CONTRACEPTIVE TECHNOLOGY UPDATE®

THE TRUSTED SOURCE FOR CONTRACEPTIVE AND STI NEWS AND RESEARCH SINCE 1980

INSIDE

RELIAS MEDIA

SEPTEMBER 2020 Vol. 41, No. 9; p. 97-108

Supreme Court's Contraception Ruling Could Affect Women Nationwide

By Melinda Young

It has been a difficult year for family planning clinics, reproductive health providers, and the people who seek their services. While providers struggled with dramatic changes to Title X funding, the COVID-19 pandemic hit, which made contraceptive access even more challenging.

In July, the Supreme Court dealt another blow: a 7-2 decision that allows employers to opt out of the Affordable Care Act (ACA) requirement that all health insurance plans include free coverage of contraceptives. *(More information is available at: https://nyti.ms/2OBnz1I.)*

> "ANY ROLLBACK OF THE AFFORDABLE CARE ACT'S BIRTH CONTROL BENEFIT IS ESPECIALLY APPALLING DURING THIS NATIONWIDE COVID-19 CRISIS."

"This decision will harm the people who can least afford it: low income, people of color, young women, and groups that already have a difficult time accessing reproductive healthcare," says **Julie Rabinovitz**, MPH, president and chief executive officer of Essential Access Health in Berkeley, CA. "Any rollback of the Affordable Care Act's birth control benefit is especially appalling during this nationwide COVID-19 crisis."

The decision could immediately affect 120,000 people, but it also could go much further. "Millions of

Financial Disclosure: Consulting Editor **Robert A. Hatcher**, MD, MPH, Nurse Planner **Melanie Deal**, MS, WHNP-BC, FNP-BC, Author **Melinda Young**, Author **Susan Wysocki,** Editor **Jill Drachenberg**, Executive Editor **Shelly Morrow Mark,** and Editorial Group Manager **Leslie Coplin** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

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.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421
customerservice@reliasmedia.com
ReliasMedia.com

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at groups@reliasmedia.com or (866) 213-0844.

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.

ACCREDITATION: Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.5] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

Relias LLC is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. Relias LLC designates this enduring material for a maximum of 1.5 *AMA PRA Category 1 Credits*™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

This activity is intended for OB/GYNs, nurses, nurse practitioners, and other family planners. It is in effect for 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

AUTHOR: Melinda Young
AUTHOR: Susan Wysocki
EDITOR: Jill Drachenberg
EXECUTIVE EDITOR: Shelly Morrow Mark
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS DIRECTOR: Amy M. Johnson, MSN, RN, CPN

people could ultimately lose their birth control coverage because of this," Rabinovitz warns. "We're very concerned about this. The issue of birth control has long been decided in the court of public opinion, and you need to expand access to birth control — not restrict it."

Title X Funding in Jeopardy

Surveys continually show that a vast majority of Americans favor greater access to contraception for women, she adds. *(Find out more at: https://bit.ly/32z5ZUy.)*

"We need to question why this administration will try to limit access to birth control when nearly everyone supports birth control funding," Rabinovitz says.

Essential Access Health and other reproductive health advocates have fought with the Trump administration over the changes it imposed on Title X programs, which were forced to eliminate the word "abortion" from its reproductive health clinics or lose funding. As a result, many family planning centers withdrew from Title X, losing that funding. *(For more information, see "Title X Problems Worse with Recent Court Decision" in the May 2020 issue of* Contraceptive Technology Update *at: https://bit.ly/32Qmifw.)*

"One of the reasons we sued the Trump administration over Title X regulations is because they changed the definition of 'low income,'" Rabinovitz explains.

For Title X to be fully funded, it needs more than $700 million in funding. It is currently funded at $286 million, she says.

"You already don't have enough funding to meet the needs of everyone who is a part of the program. Now, with the Supreme Court decision, here's another 120,000 people that we're going to put in the safety net program that's already overburdened," Rabinovitz adds.

In states where funding remains a big access challenge for reproductive health services, the Supreme Court's decision makes things even worse.

"Specifically for Missouri, our safety net is already stretched very thin," says **Michelle Trupiano**, MSW, executive director of the Missouri Family Health Council, Inc. The council works with health centers across Missouri. *(See story in this issue on how family planning centers will cope in trying times.)*

"There's not a lot of funding for family planning services, so any time

EXECUTIVE SUMMARY

The Affordable Care Act mandated that employers provide contraceptive coverage to workers at no cost. In July, the U.S. Supreme Court allowed a Trump administration regulation to let employers with religious or moral objections opt out of the mandate.

- The Supreme Court's decision could cause 120,000 people to lose access to birth control.
- Survey data show that most Americans favor access to birth control.
- The court decision hits low-income people seeking contraception and family planning clinics especially hard during the pandemic, which has caused millions of people to lose their health insurance.

we're putting more burden back on our most vulnerable citizens, that safety net is going to get stretched. Eventually, it's going to break," Trupiano says.

Mandate Reduced Unplanned Pregnancies

This new court decision comes on the heels of data that highlight the positive effect the ACA has had on birth control access.

"We've seen a decrease in unintended pregnancies and births for the first time in 30 years, and part of that is attributed to access to birth control through the Affordable Care Act," says **Bré Thomas**, MPA, chief executive officer of the Arizona Family Health Partnership, a Title X grantee.

When legislation and court decisions chip away at those advancements, low-income people will lose access to contraceptives, she adds.

"If people have to make a choice during a pandemic between food, transportation, shelter, and [contraceptives], birth control will fall down on their list," Thomas says. "Hopefully, they will have access to condoms or other forms of birth control to protect themselves, but they may not."

While the ACA made birth control free for people with insurance, the Supreme Court's ruling will make cost a factor again — at least for workers whose employers opt out of contraceptive coverage. These employees often earn too much to receive subsidies through Title X programs, but too little to afford the out-of-pocket costs.

