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A Monthly Update on Contraception and Sexually Transmitted Diseases

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IN THIS ISSUE

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Large-scale study of anti-HIV gel shows promise — What's the next step?

Look to upcoming results from Phase III trial of PRO 2000

Research findings presented at a February 2009 international conference indicate that an investigational gel known as PRO 2000 (Indevus Pharmaceuticals; Lexington, MA) proved about 30% effective in preventing HIV infection in women.[1] The other candidate microbicide tested in the trial, BufferGel (ReProtect, Baltimore), did not reduce HIV risk among women. While the finding for PRO 2000 was not found to be statistically significant, the study is the first human clinical research to suggest that a microbicide might prevent male-to-female sexual transmission of HIV infection.

Women's health advocates now look to the results of a separate, larger clinical study that should definitively assess the effectiveness of PRO 2000 in preventing HIV infection. Sponsored by the Medical Research Council and the Department for International Development of the United Kingdom, the Phase III study involves some 9,400 African women and is set to conclude in August 2009.

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Research findings indicate that an investigational gel known as PRO 2000 proved about 30% effective in preventing HIV infection in women in a study conducted in six sites in Africa and one in the United States. While the finding for the gel was not found to be statistically significant, the study is the first human clinical research to suggest that a microbicide might prevent male-to-female sexual transmission of HIV infection.

- Women's health advocates now look to the results of a separate, larger clinical study that should definitively assess the effectiveness of PRO 2000 in preventing HIV infection.
- The Phase III study involves some 9,400 African women and is set to conclude in August 2009.

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The trial, labeled as HPTN 035, was conducted by the National Institutes of Health-funded Microbicide Trials Network. The combination Phase II/IIb clinical trial was designed to determine whether BufferGel or PRO 2000 demonstrated sufficient promise for testing in a larger Phase III clinical trial. Scientists did not design the trial to compare the two microbicides to each other, but rather to evaluate each against a placebo gel that contained no active ingredient and use of no gel at all. The Phase II portion of the study enrolled 799 women; the Phase IIb phase involved the initial 799 participants, as well as an additional 2,300 women. Women in the study were assigned randomly to one of four equal-sized treatment groups: BufferGel, PRO 2000, placebo gel, or no gel. All women in the study were counseled about the possible risks and benefits of trial participation prior to enrollment and were monitored closely throughout the study. In addition, they were counseled regarding safe sex practices, provided condoms, and tested and treated for sexually transmitted infections throughout the study. The study was conducted in six sites in Africa and one in the United States.

In the final analysis, 194 women in the study became infected with HIV. Of those infections, 36 occurred in the PRO 2000 group, 54 in the BufferGel group, 51 in the placebo gel group, and 53 among those who did not use a gel. Based on those findings, PRO 2000 was 30% effective, while BufferGel had no detectable effect on preventing HIV infection. Both microbicides were found to be well tolerated and did not result in any significant adverse events, researchers report.[1]

"We think it certainly is an encouraging piece of news," says **Anna Forbes**, deputy director for the Global Campaign for Microbicides, an international coalition of organizations working to accelerate new HIV prevention options, particularly for women. "The trial results were not ultimately statistically significant, but the subanalyses certainly suggest a trend in the right direction, which is that PRO 2000 may have had some protective effective."

Is progress being made?

Where do the results of the current trial place science in the development of an effective microbicide? Since the concept of a microbicide first was proposed almost 20 years ago as an HIV prevention strategy that women can initiate or control, there have been several effectiveness trials to assess impact on HIV infection, observes **Salim Abdool Karim**, MB, BCh, professor in clinical epidemiology at the Mailman School of Public Health at Columbia University in New York City and deputy vice chancellor of research and development at the University of Natal in Durban, South Africa. Abdool Karim, who led the HPTN 035 study as protocol chair, presented findings at the recent Conference on Retroviruses and Opportunistic

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Editorial Questions

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Infections in Montreal.

