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INSIDE

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What will it take to get emergency contraception to women who need it?

14% of hotline calls failed to gain appointment or pills in 72 hours

You might be an active prescriber of emergency contraception (EC). In fact, you might be listed in the provider directory offered by the national Emergency Contraception Hotline ([888] NOT-2-LATE) and companion Web site (not-2-late.com). But are women who contact you able to obtain EC?

While many requests for EC are indeed being fulfilled, results from a just-published quality assurance study shows that 14% of calls to providers listed in the national directory resulted in failure to get an appointment or prescription for EC within 72 hours of calling.[1] The main reasons for a hotline call being classified as a failure were inability to make telephone contact, refusal to see women who were not established clients, and unavailability of appointments, researchers say.

The results of the study are both "encouraging and disappointing," says **James Trussell**, PhD, professor of economics and public affairs, faculty associate of the Office of Population Research (OPR), and associate

EXECUTIVE SUMMARY

While many women are successful in receiving emergency contraception (EC) from American providers, results from a just-published quality assurance study shows that 14% of calls to providers listed in the national Emergency Contraception Hotline directory resulted in failure to get an appointment or EC prescription within 72 hours of calling.

- Inability to make telephone contact, refusal to see women who were not established clients, and unavailability of appointments were the leading reasons for a hotline call to be classified as a failure.
- Clinicians can maximize EC access by providing pills or a prescription in advance, prescribing by telephone, and eliminating unnecessary pregnancy tests and physical exams.

New design for EC Web site

Check out the Emergency Contraception (EC) Web site, http://not-2-late.com, to see its new look. The site has been redesigned, reprogrammed, and reorganized to make users' visits easier, more educational, and more fun, says **James Trussell**, PhD, professor of economics and public affairs, associate dean of the Woodrow Wilson School of Public and International Affairs, and faculty associate of the Office of Population Research at Princeton (NJ) University.

Redesign highlights include a new tool bar to facilitate easy navigation between pages and multiple search engines for finding the closest EC provider. Page users now can search for providers by zip code, area code, city, or state, or by clicking directly on a U.S. map, he says.

Extensive information also is available on emergency contraceptive pills (ECPs) worldwide. The site offers the ability to search by country or pill type to learn which ECPs are available around the world, as well as dose and pill content, Trussell notes. ■

dean of the Woodrow Wilson School of Public and International Affairs at Princeton (NJ) University. The OPR and the Washington, DC-based Reproductive Health Technologies Project operate the national hotline, which is a toll-free, automated, confidential service available 24 hours a day in English and Spanish.

"The vast majority of the more than 3,000 providers [listed in the directory] do an excellent job of providing women with access to emergency contraception, but we found it very worrisome that we were unable to get an appointment or prescription for ECPs within 72 hours of calling from 14% of the providers in our sample," remarks Trussell. "In general, women seeking emergency contraception are likely to fare less well, because the providers in our sample had proactively asked to be listed on the hotline and Web site, and our mystery callers were highly educated about emergency contraception."

The research study employed college-educated investigators who identified themselves as women who had a condom break the previous night. A total of 200 providers were contacted, with calls made during standard business hours only. No calls were made on weekends or holidays.

Approximately 76% of attempts resulted in an appointment or telephone prescription from a hotline provider within 72 hours, researcher note. A total of 11% resulted in referrals to other providers not listed on the hotline or Web site.

Of the attempts that resulted in appointments or telephone prescriptions within 72 hours, nearly three-fourths of callers were offered appointments for the same day, 16% for the next day, and 2% for the day after that. Telephone prescriptions were offered in 8% of successful calls. Calls to Planned Parenthood affiliates were more likely to result in successes than other calls; however, only one Planned Parenthood provider offered to call in a prescription.

Of the attempts that resulted in referrals, the top reasons cited were unavailability of appointments, refusal to see women who were not established clients, and unavailability of emergency contraception at that site.

Tests, exams, and costs

The road to EC doesn't always end with a provider appointment, researchers found. For those facilities that offered appointments, 31% required pregnancy tests and 27% required pelvic examinations prior to prescription.

For many low-income women and teens, the cost of pills and related services can be a potential barrier to EC access. Three-fourths of sites that responded to questions about service costs charged a fixed price, including the cost of the clinic visit, the prescription, or both. Researchers added $20 — the market price for the dedicated ECP Preven (Gynétics, Belle Meade, NJ) — to the cost quoted by those who explicitly stated that pills were not included in the overall fee.

