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New Year, New President Affect Abortion, Title X Changes

Rescinding gag rule a top priority

Reproductive health advocates and Title X providers have reason to be both optimistic and concerned in 2021 as the new Biden administration made a promising — but not yet decisive — move to improve Title X and reproductive healthcare for American women.

The Biden administration immediately included Title X changes on the president's list of early executive orders. The intended goal appeared to be to turn back the Trump-era rules that forced hundreds of family planning clinics to leave Title X, leaving more than a million women without access to Title X services.

> "REVERSAL OF TRUMP'S REGULATIONS CANNOT COME SOON ENOUGH FOR THE MILLIONS OF LOW-INCOME PATIENTS WHO RELY ON TITLE X FOR BIRTH CONTROL, STD TESTING, AND TREATMENT."

President Biden released a memorandum on Jan. 28, 2021, saying the Secretary of Health and Human Services (HHS) "shall review the Title X Rule and any other regulations governing the Title X program that impose undue restrictions on the use of federal funds or women's access to complete medical information and shall consider, as soon as practicable, whether to suspend, revise, or rescind" the final rules that severely impacted Title X programs.[1]

The consequences of the Trump administration's new regulations for Title X funding have been devastating to Title X programs, says

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While the memorandum is a good first step, it does not go far enough to undo the previous administration's damage to Title X, she says.

"Reversal of Trump's regulations cannot come soon enough for the millions of low-income patients who rely on Title X for time-sensitive health services like birth control, STD testing, and treatment," Rabinovitz says. "The Trump-era regulations are the most extreme rules implemented since Title X was established with strong bipartisan support and signed into law by President Richard Nixon in 1970."

Effects of the Gag Rule

The Trump administration's final rule for the Title X program, released in early 2019, required strict physical and financial separation of Title X services from abortion services. It further stated Title X providers could not refer patients for abortion care or offer any information and counseling that includes abortion information, referred to as a "gag rule." Historically, Title X does not pay for abortion services.[1]

Since many family planning centers could not come into compliance with the new rule, they withdrew from Title X. This left many women with less access to reproductive health and contraceptive services.

"One in four Title X providers have had to withdraw from the program," Rabinowitz says. "A report from Trump's HHS [Department of Health and Human Services] show that the number of Title X patients affected by the change was 21% in 2019."

The report from the Congressional Research Service revealed that Title X in 2019 served 3.1 million clients, 21% fewer than in 2018. Of these clients, 64% reported incomes at or below the federal poverty guidelines. Sixty percent had no other source of healthcare.[2]

In 2020, that percentage of people no longer receiving Title X services was expected to be even more devastating, although updated numbers were not yet available, Rabinovitz adds.

"Our healthcare providers in California cannot wait to rejoin the program," she says. "As soon as the

EXECUTIVE SUMMARY

Family planning providers anticipate positive changes to the Title X program as President Biden announced his administration would roll back the Trump rules that forced hundreds of family planning clinics out of the program.

- In 2019, the Trump administration issued a final rule for Title X that required strict physical and financial separation of Title X services from abortion services, going further than had occurred anytime previously.
- The new rules led to hundreds of family planning centers withdrawing from Title X, leaving more than 1 million women without access to Title X programs for their reproductive healthcare.
- If the Biden administration rescinds the rules, the Title X program can expand and the family planning centers that pulled out could rejoin.

Biden administration takes action, we will welcome them with open arms."

In Missouri, only one provider (Planned Parenthood of Missouri) chose to leave the Title X network because of the Trump administration's gag rule, says **Michelle Trupiano**, MSW, executive director of the Missouri Family Health Council. "We're working with them so that once the rules are rescinded, we can bring them back in because we were not able to fill the gap that was left when they pulled out of the network," Trupiano explains.

"Although we're disappointed the Biden administration did not suspend the dangerous Title X gag rule, we're encouraged that the president has placed such an emphasis on access to quality, affordable healthcare so early in his term," Trupiano adds.

Planned Parenthood of Missouri served 14% of the Title X patient base in Missouri. The state was unable to bring in a new provider with that much capacity. "I think we're all looking forward to rescinding the Trump rules and going back to providing quality care," Trupiano says.

Missouri's Title X program might be able to bring in Planned Parenthood before its budget year starts in March 2021 because there already is some funding available, she adds.

Efforts to Reverse Damage 'Encouraging'

Title X organizations have a lot of work ahead to restore the network to pre-2018 levels, but President Biden's interest in repairing the damage is encouraging. "President Biden has vowed to rescind the rule, rebuild Title X, and make it right for millions of people who rely on the program for care," says **Audrey Sandusky**, MPH, senior director of advocacy and communications with the National Family Planning and Reproductive Health Association in Washington, DC. "We are working very closely with the White House and our national partners to ensure the administration acts swiftly to repair damage done under the Title X rule and to restore critical health services to communities that are currently without Title X support. To date, 33 states had entities leave the program due to the rule, and six states are without any Title X funding whatsoever right now."

> "PROVIDERS ARE MOST EXCITED THAT THEY DON'T HAVE TO CONCENTRATE ON ADMINISTRATIVE BURDENS AND POLICIES AND PROCEDURES THAT DON'T BENEFIT PATIENTS."

Underfunding Is an Issue

About 1.5 million people lost access to Title X-funded care. "Both providers and patients are in desperate need of Title X support again," Sandusky says. "Reversing the damage done under the rule cannot happen overnight. It's going to be a long road ahead to rebuild the provider network — to bring back health centers, restore services, reinstate quality standards. That's what we'll be focused on this year."

