

Meeting the Family Planning Needs of Adolescents and Males

Erica Monasterio, MN, FNP
 Division of Adolescent Medicine
 and Family Health Care Nursing
 University of California

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Tools you can use – Feedback Toolbar

The screenshot shows a toolbar with several icons. A 'Raise Hand' icon is labeled with an arrow. A 'Feedback Results' window is shown above the toolbar, displaying 'Current Results Of 2 Participant(s)' with 'Yes: 1' and 'No: 1'. Below the toolbar, 'Yes' and 'No' buttons are labeled with arrows. An 'Emoticons' window is also shown below the toolbar with various smiley face icons.

Floating Icon Tray

- Use the floating toolbar to communicate in today's session.

The screenshot shows a floating toolbar with icons for a globe, a refresh symbol, a group of people, a question mark, and a bar chart. Arrows point from the text labels 'Participant List', 'Polling', and 'Q&A' to their respective icons in the toolbar.

Q&A -

The screenshot shows a window titled 'O&A' with a tab 'All (0)'. Below the tab is a text input field with the placeholder text 'Type Question'. Below the input field is a 'Send' button. A label 'Click Send' with an arrow points to the button. A character count 'Type your question here. There is a 256 character limit.' is visible above the input field. A dropdown menu labeled 'Ask:' is set to 'All Panelists'.

Evaluation and Continuing Education Forms

At the conclusion of session complete:

1. Evaluation Form
2. Continuing Education Form (if applicable)
3. Sign-in sheet

Forms can be downloaded at the end of this session by file transfer.
 Those without web access can get forms by calling 1-877- FAMPACT

File Transfer

The screenshot shows a 'Press Download' window with a table of files. A label 'Click File' with an arrow points to the first file in the table.


File name	Location	Size	Status
CE_UPDATEFORM.doc		45028 B	Not Saved
STD_Update_Evaluat...		53760 B	Not Saved

Reason Youth Give for NOT Seeking Care

- They are embarrassed to be seen at the clinic
- They are concerned about privacy and confidentiality
- They are afraid of medical procedures, especially pelvic exams
- They find the clinic staff unfriendly or hostile
- They don't know where or how to access the services they need
- The facility is not open during convenient hours
- Transportation to the clinic is unavailable
- The cost of services is beyond their means


Creating an Adolescent Friendly Environment

- Choose an accessible location:
 - Take the services to the youth: school, mall, multi-service centers, detention facilities, vans
 - Include information about access by public transportation in all materials



Reduce barriers

- Consider alternative hours:
 - After-school, evenings, Saturdays
- Create a safe and appropriate space
 - Teen specific clinic hours, separate location
- Redefine scheduling
 - Open access, same day, drop-in



Confidentiality is a Major Concern

- Train ALL staff on minor consent and confidentiality
- Discuss consent, confidentiality, and it's limits with all clients
- Consider confidentiality in all programs and policies
 - Abnormal Pap result follow-up
 - Appointment reminders
 - + test results notification
 - Client-satisfaction surveys

Who Can Consent To Medical Care?

General Rule:

- Minor needs adult to consent.
- Age of Majority is 18.

Which "adults" can consent for care?

- Parent
- Relative
- Non-related adult



Minor Consent Exceptions Based On Status

Under these circumstances, minors may consent to medical and dental care:

- Married/Divorced
- Armed Forces
- Emancipated by Court
- > 15, Living Apart from Parents & Managing One's Own Financial Affairs

Minor Consent Exceptions Based On Services

Minors may consent to specific care & treatment for the following:

- Pregnancy related services at any age
- Outpatient mental health services*
- Reportable communicable diseases/STDs*
- HIV counseling and testing*
- Drug and alcohol treatment*
- Rape services*

* > 12 years (Note age restrictions on certain services)

HEY TEENS! Did You Know?
 Anything you say about sex, drugs, and feelings is **CONFIDENTIAL** unless you give me permission to share it.

“What we say here... stays here.”

