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INSIDE

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Join the Mission: Increase HPV Vaccinations for Girls and Boys

Will U.S. reach 80% coverage to meet Healthy People 2020 target?

The 67 National Cancer Institute designated cancer centers and a host of other cancer organizations now are fully endorsing the goal of eliminating cancers caused by human papillomavirus (HPV) through gender-neutral HPV vaccination and evidence-based cancer screening.

A call to action has been issued, which falls in line with the nation's Healthy People 2020 goals:

- Vaccination of more than 80% of males and females ages 13-15 by 2020;
- Screening of 93% of age-eligible females for cervical cancer by 2020; and
- Providing prompt follow-up and proper treatment of females who screen positive for high-grade cervical pre-cancerous lesions.

> "WE NEED TO MAKE SURE PATIENTS AND PROVIDERS UNDERSTAND THE IMPORTANCE OF COMPLETING THE FULL SERIES."

In a similar move, the American Cancer Society has launched "Mission: HPV Cancer Free," a public health campaign to eliminate vaccine-preventable HPV cancers, starting with cervical cancer.

"If we can achieve sustained 80% HPV vaccination in pre-teen boys and girls, combined with continued screening and treatment for cervical pre-cancers, we could see the elimination of cervical cancer in the U.S. within 40 years," said **Richard Wender**, MD, chief cancer control officer for the American

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Cancer Society, in announcing the new campaign. "No cancer has been eliminated yet, but we believe if these conditions are met, the elimination of cervical cancer is a very real possibility."

About 26,000 new cancers attributable to HPV occur each year, including 18,000 among females and 8,000 among males.[1] A 2014 study by the Centers for Disease Control and Prevention (CDC) estimated that more than 90% of sexually active women and 80% of sexually active men will be infected with at least one type of HPV at some point in their lives.[2] Data indicated about one-half of these infections were with a high-risk HPV type.[3]

All girls and boys who are 11 or 12 years of age should receive two shots of HPV vaccine six to 12 months apart.[4] While HPV vaccination prevents an estimated 90% of HPV cancers when given at the recommended age, cancer protection decreases as age at vaccination increases.[5]

"The American Cancer Society is determined to protect the future of every boy and girl by preventing six types of cancer with the HPV vaccine," notes **Debbie Saslow**, PhD, senior director of HPV related and women's cancers for the American Cancer Society. "We have a historic opportunity and all we have to do is make sure the children in our lives are vaccinated and the women in our lives are screened."

To help improve vaccination rates, the CDC notes that receiving a provider's recommendation for a vaccine is an important reason parents decide to vaccinate their children. Clinicians can take the opportunity to strongly recommend the HPV vaccine to parents of children ages 11-12 at the same time that they recommend the Tdap and meningococcal vaccines.

Overcome Vaccine Challenges

New research from the University of North Carolina at Chapel Hill indicates that follow-through on the HPV vaccine — the percentage of those who complete the series within a year of receiving their first dose — is low and has declined over time.[6]

The analysis used data from insurance claims for more than 1.3 million privately insured individuals in the United States, ages 9 to 26 years, who initiated the HPV vaccine series between 2006 and 2014. Researchers reported the vaccination follow-through for females fell from 67% in 2006 to 38% in 2014, and dropped from 36% in 2011 to 33% in 2014 for males. This means that only one-third of males and one-third of females received all recommended doses of the HPV vaccine.

The study findings indicate that follow-through was highest among patients initiating HPV vaccine through an obstetrician/gynecologist and lowest among those initiating the series with a physician's assistant or nurse practitioner. Patients with HMO insurance plans also had lower follow-through than those with other insurance plan types, researchers reported.[6]

"We've focused a lot on ways to increase initiation of the vaccine, but this work really shows that's only part of the story," states **Jennifer Spencer**, MSPH, lead author and health policy and management doctoral student at the University of North Carolina Gillings School of Global Public Health. "We need to make sure patients and providers understand the importance of completing the full series."

EXECUTIVE SUMMARY

The 67 National Cancer Institute-designated cancer centers and a host of other cancer organizations now are fully endorsing the goal of eliminating cancers caused by human papillomavirus (HPV) through gender-neutral HPV vaccination and evidence-based cancer screening.

