The Hidden Agenda
Facilitator's Guide

Case Authors:
Estherann Grace, MD
S. Jean Emans, MD
Harvard Medical School
Children's Hospital, Boston

Topic: Contraception

Abstract:
Unintended pregnancy and sexually transmitted diseases (STDs) are important consequences of teenage sexual activity. Approximately half of ninth to twelfth grade high school girls have had sexual intercourse. Older adolescents may make an appointment specifically to discuss contraception. Many adolescents, however, have a "hidden agenda" and may present for a sports physical examination or the complaint of painful or irregular menses. Clinicians must know how to take a sexual history and provide contraceptive counseling. In this case, Julie presents for her yearly physical examination and clinical preventive services, but is requesting treatment for dysmenorrhea. During the history, Julie reveals she is sexually active and would like to start oral contraceptive pills.

Goal:
To provide an understanding of contraceptive counseling for a sexually active adolescent.

Objectives:
As a result of this session, learners will be able to:
1. Take a sexual history.
2. Provide contraceptive counseling to an adolescent.
3. Counsel the adolescent about oral contraceptive pills.

Prerequisite Case: "But All My Friends Do It" (The Middle Adolescent Health Screening)

Related Cases:
"The Telephone Call" (Oral Contraceptive Scenarios)
"Michael's Disclosure" (HIV and the Adolescent)
"The Burning Issue" (Sexually Transmitted Diseases)
"Decisions to be Made" (Teen Pregnancy)
"Amy Goes to College" (Older Adolescent Health Screening)

Themes:
Adolescent Health

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Key Words:
Contraception, oral contraceptives, birth control pills, reproductive history, sexuality, sexuality counseling, family planning, adolescent health services, pregnancy prevention, dysmenorrhea

Bright Futures Core Concepts:
While all of the Core Concepts are included in each case, this particular case can be used to highlight communication, partnership, advocacy, and prevention/health promotion.

Materials Provided:
- Facilitator's Guide
- 3-part Case Narrative: Part I, Part II, Epilogue
- Handout #1: Contraception Fact Sheet
- Handout #2: Information about Emergency Contraception
- Bibliography

Facilitator Preparation:
Facilitators should thoroughly review this guide and the other materials provided. At the end of the guide we have included a section entitled, "**Independent Learning/Prevention Exercises**," that will further stimulate group and individual education on this topic. (Please note that this is the same suggestion list as in the associated case on Oral Contraceptive Scenarios, *"The Telephone Call."*)

Suggested Format of a One Hour Session:
We anticipate that case facilitators will modify implementation of the case session to best fit their educational setting and learners. For detailed recommendations on case facilitation, please see the chapter entitled, "A Brief Guide to Facilitating Case Discussion," found in *The Case Teaching Method; and Growth in Children and Adolescents* (book 1 of this series).

Introduction: Adolescents being seen for their annual clinical preventive services visit may have questions or concerns about their sexuality. Many adolescents choose to postpone initiation of intercourse; others make a decision to become sexually active and need sensitive counseling, screening for STDs and Pap smears, and access to contraceptive methods.

According to the 1999 Youth Risk Behavior Survey (YRBS)*, 49.9% of high school students (9th to 12th grade) reported ever having been sexually active.

- 52.2% of boys, 47.7% of girls reported ever having sexual intercourse
  - 32.5% of girls, 44.5% of boys in 9th grade
  - 65.8% of girls, 63.9% of boys in 12th grade
- 50.7% of girls and 65.5% of boys used a condom at last intercourse

*Facilitators should check the complete 1999 and future YRBS results available from the Center for Disease Control and Prevention web site (**www.cdc.gov/nccdphp/dash/yrbs/index.htm**).

Similarly, the 1995 Survey of Family Growth found that 48.1% of 15-19 year old never married women had had sexual intercourse. There has been a steady, small decrease in the number of teens

reporting sexual activity on the YRBS from 1991 to 1999. It is essential for clinicians to take a sexual history from all teens as part of the interview at the yearly preventive services visit, and support those who choose abstinence.

Open the Discussion: Introduce the case title and the goal for the session. Explain that the format will be an interactive case discussion and not a lecture. Distribute Part I of the case and ask one of the participants to read it aloud.

Part I

Julie, a 17 year old high school senior, comes to your office with her school physical form for participation on the soccer team. Julie has been playing soccer for four years and has never had an injury. Julie has been a patient of yours since she was 11 years old.