But, if you tell me:

- You are being abused (physically and/or sexually)
- You are going to hurt yourself or someone else
- You are under 14 and having sex with someone 14 years or older
- You are under 16 and having sex with someone 21 years or older

I must contact someone to help.

“Talk (I’ll listen.) to me!”

Create a Space that is Friendly and Pleasant for Teens

- Establish a youth advisory board and use it
- Provide reading material and other media of interest to youth
- Invest in youth-appropriate health education materials
- Utilize waiting time as an opportunity to interact with peer educators

Adolescent Pregnancy Prevention


Abstinence: Not a method we discuss with adult clients

What are we talking about?

- Refraining from sexual activity?
 - What about oral and anal sex?
 - What about masturbation/mutual masturbation?
- Refraining from sexual intercourse?
 - Until marriage, or when?
- Periodic abstinence: choosing to refrain from intercourse *now*?
 - What happens when you make a different choice?


The “Promise” of Abstinence (failures per hundred women per year)

Method	Perfect Use	Typical Use
Abstinence	0	?????
Oral Contraceptives	0.1-0.5	7.5
Male Condom	3	13.7
Withdrawal	4	24.5


 **Virginity Pledges: Do they result in abstinence?**

- 88% of 12,000 teenagers who had pledged to remain abstinent until marriage reported having had sexual intercourse before they married.
- "Pledgers" also had STD infection rates comparable to their peers who did not take virginity pledges.


Bruckner, H Journal of Adolescent Health, 2005

 **Risks of Abstinence**


- Although they delayed intercourse for up to 18 months, when they became sexually active, teenagers who had signed pledges were less likely to use condoms and less likely to seek medical help for STD infections than their peers
- Bruckner, H Journal of Adolescent Health, 2005

 **Integrating Abstinence into Family Planning Counseling**


- Use a client-centered approach
 - Start where the client is and build your intervention from there
- Utilize the data
 - Know what is normative and developmentally appropriate
 - Target abstinence messages to younger teens

 **Integrating Abstinence**

- Encourage adult involvement in adolescent sexual decision-making
- Validate periodic abstinence decisions
 - Honor the choice
 - Support planning for different decisions in the future
- Add abstinence to your list of approaches to prevent pregnancy

 **Be Prepared to Discuss Abstinence as a “Method”**

- Use the same model used for other methods of pregnancy prevention
 - Effectiveness rate (perfect and typical use)
 - Benefits or advantages
 - Risks or disadvantages
 - What will help the client use the method successfully
 - What barriers to successful use might to client encounter

 **Many teens use contraceptives**

- The majority of teens (74% of females and 82% of males) used contraceptives the first time they had sex
- The majority of teens (83% of females and 91% of males) used contraceptives the last time they had sex
- A sexually active teen who does not use contraceptives has a 90% chance of becoming pregnant within a year

Abma JC et al., Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2002. *Vital and Health Statistics*, 2004, 23(24).

Many young teens become pregnant each year

- 280,000 teens younger than 18 become pregnant annually
- 87% of these pregnancies are unintended
- Of pregnancies to 15–17-year-olds:
 - 56% result in live births
 - 30% result in abortions
 - 14% end in miscarriage

Guttmacher Institute, U.S. teenage pregnancy statistics: national and state trends and trends by race and ethnicity, New York: Guttmacher Institute, September 2006, <http://www.guttmacher.org/pubs/2006/09/15/US15Trends.pdf>, accessed October 9, 2006; and Finer LB et al., Disparities in unintended pregnancy in the United States, 1994 and 2001, *Perspectives on Sexual and Reproductive Health*, 2006, 38:2198–96.