- The call to action seeks vaccination of more than 80% of males and females ages 13-15 by 2020, screening of 93% of age-eligible females for cervical cancer by 2020, and provision of prompt follow-up and proper treatment of females who screen positive for high-grade cervical pre-cancerous lesions.
- Results of a 2014 study indicated that more than 90% of sexually active women and 80% of sexually active men will be infected with at least one type of HPV at some point in their lives. Data indicate about one-half of these infections were with a high-risk HPV type.

Data Underscore Safety, Efficacy

Results of a new comprehensive review of the most recent clinical data on the subject show that HPV vaccines can help prevent cervical cancer without producing any serious side effects.[7]

The review summarizes 26 studies that involved 73,428 women and that were conducted across the globe during the past eight years. Most women in the studies were younger than 26 years of age; three trials recruited women between 25 and 45 years of age. All studies in the review randomized women to receive either an HPV vaccine or a placebo. Two types of vaccine were included in the review: the bivalent vaccine, which targets HPV 16 and 18, and the quadrivalent vaccine, which guards against HPV 16/18 and two other HPV types of low risk that cause genital warts. Researchers did not include the newest vaccine, Gardasil 9, in the review because it has not been compared to a placebo in a randomized controlled trial. Gardasil 9 is designed to target four HPV types (16, 18, 6, and 11), as well as five more HPV types that are associated with cervical cancer (HPV 31, 33, 45, 52, and 58). Research indicates that the vaccine can reduce 90% of cervical cancers throughout the world.[8]

The review focused on women who did not have high-risk HPV at the time of vaccination, and all women regardless of HPV status at vaccination. The researchers measured the effects of the vaccine according to precancer related to HPV 16/18 and precancer no matter the type of HPV. The data were from 10 trials with information about cervical lesions from three and a half years to eight years after vaccination.[7]

The researchers found that among young women who did not have HPV, the risk of developing precancer was decreased. About 164 per 10,000 women who received the placebo and two per 10,000 women who received the HPV vaccine later developed cervical precancer.[7] ■

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Add the IUD to EC Counseling

Are clinicians including information about use of the intrauterine device (IUD) as emergency contraception (EC)? Results of a new study indicate that many young women are not aware that the IUD can be used for EC or that it is effective. Researchers report that if young women needed emergency contraception, most indicated that they would want to know about IUDs in addition to emergency contraceptive pills.

IUDs are effective for emergency contraception, as demonstrated in a 2012 evidence review.[2] Results of the 2012 review indicated that 99.86% of women overall did not become pregnant after unprotected intercourse when they received an IUD inserted after intercourse. Since intrauterine devices are safe for most women, and effective and cost-effective when used as ongoing contraception, clinicians should include IUDs in the emergency contraception options they offer patients who present for emergency contraception after unprotected intercourse.[2]

Results of the current paper are a secondary analysis of data from 1,500 women ages 18-25 years who presented for care at 40 Planned Parenthood health centers between 2011 and 2013. The young women, who did not wish to become pregnant within 12 months, were part of a cluster-randomized trial in which the staff at health centers were randomized to receive additional training about contraceptive counseling and IUD placement or to give standard care. The intervention did not focus specifically on use of the IUD as EC. The women involved in the study completed a survey about demographic information, previous contraceptive use (noted as any contraceptive use and the most effective method used within the previous three months), and awareness of contraceptive methods. The study participants completed quarterly phone or online surveys for one year.[1]

Researchers assessed participants' awareness about using the IUD as EC, their interest in more information about EC, and their most trusted source of information. Results of the analysis indicate that at follow-up, few of the young women (7.5%) were aware of using the IUD for EC. However, if they needed EC, most (68%) said they would want to know about IUDs in addition to emergency contraceptive pills, particularly among women who would be very unhappy to become pregnant (adjusted odds ratio [aOR],1.3; 95% confidence interval, 1.0-1.6, P < .05). More than 90% of participants reported that their most trusted source of information for EC was a doctor or nurse, in comparison to the Internet (6%) or friends. Of the women who had heard of IUD as EC, less than half correctly reported that the IUD is more effective than emergency contraceptive pills.[1]

Suzan Goodman, MD, MPH, associate clinical professor at the University of California, San Francisco, and national training director for the Bixby Center for Global Reproductive Health's Beyond the Pill Program, says that in her work training providers across the country, she is "always struck" by how few providers offer intrauterine contraception as EC, and how few patients are aware of it.

