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INSIDE

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Study: Hormonal IUDs Provide Safe, Effective Emergency Contraception

The IUDs can be placed anytime

When patients seek an emergency contraceptive option, some will select the copper intrauterine device (IUD) over the Plan B levonorgestrel emergency contraception pill because of the IUD's greater efficacy and long-term contraceptive benefit.

But, until now, clinicians would not have recommended a hormonal IUD for that purpose. This may change in 2021, as more physicians follow the evidence from a recent study that shows the levonorgestrel IUD is noninferior to the copper IUD for emergency contraception.[1]

For people who need emergency contraception and also seek a highly effective, ongoing contraceptive, this research suggests the hormonal IUD is a good option, says **Krishna Upadhya**, MD, MPH, vice president of quality care and health equity with Planned Parenthood Federation of America.

> FOR PEOPLE WHO NEED EMERGENCY CONTRACEPTION AND A HIGHLY EFFECTIVE, ONGOING CONTRACEPTIVE, THIS RESEARCH SUGGESTS THE HORMONAL IUD IS A GOOD OPTION.

"This is significant because many people might prefer the hormonal IUD. Having that as a clear option for emergency contraception is really beneficial," Upadhya explains. "That's the main takeaway,

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and it's something that many of our health centers are eager to put into practice."

IUD Advantages

IUDs as emergency contraception have a couple of advantages over Plan B: They are more effective at preventing pregnancy, and they provide a long-term contraception solution. More than a decade of research shows that Plan B does not reduce rates of unintended pregnancy.[2,3]

"Studies show that oral emergency contraception has no effect on unintended pregnancy," says **David K. Turok**, MD, MPH, lead author of the study and associate professor in the department of obstetrics and gynecology at the University of Utah.

Estimates suggested that Plan B would lead to a 50% drop in unintended pregnancy and abortion rates, but this never happened. Researchers found that the copper IUD is much more effective than oral emergency contraceptives at preventing both fertilization and implantation.[2]

Surprised that emergency contraception did not solve this problem, Turok and other researchers decided to investigate the use of an alternative to the Plan B pill: a hormonal IUD.

"In our current study, people came to the clinic, requesting emergency contraception. [If they enrolled in the study] they were randomized to get either the copper or hormonal IUD," Turok explains.

This IUD research took place in the past decade when IUD use was increasing in the United States. By 2014, IUDs comprised almost 12% of overall contraceptive use among people in the United States,[4] says **Elizabeth Watkins**, PhD, dean of the graduate division, vice chancellor of student academic affairs, and professor of history of health sciences at the University of California, San Francisco. *(See story on the history of IUDs in this issue.)*

Between 2008 and 2014, the largest increase in contraceptive use was among people who used long-acting, reversible contraceptive (LARC) methods, including the IUD.[4-6]

"First, we looked at emergency contraceptive vs. copper IUD. Second, we had people select a copper IUD or levonorgestrel IUD, and if they got the hormonal IUD, they also took Plan B," Turok

EXECUTIVE SUMMARY

A recent study reveals hormonal intrauterine devices (IUDs) are safe and effective as emergency contraception.

- Hormonal IUDs are more effective at preventing pregnancy than the Plan B levonorgestrel emergency contraceptive pill, and they provide a long-term contraception solution.
- The copper IUD already was shown to be an effective form of emergency contraception. Now, the new research opens the path for providers to prescribe the hormonal IUD for the same purpose.
- Another positive finding is that the hormonal IUD can be placed safely at any point in a patient's menstrual cycle (following a negative pregnancy test).

explains. "The third study compared the copper IUD and hormonal IUD."

More people wanted the hormonal IUD, and the pregnancy rates were lower than expected. "The point of doing this current study was to show you didn't also need Plan B," Turok says.

While IUDs do not work for all people, they are a good option for patients interested in using a quick-start contraceptive. A family planning clinic can provide patients with an IUD on the day they walk into the clinic, Turok says.

Many physicians will not place a hormonal IUD on the same day of the patient's walk-in visit if the patient says she has just had unprotected intercourse. "These data say you can place it, and you can do it with confidence," he adds.

Physicians concerned about same-day IUD placement worry about a pregnancy that is so early that placing an IUD would interfere. "In the study, we got a urine pregnancy test on everyone before the IUD was placed to make sure it was negative. If you do that, the risk going forward is very low," Turok explains.