You ask Julie, "*Do you have any health concerns today?"*
Julie hesitates, and then responds, *"I think I need something for my cramps."*

Julie's menses have been regular since she was 13 years old, but over the past two years she has had increasing dysmenorrhea and often misses a day of school each month. She has used ibuprofen with some relief. Her last menstrual period was three weeks ago. In response to questions, Julie tells you that she has been sexually active with one partner for the past six months and has "*always*" used condoms. On one occasion, the condom slipped off as he was withdrawing. She denies ever being forced to have sex. She drinks one or two beers one weekend a month and smokes 1-2 cigarettes a week with friends. She is a B student and plans to attend a local college.

When asked about birth control options that she has thought about, she responds, *"I have several friends on the pill who are fine, but I'm worried I'll gain weight. Should I use some other method?"*

Following this reading, ask all participants, "*So what do you think about this case? What would you like to focus on during our discussion today*?" List agenda items on a blackboard or flipchart. Then use the questions below to guide the discussion. Remember that the key to successfully leading a small group is facilitation of the discussion rather than lecture. Draw as many participants as possible into the discussion. Allow silences while group members think about questions and answers. Present material from the discussion guide only when needed to complement or redirect the group discussion.

Guiding Questions for Discussion:

A sexual history is an integral part of an adolescent's health evaluation. How can this be done in a respectful way? The review of systems (which includes the sexual history) should be preceded by the statement, *"I ask all my patients these questions."* Questions about sexual intercourse can be straightforward. *"Have you ever had sex? Have you ever had sexual intercourse?"* Not all teens understand the term "sexually active." *"Have you ever been forced or pressured to have intercourse?..."* or *"Have you ever been forced to do something sexually that you did not want to do?"*

Other questions that are part of the initial sexual history are:

"*Do you date? Are you thinking about going out with men, women, or both? Do you have a steady partner? Are you happy with dating/this relationship? Do you have concerns or questions about sex? On what will you/do you base your decision to have sex?"*

If the answer to sexual intercourse is *"no,"* the health care provider should reinforce the decision of the adolescent to delay coital debut, *"That sounds like a healthy decision for you."* Adolescents also may decide to become secondarily abstinent after counseling or life experiences.

If the answer to the question about sexual intercourse is *"yes,"* more questions are needed to understand the patient's sexual choices and risks. It is important that questions not be heterosexually biased at the initiation of the discussion about sexuality; for example, *"Tell me about your partners."* Followed by, *"How many partners? What methods have you used? Have you ever used condoms? How often? What percentage of the time? Will your partner continue to use condoms if he knows you are using a hormonal method? Have you ever had an STD? What are you planning to use for STD prevention? Have you ever been pregnant (or gotten someone pregnant)?"*

Julie's partner has used condoms by her report. She did relate an instance when one slipped, and there may have been other episodes of which she was unaware or about which she failed to tell her provider. This puts her at risk for both pregnancy and sexually transmitted diseases. It is prudent for health care providers to screen adolescents for STDs regardless of a history of condom use. Adolescents have a high risk of acquiring STDs and need ongoing reinforcement to continue to use condoms or to abstain.

What other health questions should be asked? Teens should be asked about all health risks, especially since risk behaviors may cluster together. Julie has also used alcohol and might fail to use condoms under the influence of alcohol. Even though she is not smoking very much, her use may escalate depending upon her group of friends, especially in college. Her concern for her health and the initiation of oral contraceptive (OC) use can be used positively to promote smoking cessation. HIV risks and sources of counseling and testing should be identified as well. Julie should also have a thorough review of systems to assure that she does not have health problems that might be affected by oral contraceptive use. The history should include weight gain or loss, dieting, depression and mood changes, hirsutism, acne, hypertension, headaches, breast tenderness, nausea/vomiting, chronic illnesses, medications, allergies, and family history of blood clots.

What contraceptive methods are available to Julie? How would you counsel her?
Although Julie has stated her choice of oral contraceptives (OCs), she should receive counseling about *all* methods of contraception. A brief description of the diaphragm, cervical cap, vaginal spermicides, female condom, depot medroxyprogesterone acetate shots, monthly estrogen/progestin injections, and levonorgestrel implants including benefits, side effects, and pregnancy rates of each method can be given verbally and, as needed, in written form.

Regardless of Julie's choice of contraception, the need for consistent condom use is emphasized. Adolescents are often grateful for the opportunity to role play asking a partner to wear a condom (e.g. *"What would you say if he says he doesn't like condoms?"*).

The oral contraceptive is the most commonly chosen hormonal method for teens but requires daily compliance. Injectable and implanted progestin-only methods have a much longer duration of action but are usually accompanied by menstrual irregularity (which is often accepted if extensive counseling preceded the method) and sometimes significant weight gain. IUDs are most appropriate for adults with monogamous relationships. Condoms are essential for STD prevention, and their use should be recommended *in addition to* hormonal contraceptives.

