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INSIDE

AHC Media

Short-term bleeding and cramping with LARC method satisfaction eyed

Satisfaction remains high at 3 and 6 months, CHOICE data suggests

Just-released research findings from the Contraceptive CHOICE Project, a St. Louis prospective cohort study, examined the short-term bleeding and cramping patterns of long-acting reversible contraception (LARC) methods and the impact on method satisfaction.[1] Findings indicate that regardless of the LARC method chosen, satisfaction at three and six months was very high.

To perform the current analysis, researchers at the Washington University School of Medicine in St. Louis looked at three- and six-month survey data from intrauterine (IUD) and implant users in the Contraceptive CHOICE Project. Women who received one of the LARC methods — the levonorgestrel-releasing intrauterine system (LNG-IUS), copper IUD, or the etonogestrel implant — and completed their three- and six-month surveys were included in the analysis. Investigators used univariable and multivariable analyses to examine the association of bleeding and cramping patterns with short-term satisfaction.

The analysis included 5,011 project participants: 3,001 LNG-IUS users, 826 copper IUD users, and 1,184 implant users. Analysis findings indicate that at three months, more than 65% of LNG-IUS and implant users reported no change or decreased cramping, while 63% of copper IUD users reported increased menstrual cramping. Lighter bleeding was reported by 67% of LNG-IUS users, 58% of implant users, and 8% of copper IUD users. At three and six months, most women were satisfied (somewhat satisfied or very satisfied) with their LARC method. At three months, 95% of LNG IUS users, 94% of copper IUD users, and 94% of implant users were satisfied. At six months. 94% of LNG-IUS users, 93% of copper IUD users, and 90% of implant were satisfied.[1]

Women who reported increased menstrual cramping (relative risk adjusted [RRadj], 0.78; 95% confidence

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interval [CI], 0.72-0.85), heavier bleeding (RRadj, 0.83; 95% CI, 0.76-0.92), and increased bleeding frequency (RRadj, 0.73; 95% CI, 0.67-0.80) were less likely to report being very satisfied at six months. *(To read more about the project, see the* Contraceptive Technology Update *articles, "How to make LARC first at your clinic," October 2014, p. 115; "LARC methods: 7 things you need to know," January 2014, p. 4, "Research proves LARC methods are best — What happens now in practice?" August 2012, p. 85, and "New data: Long-acting reversible methods superior in effectiveness," July 2012, p. 73.)*

Counseling is key

In previous research, results from a randomized trial found that long-term copper IUD users were more likely to discontinue the device because of heavy menstrual bleeding and dysmenorrhea (9.7 per 100 women using the copper IUD versus 1.3 per 100 women using the levonorgestrel intrauterine system), whereas LNG-IUS users were more likely to discontinue the device because of amenorrhea and spotting compared with copper IUD users (4.3 per 100 women versus 0 per 100 women, respectively).[2]

What role does counseling regarding bleeding and cramping play in patient satisfaction with LARC methods? "Counseling regarding bleeding and cramping before starting LARC methods is crucial," says **Justin Diedrich**, MD, a research fellow in the Washington University in Saint Louis' Department of Obstetrics & Gynecology's Division of Clinical Research. "Because each person is different, counseling helps patients choose which method is best for them."

Researchers involved in the Contraceptive CHOICE Project found that women with more bleeding and cramping are less likely to choose a method that might worsen their symptoms, says Diedrich, who served as lead author of the current paper. In addition, when providers hear that a woman has very heavy menses or painful periods, they are less likely to recommend a device associated with heavier bleeding or cramping, Diedrich notes.

EXECUTIVE SUMMARY

Research findings from the Contraceptive CHOICE Project, a St. Louis prospective cohort study, examined the short-term bleeding and cramping patterns of long-acting reversible contraception (LARC) methods and the impact on method satisfaction. Findings indicate that regardless of the LARC method chosen, satisfaction at three and six months was very high.

