CONTRACEPTIVE TECHNOLOGY UPDATE®

Interpreting News and Research on Contraceptives and STIs

November 2011: Vol. 32, No. 11
Pages 121-132

IN THIS ISSUE

Financial Disclosure:
Consulting Editor **Robert A. Hatcher**, MD, MPH, Author **Rebecca Bowers**, Executive Editor **Joy Dickinson**, **Anita Brakman** and **Melanie Gold** (Guest Columnists) report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. **Sharon Schnare** (Nurse Reviewer) discloses that she is a retained consultant and a speaker for Barr Laboratories, Berlex, and Organon; she is a consultant for 3M Pharmaceuticals; and she is a speaker for FEI Women's Health, Ortho-McNeil Pharmaceuticals, and Wyeth-Ayerst Pharmaceuticals.

AHC Media

Potential link found between hormonal contraception, HIV risk

WHO to hold technical consultation in early 2012

Results from an analysis presented at the recent 2011 International AIDS Society conference in Rome suggest that using certain methods of hormonal contraception — particularly injectable contraception – might double the risk of HIV acquisition in a previously uninfected woman and also might double the risk that an HIV- infected woman will transmit HIV to a previously uninfected male sexual partner.[1]

The researchers analyzed data from women and men in HIV discordant couples, prospectively following 3,790 heterosexual HIV-1 serodiscordant couples (in which one partner was HIV-1 seropositive and the other seronegative) from Kenya, Uganda, Rwanda, Botswana, Zambia, Tanzania, and South Africa for up to 24 months. The scientists looked at hormonal contraceptive users and nonusers, comparing rates of HIV-1 acquisition in women and HIV-1 transmission from women to men using multivariate Cox proportional hazards regression and marginal structural modeling. The information presented at the Rome conference has not yet been peer-reviewed or published; its findings are available only in slide and oral form.

EXECUTIVE SUMMARY

Results from a new study suggest that using certain methods of hormonal contraception — particularly injectable contraception -- might double the risk of HIV acquisition in a previously uninfected woman and also might double the risk that an HIV- infected woman will transmit HIV to a previously uninfected male sexual partner.

- A technical consultation to review all available data has been scheduled for early 2012 by the World Health Organization.
- No change in contraceptive policy is appropriate or necessary at this time, international reproductive health groups advise. U.S. medical eligibility criteria currently categorize use of combined hormonal methods, progestin-only pills, contraceptive injection, and implant as "1," which means no restrictions on use, in women at high risk for HIV, HIV-infected, or AIDS diagnosed.

Most of the couples for whom data were available were part of a randomized placebo-controlled trial, designed to assess the efficacy of acyclovir in preventing HIV infection associated with herpes simplex infection.[2,3] Other data in the analysis came from a parallel observational study of immune correlates of HIV protection at two of the same study sites. All couples were provided comprehensive HIV-prevention services, including risk-reduction counseling for individuals and couples, free condoms, and treatment for sexually transmitted infections (STIs). Most couples reported using condoms.

Among 1,314 couples in which the HIV-1 seronegative partner was female, HIV-1 acquisition rates were 6.61 and 3.78 per 100 person-years in women using and not using hormonal contraception (adjusted hazard ratio [HR] 1.98, 95% confidence interval [CI] 1.06-3.68, p=0.03). Among 2,476 couples in which the HIV-1 seronegative partner was male, HIV-1 transmission rates from women to men were 2.61 and 1.51 per 100 person-years in those whose partners used versus did not use hormonal contraception (adjusted HR 1.97, 95% CI 1.12-3.45, p=0.02).][1]

The U.S. Agency for International Development (USAID) in Washington, DC, plans to co-fund a technical consultation being organized by the World Health Organization (WHO) for late January in Geneva, Switzerland, says Chelsea Polis, PhD, USAID epidemiological advisor. The consultation is being called to assess whether current WHO recommendations on contraceptive use for women at risk of HIV infection, women with HIV infection or AIDS, or women taking antiretroviral therapy remain consistent with the current body of evidence, given the new research findings, states Mary Lyn Gaffield, MPH, PhD, a scientist at WHO's Department of Reproductive Health.

The consultation will include a multi-disciplinary group of experts who will evaluate the available scientific evidence on the use of hormonal contraceptives and HIV acquisition, progression, and infectivity/transmission. The consultation is designed to review implications for programs, service delivery, and future research, notes Gaffield.

More information needed

Both the USAID and the International Planned Parenthood Federation (IPPF) in London have issued separate statements regarding current practice with hormonal contraception in light of the new data. "USAID does not believe that a change in contraceptive policy or programming is appropriate or necessary at this time," reads an August 2011 field communication.[4] "We do not yet have full information on this analysis or its implications."

In a response to the release of the study information, IPPF says it is consulting with partners in the family planning and HIV/AIDS communities to fully understand the implications of the study's findings and its potential affect on family planning clients and services.[5] "Currently, IPPF considers that this

Contraceptive Technology Update® (ISSN 0274-726X), including STI Quarterly™, is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, NE, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Contraceptive Technology Update®, P.O. Box 105109, Atlanta, GA 30348.

Subscriber Information
Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST. Subscription rates: U.S.A., one year (12 issues), $449. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Back issues, when available, are $75 each.(GST registration number R128870672.)