"Costs at the sites with flat fees ranged from free to $220, with mean and median costs of $48 and $38, respectively," researchers note. "Fifteen

COMING IN FUTURE MONTHS

- Impact of abstinence-only education
- New HPV testing guidelines
- Public supports access to emergency contraception
- Wait intensifies for U.S. introduction of mifepristone
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percent of providers offered services at no cost, 36% charged $25 or less, and 10% charged $100 or more." Costs for those providers who used sliding-scale pay systems ranged from free to $54, with mean and median costs of $22 and $18, respectively; 29% provided services at no cost, and 67% charged $25 or less.

Not only do access barriers weaken a woman's ability to obtain EC, they delay when she can start it, says **Anita Nelson**, MD, professor in the obstetrics and gynecology department at the University of California in Los Angeles (UCLA) and medical director of the women's health care clinic and nurse practitioner training program at Harbor-UCLA Medical Center in Torrance. Because the efficacy of emergency contraceptive pills declines significantly with time following unprotected intercourse, treatment should be initiated as soon as possible.[2] "We know that the sooner EC is initiated, the better it protects women from unplanned pregnancy," she says. "The ultimate goal for EC is to make it available to all at-risk women before they need it."

Advance prescription should be routine practice for all barrier users and for women who forget to take oral contraceptives or who are late returning for their contraceptive injections, advocates Nelson. Just as women keep antiseptic and bandages on hand in the medicine cabinet "just in case," so should providers make EC available to women, she notes.

Melanie Gold, DO, assistant professor of pediatrics at the University of Pittsburgh's school of medicine, agrees that advance prescriptions would reduce many of the barriers to EC. "I think if every health care provider prescribed it prophylactically, it would solve part of the problem," she states." But [some providers] are still so worried that it will cause people to have bad contraceptive behavior that they are unwilling to or uncomfortable to prescribe it that way."

One step providers can take is to counsel about EC at every opportunity, says Gold. "Sports physicals, driver's physicals, acne check — any time where EC is a possible issue," she says. "Even talk to virginal kids about what their plans are for the future in terms of when they think they might be sexually active, and at least educate them about EC so they know that it exists."

"I believe EC should be in every medicine cabinet in America, and I want to see EC over the counter," says **Sharon Schnare**, RN, FNP, CNM, MSN, women's health consultant and clinician with the Seattle King County Health Department and the International District Community Health Center in Seattle. She now provides Plan B (the levonorgestrel ECP from Women's Capital Corp., Bellevue, WA) or a prescription for Preven to nearly all her patients.

ECPs are now available over the counter without prescription in France, notes Trussell. While such an option is not available in the United States, clinicians can maximize ECP access by providing pills or a prescription in advance, prescribing by telephone, and eliminating unnecessary pregnancy tests and physical exams, he advocates. **(See tips on easing access, below.)**

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Help patients obtain emergency contraception

How can you can eliminate barriers to women who seek emergency contraception (EC) from your facility? First, use a role-play staff session to see how staff respond when they receive a request for EC over the telephone.

"I think that even if the health care providers know about [EC], the receptionists and the front-end people don't," says **Melanie Gold**, DO, assistant professor of pediatrics at the University of Pittsburgh's school of medicine.

Second, educate your patients about how to ask for EC over the telephone, says Gold. That education could be done by giving patients a telephone script that states, "Hi, my name is . . . . I need emergency contraception as soon as possible. Please let me speak to a nurse or doctor." You can include the script in your EC pamphlets so patients know how to ask for care when they call the clinic, she suggests.

Advance counseling on common side effects such as nausea and vomiting helps patients to know what to expect and might lead to greater tolerance, according to *Contraceptive Technology*.[1]

Patients, particularly adolescents, might fear that such side effects will be so severe that others will suspect they have taken EC, says Gold.

Patients also might be concerned about the long-term effects of EC, she notes. Teens might be especially concerned about the effect of EC on their future fertility, so it is important to assure them of the drug's safety.

When is emergency contraception available at your facility? McCosh Health Center at Princeton (NJ) University offers EC "pretty much around the clock," notes **Brian Zack**, MD, university physician and medical director of sexual health services. The center operates an inpatient service for university students that is open 24 hours a day except for summers and Christmas break.

During regular hours, students come into the urgent care clinic, where they are seen by a triage nurse and assigned to one of the nurse practitioners or physicians who are available to provide EC, notes Zack. The clinic stocks Plan B and dispenses it with some basic counseling and written information. For those who seek EC at night or on weekends, the registered nurses on duty call the back-up physician for orders to provide EC, and pills are dispensed on the spot.

