

5.0

FAMILY PLANNING NEEDS OF SPECIAL POPULATIONS

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INTRODUCTION

Family Planning program services are prioritized to emphasize women who will experience high medical risk if pregnant, particularly adolescent women, women over the age of 35, women with a history of pregnancy difficulties, women with pregnancies spaced less than 3 years apart and women whose income is at or below 250% of poverty.

SERVICE POPULATION

Uninsured or underinsured reproductive age women and men who may be at high risk of unintended pregnancy.

METHODOLOGY

5.1 ADOLESCENTS AND FAMILY PLANNING

Adolescent pregnancy continues to be a public health problem of epidemic proportions in this country.

COMMUNICATION WITH PARENTS, PARTNERS, AND TEENS

Confidentiality is essential in services to teenagers. At the same time, PHD clinics should encourage teenagers to communicate with parents and help teens who are willing to do so.

Clinic staff may offer factual information to parents and teens to help them in responsible decision making about sex, and encourage discussion of values and choices at home. Teens who choose not to be sexually active may need information to support their decision as a normal one. Teens who choose to be sexually active may need information to support a decision to stop somewhere other than "going all the way."

Educating parents to talk to their children about sexuality will help establish the local health office as a safe place to receive services. Parents need to learn that research indicates that the more teens know about sexuality, the longer they are likely to postpone their first sexual experience.

Clinics might encourage a "buddy system" whereby young women can support one another through the experience. Partners may also attend. Many areas send staff to the schools to provide pre-clinic services so that teen time spent in the clinic location is minimal.

SEXUALLY TRANSMITTED INFECTIONS

Teenagers tend to think of themselves as invulnerable and immortal. However, rates of sexually transmitted infections, unintended pregnancy, and intercourse outside of committed relationships such as marriage are high in U.S. teenagers and individuals in their twenties. Although the number of cases of AIDS in teenagers is small thus far, these statistics are very deceptive because the interval between infection with HIV and diagnosis of AIDS may be as great as 5 - 10 years or more.

Oral contraceptives provide no protection against AIDS. Dual protection, adding the male or female condom for STD protection to a reliable method for contraception, is strongly advised.

CERVICAL CANCER SCREENING

Regardless of choice of birth control method, sexually active women of all ages need routine Pap smear screening as recommended in Section 4. Community outreach and individual counseling are important for cervical cancer prevention.

CONTRACEPTION

Public Health Nurses also have the option of implementing the "QUICKSTART" Protocol (See Section 2). This protocol allows the young client to begin contraception while delaying her physical exam for 3 to 6 months if fear of the exam itself is a barrier to her obtaining services.

5.2 SERVING UNEMANCIPATED* MINOR CLIENTS

INTRODUCTION

It is the purpose of the Family Planning Act 24-8-1 thru 24-8-8 NMSA 1978 “to assure that comprehensive family planning services are accessible on a voluntary basis to all who want and need them.”

SERVICE POPULATION

Clients under the age of 18 seeking reproductive health services and contraception at Title X service sites.

* Definition of an emancipated minor.

An emancipated minor is a person sixteen (16) years of age or older who:

1. is or has been validly married (annulment of marriage of a 15 year old will not count): or
2. is on active duty with the armed forces; or
3. has obtained a declaration of emancipation from the district court.

Note that no one under 16 can be emancipated. A person may apply for and obtain a declaration of emancipation if he/she is willingly living separate and apart from parents or guardian and managing his/her own financial affairs.

METHODOLOGY

1. Counsel the client to request parent, family or legal guardian involvement as it is generally beneficial, but explain that the client has the right to choose to do so or not. Give the client a copy of the brochure “Birth Control: Talking with Your Parents”. You may order this from the Family Planning Program. It is included in Appendix D, “Pamphlet Order Form”.
2. If the client does not want parent, family or legal guardian involvement, have the client sign “Public Health Division Parental/Family Involvement in Services to Minor Age Clients” (next page) requesting confidentiality.
3. If the client does not object to parent/family involvement, have the client sign the parental/family involvement in services form indicating that the appropriate PHD staff member (PHN, NP, PA, MD) may answer any inquiries from her/his parent about the information on minor client’s family planning chart.
4. Screen and counsel client (if appropriate) regarding avoidance of coercive relationships. See Section 5.3 for counseling guidelines.
5. Review and have the client sign the consent form annually for any services given to adolescents. These consent forms are not necessary once the client reaches age 18.

If the parent brings the minor client to clinic, a note in the client’s chart should read:

- a. Parent in conference and/or exam; or
- b. Parent present at clinic, but did not participate in conference and/or exam.
- c. The parental/family involvement form should also be completed.

**PUBLIC HEALTH DIVISION, FAMILY PLANNING PROGRAM
PARENTAL/FAMILY INVOLVEMENT IN SERVICES TO MINOR-AGE CLIENTS**

The Public Health Nurse (PHN) has encouraged me to involve my parent(s)/family in my counseling and decision to receive family planning services to prevent pregnancy because it is usually beneficial to do so.
I have considered this and have decided that:

- The PHN or clinic doctor may answer any inquiries from my parent(s) /legal guardian about my family planning services.
- I do not want my parent(s) /legal guardian to know about my family planning services.

Name of Client	Date of Birth & Age	Date
Witness	Title	Date

**PROGRAMA DE PLANIFICACION FAMILIAR PARTICIPACION DE LOS PADRES/FAMILIA EN LOS SERVICIOS A
PACIENTES MENORES DE EDAD.**

La enfermera de Salud Publica me ha recomendado que invite a mis padres/familia que participen en mi asesoramiento y decision de recibir servicios de planificación familiar para prevenir un embarazo porque generalmente la participacion de los padres/familia es beneficiosa. Lo he pensado y he decidido que:

- La Enfermera de Salud Publica o el doctor de la clinica pueden responder a preguntas que tengan mis padres/guardián legal acerca de mis servicios de planificación familiar.
- No deseo que mis padres/ guardián legal sepan acerca de mis servicios de planificación familiar.

Nombre del paciente	Fecha de nacimiento(edad)	Fecha
Testiga	Titulo	Fecha

For Staff Use Only:

- ? I have discussed Confidentiality with this client, including:
- We have to report to CYFD (1-800-797-3260) if:
 - We think he/she will harm him/herself or others (homicide or suicide).
 - We know or strongly suspect that he/she is being abused or neglected.
- We may have to discuss with your parents or guardians if:
- During visits here, we find a condition/situation that can harm his/her health and he/she needs help with this.
 - I have screened (and counseled, if appropriate) this client regarding coercion.

The plan for contacting this client when he/she has abnormal test results or is not following the plan of care is:
(list 2 ways to contact this client below.)

At client's address. Phone # _____

At parent's address. Phone # _____ Name of Parents _____

DO NOT CONTACT PARENTS _____

Pager/Phone: Whose: _____ Number: _____

School: _____ Current Grade: _____

(New Mexico Public Health Division - Family Planning - Parental Involvement English /Spanish 06/01)

ARTICLE 8

Family Planning

Sec.	Sec.
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24-8-2. Definitions.	
24-8-3. Legislative findings: purpose of act.	
24-8-4. Prohibition against interference with medical judgement of physicians.	
24-8-5. Prohibition against imposition of standards and requirements as prerequisites for receipt of requested family planning services.	
24-8-6. Health facility licensure; affirmative state-	
	ment of compliances required as condition of licensure; prohibition against certain policies of health facilities, state and local governmental units.
	24-8-7. Publicly funded family planning services; provision of certain services to medically indigent persons free of charge and to other persons at a cost consistent with their ability to pay.
	24-8-8. Coordination of family planning services.

24-8-1. Short title.

This act [24-8-1 to 24-8-8 NMSA 1978] may be cited as the "Family Planning Act".

History: 1953 Comp. § 12-30-1, enacted by Laws 1973, ch. 107, § 1.

Am. Jur. 2d, A.L.R. and C.J.S. references.--
12 Am. Jur. 2d Birth Control §§ 1 to 6.

Validity of regulations as to contraceptives or the dissemination of birth control information, 96 A.L.R.2d 955.

Liability of manufacturer or seller for injury or death allegedly caused by use of contraceptive, 70 A.L.R.3d 315.

Sexual partner's tort liability to other partner for

fraudulent misrepresentation regarding sterility or use of birth control resulting in pregnancy, 2 A.L.R.5th 301

Parent's child support liability as affected by other parent's fraudulent misrepresentation regarding sterility or use of birth control, or refusal to abort pregnancy, 2 A.L.R.5th 337.

1 C.J.S. Abortion and Birth Control; Family Planning §§ 1 to 12; 39A C.J.S. Health and Environment § 43.

24-8-2. Definitions.

