

CONTRACEPTIVE TECHNOLOGY

U P D A T E[®]

A Monthly Newsletter for Health Professionals

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Take aim at eliminating spread of hepatitis B virus in U.S. population

Sexual activity is responsible for almost half of new HBV infections

When discussing prevention strategies against sexually transmitted diseases (STDs) with your patients, do you discuss immunization against hepatitis B? The message may not be getting through; 42% of 1,150 adults ages 18-35 participating in a 2004 national survey did not know they could protect themselves from hepatitis B virus (HBV) infection through vaccination.¹

Sexual activity is responsible for almost 50% of new HBV infections.² As *Contraceptive Technology* points out, latex or synthetic condom use reduces the risk of many bacterial and viral STDs, including those transmitted primarily through genital secretions, such as HBV.³ HBV continues to be among the most frequently reported vaccine-preventable diseases in the United States. In 2003, about 73,000 individuals were infected with HBV.⁴ About 1.2 million people in the United States have chronic HBV infection, and an estimated 5,000 people die each year from HBV-related liver disease.⁵

Get ready to implement new recommendations on adult HBV immunizations from the Advisory Committee on Immunization Practices

EXECUTIVE SUMMARY

Get ready to implement new recommendations on adult hepatitis B (HBV) immunizations from the Advisory Committee on Immunization Practices.

- Hepatitis B continues to be among the most frequently reported vaccine-preventable diseases in the United States. In 2003, about 73,000 individuals were infected with HBV.
- About 1.2 million people in the United States have chronic HBV infection; an estimated 5,000 people die each year from HBV-related liver disease.
- More work is needed to reach the federal government's 2010 goal for 90% of STD clinics to routinely offer hepatitis B vaccines to all STD clients.

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(ACIP), which aids the federal government in designing the most effective means to prevent vaccine-preventable diseases. The committee met in October to review proposed changes, the first to be implemented since 1991. While the committee voted to accept the new recommendations, they remain provisional until they are released in

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Editorial Questions

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the *Morbidity and Mortality Weekly Report*, published by the Centers for Disease Control and Prevention (CDC). Recommendations on immunizations for infants, children, and adolescents were published in December 2005.⁶ While publication of the adult immunization recommendations is expected in 2006, a release date has not yet been set, says **Eric Mast**, MD, MPH, chief of the prevention branch in CDC's Division of Viral Hepatitis.

Review recommendations

Who should receive HBV vaccination? According to the provisional ACIP recommendations, candidates include:

- **All unvaccinated adults at risk for HBV infection and all adults seeking protection from HBV infection.** Acknowledgment of a specific risk factor is not a requirement for vaccination. (See listing on p. 27 of risk groups.)

- **In settings where a high proportion of adults are likely to have risk factors for HBV infection, all unvaccinated adults should be assumed to be at risk and should receive hepatitis B vaccination.** These settings include STD treatment facilities, HIV testing facilities, HIV treatment facilities, facilities providing drug abuse treatment and prevention, correctional facilities, health care settings serving men who have sex with men (MSM), chronic hemodialysis facilities and end-stage renal disease programs, and institutions and nonresidential day care facilities for developmentally disabled persons.

- **Standing orders should be implemented to identify and vaccinate eligible adults in primary care and specialty medical settings.** If ascertainment of risk for HBV infection is a barrier to vaccination in these settings, providers may use alternative vaccination strategies such as offering hepatitis B vaccine to all unvaccinated adults in age groups with highest risk for infection, such as those younger than age 45.⁷

Some in the public health field had looked to ACIP to recommend an age-based, universal hepatitis B vaccination strategy for adults.⁸ Routinely immunizing adults against hepatitis B would only be needed for a limited period, since the program would serve as a "catch-up" to vaccinate those adults who have not yet benefited from child and adolescent vaccination programs.⁹

An age-based strategy was considered by ACIP, says Mast; however, the strategy that was approved by the committee emphasizes achieving high

Who is at Risk for Hepatitis B Virus?

- Persons with multiple sex partners or diagnosis of a sexually transmitted disease
- Men who have sex with men
- Sex contacts of infected people
- Injection drug users
- Household contacts of chronically infected persons
- Infants born to infected mothers
- Infants/children of immigrants from areas with high rates of hepatitis B virus infection
- Health care and public safety workers
- Hemodialysis patients

Source: *Hepatitis B Fact Sheet*, Centers for Disease Control and Prevention, Atlanta.

vaccine coverage among people at risk because approximately 85% of new hepatitis B cases occur in persons with well-defined risk characteristics.