Editor: **Rebecca Bowers.**
Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey.**

Editorial Questions
Questions or comments? Call Joy Daughtery Dickinson (229) 551-9195.

study should not be used to draw conclusions on hormonal contraceptive use overall and its potential role in increasing users risk of HIV acquisition or transmission," states the IPPF response. "There were not enough women using oral contraceptives (OC) in this study to find statistically significant results on the links between use of OC and HIV."

Women using contraceptive implants or intrauterine devices containing hormonal contraception were not included in this study, the IPPF response notes. "The study's findings can therefore only really highlight important considerations for injectable contraceptives," the IPPF response notes. "Available information we have from the study thus far does not indicate which injectables were used (depot medroxyprogesterone acetate [DMPA] or northisterone enanthate), nor the duration of use — factors which could affect the level of risk."

Stay tuned for more

Safe and effective contraceptive choices are essential for women with and at risk for HIV-1 infection. The new data have highlighted concerns about the safety of hormonal contraceptives in settings with high HIV prevalence and incidence, and they require a thorough review of all data, the context, and alternative options available to women wishing to avoid unwanted pregnancy, says Gaffield.

More than 50 studies have looked at whether use of hormonal contraception is a risk factor for HIV-1 infection. Most were cross-sectional; 15 were prospective studies.[6]

In a 2007 study designed to measure the risk of HIV-1 infection associated with hormonal contraceptive use, neither OCs nor DMPA was associated with HIV-1 acquisition.[7] However, among women who were negative for herpes simplex virus type 2 at study enrollment (48% of the study population), both methods increased risk of HIV-1 acquisition. (To read more about the study, see the Contraceptive Technology Update article "Hormonal contraception use doesn't up HIV risk," March 2007, p. 29.)

What should providers do until more definitive data is available? The IPPF directs clinicians to look to the WHO Medical Eligibility Criteria for Contraceptive Use.[8] "Until conclusive findings are available, the World Health Organization (WHO) guidance is the best available guide for programmatic decisions that affect most women," the IPPF statement reads. "The WHO has addressed this issue in the context of Medical Eligibility Criteria for Contraceptive Use and concluded that hormonal contraception remains a safe option for women at high risk of and living with HIV."

U.S. medical eligibility criteria currently categorize use of combined hormonal methods, progestin-only pills, contraceptive injection, and implant as "1" — no restrictions on use — in women at high risk for HIV, HIV-infected, or AIDS diagnosed. Initiation and continuation of the levonorgestrel intrauterine system and the Copper T380A intrauterine device are categorized as "2" — advantages generally outweigh theoretical or proven risks- for women at high risk for HIV or HIV-infected. Initiation of both types of intrauterine contraception are classified as "3" — theoretical or proven risks usually outweigh the advantages — for women who are diagnosed with AIDS. Continuation of both devices is categorized as a "2" for women with AIDS.[9]

Dual protection against unintended pregnancy and STIs, including HIV, can be achieved by using condoms along with a highly effective method of contraception, advises USAID. Program managers should continue to promote condoms to prevent transmission of STIs, including HIV.[4]

REFERENCES

1. Heffron R, Donnell D, Rees H, et al. Hormonal contraceptive use and risk of HIV-1 transmission: a prospective cohort analysis. Presented at the sixth annual International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention. Rome, Italy; July 2011.
2. Celum C, Wald A, Lingappa JR, et al. Acyclovir and transmission of HIV-1 from persons infected with HIV-1 and HSV-2. NEJM 2010; 362:427-439.
3. Heffron R, Were E, Celum C, et al. A prospective study of contraceptive
use among African women in HIV-1 serodiscordant partnerships. Sex Transm Dis 2010; 37:621-628.
4. Radloff R. USAID communication to the field (Aug. 5, 2011): USAID response to new findings on hormonal contraception and HIV acquisition in uninfected women and HIV transmission from infected women to male partners. Accessed at http://www.usaid.gov/our_work/global_health/pop/techareas/docs/usaid_hc_hiv.pdf.
5. International Planned Parenthood Federation. IPPF's response to "Hormonal contraceptive use increases women's risk of acquiring and transmitting HIV, 2011." Accessed at http://www.ippf.org/en/Resources/Statements/IPPFs+response+to+Hormonal+contraceptive+use+increases+womens+risk+of+acquiring+and+transmitting+HIV.htm.
6. Baeten JM, Lavreys L, Overbaugh J. The influence of hormonal contraceptive use on HIV-1 transmission and disease progression. Clin Infect Dis 2007; 45:360-369.
7. Morrison CS, Richardson BA, Mmiro F, et al. Hormonal contraception and

the risk of HIV acquisition. AIDS 2007; 21:85-95.
8. World Health Organization. Medical eligibility criteria for contraceptive use. Fourth ed. Geneva: WHO; 2009.
9. Centers for Disease Control and Prevention (CDC). U S. medical eligibility criteria for contraceptive use, 2010. MMWR Recomm Rep 2010; 59(RR-4):1-86. ■

More clinicians put US MEC into practice

Are you implementing guidance from the US Medical Eligibility Criteria for Contraceptive Use, 2010, (US MEC) released by the Centers for Disease Control and Prevention (CDC)?[1] The American College of Obstetricians and Gynecologists (ACOG) has just issued a Committee Opinion on the guidelines to help clinicians provide family planning services to women, especially those with medical conditions.[2]

ACOG decided to publish the Committee Opinion to publicize the "extremely useful" evidence-based recommendations originally developed by the World Health Organization, but they were adapted specifically for use in the United States by the CDC, says Eve Espey, MD, MPH, professor in the Department of Obstetrics and Gynecology in the School of Medicine at the University of New Mexico. (To read more about the criteria, see the Contraceptive Technology Update article, "Base your family planning practice on evidence-based medicine in 2010," August 2010, p. 85.)

