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INSIDE

RELIAS MEDIA

MAY 2020 Vol. 41, No. 5; p. 49-60

COVID-19 Shuts Down Nation; Family Planning Need Not Stop

Clinics resort to remote care

The COVID-19 pandemic has affected every aspect of American life, including nonemergency doctor visits. But from a family reproductive health point of view, the consequences of weeks of social distancing and quarantines can present new challenges.

For instance, too little is known about the transmission of the virus to pregnant women and women who are breastfeeding. Also, people seeking sexual and reproductive healthcare and contraceptive services could face even greater economic and social hurdles than before.

> "ACCESS TO CONTRACEPTION IS ESSENTIAL HEALTHCARE FOR WOMEN OF REPRODUCTIVE AGE, BUT MANY CLINICS ARE HAVING TO RESTRICT ON-SITE SERVICES TO EMERGENCY CARE."

Women facing weeks or even months of being homebound might wish to have a three-month supply of contraception or switch to an intrauterine device (IUD), but the closing of nonessential businesses in various states and cities might make it more difficult for women to access safe contraception when their current supply is exhausted.

"Access to contraception is essential healthcare for women of reproductive age, but many clinics are having to restrict on-site services to emergency care," says **Julie Rabinovitz**, MPH, president and chief executive officer of Essential Access Health in Berkeley, CA. "Title

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CONTRACEPTIVE TECHNOLOGY UPDATE®

***Contraceptive Technology Update*® (ISSN 0274-726X), is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals Postage Paid at Morrisville, NC, and additional mailing offices.**
POSTMASTER: Send address changes to: *Contraceptive Technology Update*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.

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Back issues: $75. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

GST Registration Number: R128870672.

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X providers in California are exploring and implementing a variety of strategies to best support the family planning needs of their patients and making adjustments based on guidance from local health authorities."

For example, a Bay Area provider had to temporarily close because of shelter-in-place orders in that county. "They posted information on their doors referring patients to other providers in their area that are still offering services, including emergency contraception and STD treatment," Rabinovitz says. "Other providers are offering family planning visits and providing contraception/emergency contraception refills by phone, and they're considering doing drive-through options for receiving contraceptive injections."

Is Supply Chain Affected?

Another issue involves the supply of contraceptives. International reports suggest that contraceptives manufactured in Asia could be in low supply as many factories were closed during China's COVID-19 outbreak.

But there is no evidence that the pipeline for the delivery of contraceptive products is compromised or will be, said **Michael S. Policar**, MD, MPH, professor emeritus of obstetrics, gynecology, and reproductive sciences at the University of California San Francisco School of Medicine. Policar spoke at the National Family Planning & Reproductive Health Association National Conference, held March 8-10, 2020, in Washington, DC. Policar provided a COVID-19 resource list for reproductive health providers and others to access. *(The list is available online at: http://bit.ly/2x9O0Gk.)*

"I understand that this is a theoretical concern for certain drugs, but there is no reason to be concerned at this point," Policar explained. "The essential ingredients in hormonal contraceptives are estrogen and progestins, plus inert binders and coloring, in the case of tablets. My understanding is that the major source of manufacture of these hormones is not China, but other parts of the world."

More concerning, family planning centers could lose staff due to personal illness, self-isolation, or the need to care for someone who is quarantined or out of work or school, Policar noted. "Family planning clinics were stretched thin for adequate staffing, especially by nurse practitioners and other clinicians, before the outbreak occurred. This will make it far worse," he said.

Mitigation tactics include:

• **Phone triage.** "Clinics can phone triage patients before a scheduled visit to determine whether the visit can be done by telephone visit, or synchronous or asynchronous telemedicine," Policar said.

EXECUTIVE SUMMARY

Women continue to need access to reproductive health services during a pandemic that is causing American society to shut down, limiting options.

- Many clinics have to restrict on-site services to emergency care.
- Family planning providers can practice telemedicine and offer video visits.
- Providers can give patients prescriptions for several months in advance.

• **Advance prescription.** Giving patients advance provision or prescriptions for contraceptive products also could help people get through the social distancing/isolation period.

• **Postponing services.** Clinics could postpone elective services, including well-woman visits, until the summer or later, Policar noted.

Telehealth is especially important in this time of distancing. "The need for social distancing has brought to light the need to expand access through a broad range of modalities," Rabinovitz says. "Enhancing provider capacity to deliver services through telehealth is critical."