The committee recommended that as part of routine services, all primary care and specialty medical settings (e.g., physicians' offices, family planning clinics, community health centers, liver disease clinics, and travel clinics) should implement standing orders to identify at-risk adults who should be vaccinated and to administer hepatitis B vaccination to unvaccinated adults, Mast says. In addition, providers should help patients assess their need for hepatitis B vaccination by obtaining a history of risks for sexual transmission and percutaneous or mucosal exposure to blood. If ascertainment of risk for HBV infection is a barrier to hepatitis B vaccination, providers are encouraged to use other vaccination strategies, such as vaccinating all people younger than 45 years of age, which is the age group with the highest risk of infection, explains Mast.

"The recommendations give flexibility to clinicians to implement age-based vaccination strategies if those are required to achieve high vaccine coverage among adults who need to be vaccinated, which is what we are trying to achieve," Mast says.

STD clinics have been increasingly implementing HBV vaccination programs, and the ACIP's new recommendations will strengthen their efforts to routinely administer vaccine to adults, says Mast. However, substantial gains will need to be made if public health officials are to achieve the

federal government's Healthy People 2010 goal for 90% of STD clinics to routinely offer hepatitis B vaccines to all STD clients.¹⁰ (See the accompanying article on p. 28, as well as the resource listing on p. 29, for information on setting up an immunization program within an STD clinic.)

Frequent barriers to integrating hepatitis B programs into STD clinic services are lack of funding, lack of resources to track patients, patient noncompliance, and lack of awareness about the hepatitis B vaccine, says **Lisa Gilbert**, PhD, director of research at the American Social Health Association (ASHA) in Research Triangle Park. Gilbert served as lead author of an ASHA study of STD clinic and program managers, designed to check the progress of implementing HBV prevention programs in STD treatment facilities.¹¹ While researchers found that HBV policies and vaccination and education efforts in STD clinics have improved, hurdles are left to be cleared.

"To increase integration efforts, STD clinics need more resources including funds, vaccine, training, and educational materials for clients and health care providers," she notes.

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Use the Internet to set up hepatitis B programs

Your facility offers sexually transmitted disease (STD) services, but does it include vaccinations for hepatitis B virus (HBV)?

If it does not, what will it take to integrate an immunization program into existing services? Take a tip from the Internet. Consult the online guide, *Hepatitis B Immunization in a STD Clinic: Lessons Learned in San Diego County*.¹

Developed by the STD and Hepatitis Prevention Program of the San Diego County Health and Human Services Agency's Office of Public Health, the guide covers specific information from the agency's experience and includes educational materials, protocols, and data collection tools developed by the program. (See the resource listing on p. 29 to access the publication.)

The guide was written following the 1997 implementation of a hepatitis B vaccination demonstration project designed to reach high-risk adults and adolescents, funded by the Centers for Disease

Control and Prevention (CDC). CDC funding for the demonstration program ended in 2003; however, the county-operated STD clinics continue to offer selective viral hepatitis services based on risk factors reported by clients, says **Craig Sturak**, health information specialist in the San Diego agency's HIV, STD, and Hepatitis Branch. These services include hepatitis B and C screening, hepatitis B vaccination, educational materials, and medical referrals for clients who test positive for hepatitis B or C to seek follow-up care, he notes.

How has the guide been used by other programs? According to Sturak, the guide — or portions of it — is in wide circulation due to its availability on the Internet. From March 2002 to June 2003, the entire guide was downloaded 660 times from one site operated by the St. Paul, MN-based Immunization Action Coalition (IAC). Portions of the guide, such as specific chapters or training materials, were downloaded 5,251 times from the IAC site, says Sturak.

Take a basic approach

Integrating hepatitis B programs into STD clinic services can mean several things, says **Lisa Gilbert**, PhD, director of research at the American Social Health Association (ASHA) in Research Triangle Park. Programs can include such elements as vaccinating STD clients; educating clients and health care providers; developing and disseminating written hepatitis B prevention policies; collaborating with immunization programs to establish hepatitis B vaccination efforts; enrolling in the Vaccine for Children program (a federal program that provides free vaccine to eligible children); and identifying other sources of funding for vaccine through city, county, state, and federal programs, she explains.