Title X also has suffered for years because of underfunding. "The program has experienced eight straight years of stagnant funding, despite a growing need for publicly funded care," Sandusky explains. "At current funding, the program can serve one-fifth of the needs among women in the United States."

Funding is a little more than one-third of the $800 million that is needed, Trupiano says. The year 2020 was one of the Title X program's most challenging periods not only because of the Trump rule change, but also because of the COVID-19 pandemic.

"The rules and COVID on top if it have put a lot of stress on our network throughout the state," Trupiano adds. "Now, we're excited that providers can go back and not worry about compliance and what they can and cannot say to patients."

Instead, Title X providers can get back to focusing solely on what they always have: providing the highest-quality care possible.

"Providers have a sense of relief," Trupiano explains. "They're most excited that they don't have to concentrate on administrative burdens and policies and procedures that don't benefit patients. Instead, they can spend time and energy on increasing access." ■

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Supreme Court Decision Reinforces Barrier to Medication Abortion

Biden administration could change this

A recent decision by the U.S. Supreme Court could make it more difficult for women to access medication abortions.

In an unsigned brief order on Jan. 12, the Supreme Court said a district court should not have compelled the Food and Drug Administration (FDA) to lift a requirement that mifepristone, the abortion pill, has to be picked up in person.[1]

"The recent Supreme Court decision requires patients to come in person to a facility to receive mifepristone for a medication abortion," says **Daniel Grossman**, MD, professor in the department of OB/GYN reproductive sciences and director of Advancing New Standards in Reproductive Health at the University of California, San Francisco. "This requirement, codified in the FDA's risk evaluation and mitigation strategy [REMS] for mifepristone, had been temporarily suspended during the COVID-19 public health emergency, thanks to a federal judge's order in July."

No Medical Reason for In-Person Visit

There is no medical reason to force patients seeking medication abortion to obtain the pills in person. "This requirement puts them at increased risk of exposure to the coronavirus," Grossman adds. "It also restricts the number of clinicians who can provide medication abortion, since not all stock the drug in their clinics, and it creates an obstacle to care."

Numerous studies have established the safety of mifepristone, says **Julie Rabinovitz**, MPH, president and chief executive officer of Essential Access Health in Berkeley, CA. "Acetaminophen, the active ingredient in Tylenol, has a much higher rate of adverse reactions," she notes.

Research also shows that medication abortion can be provided safety and effectively through telemedicine. "The FDA already permits patients to take the pill at home, but they require clinicians to provide the pill in person in a clinical setting," she says. "It's an onerous requirement and puts patients at risk, especially during the pandemic. It maintains many barriers to access to early abortion care."

Last summer, several organizations challenged this rule in court. A federal judge in Maryland issued a nationwide injunction blocking the FDA requirement that mifepristone be given in a clinical setting, Rabinovitz explains.

"This was particularly important to communities of color and low-income communities suffering from COVID," she explains. "The government appealed, and [in January] the Supreme Court lifted the injunction and allowed the block to be enforced again."

New Administration Could Remove Barrier

The new Biden administration could take steps to remove this barrier. "There may be a way for the administration to instruct the FDA to temporarily suspend the in-person dispensing requirement during the pandemic," Grossman says.

Under the new administration, the FDA could take immediate action to increase access to mifepristone during the pandemic by updating the FDA's March 2020 guidance on "REMS Requirements During the COVID-19 Public Health Emergency" to include explicit permission to provide remote access to early abortion treatment, Rabinovitz says.

"A group of over 100 congressional leaders called on FDA Commissioner Hahn to do so last summer," she explains. "It is our hope and expectation that President Biden will direct the FDA to put this temporary fix in place while they work on a longer-term solution."[2]

The permanent solution would require an FDA review of evidence. "They also could encourage the FDA to review the evidence in-depth to determine whether the mifepristone REMS could be modified or removed permanently," Grossman says.

A first step would be to form a team of FDA clinical and safety reviewers to determine if REMS requirements are needed. They could seek information from outside experts and patients. "In making the determination, they must consider whether there is a particular risk or risks associated with the medication, and if the risks outweigh its benefits," Rabinovitz says. "The potential burden of REMS requirements also have to be taken into consideration."

REMS requirements are not designed to be permanent. "When FDA leaders direct their reviewers to take this critical step, they will find that mifepristone's benefits clearly outweigh the risks, and that for the advancement of public health, the REMS requirements should be lifted," Rabinovitz adds. "After the REMS requirements are lifted, widespread coverage and adequate reimbursement for the provision of medication abortion through telehealth across payers has to be the next step."

This will advance health equity and ensure that patients nationwide can access the early abortion care they want, when they want it, Rabinovitz says. ■

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Researchers Study Immigrant Latinas' Experience with Reproductive Healthcare

Language barrier is prominent obstacle

Latina-identified immigrants experience multiple barriers to healthcare, including contraception and reproductive care. This can result in lack of access to affordable preventive screenings, such as Pap smears, mammograms, and tests for sexually transmitted infections (STIs), according to the authors of a recent study.[1]

"The question I had was: 'How do immigrant Latinas find out about and go for reproductive healthcare, generally?'" says **Lucia Guerra-Reyes**, PhD, MPH, MA, associate professor in the department of applied health science at Indiana University Bloomington. "Most of my prior research was in Peru, and I am Peruvian. I wanted to focus on people [in the United States] who did not have employer-based insurance, and most of them are undocumented immigrants."