- Analysis findings indicate that at three months, more than 65% of levonorgestrel intrauterine system (LNG-IUS) and implant users reported no change or decreased cramping, while 63% of copper intrauterine device (IUD) users reported increased menstrual cramping. Lighter bleeding was reported by 67% of LNG-IUS users, 58% of implant users, and 8% of copper IUD users.
- At three and six months, most women were somewhat satisfied or very satisfied with their LARC method.

"At three and six months, women who chose LARC methods were highly satisfied with the method they chose," Diedrich observes. "We believe their high level of satisfaction is related to extensive pre-insertional counseling."

Put steps into practice

Long-acting reversible contraceptive methods have an effect on menstrual bleeding, and patients should be given anticipatory guidance about these effects, according to a practice bulletin from the American College of Obstetricians and Gynecologists.[3]

The Contraceptive CHOICE Project used a standardized counseling session at the time of method selection, where participants were informed of potential method-specific symptoms.[4] Women were reassured that irregular and unpredictable bleeding are side effects of all LARC methods. Women choosing the LNG-IUS were counseled that bleeding typically gets lighter over time and amenorrhea is common. With the copper IUD, menses typically become regular, but flow might be slighter heavier. With the implant, the bleeding pattern is unpredictable, and patients must accept the fact that the implant can cause irregular bleeding. (*To read more on the Project's counseling strategy, see the April 2013 article, "More women moving to LARC methods: Will your facility follow the trend?" p. 37.)*

For dysmenorrhea with the copper IUD, evidence supports first-line treatment with nonsteroidal anti-inflammatory medications.[5] Research indicates that reports of bleeding and dysmenorrhea decrease over time in copper IUD users.[6]

A large randomized control trial compared the LNG-IUS and the copper IUD. [7] One-third of LNG-IUS users immediately developed oligomenorrhea (defined as no more than one episode of bleeding in a 90-day interval) or amenorrhea, and 70% of women experienced oligomenorrhea or amenorrhea at the end of two years. Symptoms of dysmenorrhea were reduced in women using the LNG-IUS.

Dysmennorhea impacted

One noncontraceptive benefit of the implant is a significant decrease in dysmenorrhea.[8-10] However, unpredictable uterine bleeding patterns associated with contraceptive implant use are cited as the no. 1 most common reason for discontinuation.[3]

For teens using LARC methods, encourage them to accept changes in bleeding in exchange for the next few years of extremely effective and easy contraception.[11]

Suggest charting menstrual bleeding on a calendar or with a smartphone app to provide objective evidence of the frequency of bleeding. When such evidence is reviewed, teens might see their "daily" bleeding might or might not be so frequent.[11]

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Are women getting their desired LARC methods?

Women in Texas are facing hurdles when it comes to getting long-acting reversible contraceptive (LARC) methods following cuts to the state family planning budget by the 2011 Texas Legislature. Research by the Texas Policy Evaluation Project indicates that after giving birth, nearly 75% of women reported their ideal form of birth control for the postpartum period would be a LARC method or sterilization. However, six months after birth, only 27% of women were using those preferred methods, with the key factors linked with nonuse of preferred method being low income and not having health insurance.[1]

The research is based on interviews with more than 800 women ages 18-44 from Austin and El Paso who had just given birth and wanted to wait at least two years before having another child. The women had private or public insurance. Participants were asked about their current contraceptive use and the method they would prefer to use at six months after delivery.

At six months postpartum, 13% of women were using an intrauterine device or implant, and 17% were sterilized or had a partner who had had a vasectomy. Twenty-four percent were using hormonal methods, and 45% relied on less effective methods, such as condoms. However, 44% reported that they would prefer to use sterilization, while 34% said they would prefer to use LARC methods.[1]

The research is part of the evaluation project's five-year, comprehensive effort to analyze the impact of the measures affecting reproductive health passed by the Texas Legislature. Team members include researchers from the University of Texas at Austin's Population Research Center, Cambridge, MA-based Ibis Reproductive Health, and the University of Alabama — Birmingham.

