AMERICAN HEALTH CONSULTANTS®

CONTRACEPTIVE TECHNOLOGY UPDATE®

A Monthly Newsletter for Health Professionals

INSIDE

FEBRUARY 1999

VOL. 20, NO. 2 (pages 13-24)

American Health Consultants® is A Medical Economics Company

Do you screen for domestic violence? Call goes out for universal screening

Reproductive-age women at highest risk for domestic violence

Can you identify the victim of domestic violence? Consider these cases: A young woman, despite receiving contraceptive counseling and pills at her last visit, returns with a positive pregnancy test. A mother in her early 30s has a persistent vaginal infection but doesn't follow her treatment regimen. A pregnant 18-year-old seeks a first-trimester abortion.

All of the women described above could easily be abuse victims, but because many signs of violence are relatively subtle, providers may fail to detect them unless they screen every patient.

There is room for improvement when it comes to implementing universal screening into daily practice. Close to half of 397 pregnant and nonpregnant women seen at an urgent care OB/GYN unit reported that they had been victims of either physical or sexual abuse, but only 18% of them could remember having been asked about abuse by a provider.[1]

"It's like Pap smear screening: There are no outward signs of precancer or cancer of the cervix, but we routinely screen to detect it," says **Jeffrey Peipert**, MD, MPH, associate professor of OB/GYN at Brown University and director of clinical research in the OB/GYN department of Women and Infants Hospital in Providence, RI. "The same thing holds true for violence: You want to routinely screen so

EXECUTIVE SUMMARY

Because violence is prevalent among women in their reproductive years, providers should implement universal screening in their daily practice.

- Abuse can take many forms, such as slapping, punching, and hitting; criticism, threats, and humiliation; forced isolation or control of money; or forced sexual activities.
- Send the signal that the provider's office is a "safe space" to discuss domestic violence. Use posters and patient handouts, and educate your staff on the issue. Be sure to ask questions about abuse when alone with the patient.

Ask these questions to assess abuse

All women presenting for care should be screened for the possibility of past or current abuse. Screening should take place in private and should be repeated at every visit, particularly during pregnancy. Using this abuse assessment tool may be helpful:

- ❑ Do you feel emotionally abused by your partner?
- ❑ Has your partner ever hit, slapped, punched, shoved, kicked, or otherwise physically hurt you?
- ❑ Are you afraid of your partner or any family member?
- ❑ Do you feel your partner tries to control you socially, financially, or emotionally?
- ❑ Has your partner ever forced you into sex or sexual activities when you did not wish to participate?
- ❑ Did any of these behaviors start during your pregnancy or change during the course of your pregnancy?
- ❑ During the pregnancy, did your partner ever prevent you from seeking prenatal care?

Keep in mind that some women may not answer the first time, but that many women will disclose violence in their relationship if asked. It is your responsibility to ask.

Source: Any Woman Can Be Hurt...No Woman Deserves It. American College of Nurse-Midwives, Washington, DC.

you can detect as many cases as possible."

Abuse can take many forms, such as slapping, punching, and hitting; criticism, threats, and humiliation; forced isolation or control of money; or forced sexual activities. While the majority of abuse victims are women in a heterosexual relationship, victims can be men or same-sex partners.

The highest rates of intimate violence are recorded in women ages 16 to 24, according to national statistics.[2] This age group constitutes a sizable segment of the family planning population. A study of women seeking elective pregnancy termination found that almost 40% reported a history of abuse.[3]

Violent men typically seek control over their partner's behavior and sexuality. In a U.S. focus group study, women reported that their violent partners often dictated contraceptive choice.[4]

Some men do not want their partners to use birth control because they believe they will then have sex outside the relationship, says **Ronald Chez**, MD, professor of OB/GYN and community and family health at the University of South Florida in Tampa. Women may not even to able to negotiate condom use for STD protection if the man considers it a threat to his sense of control or masculinity.

Screen routinely

"I think clinicians need to first routinely screen women for abuse, such as physical violence and other aspects of control, such as contraceptive decision making, so that they know which women are facing this issue," explains **Jacquelyn Campbell**, PhD, RN, FAAN, associate dean of doctoral education programs and research in the school of nursing at Johns Hopkins University in Baltimore. "The screen for abuse needs to include asking specifically about forced sex, since this form of abuse is not always accompanied by [other] physical violence."