"We're very concerned that more women are going to have difficulty being able to afford their desired method of birth control," she adds. "We know that people — not employers, government, or court — should be able to decide what's best for them."

Trupiano was not surprised by the Supreme Court's decision, but she had hoped for a different outcome. "On a personal level, it just seems so outrageous to me that your employer can pay for everything except contraception," Trupiano says. "It sends a message of control: 'We're going to control what you can and can't do with your own body.'"

The Supreme Court case is about rules the Trump administration issued in 2018 to broadly allow any employer or nonprofit to be exempt from the contraception requirement if they have a religious or moral objection, says **Liz McCaman**, JD, MPH, staff attorney with the National Health Law Program in Washington, DC.

"The case was whether the 2018 rules, which are broad, are valid," she explains. "The court said the administration had the right to do this, and that the way they did it was fine."

Ruling May Have Unintended Effects

For an organization to claim the contraception exemption, they do not have to notify the public, but they do have to notify the insurer or third-party administrator, McCaman says. Also, they should notify employees about the change to benefits.

"It is concerning because this could set a precedent — not just with birth control that people claim an objection to, but every time someone doesn't like the kind of healthcare," McCaman says. "On the extreme end of the argument, it opens the door to people having objections to other healthcare services."

While the court ruled about employers' objections, the ruling does not address what employees decide and believe, she adds.

There are contraceptive and ACA cases that likely will continue to play out in lower courts, she notes.

"How this will exactly play out in the future, we're arguing a guessing game," McCaman says. "It means organizations have some room to make new decisions. Currently, there's not a legal hurdle for that happening."

The potential risk is any organization with a founder who has a religious objection could make changes to their health plan to exempt contraceptive coverage.

"There's not a current legal hurdle for them doing that," McCaman says. "Also, a moral objection means that any corporation could say they have a moral objection to providing it. What's scary is this could happen very quietly."

It is possible this same issue could return to the Supreme Court, McCaman says.

"Now, it will go to a lower court, and they'll make a ruling on substance," she says. "We don't know how they'll rule on that, but it seems likely that whatever the other side is, the other side will appeal it."

The Supreme Court's decision will significantly affect many states. "Already, we know that every dollar invested in family planning saves $7 down the pike in costs associated with unintended pregnancies," Rabinovitz says. "We know there are millions of women who need birth control in this country."

The ACA mandates have lowered rates of abortion and unintended pregnancies, she adds.

Any changes to the ACA that

undo its provisions could have a negative effect. "We know publicly funded family planning works. There could be potentially an increase in unintended pregnancies, as a result, and teen births," Rabinovitz says.

Some of the effects will depend on what employers decide to do about it. "Contraception is a pretty important benefit, and employees are not really happy when employers cut their benefits and don't give them really good reasons for impacting their access to contraceptives," McCaman says. "I don't think there will be a huge swath of people in the wings, waiting to do this, if only because people would not want to work for them. It's a tough line to walk."

The most likely scenario is low-income workers will be hit the hardest. "No matter what their employers decide, they'll go along," she says.

Some states have programs that can help mitigate the problem. For example, California passed the Contraceptive Equity Act, which codified the ACA birth control benefit for state-regulated insurance plans. California also offers a program to help low-income people access contraception when they cannot obtain it through insurers, Rabinovitz says.

States that did not expand Medicaid under the ACA also could have harmful effects, she adds.

"State laws are important, but the states that pass laws that improve contraceptive access are liberal states. These leave out people in the Midwest and South, who are stuck with federal rules," McCaman says. "Additional federal action is needed on this issue or else more people will be left behind when it comes to contraception." ■

Family Planning Centers Looking for Solutions in a Difficult Era

Privately funded programs can help

By Melinda Young

The past few years have made ensuring contraception access challenging for family planning centers and reproductive health clinicians. Most challenging are the financial cuts and restrictive new rules regarding Title X coupled with the recent Supreme Court ruling that allows broad exceptions to the Affordable Care Act (ACA)'s contraception mandate.

These governmental actions are magnified by the COVID-19 pandemic, which is stressing family planning clinics in ways they never imagined. Health departments, federally qualified health centers, and family planning clinics are being pulled in many different directions as they try to provide services safely, says **Michelle Trupiano**, MSW, executive director of the Missouri Family Health Council, Inc.

"At this time, contraception is extremely important across our state," she says. "Evidence shows that a lot of times — during any crisis, but especially when individuals are staying home for extended periods of time — contraception is important. There's uncertainty of what's ahead. Many women at this point in time want to delay pregnancy."

Americans are facing job losses, financial burdens, loss of insurance, and the additional stress of the pandemic. For many, the year 2020 is not the time to have a baby and add additional stress to their lives.

Women do not want to delay their desires, but they also might not want to get pregnant during the pandemic.

"Some people are very worried about getting pregnant right now,"

EXECUTIVE SUMMARY

In recent years, family planning clinics have faced many obstacles to providing contraceptive access to all patients who need it.

- Access issues worsened under changes to Title X and the Supreme Court's recent ruling that allows some employers to opt out of providing contraception coverage.
- Reproductive health experts worry these recent changes — and COVID-19's effect on access — could result in more unintended pregnancies.
- Some states, like Missouri, have helped low-income and uninsured people maintain access to contraceptives through privately funded programs.

says **Julie Rabinovitz**, MPH, president and chief executive officer of Essential Access Health in Berkeley, CA.

With the increased obstacles to obtaining affordable contraception, there is the danger of a spike next year in unplanned pregnancies.

"It's a perfect storm of what could happen with an increase in unintended pregnancies because of people not having access due to the Supreme Court decision, and not having access due to the pandemic," Rabinovitz says.

Providers Under Pressure

Contraceptive providers also are under stress. Millions of Americans have lost their insurance since March. The continual assault on Title X and the ACA's contraceptive mandate also put providers under financial worry.