For instance, Medicaid and other payers could cover telehealth services. "In California, we successfully advocated for the Medi-Cal [state Medicaid program] and the Family PACT programs to cover and reimburse services delivered through telehealth platforms," Rabinovitz says. "Providers need additional technical assistance and funding to more fully integrate the provision of sexual and reproductive healthcare through telehealth into their practice."

California also passed legislation to cover all methods of birth control without cost-sharing or restrictions. Public and private health plans must cover a 12-month supply of self-administered hormonal contraceptives furnished at one time, she says.

"Pharmacists are also allowed to dispense the pill, patch, and ring without a prescription," Rabinovitz adds. "It's important for more states to follow suit and for California to continue building on these successes in the coming year."

Condoms and emergency contraceptives also could be made more readily available during the pandemic crisis. But one contraceptive that might not be as easily handled during this period is the IUD. Family planning clinics that are limited to providing only emergency services will not be able to schedule appointments for IUDs until the crisis is over.

"There won't be a whole lot of providers inserting IUDs right now," Rabinovitz says.

If there is an increased demand for IUDs, the industry can meet that demand now and in the future, Policar said.

"The problem is not access to an insertion kit for an IUD or implant," he explained. "It's having a family planning or primary care clinic that is open for business, with adequate staffing by qualified clinicians, to perform same-day placements." It is a staffing challenge, not a hardware problem, he added. ■

How Providers Can Weather the Pandemic

Telehealth is new normal

As pandemic messaging moves from containment to mitigation to recovery, national experts are giving healthcare providers tips on how to weather the storm:

• **End barriers to telehealth.** Federal and state governments could remove some of the financial and other barriers to telemedicine.

"The first barrier is being able to enter the content of the telephone visit into the patient's medical record in a way that is HIPAA compliant," said **Michael S. Policar**, MD, MPH, professor emeritus of obstetrics, gynecology, and reproductive sciences at the University of California, San Francisco School of Medicine. Policar spoke at the National Family Planning & Reproductive Health Association National Conference, held March 8-10, 2020, in Washington, DC.

The second barrier is payment by Medicaid, state family planning programs, and commercial payers for phone visits, Policar said.

"Most payers now pay for telehealth visits, but they require that these visits are synchronous, meaning there is a real-time interaction between a provider and a patient that includes both audio and video — a Skype-like application," Policar explained. "Some family planning providers and at least 10 telehealth companies offer this service already, but the majority of family planning clinics do not have the software platform to be able to do this in a way that is synchronous, HIPAA compliant, and directly tied into the patient's medical record."

The solution is for state Medicaid programs and commercial payers to relax the rules and permit audio-only telehealth visits, Policar said.

Governments also should allow asynchronous visits. For example, clinicians and patients could interact via a questionnaire completed by the patient and sent by protected transmission to a clinic or telehealth company. Then, it is reviewed by a clinician, who can decide whether to complete a prescription for the patient, Policar explained.

"Asynchronous visits currently are provided by all the telehealth companies that I mentioned. But, so far, either the patient has to pay out-of-pocket for the visit and supplies, or — in some cases — it might be covered by commercial health insurance," he said. "I don't know of any Medicaid programs that cover strictly asynchronous family planning visits yet."

• Go beyond basic public health measures. "With COVID-19, the disease is spread by asymptomatic individuals and before individuals feel sick," said **Paul Biddinger**, MD, MGH, endowed chair in emergency preparedness, director of the Center for Disaster Medicine, and vice chairman for emergency preparedness in the department of emergency medicine at Massachusetts General Hospital in Boston. Biddinger spoke at a web conference on March 13 that was co-sponsored by WIRB-Copernicus Group and Accumen. "This coronavirus, in some ways, does not act like two previous coronaviruses — SARS and MERS. With MERS and SARS, you could not transmit before there were symptoms, and both were amenable to public health controls."

SARS was controlled relatively soon after it occurred on the global stage. MERS still occurs, but not in large outbreaks, Biddinger explained.

Once COVID-19 is in a community and has asymptomatic spread, it takes root before patients even have symptoms. "Some communities have been tremendously hard hit, while others like the outbreak in Taiwan have been mild and contained," he said. "In the United States, we have increasing community transmission and have to focus on mitigating the impact of outbreak and provide the best care we can."