"The 4-[category] rating US MEC recommendations are in a format that is easy for clinicians to understand and use as a reference for the many contraceptive scenarios they face on a daily basis," explains Espey, chair of ACOG's Long-Acting Reversible Contraception Work Group and a co-developer of the bulletin.

The CDC MEC guidelines provide a sound, evidence-based document that when used on a national basis, will provide consistently high-level contraceptive care, says Sharon Schnare, FAANP, clinical instructor in the Department of Family and Child Nursing at the University of Washington School of Nursing in Seattle.

Put it into practice

The US MEC contains combinations of medical conditions and contraceptive methods that are rated on a scale of 1 to 4 in terms of safety. Category 1 indicates there are no restrictions for use of the method, while category 4 indicates the method could present an unacceptable health risk for the patient. (See box item on p. 125 for an explanation of the four categories.)

More than 65 medical conditions and characteristics, from women's cancers and chronic diseases to breastfeeding and smoking, with additional sub-conditions, are covered in the US MEC. Consider women who smoke: Use of combined oral contraceptives (OCs) in a woman age 35 or older who smokes 15 or more cigarettes per day is considered a Category 4 due to the risk of myocardial infarction and stroke. Use of combined pills in a woman who is the same age, but smokes fewer than 15 cigarettes per day, is classified as Category 3 and generally is not recommended unless other methods are unavailable or unacceptable to her. Use of combined OCs is classified as Category 2 for smokers younger than 35.[2]

Women with certain medical conditions are at higher risk for adverse outcomes with an unintended pregnancy, and these recommendations can assist clinicians in helping patients choose the most appropriate contraceptive method, notes Espey. These conditions include endometrial cancer, epilepsy, history of bariatric surgery, ovarian cancer, peripartum cardiomyopathy, solid organ transplantation, stroke, systemic lupus erythematosus, thrombogenic mutations, and tuberculosis. They are marked with an asterisk in the Committee Opinion.

Check chronic conditions

Most patients can choose from an array of available contraceptive methods without substantial concerns about the safety of the method. However, for women with chronic medical conditions, questions

EXECUTIVE SUMMARY

The American College of Obstetricians and Gynecologists has issued a Committee Opinion on the *US Medical Eligibility Criteria for Contraceptive Use, 2010* (US MEC) to help clinicians provide family planning services to women, especially those with medical conditions.

- The 4-category rating US MEC recommendations are presented in a format that is easy for clinicians to understand and use as a daily reference.
- While the guidance is an important element that needs to be considered by the provider and the patient when choosing the most appropriate method, other elements such as effectiveness, availability, and acceptability should be included in the decision-making process.

US Medical Eligibility Criteria for Contraceptive Use

- Category 1: A condition for which there is no restriction for the use of the contraceptive method.
- Category 2: A condition for which the advantages of using the method generally outweigh the theoretical or proven risks.
- Category 3: A condition for which the theoretical or proven risks usually outweigh the advantages of using the method.
- Category 4: A condition that represents an unacceptable health risk if the contraceptive method is used.

Source: Centers for Disease Control and Prevention. U S. medical eligibility criteria for contraceptive use, 2010. *MMWR Recomm Rep* 2010; 59(RR-4):1-86.

can arise regarding contraceptive safety, notes Emily Godfrey, MD, MPH, assistant professor of family medicine at the University of Illinois at Chicago College of Medicine.

For example, the use of combined hormonal contraceptives by women with known thrombogenic mutations has been shown to carry unacceptable risks of venous thromboembolism, observes Godfrey, who presented information on the US MEC at the recent Reproductive Health 2011 conference.[3]

The US MEC contains recommendations for the safe use of contraceptive methods by women and men with various characteristics and medical conditions and is intended to assist healthcare providers when counseling patients about contraceptive method choice, explains Godfrey. In collaboration with the World Health Organization, the CDC regularly identifies new relevant, scientific evidence as it is published and updates the guidance as needed. (The US MEC was just updated regarding postpartum contraception; see the CTU article, "Contraception guidance for postpartum period," September 2011, p. 101.)

While it is intended that the US MEC will become the primary reference for clinicians to assist patients with making safe contraceptive choices, the guidance is just one element that needs to be considered by the provider and the patient when choosing the most appropriate method, Godfrey notes. Other important elements providers should consider are effectiveness, availability, and acceptability.

"Hopefully, clinicians who follow the US MEC guidance when treating patients with chronic medical conditions will better counsel patients regarding safe contraceptive choices, including restricting use when there is evidence of risk, but also facilitating use where there is evidence of safety," states Godfrey.