Directors at Health Interested Teens Own Program on Sexuality (HITOPS), a Princeton-based nonprofit service for adolescents, have decided to implement a trial protocol to offer telephone ECP prescriptions for new patients, says **Barbara Reale**, CNM, MS, director of clinical services.

Two nurse-midwives and two registered nurses — with a back-up physician as medical director — staff the clinic, which has been offering emergency contraception since the early 1990s. Pills are dispensed at the site when patients come into the clinic, and written prescriptions are given to those using barrier contraceptive methods and to first-time method users. Heretofore, telephone prescriptions have been called in only for existing patients, and they usually have been called in during the weekends when the clinic is not in operation.

With the new change in protocol, staff will take a medical history over the phone from new patients seeking EC. Callers will be required to provide contact information, as well as to schedule a clinic appointment for the next available day. Staff also will ask if callers can be contacted if they fail to make an appointment. The clinic plans to chart statistics for the next six months to determine how many new patient callers enter the clinic for a visit.

EC use is growing at the clinic, with a much larger increase recorded last fall, says Reale. For many teens, EC represents the reason for their first visit to the facility.

Because a teen's first clinic visit offers a chance to counsel on contraceptives and sexually transmitted diseases, HITOPS officials will carefully monitor the trial telephone protocol. While officials want to help prevent unintended pregnancies, they also want to provide care for the adolescents who seek their services, she notes.

Reference

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Mirena intrauterine system seeks U.S. nod

American women might have another option in long-term intrauterine devices if Wayne, NJ-based Berlex Laboratories' receives approval for the Mirena levonorgestrel intrauterine system (IUS) from the Food and Drug Administration.

A unique intrauterine contraceptive that delivers a 20 mcg daily dose of locally acting hormone directly in the uterus, Mirena is now used by more than 1.4 million women in Europe, Asia, and Latin America. The company bills the device as an IUS rather than an intrauterine device (IUD) due to its hormone reservoir.

News of the February filing of a new drug application with the federal regulatory agency has been met with enthusiasm by national family planning experts, who have been calling for U.S. introduction of the device since it debuted overseas in 1990. **(*Contraceptive Technology Update* has covered Mirena in these issues: January**

EXECUTIVE SUMMARY

Mirena, the levonorgestrel intrauterine system, has taken the first step in seeking Food and Drug Administration approval, with Berlex Laboratories filing a new drug application with the agency.

- The device, which delivers a daily 20-mcg dose of progestin, is used by more than 1.4 million women in Europe, Asia, and Latin America. If the FDA approves Mirena, it will be indicated for five years of contraceptive efficacy, say Berlex officials.
- A new proprietary introducer has been developed for device insertion. A comprehensive provider education program will be launched pending product approval.

1997, p. 4, a complete overview; and June 1999, p. 65, an announcement of Berlex's evaluation of the device for possible U.S. marketing.)

"It would be wonderful for American women to have access to two outstanding IUDs which provide protection equal to that of a sterilization procedure but are totally reversible," says **Allan Rosenfield**, MD, dean of the Joseph L. Mailman School of Public Health, DeLamar Professor of Public Health at Columbia University in New York City, and professor of obstetrics and gynecology in Columbia University's School of Medicine.

"To my mind, this device and the Copper T 380A are ideal, safe, and highly effective contraceptive methods and should be widely available," he says. The Copper T 380A is marketed in the United States as the ParaGard by Ortho-McNeil Pharmaceuticals in Raritan, NJ.

Mirena would be a welcome addition to the menu of contraceptive options for U.S. women, agrees **Andrew Kaunitz**, MD, professor and assistant chair in the obstetrics and gynecology department at the University of Florida Health Science Center / Jacksonville and director of menopause and gynecology services at the Medicus Women's Diagnostic Center in Jacksonville.

"Mirena provides the convenience and high contraceptive efficacy characteristic of IUDs while reducing menstrual flow and cramps," Kaunitz observes. "These characteristics would expand the number of IUD users among my patients."

The clinical safety and efficacy information presented to the FDA is based on the European patient experience database, says **Herman Ellman**, MD, Berlex's director of medical science liaison. The database includes results from more than 20 studies conducted by Leiras, the Finnish company that developed the Mirena in conjunction with the New York City-based Population Council, as well as several investigator-sponsored studies.

Berlex is planning to conduct studies of Mirena in the United States, says **Wendy Neininger**, director of corporate communications. However, those studies are not part of the new drug application, which already has been submitted, she notes.

