Put myths to bed: Study shows IUD insertions don’t cause PID in women

Low risk shown following IUD insertion with same-day screening

Add new research to your clinic’s protocols: The risk of developing pelvic inflammatory disease (PID) following insertion of an intrauterine device (IUD) is very low, whether or not women have been screened beforehand for gonorrhea and chlamydia.

The findings come from a just-published retrospective cohort study.¹ Scientists looked at 57,728 women, ages 14 to 49, who had a levonorgestrel intrauterine system or copper-T IUD inserted for contraceptive or non-contraceptive use between January 2005 and August 2009 at Kaiser Permanente Northern California in Oakland. To perform the study, researchers compared the date of the IUD insertion visit to the most recent gonorrhea and chlamydia screening date to categorize women into four screening groups: those who were screened on the same day as insertion; those screened from one day up to eight weeks before insertion; those tested from eight weeks up to one year before insertion; and those who received no screening within one year before insertion.

Previous research shows that the risk of upper genital tract infection is limited to the first 20 days after IUD insertion.² However, researchers selected 90 days after insertion as the benchmark to be conservative in estimating the risk of PID. PID risks for the gonorrhea and chlamydia screening

EXECUTIVE SUMMARY
The risk of developing pelvic inflammatory disease following insertion of an intrauterine device (IUD) is very low, whether or not women have been screened beforehand for gonorrhea and chlamydia.

• The study results support IUD insertion protocols in which clinicians test women for Neisseria gonorrhoea and Chlamydia trachomatis based on risk factors and perform the test on the day of insertion.
• Current data do not support routine screening for sexually transmitted infections (STIs) before IUD insertion for women at low risk of disease. For women at high risk of STIs, it is reasonable to screen and place the IUD on the same day.

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groups were compared by calculating unadjusted and adjusted risk differences and odds ratios with 95% confidence intervals (CIs), with adjustments for age and race, both factors known to be associated with PID.

The overall risk of PID was 0.54% (95% CI 0.48-0.60%). Nonscreening had an equivalent risk of PID as any screening (risk difference -0.0034, 95% CI -0.0045 to -0.0022), and the same-day screening was equivalent to prescreening (risk difference -0.0031, 95% CI -0.0049 to -0.0008). The equivalence persisted when adjusted for age and race and when stratified by age.¹

The study results support IUD insertion protocols in which clinicians test women for Neisseria gonorrhoea and Chlamydia trachomatis based on risk factors and perform the test on the day of insertion, the researchers conclude. “This study affirms that there is a low risk of pelvic inflammatory disease after IUD insertion, which has the potential to reduce barriers to IUD access, such as making women have a separate screening visit before the IUD insertion,” says lead author Carolyn Sufrin, MD, MA, assistant professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco in the San Francisco General Hospital Division and faculty member of the Bixby Center for Global Reproductive Health.

Why the wait?

The current study fills a large gap in the evidence base for the optimal timing and necessity of testing women who have no symptoms of gonorrhea or chlamydia prior to insertion of an intrauterine device, says Debbie Postlethwaite, RNP, MPH, assistant director of the Biostatistical Consulting Unit within the Division of Research at Kaiser Permanente in Oakland.

Data from the study provides evidence to support using the Centers for Disease Control and Prevention’s screening guidelines for testing for gonorrhea and chlamydia in women receiving IUDs,³ the same as with other contraception methods, says Postlethwaite, a study co-author. “If testing is indicated, based on the woman’s risk factors, our results suggest that it is safe to do so on the day of IUD insertion, with prompt treatment of positive results,” she says. “The most accurate time to clinically assess and screen for cervical infection is on the day of IUD insertion.”

Many providers require a recent negative gonorrhea and chlamydia test before inserting an IUD, which creates the need for multiple patient visits. This reluctance to perform insertions on the same visit dates to the 1970s, when the poor design of the Dalkon Shield IUD promoted upper genital tract bacterial infection and led to thousands of lawsuits, Postlethwaite observes.

Although the Dalkon Shield was removed from the market, it had a lasting negative impact on IUD

¹ Postlethwaite observes.
use in the United States, says Postlethwaite. This lingering fear of PID leads many providers to require a recent negative gonorrhea and chlamydia test before inserting an IUD, thus creating the need for multiple patient visits. “This research proves that this is an unnecessary burden on the patient and, theoretically, a potential barrier to use of IUDs as a contraceptive option,” she states.