Guerra-Reyes' broad questions were about how people learned about contraceptive options, family planning, and reproductive health. "We were just trying to understand these women," Guerra-Reyes says. "In the literature there is a lot of information on barriers, and they tend to be structured around things that are very common when you look at Latinas in the United States."

The new study focuses on an emergent Latino community. This is a community where there is not a large, established Latino population. "Therefore, the resources of providers who speak Spanish or culturally adaptive reproductive health services was quite low," Guerra-Reyes says.

Investigators also studied how providers and organizations viewed Latina patients. In the first phase of the study, they identified organizations that provided reproductive health services to undocumented and uninsured Latinas. They interviewed representatives from these organizations.[1]

"Providers saw themselves in the preventive arena; they felt Latinas did not think about preventive care, especially for non-contraceptive care," Guerra-Reyes says.

In the second phase, researchers interviewed immigrant Latinas in one county in which the Latino population had increased by 52.4% in 2005-2009 and 2010-2014. The women reported various barriers to seeking non-contraceptive reproductive care services. For example, a few women reported that they were unable to get a Pap smear at a Title X clinic because they had been sterilized and were no longer reproductive.

The study's reviewers disputed this belief, saying this was not a regulation or common policy at Title X clinics, Guerra-Reyes notes.

"This is the experience of the people I interviewed, and this put some specific stress on women who were not fertile," she says. "The women told me that because of a funding structure, the clinic could only provide sexual reproductive healthcare to women who were still potentially fertile."

The Title X statute says that grants were made to assist the operation of voluntary family planning projects,

which provide a broad range of acceptable and effective family planning methods and related preventive health services. It does not explicitly prohibit preventive health services for women who are no longer able to procreate.[2]

"The other thing that was important in this for women was that there were language barriers, and — to some extent — discrimination in how they felt and what they felt they could receive from the clinics," Guerra-Reyes says. "There was an expectation that they had very little they could receive."

The women appeared to believe that their undocumented immigrant status meant that they would receive deficient care, she adds.

Since the clinics and providers were in an emergent Latino community, and not in an area with many Spanish-speaking healthcare workers, language was a big barrier. "Not all clinics can pay for phone translation services," Guerra-Reyes explains. "There were translators in town, but it's sort of a free-for-all. It had reached the point that [some] clinics were asking patients to bring their own translators."

The community had one OB/GYN provider who worked with many Latina immigrants. The doctor spoke some Spanish, but this did not resolve the language barrier. "Because he spoke some Spanish, he didn't use a translator," she notes.

Another limitation is the cost of services. When the women did not use a Title X clinic, whether by choice or because they were turned away, they had to find a provider they could afford and who would welcome them as patients.

"The women who wanted a Pap smear got on the road to a bigger city, where there is a medical clinic that is independent, for-profit, and is managed by a couple of doctors who are Latinos and speak Spanish," Guerra-Reyes says. "That clinic specifically advertises in Spanish language radio."

Although the patients had to pay out of pocket for their care, the overall cost was less than it would have been at some other facilities. The women reported that their healthcare decisions were respected at this clinic. "We had the case of one woman who got an IUD [intrauterine device], and she went to the Title X clinic and didn't like it," Guerra-Reyes says.

The woman had gained weight and experienced a lot of bleeding after receiving the IUD, and she asked her Title X provider to take it out. The provider refused.[1]

"She felt horrible," Guerra-Reyes laments. "They told her to hang in there and it would get better, and she did not like it. She went to this other clinic, and they took it out."

None of the women interviewed said they felt pressure to use an IUD, but several were concerned about the unwelcome side effects of IUD use.

The interviewees' stories of not being understood or heard contributed to feelings that they were neglected by individuals who were not culturally competent. "It creates stress and a feeling that it's not really worth my time to go to this clinic, and I might as well use my money to get care," Guerra-Reyes adds.

Reproductive care providers should recognize their own tendency to narrowly define women's health and what constitutes the best outcomes. "A lot of the issues that come forward on the side of immigrant communities is trying to negotiate that they would like to be understood and be tended by people who recognize that their concerns are valid," she explains. "They want their cultural perspective on these concerns understood."

Even when providers are not culturally prepared to care for immigrant patients, it is important that they arrange for effective translation and reflect on how their own biases might affect patient care, she adds. For instance, one cultural bias is the belief that Latinas do not want preventive reproductive healthcare and do not seek preventive care.

"In our interviews, clinicians brought this up, but the women in interviews contested that belief," Guerra-Reyes says. "The women said they wanted preventive care, but there are a lot of barriers to getting it."

In some medical settings, the challenge of providing healthcare to an individual who does not speak the language of a provider, the provider can call a translation service to speak to the patient.

Providers could do a better job of communicating the drawbacks to IUDs, perhaps by offering a video in Spanish. "Also, in these smaller communities, there is an opportunity for outreach, partnerships with Latino-focused organizations," she says. "I know this is an added burden on clinics and healthcare providers."

But organizations that are trusted by the community can help improve healthcare engagement by suggesting that women with a particular health issue go to a particular clinic or provider.

"People are people, and you need to manage this in terms of trying to get at outcomes and better science and answering people's concerns to the best of your ability," Guerra-Reyes says. ■

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Contraceptive Use Is Less Consistent for Young Women Experiencing Hardships

Electricity cutoffs, food insecurity play role

Researchers studied more than 1,000 women, ages 18 and 19 years, over several years, asking them weekly questions about their contraceptive use, sex, and pregnancy. They found that women who experience material hardship use contraceptives less consistently.[1,2]

"A lot of studies ask you retrospectively if, in the past year, you used contraceptives consistently, and people would say they use it consistently every time," says **Elly Field**, MA, PhD candidate in sociology, National Science Foundation graduate research fellow, and predoctoral trainee at the Population Studies Center at the University of Michigan. "But being overall consistent is different from being consistent every time."