What are some of the biggest challenges when it comes to implementing a HBV vaccination program in an existing STD program? Sturak lists three candidates: cost of vaccine; staff buy-in — fitting hepatitis services into the flow of a STD clinic; and determining the eligibility criteria for services, if a program chooses to do selective vaccination. Medicare covers HBV vaccine administration for those at intermediate or high risk for hepatitis B, but there is no federal policy for Medicaid reimbursement for vaccination. Each state determines coverage and services; private insurance plans and health maintenance organizations also determine reimbursable services.²

What are some ways to get started in HBV prevention? Consider the following options:

EXECUTIVE SUMMARY

Rely on Internet resources to help set up hepatitis B prevention efforts as part of your sexually transmitted disease (STD) services.

- Consult an on-line guide developed by the San Diego County Health and Human Services Agency. The publication covers specific information from the agency's experience and includes educational materials, protocols, and data collection tools developed by the program.
- Offer viral hepatitis education and counseling for all patients accessing STD or HIV testing programs. Key information can be delivered in three to five minutes and can be integrated in current STD and HIV prevention messages. Use freely reproducible educational material to accentuate the prevention message.

- Offer viral hepatitis education and counseling for all patients accessing STD or HIV testing programs. Key information can be delivered in three to five minutes and can be integrated in current STD and HIV prevention messages. Use free handouts and posters to educate your clients. (See the resource listings, this page.)

- Offer HBV vaccination to all those younger than 19 years of age who seek STD or HIV

RESOURCES

For more information on hepatitis B vaccination programs, contact:

- **Immunization Action Coalition (IAC)**, 1573 Selby Ave., Suite 234, St. Paul, MN 55104. Telephone: (651) 647-9009. Fax: (651) 647-9131. E-mail: admin@immunize.org. Web: www.immunize.org. To see links to information on various HBV programs around the United States, go to the main web site, click on www.hepprograms.org under "IAC web sites," then click on "STD/HIV" under "Prevention Programs." Review the *Hepatitis B Immunization in a STD Clinic: Lessons Learned in San Diego County* at no cost by clicking on "San Diego County HIV, STD, and Hepatitis Branch," then the link at the bottom of the page. To review the IAC publication *Adults Only Vaccination; A Step-By-Step Guide* at no cost, go to the main web site, click on "Adults Only Vax Guide" under "Favorites from IAC." The guide is designed to help integrate immunization services into health care settings new to vaccination. It covers all aspects of a vaccination program, from assessing vaccine indications and contraindications to determining billing codes. The IAS site also offers free patient information sheets as well as links to abstracts of journal articles and provider resources. The IAC and its Hepatitis B Coalition program publish *Hep Express*, an on-line news publication. It can be reviewed on the IAC web site as well as through free e-mail subscription, which is available on the web site.
- **The Centers for Disease Control and Prevention's Division of Viral Hepatitis** in the National Center for Infectious Diseases offers many online resources at its web site, www.cdc.gov/ncidod/diseases/hepatitis. Click on "Hepatitis B" to review information on HBV. Click on "Integrating Hepatitis B Vaccination into STD and HIV/AIDS Programs" for specific information on vaccination programs. The publication, *Hepatitis B Immunization in a STD Clinic: Lessons Learned in San Diego County* is available at no cost at this site.

services. The vaccine is available under the Vaccines for Children federal program.

- Use a self-administered health risk assessment form to identify persons at increased hepatitis risk. Use local or state vaccine funds to purchase HBV vaccine, which can be offered on a risk-based case.³

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Research signals safety of Pill use in lupus

Women with inactive or stable systemic lupus erythematosus — a disease in which the body's immune system mistakenly attacks and damages healthy tissues of the skin, joints and internal organs — need effective contraception. When women with inactive or stable systemic lupus erythematosus need effective contraception, clinicians rarely prescribe oral contraceptives (OCs) due to fears that the Pill might increase disease activity.

Results of two separate studies indicate that women with inactive or stable forms of the disease are able to use oral contraceptives without increased risk of flares that characterize the disease.^{1,2} The research provides prospective data that support the use of combined pills by those with inactive or moderately active, stable disease, according to an editorial accompanying the two publications.³

The Lupus Foundation of America estimates about 1.5 million Americans have some form of lupus. Although lupus can strike men and women of all ages, 90% of those diagnosed with the disease are women; 80% of those with systemic lupus develop it between the ages of 15 and 45.⁴

Women with lupus have the same needs as any other young women when it comes to contraception, says **Jorge Sanchez-Guerrero**, MD, head of

RESOURCES

New research indicates that women with inactive or stable forms of systemic lupus erythematosus are able to use oral contraceptives without increased risk of flares that characterize the disease.