Distribute Handout #1: Contraceptive Methods—Contraception Fact Sheet and review its contents.

Contraceptive methods — Pregnancy rate per 100 women in first year of perfect use and first year of typical use[1]

Type	perfect use	typical use
Oral contraceptives		5
combined	0.1	
progestin-only	0.5	
IUDs		
Progesterone T IUD	1.5	2
Copper T 380A	0.6	0.8
Levonorgestrel releasing IUS	0.1	0.1
Depot medroxyprogesterone acetate	0.3	0.3
Estrogen/progestin monthly injection	0.2	0.2
Levonorgestrel implant	0.05	0.05
Cervical Cap		
Nulliparous	9	20
Parous	26	40
Spermicides	6	26
Diaphragm	6	20
Condom		
Male	3	14
Female (Reality)	5	21
No method	85	85
Abstinence	0	0

Adolescent girls have higher risks of failure with typical use of oral contraceptives – up to 9-12 pregnancies/100 women.

What are the worries of adolescents about the oral contraceptive pill and how should they be addressed? A study[2] of adolescents initiating oral contraceptive use identified a number of concerns including: weight gain (45%), interaction with cigarettes (19%), blood clots (13%), cancer (12%), blood pressure (5%), fertility (5%), birth defects (4%). Eighty-six percent of adolescents seen in a suburban private practice were worried about weight gain. And yet there was no mean weight change in >200 users on monophasic and triphasic pills.[2,3] Teens need to be reassured that by consuming a balanced diet, decreasing TV time, and increasing exercise that they can keep their weight stable.

Providers should ask their adolescent patients about past experiences and concerns regarding contraception as part of routine care.
Questions to ask the teen include:

- What methods have you used before?
- What are your worries about this method? What have you heard about this method?
- Do you have friends who have used this method? What were their experiences? Did they have problems?
- Do you think you can use this method effectively?
- Do you have questions I haven't answered?
- Have you ever had problems with your weight? Have you ever dieted?
- Is your partner in favor or opposed to this method?
- How will you be able to handle unexpected bleeding?
- Do you have questions I haven't answered?

When should emergency contraception be discussed with adolescents?

Distribute Handout #2: Information about Emergency Contraception and review the contents.

Emergency contraception (ECPs) should be mentioned during routine office visits and is especially important for Julie who is sexually active and has had a condom slip. An adolescent will not use the method without prior knowledge. Emergency contraception is a therapy which can prevent approximately 75% to 88% (pregnancy rate 0.2-2.0% with emergency contraception v. 4.7-5.5% of expected pregnancies in women who have an act of unprotected sexual intercourse).[4,5] Two types of emergency contraception use high-doses of hormones.

(1) The Yuzpe regimen uses estrogen and progestin.

2 tablets of Ovral* (total dose of 1.0 mg norgestrel and 0.1 mg of ethinyl estradiol) STAT and then 2 tablets 12 hours later

OR

4 tablets of Lo-Ovral, Nordette, Levlen, or Levora (0.120 mg ethinyl estradiol plus 1.2 mg norgestrel or 0.6 mg levonorgestrel) STAT and then 4 tablets 12 hours later

OR

4 tablets of Triphasil or TriLevlen (yellow tablet only) STAT and then
4 tablets 12 hours later

OR

5 tablets of Alesse or Levlite (total dose of 0.5 mg levonorgestrel and 0.1 mg ethinyl estradiol) STAT and then 5 tablets 12 hours later

OR

2 tablets of Preven (0.1 mg ethinyl estradiol and 0.5 mg of levonorgestrel) STAT and then 2 more pill 12 hours later

(*Note: The use of specific names above does not imply endorsement of particular products.)

(2) The second emergency contraceptive method is a progestin-only regimen. The progestin-only option consists of levonorgestrel 0.75 mg (20 Ovrette or 1 Plan B pill) taken as soon as possible and repeated in 12 hours (pregnancy rate 1.1%-2.9%). This method results in an 88% reduction in pregnancies with lower rates of nausea and vomiting.[5]

The treatments must be taken within 72 hours (3 days) of unprotected sex with higher efficacy the sooner the first dose is taken.[5]