According to *Contraceptive Technology*, over the long run, the levonorgestrel IUD is the single most effective method available in the world today, followed closely by the Copper T 380A.[1] Over seven years of wear, the cumulative probability of pregnancy with the levonorgestrel IUD is only 1.1%; for the Copper T, it is 1.7%.[1]

Proposed recommended patient profile labeling for the Mirena is similar to that for the ParaGard, says Ellman. Such labeling recommends the device for women who have had at least one child, are in a stable, mutually monogamous relationship, and have no history of pelvic inflammatory disease. Berlex is seeking a U.S. indication of five years' use for the device, which is similar to its current indication in other countries, he confirms.

Women's health providers are intrigued with Mirena's many uses, notes **Robert Hatcher**, MD, MPH, professor of gynecology and obstetrics at Emory University School of Medicine in Atlanta.

"It dramatically decreases menstrual blood loss, is beneficial in the management of the No. 1 cause of hysterectomies in the U.S., leiomyomata [fibroids], and it may be used as the progestin in women on estrogen replacement therapy who have an intact uterus," he notes.

Berlex is seeking U.S. approval for only the contraceptive indication of the device, says Neininger. Some European countries have given approval for the device's therapeutic use in the management of dysfunctional uterine bleeding, she confirms.

Mirena's insertion procedure is easy, but it is different from previous devices and will require hands-on instruction, observes **Anita Nelson**, MD, professor in the obstetrics and gynecology department at the University of California in Los Angeles (UCLA) and medical director of the women's health care clinic and nurse practitioner training program at Harbor-UCLA Medical Center in Torrance.

A new proprietary device developed by Leiras should aid in inserting the IUS, reports **Don Atkinson**, Berlex director of marketing for the female health care division. The new introducer will debut in Europe and the United States, but its debut has not been scheduled.

Fewer than 1% of U.S. women at risk for pregnancy currently use an IUD,[2] so Berlex recognizes that many providers may have limited or no experience with IUD products, says Atkinson. Appropriate physician education and patient support programs will accompany the product upon approval, Neininger says.

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HPV hotline is focus of new resource center

No doubt your patients have questions about human papillomavirus (HPV) — it is the most common sexually transmitted disease (STD) in America.[1] It is estimated that 80% of sexually active people contract it at some point in their lives, with 5.5 million new infections occurring yearly in the United States alone.[2]

To help answer questions on HPV, a national hotline has been established as the first project of the new National HPV & Cervical Cancer Prevention Resource Center. The center has been launched by the Research Triangle Park, NC-based American Social Health Association (ASHA), a nonprofit organization dedicated solely to the prevention and control of all STDs. Callers can access the hotline at (877) 478-5868 from 2 p.m. to 7 p.m. Eastern time, Monday through Friday.

ASHA has designed the resource center to collect, interpret, and disseminate current research data in lay terms to patients, providers, policymakers, and the media, says **Linda Alexander**, PhD, FAAN, ASHA president. The center offers the hotline and a Web site (available through ASHA's site, www.ashastd.org), and it will expand to include consensus guidelines, a continuing medical education curriculum, and other educational materials.

"The center bridges the gap between the most recent scientific data about HPV and its link to cervical cancer, and [the data's] access, translation, and utilization by the general public," notes Alexander. "This center should be considered the nation's champion of communication that cervical cancer is detectable, treatable, and curable."

Approximately 30 HPV types are sexually transmitted, according to resource center statistics. In most cases, the virus is harmless and symptomless. Most people will not have any obvious symptoms, while some will get genital warts, and some will get cancer of the cervix.

While most HPV infections do not lead to serious problems, high-risk HPV types are responsible for nearly all cervical cancers, says **J. Thomas Cox**, MD, the center's executive medical director. The primary measure for preventing cervical cancer is early detection by Pap smear screening, which detects cell changes caused by HPV before they become cancerous. The most recent HPV DNA detection technology enhances the performance of Pap screening. **(*Contraceptive Technology Update* reviewed information on HPV testing and treatments in its April 1998 issue, p. 48.)**

The incidence of invasive cervical cancer has decreased significantly over the last 40 years, in large part due to early detection efforts. The National Breast and Cervical Cancer Early Detection Program, operated by the Centers for Disease Control and Prevention in Atlanta, estimates 12,800 new cases in 1999, with 4,800 deaths attributed to the infection.