• Practice social distancing. "In the ambulatory space, social distancing is something to think about," Biddinger said. "The mortality rate increases substantially with age. There's an inflection point at age 50. At 60 and 70 and 80, it's an accelerating relationship between age and mortality."

Ambulatory providers do not want patients to visit unless they have to. "We can do lots of things, like telemedicine and virtual visits, so providers can see patients in a way that's safe," Biddinger noted.

• Help patients manage anxiety. During any period of uncertainty, people become anxious. Providers can reassure their patients and offer suggestions for actions that will help them reduce risk and anxiety.

For example, providers can ask patients to avoid crowds and group settings, and to wash their hands more frequently, said **Jennie Kuckertz**, PhD, a psychologist at McLean Hospital in Belmont, MA. Kuckertz spoke at a March 16, 2020, COVID-19 video conference by Newswise. *(The recording is available at: http://bit.ly/2Ql7b6U.)*

"People can call their friends and relatives to let them know we're thinking of them, and they shouldn't constantly glue their faces in front of the news, where there is a lot of conflicting, confusing information," Kuckertz said. ■

Title X Problems Worsen With Recent Court Decision

Rule decimates Title X network

More than 1 million patients of family planning centers lost their Title X access in the past couple of years because of the Trump administration's rules prohibiting providers from discussing all reproductive health options with their patients. The final rule was issued by the U.S. Department of Health and Human Services (HHS).

Family planning advocates hoped to overturn the ruling in federal court, a strategy that became less likely after the Feb. 24, 2020, ruling by the 9th U.S. Circuit Court of Appeals upholding the gag rule. The 9th Circuit, which ruled without the full administrative record, found the Title X rule is lawful.

Another court ruling applies only to the state of Maryland. The U.S. District Court for the District of Maryland ruled in favor of Baltimore's legal challenge to the Title X rule changes. *(More information can be found at: http://bit.ly/2Umjy3W.)*

"The district court judge ruled that HHS adopted the Title X regulation in a capricious manner and that it should be vacated," says **Ruth Harlow**, JD, senior staff attorney for the American Civil Liberties Union Reproductive Freedom Project in New York City. "But the judge only issued that decision to be effective in the state of Maryland, and it's a national rule."

There are other cases still pending in courts over the Title X changes, she

notes. "I think the different litigating groups are trying a variety of options to try to get to a point where we have the rule vacated everywhere," Harlow explains. "The Baltimore court held that the agency promulgated the rule in an improper way. If you prove such a claim, the rule should have been set aside."

The final rule, released Feb. 22, 2019, requires strict physical and financial separation of Title X services from abortion services. Title X providers cannot refer patients for abortion care or offer information and counseling that includes abortion information. *(See "Title X Final Rule Is Troubling for Providers," page 54.)*

"The rule has had a decimating effect on our network," says **Julie Rabinovitz**, MPH, president and chief executive officer of Essential Access Health in Berkeley, CA.

Essential Access Health celebrated its 50th anniversary in 2019, the same year that the organization saw the number of Title X clinics plummet from 366 to 217 because of the rule. Since then, the number of clinics has risen to 251, but this could fluctuate as another new rule goes into effect.

"We're the lead Title X grantee in California," Rabinovitz says. "Title X was a law signed by President Nixon."

Essential Access Health will continue accepting Title X funding, she says. "We'll continue to participate in the program, and we know the majority of health centers will continue, but several will drop out of the program," Rabinovitz says.

Voters Want Access

Voters want greater access to family planning services, not less, according to data from public polling about Title X services, says **Cate Gormley**, vice president, Lake Research Partners in Washington, DC. Lake Research Partners conducted a poll about Californians' perceptions of family planning for Essential Access Health.

"They feel very positively toward birth control, and they feel very positively toward family planning," Gormley says. "We could say from the polls that voters want individuals to make decisions about what works for them, and they don't want to see any politician on either side of the aisle interfere with family planning that works best for individuals."

The poll also found that California respondents did not approve of the Trump administration's changes to Title X, which do not allow providers to give women information about all of their pregnancy options — even if they request that information, she says.

"People were concerned about the gag rule piece of the administration changes," Gormley says. "People thought that if the change were implemented, it would make it harder for women to access birth control." *(Results of the poll are available at: https://bit.ly/2UwAFAc.)*

That fear has been realized across the country, where about 900 Title X sites withdrew from the program after the final rule went into effect in 2019, Harlow says.

