CONTRACEPTIVE TECHNOLOGY UPDATE®

A Monthly Update on Contraception and Sexually Transmitted Diseases

AHC Media LLC

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Teen birth rate rises, reversing 14-year decline — What is behind the numbers?

Teen birth rates increase in more than 50% of states

Strides in lowering teen pregnancy rates have been reversed. The latest report from Centers for Disease Control and Prevention's National Center for Health Statistics shows that the teen birth rate increased in more than half of all 50 states in 2006, reversing a 14-year drop in numbers.[1] About two-thirds of the increase is attributed to teens ages 18-19, with one-third to teens ages 15-17.

Nationally, the U.S. teen rate increased from 40.5 births per 1,000 women ages 15-19 in 2005 to 41.9 in 2006. Mississippi, with 68.4 births per 1,000 teen girls ages 15-19, recorded the highest teen birth rate, followed by New Mexico (64.1) and Texas (63.1). Teen birth rates in 2006 were lowest in the Northeast, led by New Hampshire (18.7), Vermont (20.8), and Massachusetts (21.3). The only states with a decrease in teen birth rates between 2005 and 2006 were North Dakota (26.5), Rhode Island (27.8), and New York (25.7).[1]

"It may be that one of the nation's most extraordinary success stories

EXECUTIVE SUMMARY

Teen birth rate increased in more than half of all 50 states in 2006, which reversed a 14-year drop in numbers. About two-thirds of the increase is attributed to teens ages 18-19, with one-third to teens ages 15-17.

- The U.S. teen rate increased from 40.5 births per 1,000 women ages 15-19 in 2005 to 41.9 in 2006. Mississippi, with 68.4 births per 1,000 teen girls ages 15-19, recorded the highest teen birth rate, followed by New Mexico (64.1) and Texas (63.1).
- Factors may include complacency and the federal government's emphasis on abstinence education, which has left teens without the information they need to make responsible decisions about contraception, family planning experts say.

of the past two decades is coming to a close," says **Sarah Brown**, CEO of The National Campaign to Prevent Teen and Unplanned Pregnancy in Washington, DC. "Although teen pregnancy and birth rates have declined by about one-third since the early 1990s, many recent signs, including trends in teen sex and contraceptive use, seemed to have stalled or perhaps gone in the wrong direction."

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Take a closer look

A review of the new data gives further insight into women's health trends:

- A total of 4.3 million births were registered in the United States in 2006, a 3% increase over 2005. The birth rate was 14.2 live births per 1,000 people in 2006, also representing an increase from 2005.
- The average age of mothers giving birth for the first time decreased from 25.2 in 2005 to 25 years in 2006, the first decline in age since the measure became available. The average age at first birth had increased 3.8 years from 1970 to 2003.
- The birth rate for unmarried women increased 7% between 2005 and 2006. There were 50.6 births per 1,000 unmarried women ages 15-44.
- Women were less likely to receive timely prenatal care in 2006. Prenatal care utilization rose steadily from 1990 to 2003, but it remained flat in 2004 and 2005.
- The low birth weight rate (defined as less than 5.5 pounds) rose to 8.3% in 2006, the highest level in four decades. The preterm birth rate also rose in 2006, to 12.8% of all births.[1]

According to an analysis of the 2006 statistics by Child Trends, a Washington, DC-based research group, birth rates per 1,000 females ages 15-19 among Hispanic teens (83) were higher than rates among non-Hispanic black teens (63.7), American Indian teens (54.7), non-Hispanic white teens (26.6), and Asian teens (16.7).[2]

According to the analysis, Hispanic teens represent an important risk group because they are part of the fastest-growing segment of the population. Research indicates that sexually experienced Hispanic adolescents are less likely than other teens to talk to their partners about contraception before sex and to use contraception.[3]

Education a factor?

Why the rise in teen births? It might be that the federal government's emphasis on abstinence education has left teens without the information they need to make responsible decisions about contraception, Brown observes.

