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Interpreting News and Research on Contraceptives and STIs

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What are `must-have' services for your adolescent males?

Increased emphasis to come in Title X guidance update

Does your facility provide reproductive health care for adolescent males? If so, add two newly published reports to your knowledge base to provide optimum care for teen boys.[1,2] The two reports highlight the need for greater recognition of the sexual and reproductive healthcare needs of teen boys and enumerate which services should be provided at least once a year to this often-overlooked population segment.

One problem is that there are no established national guidelines on what services are required for adolescent male care, says **Arik Marcell**, MD, MPH, director of adolescent services and the Title X program at the Harriet Lane Clinic in Baltimore and assistant professor in the Department of Pediatrics and Department of Population, Family & Reproductive Health, Division of General Pediatrics and Adolescent Medicine at Johns Hopkins University. Marcell served as lead author on both reports.

The first report, published in the December 2011 issue of *Pediatrics*, offers a list of clinical practice recommendations to help fill that gap, notes Marcell. The second report, based on interviews with 17 primary-care clinicians who specialize in male teen health, identifies what providers deem core sexual and reproductive services every male teen should receive during annual physical exams.

Get ready for further information to emerge when the Department of Health

EXECUTIVE SUMMARY

Two new reports highlight the need for greater recognition of the sexual and reproductive healthcare needs of adolescent males. The reports spell out which services should be provided at least on an annual basis.

- Look for expanded information on provision of male reproductive health services in new Title X guidelines, scheduled to be released in late 2012.
- Core services for teen boys should include a physical exam that includes a genital exam; screening and counseling for sexually transmitted infections; screening for substance abuse and mental health; screening for physical/sexual abuse; and discussion of the male role in pregnancy prevention, including condom use and abstinence.

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& Human Services' Office of Population Affairs issues revised Title X guidelines in 2012, says Marcell. The new guidance will include expanded information on provision of male reproductive health services, says Marcell, who is participating in development of the clinical information. *(To read more on the updated Title X guidance, see the* Contraceptive Technology Update *article, "Hot topic: Medicine that is evidence-based," January 2012, p. 4.)*

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Editorial Questions
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What are top services?

Which services should be performed during every adolescent male annual exam? According to primary care clinicians who specialize in adolescent male health, "go-to" services include:

- a physical exam that includes a genital exam to assess pubertal growth and screen for inherited disorders of sexual differentiation, such as Klinefelter syndrome and fragile X syndrome, as well as for non-sexually transmitted infections that can affect sexual function and reproduction;
- screening and counseling for sexually transmitted infections that include the offer of HIV testing to those age 13 and older;
- screening for substance abuse and mental health;
- screening for physical/sexual abuse;
- discussion of the male role in pregnancy prevention, including condom use and abstinence.[2]

Other suggested core services include making hepatitis A, B, and HPV vaccinations part of the annual exam and urging parents to engage their sons in age-appropriate discussions of sexuality and health.[1]

Counseling is a big part of providing optimum care for adolescent males, but it often goes lacking, Marcell notes. Research indicates that primary care providers are three times more likely to take sexual health histories from female than male patients, and they are twice as likely to counsel female patients on the use of condoms.[3,4]

Clinicians also need to strategize on reaching young men outside of routine visits to deliver more of the necessary services, says Marcell. Such clinical "hooks" as sports physicals and acne follow-up visits can help keep young men enrolled in general and sexual/reproductive health care. Facilities should consider promoting an annual sexual/reproductive health visit for male adolescents to address core sexual/reproductive health issues.[1]

Get men in the picture

Researchers involved in developing the two new reports say they hope their findings will be a catalyst for policymakers and adolescent health experts to draft and issue national guidelines and recommendations. Medical school and residency training programs curricula on teen males' sexual and reproductive health should be expanded to better prepare the next generation of providers to care for adolescent males.

"Our study indicates that clinicians who specialize in male teen health agree on the services they deem

essential for their patients," Marcell says. "What we need now is a set of uniform guidelines to help all pediatricians do the same."

Developing evidence-based guidance for male services is challenging, given that most research in the field ranks as "I" (insufficient), meaning the risk versus benefit balance cannot be assessed, observes Marcell. Most research on reproductive health care and delivery to date has focused on women and clinical services surrounding women's care, he observes.

This focus has extended to clinical practice as well, notes **Warren Seigel**, MD, MBA, FAAP, FSAHM, chairman of the Department of Pediatrics and director of adolescent medicine at Coney Island Hospital in Brooklyn, NY. Seigel served as a co-author of the report in Pediatrics.

"I believe that we as pediatricians and adolescent medicine providers have historically focused more on the females within our practices and have given little attention to the healthcare needs of males," says Seigel. "Issues like teen pregnancy have caused us to look toward ways to reduce the pregnancy rates in our young adolescent women, but we have unfortunately done this at the exclusion of our young adolescent men."

Federal and state funds often go toward adolescent females as well, adds Seigel. The result?

"We have neglected this important segment of our adolescent population," Seigel comments.

Make it "male-friendly"

What are some practical tips to help males who seek services in a family planning setting? Remember that men coming to a family planning clinic are coming into unknown territory; help them get and stay as comfortable as possible, said **Wayne Pawlowski**, ACSW, LICSW, CSE, a consultant, trainer, and clinical social worker based in Fort Lauderdale, FL, and Washington, DC. Pawlowski participated in an April 2011 male services webinar program, sponsored by the Philadelphia-based Male Training Center for Family Planning and Reproductive Health in collaboration with the Region VIII Family Planning Training Center, JSI Research and Training Institute, and the Colorado Department of Public Health and Environment, all in Denver. *(To review the webinar, visit the Male Training Center for Family Planning and Reproductive Health site, www.fpcmtc.org. Select "Resources," and then under "Media Room," select "here." Across from the title "Improving Communication between Family Planning Staff and Male Clients," select "View Webinar.")*

Clinicians can explain the clinical process and everything that is going to happen; this explanation can help to relieve the stress and anxiety of "not knowing," said Pawlowski.