"A lot of our sites are worried about keeping their doors open right now and having the funds to be able to do so," Trupiano says. "When you add additional burdens, where they are reimbursed by insurance for a client and now are providing free or reduced costs, it will put even more burden on health centers."

No one knows what the full repercussions will be, but health centers are feeling that strain, she adds.

For example, family planning centers in Arizona have been underfunded for a long time, says **Bré Thomas**, MPA, chief executive officer of the Arizona Family Health Partnership, a Title X grantee.

"We're not funded to meet current demand in Arizona, so it's hard to anticipate if folks are no longer able to access birth control through their health plan how they will come into the Title X system," she explains. "They probably wouldn't meet the need requirements for Medicaid, and our system is set up for no-income or low-income folks. If you make 250% of the federal poverty level [FPL], you pay the cost of the service."

Private Funding Helps

Anyone in need of reproductive health services can visit a Title X clinic, but if they make more than the 250% of FPL, they will have to pay for the services out of pocket, she adds.

Title X centers cannot refuse service due to the person's inability to pay. "We can make allowances for that, but we don't have enough resources to cover the need," Thomas says.

In some cases, private funding is helping to alleviate some of the burden. In Missouri, the effect would be worse if not for the Right Time initiative, a privately funded program focused on reducing all cost barriers for uninsured and underinsured women, Trupiano says. The initiative works with 12 health centers across Missouri.

"It's a multipronged initiative, and it funds their visit and contraceptive method of choice at no cost to them if they're uninsured or underinsured," Trupiano explains. "In the short term, we hope we will be able to support anyone who will be losing their coverage. We know long-term funding sources change, and these now have long-term consequences."

The Missouri initiative was in the works before the Trump administration proposed changes to Title X, but the need for the funding has increased because of the administration's actions, she notes.

"Missouri has always been in need of additional funding for family planning services," Trupiano says. "But having the funding available at this particular moment when health centers are under additional stress and strain has allowed us to support health centers to the point where we haven't seen dramatic closings of health centers." ■

Model Contraceptive Program Increased LARC Access Among Title X Clients

DelCAN helps reduce time barrier

By Melinda Young

The Delaware Contraceptive Access Now (DelCAN) program was created to increase access to contraceptives for women across the state, including long-acting, reversible contraceptives (LARC).

While the Affordable Care Act (ACA) contraceptive mandate led to an increase in injectable contraceptives, it did not increase the use of LARCs. This suggests a problem with clinics stocking LARCs, or a lack of training on insertion.[1,2]

DelCAN helped overcome these obstacles by using techniques that could be reproduced in other states. Researchers found a 40% increase in LARC use from the baseline.[1]

DelCAN's goals are to reduce unintended pregnancies, reduce Medicaid costs for unintended pregnancies, and support policy development to increase contraceptive access to all women who desire it. *(More information is available at: https://bit.ly/2OsLu3A.)*

"We wanted to improve access to a full range of contraceptives, but LARCs were the ones with the most barriers to access because they required a technical skill that most providers didn't have," says **Michel Boudreaux**, PhD, assistant professor of health policy and management at the University of Maryland. "To get same-day service, clinics have to have LARC devices stocked. That's something clinics weren't doing and didn't know how to do. They weren't used to having that stock there and available."

Cost Is Barrier to Access

Cost also was a barrier to access for LARCs. "The operating margins at these clinics is not super high, and they don't like spending money on things they won't get a return on," Boudreaux explains.

It makes little financial sense for a clinic to store LARCs when they have no idea whether LARCs will be used, he says. But this practice limits access to a full range of contraceptives.

"To improve access to care, you want as many services as possible to be delivered on a same-day basis," Boudreaux says.

Family planning centers and gynecologists want to avoid having patients ask for a particular contraceptive, only to be told they need to make another appointment to obtain it, he adds.

"That puts a lot of onus on the patient, who now will have to take time off, set up childcare, and get transportation for the second appointment," he explains. "Making multiple appointments is a barrier to care, so you would want to have LARC at the clinic."

DelCAN helped overcome this barrier by directing some state funding toward Title X programs for clinics to purchase a supply of LARCs, Boudreaux says. This is managed through the state pharmacy to help clinics get started.

"Then, they changed the way federally qualified health centers can bill, which means the clinics can bill Medicaid, the state, or whatever at a level that makes them whole," Boudreaux explains. "In the private market, the ACA has regulations that say you have to be providing contraception at no cost to patients. In practice, it's not working the way it's intended."

One of the reasons for this is legacy plans that started prior to the ACA. "The other thing — and I hesitate to say I know what's going on with this — but there's sometimes a mismatch between regulations and what the plans actually do,"

EXECUTIVE SUMMARY

The Affordable Care Act's contraceptive mandate led to an increase in injectable contraceptives, but did not help improve access to long-acting, reversible contraceptives (LARCs), research revealed.

- On the clinic side, one of the chief barriers to LARC is the high cost to keep them in stock.
- New research shows that state-run programs, such as the Delaware Contraceptive Access Now (DelCAN) program, can help improve LARC access.
- DelCAN contributed to a 40% increase in LARC use.

Boudreaux says. "It's not unusual if someone with a private plan is not getting the benefits they are entitled to, and that happens across the spectrum."

The program's success in increasing LARC use did not carry over to access to other contraceptives. "We looked at other contraceptive points, like other methods such as oral contraceptives, the patch, and the ring. Our study could not come to any conclusive finding on how use of those methods changed as a result of the intervention," Boudreaux says. "That doesn't mean that we found no effect; we just can't confidently say we know what happens with other contraceptive types. The result for LARC is what we have the most confidence in."

Other states, like Colorado, created programs similar to DelCAN. Some of these programs worked to reduce financial barriers to contraceptive care by making all methods free and ensuring clinics had the capacity to deliver services, he explains.

"Delaware was not the first of these programs, but was an early example of a comprehensive, statewide program," Boudreaux says. "Other states are in the process of implementing programs or thinking about it."

