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INSIDE

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LARC for the Medically Complicated Patient

Few medical conditions are absolute contraindications to long-acting reversible contraceptive methods

Half of all pregnancies in the United States are unintended; at the same time, more than 45% of all Americans suffer from a chronic disease.[1] Chronic medical conditions can complicate maternal and fetal health during pregnancy, making unintended or mistimed pregnancy problematic.[2] Results from a 2016 study indicate that fewer than 30% of females ages 14-25 years prescribed teratogenic medications also demonstrated documented contraceptive use.[3] An analysis of a nationwide healthcare claims database of reproductive-age women enrolled in private insurance during 2004-2011 indicates that despite the potential for serious maternal and fetal pregnancy-associated risks, contraceptive use was not optimal among women with medical conditions.[4]

"THE U.S. MEDICAL ELIGIBILITY CRITERIA FROM THE CDC HAVE BEEN ENDORSED BY AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AND THE EVIDENCE-BASED REPORT FINDS FEW MEDICAL CONDITIONS THAT ARE ABSOLUTE CONTRAINDICATIONS TO LARCS." RAMEET SINGH, MD, MPH, CHIEF, DIVISION OF FAMILY PLANNING, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, UNIVERSITY OF NEW MEXICO SCHOOL OF MEDICINE

Family planning providers know that use of effective reversible contraceptives is important for women with health issues, yet sometimes those same illnesses make the contraceptives themselves less effective or less safe.

There is limited research on the use of contraceptive methods in women with medical problems, says **Rameet Singh**, MD, MPH, chief of the Division of Family Planning, Department of Obstetrics and Gynecology, at the University of

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New Mexico School of Medicine in Albuquerque. The current evidence supports safe use of long-acting reversible contraceptives (LARCs) in both healthy women and those with medical problems, she notes.

On the other hand, the alternative of pregnancy often poses a greater risk of morbidity or mortality in women presenting with medical problems, Singh says. Intrauterine devices (IUDs), in particular, offer low systemic exposure to progesterone through the levonorgestrel IUDs or no hormonal exposure via the copper IUD, she states.

"The *U.S. Medical Eligibility Criteria* from the CDC have been endorsed by American College of Obstetricians and Gynecologists, and the evidence-based report finds few medical conditions that are absolute contraindications to LARCs," Singh says.

Check the Evidence

Because all LARC methods are estrogen-free, they often are a good class of methods for women whose medical conditions may put them at increased risk of arterial or venous thrombosis, says **Courtney Schreiber**, MD, MPH, associate professor of obstetrics and gynecology at the Hospital of the University of Pennsylvania in Philadelphia. Additionally, they are highly effective at preventing unintended pregnancy, which can be of particular importance for women with medical conditions who wish to maximize their health before becoming pregnant, she notes.

The recently updated *U.S. Medical Eligibility Criteria* (*MEC*) and *Selected Practice Recommendations* (*SPR*) offer guidance for the contraceptive management of these complicated patients. The 2016 U.S. MEC was updated to include the addition of recommendations for women with cystic fibrosis, women with multiple sclerosis, and women using certain psychotropic drugs or St. John's wort, as well as revision of recommendations for women with known dyslipidemias, migraine headaches, superficial venous disease, gestational trophoblastic disease, factors related to sexually transmitted infections, and HIV.[5] *(For more information, please see the October 2016* Contraceptive Technology Update *article, "Updates Issued For U.S.* MEC *and* SPR*: What*

EXECUTIVE SUMMARY

Women with chronic medical conditions can safely use LARC methods. The *U.S. Medical Eligibility Criteria* from the CDC has been endorsed by the American College of Obstetricians and Gynecologists, and the evidence-based report finds few medical conditions that are absolute contraindications to LARCs.

- Many chronic medical conditions, such endometriosis, endometrial hyperplasia, polycystic ovarian syndrome, and sickle cell disease, improve when women use one of the LARC methods.
- An analysis of a nationwide healthcare claims database of reproductive-age women enrolled in private insurance during 2004-2011 indicates that despite the potential for serious maternal and fetal pregnancy-associated risks, contraceptive use was not optimal among women with medical conditions.

Do the Changes Mean?" at: http://bit.ly/2dutOl1.)