The prescribing of emergency contraception should ideally include patient counseling in which the patient discusses her history, recent episodes of unprotected intercourse, attitudes about pregnancy and contraception, and identifies potential risk factors. The provider should then describe the emergency contraception regimen, its mechanism of action, its window of effectiveness, and safety. Nausea and vomiting might occur, and if vomiting occurs within the first hour of treatment, the dosage should be repeated. The patient should also be instructed to abstain from intercourse or at minimum use a condom for the remainder of her cycle. It is important that the provider emphasize that emergency contraceptive pills are not as effective as other forms of birth control and are meant to be a one time contraceptive procedure. The patient should be reminded to protect herself against HIV and other sexually transmitted diseases as well as unintended pregnancy by using a condom with each sexual act. Many providers prescribe emergency contraception over the phone or in advance, and providers should educate teens about the methods. Adolescents may particularly benefit from an actual visit to check blood pressure, obtain a pregnancy test to exclude a preexisting pregnancy that the adolescent may be unaware of or in denial about, and to provide important counseling for the future. If patient decides on therapy, the first dose of hormones is usually administered during the visit with or without antiemetics (Meclizine 25 mg 1-2 tablets 1 hour before first dose). The clinician should assure that the patient has access to the second dose (in addition to an extra dose, if possible, if vomiting occurs). At a follow-up visit in 2-3 weeks, a pregnancy test is performed, especially if menses have not occurred. Importantly, further counseling about contraception should be provided. (See web sites for Emergency Contraception and for Plan B.)

How should you prepare Julie for her first pelvic exam? What laboratory tests are indicated for Julie? In order to perform a pelvic exam, the provider should counsel the adolescent about what she can expect. Allaying her fears is essential. This is done with a clear explanation of what she will feel before she experiences it. Demonstrating on a pelvic model, keeping the language age appropriate, and using examples she is familiar with is helpful. Before inserting the speculum, ask if she has used tampons. If she has, you can tell her the speculum insertion will remind her of a tampon insertion. All necessary equipment to do a pelvic exam should be kept readily available so there is no disruption in completing the exam. If the adolescent is particularly worried about a pelvic examination, it can be delayed so that she can become more comfortable with the procedure. In that case, she can have a general physical exam, a urine test to exclude pregnancy and, if available, urine tests for STDs, and be given a prescription. However, most adolescents can have a successful pelvic exam to complete routine preventive care on the first visit.

Irrespective of contraceptive choice, sexually active teens should have a Pap smear annually and be tested for STD's. Chlamydia infections occur in 5-15% of sexually active teens and are 3 to 4 times more common than in adult women. All adolescents should be tested for chlamydia at least annually, and more frequently with a change in partners or symptoms. Gonorrhea is also common

among youth; screening for gonorrhea can be universal in teens or selective if the patient is low risk such as a college student with a single partner using condoms. Gonorrhea screening is clearly indicated in urban youth, those with multiple partners, other STDs, early coitus, or girls who are pregnant. A urine pregnancy test should be obtained if the menstrual period is late or the patient has any signs, symptoms or worries about pregnancy. Serology for syphilis is indicated if the patient has other STDs, high risk behaviors, multiple partners, or "survival sex" (sex in exchange for money, food, or shelter). HIV counseling and testing should be offered to all teens. The provider should assure that Julie has completed hepatitis B immunization.

Distribute Part II of the case and have participant(s) read it aloud.

Part II

You discuss with Julie the methods of contraception, pregnancy prevention and sexually transmitted disease (STD) prevention. You talk about the risks and benefits of combined oral contraceptives, progestin only methods (pills, depot medroxyprogesterone acetate, and levonorgestrel implants), estrogen/progestin injections, and barrier methods (condoms, spermicides, female condom, and diaphragm).

Julie is nervous about having a pelvic examination, and you explain what she can expect during a pelvic examination by pointing to the plastic model on the desk and talking about what she might feel. *"It will take about 3 minutes, and the speculum will feel similar to the tampons you have used."*

After you complete the physical exam including a pelvic exam, STD and Pap smear screening, Julie decides that she wants to use oral contraceptive pills. You prescribe a low dose pill and explain the potential side effects, asking her, *"Do you know any of the health benefits of the pill?"*

> Julie responds, *" I have heard that they make your cramps better."*
> You agree*, "Teens who take the pill do have fewer cramps and that often helps them to take the pill better. The pill also lessens your chance of getting ovarian and uterine cancer, lessens acne, makes you less likely to develop anemia or pelvic infections, and may improve your bone density."*

Demonstrating how to take the pill using the actual pill package, you give simple instructions: *"Start the pill on the Sunday following the first day of your next period. Take one a day, every day at the same time. If there are any problems or you have any questions, call."* You go over each point in the written instructions, reinforce Julie's need to continue to use condoms, and assist Julie in figuring out a time that is good for her to take the pill on a daily schedule. You tell Julie to make an appointment in three months to check her weight and blood pressure and see how she is doing. Just before leaving, Julie asks, *"What are you going to tell my mother?"*

Julie's exam is normal and she has no medical conditions that preclude her use of oral contraceptives. What is an appropriate choice of pill? How would you counsel her?