"Those providers were unwilling to comply with rules and requirements around pregnancy counseling that did not allow for a referral to abortion at women's request," Harlow says. "As soon as a huge number of sites were lost to the program — and those were sites where most patients were seen — 50% of [Title X] patients are no longer in the program."

'The Damage Is Significant'

Despite the efforts of many of the providers to stop the final rule through court challenges, the rule already has had a tremendously negative effect, Harlow adds.

"This rule is wreaking havoc on communities," says **Robin Summers**, JD, vice president, healthcare strategy and analysis, and senior counsel, National Family Planning & Reproductive Health Association (NFPRHA) in Washington, DC. "About 1.5 million people have lost access to family planning care," she explains. "The damage is significant."

From NFPRHA's perspective, the rule was intended to erode access to contraceptive care. "This rule absolutely puts more strain on a system that already was struggling to meet demand. Now, it's unable to serve 1.5 million people," Summers

EXECUTIVE SUMMARY

The recent Title X changes have proven devastating to women depending on family planning centers for their reproductive healthcare needs.

- The 9th U.S. Circuit Court of Appeals ruling upheld the Trump administration's gag rule that prohibits Title X providers from referring patients for abortion care or even giving them answers to questions about abortion.
- The ruling decimated the Title X network, causing hundreds of clinics to pull out of Title X and affecting tens of thousands of patients nationwide.
- Data show that voters want women to have more access to birth control and family planning services.

says. "That system is already dramatically strained, and it puts further strain on it." Cost is a barrier to women seeking contraception, she adds.

Women with health insurance have access to high quality and affordable contraceptives because of the Affordable Care Act (ACA), which pays for contraception at no cost to the women, Summers says. "But the ACA does nothing to address low-income people who don't have insurance coverage. This is what the focus of Title X has been since enacted," she adds.

"Title X serves anyone who wants high-quality care in contraceptive and family planning," Summers continues. "It will make it that much harder for Title X providers to continue to provide high-quality care across the country. It will make them stretch scarce resources even further."

The final piece of the HHS rule went into effect March 4. This also has a negative effect on family planning services at Title X clinics, Harlow says.

"This final piece requires Title X providers to separate their Title X activities, physically, from all kinds of things that may be related to abortion, including referrals for abortions," Harlow explains. "It covers electronic health records, staff, and all kinds of infrastructure."

Family planning providers must use duplicate facilities and systems for Title X projects. It is not financially feasible for family planning centers to physically separate their services and activities, Rabinovitz says.

"What healthcare organizations are allowed to do — and we received confirmation from HHS — is offer the option of counseling done by a physician or an advanced practice provider, but they cannot refer a patient for an abortion," she explains. "They can hand patients a list of all different providers that provide comprehensive primary care and prenatal care, and some of these may offer abortion services. But you may not tell patients which ones offer abortion services, and you can't just put Planned Parenthood on the list."

HHS even says that fewer than 50% of organizations on the list can offer abortion services. "We can't just tell volunteers to give them more information, because we're responsible for implementing federal law," Rabinovitz adds. ■

Title X Final Rule Is Troubling for Providers

Word 'abortion' prohibited

The recent Title X changes enacted by the Trump administration are creating major ethical dilemmas and operational challenges for family planning and reproductive health clinics nationwide.

"This rule has forced providers into a no-win situation. Long-term providers are being driven out of the program," says **Robin Summers**, JD, vice president, healthcare strategy and analysis, and senior counsel, National Family Planning & Reproductive Health Association (NFPRHA) in Washington, DC.

The U.S. Department of Health and Human Services (HHS) revised Title X regulations through a notice of rulemaking, published March 4, 2019, in the *Federal Register. (The Notice of Final Rule is available at: http://bit.ly/2QtMpls.)*

The rule change included these main features:

• Title X recipients must ensure clear physical and financial separation between a Title X program and any activities that fall outside the program's scope, including abortion services. The July 3, 2000, regulation required no physical separation and only limited financial separation.

• Title X recipients may not provide referrals, counseling, and information about abortion services. The 2000 regulation said Title X projects could provide abortion referral and nondirective counseling on abortion, if requested. The new rule states, "The department believes this requirement is inconsistent with federal conscience laws."

• The new rule also requires that Title X providers encourage appropriate family participation in family planning decisions. It emphasizes family participation with minors seeking family planning services. It reads, "The department will continue to enforce compliance with this provision."