The majority of Americans are unaware of the link between certain types of HPV and cervical cancer, and even many health care providers are unsure of the HPV-cancer link, according to Resource Center information. Among policymakers, the misinformation and confusion surrounding HPV has fueled discussion. A 1999 congressional debate centered on whether to require screening for and reporting of HPV, condom labeling, and warnings on educational materials about HPV and other STDs.[3]

Cox, who also serves as director of the University Health Services' gynecology clinic at the University of California, Santa Barbara, sees provider education as an important component of the resource center.

Just as certain portions of the center's Web site will be devoted to information for the lay public, Cox says the provider section will offer constant up-to-date information on HPV's epidemiology, natural history, diagnosis, treatment, and advances such as vaccine development and immunotherapy. A centerpiece will be on-line continuing medical education, developed with the Hagerstown, MD-based American Society for Colposcopy and

EXECUTIVE SUMMARY

A national toll-free hotline is available to answer patient and provider questions on human papillomavirus (HPV), the most common sexually transmitted disease in America.

- The hotline is the first service from the new National HPV & Cervical Cancer Prevention Resource Center, launched by the American Social Health Association.
- The center plans to offer consensus guidelines, a continuing medical education curriculum, and other educational materials. It is estimated that 80% of sexually active people contract HPV, with 5.5 million new infections occurring yearly in the United States alone.

RESOURCES

A one-year subscription to *HPV News* is $25, or $45 for two years and $60 for three years. An annual subscription includes four quarterly issues and the booklet, "HPV in Perspective: A Patient Guide." To subscribe, contact:

- **American Social Health Association**, ASHA Resource Center, P.O. Box 13827, Research Triangle Park, NC 27709. For credit card orders, call (800) 230-6039 between 8 a.m. and 5:30 p.m. Eastern time or fax to (919) 361-8425, attention: customer service, along with credit card number, expiration date, printed name, and signature.

Subscription fee for the quarterly *Journal of Lower Genital Tract Disease* is included with membership to the American Society for Colposcopy and Cervical Pathology. Nonmember U.S. rates are $85, individual; $60, resident; and $125, institution. To subscribe, contact:

- **American Society for Colposcopy and Cervical Pathology,** 20 W. Washington St., Suite 1, Hagerstown, MD 21740. Telephone: (301) 733-3640. Fax: (301) 733-5775.

Cervical Pathology (ASCCP). The society is an organization of health care professionals committed to improving health through the study, prevention, diagnosis, and management of lower genital tract disorders. It has been active in development of guidelines on HPV testing and Pap smear management.

Cox also points to *HPV News,* a quarterly ASHA publication, as another valuable provider resource. The newsletter covers psychosocial issues surrounding HPV and offers medical news on possible diagnostic tools and treatments. **(See resource box, above, for ordering information.)**

The resource center will feature the most up-to-date news on guideline updates for Pap smear management and HPV DNA assay testing, says Cox. It will offer information based on the upcoming guidelines for management of low-grade squamous epithelial lesions (LSIL), scheduled to be published in the March issue of the *Journal of Lower Genital Tract Disease* published by the ASCCP. **(See resource box for ordering information.)** Further information on LSIL will become available this year from the multiyear ASCUS (atypical squamous cells of undetermined significance)/ LSIL Triage Study sponsored by the National Cancer Institute of Rockville, MD.

This year promises to be a watershed in terms of new scientific information in the HPV field, Cox observes. The resource center should prove to be an important aid in keeping both providers and patients up to date on new developments, he says.

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2. National HPV & Cervical Cancer Prevention Resource Center. First HPV Hotline Answers America's Questions. Research Triangle Park, NC; January 2000.
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Widen prevention focus to include young males

Want to reach adolescent males with a pregnancy prevention message? An innovative approach developed by the Washington, DC-based National Campaign to Prevent Teen Pregnancy may be the perfect fit.

The campaign has teamed up with Grant Hill, a professional basketball star with the Detroit Pistons, in developing a prevention-forward campaign. It centers on an advertisement featuring a photo of the athlete and the following message: "At 15, you should be pushing your game, not a stroller. Getting someone pregnant can detour your dreams."

The ad, developed by New York City-based ad agency Ogilvy & Mather, has been incorporated into a print and electronic postcard, as well as a 14" × 11" locker-size poster. **(See resource box, p. 48, for ordering information.)** Introduction of the

EXECUTIVE SUMMARY

The National Campaign to Prevent Teen Pregnancy of Washington, DC, has joined professional basketball star Grant Hill to develop a prevention message aimed at adolescent males.