"Because over half of unintended pregnancies in the U.S. occur in the two years following delivery, we are especially concerned that a large number of women who do not want to conceive rely on less effective methods such as condoms and withdrawal as late as six months after delivery," said **Daniel Grossman**, MD, vice president of research at Ibis Reproductive Health and a research co-author, in a press statement.

In 2011, the Texas Legislature reduced family planning funding by two-thirds and allocated the remaining funds through a three-tiered priority system. Public entities such as health departments were classified as Tier 1, and specialty family planning providers were placed in Tier 3. The remaining non-public entities that provided comprehensive preventive and primary care in addition to family planning were classified as Tier 2.

The funding changes affected all three tiers of facilities, according to the researchers. Organizations in all tiers closed clinics and reduced hours at other locations.[2] Tier 3 clinics reported a higher percentage of clinics closed or reduced hours compared with Tier 1 and 2 organization clinics. While Tier 3 organizations accounted for a smaller number of total sites, researchers found they served about 40% of women seeking publicly funded family planning services.[2]

Nearly half of the organizations reported staff reductions between September 2011 and January 2012, with some organizations cutting total staff by more than 50%.[2] Following the funding cuts, organizations reported more limited availability of nearly all methods. Fewer organizations widely offered long-acting methods, and more Tier 3 organizations reported limited or no availability of such methods, primarily due to the higher up-front costs.[2]

In 2013, the Legislature took a critical step forward and restored much of the public funding for family planning.[1]

EXECUTIVE SUMMARY

Women in Texas face hurdles when it comes to getting long-acting reversible contraceptive (LARC) methods following cuts to the state family planning budget by the 2011 Texas State Legislature.

- Research indicates that after giving birth, nearly 75% of women reported their ideal form of birth control for the postpartum period would be a LARC method or sterilization. However, six months after birth, only 27% of women were using those preferred methods.
- In 2011, the Texas state legislature reduced family planning funding by two-thirds and allocated the remaining funds through a three-tiered priority system.
- In 2013, the legislature took a critical step forward, restoring much of the public funding. However, much of the funding is only now beginning to replenish or start programs.

"However, much of this funding is only now beginning to replenish or start programs, and it remains to be seen whether these efforts will substantially increase access to long-acting and permanent methods," the researchers state.

Colorado, Iowa, Georgia, Louisiana, New Mexico, New York, and South Carolina provide Medicaid coverage for immediate postpartum IUD and contraceptive implant placement outside of the global fee for delivery.[3,4]

"It is our hope that Texas Medicaid and the Department of State Health Services will consider this option to increase access to highly effective contraception for women in Texas," said **Joseph Potter**, PhD a demographer at the University of Texas at Austin and lead author of the study.

Project investigators will be following the women in the Austin part of the study for two years and will be assessing the number of unintended pregnancies that could have been prevented if the women being studied were using their preferred method of contraception. The telephone interviews are scheduled every three months, says **Kristine Hopkins**, PhD, research assistant professor in the Department of Sociology at the University of Texas at Austin and co-author of the current paper.

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Contraceptive shot offers family planning options

Women in the West African nation of Burkina Faso now have access to a lower-dose formulation of depot medroxyprogesterone acetate (DMPA) packaged in a novel injection system that is designed to increase access to contraception at all levels of the health system.

Named Sayana Press, the formulation is familiar to U.S. family planners as Depo-Provera SC (Pfizer Inc., New York City). The drug is packaged in the Franklin Lakes, NJ-based Becton, Dickinson and Co.'s Uniject system, a single dose, non-reusable, pre-filled injection device.

The Uniject injection system originally was developed by PATH, a Seattle-based international health non-profit organization, with support from the U.S. Agency for International Development (USAID). It is now licensed to Becton, Dickinson and Co. The system allows the drug to be delivered via subcutaneous injection. It also eliminates the need to prepare a needle and syringe. Each device contains 104 mg of DMPA per 0.65 mL dose. Burkina Faso is the first of four African countries to introduce the contraceptive, followed shortly by Niger, which held its formal launch in July 2014. The Uganda and Senegal launches have been scheduled to take place in September and October, according to **Sara Tifft**, MBA, director of the Sayana Press project at PATH. At press time, all four countries were projected to have introduced the method by November, notes Tifft.