Indications for EC

- After unprotected intercourse
- After under-protected intercourse
 - After barrier method “accidents”
 - After missed OCPs (>2)
 - After missed progestin-only pills (1)
 - >14 weeks since last Depo-Provera shot
 - Transdermal patch detached >24 hrs.
 - Vaginal ring expelled/removed >3 hours
 - Vaginal spermicide used alone


Yuzpe Regimen: Regular OCP Formulations Used as EC

Brand Name	Pills/Dose	µg EE/ Dose	mg levonorgestrel/ Dose
Ovral	2 white	100	0.50
Alesse	5 pink	100	0.50
Levlite	5 pink	100	0.50
Nordette	4 light orange	120	0.60
Levlen	4 light orange	120	0.60
Levora	4 white	120	0.60
Lo/Ovral	4 white	120	0.60
Triphasil	4 yellow	120	0.50
Tri-Levlen	4 yellow	120	0.50
Trivora	4 pink	120	0.50

Adapted from ACOG Practice Bulletin. Int J Gynecol Obstet. 2002;78:191-198.
Slide Source: ContraceptionOnline www.contraceptiononline.org

“Plan B”

- Brand name for progestin only emergency contraceptive pills
- Recently approved for over-the-counter purchase by women ≥ 18 years old



Contraindications to Progestin-Only ECP

- Pregnancy
- Hypersensitivity to any component
- Undiagnosed abnormal vaginal bleeding

Instruction for Use

- As soon as possible after unprotected or under-protected intercourse
- Effective up to **5 days** (120 hours) after event
- Can take both pills at once if using Plan B (package instructions are 1 pill followed by 2nd pill 12 hours later)
- Next menses may be earlier, later, and/or heavier
- Return for pregnancy test if no menses in 3 weeks
- Discuss STI screening and effective contraceptive plan as appropriate

**Answering the Concerns:
Will access to EC interrupt
regular care?**

- Young women who have easier access to EC are also no more likely to use EC repeatedly, than women who obtain it from a clinic or healthcare provider
- Furthermore, research show that a request for emergency contraception may actually lead to initiation of routine gynecologic care, including counseling about sexual behaviors and prevention strategies

Stewart, HE, Gold MA, Parker AM. The Impact of Using Emergency Contraception on Reproductive Health Outcomes: A Retrospective Review in an Urban Adolescent Clinic. Journal of Pediatric Adolescent Gynecology (2003) 16: 313-318.

**Answering the Concerns: Is
it a contradictory message?**

- 68% of adults and 77% of teens think making emergency contraception more widely and easily available is consistent with a strong message to teens that abstinence from sex is their best option by far

National Campaign to Prevent Teen Pregnancy Website.
<http://www.teenpregnancy.org>.

- Removing the barriers to access ensures that teens who have sex when they do not want or do not plan to – as well as those who experience a contraceptive accident – are able to avoid unintended pregnancy

Access to EC

- Individual providers have an essential role:
 - Counsel all youth, regardless of current sexual activity or current method of contraception
 - Assess for current risk
 - Provide on-site access when possible
 - Offer prescription along with a list of local pharmacies where EC can be obtained

**Contraceptive Use: It's the
Relationship**

Half of teens (51.7%) believe that one of the main reasons that teens do not use birth control is because their partner doesn't want to.

National Campaign to Prevent Teen Pregnancy Website.
<http://www.teenpregnancy.org>.

It's the Relationship

Increased contraceptive use and consistency in a first sexual relationship is associated with:

- Longer time between start of relationship and 1st sex
- Discussing contraception with partner before 1st sex
- Using dual methods

Increased length of relationship was associated with increased use but decreased consistency

Manlove, Ryan and Franzetta 2003

It's the Relationship

Decreased contraceptive use and consistency in a first sexual relationship is associated with:

- Taking a virginity pledge
- Having an older partner
- Being in a "liked" rather than "romantic" relationship with 1st sex partner

Manlove, Ryan and Franzetta 2003

Adolescent Pregnancy Risk and Contraceptive Use

- Three-quarters of unintended teenage pregnancies occur to adolescent women who do not use contraception. (Westoff, 1988)
- 90% of sexually active adolescent women who use no method become pregnant within one year of initiating intercourse. (Alan Guttmacher Institute, 2006)

