

## **5.0**

### **FAMILY PLANNING NEEDS OF SPECIAL POPULATIONS**

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## 5.1 TEEN CLIENTS

### 5.1.1 CONFIDENTIALITY AND FAMILY PLANNING TEEN CLIENTS

All information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality. Otherwise, information may be disclosed only in summary, statistical, or other form which does not identify particular individuals (*45 CFR Part 59.11*).

While the clinic must comply with the federal Health Insurance Portability and Accountability Act (HIPAA), which permits disclosure of certain protected health information, the Title X regulations are more stringent and do not allow the disclosure of information about individuals receiving Title X FP services except:

- a. With documented consent;
- b. To provide services to the patient; or
- c. As required by law.

Reporting requirements are for child abuse/neglect and abuse/neglect/exploitation of incapacitated adults ONLY. If the situation does not meet these criteria, any information obtained from the patient may only be disclosed with the individual's consent, for treatment purposes, or as required by law.

For example, a provider of non-family planning services may disclose protected health information to a law enforcement or Public Health officials if such information will reasonably contribute to the prevention or lessening of a serious and imminent threat to the health and safety to an individual or the public. A Title X provider however, may not do so without the patient's documented consent (unless the report is required by law).

All clinic staff (every person who works with or has contact with Title X clients, including reception) must familiarize themselves and comply with NM legal requirements regarding notification or reporting of child abuse, child molestation, sexual abuse, rape, or incest, as well as human trafficking (OPA Program Instructions 11-01; 06-01 and 99-1) and are required to take "Mandatory Reporting & Human Trafficking" training annually. See Appendix D Staff Orientation.

Child abuse/neglect/human trafficking reporting must be documented in the client record. All clinics must have a mechanism in place to track reports made, for example a log.

### 5.1.2 MINORS AND FAMILY PLANNING

Federal regulations establish special access rules for family planning services funded through Title X. Providers delivering services funded in full or in part with Title X monies must comply with the federal regulations. Federal law requires that Title X funded services be available to **all** teens, regardless of their age, without the need for parental consent (*42 C.F.R.59.5 (a)(4)*). This regulation supersedes any state law to the contrary. Minors of any age may consent to family planning services when those services are funded in full or in part by Title X monies.

Clinic staff may offer factual information to teens and parents to help them in responsible decision making about sex, and encourage discussion of values and choices at home. Teens that 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."

## Steps in counseling sexually active teens

1. Confidentiality is essential in services to minors. Interview the client alone. Discuss the policy on confidentiality and its limits by reviewing the Parental/Family Involvement form (as part of the Consent for Family Planning Services form) with the minor.
  - a. Emphasize that anything your client discusses with you is held in strict confidence (meaning that you discuss nothing about them with anyone unless you have their permission to do so).
  - b. You must also state that the exception is if you believe that they are/have been abused or neglected by their parent, guardian, or custodian. You must also tell them that if their sexual partner(s) are considerably older than them then that may require reporting as well, however a client is under no legal obligation to report the age of their partner(s).
2. Clinical staff will encourage minors who seek family planning services to consider family participation in their decision. Explain that the client has the right to choose to do so or not.
  - a. If the client agrees to parent/family involvement, have her/him sign the Parental/Family Involvement in Services form, indicating that the appropriate clinical staff (Nurse, CNM, NP, PA, MD) may answer any inquiries from her/his parent about the information on the minor client's medical record.
  - b. If the client does not want parent, family, or legal guardian involvement, have her/him sign the form choosing confidentiality and flag the medical record. This means that, when talking to the parent, guardian, or custodian, 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.
3. **Clinical staff will screen clients for coercion** and provide counseling to minors on how to resist attempts to be coerced into engaging in sexual activity. Staff should use the NM DOH FPP approved sexual coercion materials. **This coercion screening and counseling documentation is required annually. In addition, if the minor has a positive STD, positive pregnancy test, or there is a suspicion of abuse, the provider should ensure this screening occurred on the day of the visit and is documented.**
4. Collect alternate contact information to further clarify how the client wants to be contacted. Staff should consider documenting the client's preferred contact information in the medical record so it is readily available for other clinic staff to view and use in the future.
5. Review and have the client sign the form annually for any services given to minors, and file the form in the medical record. The form is not necessary once the client reaches age 18.
6. If the parent brings the minor client to clinic, a note in the client's record should read:
  - a. Parent in conference and/or exam; or,
  - b. Parent present at clinic, but did not participate in conference and/or exam.

Educating parents to talk to their children about sexuality will help establish the clinic 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. Nurse/clinician should explain to the parent/guardian/custodian the clinic staff's legal responsibility and obligation to safeguard the minor's confidential information.