"When guys are sharing personal/sexual/embarrassing information, it can feel DISempowering to do so," he says. "It can feel like they are handing power over to the receiver. Power and control are big issues in male culture, so handing power over is a huge deal; it is not experienced as simply communicating information."

Don't start by asking a male patient if he has any questions, advised Pawlowski. Start the conversation with wording such as "Most men have questions about XYZ, so if you would like, I can explain that to you." Or you can say, "Can I share with you some things that have worked for guys I have worked with in the past?" Clinicians also may choose a more direct approach, Pawlowski suggested. Such wording could include, "Most men have questions about this, so to be sure I am doing my job, I am going to explain it all to you, even though I know I am likely to go over things you already know."[5]

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Reproductive health: Where does it stand?

Reproductive health is in for a bumpy ride in 2012, if new 2011 legislative actions are any indicator, according to a new Guttmacher Institute analysis.[1] Case in point: 68% of 2011 state legislative provisions (92 in 24 states) restrict access to abortion services, and three states (Montana, New Hampshire, and Texas) imposed stringent budget cuts for family planning.

EXECUTIVE SUMMARY

Reproductive health is in for a bumpy ride in 2012, based on new 2011 state actions. According to a new Guttmacher Institute analysis, 68% of 2011 state legislative provisions (92 in 24 states) restrict access to abortion services.

- Family planning funding escaped major reductions in nine of the 18 states calling for a specific family planning line-item. The nine are Colorado, Connecticut, Delaware, Illinois, Kansas, Massachusetts, Maine, New York, and Pennsylvania.
- Family planning programs in Florida, Georgia, Michigan, Minnesota, Washington, and Wisconsin sustained deep cuts. Funding cuts were disproportionate to those to other health programs in three states. Montana eliminated its line item. New Hampshire and Texas cut funding by 57% and 66%, respectively.

The family planning escaped major reductions in nine of the 18 states where the budget has a specific line-item for family planning. The nine are Colorado, Connecticut, Delaware, Illinois, Kansas, Massachusetts, Maine, New York, and Pennsylvania. However, the story was different in the remaining nine states, the report notes. In six states (Florida, Georgia, Michigan, Minnesota, Washington, and Wisconsin), family planning programs sustained deep cuts, although they were generally in line with decreases for other health programs. However, the cuts to family planning funding were disproportionate to those to other health programs in the remaining three states, the report notes. Montana eliminated the family planning line item. New Hampshire and Texas cut funding by 57% and 66%, respectively.[1]

Last year was indeed a rough year for family planning providers, acknowledges **Clare Coleman**, president and chief executive officer of the Washington, DC-based National Family Planning and Reproductive Health Association (NFPRHA). "State legislatures made serious cuts to public health and family planning programs, under pressure both to balance budgets and achieve blatantly ideological aims," observes Coleman. "At the federal level, the U.S. House of Representatives voted to eliminate Title X, specifically targeted providers that offer abortion care, and even tried to undermine Medicaid."

Get ready for battle

The budget battles of 2011 will persist through 2012, which means that the best-case scenario is to maintain present funding, states Coleman. In 2011 alone, Title X sustained two funding cuts totaling $20.7 million.

"In real terms, reductions in funding mean reduced access to basic and preventive health care," says Coleman. "Health centers have already reported having to reduce center hours, lay off staff, and even limit the range of services made available to patients."

NFPRHA expects the partisan hostilities on family planning, abortion, and sexual health services to continue, given that 2012 is an election year, says Coleman. These inherent challenges will make sustaining funding for family planning and reproductive health that much harder, she states.

Expansions might hold key

Given the difficult fiscal and political climate states are confronting, it is especially noteworthy that significant interest continues in expanding Medicaid eligibility for family planning, says **Rachel Benson Gold**, MPA, director of policy analysis at the Guttmacher Institute Washington, DC office. Gold points to three significant developments in 2011:

- The Maryland legislature directed the state to extend coverage to individuals with an income of up to 200% of the federal poverty level. The state previously had a more limited expansion that extends coverage only to women following a Medicaid-funded delivery, states Gold. The state's request was approved by the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicaid. The program went into operation at the first of January 2012.
- The legislature in Washington state directed officials to raise eligibility under the program from 200% to 250% of the federal poverty level. The action reversed an earlier attempt by the state agency, as part of a larger effort to cut state expenditures, to discontinue its existing Medicaid family planning expansion.
- The federal CMS approved Ohio's request to expand eligibility for its family planning program to individuals with an income of up to 200% of the federal poverty level. This move is particularly significant because Ohio is the first totally new state to utilize the authority under healthcare reform to expand Medicaid eligibility for family planning; all the other states that have done so had previously expanded eligibility by obtaining a federal waiver, says Gold.

Guttmacher Institute analysts are seeing continued interest in other states in expanding Medicaid eligibility for family planning moving forward into 2012, reports Gold. Several states are moving to extend waivers that are nearing their expiration dates; at least one state with a waiver nearing expiration is seriously considering significantly expanding its program, and another state that has not expanded at all appears

close doing so, she notes. All of these moves underscore the benefits seen in states that have expanded, says Gold.