Oral contraceptives (OCs) are a combination of estrogen and progestin. The estrogen doses range from 20-50 ug, and a low dose pill with 20-35 ug of ethinyl estradiol is selected. Progestins include norethindrone, norethindrone acetate, norgestrel, levonorgestrel, ethynodiol diacetate, norgestimate, and desogestrel. The majority of OCs are balanced and have low rates of amenorrhea and breakthrough bleeding and are well tolerated. It is helpful to start patients on pills that are available in the office so that the actual packaging can be demonstrated to the patient. A particular OC may be selected because of availability (office, health plan, clinic), cost (generics tend to cost less than nongenerics), hormone balance, previous side-effects with other OCs, and current problems such as dysfunctional uterine bleeding, headaches, nausea, etc.

Counseling should focus on minor side-effects (breakthrough bleeding, amenorrhea, nausea, headaches), rare major side-effects (thromboembolism), missed pill options, perceptions about the

pill such as weight gain and infertility, and health benefits.[6] Those who have severe dysmenorrhea and experienced a reduction on OCs have been shown to be 8 times more likely to be consistent OC users.[7] Some centers use a written consent form to help assure that counseling brings out the important issues. Focusing on future orientation, reviewing the complex behaviors for effective use, assessing intentions, interpreting problems with contraception correctly, and mobilizing self-planning are essential.[8]

The low dose pills available today have been formulated to reduce side effects. Breakthrough bleeding (BTB) is a major source of discontinuance so it is essential to counsel in the initial education session that BTB occurs commonly in first three months and can usually be ignored. However, BTB can also result from pregnancy, pelvic infection with Chlamydia trachomatis or gonorrhea, missed pills, post-coital bleeding, or concurrent use of medications (e.g. anti-convulsants, rifampin). Some patients will experience nausea which usually disappears within a week or two of initiating the pill, especially if the pill is taken with food or at bedtime with a snack. If nausea persists, the amount of estrogen in the pill should be reduced from 35 ug to 30 or 20 ug. Starting with a 20 ug pill at the onset is associated with less complaints of nausea.

To lessen concerns about weight gain, patients with easy weight gain in the past can be counseled to avoid all fast foods for the first three months on OCs (less salt, calories, fat), decrease TV time and increase exercise.

Although studies are conflicting on whether OCs are associated with mood change (depression, irritability) because of the many life stresses, some patients seem to improve after a change to a different pill balance or discontinuing the OC.

What can you advise Julie to do to help her remember to take her pill at the same time everyday? How can the provider help improve compliance with oral contraceptives in teens?
Keep your instructions simple: *"Start the pill on the Sunday following the first day of your period; take one a day, everyday, at the same time."* Alternatively, pills can be started on the first day of the menstrual cycle (depending on the pill package).

Optimally the patient can determine a time of the day and an activity such as brushing teeth at bedtime which will help her with compliance and regular pill taking. For teens who wish to keep their pill use private, leaving the package in the bathroom next to their toothbrush is not an option. Since most adolescent women keep their underwear in a drawer, patients may be advised to keep their pills there. As they reach for a clean pair they'll be reminded by their pill package! Alternatively, many teens keep their pills in their backpack or purse. Others place a happy face sticker on their toothbrush or mirror as a secret message and cue to action. Most individuals can devise their own memory jogging methods.

Patients should understand the instructions for dealing with missed pills which can be on an instruction sheet and are found with the routine patient handout that accompanies the oral contraceptive pills:

- If the patient misses one pill, takes as soon as she remembers. She takes the regular pill for that day at the normal time.

- If patient misses two pills in first 2 weeks, take 2 pills a day for 2 days and then 1 pill a day until pack is finished. Use back-up contraceptive method for 7 days.
- If patient misses 2 pills in a row during the third week OR misses 3 pills or more in a row any time, then:
  - Sunday starter: Keep taking a pill every day until Sunday. On Sunday throw away the unused portion and start a new pack. Use a back-up method for at least 7 days.
  - Non-Sunday starter: Throw away rest of current pack and start a new pack the same day. Use a back-up method for at least 7 days.

Patients should also consider using emergency contraception if 2-3 pills have been missed and unprotected intercourse has occurred.