"Our patients deserve access to the IUD as both emergency and ongoing contraception, and providers should take an active role in increasing awareness," says Goodman, who served as lead author of the current paper. "It offers the strongest motivation for clinics to provide same-day services or rapid-access referral, and I wanted to provide more data to encourage this."

EXECUTIVE SUMMARY

Results of a new study indicate that many young women don't know that the IUD can be used for emergency contraception or that it is effective. Researchers report that if young women needed emergency contraception, most indicated they would want to know about IUDs in addition to emergency contraceptive pills.

- IUDs are safe for most women and are effective when used as ongoing contraception. Clinicians should add them to the emergency contraception options they offer to patients who present for emergency contraception after unprotected intercourse.
- Clinics should seek to provide same-day EC IUD services or rapid-access referral. A 2016 study indicates that many clinicians may not be offering such emergency contraceptive placement.

Assess Your Practice

According to a 2017 Committee Opinion from the American College of Obstetricians and Gynecologists, clinicians should counsel patients that a copper IUD is the most effective form of EC. The committee opinion states that healthcare providers should consider integrating the provision of copper IUD EC into their practices

and allowing same-day provision of IUDs.[3]

Is your clinic prepared to do same-day IUD placement for EC? In a pilot study in nine family planning clinics, researchers found that clinics could accommodate 77% of patients who wanted an IUD as EC the same day. The rest of the patients returned for IUD placement within the five-day window after unprotected intercourse.[4]

Research indicates that many clinicians may not be offering IUD placement for emergency contraception. In a 2016 survey, researchers used a mystery caller to contact 199 primary care, family planning, and obstetrician/gynecology clinics in nine U.S. cities. The caller assumed the role of a patient requesting the copper IUD for EC. The researchers found that although two-thirds (68%) of primary care clinics, 87% of family planning clinics, and all obstetrician/gynecology clinics offered the copper IUD, few primary care or obstetrician/gynecology clinics offered it as EC. Less than half (49%) of the family planning clinics offered such service.[5]

Science Examines IUD EC Options

How about use of the levonorgestrel IUD for EC? Researchers in the Department of Obstetrics and Gynecology at Washington University School of Medicine in St. Louis are now running the LIFE (Levonorgestrel Intrauterine System for Emergency Contraception) trial to examine the device's use.

The study is designed to evaluate the effectiveness of the levonorgestrel intrauterine system as a method of EC by comparing observed pregnancy rates in those who receive oral levonorgestrel, ulipristal acetate, or the device. Results are expected after 2019.

Robert Hatcher, MD, MPH, professor emeritus of gynecology and obstetrics at Emory University School of Medicine in Atlanta, notes that when a woman needing EC strongly prefers placement of a levonorgestrel IUD, one may be placed, accompanied by provision of an oral dose of Plan B One Step or generic equivalent. ■

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Blood Test for Pregnant Women May Predict Preterm Births

In pilot studies of pregnant women, data indicate that ribonucleic acid-based tests of maternal blood can predict delivery date and risk of early childbirth.[1] If proven successful in advanced trials, such tests could aid in decreasing the preterm birth rate in the United States, which has recorded its third consecutive annual increase after steady declines during the previous seven years.[2]

Babies who are born too early have higher rates of death and disability. Data from the Centers for Disease Control and Prevention show that 17% of infant deaths in 2015 were attributed to preterm birth and low birth weight.[3] Infants who are born too early may experience problems with breathing, feeding, vision, and hearing, as well as cerebral palsy and developmental delay.

Currently, there has not been a reliable way to determine which women will experience premature delivery. It is challenging for clinicians, particularly those in low-resource settings, to pinpoint delivery dates accurately.