Today’s intrauterine devices are advanced in design beyond the Dalkon Shield. The Dalkon Shield had multi-filament threads that might have contributed to infections by acting as a wick to allow bacteria to ascend to the upper genital tract. Both a randomized controlled trial and cohort studies indicate that the monofilament thread used in current IUDs does not increase the risk of upper genital tract infection. According to the American College of Obstetricians and Gynecologists (ACOG), current data do not support routine screening for sexually transmitted infections (STIs) before IUD insertion for women at low risk of disease. For women at high risk of STIs (such as those age 25 or younger or those with multiple partners), it is reasonable to screen for STIs and place the IUD on the same day. Treatment can be administered if the test results are then positive, or when the test results are available. An asymptomatic woman with a positive test result for chlamydia or gonorrhea at the time of IUD insertion may be treated and the IUD may be left in place, ACOG guidance states. Should antibiotic prophylaxis be used prior to IUD insertion? Research points to “no.” In a meta-analysis of four randomized controlled trials of women with a low prevalence of STIs, antibiotic prophylaxis at the time of IUD insertion did not decrease the risk of PID, nor did it reduce the likelihood of removal within the first three months.

Ground to gain

Intrauterine devices are among the safest, most effective methods of contraception and provide benefits in managing menorrhagia, chronic pelvic pain, and endometriosis, says Postlethwaite. Whereas the risk of pregnancy is 9% annually with pills, patches, and rings, IUDs offer highly effective contraception: less than one pregnancy per 100 women in one year. With their long-acting, yet reversible, properties, IUDs allow women almost complete control in planning their pregnancies, says Postlethwaite.

Nonetheless, the use of IUDs for contraception is very low, approximately 5%, in the United States. By comparison European countries average about 20%, says Postlethwaite. “[Our] study corrects long-standing misperceptions that IUDs cause PID,” she notes. “The study affirms that there is a low risk of pelvic inflammatory disease after IUD insertion, which has the potential to reduce barriers to IUD access due to misperceptions.”

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EXECUTIVE SUMMARY

Combined oral contraceptives should be sold over the counter in drugstores without a provider’s prescription, according to a new committee opinion issued by the American College of Obstetricians and Gynecologists. The benefits of making OCs easily accessible to women outweigh the risks, the opinion states. Easier access to the pill should help lower the nation’s high unintended pregnancy rate, the opinion notes.

- Progestin-only pills might be the first candidate for over-the-counter use, because they are extremely safe with very few contraindications. However, only about 4% of Pill users used progestin-only pills during 1996-2008.

What are the concerns?

While no drug is risk-free, the overall consensus is that OCs are safe, the opinion notes. While there is a risk of blood clots with Pill use, it is extremely low and significantly lower than the risk of blood clots during pregnancy and the postpartum period, the opinion states. Current OTC products such as aspirin and acetaminophen are readily available, even though they have well-known health risks, the opinion notes.

The benefits of making OCs easily accessible to women outweigh the risks, the opinion states. Easy access might make an impact on unintended pregnancy, which remains a major public health problem in the United States. Over the past 20 years, the overall rate of unintended pregnancy has not changed and remains unacceptably high, accounting for approximately 50% of all pregnancies, the opinion notes.

As the discussion proceeds, it might be prudent to first consider progestin-only pills (POPs) for over-the-counter use, because they are extremely safe with very few contraindications, says Anita Nelson, MD, professor in the Obstetrics and Gynecology Department at the David Geffen School of Medicine at the University of California in Los Angeles.

However, there will have to be a concerted effort to inform women about progestin-only pills as part of any OTC switch for this formulation, says Dan Grossman, MD, vice president of research for Ibis Reproductive Health of Oakland, a nonprofit reproductive health research and advocacy group. Ibis Reproductive Health is coordinating the Oral Contraceptives (OCs) Over-the-Counter (OTC) Working Group, which represents reproductive health and rights organizations, nonprofit research and advocacy groups, university-based researchers, and prominent clinicians who share an interest in women’s health and access to contraception. (Contraceptive Technology Update reported on the group’s work in the May 2012 article, “Progestin-only pill eyed as OTC OC candidate,” p. 52.)