Participants, recruited from six Utah clinics, had at least one episode of unprotected intercourse within five days before presenting at the clinic. They agreed to a placement of an IUD, and were followed to see if pregnancies occurred within one month of IUD insertion.

There was a pregnancy rate of one in 317 in those enrolled in the levonorgestrel IUD group; in the copper IUD group, the pregnancy rates was zero in 321. Adverse events in the first month after placement amounted to 5.2% for the levonorgestrel IUD group, and 4.9% of the copper IUD group.[1]

"People are currently offering the copper IUD as emergency contraception, but it's definitely being underutilized, and an even smaller group is offering levonorgestrel IUD with Plan B," Turok says. "But this will raise awareness of both options."

Menstrual Cycle Should Not Be a Barrier

The study results also reveal that menstrual cycle timing should not be a barrier to starting the IUD. "Historically, there have been a lot of barriers to starting contraceptive methods, and it's been around timing of menstrual cycles because providers know women are unlikely to be at risk for pregnancy if they're menstruating, so they do an IUD insertion at that time," says **Lori M. Gawron**, MD, MPH, FACOG, study co-author and associate professor of obstetrics and gynecology at the University of Utah. "That's a barrier, too. Accessing care and scheduling care puts them at risk until they can get in and have that IUD placed."

The study results alleviated providers' concerns about when to place an IUD because it reinforced the idea that as long as a pregnancy test is negative, it does not matter where a woman is in her menstrual cycle, Gawron adds.

Family planning clinics likely will be the first places to change emergency contraceptive policies because of the researchers' findings. Individual physician offices might not be able to provide same-day IUD insertion, whereas some family planning clinics can offer IUDs to women who walk in that day.

"Family planning clinics are set up for more walk-in, same-day availability," Gawron explains. "Women can walk in for whatever they need, and there are providers on hand who can always insert IUDs."

The finding that the hormonal IUD works as well as the copper IUD for emergency contraception means more American women may be open to that solution to prevent an unintended pregnancy.

Globally, the copper IUD is more widely used. But in the United States, more women prefer the hormonal IUD for the benefit of less bleeding, Gawron notes.

"We already knew the copper IUD works better than oral emergency contraception," she adds. "Now, we know the hormonal IUD is equivalent to the copper one." If a woman enters a doctor's office or clinic and wants the best chance of preventing pregnancy, then the IUD is the best option, she says.

Policy Changes Pending

The fact that the study was published in the *New England Journal of Medicine* suggests it could soon lead to changes in clinical practice regarding emergency contraception, Turok says.

"This study comes from a single Planned Parenthood affiliate, and it's very much a local study, answering a local question that has national and global implications," he explains. "The data are going to be used all over the place, hopefully."

Planned Parenthood Federation of America has not yet changed its standards to state that a hormonal IUD could be quick-started at any point in the cycle, or that the hormonal IUD could be a good option for an emergency contraceptive.

"That's something we're reviewing in terms of our guidelines," Upadhya says. "The fact that being able to initiate an IUD at any point in the cycle would be an advantage."

Planned Parenthood guidelines go through a standard review process before they are updated. "A complete update goes through the guidelines every couple of years," Upadhya says. "We review data as it comes out and make changes to practices as needed."

The new study's findings are huge and exciting. "There are a lot of people for whom the hormonal IUD is a preferred method of birth control, and having that as an option equal to the copper IUD is a great thing for people," Upadhya says.

"We encourage our affiliates to let us know if this is something they want to implement, and we review with them the parameters of how to do it," she adds. "Most of our affiliates have indicated this is something they want to move forward with." ■

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After Decades of Highs and Lows, IUDs Once Again Rising in Popularity

Dalkon Shield fallout led to nadir in IUD use

After falling in and out of favor, the intrauterine device (IUD) is once again gaining popularity among women in the United States and worldwide.

In the late 1960s and early 1970s, the IUD was used by one out of 10 reproductive-age women in the United States. But by the mid-1990s, the IUD had mostly disappeared from use, according to a new paper on the IUD's rocky history.[1]

One particular IUD nearly ended the contraceptive: The Dalkon Shield.