If women indicate they have been abused, the first intervention concerns their ongoing safety, notes Campbell, referring to domestic violence programs, providing information about their legal options, and planning for their safety. Further interventions can focus on sexual coercion. This measure can include discussion of which contraceptive methods are least intrusive, what actions the patient can take unilaterally, and what it means when a woman cannot control her own sexuality, she says.

While a national survey of OB/GYNs show that the majority of providers screen when they suspect abuse, there is room for improvement when it comes to universal screening.[5]

COMING IN FUTURE MONTHS

- ■ Update on emergency contraception
- ■ Osteoporosis and bone markers
- ■ Defining clinic policies on Norplant removals
- ■ Developments in pharmaceuticals for women
- ■ Brief, interactive STD counseling effective

"Our survey indicated that when physicians have reason to screen, they do a wonderful job," notes **Deborah Horan**, manager of special issues at the American College of Obstetricians and Gynecologists (ACOG) in Washington, DC, which conducted the national poll. "But if someone does not present with symptoms, and she is in an abusive relationship, she may not be screened and may not have an opportunity to be offered assistance."

ACOG is leading the charge toward incorporating abuse screening into clinical practice. It has developed a number of provider resources to educate both medical residents and practicing physicians, says Horan.

The American College of Nurse-Midwives in Washington, DC also has taken an activist stance in promoting universal screening. Abuse often begins or escalates during pregnancy, so nurse-midwives must be vigilant in screening for violence, says **Pat Paluzzi**, CNM, MPH, associate medical director of Planned Parenthood of Maryland in Baltimore. Paluzzi served as director of the college's domestic violence project, which addressed policy, education, and materials development, as well as advocacy / activism among nurse-midwives.

If domestic violence is so prevalent, why aren't more providers putting universal screening into practice? Chez and Peipert agree that a concern about time constraints may make clinicians hesitant to raise such a sensitive subject. The process, however, need not be time-consuming.

First, be sure to be alone in the room with the patient. Then preface your question with the following statement: "Because it is so common, I've started asking all patients about the presence of violence and abuse in their home. I routinely ask these questions of all of my patients because I'm concerned about their safety and well-being."

RESOURCES

Deborah Horan, American College of Obstetricians and Gynecologists (ACOG), 409 12th St. SW, P.O. Box 96920, Washington, DC 20090-6920. Phone: (800) 673-8444, ext. 2487 or (202) 863-2487. Fax: (202) 484-3917. E-mail: violence@acog.org. Patient brochures, pocket cards, tent cards, and posters, some also available in Spanish, are free in limited quantities. Contact Chris Himes at (800) 673-8444, ext. 2434. ACOG also offers patient and provider information at its Web site, http://www.acog.org. Click on Department News then Violence Against Women.

American College of Nurse-Midwives, 818 Connecticut Ave. NW, Suite 900, Washington, DC 20006. Phone: (202) 728-9860. Fax: (202) 728-9897. E-mail: info@acnm.org. Web: http://www.midwife.org. A domestic violence video set and companion manual (No. DV7) is $95; bulk discounts available for six or more. Call (202) 728-9879 for details. A domestic violence awareness packet (No. DV1), including a poster, stand-up card, provider brochure, prescription pad, and patient handouts, is $15. Some items may be ordered separately. Add 15% for shipping/handling. Orders may be placed at the college s Web site; mailed to American College of Nurse-Midwives Publications; P.O. Box 5036, Washington, DC 20061- 5036; or faxed with credit card information to (202) 728-9897.

National Domestic Violence Hotline. Phone: (800) 799-7233 [(800) 799-SAFE] and (800) 787-3224 (TDD). The hotline offers immediate help, in English or Spanish, 24 hours a day, seven days each week. It also has interpreters available to translate an additional 139 languages. It may be reached toll-free from all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

Use HITS to screen patients

Chez points to a short domestic violence screening tool, HITS, as one way to assess abuse. Providers who use the HITS acronym ask patients how often their partners:

- physically *hurt* them;
- *insult* or talk down to them;
- *threaten* them with physical harm;
- *scream* or curse at them.

This practice has proven effective in identifying abuse.[6] **(See abuse assessment offered by American College of Nurse-Midwives, p. 14, for more questions.)**

All women should be screened for domestic violence at the outset of the examination, says Paluzzi. If disclosure is not forthcoming, contraceptive counseling can offer an ideal time to explore the issue again. Ask about how a partner feels about different methods of contraception. If the woman is currently using a method, but she seems be a poor contraceptor, treat it as a "red flag" for potential abuse, she says.