“I think clinicians have pigeon-holed this formulation as being appropriate for a very narrow population, including breastfeeding moms and older women with medical problems,” says Grossman. “But it’s a great option for women who want to use an oral contraceptive and want to avoid estrogen.”

A recent study bears out Grossman’s observation of clinicians’ approach to using progestin-only pills. In looking at nationally representative data, analysts found only about 4% of Pill users used progestin-only pills during 1996-2008. Compared to women who took combined pills, progestin-only pill users were more likely to be older, in the postpartum period, or to have certain medical conditions such as high blood pressure, the report notes. From looking at this data, it appears that providers might think POPs are appropriate only for a narrow segment of the population with certain conditions.

Many hurdles to clear

What is the current status of bringing OCs over the counter? According to Grossman, the next step would be for a pharmaceutical company to do the necessary research to bring before the FDA. This step would include a label comprehension study showing that women can read and understand a simple OTC label and use that information to determine if the product is appropriate for them. Another requirement would be an actual use study, demonstrating that women take the product correctly in a simulated OTC environment. Grossman says he is not aware of any pharmaceutical company that has already started such research.

If oral contraceptives do move to OTC status, clinicians will need to be as creative as possible to help women be successful in using an OTC product, says Susan Wysocki, WHNP-BC, FAANP, president & chief executive officer of Washington, DC-based iWomansHealth, which offers information on wom-
en's health issues for clinicians and consumers. Women now live in an age when information is instantaneous and in one's pocket, notes Wysocki. Pill instructions for an OTC product also could include when and why a woman should see a provider for an exam, she notes.

Financial issues also are important to consider, notes Nelson. Pills still will be available by prescription so that third-party partners will continue to cover pills, notes Nelson. According to the OCs OTC Working Group, it is unclear how women on Medicaid will be affected if the Pill were to go over the counter. Federal Medicaid funds cannot be used to pay for OTC medications without a prescription, although in some states, Medicaid funds are used to cover OTC emergency contraception without a prescription for women 17 and older, the group notes.

Clinicians have concerns that women might not access providers for needed healthcare information if they were to purchase the Pill directly from the pharmacy.4 “If women bypass clinics to get pills OTC, we will lose access to women who might be better candidates for implants and intrauterine devices,” says Nelson.

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Could technology be multi-purpose?

What if multipurpose prevention technology (MPT) could prevent women from unintended pregnancy and sexually transmitted infections? University of Washington researchers are exploring electrically spun cloth with nanometer-sized fibers that dissolve to release drugs, which provides a potential platform for inexpensive, discrete, and reversible protection.1

The University of Washington researchers, led by Kim Woodrow, PhD, MS, assistant professor of bioengineering, are working with electrospinning, which uses an electric field to project a charged fluid jet through air to create nanometer-scale fibers. The fibers are then manipulated to control the material’s solubility and strength. Based on their current research, the scientists believe such drug-eluting fibers might be better at delivering medicine than gels, tablets, or pills. No high temperatures are involved in creating the fiber, so the method is suitable for heat-sensitive molecules. The fabric also can incorporate large molecules, such as proteins and antibodies, that are hard to deliver through other methods, the scientists note.

Woodrow’s team is looking at use of the drug glycerol monolaurate (GML) in the spun fibers as a potential spermicide and nonhormonal contraceptive. What led them to investigate this drug? The scientists first screened several non-hormonal chemical contraceptives reported in the literature to have spermicidal activity; however, they were unsuccessful at showing potent function of these agents, according to Woodrow. Researchers then turned to glycerol monolaurate; research published by the group led by Ashley Haase, MD, head of the Microbiology Department at the University of Minnesota, Minneapolis, indicates that GML is safe, non-inflammatory, and has function against vaginal pathogens including HIV.2

Investigation of GML’s structure led the Washington researchers to believe it could interact with the sperm cell and act in a manner that has been reported for its function against bacteria, says Woodrow. “In the end, we were committed to identifying a non-hormonal chemical contraceptive to use in our

EXECUTIVE SUMMARY

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- The fibers are manipulated to control the material’s solubility and strength.
- Based on their current research, the scientists believe such drug-eluting fibers might be better at delivering medicine than gels, tablets, or pills.
materials, and there were few options for us to evaluate,” Woodrow states. “We knew that if GML did demonstrate activity against sperm, like we showed in our paper, it would build on the work from the Haase group and could be very significant for the field.”