Other helpful strategies to help teens take their pills effectively include appointing one professional in the office to establish rapport and to answer calls from the patient, the prescription of 28 day packs with use demonstrated, establishment of rapport and confidentiality at the first visit, encouragement of the patient to discuss concerns as well as to be knowledgeable about the benefits, asking the patient to CALL if she decides to quit, and reviewing payment for pills and refills. Compliance/concerns should be checked at each visit and teens should be educated about all methods including abstinence since method switching is common. Anticipatory guidance needs to be tailored to patient worries. Although Julie was given an appointment in 3 months, she should then be seen every six months for several years until she has established a regular contraceptive method. The frequency of visits and outreach needs to be increased for at risk patients with school failure, parenting sibs, STDs, multiple partners, and substance use.

At the follow-up, the visit should include a weight, blood pressure, assessment of side-effects and strategies, use of condoms, and compliance. Questions such as *"It's hard to remember to take pills all the time, how many do you think you have missed?"* can be helpful. Look for barriers to compliance asking *"What do you find is particularly difficult about pill-taking?"* Review of systems can follow the ACHES format: A=abdominal pain (severe); C=chest pain, cough, shortness of breath; H=headaches, dizziness, weakness, speech problems; E=eye problems (vision loss or blurring); S= severe leg pain (calf or thigh).

Factors that have been associated with long-term (1 yr.) OC compliance include suburban residence, health care in a private practice, college bound, higher level of father's education, satisfaction with OCs, and absence of side effects.[2,3]

How is confidentiality defined and implemented? When a patient enters puberty, the importance of a confidential patient-doctor relationship needs to be defined with the adolescent and her family so that the adolescent can receive counseling about health risks and contraception. The parents should be reassured that situations that place a patient at risk for serious harm to themselves or others will be shared with parents. Health care providers should also let the family know that they will encourage the adolescent to share her health information with her parents. Stating these guidelines to parents and patients together emphasizes the new patient-doctor relationship. Encouraging adolescents to share their lives with their parents helps to dispel parental fears.

Since parents may receive a bill or a statement of benefits (often called an "EOB," Explanation Of Benefits), teens should be encouraged to share the timing of their appointments and the fact that they had a pelvic examination with their families. If this is not possible, self payment for bills (over several months) or free or low-cost care through a hospital or family planning clinic may provide another avenue for prevention of pregnancy. Questions to ask include:

- *Can you share your birth control needs with your parent? Can I help you?*
- *Do you have dysmenorrhea or irregular menses and can you share taking oral contraceptives (OCs) for that reason?*
- *If not, what will you do when your parent finds the pills?*
- *How will you pay for the visit? Does insurance send an Explanation of Benefits (EOB) to your parents?*

Julie should be reassured that the basis of the confidential relationship began when she was younger, but that there are realities to her being able to take the pill confidentially. She can be counseled to discuss her visit, complaint of dysmenorrhea, and pill prescription with her mother. She should be encouraged to discuss relationships, values, and sexuality with her family, but her need for privacy should be respected if she cannot share information about her own sexual relationship.

Providers should discuss with the patient information that will be shared. The teen may be asked *"Is it OK if I tell your mom that you did well with the pelvic examination?"* The parent can be reassured that the examination was normal and that her daughter is healthy.

Distribute the Bibliography page and Epilogue. Ask someone to read the Epilogue aloud.

Epilogue

Julie's Pap smear and cultures are negative, and she returns three months later. Her weight is unchanged and her blood pressure is normal. She had mild spotting in the first cycle of pills but has been regular since then. She has quit smoking and is doing well in school.

Refer back to group's learning agenda and summarize the key teaching points that were made. This will give the group a sense of accomplishment, and emphasize the important messages. Suggest further sources of reading or other information if there are agenda items that were not covered in the discussion.

Independent Learning/Prevention Exercises: Facilitators may wish to assign "Independent Learning/Prevention Exercises" to the group, particularly if time constraints hinder the completion of the case. The following list includes suggestions to explore the available community resources that focus on Contraception which can be integrated during or after the session. If the exercise is done in the absence of the facilitator, learners should take notes on their experience, then discuss with a faculty member for feedback.

1. Find out where patients can receive free or low cost contraceptive services.
2. Practice a "show and tell" with different contraception types/pill packs (how to explain these to a patient and how to promote abstinence and safer sex).
3. Interview a peer educator.
4. Find out what is being taught about sexuality, abstinence, contraception, and HIV protection in the local schools (and check the accuracy of the information).
5. Offer to give a talk or serve as a resource to a high school or community group.

The Hidden Agenda

Case Authors:
Estherann Grace, MD
S. Jean Emans, MD
Harvard Medical School
Children's Hospital, Boston

Part I

Julie, a 17 year old high school senior, comes to your office with her school physical form for participation on the soccer team. Julie has been playing soccer for four years and has never had an injury. Julie has been a patient of yours since she was 11 years old.