REFERENCES

1. Centers for Disease Control and Prevention (CDC). U S. medical eligibility criteria for contraceptive use, 2010. MMWR Recomm Rep 2010; 59(RR-4):1-86.
2. Committee opinion no. 505: understanding and using the U.S. medical eligibility criteria for contraceptive use, 2010. Obstet Gynecol 2011; 118:754-760.
3. Godfrey E. Overview of CDC MEC guidelines. Presented at the 48th annual meeting of the Association of Reproductive Health Professionals. Las Vegas; September 2011. ■

EPT gets support from ACOG

If you haven't included expedited partner therapy (EPT) in your practice of treating patients with gonorrhea and chlamydia, more support for the measure has arrived in the form of a new committee opinion from the American College of Obstetricians and Gynecologists.[1] The national organization is calling for providers to prescribe antibiotics for the male partners of their female patients diagnosed with chlamydia or gonorrhea to reduce high reinfection rate, as well as to push for legalization of expedited partner therapy in those states and jurisdictions where it is illegal or where the legal status of EPT is unclear or ambiguous.[1]

Chlamydia and gonorrhea are the top two most commonly reported sexually transmitted infections (STIs) in the United States. Girls ages 15-19 and young women ages 20-24 are especially impacted: The largest number of reported cases in 2009 of both STIs was among females in these two age groups.[2]

Evidence indicates that EPT can decrease reinfection rates compared to standard partner referrals for examination and treatment, said Diane Merritt, MD, chair of ACOG's Committee on Adolescent Health Care in a press release accompanying the publication. "Of course, it's preferable that a physician examine a patient in-person before prescribing medication, but the benefits of EPT among individuals whose partners are otherwise unlikely to seek care in preventing chlamydia and gonorrhea reinfections outweigh the risks to the partners," noted Merritt.

Available evidence indicates that EPT is at least equally effective to standard partner management for gonorrhea and chlamydia, notes Gail Bolan,

MD, director of the Division of Sexually Transmitted Disease Prevention at the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention in the Centers for Disease Control and Prevention (CDC). Evidence also indicates that traditional partner management by public health agencies and healthcare providers for these sexually transmitted infections (STIs) often is not feasible and that the benefits of EPT outweigh the risks, states Bolan. "We are pleased to hear that ACOG joins the list of professional organizations that now endorse EPT," Bolan comments. "These endorsements are important elements in establishing a standard of care for EPT."

Get on board

According to the CDC's most recent analysis, EPT might be legally permissible in 30 states, states Bolan. However, it is not widely practiced among many practitioners due to numerous barriers, including policies that don't allow for reimbursement for the cost of partner treatment, she notes.

"We hope that the ACOG opinion will encourage more practitioners to practice EPT to prevent reinfection of STIs and work with stakeholders to remove barriers to its implementation," says Bolan.

The CDC has developed a toolkit to help policymakers and practitioners address barriers related to EPT implementation, notes Bolan. The information can be found at www.cdc.gov/std/ept. (Contraceptive Technology Update reported on the toolkit in the article "STD treatment: time to get on board with expedited partner therapy," April 2011, p. 37.)

Chlamydia and gonorrhea are infections that might not cause symptoms, or if they do, their presentation — vaginal or penile discharge, abnormal vaginal bleeding, cramping — might not set off warning bells in those who are infected. "Many people who have an STI are not aware of it and pass it to their partners," said Merritt. "Undiagnosed and untreated STIs can cause scarring and damage a woman's ability to become pregnant when she's ready to have a baby.

Chlamydia and gonorrhea can be quickly diagnosed with a simple urine test and treated with a short course of antibiotics, notes ACOG.

More data coming

Researchers in Washington state are doing a final analysis of data in a community-level trial of EPT. The goal of the study is to determine if an EPT program can decrease the prevalence of chlamydia and/or the incidence of gonorrhea in the state's women.

Case report-based triage appears to be working, which confirms earlier experience in King County[3], reported Matthew Golden, MD, MPH, professor in the Department of Medicine and adjunct professor of epidemiology at the University of Washington, at the 2011 International Society for Sexually Transmitted Diseases Research in Quebec City, Canada.[4] The program appears to have increased patient-delivered partner therapy use by providers and partner treatment, though not in all areas. Effect on prevalence of infection are yet to be defined, he stated.[4]

REFERENCES

1. Committee opinion no. 506: expedited partner therapy in the management of gonorrhea and chlamydia by obstetrician-gynecologists. Obstet Gynecol 2011; 118:761-766.
2. Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2009. Atlanta: Department of Health and Human Services; 2010.
3. Golden MR, Hughes JP, Brewer DD, et al. Evaluation of a population-based program of expedited partner therapy for gonorrhea and chlamydial infection. Sex Transm Dis 2007; 34:598-603.
4. Golden MR. Expedited partner therapy. Presented at the International Society for STD Research. Quebec City, Canada; 2011. ■

HPV vaccine rates trail teen vaccines

Results from a new survey by the Centers for Disease Control and Prevention (CDC) show that teen vaccination rates for human papillomavirus (HPV) remain low in comparison with other vaccines administered to young adults.[1] The Advisory Committee on Immunization Practices recommends that teens routinely receive three vaccines: meningococcal conjugate (MenACWY, 2 doses); tetanus, diphtheria, acellular pertussis (Tdap, 1 dose); and the three-dose HPV vaccine. To conduct the current survey, more than 19,000 parents of teenagers ages 13-17 were contacted by telephone regarding vaccination rates. The calls were followed by verification of records with healthcare providers.