**CONSENT FOR FAMILY PLANNING SERVICES**

1. I am voluntarily requesting family planning services from the New Mexico Department of Health, Public Health Office. I understand that I have the right to accept or refuse these services without being denied other services from this agency.
2. I understand that my services and records will be kept confidential and will be released only as permitted or required by law and that my health information will not be released to an outside agency or person except as specified in "Notice of Privacy Practices" which I have received a copy of.
3. I understand that in cases of abuse or neglect of minors by parent(s)/guardian(s)/custodian(s) a referral or a report to law enforcement and CYFD will be filed, as required by law.
4. I understand that if my parent(s)/guardian(s)/custodian(s) have failed to protect me from a harmful situation including if my partner is considerably older than me (otherwise known as statutory rape), a referral or a report to CYFD or law enforcement will be filed, as required by law. I understand that I am under no obligation to report the age of my partner(s) if I do not wish to do so.
5. I understand that if I am seen in the clinic and I receive Family Planning services and supplies I may be charged from a sliding fee scale. I will be responsible for these charges if they apply.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FAMILY INVOLVEMENT AND COERCION SCREENING IN SERVICES FOR MINOR-AGE CLIENTS  
(under 18 years old)**

**For Nurse/Clinician Use Only:**

- \_\_\_ I have discussed the limitations of confidentiality with this client, including that we have to report to CYFD if we know or have a reasonable suspicion that he/she is being abused or neglected by the parent/guardian/custodian. I explained that a failure to protect from a harmful situation by a parent/guardian/custodian will also need to be reported to CYFD, possibly including statutory rape. The client was informed that he/she is under no legal obligation to report the age of their partner(s). (1-855-333-7233) (Staff may use the confidentiality materials).
- \_\_\_ I have discussed that we encourage family involvement if we find a condition/situation that can harm her/his health and she/he needs help with this.
- \_\_\_ I have screened this client regarding coercion and/or counseled how to resist attempts of being coerced into sexual activities. (Staff may use the sexual coercion brochure.)

\_\_\_\_\_  
Nurse/Clinician Signature Title Date

The nurse has encouraged me to involve my parent(s)/family in my counseling and decision to receive family planning services. I have considered this and have decided that:

- \_\_\_ The clinic nurse or 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.

The plan for contacting me is: (list 2 ways to contact you below.)

Address other than home \_\_\_\_\_  
Phone # \_\_\_\_\_ Alternate Phone # \_\_\_\_\_  
Only contact me at School \_\_\_\_\_ Current Grade \_\_\_\_\_

\_\_\_\_\_  
Signature of Minor Client Date of Birth & Age Date

### 5.1.3 MINORS AND COERCION

Sexual coercion among teens is a serious public health issue. Dating violence, sexual harassment, sexual abuse and unhealthy relationships are too common. The majority of these incidents go unreported, leading victims and perpetrators to believe sexual coercion is an acceptable part of sexual behavior.

When screening for coercion, be aware of time. Do not ignore a situation or start a conversation that cannot be finished in the allowed time. Ask open-ended questions to allow for unanticipated and multiple answers. Phrase questions in a neutral way, and be mindful of your tone of voice and body language. If the client feels the practitioner is disapproving they will shut down. Also, ask specific questions about sexual coercion, including:

- 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 you to have 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?

Listen carefully, validate feelings, and offer tangible help.

Some teens 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.

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. Keep an updated referral list in the clinic to give to clients.

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

- 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 clinician/supervisor/RHO.
- If you "know or have reasonable suspicion that the child is an abused or neglected child", you shall report to Child Protective Services (1-855-333-7233), and may disclose minimum necessary PHI to make the report.
- If you are unsure if the situation is abuse or neglect, then consult with your clinician/supervisor/RHO or OGC.
- Discuss your concerns in a non-judgmental way with your client (e.g., "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.

#### 5.1.4 CHILD ABUSE REPORTING

In addition to Section 5.1-5.3, Title X providers must take the FPP “Reporting Abuse Training”. A medical evaluation must include a careful assessment for abusive or unwanted sexual encounters, appropriate physical examination, appropriate psycho-social evaluation and counseling.

##### 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 [http://www.adolescenthealth.org/SAHM\\_Main/media/Advocacy/Positions/Nov-04-Protecting Adolescents Ensuring Access to Care and Reporting Sexual Activity and Abuse.pdf](http://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Nov-04-Protecting%20Adolescents%20Ensuring%20Access%20to%20Care%20and%20Reporting%20Sexual%20Activity%20and%20Abuse.pdf) Accessed on 3/31/17).

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.

##### Making a Report

If it is determined that abuse or neglect of the child is suspected, you must report to CYFD using the following information:

**CYFD Statewide Central Intake (SCI) at 1-855-333-7233**

or

**#SAFE from a cellphone**

You may also report to local law enforcement. Please note that CYFD will cross report allegations of abuse and neglect to local law enforcement.

**For a Native American child**, report is made to tribal law enforcement or social services agency.

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 and; 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.

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. 1978, §32A-4-5(B)).

Child abuse/neglect/human trafficking reporting must be documented in the client record. All clinics must have a mechanism in place to track reports made, for example a log.

For PHOs using the BEHR, this is documented in the Family Planning “Personal History” tab using either “physical abuse” or “abused as a child sexually” template findings. Document in the “text box” utilizing the code: MRM (Mandatory Report Made), Date of report, Agency reported to, and the city of the local health office and nature of the call or clinic visit.

- Example: MRM, 4/30/11, CYFD, Santa Fe, alleged child abuse/neglect.

The New Mexico child abuse and neglect reporting laws are included in the following pages with selected interpretation from NMDOH Office of General Counsel.

## New Mexico Mandatory Reporting Regarding Child Abuse or Neglect

The mandatory reporting statute (NMSA 1978, 32A-4-3) requires mandatory reporting of suspected **abuse or neglect by the child's parent/guardian/or custodian** when the reporter "knows or has reasonable suspicion that a child is an abused or neglected child." (NMSA 1978, 32A-4-3).