"For people who were around in the 1970s or early 1980s, and for those of us who studied birth control, the Dalkon Shield looms so hard over the history of IUDs," says **Elizabeth Watkins**, PhD, dean of the graduate division, vice chancellor of student academic affairs, and professor of history of health sciences at the University of California, San Francisco.

The Dalkon Shield consisted of a five-pronged, crablike shield. It contained small amounts of copper and was attached at the base to a string. Its marketing campaign emphasized its safety over traditional contraceptive pills, according to the Embryo Project Encyclopedia.[2]

Within a few years, 2.2 million women used the Dalkon Shield, making it the most popular IUD in the United States in the 1970s. But problems emerged, including septic infections. Investigators found that the string attached to the device would fray, disintegrate, and draw bacteria into the uterus, leading to septic infection, miscarriage, and death.[2]

Women also reported that the IUD did not prevent pregnancy, which was confirmed by a 1973 study from the Centers for Disease Control and Prevention (CDC). Researchers found that the Dalkon Shield was correlated to increased pregnancy-associated complications and other health problems requiring hospitalization and resulted in 18 known deaths. After more studies confirmed the IUD's ineffectiveness at preventing pregnancy and its health risks, the manufacturer pulled it from the market.[2]

"There were thousands of lawsuits against the company, which later filed for bankruptcy," Watkins says.

By 1995, only 0.8% of American women on contraceptives used the IUD. But 20 years later, that percentage shot up to almost 12% using a device. The IUD's ranking in preferred contraceptive methods rose from 10th to fourth. The top three methods are the pill, female sterilization, and the male condom.[1]

The IUD's rehabilitated image largely is due to physicians and researchers. The Affordable Care Act's elimination of an upfront cost for IUD insertion for people with insurance meant more women could afford and access IUDs, Watkins says.

Between 1986 and 1988, there were no IUDs on the market in the United States, Watkins says. Family planning organizations sought to change this. In 1988, the copper IUD (Paragard) was approved for marketing in the United States. Mirena, the first hormonal IUD, was marketed in Finland in 1990, then a decade later in the United States.

"The story I tell is about one physician who took it upon herself to spread the gospel of long-acting reversible contraceptives [LARCs]. Her name is Eve Espey," Watkins explains.

In the early 1990s, Espey was a staff physician for the Indian Health Service. She was concerned about how few birth control options were available to girls in the teen clinic. She personally used the new Paragard copper IUD and wondered why other physicians were not enthusiastic about the method, so she researched it for her master's in public health thesis.[1]

"Dr. Espey looked at the literature and found out that research articles, even in the 1980s, should have supported IUD use, but because of the Dalkon Shield, it passed a pall over IUDs," Watkins says. "She realized IUDs were safe, so she worked with the American College of Obstetricians and Gynecologists to get them to promote the use of LARCs."

There is ongoing debate over whether LARCs should be promoted as first-line contraceptives, over all others. "There's a lot of concern about coercive use, contraception where women don't have control, and it requires a physician to remove them," she says. "There's a backlash against directive counseling because of concerns that young women and women of color will be forced into this choice."

Some of this concern is based on historic paternalism, in which people involved in population control, from 50 and 60 years ago, did not believe women in underdeveloped countries would be able to take a daily contraceptive pill. They were looking for other solutions, Watkins explains. "And they believed economic development was tied to women's fertility, instead of education and job opportunities. IUDs gained in popularity in the 1960s."

By the 1970s, almost 10% of women were using IUDs. After the Dalkon Shield, IUDs fell out of favor.

Current IUDs marketed in the United States are both safe and highly effective at preventing pregnancy. Confidence in IUDs has risen among physicians and women.

"There should be a menu of contraceptive options," Watkins says. "Clearly, the long-lasting ones are the most effective." ■

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As Title X Advocates Wait for Biden to Lift Gag Rule, Top Court Takes Case

The U.S. Supreme Court will hear a case that could have a long-term effect on the operations of Title X programs and access to affordable reproductive health services for millions of women.

For the past two years, reproductive health organizations and advocates have challenged the former Trump administration's Title X rule changes that prohibit Title X providers from mentioning or counseling on abortion. Court rulings were mixed, and one in four Title X providers left the program because of regulatory changes that included modifications to many sites' physical space, as well as a gag rule about abortion.