According to preliminary research, the new blood test, led by a team of researchers at Stanford University, detects within 75-80% accuracy whether pregnancies will end in premature birth. The same technique also can be used to estimate a fetus's gestational age as reliably as and less expensively than ultrasound, researchers conclude.[1]

Stephen Quake, PhD, professor of bioengineering at Stanford and co-senior author of the current paper, praises the collaboration of researchers around the globe in

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developing the test. The research was funded by the Bill and Melinda Gates Foundation, the March of Dimes Prematurity Research Center at Stanford University, the March of Dimes Prematurity Initiative Grant at the University of Pennsylvania, and the Chan Zuckerberg Biohub.

"We have worked closely with the team at the Stanford March of Dimes Prematurity Research Center, and the research involved collaborations with scientists in Denmark, Pennsylvania, and Alabama," said Quake in a press statement. "It's really team science at its finest."

Review the Results

Researchers developed the gestational-age test by studying a group of 31 Danish women, who gave blood weekly throughout their term pregnancies. The investigators used the blood samples from 21 of the women to build a statistical model, which identified nine cell-free ribonucleic acids (RNAs) that predict gestational age. Researchers then validated the model by using samples from the other 10 women. The gestational age estimates using the model were accurate about 45% of the time, compared to the accuracy of 48% for estimates that used first-trimester ultrasound, the researchers noted.[1]

By measuring cell-free RNA in mothers' blood, clinicians also may be able to gather valuable information about fetal growth, says **Thuy Ngo**, PhD, now research assistant professor of medicine at Oregon Health and Science University.

"This gives a super-high resolution view of pregnancy and human development that no one's ever seen before," said Ngo. "It tells us a lot about human development in normal pregnancy."

To use testing to predict preterm birth, researchers studied blood samples from 38 American women with a risk for premature delivery because of early contractions or a previous preterm birth. Each woman submitted one blood sample during the second or third trimester of her pregnancy. Thirteen women delivered prematurely, while 25 delivered at term. Data from the test indicated that levels of cell-free RNA from seven genes from the mother and the placenta could indicate which women would have premature deliveries.[1]

More Research Needed

The research team plans to evaluate the new tests further with larger groups of women. Although scientists still don't know the mechanism that causes preterm birth, they plan to study genes further to gain more understanding. The researchers also hope to determine whether drugs may be able to help prevent premature births.

"By measuring cell-free RNA in the circulation of the mother, we can observe changing patterns of gene activity that happen normally during pregnancy, and identify disruptions in the patterns that may signal to doctors that unhealthy circumstances like preterm labor and birth are likely to occur," said **David Stevenson**, MD, the principal investigator of the March of Dimes Prematurity Research Center at Stanford University. "With further study, we might be able to identify specific genes and gene pathways that could reveal some of the underlying causes of preterm birth, and suggest potential targets for interventions to prevent it."

Clinicians can help pregnant women to have healthy pregnancies and reduce their risk of preterm birth. The Centers for Disease Control and Prevention suggests these recommendations for pregnant women:

- Stopping smoking;
- Obtaining prompt prenatal care as soon as a woman thinks she is pregnant, followed by routine care throughout pregnancy;
- Seeking medical attention for any warning signs or symptoms of preterm labor; and
- Talking with a healthcare provider about the use of progesterone treatment if a woman has had a previous preterm birth. ■

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Research Examines Options for Those With Early-stage Breast Cancer

Time to update your practice: Results of a large-scale study indicate that chemotherapy does not benefit 70% of women who have a common type of breast cancer.[1] Data suggest that for women with hormone receptor-positive (HR-positive), human epidermal growth factor receptor 2-negative (HER2-negative), axillary lymph node-negative breast cancer, post-surgery treatment with chemotherapy and hormone therapy is no more helpful than hormone therapy treatment on its own.

The Phase 3 clinical trial, known as TAILORx, began in 2006. Researchers used a molecular test, Oncotype DX Breast Recurrence Score, which checks the expression of 21 genes associated with breast cancer recurrence. Results of the test were used to assign more than 10,000 women with early-stage, HR-positive, HER2-negative, axillary lymph node-negative breast cancer to different post-operative treatments. The research sites were in the United States, Australia, Canada, Ireland, New Zealand, and Peru.

Scientists analyzed and assigned each tumor a number on a 0-100 scale risk score for cancer recurrence. By looking at results from previous trials, researchers were able to assign women with a low-risk score to the hormone therapy-only group, while women with high risk were assigned to a group that received hormone therapy and chemotherapy. Researchers randomly assigned those with intermediate-range scores to receive either only hormone therapy or hormone therapy along with chemotherapy.