**What’s the next step?**

Woodrow’s team will be working to demonstrate the versatility of the drug-eluting fiber technology for delivering diverse agents useful for different sexual health indications, including HIV and contraception. Support comes from the National Institutes of Health/National Institute of Allergy and Infectious Diseases in Bethesda, MD, and the Bill and Melinda Gates Foundation in Seattle.

“We also are interested in how to control independently the mechanical and chemical barrier function of these materials,” Woodrow states. “A significant focus of our future work will focus on understanding the materials and manufacturing requirements for scale-up as we move toward translating the technology.”

The foundation’s 18-month grant was made in October 2012, at a funding level just under $1 million, confirms Katie Harris, foundation spokesperson.

“This is an area the foundation is continuing to explore,” Harris states. “We have an internal cross-team working group that has identified MPTs as a priority and – together with partners – is working to determine our investment strategy in this area.”

**Which technology best?**

Other projects funded by the Gates Foundation include investigation led by Lisa Rohan, PhD, associate professor at the University of Pittsburgh School of Pharmacy and associate investigator at Magee-Women’s Research Institute (MWRI), both in Pittsburgh. Rohan’s team is looking at whether polymeric films are a viable alternative topical dosing strategy for delivery of drug candidates such as those targeting HIV and contraceptive agents. The 15-month grant, made in October 2012, provides about $750,000 for such work, says Harris. The investigators hope to find out if such films can be manufactured and distributed to “resource-poor” places in the world before early-stage clinical trials can be expanded. Rohan also is working with Sharon Hillier, PhD, professor of obstetrics, gynecology and reproductive sciences and of molecular genetics and biochemistry at the University of Pittsburgh School of Medicine and MWRI senior investigator, on a recently launched, early-stage clinical trial to test the safety of a vaginal film preparation containing the microbicide dapivirine to ward off HIV infection.

The foundation also has made a grant to the New York City-based Population Council to explore the acceptability of progesterone-releasing vaginal contraceptive rings in sub-Saharan Africa, says Harris.

“While this is a contraceptive-only product, not an MPT, we do hope to learn more about the acceptability of vaginal rings in general in sub-Saharan Africa, since MPT products may take the form of vaginal rings,” states Harris.

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**Time to up HIV testing in U.S. youth ages 13-24**

Young people between ages 13-24 represent more than a quarter of new HIV infections each year, and 60% of youth living with HIV are unaware they are infected, according to a new report from the Centers for Disease Control and Prevention (CDC).

Too few youth are tested for HIV, and many don’t know they are infected, agrees Jonathan Mermin, MD, MPH, director of CDC’s Division of HIV/AIDS Prevention. Just 13% of high school students, and 35% of those ages 18-24, have ever been tested for HIV.

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Young people between ages 13-24 represent more than a quarter of new HIV infections each year, and 60% of youth living with HIV are unaware they are infected, according to a new report. Just 13% of high school students, and 35% of those ages 18-24, have ever been tested for HIV, the report states. In 2010, an estimated 12,200 new HIV infections occurred among young people ages 13-24. In that same time period, 72% of estimated new HIV infections in young people occurred in young men who have sex with men. By race/ethnicity, 57% of estimated new infections in this age group occurred in African-Americans.
tested for HIV, the new report reveals. These low numbers persist even though recommendations from the CDC and the American Academy of Pediatrics call for routine HIV testing of youth in medical settings.

“A number of factors increase HIV risk among youth and pose challenges to prevention efforts, including making HIV testing easily available,” observes Mermin. “In addition, many young people underestimate their risk of infection, or experience social and economic barriers that impede access to health care.”

One challenge with reaching young people with HIV testing in medical settings is that adolescents and young adults don’t go to the doctor very often, Mermin notes. This fact underlines why it is critical that HIV testing also is available in communities, outside of medical settings, says Mermin.