**32A-1-4(P) "parent" or "parents"** includes a biological or adoptive parent if the biological or adoptive parent has a constitutionally protected liberty interest in the care and custody of the child;

**32A-1-4(I) "guardian"** means a person appointed as a guardian by a court or Indian tribal authority or a person authorized to care for the child by a parental power of attorney as permitted by law;

**32A-1-3(E) "custodian"** means an adult with whom the child lives who is not a parent or guardian of the child;

**32A-4-2(B) "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;

**32A-4-2€ "neglected child"** means a child:

- (1) who has been abandoned by the child's parent, guardian or custodian;
- (2) who is without proper parental care and control or subsistence, education, medical or other care or control necessary for the child's well-being because of the faults or habits of the child's parent, guardian or custodian or the failure or refusal of the parent, guardian or custodian, when able to do so, to provide them;
- \*\* (3) who has been **physically or sexually abused, when the child's parent, guardian or custodian knew or should have known of the abuse and failed to take reasonable steps to protect the child from further harm**; \*\*\*(see explanation below)
- (4) whose parent, guardian or custodian is unable to discharge that person's responsibilities to and for the child because of incarceration, hospitalization or physical or mental disorder or incapacity; or
- (5) who has been placed for care or adoption in violation of the law; provided that nothing in the Children's Code [ 1978] shall be construed to imply that a child who is being provided with treatment by spiritual means alone through prayer, in accordance with the tenets and practices of a recognized church or religious denomination, by a duly accredited practitioner thereof is for that reason alone a neglected child within the meaning of the Children's Code; and further provided that no child shall be denied the protection afforded to all children under the Children's Code;

The fact that a child is sexually active or contemplating sexual activity does not automatically mean that the child's parents are neglectful or abusive. Neither does the fact that a child is having a sexual relationship with somebody somewhat older necessarily indicate that a child is abused or neglected by the child's parent, guardian, or custodian. **Parental knowledge (or lack of knowledge) of a minor's voluntary sexual activity does not necessarily give rise to reasonable suspicion of abuse or**



**neglect.** Practitioners are under no legal obligation to ask a client who presents themselves for family planning services about the age(s) of any sexual partner(s).

Although New Mexico courts have not spoken on the issue of voluntary teen sexual activity, other state courts have held that most cases of voluntary teen sexual activity do not give rise to reasonable suspicion of child abuse or neglect. When a health provider does not have a reasonable suspicion or knowledge of child abuse or neglect by the parent/guardian/custodian, then there may be no legal basis to breach a patient's confidentiality by filing a report with CYFD or law enforcement.

**§ 32A-4-3.** Duty to report child abuse and child neglect; responsibility to investigate child abuse or neglect; penalty

A. **Every person**, including a licensed physician; a resident or an intern examining, attending or treating a child; a law enforcement officer; a judge presiding during a proceeding; a registered nurse; a visiting nurse; a schoolteacher; a school official; a social worker acting in an official capacity; or a member of the clergy who has information that is not privileged as a matter of law, **who knows or has a reasonable suspicion that a child is an abused or a neglected child shall report the matter immediately** to:

- (1) a local law enforcement agency;
- (2) the department (CYFD); or
- (3) a tribal law enforcement or social services agency for any Indian child residing in Indian country.

**Under the NM Children's Code, "child" means a person who is less than 18 years old. § 32A-1-4B**

**Criminal sexual penetration, criminal sexual contact, or statutory rape by someone other than the parent/guardian/custodian** *may be neglect if the parent, guardian or custodian knew or should have known of the abuse and failed to take reasonable steps to protect the child from further harm.*

### 5.1.5 Human Trafficking

Human trafficking is a form of modern-day slavery that is widespread throughout the U.S. today. Human trafficking is the recruitment, transportation, transfer, harboring, or receipt of persons by means of force, fraud, or coercion for the purpose of exploitation. Since Title X clinics provide low/no cost reproductive health care to uninsured populations, providers may encounter victims of human trafficking. It is essential for clinic staff to recognize the signs and symptoms of human trafficking. The following information summarizes key issues in human trafficking.

| Three Categories of Human Trafficking                                     |                                   |   |
|---|-----------------------------------|---|
| Those 18 or over involved in commercial sex via force, fraud, or coercion | Minors involved in commercial sex | Adults or Minors in forced labor, services or involuntary servitude via force, fraud, or coercion |

According to the legal definition:

- Trafficking does not require:
- Transportation across state or national borders.
- Physical restraint. Psychological means of control can be sufficient elements of the crime.
- Consent prior to an act of force, fraud or coercion (or if the victim is a minor with sex trafficking) is not relevant, nor is payment.
- Relatives can be traffickers.

Potential red-flags/indicators for human trafficking include individuals who:

- Are under 18 and provide commercial sex acts or trade sex for something of value;
- Are inconsistent in their story or claim of “just visiting” coupled with inability to clarify their addresses;
- Are in demeanor: fearful, anxious, submissive, tense or nervous;
- Are not in control of own identification documents;
- Are not in control of their own money;
- Have few or no personal possessions/financial records;
- Have excessively long working hours or odd tasks at odd hours;
- Have jobs that do not pay or pay very little;
- Have large debt and cannot pay it off;
- Have restricted, mediated, or controlled communication by third parties (have someone speaking for her/him);
- Have an unusually high number of sexual partners for his/her age;
- Have signs of malnourishment, general lack of health care, physical abuse/restraint, confinement, torture, branding, sexual abuse, or untreated STIs;
- Lack of freedom to leave living/working conditions;
- Lack of knowledge of a given community/whereabouts, frequent movement.