The weekly questions capture women's answers closer to the time of their reported behavior. The data came from the Relationship Dynamics and Social Life Study.

"I was interested in women's health and experience with inequality and poverty, and I used a set of questions that asked if they were economically disadvantaged," Field says.

The questions included:

• Have you experienced food insecurity?

• Was your electricity cut off?

• Were any utilities cut off?

Measuring the young women's income was challenging. "They have varying levels of reliance and support on their families," Field explains. "An income measure might not indicate the same level of hardship."

Some young women with low incomes have their basic needs met by their families. Others are suffering from material hardship. "Income is important, and it's also important to get at hardship, as well," Field says. "We can miss people who don't meet an income threshold but are experiencing the inability to meet their needs."

For instance, young women with relatively higher income levels might experience medical costs that force them to choose between paying rent and paying for their medical needs. Variations in income and hardship are common for this population of young women transitioning into adulthood, she notes.

Field also studied the women's answers about contraceptive consistency and how this related to their income and material hardship answers. Questions included:

• Are you using contraceptives at all?

• Which methods are you using?

• Are you using this method every time?

• Are there gaps in your use?

The answer was that hardship made it more challenging for women to use contraceptives consistently.

"I didn't look at the pregnancy rates in this paper because it's a smaller group," Field explains. "There were not quite enough pregnancies in that time period."

Field focused on women who had unprotected sex even when they said they did not want children. "I restrict analyses to women who don't want to become pregnant and would like to avoid pregnancy," she says. "These were divided between those who experienced material hardship and those who did not have material hardship."

Material hardship includes lack of insurance, homelessness, and unmet needs. Young women experiencing material hardship might have to pawn their belongings or donate plasma to make ends meet.

While some poor families can meet their needs through social assistance programs that provide food and housing essentials, other people with similar incomes find that their demands exceed their resources. "I find that women experiencing multiple hardships are much less likely to use any contraception over the period of the study," Field says. "They're unlikely to use contraceptive methods because they don't have insurance, and they're also less likely to use condoms and other coital-specific methods like spermicides or diaphragms."

Women experiencing material hardship also are more likely to switch from more effective methods to less effective methods. They also go through periods without using any contraceptive methods at all, she adds.

Investigators studied different factors to explain the connection between material hardship and contraceptive use. One factor is access. "We asked women, 'Do you believe you can afford contraception, and is it easy to access?'" she explains. "Access does explain why women experiencing hardship are less likely to use contraception, and why women who do not have insurance are less likely to use contraception."

In much of contraception literature, it is assumed that birth control is reasonably priced and widely available. "But that's not really always true," Field notes. "It should be a priority to enhance access through programs like Title X clinics."

But reproductive health clinicians should keep in mind that access still is a barrier in the United States. "Even if condoms can be purchased anywhere, that's not enough for women who are experiencing the acute effects of poverty," Field says. "This study is before the expansion of the ACA [Affordable Care Act], but it's not a failsafe even with the ACA."

Field suggests that family planning providers and reproductive health clinicians help women improve access through these changes:

- Recognize how material hardship, poverty, and lack of insurance can affect women's health and how economic insecurity is a risk factor;
- Keep in mind that women who carry the burden of worrying about contraception also carry the burden of worrying about money, family members, and other factors that can affect their ability to process information and make wise decisions;
- Consider what a person needs to obtain the form of birth control the provider recommends.

"It's easy to write a prescription and say, 'Pick it up every month.' But if she has an unreliable work schedule or child care responsibilities, it can be a real burden, hard to remember, and hard to get to the store to pick it up," Field says. "Someone might not have a car or be able to pay for gas this month, and these barriers can add up. Not having enough money to make ends meet and support yourself can impact health and other domains in your life, and that's not understood as well as it should be. It's a really important part of poverty, and it's one that has cascading effects on your life." ■

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Study: Contraception Program for Incarcerated Women Can Prevent Pregnancies

An estimated 5% of women in jails are pregnant, and human rights groups and researchers have collected evidence that these women often receive poor care and are neglected.[1]

One solution is to provide contraceptive care to incarcerated women who would like to avoid pregnancy. *Contraceptive Technology Update* interviewed two researchers who have studied a program that provides contraceptive access to women with substance use disorders in county jails: **Clea McNeely**, DrPH, research professor at the University of Tennessee College of Nursing, and **Tara L. Sturdivant**, MD, regional medical director at the Tennessee Department of Health.

McNeely and Sturdivant answered a few questions via email about their research.

CTU: How would you describe your study's comprehensive family planning education sessions and the impetus behind these?

Sturdivant: The original objective of our comprehensive family planning education sessions was to educate female inmates in the jail system on the value of reproductive life planning and the potential risks that occur when an infant has in utero exposure to addictive drugs. We also discussed the availability of family planning services, various contraceptive methods, and other preventive health services available at the local health departments.