Long-acting, highly effective contraceptive methods might be the best choice for women with conditions that are associated with increased risk for adverse health events as a result of pregnancy, the new *MEC* notes. These women should be advised that sole use of Tier 3 methods (condoms, female condoms, fertility-based awareness methods, vaginal sponge, and spermicide) might not be the most appropriate choice because of their relatively higher typical-use rates of failure, it states.[5]

Schreiber recently presented information on the use of LARCs in women with coexisting medical conditions in a webinar, "LARC for the Medically Complicated Patient," sponsored by ACOG. One case study featured a young woman in her 20s with cystic fibrosis (CF). According to research, women with CF experience a relatively high rate of unplanned pregnancy and do not receive optimal advice or use the full range of contraceptive methods.[6]

Patients with CF are at increased risk for diabetes, liver disease, gallbladder disease, and venous thromboembolism (particularly related to use of central venous catheters), and are prescribed antibiotics frequently. Categories assigned to such conditions in U.S. *MEC* should be the same for women with CF who have these conditions, the guidance notes. For CF, classifications are based on the assumption that no other conditions are present; these classifications must be modified in the presence of such conditions, it advises.

For women with CF, combined oral contraceptives, progestin-only pills, the contraceptive implant, the levonorgestrel IUD, and the copper IUD all are classified as Category 1 (no restrictions on use); the contraceptive injection is classified as Category 2 (advantages generally outweigh theoretical or proven risks).[5] However, certain drugs to treat CF, such as lumacaftor, might reduce effectiveness of hormonal contraceptives, including oral, injectable, transdermal, and implantable contraceptives.

LONG-ACTING, HIGHLY EFFECTIVE CONTRACEPTIVE METHODS MIGHT BE THE BEST CHOICE FOR WOMEN WITH CONDITIONS THAT ARE ASSOCIATED WITH INCREASED RISK FOR ADVERSE HEALTH EVENTS AS A RESULT OF PREGNANCY.

Women with CF have a higher prevalence of osteopenia, osteoporosis, and fragility fractures than the general population; use of the contraceptive injection, which has been associated with small changes in bone mineral density, might be of concern.

Many medical conditions are associated with increased risk for adverse health events as a result of pregnancy, the 2016 *MEC* notes.

These conditions include: breast cancer; complicated valvular heart disease; diabetes (insulin dependent; with nephropathy, retinopathy, or neuropathy or other vascular disease; or of more than 20 years' duration); endometrial or ovarian cancer; epilepsy; history of bariatric surgery within the past two years; gestational trophoblastic disease; hepatocellular adenoma and malignant liver tumors (hepatoma); peripartum cardiomyopathy; schistosomiasis with fibrosis of the liver; severe (decompensated) cirrhosis; sickle cell disease; solid organ transplantation within the past two years; stroke; systemic lupus erythematosus; thrombogenic mutations; and tuberculosis.[5] ■

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Does Weight Gain Play a Role in Women's Contraceptive Choices?

Concerns about weight gain may be driving contraception choices, new data released by Penn State College of Medicine indicate.[1] Women who are overweight or obese are less likely than women who are not overweight or obese to use the birth control pill and other hormonal contraceptive methods, the research suggests.[1]

Weight is an important issue; more than half (58.5%) of U.S. reproductive age women are overweight or obese.[2] Previous research indicates that overweight and obese women may be less likely to use oral contraception or the contraceptive shot, depot medroxyprogesterone acetate (DMPA), because of concerns about weight gain.[3] Many women may discontinue hormonal contraception because of weight gain, which increases their risk of unintended pregnancy.[4]

Review the Research

Cynthia Chuang, MD, MSc, Penn State professor of medicine and public health sciences, and fellow researchers performed the study to see if women's weight or their perception of weight influenced the type of birth control they used. To do so, they examined demographic and survey data from almost 1,000 privately insured women in Pennsylvania. The scientists determined weight category based on body mass index (BMI).

Chuang says as a women's healthcare provider, she has always wondered how weight — or perception of weight — may affect birth control choice. Research indicates that weight (and fears of weight gain) affects other medication choices, such as with antidepressants.[5]

"We were further intrigued after Julia Kohn et al published their article showing that contraceptive method choices differed by obesity status, with obese women more likely to use Tier 1 [implant or IUD] or Tier 3 [condoms, female condoms, fertility-based awareness methods, vaginal sponge, and spermicide]," she states. "While that was a very large data set of nearly 150,000 women, we had more sociodemographic and pregnancy-related variables, as well as questions on weight perception that we thought could help further tease out the relationships between weight and contraceptive method use."