While vaccination coverage increased for all three vaccines from 2009 to 2010, rates for HPV vaccination lagged behind, statistics indicate. Tdap coverage increased from 55.6% to 68.7%, while MenACWY rates climbed from 53.6% to 62.7%. When it came to the HPV vaccine, though, girls who had received one dose of the three-shot series increased 4.4 percentage points to 49%. Just 32% of girls received the

entire series, reflecting a 5 percentage point increase over the previous year.[1]

The HPV results are very concerning, noted Anne Schuchat, MD, director of the CDC's National Center for Immunization and Respiratory Diseases in a press release accompanying the survey results publication. "Our progress is stagnating, and if we don't make major changes, far too many girls in this generation will remain vulnerable to cervical cancer later in life," stated Schuchat.

Two vaccines are available to prevent the HPV types that cause most cervical cancers: Cervarix, manufactured by GlaxoSmithKline, and Gardasil, manufactured by Merck. As of July 2011, the CDC reported the retail price of the vaccine at about $130 per dose, or $390 for full series.

The HPV vaccine is covered under the Vaccines for Children (VFC) program, which helps families of eligible children who might not otherwise have access to coverage. The program provides vaccines at no cost to providers who serve eligible children. The VFC program covers those who are younger than age 19 if they are Medicaid-eligible, American Indian, Alaska Native, or have no health insurance. Those youth who have health insurance that does not cover vaccination can receive VFC vaccines through federally qualified health centers or rural health centers.

HPV vaccination is recommended with either vaccine for 11- and 12 year-old girls; it also is recommended for girls and women ages 13-26 who have not yet been vaccinated or completed the vaccine series. For males, the Advisory Committee on Immunization Practice's guidance is that the three-dose series of quadrivalent HPV vaccine might be given to males ages 9-26 to reduce their likelihood of acquiring genital warts. (See the box, p. 128, for information to provide to parents & young adults about the vaccines.)

The CDC is urging healthcare providers to make strong recommendations for HPV vaccinations and vaccinate every eligible patient on time. "Stronger provider recommendations for HPV vaccination, implementing reminder-recall systems, eliminating missed opportunities, and educating parents of adolescents regarding the risk for HPV infection and the benefits of vaccination, are needed to effectively protect adolescent girls against cervical cancer," the new analysis states.[1] (To help providers get across the vaccination message, the CDC has developed several free provider resources. Visit the Vaccines and Immunizations portal at the CDC web site, www.cdc.gov/vaccines. Under "For Specific Groups," select "Preteens and Teens" then "Health Care Professionals." At the bottom of the page, under "Related Pages," select the links under "Adolescent Campaign Materials" to download free resources, such as a fact sheet on HPV vaccinations. Also, text messaging might help patients complete three doses; see the Contraceptive Technology Update article, "HPV vaccines on time via text messaging," August 2011, p. 94.)

HEDIS measure may help

More impetus to follow through with HPV vaccination might come in the form of a new measure added to the 2012 edition of the Healthcare Effectiveness Data and Information Set (HEDIS) by the National Committee for Quality Assurance (NCQA). HEDIS is the most widely used performance measurement tool in healthcare; it is used by more than 90% of U.S. health plans.

NCQA's human papillomavirus vaccine measure aligns with guideline recommendations released by the CDC's Advisory Committee on Immunization Practices, says Andy Reynolds, NCQA spokesperson. The HPV measure will assess whether female adolescents complete the three-dose vaccination series by age 13, Reynolds states.

The new measure went through NCQA's review and approval processes, going through field tests, a public comment session, and feedback from experts and stakeholders, says Reynolds. The HPV measure was added as a first-year measure for the HEDIS 2012 measure set, he states.

How might the new measure impact HPV vaccination rates? Melinda Wharton, MD, MPH, deputy director of the National Center for Immunization and Respiratory Disease at the CDC, says, "We hope that the new HEDIS measure will help improve coverage in this age group."

As is the case with texting while driving, buckling one's seat belt prior to ignition, and drinking and driving, accepting and acting upon the most important public health initiatives fall upon the shoulders of an individual, says Robert Hatcher, MD, MPH, professor of gynecology and obstetrics at Emory University School of Medicine in Atlanta. "It is the obligation of the medical community and health educators to inform women and men about the vaccine for human papillomavirus and its protective effects against cervical and other reproductive health cancers," says Hatcher.

The effectiveness of Gardasil, the initial HPV vaccine, has been well-documented, notes Hatcher. In clinical trials, among persons not previously exposed to a targeted HPV type, data indicate nearly 100% vaccine efficacy in preventing cervical precancers,

What to Tell Parents,Teens about HPV Shot

• Vaccination with either brand of HPV vaccine (Gardasil or Cervarix) is routinely recommended for girls ages 11-12. It is also recommended for girls and women ages 13-26 who have not yet been vaccinated or completed the vaccine series.

• Gardasil, is also licensed, safe, and effective for males ages 9-26. Boys and young men may choose to get this vaccine to prevent genital warts.