Current Trends in Contraception

- Developing new delivery systems
- Increasing access to a full range of options
- Emphasizing better compliance
- Widening use of emergency contraception

www.contraceptiononline

Ultra-Low Estrogen Dose Oral Contraceptives

- Many providers choose as 1st option, but have some disadvantages for teens
 - Poorer cycle control than 30 mcg pills (increased BTB) in 1st 2-3 cycles
 - May carry increased risk of ovulation with missed pills (theoretical risk if progestin component is also ultra-low)
- A good choice when you want to lower estrogenic effects

Extended Cycling with OCPs

- Most often recommended in teens for:
 - Inducing amenorrhea for a specific event
 - Accommodating patient preference for fewer menses
 - Managing menses related problems such as dysmenorrhea, menorrhagia, cyclic headaches
 - Youth with developmental and/or physical disabilities or behavioral problems which make managing menses problematic

Gerschultz et al. 2007

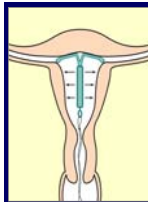
Alternative Regimens

- 84/7 active vs. placebo days
- Can use multiple packs or proprietary formulation
- Increase in break through bleeding with extended cycling
- No FDA recommendation re: vaginal ring or patch



Intrauterine Contraceptives: Mirena and ParaGard

- Highly effective
- Lasts 5 years (Mirena), 10 years (ParaGard)
- Decreases bleeding (Mirena)
- May be particularly appropriate for teen parents
- Insertion may be more difficult in the nulliparous teen
- Expulsion rates slightly higher in nulliparas




Vaginal Ring: NuvaRing

- Increasing interest among older teens
- Worn for 3 out of 4 weeks
- Self insertion and removal
- Highly effective
- Good cycle control



Contraceptive Patch: Ortho Evra

- Lots of initial interest among teens
- Teens tend to discontinue due to problems with adhesive
- Total estrogen exposure is 60% higher than 35 mcg pills, although peak levels are lower
- Rates of DVT, MIs and CVAs similar in patch and OC users



Depo Provera

- Popular among younger teens
- Associated with weight gain, particularly in obese users
- Associated with decreased bone density, calcium supplementation has no documented impact, adding estrogen back helps
- Impact on developing bone not well understood

Depo-Provera and Bone Density (cont)

- Clinicians should continue to prescribe, with adequate explanation of benefits and potential risks
- Bone density is mostly regained after discontinuance
- FDA recommendation to counsel women regarding use longer than 2 years, but no evidence re: specific cut-off, as bone loss rate actually may slow with continued use

Cromer BA, Depot Medroxyprogesterone Acetate and bone mineral density
Society for Adolescent Medicine Position Paper

**Quick Start Regimens:
Don't Wait for the Next Menses**

- Effective use of hormonal contraception is more likely if a teen can initiate the method right away
- If beyond day 6 of current cycle, condoms use is recommended for the next 7 days
- Emergency contraception should be offered if there has been unprotected intercourse in the prior 5 days
- A urine pregnancy test should be performed if an early pregnancy is a possibility and at least 10 days have passed since the earliest day of ovulation

Counseling Approaches

- Use open-ended questions and listen to gain an understanding of the client's contraceptive
 - Experiences
 - Interests
 - Concerns
 - Biases
- Provide information about the range of new contraceptive options
- Raise the issue of STD prevention as well as pregnancy prevention


Challenge of New Hormonal Contraceptive Options

- Associated with a lower PID risk
- Highly effective in preventing pregnancy
- *Do not reduce STD/HIV acquisition risk*
- Dual method use is not common in teens

Challenge of New Hormonal Contraceptive Options

- Clients need and deserve the opportunity to explore STD/HIV risk reduction approaches
- Using a client-centered counseling approach has been shown to reduce risky behaviors and impact on the acquisition of STDs/HIV

STDs



Teen Advisory Board:
A History

Adolescent Risk for STD Acquisition


- Biological vulnerability
- Early sexual debut
- Developmental factors/Behavioral risk

Pelvic Exams


- Neither a pelvic nor a Pap Smear are indicated for initiation of hormonal contraception
- Use non-invasive screening approaches (NAAT for GC/CT, OraSure for HIV) when possible and appropriate
- Pelvic exams are indicated when the client is symptomatic