Researchers found that 23% of overweight and 21% of obese women used LARCs, the most effective forms of birth control. In contrast, just 6% of underweight and normal-weight women used LARCs in the study.[1] There also was a trend toward overweight and obese women being more likely to use non-prescription methods such as condoms, withdrawal, and natural family planning, or no method at all. However, these results did not reach statistical significance, researchers note.

Check Patient's Perspective

In the current study, researchers also evaluated whether perception of weight influenced contraceptive choice. Results indicate that half the women perceived themselves to be overweight, although only about 42% were overweight or obese based on BMI. However, this perception did not appear to influence birth control choice.

"Women may be worried about weight gain when they're making decisions about birth control, so clinicians need to be aware of that," Chuang says. "It could be an opportunity to counsel women about LARCs, which are more effective forms of contraception."

EXECUTIVE SUMMARY

Concerns about weight gain may be driving contraception choices, new data released by Penn State College of Medicine indicate. Women who are overweight or obese are less likely than women who are not overweight or obese to use the birth control pill and other hormonal contraceptive methods, the research suggests.

- In the current study, 23% of overweight and 21% of obese women used long-acting reversible contraceptives (LARCs), while 6% of underweight and normal-weight women used LARCs.
- Previous research indicates that overweight or obese women may be less likely to use oral contraception because of concerns about weight gain. However, a Cochrane Review found available evidence was insufficient to determine the effect of combination contraceptives on weight, and that no large effect was evident.

For women who look to use the pill or other combined hormonal methods, a 2014 Cochrane Review concluded that available evidence was insufficient to determine the effect of combination contraceptives on weight, but no large effect was evident. Most studies of different birth control methods reviewed showed no large weight difference.[6]

Some adolescents may be more susceptible to weight gain with the contraceptive injection. Teens who demonstrate a 5% increase in body weight during the first six months of DMPA use may be at risk for continued weight gain while using this method.[7]

Providers can help overweight and obese women choose the most effective method. Whether excess weight significantly affects the effectiveness of hormonal contraceptives is not entirely clear; in a Cochrane Review of five studies from 2002 to 2012, only one demonstrated a higher pregnancy risk in obese women using oral contraceptives as compared to their normal-weight counterparts.[8] The efficacy of the implant and injectable contraception has not been shown to be affected by patient weight.[8] ■

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College Health Services Are Making the Grade

Young people 15-24 years of age account for half of the nearly 20 million new sexually transmitted infections (STIs) that occur each year in the United States, according to data from the CDC.[1] Both the number and rates of reported cases of chlamydia and gonorrhea continue to be highest among people in this age group, with young women facing the most serious long-term health consequences. The CDC estimates that undiagnosed STIs cause more than 20,000 women to become infertile each year.[1]

College health centers are playing a pivotal role in the introduction and performance of timely STI screenings. To get an overview of what services are being offered, CDC researchers recently surveyed colleges and universities across the United States to describe the array of sexual health services provided.[2]

To perform the survey, researchers sampled 885 U.S. colleges from the 2014-2015 Integrated Postsecondary Education Data System, a system of interrelated surveys conducted annually by the U.S. Department of Education's National Center for Education Statistics. Only active, two- or four-year, degree-granting, accredited institutions, which enrolled at least 500 students, were included. A total of 482 schools responded to the survey (55%), and were weighted

EXECUTIVE SUMMARY

Young people 15-24 years of age account for half of the nearly 20 million new sexually transmitted infections (STIs) that occur each year in the United States, according to data from the CDC. College health centers are playing a pivotal role in the introduction and performance of timely STI screenings.

• Colleges with health centers provide a variety of sexual health services, but two-year colleges may require additional support, a recent national analysis notes. Possible improvements include increasing routine chlamydia screening for women, extragenital STI testing for men who have sex with men, and removing barriers to testing by offering express and self-testing.

to be nationally representative. The analysis stratified results by minority-serving institutions (MSIs) and non-MSIs, as well as two-year (2y) and four-year (4y) facilities.