EXECUTIVE SUMMARY

Results of a large-scale study indicated that 70% of women with a common type of breast cancer do not experience a benefit from chemotherapy. Data suggest that for women with hormone receptor-positive, human epidermal growth factor receptor 2-negative, axillary lymph node-negative breast cancer, post-surgery combination chemotherapy and hormone therapy treatment provides no additional benefit over hormone therapy on its own.

- Results from the Trial Assigning Individualized Options for Treatment trial offer clinicians data that can lead to treatments that are individualized, researchers say.
- Until now, clinicians could recommend treatment for women who had cancers with high and low recurrence risk, but the right strategy for patients at intermediate risk has been unclear.

What Were the Results?

The researchers found that both treatment groups were similar in terms of the proportion of women who survived and who did not have a cancer recurrence or development of a second primary cancer. Findings suggest that the invasive disease-free survival rate was 92.8% for the women who received hormone therapy alone, compared to 93.1% for the women with dual treatment (hormone therapy plus chemotherapy). At the nine-year mark, the rate was 83.3% for women who received only hormone therapy compared to 84.3% for the women who received both treatments.[1]

The groups also had similar overall survival rates, the researchers reported. For the women who received only hormone therapy, the overall survival rate at five years was 98%, compared to 98.1% for the women who had hormone and chemotherapy treatments. At nine years, the overall survival rates were 93.9% and 93.8%, respectively.[1]

At the nine-year point, women in the low-risk score group who had only hormone therapy exhibited very low recurrence rates, which was similar to findings from earlier studies, researchers reported. Women in the high-risk score group, who had combined therapy, had a recurrence rate of 13%. Women in this risk group

may need more effective therapies, researchers noted.[1]

Offer Personalized Therapy

These results offer clinicians data that can lead to treatment recommendations that are more individualized, says **Joseph Sparano**, MD, associate director for clinical research at the Albert Einstein Cancer Center and Montefiore Health System in New York City and vice chair of the ECOG-ACRIN Cancer Research Group, which designed the trial.

"These data confirm that using a 21-gene expression test to assess the risk of cancer recurrence can spare women unnecessary treatment if the test indicates that chemotherapy is not likely to provide benefit," said Sparano in a press statement. Sparano and colleagues presented the results at the recent American Society of Clinical Oncology annual meeting in Chicago.

What Is Best Treatment Approach?

How might the study's findings be applied in practice? Based on the trial's results, approximately 70% of women with HR-positive, HER2-negative, node-negative breast cancer may be able to avoid chemotherapy. This includes:

- women older than age 50 and who have a recurrence score in the 11-25 range;
- any age women who have a recurrence score in the 0-10 range; or
- women age 50 or younger and a recurrence score in the 11-15 range.

For the other 30% of women of any age with HR-positive, HER2-negative, node-negative breast cancer and a recurrence score in the range of 26-100, chemotherapy may be helpful. Women who are age 50 or younger and have a recurrence score of 16-25 also may benefit.

For most women in the group with intermediate risk, the scientists concluded that chemotherapy is not indicated. The current findings are in line with a 2015 TAILORx analysis that indicated prospectively that women who had a low risk of recurrence and could avoid chemotherapy could be determined by the gene expression test.[2]

When researchers separately analyzed women in the higher intermediate-risk range who were premenopausal and those younger than age 50, the results indicated a small benefit from chemotherapy.[1] Such women may consider chemotherapy with their clinician, they state.

Until now, clinicians could recommend treatment for women who had cancers with high and low recurrence risk, but the right strategy for patients at intermediate risk has been unclear, notes **Jeffrey Abrams**, MD, associate director of the National Cancer Institute's Cancer Therapy Evaluation Program.

"These findings, showing no benefit from receiving chemotherapy plus hormone therapy for most patients in this intermediate-risk group, will go a long way to support oncologists and patients in decisions about the best course of treatment," said Abrams in a press statement. ■

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Data Suggest Abortion Does Not Lead to Depression

Results of a new study of almost 400,000 women indicate that having an abortion does not increase the risk of depression for women.[1] The publication comes at a time when many state policies restricting abortion access in the United States have been justified by claims that abortion causes women psychological harm.