Earlier microbicide trials include those of the nonoxynol-9 (N9) sponge, N9 film, N9 gel (COL-1492), Savvy, cellulose sulphate, and Carraguard prior to the release of the HPTN 035 results, recalls Abdool Karim. Unfortunately, those six products produced disappointing results, he says; two trials (N9 film and Carraguard) showed no impact on HIV; one trial did not produce a meaningful result due to lower-than-expected HIV incidence in the study population (Savvy); and three trials suggested that the product may be harmful (N9 sponge, N9 gel, and cellulose sulphate)**. (Review *Contraceptive Technology Update* reports on these microbicide candidates; see "Nonoxynol-9 fails test as female microbicide," October 2000, p. 119; "Research halted on cellulose sulfate microbicide — What's next in research?" April 2007; and "Microbicide candidate found safe, but not effective: What's the next step in research?" *STD Quarterly* supplement, May 2008, p. 1.)**

Against this backdrop, the HPTN 035 results showed that BufferGel and PRO 2000 were safe, observes Abdool Karim. BufferGel had no impact on HIV prevention; PRO 2000 demonstrated a 30% reduction in HIV infection in an intent-to-treat analysis; and the subgroup analysis provided evidence suggesting a potential protective effect of PRO 2000. The overall 30% level of protection is modest and is not statistically significant, says Abdool Karim. While it is a promising signal, it is insufficient to make any conclusive statement on PRO 2000 as a protective microbicide, he notes.

"In light of the sequence of disappointing results from the preceding six trials, HPTN 035 provides the first indication that a vaginally applied gel may be able to protect against HIV infection," says Abdool Karim. "The results of the current PRO 2000 effectiveness trial under way are now patiently awaited; these results are likely to determine if PRO 2000 will be able to assume the mantle of being the first effective microbicide."

It is a positive development that a major study has found a 30% protective effect against HIV transmission when women use a vaginal agent, says **Robert Hatcher**, MD, MPH, professor of obstetrics and gynecology at Emory University in Atlanta. The larger study of PRO 2000 now under way will confirm, he hopes, this initial report.

The good news is that there might be a product that a woman can use to lower her risk of being infected with HIV, Hatcher says. The bad news is that the results of the HPTN 035 trial indicate the gel is found to have only a 30% protective effect. "This raises the question: Could PRO 2000 use lead to decreased use of a far more effective method of preventing HIV transmission: male condoms?" Hatcher asks.

More options in line

Look for more research to emerge on other microbicides. The International Partnership for Microbicides (IPM), based in Silver Spring, MD, is testing a new generation of microbicide candidates that contain highly potent antiretrovirals that specifically target HIV. These microbicides are based on the same antiretroviral drugs being successfully used in HIV treatment and to prevent mother-to-child transmission of HIV. The IPM announced in February 2009 that it had received a total of US $130 million in grants from the United Kingdom Department for International Development and the Bill & Melinda Gates Foundation to pursue such product development.

IPM is eyeing use of the antiretroviral dapivirine in vaginal ring and gel delivery formulations, says **Zeda Rosenberg**, ScD, IPM CEO. Safety studies of the gel began in March 2009 in four U.S. cities: Baltimore; Birmingham, AL; Chicago; and Seattle. Research is expected to expand into South Africa and other African countries once regulatory approval is received, she reports. If successful, safety studies for dapivirine in ring and gel formulations are geared to move into large-scale efficacy studies in 2011, Rosenberg states.

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Check progress of emergency contraception

Access barriers to the dedicated emergency contraceptive pill (ECP) Plan B are set to be lifted. A federal judge has instructed the Food and Drug Administration (FDA) to make Plan B available to 17-year-olds and ordered the agency to review whether to make the ECP available to

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Access barriers to the dedicated emergency contraceptive pill (ECP) Plan B are set to be lifted. A federal judge has instructed the Food and Drug Administration to make Plan B available to 17-year-olds and ordered the agency to review whether to make the ECP available to females 17 and under without prescription.

- Recent research indicates that many physicians may not offer ECPs to adolescents who might benefit from them during emergency department visits.
- A telephone survey of Los Angeles area pharmacies between October 2007 and April 2008 found that while most pharmacies provided information about Plan B that was consistent with labeling, barriers still exist to accurate information and timely access to the drug.

females 17 and under without prescription.