Abstinence-only sex education programs are required to present only the benefits of abstinence to adolescents, so students end up learning one-sided and sometimes incorrect information about condoms and birth control,

says **Janet Rosenbaum**, PhD, a postdoctoral fellow at the Johns Hopkins Bloomberg School of Public Health and the Johns Hopkins STD Center in Baltimore. Rosenbaum recently published results of a study that compared teens who took an abstinence pledge with teens of similar backgrounds and beliefs who did not.[4] Findings indicated no difference in pledgers'/nonpledgers' sexual behavior, the age at which they began having sex, or the number of partners; however, the group that promised to remain abstinent was significantly less likely to use birth control, especially condoms, when they did have sex.[4]

More than 90% of abstinence funding does not require that curricula be scientifically accurate.[5,6] A 2004 review found incorrect information in 11 of 13 federally funded abstinence programs, with most of the incorrect material surrounding birth control and condom effectiveness.[7] Despite those findings, the U.S. government allotted $176 million in FY 2008 to support programs that exclusively promote abstinence-only behavior outside of marriage.[8]

Abstinence-only programs are not allowed to mention the ways in which condoms protect against disease, only that they do not protect fully against all diseases, Rosenbaum notes. Commonly used abstinence-only curricula do not provide complete, current, or accurate medical knowledge about the effectiveness of condoms, confirms a 2008 review of programs.[9]

Can comprehensive sex education programs make a difference? A 2008 assessment of 56 education programs indicates abstinence-only programs do not delay initiation of sex. However, most comprehensive programs, which emphasize abstinence and the use of protection for those who do have sex, showed strong evidence of positive influence on teens' sexual behavior, including delaying initiation of sex and increasing condom and contraceptive use.[10]

Complacency might have become the enemy of progress when it comes to teen pregnancy, says Brown. Fourteen consecutive years of declines in the teen birth rate might have led to a "ho-hum" view of the issue and diverted important attention, resources, and funding to other pressing issues, she states.

"Let's hope this sobering news on teen births serves as a wake-up call to policy-makers, parents, and practitioners that all our efforts to convince young people to delay pregnancy and parenthood need to be more intense, more creative, and based more on what we know works," says Brown.

Increased funding for teens in need might be harder to get. The Medicaid Family Planning State Option was dropped from the recently implemented federal economic stimulus bill. The option would have allowed states to expand their Medicaid family planning services without having to go through the burdensome Medicaid waiver process. Teens use publicly funded programs; adolescents represent about one in four (28%) contraceptive clients served by publicly supported clinics.[11]

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Chlamydia rates up — Put screening into practice

Your next patient is a 16-year-old female who says she has a burning sensation when urinating. She has a steady boyfriend, but they have never

EXECUTIVE SUMMARY

New surveillance figures are in from the Centers for Disease Control and Prevention (CDC). More than 1.1 million chlamydia cases were reported in 2007, up from about one million in 2006. The increase represents the largest number of cases ever reported to the CDC for any condition.

- In 2007, the chlamydia rate among women was three times that of men: 543.6 cases per 100,000 women, compared to 190 cases per 100,000 men.
- Look to late spring 2009 for the publication of *Why Screen for Chlamydia?* which is a chlamydia screening implementation guide for providers. It will summarize the latest information about chlamydia screening and treatment, and it will provide suggestions and examples of ways chlamydia screening can be integrated into medical practice.

discussed condom use. What is your next move?

Screen for chlamydia. The Centers for Disease Control and Prevention (CDC) has just released new surveillance figures. More than 1.1 million chlamydia cases were reported in 2007, up from about 1 million in 2006. The increase represents the largest number of cases ever reported to CDC for any condition.[1]

In 2007, the chlamydia rate among women was three times that of men: 543.6 cases per 100,000 women, compared to 190 cases per 100,000 men. What can clinicians do to increase chlamydia screening and treatment?

Look to late spring 2009 for the publication of *Why Screen for Chlamydia?* which is a chlamydia screening implementation guide for providers developed by the National Chlamydia Coalition (NCC) and the Partnership for Prevention, says **Raul Romaguera**, DMD, MPH, the national chlamydia screening coordinator of the CDC's Division of STD Prevention.