Of the weighted sample, researchers say 67.7% of colleges reported having a student health center, of which 74.4% offered STI diagnosis and treatment (4y vs. 2y; 78.3% vs. 57.6%; $P < 0.001$). Almost three-quarters (73.5%) of health centers reported routine chlamydia screening in women (4y vs. 2y; 75.4% vs. 63.6%; $P = 0.004$) and 24.7% offered express STI testing (26.1% vs. 15.6%; $P = 0.005$); follow-up chlamydia screening and self-collected vaginal swabs were offered at 82.7% and 31.0% of health centers, although no significant differences existed. Almost all facilities offered HIV testing (92.3%), with MSIs reporting higher availability of HIV testing compared to non-MSIs (96.2% vs. 91.2%; $P = 0.005$). In regard to services for men who have sex with men (MSM), 46.8% of facilities offered pharyngeal and rectal (43.8%) STI testing. HPV vaccination was offered at 70.3% of centers. Free testing was offered at only 10.3% of health centers. Of note, 37% of facilities reported that a local health department or outside organization was the primary source of STI services.[2]

Colleges with Health Centers

Colleges with health centers are providing a variety of sexual health services, but two-year colleges may require additional support, the analysis notes. Possible improvements include increasing routine chlamydia screening for women, extragenital STI testing for MSM, and removing barriers to testing by offering express and self-testing.[2]

The American College Health Association (ACHA) is a national nonprofit association serving as the nation's principal leadership organization for advancing the health of college students and campus communities. In 2015, it marked its 25th year of polling member institutions to obtain information about their screening practices for cervical cytology and STIs. The most recent available data set includes information about gynecologic services, Pap tests, and testing for STIs performed at U.S. colleges and universities during calendar year 2014.

A total of 152 institutions/health centers completed the survey online; however, not all respondents completed every question. Health centers reported 3,090,509 visits in 2014, including 423,534 women's health visits. More than three-quarters of facilities (75.7%; n =115) were public, four-year institutions.

What did the survey show? Basic screening for chlamydia, gonorrhea, and HIV is widely available upon patient request; 96.1% of health centers (n = 146) reported offering routine screening for STIs for sexually active students upon request, regardless of risk factors. More than half (65.1%; n = 99) indicated they offered STI testing based on identified demographic risks.

Most of the health centers (88.2%; n = 134) reported routinely screening sexually active women younger than age 26 for chlamydia. This area indicates room for improvement; the CDC recommends annual chlamydia screening for all sexually active women younger than age 25.

When it comes to gonorrhea testing, most health centers (72.8%; n = 110) reported they perform gonorrhea testing from nongenital sites (rectal or pharynx) in MSM. This number has increased from 60.3% in 2012 and 70.8% in 2013. The CDC recommends screening for gonorrhea at all exposed sites in MSM and for rectal chlamydia in MSM who report a history of receptive anal intercourse.[3]

Health centers are doing their part when it comes to promoting safer sex: 72% reported they provided free male condoms, while 47.3% said they offered oral dams and 46.7% provided lubrication at no cost.

The ACHA Sexual Health Education and Clinical Care Coalition is working with results from the 2015 college year survey to prepare the data set, says **Lesley Eicher**, MEd, CHES, CSE, coalition chairperson. ■

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Research Looks at Antibiotic Option for Gonorrhea

Early research is emerging on ETX0914, a potential candidate for treatment of gonorrhea.[1] The drug, administered as a single-dose oral therapy, could be used as an alternative to ceftriaxone injection as a component of recommended therapy for gonorrhea, replacing the need for intramuscular injection.

In 2015, 395,216 cases of gonorrhea were reported in the United States, for a rate of 123.9 cases per 100,000. The uptick in the gonorrhea rate during 2014-2015 was observed among both males and females; however, the increase was larger among males, rising from 119.0 to 140.9 cases per 100,000. Young adults 15-24 years of age accounted for nearly half the gonorrhea diagnoses.[2]

Finding new options for treatment of gonorrhea is a high priority for public health officials. For the first time in the United States, health officials have identified a cluster of gonorrhea infections that shows both decreased susceptibility to ceftriaxone and very high-level resistance to azithromycin. Although all patients were treated successfully using the recommended dual regimen, and no further cases have been identified since May 2016, both the resistance pattern and the occurrence of a cluster of cases are cause for concern.[3] *(For more, please see the article, "STDs at Unprecedented High in United States," in the January 2017 issue of* Contraceptive Technology Update, *available at: http://bit.ly/2hrYtkh.)*

N. gonorrhoeae has developed resistance to each of the antimicrobials used for treatment of gonorrhea, presenting a public health challenge. Because of declining susceptibility to cefixime, the latest CDC treatment guidelines now call for dual therapy with ceftriaxone (an injectable cephalosporin) and azithromycin as the sole CDC-recommended treatment regimen for gonorrhea.[4]

Potential Drug in Focus

ETX0914, which is the first of a new class of antibacterial agents targeted for the treatment of gonorrhea, operates by a novel mode of inhibition against bacterial type II topoisomerases.[5] Under development by Entasis Therapeutics, it is the first of the company's portfolio to be tested in a clinical setting, said **Manos Perros**, PhD, president and CEO, in a statement accompanying the Phase II results presentation.