In 2006, Duramed Pharmaceuticals began distributing the dual-label version of Plan B, which allowed the drug to be sold "behind the counter," but without a prescription, to women 18 years of age and older, with prescription-only availability for females 17 and younger. In handing down its decision on March 23, 2009, the U.S. District Court for the Eastern District of New York ordered the FDA to make Plan B available over the counter to women ages 17 and older within 30 days. U.S. District Judge Edward Korman also instructed the FDA to reconsider whether minors under age 17 should be permitted to obtain emergency contraception over the counter (OTC). The ruling was spurred by a lawsuit filed in 2005 by the Center for Reproductive Rights on behalf of the Association of Reproductive Health Professionals (ARHP) and a number of other women's health organizations.

As the FDA reconsiders whether to allow OTC access for women of all ages, health care providers around the country should encourage the agency to make a decision free from political and ideological influence, said **Beth Jordan**, MD, ARHP medical director. Safety and efficacy are the only legitimate criteria the FDA should use in its review process, and Plan B passes those tests, she said in a press statement issued following the court ruling. It is safe and easy for a reproductive-age woman to self-diagnose her own need for Plan B and then to use it, Jordan said. The FDA's own panel of independent medical experts advised them on this fact prior to the FDA's politically motivated decision, she maintained.

ECPs work to prevent pregnancy fairly well for a single act of intercourse; however, several global studies have shown that after a protracted period of time, ECPs do not lower rates of pregnancy in populations of women, says **Robert Hatcher**, MD, MPH, professor of obstetrics and gynecology at Emory University in Atlanta. **(To review the research, see "Face facts about effectiveness of ECPs," June 2007, p. 68.)** "On the other hand, the emergency contraceptive insertion of a copper T-380A intrauterine device is more effective than Plan B in preventing pregnancy from a single act of intercourse and, if tolerated by a woman, leaves her extremely well protected against pregnancy for a number of years," he explains.

Access limits in EDs?

Hospital emergency departments (EDs) might represent one barrier when it comes to ECP access. Recent research indicates that many physicians may not offer ECPs to adolescents who might benefit from them during ED visits.[1]

Researchers affiliated with The Children's Hospital of Philadelphia performed a cross-sectional, anonymous, Internet-based survey of members of the American Academy of Pediatrics' Section of Emergency Medicine. They found that while 85% of physicians had prescribed ECPs, more than 80% of those doctors had done so fewer than five times in a year. Physician knowledge about the drug and its use may be an important factor: 43% of physicians incorrectly answered half of the questions in the web-based survey.

Monika Goyal, MD, lead author of the study and an emergency medicine physician at Children's Hospital, says, "It is extremely important for emergency department physicians to be knowledgeable about emergency contraception — a safe and effective method of pregnancy prevention — because unintended teenage pregnancy is a major public health issue, and adolescents frequently utilize the emergency department. Moreover, adolescents may feel embarrassed or may not know about emergency contraception, so it is even more important for physicians caring for teens in the ED setting to be cognizant of the indications for EC and to consider it when they evaluate patients."

As emergency contraception becomes increasingly available without prescription, it is important that women in need be provided accurate information about its use. Researchers at Los Angeles Biomedical Research Institute at Harbor — UCLA Medical Center in Torrance performed a

telephone survey of all retail pharmacies in Los Angeles County to assess the accuracy of the information a vulnerable young woman would be given about Plan B.[2] The survey was conducted four years after it became available without a prescription through the California State Pharmacy Access Project and 12-18 months after Plan B became available on a dual-label status basis.

There were 1,460 pharmacies called between October 2007 and April 2008. Sixty-nine percent had the ECP available on site, and 19% referred the caller elsewhere. While most pharmacies provided information about Plan B that was consistent with labeling, barriers still exist to accurate information and timely access to the drug, researchers note. While most pharmacies that volunteered details over the telephone provided accurate information, some offered misinformation, such as recommendations for medications that are not Food and Drug Administration-approved for emergency contraception, including "a cream that kills sperm," "herbs to cleanse the ovaries," and douching.[2]

New EC on the way?

Will the United States see a second dedicated ECP? CDB-2914, a second-generation emergency contraceptive pill, is in a U.S. Phase III clinical trial conducted in 14 states in 17 clinics affiliated with the Planned Parenthood Federation of America. The manufacturer of the prospective drug, HRA Pharma of Paris, estimates study completion in 2009, according to **Christina Aplington**, company spokeswoman. The company has not yet applied for FDA approval, but it plans to do so, she says.