The guide is designed as a brief resource for primary care providers to summarize the latest information about chlamydia screening and treatment, and provide suggestions and examples of ways chlamydia screening can be integrated into medical practice, explains Romaguera. It also includes information on issues related to providing confidential care to adolescents and tools for taking a sexual history with adolescent and young adult patients, he notes. The guide also will provide a list of online resources where providers can get up-to-date information regarding chlamydia screening and obtain access to evidence-based resources developed by other organizations, states Romaguera. *(Editor's note: CTU will report further on the guide upon publication. To educate your patients on chlamydia, use a handout available on the CDC web site, www.cdc.gov. Click on "Diseases & Conditions," "Chlamydia," then "Fact Sheet." The fact sheet is available in English and Spanish.)*

When talking with women about chlamydia, be sure to counsel on correct and consistent condom use. Condoms greatly reduce the risk of sexually transmitted diseases, such as chlamydia, which are transmitted to or from the penile urethra.[2]

The CDC recommends yearly chlamydia testing of all sexually active women age 25 or younger; older women with risk factors for chlamydial infections, such as those who have a new sex partner or multiple sex partners, and all pregnant women. An appropriate sexual risk assessment by a health care provider always should be conducted and might indicate more frequent screening for some women, the CDC advises.[3]

Women who are treated for chlamydia should be retested for infection about three months after treatment, advises the CDC.[4] It also is recommended that when possible, expedited partner therapy should be implemented. With that therapy, antibiotic therapy is delivered by heterosexual patients to their partners, if other strategies for reaching and treating partners are not likely to succeed.

With the formation of the NCC in June 2008, what steps have been taken to increase public awareness of chlamydia screening and to identify and address provider and policy-level barriers to widespread adherence to screening guidance?

The coalition is completing an inventory of resources, including social marketing campaigns, educational materials, brochures, and posters developed by other national and local organizations to increase community and provider awareness of chlamydia screening, says Romaguera.

"The NCC has had some conversations with a few of these organizations about the possibility of adapting these campaigns or resources to different audiences or target populations," Romaguera states. "In addition, the NCC is also exploring how they can join other national efforts to promote chlamydia screening."

A woman who has been using oral contraceptives (OCs) with good control who presents with intermenstrual bleeding might need to be screened for chlamydia. Cervicitis, which can be caused by chlamydia, gonorrhea, and trichomoniasis, is an important, but largely unrecognized, source of unplanned bleeding in women using OCs.[5] Women

who experience intermenstrual bleeding who have been previously well controlled on OCs might have asymptomatic chlamydia cervicitis.[5]

In a 1993 study, researchers found that 29.2% of women who had been taking OCs for more than three months and presented with intermenstrual spotting had a positive test for *Chlamydia trachomatis*.[6] By comparison, chlamydia cervicitis was found in 10.7% of matched controls taking OCs without spotting who were screened for symptoms of vaginitis or high-risk sexual behavior, and in 6.1% of women undergoing routine screening before the initiation of contraception.[6]

Smoking also has been linked to similar intermenstrual spotting while using OCs;[7] despite awareness of those potential confounding factors, few studies control for cigarette smoking or chlamydial infection, even though it is common for most studies to report the proportion of smokers recruited.[8] Since chlamydial cervicitis often causes abnormal bleeding and spotting, guidance from a 2005 Hormonal Contraceptives Trial Methodology Consensus Conference advised that women entering trials of hormonal contraceptives who are at risk for chlamydia should be screened for untreated chlamydia infection.[9]

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Emphasize long-acting reversible methods

Despite the safety and efficacy of the Copper T intrauterine device (ParaGard IUD, Barr Pharmaceuticals; Pomona, NY), the levonorgestrel intrauterine system (Mirena IUS, Bayer HealthCare Pharmaceuticals; Wayne, NJ), and the single-rod contraceptive implant (Implanon, Organon; Roseland, NJ), the most popular methods in the United States are oral contraceptives (OCs) and sterilization.[1] How can clinicians counsel more effectively on these long-acting methods to increase their use?

Research now under way by **Jeffrey Peipert**, MD, MPH, MHA, professor of obstetrics and gynecology at the Washington University School of Medicine in St. Louis, might yield answers to this question. Peipert is leading a cohort study of 10,000 women in the St. Louis region, looking at use of such reversible long-term methods of birth control as subdermal implants and intrauterine contraception (IUC). Implemented in 2007, the Contraceptive Choice Project is providing birth control at no cost to all participants for three years, reports Peipert. So far, researchers have recruited approximately 2,800 women; more than half (55%) are choosing IUC, and another 10% are selecting Implanon.