As used in the Family Planning Act [24-8-1 to 24-8-8 NMSA 1978]:

- A. "contraceptive procedures" means any medically accepted procedure to prevent pregnancy;
- B. "family planning services" includes contraceptive procedures and services (diagnosis, treatment, supplies and follow-up), social services, educational and informational services;
- C. "health facility" means a hospital, clinic, nursing home, intermediate care facility or pharmacy;
- D. "medically indigent" means a person who has insufficient funds to pay for family planning services;
- E. "local governmental units" means counties, municipalities and public school districts and any of their agencies, departments, commissions, committees, institutions and educational institutions;
- F. "physician" means a person licensed or authorized to practice medicine or osteopathy under the provisions of Sections 61-6-1 through 61-6-28 and 61-10-1 through 61-10-21 NMSA 1978; and
- G. "state" means the state and its agencies, departments, commissions, committees, institutions and educational institutions.

History: 1953 Comp., § 12-30-2, enacted by Laws 1973, ch. 107, § 2

Law reviews. -- For comment, "Voluntary Steril-

ization in New Mexico: Who Must Consent?" see 7 N.M. L. Rev. 121 (1976-77).

24-8-3. Legislative findings; purpose of act.

- A. The legislature finds that:
- (1) family planning has been recognized as an essential component of standard health care and has been recognized nationally and internationally as a universal human right;
 - (2) continuing population growth causes or aggravates many social, economic and environmental problems, both in this state and in the nation.
 - (3) family planning services are not available as a practical matter to many persons in this state;
 - (4) it is desirable that family planning services be readily accessible to all who want and need them;
- and
- (5) dissemination of information about family planning by the state and its local governmental units is consistent with public policy.

B. It is the purpose of the Family Planning Act [24-8-1 to 24-8-8 NMSA 1978] to assure that comprehensive family planning services are accessible on a voluntary basis to all who want and need them.

History: 1953 Comp., § 12-30-3, enacted by Laws 1973, ch. 107, § 3.

24-8-4. Prohibition against interference with medical judgment of physicians.

The Family Planning Act [24-8-1 to 24-8-8 NMSA 1978] does not prohibit or inhibit any person from refusing to provide any family planning service on the grounds that there are valid medical reasons for the refusal and those reasons are based upon the judgment of a physician given in the specific case of the person for whom services are refused.

History: 1953 Comp., § 12-30-4, enacted by Laws 1973, ch. 107, § 4.

24-8-5. Prohibition against imposition of standards and requirements as prerequisites for receipt of requested family planning services.

Neither the state, its local governmental units nor any health facility furnishing family planning services shall subject any person to any standard or requirement as a prerequisite to the receipt of any requested family planning service except for:

- A. a requirement of referral to a physician when the requested family planning service is something other than information about family planning or nonprescription items;
- B. any requirement imposed by law or regulation as a prerequisite to the receipt of a family planning service; or
- C. payment for the service when payment is required in the ordinary course of providing the particular service to the person involved.

History: 1953 Comp., § 12-30-5, enacted by Laws 1973, ch. 107, § 5.

Law reviews. -- For comment, "Voluntary Sterilization in New Mexico: Who Must Consent?" see 7 N.M.L. Rev. 121 (1976-77).

For article, "Treating Children Under the New Mexico Mental Health and Developmental Disabilities Code," see 10 N.M.L. Rev. 279 (1980).

24-8-6. Health facility licensure; affirmative statement of compliance required as condition of licensure; prohibition against certain policies of health facilities, state and local governmental units.

- A. No health facility shall include in its bylaws or other governing policy statement a statement that:
- (1) interferes with the physician-client relationship in connection with the provision of any family planning service; or
 - (2) establishes or authorizes any standard or requirement in violation of Section 5 [24-8-5 NMSA 1978] of the Family Planning Act, provided that nothing in the Family Planning Act [24-8-1 to 24-8-8 NMSA 1978] shall be construed to require any hospital or clinic that objects on moral or religious grounds to admit any person for the purpose of being sterilized.

B. Neither the state nor its local governmental units shall have any written or unwritten policy that interferes with the physician-client relationship in connection with the provision of family planning services except for provisions required by law or regulations relating to payment from public funds to a provider of family planning services.

C. No license or a renewal of a license shall be issued by the state to a health facility if it is in violation of the provisions of Subsection A of this section.

History: 1953 Comp., § 12-30-6, enacted by Laws 1973, ch. 107, § 6. **Cross references.** -- For licensing of health facilities generally, see 24-1-5 NMSA 1978.

24-8-7. Publicly funded family planning services; provision of certain services to medically indigent persons free of charge and to other persons at a cost consistent with their ability to pay.

To the extent that public funds are available, in any family planning services program operated by the state and its governmental units and in any family planning services program in which public funds are expended:

A. family planning services consisting only of information about family planning shall be furnished to persons free of charge; and

B. other family planning services shall be furnished to medically indigent persons free of charge and to all other persons at a cost consistent with their ability to pay.

History: 1953 Comp., § 12-30-7, enacted by Laws 1973, ch. 107, § 7.

24-8-8. Coordination of family planning services.

Any family planning services program developed or operated by the state or its local governmental units shall be developed and operated in coordination with other public and private family planning services programs existing in the state.

History: 1953 Comp., § 12-30-8, enacted by Laws 1973, ch. 107, § 8.

Parental consent is not required for, and shall not bar children from receiving, the following services: pregnancy testing, diagnosis and treatment of sexually transmitted diseases, family planning services and Human Immunodeficiency Virus testing, pursuant to Section 24-1-13 NMSA 1978, Section 24-1-9 NMSA 1978, Section 24-2B-3 NMSA 1978 and 42 U.S.C.A. Section 300 et seq., 42 U.S.C.A. Section 1396 et seq. New Mexico state law also permits minors on their own to consent to treatment for substance abuse and mental health counseling. However, the health office staff should make every effort to encourage discussion between the minor and parent/guardian regarding these subjects.

5.3 ADOLESCENTS AND COERCION

Introduction. Sexual coercion among adolescents is a serious public health issue. Dating violence, sexual harassment, sexual abuse and unhealthy relationships are all too common among today's youth. The majority of these incidences go unreported; leading victims and perpetrators to believe sexual coercion is an acceptable part of sexual behavior.

Victims of sexual coercion rarely report the incident to anyone. The practitioner's role is to determine if sexual coercion has occurred, and the current level of the client's safety, provide support and appropriate referrals and report to authorities if the minor fits the legal definition for an abused or neglected child. A medical evaluation must include a careful assessment for abusive or unwanted sexual encounters, appropriate physical examination, appropriate psycho-social evaluation and counseling.

“Abused child” means a child:

- 1) who has suffered or who is at risk of suffering serious harm because of the action or inaction of the child’s parent, guardian or custodian;
- 2) who has suffered physical abuse, emotional abuse or psychological abuse inflicted or caused by the child’s parent, guardian or custodian;
- 3) who has suffered sexual abuse or sexual exploitation inflicted by the child’s parent, guardian or custodian;
- 4) whose parent, guardian or custodian has knowingly, intentionally or negligently placed the child in a situation that may endanger the child’s life or health; or
- 5) whose parent, guardian or custodian has knowingly or intentionally tortured, cruelly confined or cruelly punished the child. (Abuse and Neglect Act 32A-4-2)

According to the New Mexico criminal code children less than thirteen years of age cannot consent to sexual activity, thus any sexual activity in this age group is of concern, and requires careful assessment of need for supervision, abuse and neglect. It must be reported to appropriate authorities if you suspect that your patient is being sexually abused using the above criteria.

Guiding Principles. Some guidelines for practitioners in assessing the presence of abuse or suspected abuse follow below. They are based on guidance and principles presented by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and the Society for Adolescent Medicine in 2004 (Position Paper of the AAFP, AAP, ACOG, and SAM, *Journal of Adolescent Health* 2004:35:420-423). These guidelines include the following:

- Sexual activity and sexual abuse are not synonymous. It should not be assumed that adolescents who are sexually active are, by definition, being abused. Many adolescents have consensual sexual relationships.
- It is critical that adolescents who are sexually active receive appropriate confidential health care and counseling.
- Open and confidential communication between the health professional and the adolescent client, together with careful clinical assessment, can identify the majority of sexual abuse cases.
- Clinicians must know state laws and report cases of sexual abuse to the proper authority, in accordance with those laws, after discussion with the adolescent and parent, as appropriate.

Steps in taking a history and counseling sexually active adolescents ages 13-17.