CDB-2914 is a second-generation progesterone receptor modulator that is akin to mifepristone, a first-generation progesterone receptor modulator. Previous research indicates CDB-2914 is at least as effective as levonorgestrel in preventing pregnancies after unprotected intercourse and has a similar side effect profile.[3] **(See "Progesterone receptor modulator eyed for EC," *Contraceptive Technology Update*, February 2007, p. 16.)** The drug is under evaluation by the European Medicines Agency, the European marketing authorization body based in London, says Aplington. The agency's final decision is expected later in 2009, she states.

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Contraception safe for HIV-positive women

Today, women account for more than one-quarter of all new HIV/AIDS diagnoses in the United States, according to the Centers for Disease Control and Prevention.[1] Most of those women use some form of contraception, with condoms as the most popular choice.[2]

With the advent of potent antiretroviral therapy (ART), the outlook has greatly improved the outlook for HIV-infected women, even those with an AIDS diagnosis.[3] Recent findings presented at the February 2009 Conference on Retroviruses and Opportunistic Infections indicate that HIV progression is not affected by hormonal contraception.[4]

While results are encouraging, more research is needed to examine the effects of different types of contraceptive agents on disease progression, researchers conclude.

To perform the current analysis, researchers from the University of Alabama at Birmingham and the Centre for Infectious Disease Research in Zambia studied women enrolled in nine developing countries in Africa and Asia as part of the MTCT (Mother-to-Child Transmission) Plus

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Findings presented at the February 2009 Conference on Retroviruses and Opportunistic Infections indicate that HIV progression is not affected by hormonal contraception. While results are encouraging, more research is needed to examine the effects of different types of contraceptive agents on disease progression, researchers conclude.

- Highly effective, long-acting reversible birth control methods, such as intrauterine contraception and the contraceptive implant, can be safely used by women who are HIV-positive and receiving medical care.
- A woman who is infected with HIV should use condoms to prevent HIV transmission and to avoid reinfection.

Initiative, a multicountry program of family-based HIV care and treatment. Women who qualified for the study were not yet on ART, were not pregnant or were at least three months postpartum, and had documentation of exposure to hormonal or nonhormonal contraceptive methods. HIV disease progression was defined as becoming eligible for ART or death. Scientists used Cox regression and categorized exposure by the method reported at the time of entry into the cohort. Because some women switched methods over time, researchers also performed a separate time-varying analysis where women who switched contributed person-time to each exposure category.

The research team enrolled 5,993 women between August 2002 and December 2006. Of these women, 3,837 fit criteria for inclusion in the analysis. At baseline, 2,577 of 3,837 reported using no or nonhormonal contraception and 1,106 of 3,837 reported use of hormonal contraception. A further breakdown of contraceptive users shows 800 of 1,106 used injectables or implants, and 216 of 1,106 used oral contraceptive pills.

Risk factors for HIV disease progression were CD4 count > 200 to < 350 cells/mm^3 [adjusted hazards ratio (AHR) 5.69, 95% confidence interval (CI) 4.83 to 6.71] and World Health Organization (WHO) HIV Clinical Stage II (AHR 1.52, 95% CI 1.23 to 1.88) and WHO Stage III (AHR 3.46, 95% CI 2.51 to 4.75).

Researchers found that exposure to hormonal contraceptives was not associated with HIV disease progression.

How to counsel women

Research indicates that HIV-positive women have reproductive patterns similar to those of HIV-negative women, with most having borne children and many wanting children in the future.[3] What are some important counseling messages for those women when it comes to reversible contraception?