> You ask Julie, "*Do you have any health concerns today?"*
> Julie hesitates, and then responds, *"I think I need something for my cramps."*

Julie's menses have been regular since she was 13 years old, but over the past two years she has had increasing dysmenorrhea and often misses a day of school each month. She has used ibuprofen with some relief. Her last menstrual period was three weeks ago. In response to questions, Julie tells you that she has been sexually active with one partner for the past six months and has "*always*" used condoms. On one occasion, the condom slipped off as he was withdrawing. She denies ever being forced to have sex. She drinks one or two beers one weekend a month and smokes 1-2 cigarettes a week with friends. She is a B student and plans to attend a local college.

When asked about birth control options that she has thought about, she responds, *"I have several friends on the pill who are fine, but I'm worried I'll gain weight. Should I use some other method?"*

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You discuss with Julie the methods of contraception, pregnancy prevention and sexually transmitted disease (STD) prevention. You talk about the risks and benefits of combined oral contraceptives, progestin only methods (pills, depot medroxyprogesterone acetate, and levonorgestrel implants), estrogen/progestin injections, and barrier methods (condoms, spermicides, female condom, and diaphragm).

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The Hidden Agenda

Epilogue

Julie's Pap smear and cultures are negative, and she returns three months later. Her weight is unchanged and her blood pressure is normal. She had mild spotting in the first cycle of pills but has been regular since then. She has quit smoking and is doing well in school.

The Hidden Agenda
Handout #1: Contraception Fact Sheet

Contraceptive methods	**Pregnancy rate per 100 women in the first year of perfect use and first year of typical use.**		**Cost (by 1999 rates*)**	**Possible side effects**
Type	Perfect use†	Typical use†		
Oral contraceptives		5	$15-$30 per monthly pill pack	Irregular vaginal bleeding or spotting, nausea, weight gain, change in appetite, mood change, headache
Combined	0.1			
Progestin-only	0.5			
Depot medroxyprogesterone acetate				
Depo-Provera®	0.3	0.3	$30-$75 every 3 months	Irregular bleeding, increased appetite, weight gain, depression, headaches, hair loss. Side effects cannot be reversed until medication wears off (up to 12 weeks).
Estrogen/progestin monthly injectable				
Lunelle©	0.2	0.2	$30-50 every month	Headaches, water retention, weight gain, breast pain/tenderness, acne, dizziness, mood swings
Levonorgestrel implant (Norplant®)	0.05	0.05	$450-$900/5 years $100-$300 removal fee	Irregular bleeding, increase in appetite, weight gain, acne, headache, depression, hair loss
Condom				Allergies to latex or spermicide; can use polyurethane male or female condom if latex allergies occur
Male	3	14	$0.50-$3.50 per use	
Female	5	21	$1.50-$4.00 per use	
IUDs				Increase in cramps, heavier and longer periods with spotting between periods, backache, slight increased chance of infection, rarely – uterine perforation
Progesterone T IUD	1.5	2	$150-$400/year	
Copper T 380A	0.6	0.8	$250-$750/10 years	
Levonorgestrel releasing IUS	0.1	0.1		Bleeding diminishes during menstrual cycle, reduced cramping
Spermicides	6	26	$0.50-$3.50 per use	Vaginal irritation, allergies to spermicides, increased risk of urinary tract infections (UTIs), change in vaginal flora
Diaphragm	6	20	$15-$45 for the diaphragm, gel	Allergies to latex or spermicide, increased risk of UTIs Requires more spermicide than cervical cap
Cervical cap			$13-$50 for the cap, gel	Allergies to latex or spermicide Should not be used by women with history of abnormal Pap smears
Nulliparous	9	20		
Parous	26	40		
No method of contraception	85	85	$0.00	Pregnancy, STDs
Abstinence	0	0	$0.00	None

†Data from: Trussell J. Contraceptive efficacy. In: Hatcher RA, Trussel J, Stewart F, et al, eds. Contraceptive technology, 17th revised edition. New York: Ardent Media, Inc., 1998:779-801 (updated from: Trussell J, Hatcher RA, Cates W, Stewart FH, Kost K. Contraceptive failure among married women in the United States: an update. *Stud Fam Plann* 1990;21:51-54, and Trussell J, Kost K. Contraceptive failure in the United States: a critical review of the literature. *Stud Fam Plann* 1987;18:237-283.)

"Perfect use" means that the couples followed all instructions correctly, every time. "Typical use" means that the couples did not use the method correctly every single time.

*Data from: JAMA Contraception Information Center (www.ama-assn.org/special/contra/support), Planned Parenthood Federation of America (www.plannedparenthood.org/bc/).

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Handout #2: Patient Information about Emergency Contraception

What is emergency contraception?