Cervical Cancer Screening


- Recommendations for Pap Smears:
 - Obtain a Pap Smear 3 years after the onset of sexual intercourse or by age 21 (ACS)
 - Manage ASCUS/LGSIL in adolescents with repeat cytology 6 and 12 months after index Pap, followed by colposcopy if persists as \geq ASC
 - HPV DNA testing is no longer recommended for adolescents as it will not impact on management (ACOG 2007)

 **STD Screening**


- Chlamydia:
 - All sexually active adolescent females should be screened annually for CT
 - All positives should be treated and then screened for re-infection 4 months after treatment
 - Option of partner delivered therapy to facilitate treatment of all sexual contacts

 **STD Screening**


- Gonorrhea and Syphilis
 - Screening decisions should be based on local prevalence data
 - Screen all pregnant women
 - Any STD diagnosis is an indication for screening for other STDs

 **New CDC HIV Screening Recommendations**


- In all health-care settings, screening for HIV infection should be performed routinely for all patients aged 13--64 years
- Special consent is not required
- Testing should be offered on an “opt-out” basis

 **HIV Screening Recommendations**

- All patients seeking treatment for STDs should be screened routinely for HIV during each visit for a new complaint, regardless of whether the patient is known or suspected to have specific behavior risks for HIV infection.

 **HIV Re-screening Recommendations**

- Health-care providers should test all persons likely to be at high risk for HIV at least annually.
- Persons likely to be at high risk include:
 - injection-drug users and their sex partners,
 - persons who exchange sex for money or drugs
 - sex partners of HIV-infected persons
 - MSM or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test.

 **Common Clinician Errors**

- Inadequate risk assessment/ missed opportunities
- Assumptions about sexuality and behaviors
- Information giving instead of Client Centered Counseling
- Failure to stay current

Making Services Accessible to Males



What Gets in the Way

- Facility barriers
- Staff barriers
- Client barriers

Facility Barriers

- Name
- Public Perception
- What's on the Walls?
- Signage
- Restroom access
- Hours and services




Staff Barriers



- Personal Mission
- Attitudes and Stereotypes
- Personal Level of Comfort
- Appropriate Skills Set

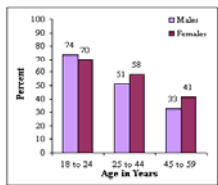
Personal Mission

- Give staff the opportunity to explore and share
- Start with self-awareness
 - Why did I get into this kind of work
 - What keeps me doing it?



Attitudes and Stereotypes

- Uncover the attitudes and stereotypes
- Challenge the myths with information



Age in Years	Males (%)	Females (%)
18 to 24	74	70
25 to 44	51	58
45 to 59	39	41

SOURCE: National Health and Social Life Survey, 1992

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Personal Level of Comfort

- Uncertainty leads to discomfort
 - Unsure of services/benefits
 - Unsure of eligibility
 - Unsure of ability to address needs
 - Inadequate training/skills
- Perceived conflict between personal mission and actual job
- Previous experiences

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Client Barriers

- Male care-seeking patterns
- Personal Perceived Need (or lack thereof)
- Gender role and Stereotyping



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Addressing Barriers: Planning and Outreach

- Are any men, particularly young men, involved in the planning of male services?
- Do your outreach materials include information on services for males?
- Is there a male-specific outreach program with male outreach workers?
- Is your program part of a strong community network involved with youth, since adolescent and young adult males are the most common male clients?

FamilPACT

Addressing Barriers: In the Clinic

- Is there at least one male “friendly face” on staff during client service hours?
- Is it easy for a man to come in and receive condoms?
- Is your staff trained to work with males?
- Are the counselors trained to work with males?

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Addressing Barriers: In the Clinic

- Are there pamphlets/educational materials that address male health and developmental issues?
- Is the environment (i.e. the name of the site, posters on the walls, signs on the door, restroom access, reading materials) welcoming to men?
- Are ALL forms gender neutral with separate reproductive health sections for males and females?
- Do you have a well-developed and specific referral system for men?