Highly effective, long-acting reversible birth control methods, such as intrauterine contraception and the contraceptive implant, can be safely used by women who are HIV-positive and receiving medical care, says **Nancy Stanwood**, MD, MPH, associate professor of obstetrics and gynecology in the Department of Obstetrics & Gynecology at the University of Rochester (NY) Medical Center. Women need to hear that having HIV still will allow them to have a successful pregnancy with a healthy, uninfected baby, she says. Women also need to understand that tubal ligation is permanent surgical sterilization, Stanwood notes. Stanwood's research indicates relatively high rates of tubal ligation regret in HIV-positive women.[3]

The WHO Expert Working Group in 2003 concluded that a woman generally can start using an intrauterine device, even if she has AIDS, provided she is receiving ART and is clinically well, or if she has HIV infection, or she is at high risk of HIV infection.[5] ***(Contraceptive Technology Update* reported on the group's actions; see "Update your practice: Check new WHO Medical Eligibility Criteria," June 2004, p. 61.)**

When it comes to hormonal contraception, some studies have suggested that antiretroviral drugs might reduce the effectiveness of hormonal contraceptives and might increase the risk of pregnancy.[6] Because the limited number of pharmacokinetic studies of ARTs used with combined oral contraceptives showed positive and negative effects on hormone levels, the Expert Working Group placed hormonal contraceptives for users of ART as a Category 2 (a condition where the advantages of using the method generally outweigh the theoretical or proven risks.)

Clinicians should remember to stress the importance of condoms when discussing reproductive health with HIV-positive women. A woman who is infected with HIV should use condoms to prevent HIV transmission and to avoid reinfection. Consistent and correct use of condoms might compensate for any decrease in the effectiveness of hormonal methods theoretically linked to hormonal contraceptive use.[6]

Spermicides are not suitable for women with high HIV risk, HIV, or AIDS, due to research indicating that nonoxynol-9 use is associated with an increase in irritation, and colposcopic and histologic evidence of inflammation.[7] The Working Group classified spermicide as Category 4 (not to be used).[6] Diaphragms used with spermicide were classified as Category 3 (usually not recommended) for conditions related to HIV/AIDS.

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DMPA and weight gain: Science considers link

The next patient in your exam room is a 17-year-old female who uses the contraceptive injection depot medroxyprogesterone acetate (DMPA) for birth control. She has been using the method for about a year. She tells you she has gained about 10 pounds since initiating the method. What is your next move?

Findings from a new study indicate that women using DMPA gained an average of 11 pounds and increased their body fat by 3.4 % over three years.[1] The amount of weight gain was dependent on the length of time DMPA was used, as the rate of weight gain slowed over time, data suggest.

Clinicians should tell women that there is an increased risk with weight gain while using DMPA, says **Abbey Berenson**, MD, professor in the Department of Obstetrics and Gynecology and director of the Center for Interdisciplinary Research in Women's Health at the University of Texas Medical Branch in Galveston. However, not all women who use this method will gain weight, and it is a highly effective method of birth control, notes Berenson, who serves as lead author of the research.

"Unfortunately, it is difficult to predict who will gain weight and who will not," she says. "At this time, the best advice we can give is to monitor [patients'] weight and, if they experience significant weight gain during the first six months, they may want to consider using another method."

Weight gain is common in many women who use DMPA; however, this effect is not consistent for all women, state authors of *Contraceptive Technology*.[2] Counsel on weight gain prior to method initiation. Weight gain is commonly cited as a reason for discontinuation of DMPA, with 12%-19% stopping use for this reason.[3]

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Findings from a new study indicate that women using depot medroxyprogesterone acetate (DMPA) gained an average of 11 pounds and increased their body fat by 3.4% over three years. The amount of weight gain was dependent on the length of time DMPA was used, as the rate of weight gain slowed over time, data suggest.

- Weight gain is common in many women who use DMPA; however, this effect is not consistent for all women.
- Clinicians should counsel on weight gain prior to method initiation. Between 12% and 19% cite weight gain as reason for discontinuation of DMPA.

Review the research

To perform the study, researchers followed 703 women in two age categories: ages 16-24, and 25-33, using DMPA, a combined oral contraceptive (OC), or nonhormonal methods (bilateral tubal ligation, condom, or abstinence) for three years. DMPA users who discontinued use of the injection and selected another form of birth control were followed for up to two additional years to examine the reversibility of the observed changes. Throughout the study, researchers compared changes in body weight and composition and analyzed the influence of age, race, caloric intake, and exercise among the study population.