Additional questions to consider (Each question taken individually can imply a trafficking situation. Questions are not intended to be cumulative in nature.):

- Was the person recruited? Were they promised anything?
- How did the person find out about the job? What are the working conditions?
- Is the person being paid? Is the person free to leave?
- Are there incidences of physical and/or sexual assault?
- Has the person been threatened? What are the threats?
- Is the person in control of their own identification documents?
- How many hours does the person work each day?
- What are the person’s living conditions?
- Is the person being held against their will?
- Is the person afraid to discuss her or himself in presence of others?

If you think you have come across a case of trafficking and/or have identified a victim of trafficking,

- In the case of a minor, call the Children Youth and Family Department (CYFD) State Central Intake hotline at 1-855-333-7233.
- For non-minors, only if the patient allows you to make a report and disclose their confidential information may you contact law enforcement to make a report.

**NMSA 30-52-2. Human trafficking; benefits and services for human trafficking victims.**

A. Human trafficking victims found in the state shall be eligible for benefits and services from the state until the victim qualifies for benefits and services authorized by the federal Victims of Trafficking and Violence Protection Act of 2000; provided that the victim cooperates in the investigation or prosecution of the person charged with the crime of human trafficking. Benefits and services shall be provided to eligible human trafficking victims regardless of immigration status and may include:

- (1) Case management;
- (2) Emergency temporary housing;
- (3) Health care;
- (4) Mental health counseling;
- (5) Drug addiction screening and treatment;
- (6) Language interpretation, translation services and English language instruction;
- (7) Job training, job placement assistance and post-employment services for job retention;
- (8) Services to assist the victim and the victim’s family members; or,

(9) Other general assistance services and benefits as determined by the children, youth and families department.

B. As used in this section, “human trafficking victim” means a person subjected to human trafficking by a person charged in New Mexico with the crime of human trafficking.

For additional information and reporting, please contact National Human Trafficking Resource Center (NHTRC): 24 Hour National Hotline 1-888-373-7888, Email: [NHTRC@PolarisProject.org](mailto:NHTRC@PolarisProject.org), or website <https://humantraffickinghotline.org/>.

## 5.2 POSTPARTUM CLIENTS AND FAMILY PLANNING

Use the CDC's U.S. MEC for Contraceptive Use, 2016 (Appendix G) to guide your client-centered approach to providing postpartum contraception. Most contraceptive methods can be used postpartum and recommendations are based on patient preferences, medical conditions and timing of initiation.

- The recommended period before attempting the next pregnancy after childbirth is at least 24 months (World Health Organization, 2007 [http://apps.who.int/iris/bitstream/handle/10665/69855/WHO\\_RHR\\_07.1\\_eng.pdf;sequence=1](http://apps.who.int/iris/bitstream/handle/10665/69855/WHO_RHR_07.1_eng.pdf;sequence=1)).
- Immediate postpartum options for contraception include the implant, DMPA, POP and IUD.
- Use the U.S. MEC to guide initiating interval postpartum contraception. Women who use non-breast feedings ovulate on average by 35 days, however ovulation has been reported as early as 25 days, placing them at risk for pregnancy (Jackson, E, Glasier, A., Return of ovulation and menses in postpartum nonlactating women: a systematic review. *Obstet Gynecol* 2011; 117-657).
- Lactational Amenorrhea Method (LAM) is an effective *temporary* method of contraception.

In addition to the complete medical history described in Section 1, Subsection 1.2.H.a Contraceptive Services, the interview should expand on the history to include:

- 1) Events of the recent pregnancy
- 2) Description of the birth
- 3) Events since the birth

Some of the physical/psychological could include:

Physical:

fever  
breast engorgement  
lochia/menses  
constipation/hemorrhoids

stitches  
lactation  
pelvic pain  
fatigue

Psychosocial:

baby care/feeding  
family interactions  
housework  
sleep patterns

baby blues/depression  
sex/contraception  
work/school  
exercise/recreation

When the postpartum client have not yet received any postpartum care, special attention on physical exam/lab work to note:

- Signs and Symptoms of anemia
- Blood pressure
- Infections, condition of any episiotomy/laceration and pain
- Vaginal tone, lubrication, cervical laceration, uterine size.
- Weight as compared to pregnant/pre-pregnant
- Breast condition
- Abdominal tone

All postpartum women should see their obstetrical care providers within the first 3 weeks of delivery with ongoing visits scheduled. This contraceptive visit should not substitute the postpartum visits, particularly when the services are not delivered in a primary care clinic.

## 5.3 BREASTFEEDING AND FAMILY PLANNING

Lactation is included in the required medical history to highlight its importance. Clients are encouraged to consider temporary contraceptive effect of breast feeding and determine/initiate a longer-term method.