To perform the randomized, open-label Phase II trial of ETX0914, researchers enrolled 179 patients (167 men and 12 women) with urogenital gonorrhea who were treated with ETX0914 alone (at either 2 gram or 3 gram dosage levels) or ceftriaxone alone. All patients in the 3 gram ETX0914 arm (47/47) and 98% of patients in the 2 gram arm (48/49) were cured of the infection. Scientists report the drug was well tolerated, with 21 of 179 patients reporting side effects, which were mostly mild and primarily gastrointestinal.[1]

The next step in research is a Phase III trial that will include a larger patient enrollment to yield information on the drug's safety and efficacy, says **Stephanie Taylor**, MD, professor of medicine and microbiology at the Louisiana State University Health Sciences Center. Taylor served as the Phase II trial's lead investigator.

Stay Vigilant

What can healthcare providers do to prevent untreatable gonorrhea from becoming a reality? The CDC encourages all providers to:

EXECUTIVE SUMMARY

Early research is emerging on ETX0914, a potential candidate for treatment of gonorrhea. The drug, administered as a single-dose oral therapy, could be used as an alternative to ceftriaxone injection as a component of recommended therapy for gonorrhea, replacing the need for intramuscular injection.

- Finding new options for treatment of gonorrhea is a high priority for public health officials. For the first time in the United States, health officials have identified a cluster of gonorrhea infections that shows both decreased susceptibility to ceftriaxone and very high-level resistance to azithromycin.
- Although all patients were treated successfully using the recommended dual regimen, and no further cases have been identified since May 2016, both the resistance pattern and the occurrence of a cluster of cases are cause for concern.

• take a sexual history, which will help determine which sexually transmitted infections to test for, as well as at which anatomic sites;

• adhere to CDC's recommendations by always treating gonorrhea promptly with a combination of injectable ceftriaxone and oral azithromycin, including post-treatment testing to confirm cure when recommended.

Don't forget to follow key CDC screening recommendations, including:

• Screen all sexually active women younger than age 25, as well as older women with such risk factors as new or multiple sex partners, or a sex partner who has a sexually transmitted infection.

• Screen sexually active men who have sex with men at anatomic sites of possible exposure at least annually.

• Evaluate and treat all patients' sex partners from the previous 60 days.

• Obtain cultures to test for decreased susceptibility from any patients with suspected or documented gonorrhea treatment failures.

• Report any suspected treatment failure to local or state public health officials within 24 hours. This will help ensure that any potential resistance is recognized early, according to the CDC. ■

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TEEN TOPICS

Offer Reproductive Life Planning for Adolescents

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In recent years, the U.S. teen pregnancy rate has declined significantly. In 2011, the rate was 52.4 pregnancies per women ages 15-19, the lowest rate in four decades and a decline of 23% since 2008, when the rate was 68.2 per 1,000.[1] The change has been attributed nearly entirely to changes in contraceptive use among adolescents, as the rates of sexual activity have remained steady. Increase in contraceptive use, as well as an increase in the uptake of more effective methods among young patients, have resulted in major decreases in teen pregnancy, as well as teen birth and abortion rates.[2]

Reproductive Life Plan

One approach to discussing contraception and other ways to avoid unintended pregnancies and plan for healthy future pregnancies is for providers to engage patients in developing a reproductive life plan (RLP). An RLP is a set of personal goals regarding whether, when, and how to have children based on individual priorities, resources, and values.[3]

The CDC recommends all persons capable of having a child create an RLP.[4] The American College of Obstetricians and Gynecologists (ACOG) also "strongly supports women's access to comprehensive and culturally appropriate reproductive life planning."[5]

In practice, reproductive life planning is a series of questions that can be integrated into any healthcare visit to assess a patient's goals around childbearing.

Here are some examples of reproductive life planning questions:

• Do you plan to have (more) children at any time in your future?

• How long would you like to wait until you become a parent?

• What can I do today to help you achieve your plan?

For those not desiring pregnancy, consider using these questions:

• What family planning method(s) do you plan to use until you (or your partner) are ready to become pregnant?