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Don't Miss the Chance

- Consider male healthcare-seeking patterns
- Take advantage of every opportunity (sports, school, employment PEs) as counseling opportunities regarding male involvement in family planning
- Look for opportunities for integrated services with multiple funding streams

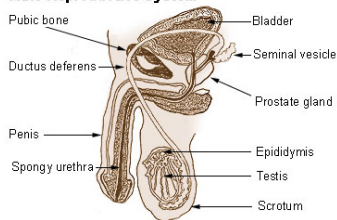
Counseling Issues

- EC
- Condom use
- Ever involved in a pregnancy
- Relationship roles
- Legal issues for males
 - Age disparity
 - Sex under the influence
 - The meaning of “NO”
- Sexual satisfaction/issues of sexual function
- Injury prevention
- Nutrition and Activity
 - supplement/steroid use
- Sexual risk
- Substance Use
- Mental Health Issues
 - Depression



Clinical Care of Men in Family PACT

Male Reproductive System




Covered Services

- Family PACT *ONLY* covers the reproductive tract exam in symptomatic men (evaluation of men with urethritis symptoms, genital ulcers, and genital warts) and blood pressure screening
- Asymptomatic men may be screened through non-invasive means (NAAT) for GC and CT


Who should be tested for GC and Ct

- Men with clinical findings including dysuria, urethral discharge, or epididymal, or testicular pain
- Men with a newly diagnosed sexually transmitted infection (STI) including GC, Ct, syphilis, primary genital herpes, human immunodeficiency virus (HIV), or trichomoniasis
- Men who report contact with partner known to have a recently diagnosed STI, including GC, Ct, nongonococcal urethritis, epididymitis, trichomoniasis, syphilis, primary genital herpes, or HIV


Recognizing STD's: Condyloma



Recognizing STD's: Pearly Penile Papules




**Recognizing STD's:
Herpes**




©1996 Cornell University Medical College

**Recognizing STD's:
Primary Syphilis**



syphilis
www.healthac.org


**Recognizing STD's:
Secondary Syphilis**



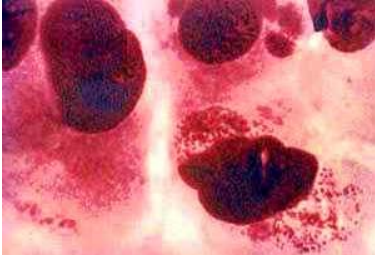
**Genital Ulcer
Evaluation**

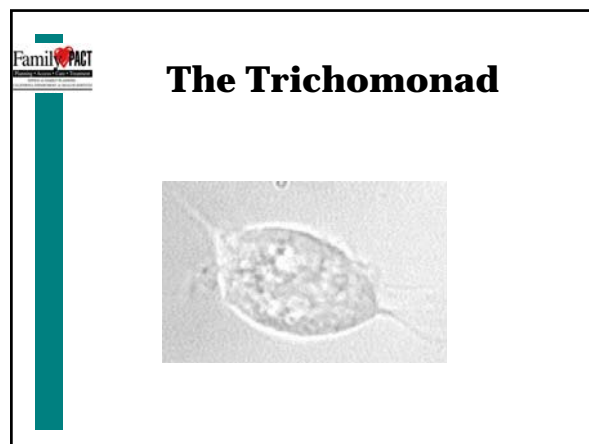
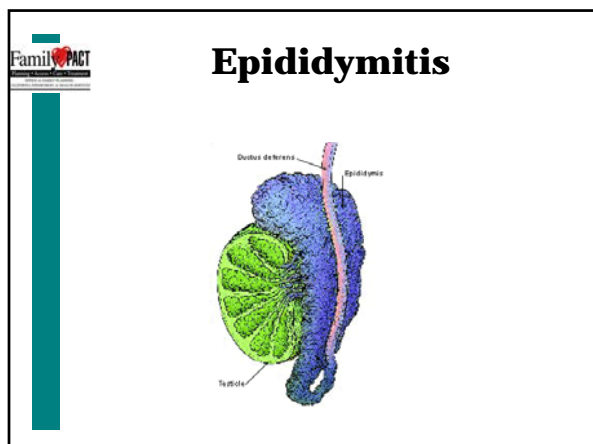
- Diagnosis based on medical history and physical examination often inaccurate
- Serologic test for syphilis
- Culture/antigen test for herpes simplex
- Haemophilus ducreyi culture in settings where chancroid is prevalent (refer to your County STD services)
- Biopsy may be useful in difficult to diagnose cases

