyllin application; TCA (trichloroacetic acid) or BCA (bichloroacetic acid) application; or surgical removal via scissors, shaving excision, curette, or electrocautery. Other provider-administered treatments include laser surgery or intralesional interferon.

Look at patient options

When it comes to patient-applied options, two therapies are available in the United States: imiquimod (Aldara Cream, 3M Pharmaceuticals, St. Paul, MN) and podofilox (Condylox Gel, Oclassen Pharmaceuticals, a division of Watson Labs, Corona, CA). Both therapies were approved by the U.S. Food and Drug Administration in 1997. ***(Contraceptive Technology Update* reported on the two options in its April 1998 article, "New tests, treatments aid in fight against HPV," p. 48.)**

Imiquimod is the first in a new class of drugs called immune response modifiers, which demonstrate in vivo antiviral and antitumor activity. Other treatments work by destroying the wart tissue, but imiquimod actually boosts the immune system to fight HPV. The drug also is being examined for other uses such as treatment of actinic keratosis and superficial basal cell

carcinoma, according to **Deneen Law**, 3M market development manager.

A just-published international open-label study is the first to investigate the efficacy of a topical therapy for external genital warts in a large group of patients.[3] A total of 114 clinics across Europe, Canada, Latin America, Australia, and South Africa participated in the trial. The study reports that the efficacy of Aldara in 943 male and female patients of different ethnic backgrounds was similar to that in previous randomized, vehicle-controlled studies.[4]

Patients whose warts decreased in size but did not totally clear in the initial 16 weeks of therapy (191; 20%), were offered the option to apply Aldara for up to an additional 16 weeks. This resulted in total clearance in 33% of these patients. Patients whose warts cleared with imiquimod therapy tended to remain clear, researchers report.

The fact that fewer than 10% of the study participants required re-treatment in the three months after their warts cleared poses a considerable advantage over other available therapies, says lead author **Suzanne Garland**, MD, associate professor in the department of microbiology and infectious diseases at the Royal Women's and Royal Children's Hospitals in Victoria, Australia.

New therapy eyed

European researchers are studying another potential topical treatment for genital warts. The first clinical Phase III trial for Polyphenon E was completed in October 2001 by its developer MediGene AG, a German biopharmaceutical company with headquarters in Martinsried, Munich, and a subsidiary, MediGene in San Diego. A second Phase III trial is being prepared, according to company officials.

Applied as cream or ointment, the drug's active ingredients include polyphenols that inhibit the infectious properties of HPV. While results of the first trial have not yet been published, the company reports positive results from the multicenter clinical trial. A total of 272 patients in 30 centers in Europe participated in the randomized, double-blinded and placebo-controlled trial. Two formulations of the drug, a cream and an ointment, were tested for their efficacy for the topical treatment of external genital warts.

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Draw the 'invisible man' into the clinic

Are men a part of the picture at your family planning facility? Planned Parenthood of Pasadena (CA) has established a male advocate program to bring the "invisible man" into the clinic.

The agency has hired a full-time male advocate, **Adam Arzate**, to reach men in the Pasadena community. The program, initiated in 2001, has just received its second year of federal Title X funding for the program, administered through a grant through the California Family Health Council. The program received $18,697 for the 2001 calendar year, with $24,912 allocated for the 2002 calendar year, says Arzate.

"By having additional funding to provide for and promote male services and male involvement in family planning, we are not only able to promote male responsibility, but we also are able to work with both sides of the equation — the woman and the man — and therefore ultimately teach prevention and how to make responsible choices, in addition to just treating both of the patients at the current visit," says

EXECUTIVE SUMMARY

Drawing men into family planning/reproductive health information and service programs requires approaches that focus on their needs.

- Planned Parenthood of Pasadena (CA) has established a male advocate program.
- The agency has hired a full-time male advocate.
- The program has just received its second year of federal Title X funding.

Kate Alson, Planned Parenthood of Pasadena vice president of public affairs.

This program has had a significant impact on the services at Planned Parenthood of Pasadena as it addresses two of the organization's core mission statements: prevent as many unintended pregnancies as possible, and provide access to quality reproductive health care, Alson says.

Arzate sees the male outreach program's primary concern as to instill in men a sense of equal responsibility and overall better understanding of their own individual male health issues.

"For too long, the sole emphasis has been placed on women," observes Arzate. "It's now time for men to step up to the plate."