Patient-centered contraceptive access programs are worth a public investment, he notes. "We should make sure when people say they want to use a certain contraceptive, they can access it in the least-expensive way possible," Boudreaux says.

Future research of these programs should study various populations outside of Title X programs, including the effects on unintended pregnancies and cost-benefit analysis, he adds.

"To choose the best program, we probably want to choose the one that costs the least amount of money, but has the most effect. We don't have the financial data yet," Boudreaux says. "So far, we find the program definitely seems to have increased long-acting contraceptive use among Title X clinics. I think a lot more research needs to be done to see how it impacts other populations and impacts unintended pregnancies." ■

REFERENCES

1. Boudreaux M, Xie L, Choi, YS, et al. Changes to contraceptive method use at Title X clinics following Delaware Contraceptive Access Now, 2008-2017. *Am J Public Health* 2020;110:1214-1220.
2. Bullinger LR, Simon K. Prescription contraceptive sales following the Affordable Care Act. *Matern Child Health J* 2019;23:657-666.

Study Results Highlight Challenge of Ruling out Pregnancy During Contraceptive Counseling

Physicians can use anticipatory medicine

By Melinda Young

The recommended ways of ruling out patient pregnancy before starting a new contraceptive include a pregnancy test, the date of the patient's last unprotected sexual intercourse, and the patient's symptoms. But there often are cases where it is difficult to rule out pregnancy.

The authors of a new study concluded that when medical providers cannot rely on standard practices for diagnosing a potential pregnancy, they might rely on anticipatory medicine by projecting possibilities.[1]

"Medical providers take this seriously and spend a lot of time ruling out pregnancy before contraception," says **Eliza Brown**, MA, MPhil, researcher and doctoral candidate in sociology at New York University. "Ruling out pregnancy is often quite difficult, even if it seems like a preliminary step before moving on to determine the best mode of contraception. It might be too early to accurately use a urine pregnancy test."

A provider may recommend emergency contraception for a patient soon after unprotected sex. "But for those who had unprotected sexual intercourse seven or eight days ago, the provider is in a bit of a tricky situation," Brown explains. "It's too late for emergency contraception and too early to accurately use a pregnancy test, but the patient still wants to go home with contraception. Providers lean on their theoretical knowledge about how pregnancy works."

If a woman is pregnant and begins to take a contraceptive, it could pose a risk to her pregnancy. Then, because the woman is on hormonal birth control, she might not expect menstrual bleeding, so it could be months before she realizes she is pregnant, Brown explains.

"There might be a substantial period of time before they see a doctor about the pregnancy, and they might drink alcohol or have other behaviors they wouldn't have if they knew they were pregnant," Brown adds.

Anticipatory Medicine Possibilities

Using anticipatory medicine, clinicians can consider these possibilities:

- If the patient wants an oral birth control method, there might be less concern about potential pregnancy than if the patient wanted a long-acting, reversible contraceptive (LARC), an implant, or injections, Brown says.
- Providers could ask patients how they might feel if it turned out they were pregnant. "If they are interested in seeing if they really are pregnant because they'd be happy with pregnancy outcomes, then maybe they wouldn't want to insert an IUD at that time," Brown says. "That could be a point of decision."
- Providers could prescribe a birth control pill for two weeks and ask patients to take a second pregnancy test to confirm they are not pregnant.
- Providers could defer contraception until a negative pregnancy test, but this would place the patients at risk of pregnancy if they continue to have unprotected sex.

"One of the interesting parts of the study's findings is about what providers and patients make of patient reports," Brown says. "For the most part, providers are putting a lot of trust in patients' reports and making decisions based on their memory of whether they had sexual intercourse and when it occurred."

Patients also report which protection they used (if any) and the length of their menstrual cycles. Providers base their decision on the information.

"But there are times when patients' information might be interpreted differently by the provider and patient," Brown explains. "Say the patient saw some vaginal bleeding, and say that is implantation bleeding."

ANTICIPATORY MEDICINE IN CONTRACEPTIVE COUNSELING INVOLVES TURNING TOWARD THEORETICAL KNOWLEDGE ABOUT WHAT MIGHT BE OCCURRING IN THE PATIENT'S BODY.

When patients report vaginal bleeding, providers need to rule out pregnancy as the cause, using some other criteria, such as whether the bleeding is lighter than the patient's typical menstrual bleeding.

"Overall, providers and patients absolutely rely on one another," Brown says. "Without having [certain] physical evidence, sometimes it's difficult to come to a conclusion."

When pregnancy is ruled out through a urine test, providers can begin discussing types of contraception. But if this is not possible, they need to rule out possibilities, she says.

"Providers can say, 'Let's talk about your cycle and the pull-out method,'" she adds. "It might be difficult to come to a resolution, so we can see how patients and providers will go back and forth to rule out pregnancy."

Anticipatory medicine is a growing area of sociology and medicine in which medical care transitions to preventing and managing conditions that have not yet manifested, Brown says.

"Providers are in a situation where they need to project a diagnosis into the future," Brown explains. "It's unlike other areas, where there is a chance of XYZ happening, so let's just wait and see later."

Instead, providers want to make a decision that anticipates various possibilities. "This is so patients aren't sent away without receiving the treatment they came in to seek in the first place," Brown says. "You anticipate various scenarios and act according to what is the most likely scenario."

Look Toward Theoretical Knowledge

Anticipatory medicine in contraceptive counseling involves turning toward theoretical knowledge about what might be occurring in the patient's body. "It's a way to look into the future, and there still is a lot of uncertainty," Brown says.

For example, a patient might say there was no intercourse at all. "But relying on this self-report is complicated unless the provider knows this patient has never had sex or has been abstinent for a long period," Brown says. "There are obstacles to determining those dates for sexual intercourse and last menstrual period."