When taking a history from a client it is the *provider’s* responsibility to ask about coercive sexual behavior. If sexual coercion is suspected, regardless of the nature of the relationship or the issue of consent, counseling, referral and possible reporting should be considered.

- 1) Interview the client alone. This is critical in determining the presence of sexual coercion, current or previous abuse, or family violence.
- 2) Discuss the policy on confidentiality and its limits. Using the Parental/Family Involvement form provided which states that anything your clients discusses with you is held in strict confidence; meaning that you discuss nothing with anyone about them unless you have their permission to do so. You must, however, also mention that the exceptions to this are if you believe they might harm themselves or someone else, or if you believe they are being abused or neglected.
- 3) Context of confidentiality and the adolescent client.
 - The child is your patient/client.
 - As your patient/client, the child is entitled to the same confidentiality for all information you get from the child that you would for any other patient or client, subject to your responsibilities to report as required by law.
 - This means, when talking to the parent, guardian, or custodian, that you respect the child’s confidentiality except to the extent that the child has given you permission to share information with the parent, guardian or custodian. You are interviewing and/or evaluating the parent, guardian, or custodian and their roles and actions, not disclosing or discussing.

- 4) Create a nonjudgmental, teen friendly environment. Have posters on the walls and brochures about sexual coercion openly visible and available.
- 5) Present questions in an open-ended format to allow for unanticipated and multiple answers. Listen carefully, validate feelings and offer tangible ways of help.
- 6) Be aware of time. Do not ignore a situation or start a conversation that cannot be finished in the allowed time.
- 7) Phrase questions in a neutral way, and be mindful of your tone of voice and body language. If teens feel the practitioner is disapproving they will shut down. Ask specific questions about sexual coercion
 - Have you ever had sex without protection because your partner didn't want to use it?
 - Has anyone including your partner, pushed, coerced, or forced sex?
 - Have you ever had too much to drink or taken drugs and then had sex when you didn't want to?
 - Have you ever had a sexual experience that hurt you; or was frightening, confusing, or you felt had to be kept secret?
 - Have you confided in your parents about any of these experiences?
- 8) Use visual aids, including posters on the walls and brochures.

Some adolescents do not feel comfortable disclosing coercive or abusive situations with a provider at the first meeting. Some may never disclose abuse, even if asked directly. Each provider's strategy may vary, with some using interview forms for the client to fill out, and others using a more open approach. Providers should express care and concern for the client to increase comfort and therefore support more honest disclosure.

First, are you concerned there is sexual abuse? If the following questions are answered "yes", there is sexual abuse.

1. Is the suspected person engaging in sexual activity (penetration or sexual contact) with your client?
2. Is the suspected person in a custodial or authoritative position with respect to the client? (Parent, relative, household member, teacher, employer or other person who, by reason of that position, is able to exercise undue influence over a child)

Second, are there other issues that raise concerns about your client's sexual activity?

1. Are you concerned about your client's ability to consent to sexual activity?
2. Does developmental delay or mental illness affect your client's ability to fully understand consequences or his/her behavior?
3. Does your client have the ability to avoid the person? Does the person have constant or frequent access to your client?
4. Is there force, coercion, or intimidation used during sexual contact? This is rape, regardless of the age of either party. While we are required to report sexual or other abuse by people in authoritative or custodial roles, we are not required to report crimes. It is important, however, to explain to clients that this is a crime, and that victims of crimes can report them.
5. If the client's partner is over eighteen and at least four years older than your client, the partner is committing fourth degree criminal sexual penetration (statutory rape).
6. Although a wide discrepancy in age between partners is of concern when caring for the adolescent client, partner age by itself is not the only indicator of exploitation or abuse. However, sexual abuse and exploitation of an adolescent may occur in any relationship, including those where the partners are the same age, younger, or older". As clinicians, our goal is not to blindly and rigidly use age guidelines. We do not want to miss any abuse at any age.
7. Verbal and physical coercion, as well as alcohol and drugs, are some of the strategies used by sexual predators to victimize adolescents.
8. A separate but related issue is whether there is child abuse that is not sexual abuse. This would involve custodial or authoritative person physically or emotionally abusing, or neglecting your client. There are legal definitions of "abused child" on previous page.

If a client denies sexual coercion but you are still concerned, here are some suggestions for what to do next:

- Schedule short-term follow-up with your client. Offer your continuous support and willingness to talk.
- Ask your client if they could bring a supportive adult with them to the next visit
- Consider asking your client to bring their sexual partner to the next visit
- **Consult** with your **supervisor**.
- Call one of the people listed in your resource list, or call your local Child Protective Services office for a consultation. Ask to speak to a supervisor. Pose your question. You may do so without revealing names and ask for advice and recommendations
- Discuss your concerns in a non-judgmental way with your client - ex: "I'm concerned about your sexual activity. What are you getting out of this? Is there any part of this that makes you uncomfortable?"
- Consider referral to a social worker or therapist

If a client does disclose sexually coercive experiences, first determine the current level of safety. Ask if they could confide in their parent(s) or other family members for support and security. Ask if they are able to avoid the alleged offender in the future, and what is the plan. The availability of community services such as counselors, domestic violence shelters and rape crisis centers should be readily available. A copy of the New Mexico Sexual Abuse Program Coordinators and additional counseling strategies are included in the VAST protocol.

If you need assistance with this assessment process, contact your RHO or Children Youth and Families Department (CYFD) at 1-800-797-3260.

5.4 CHILD ABUSE REPORTING

If, in your clinical judgment you suspect the minor meets the legal definition for an abused or neglected child inform client of your duty to report.

1. Report it to:

Children Youth and Families Department (CYFD) at 1-800-797-3260
Or
Local Law Enforcement

Report is made to tribal law enforcement or social services agency for an Indian child.

2. The following is a list of information that must be given when reporting.

- Names and addresses of the child and child's parents, guardian, or custodian
- The child's age
- Nature and extent of child's injuries; any evidence of prior injury
- Identity of person responsible for the injuries
- Any other information that might be helpful such as street address, SS#, names of other professionals in contact with the child, past history of the child or the family, child's affect or disability, history of domestic violence, substance abuse/mental illness, or criminal activity.

3. Document on the Narrative Notes in SOAP format in the client medical record the date, time and nature of the call.

A red alert is placed in the INPHORM utilizing the code: MRM (Mandatory Report Made), Date of report, Agency reported to, and the city of the local health office.

Example: MRM, 4/30/05, CYFD, Santa Fe.

Anyone reporting an instance of alleged child neglect or abuse or participating in a judicial proceeding brought as a result of a report required by the reporting laws is presumed to be acting in good faith and shall be immune from civil or criminal liability that might otherwise be incurred or imposed by the law, unless the person acted in bad faith or with malicious purpose. (N.M. Stat. Ann. §32A-4-5(B)(Michie 1995)

5.5 METHOD CONSIDERATIONS FOR TEENS

ABSTINENCE

Advantages

Free and available to all

Effective at preventing both STIs and pregnancy

It can be started at any time in one's life

Can increase self-esteem and positive self-image if consistent with personal values

Risk of cervical dysplasia far less if no vaginal intercourse has ever occurred.

Disadvantages

Substantial risk of pregnancy (22%) if practiced on periodic basis

Frustration or sense of rejection if abstinence not self-selected

Requires commitment and self control; non-understanding partner may seek other partner(s)

Client and her partner may not be prepared to contracept if they stop abstaining.

If only abstaining from penis-in-vagina intercourse, there may be no protection against infections transmitted through other activities such as oral and anal intercourse, including herpes, genital warts, gonorrhea, chlamydia, syphilis and HIV/AIDS.

Some who choose to no longer abstain may have little knowledge about other methods

SPERMICIDE/CONDOMS

Advantages

Available without a medical exam or prescription.

Latex condoms when used consistently and correctly are highly effective in preventing transmission of HIV and can reduce the risk of other sexually transmitted infections as well as pregnancy prevention.

Use is determined by need. This method is used only when it is needed. No preliminary steps need be taken except to have it on hand.

VCF film and condoms can be carried and used discreetly.

Both VCF film and foam are female-controlled methods.

Disadvantages

Rare complications such as latex allergy or sensitivity to spermicide. Frequent use may predispose some women to vaginal yeast infections.

Fear of discovery or embarrassment may dissuade purchase and storage, especially of foam.

Unpredictability of place of sexual activity may mean that supplies are not accessible when needed.

ORAL CONTRACEPTIVES

Advantages

Popular, perceived as easy to take.

Regulates menses, minimizes bleeding and cramps.

Less medical risk to teenage women than to any other age group.

Protection against ovarian and endometrial cancer.

Excellent reversibility.

Disadvantages

Requires medical exam, prescription, and resupply visits.