Likewise, a woman who continues to present with a recurrent infection may be a victim of ongoing violence.

How can you help women become comfortable in sharing information on abuse?

- Send out the signal that your office is a "safe

space." Put up posters, not only in waiting rooms but in bathroom stalls and exam rooms as well. Chez places ACOG printed material in several strategic areas so patients know that it is OK to talk about abuse. **(See resources, p. 15.)**

• Make sure your office staff are informed about domestic violence, Paluzzi recommends. Hold inservice training so everyone understands the importance of confidentiality and privacy issues.

• Have fingertip information on community resources. Because domestic violence laws vary from state to state, providers need to understand the legalities of documenting and reporting abuse. In many cases, reporting is not a substitute for thorough documentation of the abuse in the medical records.

Watch out for reports of aches

Women in abusive situations often present with chronic, multisymptom complaints, such as headaches or backaches. By identifying the source of the problems, providers can eliminate the series of repeat visits and lab work and move forward in referring women to community resources.

"I am not skilled at counseling, but I am skilled at giving patients permission to seek alternatives," Chez explains. "Knowing the community resources in my locale allows me to provide information about them to the patient after giving her permission to the right to safety and the right to seek viable alternatives for a crime which is not her fault."

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Depressive symptoms not tied to DMPA, Norplant

Do concerns about possible mood changes lead to you to withhold Depo Provera (DMPA) or Norplant from patients? Results from two analyses from a large prospective study offer reassurance that neither progestin-only method causes or exacerbates depressive symptoms.[1,2]

"Concerns re: mood changes should not be a reason to deny either DMPA or Norplant to otherwise appropriate candidates," explains **Andrew Kaunitz**, MD, professor and assistant chair of the department of OB/GYN at the University of Florida Health Sciences Center in Jacksonville. "Both of these highly effective methods are appropriate for women with a history of depression, including those actively being treated, on or off medication."

While the results are not surprising, the reports do offer further information for use in counseling those patients with diagnosed depression as well as those who may be concerned about developing depressive symptoms, in choosing an appropriate contraceptive, notes **Anita Nelson**, MD, medical director of the Women's Health Care Clinic, Harbor-University of California at Los Angeles Medical Center in Torrance.

Women with depression, who may be overwhelmed and having trouble coping with daily life tasks, may benefit the most from the two long-term, low-maintenance birth control methods,

EXECUTIVE SUMMARY

Analyses from a large prospective multicenter studies indicate that Norplant implant systems and Depo Provera (DMPA) do not cause or exacerbate depressive symptoms.

- Women who continued either method had lower scores at baseline than did the women who discontinued the method or who were lost to follow-up. Those with the highest depressive symptom scores at enrollment demonstrated improved scores during follow-up.
- While the findings do not rule out the occurrence of rare or idiosyncratic mood changes in DMPA and Norplant users, they do offer reassurance. Because mood disorders are prevalent in young women, it is expected that some users of Norplant, DMPA, or any other birth control method, will develop depressive symptoms.

says **Carolyn Westhoff**, MD, MSc, medical director of family planning at Columbia Presbyterian Medical Center and associate professor of clinical OB/GYN and public health at Columbia University, both in New York City.

Westhoff and researchers at Columbia Presbyterian Medical Center in New York City, Magee-Women's Hospital in Pittsburgh, and the University of Texas Southwest Medical Center in Dallas designed a large prospective study to examine the determinants of contraceptive choice. Analyses of depressive symptoms and use of DMPA and Norplant were derived from this study.

Women and depression

Depressive symptoms are found in many women in the United States, with a lifetime rate of major depression reported at 7.4/100 women, and the annual rate for depressive episodes for both men and women estimated at 3.0/100 persons.[3]

Some women experience depression when they use progestin-only contraceptives, note the authors of *Contraceptive Technology*.[4] The product labeling for DMPA lists depression as an infrequent side effect, while Norplant's labeling notes it as a rare side effect.

Westhoff and researchers at Columbia University looked at depression and use of DMPA and Norplant in earlier, smaller studies.[5,6] Although the studies showed no evidence of a link between depressive symptoms and method use, concerns continued to be voiced about use of the progestin-only methods in women with or at risk for depression, she says.

Assessment is a key tool

Women were enrolled in the study through the family planning clinics at the three urban medical centers. The 910 women who chose Norplant were interviewed at enrollment, at six months, and at 24 months, while the 495 patients who selected DMPA were interviewed at enrollment and again at 12 months.