Lactational Amenorrhea Method (LAM) requires "full or nearly full breastfeeding" to provide >98% protection from pregnancy in the first 6 months following birth through the infant's maximal suckling stimulation at the breast. In order to achieve/maintain this contraceptive efficacy,

1. The infant must be breastfed exclusively with no other liquid/solid given or almost exclusively with the vast majority of feeds are breastfeeds. Breastfeeding intervals should not exceed 4 hours during the day or 6 hours at night, and supplementation should not exceed 5-15% of all feeding episodes. *Milk expression by hand/pump is not a substitute for breastfeeding for its fertility-inhibiting effect, and*
2. The woman has not experienced her first postpartum menses (defined as any bleeding occurring after 56 days postpartum).

To maintain effective protection against pregnancy, another method of contraception must be used as soon as menstruation resumes, the frequency/duration of breastfeeds is reduced, bottle feeds or regular food supplements are introduced, or the baby reaches 6 months of age. For method specific consideration for breastfeeding women refer to CDC's U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 (Appendix G).

## BREASTFEEDING: NATURE'S WAY OF SPACING BABIES LACTATIONAL AMENORRHEA METHOD (LAM)

### COUNSELING HANDOUT

#### Does breastfeeding work as birth control?

If you are feeding your baby only milk from your breasts, it is quite likely that your periods will not come back for a number of months. If this is the case for you, then you **probably** won't get pregnant during the first 6 months of breastfeeding. The contraceptive effect of breastfeeding decreases after your baby is 6 months old. The birth control effect of breastfeeding decreases when your periods return or you start giving your baby formula or foods other than breast milk. At this point, you need to use other methods to protect you from getting pregnant.

#### What are the advantages of using breastfeeding as birth control?

- \* It doesn't cost anything.
- \* It's convenient.
- \* It works about 98% of the time for about 6 months.
- \* The uterus returns to normal faster than when using other methods.
- \* You don't get a period.
- \* It does not interfere with sex.
- \* It's good for you and your baby.

#### What are the disadvantages of using breastfeeding as birth control?

- \* It does not keep all women from having their periods.
- \* Breastfeeding is not an effective birth control method once your periods return.
- \* **It is difficult to tell when breastfeeding stops working as birth control.**
- \* The effectiveness of breastfeeding as birth control is greatly reduced after 6 months.
- \* It works best if you feed your baby only your breast milk.
- \* Some women are bothered by a dry vagina while breastfeeding. This is normal. Intercourse may be more comfortable if you use a lubricant for sex, such as Astroglide, Aqua Lube or KY jelly.
- \* It does not protect you from sexually transmitted infections (STIs)
- \* Breastfeeding is not recommended for HIV-positive mothers who have other safe and healthy food available for their babies.

#### Where can I learn more?

Contact *La Leche League* at 1-877-4LA LECHE (1-877-452-5324) or <http://www.llli.org/> for free information.

**What if I am depending on breastfeeding as birth control, my period returns, and I have unprotected sex?** Call the office for Emergency Contraceptive Pills to prevent pregnancy up to 5 days after unprotected sex. You can also visit [www.Not-2-Late.com](http://www.Not-2-Late.com) for more information.

## **La lactancia: la forma natural de espaciar los bebés Método Lactancia-Amenorrea (MELA)**

### **¿Es dar el pecho un método anticonceptivo?**

Si le estás dando a tu bebé solamente leche de tus pechos, es muy posible que tu menstruación no vuelva por algunos meses. Si este es tu caso, es muy posible que no quedés embarazada en los primeros 6 meses de dar el pecho. Después de que tu bebé cumpla 6 meses, el efecto anticonceptivo de la lactancia disminuye, especialmente si vuelve tu menstruación o cuando comienzas a darle al bebé fórmula u otros alimentos que no son la leche materna. En este momento necesitas otros métodos para evitar quedar embarazada.

### **¿Cuáles son las ventajas?**

- No cuesta nada.
- Es conveniente.
- Por cerca de 6 meses, es eficaz el 98% del tiempo.
- El útero vuelve a la normalidad más rápido que cuando se usan otros métodos.
- No menstrúas.
- No interfiere con las relaciones sexuales.
- Es bueno para ti y su bebé.

### **¿Cuáles son las desventajas?**

- No es un método eficaz anticonceptivo una vez que vuelve la menstruación.
- No interrumpe la menstruación a todas las mujeres.
- Es difícil decir cuándo deja de trabajar como método anticonceptivo.
- Su eficacia como método anticonceptivo se reduce mucho después de 6 meses.
- Trabaja mejor si alimentas a tu bebé sólo con la leche de tus pechos.
- Es normal que se produzca sequedad en la vagina mientras se da el pecho y a algunas mujeres esto les molesta. Las relaciones sexuales pueden ser más cómodas si usas un lubricante como Astroglide, Aqua Lube o jalea KY.
- No te protege contra enfermedades de transmisión sexual (ETS).
- Este método no se recomienda para madres con un resultado positivo del VIH, si tienen otros alimentos seguros y sanos para sus bebés.

### **¿Dónde puedo aprender más?**

Llama a La Leche League al 1-877-452-5324 para recibir información gratis.

### **¿Qué pasa si estoy usando la lactancia como método anticonceptivo, me vuelve la menstruación y tengo relaciones sexuales sin protección?**

Llame a la oficina para conseguir Pastillas Anticonceptivas de Emergencia para prevenir el embarazo hasta 5 días después de que haya tenido sexo sin protegerse. También se puede visitar [http://ec.princeton.edu/es\\_index.html](http://ec.princeton.edu/es_index.html) para más información.