Make the connection

For the past three years, the federal Office of Population Affairs / Office of Family Planning, which directs Title X monies, has funded similar programs that address family planning and reproductive health information and services for males. While research shows that young men recognize unintended pregnancy, sexually transmitted diseases, and HIV / AIDS as serious problems and acknowledge their role in prevention, drawing men into family planning / reproductive health information and service programs requires approaches that focus on their needs. **(*Contraceptive Technology Update* reported on such research in its August 1998 issue, p. 97, in the article "Involve Young Men in Preventing Teen Pregnancy: Draw Them Into Your Clinic.")**

The Pasadena program reaches out to men through various means, including classroom presentations, team sport talks, and word of mouth in community meetings at the local department of social services, Foothill Family Services, and other agencies. Many men come with referrals from their doctors, says Arzate. Arzate also frequents places where men congregate, such as gathering spots for day laborers, to act as an accessible community resource.

Most of the program's promotion is on the grass-roots level, notes Arzate. Fliers and brochures carry information on the program, as does Planned Parenthood of Pasadena's web site, www.pppasadena.org. Information also is presented during the agency's community luncheons, scheduled every six to eight weeks, as well as through allied community organizations.

RESOURCES

For more information on the male advocate program, contact:

- **Adam Arzate**, Planned Parenthood of Pasadena. Telephone: (626) 794-5737. Fax: (626) 798-4706. E-mail: adam.arzate@ppfa.org. Web: www.pppasadena.org.

Planned Parenthood of Pasadena offers family planning services specifically for men, including physical exams and teaching males how to do self-testicular, prostate, and breast exams. It also gives referrals to low-cost or no-cost agencies that offer other medical services not provided at its facilities.

Reach young men at risk

To reach young men at risk, the male advocate program targets many groups such as recovery homes, substance abuse programs, and young parenting services, as well as community centers, area parks, and continuation schools.

"Our intent is to educate our overall service area, dispel myths, and create easy access to quality reproductive health care services to all who seek it," says Arzate.

When Arzate is not in the field, he works in the clinic taking patient history, assisting in the recovery room, and answering any concerns or questions patients may have, says Alson.

"He's the personal contact they remember when they step inside, and he's the friendly face they can turn to to alleviate any anxieties they may have," she notes.

Dispel male myths

An important aspect of Arzate's job is to provide education on vasectomy services. There are many misconceptions among men about what takes place during a vasectomy procedure, he observes.

"The majority of men I come in contact with are so confused with what the service is that they are reluctant in even obtaining information," states Arzate. "My role is to educate them about the realities of the service, explain how it can beneficial, and how they can obtain it, and most important, be a friendly face when they walk through the door." ■

Get teen statistics at these web sites

May is National Teen Pregnancy Prevention Month. Present the latest statistics and information on teen sexual health issues to your patients and community by collecting information from the following web sites:

• **Adolescence Directory On-Line. http://education.indiana.edu/cas/adol/adol.html.**

Adolescence Directory On-Line, a service of the Center for Adolescent Studies at Indiana University, is an electronic guide to information on adolescent issues. Links of interest to educators, counselors, parents, researchers, health practitioners, and teens are featured, including those on sexual health and mental health issues.

• **Child Trends. www.childtrends.org.**

Child Trends is a Washington, DC-based nonprofit, nonpartisan research organization that studies children, youth, and families through research, data collection, and data analysis. It offers research data on adolescent sexual behavior; some is available in Adobe Portable Document Format (PDF) format. A timely publication is *Facts At A Glance 2001*, which covers a broad cross-section of teen sexual health issues.

• **KIDS COUNT. www.aecf.org/kidscount.**

KIDS COUNT, a project of the Annie E. Casey Foundation in Baltimore, is a national and state-by-state effort to track the status of U.S. children. One feature of the initiative is the publication of the annual *KIDS COUNT Data Book*, published since 1990, which uses the best available data to measure the educational, social, economic, and physical well-being of children on a state-by-state basis. Take a look at such indicators as percent of low birth-weight babies; infant mortality rate; child death rate; rate of teen deaths by accident, homicide, and suicide; teen birth rate; percent of children living with parents who do not have full-time, year-round employment; percent of teens who are high school dropouts; percent of teens not attending school and not working; percent of children in poverty; and percent of families with children headed by a single parent. The *Data Book* also provides background information for each state, including demographic and family income data.