When researchers compared all three groups, DMPA users were more than twice as likely as women using OC or nonhormonal methods to become obese over the next three years. Over 36 months, DMPA users increased their weight (+5.1 kg), body fat (+4.1 kg), percent body fat (+3.4%), and central-to-peripheral fat ratio (+0.1) more than Pill and nonhormonal method users ($P < 0.01$).

Women using oral contraception did not gain more weight than those using a nonhormonal form of birth control. However, the study found that their body fat increased slightly while their lean body mass decreased. Researchers said this was less likely among those women who exercised regularly and consumed a healthy diet that included increased protein intake.

After discontinuation of DMPA, some decrease in body weight and fat (0.42 kg in six months) occurred when nonhormonal methods were used, researchers report. In comparison, those who used

the combined pill formulation after DMPA discontinuation gained 0.43 kg in six months.[1]

What causes gain?

Previous research indicates that DMPA is associated with significant weight gain compared with an oral contraceptive or no contraceptive.[4] In a study that looked at adolescent girls initiating DMPA, OC, or no hormonal contraceptive method, scientists found a significant relationship between baseline obesity status and subsequent weight gain.[4] Teens who were obese (body mass index kg/m^2 30 or above) prior to use of DMPA gained significantly more weight than obese girls starting the Pill or no contraceptive method. In addition, obese adolescents using DMPA gained more weight than did nonobese adolescents using DMPA, OC, or no hormonal contraception method.[4] ***(Contraceptive Technology Update* reported on the research; see "Contraception, weight gain: Weigh evidence and myths," April 2006, p. 39.)**

Some researchers have hypothesized that the relationship between DMPA and weight gain may lie in behavioral eating or exercise; however, the link might be found at the metabolic level, suggests **Andrea Bonny**, MD, assistant professor of pediatrics at Case Western Reserve University School of Medicine and MetroHealth Medical Center in Cleveland. Bonny and fellow researchers are looking at this question, with research findings tentatively scheduled for release in the next year. "My personal guess is at this point is that something is happening metabolically at the level of the fat cell," she says, "and what is driving that, I don't know if we're entirely clear on, whether it's driven by the lack of estrogen or a direct effect of progesterone."

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Research supports safety of HPV vaccine

Your next patient is an adolescent female who has requested immunization with the vaccine for human papillomavirus (HPV). When she asks specifically about the vaccine's safety, what can you tell her?

Research continues to support the safety of the HPV vaccine, according to a recent review of material by the World Health Organization's (WHO) Global Advisory Committee on Vaccine Safety.[1] The group examined pre- and post-licensure data from the United States for the HPV vaccine (Gardasil, Merck & Co.; Whitehouse Station, NJ). The vaccine's safety profile is similar to that found in the pre-licensure trials, the group noted.[1] The group also looked at safety data from other countries and concluded that Gardasil is a safe vaccine, says **Martin Myers**, MD, director and editor of the National Network for Immunization Information, a service provided by Immunizations for Public Health, a Galveston, TX-based nonprofit corporation that provides current, science-based information to health care professionals, the media, and the public. The WHO committee is calling for increased attention to building capacity for post-marketing surveillance in those countries where introduction is being planned, since many countries only recently have introduced HPV vaccines at the national level.[2]

Newly published research adds to the database

EXECUTIVE SUMMARY

Research continues to support the safety of the HPV vaccine, according to a recent review of material by the World Health Organization's Global Advisory Committee on Vaccine Safety. The group examined pre- and post-licensure data from the United States for the HPV vaccine Gardasil and looked at safety data from other countries.

- Findings from a recent study of Australian teens ages 12-18 indicate that hypersensitivity reactions to the quadrivalent vaccine are uncommon and most girls in this age range can tolerate subsequent doses.
- As with many other vaccines, fainting and dizziness are common side effects after receiving the HPV vaccine. Vaccine labeling states that observation for 15 minutes after administration is recommended.

on the safety of the vaccine. In one study analyzing use of the vaccine in Australian teenagers ages 12-18, researchers report that hypersensitivity reactions to the quadrivalent vaccine are uncommon and that most girls in this age range can tolerate subsequent doses.[3] Scientists based their findings on results of clinical evaluations, skin tests, and examination of vaccine challenges in 25 schoolgirls with suspected hypersensitivity to the vaccine after more than 380,000 doses were administered in schools in Victoria and South Australia.