The introductions are being led by each country's ministry of health and are supported by a consortium of public and private partners, including the United Kingdom's Department for International Development, the United Nations Population Fund (UNFPA), the Bill & Melinda Gates Foundation, USAID, Pfizer, and PATH.

"One of my villages, Congodjan, is 24 km from the health center, and there is a river on the pathway reducing access of these women to the health center," says **Issoufou Benghaly**, chief of the Urban Health Center at District of Dandé, Health Region of Hauts Bassins in Bobo Dioulasso, Burkina Faso. "With the outreach approach in the Sayana Press pilot introduction, I will be able to meet their needs, because in this area, women like to use injectable contraceptive."

Alexander Farma, a member of the health district management staff at District of Karangasso Vigué in Hauts Bassins, is sure that the introduction of the new contraceptive method will boost the district's metrics in family planning. Why? Because the outreach approach will

enable the district to reach many people located in remote areas and who would like to use injectable contraception, he notes.

Sayana Press could be a "game changer" where unmet need for family planning is the greatest, in part due to its potential for in-home or self-injection, notes a recent editorial in the medical journal *Contraception*.[1] The global initiative to support Sayana Press introduction was launched at the 2012 London Summit on Family Planning as part of a larger effort to ensure that voluntary family planning information, contraceptives, and services reach 120 million more women and girls in the world's poorest countries by 2020.

Contraceptive shots represent a popular family planning method among women in developing countries.[2] However, in some places, women must return to a clinic every three months for a new injection, which limits access in remote and other hard-to-reach areas. With Sayana Press' unique delivery system, injections may be provided by health workers to women at home or in other convenient settings. Because the Uniject device is nonreusable, it minimizes patient-to-patient transmission of bloodborne pathogens through needle reuse.

Sayana Press is accepted by providers and patients, research findings suggest.[3,4] In an open-label observational study conducted in clinics in three districts in Senegal and community-based services in two districts in Uganda, providers administered Sayana Press to clients seeking reinjection of DMPA. Almost all providers (84/86; 98%) preferred Sayana Press over DMPA, and they noted that the prefilled/all-in-one design made preparation and administration easier and faster. Providers also thought clients preferred the shorter needle in Sayana Press because it is less intimidating and less painful.[3] Women who had been using DMPA said they selected Sayana Press due to fewer side effects, fast administration, less pain, and method effectiveness.[4]

Research also indicates that self-injection of Sayana Press is feasible and acceptable among many women.[5-7] Study findings suggest that women are capable of successfully self-administering injectable contraception via the Uniject system.[8]

"This initiative is a major innovation in family planning service delivery," said **Steve Davis**, PATH president and chief executive officer in a press statement issued with the pilot introduction. "By making injectable contraceptives available at the community level, it offers more women control over the timing and spacing of their children and a better chance at a healthy life."

EXECUTIVE SUMMARY

Women in the West African nation of Burkina Faso now have access to a lower-dose formulation of depot medroxyprogesterone acetate (DMPA) packaged in a novel injection system that is designed to increase access to contraception at all levels of the health system.

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New terminology helps menopausal talks

It's time to incorporate new terminology in your discussion of menopause: genitourinary syndrome of menopause (GSM). Developed and endorsed by the North American Menopause Society (NAMS) and the International Society for the Study of Women's Sexual Health, the term defines "a collection of symptoms and signs associated with a decrease in estrogen and other sex steroids involving changes to the labia majora/minora, clitoris, vestibule/introitus, vagina, urethra and bladder."[1-4] The syndrome might include but is not limited to genital symptoms of dryness, burning, and irritation; sexual symptoms of lack of lubrication, discomfort or pain, and impaired function; and urinary symptoms of urgency, dysuria, and recurrent urinary tract infections.