"We hope to reduce the rate of unintended pregnancy and teen pregnancy in our region," he says.

EXECUTIVE SUMMARY

Despite the safety and effectiveness of long-acting reversible birth control such as intrauterine contraceptives and contraceptive implant, the most popular methods in the United States are oral contraceptives and sterilization.

- A large study under way at the Washington University School of Medicine is looking at use of long-term reversible methods. The cohort study of 10,000 women will examine how such methods impact the rate of unintended pregnancy and teen pregnancy in the region, as well as monitor continuation rates and satisfaction with current reversible contraceptives.
- In recent labeling changes approved by the Food and Drug Administration for the levonorgestrel intrauterine system, neither nulliparity nor nulligravity is listed as a contraindication.

"We are also studying continuation rates and satisfaction with current reversible contraceptive methods."

To determine how often patients switched from combined hormonal methods or depot medroxyprogesterone (DMPA) at initial screening for the project, researchers looked at the first 500 women enrolled.[2] They evaluated the contraceptive method used at screening, then the method chosen at enrollment following contraceptive counseling.

At screening, half of the women were not using contraception, 12% used barrier methods, 36% used combined hormonal methods or DMPA, and less than 1% used long-acting reversible methods. At enrollment, 66% of patients initiated long-acting methods, and 32% initiated combined hormonal contraception or DMPA. Of the 181 patients using a combined hormonal method or DMPA at screening, 59% of patients switched to long-acting reversible methods at enrollment (39% levonorgestrel intrauterine contraception, 6% copper intrauterine contraception, 14% subdermal implant). A small percentage (10%) of those participants requested long-acting methods but used a shorter-acting contraceptive method to "bridge" until insertion could be performed.

Findings indicate that once financial barriers are removed and appropriate contraceptive counseling provided, a significant number of women, including those currently using shorter-acting hormonal contraceptive methods, ultimately will choose long-acting methods, researchers note.

In 2002, the leading method of contraception in the United States was the oral contraceptive pill, used by 11.6 million women, followed by female sterilization, used by 10.3 million women.[1] Clinicians' mindset must change when it comes to offering long-acting reversible contraception, says Peipert. Intrauterine contraception and the contraceptive implant should be considered first-line options for almost all women, he maintains.

These methods are forgettable; they are not dependent on remembering to take a pill, put in a ring, put on a patch, or get an injection, Peipert states. They are the most effective reversible methods available; all, or at least most, women interested in avoiding pregnancy should be offered these methods, he says.

Women with histories of myocardial infarction, stroke, deep vein thrombosis, systemic lupus erythematosus, hypertension, and even older smokers can use each of these top-tier methods.[3]

No longer should clinicians reserve intrauterine contraception for parous women, says Peipert says. It is perfectly fine to use intrauterine contraception in women who have not had children, he says. The World Health Organization eligibility criteria classes use of IUDs in young women ages 20 and younger, as well as for nulliparous women, as a "2," which means the advantages of using the method generally outweigh the theoretical or proven risks.[4]

The ParaGard IUD is approved for use for nulliparous women in stable relationships from ages 16 through menopause. In recent Food and Drug Administration-approved labeling changes for the levonorgestrel intrauterine system, neither nulliparity nor nulligravity is listed as a contraindication.[5]

Clinicians do not need to avoid use of intrauterine contraception in women with a past history of a sexually transmitted infection (STI), advises Peipert. However, providers should avoid insertion in women who have an active STI or current cervicitis, or who are at high risk for STIs, he notes. "Bottom line: IUCs are not just for married, monogamous, parous women," says Peipert. "They should be offered to all women as an excellent and highly effective contraceptive option."

Clinicians also should counsel on use of Implanon, which Peipert sees as a very effective, "forgettable" method. All women should be counseled regarding the unpredictable bleeding associated with this method for successful use, he notes.