"As we discussed in our recent report, these benefits include increased contraceptive use, including both increased use of more effective methods and improved continuity of use, which has translated into measurable declines in unplanned pregnancy and teen pregnancy, and the births, abortions, and miscarriages that would otherwise have resulted," Gold states. "It has also helped women to plan and space their pregnancies, which has positive implications for the health of pregnant women and newborns, as well as the economic and social well-being of families; at the same time, these programs have generated significant cost savings for the federal and state governments." *(Readers can download the Guttmacher Institute report on Medicaid expansions at http://www.guttmacher.org/pubs/Medicaid-Expansions.pdf.)*

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Is EC easily found? Evidence says no

The next time you offer counseling on emergency contraception (EC) for your adolescent patients, don't assume they can easily access it in their local pharmacies. Results of a new survey indicate that in pharmacies in low-income neighborhoods access to EC might be hampered because of misinformation about the age at which it can be accessed over the counter.[1] Low-income neighborhoods often have the highest teen pregnancy rates.[1]

"Even though we found approximately 80% same-day availability of emergency contraception in [selected] metropolitan cities, misinformation regarding access was common, particularly in low-income neighborhoods," says **Tracey Wilkinson**, MD, MPH, a fellow in the Division of General Pediatrics at Boston Medical Center and Boston University School of Medicine.

Anyone (female or male) who is 17 or older can obtain the emergency contraceptives Plan B One-Step (Teva Pharmaceuticals, Woodcliff Lake, NJ) or Next Choice (Watson Pharmaceuticals, Parsippany, NJ) from a pharmacist without a prescription.

From September to December 2010, female research assistants posing as adolescents who recently had unprotected intercourse were assigned randomly to call all commercial pharmacies in Nashville, TN; Philadelphia; Cleveland; Austin, TX; and Portland, OR. Cities were chosen in geographically diverse states without pharmacy access laws that supersede uniform federal regulations. The callers were instructed to follow scripts to simulate real-world calls and elicit specific information on emergency contraception availability and access. Researchers then examined same-day availability of emergency contraception, whether emergency contraception could be accessed by the caller, and whether the pharmacy communicated the correct age at which emergency contraception was accessible over the counter.

In 19% of all locations, the caller was told EC was not available; the availability of the drug did not differ according to neighborhood income. If EC was available, then the caller stated she was 17 years old and asked whether she could get the drug. In 19% of calls, the caller was told she could not obtain EC under any circumstance. This misinformation occurred more often (23.7% versus 14.6%) among pharmacies in low-income neighborhoods. When callers inquired as to the age threshold for over-the-counter access, they were given the correct age less often by pharmacies in low-income neighborhoods (50.0% versus 62.8%). In all but 11 calls, the incorrect age was stated too high, which potentially restricted access.[1]

Advance provision is recommended so that EC can be taken as soon as possible after unprotected sex.[2] A recent review of available literature suggests that among women 24 years of age or younger, advance provision of EC has a positive impact on use and time to use of EC.[3]

"I am a huge advocate for advance provision, because when we were doing this study, I realized that

EXECUTIVE SUMMARY

A telephone survey of commercial pharmacies was performed in five U.S. cities. The survey indicates that in pharmacies in low-income neighborhoods, which tend to have the highest teen pregnancy rates, access to emergency contraception (EC) might be hampered because of misinformation about the age at which it can be accessed over the counter. Anyone who is 17 or older (females and males) can obtain the emergency contraceptives Plan B One-Step or Next Choice from a pharmacist without a prescription.

- Results of a new study indicate that most women are unaware of the copper IUD for EC.
- There is little discussion between women and their healthcare providers about EC.

if you need it that day, you're not guaranteed to get somebody who can get it to you," says Wilkinson.

How about the IUD?

The Copper T-3801 A copper intrauterine device (ParaGard IUD, Teva Women's Health, North Wales, PA) is a highly effective method of emergency contraception, and it can be used as ongoing contraception for at least 10 to 12 years.[4] Results of a new study indicate that most women are unaware of the copper IUD for EC; furthermore, there is little discussion between women and their healthcare providers around EC.[5]

To conduct the study, researchers undertook in-depth interviews with 14 emergency contraceptive IUD users and 14 emergency contraceptive pill users ages 18-30 years who were accessing public health clinics to study the factors influencing a woman's selection of EC method. The researchers report that EC users associated long-term methods of contraception with long-term sexual relationships. Cost was identified as a major barrier to accessing IUDs; also, perceived side effects and impact on future pregnancies further influenced the EC method a participant selected.[5]

What will it take to get more providers to offer information on the IUD as an EC method? Several items need to be set in motion, says **Rachel Wright**, a PhD candidate and graduate assistant in the College of Social Work at the University of Utah in Salt Lake City. Many healthcare offices are not equipped to offer immediate insertion of the IUD, which might limit their willingness or ability to offer it as a method of EC, notes Wright, who served as lead author of the current study.

"Many participants in the study I conducted further reported that they were told by their primary care providers that they were not eligible for an IUD for emergency contraception if they had not previously given birth," Wright comments. "To me, this is an indication that current guidelines and information on the copper IUD must be promoted, not only to potential EC users, but to healthcare providers as well."

Providers can be significant sources of support and information for women, and they often are their only exposure to accurate information, notes Wright.

"Few women in the U.S. use IUDs compared to other countries and additionally report low levels of knowledge about the IUD and its function as either a highly effective method of contraception or as emergency contraception," says Wright. "I think it would make a huge difference if discussions around all methods of emergency contraception were made a part of standard care, instead of limited to visits specifically for EC."

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Many providers continue unnecessary pelvic exams

Do you use a pelvic exam to screen for sexually transmitted infections, check for ovarian and other gynecologic cancers, or determine whether women should receive hormonal contraceptives? If so, your practice is not supported by scientific evidence and is not recommended by any U.S. organization, according to newly published research.[1]

The research, which includes the result of a recent nationwide survey, show many providers continue to perform pelvic exams in such circumstances, even though such practices are not evidence-based. What prompted the investigators to look at the practice of

EXECUTIVE SUMMARY

Results of a recent nationwide survey show many healthcare providers continue to perform pelvic exams to screen for sexually transmitted infections, check for ovarian and other gynecologic cancers, or determine whether women should receive hormonal contraceptives, even though such practices are not evidence-based.