The new terminology is medically accurate, isn't embarrassing to say, and should help providers and patients more comfortably discuss the changes often associated with menopause, says **Margery Gass,** MD, NAMS executive director.

Up to now, terms such as "atrophic vaginitis" and "vulvovaginal atrophy." have been used to describe the genital problems women can have when estrogen drops after menopause, notes Gass. With "atrophic vaginitis," the term implies infection or inflammation, which isn't the main problem. And with "vaginal atrophy," atrophy has negative connotations for midlife women, and the word "vagina" is not a generally accepted term for public discourse or for the media.[1-4] Both terms also ignore the urinary symptoms that come along with menopausal genital changes, including urgency, painful urination, and recurring urinary tract infections.

With the new terminology, look for increased communication, research, education, and treatments, much as when the term "impotence" was replaced by erectile dysfunction (ED). "When the stigma associated with the term impotence was removed, the definition of ED refined, and guidelines for assessment and therapy provided, communication between healthcare professionals and patients greatly improved, as did treatment and quality of life," observes the GSM consensus panel.

Regardless of what terminology is used, atrophic genital changes accompanying menopause are common, represent an important cause of sexual dysfunction, and too often are untreated, says **Andrew Kaunitz**, MD, University of Florida Research Foundation professor and associate chairman of the Department of Obstetrics and Gynecology at the University of Florida College of Medicine — Jacksonville.

"I am hopeful this new terminology will make it easier for women and clinicians to discuss this issue, leading to greater recognition and treatment," says Kaunitz, who serves on the NAMS board of trustees.

Being able to discuss GSM is important, because most menopausal women remain sexually active after menopause. Low hormone levels after menopause result in thinning tissue, loss of elasticity, fewer blood vessels, dryness, and physical changes that can make intercourse painful and the urethra easily irritated if not treated.[5] These changes can be problematic for many women. In a study of 94,000 postmenopausal women ages 50-79, 52% reported that they had been sexually active with a partner in the past year.[6]

In an international survey of women ages 55-65 years in Canada, Finland, Sweden, the United Kingdom, and the United States, 30% of women who reported experiencing vaginal discomfort did not talk to anyone about it, even to partners or friends.[7] Vaginal discomfort was defined in the survey as dryness, smarting pain, itching, involuntary urination, or pain in the vagina in connection with touching and/or intercourse.

To get discussions rolling, an

EXECUTIVE SUMMARY

The North American Menopause Society and the International Society for the Study of Women's Sexual Health have developed and endorsed the term "genitourinary syndrome of menopause" (GSM) to define "a collection of symptoms and signs associated with a decrease in estrogen and other sex steroids involving changes to the labia majora/minora, clitoris, vestibule/introitus, vagina, urethra and bladder." The syndrome might include but is not limited to:

- genital symptoms of dryness, burning, and irritation;
- sexual symptoms of lack of lubrication, discomfort or pain, and impaired function;
- urinary symptoms of urgency, dysuria, and recurrent urinary tract infections.

article covering the development of the new terminology has been simultaneously released in four medical journals.[1-4] Presentations are being made at professional societies such as the Association of Reproductive Health Professionals' annual conference in Charlotte, NC, says Gass.

Panelists who participated in the consensus panel are developing a tool to help standardize physical examination to look for GSM changes. With such a tool in hand, providers will be able to make diagnoses swiftly and accurately to supply needed treatment.

Remember that terms such as "vaginal atrophy" and "atrophic vaginitis" still might be listed in indications for use in existing approved drugs, notes Gass. These drugs will continue to be used in treatment of GSM, she states.