Included in the initial and follow-up questions were six questions from the Mental Health Inventory concerning depressive symptoms during the past month. Additional information was gathered concerning other factors related to depressive symptoms. Average age of participants was 23 years, with 50% at or below age 22.

Of the 910 who chose Norplant, 820 completed six-month follow-up interviews, with 727 continuing with the method and 93 reporting discontinued use. At the two-year follow-up, 81% who had been using Norplant at six months were re-interviewed. A total of 293 women were still using the method, and 295 had discontinued it. A total of 393 women on DMPA completed 12-month follow-up interviews, with 172 still using the method and 221 no longer receiving injections.

Women who continued either method had lower scores at baseline than did the women who discontinued the method or who were lost to follow-up. Those with the highest depressive symptom scores at enrollment demonstrated improved scores during follow-up.

Researchers were especially interested in looking at the 20% of patients who scored highest on the depressive symptom scale prior to starting the progestin-only methods, since this group would be the most likely to contain the women who were clinically depressed, Westhoff says. This quintile showed improved scores at follow-up, she notes.

A high depressive symptom score is not the same thing as clinical depression.

A high depressive symptom score is not the same thing as clinical depression, she says. Women with depression probably will have a high score, and women with a high score have a heightened probability of depression over those with a low score, but the score is not the same thing as a clinical diagnosis, she points out.

"The fact that when groups of women are studied, and depression symptoms improve when they use DMPA, Norplant, and combined pills, does not preclude the possibility that depression may improve or become worse in an individual woman," warns **Robert A. Hatcher**, MD, MPH, professor of OB/GYN at Emory University in Atlanta. "Certainly depression should not be considered a reason to avoid these hormonal contraceptives."

These findings do not rule out the occurrence of rare or idiosyncratic mood changes in DMPA and Norplant users, says Westhoff. Because mood disorders are prevalent in young women, it is expected that some users of Norplant, DMPA, or any other birth control method, will develop depressive symptoms.

Based on anecdotal experience, some women may be predisposed to progestin-induced mood changes, Kaunitz says. Large, high-quality studies such as the two analyses described in this article have not been able to demonstrate clinical significance, he notes.

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Research affirms female condom's effectiveness

A new study of the Reality female condom finds that the method, when used consistently and correctly, offers higher levels of contraceptive efficacy than shown in previous research.[1]

In an analysis of use among 190 Japanese women, the female condom, manufactured by the Female Health Company of Chicago, demonstrated a six-month life table probability of pregnancy of 3.2% during typical use and 0.8% during perfect use. (Pregnancy rates during typical use reflect how effective methods are for the average person who does not always use methods correctly or consistently, according to *Contraceptive Technology*.[2] Pregnancy rates during perfect use reflect how effective methods can be when used consistently and correctly.)

The study, conducted by **James Trussell**, PhD, associate dean of the Woodrow Wilson School of Public and International Affairs at Princeton (NJ) University, was completed as part of the Female Health Company's efforts to gain market approval in Japan. Final approval had not been announced at *Contraceptive Technology Update*'s press time.

Women who used the female condom in the Japanese efficacy trial found it a highly acceptable (11.8%), acceptable (41.5%), or somewhat acceptable (35.9%) method of birth control. About 8% found it not very acceptable, with 3.1% deeming it undesirable.

About 85% of couples in Japan rely on barrier methods for contraception, says **Mary Ann Leeper**, PhD, president and chief operating officer of the Female Health Company. Approval of the Reality condom in Japan would open doors to a very significant market, she notes.

The Reality female condom demonstrated a higher level of contraceptive effectiveness in the Japanese trial than in two previous studies. The first clinical trial of the condom, conducted in the United Kingdom, reported a 15% typical use rate based on a 12-month life table probability of pregnancy.[3] A second multinational trial recorded a six-month typical use rate at 12.4% in the United States and 22.2% in Latin America.[4] Perfect use rates during this trial were 2.6% in the United States and 9.5% in Latin America.

Ten centers participated in the Japanese study, with participants expected to use the female condom as their only form of birth control for six months. All women were required to be between ages 20 and 40 at enrollment and have an average coital frequency of at least four times per month. Of the 190 women in the efficacy analysis, 11 did not complete the study. Six became pregnant, and five discontinued due to other reasons. Of the six pregnancies, only one occurred despite consistent and correct use.

Trussell points out that differences across studies in pregnancy rates during typical uses are primarily affected by the extent and type of imperfect

EXECUTIVE SUMMARY

A new study of the Reality female condom shows higher levels of contraceptive efficacy than shown in previous research.