## 5.4 FAMILY PLANNING SERVICES FOR WOMEN OVER AGE 35

Providing family planning services to fertile women over age 35 is important because pregnancy in an older woman may place her or her fetus at high medical risk.

For older women who are non-fertile and do not require family planning services to plan/prevent pregnancy because they may have had a tubal ligation or are in menopause but are uninsured, low income and require cervical/breast cancer screening services, please refer them to the BCC Program for routine or specialized care.

For mammography screening of women over 40, follow the BCC Program recommendations.

### 5.4.1 PERIMENOPAUSE AND MENOPAUSE (FOR CLINICIAN)

Perimenopause starts when a woman first experiences menstrual irregularities or other symptoms that reflect her diminishing ovarian reserve e.g. onset of vasomotor symptoms. **The diagnosis of perimenopause is a clinical one.** Hormone levels fluctuate rapidly and erratically during this period. Therefore, measuring gonadotropins or sex steroids is not only unnecessary to make the diagnosis, but may lead to a misdiagnosis. Testing is needed only when history and physical exam suggest other etiologies e.g., thyroid dysfunction, tuberculosis. Perimenopause ends 12 months after her final menstrual period (menopause), when she becomes, by definition, postmenopausal.

**The median menopause age of U.S. women is 51.4.** Menopause before age 40 is rare (1%) and is called premature ovarian failure. At the other extreme, 2% of women are still menstruating at age 55.

### 5.4.2 CONTRACEPTIVE OPTIONS IN PERIMENOPAUSAL WOMEN (FOR CLINICIAN)

Perimenopausal women have declining fertility but many are intermittently at risk for pregnancy and also need contraceptive services.

Perimenopausal women often have abnormal bleeding during this period that is functional in origin and can be managed with hormonal contraception. Several contraceptive options can be used in perimenopausal women. While hormonal birth control often treats excessive vaginal bleeding, which is a significant problem during perimenopausal period, initiation of a new long-acting reversible contraceptives, especially Cu-IUD/Paragard or implant, in most cases is unnecessary and may complicate the vaginal bleeding.

#### Combined Hormonal Contraceptives (CHCs)

Healthy (no diabetes or HTN), normal weight, non-smoking women can use CHCs (pills and rings) until menopause. These methods can maintain predictable cyclic bleeding while reducing vasomotor symptoms. Refer to the U.S. MEC for additional guidance. Age and obesity are independent risk factors for venous thromboembolism and estrogen-containing methods of contraceptives should be used by these women "with caution."

When should CHCs be discontinued in perimenopausal/menopausal women? Contraceptive Technology 20<sup>th</sup> Revised Edition recommended 2 approaches:

1. Continue CHCs until about age 50-52 unless the woman's risks with these methods exceed the benefits she is enjoying. If the risks are related to estrogen, switch her to a progestin-only method.
2. Stop CHCs, provide a barrier method and follow her clinically as you would any woman undergoing natural menopause. The effects of the pill, or ring will be completely gone 14 days after product cessation (so her FSH and estradiol levels will reflect her own status).

## **Progestin-Only Methods (Progestin-only Pills, DMPA, Implant and LNG-IUD)**

These methods can be used by the majority of perimenopausal woman with few exceptions. Women with medical problems such as hypertension, diabetes, obesity and tobacco smoking are good candidates for most progestin methods. Other benefits of progestin are that it provides endometrium protection from unopposed estrogen stimulation as well as some relief from vasomotor symptoms (but less than CHCs).

The only major potential issue that progestin only methods raise is their impact on the menstrual cycle. None of the progestin-only methods provides the predictable cyclic bleeding that is delivered by CHCs.

- 1) **Depo-Provera (DMPA)** can be used for both contraception and treatment of excessive bleeding. After about two injections, nearly half of perimenopausal women have no spotting/bleeding. The effect of DMPA may linger for months after the last injection.
- 2) **Progestin-only Pills (POPs)** are underutilized in this population. Women with current breast cancer are contraindicated from using POPs (category 4). Those with a prior history and no evidence of current disease for 5 years fall in U.S. MEC category 3. POPs are safe, low cost, and rapidly reversible.
- 3) **Contraceptive implant** may be less well-tolerated by perimenopausal women than younger women because of the unpredictable bleeding patterns associated with the implant.

## **Non-hormonal Methods**

- 1) **Copper intrauterine device (Cu-IUD)** placement in a perimenopausal woman who only needs a few years of contraception and who may already be experiencing irregular/prolonged bleeding may not be a first-line choice. However, Cu-IUD users who are happy with their method in their perimenopausal years but are approaching their 10<sup>th</sup> year of use are excellent candidates for extended use of their IUD for a couple more years.
- 2) **Barrier methods** may seem to be very appropriate for women at this time in their lives when pregnancy risks are reduced and coital frequency may be somewhat diminished compared with earlier years. However, couples need to be asked about any erectile dysfunction because male condom may amplify that problem.
- 3) **Coitus interruptus (withdrawal method)** is a reasonable behavior option.
- 4) **Fertility awareness methods** are far less applicable.
- 5) **Sterilization** benefits are markedly reduced because women will need protection for only a few more years, while the risks of the procedure increase as women age.

(Chapter 25, Contraceptive Technology, 20<sup>th</sup> revised edition, Robert A. Hatcher, MD, MPH, et al.)

## **5.5 CLIENT WITH DISABILITIES**

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.