**Recognizing STD's:
Gonococcal Urethritis**



**Recognizing STD's:
Chlamydia**





**Trichomoniasis
Management of Male Sex Partners**

- Sex partners should be treated
- Avoid intercourse until therapy is completed and patient and partner are asymptomatic
- Trichomoniasis is an STD, and screening for other STD's is indicated when trichomonas is diagnosed

**Bacterial Vaginosis
Management of Male Sex Partners**

- Woman's response to therapy and the likelihood of relapse or recurrence not affected by treatment of sex partner

**GC, CT and Syphilis
Management of Male Sex Partners**

- All sex partners within 60 days prior to diagnosis should be evaluated, tested, and presumptively treated.
- While drugs for partner treatment are not a Family PACT benefit, eligible partners who enroll in Family PACT can receive presumptive treatment for GC and Ct at no cost.

Non-Covered Services

- In the context of a male exam, other findings may be uncovered
- It is important for the clinician to recognize conditions that may necessitate a referral to primary care
- Opportunities may exist where male services are reimbursable through a variety of other funding streams

Other Genital Findings






- Services related to the genital findings on the following slides are NOT covered by Family PACT
- Familiarity with these findings may assist the clinician in feeling comfortable evaluating male STIs
- The ability to recognize and diagnose these conditions will facilitate appropriate referrals to primary care

Other Genital Findings

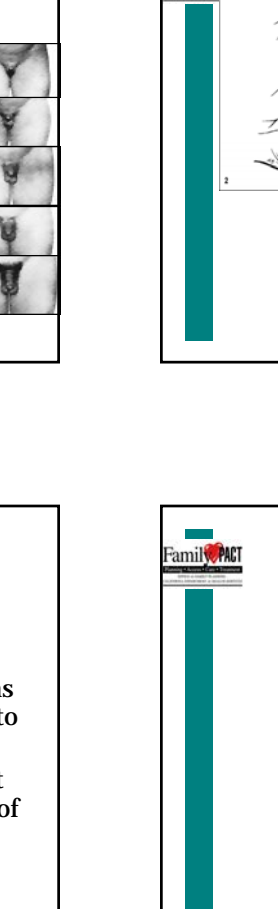
Not Covered by Family PACT:

- Hernias
- Hydrocele
- Varicocele
- Spermatocele

Tanner Staging of Teen Males

SMR	Testicular Length	Testicular Volume	CA	BA	
I.	<2.5cm	<4ml			
II.	>2.5cm	4-6 ml	11.2 (9.2-14.2)	11.5 (9.0-13.5)	
III.	>3.0cm	6-10 ml	12.9	13.2	
IV.	>4.0cm	10-15 ml	13.8	14.5	
V.	>5.0cm	>15ml	14.7		
Peak height velocity			13.9 (12.3-15.5)	14.5	

Testicular Self Exam



Final Thoughts

- Adolescents and males have unique needs in the Family Planning setting
- Providing services to these populations demands flexibility and a willingness to try new approaches
- Involving individuals from your target outreach populations in the planning of services will help assure that your services will meet their needs

Q & A



Processing Forms

Download Now:

- **Evaluation Form**
- **Continuing Education Form**

No Web Access Now:

- **Call 1-877-FAMPACT for forms**
- **All participants that return an evaluation form will receive a Certificate of Participation**
- **Those requesting CE credit must return evaluation and CE form-indicate CE requesting**

Complete forms and fax to 213 368-4410

Thank you for your participation!