For intrauterine contraception and the implant, financial barriers continue to represent a major obstacle to use of long-acting methods, even among otherwise well-insured women, observes **Andrew Kaunitz**, MD, professor and associate chair in the obstetrics and gynecology department at the University of Florida College of Medicine — Jacksonville. Although the IUD and the IUS have upfront costs of about $500 each in product and medical costs, they are the most cost-effective contraception over a five-year period, when the financial price of a possible unwanted pregnancy is considered.[6] If existing long-acting contraceptives were used by more patients, rates of unintended pregnancy and abortion would fall substantially, Kaunitz states.

"I look forward to a time when long-acting methods are universally accessible to U.S. women," he says. "More educational outreach to women about long-acting methods, including direct-to-consumer advertising, would also be desirable and welcome."

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Boost patient knowledge on Pap test importance

Cervical cancer, once one of the most common cancers affecting U.S. women, now ranks 14th in frequency among American women. Thanks to the introduction of the Papanicolaou (Pap) smear, the incidence of invasive cervical cancer has seen a dramatic drop. Between 1955 and 1992, U.S. cervical cancer incidence declined by 74%.[1]

Almost all cases of cervical cancer are caused by persistent infection with specific types of human papillomavirus (HPV), which can be transmitted by sexual contact. While there are more than 100 types of HPV, 15 types are considered to be cancer-causing. HPV types 16 and 18 are responsible for about 70% of cervical cancers worldwide.[1]

With the 2006 approval of the first HPV vaccine, more women are becoming aware of the link between HPV infection and cervical cancer. So why is it important for women to continue having Pap test, now that a HPV vaccine is available? The answer is very simple: The HPV vaccine Gardasil (Merck & Co.; Whitehouse Station, NJ) only protects against four strains of the virus, says **Andrea Milbourne**, MD, associate professor in the Department of Gynecologic Oncology at the University of Texas M.D. Anderson Cancer Center in Houston. For example, a woman could be infected with HPV types 58 or 45 (both of which have been implicated in causing cervical cancer), but be protected against types 6, 11, 16, and 18 due to vaccination, she explains.

Even with HPV vaccination, there is no definitive answer yet as to long-term efficacy of the immunization, says Milbourne. Published data show efficacy five years out from immunization.[2] Long-term follow-up studies are under way to determine duration of protection.[3] Vaccine efficacy can diminish over time, Milbourne notes; she points to pertussis (whooping cough). Pertussis incidence has increased as the vaccine's effectiveness wanes over time; however, many clinicians who treat adults have little knowledge that newly available booster vaccines against pertussis are needed.[4]

Women who receive the HPV vaccine should be counseled about the continued importance of consistent and correct use of condoms. Even with the availability of the vaccine, consistent condom use offers protection against infection with other high-risk types of HPV that put women at risk for cervical cancer.[5] Condoms also are an important defense against HIV, since the HPV vaccine does not offer such protection.

More HPV-associated cancers occur in the cervix than any other site: about 10,800 per year, according to a 2008 analysis of the largest, most comprehensive assessment of HPV-associated cancer data to date in the United States.[6] Black and Hispanic women had higher rates of cervical cancer (12.6 and 14.2, respectively) than white and non-Hispanic women (both 8.4). When examined by region, the South led in the highest incidence of cervical cancer.[6]

Disparities by race/ethnicity and region persist in the burden of cervical cancer in the United States, researchers found.[6] Comprehensive screening and vaccination programs, as well as improved surveillance, are essential if incidence rates are to be reduced, they state.[6]

Research indicates that cervical cancer is closely linked to failure to receive regular Pap test screenings, the presence of the HPV infection, intercourse

EXECUTIVE SUMMARY

Almost all cases of cervical cancer are caused by persistent infection with specific types of human papillomavirus (HPV), which can be transmitted by sexual contact. While there are more than 100 types of HPV, 15 types are considered to be cancer-causing.

- While the HPV vaccine is an important tool in the fight against cervical cancer, it only protects against four strains of the virus.
- A 2008 analysis of the largest, most comprehensive assessment of HPV-associated U.S. cancer data reports that black and Hispanic women had higher rates of cervical cancer than white and non-Hispanic women. When examined by region, the South led in the highest incidence of cervical cancer.