For example, one of the main Title X regulatory changes was a rule that prohibited doctors and others in Title X clinics from mentioning abortion or counseling patients about abortion, even when asked about it as an option. Because of this prohibition, many Title X clinics pulled out of the program, leaving more than 1 million people, mostly economically vulnerable women, without access to Title X services.

In January, the Biden administration announced it would review the changes to Title X, but had not suspended enforcement of the changes through the end of February. *(See story on Title X and Biden administration in March 2021 issue of* Contraceptive Technology Update, *available at: https://bit.ly/3b8isSW.)*

"The U.S. Supreme Court granted Essential Access Health's request to review our Title X challenge, submitted in the fall [2020]," says **Julie Rabinovitz**, MPH, president and chief executive officer of Essential Access Health in Berkeley, CA.

Legal challenges to the Title X regulatory changes by the U.S. Department of Health and Human Services (HHS) lost in a Feb. 24, 2020, decision by the 9th U.S. Circuit Court of Appeals.[1]

Essential Access Health, along with the American Civil Liberties Union (ACLU) and other organizations, filed a petition to the Supreme Court, which has requested briefs by mid-April. "It is our hope and expectation that long before oral arguments can be heard, the Biden administration will provide relief to organizations," Rabinovitz says. "Title X organizations cannot wait for our case to play out; we need swift executive action right away."

For instance, the Biden administration could suspend enforcement of the Title X gag rule, or it could say that HHS will not defend the case in court.

"We were very disappointed [with the Biden administration's memorandum]," Rabinovitz says. "We believe the presidential memorandum, while it was a first step, really fell short."

In 1993, President Bill Clinton's new administration faced a similar challenge because of the Supreme Court's 1991 decision to uphold the Title X abortion-counseling gag rule. President Clinton quickly directed HHS to suspend enforcement of the gag rule. "We're now asking for swift action by the Biden administration," she adds. "It needs to happen before oral arguments are due to the Supreme Court."

The Trump administration's rule brings immense harm to people who depend on affordable reproductive healthcare, including birth control, breast and cervical cancer screenings, and testing and treatment of sexually transmitted infections (STIs), according to a Feb. 22 joint statement by the ACLU, the American Medical Association, Essential Access Health, the National Family Planning & Reproductive Health Association, and Planned Parenthood Federation of America.

"Tragically, but predictably, this disproportionately impacts Black and brown patients who are more likely to face the worst health and economic impacts from the COVID-19 pandemic," according to the statement.[2]

About one in four Title X providers left the program, and 1.5 million people lost their Title X reproductive health services.[3] Planned Parenthood Federation of America was one of the organizations that pulled out of Title X because of the rule.

"The Title X gag rule is designed to target abortion providers to score political points; in practice, it forces community healthcare providers like Planned Parenthood out of the program, taking away access to reproductive healthcare, like birth control and life-saving cancer screenings," **Alexis McGill Johnson**, president and chief executive officer of Planned Parenthood Federation of America, said in a Feb. 23 statement on the Supreme Court's action. "The gag rule's harm is felt most by those who have always faced systemic barriers to healthcare, including people in rural areas, and Black, Latino, and indigenous communities. We are proud to join with our partners in taking this fight to the highest court; however, patients need access now and can't wait for a Supreme Court decision."

The Trump administration's changes to Title X jeopardize women's reproductive health. "Each day these federal regulations are in place, the federal government is dictating a lower standard of care for women across America, disproportionately impacting rural regions and communities of color," Rabinovitz says.

"We're thankful the Biden-Harris administration already initiated a review of the Trump administration's harmful changes to the Title X program and look forward to working with them to quickly create a pathway to program re-entry for healthcare providers who have been forced out," Johnson said. "We need to modernize and expand Title X to ensure that the delivery of sexual and reproductive healthcare meets the needs of all people." ■

EXECUTIVE SUMMARY

The U.S. Supreme Court will hear the multiorganization challenge to the former Trump administration's Title X regulatory changes that caused one out of four Title X providers to leave the program.

- The Biden administration said it will review the Title X changes, but did not suspend enforcement, at least through the end of February.
- The Title X gag rule was a political move that cost many vulnerable women access to affordable reproductive healthcare.
- Black, Latino, Indigenous, and rural populations have suffered the most under the Title X changes.