Higher use failure rates due to discontinuation, inconsistent use.

COCs may adversely affect milk production when used while breastfeeding a baby less than 6 months old.

DIAPHRAGM

Advantages

Less need for male cooperation.

Inserted ahead of time so available in case of need.

Use varies with amount of sexual activity which may be infrequent.

Either partner could keep it and insert it.

Disadvantages

Only medical complication may be urethral irritation or tendency toward UTIs.

Requires medical exam and prescription and resupplies of spermicide.

If stored elsewhere may not be available when needed.

Fear of discovery may discourage use unless teen has safe place to store and insert.

Teen modesty, reluctance to explore/touch own genitals may discourage use.

Less contraceptive effectiveness than other/hormonal methods of contraception.

INTRAUTERINE DEVICE

Advantages

No supply visits.

Cannot be "discovered" in routine use.

Does not require constant decision making, commitment to use in direct relation to sexual encounters.

Always available.

Disadvantages

Requires a medical examination and insertion, which may be transiently uncomfortable for some clients.

Complications may result in discovery; may also negatively impact on future fertility (see below).

Does not protect against STI; if exposed may predispose to serious infection.

Not recommended for those having multiple or serial partners.

Paragard may cause severe cramps and/or increased menstrual bleeding.

DEPO-PROVERA

Advantages

Discreet, reliable, and easy to use.

Requires no additional supply, action or preparation at time of intercourse.

Offers 24-hour protection for 3 months.

Disadvantages

May increase risk of osteoporosis with long term use

Weight gain and unpredictable menses may be troublesome to teens.

Offers no STI protection.

Need to return to clinic every 3 months to repeat dose may be seen as barrier.

Women who are phobic about injections may see this as a problem.

6-12 month delay in return to fertility and regular menses.

ORTHO EVRA

Advantages

Easy to use.

Can be used discreetly

Regulates menses, minimizes bleeding and cramps.

Less medical risk to teenage women than to any other age group.

Protection against ovarian and endometrial cancer.

Excellent reversibility.

Disadvantages

Requires medical exam, prescription, and re-supply visits.

Higher use failure rates due to discontinuation, inconsistent use.

May adversely affect milk production when used while breastfeeding a baby less than 6 months old.

5.6 POSTPARTUM CLIENTS AND FAMILY PLANNING

In most offices which provide prenatal services the 4 - 6 week postpartum exam also enrolls the woman as a family planning client, in which case, a Family Planning record is started. In a few offices the postpartum client is referred elsewhere for family planning. This situation has highlighted the special concerns, which should be addressed at 4 - 6 weeks postpartum.

While using the family planning record the interviewer should expand on the history to note:

- Events of the recent pregnancy
- Description of the birth
- Events since the birth

<u>Physical:</u>	fever	<u>Psychosocial:</u>	baby care/feeding
	fatigue		baby blues/depression
	stitches		family interactions
	breast engorgement		housework
	lactation		work/school
	pelvic pain		exercise/recreation
	lochia/menses		sleep patterns
	constipation/hemorrhoids		sex/contraception

Special attention on physical exam/lab work to note:

- Hemoglobin** absolute compared to pregnant/pre-pregnant
- Weight absolute compared to pregnant/pre-pregnant
- Blood pressure
- Breast condition
- Abdominal tone
- Uterine size, cervical laceration
- Vaginal tone, lubrication, infections, condition of any episiotomy/laceration and pain

If the Pap smear on the record was abnormal or more than 6 months old, it should be repeated at this time; then the "annual" repeat may be postponed for 12 months from the date of the postpartum check.

Offer screening for Medicaid Category 35F for family planning coverage if appropriate or give Medicaid application as found in Appendix F. If the client will be referred elsewhere for contraception, consideration needs to be given to the time lag until the Family Planning appointment and possible need for spermicide/condoms as an interim method. Some sites may wish to consider offering Depo-Provera to this population. (See risks for women with history of Gestational Diabetes Mellitus in section 5.9E3)

5.7 BREASTFEEDING AND FAMILY PLANNING

Breastfeeding is encouraged by Public Health Division's WIC and Prenatal Programs. Clients are to be encouraged to consider the inter-relationship between breastfeeding and their family planning choices. Clients are encouraged to think about family planning in the prenatal period.

The advantages/disadvantages for each method are listed in this section so that it may be photocopied and handed to clients in prenatal clinic or on WIC visits as well as in family planning clinic. See also Contraceptive Technology for discussion of the use.

Lactation has been specifically added to the "History and Physical Examination" section of the Family Planning Record to highlight its importance especially if the client has recently given birth.

Lactation can provide significant contraceptive benefits. If the infant is fed only its mother's breastmilk (or is given supplemental non-breastmilk feedings only to a very minor extent) and the woman has not experienced her first postpartum menses, then breastfeeding provides more than 98% protection from pregnancy in the first 6 months following birth. "Full or nearly full breastfeeding" is defined by breastfeeding intervals which do not exceed 4 hours during the day or 6 hours at night, and supplementation should not exceed 5-15% of all feeding episodes, preferably fewer.

METHOD CONSIDERATIONS FOR BREASTFEEDING WOMEN

See Contraceptive Technology or Pocket Guide for Lactational Amenorrhea Method and use of oral contraceptives.

SPERMICIDE/CONDOMS

Advantages

No effect on amount/composition of breast milk.

Spermicide or lubricated condoms may counteract vaginal dryness which may occur due to lower levels of estrogen while breastfeeding.

May be obtained without prescription/clinic visit and started as soon as intercourse is resumed postpartum either as long term choice or interim method.

Provides some protection against STI including HIV.

Disadvantages

Use of spermicide may predispose some women to vaginal yeast infections.

Must be used with every act of intercourse.

DIAPHRAGM

Advantages

No effect on amount/composition of breast milk.

Jelly/cream used with diaphragm may counteract vaginal dryness which may occur due to lower levels of estrogen while breastfeeding.

Disadvantages

Not reliable/practical immediately postpartum as must be measured 6 weeks after childbirth to establish/re-establish correct size.

Spermicide use may predispose some women to vaginal yeast infections.

Urethral irritation may predispose some women to UTIs.

Must be used with every act of intercourse.

Less contraceptive effectiveness than other/hormonal methods of contraception.

INTRAUTERINE DEVICE

Advantages

No effect on amount/composition of breast milk.

Disadvantages

The IUD is more likely to fall out if insertion is done prior to 3 months postpartum.

Cramps may be aggravated by breastfeeding-induced uterine contractions with Paragard.

ORAL CONTRACEPTIVES

Advantages

American Academy of Pediatric policy approves use of COCs once breastfeeding is well established.

Lower dose or progesterone-only pills started after breastfeeding is well established (6-8 weeks postpartum) do not seem to affect amount/composition of breastfeeding, whereas COCs may decrease breastmilk production.

Disadvantages

Trace amounts of estrogen/progesterone appear in the breast milk. Unknown long term effects on infant.

Higher estrogen dose pills may suppress lactation/alter milk composition especially if started immediately postpartum.

TUBAL LIGATION

Advantages

No ongoing effect on amount/composition of breast milk.

Disadvantages

Drugs used to numb areas or put woman to sleep for the surgery are secreted in the breast milk and may depress the infant's sucking response. This may delay successful initiation of breastfeeding especially if the operation is done immediately after delivery.

NATURAL FAMILY PLANNING

Breastfeeding is considered a "special circumstance" for users of NFP since the menstrual cycle may be altered. The couple may need to review or consult their NFP instructor.

Advantages

No effect on amount/composition of breastmilk.

Is a family-centered approach involving both partners.

Inexpensive.

Disadvantages

Requires periodic abstinence which may be a problem for some couples.

ORTHO EVRA

Advantages

American Academy of Pediatric policy approves use of estrogen containing contraceptives once breastfeeding is well-established.

Disadvantages

Trace amounts of estrogen/progesterone appear in the breast milk. Unknown long term effects on infant.

May suppress lactation/alter milk composition especially if started immediately postpartum.

DMPA OR DEPO-PROVERA

Advantages

Discrete and private method.

Provides 3 months of pregnancy protection for each injection.

This method is not user-controlled nor intercourse-related.

Easy to stop using simply by not repeating injection.

Has no adverse effect on quality or quantity of breastmilk.

No evidence of adverse effects on infants breast-fed by users of this method.

Disadvantages

May cause weight gain.

Once administered, isn't reversible (except by passage of time).

Infant receives a small amount of progestin in the milk.

Not recommended for use by women who are less than 12 months postpartum, breastfeeding and who had Gestational Diabetes with pregnancy (All 3 criteria).