RESOURCE

To help women understand their Pap test results, use a patient handout developed by the Association for Reproductive Health Professionals. At the organization's web site, www.arhp.org, click on "Publications & Resources," "Patient Resources," "Health Matters Fact Sheets," then "Understanding Pap Test Results." The fact sheet is available in English and Spanish.

at an early age, multiple male sexual partners, and sex with a male partner who has had multiple sexual partners and immunosuppressive disorders such as HIV/AIDS.[7]

Findings from a 2005 analysis indicate that half of women who had cervical cancer diagnosed in the United States had not had a Pap test in the three years before diagnosis.[8] Efforts to step up screening have come from the National Breast and Cervical Cancer Early Detection Program, sponsored by the Centers for Disease Control and Prevention. The program provides low-income, uninsured, and underserved women access to timely breast and cervical cancer screening and diagnostic services. In program year 2007, the program screened 318,220 women for cervical cancer with the Pap test and found 4,996 cervical cancers and high-grade precancerous lesions.[9] ***(Editor's note: To help women understand their Pap test results, use a patient handout developed by the Association for Reproductive Health Professionals. See resource box, above.)***

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Make the connection to online birth control

Thinking of new ways to reach out to patients? Planned Parenthood Columbia Willamette (PPCW) in Portland, OR, has linked services to the Internet. It has an online health center that offers Oregon and Washington women easy, 24/7 access to low-dose, hormonal contraception without requiring an office visit or a trip to the drug store, as well as access to refills, emergency contraception, appointment requests, and health information.

The PPCW Online Health Center and its contraceptive access program, promoted as "Instant Birth Control," increase access to birth control by removing barriers to reproductive health care. By providing a nonthreatening introduction to the importance of annual exams and cancer screening, 25% of online patients who pick up their prescription at a Planned Parenthood clinic schedule an exam there, say program officials. As of March 2008, more than 9,000 contraceptive visits had been provided through the online center.[1]

Many patients have enjoyed having another option to access birth control, reports **Liz Delapoer**, PPCW's marketing director. Especially for patients located in rural areas far from a health center or with busy schedules, the convenience of ordering birth control online has been a plus, she notes.

Current low-dose hormonal birth control methods do not require a pelvic exam or cervical and breast cancer screening before administration. Instant Birth Control provides a HOPE visit (hormonal contraception provided with an optional — at another time — physical exam component) conducted via an online or telephone health history, explains **Mark Nichols**, MD, PPCW medical director. It is followed up with a telephone consultation with appropriate licensed staff, who clarify any

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history components and provide the appropriate medication teaching and other required components of prescribing based on state rules.

To start the process, a woman goes to PPCW's Online Health Center at its web site, www.ppcw.org, and completes a patient intake and medical history form. She then reads about and selects a method of hormonal contraception; birth control pills, transdermal patches, and vaginal rings are available through the program. A registered nurse or nurse practitioner then reviews the patient's health history and follows up by telephone with additional medical questions.

Once the patient is in contact with clinic nurses, PPCW authorizes two months of medication, with the method of delivery left up to the patient. Patients may choose to have their prescription mailed to them, at no additional cost, or called in to a pharmacy of their choice.

Once the patient receives her birth control, she must have her blood pressure measured and the reading verified by a qualified entity (such as at a clinic or drug store) at any point during her two initial cycles of contraceptive use. The patient then mails or faxes the blood pressure report to PPCW. If the reading is within appropriate limits, up to 11 more cycles of the medication can be prescribed.

Patients must be able to pay for the annual $75 consultation fee and medication up front by credit card. The annual costs for a year of birth control are $360 to $600 for birth control pills, $600 for transdermal patches, and $500 for vaginal rings. The program is not covered by the state Medicaid programs in Washington and Oregon. Patients can be reimbursed by private insurers if their health insurance covers contraceptive services.

To operate the program, Planned Parenthood registered nurses, operating under standing orders of nurse practitioners, review the patients' medical histories and prescribe the medications. Nurse practitioners conduct chart reviews of every patient treated by the registered nurses. During the Instant Birth Control program's first two years of operation, existing nursing and administrative staff were able to fulfill program functions.