Some patients might track their

periods on a cellphone app. This report could be more accurate, or at least give the provider more information to explore. The provider might say, "You said your last unprotected sexual intercourse was June 20, and your last period was June 18."

The most surprising finding in the study was how much time providers spend ruling out pregnancy and how difficult it is to do that, Brown says.

"The previous recommendations seem kind of cut-and-dry until you get into the weeds of it," Brown says. "Think about how complex it is to quickly go through the information with a patient about when they last had intercourse, the length of their menstrual cycle, when they took their last birth control pill, and when they had a miscarriage or thought they might be pregnant." ■

REFERENCE

1. Brown E. Projected diagnosis, anticipatory medicine, and uncertainty: How medical providers 'rule out' potential pregnancy in contraceptive counseling. *Soc Sci Med* 2020;258:113-118.

Study Reveals Connection Between Condom Use and Sexual Stimuli Response

More unprotected sex means less sexual interest

By Melinda Young

Researchers studied a population of young adult women at risk of sexually transmitted infections (STIs) and HIV. They hypothesized that women with higher positive affective bias to sexual stimuli would report higher sexual risk behaviors.[1]

The opposite proved to be true. The higher-risk group showed significantly less activation in the mesolimbic brain regions and lower affective bias scores to sexual cues, compared with the low-risk group.[1]

Investigators showed women sexual cues selected from the International Affective Picture System as well as additional sexual cues chosen to reflect the diversity of the study group. The sexual cues included pictures of naked men and romantic situations, says **Paul Regier**, PhD, post-doctoral researcher in the department of psychiatry at the University of Pennsylvania Perelman School of Medicine.

"The pictures were shown for about half a second — brief, but not so brief that you don't see what it is," Regier explains. "Our hypothesis was that those engaging in riskier types of behaviors, more sexual risk behavior, would have higher reward response to those cues. We call it a mesolimbic brain response."

The idea was that sexual cues would be a goal mechanism, eliciting pleasure, says **Anne Teitelman**, PhD, FNP-BC, FAANP, family nurse practitioner and associate professor in the department of family and community health at the University of Pennsylvania.

High Risk Showed Low Response

The researchers found women with higher-risk behaviors did not respond favorably to the sexual cues. "To make sense of it, a lot of literature was done in males," Regier says. "In males, they showed a higher brain response to these cues in those who were engaging in higher-risk behaviors."

But women showed the opposite effect. The women who reported their partners wore condoms 100% of the time had a higher brain response to the sexual cues when compared with the women whose partners did not wear condoms within the past three months, he explains.

"It's possible that women feel more weight of the responsibility because they face the consequences of pregnancy that men don't face," Teitelman explains. "If they get STIs, they suffer more consequences, like pelvic inflammatory disease, and they face more stigma than do men."

Women who feel protected by men wearing condoms might feel safer and more able to enjoy sex without worrying, Teitelman adds.

"One could say that women find men sexier if they were to use a condom," she says. "We can't prove that in this study, but that's a potential implication because the women who were more excited by these pictures were the women whose partners used condoms more."

Intimate Partner Violence Likely

The group most engaged in risky sexual behavior also was most likely to

experience intimate partner violence, Regier says. They also are more likely to have a history of STIs. "But we don't know that for sure," Teitelman says.

The message for reproductive health clinicians is that women who engage in the riskiest sexual behavior of not using condoms might benefit from pre-exposure prophylaxis (PrEP) to prevent HIV infection, Teitelman notes.

"We can do more now to prevent HIV, using a woman-controlled method that is not just condoms," she explains. "For those women who are unable to use condoms, PrEP might be a good alternative." ■

REFERENCE

1. Regier PS, Teitelman AM, Jagannathan K, et al. Women at greater sexual risk for STIs/HIV have a lower mesolimbic and affective bias response to sexual stimuli. *Front Behav Neurosci* 2020;13:1-11.

Engaging Young Males in Family Planning Settings

By Susan Wysocki, WHNP-BC, FAANP

By the time most American adolescents reach the age of 13 they stop seeing a pediatrician. Young females most often transition seamlessly to a provider for gynecologic and contraceptive needs that connects them, even if loosely, to providers who can flag health issues beyond gynecological needs. However, young males often do not have a regular healthcare provider who serves as a gatekeeper for their ongoing health needs.

For the most part, young males' interactions with the healthcare system involve episodic care, such as sports physicals, emergency department visits, and, when needed, care related to sexually transmitted infections (STIs). Unlike young females who can easily identify where to go for ongoing preventive care, most adolescent and young adult (AYA) males are largely on their own to find a way to connect with healthcare providers and the healthcare system for wellness care.

Consider that data from the Centers for Disease Control and Prevention identify higher risks for AYA males vs. females for death by suicide, attention deficit deficit hyperactivity disorder, substance abuse, homicide, risky behaviors, accidental injury, and certain STIs.

In addition, due to a lack of continuity of care for AYA males, illnesses that can be prevented or modulated are not identified until they are further along the path toward chronic problems or illness.

It is important to systematically recognize the unique and unmet needs of AYA males and to identify and develop points of care that keep AYA males connected to services that are designed to keep them healthy beyond episodic health visits.

Unfortunately, very few services are designed to engage young males. Many family planning clinics offer focused services to males for STI testing and treatment. However, once the STI is tested and treated, the male's interaction with the clinic often is not continued for primary care or preventive care.

Program Connects with AYA Males

Dennis Barbour, JD, president, chief executive officer (CEO), and co-founder of the Partnership for Male Youth (PMY) and former president of the Association of Reproductive Health Professionals (ARHP), notes that when he asked the ARHP members how young males were being served in family planning clinics, including Planned Parenthood, he was met with blank stares and an obvious lack of enthusiasm.

Barriers to care for young males include lack of training and education of providers to treat males, even for STI checks. In particular, as the president and CEO for the Nurse Practitioners in Women's Health, I received a number of calls from nurse practitioners (NPs) who expressed their discomfort in treating males. Some of that discomfort related to a lack of training while other concerns related to how to communicate with males. There also were explicit or implicit concerns about how to deal with the awkwardness of female providers examining males. The majority of NPs in women's health and family planning are female.