5.8 INFERTILITY

Section 8.5 of the Title X Guidelines requires programs to offer at least Level I infertility services. These services include an initial interview, education, physical examination, counseling, and referral for more extensive services.

Infertility is the inability to achieve pregnancy despite regular unprotected intercourse or to carry the pregnancy successfully to the point of viability. Eighty percent of couples will achieve pregnancy within one year. Infertility investigation is difficult, complex and expensive; therefore, it is customary not to begin medical infertility investigations until the couple has been trying to conceive for at least 12 months.

Couples may seek assistance earlier. Especially if they are over 35 years old, it may be best to begin basic counseling, screening, and in some cases referral, right away.

Fertility concerns are very stressful to the individuals involved. Sensitivity and support are essential. PHD clinics will have a very limited role in cases of true infertility. Caution should be exercised so that couples are not subjected to steps (in-depth medical history, physical examinations) which would invariably be repeated by the infertility specialist.

The couple should be given a copy of their clinic records, especially if a detailed menstrual and sexual history has been taken, and a summary of any education or counseling that was provided.

Many PHNs and clinicians in LHOs would be able to do the following:

1. Ascertain client's level of knowledge about conception and provide information to complete or correct their understanding of the process.
2. Ascertain how clients have been "trying to get pregnant". This would involve a detailed menstrual and sexual history to determine the type and frequency of sexual activity in relation to the woman's estimated fertile time. History relating to drug and alcohol use should be included.

If indicated, provide instruction in fertility awareness. Offer the couple **CycleBeads instruction**. A **digital thermometer** may be provided **if applicable**.

3. If their knowledge level and sexual patterns were adequate or other factors like irregular menses were noted during this initial interview, or pregnancy did not occur within 3 months of applying fertility awareness, the couple should be referred to a physician familiar with infertility.

See the current Contraceptive Technology for more detailed discussion. Couples might also profit from reading the chapter on Infertility for the information on the various tests involved in a workup, and discussing it with the staff.

There is a support group of couples with infertility problems - RESOLVE. Contact their national headquarters RESOLVE, 1310 Broadway, Somerville MA, 02144; Phone (301) 652-8585 or web site, www.resolve.org.

5.9 WELL WOMEN HEALTH CONCERNS

5.91 SERVICES FOR WOMEN OVER AGE 35

WHY SEE OLDER WOMEN? While providing services to adolescents is our primary goal, fertile women over age 35 remain our second priority target population (see section 1.4, clinic services). This is because pregnancy in an older woman may place her or her fetus at high medical risk. This priority often gets lost in the rush to provide adolescent services. Please use the following ideas to help address the needs of this forgotten group in our Family Planning clinics.

WHAT SERVICES CAN WE OFFER? Although some women in this age group have chosen a permanent method, there are many others who are still in need of contraception. Please take a look at how your clinics are handling these older women: are you seeing clients in this age group? If not, why not? Does your clinic have a "teens only" image? Are your clinicians offering oral contraceptives to non-smokers up to age 50? Do your clients know that tubal ligations and vasectomies are available through the Family Planning Program? Will you offer Depo-Provera to these clients? Are you providing fertility awareness information or counseling for women experiencing menopausal symptoms? Are you continuing to offer combined oral contraceptive pills to older non-smoking clients, or progestin-only pills to smokers? Do you or someone else on your staff need training regarding outreach or services for this age group? Do you have adequate educational materials for their needs? Please let us know how to help you provide family planning services for these older women in your community.

WHAT ABOUT WOMEN WHO HAVE HAD TUBAL LIGATION? We also want to encourage continued well-woman care for non-fertile older women (who may have had a TL). Although these women have chosen a permanent method, they are still family planning clients. Since they are non-fertile, they are lower priority than fertile clients. Consider putting these non-priority clients on a "wait call" list to fill slots left by "no show" clients. If all your clinic appointments are consistently filled with higher priority clients, please refer them to the Breast and Cervical Cancer Prevention Program for routine or specialized care if they are 50 years old or older.

HOW DO WE CHARGE FOR THESE SERVICES? If seen in Title X family planning clinic, these older clients are subject to the same fee schedule as other clients.

5.92 BREAST CONCERNS

Education/self help: yes, available through Family Planning clinic

Screening: yes, through referral to Breast and Cervical Program

Treatment: limited; work with Breast and Cervical Program and local providers.

- A. PHD clinics have a strong focus on Breast Self-Exam through the Prenatal, Family Planning, and Breast and Cervical Program activities.

For referral to the B&CC Program, complete the B&CC referral form. You may need to call for a prior approval (505-841-5850). The nurse will be able to answer questions about what services will be provided at no expense to the client. A Regional Nurse Coordinator is available in each Regional Office to provide information and training on the B&CC Program.

Although 80% of all lumps found are benign, any woman with a lump is going to experience some fear, anxiety, and uncertainty during a workup. She will probably go through a grief process if a diagnosis of malignancy is made.

Some anticipatory guidance regarding the tests that may be done will be useful for all clients. For clients being referred for such testing, stress that earlier identification allows for more treatment options.

B. Fibrocystic Breasts

A woman may come to/return to a PHD clinic with a diagnosis of fibrocystic breasts or a woman with no suspicious masses may report cyclic breast tenderness.

This is the most common type of breast concern in the age groups seen in family planning clinic. It is generally caused by fluid retention due to estrogen-dominant hormone balance. In these situations the following self-help measures may be recommended:

1. Stop or reduce smoking.
2. Invest in a well fitted bra and wear it 24 hours a day.
3. Try hot or cold compresses to relieve discomfort.
4. Take mild analgesics: aspirin or acetaminophen. Check label for added caffeine.
5. Some evidence to suggest that decreasing dietary intake of caffeine (coffee, tea, soft drinks containing caffeine, and chocolate) may help to decrease symptoms.
6. Decrease salt intake.
7. Take Vitamins B, C, E and Evening Primrose Oil.

If these are not effective in two to three months:

1. Consider a lower estrogen COC or a progestin-only pill if the woman is in need of contraception and is otherwise a good candidate for OCs.
2. Consider IUD, Depo-Provera or other non-estrogen containing contraceptive as possible contraception.

C. Mammography:

The Public Health Division recommendations are consistent with those of the Breast and Cervical Cancer Prevention Program. See mammography algorithm in the B&CC program protocols for details on follow-up.

IF YOU ARE LESS THAN 40 YEARS OLD AND HAVE NO FAMILY HISTORY OF BREAST CANCER, YOU ARE ENCOURAGED TO:

Examine your breasts monthly.
Have a breast exam by your clinician each year.
Have a mammogram at age 40.

IF YOU ARE BETWEEN 40 AND 49 YEARS OLD:

Examine your breasts monthly.
Have a breast exam by your clinician every year.
Have a mammogram every 1 to 2 years.

IF YOU ARE AGE 50 AND OVER:

Examine your breasts monthly.
Have a breast exam by your clinician every year.
Have a mammogram every year

5.93 PREMENSTRUAL SYNDROME

Premenstrual syndrome is a constellation of symptoms which varies from woman to woman and even from month to month. This variety makes accurate definition difficult and partially accounts for the range of estimated prevalence.

Imprecise definition, diagnosis by self-report, and small poorly designed studies further confuse the search for etiology and treatment. The most recent studies point toward hormonal and nutritional causes.

The symptoms ascribed to PMS include: tension, depression, migraine-type headaches, cyclic weight gain, irritability, insomnia, lower backache, acne, diarrhea, constipation, changes in libido, excessive tiredness, sudden bursts of energy, water retention, craving for sweets, increased appetite, dizziness, forgetfulness, confusion, crying easily, breast tenderness, abdominal bloating, and swelling of the extremities.

A diagnosis of PMS should probably be limited to those women who:

1. Identify a set of symptoms as incapacitating; interfering with family life, physical activity, or career goals.
2. Have a menstrual calendar that demonstrates that symptoms appear in the one to ten days prior to menses and resolve with menses.

Preventative treatment measures that may be initiated include:

1. Diet high in carbohydrate-rich, low-protein foods consumed during the luteal phase may improve mood swings.
2. Avoidance of caffeine and related compounds from all sources such as coffee, tea, sodas, chocolates, OTC meds, etc. may be helpful in reducing PMS symptoms.
3. Regular moderate daily exercise.
4. Reassurance that it's not "all in the head." Family members may need inclusion in counseling to encourage their support. Advise interests outside home/work to reduce stress and increase relaxation.