- When women with inactive or stable systemic lupus erythematosus need effective contraception, clinicians rarely prescribe oral contraceptives (OCs) due to fears that the Pill might increase disease activity.
- More research is needed on use of combined oral contraceptives in women with severe active systemic lupus erythematosus, because the new studies did not look at this subgroup.

the department of immunology and rheumatology at the National Institute of Medical Sciences and Nutrition in Mexico City and lead author of one of the studies.

With advances in treatment, women with inactive or stable lupus erythematosus are able to do anything they want, such as have a career and/or become a mother, because the prognosis of the disease is excellent, he says. However, when the disease is active, rheumatologists advise that patients wait until the disease is quiescent and disease activity is stable in order to become pregnant, because disease manifestations may be dangerous to the woman and the fetus, says Sanchez-Guerrero.

Is estrogen a concern?

Since effective contraception is so important for women with lupus, why have clinicians been hesitant to prescribe combined oral contraceptives?

In a study of mice with the disease, estrogen worsened the disease,⁵ says **Michelle Petri**, MD, MPH, professor in the division of rheumatology in the department of medicine at Johns Hopkins University in Baltimore and lead author of one of the current research papers. In humans with lupus and lupus kidney disease, a past study showed that oral contraceptives made the kidney disease flare up,⁶ she notes.

To perform the multicenter study, which was funded by the National Institutes of Health (NIH), scientists randomized 183 ethnically diverse young women with inactive or stable lupus to receive a combination OC or placebo. During a year of treatment, the two groups had nearly identical rates of severe disease flare and mild or moderate flare.

Two thrombotic events occurred in the OC group, and three occurred in the placebo group.²

In the study led by Sanchez-Guerrero, which was funded by the World Health Organization, researchers looked at outcomes among 162 young women with lupus who were randomly assigned to use a combination pill, a progestin-only pill, or a copper intrauterine device. During a year of treatment, rates of overall flare and severe flare were similar in all three groups. Scientists recorded two thrombotic events in each pill group; low titers of antiphospholipid antibodies were found in all four patients. One woman in the combined pill group died from amoxicillin-related neutropenia during the study.¹

What's the next step?

The NIH-funded study is one of two separate randomized, placebo-controlled studies designed to examine the safety of estrogens in women with lupus erythematosus. Results from the other study, which looked at use of in hormone replacement therapy in postmenopausal women, indicated no increased risk of severe flares in the study group.⁷

For most women with moderate lupus that is inactive or stable, combined OCs appear to have no detrimental effect on disease activity, conclude researchers in the two current studies. However, both sets of researchers note that oral contraceptives are not advised for women who have a history or at high risk for venous thrombosis, because estrogen has been associated with dangerous blood clots.

More research will need to focus on use of combined OCs in women with severe active systemic lupus erythematosus, because neither study included these women in the study groups. Whether combined OCs can be used safely in this subgroup has yet to be determined, notes the editorial accompanying the two publications.³

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Does contraceptive use impact cancer risk?

Contraceptive use has been reported as a risk factor for cervical cancer^{1,2}; however, since the discovery of the strong link between human papillomavirus (HPV) infection and cervical cancer, evidence has been unclear on its association. Findings from a new study indicate that it may well be HPV infection, rather than use of hormonal contraception, that causes high-grade cervical intraepithelial neoplasia (CIN).³

The new study looked at the relationship of oral contraceptive (OC) use, hormonal contraceptive use, and multiparity as potential risk factors for cervical precancer. More research is needed on the subject, says **Philip Castle**, PhD, MPH, an investigator with the National Cancer Institute

EXECUTIVE SUMMARY

A new study looks at the relationship of oral contraceptive use, hormonal contraceptive use, and multiparity as potential risk factors for cervical precancer. Findings indicate that it may well be human papillomavirus (HPV) infection, rather than use of hormonal contraception, that causes high-grade cervical intraepithelial neoplasia (CIN).