- In an analysis of use among 190 Japanese women, the female condom demonstrated a six-month life table probability of pregnancy of 3.2% during typical use and 0.8% during perfect use.
- The Reality female condom, manufactured by the Female Health Company of Chicago, continues to gain acceptance throughout the world. The efficacy study was conducted in efforts to gain marketing approval in Japan, a significant market for barrier contraceptives.

use. In comparing perfect use rates, one must keep in mind the influence of the fecundity of the couple and coital frequency. A woman becomes less fertile as she ages, and coital frequency declines with age and marital duration.

While the mean ages of the women in all three studies were similar (26 in Latin America, 29 in the United States, 21 in the United Kingdom, and 32 in Japan), numbers for average coital frequency differed. The mean coital frequency for women in the Japanese trial was 4.9 times per month, 59% lower than the 12.0 recorded among U.S. women. This low frequency rate may attribute to the reduced risk of pregnancy during perfect use in the Japanese trial, says Trussell.

Women embrace Reality

The Reality female condom continues to gain acceptance around the globe, says Leeper. Unit sales increased 91% during the fourth quarter of 1998 to 2.1 million units, up from 1.1 million units during the same period in 1997, according to company press reports.

Markets in Zimbabwe, Zambia, Cote d'Ivoire, Bolivia, Haiti, and South Africa were opened in 1998, with future launches expected to include Tanzania, Kenya, Nigeria, Uganda, Columbia, and Central American countries. In the United States, the company's customer list has expanded to include 10 major cities and 15 states, including Miami, Washington, DC, Chicago, Houston, Philadelphia, Illinois, New York, New Jersey, Connecticut, Florida, Pennsylvania, and Washington.

The Female Health Company has developed a new training manual for trainers and outreach counselors to use in teaching women about the female condom says Leeper. **(See resource listing, above right, for more information.)**

"We are doing a lot of programs with community-based organizations that are playing a more increased role in prevention of both unintended pregnancy, as well as STDs," she reports. "They are going into the communities, developing programs, and talking among their peers about practicing safer sex, so we have developed educational materials for them."

Young adults who have been educated on the importance of safer sex represent a significant segment of the female condom market, she says. Once they learn about the method, young people are very receptive to trying the Reality condom, and the majority continue to use it, she notes.

RESOURCE

For more on the Reality Female Condom, contact:

Female Health Company, 875 N. Michigan Ave., Suite 3660, Chicago, IL 60611. Phone: (312) 280-1119. Fax: (312) 280-9360. E-mail: info@femalehealth.com. Web: http://www.femalehealth.com. The company offers a training manual for counselors, trainers, educators, and providers. It includes a binder with a videotape and educational materials. Cost is $9.50, plus $3 for shipping/handling. For details, call (800) 884-1601.

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Maximizing the use of the progestin minipill

The progestin-only minipill offers safe, effective birth control for lactating women and for those who cannot take estrogen, yet it represents a small fraction of the contraceptive market in the United States. It is estimated that only 1% of the 26% of U.S. reproductive-age women who use oral contraceptives (OCs) choose minipills.[1]

Progestin-only pills (POPs), often called minipills, are generally less effective than combined oral contraceptives. About 5% of women who use the minipill consistently and correctly will become pregnant in the first year.[2] In lactating women, however, the added contraceptive effect of breast-feeding makes the method nearly 100% effective.

Unlike combined OCs, minipills do not interfere with the quality or quantity of milk production during breast-feeding, says **Linda Potter**, DrPH, visiting research collaborator at the Office of Population Research at Princeton (NJ) University. Except for increased menstrual irregularities, they cause fewer and milder side effects and have

fewer serious adverse effects than do combined pills, she states.

Irregular bleeding is a potential downside, agrees **Andrew Kaunitz**, MD, professor and assistant chair of the department of OB/GYN at the University of Florida Health Sciences Center in Jacksonville, FL. Despite such downsides, minipills offer excellent contraception for lactating women and can play an important role for women with medical contraindications such as migraine headaches, hypertension, diabetes, or cardiovascular problems.