The impetus behind these sessions was the very high number of babies born drug-dependent in Tennessee, particularly in rural east Tennessee. According to the Tennessee Department of Health Office of Health Statistics, Hospital Discharge Data and Birth Statistical Data, Tennessee had

seen almost a seventeenfold increase in the NAS [neonatal abstinence syndrome] hospitalization rate between 1999 and 2012. A total of 921 NAS cases were identified in 2013, the year the program was conceived. The rural, 15-county region where the program began accounted for 268 of those reported cases.[2]

CTU: What did your data show?

McNeely: We conducted a pilot study, which means that our findings are not necessarily generalizable to people who didn't participate in the study. We asked two questions: Was the information delivered to women accurate? Did the participants in the education sessions feel pressured to get a long-acting reversible contraceptive (LARC) method?[2]

The answer to the first question was yes. We found that the information delivered in the comprehensive family planning education sessions was accurate. The answer to the question of whether participants felt pressured to get a LARC was no. The women reported that their participation in the education session was voluntary, as was the choice to receive a LARC. A few women thought that the nurse educators were actively promoting the benefits of birth control, but none of the women we spoke to perceived any pressure to receive a contraceptive method.[2]

Several of the women expressed appreciation for the opportunity to get a LARC at no cost, which was made available after the education session. There are some quotes in the paper that are representative of women's experiences.

CTU: How might this type of education session help reduce disparities and fill gaps in contraceptive care?

Sturdivant: The education enables individuals to make informed decisions and better understand the options that are available to them. The participants interviewed reported increased knowledge, participation in, and comfort with decision-making regarding contraceptive use.

The key to the success of the education sessions was the direct linkage between education and access to family planning services. No-cost family planning services were offered at the education sessions, along with information about how to access low-cost preventive health services.

The Tennessee Department of Health is focused on improving rural maternal health outcomes through the implementation of innovative partnerships with national, state, and local organizations. A priority is to reduce the maternal mortality rate for rural women.

CTU: Since your paper was published in 2019, have other departments of health inquired and/or implemented similar education programs? Has the partnership between the East Region of the Tennessee Department of Health and county correctional facilities continued for the purpose of these educational sessions?

Sturdivant: We have had other states reach out for study information and teaching tools. We have shared this outreach initiative with state family planning administrators through our collaboration with the National Family Planning and Reproductive Health Association. We discontinued group in-person educational sessions in March, once COVID-19 became a safety concern in jails, courthouses, and health departments.

CTU: What do you think is the take-home message from your study and intervention?

McNeely: The take-home message of our study is that it is possible to provide comprehensive reproductive health education in rural jails and to increase voluntary access to contraception in a way that women feel respected and valued, and in a way that protects their autonomy. ■

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Study: Risk Assessment for Contraceptives Is Influenced by Cultural Biases

Contraceptive side effects ignored

Cultural assumptions create unbalanced risk assessment when the medical community weighs the risks and benefits of common contraceptive methods, the authors of a recent study concluded.[1]

Researchers studied contraception risks and assessed how these risks were prioritized in reproductive health providers' understanding of contraceptives and their potential side effects.

"We were interested in how contraceptive counseling prioritizes effectiveness over side effects and reproductive autonomy," says **Andrea Bertotti**, PhD, professor of sociology at Gonzaga University in Spokane, WA. "Why is effectiveness the most important thing, over side effects or women having autonomy? By autonomy, I mean that if you end up with LARC [long-acting reversible contraceptive] or sterilization, you don't get to decide, daily, if you're going to do that or not."

Risk Assumptions

Bertotti breaks down risks into three categories:

- **Embodied risk.** This is the risk that is contained in the patient's body, including ovulation, menstruation, and pregnancy.
- **Medical risk.** These are the risks of side effects from various contraceptive methods.
- **Lifestyle risk.** This risk pertains to the choices people make, such as women not engaging in contraceptive self-management.

"We ultimately found that the reason contraceptive effectiveness ended up being more important is the underlying assumption about women's bodies being risky," Bertotti says.

This assumption included the idea, whether conscious or not, that it is better for individual women to put their bodies at risk from contraceptives than to experience the scourge of pregnancy. "Both are based on assumptions, and risk becomes illogical," she adds.

For instance, the assumption that women's bodies are risky does not consider the health benefits of pregnancy and breastfeeding. "Some of the benefits associated with hormonal contraception are also benefits of pregnancy and breastfeeding, and they don't bring that into the risk-benefit analysis," Bertotti says. "Some women would consider pregnancy is better than headaches, and some women are really concerned about side effects from contraception."

Clinicians who have not considered this way of looking at contraception and risk-benefit analysis might have been influenced by gynecology textbooks, which are based on a particular set of paradigms. Women's concerns about adverse contraceptive effects were often interpreted by providers as myths because what the women reported was inconsistent with their formal medical knowledge and their trust in the value of pharmacontraceptives.[2]

"The language in the medical textbooks undermines the side effects," Bertotti says. "They'd say, 'Here are the side effects, but it's not that important.'"

Also, the language in medical textbooks creates a certainty for benefits of contraceptives and suggests doubt of side effects, she adds.

Investigators assessed the disparities in medical textbook

language and how risks and benefits were described. "I don't know what's going on in the exam room; I don't have that data, but the textbooks are framing it this particular way," Bertotti explains.

Another illogical risk-benefit comparison is the assumption that any side effects of contraceptives are better than pregnancy. "What they're doing is not distinguishing the risks, not doing a clear job of distinguishing the risks of mechanism of action," Bertotti explains. "One mechanism of action could cause blood clots, while another mechanism of action — condoms — does not have any side effects, unless there's a latex allergy."