- Contraceptive use has been reported as an environmental risk factor for cervical cancer; however, since the discovery of the strong link between HPV infection and cervical cancer, evidence has been unclear regarding the impact of hormonal contraception.
- Findings from the new study indicate that current use of hormonal contraception does not impact CIN3 risk. Although use of the contraceptive injection DMPA was found to marginally increase the risk of CIN3, further examination is needed since findings conflict with other large studies with reassuring findings regarding its use.

in Bethesda, MD, and lead author of the study. Castle points to such research avenues as:

- ascertainment of specific contraceptives used and their composition of hormones in epidemiologic studies to assess any dose-response relationships;
- analyses in cohort studies to examine the stage at which hormonal contraceptive use might influence cervical carcinogenesis: HPV acquisition, HPV persistence, development of cervical precancer, and development of cancer;
- in vitro models to examine the impact of contraceptive hormones on expression of HPV viral genes.

As *Contraceptive Technology* points out, research indicates that condoms help provide protection against HPV and other sexually transmitted diseases that are transmitted primarily through skin-to-skin contact.⁴

To perform the analysis, scientists looked at 5,060 women with minimally abnormal Pap smears who were enrolled in the ASCUS (atypical squamous cells of unknown significance) and LSIL (low-grade squamous intraepithelial lesion) Triage Study (ALTS), a randomized clinical trial designed to evaluate management strategies.

Cervical specimens collected at enrollment were tested for HPV DNA. Scientists then calculated odds ratios developing CIN3 during the two-year study for women who were found to have infections with oncogenic HPV at baseline.

Oral contraceptive use, Norplant use, a history of pregnancy, age at first pregnancy, lifetime numbers of pregnancies, and lifetime numbers of live births were not associated with CIN3, researchers conclude.³ Current use of the contraceptive injectable depot medroxyprogesterone acetate (DMPA, Depo-Provera, Pfizer, New York City) was found to marginally increase the risk of CIN3; however, because other contraceptives did not have the same impact, researchers said further examination is needed.³ Previous studies have not found an association of injectable contraceptive use and cancer.^{5,6}

Screening is vital

Most well-controlled studies, including three case-controlled reports,⁷⁻⁹ have found no association between OC use and CIN, says **Andrew Kaunitz**, MD, professor and assistant chair in the obstetrics and gynecology department at the University of Florida Health Science Center/Jacksonville.

In the United States, HPV 16 alone accounts for more than half of all cervical cancer cases, followed

by HPV 18, 31, and 45.¹⁰ While strides have been made in reducing the impact of cervical cancer in America, 2005 statistics from the American Cancer Society (ACS) estimate about 10,370 cases of invasive cervical cancer to be diagnosed in the United States.¹¹ About 3,710 women will die from cervical cancer in the United States during 2005, according to the ACS.¹¹

“From a public health perspective, the most important risk factors for cervical cancer are persistent HPV infection of a carcinogenic HPV type and failure to be screened,” says Castle. “Regular screening will protect women from cervical cancer.” (Some strains of HPV account for most cervical cancer cases. See *Contraceptive Technology Update’s* article, “Are you talking to women about HPV and cervical cancer screening?” September 2005, p. 101.)

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Scientists eye delivery options in microbicides

The last patient on your list is a young woman with a positive test for a sexually transmitted disease (STD). When discussing strategies for protection from future infections, she tells you she is not comfortable with using a female condom and has problems negotiating male condom use with her boyfriend. Outside of abstinence, what are her options?

Scientists now are looking at microbicides — substances designed, when applied vaginally, to reduce transmission of HIV or other STDs — to give women more protection options. Ten candidates are in Phase I or I/II studies, six in Phase II/IIb, and four in Phase III trials.¹ (*Contraceptive Technology Update* reported on microbicide research in its article, “Microbicide development gets a corporate boost,” January 2006, p. 5. For tips on facilitating correct condom use, look at the article, “Overcome barriers to correct condom use,” March 1999, p. 31.) According to *Contraceptive Technology*, look to at least 2007 before a candidate will be ready for FDA approval.²

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EXECUTIVE SUMMARY

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- Microbicide formulations are being analyzed in several delivery methods, including gels, creams, films, suppositories, and vaginal rings.
- One microbicidal candidate, TMC120, is being evaluated for use in a vaginal ring as well as in a topical gel, while another candidate, Amphora, is being tested in combination with a diaphragm.

microbicidal candidate, TMC120, is being evaluated for use in a vaginal ring as well as in a topical gel, says **Mark Mitchnick**, MD, chief scientist at International Partnership for Microbicides (IPM) in Silver Spring, MD, a nonprofit organization.