How minipills work

Minipills have very low doses of progestin, even lower than combined pills. Both Nor-QD, manufactured by G.D. Searle and Co. of Chicago, and Micronor, manufactured by Ortho-McNeil Pharmaceutical Corp. of Raritan, NJ, contain 0.35 mg of norethindrone. Ovrette, manufactured by Wyeth-Ayerst Laboratories of Philadelphia, relies on 0.075 mg of norgestrel. The progestin in minipills inhibits ovulation and causes a thickening of the cervical mucus. Minipills also produce changes in the endometrium so it becomes less receptive to implantation, and they help to slow the movement of the egg through the fallopian tube.[3]

The small amount of progestin in minipills is quickly metabolized by the body, with little or no progestin left 24 hours following ingestion of the dose. This mechanism of action demands that minipills be taken every day at the same time for contraceptive efficacy.

EXECUTIVE SUMMARY

The progestin-only minipill is safe and effective for women who cannot use combined oral contraceptives, including those who are lactating or who are at risk for vascular events.

- The amount of progestin in each minipill is small and is completely metabolized within a 24-hour period. Minipills must be taken at the same time each day to maximize effectiveness.
- Revised U.S. labeling now indicates minipills may be started in non- or partially lactating women at three weeks after delivery, and at six weeks postpartum for women who are fully breast-feeding. However, *Managing Contraception* states that if a woman is breast-feeding her baby, is immediately postpartum, and desires to use minipills soon after leaving the hospital, it may be appropriate to provide them.

If pills are taken more than three hours late, a backup method of contraception, such as condoms, must be used until the woman is back on the pill schedule for 48 hours, unless she is fully breast-feeding, says Potter.

Women who cannot follow such a rigid pill-taking schedule should be counseled to select another less-demanding method. Although the pill-taking schedule is stricter for minipills, backup contraception is only needed for 48 hours after the late dose, rather than the seven days needed for combined OCs, she notes.

Minipills are easier to use, but "the method is less forgiving if women miss pills."

"It is actually easier to use minipills: one pill every single day, no time off, and pills can be started at any time during a woman's cycle," says **Robert Hatcher**, professor of OB/GYN at Emory University in Atlanta. "While easier to explain to women, it is also true that the woman must adhere to her schedule very attentively. The method is less forgiving if women miss pills."

Change in label a plus

Family Health International, a nonprofit research and technical assistance agency in Research Triangle Park, NC, drafted new labeling for minipills, which was accepted in 1995 with some modifications by the federal Food and Drug Administration (FDA) and issued as guidance to manufacturers. The labeling is much shorter and simpler to read than that in combined OC packs, says Potter.

The revised labeling states that fully breast-feeding women can start using minipills six weeks after delivery. If women are partially breast-feeding, they should begin minipills three weeks after delivery. These revised instructions are now included in norethindrone pill labeling; Wyeth-Ayerst has similar labeling now under review with the FDA, says **Robyn Boyle**, RPh, product information manager.

Managing Contraception states that if a woman is breast-feeding her baby, is immediately postpartum, and desires to use minipills soon after leaving the hospital, it may be appropriate to provide them.[4] Providers at Grady Memorial Hospital in Atlanta, San Francisco General Hospital, and Harbor General Hospital in Torrance, CA, follow

that advice. The National Medical Committee of the Planned Parenthood Federation of America, in sharp contrast to the World Health Organization in Geneva, Switzerland, and the International Planned Parenthood Federation in London, states that DMPA, Norplant, and minipills may begin immediately postpartum in lactating and nonlactating women.

Women in the later years of their reproductive lives, including smokers over 35, may be good candidates for minipills, says Kaunitz. The pills provide efficacy during a time of diminishing fertility and do not have the thrombotic complications associated with combined OC use.

Ectopic pregnancies more likely

When a pregnancy occurs in a woman using minipills, it is more likely to be ectopic because of the contraceptive effect of the progestin on the endometrial lining.[2] "Because of the low dose of progestin, minipills are not a good choice for women taking hepatic enzyme-inducing medications, such as carbamazepine, felbamate, phenobarbitol, phenytoin, primidone, rifampin, and topiramate," says Kaunitz.

A recent study found that use of minipills during lactation by mothers with a history of gestational diabetes was associated with an elevated risk of developing type 2 diabetes.[5] The same study found that use of combination OCs by women with a history of gestational diabetes was not associated with an increased risk of developing diabetes.

"Although future investigations will help clarify the impact that hormonal contraception has on risk of developing diabetes in low- and high-risk women, this study reminds clinicians that monitoring for evidence of diabetes is important when following high-risk women, regardless of their contraceptive method," Kaunitz says.

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Linking men to family planning services

The federal Office of Family Planning in Bethesda, MD, has taken the first step in what may lead to expanded services for men through Title X-funded programs. Ten research grants totalling $2 million have been awarded to male-oriented organizations in developing, implementing, and testing approaches to involve young men in family planning and reproductive health services.