Data show that about two out of three women using reversible contraception rely on either short-acting hormonal methods or LARCs, such as hormonal intrauterine devices.[2]

Since a woman is more likely to become pregnant with condom use than from LARC or birth control pills, the condom is considered riskier because of the risk associated with pregnancy, although that does not take into consideration the risk of side effects, she adds.

"The current model of contraceptive counseling is very much about long-acting, as much as possible, because the goal is to avoid unintended pregnancy," Bertotti says.

But the model does not take into account the historic — and even current — reproductive abuses that vulnerable women have experienced. As a sociologist, Bertotti has taught medical students about the historical context of reproductive coercive behavior.

"Assumptions embedded in our current situation that are rooted into behaviors of the past have placed us at risk of replicating that kind of coercive position as experts in medicine," she explains. "This happens if you're looking at someone as a statistic and not looking at them as individual people."

One common assumption is that women's reproductive choices have a huge impact on their lives. "There's a little too much weight on what the rest of your life would be like if you get pregnant," she says.

When people begin to consider the possibility that contraceptive side effects might be a worse outcome to some women than is pregnancy, they can assess, without bias, the risks and benefits of nonhormonal contraceptive methods, including those with less efficacy in preventing pregnancy, such as condoms, the withdrawal method, and natural family planning.

To improve patient care, providers need to look at people as individuals and gear counseling to their individual needs rather than viewing them as potential threats to society if they do not use contraception wisely, she adds.

Historical Abuses

The historical context is especially important to know. For instance, American history and its eugenics movement has many examples of federally funded programs that coerced sterilization of immigrants, people of color, poor people, unmarried mothers, the disabled, and the mentally ill.[3]

California performed about 20,000 sterilizations at state institutions in the 20th century, without the full knowledge and consent of the men and women involved. A report from The Center for Investigative Reporting found that California paid doctors $147,460, between 2006 and 2010, to perform tubal ligations on female inmates. More than one-quarter of the former inmates reported being coerced into the sterilization. Most of the women were Latino and Black Americans.[3,4]

"It's not ancient history, and it's not just the eugenics movement," Bertotti says. ■

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COMING IN FUTURE MONTHS

- PATCH program has teens educate peers on sex, responsibility
- Sex trafficking prevention challenges outlined by experts
- Teens often do not use emergency contraception because of misunderstandings
- Researchers study LARC use pattern differences by race

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 QUESTIONS

1. **What was the result of the Trump administration's rule changes to the Title X program after the final rule of early 2019?**

   a. One out of five Title X clinics closed.
   b. A half-million women lost Title X services.
   c. Title X served 21% fewer patients than in 2018.
   d. Half of Title X providers left the program.

2. **What was the takeaway finding of a recent study about contraceptive care for incarcerated women?**

   a. It is possible to provide comprehensive reproductive health education in rural jails and to increase access to contraception in a way that makes women feel respected and valued.
   b. Incarcerated women do not trust clinicians and are more likely to turn down family planning services than are women in the general public.
   c. Rural jail administrations are hostile to family planning services for their inmates.
   d. Incarcerated women report high rates of contraceptive coercion, saying they did not want long-acting reversible contraceptives but felt they had no choice but to agree to these.

3. **In an unsigned brief order on Jan. 12, the U.S. Supreme Court made what decision regarding abortion services?**

   a. It upheld a state law that banned abortions after six weeks gestation.
   b. It said that a district court could not compel the FDA to lift its requirement that mifepristone is picked up in person during the pandemic.
   c. It said that abortion clinics could not open in areas with high COVID-19 case rates.
   d. It said that abortion care is an essential service during a pandemic.

4. **In a study of the experiences of immigrant Latinas in an emergent Latino community in the Midwest, investigators found what barrier to women receiving family planning services and care?**

   a. Cost and lack of insurance were barriers.
   b. The women's husbands opposed their receiving contraception.
   c. Language was a barrier, and the women thought they would receive only deficient care because of their undocumented immigrant status.
   d. The women did not know about Title X family planning clinics and how they could be treated confidentially and affordably at those sites.

STI QUARTERLY™

A SUPPLEMENT TO CONTRACEPTIVE TECHNOLOGY UPDATE

Educational Sessions for Women with Opioid Use Disorder Improve Engagement

Outreach led to STI testing and telehealth

A Maine family planning clinic launched a program to reach women who experience barriers to reproductive healthcare, counseling, and testing for sexually transmitted infections (STIs). The program focused on outreach, sending an educator to various locations and providing an educational session for women who are especially vulnerable, including those who use opioids.

Three out of five people in Maine live in rural areas. Accessing healthcare is challenging because it involves considerable travel time and related costs. Also, 64,000 Maine women of reproductive age live in a contraceptive desert.[1]

These factors suggest that a telehealth option for contraceptive and reproductive health services would be a potential solution to overcoming access barriers. The pilot program offered the women, who attended the outreach sessions, access to HIV counseling and testing, STI testing, and contraceptive or pregnancy testing and counseling.

"The program was pre-pandemic, but we altered it since the pandemic," says **Leah Coplon**, CNM, MPH, program director of Maine Family Planning "This was designed before telehealth was all the rage to have a way to connect patients with clinical services. Outreach coordinators would go and do sessions and connect people to a nurse practitioner."

> "WE WERE TRYING TO THINK ABOUT WAYS TO BRING SERVICES TO A POPULATION THAT IS HARD TO REACH BECAUSE OF STIGMA AND OTHER FACTORS THAT PREVENT THEM FROM GOING INTO A CLINIC TO ACCESS SERVICES."