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WASHINGTON WATCH

Pay for performance may impact family planning

By ***Adam Sonfield***
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Attempts to redesign the ways in which insurance in the United States pays and incentivizes health care providers have accelerated in the wake of the Affordable Care Act (ACA). At the center of many of these attempts is the concept of pay for performance (P4P), under which providers are rewarded not merely according to how much care they provide, but for the quality and impact of that care. As P4P initiatives expand across Medicaid and private-sector insurance plans, it seems clear that family planning providers must take P4P into account and vice versa.[1]

P4P initiatives typically use data-based financial incentives toward the goals of better quality care, better health outcomes, and lower costs.[2] Measures of better care might look at whether the services and information provided are in line with medical best practices, along with patient satisfaction and provider benchmarks such as staff credentials and appointment wait times. Measures of better health involve patient health outcomes, sometimes adjusted for the patient's initial condition and other factors outside of a provider's control. Measures of cost are typically assessed on a per-patient basis, with the expectation that high-quality care, such as effective preventive care, might result in savings.

Providers that surpass thresholds for quality, outcomes, and costs — or that improve over time or in comparison with their

peers — might receive additional reimbursement under a P4P initiative. Alternatively, providers might be penalized if they fail to reach such thresholds or standards. P4P initiatives might be freestanding or might be part of broader care coordination models that have expanded with ACA funding.

Many potential P4P measures, such as those around patient satisfaction and appointment wait times, are just as applicable to safety-net family planning centers as they are to other healthcare providers. Yet, the range of available measures on standards of care and health outcomes is more problematic.[1] There are commonly used measures related to chlamydia screening, cervical cancer screening, and human papillomavirus vaccination, each of which is an important family planning–related service. However, the major established performance measures — included in the Healthcare Effectiveness Data and Information Set (HEDIS) and endorsed by the National Quality Forum — don't yet include measures related to contraceptive services and counseling or the prevention of unintended pregnancy. Without them, P4P initiatives cannot fully assess a provider's performance and provide appropriate QI incentives.

One effort to address this gap comes from the Office of Population Affairs (OPA) and the Centers for Disease Control and Prevention (CDC), which are developing several contraception-related measures and working toward an endorsement from the National Quality Forum as early as 2015. OPA staff members also are working through Integrating the Healthcare Enterprise, which is an international organization that establishes standards used by EHR system vendors for encoding and transmitting data. They are working on family planning-related variables, such as pregnancy intention and current contraceptive method.[3] Public comments on those variables were collected in spring 2014. These efforts are aimed at enhancing QI initiatives by government programs, health plans, and family planning providers. Some of the measures also might be adapted for use in P4P initiatives.

Officials in Oregon are also making progress on incorporating family planning into P4P. The state's Medicaid program is organized around Coordinated Care Organizations (CCOs), each of which has a contract to organize Medicaid services for a region of the state. The system uses P4P quality measures to incentivize the CCOs and their providers. For 2014, the state is using population-level survey data to assess CCOs' performance related to a state-designed measure on effective contraceptive use among women at risk of unintended pregnancy. That current measure is not tied to dollars, but for 2015, the state is switching to a similar contraceptive measure using patient-level data under the P4P part of its initiative.[4] Specifications for the measure are still in the works.

Beyond the selection of specific performance measures, there are several other aspects of P4P initiatives that might matter for family planning providers and their clients.[1] For example, the incentives in a P4P program must be designed appropriately, so as not to penalize safety-net providers for serving disadvantaged patients at a heightened risk of poor outcomes or to give providers a financial stake in the methods their clients choose. If designed well, P4P initiatives might provide family planning centers with new reasons and opportunities to expand their ongoing efforts to assess and improve quality of care, adopt new clinical technologies and techniques, bolster their staff members' skills and their physical and electronic infrastructures, and integrate better with health plans and other community providers. Clinics would be able to attain greater stability and financial security, and clients would be able to rely on access to quality reproductive healthcare.