While the money may represent a small fraction of the $203.4 million of Title X funds administered by the government agency, it is a move in the right direction in including young men in the family planning scene.

"Experience has shown us that traditional family planning clinics have difficulty attracting males," says **Barbara Cohen**, a policy analyst with the agency. "What we are trying to find are places and programs that already involve males in some aspect, and putting the services or a good referral mechanism for services in there because they have a captive audience."

About 2% of federal dollars now go to reproductive health services for young men, she says. There is an established need for such services: Only 32% of sexually experienced young men and 17% of male virgins in a national survey say they have received contraceptive information from health care providers.[1] **(For details, see *Contraceptive Technology Update,* August 1998, p. 97.)** "We believe that the research gives reason to think that males want to be involved in family planning and that they can actually help with even their partner's own use of contraceptives, even if they rely on a female method."

EXECUTIVE SUMMARY

Steps are being taken to increase reproductive health services for men, with the federal Office of Family Planning in Bethesda, MD, funding $2 million in grants to 10 programs across the nation.

- While the grant money is a small fraction of the $203.4 million of Title X funds administered by the government agency, it is drawing more males into the family planning scene.
- The grants support a variety of approaches that will bring family planning education and service to areas where men are already receiving other health, educational, and social services.

The grants, ranging from $100,000 to $250,000, have been awarded to 100 Black Men of America in Atlanta; Action for Boston Community Development; Bienvenidos Children's Center in Los Angeles; Brooklyn (NY) Perinatal Network; Challengers Boys and Girls Club in Los Angeles; Concerned Black Men (national) in Washington, DC; Concerned Black Men (Philadelphia chapter); Fifth Ward Enrichment Program in Houston; Youth Opportunities Unlimited in Marks, MS; University of North Carolina at Greensboro, Institute for Health, Science and Society.

The Greensboro program is a cooperative venture among the University, the Guilford County health department, and Wise Guys, a male responsibility/teen pregnancy prevention program offered by the local Family Life Council. Wise Guys, developed in 1989, includes young men ages 10 to 19, focusing on those in the seventh grade, says **Rodd Smith**, Family Life Council male responsibility educator. The council has worked with area schools to implement Wise Guys in grade seven because its program research indicates that the majority of young men in that age group are not yet sexually active.

The Title X grant has allowed Wise Guys to add a peer education component and the university to perform program analysis. Perhaps the most significant benefit, though, has come from the addition of **Jonathan Lucas**, the first male educator in the Guilford County health department. While the agency does have STD clinic and vasectomy services for males, there have been no dedicated services especially for men, says **Annette Sentner**, MS, an agency community health educator.

By having a male educator in the health department, young men perceive the agency as more "male-friendly." Lucas plays a game with Wise Guys participants called "Myth or Reality in the Health Department," to educate them on available services. "He asks if men can go to the health department and receive services, and all the guys in the class say 'no,'" Smith explains. "Of course, that is where *he* is employed, so yes, men can go there." In addition to providing contraceptive and reproductive health education through Wise Guys, Lucas offers one-on-one reproductive health counseling at the health department.

The greatest misconception about the health department is that test results are shared with parents, he says. Other myths include the belief that the agency serves only poor people and that everyone must be tested for pregnancy or sexually transmitted diseases. Lucas addresses misconceptions about sex through classes and one-on-one counseling, and he accompanies young men concerned about STD infections to testing to help ease their fears. "They have all heard horror stories of going to the clinic, and they don't want to go. When I first started here, I went to the clinic to see what it was actually like because I didn't know myself, and it can get scary."

The traditional clinic setting, especially when it is the site for HIV testing, can be off-putting for adults, and even more so for adolescent patients. **(For information on how to make a clinic "teen-friendly," see *CTU*, October 1997, p. 128.)**

The addition of Lucas has definitely expanded the reach of the health department, says Sentner.

"We have had schools over the last few years who have been interested in education, but it was hard to reach them all with the limited number of educators we had on staff," she notes. "The Title X has helped us get into more of the middle schools in Guilford County and reach more teen males."