• **National Adolescent Health Information Center. http://youth.ucsf.edu/nahic.**

The National Adolescent Health Information Center (NAHIC), established in 1993, is based within the University of California, San Francisco's Division of Adolescent Medicine, Department of Pediatrics, and Institute for Health Policy Studies. Download the PDF files or order printed copies of the center's publications, including *America's Adolescents: Are They Healthy?*, a monograph that describes the health status of adolescents with a focus on health care access and utilization, mortality, and risky behaviors. This report, recently updated, includes the most current national data available on specific adolescent health issues such as substance use, sexual behavior, violence, and unintentional injuries.

• **National Campaign to Prevent Teen Pregnancy. www.teenpregnancy.org.**

The Washington, DC-based National Campaign to Prevent Teen Pregnancy, founded in February 1996, is a nonprofit, nonpartisan initiative aimed at improving the well-being of children, youth, and families by reducing teen pregnancy. Its goal is to reduce the teen pregnancy rate by one-third between 1996 and 2005. Recent information issued by the campaign includes *Not Just Another Single Issue: Teen Pregnancy Prevention's Link to Other Critical Social Issues*, which makes the case that preventing teen pregnancy should be viewed not only as a reproductive health issue, but as one that works to improve such measures as welfare dependency and overall child well-being, out-of-wedlock births, responsible fatherhood, and work force development. ■

Make plans for June AWHONN convention

The Washington, DC-based Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) 2002 convention is scheduled

for June 23-26 in Boston.

Highlights include more than 100 educational offerings, pre-convention continuing education workshops, poster presentations, and exhibits focused on women's health.

The registration fee, if received on or before May 17, is $325 for AWHONN members and $453 for nonmembers. If received on or after May 18, the registration is $375 for AWHONN members and $503 for nonmembers. Pre-convention workshops also will be available for an additional fee.

To review the convention program, register, or reserve hotel rooms, check the AWHONN web site, www.awhonn.org. Requests for information also may be sent to AWHONN, 2000 L St., N.W., Suite 740, Washington, DC 20036. Or call (800) 673-8499. ▼

Get latest figures on U.S. women's health

Get a comprehensive overview of current women's health data in the latest edition of the *Women's Health Data Book: A Profile of Women's Health in the United States.*

Available through the Menlo Park, CA-based Henry J. Kaiser Family Foundation and the Washington, DC-based Jacobs Institute of Women's Health, the book addresses social and economic factors and provides up-to-date information on chronic conditions, reproductive health, mental health, violence, health behaviors, and access to and quality of health services received by women. Information also is presented on disparities in health status and access to care among subgroups of women, and the information highlights the populations who are at greatest risk.

Also available are three new fact sheets that highlight the key findings from the data book, which include overall trends and emerging issues for women, data for women of color, and highlights for adolescents.

Download the publications, including the fact sheets, free of charge from the Kaiser Family Foundation web site, www.kff.org; click on "Publications." Free individual copies also may be ordered by calling the foundation's publication request line, (800) 656-4533; ask for publication number 6004. Multiple copies may be obtained from the Jacobs Institute by calling (202) 863-4990. ■

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CE/CME Questions

Please save your monthly issues in order to take the two semester tests in June and December.

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

- Identify the most effective method of reversible contraception available in the world today. (See "Intrauterine contraception: What will it take to shift provider practice?" in this issue.)
- Give the dosage amount of mifepristone used in medical abortion. (See "Research looks at new uses for mifepristone.")
- Cite the potential mechanism of action of the BufferGel microbicide. (See "2 trials will examine capability of microbicide.")
- Name the two patient-applied therapies for external genital warts named in treatment guidelines issued by the Centers for Disease Control and Prevention. (See "Examine genital wart treatment options.")

13. What is the single most effective method of reversible contraception available in the world today?

A. combined oral contraceptives
B. Norplant implant
C. levonorgestrel IUD
D. Copper T380A IUD

14. What is the dosage amount of mifepristone when it is used for medical abortion?

A. 600 mg, provided in three 200-mg tablets
B. 800 mg, provided in four 200-mg tablets
C. 400 mcg, provided in two 200-mcg tablets
D. 200 mg, provided in one 200-mg tablet

15. What is the potential mechanism of action of the microbicide BufferGel?

A. It inhibits viral replication.
B. It uses detergent to inactivate sperm and germs.
C. It inhibits viral entry.
D. It reinforces the mild acidity that occurs naturally in the vagina to inactivate sperm and germs.

16. What are the two patient-applied therapies for external genital warts listed in the treatment guidelines issued by the Centers for Disease Control and Prevention?

A. trichloroacetic acid or bichloroacetic acid
B. podophyllin or bichloroacetic acid
C. imiquimod or podofilox
D. podofilox or podophyllin

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