- The American College of Obstetricians and Gynecologists (ACOG) includes pelvic examinations as a component of periodic assessments for women ages 21-64.
- However, the ACOG guidance states that it is reasonable to discontinue pelvic examinations "when a woman's age and other health issues are such that she would not choose to intervene on conditions detected during the routine examination."

pelvic exams among U.S. providers?

The routine pelvic exam has been considered as a central component of well-woman visits for many decades, says **Analia Stormo**, a research fellow at the Centers for Disease Control and Prevention (CDC) and lead author of the current investigation. It is only recently that health officials have started to gather evidence to examine the benefits and harms of various tests and procedures, including the pelvic exam, she states. "Given the growing body of evidence questioning the value of performing pelvic exams as a screening tool among asymptomatic women, we thought it was important to examine these practices, as they had remained unexplored for many years," says Stormo. "This issue is more salient than before because annual cervical cancer screening is being actively discouraged by many organizations, while well-woman visits are being supported."

Look closer at study

In conducting the survey, Stormo and colleagues from the CDC's Division of Cancer Prevention and Control and researchers from the Soltera Center for Cancer Prevention and Control Research, Tucson, AZ, analyzed data from the 2009 DocStyles survey of 1250 U.S. internists, family practitioners, general practitioners, and obstetrician/gynecologists (OB/GYNs). Providers were questioned whether they performed pelvic examinations for each of the following reasons: ovarian cancer screening, other gynecological cancer screening, as a requirement for starting oral or hormonal contraception, to screen for sexually transmitted infections (STIs), or as part of a well-women exam.

What did the researchers learn? More than half of all physicians reported conducting routine pelvic exams as part of a well-woman exam, with 98.4% of obstetrician/gynecologists reporting such practice, compared to 89.5% of family practitioners/general practitioners (FP/GPs) and 54.0% of internists. In the case of ovarian cancer screening, routine pelvic exams were reported by 95.2% of OB/GYNs, 55.2% of FP/GPs, and 29.7% of internists; for screening for other gynecological cancers, the percentages were 96%, 68%, and 41.2%, respectively. More than 90% of OB/GYNs said they routinely performed such exams to screen for STIs, compared to 72.9% of FP/GPs and 39.9% of internists.

Where's the evidence?

It is not surprising that most OB/GYNs perform routine pelvic exams, given that the American College of Obstetricians and Gynecologists includes pelvic examinations as a component of periodic assessments for women ages 21-64.[2] However, the guidance states that it is reasonable to discontinue pelvic examinations "when a woman's age and other health issues are such that she would not choose to intervene on conditions detected during the routine examination."[2]

Many providers said they performed a routine pelvic examination as a screening test for ovarian cancer in asymptomatic women; however, it is unlikely that such an examination has value, points out **George Sawaya**, MD, professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences at the University of California, San Francisco, in an accompanying commentary.[3] Sawaya points to results from a recent randomized trial of 78,216 women ages 55 to 74, which demonstrated that screening with CA-125 and pelvic sonograms (a practice more accurate than bimanual examinations) are ineffective in preventing ovarian cancer mortality.[4]

"The high percentage of OB/GYNs who continue to use pelvic examinations to screen average-risk women for ovarian cancer is particular cause for concern, given that an estimated 98% of positive screening results among such women are false positives," state Stormo and her colleagues.

Exam for contraception?

Hormonal oral contraception can be prescribed safely without a pelvic examination, according to guidelines from the World Health Organization and the American College of Obstetricians and Gynecologists.[5,6] *(*Contraceptive Technology Update *reported on the research; see "Pelvic exam necessary for contraception Rx?" March 2011, p. 32.)* Screening for such STIs as chlamydia can be performed with lab tests.

Requiring women to undergo pelvic exams to check for STIs or before prescribing hormonal contraceptives might discourage women from seeking needed birth control or deter them from routine screening for STIs, write Stormo and colleagues.

In his commentary, Sawaya calls for future studies to focus on defining the potential benefits and harms of the pelvic examination in asymptomatic women.

"In the absence of direct evidence of benefits and harms, a thoughtful decision analysis of various aspects of the examination (i.e., inspection of the external genitalia, speculum examination,

bimanual examination) including potential benefits (e.g., identifying neoplastic vulvar/vaginal lesions, identifying benign ovarian lesions that may cause medical emergencies such as rupture and torsion) and harms (e.g., complications due to false-positive testing results) would be useful," writes Sawaya. "Given plausible outcomes, clinicians should not be surprised if the examination is deemed to be more harmful than beneficial and ultimately is discouraged as part of a well-woman exam."

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Use new technology for communication

Since 2001, the United States has not gained traction in reducing the rate unintended pregnancy. Research indicates that of the 6.7 million pregnancies in 2006, nearly half (49%) were unintended.[1]

How can your facility reach out to young adults with accurate reproductive health information to help prevent unintended pregnancy? Take a look at two programs: Planned Parenthood of the Rocky Mountains' new text messaging program, "In Case You're Curious," and www.bedsider.org, sponsored by the National Campaign to Prevent Teen and Unplanned Pregnancy.

Getting accurate information to young adults is imperative if they are to make educated, effective choices for pregnancy and disease prevention, say reproductive health advocates. According to a 2008 national survey of young women and men ages 18-29 conducted by the campaign, while significant proportions of young adults say they know either "everything" or "a lot" about some methods of contraception such as condoms or the Pill, they have gaps when it comes to other methods.[2] For example:

- 70% of young adults (71% of men and 69% of women) say they know little or nothing about contraceptive implants;
- 67% (73% of men and 61% of women) say they have limited knowledge about intrauterine devices;
- almost one-third of young adults (32% of men and 30% of women) say they know little or nothing about emergency contraception.[2]

Teens take to texts

To reach out to youth in the Denver region, Planned Parenthood of the Rocky Mountains has rolled out "In Case You're Curious," or ICYC. The program allows young people to text questions by typing "ICYC" to 66746. Questions are answered within 24 hours by a trained Planned Parenthood Community Education staff member.