Reference

1. Urban Institute. *1995 National Survey of Adolescent Males*. Washington, DC; 1998. ■

Capitol Hill forecast: The more things change…

By **Lisa Kaeser**, JD
Senior Public Policy Associate
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The results of the November Congressional elections relieved many advocates of family planning and related reproductive health issues, who had been deeply concerned that a significantly more conservative Congress, combined with a weakened president, would fundamentally destroy many of the programs they had worked to preserve. Instead, the new Congress, despite new leadership in the House, is more evenly balanced than before. With some exceptions, therefore, few major policy changes are expected to occur.

At the same time, it would be politically naive to think that reproductive health issues will go unnoticed and unmentioned. Many of the members of Congress who have shown themselves to be staunchly opposed to reproductive rights, and even family planning, are returning.

Before the new Congress even convened, some members got a head start on what will become an ongoing issue for biomedical researchers and advocates alike: whether the groundbreaking research on human stem cells falls within the federal ban on all research using human embryos. Just last year, Congress backed off the "sure-fire" issue of a federal ban on cloning as many members became aware of the incredible complexity of crafting a ban that would not also prevent much-needed research on cures for devastating diseases.

This year, the focus is on the embryo research ban already in place. In December, Sens. Arlen Specter (R-PA) and Tom Harkin (D-IA) held a hearing to examine whether — in light of new findings — the federal ban is, in fact, creating an unnecessary chilling effect on federally funded research. Most of the scientists and ethicists who were called to testify, including National Institutes of Health (NIH) director Harold Varmus, MD, stated their beliefs that stem cell (a primitive type of cell) research was not the same as research on human embryos and thus does not fall within the federal ban. Others argued that all human life, no matter how primitive, is deserving of the highest level of respect and protection. No clear conclusions have been reached.

Instead of raising new questions about groundbreaking issues, it is likely that teen-agers' access to federally funded family planning services will be reprised again this year. Last year, for the first time, the U.S. House of Representatives voted to require that family planning clinics obtain prior consent before providing services to adolescent clients. The provision was ultimately dropped before the final legislation was passed.

In the other house, Sen. Specter, who chairs the subcommittee that oversees Title X appropriations and who was considering switching committees, recently announced that he would remain in that position. His strong support for higher funding levels for Title X bodes well; however, the key question facing legislators in both houses is to what extent they will "go out on a limb" for the beleaguered family planning program.

Teens also may be the primary subjects of rumored legislation, already dubbed "welfare reform, part II" that would reportedly focus on expansion of abstinence-only programs.

Fresh from last year's victory in ensuring that federal employees be offered the full range of contraceptive drugs and devices approved by the Food and Drug Administration, supporters of contraceptive coverage are planning to reintroduce a similar measure that would require any private insurer that already covers prescription drugs to also include contraceptive methods. They are hoping that basic equity, along with the undoubted cost savings to insurers and others of preventing unintended pregnancies, will help to carry the day so that all women and their partners may truly choose among the methods, rather than using one only because they can afford to do so.

One of Congress' longest-running battles is likely to continue when it considers whether to attach the so-called "Mexico City Policy" to any foreign aid bill. This provision would prevent non-governmental organizations from referring for or even discussing abortion with women, even in

Contraceptive Technology Updatefi (ISSN 0274-726X), including **Women s Health Update** and **STD Quarterly** , is published monthly by American Health Consultantsfi , 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Contraceptive Technology Update**fi , P.O. Box 740059, Atlanta, GA 30374.

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Customer Service: (800) 688-2421 or fax (800) 284-3291, (custserv@ahcpub.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

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countries where the procedure is legal. It became the price for U.S. payment of its arrears to the United Nations and probably is going to remain a political football again this year. ■

Corrections

The September 1998 *Contraceptive Technology Update* article on contraception and epilepsy contained transposed information concerning the menstrual cycle and its effects on epileptic seizures. The information should be stated as follows: Partial seizures may increase during the time from menstruation to ovulation, known as the follicular phase, while absence seizures may intensify during the luteal phase, which is the time from ovulation to menstruation.

Family Planning Services of Elyria, OH, provides services to an area outside of Cleveland, not Cincinnati, as reported in the January 1999 article on the impact of Depo-Provera costs on family planning clinics. ■

CE objectives

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

• Identify clinical, legal, or scientific issues related to development and provisions of contraceptive technology or other reproductive services. **(See "Research affirms female condom's effectiveness" and "Maximizing the use of the progestin minipill.")**

• Describe how those issues affect service delivery and note the benefits or problems created in patient care in the participant's practice area.

• Cite practical solutions to problems and integrate information into daily practices, according to advice from nationally recognized family planning experts. **(See "Do you screen for domestic violence? Call goes out for universal screening.")** ■

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