• If a pre-teen was not vaccinated against HPV at ages 11 or 12, the vaccines can be given later in the teen years. However, studies show that 11 through 12 years is the ideal age to get maximum protection from HPV vaccines.

• Pre-teens should get vaccinated before their first sexual contact (i.e., when they could be exposed to HPV). This is because the vaccine prevents disease in people who have not previously gotten one or more HPV types. It does not work as well for those who were exposed to the virus before getting the vaccine.

Source: Centers for Disease Control and Prevention, *Questions & Answers for Parents of Pre-Teens and Teens about Human Papillomavirus (HPV) and the HPV Vaccine*; accessed at http://www.cdc.gov/vaccines/who/teens/products/downloads/print-materials/f-qahpv-parents-color.pdf.

vulvar and vaginal precancers, and genital warts in women caused by the four HPV types (16, 18, 6 and 11), as well as 90% vaccine efficacy in preventing genital warts and 75% vaccine efficacy in preventing anal precancers in men.[2]

REFERENCES

1. Centers for Disease Control and Prevention (CDC). National and state vaccination coverage among adolescents aged 13 through 17 years — United States, 2010. MMWR 2011; 60:1,117-1,123.
2. Centers for Disease Control. HPV Vaccine Information for Clinicians. Fact sheet. Accessed at http://www.cdc.gov/std/hpv/STDFact-HPV-vaccine-hcp.htm. ■

What will it take to boost vasectomy use?

While vasectomy is a safe, simple, effective form of contraception, female sterilization is the preferred method of sterilization among couples in the United States. About 17% of women between ages 15-44 have had tubal sterilizations, while only 6% rely on male sterilization for birth control.[1]

What will it take to reverse that trend?

Underutilization of vasectomy is multifactorial, according to a new overview of U.S. vasectomy use and techniques.[2] There are patient, provider, and system level factors that contribute to its underuse, says Grace Shih, MD, MAS, assistant clinical professor in the Department of Family & Community Medicine in the School of Medicine at the University of California, San Francisco (UCSF). Shih, a co-author of the review and accompanying editorial,[3] is conducting a qualitative study of vasectomy use to explore patient level factors by race/ethnicity.

"Our preliminary analysis shows that there is a wide range of misconceptions about vasectomy," says Shih. "In addition, ideas of contraceptive responsibility, manhood, and regret/permanence are common themes."

Shih also is conducting a survey of California Family PACT (Planning, Access, Care, Treatment) clinics to check provider level factors. Results are pending on both studies, she notes.

What's the holdup?

Racial disparities still exist in male sterilization, according to the overview article. In particular, black and Latino men are less likely to rely on vasectomy for contraception than white men.[4]

While combined female and male sterilization rates are about 23-24% in all racial/ethnic groups, significant differences in distribution of the two types of sterilization exist across racial/ethnic groups. This disparity is most evident in non-Latino black populations, notes the overview. While 22% of women rely on female sterilization, just 1% rely on male sterilization. In Latino populations, 20% use female sterilization, while 3% use male sterilization.[2]

What steps can you take in your practice to increase access to vasectomy?

Increasing men's awareness, acceptance, and selection of the procedure is one key, states the editorial.[4]

Providers need to dispel common myths surrounding vasectomy, such as "vasectomy is like castration," "a man cannot have sex or an ejaculation after vasectomy," and "vasectomy makes men weak and less productive."[5]

Explain to men that a vasectomy will not change sexual function and experience. There will be no change in interest in sex, no difference in ability to reach orgasm, no problems with erection, and no change in sexual pleasure.[5]

Remind men that vasectomy is safe and effective; in fact, it is one of the safest and most effective family methods, according to Contraceptive Technology.[6] The first-year failure rate in the United States is estimated at 0.15%, with a range of 0% to 0.5%; failure rates are believed to be similar to those for female sterilization and lower than those for reversible methods.[6] (The Association of Reproductive Health Professionals offers a free vasectomy patient handout. Go to its web site, www.arhp.org. Select "Publications and Resources," "Patient Resources," then under "Fact Sheets," select "Vasectomy." It is available in English and Spanish.)

The current editorial call for increasing the number of providers trained in the no-scalpel vasectomy technique, An integral step to increasing vasectomy use is increasing the number of providers trained in the simple no-scalpel vasectomy (NSV) procedure. (Review information on NSV; see the Contraceptive Technology Update article, "Add no-needle to no-scalpel vasectomy," July 2007, p. 79.)

Make it more visible

How does Shih promote vasectomy in her practice?

"Our primary method at UCSF has been to increase visibility of our vasectomy services to the community and to clinicians," she explains. "We have included our referral protocol in Department of Public Health bulletins/newsletters and collaborate with the Obstetrics and Gynecology Department to make sure our services are known.

Shih says plans are under way to present educational talks on vasectomy to familiarize providers with the no-scalpel procedure. UCSF clinicians and residents are encouraged to discuss vasectomy as an option for any couple desiring permanent sterility.

In California, Family PACT covers vasectomy services, so insurance coverage is less of an issue, notes Shih.