The CDC issued the report to help increase education and awareness of the problem, Mermin states. Young people need to know the facts about HIV, how they can get tested, and what they can do to protect themselves and their partners from HIV, while healthcare providers should test teen and young adult patients per CDC guidelines, and parents should talk to their children about HIV, he states. “Here at CDC, we are working with partners across the nation to protect young people from HIV and other STDs, including funding targeted HIV testing and prevention efforts to reach those youth at greatest risk,” Mermin reports.

**Who is most affected?**

Which groups of young people are most at risk for HIV infection? The most-affected young people are young gay and bisexual men and African-Americans, the report says.

In 2010, an estimated 12,200 new HIV infections occurred among young people ages 13-24, with young gay and bisexual men and African-Americans hit harder by HIV than their peers. In that same time period, 72% of estimated new HIV infections in young people occurred in young men who have sex with men (MSM). By race/ethnicity, 57% of estimated new infections in this age group occurred in African-Americans.

In compiling the current report, the CDC also looked at risk behaviors among high school students in 12 states and nine large urban school districts. They found that young men having sex with men reported engaging in substantially higher levels of risk behavior than their heterosexual male peers. These young men were more likely to report having had sex with four or more partners or ever injecting illegal drugs. Among students who were sexually active, young men having sex with men were more likely to have used alcohol or drugs before their last sexual experience and were less likely to have used a condom. Young MSM were also less likely to report having been taught about HIV or AIDS in school, the report notes.

**New program seeks impact**

Young, black men who have sex with men are the only group in the United States among whom new infections are increasing, says Nick DeLuca, MA, branch chief for the Prevention Communications Branch in the CDC’s Division of HIV/AIDS Prevention. Between 2006 and 2009, new HIV infections increased by almost half (48%) among those ages 13 to 29, he notes.

To address the urgent need to reduce HIV infections in this population, CDC has launched “Testing Makes Us Stronger,” a public awareness and education campaign designed by black gay men for black gay men. Launched in 2011, the campaign encourages HIV testing among black gay and bisexual men ages 18-44 using positive, empowering messages that emphasize HIV testing as a source of strength.

Increasing HIV testing is critical to reducing new infections, because people who know they have HIV can take steps to decrease the risk that they will transmit the virus to others, observes DeLuca. Testing also provides the gateway to treatment; research shows that people on antiretroviral treatment are less likely to transmit HIV to others, he states. Those who test negative can take action to protect themselves from infection, says DeLuca.

National online and magazine ads, as well as transit and billboard ads, have been developed to reach out to men at risk, says DeLuca. Facebook, Twitter and blogs targeted to black gay and bisexual men are being employed as social media outreach. A dedicated website, http://hivtest.cdc.gov/stronger, offers freely reproducible materials for use by local communities and health departments, reports DeLuca. The program initially launched in six cities (Atlanta, Baltimore, Houston, New York, Oakland, and Washington, DC) where black gay and bisexual men are heavily affected, he states.

“Together, we must break the cycle of HIV among black gay and bisexual men if we are to stop the HIV epidemic in the U.S.,” says DeLuca. “This campaign is just one part of the solution; we need a nationwide movement to stop HIV in this community and beyond.”
Reach out to young men with `Man Up Mondays’

Check your clinic’s patient files for the last year. How many visits were made by males? According to 2010 data from the Agency for Healthcare Research and Quality, just over half of U.S. men (57%) see a doctor, nurse practitioner, or physician assistant for routine care, compared to nearly three-quarters (74%) of women.

Drawing in men, especially young men, for routine care becomes even more important when it comes to sexual health. Estimates suggest that even though young people ages 15–24 years represent only 25% of the sexually experienced population, they acquire nearly half of all new sexually transmitted infections (STIs).

The Mondays Campaign, a New York City-based nonprofit initiative backed by leading public health schools, has rolled out its “Man Up Monday” campaign to reach at-risk young men. Thanks to a collaboration among the campaign, the Columbia Mailman School of Public Health, and the Harlem Health Promotion Center, both in New York City, the “Man Up” campaign is directed at making men more aware of such issues as condom use and getting regular check-ups for HIV and STIs. By using provocative images to encourage sexually active men to “man up” and get tested for STIs and prevent disease by restocking condom supplies, the campaign seeks to work with interested programs in getting the word out on the importance of testing and prevention. It received the public health education and health promotion materials award in the print materials category at the annual American Public Health Association meeting in San Francisco in October 2012.