- The message is reinforced by a print advertisement, printed and electronic postcards, and locker-size posters.
- If your facility is considering implementing services for young men, invite them to your facility for a focus group to get their feedback on desired programs.

ad was kicked off in the magazine *Teen People,* with an accompanying article on the campaign, says **Marisa Nightingale**, director of media programs. Other national magazines have expressed interest in publishing the advertisement as a public service, says Nightingale.

Copies of the print postcard are scheduled to be distributed free for two months at all Tower Records locations through "M@x Racks" displays operated by the New York City-based national postcard rack company. By placing the postcards where young men congregate, the cards — and the message — are easily accessible, says Nightingale.

"That is a really important piece to this campaign, that it not just be an ad that has to be seen in a publication," she notes. "Having these postcards out there gives us a way to get it in the hands of young people who may not be reading a lot of magazines."

Several public health and teen pregnancy agencies also are placing orders for the postcards and locker posters, confirms Nightingale. While the ad and accompanying collateral material were not specifically designed for the purpose, they would serve as an tool in May's observance of National Teen Pregnancy Prevention Month.

Focusing on the future

In working with Hill, the campaign is seeking to offer a positive message to young men, Nightingale observes. "The reason we like [the advertisement] is that it focuses on the future and the possibilities that exist for teen boys. It doesn't tell them what to do; it basically says, 'whatever it takes, prevent teen pregnancy.'"

The campaign, in conducting focus groups with young men, found that an effective message had to reach both abstinent and sexually active young men. "When we did some focus group work with teen boys, the younger boys felt that an abstinence message was relevant, but the older ones tuned it out," says Nightingale. "What we found was that the message needed to be both support for abstaining and support for using protection."

The campaign also worked with Hill in developing a prevention message that is featured on the athlete's Web site, www.granthill.com. The message is headed by "Guys, teen pregnancy is your problem!" and goes on to read: "Too many guys think "responsibility" only means taking care of a baby after it's born. That's important, of course, but think about it this way: Really being responsible means not getting someone pregnant when you're teen-agers."

RESOURCE

- **National Campaign to Prevent Teen Pregnancy**, 2100 M St. N.W., Suite 300, Washington, DC 20037. Web: www.teenpregnancy.org. Visitors to the Web site can send the Grant Hill postcard electronically or choose from three additional messages by typing the following in their Web browser: www.teenpregnancy.org/postcards/postcard.html. Postcards are sold in 50-item bundles for $5 per bundle, and posters are $3.50 each. A 15% shipping and handling charge is added for regular delivery orders; a 5.75% sales tax is added for DC residents. Go to the "Resources" page of the Web site to order these and other educational items.

What does your facility provide in terms of service for young males? If you are considering implementing services, invite young men in for a feedback session on what they want, says **Hector Sanchez-Flores**, senior research associate with the Center for Reproductive Health Policy and Research at the University of California, San Francisco. Sanchez-Flores works with several California-based male involvement programs.

During the feedback session, walk the young men through the facility so they get a sense of what is offered, he suggests. While some clinics do invite men to come into exam rooms as part of their partners' exams, some clinics offer no access, which leaves men in the waiting room with no understanding of the clinic process.

If education is a special interest to young men, ask them if there is a preference for a male or female educator. Also, find out if your staff has an awareness of the specific issues and needs of young men in both general and reproductive health. Young men are interested in knowing more about their bodies, so be prepared to teach them, says Sanchez-Flores.

"I remember hearing a lot more when I was younger about the woman's reproductive health system, and very little was mentioned other than the gross motor parts for men," says Sanchez-Flores. "I've been in group settings where both adult men and teen-age boys are being told about a woman's reproductive health system and then their own, and the men will say, 'I never knew that my parts were that complex.'" ■

Talk up menopause in discussion groups

Women who are moving into the transition years have many valid concerns and questions that often cannot be answered in a single office visit. Providers pressed for time in the stepped-up pace of today's medical scene are torn between stacked patient visits and the desire to help patients fully understand the dynamics of menopause.

How can you solve this problem? Supplement the information provided in your office with menopause discussion groups. Not only do such groups serve as an effective vehicle for disseminating information, they also allow women to help themselves by sharing their personal experiences.

The Cleveland-based North American Menopause Society (NAMS) has developed a booklet to aid providers in forming such small groups within their communities.

Women strongly desire those types of groups, says **Nancy Siskowic**, MSN, NP, CNS, a Torrance, CA, women's health nurse practitioner with a specialty in midlife and menopause. "Women respond immediately because they all have similar concerns" she says. "They don't realize that many of the symptoms they are having are part of menopause, and they feel so validated when they realize that."