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COMING IN FUTURE MONTHS

- "Must-have" sexual health services for men
- Gonorrhea drugs now in research spotlight
- Bariatric surgery: How does it impact contraception?
- Update your STI partner services program

Telephone intervention successful in teens

Research indicates that brief phone counseling sustained long-term impact from a STI/HIV intervention program among African American female adolescents.[1] The Centers for Disease Control and Prevention (CDC) estimates that African American youth continue to be one of the groups most severely affected by HIV infection.[2] Black youth represent more than half (57%) of new HIV infections among young people ages 13 to 24.[2]

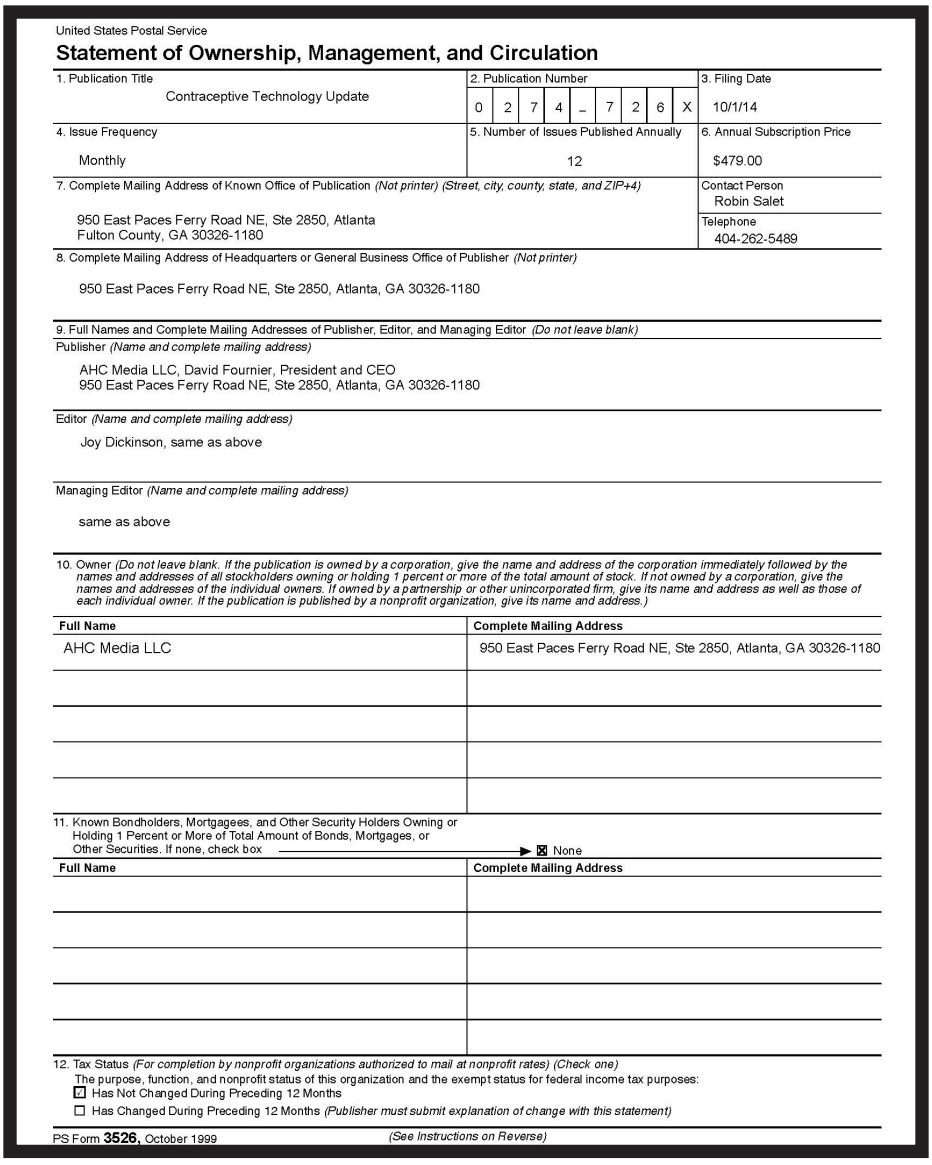
About 75% of young people ages 12-17 have a mobile phone, including 58% of 12-year-olds.[3]

"The counseling fits into a communications system that many adolescents already use," observes the study's lead author, **Ralph DiClemente**, PhD, Candler Professor in the Rollins School of Public Health at Emory University and associate director for prevention sciences at Emory's Center for AIDS Research in Atlanta. "It's nothing they have to go out and buy, nothing they have to learn, and it's a system they carry with them, so you can reach them any time, anywhere."