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Women Have Expressed Pregnancy Hesitancy in the COVID-19 Pandemic

Research suggests that many women have been unwilling to become pregnant and start or increase their families during the COVID-19 pandemic, but they sometimes have faced new contraceptive barriers.[1]

Beginning in May 2020, researchers recruited reproductive-age women through social media, including Facebook and Instagram, to answer questions about their economic status and pregnancy intentions before and during the pandemic.

"The study took place when everyone started sheltering in place and everything was chaotic," says **Tracy Kuo Lin**, PhD, MSc, the study's lead author and assistant professor of health economics for the Institute for Health and Aging at the University of California, San Francisco. "We asked women specific questions about their economic situation and family planning and pregnancy intentions during the early part of the pandemic."

The researchers asked women about these factors, both before and during the pandemic:

• Demographics, including age, race/ethnicity, relationship status, number of children, household size, income, state of residence, and employment status;

• Ability to afford food, transportation, and housing;

• Their risk of severe illness from COVID-19 due to comorbid health conditions, such as asthma, heart conditions, lung disease, diabetes, liver disease, immunocompromised status, and dialysis;

• How concerned they were about contracting COVID-19 and the status of their location's shelter-in-place orders;

• Pregnancy intention/desires, based on the Desire to Avoid Pregnancy scale;

• Contraceptive use, including type of contraceptive, frequency of use in the past three months, and how contraception access was affected by the pandemic;

• Frequency of sexual intercourse in the past 30 days, if they chose to have sex, and why they had sex if it was not their choice.

"We wanted to capture the situation from before and after the pandemic began," Lin says.

Investigators analyzed respondents' household income to see if it fell below or above the federal poverty level (FPL). They also asked respondents to indicate how they felt about becoming pregnant and how their desire to bring a child into the world changed during the pandemic.

"We found that there was an increase in food insecurity," she says. "We also found that those who expressed a reduction in desire to be pregnant also experienced difficulties in accessing contraceptives."

It turned out that some vulnerable groups of women experienced a reduction in income and a desire to avoid pregnancy, but they had difficulty accessing contraceptives. "It's a really bad place where you know you have economic difficulties in supporting a child, as much as you want," Lin says. "You may have lost money in the pandemic and may have a reduced income in the pandemic, but you are having issues accessing contraception, and that includes a barrier to doctor's appointments or lost healthcare because of the lost employment."

At the end of the survey, researchers asked women if there was anything else they wanted to share. This elicited some surprising responses.

"Usually, people skip that question, but a lot of women wrote paragraphs about their experience," Lin says. "They were using contraceptives before the pandemic and were employed with health insurance, and then they lost their job and insurance and were having difficulty paying for the contraceptives they were using prior to the pandemic."

Some women explained their difficulties making appointments with providers to change their contraceptive method or to have an IUD inserted or removed.

"We also found that there was a disproportionate impact on people

of color in the pandemic," Lin notes. "Those who identified as Latina or African American were more likely to experience difficulty with transportation, food, and housing during the pandemic."

Based on the data, people who were more vulnerable, including minorities, experienced economic insecurity and barriers to accessing contraceptives even though they wanted to avoid pregnancy.

Some of the women worried about bringing a child into the world during the pandemic — or ever.

"One woman shared, 'I was about 90% sure I did not want to have children prior to the pandemic. But seeing everything going on with quarantine and the inability to have school and child care and the loss of jobs, plus greater health risk of the pandemic, have solidified any doubt in my mind that I might want to have children,'" Lin says.

Other women expressed concern about their current pregnancies. "One woman wrote, 'It has been rough being in a state lockdown so close to giving birth, on top of depression and anxiety. I felt so terrified and still do about the current state of everything, and it has made me feel guilty about bringing children into the world at this scary time,'" Lin says.

Women shared feelings of being alone. One woman even said that she found it oddly comforting to take part in the survey because it made her feel as though someone outside of her family cared about her. "It was heartbreaking and difficult reading this at the start of the pandemic," Lin says.

Using quantitative analysis, researchers assessed respondents' desire to avoid pregnancy. One in four respondents expressed a decreased desire to become pregnant. But close to one in six respondents said they had difficulty accessing contraceptives.

Women also had unmet reproductive health concerns during the pandemic. One woman said, "'When under extreme stress, my body tends to internalize it, and my menstrual cycle is off the normal pattern by either skipping a period or having an extra heavy flow,'" Lin recalls.