If these measures are ineffective or the symptoms are particularly severe:

1. Refer client to a private physician who treats PMS. SSRI therapy may be indicated.
2. "PMS ACCESS" is another resource: a toll-free telephone line offering information on the causes, symptoms, management, as well as physician referrals, symposiums, support group meetings, etc. (1-800-222-4PMS)

5.94 NUTRITIONAL NEEDS OF WOMEN

The following is a brief synopsis of nutritional needs of non-pregnant women who are likely to be encountered in the Family Planning Program. For a more detailed discussion, see [5.98](#) for a section on weight management.

The WIC Program is another resource for nutrition education and information. The County Extension Service also provides nutrition education materials.

Women who come for family planning services may be just past the age of menarche or close to the age of menopause. In addition to their own nutritional needs they are often in a position to direct the nutrition of other family members. Good nutrition is important for good health throughout the life cycle.

General Principles:

We do not recommend routine supplementation with vitamin/mineral preparations. A well balanced diet can meet the nutritional needs of healthy women and their families.

However, women at risk of pregnancy should take a multivitamin with 0.4mg of folic acid daily and foods high in folate. Folic acid helps to prevent certain birth defects if she conceives, and should be taken before conception. This vitamin can be found in most complete multivitamin/mineral supplements.

The United States Department of Agriculture (USDA) has revised the food pyramid. The new "My Pyramid" is an individualized food guidance system based on age, sex and daily level of physical activity. Additional information can be found at <http://www.mypyramid.gov/>

General guidelines for healthy eating are:

- Eat a variety of foods.
- Maintain a healthy weight.
- Choose foods low in saturated fat and cholesterol.
- Eat plenty of vegetables, fruits, grain products and fiber.
- Use sugars, salt and sodium in moderation.
- Drink alcoholic beverages not at all, or in moderation.

WOMEN'S GENERAL NUTRITION NEEDS

CALCIUM

Bone is capable of increasing in density until approximately age 35. It remains stable until menopause. After menopause the hormonal changes result in shifts of calcium metabolism out of the bones. If the bone density was borderline, the resulting osteoporosis can lead to fractures, especially of the hip.

The diets of many women are deficient in calcium prior to and after menopause. Intake of 1200-1500 mg of calcium per day may help to prevent osteoporosis by increasing bone density. It is never too late to insure this intake although it is best to start before age 35.

Calcium supplement of about 1000 mg per day may be indicated for women whose diet is now or has been deficient in calcium. Teens need at least 1300 mg per day. Calcium supplements should provide elemental calcium.

<u>Calcium Supplements</u>	<u>Size</u>	<u>Mgm/cal tablet</u>
calcium carbonate	650 mg	260
calcium gluconate	650 mg	59
Os-Cal (with 125 IU Vit D)		500
Tums (sodium free)		200
Tums Extra-Strength		400

There is more to prevention of osteoporosis than diet alone. See OSTEOPOROSIS this Section.

IRON

Iron is one of many elements involved in the formation of normal red blood cells. Iron requirements can be met by a well balanced diet but the usual diet plus blood loss through menses makes women prone to low iron stores. This may manifest as anemia under the added demands of pregnancy or use of an IUD. Anemia is not a common finding in family planning clients. Diet counseling using the Iron Sheet as a handout should be an adequate response to most women. We do not recommend routine iron supplement. If a women wishes to take iron, 60 mg or less should be adequate to avoid the risk of toxic levels.

Women and their families may also benefit from other PHD Nutrition Education programs:

- WIC
- Weight Management
- Hypertension
- Diabetes

FOLIC ACID, B6 AND VITAMIN C

Adequate stores of folate, or folic acid, in a woman's body BEFORE and during the FIRST 28 DAYS of pregnancy greatly reduce the risk of having a baby with neural tube (brain and spine) defects (NTD).

The Institute of Medicine recommends that women increase their intake of synthetic folic acid to 600 micrograms a day once their pregnancy is confirmed. Most doctors recommend a prenatal vitamin that contains at least this amount of folic acid. However, women should not take more than 1,000 micrograms (or 1 milligram) without their doctor's advice.

If a woman already has had a baby with a neural tube defect, she should consult her doctor before her next pregnancy about the amount of folic acid she should take. Studies have shown that taking a larger dose of folic acid daily (4 milligrams), beginning at least one month before pregnancy and in the first trimester of pregnancy, reduced by about 70% the risk of having another affected pregnancy. (March of Dimes 2001) Additional information can be found at <http://www.modimes.org/>.

High doses can mask a vitamin B-12 deficiency (including pernicious anemia) while allowing irreversible neurologic damage to take place. Care should be taken to keep total folate consumption at less than 1 milligram per day, except under the supervision of a physician.

Some family planning clients may have marginal nutritional status for folic acid, B6 and Vitamin C.

5.95 PERINEAL HYGIENE - URINARY TRACT INFECTION

Because the urethra in women is only 2" long from meatus to bladder, women are prone to the development of cystitis - bladder infection. The following recommendations are good for everybody but especially for those who get recurrent infections.

1. Drink large quantities (twelve or more 8 oz. glasses) of water/juice to help clean urinary tract per day.
2. Avoid caffeine drinks as they irritate the lining of the urinary tract.
3. Urinate frequently e.g., every two hours; your bladder is able to hold more but this gives the bacteria less chance to grow and cause infection.
4. Avoid washing vaginal and vulvar mucous membrane areas with soap; avoid bubble baths and genital deodorants.
5. Urinate after intercourse.
6. Avoid tight clothing, pants, jeans.
7. Wear cotton or cotton crotch underwear.
8. If you use a diaphragm and get recurrent UTI, have the fit rechecked to make sure it's not too tight. Don't leave it in longer than necessary (6 hours after intercourse). Consider another method.

5.96 OSTEOPOROSIS

Osteoporosis is bone mass loss. It is not a benign condition.

Each year there are 200,000 hip fractures caused by osteoporosis in elderly women. Of these 15% will be dead within a week; 34% will be dead in 6 months. This represents 68,000 deaths per year compared to 3,000 deaths per year from uterine cancer. Osteoporosis affects more than 20 million people (both women and men) in the United States. There are 1.3 million osteoporosis-induced fractures yearly among people over 45 years of age. Fifty percent of Caucasian women have an osteoporosis-induced fracture in their lifetimes.

Who is at risk for osteoporosis? Women with:

Estrogen deficiency:

Late menarche (> 14 years old)

Early menopause (< 45 years old or surgical menopause)

Prolonged premenopausal amenorrhea (> 1 year)

Slight frame/thin build

Family history of osteoporosis

Caucasian or Asian race

Smoking (due to increased estrogen metabolism)

Excessive alcohol consumption

Steroid therapy

Diets low in milk (vitamin D and calcium)

Inactive life styles or immobilization

Excessive caffeine intake (> 8 cups daily)

Age over 65

What can be done to prevent osteoporosis?

Calcium: 1200-1500 mg daily for the perimenopausal woman. Dietary sources can do it. Four servings from the dairy group supply over 1000 mg. of calcium.

Exercise: Activity like walking. Does not have to be strenuous to increase bone density, but must be weight bearing.

5.97 MENOPAUSE AND HORMONE REPLACEMENT THERAPY (HRT)

Menopause, the cessation of menses, is commonly used to denote a wider time span of several years (the climacteric) during which the transition is made which ends biological reproduction.

This usually takes place between ages 45 and 55 and involves physical and psychological changes.

Physical changes result from the gradual decrease in ovarian function, which results in cessation of ovulation, decreased production of estrogen and progesterone, and subsequently increased FSH and LH levels.

These basic changes and adjustments result in somewhat predictable physical changes, which some women may view subjectively as positive or negative.

Physical changes:

1. Menstrual irregularity; variable flow, variable cycle length eventually diminishing, then ceasing altogether.
2. Vasomotor instability causing hot flashes, perspiration, night sweats.
3. Decreased vaginal lubrication, decreased vaginal wall thickness and elasticity, possibly resulting in atrophic vaginitis and dyspareunia.
4. Decreased pelvic muscle tone which may result in cystocele, rectocele, stress incontinence, uterine prolapse.
5. Altered calcium metabolism which may result in osteoporosis.
6. Altered cholesterol metabolism which may increase cardiovascular disease risk.

Psychological changes are in part a reaction to the physical changes, in part to sociocultural expectations of the meaning of reproduction and womanhood, and in part to the individual's coping patterns developed throughout her life time.

Psychological changes include: irritability, depression, loss of self-esteem, decreased libido, increased libido, crying.