Texting is an accepted mode of communication for teens. Research conducted by the Pew Internet & American Life Project indicates that half of teens send 50 or more text messages a day, or 1,500 texts a month, and one in three send more than 100 texts a day, or more than

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Planned Parenthood of the Rocky Mountains' new text messaging program, "In Case You're Curious," and www.bedsider.org, sponsored by the National Campaign to Prevent Teen and Unplanned Pregnancy, are aimed at providing young adults with accurate reproductive health information to help prevent unintended pregnancy.

- The Planned Parenthood of the Rocky Mountains "In Case You're Curious" program allows young people to text questions, which are answered within 24 hours by a trained community education staff member.
- Bedsider.org is a comprehensive online and mobile program to help sexually active women ages 18-24 find the right birth control method and use it carefully and consistently to prevent unplanned pregnancy.

3,000 texts a month.[3]

The idea to create a text program was based on the Denver organization's more than 30 years of experience in the educational setting, says **Marie Logsden**, the agency's vice president for community education, professional training, and organizational diversity. "Youth want a confidential yet medically accurate and trusted source to turn to," says Logsden. "Texting embraces this concept, as well as adopts new technology to reach teens where they already are and in a way they are familiar with."

The ICYC program originally was created in 2010 for the Denver Teen Pregnancy Prevention Partnership. It became a program of Planned Parenthood of the Rocky Mountains in October 2011; the agency publically launched the program in December 2011, says Logsden. The launch received a significant amount of media attention, which fueled numerous tweets as well as Facebook discussions, says Logsden.

"Social media has been a great tool for us in informing audiences about this program," she explains. "When teaching, our educators mention ICYC as a resource for medically accurate, age-appropriate information on sexual health issues. We often see a spike in texts after our educators meet with a school or after-school group, for example."

The Denver agency estimates the program will cost up to $12,000 to implement this year, which includes technology as well as human resources, says Logsden. "As the program grows and text volume increases, we anticipate incurring additional costs," she states. "This year will be spent monitoring and tracking trends in order to more effectively forecast costs for next year."

Get those on the go

The National Campaign to Prevent Teen and Unplanned Pregnancy has developed Bedsider.org as a comprehensive online and mobile program to help sexually active women ages 18-24 find the right birth control method and use it carefully and consistently to prevent unplanned pregnancy.

"Although nearly all unmarried young women say they don't want to get pregnant at this point in their lives and strongly believe that pregnancy is something that should be planned, many young adults are not taking active, careful, and consistent steps to avoid unplanned pregnancy," says **Bill Albert**, chief program officer with the campaign. "Many are unaware of the many methods of birth control now available; many more harbor myths about birth control, doubt whether it actually works, and are overly fearful of side effects."

The Bedsider web site is designed to help young women find a method of birth control that's right for them and stick with it, through a series of online, video, and mobile components. Visitors can explore, compare, and contrast all available methods of contraception, set up birth control and appointment reminders, view videos of their peers discussing personal experiences, and watch animated shorts that debunk myths about contraception.

Visitors to Bedsider can type in their zip code to find the closest location for contraception or emergency contraception, or to get information on over-the-counter contraception. "We continue to add new health centers and clinics all the time and encourage users to provide us with updated information on already-listed centers or clinics or to provide us with information those that might be missing from the Bedsider database," says Albert. "Providers can update information by using the online form in the 'Where to Get It' section of Bedsider or simply send the information to information@Bedsider.org." *(Check to see if your clinic is listed; type in your zip code at "Where To Get It." If your clinic isn't listed, click on ""Are we missing a health center? Let us know" on the search results page, under the map, and follow the prompts.)*

Early indications from users since its 2010 inception suggest that the web site is helpful, says Albert.

"In a recent pilot test, more than 80% of all Bedsider users said that that the program made them more careful about birth control and less inclined to have unprotected sex."

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Sex education remains active battleground

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

The trend over the past several years toward more progressive federal and state sex education policymaking hit something of a wall in 2011. Proponents of education exclusively promoting abstinence outside of marriage made modest gains in reviving their cause. There is every reason to expect the issue of sex education to remain contentious in the near future; the longer-term outlook depends heavily on the results of the 2012 elections.

In 2009 and 2010, policymakers and advocates supportive of comprehensive sex education made major progress at the federal level. After more than a decade of federal emphasis on rigid "abstinence-only" education, funding for those programs was slashed substantially, highlighted by the elimination in FY 2010 of the Community-Based Abstinence Education (CBAE) program.[1] That program provided grants to local organizations adhering to an eight-point definition of "abstinence education" that required teaching, among other things, that "a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity" and that "sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects."[2]

Instead, two new programs have been implemented under the Obama administration: the Teen Pregnancy Prevention Initiative (TPPI) and the Personal Responsibility Education Program (PREP), which together provide more than $180 million per year for evidence-based, medically accurate and age-appropriate programs that address teen pregnancy and its underpinnings through a more comprehensive approach.[1]

In 2011, funding for TPPI absorbed only marginal cuts, in line with those for most other federal programs, as policymakers turned their focus to the federal deficit. Yet, conservatives managed to secure $5 million in new funds for abstinence education grants tied to the restrictive eight-point definition.[3] Although that amount pales in comparison to CBAE's allotment at the height of its run, proponents and opponents of abstinence-only education believe it could open the door to greater amounts in the future.

At the state level, similarly, the trend in the latter half of the last decade had been a shift toward policies supporting medically accurate and more comprehensive sex education, with seven states (Colorado, Hawaii, Iowa, North Carolina, Oregon, Washington, and Wisconsin) enacting laws on that front between 2007 and 2010.[4] In 2011, after the previous year's elections resulted in a conservative legislative and gubernatorial shift in many states, no further progress was made. Instead, two states enacted laws promoting a focus on abstinence: North Dakota required health education classes to include information on the benefits of abstinence outside of marriage, and Mississippi, which has long mandated abstinence education, required school districts to receive specific permission from the state before teaching other subjects, such as contraception.