"She said, 'I haven't had my periods since the end of February. As a precaution, I took two pregnancy tests last week, and both were negative. I'm curious — are there any other women experiencing this as well?'" Lin adds.

Almost half of the respondents experienced a loss of income during the pandemic compared to pre-pandemic. The percentage of respondents who said they could not afford basic living needs doubled during the pandemic from 8% to 16%.

Respondents found it harder to obtain a contraceptive prescription or to have a long-acting reversible contraceptive placed, Lin says.

There were some positive reports from the respondents. For example, some women said they received assistance from nonprofit organizations and social networks for their economic needs. "They had commented on how local food banks and community assistance played a huge role in easing food insecurity," Lin says. "Family planning clinics that offered free healthcare in the pandemic helped them a lot, and some family planning clinics were willing to treat UTIs [urinary tract infections] for free."

While these community and nonprofit organizations did not completely fill the economic and healthcare gap, they helped a little.

"We really need a healthcare system and health insurance that is not tied to employment, because often when employment goes, people need more healthcare," Lin says. "In dire situations, people need more care." ■

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Teen Educator Program Helps Youths with Reproductive Health

A team of teen educators in Wisconsin teach their peers about reproductive healthcare and how to advocate for their own needs.[1]

"These are peer-to-peer sessions where teens go out and educate other teens about their healthcare," says **Erica Koepsel**, MA, implementation director of Providers and Teens Communicating for Health (PATCH) with the Wisconsin Alliance for Women's Health.

Teen educators, typically ages 15-18 years, are hired in the summer and usually are ready to provide educational sessions by fall. "They do education around sexual and mental health, social justice, and equity," Koepsel says.

PATCH teens also help educate providers on various topics:

• **Building a relationship with a teen.** This covers body language and how to make teens feel more comfortable around the provider, Koepsel says.

• **Explaining patient rights.** "We want providers to know that teens have rights, and teens don't always know they have rights," she explains. "We talk about confidentiality and how providers can better explain confidentiality to them and what it means to have parents in the room."

• **Talking about teen patients' responsibility.** "This piece is making sure providers are helping teens transition from adolescent to adult care," Koepsel says. "Teens can make their own doctor's appointments."

Providers also can speak with teens in ways that show respect for where they are in their transition to adulthood.

• **Making sure they know about confidentiality.** "If something is wrong in the provider relationship, and if they feel they are not heard, we encourage them to find another provider," Koepsel says. "We say, 'You have a right to confidentiality.'"

Sometimes, teens react angrily to being told about confidentiality. "They say, 'You mean you're telling me I could have a conversation alone with my doctor and have no one with me?'" she says.

Confidentiality laws vary from state to state. But all states permit teenagers to consent to some treatment for sexually transmitted infections, and many states permit teens to access contraceptive care, HIV testing, or other care related to reproductive health,[2] Koepsel says.

"The American Academy of Pediatrics suggests allowing one-on-one time with providers and young persons, starting as early as 11 or 12 years old," she adds. "They cannot consent to their own care, really, but they can have a conversation about confidentiality."

Teen are less likely to open up to their physicians about their sexual health or mental health if a parent or siblings are in the room with them. "They don't want to disappoint the people in their lives with their decisions," Koepsel explains. "The provider can't force the parent out of the room, but they can make a suggestion."

Providers also can find subtle ways to get one-on-one time with adolescent patients. For example, they could say, "Wait here. I'm going to take Suzy back. We're going to have a conversation, and then you can join us," she suggests.

"We've also seen providers take the child to the room first and talk to the teen while taking their height and weight," Koepsel adds. "Teens don't want to ask for it themselves, so it's really about the provider initiating the [confidential] conversation. There are abundant ways that people are doing this well."

Title X clinics are a safe way for teens to access confidential care. Many have learned about these clinics through peers or the internet, and visit without their parents or guardians. "We have teens who take a lot of their peers to Title X clinics around here," she says. "We see a lot of teens supporting teens, which is great."

Confidentiality also continues after the teen leaves the clinic. Without precautions, this could be a major privacy breach for vulnerable patients. For example, one teen took a confidential pregnancy test before starting contraception. Two weeks later, the clinic mailed the teen an explanation of benefits, listing the test, and her parents saw this.