The following self-help measures may be recommended:

1. Eat a well-balanced diet - increase calcium, decrease calories.
2. Exercise regularly. A brisk daily walk for 20-30 minutes is recommended.
3. Kegel exercises which strengthen the pubococcygeus (PC) muscle. (See Below)
4. Maintain positive outlook. Talk with family and friends about your needs. Join a support group. Learn something new. If you find yourself constantly depressed/unhappy, get counseling, because these symptoms are not an inevitable result of menopause.
5. Use water-soluble lubricants like KY jelly or "Astroglide" if vaginal dryness is hampering your enjoyment of sex. If this is not enough lubrication, check with your doctor or clinic for prescription vaginal creams.
6. Prepare for your hot flashes, if you get them. Wear loose, cool, layered clothing. Take a break and go where it's cool; use a fan. Have a cool drink.

In addition, to avoid unintended pregnancy, all sexually active perimenopausal women should continue effective contraception until no menses have occurred for 12 months.

Hormone replacement therapy will alleviate many of the physical changes for subjective and clinical improvement.

1. If the general symptoms are mild or responding to self-help measures but decreased vaginal lubrication, dyspareunia, or atrophic vaginitis continues, an estrogen-based vaginal cream may be needed.
3. If the client has persistent multiple signs, or personally chooses, she may be referred to a physician for estrogen replacement therapy.

HORMONE REPLACEMENT THERAPY (HRT)

Many women going through menopause wonder: "Should I take estrogen?" Will it help or is it too dangerous?

Hormone replacement includes both estrogen and progesterone **in women with a uterus**. Unopposed estrogen increases the risks of uterine cancer; progesterone counteracts this. In fact women who take estrogen and progesterone appear to have less risk of uterine and ovarian cancer and less risk of osteoporosis than women who do not. **However estrogen therapy can increase the risk of blood clots, heart attack and breast cancer**

Still, there are some women who should not use HRT:

- Women who don't want it.
- Women who don't need it.
- Women who have medical contraindications to it.
- Women who are not willing to accept risks associated with its use.

1. Who doesn't want it? No matter what the studies say about risks, pros and cons, it's your decision. Don't take it if you don't want to.
2. Who doesn't need it? For control of menopausal discomforts: Studies vary but as many as 70% of women have no or minor menopausal discomforts. Of the 30% or so who are uncomfortable enough to seek medical help many are bothered by discomforts for which HRT is not effective. Counseling, diet, progesterone alone, or other treatments/medications may be indicated.
3. Who has medical contraindications to it? Past or present thromboembolic (blood clots) disease. Past or present estrogen-dependent cancer (breast, cervix, uterus, ovary). Active liver disease.

HRT will alleviate vasomotor symptoms (hot flashes, perspiration, night sweats), maintain vaginal lubrication and elasticity, and help to reduce osteoporosis.

If you are bothered by these signs or are at increased risk for osteoporosis, see a doctor who is experienced in HRT.

KEGEL EXERCISES

These exercises are recommended to help prevent dryness of the vagina and to increase enjoyment of intercourse at any age. All the exercises may be continued indefinitely.

HOW TO DO THEM

First to identify the pubococcygeus (PC) muscle you are trying to strengthen:

Sit on the toilet. Spread your legs as far apart as possible, and start and stop the flow of urine. The PC muscle is the only one that can accomplish this while in this position.

Once one learns where the muscle is, the Kegel exercises can be done during daily activities such as driving an automobile, sitting, doing dishes, watching television, or lying in bed.

Exercise 1 - Contract the PC muscle, hold for three seconds, relax and repeat the process. These may be done as often during the day as desired, but approximately 90 contractions (six one-minute periods each day) are recommended. With too strenuous exercise, the PC muscle can become sore. If this happens, either stop doing the exercises for one or two days until the temporary soreness disappears and resume, or reduce the number done per day and then gradually increase.

Exercise 2 - Contract and release the PC muscle very rapidly, 25 to 50 times a day (ten contractions at a time). Although the contractions during orgasm are much more rapid, this exercise approximates what the PC muscle does during orgasm.

Exercise 3 - This exercise involves bearing down as though trying to expel a baby during labor. With this exercise, it has been demonstrated that the blood supply to the genitals increases, with a consequent increase of lubrication in the vagina.

For three seconds (holding to a count of three) bear down, relax, and repeat. Do the same number daily as in Exercises 2 and 3.

KEGAL EXERCISES

Why exercise pelvic muscles?

Life's events can weaken pelvic muscles. Pregnancy, childbirth, and being overweight can do it. Luckily, when these muscles get weak, you can help make them strong again.

Pelvic floor muscles are just like other muscles. Exercise can make them stronger. Women with bladder control problems can regain control through pelvic muscle exercises, also called Kegel exercises.

Pelvic fitness in minutes a day

Exercising your pelvic floor muscles for just 5 minutes, three times a day can make a big difference to your bladder control. Exercise strengthens muscles that hold the bladder and many other organs in place.

The part of your body including your hip bones is the pelvic area. At the bottom of the pelvis, several layers of muscle stretch between your legs. The muscles attach to the front, back, and sides of the pelvis bone.

Two pelvic muscles do most of the work. The biggest one stretches like a hammock. The other is shaped like a triangle. These muscles prevent leaking of urine and stool.

How do you exercise your pelvic muscles?

Find the right muscles. This is very important.

Your doctor, nurse, or physical therapist will help make sure you are doing the exercises the right way.

You should tighten the two major muscles that stretch across your pelvic floor. They are the "hammock" muscle and the "triangle" muscle. Here are three methods to check for the correct muscles.

1. Try to stop the flow of urine when you are sitting on the toilet. If you can do it, you are using the right muscles.
2. Imagine that you are trying to stop passing gas. Squeeze the muscles you would use. If you sense a "pulling" feeling, those are the right muscles for pelvic exercises.
3. Lie down and put your finger inside your vagina. Squeeze as if you were trying to stop urine from coming out. If you feel tightness on your finger, you are squeezing the right pelvic muscle.

Don't squeeze other muscles at the same time. Be careful not to tighten your stomach, legs, or other muscles. Squeezing the wrong muscles can put more pressure on your bladder control muscles. Just squeeze the pelvic muscle. Don't hold your breath.

Repeat, but don't overdo it. At first, find a quiet spot to practice--your bathroom or bedroom--so you can concentrate. Lie on the floor. Pull in the pelvic muscles and hold for a count of 3. Then relax for a count of 3. Work up to 10 to 15 repeats each time you exercise.

Do your pelvic exercises at least three times a day. Every day, use three positions: lying, sitting, and standing. You can exercise while lying on the floor, sitting at a desk, or standing in the kitchen. Using all three positions makes the muscles strongest.

Be patient. Don't give up. It's just 5 minutes, three times a day. You may not feel your bladder control improve until after 3 to 6 weeks. Still, most women do notice an improvement after a few weeks.

Exercise aids. You can also exercise by using special weights or biofeedback. Ask your health care team about these exercise aids.

Hold the squeeze 'til after the sneeze

You can protect your pelvic muscles from more damage by *bracing yourself*.

Think ahead, just before sneezing, lifting, or jumping. Sudden pressure from such actions can hurt those pelvic muscles. Squeeze your pelvic muscles tightly and hold on until *after* you sneeze, lift, or jump.

After you train yourself to tighten the pelvic muscles for these moments, you will have fewer accidents.

National Kidney and Urologic Diseases Information Clearinghouse 1-800-891-5388

EJERCICIOS DE KEGEL

¿Por qué hacer ejercicios para los músculos de la pelvis?

Ciertos acontecimientos de la vida, como el embarazo, el parto y el tener sobrepeso, pueden debilitar los músculos de la pelvis. Por suerte, cuando esos músculos se debilitan, usted puede fortalecerlos otra vez.

Los músculos del suelo de la pelvis son como otros músculos. El ejercicio los puede fortalecer de nuevo. Las mujeres que tienen problemas de control de la vejiga pueden recuperar el control con ejercicios para los músculos del suelo de la pelvis, que se llaman ejercicios de Kegel.

En buena forma en unos minutos al día

Ejercitar los músculos del suelo de la pelvis durante cinco minutos tres veces al día puede significar una gran diferencia en el control de la vejiga. El ejercicio fortalece los músculos que sostienen la vejiga y mantienen los otros órganos de la pelvis en su lugar.

La *pelvis* es la parte del cuerpo que se encuentra entre los huesos de la cadera. El límite inferior de la pelvis es la parte que se encuentra entre las piernas y está formada por varias capas de músculos elásticos. Los músculos se adhieren a la parte anterior, posterior y lateral del hueso pélvico.

Son principalmente dos músculos los que hacen el trabajo. El más grande se estira como si fuera una hamaca. El otro tiene forma triangular. Estos músculos evitan la salida involuntaria de orina y materia fecal.

¿Cómo hacer los ejercicios para los músculos de la pelvis?

Encuentre los músculos adecuados. Esto es muy importante.