Menopause is not a disease, and discussion groups are not support groups in which participants need mental health support. Rather, they are forums in which women to do most of the talking, says **Miriam Rosenthal**, MD, who aided in development of the NAMS booklet. She is chief of the division of psychological and behavioral medicine at University Hospitals of Cleveland and associate professor of psychiatry and reproductive biology at Cleveland's Case Western Reserve University.

Bigger is not better when it comes to discussion groups. Groups should have enough participants to keep the discussion going, but they should allow each woman to have a turn at expressing her concerns, says Rosenthal. Groups can range in size from about five to 15 women, with eight seen as an optimum number.

Whether it's a clinician, a health educator, or a counselor, make sure the person heading the group is a facilitator who can help the group achieve its desired goals. While the facilitator allows each participant to talk, he or she must be strong enough to intervene if the discussion is monopolized, stresses Siskowic.

Keep "hidden agendas" out of the way when serving as a facilitator, says Rosenthal. Those who are of a singular mindset, such as pro-hormone replacement therapy or herbal therapies only, should put ideologies aside when working with discussion groups.

An informal needs assessment can help determine whether a menopause discussion group would be beneficial for your patients. If there isn't a group in your community, the opportunity is open. If such a group does exist, with the number of women now entering the menopause transition, there is room for growth. Also determine the target audience for your group. Will it be women of all ages, or just peri- or postmenopausal women? Keep your group unique for the greatest success.

How will costs be covered? One approach is to solicit funding from various sources, such as pharmaceutical sales representatives, a managed care group, or a local pharmacy or fitness center.[1] Those who contributed to the NAMS guide said the groups that charged participants a fee were the most successful overall. Charging a fee can aid in covering costs, as well as solidify commitment among group members. However, be sure to offer a sliding-scale fee or perhaps a scholarship underwritten with outside funding to help those women who may not be able to afford the fees.

Once you have determined the need for a menopause discussion group, advertise it through such avenues as in-house posters, mailers to other clinics or providers, and community fliers. Then prepare for the first meeting. Start it

EXECUTIVE SUMMARY

Menopause discussion groups offer an excellent patient resource for midlife women who want more information on the dynamics of menopause.

- The North American Menopause Society in Cleveland has developed a booklet to aid providers in forming such small groups within their communities.
- Not only do such sessions disseminate information effectively, they allow women to help themselves by sharing their personal experiences.
- Menopause is not a disease, and discussion groups are not support groups in which participants need mental health care from the facilitator.

RESOURCE

- **The North American Menopause Society** has organized a "How to Develop a Menopause Discussion Group" kit. It contains a 48-page discussion group booklet, a copy of the *Menopause Guidebook,* a current suggested reading list, and an order form for additional copies. The kit costs $15 for members and $21 for nonmembers, with an $8 shipping charge for orders up to $25 and a 7% sales tax for Ohio residents. To order, contact the society at P.O. Box 94527, Cleveland, OH 44101. Telephone: (440) 442-7550. Fax: (440) 442-2660. Phone orders are not taken. NAMS suggests use of the on-line order form at its Web site: www.menopause.org, or a photocopy of the on-line order form.

on time and focus on two key tasks: determining how the group will reach its goals and attending to social relationships within the group.[1]

"I always ask, 'Why are you here? What brings you here? What are your burning questions or concerns?'" says Siskowic.

Groups generally meet for six to eight sessions, says Rosenthal. They can cover varying topics, such as exercise, diet, emotional aspects, and other lifestyle issues for midlife women.

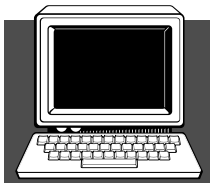
"We talk a lot about the hormonal and herbal [approaches]," notes Siskowic. "I want to get them listening to their bodies, because their body has all the answers."

From the onset, group members need to know what to expect and what is expected of them. By signing and keeping a copy of a "ground rules" sheet, everyone has a firm understanding of the purpose of the group.

While menopause discussion groups provide women with accurate and up-to-date information, they also facilitate sharing experiences. By helping one another understand their choices and empowering themselves to be informed and take of themselves, women in discussion groups gain both individual and group benefits, she says.

Reference

1. Boggs PP, Rosenthal MB. Helping women help themselves: Developing a menopause discussion group. *Menopause Management* 1999; May/June:12-16. ■



WEB WATCH

Readers share favorite advocacy Web sites

Which Web sites advocating reproductive health issues are visited by *Contraceptive Technology Update* readers? A look at our fax inbox and mailbag reveals a wide variety of choices.