All told, state policies on sex education and HIV education are decidedly mixed. Thirty-seven states require abstinence to be covered whenever sex education is taught, with 18 states requiring students to be taught the importance of engaging in sexual activity only within marriage.[5] By contrast, 18 states and the District of Columbia require sex education to include information on contraception, 13 states require sex and HIV education to be medically accurate, and 27 states and the District of Columbia require such instruction to be age appropriate.

Nevertheless, statewide policies do not adequately depict the reality in schools, as much depends on the policies of specific districts and schools and what is taught by individual teachers. Proponents of comprehensive sex education are hoping for new progress on that front with the January 2012 release of the National Sexuality Education Standards: Core Content and Skills, K-12.[6] The new standards were developed by a consortium of groups focused on health and sex education, including the American Association of Health Education, the American School Health

COMING IN FUTURE MONTHS

- 10 gynecologic cancer symptoms women shouldn't ignore
- Study eyes contraceptives' effect on markers of mucosal immunity
- Condom use: Review research on HIV protection
- HIV testing: Program aimed at African-American women

Association, the National Education Association Health Information Network, the Society of State Leaders of Health and Physical Education, and the Future of Sex Education Initiative.

The standards are designed to delineate for teachers, schools, districts, and state education agencies the minimum essential content and skills for sex education, given current conditions of limited time and resources devoted to the subject. They echo the federal TPPI and PREP programs in emphasizing that the education be evidence-based, medically accurate, and age-appropriate.

Specifically, the standards provide performance indicators, which are the knowledge and skills students should have by the end of grades two, five, eight and 12, in seven key areas: anatomy and physiology, puberty and adolescent development, identity, pregnancy and reproduction, sexually transmitted infections and HIV, healthy relationships, and personal safety. As just a few examples, on the topic of pregnancy and reproduction, students are expected to be able to "describe the process of human reproduction" by the end of fifth grade; to "explain the health benefits, risks, and effectiveness rates of various methods of contraception, including abstinence and condoms" by the end of eighth grade; and to "analyze internal and external influences on decisions about pregnancy options" by the end of 12th grade.

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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%.
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5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

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. Which service listed below was NOT included by primary care clinicians who specialize in adolescent male health as an essential component of every adolescent male annual exam?
   A. Screening and counseling for sexually transmitted infections that include the offer of HIV testing to those age 13 and older
   B. Screening for substance abuse and mental health
   C. Screening for physical/sexual abuse
   D. Testicular cancer screening

2. Who can get the emergency contraceptives Plan B One-Step or Next Choice from a pharmacist without a prescription?
   A. Anyone who is 17 or older (females and males)
   B. Anyone who is 16 or older (females and males)
   C. Anyone who is 18 or older (females and males)
   D. Females who are 18 or older

3. When is a pelvic exam warranted, according to the American College of Obstetricians and Gynecologists?
   A. Before initiation of hormonal contraception
   B. Initial screening for ovarian cancer
   C. Screening for sexually transmitted infections
   D. As a component of periodic assessments for women ages 21-64

4. According to research, what percentage of the 6.7 million pregnancies in the United States in 2006 was unintended?
   A. 49%
   B. 35%
   C. 25%
   D. 20%

Continued from p. 35

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Correction

In the February issue of *Contraceptive Technology Update*, we inadvertently printed the wrong graphic from the Contraceptive Survey on p. 19. The online issue now has the correct graphic. To access the February issue, go to www.contraceptive-update.com. On the right side of the page, select "Access Your Newsletters – Sign In." You will need your customer ID number from your mailing label. For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com. ■

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S·T·I
QUARTERLY

HPV vaccine update: No association between shot, risky sexual behavior

Continue to counsel: Shot does not protect against other STIs

Good news: Results of a cross-sectional analysis of young women interviewed as part of the National Survey of Family Growth who received recommended vaccinations to prevent human papillomavirus (HPV) infection found no association between HPV vaccination and risky sexual behavior.[1]

The analysis was designed to examine sexual behavior and demographic correlates of HPV vaccine initiation from the national survey; a total of 1,243 females ages 15-24 responded to questions about receiving the HPV vaccine.

Early in the HPV vaccine delivery process, reports were received that many parents were concerned that receipt of the HPV vaccine would lead to increased sexual risk among vaccinated youth, observes **Nicole Liddon**, PhD, a health scientist in the Division of Adolescent and School Health at the Centers for Disease Control and Prevention (CDC). Investigators undertook the analysis to determine if such an association exists, explains Liddon, who served as lead author of the study. If the data proved positive, a public health approach would need to be developed to counteract it, she observes.

HPV vaccination was not associated with being sexually active or number of sex partners at either age range (ages 15-19, ages 20-24), researchers note. Another positive note: Among sexually active adolescents ages 15-19, those who received HPV vaccine were more likely to always wear a condom, results indicate.[1]

"The data that we have is all preliminary in that it is all cross-sectional data," notes Liddon. "We don't know if there is a cause and effect with vaccine and increased sexual risk, but we found no association between the two."

EXECUTIVE SUMMARY

Results of a cross-sectional analysis of young women who received recommended vaccinations to prevent human papillomavirus (HPV) infection found no association between HPV vaccination and risky sexual behavior.

- When talking with adolescents about the HPV vaccine, be sure to counsel that the vaccine works by preventing the most common types of HPV that cause cervical cancer and genital warts, but it does not provide protection against other sexually transmitted infections (STIs).
- Results of a separate cross-sectional baseline analysis suggest that while most girls understand that the vaccine does not protect them from STIs other than HPV, 23.6% of study participants reported a perceived risk of STIs in the lower half of the scale.