In a pilot test of the program, Planned Parenthood of Southeastern Virginia of Virginia Beach saw a 200% increase in testing over the previous year when it combined use of the program with a half-price testing offer for those who called on Monday to schedule an appointment. The organization is continuing to promote the program in 2013, says Erin Zabel, vice president of external affairs at Planned Parenthood of Southeastern Virginia.

How did it work?

Why did Planned Parenthood of Southeastern Virginia decide to implement the pilot project? Zabel says the organization had been looking for creative ways to engage more men to come to Planned Parenthood for testing and other reproductive health services.

“It’s been challenging since Planned Parenthood is considered a women’s health organization primarily, and it’s hard to move men to visit the doctor anyway,” notes Zabel. “We loved the Man Up Mondays campaign idea as a way to brand our STI services for men in an engaging way that would interest young men, who have such high rates of STIs locally.”

How did the organization get the word out to local young men about the project? Planned Parenthood of Southeastern Virginia used its more than 100 community contacts, as well as its Facebook page, Twitter, website, and radio spots. Posters and advertising, developed through The Monday Campaigns, were adapted for local use. The program has been well-received by staff and patients, says Zabel.

“Women love the campaign, too, as it gives them

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- In a pilot test of the program, Planned Parenthood of Southeastern Virginia of Virginia Beach, VA, saw a 200% increase in testing over the previous year when it combined use of the program with a half-price testing offer for those who called on Monday to schedule an appointment.
- Drawing in men, especially young men, for routine care is important when it comes to sexual health. Estimates suggest that even though young people ages 15–24 years represent only 25% of the sexually experienced population, they acquire nearly half of all new sexually transmitted infections.
a way to encourage their partners and male friends to be tested,” she notes.

Participation in the Man Up Monday campaign has been of no significant cost to the organization; however, the agency makes less money on the 50% discounted testing on Mondays, Zabel states.

Monday is a fresh start

According to The Monday Campaigns, people view Monday as a day for a fresh start and a chance to set healthy intentions for the next six days. They’re more likely to start diets, exercise regimes, quit smoking, and schedule doctor’s appointments on Monday than any other day, and they are looking for ways to reinforce positive health behaviors. Other public health campaigns initiated by the campaigns include Meatless Monday, Quit & Stay Quit Monday, and Healthy Monday.

The Monday Campaigns is inviting health organizations to join in creating a Man Up Monday movement, says Morgan Johnson, MPH, program development and research director. Information is available at www.manupmonday.org. Program developers plan to include an interest survey on the web site that interested organizations can fill out as an application for participation, she says. The campaigns then can contact organizations to see what materials and assistance will be needed to get their own campaign underway, says Johnson.

Robert Hatcher, MD, MPH, professor of gynecology and obstetrics at Emory University School of Medicine in Atlanta, is enthusiastic about the concept of “Man Up Mondays.” Hatcher hopes that the provision of a bag of 20 free condoms can be incorporated into the program to increase its popularity as it is expanded across the nation.

The focus of the campaign is to aid public health professionals in promoting health among young men, states Johnson.

“This population tends to ignore health problems until they become acute,” she observes. “Man Up Monday is a great way to remind them to take stock of their health and make changes as needed to maintain a healthful lifestyle.”

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Of course, CHCs, providing a safety net to those in need, also serve uninsured and underinsured adolescents.

**How can they be more teen-friendly?**

There are several guides to providing adolescent health services created by professional organizations. One of the most widely known is the American Academy of Pediatrics’ Bright Futures.

Bright Futures, a broad set of principles, strategies, and tools, can be used to improve the health and well-being of children through culturally appropriate interventions that address current and emerging health promotion needs at family, clinical practice, community, health system, and policy levels. The National Association of Community Health Centers, the American Academy of Family Physicians, and many other organizations are partners in Bright Futures. Among the resources available for adolescent health are sample visit forms and medical, developmental, behavioral, and psychosocial assessment and screening tools, as well as resources for talking to parents and teens.

Additionally, the Society for Adolescent Health and Medicine (SAHM) is an essential source of information for providers and sites trying to expand or improve services for adolescents. The SAHM website, www.adolescenthealth.org, includes administrative tools on billing and coding as well as a wide variety of clinical resources on topics ranging from confidential care to vaccines and sexually transmitted infections.