Researchers from the University of Maryland School of Public Health and colleagues looked at data that identified a cohort of women who were born in Denmark. The study included a total of 396,397 women.

An analysis of the data shows 4.4% of women had no children and had a record of at least one abortion in the first trimester, 18.2% had at least one childbirth and no abortions, 3.4% had at least one abortion and one childbirth, and 74.1% had not given birth and had not had an abortion. For 59,465 women (15.0%), records indicated a first use of an antidepressant.

In looking at the data, researchers noted that women who had a first abortion had an increased risk of a first-time prescription for an antidepressant when compared with women who had not undergone an abortion. The risk of first-time

EXECUTIVE SUMMARY

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- According to a 2008 report from the American Psychological Association, the best indication of the state of a woman's mental health following an abortion is the status of her mental health prior to the abortion.
- Of the 20 states that include information on the risks of abortion, eight states (Kansas, Louisiana, Michigan, Nebraska, North Carolina, South Dakota, Texas, and West Virginia) include information that stresses negative emotional responses.

prescription for antidepressant medication was similar to the year prior to and following an abortion. Although giving birth was related to a lower chance of receiving an antidepressant prescription, the likelihood of receiving a prescription increased after the birth of a child and rose for five years after childbirth. Researchers identified previous mental health care and prescriptions for anti-anxiety and antipsychotic medications as the strongest predictors of new prescriptions for antidepressants.[1]

Julia Steinberg, PhD, assistant professor in the Department of Family Science in the School of Public Health at the University of Maryland, says policies founded on an idea that abortion negatively affects the mental health of women are "misinformed."

"Abortion is not causing depression," said Steinberg in a press statement. "Our findings show that women were not more likely to suffer from depression after an abortion compared to beforehand."

Women may experience a range of emotions after an abortion; many report feeling satisfied or relieved.[2] Research indicates that teens are no more likely than older women to experience negative mental health outcomes after an abortion.[3] According to a 2008 report from the American Psychological Association, the best indication of the state of a woman's mental health following an abortion is the status of her mental health prior to the abortion.[4]

Check States' Policies

A statewide policy analysis from the Guttmacher Institute indicates that of the 20 states that include information on the risks of abortion, eight states (Kansas, Louisiana, Michigan, Nebraska, North Carolina, South Dakota, Texas, and West Virginia) include information that stresses negative emotional responses.

Inaccurate information can be detrimental for women. Results from a 2014 study suggest that among women seeking an abortion in Utah, the proportion who falsely believed that abortion causes depression or anxiety increased from 24% to 34% after they received inaccurate state-developed counseling on the mental health risk of an abortion.[5]

In Texas, women are given a booklet warning them that they are at increased risk of becoming suicidal if they have an abortion. New research from the Advancing New Standards in Reproductive Health, a collaborative research group at the University of California, San Francisco's Bixby Center for Global Reproductive Health, has found no evidence that women who have abortions are at higher risk of developing symptoms of suicidal ideation than women denied abortions.[6] ■

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WASHINGTON WATCH

Trump Administration Revives Title X 'Domestic Gag Rule'

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Last month's "Washington Watch" column walked through the Trump administration's first major step to reshape the Title X national family planning program, and noted that even bigger dangers were on the horizon.[1] And indeed, on June 1, 2018, the administration published a series of proposed changes to Title X regulations.[2,3] Most notably, the administration is proposing a new version of the Reagan administration's "domestic gag rule" (a policy that was never fully implemented and later reversed by President Clinton) by barring abortion referral, undermining patients' right to comprehensive pregnancy options counseling, and excluding from Title X organizations that provide abortion using non-federal dollars. In addition, the rule would alter the services and providers that could be supported by Title X in ways that would shift the program away from its mission of providing comprehensive, high-quality family planning care.

The move to bar clinicians from referring pregnant patients for abortion services would be a 180-degree reversal from Title X's long-standing policy of requiring programs to offer referrals upon request for any of a pregnant patient's options, including abortion. Offering referrals promotes continuity of care and helps prevent delays that can make care riskier and more expensive. Moreover, the proposed regulations would require Title X providers to refer all pregnant patients for prenatal care and social services such as foster care or adoption, regardless of the patient's wishes.