David Bell, MD, co-founder of PMY, president-elect of the Society of Adolescent Health and Medicine, and medical director of the Young Men's Clinic (YMC) at Columbia New York-Presbyterian, has been engaged with AYA male health for decades.

YMC is one of the most recognized health programs for young men

in the United States. It grew out of the Title X family planning clinic for women. The program began as a street outreach and condom distribution program in the late 1980s. Early on, faculty and students worked with community agencies to sponsor sports events, dances, and other community-based activities. These community collaborations created a foundation for trust by the community's adults and youth. Today, the YMC provides services at almost 4,000 visits each year. In addition to Title X funds, foundation grants, Medicaid, other insurances, and patient fees also support the clinic.

YMC is a model for establishing and providing services to AYA males whether as an expansion of family planning clinics or as independent entities. The clinic provides a broader scope of services than just sexual and reproductive healthcare, including physical exams for sports, school, work, and general healthcare. Other services include medical care for minor injuries and illness; individual and group health education; counseling for stress and relationship issues; and other health concerns. In addition, the clinic provides referrals to education, employment, vocational programs, and social services.

YMC occupies a separate space at the family planning clinic. Rather than males walking into a clinic primarily focused on women and decorated with women in mind, the YMC is designed with males in mind. The atmosphere conveys that males are welcome. It is their space.

The importance of comprehensive services is illustrated in the experience of one young male, who was born in the United States and grew up in the Dominican Republic. In his early teens, he returned to the United States with a language barrier and few resources for housing, food, or healthcare. Shortly after returning, he was homeless, living on the street, and had a respiratory infection. He found his lack of insurance and ability to pay thwarted his best efforts to access care. Finally, he found the YMC, where he received treatment for his respiratory infection. Bell said, "Now, we need to address these other issues such as getting a roof over your head and getting regular food." Now, the young man is applying for medical school. He also is an advocate for the YMC among his peers. In fact, young males learn about the clinic by word of mouth from trusted friends.

YOUNG MALES OFTEN DO NOT HAVE A REGULAR HEALTHCARE PROVIDER WHO SERVES AS A GATEKEEPER FOR THEIR ONGOING HEALTH NEEDS.

This example demonstrates the importance of integrated services and relational health. Relational healthcare creates a connection between the provider and patient. Relational health is the creation of a connection where the patient feels valued by others. It involves more than seeing the patient from the narrow perspective of their problem — it is about seeing the whole person.

Approaching interactions with patients/clients from a relational health perspective can have a significant effect on patient outcomes. Relational health may be especially important in interactions with young males. **Niobe Way**, PhD, a PMY board member, professor of applied psychology at New York University, and founder of the Project for the Advancement of Our Common Humanity, has studied young males for decades. Her research has shown that boys in their early teens (ages 12-15 years) have close relationships with other boys they describe with affectionate terms like "I love my best friend." These young, adolescent males also talk about their best friends as the people with whom they can share their secrets. In later adolescence, boys may lose that kind of connection. Terms of affection for friends are swapped for statements that reflect male "norms" that discourage close connections with other males. "This goes against the nature of males and their desire to have male friendships," Way explains.

It is with this understanding that the PMY has assembled a broad swath of organizations and experts that touch the lives of AYA males. This includes representatives from health institutions, juvenile justice, federal agencies, education, sports organizations, and community service agencies.

Early on, PMY recognized the humanity of young males struggling with their own identities in a world that does not match what they really feel. Many programs today for AYA males center on rape prevention and consent. However, there is a need to foster healthy lives for AYA males.

PMY has continued to engage a think tank group representing a wide range of agencies and leaders to develop the next summit for PMY. The outcome became a mandate for the next PMY summit to address relational health needs for AYA males at points of contact that can improve their health and well being.

Plans for a summit in 2020 and beyond are ongoing. ■

CONTRACEPTIVE TECHNOLOGY UPDATE®

Contraceptive Technology Update is endorsed by the **National Association of Nurse Practitioners in Women's Health** and the **Association of Reproductive Health Professionals** as a vital information source for healthcare professionals.

CME/CE INSTRUCTIONS

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

1. Read and study the activity, using the provided references for further research.

2. Log on to ReliasMedia.com and click on My Account to view your available CE activities. Tests are taken after each issue. First-time users must register on the site using the subscriber number on their mailing label, invoice, or renewal notice.

3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%. Tests are taken with each issue.

4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be emailed to you.

CME/CE QUESTIONS

1. **The Supreme Court's July 2020 ruling that some employers can be exempt from providing no-cost contraception to employees via insurance was based on what rule change?**

   a. The Obama administration included a much-challenged caveat to the Affordable Care Act (ACA) contraception mandate.
   b. In 2018, the Trump administration issued a rule to broadly allow any employer or nonprofit to be exempt from the contraception requirement if they have a religious or moral objection.
   c. The Trump administration challenged the ACA in court, saying the entire law is unconstitutional.
   d. The Trump administration issued Health and Human Services rules that contraception cannot be funded by organizations receiving federal funds.

2. **According to the results of a study published in the *American Journal of Public Health*, the biggest barrier to health clinics providing long-acting, reversible contraception is:**

   a. the cost of stocking it.
   b. clinics stock more samples of birth control pills.
   c. a lack of knowledge about the product.
   d. women's preferences.

3. **According to researcher Eliza Brown, MA, MPhil, why might reproductive health clinicians rely on anticipatory medicine when screening for pregnancy during contraceptive counseling?**

   a. They can anticipate the probability of pregnancy based on the urine pregnancy test and the date of the last menstrual period.
   b. If ruling out pregnancy is difficult, providers can use theoretical knowledge to anticipate various scenarios and act accordingly.
   c. They can rule out pregnancy based on the patient's description of recent sexual encounters.
   d. They can anticipate the patient being pregnant based on self-reports of previous birth control methods.