Another study released prior to the American Academy of Neurology's 61st Annual Meeting in Seattle looked at reports of use of the vaccine and Guillain-Barré syndrome, a rare disorder that causes muscle weakness.[4] Results indicate that Guillain-Barré is not occurring more often after HPV vaccination than it does in the general population.

To perform the analysis, researchers examined data from the Vaccine Adverse Event Reporting System. They noted 36 cases of Guillain-Barré reported after HPV vaccination in the United States from 2006 to 2008; the disorder occurred within six weeks after vaccination in 75% of the people. In 60% of those with the disorder, the HPV vaccine was the only immunization they received at the time, while the remaining 40% received the HPV vaccine along with other vaccines.[4]

Watch for fainting

From the time Gardasil was approved by the Food and Drug Administration (FDA) in June 2006 until August 2008, more than 20 million doses of HPV vaccine were distributed in the United States. A total of 10,326 adverse events following immunization were reported in that time period to the Vaccine Adverse Events Reporting System, with the most commonly reported adverse events noted as fainting and dizziness.[5] However, studies suggest that increased fainting occurs among females 13 years and older after receiving any vaccine.[6]

It is important for clinicians to take the precaution to have patients sit for 15 minutes following immunization, says Myers, who also serves as professor of pediatrics and preventive medicine and community health at the University of Texas Medical Branch in Galveston. The package labeling for the HPV vaccine now reads "Syncope has been reported following vaccination with Gardasil and may result in falling with injury; observation for 15 minutes after administration is recommended."[7] *[Editor's note: Use a FDA Consumer Health Information Sheet, "Addressing Questions on Gardasil," to help answer patient questions. Access the sheet by going to the FDA web site, www. fda.gov, and under "Consumers," select "Consumer Health Information." Select "All Consumer Updates," "Vaccines," and "Addressing Questions on Gardasil." Also use a fact sheet, "Questions and Answers about HPV Vaccine Safety," prepared by the Centers for Disease Control and Prevention (CDC). Go to the Vaccine Safety section of the CDC web site, www.cdc.gov/vaccinesafety. Under "Featured Items," select "Human Papillomavirus (HPV) Vaccine Safety." Under "HPV Vaccine Safety," select "Questions and Answers about HPV Vaccine Safety." There is a printer-friendly version available.]*

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Advocates move to rescind 'conscience' rule

Reproductive health advocates are throwing their support behind the Obama administration's move to rescind a controversial "conscience" rule that would expand the right of

EXECUTIVE SUMMARY

Reproductive health advocates are throwing their support behind the Obama administration's move to rescind a controversial "conscience" rule that would expand the right of health care personnel and institutions to refuse to provide or assist in the provision of services on moral or religious grounds.

- The Bush administration regulation, enacted in December 2008, cuts off federal funding for thousands of state and local governments, hospitals, health plans, clinics, and other entities if they do not accommodate doctors, nurses, pharmacists, or other employees who refuse to participate in care they feel violates their personal, moral, or religious beliefs.
- The Department of Health and Human Services finalized the rule despite receiving more than 200,000 letters in opposition from a number of medical professional associations, state officials, members of Congress, and the general public.

health care personnel and institutions to refuse to provide or assist in the provision of services on moral or religious grounds.

The Bush regulation, enacted in December 2008, cuts off federal funding for thousands of state and local governments, hospitals, health plans, clinics, and other entities if they do not accommodate doctors, nurses, pharmacists, or other employees who refuse to participate in care they feel violates their personal, moral, or religious beliefs.[1] The Department of Health and Human Services (HHS) finalized the rule despite receiving more than 200,000 letters in opposition from several medical professional associations, state officials, members of Congress, and the general public.[2] **(To read more about the proposed rule, see the following *Washington Watch* columns in *Contraceptive Technology Update*: "Proposed rule expands reach of refusal laws," October 2008, p. 117, and "Advocates press agenda for new administration," February 2009, p. 22.)**