PPCW has partnered with four other Planned Parenthood affiliates (Planned Parenthood of Western Washington, Central Washington, Mount Baker, and the Inland Northwest) to offer the contraceptive access service to women in Oregon and Washington. The five affiliates share operating expenses and revenue, thus reducing duplication of health care and support services and, when appropriate, taking advantage of economies of scale, say PPCW officials.

PPCW's Online Health Center is a work in progress. Staff members constantly are looking for ways to improve the patient experience online and make the service more accessible or applicable to patients, says Delapoer.

The Online Health Center is a great service for certain patients, but isn't the best option for everyone, she notes.

At present, patients using the Online Health Center cannot use state or federal funding programs, and they must pay for their services and prescriptions with a credit card, explains Delapoer. For patients who don't have a credit card, who cannot afford their visit, or who want to use one of the funding programs, visiting one of PPCW's other health centers would be a better option for them, she says. "We hope to continue improving and expanding our Online Health Center to serve more patients and provide more services online," says Delapoer.

One Internet venture now in place is the agency's "Take Care Down There" web site, www.takecaredownthere.org, she reports. The web site and its marketing campaign are PPCW's effort to reach out to mature teens and young adults to start conversations about sexual and reproductive health. The web site offers colorful graphics and easy-to-read information on sexual health subjects.

"We wanted to find a way to talk to teens and young adults in a way that they could relate to, that they would find interesting and engaging, and potentially encourage further conversations

with friends, teachers, or family about the topics we address," says Delapoer. "We hope to educate this age group about the services offered at Planned Parenthood health centers and encourage them to proactively take care of their reproductive and sexual health."

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Reach at-risk youth with rapid HIV tests

When it comes to HIV in the United States, young people are disproportionately at risk: An estimated 50% of new HIV infections occur among those under age 25.[1] Among youth infected with HIV, 55% are African American, and 24% are Latino.[2]

How can clinicians reach these at-risk youth with a prevention message? The Rapid HIV Testing Program offered through St. Christopher's Hospital for Children in Philadelphia provides sexual health education and counseling, rapid HIV testing, and additional intensive counseling to those who test positive. Conducted in a variety of community-based settings that are easily accessible to youth, post-implementation data indicate the program has been successful in identifying HIV-positive, minority youth and facilitating access to care.

The program, which has been in existence since 2002, has tested as many as 500 at-risk individuals in a year. Over one 10-month period, 450 individuals were tested, including 248 at-risk youth between ages 14 and 24. Within the group of 248, seven tested positive for HIV.[3]

St. Christopher's is a nonsectarian, 161-bed hospital, with more than 270 pediatric specialists offering services exclusively to children. The physicians also serve at the Pediatrics Department at the Drexel University College of Medicine, also in Philadelphia.

EXECUTIVE SUMMARY

The Rapid HIV Testing Program offered through St. Christopher's Hospital for Children in Philadelphia provides sexual health education and counseling, rapid HIV testing, and additional intensive counseling to those who test positive.

- The program provides consistent testing at a variety of community locations, including family homeless shelters, homeless youth shelters, charter schools, and local college health centers.
- In existence since 2002, the program has tested as many as 500 at-risk individuals in a year. Over one 10-month period, 450 individuals were tested, including 248 at-risk youth between ages 14 and 24. Within the group of 248, seven tested positive for HIV.

The Rapid HIV Testing Program began as a pilot designed to increase access to HIV testing by offering services in the neighborhoods where young people live, rather than requiring them to travel to clinic locations in downtown Philadelphia, to receive HIV testing.

The program provides consistent testing at community locations, including family homeless shelters, homeless youth shelters, charter schools, and local college health centers, says **Theresa Parrino**, LCSW, assistant director of the Drexel University College of Medicine/St. Christopher's Pediatric/Adolescent HIV/AIDS Program. Additionally, the program offers the rapid test during the year at various events throughout the city, such as health fairs, social events for teens, and church functions, she notes.

Within each location, the program generally operates during set hours in two private rooms to maintain confidentiality, with one room used for initial testing and one for follow-up testing and counseling to those who initially test positive. For example, a location may provide services on the first Tuesday of the month between 4 p.m and 7 p.m.; during this time period, counselors come to the site to offer program services.