- Emergency contraception is a treatment to prevent pregnancy in adolescent girls and adult women who have had unprotected sex in the past 72 hours.
- Emergency contraception uses a high dose of the hormones in birth control pills. This method is sometimes called the "Morning After Pill."

How does emergency contraception work?

- Emergency contraception gives a strong, short burst of hormones. This breaks the hormonal cycle your body would need to get pregnant.
- It is important to remember that emergency contraception does not always work. It does not guarantee that pregnancy is prevented.
- The best way to prevent pregnancy is to use a regular birth control method or not have sexual intercourse.

How is emergency contraception taken?

There are two types of emergency contraception that use hormone pills:

- The first type uses two hormones, estrogen and progestin, which are contained in birth control pills. The treatment consists of 2 doses. The first dose (2, 4, or 5 pills depending on the type of pills used) is taken within 72 hours of unprotected sex, and the second dose (2, 4, or 5 pills) is taken twelve hours later. Do not take extra pills. This will not decrease the risk of pregnancy. It will increase the risk of nausea and vomiting. There is also a special kit that comes with a pregnancy test that may be prescribed by your health care provider.
- The second type uses only one hormone, a progestin, which is contained in a special kind of birth control pill, often called the "mini-pill." This treatment also consists of 2 doses. This method causes less nausea and vomiting. You need to take either the new Plan B or 20 mini-pills for each of 2 doses, 12 hours apart.

Before you take emergency contraception, your provider will want to know:

- the first day of your last menstrual period;
- the exact date and time of unprotected sex;
- types of birth control you have used in the past, and when; and
- if you have ever had high blood pressure, migraine headaches, blood clots in your legs or lungs, a stroke, or any serious medical problems.

You cannot have emergency contraception if you are already pregnant.

Possible side effects of emergency contraception hormones include nausea and vomiting, breast tenderness, dizziness, or headache. An anti-nausea pill can be prescribed and taken an hour before each dose or you can use over the counter meclizine (Dramamine II or Bonine). The emergency contraception pill can also be taken with food to help prevent nausea.

When to Expect Your Next Period:

- Your period usually starts within 7 to 9 days after treatment.
- Your next period may start a little early or a few days later than expected.

Follow-Up Appointments:

See your health care provider two to three weeks after treatment for a visit to discuss effective contraceptive methods and to get a pregnancy test.

- Avoid intercourse or use a barrier method, such as a condom, consistently and correctly until the end of your next menstrual period.
- As soon as possible, begin using a method of birth control that you can use regularly.

Remember That…

- Emergency contraception is meant to be a one-time emergency treatment.
- Emergency contraception does not work as well as other forms of birth control.
- The risk of getting pregnant depends on where you are in your menstrual cycle when you have sex. You are most likely to get pregnant during ovulation, when the ovary releases a mature egg. Ovulation usually happens 14 days after your period starts.
- You should protect yourself against AIDS and other sexually transmitted diseases by using condoms every time you have sex.

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11. World Health Organization. *Improving access to quality care in family planning. Medical eligibility criteria for initiating and continuing use of contraceptive methods*. Geneva; 2000.
12. Trussell J, Hatcher RA, Cates E, et al. A guide to interpreting contraceptive efficacy studies. *Obstetrics and Gynecology* 1990;76:558-67.

Suggested Readings (Annotated)

Emans SJ, Laufer MR, Goldstein DP. *Pediatric and Adolescent Gynecology,* Fourth edition. Philadelphia: Lippincott, Williams and Wilkins; 1998.
This text provides a chapter on counseling the teen on contraceptive options, the health benefits and risks of the hormonal methods, an overview of barrier methods, and a review of studies on contraceptive compliance in teens.

Trussell J, Hatcher RA, Cates E, et al. A guide to interpreting contraceptive efficacy studies. *Obstetrics and Gynecology* 1990;76:558-67.
An excellent review of the pitfalls of the theoretical and actual pregnancy rates reported for various contraceptive methods.

World Health Organization. Improving access to quality care in family planning. Medical eligibility criteria for initiating and continuing use of contraceptive methods. Geneva; 1996.
An evidence based review of medical conditions and the risks of using contraceptive methods.

Educational Resources on the World Wide Web:
The Emergency Contraception website: http://opr.princeton.edu/ec/, or call (1-888-NOT-2-LATE)

Plan B website: http://go2PlanB.com

PATH (client materials on ECPs) http://www.path.org/programs/p-wom/emergency_contraception.htm

Planned Parenthood http://www.plannedparenthood.org and http://www.teenwire.com

The Children's Hospital League's Young Women's Resource Center website:
http://www.youngwomenshealth.org/information_sheets.html