"This young person, luckily, had a good home environment," Koepsel recalls. "But it made an uncomfortable dinner."

Clinicians should recognize this confidentiality challenge and find a safer way to send the patient follow-up results and information. For instance, one tactic many family planning clinics use is to ask for results and benefits information to be mailed back to the clinic where the patient could return to pick it up on a return visit, Koepsel suggests.

• **Watching body language.** Clinicians should be cognizant of their own body language as well as the teenage patient's, as these messages are important when working with this population. Since many healthcare organizations have adopted electronic records and patient notes, this has made it a bit more challenging to watch patients' body language.

"It can feel impersonal, taking down information with virtual notes," Koepsel says. "Get on the patient's eye level, letting them know that you're interested in them as a person."

• **Showing interest to improve rapport.** "Find something to talk about with teens. It doesn't have to be about healthcare," she says.

Providers can ask patients about their high school sports or club activities. Then, providers can explain what they are doing and what any procedure or test might entail.

The teenagers say they want providers to get to know them, to explain what will happen, and to treat them like young adults, giving them respect through body language (not expressing boredom or being in a hurry) and in how they speak with them. "They say, 'Don't assume we know everything, and don't talk down to us,'" Koepsel says. "'Treat us like young adults.'"

One model that providers can use is the HEADSS model, a method for asking about the adolescent patient's

life, from the least sensitive to the most sensitive conversations. This model can start with the patient's activities and move toward drug and alcohol use and sexuality.[3]

"We talk about the [HEADSS] model, and that's where a teen's body language comes into play," Koepsel says. "If you ask about their family first, the teen will shut down, cross arms over chest."

The HEADSS model covers these interview topics:

- home and environment;
- education and employment;
- activities;
- drugs;
- sexuality;
- suicide and depression.

The theory is that it is better to start the conversation with questions about school, an afterschool activity, or interest before asking questions about the teen's drug use, sexual experience, mental health, and relationship with parents.

"We see that providers do really well with getting to know teens and making them feel comfortable," Koepsel notes. "When providers share pieces of themselves, tell them something they're interested in, teens respond well to that. It's a two-way relationship that means a lot."

Teens also appreciate it when providers explain what is happening, diving into details. "Some teens are interested in becoming healthcare providers one day, and they enjoy learning," she says.

"Our hope is that providers will examine what they're doing and determine if it's serving patients the way they want to serve patients," Koepsel adds. "Are they providing young people the opportunity to learn about their healthcare? Are they defining words for them and asking them about their family history, instead of asking the parent or guardian?" ■

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For Adolescents, Menstrual Health Is a Vital Sign

From both a global and domestic perspective, reproductive health providers should focus on menstrual health issues with women as part of their overall reproductive wellness and healthcare, according to the authors of a new paper on sexual and reproductive healthcare and rights.[1]

Menstruation should be thought of as a vital sign, particularly for adolescents, says **Lucy C. Wilson**, MPH, independent consultant with Rising Outcomes in Hillsborough, NC.

"Ask about menstruation as a potential indicator of other health problems, particularly in girls and adolescents," she advises.

In 2006, the American Academy of Pediatrics Committee on Adolescence and the American College of Obstetricians and Gynecologists (ACOG) Committee on Adolescent Health Care said the menstrual cycle should be used as a vital sign for girls and adolescents. In 2015, ACOG reaffirmed this in a committee opinion.[2,3]

Clinicians learn what is clinically relevant in family planning and reproductive health, but they tend to forget their personal experience when speaking with patients in a professional setting, Wilson says. For example, Wilson recently spoke with a man who ran a program providing reproductive healthcare to adolescents. He also was a father of an adolescent girl.

"He said, 'I'm taking my daughter to the gynecologist next week; she's 13 and started her period, and it's really painful, so we'll take her to the doctor to get her on contraceptives to make it less painful,'" Wilson recalls. "He only thought about this from the perspective of his daughter, and it didn't translate for him to the work he was doing professionally, partly because menstruation is not talked about openly."

Once this dichotomy is brought to providers' perspective, they can think about how their patients' decisions about contraception might be affected by menstruation. "Taboos around menstruation make it more challenging for someone in a reproductive health program to address it," Wilson notes.