Talk about STI protection

When talking with adolescents about the HPV vaccine, be sure to counsel that the HPV vaccine

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Consulting Editor **Robert A. Hatcher**, MD, MPH, Author **Rebecca Bowers**, and Executive Editor **Joy Dickinson** 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.

works by preventing the most common types of HPV that cause cervical cancer and genital warts, but it does not provide protection against other sexually transmitted infections (STIs). *(See article below right for information on who should receive the HPV vaccine.)*

Researchers enrolled patients ages 13-21 attending a Cincinnati Children's Hospital Medical Center adolescent primary care office to see if adolescent attitudes toward safer sexual behaviors would change after vaccination, says **Tanya Kowalczyk Mullins**, MD, MS, assistant professor of pediatrics in the Division of Adolescent Medicine at Cincinnati Children's Hospital Medical Center. The primary outcome measures were scales assessing perceived risk of HPV, perceived risk of other STIs, and perceived need for safer sexual behaviors. Each scale had a possible mean scale score of 0-10, with lower numbers indicating lower perceived risk of HPV/STI and less need for safer sexual behaviors.[2]

Results of the cross-sectional baseline analysis, derived from an ongoing longitudinal cohort study, suggest that most girls understood that the vaccine does not protect them from STIs other than HPV, says Mullins, who served as lead author of the current research. "The vast majority of girls still plan to practice safer sex after getting their first HPV vaccination," reports Mullins. "Our findings are very reassuring. The vast majority of girls understand that safer sex is still important after getting their first HPV vaccination."

Researchers note that while it is appropriate for girls receiving the vaccine to perceive themselves to be at less risk for HPV after vaccination, it is concerning that a small subset of girls also perceived themselves to be at less risk for other STIs; 23.6% of study participants reporting perceived risk of STIs in the lower half of the scale.

Clinicians discussing HPV vaccination with girls and their mothers might need to emphasize the limitations of the vaccine and to specifically address that the vaccine does not prevent other STIs, researchers note. Further studies are needed to examine the association between risk perceptions after HPV vaccination and future sexual behavior.[2]

Reimbursement a factor

Does reimbursement for the HPV vaccine play a factor in your practice? Findings from a recent survey of Virginia gynecologists and family practitioners indicate reimbursement concerns might have a negative impact on doctors' recommendation of the HPV vaccine.[3] The cross-sectional survey questionnaire was mailed to 500 family practitioners and 500 gynecologists. After exclusion of ineligible physicians, 385 of 790 doctors responded.

The cost of the full HPV shot series runs just under $400. While many private insurers cover the immunization series, which is included in the CDC's Advisory Committee for Immunization Practices guidelines, policies vary in the age of the coverage, the reimbursement levels paid by different payers, and the out-of-pocket costs faced by healthcare consumers.[4]

Statistics show 13% of girls ages 9-18 and 27% of women ages 19-26 years old are uninsured. For those younger than age 19, HPV vaccines are included in the Vaccines for Children (VFC) program. Medicaid also includes the HPV vaccine as part of its early and periodic screening diagnosis and treatment program for women ages 19 and 20. For those age 21 years and older, vaccine coverage is an optional benefit and is decided on a state-by-state basis.[4]

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Who should get the HPV vaccine?

According to the Centers for Disease Control and Prevention (CDC), the human papillomavirus (HPV) vaccines Gardasil (Merck & Co.) and Cervarix (GlaxoSmithKline) are licensed, safe, and effective for females ages 9-26.

The CDC recommends that all 11- or 12-year-old girls receive the three doses of either brand of HPV vaccine to protect against cervical cancer. Gardasil also protects against most genital warts, as well as some cancers of the vulva, vagina, and anus. Girls and young women ages 13-26 should receive the HPV vaccine if they have not received any or all doses when they were younger, advises the CDC.

Gardasil is also licensed, safe, and effective for males ages 9-26. The CDC recommends Gardasil

for all boys aged 11 or 12, and for males aged 13-21, who did not get any or all of the three recommended doses when they were younger. All men may receive the vaccine through age 26 and should speak with their provider to find out if getting vaccinated is right for them.

The vaccine is also recommended for gay and bisexual men (or any man who has sex with men) and men with compromised immune systems (including HIV) through age 26, if they did not get fully vaccinated when they were younger, according to the CDC.

SouRce

Centers for Disease Control and Prevention. HPV Vaccine -- Questions & Answers. Accessed at http://www.cdc.gov/vaccines/vpd-vac/hpv/vac-faqs.htm. ■

New approaches eyed to herpes simplex virus

New research points to the need for more potent approaches to containing the genital herpes simplex virus (HSV). In three separate but complementary open-label crossover studies examining standard and high-dose therapies, scientists found short bursts of subclinical reactivation are frequent, even during high-dose antiherpes therapy, and probably account for continued transmission of HSV during suppressive antiviral therapy.[1]

The Centers for Disease Control and Prevention estimates about one out of six people ages 14-49 have genital type 2 (HSV-2) infection.[2] While there is no treatment available to cure herpes, clinicians have looked to antiviral medications to shorten and prevent outbreaks and daily suppressive therapy to reduce transmission to partners.[2]

To perform the studies, scientists designed the trials to compare no medication versus aciclovir 400 mg (the standard dose for the drug) twice daily, valaciclovir (the standard dose for the drug) 500 mg daily versus aciclovir 800 mg (high-dose aciclovir) three times daily, and standard-dose valaciclovir versus valaciclovir 1 g (high-dose valaciclovir) three times daily. Patients enrolled in the study were HSV-2-seropositive, HIV-seronegative healthy adults age 18 and older who were enrolled at the University of Washington Virology Research Clinic in Seattle between November 2006 and July 2010. Investigators collected genital swabs four times daily throughout the study period; study periods lasted 4-7 weeks, separated by one week wash-out.