The microbicide, a non-nucleoside reverse transcriptase inhibitor, is in advanced safety trials in Africa, he reports. If results from the safety trial are positive, scientists look toward implementing a Phase III efficacy trial in 2007, Mitchnick estimates.

IPM completed a small safety trial of TMC 120 gel in vaginal ring form last July. Thirteen women participated in the Ghent, Belgium, study, using the ring for seven consecutive days. Warner Chilcott PLC, based in Northern Ireland, developed the ring, and IPM collaborated with Medisearch International and the University of Ghent, both based in Belgium, to conduct the study, which is not yet published. Results from an earlier trial indicate that rings are capable of releasing amounts needed to prevent infection.³

Ring applicators would offer women the convenience of fewer applications; however, the delivery method offers some restrictions, notes Mitchnick. It is more difficult to combine compounds to work effectively in ring delivery, he observes. There are a limited number of ring manufacturers. Production of rings would need to be stepped up if scientists can show that a microbicidal candidate is safe and effective in such a delivery mechanism, Mitchnick states.

Barrier method in focus

Amphora, an acid-buffering bioadhesive vaginal formulation also known as Acidform, is in research in Madagascar to test its acceptance by urban women at high risk for STDs. The study is cosponsored by the Centers for Disease Control and Prevention (CDC) in Atlanta, the United States Agency for International Development in Washington, DC, the Contraceptive Research and Development (CONRAD) program in Arlington, VA, and the University of North Carolina at Chapel Hill.

Amphora is being tested in Madagascar with the diaphragm as a cervical barrier device. Previous research indicates that acceptance of such a barrier device is high among the women in the study population.⁴ Studies indicate that Amphora is safe and well tolerated by men and women.^{5,6}

What are some potential advantages of using a barrier device to deliver a microbicide? "Any kind

of barrier device can slow or inhibit movement of pathogens to the cervix, and more importantly, will hold a microbicide in the vagina by preventing it from leaking out," explains **Barbara North**, MD, medical director of Instead, the San Diego manufacturer of Amphora. "Also, since barrier devices have two sides, you can technically use both the inside and the outside to deliver appropriate substances to either the vaginal or the cervical tissue."

Instead also is looking at use of Amphora as a possible contraceptive in combination with its Instead Softcup, says **Ariel Herr**, company spokesperson. The Softcup is marketed as a feminine hygiene product. While Amphora received Food and Drug Administration (FDA) approval in September 2004 as a personal lubricant, the company has not yet released it on the retail market, says Herr. (**CTU reported on the approval in its article, "Progress under way on the microbicide front," December 2004, p. 136.**)

"Instead is currently in discussions with various public funded organizations and research groups to discuss the scope and timing of a trial for the company's proposed Choice Cup contraceptive device, which will combine the company's flagship Instead Softcup as a disposable diaphragm with its candidate microbicide Amphora as a spermicide," says Herr. "While Amphora will be monitored for contraceptive effectiveness in the 2006 CDC clinical trial that will follow the current pre-clinical in Madagascar, the company also aims to launch a Choice Cup trial in 2006 to eventually make the product available to and accessible for women around the world."

References

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Use the phone and web to expand EC access

While women wait for a decision from the Food and Drug Administration (FDA) on the status of moving emergency contraception over the counter (OTC), some family planning providers are looking at using the telephone and Internet to help expand access to the method.

More providers are looking into offering hotline numbers or web sites that enable women anywhere in their state to obtain a prescription for emergency contraceptive pills (ECPs) without a clinical appointment. They were spurred by a call from the Association of Reproductive Health Professionals (ARHP) and the Office of Population Research at Princeton (NJ) University, which jointly sponsor the toll-free Emergency Contraception Hotline [(888)-NOT-2-LATE] and the Emergency Contraception Website (<http://not-2-late.com>).

ARHP is interested in helping women access EC as quickly as possible, says **Janet Riessman**, ARHP's director of communications. Over-the-counter access is the ideal way for women to access the time-sensitive medication 24 hours a day, seven days a week, says Riessman. Until that access is

available, health care providers can and should offer to call in EC prescriptions and/or to give women EC prescriptions ahead of time, she notes. By doing so, women can access the drug more quickly when they need it, Riessman explains.