Current law already protects physicians and health care providers who refuse to provide abortions and sterilizations based on religious or moral beliefs, notes the American College of Obstetricians and Gynecologists, which joined other health care organizations in asking the Obama administration to rescind the rule. In proposing to rescind the rule in its entirety, the Obama administration is requesting comments from the public and advocacy groups to provide information about several issues, including specific examples to support or refute allegations that the final rule reduces access to information and health care services, particularly by low-income women. *(Editor's note: April 9, 2009, was the cut-off date for public comment on the rule rescission. To enter a comment online, go to the web site, www.regulations.gov and in "Search Documents," enter "HHS_FRDOC_0001." Under "Rescission of the Regulation titled 'Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law,'" click on "Send a Comment or Submission.")*

Reg said to be 'hopelessly flawed'

The regulation is "hopelessly flawed" and should be rejected outright, said **Nancy Northup**, president of the Center for Reproductive Rights. The center has joined such groups as the National Asian Pacific American Women's Forum and the National Latina Institute for Reproductive Health in entering comments about the regulation's impact on low-income women. While the ruling suffers from numerous failings, its most glaring defect is that it does not address the rights and medical needs of patients, said Northrup in a press statement.

"Specifically, the more-than-17 million women across the country who rely most heavily on public health programs are bearing the burden of this rule — a disproportionate number of them low-income and women of color," she said. "As it is, these groups already face tremendous barriers getting health care, including inadequate funding

COMING IN FUTURE MONTHS

- Douching increases STD risk
- FDA OKs first DNA test for two HPV types
- Check alternative therapies for menopause
- Use practical approaches to contraceptive counseling
- Review: Male and female sterilization office procedures

of medical assistance programs, cultural barriers, logistical obstacles such as inflexible work schedules, and insufficient child care."

Legal battle launched

In January 2009, the National Family Planning & Reproductive Health Association (NFPRHA), represented by the American Civil Liberties Union, filed a lawsuit in federal court challenging the conscience rule. The case was filed along with two other legal challenges: one brought by the state of Connecticut, joined by California, Illinois, Massachusetts, New Jersey, New York, Oregon, and Rhode Island; and the other, by Planned Parenthood Federation of America and Planned Parenthood of Connecticut.

States that are involved in the legal battle note why the regulation impedes care. For example, in New York, the rule conflicts with state laws that require hospitals treating rape victims to provide information on all legal options, including emergency contraception. The provider conscience regulations would likely make it impossible for the state to enforce such laws and adequately protect the rights of sexual assault victims, according to a statement from Attorney General Andrew Cuomo's office.[3] Advocates involved in Connecticut's lawsuit say the conscience regulation could undermine the $1.3 billion in Medicaid stimulus money targeted for Connecticut over the next three years.[4]

The regulations limit access to essential health

CNE/CME Instructions

Physicians and nurses participate in this continuing medical education/continuing nursing 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. ■

CNE/CME Questions

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.

17. Which category of contraceptives are classified as Category 4 (not to be used) by the World Health Organization for women who are HIV-positive?
A. Spermicides
B. Combined oral contraceptives
C. Contraceptive injection
D. Intrauterine device

18. What is a commonly cited reason for discontinuation of depot medroxyprogesterone acetate (DMPA)?
A. Weight loss
B. Weight gain
C. Hirsutism
D. Acromegaly

19. What are the most commonly reported adverse events reported to the Vaccine Adverse Events Reporting System for the HPV vaccine Gardasil?
A. Runny nose, nasal congestion or cough
B. Abdominal pain or occasional vomiting or diarrhea
C. Fainting and dizziness
D. Swelling of glands in the cheeks or neck

20. While emergency contraceptive pills work best if taken as soon as possible after unprotected sex, they can be used up to what period of time after unprotected sex to significantly reduce the chances of unintended pregnancy?
A. Two days (48 hours)
B. Three days (72 hours)
C. Four days (96 hours)
D. Five days (120 hours)

Answers: 17. A; 18. B; 19. C; 20. D.

care for millions of low-income women, says **Mary Jane Gallagher**, NFPRHA president and CEO. "Patients deserve — and in this time of economic crisis, sorely need — the ability to access necessary, widely used medical services," she asserts. "NFPRHA plans to continue our lawsuit and fight the proposed rule in every way possible until it is reversed."

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