After the COVID-19 pandemic hit, the sites no longer allowed outreach coordinators to visit. Before the pandemic, outreach coordinators spoke to recovery groups about hepatitis C and HIV. They gave out gonorrhea and chlamydia testing kits that women could use and drop off or send in to obtain results, Coplon says.

The family planning clinic partnered with community organizations that serve women with opioid use disorder (OUD). These included programs for domestic violence, harm reduction, intensive outpatient, OUD treatment, needle exchange, and behavioral health organizations.

"Some sites wanted a more formal discussion, and they put aside some time for that," she adds. "We tried to cater these discussions to the site." Their goal was to be adaptable and not just present a PowerPoint lecture.

Research has shown that telehealth for HIV/STI prevention and care can work well, through digital innovations and text messages. These can improve adherence with treatment, says **Terri-Ann Thompson**, PhD, senior associate with Ibis Reproductive Health in Cambridge, MA.

"We looked at a hybrid model of both in-person and telehealth to reach this hard-to-reach population — women with opioid use disorders," Thompson says. "We were trying to think about ways to bring services to

a population that is hard to reach because of stigma and other factors that prevent them from going into a clinic to access services."

Women with OUD are at high risk for STIs, but they often do not visit family planning or other healthcare clinics, she adds. It also is important to bring interventions that involve telehealth to states that are more rural, such as Maine.

Patients Fear Stigma

Outreach coordinators visited some of Maine Family Planning's 18 clinics across Maine. Even when the targeted population of women lived fairly close to one of these clinics, they were not visiting them because of stigma around their opioid use, Coplon says. When the pandemic hit, no one visited the clinic for weeks.

"Many of these sites were reinvented in a virtual way, so they would do a virtual recovery group and our outreach educators would show up at the beginning of the virtual group meeting and then link people to telehealth services," Coplon explains. "The outreach educators were able to answer questions about STI screening and HIV and help clients with scheduling visits."

Some of their experiences suggested the effort to reach women who otherwise would have been difficult to help was working.

"One of our outreach educators, once the pandemic hit, was moved into a clinic role as a medical assistant to help her with her hours," Coplon says. "She said, 'I'd see so many clients I saw in other places, and I'd see them at the clinic, and they would be asked if they used substances, and they would say no.'"

The outreach educator knew they had OUD, but the women did not feel comfortable sharing their drug use with family planning clinic staff, despite the staff's open and nonjudgmental approach with patients, she says.

Stigma and fear of judgment are so important in these women's minds that they were willing to miss out on optimal care to protect their privacy. But they did feel comfortable with the outreach educators because of the nature of that intervention and how it was a collaboration with community organizations the women trusted, such as substance use support groups.

"Embedding an outreach educator in those sites actually made a huge difference," Coplon says.

The study authors found interactions between clients and outreach educators could lead to more services for the women. The program, adjusted for the pandemic, connected outreach coordinators with family planning clinic staff, as well as with patients. Through telehealth, family planning clinical staff provided preventive reproductive health services, including HIV/STI counseling, testing, and contraceptive care.[1]

"While not every individual went ahead to request STI testing, the interaction led to many seeking condoms, as well as many asking sexual and reproductive health questions," Thompson says. "There's something to be said here about having increased access to information, whether for program directors or for individuals getting services for themselves."

Telehealth Means Greater Access

The revised program is to provide robust telehealth and remote care, including HIV testing and STI testing. "As much as possible, we're trying to promote telehealth for everybody and simultaneously work on larger issues like broadband," Coplon says. "We don't want to prevent anyone from accessing services."

The goal was to encourage family planning clinics to leverage telemedicine technologies, including training, services, and support, to other providers in terms of STI prevention services. "As folks are more dispersed, people are getting lots of

EXECUTIVE SUMMARY

Maine is a rural state. Women — particularly those with opioid use disorder — sometimes encounter barriers to reproductive healthcare services, including screening for sexually transmitted infections (STIs).

- Telehealth is a good option for contraceptive and other reproductive health services for women who choose not to enter a family planning clinic because of transportation barriers or stigma from their substance use.
- Outreach educators met women with opioid use disorder through partnerships with community organizations, including programs that serve women affected by domestic violence, substance use treatment, needle exchange, and behavioral health.
- Women could receive HIV/STI counseling, testing, and contraceptive care through telehealth. Outreach educators help them access telehealth providers and give them condoms and STI test kits.

care in different kinds of settings," Thompson says. "The more we can make information widespread for providers, the better off we'll be." With reproductive health services, telecommunication technology can help increase the spread of information, she says.

There are some issues with telehealth that family planning clinicians need to keep in mind, Coplon notes. For instance, at the start of each telehealth call, the provider introduces the patient to each person in the room, even if the person cannot be seen on the video call.

"We make sure they understand that nothing is recorded, and there is no lasting documentation about the visit," Coplon says. "They sign a consent specifically related to telehealth."

When patients discuss STIs and abortion services, they may not want their family members to hear them speak on the telehealth call. Clinicians will ask the patients for a code word they can give when their family member walks into the room and they want the talk to shift to something that appears to be non-healthcare-related, she explains.

The study authors' findings that telehealth can benefit women with OUD suggest that an expansion of telehealth services to additional populations would be practical and helpful. "The pandemic has shown us that many parts of sexual and reproductive health services can be provided outside the clinic setting," Thompson says. "Counseling, screening, prescriptions, and follow-up care are not out of reach of individuals because they can't make it to a clinic."