Weighing Ethics, Fiscal Viability

Title X family planning and reproductive health providers have to weigh ethics against fiscal viability. The physical separation provision means that if a family planning center wants to continue to offer abortion counseling or services, it can only offer these in a physically separate space from their other reproductive health services.

"It is incredibly cost-prohibitive to have separate space," says **Julie Rabinovitz**, MPH, president and chief executive officer of Essential Access Health in Berkeley, CA. "That's an awful experience for patients to go out to the shed in the back for counseling, and that's terrible patient care. We are committed to providing comprehensive, quality care on a continuum."

Also, the Title X change removes the requirement that Title X clinics only can offer medically approved contraception, Rabinovitz says.

"That is a big concern to us, and there is a focus with this administration on natural family planning," she says. "In California, for the first time ever, a crisis pregnancy center was funded."

More continue to receive federal Title X funds, even though they offer women no medical services and tell pregnant women to not kill their baby, Rabinovitz adds.

The Trump administration's rulemaking on Title X is based on a model that was tried in the Reagan administration, but it went beyond that, says **Ruth Harlow**, senior staff attorney for the American Civil Liberties Union Reproductive Freedom Project in New York City.

"This rule is more insidious and sweeping than the rule proposed in 1988," Harlow says. "What's happening now is unprecedented in terms of a network having to try to comply with these very difficult rules."

Clinicians and providers have worked hard to cope with the Title X changes, and some have been creative in seeking other funding, Harlow notes.

"But it may mean, in certain geographic locations, clinics or hospitals or doctors' offices might see an unusual influx of patients needing new caregivers because [the Title X clinic] where they used to go is not available anymore," she adds.

In some states where Title X clinics have closed, state governments have stepped up to fund similar access. This provides a solution, but is draining state coffers of money that might be needed elsewhere, Harlow says.

"There have been workarounds, but it's very unfortunate because the whole reason for this program at the federal level is to fill in holes and make sure there is nationwide access to reproductive health services," Harlow says.

Clinics that continue receiving Title X funding also find it challenging to interpret the new rule. "The rule is so vague with regard to the actual mechanics of compliance that providers around the country are struggling right now with what they can do," Summers says. "It is incredibly difficult for providers to continue to offer the full range of services that the rule even allows them to do, and to understand they aren't putting themselves at risk by doing it."

Federal regulators have offered no guidance for Title X providers, she adds. "One of the hallmarks of Title X is that everyone receives an equal opportunity to contraceptive methods of their choice, and this rule has undermined that," Summers says. ■

Rheumatology Association Issues Its First Reproductive Health Guidelines

Recommendations also can help OB/GYNs

The 2020 Guideline for the Management of Reproductive Health in Rheumatic and Musculoskeletal Diseases is the first set of evidence-based recommendations regarding contraception and other reproductive health issues from the American College of Rheumatology (ACR).

Women with rheumatic and musculoskeletal diseases are improving so much with treatment that they can consider pregnancy in a way that was not practical in the past, says **Lisa Sammaritano**, MD, associate professor of clinical medicine at Hospital for Special Surgery in New York City.

"Rheumatology has changed quite a bit over the years," she explains. "Our therapy and management for various rheumatic and musculoskeletal disorders have improved, so prognosis for our patients have improved."

For instance, patients with lupus typically were told they should never get pregnant because the risk to their health was too great, Sammaritano says.

"Many patients with lupus did very poorly. One of the theories over the years was that high levels of estrogen are detrimental to lupus activities," she says. "Patients, when pregnant, have higher levels of estrogen, and that could lead to greater frequency of a flare-up than it would if they were not pregnant."

Lupus patients also were told not to take estrogen-containing contraception due to the risk of disease flare-up. "That was not proven, but it was a common thought among rheumatologists," Sammaritano says.

Over the decades, it was clear that the field did not know what exactly put pregnant women at greatest risk, she notes. "It turned out that having a diagnosis of lupus was a risk factor," she says. "Having an aPL [antiphospholipid] antibody is associated with two important clinical complications: one, risk of blood clots; two, risk of pregnancy loss. One-third of patients with lupus have these antibodies."

As more evidence accumulates, showing precisely what creates a risk for women with rheumatic and musculoskeletal diseases, experts have changed their thinking about which patients could use different kinds of contraception and which can safely consider pregnancy, Sammaritano says.