It is prudent to verify the client's capacity to understand the nature and consequences of the method/treatment to which they are consenting. It is the responsibility of the nurse/clinician to use good judgment through reasonable inquiry of the client, i.e., does the client understand why they are here, and what they expect to receive from the clinic? Ascertain if further assessment is needed.



**If nurse/clinician has reasonable doubt regarding a client's mental capacity, consultation with another qualified medical staff member is indicated**, and the client should be asked if they have a legal guardian for medical decisions or if there is someone else responsible for their major decisions.

- If the client has a legal guardian with current documentation of medical guardianship by court order, the guardian must give consent for services.
- If they deny having a guardian, they must be treated using the above guidelines.

Women with disabilities are at a higher risk of sexual abuse and STDs 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.

## **ROUTINE SCREENING RECOMMENDATIONS FOR WOMEN WITH DISABILITIES**

Cervical cytology screening intervals are not different for sexually-active disabled clients than any other Title X client.

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, Developmental Disabilities Support Division at (505) 476-8973 or Toll Free 1-877-696-1472.
- UNM Health Sciences Center Developmental Disabilities Team, Transdisciplinary & Support Clinic. (505) 272-2579 or (505) 272-3000.

## **5.6 WELL WOMEN HEALTH CONCERNS**

### **5.6.1 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 adequate (at least eight 8 oz. glasses per day) water to maintain a healthy urinary tract.
2. Avoid caffeine drinks as they irritate the lining of the urinary tract.
3. Don't hold your urine. Urinate when you feel like you need to.
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, and 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.

## 5.6.2 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 Title X FP 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.)

| Risk of Associated Disease* According to BMI and Waist Size |                 |  |  |
|---|-----------------|--|--|
| BMI   |                 | Waist < or equal to 40 in. (men)<br>or<br>35 in. (women) | Waist > 40 in. (men)<br>or<br>35 in. (women) |
| 18.5 or less  | Underweight     | --   | NA   |
| 18.5 – 24.9   | Normal          | --   | N/A  |
| 25.0 – 29.9   | Overweight      | Increased  | High   |
| 30.0 – 34.9   | Obese           | High   | Very High                                    |
| 35.0 – 39.9   | Obese           | Very High  | Very High                                    |
| 40 or greater   | Extremely Obese | Extremely High   | Extremely High                               |

\* Hypertension, Cardiovascular Disease, High Triglycerides or Cholesterol, Diabetes, Sleep Apnea, Osteoarthritis

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 the following recommendations for physical activity and nutritional intake.

### Children and Adolescents (aged 6–17)

- Children and adolescents should do 1 hour (60 minutes) or more of physical activity every day.
- Most of the 1 hour or more a day should be either moderate- or vigorous-intensity aerobic physical activity.
- As part of their daily physical activity, children and adolescents should do vigorous-intensity activity on at least 3 days per week. They also should do muscle-strengthening and bone-strengthening activity on at least 3 days per week.

### Adults (aged 18–64)

- Adults should do 2 hours and 30 minutes a week of moderate-intensity, or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. Aerobic activity should be performed in episodes of at least 10 minutes, preferably spread throughout the week.
- Additional health benefits are provided by increasing to 5 hours (300 minutes) a week of moderate-intensity aerobic physical activity, or 2 hours and 30 minutes a week of vigorous-intensity physical activity, or an equivalent combination of both.
- Adults should also do muscle-strengthening activities that involve all major muscle groups performed on 2 or more days per week.

For all individuals, some activity is better than none. Physical activity is safe for almost everyone, and the health benefits of physical activity far outweigh the risks. People without diagnosed chronic conditions (such as diabetes, heart disease, or osteoarthritis) and who do not have symptoms (e.g., chest pain or pressure, dizziness, or joint pain) do not need to consult with a health care provider about physical activity.

#### Children and Adolescents with Disabilities

- Work with the child's health care provider to identify the types and amounts of physical activity appropriate for them. When possible, these children should meet the guidelines for children and adolescents—or as much activity as their condition allows. Children and adolescents should avoid being inactive.

#### Adults with Disabilities

- Follow the adult guidelines. If this is not possible, these persons should be as physically active as their abilities allow. They should avoid inactivity.

#### Pregnant and Postpartum Women

- Healthy women who are not already doing vigorous-intensity physical activity should get at least 2 hours and 30 minutes (150 minutes) of moderate-intensity aerobic activity a week. Preferably, this activity should be spread throughout the week. Women who regularly engage in vigorous-intensity aerobic activity or high amounts of activity can continue their activity provided that their condition remains unchanged and they talk to their health care provider about their activity level throughout their pregnancy.

(2008 Physical Activity Guidelines for Americans <https://health.gov/PAGuidelines/>)

**All women** should be encouraged to follow standard dietary guidelines for health promotion, for example, My Plate at: <http://www.choosemyplate.gov/>

- As a major part of the daily diet, eat a variety of foods; whole grains, fruits and vegetables, healthy fats and calcium-rich foods.
- Adjust food intake to meet nutritional and fuel needs.
- 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.