Adding more telehealth to family planning services in the post-pandemic environment will extend the clinic and reduce the need for patients to travel. It will save patients the time and cost of finding child care and transportation, reducing barriers to care.

"There are ways to bring parts of the service to individuals using technology. That's a really important lesson, especially as we think about sustaining access to care during a public health crisis," Thompson says.

However, the benefits of telehealth do not mean that clinics should ignore potential disparities and barriers to this service.

"Telehealth is not a silver bullet," Thompson says. "I think about younger people who, if they are in spaces that don't allow for privacy, where patients can receive services safely, then telehealth is challenged and there still is a barrier." ■

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New Guidelines Reinforce Need for Change in Cervical Cancer Screening Practice

Goal is fewer routine Pap smears

Screening standards for cervical cancer have changed over the past two decades, including several updates since the first consensus guidelines, published in 2001 by the American Society of Colposcopy and Cervical Pathology (ASCCP). The 2020 revision is based on data showing that patients' risk of developing cervical precancer or cancer can be estimated using screening test results, biopsy results, and consideration of personal patient factors.[1]

The new guidelines are for the management of cervical screening abnormalities and accommodate the available cervical screening techniques, such as primary human papillomavirus (HPV) screening, co-testing with HPV testing and cervical cytology, and cervical cytology alone.

"Thirty years ago, there were only Pap smear pathology screening, and if you found something, you followed people carefully to make sure they're clear of disease," says **Naomi Jay**, RN, NP, PhD, assistant clinical professor of nursing at the University of California, San Francisco School of Nursing. Jay is a former member of the ASCCP board and is the immediate past president of the International Anal Neoplasia Society (IANS). "Over the years, the standards have built on changes in technology and changes in the understanding of the natural history of the disease."

Endometrial cancer is rare in premenopausal patients who do not have any risk factors. But the prevalence of premenopausal endometrial cancer is on the rise.[1]

Endometrial cancer also has increased for postmenopausal women, ages 50 to 74 years, research

shows. One study revealed that the endometrial cancer rate increased 10% from 2006 to 2012.[2]

Researchers studying cervical cancer and HPV found that some HPV infections spontaneously resolve, Jay says.

"What we learned was we could do less referrals to treatment," she explains. "When I started [practice], we treated everything, including mild dysplasia and warts." Now, clinicians have learned they do not need to treat mild dysplasia.

The new risk-based management guidelines for cervical cancer advise clinicians to refer patients for a colposcopy based on the patient's risk of high-grade dysplasia or cancer. "A lot of hybrid dysplasia will never progress to cancer," she explains. "What we want to do in this field is the least amount of harm, and part of the way we can do that is by only referring people to colposcopy when they absolutely need it."

Patients with high-grade dysplasia would be treated, while those who do not need those exams would be spared that experience. "The paradigm shift in these guidelines is it's shifting us from basing our clinical actions on the results to a threshold on what the patient's actual risk is to have severe dysplasia or cancer," Jay says. "Colposcopies are expensive, uncomfortable, involve biopsies. It's overtesting, unnecessarily."

The guideline change treats this screening like other tests, such as colonoscopies, that are recommended based on a person's age and risk factors. "If you have a colonoscopy and there's an abnormal result, you come back in three years, five years, or one year," Jay says.

If there are no concerning results, then people do not have to come back for 10 years. "It's the same idea that we're trying to do the least harm, and the least harm is doing as few of these extra procedures as possible," Jay says. "A lot of colposcopies turn out to be unnecessary. If there's a lesion in a 26-year-old, it might go away by itself; you would worry about it in a 35-year-old differently than in a 22-year-old."

"IT'S SHIFTING US FROM BASING OUR CLINICAL ACTIONS ON THE RESULTS TO A THRESHOLD ON WHAT THE PATIENT'S ACTUAL RISK IS TO HAVE SEVERE DYSPLASIA OR CANCER."

The guidelines provide clear recommendations based on risk, including the grade of cervical intraepithelial neoplasia (CIN). The new risk-based guidance says colposcopy can be deferred for patients with minor screening abnormalities indicating HPV infection with a low risk of underlying CIN 3.[1]

ASCCP also recommends excisional treatment instead of ablative treatment for histologic HSIL (high-grade squamous intraepithelial lesion), CIN 2, or CIN 3.

Another change in the revised guidelines is the suggestion to continue surveillance with HPV testing or co-testing at three-year intervals for at least 25 years after treatment and initial post-treatment management of histologic HSIL, CIN 2, CIN 3, or adenocarcinoma in situ. Surveillance at three-year intervals beyond age 25 is acceptable.

"The 2012 guidelines recommended return to five-year screening intervals and did not specify when screening should cease. New evidence indicates that risk remains elevated for at least 25 years, with no evidence that treated patients ever return to risk levels compatible with five-year intervals," the guidelines state.[1]

"The decision algorithms are based on a woman's risk rather than her results," Jay says. "The guidance is very simple with examples, so the clinician always is going to be making decisions because not everyone will fall neatly into algorithms, and patients are going to have a say about it."

The main takeaway message of the revised guidelines is that clinicians can perform fewer colposcopies and increase HPV testing.

"HPV testing is taking over Pap smears as the better tool," she adds. "It's looking at whether the woman has a high-risk HPV strain, vs. looking at the cellular level as a Pap smear does."

Evidence and subsequent guidelines on HPV screening and Pap smears have changed over the past decade in terms of which screening test should be used for women being seen in a clinic for cervical cancer screening, Jay says. ■

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