There is no one way to expect people to view their menstruation and its effect on their contraception decisions. For many people, using a contraceptive that reduces or ends monthly bleeding and menstrual pain is a positive. But for others, menstruation means something different.

"Some people see bleeding as a positive, and without the monthly reminder, they worry about whether or not they're pregnant," Wilson says. "Others feel menstruation makes them feel like a woman; others like it because it allows them to not have sex that week."

Menstruation and bleeding changes also can affect women's decisions to discontinue a particular contraceptive method. Some people might view the sporadic bleeding and spotting that occurs when switching to a progesterone-only contraceptive as an adverse effect instead of a potential benefit, Wilson says. Or, patients may want a particular contraceptive because it will stop their bleeding eventually, but some providers only note the expected change in menstruation and do not frame it as a potential benefit.

Women in the United States and in other countries often lack the financial resources to afford menstrual health products, or they do not want to be inconvenienced with them. For them, contraceptives that stop their monthly bleeding could be attractive options.

"Contraception can be seen as an option for managing menstruation, but it can't be seen as the only solution, as in, 'We'll use contraception, and you won't need another menstrual health product,'" Wilson explains.

Clinicians also can open discussion about menstruation to assess patients' pain and other symptoms. This could be an opportunity to educate patients and assess whether their experience is normal or if their pain could be the result of a problem.

For instance, clinicians could ask patients about these menstrual issues:

• **Menstrual pain.** "Several menstrual disorders or disorders of reproductive organs can contribute to more painful periods," Wilson says. "These include endometriosis, uterine fibroids, and adenomyosis."

When a patient says that menstruation is painful, rather than suggest an ibuprofen, the clinician can ask questions to learn more about the type of pain, which could be a sign of other health issues.

• **Menstrual flow.** "There's not a lot of research out there on menstrual flow and anemia, but there is some research around heavy menstrual bleeding, and some contraceptive methods are potential treatments for heavy menstrual bleeding," Wilson explains. "The hormonal IUD [intrauterine device] is marketed for heavy menstrual bleeding and has been used off-label for endometriosis."[4]

• **Premenstrual syndrome (PMS) symptoms.** "Some classic PMS symptoms can be alleviated with contraceptive methods," Wilson says. "Hormonal methods will affect the symptoms that women feel during that cycle."

For instance, the original birth control pill was marketed initially as a treatment for menstrual bleeding and pain. "That was a way to get it approved before it was approved for contraception," Wilson says.

Discussing menstruation with patients also provides an opportunity to determine which contraceptive method will fit with a woman's lifestyle. For example, women who experience problematically heavy periods may not want a copper IUD, which could increase menstrual flow volume.

"I think asking about menstruation and explaining why you're asking about it would be an important step to overcoming the taboo — at least in the doctor's office setting," Wilson says. "Having that conversation with your provider is important, not only to identify whether or not menstruation is problematic or that it underlies potential health problems, but to also help them identify a contraceptive method."

"Providers should recognize that people have distinctly different views about their menstruation," she adds. "Providers may think of it as the curse, but for some it may be an important part of who they are, and they really want to continue menstruating on a regular cycle." ■

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CME/CE QUESTIONS

1. **Investigators found that which form of contraception works as well as the copper intrauterine device (IUD) for emergency contraception?**

   a. Plan B pill
   b. Transdermal contraceptive patch
   c. Hormonal IUD
   d. Oral contraceptive

2. **Which birth control method has risen in popularity since it reached its lowest point in the early 1990s?**

   a. Transdermal contraceptive patch
   b. IUD
   c. Diaphragm
   d. Condom

3. **New research reveals that the COVID-19 pandemic led to economic insecurity and which issue related to contraceptive use?**

   a. Increased demand for contraceptives
   b. Less desire to become pregnant and difficulty in accessing contraceptives
   c. Increased desire to become pregnant and decreased demand for contraceptives
   d. Desire for condoms and mail-order contraceptive pills

4. **One good method for building rapport between providers and teen patients is for providers to:**

   a. share a little information about themselves.
   b. ask teens about their relationship with their parents.
   c. ask the teen's siblings to stay in the room.
   d. show the teen a chart of various topics related to sexual reproductive health and ask him or her to check off the ones they are willing to discuss.

CME/CE OBJECTIVES

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

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