Removing the guarantee that all pregnant patients receive unbiased, factual counseling on all of their options would be another major reversal for Title X. Denying this information would constitute a clear violation of the principle of informed consent and run contrary to clinical guidelines established by leading medical organizations and the federal government itself.[4] The shift would reinforce the Trump administration's efforts to promote religious and moral objections over patients' rights and health.[5]

The proposed rule also would impose extensive new requirements for Title X–supported entities to be physically and financially separate from any entity that provides abortion using non-federal funds. That would include separate accounting records, physical spaces, staff, phone numbers, email addresses, patient health records, signs, and more. The clear intent is to exclude Planned Parenthood and other health centers that offer abortion care from Title X. Excluding those providers would severely damage the Title X network, strain the capacity of other providers, and make it harder for patients to obtain the care they need.[6]

Reshaping Title X Services and Providers

As described in last month's column, a February 2018 funding opportunity announcement contained multiple requirements designed to shift the Title X program's services and provider network along conservative ideological lines.[7] The proposed regulations advance many of those same goals and, by entrenching them in the program's regulations, would make them more difficult to undo.

First, the proposed rule continues the push away from Title X's traditional focus on offering patients a broad range of contraceptive methods. It uses a definition of "family planning" that eliminates the requirement that providers offer "medically approved" family planning methods, and instead emphasizes natural family planning, other fertility awareness-based methods, abstinence, and adoption.

Second, the proposed rule echoes the funding announcement in how

it is designed to reshape the Title X provider network. It disadvantages specialized reproductive health providers by favoring sites that offer primary care services. Moreover, it encourages the inclusion in Title X of entities "that refuse to provide abortion counseling and referrals," those that serve "patients who seek providers who share their religious or moral convictions," and "specialized, single-method [natural family planning] service sites."[2]

In addition, the proposed rule continues to threaten adolescent patients' confidentiality. For example, it imposes new requirements for clinicians to document their efforts to encourage parental involvement in minors' decisions, and it codifies the funding announcement's policy that providers must screen any teen who has a sexually transmitted infection or is pregnant to "rule out victimization." These requirements go beyond what is needed to adhere to federal and state notification and reporting requirements and could discourage adolescents from seeking needed care.

Finally, the Trump administration is proposing to use Title X to provide free family planning services to people whose employer-based insurance excludes contraceptive coverage because of the employer's religious or moral objections. Essentially, the administration is proposing to redirect scarce Title X funds to fix a problem it created with its October 2017 contraceptive coverage regulations.[8]

Public comments on the proposed rule are due on July 31, 2018, after which the administration must consider and respond to comments before finalizing the rule. Overseeing that process will be Diane Foley, who was tapped to head the Office of Population Affairs on May 29. Foley is the former president of Life Network, which operates anti-abortion counseling centers and abstinence-only-until-marriage programs in Colorado.[9] ■

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CME/CE QUESTIONS

1. **What is the recommended dosing schedule for administration of the HPV vaccine in girls and boys ages 11-12 years?**

   a. Two shots, one month apart
   b. Two shots, six to 12 months apart
   c. Three shots, two months apart
   d. Three shots, three months apart

2. **What is the most effective method of emergency contraception?**

   a. The Yuzpe regimen
   b. The levonorgestrel emergency contraceptive pill
   c. Ulipristal acetate
   d. The copper IUD

3. **According to recent research, chemotherapy may be avoided in which group of women with HR-positive, HER2-negative, node-negative breast cancer?**

   a. Those older than 50 years of age and with a recurrence score of 11-25
   b. Those of any age with a recurrence score of 0-10
   c. Those 50 years of age or younger with a recurrence score of 11-15
   d. All of the above

4. **Which states include information that stresses negative emotional responses as a risk of abortion?**

   a. Kansas, Louisiana, Michigan, Nebraska, North Carolina, South Dakota, Texas, West Virginia
   b. Mississippi, Oklahoma, Oregon, Minnesota, Illinois, Ohio
   c. Arizona, Utah, New Hampshire, Maine, Arkansas, Montana
   d. South Carolina, Georgia, North Dakota, Pennsylvania

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.