• How sure are you that you can use that method without problems?

These questions can be asked by a clinician, integrated into the electronic health record, or be included in intake materials so that the answers can be part of a more focused discussion in the limited time of a visit. Incorporating these questions into visits with patients of all genders, even visits not scheduled for family planning services, can provide an opportunity to help patients who wish to become parents to address health issues or behaviors that can complicate a healthy pregnancy, such as smoking.

Those wishing to avoid pregnancy can engage in a patient-centered discussion about a contraceptive method that will work for their lifestyle. Creating an RLP also may be useful for the many patients, adolescents, or adults who express pregnancy ambivalence.

Interpreting the Data

Although the CDC recommends an RLP for any patient of reproductive capacity, there is limited data about its use as a tool when working with adolescent patients. Authors of one study of 247 female patients ages 12-18 in Atlanta found an RLP to be a useful tool in patient-centered counseling, using the adolescent's stated goals regarding pregnancy as a motivation to connect her with the best contraceptive for her.[6]

Despite limited data, some state health departments already have created dedicated written and online materials aimed at reproductive life planning for adolescents. The Delaware Division of Health created the "My Life, My Plan" tool in collaboration with adolescents (http://bit.ly/2izOGwp). The site includes tools for young people to consider and identify their goals around education, career, healthy relationships, nutrition, exercise, and parenting. California also uses a comprehensive life plan approach and offers resources for teens and healthcare providers (http://bit.ly/2iAkayp).

> A REPRODUCTIVE LIFE PLAN IS A SET OF PERSONAL GOALS REGARDING WHETHER, WHEN, AND HOW TO HAVE CHILDREN BASED ON INDIVIDUAL PRIORITIES, RESOURCES, AND VALUES.

The definition of an RLP used by Every Woman California may be better suited for working with adolescents: "A plan to attain a state of sexual and reproductive health that begins in infancy and continues throughout the life of the individual regardless of a person's choice to reproduce."[7] This take on the RLP emphasizes that reproductive health is important at any age, having a baby is a significant event, and planning for it is essential. Instead of using only the risk-based approach of focusing solely on pregnancy prevention, creating an RLP highlights the need to plan and consider an important decision like becoming a parent. It also provides an opportunity to talk about positive aspects of parenting, whereas some risk-based pregnancy prevention materials paint young parenthood as only a negative experience.

If integrating reproductive life planning into patient care, it remains essential to recognize that a patient's reproductive life plan may change over time and should be revisited to account for changing circumstances, such as partner changes, financial effects, or completion of goals, such as education or employment.

Reproductive life planning may not be the approach that works for each patient or provider, but it is quickly becoming one of the tools many clinicians use to help adolescent and adult patients plan for their futures. ■

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WASHINGTON WATCH

Reproductive Health and Rights Face Period of Crisis

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The Trump administration and the 115th Congress will have powerful levers at their disposal to roll back decades' worth of progress in sexual and reproductive health and rights. As of mid-December 2016, few of the specifics are certain. What we do know is that many of the conservatives now in power — including Vice President Mike Pence and Tom Price, Trump's nominee to head the Department of Health and Human Services (HHS) — have long histories of anti-abortion and anti-family planning activism — and long wish lists to match.

Several attacks are almost certain to come in January 2017. In his first week in office, President Trump is expected to reinstate the global gag rule, which would prohibit U.S. international family planning aid from going to foreign nongovernmental organizations that use their own, non-U.S. funds for abortion services or advocacy. That policy was first instituted by President Reagan and also was in place under the two Bush administrations. Historically, the gag rule has had the effect of forcing many family planning providers to fire staff, reduce services, or even close their clinics altogether, undermining patients' access to needed care.[1] Advocates worry that the new administration also might extend the policy to other global health accounts, such as HIV or maternal and child health.