How does the program get the word out about offsite testing? According to Parrino, the program

COMING IN FUTURE MONTHS

■ HIV progression not affected by contraception

■ Condoms weather recession's toll

■ Vaccine eyed for gonorrhea

■ Male contraceptive: Research in works

■ New research eyes microbicide use

normally partners with established community agencies to provide space for testing and outreach support, with program staff using neighborhood flier postings, radio announcements, group presentations, and e-mails to promote attendance.

The program includes two full-time coordinators, three full-time social workers, a full-time outreach worker/tester, and five contracted outreach workers/testers. Generally, two to three testers can serve 12-17 youth during a three-hour period. Outreach workers/testers typically have at least some college education.

The annual operating budget is about $1.5 million. Costs include staffing, materials, and the costs related to testing. The program is funded through a combination of federal funds and grants, including monies from the Ryan White Comprehensive AIDS Resources Emergency Act, St. Christopher's Foundation, Johnson & Johnson, and the Elizabeth Glaser Pediatric AIDS Foundation.

Different formats target prevention

A key element of the program lies in its sexual health curriculum and counseling. Using a variety of formats, such as group activities, games, and movies, program officials offer youth ages 14-24 prevention information.

All youth also have individual sessions with counselors, which normally last about 20 minutes. Counselors assess the individual's STD risks and provide additional information on HIV/AIDS, including specific information on exposure, and testing and retesting options. Counselors use calendars to help youth pinpoint when they may have been exposed to HIV infection and determine the date that they should return for testing or retesting, if needed.

Youth who are interested in taking a rapid HIV test then are asked to sign two consent forms: one for testing and one for care outreach. Counselors obtain information on how to contact youth if needed. Those who are interested in testing also are screened for their readiness to test. Youth who are intoxicated, at risk for suicide, or who exhibit serious mental health symptoms are not tested. Once tested, youth take part in additional educational activities until the results are available, which usually is a 20-minute period.

Youth who initially test positive are immediately retested, with results not typically known for another week. A master's-level social worker counsels those who test positive with the rapid test, as well as provides a more thorough screening for risk of suicide. A pager number is provided in case those who test positive with the rapid test need support while waiting for the results of the second test. Results of the second test are given at a neighborhood clinic, where individuals who test HIV-positive are immediately linked to youth-specific, comprehensive HIV care.

CNE/CME Instructions/questions

Physicians and nurses participate in this continuing medical education/continuing education program by reading the articles, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers and refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity with the **June** issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

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

- **identify** clinical, legal, or scientific issues related to development and provisions of contraceptive technology or other reproductive services.
- **describe** how those issues affect services and patient care.
- **integrate** practical solutions to problems and information into daily practices, according to advice from nationally recognized family planning experts.

13. The following women can safely use long-acting reversible forms of birth control, such as intrauterine contraception and the contraceptive implant:
A. Women with history of myocardial infarction
B. Women who are hypertensive
C. Women with systemic lupus erythematosus
D. All of the above

14. Of the more than 100 types of human papillomavirus, how many types are considered to be cancer-causing?
A. 50
B. 40
C. 15
D. 10

15. In what time period should women who are treated for chlamydia be retested for infection?
A. About four months after treatment
B. About three months after treatment
C. About two months after treatment
D. About one month after treatment

16. When it comes to HIV in the United States, what percentage of new HIV infections occur among those under age 25?
A. 50%
B. 40%
C. 25%
D. 15%

Answers: 13. D; 14. C; 15. B; 16. A.

Why is off-site testing so important in reaching adolescent populations?

"We developed our program based on the premise that the most at-risk youth do not often present to large medical facilities or anonymous test sites that in Philadelphia are located in the Center City district, which is quite a distance from some of the hardest-hit communities by HIV standards," says **Jill Foster**, MD, section chief of the Drexel University College of Medicine/St. Christopher's Pediatric/Adolescent HIV/AIDS Program. "These kids also do not access primary care physicians and thus slip through most of the prevention cracks in Philadelphia."

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Contraceptive Technology Update *is endorsed by the National Association of Nurse Practitioners in Women's Health and the Association of Reproductive Health Professionals as a vital information source for health care professionals.*