"This is the American College of Rheumatology's first attempt to produce a guideline that is helpful to every patient with a rheumatological disorder and to cover important areas related to reproductive health," she says. "It looks at safe and effective contraception, assisted reproductive technologies, measures to prevent loss of fertility in patients undergoing treatment, recommendations for hormone replacement therapy, and looking at pregnancy in terms of management and medication use before and after pregnancy."

The guideline also addresses paternal medication use when a couple is trying to conceive. "We tried to present a broad series of recommendations that are most commonly encountered issues," Sammaritano says.

Rheumatology physicians and experts helped create the questions that led to the literature review and the recommendations. "There is a core group of six people who devoted a lot of our time to the project," she says.

The core group compiled published studies and information, and graded these according to the strength of data. "That means a case report of one person who developed a complication from taking oral contraception is not strong data," Sammaritano explains. "But a randomized, controlled trial, looking at oral contraception vs. placebo, is strong."

> WOMEN WITH RHEUMATIC AND MUSCULOSKELETAL DISEASES ARE IMPROVING SO MUCH WITH TREATMENT THAT THEY CAN CONSIDER PREGNANCY IN A WAY THAT WAS NOT PRACTICAL IN THE PAST.

Some studies lacked information about contraception among people with rheumatic and musculoskeletal diseases, but had data involving patients with similar immunosuppression medication. The group discussed these studies, as well. "We tried to cover general rheumatology patients and focus on those subsets where it does make a difference, involving more complicated patients with lupus," she says.

One of the important goals of the guidelines was to integrate obstetrics/gynecology and rheumatology in a way that had not been done, Sammaritano says.

"Rheumatologists don't know much about contraception," she adds. "Some people are not aware that recommended contraception for young women includes consideration of long-acting contraception."

OB/GYNs also are unfamiliar with contraceptive considerations for rheumatology patients. They might be reluctant to recommend contraceptives when they do not know whether they are safe for these patients, she says. "An important part of the process is bringing together these two types of specialists," Sammaritano says.

The first emphasis is that contraception is an integral part of patient care, and rheumatologists are as responsible as OB/GYNs for helping their patients identify the best contraceptive for themselves, she adds. "Patients with rheumatology disorders are less likely to use effective contraception," she says. "We recommend highly effective contraception like IUDs [intrauterine devices] and progesterone subdermal implants."

The IUD recommendation might surprise some rheumatologists. "A lot of practitioners were around when earlier IUDs were around, and these caused pelvic inflammatory disease," Sammaritano says.

This is no longer an issue. IUDs with either progesterone or copper are fine for patients with rheumatic and musculoskeletal diseases, she adds. "Any patients with positive aPL antibodies cannot use estrogen-containing contraception because it increases their risk of blood clots," Sammaritano says.

Family planning providers also could read the guideline to learn how

they can address contraceptive needs for their patients with rheumatic and musculoskeletal diseases. "I've known gynecologists in private practice who were reluctant to place an IUD in a rheumatic patient because they were worried the patient's immune system would reject it, but that's just not true," Sammaritano says.

Practitioners should read the guidelines and refer to background data online to learn what is effective and safe for these patients, she adds. "We've tried to make the guideline user-friendly and to include flow charts," Sammaritano says. "It's an easy resource, so people will use it and refer to it."

The new guideline and appendices are available online at: http://bit.ly/2wEya6q. ■

Contraceptive Access Issues Require a Different Kind of Understanding

IUDs are not panacea solution

Contraceptive access initiatives often have focused on long-acting contraceptive methods, such as intrauterine devices (IUDs) and implants. These initiatives analyzed provider-level and financial access barriers to contraceptive methods.

But this way of thinking has changed. Family planning experts now are examining access issues within a person-centered contraceptive care framework. This framework conceptualizes access according to what individual women want in contraceptives — not just around what they can afford and what is available.

"Increasingly, it has been recognized that these are excellent methods of contraception, but they are not the best methods for all people," says **Christine Dehlendorf**, MD, MAS, professor, vice chair for research, family, and community medicine, and director, person-centered reproductive health program at University of California, San Francisco. "An access initiative should not prioritize one method over another, but provide access to the full range of methods and support women in their use of these methods. It's about what works for them."

This change considers cultural issues and historical context around contraceptive access. For instance, for decades there has been an undercurrent of racism involved in how healthcare providers handled contraceptive recommendations for black women.