#### Estimated Calorie Needs per Day by Age, Gender, and Physical Activity Level

Estimated amounts of calories needed to maintain calorie balance for various gender and age groups at three different levels of physical activity. The estimates are rounded to the nearest 200 calories. An individual's calorie needs may be higher or lower than these average estimates.

| Gender   | Age (years) | Physical Activity Level |                   |             |
|--|-------------|-------------------------|-------------------|-------------|
|  |             | Sedentary               | Moderately Active | Active      |
| <b>Female</b><br>(not pregnant or breastfeeding) | 9–13        | 1,400–1,600             | 1,600–2,000       | 1,800–2,200 |
|  | 14–18       | 1,800                   | 2,000             | 2,400       |
|  | 19–30       | 1,800–2,000             | 2,000–2,200       | 2,400       |
|  | 31–50       | 1,800                   | 2,000             | 2,200       |
|  | 51+         | 1,600                   | 1,800             | 2,000–2,200 |
| <b>Male</b>                                      | 9–13        | 1,600–2,000             | 1,800–2,200       | 2,000–2,600 |
|  | 14–18       | 2,000–2,400             | 2,400–2,800       | 2,800–3,200 |
|  | 19–30       | 2,400–2,600             | 2,600–2,800       | 3,000       |
|  | 31–50       | 2,200–2,400             | 2,400–2,600       | 2,800–3,000 |
|  | 51+         | 2,000–2,200             | 2,200–2,400       | 2,400–2,800 |

For adults, the reference woman is 5' 4" tall and 126 lbs.; the reference man is 5' 10" tall and 154 lbs.

Sedentary means a lifestyle that includes only the light physical activity assoc. with typical day-to-day life.

Moderately active means a lifestyle that includes physical activity equivalent to walking about 1.5 to 3 miles/day at 3 to 4 miles/hour, in addition to the light physical activity assoc. with typical day-to-day life.

Active means a lifestyle that includes physical activity equivalent to walking more than 3 miles/day at 3 to 4 miles per hour, in addition to the light physical activity associated with typical day-to-day life.

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 standard dietary guidelines. 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.

### 5.6.3 PREMENSTRUAL SYNDROME

Premenstrual syndrome (PMS) 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.

The symptoms ascribed to PMS include: acne, back pain, bloated abdomen, changes in appetite (including cravings for certain foods), constipation, mood swings, depression, fast heartbeat, feeling irritable, tense or anxious, feeling tired, headache, hot flashes, joint pain, not feeling as interested in sex, tender and swollen breasts, trouble concentrating, trouble sleeping, swollen hands or feet, wanting to be alone, weight gain.

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:

- Eat complex carbohydrates (such as whole grain breads, pasta, and cereals), fiber, and protein. Cut back on sugar and fat.
- Avoid salt for the last few days before period to reduce bloating and fluid retention.
- Cut back on caffeine to feel less tense and irritable and to ease breast soreness.

- Cut out alcohol. Drinking it before your period can make you feel more depressed.
- Try eating up to 6 small meals a day instead of 3 larger ones.
- Get aerobic exercise. Work up to 30 minutes, 4 to 6 times a week.
- Get plenty of sleep—about 8 hours a night.
- Keep to a regular schedule of meals, bedtime and exercise.
- Try to schedule stressful events for the week after your period.
- Taking 1,000 mg of calcium a day may reduce symptoms of water retention, cramps and back pain.

("PMS" American Academy of Family Physicians. <https://familydoctor.org/condition/premenstrual-syndrome-pms/>)

Provide 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.
2. "National Women's Health Resource Center" is another resource: a toll-free telephone line offering broad women's health information on the causes, symptoms, management, as well as physician referrals, symposiums, support group meetings, etc. at (1-877-986-9472) or [www.healthywomen.org](http://www.healthywomen.org)

#### **5.6.4 BREAST CONCERNS**

All clinical breast exams (CBE) including abnormal breast exams needing a referral must be documented in the medical record. This information is required for completing Table 10 of the Family Planning Annual Report (FPAR).

Many women with breast changes or a lump experience some fear, anxiety, and uncertainty during a workup. 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.

For referral to the BCC Early Detection Program, complete the BCC referral form. You may need to call for a prior approval (505-841-5860). 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 BCC Program.

#### **Fibrocystic changes**

This is the most common type of breast concern in the age groups seen in family planning clinic. They may be found in different parts of the breast and in both breasts at the same time. It is generally caused by fluid retention due to estrogen-dominant hormone balance. A woman may come to/return to a Family Planning clinic with a diagnosis of fibrocystic breast changes or a woman with no suspicious masses may report cyclic breast tenderness. Symptoms may include breast pain and tender lumps or thickened areas in the breasts. These symptoms may change as the woman moves through different stages of the menstrual cycle. Sometimes, one of the lumps may feel firmer or have other features that lead to a concern about cancer. When this happens, a needle biopsy or a surgical biopsy may be needed to make sure that cancer is not present. (<http://www.cancer.org> Non-Cancerous Breast Conditions)

In these situations the following self-help measures may be recommended:

1. Invest in a well fitted bra and wear it 24 hours a day.
2. Try hot or cold compresses to relieve discomfort.
3. Take mild analgesics: aspirin or acetaminophen. Check label for added caffeine.
4. Some women report that decreasing dietary intake of caffeine (coffee, tea, soft drinks containing caffeine, and chocolate) helps to decrease symptoms. Decrease salt intake.

If these are not effective in two to three months:

- 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.
- Consider IUD, Depo-Provera, contraceptive implant or other non-estrogen containing contraceptive as possible contraception.