The EC Hotline has been important in getting the word out on EC. Since it was launched on Feb. 14, 1996, the hotline has received more than 525,000 calls. More detailed information on the method is available on the Emergency Contraception web site, which has received approximately 2.5 million visits since it was launched in October 1994. The hotline and the web site are completely confidential, available 24 hours a day in English and Spanish, and offer names and telephone numbers of providers of emergency contraception located near the caller's area (in the United States and parts of Canada). The web site also is available in French and Arabic.

While your facility may be offering telephone EC assessment and prescription programs to non-established clients, has it considered publicizing this service to women throughout your state?

Such call-in prescription services for emergency contraceptive pills are available via telephone hotline in Connecticut, Georgia, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, New Mexico, New York, North Carolina, and Wisconsin. Call-in prescription services for emergency contraceptive pills are available on-line in Georgia, Illinois, Indiana, Massachusetts, Oregon, and Washington.

Setting up such a service entails:

- establishing times during which such service is available to women;
- conducting a simple health assessment over the phone;
- calling in the prescription to a pharmacy of the women's choice within your state.

Some states restrict physicians' authority to issue prescriptions without a physical examination, so providers should speak with a lawyer prior to setting up a telephone or Internet service. The New York City-based Center for Reproductive (www.reprorights.org) has researched restrictions and can provide information on individual state policies, says **Bonnie Scott Jones**, a staff attorney

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Update your counseling
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RESOURCE

For information on state policies regarding telephone/Internet prescriptions for emergency contraception, contact:

- **Bonnie Scott Jones**, Center for Reproductive Rights, 120 Wall St., New York, NY 10005. E-mail: bjones@reprorights.org.

with the center. (See resource box, above, for contact information.)

Follow the lead of Planned Parenthood of Georgia in Atlanta, which was the first to launch such an access program in 1999. (*Contraceptive Technology Update* reported on the program's launch in the article, "One call does it all for women seeking ECPs," June 1999, p. 64.)

In 1999, the affiliate provided about 2,600 doses of EC. In 2005, the affiliate provided 4,500 doses through its health centers and about 1,400 doses through its online and toll-free Emergency Contraception Connection, says **Leola Reis**, the affiliate's vice president of communications, education, and outreach. The EC Connection now represents about 25-28% of the affiliate's total EC provision, she notes.

EC telephone medical assessment and prescription are available from anywhere in Georgia by calling the service at (877) EC-PILLS [(877) 327-4557] or visiting its web site, www.ecconnection.org. The service is available Monday through Friday from 9 a.m.-4:30 p.m., Saturday from 9 a.m.-12:30 p.m., and Sundays from 1 p.m.-4:30 p.m. Patients must use a credit card as payment for the \$40 assessment; cost of the drug is not included. Also, patients must provide the name and phone number of their desired pharmacy for the prescription order. Each medical assessment takes about 20 minutes.

The EC Connection is located at the affiliate's downtown Atlanta health center. Reis estimates that nurse practitioners and patient educators spend, on a cumulative basis, about two to three hours a day checking and responding to messages, phone calls, and e-mail associated with the program.

The telephone/internet program is just one facet of Planned Parenthood of Georgia's commitment to broadening EC access, says Reis. For women who need a sliding fee scale to access EC, the affiliate's health centers can provide such service. However, for those women with a credit card who may have no time or ability to come

into the centers, the EC Connection meets their need, says Reis.

"I think that patients really like it," observes Reis of the EC Connection. It is clearly a niche market, she says. "It is a complement of our mission because we are about access, but we are also about access for women who do not have a lot of choices, either financial or location." ■

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CE/CME Instructions

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

CE/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 service delivery and the benefits or problems created in patient care in the participant's practice area.
- **Integrate** practical solutions to problems and information into daily practices, according to advice from nationally recognized family planning experts.

9. Sexual activity is responsible for what estimated percentage of new hepatitis B infections?
- A. 20%
B. 30%
C. 40%
D. 50%
10. Although lupus can strike men and women of all ages, what percentage of those diagnosed with the disease are women?
- A. 90%
B. 80%
C. 70%
D. 60%
11. Which type of human papillomavirus (HPV) accounts for more than half of all cervical cancer cases in the United States?
- A. HPV 6
B. HPV 11
C. HPV 16
D. HPV 35
12. What type of microbicide is TMC120?
- A. Surfactant
B. Post-binding fusion inhibitor
C. Acid-buffering bioadhesive
D. Non-nucleoside reverse transcriptase inhibitor

Answers: 9. D; 10. A; 11. C; 12. D.

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