ACA Under Attack

Also expected is an attempt by the new Congress to strike down much of the Affordable Care Act (ACA). Congressional leaders are planning to use a special process known as reconciliation, which is designed to ease passage of budget-related legislation and cannot be filibustered in the Senate, meaning that only 50 votes in the Senate (plus a tie-breaking vote by the vice president) would be needed. Through this process, Congress could repeal central provisions of the ACA, including the broad Medicaid expansions, the subsidies to make marketplace health insurance coverage affordable for low-income Americans, and the individual and employer mandates. Lawmakers may delay those effects for several years to give themselves time to work out a replacement, and to attempt to delay the impact past the 2018 elections. However, independent analyses predict that a repeal without an immediate replacement could leave insurance markets in chaos and result in millions of Americans losing coverage.[2]

Likely as part of the same reconciliation legislation, Congress also is expected to try to prohibit federal Medicaid funds from going to Planned Parenthood Federation of America and its affiliates. Along the same lines, the Trump administration is expected to reverse two recent Obama administration actions to protect family planning providers from discrimination by state agencies on the grounds that the provider is affiliated with Planned Parenthood or otherwise has ties to abortion: an April 2016 letter to state Medicaid directors and a regulation for the Title X program finalized in December 2016.[3,4] Defunding Planned Parenthood has been a long-time goal of social conservatives, and the Obama

administration and the federal courts have served as a bulwark against such attempts. Planned Parenthood health centers have an especially strong record of providing women with timely access to a wide range of contraceptive services and supplies, and excluding them from public funding would tear a severe gap in the safety net.[5]

Conservative policymakers also have vowed to roll back the ACA's contraceptive coverage guarantee, which requires most private insurance plans to cover the full range of contraceptive methods and services for women at no out-of-pocket cost to them. The Trump administration could do this in several ways: eliminating it entirely (since contraception is not specifically included in the statutory provision requiring coverage of preventive services), broadening the religious exemption (so that employers that object to contraception on religious or moral grounds could exclude it from the health insurance they sponsor for employees and dependents), or reducing the range of contraceptive methods covered. Congress could eliminate or undermine this guarantee as well, either in a targeted way or in legislation that repeals or revamps the entirety of the ACA.

What May Come?

Beyond those immediate concerns, lawmakers may go after reproductive health and rights in numerous other ways in the months and years to come. Through the annual appropriations process, conservatives in Congress might seek to dismantle Title X — by defunding or cutting the program, denying funds to providers that have any association with abortion, or steering all the funds to state health departments and federally qualified health centers. In addition, Congress could defund teen pregnancy prevention programs and shift that money to abstinence-only-until-marriage programs. On the international front, Congress could make deep cuts to international family planning, including completely defunding the United Nations Population Fund.

Congress or the new administration could try to expand the scope of federal refusal rights for healthcare personnel, institutions, insurers, and employers. And, of course, anti-abortion members of Congress will be seeking to push through a wide range of measures on their wish list, such as extending the reach of the Hyde Amendment (which severely restricts abortion coverage for people insured by Medicaid), restricting minors' access to abortion care, and restricting abortions based on the stage of pregnancy, the specific surgical method used, or the reason a woman is seeking the procedure. ■

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COMING IN FUTURE MONTHS

- Genital herpes — routine screening not recommended
- Decoupling Pap and contraception — what's your practice?
- Research affirms testing for Zika virus
- More women sexually active into old age, data indicate

CME/CE OBJECTIVES

After reading *Contraceptive Technology Update*, the participant will be able to:

1. identify clinical, legal, or scientific issues related to development and provisions of contraceptive technology or other reproductive services;
2. describe how those issues affect services and patient care;
3. integrate practical solutions to problems and information into daily practices, according to advice from nationally recognized family planning experts;
4. provide practical information that is evidence-based to help clinicians deliver contraceptives sensitively and effectively.

CONTRACEPTIVE TECHNOLOGY UPDATE®

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To earn credit for this activity, please follow these instructions:

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3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

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CME/CE QUESTIONS

1. **According to the *U.S. Medical Eligibility Criteria*, what category is assigned to the use of combined oral contraceptives, progestin-only pills, the contraceptive implant, the levonorgestrel IUD, and the copper IUD in women with cystic fibrosis?**

   a. Category 1
   b. Category 2
   c. Category 3
   d. Category 4

2. **What proportion of U.S. reproductive age women are overweight or obese?**

   a. less than 10%
   b. 25%
   c. 33%
   d. more than 50%

3. **The CDC recommends annual chlamydia screening for:**

   a. all sexually active women younger than age 35.
   b. all sexually active women younger than age 30.
   c. all sexually active women younger than age 25.
   d. all sexually active women younger than age 20.

4. **What is the recommended CDC treatment for gonorrhea?**

   a. Dual therapy with ceftriaxone and azithromycin
   b. Dual therapy with ceftriaxone and doxycycline
   c. Monotherapy with ceftriaxone
   d. Monotherapy with cefixime