REFERENCES

1. Mosher WD, Jones J. Use of contraception in the United States: 1982-2008. Vital Health Stat 2010; 23:23.
2. Shih G, Turok DK, Parker WJ. Vasectomy: the other (better) form of sterilization. Contraception 2011; 83:310-315.
3. Turok DK, Shih G, Parker WJ. Reversing the United States sterilization paradox by increasing vasectomy utilization. Contraception 2011; 83:289-290.
4. Eisenberg ML, Henderson JT, Amory JK, et al. Racial differences in vasectomy utilization in the United States: data from the National Survey of Family Growth. Urology 2009; 74:1,010-1,014.
5. Shih S. Turok D, Parker W. Vasectomy: the "other" form of sterilization. Presented at the 2010 Reproductive Health Conference. Atlanta; September 2010.
6. Pollack AE, Thomas LJ, Barone MA. Female and male sterilization. In: Hatcher RA, Trussell J, Nelson AL, et al. Contraceptive Technology: 19th revised edition. New York: Ardent Media; 2007. ■

Medicaid targeted by budget hawks

By Adam Sonfield
Senior Public Policy Associate
Guttmacher Institute
Washington, DC

At the federal and state levels, cutting government spending has led the political agenda in 2011, and conservative policymakers have specifically targeted Medicaid.[1]

Proposals in Congress, including a FY 2012 budget backed by House Republicans, would convert Medicaid from an open-ended entitlement program (meaning that the program's budget adjusts automatically with economic circumstances to meet fluctuating levels of demand) into a capped block grant to the states.[2] The Republican Governors Association has called for "increased flexibility" to restructure Medicaid and control costs, with a block grant cited as one option to that end.[3]

The potential contraction of Medicaid is a particular concern because the program today is the most important source of public funding for a broad range of reproductive health services (with the notable exception of abortion). It provides comprehensive coverage of family planning services and supplies, pregnancy-related care, testing and treatment for sexually trans-

mitted infections, and other reproductive health care for more than nine million women aged 15–44, including 40% of those women with incomes below the poverty level.[4] Its role in providing reproductive health services is enhanced by three types of expansion programs that provide coverage for pregnancy care, family planning services, and breast and cervical cancer treatment to people who do not otherwise qualify for Medicaid. The result is that, in 2006, Medicaid paid for 48% of all U.S. births (including 64% of births resulting from unintended pregnancy) and accounted for 71% of all public spending on family planning.[5,6]

This crucial role is slated to expand further under the Patient Protection and Affordable Care Act (ACA) of 2010. Starting in January 2014, all states must extend Medicaid eligibility to citizens and long-time legal residents with incomes up to 133% of poverty. In most states, this change will cause a considerable expansion of the program, particularly for childless adults. By 2019, experts project that Medicaid will serve 16 million people who would otherwise be uninsured.[7] Women and men newly eligible for Medicaid will not necessarily receive the full package of benefits provided traditionally under Medicaid, but provisions in the ACA, including a mandatory package of essential health benefits, should ensure strong coverage for reproductive health services. The ACA is also expected to end up encouraging millions of Americans already eligible for Medicaid to sign up for coverage, in part because it will eliminate long-standing bureaucratic obstacles to enrollment.[8]

Proposals by state governors and congressional Republicans to convert Medicaid into a block grant or otherwise scale back the program would, of course, move the U.S. healthcare system in an entirely different direction.

A block grant is attractive for many policymakers because it would provide greater predictability in costs and -- for state policymakers and advocates of a smaller federal government -- because it would shift power from the federal government to the states. It would only be effective as a cost-cutting, measure, however, if the grant amounts are structured to increase at a slower pace than is expected in the program's current form. This change is exactly what conservative policymakers are proposing. The House Republican plan, for example, projects 49% less federal funding in 2030 than would be the case under current law,(REFERENCE 2) which is a reduction likely to force considerable rollbacks in access to care, potentially including reproductive healthcare.

For its part, the Obama administration's approach toward Medicaid during the budget debates has been mixed. On the one hand, it has publicly emphasized the flexibility states already have under current law to reshape their Medicaid programs, and administration officials reportedly proposed substantial cuts to Medicaid during deficit reduction negotiations earlier this year.

On the other hand, the administration has stoutly defended the ACA and its expansion of Medicaid by citing projections that the law will reduce costs for the states and the federal government.(REFERENCES 2,8) In the end, Medicaid was given special protections under the deficit reduction agreement reached in early August. It was not touched in the initial $900 billion set of budget cuts, and it was exempted from $1.2 billion in broad-based cuts that will be triggered if a second round of congressional negotiations fails in November. These exemptions could be little more than a temporary reprieve, however. It is widely expected that Medicaid and the ACA more broadly will remain a continued object of contention in the years ahead and a prime target during future budget negotiations.