Thanks to these *CTU* readers for their submissions: **Sue Bullington**, RN, OB/GYN nurse practitioner with the Tennessee Department of Health in Nashville; **Donna Rae Faulkner**, outreach educator with Kachemak Bay Family Planning Clinic in Homer, AK; **Jen Gall**, executive assistant with Medical Students for Choice in Berkeley, CA; and **Suzanne Ward**, RNP, nurse practitioner at University of California, San Diego Student

Health Center. Keep those suggestions coming! **(See the form inserted in this issue.)**

1. Center for Law and Social Policy (CLASP): www.clasp.org. CLASP, a Washington, DC-based national nonprofit organization with expertise in law and policy affecting the poor, uses education, policy research, and advocacy to improve the economic security of low-income families with children and secure access for low-income persons to the U.S. civil justice system. The site offers listings and ordering information for CLASP's publications and audiocassettes, which cover such subjects as the federal Temporary Assistance for Needy Families Block Grant, which replaced the Aid to Families with Dependent Children program; state family cap policies that limit aid to welfare families with a new child; and teen parent / welfare issues.

2. Center for Reproductive Law and Policy (CRLP): www.crlp.org. The CRLP is a New York City-based nonprofit legal and policy advocacy organization that promotes women's reproductive rights. CRLP's domestic and international programs engage in litigation, policy analysis, legal research, and public education to ensure that all women have access to appropriate and freely chosen reproductive health services. Access the on-line version of the organization's *Reproductive Freedom News* newsletter.

3. Medical Students for Choice: www.ms4c.org. Medical Students for Choice was founded in 1993 by students concerned about the shortage of abortion care providers, the lack of abortion education in medical schools, and escalating violence against those who offer abortion services. Today, the Berkeley, CA-based group represent students at more than 100 medical schools across the United States and Canada. Check out the group's newsletter on-line, as well as its "Resources" section for videos on reproductive health subjects.

4. National Cervical Cancer Coalition: www.nccc-online.org. The National Cervical Cancer Coalition is a Van Nuys, CA-based coalition of women's groups, cytotechnologists, pathologists, laboratories, technology companies, hospitals, and other associations seeking to educate the public about the benefits, limitations, and reimbursement difficulties related to cervical cancer screening tests. New cervical / gynecological technologies, treatments, and research are available at this site.

5. National Vulvodynia Association: www.nva.org. The National Vulvodynia Association is a Silver Spring MD-based nonprofit organization created in 1994 to help individuals affected by vulvodynia, a spectrum of chronic vulvar pain disorders. The association educates affected women to help them make informed treatment choices and develop self-help strategies. It also offers a centralized source of information on suspected causes, current treatments, and ongoing research for providers and patients. The site offers answers to frequently-asked questions about the disorder.

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Editorial Questions

Questions or comments?
Call **Joy Daughtery Dickinson** (912) 377-8044.

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6. Sexuality Information and Education Council of the United States: www.siecus.org. The Sexuality Information and Education Council of the United States is a New York City-based organization dedicated to affirming that sexuality is a natural and healthy part of life. It develops, collects, and disseminates information on the subject, promotes comprehensive education, and advocates the right of individuals to make responsible sexual choices. Its on-line archive of *SHOP* (School Health Opportunities and Progress) *Talk* newsletters offers good resources for those who work with adolescent populations. ■

CE objectives

[For details on Contraceptive Technology Update*'s continuing education program, contact: Customer Service, American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. Fax: (800) 284-3291. E-mail: customerservice@ahcpub.com. Web: www.ahcpub.com.]*

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. **(See "Mirena intrauterine system seeks U.S. nod," p. 44, and "HPV hotline is focus of new resource center," p. 46.)**

• Describe how those issues affect service delivery and note the benefits or problems created in patient care in the participant's practice area. **(See "What will it take to get EC into the hands of women who need it?" p. 41.)**

• Cite practical solutions to problems and integrate information into daily practices, according to advice from nationally recognized family planning experts. ■

Correction

The article on the FemCap contraceptive device in the March 2000 *Contraceptive Technology Update* contained an inaccurate description of the vaginal barrier device. The new silicone rubber barrier contraceptive is shaped like a sailor's hat, with a dome that covers the cervix, a rim that fits into the fornices, and a brim that conforms to the vaginal walls around the cervix. ■

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