Research findings indicate that frequency of HSV shedding was significantly higher in the no medication group (n = 384, 18.1% of swabs) than in the standard-dose aciclovir group (25, 1.2%; incidence rate ratio [IRR] 0.05, 95% confidence interval [CI] 0.03-0.08). High-dose aciclovir was associated with less shedding than standard-dose valaciclovir (198 [4.2%] versus 209 [4.5%]; IRR 0.79, 95% CI 0.63-1.00). Shedding was less frequent in the high-dose valaciclovir group than in the standard-dose valaciclovir group (164 [3.3%] versus 292 [5.8%]; 0.54, 0.44-0.66). The number of episodes per person-year did not differ significantly for standard-dose valaciclovir (22.6) versus high-dose aciclovir (20.2; p = 0.54), and standard-dose valaciclovir (14.9) versus high-dose valaciclovir (16.5; p = 0.34), but it did differ for no medication (28.7) and standard-dose aciclovir (10.0; p = 0.001). Median episode duration was longer for no medication than for standard-dose aciclovir (13 hours versus seven q hours; p = 0.01) and for standard-dose valaciclovir than for high-dose valaciclovir (10 hours versus seven hours; p = 0.03), but did not differ significantly between standard-dose valaciclovir and high-dose aciclovir (eight hours versus eight hours; p = 0.23).[1]

What is the next step in research in determining alternative suppressive therapies for HSV-2?

"We need new antiviral drugs with novel mechanisms of action against HSV-2," says **Christine Johnston**, MD, MPH, acting assistant professor in the University of Washington School of Medicine in Seattle and lead author of the current research. "These drugs would ideally potently inhibit HSV-2 shedding and have a high threshold for development of resistance."

Johnston points to recent research in which a tenofovir microbicide intravaginal gel was unex-

EXECUTIVE SUMMARY

New research points to the need for more potent approaches to containing the genital herpes simplex virus (HSV). In three separate but complementary open-label crossover studies examining standard and high-dose therapies, scientists found short bursts of subclinical reactivation are frequent, even during high-dose antiherpes therapy, and probably account for continued transmission of HSV during suppressive antiviral therapy.

• In a just-published Phase III study, data indicates an investigational vaccine protected some women against infection from one of the two types of herpes simplex viruses that cause genital herpes.

• While the vaccine was partially effective at preventing HSV-1, data indicate it did not protect women from HSV-2. The company has decided not to pursue further worldwide development of the vaccine, based on the trial results.

pectedly shown to decrease HSV-2 acquisition in HSV-2 seronegative women in the CAPRISA 004 HIV prevention trial.[3] *(The tenofovir gel provided a 51% protective effect against the acquisition of HSV-2 among trial participants. See the* Contraceptive Technology Update *article, "HIV breakthrough: Trial results offer promise," October 2010, p. 114.)*

The effect of oral tenofovir and intravaginal tenofovir gel on HSV-2 shedding among HSV-2 seropositive women will be studied in an upcoming clinical trial, says Johnston. "Helicase-primase inhibitors are another example of a promising new antiviral which is being studied for HSV-2 infection," Johnston observes. "In addition, further research into interactions between HSV-2 and the human host are needed to identify protective immune responses, which could potentially be stimulated with a therapeutic HSV-2 vaccine."

Vaccines in development

Science is moving forward on vaccine development against HSV. In a just-published Phase III study, data indicates an investigational vaccine protected some women against infection from one of the two types of herpes simplex viruses that cause genital herpes. While the vaccine was partially effective at preventing HSV-1, data indicate it did not protect women from HSV-2.[4]

More than 8,000 women between ages 18-30 who did not have HSV-1 or HSV-2 infection at the start of the study were enrolled in the study; participants were randomly assigned to receive three doses of an investigational HSV vaccine (Simplirix)that was developed by GlaxoSmithKline Biologicals of London or a hepatitis A vaccine, which served as the control. Participants were followed for 20 months and evaluated for occurrence of genital herpes disease. Findings suggest that two or three doses of the investigational vaccine offered significant protection against genital herpes disease caused by HSV-1; however the vaccine did not protect women from genital disease caused by HSV-2. The company has decided not to pursue further worldwide development of the vaccine, based on the trial results.

What is the next step in research? **Robert Beishe**, MD, professor of medicine, pediatrics and molecular microbiology at Saint Louis University, says data from the current study offers some direction: A simple vaccine such as the one tested has very modest efficacy, and a more complex vaccine is needed to protect against herpes. Beishe, who served as lead author of the current paper, says his own bias lies in research of a live attenuated vaccine.

"Chickenpox is the only herpes virus for which we have a vaccine," Beishe observes. "We use a live attenuated virus there, and it's very effective. And so for all the other human herpes viruses, I think a live attenuated vaccine, or a vaccine that mimics the benefits of live attenuated vaccine, would be the way to go."

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New c Dc online atlas offers current STI data

Need the latest data on HIV, AIDS, chlamydia, gonorrhea, and primary and secondary syphilis? Check out the NCHHSTP Atlas, an interactive tool for accessing data collected by the Centers for Disease Control and Prevention's (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP).

The atlas was created to provide an interactive platform for accessing HIV, viral hepatitis, sexually transmitted infection, and tuberculosis data collected by the CDC. The interactive tool provides CDC an effective way to disseminate data, and it allows users to creating detailed reports, maps, and other graphics to observe trends and patterns. For more information and a brief training video, visit the CDC web page, http://www.cdc.gov/nchhstp/atlas. Surveillance data on each disease will be updated annually.

The atlas provides interactive maps, graphs, tables, and figures showing geographic patterns and time trends of HIV, AIDS, chlamydia, gonorrhea, and primary and secondary syphilis surveillance data. Information on tuberculosis and viral hepatitis are slated to be included later in 2012. ■