STI QUARTERLY™

A SUPPLEMENT TO CONTRACEPTIVE TECHNOLOGY UPDATE

Disparities Found When Women Visit Reproductive Health Providers

Black women asked about STI risks more often

Results of a new study revealed Black women are more likely to be asked about their sexual risk behavior and condom use than are white women in sexual health counseling settings.[1]

Researchers studied provider conversations with Black and white women about reproductive health. They specifically sought information on how often sex and sexual health were mentioned in conversations with clinicians, says **Ashley Townes**, PhD, MPH, post-doctoral research fellow with the Centers for Disease Control and Prevention. Townes conducted the study while at Indiana University.

"When sexual health does come up in conversation, what is the nature of the conversation?" Townes asks. "What types of questions are asked?"

The study relied on self-reported data by women in a survey. It revealed Black women were two times more likely to be offered testing for sexually transmitted infections (STIs).[1]

"Most often, there was no difference in Black and white women in talks about birth control and being sexually active," Townes says. "The differences came out when questions were about condom use with partners, how many partners a person had, and questions about whether they would like to be tested for STIs."

> "WHILE THIS IS IMPORTANT AND PROVIDERS SHOULD BE HAVING THESE CONVERSATIONS WITH BLACK WOMEN, THEY'RE NOT HAVING THESE DISCUSSIONS AT THE SAME RATE WITH WHITE WOMEN."

Investigators found after adjusting for age, social determinants of health, educational background, and marital status, Black women still were more likely to be offered STI tests and more likely to have a conversation about condoms. They also were more likely to receive condoms for future use, Townes says.

"Once we had this data, we had to go back into the literature to explain why this is happening," she adds. "Nationally, the priority is to decrease new STIs and decrease unintended or unwanted pregnancies."

"Since there is a disparity between Black and white women in rates of unintended pregnancies, maybe the reason why Black women are asked more often is to help with meeting national goals," Townes says. "Data show that Black women have a higher rate of unintended pregnancies and higher rates across STIs, including chlamydia, syphilis, and others."

The literature suggested a possible reason for the disparity. "Maybe because of STI disparities, providers are being encouraged to have these conversations with Black women," Townes says. "What we discuss is that while this is important and providers should be having these conversations with Black women, they're not having these discussions at the same rate with white women. This could result in unintended negative consequences. Women

of other races might not receive the same sexual healthcare. They might not be asked these questions, tested as often, or given condoms for future use."

The discrepancy in how providers approach sexual health questions also could negatively affect Black patients.

When Black patients feel they are targeted by a particular provider's questions and practice, this also can be detrimental, Townes notes.

"If they go into a sexual healthcare provider appointment and they feel like they're being judged or there's a stereotype about them when they discuss their sexual health behaviors, then that could cause some internal stigma for that Black woman," she explains. "It could make her perceive that the provider is showing her some bias. It could make her distrustful."

This could contribute to ongoing stereotypes in healthcare settings and break down that provider-patient communication, she adds.

"This study did not ask if Black women felt targeted," Townes says. "I did another study that is under consideration. I asked women about their experiences with more in-depth questions."

She discovered that some women reported they felt the provider was stereotyping them or judging them. The findings suggest that many reproductive health providers do not follow a set script or checklist when asking questions.

"My own experiences when going to different providers is that sometimes the doctor will ask those questions; sometimes the nurse will ask the questions," Townes says. "It's not standard, and not all providers follow the same routine. That's kind of the problem."

If each provider followed a standard way of inquiring about patients' sexual risk behaviors and reproductive health, then patients would accept these questions with each visit. They would know their experience is no different from any other person's experience, and that would help reduce disparity, she adds.

A standardized approach to sexual risk assessment and counseling also would be better for all women. If some women are perceived as less at risk without being asked about their experiences, then clinicians are not providing them with the highest quality sexual healthcare services. Some women may be at risk that is not identified, Townes says.

"There shouldn't be one population that is receiving this healthcare service and other populations are not," she says. "There may be missed opportunities."

Some providers might take issue with standardizing questions. But they could look into several different sexual history tools and guides.

"It's up to the providers to use them or adopt something of practice or policy and procedure of how it's implemented or used," Townes says.

Providers can think about this issue by acknowledging that part of their job is to prevent sexually based disease and illness. Can they accomplish this by selecting only certain patients to ask the tough questions about risk behavior?

"There is a perception that certain women are more or less at risk without the provider asking them about their behavior," Townes says. "Then, you find providers who are surprised that a patient is going blind because they have had syphilis for years. If we just regularly ask like we check patients' blood pressure, then everyone knows they'll be asked this and it will be made standard, reducing that feeling of discomfort."

Townes suggests providers make this part of their check-in process. When patients come in and sign a consent form, clinicians can ask patients why they're there and what problems or dysfunctions they want to address. Then, patients go back into a room to meet with the provider, who reviews the medical chart and asks about the patient's risk behaviors.

"We can't change how people feel about these questions being asked," she notes. "But it makes the conversation between the provider and patient better." Asking standard questions routinely also saves time.

Also, condoms should be offered to all patients, Townes says. Black women were offered condoms more often than white patients, but all should be given this option.

"We don't know people's lifestyles. Just because someone is or is not

EXECUTIVE SUMMARY

New research reveals that reproductive health providers are more likely to ask Black women than white women about their sexual risk behavior and condom use.

- The study found Black women were two times more likely to be offered testing for sexually transmitted infections.
- Even when age, marital status, educational background, and other factors were considered, Black women were more likely to face these questions.
- Providers need a standard assessment tool or approach to asking patients about their risk behaviors.

wearing a wedding band, we still don't know what that person's behaviors are," she explains. "There are some assumptions about their sexual life that need to be taken out of the equation."