**Confidentiality is key**

Among all available tools, a few practices stand out as critical to creating an adolescent-friendly environment, regardless of practice setting.

First, confidential services must be available to teens. While it remains important to promote family communication, this priority should not create barriers to minors accessing preventive care or treatment. To this end, it is necessary to establish clear confidentiality policies, to educate staff at all levels as well as patients and parents in advance, and to stay aware of state laws governing minors’ confidentiality and ability to legally consent for care. When considering newly insured young patients, especially those using their parents’ insurance, it is crucial to include billing and insurance practices in creating effective confidentiality protocols.

Second, a center should be physically accessible to teens and young adults. This accessibility can mean many things, but some practices to consider include having a teen-friendly waiting area or dedicated clinic days or hours where teens are encouraged to make visits. Even if a dedicated teen clinic is not possible to implement, it is important that a clinic is open during hours that are convenient for adolescents, such as after school or on weekends.

By taking advantage of community health centers’ focus on integrated and primary care, teens can benefit from comprehensive services, another important part of adolescent-friendly care. While a young patient might be in clinic for a sports physical, this time also is an opportunity to check in about the teen’s health more broadly and to discuss topics such as home life, school, mental health, diet and exercise, sexual health, and healthy relationships.

Fortunately, some provisions of the ACA also make these services easier for youth to access. As of Aug. 1, 2012, preventive services including well visits, vaccinations, domestic violence screenings, and contraceptive counseling are available to patients without co-pays. While not all services can be available on site, CHCs should build strong relationships with other health centers and community organizations in the area to provide referrals to resources such as dental care, mental health services, nutrition and dietary counseling, substance abuse assessment and treatment, abortion care, and support in finding housing, educational opportunities, and employment. In return, the CHC can offer itself as a resource for primary care, health information, education, and health advocacy.

If community health centers act now to integrate adolescent health services, they will be prepared as the number of youth and demand for preventive health care grows during ACA implementation and beyond.

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New practice tool offered by ARHP

Clinicians who are members of the Washington, D.C.-based Association of Reproductive Health Professionals (ARHP) can take advantage of a unique new service, ARHPedia. ARHPedia connects healthcare providers to pharmaceutical resources through a comprehensive and convenient portal.

Powered by Healthcare Resources Online, an organization providing physicians, nurses, and patients with a non-commercial, manufacturer and product-neutral, web-based service, ARHPedia meets the needs of providers working to offer enhanced reproductive healthcare to their patients.

Designed as a new kind of practice tool, ARHPedia provides members with a single source for free product resources that are easy to search and order, including patient education, product information, general reproductive health materials from ARHP, and a variety of patient assistance programs for each product.

The service has more than 20,000 resources available, with numbers predicted to increase. Members also have access to easy-to-use interfaces to search billing and coding references, the largest database of U.S. clinical trials, and an e-prescribing platform.

“This cutting-edge member benefit promises to support our members in enhancing their patient care by consolidating a wealth of resources into one easily accessible portal,” says Wayne Shields, ARHP president and chief executive officer.

To access the service, visit the ARHP web site, www.arhp.org and click on the ARHPedia logo.

COMING IN FUTURE MONTHS

- How to talk with youth about sexual health
- Science looks at male urinary tract health
- HIV: The South responds to surging numbers
- HPV: Implications for baby boomer women?
1. Recent research results [Sufrin CB, et al. Obstet Gynecol 2012; 120(6):1,314-1,321] support intrauterine device insertion protocols in which clinicians test women for *N gonorrhoea* and *C trachomatis* based on risk factors and perform the test when?
   A. The day of insertion
   B. Three days before insertion
   C. 20 days after insertion
   D. One month after insertion

2. Unintended pregnancy accounts for what percent of all U.S. pregnancies?
   A. 75%
   B. About 50%
   C. About 35%
   D. 25%

3. What is the drug University of Washington researchers are looking at as a potential spermicide and nonhormonal contraceptive in drug-eluting fibers?
   A. Nestragel
   B. Levonorgestrel
   C. Glycerol monolaurate
   D. Nonoxynol-9

4. Young people between ages 13-24 represent what percentage of new HIV infections in the United States each year?
   A. More than 60%
   B. More than 50%
   C. More than 35%
   D. More than 25%