"Black women recognize the history of birth control as population control and eugenics," says **Joia Crear-Perry**, MD, FACOG, president of the National Birth Equity Collaborative in New Orleans. Through medical research and public health practices that would be criminal now, black women's bodies have been exploited, she notes.

For example, the United States government funded sterilization programs in the 20th century. These were used to control populations of people of color, immigrants, poor people, disabled or mentally ill people, and others. *(More information is available at: https://to.pbs.org/3aO8fYV and: http://bit.ly/335I0dE.)*

In a 2018 study, investigators found that racism and discriminatory healthcare practices that began with slavery have compromised the reproductive health of African American women. These historical experiences continue to affect how black women perceive healthcare systems.[1]

For these reasons, family planning providers cannot assume all of their patients perceive contraception the same way they do, Crear-Perry says. "We live in different spaces," she adds.

While an OB/GYN might perceive a long-lasting contraceptive as a good option for a sexually active teenager, the teenager might desire a form of contraception over which she has more control, she explains.

Providers also should be aware of their own underlying biases. For instance, when a care provider sees a young woman who lives in poverty and does not have access to quality education, the provider might believe the myth that access to better contraception will reduce poverty, Crear-Perry says.

These prejudices cut in both directions. Some providers put barriers on the use of IUDs, despite their effectiveness, Dehlendorf says.

"A number of our studies have shown that some providers will not place an IUD in a teenager or someone who has not had a baby previously," she adds. "In the past decade, this has improved because

of evidence-based recommendations about eligibility."

The main concern was that IUDs would cause infertility, but that concern was misplaced. "Studies have found that infections like chlamydia — not IUDs — caused infertility," Dehlendorf explains. "Women who use IUDs are not more likely to get chlamydia."

Individual providers might consider their own motivations and conceptual understanding of what their patients need within the framework of societal prejudice and inequality. "There has been a lot of framing around contraceptive access as a public health initiative and initiative for societal benefits," Dehlendorf explains. "But it's an unfounded assertion that contraceptive access is a tool to address poverty on a societal level. Thinking this way can affect how providers view their work."

The goal of a new framework is to help providers view contraceptive access and equity in a new way — more in terms of the individual's needs and less in terms of perceived societal goals, she says.

"This is an ongoing conversation in our field, and I think it's encouraging people to be critical about the assumptions we make about people's reproductive health and choices," Dehlendorf says. ■

REFERENCE

1. Prather C, Fuller TR, Jeffries WL, et al. Racism, African American women, and their sexual and reproductive health: A review of historical and contemporary evidence and implications for health equity. *Health Equity* 2018;2:249-259.

Study Examines Failed Self-Managed Abortions in Texas

Data come from abortion clinics

A recent study revealed that nearly 7% of women seeking abortion services at Texas facilities in 2012 and 2014 reported they had attempted to self-manage their abortion before visiting the clinic.[1]

"The study is part of a program run by the Texas Policy Evaluation Project, looking at the impact of a variety of laws and policies in Texas, including the restrictive abortion law that went into effect in 2013," says **Daniel Grossman**, MD, FACOG, professor, department of obstetrics, gynecology, and reproductive sciences, and director, Advancing New Standards in Reproductive Health, at the University of California, San Francisco. "As part of that work, we were surveying patients who were seeking abortion care in clinics in Texas. We heard reports about patients who were trying to self-manage their abortions. We wanted to see just how common this was."

Nationally, the overall prevalence of self-managed abortion among patients seeking abortion services at a clinic is about 2%. The study revealed that the Texas rate is 6.9%.[1]

"These are abortion patients in Texas who had tried to end their current pregnancy by taking something on their own, so it does appear it's more common in Texas," Grossman says.

Seven percent could be the tip of the iceberg, he notes. "These are only the women who failed at an abortion and then went to an abortion clinic," he explains. "It's possible there are other people who did something on their own and had a successful abortion, or they did something that didn't work, and they had a baby."

The women who attempted a self-managed abortion were between the ages of 20 and 42 years. They

reported being between four and seven weeks pregnant when they attempted the abortion. Twenty percent of the women were African American, 28% were white, 42% Latina, and 10% other. More than 40% reported they had previously undergone an abortion.