REFERENCES

1. Sonfield A. Political tug-of-war over Medicaid could have major implications for reproductive health care, Guttmacher Policy Review 2011; 14(3):11-16, 23.
2. Elmendorf DW. Long-Term Analysis of a Budget Proposal by Chairman Ryan, Washington, DC: Congressional Budget Office, 2011. Accessed at http://www.cbo.gov/ftpdocs/121xx/doc12128/04–05-Ryan_Letter.pdf.
3. Republican Governors Association. GOP govs unveil Medicaid reform principles, 2011. Accessed at http://www.rga.org/homepage/gop-govs-unveil-medicaid-reform-principles.
4. Guttmacher Institute. Special tabulations of the 2010 U.S. Census Bureau Current Population Survey. Unpublished.
5. Sonfield A, Kost K, Gold RB, et al. The public costs of births resulting from unintended pregnancies: national and state-level estimates. Perspect Sex Reprod Health 2011; 43:94-102.
6. Sonfield A, Alrich C, Gold RB. Public funding for family planning, sterilization and abortion services, FY 1980-2006; Occasional Report, New York: Guttmacher Institute, 2008, No. 38.
7. Elmendorf DW. CBO's Analysis of the Major Health Care Legislation Enacted in March 2010. Washington, DC: Congressional Budget Office, 2011. Accessed at http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf.
8. Bovbjerg RR, Ormond BA, Chen V. State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2011. Accessed at http://www.kff.org/healthreform/upload/8149.pdf. ■

CNE/CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

COMING IN FUTURE MONTHS

■ Address family planning needs of women on teratogenic meds

■ Take steps to manage chronic pelvic pain

■ What's new with combined oral contraceptives?

■ What's the impact of the ACA on reproductive health?

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;
- provide practical information that is evidence-based to help clinicians deliver contraceptives sensitively and effectively.

1. According to the *US Medical Eligibility Criteria for Contraceptive Use, 2010*, use of combined oral contraceptives in a woman age 35 or older who smokes 15 or more cigarettes per day is considered what category?
   A. Category 1
   B. Category 2
   C. Category 3
   D. Category 4

2. What are the top two most commonly reported sexually transmitted infections in the United States?
   A. Chlamydia and gonorrhea
   B. Chlamydia and syphilis
   C. Gonorrhea and syphilis
   D. Chlamydia and genital herpes

3. What Healthcare Effectiveness Data and Information Set (HEDIS) measure is set to take place in 2012?
   A. A measure to assess whether female adolescents complete the three-dose vaccination series for human papillomavirus by age 12.
   B. A measure to assess whether female adolescents complete the three-dose vaccination series for human papillomavirus by age 13.
   C. A measure to assess whether female adolescents complete the three-dose vaccination series for human papillomavirus by age 14.
   D. A measure to assess whether female adolescents complete the three-dose vaccination series for human papillomavirus by age 16.

4. According to *Contraceptive Technology* (Ardent Media, 2007), what is the first-year failure rate for vasectomy in the United States?
   A. 0.15%, with a range of 0% to 0.5%
   B. 0.2%
   C. 0.8%
   D. 3%

United States Postal Service

Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication Number	3. Filing Date
Contraceptive Technology Update	0 2 7 4 - 7 2 6 X	10/1/11
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$449.00

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305
Contact Person: Robin Salet
Telephone: 404-262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*

Publisher *(Name and complete mailing address)*
James Still, President and CEO
AHC Media LLC, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and complete mailing address)*
Joy Dickinson, same as above

Managing Editor *(Name and complete mailing address)*
Felicia Willis, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
Ableco, LLC	299 Park Avenue, New York, NY 11201
GSC, LLC	500 Campus Drive, Florham Park, NJ 07932
Natixis	9 West 57th Street, 35th Floor, New York, NY 10019
NewStar Financial, Inc.	500 Boylston Street, Suite 1250, Boston, MA 02116
Fortress	1345 Avenue of the Americas, 46th Floor, New York, NY 10105
PNC	1600 Market Street, Philadelphia, PA 19103

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thompson Publishing Group Inc.	805 15th Street, NW, 3rd Floor, Washington, D.C. 20005

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☑ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, October 1999 *(See Instructions on Reverse)*

13. Publication Title: Contraceptive Technology Update	14. Issue Date for Circulation Data Below: September 2011	
15. Extent and Nature of Circulation	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies *(Net press run)*	891	902
b. Paid and/or Requested Circulation (1) Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	473	487
(2) Paid In-County Subscriptions Stated on Form 3541 *(Include advertiser's proof and exchange copies)*	0	0
(3) Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	257	270
(4) Other Classes Mailed Through the USPS	44	12
c. Total Paid and/or Requested Circulation *(Sum of 15b. (1), (2),(3),and (4))*	774	769
d. Free Distribution by Mail *(Samples, complimentary, and other free)* (1) Outside-County as Stated on Form 3541	27	26
(2) In-County as Stated on Form 3541	0	0
(3) Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or other means)*	20	20
f. Total Free Distribution *(Sum of 15d. and 15e.)*	47	46
g. Total Distribution *(Sum of 15c. and 15f)*	821	815
h. Copies not Distributed	70	87
i. Total *(Sum of 15g. and h.)*	891	902
j. Percent Paid and/or Requested Circulation *(15c. divided by 15g. times 100)*	94%	94%

16. Publication of Statement of Ownership
☑ Publication required. Will be printed in the November 2011 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner — Date: 09/12/11

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).

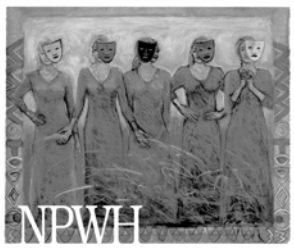
Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or, if the publication is not published during October, the first issue printed after October.
6. In item 16, indicate the date of the issue in which this Statement of Ownership will be published.
7. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of Periodicals authorization.

PS Form **3526**, October 1999 *(Reverse)*

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 healthcare professionals.



Association of Reproductive Health Professionals