El médico, la enfermera o el fisioterapeuta le ayudarán a asegurarse de que está haciendo los ejercicios correctamente.

Debe apretar los dos músculos principales que se extienden a lo largo del suelo de la pelvis. Estos son los músculos en forma de "hamaca" y de "triángulo". Hay tres métodos para comprobar que está ejercitando los músculos adecuados.

1. Cuando esté orinando, trate de detener la salida de la orina. Si lo puede hacer, eso quiere decir que está usando los músculos adecuados.
2. Imagine que está tratando de evitar la salida de gas. Contraiga los músculos que usaría para hacerlo. Si tiene la sensación de contracción, quiere decir que esos son los músculos que debe ejercitar.
3. Acuéstese e introduzca un dedo en la vagina. Apriete como si estuviera tratando de detener la salida de la orina. Si siente que aprieta el dedo, está apretando los músculos correctos.

No apriete otros músculos al mismo tiempo. Tenga cuidado de no contraer los músculos del abdomen, piernas u otras partes del cuerpo. Contraer los músculos equivocados puede ejercer más presión sobre los músculos que controlan la vejiga. Solo apriete los músculos de la pelvis. No aguante la respiración.

Repítalos, pero no exagere. Al principio, busque un lugar tranquilo para hacerlos en donde se pueda concentrar bien (en el baño o su cuarto). Acuéstese en el piso. Contraiga los músculos de la pelvis y cuente hasta tres. Relájese y cuente hasta tres. Repita de 10 a 15 veces en cada sesión.

Haga los ejercicios por lo menos tres veces al día. Hágalos todos los días en tres posiciones: acostada, sentada y de pie. Usted puede hacer los ejercicios mientras está acostada en el piso, sentada frente a su escritorio o parada en la cocina. Hacerlos en las tres posiciones fortalece los músculos.

Tenga paciencia. No deje de hacerlos. Son solamente cinco minutos, tres veces al día. Es posible que no note ninguna mejoría hasta después de tres a seis semanas. La mayoría de las mujeres notan la mejoría después de pocas semanas.

Ayuda para los ejercicios. También puede ejercitar los músculos utilizando pesas especiales o biorregulación. Pregúntele a su equipo de asistencia sanitaria acerca de ellos.

Apriete los músculos y aguante hasta después de estornudar

Si se *prepara*, puede proteger los músculos de la pelvis para que no se dañen más.

Prepárese antes de estornudar, levantar un objeto o brincar. El aumento súbito de la presión puede dañar esos músculos. Apriételos fuertemente y aguante *hasta después* de que termine de estornudar, levantar un objeto o brincar. Después de que usted misma se acostumbre a apretar los músculos de la pelvis durante esos momentos, tendrá menos accidentes.

National Kidney and Urologic Diseases Information Clearinghouse 1-800-891-5388

5.98 WEIGHT MANAGEMENT

Because significant change in weight-for-height can be an important indicator of change in health status, we still measure BMI (body mass index) at each annual visit. (Please use BMI assessments with caution--BMI has no advantage over height-weight tables, unless it is combined with measurements of waist circumference or waist-to-hip ratio. It could wrongly label fit, muscular people and/or athletes as overweight, and offer false reassurance to normal weight patients who are sedentary.) In the case of a woman who becomes pregnant, her pre-pregnancy weight can affect her pregnancy outcome. The eating habits practiced when a woman is not pregnant can affect how she eats prenatally.

Women are often concerned about their weight, and may resort to dieting, fasting, bingeing, purging, taking OTC medications, or other potentially harmful practices to try to lose weight. Successful, long-term weight-loss through food restriction is exceedingly rare, and there is scant research to support any change in morbidity or mortality after weight loss by food restriction. Counsel women to focus health improvement efforts on increasing physical activity levels and eating to meet fuel and nutritional needs rather than restricting food intake to lose weight. To assess activity levels, ask clients about minutes of exercise/physical activity per day or per week (this history has been shown to correlate well with actual activity levels), and encourage clients at *all weight levels* to meet recommendations for physical activity and nutritional intake.

All women should be encouraged to follow the general guidelines for health promotion.

- Eat a variety of foods; make whole grains, fruits and vegetables, healthy fats and calcium-rich foods a major part of the daily diet.
- Adjust food intake to meet nutritional and fuel needs; make weight-bearing exercise a daily routine.
- Total fat intake should be less than 30% of total daily calories, and should include heart-healthy fats: vegetable and olive oils, nuts, avocados. Limit animal fat and avoid all trans fats (commercially prepared chips, crackers, cookies and baked goods are the major source of trans fats.)
- Eat foods with adequate fiber (whole grains, fruits and vegetables) to get 20-25 grams of fiber a day).
- Avoid tobacco, excess sugar, salt, and caffeine.
- Avoid alcohol or drink in moderation.

Fad diets conflict with healthy eating practices and actually worsen health status. Unsound nutritional advice may be identified when it:

- promises a fast and easy solution to excess body fat
- is advertised as a secret formula
- favors one food or group of foods
- offers advice in the form of a testimonial
- sells something--a food product, apparatus, or book
- promises permanent weight loss or that you will lose more than two pounds per week.

Underweight women should be encouraged to increase caloric intake by increasing servings from the food pyramid. Refer as appropriate to food assistance programs. Identify other risk factors, such as inactivity, tobacco use, excess caffeine, alcohol use or disordered eating behaviors.

Overweight women should be encouraged to meet recommendations for activity and to adjust their food intake to meet nutritional and fuel needs:

- Avoid food restriction for weight loss/ fad diets/ mega doses of vitamin and mineral supplements.

- Consider nutritional counseling, mental health counseling or behavior modification if patient reports poor eating habits or disordered eating (repeated or fad dieting, bingeing, purging, food obsession, etc.).
- If patient desires weight loss, encourage a training program with aerobic and resistance components to increase caloric expenditures/metabolic rate.

Know the signs and symptoms of **Anorexia Nervosa** and **Bulimia**. Identify appropriate referral resources in the community and refer clients who appear to be at risk for an eating disorder. Questions that may be useful in identifying an eating disorder are:

- How do you feel about how much you weigh?
- How often have you been on a special diet? **How old were you when you first dieted?**
- How long can you go without eating?
- How often do you vomit?
- How often do you use laxatives?
- What do you think is your ideal weight?
- Do you feel shame or guilt about eating?**

Encourage **adolescent women** to make healthy choices fit their lifestyle. Options in fast foods and snacking can include foods that are convenient, accessible, enjoyable, easy to eat and socially acceptable. Healthy skin, beautiful hair, and optimal physical performance are all associated with healthy eating.

5.10 THE DISABLED CLIENT

Disability is a large public health problem in the United States, affecting an estimated 54 million persons who report disabling conditions. One of the national health goals for 2010 is to eliminate health disparities among different segments of the population, including those among persons with disabilities. During 1998, a BRFSS telephone survey found the prevalence of disability among New Mexicans aged 18-44 was 12.8%. In this survey, disability was defined by positive responses to either one of two questions. "Are you limited in any way in any activities because of an impairment or health problem?" or "If you use special equipment or help from others to get around, what type do you use?"

Women with disabilities are at a higher risk of sexual abuse and STIs than the general population and this presents the potential for increased rates of cervical cancer. However, most women who have a disability have normal reproductive health histories. Like all women, they are at risk to develop cancer of the breast, cervix and ovary.

New Mexico Family Planning Program does not exclude or deny individuals with handicaps an equal opportunity to receive program benefits and services. Individuals with handicaps have the right to participate in, and have access to program services. All efforts must be made for clinics to be readily accessible to disabled clients seeking family planning services. When making the family planning appointment, ascertain whether the client requires special accommodations for the appointment.

ROUTINE SCREENING RECOMMENDATIONS FOR WOMEN WITH DISABILITIES

Pelvic examinations and pap smears: Pap smear screening intervals are not different for sexually active disabled clients than any other Title X client. See Section 4.

- Annual pelvic examination, with routine Pap intervals.
- Breast examinations and mammograms:
 - First breast examination at 18 years and annually thereafter.
 - First mammogram at age 40 years.

If there is a family history of breast cancer in mother, sister, daughter, or two close female relatives or known genetic risk (BRACA1 or BRACA2 genes), then first mammogram should be at age 35 years. Annual mammograms thereafter.

Referral or arrangements for alternative services for clients who have disabilities (to include other than mobility problems) should be available and known to clinic staff.

Resources:

- Local resources from the Department of Health, Office of Developmental Disabilities at (505) 841-5500 or 1-800-283-5548.
- Office of Disability and Health (500) 827-0272.
- UNM Health Sciences Center Developmental Disabilities Network. Kerrie Seeger, M.D. (505) 272-5158