The women reported these reasons for attempting a self-managed abortion:

- They could not afford to get to a clinic or pay for the abortion procedure;
- Their local clinic had closed;
- A close friend or family member recommended self-induction;
- They wanted to avoid the stigma or shame of abortion.

The most common self-managed abortion method was herbs, which 43% of women attempted. Another 12% tried using a drug or medication. Nearly 8% used misoprostol, and an identical percentage of women had hit themselves in the stomach. The remainder said they had attempted an abortion induction through the use of acupressure, heating pads, and papaya preparation, as well as other methods.[1]

"There are not great data about the efficacy of herbs to end a pregnancy, but some traditions have a long history of using herbs to produce abortion," Grossman says. "Some people said they used herbs, but it didn't work, which is why they came to the clinic. A few people reported doing things that are more dangerous, like hitting themselves in the abdomen, but no one reported inserting something in the uterus."

A number of women reported going to Mexico to buy drugs, like misoprostol, or herbs to end their pregnancies. Obtaining misoprostol in the United States requires a prescription, and women must visit an abortion clinic to receive it. In states like Texas, where most abortion clinics closed because of restrictive state laws, accessing an abortion clinic is challenging, Grossman says.

"There is a clinic in New Mexico, across the border from El Paso, where people can get a medication abortion, but that only helps people in that area," Grossman says.

"There is so much stigma about abortion. Any provider who does 50 abortions has to be registered as an abortion provider in Texas, so it's hard to get medication other than going to an abortion clinic," he explains.

Although it is against the rules of the Food and Drug Administration (FDA), some people might order misoprostol through mail-order pharmacies. "The FDA says medications can't be prescribed and dispensed by mail-order pharmacies," Grossman says. "They view the sale of these medications online as illegal."

Barriers to safe and legal abortions appeared to be associated with women attempting self-management of abortion. "We found from interviews that the reason people reported trying to do this was related to the access barriers they faced," Grossman says. "Some people talked about how their local abortion clinic closed, and it was too hard to get to the next nearest clinic."

Some people said they were trying to figure out how to obtain an abortion when a close friend told them to get it on their own, he adds. "Some women talked about the stigma and shame of going to an abortion clinic. They thought they could avoid that by doing it on their own," he says.

"Maybe the reason why self-managed abortion is more common in Texas is related to the access barriers women face in the state, where half the abortion clinics closed after a 2013 state law," Grossman continues. "As restrictions on abortion access increase, it is likely that self-managed abortion also will become more common." ■

REFERENCE

1. Fuentes L, Baum S, Keefe-Oates B, et al. Texas women's decisions and experiences regarding self-managed abortion. *BMC Women's Health* 2020;20:6.

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.

COMING IN FUTURE MONTHS

- Telehealth family planning gearing up
- Crisis pregnancy centers pose risk to women's health
- How 340B drug pricing program works
- 'Free the Pill' campaign seeks over-the-counter oral contraceptive option

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CME/CE QUESTIONS

1. **How did the 9th U.S. Circuit Court of Appeals rule on the Trump administration's changes to Title X, prohibiting all counseling and information about abortion?**

   a. The rule change was capricious and should be vacated.
   b. The rule change was upheld.
   c. The rule change should be vacated until the Supreme Court weighs in.
   d. The rule change should also include emergency contraception and intrauterine devices (IUDs).

2. **Which methods could help family planning centers and their patients weather the COVID-19 pandemic's social isolation and distancing?**

   a. Ask patients to follow pandemic instructions, posted on clinics' web pages.
   b. Ask providers to visit with patients in a room with a plastic separation shield.
   c. Take patients' and staff's temperatures before they enter the clinic.
   d. Use phone triage, write prescriptions in advance, and postpone services.

3. **The 2020 Guideline for the Management of Reproductive Health in Rheumatic and Musculoskeletal Diseases was recently issued by the American College of Rheumatology. What is one of its recommendations?**

   a. Patients with rheumatology disorders should use non-estrogen contraception.
   b. Patients with rheumatology disorders should use emergency contraception.
   c. Patients with rheumatology disorders should use highly effective contraception like IUDs and progesterone subdermal implants.
   d. Providers of rheumatology disorders should leave all their patients' reproductive health issues to OB/GYNs.

4. **A recent study revealed that which percentage of women seeking abortion services at Texas facilities attempted to self-manage their abortion before visiting the clinic?**

   a. 3%
   b. 7%
   c. 12%
   d. 25%