Providers should remove their assumptions and just ask questions of everyone, Townes adds. ■

REFERENCE

1. Townes A, Rosenberg M, Guerra-Reyes L, et al. Inequitable experiences between black and white women discussing sexual health with healthcare providers: Findings from a U.S. probability sample. *J Sex Med* 2020;17:1520-1528.

Stress Linked to STIs, Poor Sexual Health of Black Women

Data from longitudinal study

Black women with high levels of stress are more likely to experience sexually transmitted infections (STIs) and poor sexual and reproductive health, according to the authors of new research.[1]

"Black women have higher stress and higher STIs and are at risk of both," says **Joy D. Scheidell**, PhD, MPH, research scientist in the department of population health at New York University School of Medicine.

"The motivation behind the research is we see stress in samples of Black and African American women are related to adverse birth outcomes: low birth weight, early delivery, and others," Scheidell says. "There has been little known about the effect of stress on STIs, which also play a role in adverse birth outcomes."

Researchers used data about Black and white female participants from Wave IV of the National Longitudinal Study of Adolescent to Adult Health. They examined stress scores from the Perceived Stress Scale, calling scores of six or more as high stress.[1]

Since 1984, the researchers of the study have collected information from individuals every eight to 10 years as part of a follow-up. Each new wave of the study introduces new participants, who also will be followed, Scheidell explains.

"We used the fourth wave of the survey with people in their 20s, and we measured their stress using a validated scale of perceived stress," she says. "The wave we use had data collected in 2008 and 2009."

Then, they compared the association of high stress scores with a self-reported, past-year chlamydia diagnosis; combined, curable STI; and lifetime pelvic inflammatory disease.[1]

Before this study, most of the literature focused on samples from Black women, which made it difficult to assess whether this was a phenomenon only in Black women, Scheidell notes.

"We examined questions around stress, STI, and stressful life events," she says. "We wanted to look at a research sample — ad hominem — and see confirmation from prior studies and specific groups to draw conclusions about it."

Investigators also decided to examine risk on a ratio scale to determine elevated risk for those with high stress vs. low risk.

"Those with high stress had two times the risk," Scheidell says. "That doesn't tell you about the burden of infection, the real prevalence difference, and the number of cases we might be able to prevent."

After analyzing data, researchers found Black women experienced a higher prevalence of chlamydia in the past year, as well as any past-year STI, including syphilis, gonorrhea, and trichomoniasis, she says.

"Those with higher stress levels have higher prevalence of sexually transmitted infections. Absolute stress levels are higher among Black women," she adds.

When investigators studied prevalence ratios, including whether prevalence is greater in high stress vs. low stress, they saw an adjusted analyses model that showed the prevalence ratio is the same. "Whether you're white or Black, if you had a higher stress load, you had two to three times the prevalence of chlamydia and the curable STIs, as well," Scheidell says.

The prevalence of stress was tricky to define, she notes. "This is a scale where a higher score equals higher stress," she explains. "We chose a cut point, so if someone had a score greater than six, they have high stress."

But with just the cut point and scores, it is difficult to determine whether the prevalence is higher in one group or another, Scheidell says.

"The mean of the perceived stress scale is higher for Black women than for white women," she explains. "They did have higher stress for Black women when compared to white."

Reproductive health clinicians can help patients reduce stress and the risk of STIs through a twofold approach, she suggests. "Sexual health clinicians should be incorporating more understanding of the stress their patients might be dealing with because those could impact their risk," Scheidell says. "This scale we used has only four items; it's very brief, so they could screen for stress among their patients to get a sense of whether they need to be a little more targeted in STI prevention."

The second approach is for behavioral health providers, who are seeing individuals dealing with stress, to talk with their patients about STI risk, she adds.

The results of the new study do not answer the question of why Black participants experienced more stress. "We need more research with other means of studying stress, as well," Scheidell says. "We don't know what the stressors are."

It is likely that a stressor for a Black woman in America is quite different than what white women experience. "We controlled for confounding effects and a range of other factors," Scheidell says. "Maybe those who are stressed have lower socioeconomic attainment or prior trauma. We did an analysis to control for those things."

What they found was that even accounting for all of these other factors, including poverty and trauma, it did not make a difference in the correlation between stress and STIs among Black women. But there was a difference for white women.

"For white women, what we saw when we accounted for those factors was a relationship between stress and STI had greatly reduced in strength, or it went away entirely," Scheidell says. "It might be all of these concurring things in white women."

For Black women, there is something unexplained about their stress. It is possible Black women experience stress that was not captured in the survey questions. For instance, this could be stress related to racism. "The weathering hypothesis says the levels of stress Black women experience over time are impacting their bodies in a real way," Scheidell says. "The accumulation of stress might be different between white and Black women."

Another way to conceptualize this difference is to look at intersectionality as an important piece for Black women's experience in the United States.

"It's not just gender, it's not just race, but an intersection of those things," Scheidell explains. "For sexual care providers, talking about contraception in that relationship is important. Others have found reduced condom use and increases in risky sexual behavior when individuals are in stress."

Sexual health providers can discuss specific issues related to stress and STIs. They can educate women about the effects of stress, referring them to counselors to reduce their stress levels.

"If stress is reducing an individual's ability to engage in condom use, then let's talk about other forms of contraception like long-acting reversible contraceptives, which might be important if their lives are overwhelming and chaotic," Scheidell says.

The area of stress and STIs needs more research, she notes. "Our study is cross-sectional," she says. "Only one study is longitudinal, and that study found two potential pathways":

- Stress affects interpersonal and behavioral things, including multiple relationships and condom use;
- The effects of stress on the body could make an individual more susceptible to infections if the person is exposed.

"We need a lot more work," she adds. "The need for future research is something I think is really important."

Stress is a prevalent issue, and it appears to be increasing in the United States — partly due to the COVID-19 pandemic, she notes.

"Understanding stress is very important and worthwhile," Scheidell says. ■