The two-arm randomized supplemental treatment trial was held at three clinics serving primarily minority teens. A total of 701 African American girls ages 14-20 received an adapted evidence-based STI/HIV intervention, HORIZONS, followed by a phone monitoring intervention. Teens randomized to the experimental condition (n = 342) received the primary intervention and a phone intervention consisting of brief telephone contacts every eight weeks over 36 months to reinforce the prevention messages. Comparison-condition participants (n = 359) received the primary intervention and a phone intervention focused on general health.

HORIZONS is a group-level, gender- and culturally tailored STI/HIV intervention for African American adolescent females seeking sexual health services, developed by DiClemente and Emory researchers. It reduces chlamydial infections and enhanced STI/HIV-preventive behaviors and psychosocial mediators of STD/HIV-preventive behaviors.[4] It is included in the CDC's Prevention Research Synthesis Project's Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention (http://1.usa.gov/1tN13UO).

The primary outcomes were the percentage with a laboratory-confirmed incident chlamydial infection and percentage with a laboratory-confirmed gonococcal infection during the 36-month follow-up. Behavioral outcomes included proportion of condom-protected sexual acts in the six months and 90 days prior to assessments; the number of episodes during the past 90 days in which participants had intercourse while high on drugs and/or alcohol; and the number of vaginal sex partners in the prior six months.



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During the 36-month follow-up, fewer participants in the experimental condition than in the comparison condition had incident chlamydial infections and gonococcal infections. Participants completing more phone contacts had a lower risk of chlamydial infection. Participants in the experimental condition reported a higher proportion of condom-protected sexual acts in the 90 days and six months prior to assessments and fewer episodes of sexual acts while high on drugs and/or alcohol.[1]

Sustaining the long-term impact of an STI/HIV intervention is achievable with brief, tailored phone counseling, researchers state. Phone counseling maintenance interventions offer a potentially cost-effective strategy to provide tailored prevention information and behavioral skills coaching to sustain STI/HIV-preventive behavior, says DiClemente.

EXECUTIVE SUMMARY

Research findings indicate that brief telephone counseling sustained long-term impact from a sexually transmitted infections/HIV intervention program among African American female adolescents.

- The Centers for Disease Control and Prevention estimates that African American youth continue to be one of the U.S. groups most severely affected by HIV infection. Black youth represent more than half (57%) of all new HIV infections among young people ages 13 to 24.
- Mobile phones represent an important communication avenue for adolescents. Estimates say 75% of people ages 12-17 have a mobile phone, including 58% of 12-year-olds.

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CNE/CME QUESTIONS

1. What is a first-line treatment of dysmenorrhea for women using the copper-T intrauterine device?

A. Nonsteroidal anti-inflammatory medications
B. Tranexamic acid
C. Misoprostol
D. Lidocaine

2. What is the drug contained in Sayana Press?

A. Etonogestrel
B. A lower-dose form of depot medroxyprogesterone acetate
C. Polymer hydrogel
D. Norethisterone

3. What is the new term developed and endorsed by the North American Menopause Society International Society for the Study of Women's Sexual Health?

A. Urogenital syndrome of menopause
B. Vulvovaginal syndrome of menopause
C. Genitourinary syndrome of menopause
D. Atrophic syndrome of menopause

4. Black youth represent what percentage of all new HIV infections among young people ages 13-24, according to the Centers for Disease Control and Prevention?

A. Less than 10%
B. 25%
C. 35%
D. More than half (57%)

CNE/CME OBJECTIVES

After reading Contraceptive Technology Update, the participant will be able to:

1. identify clinical, legal, or scientific issues related to development and provisions of contraceptive technology or other reproductive services;
2. describe how those issues affect services and patient care;
3. integrate practical solutions to problems and information into daily practices, according to advice from nationally recognized family planning experts;
4. provide practical information that is evidence-based to help clinicians deliver contraceptives sensitively and effectively.