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INSIDE

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Safe and Legal Abortion Access Under Greatest Threat Since Roe v. Wade Decision

Texas law bans nearly all abortions

The largest and most damaging crack in the *Roe v. Wade* bulwark of abortion access was breached Sept. 1, when the U.S. Supreme Court's inaction allowed the state of Texas to ban abortions after six weeks of gestation.

There are no exceptions for rape or incest. The law gives about any person in the nation the right to sue the abortion provider and anyone else who assisted someone with abortion care.

This blow could be followed by the Supreme Court deciding in favor of Mississippi's ban of abortions after 15 weeks of pregnancy. The court will hear oral arguments Dec. 1.

"All eyes are on Texas, but the Supreme Court is also expected to hand down a decision on Mississippi's 15-week abortion ban. A decision to uphold it will lead to states banning abortion entirely in areas of the South and Midwest," says **Julie Rabinovitz**, MPH, president and chief executive officer of Essential Access Health in Berkeley, CA.

Overnight, Texas providers stopped performing abortions for most of patients who sought their care. On Oct. 6, as *Contraceptive Technology Update* was going to press, U.S. District Judge Robert Pitman suspended Texas Senate Bill 8, saying Republican lawmakers had contrived a scheme to unlawfully prevent women from exercising control over their lives, depriving them of a right that is protected by the U.S. Constitution. Despite the court's hold on the six-week abortion ban, it was unclear whether abortion services would resume, as Texas officials said they would seek a reversal from the 5th U.S. Circuit Court of Appeals. They also indicated they could possibly allow people to sue abortion providers who perform post-six-week abortions while the ban was suspended.[1,2]

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"One provider would typically see 30 patients a day who are seeking an abortion. The first day after the Texas law went into effect, the provider only saw six patients, and half were past the six-week limit," says **Lauren Kokum**, spokesperson and associate director of health media with Planned Parenthood Federation of America. "The three patients past the six-week limit had to find care elsewhere, which meant going out of state."

"This has been the most hostile year since *Roe v. Wade* was first decided, even though the majority of Americans — including Texans — want legal abortion," Kokum adds. "We've seen more than 90 restrictions enacted in 2021 alone by state legislators. They're effectively pushing abortion out of reach for patients in some states."

Senate Bill 8, passed by the Texas legislature, is similar to other states' bans on abortions at six weeks of pregnancy. But the difference is in how the ban is enforced.

Other states made medical boards or nursing boards the enforcers of the law. Organizations, such as the American Civil Liberties Union (ACLU), would sue the entities that enforced the law and stop the laws from going into effect, says **Chelsea Tejada**, JD, Justice Catalyst legal fellow with the ACLU Reproductive Freedom Project.

"This law makes it for private citizens to enforce, and that makes it difficult," she explains.

The law gives enforcement power to everyone in the United States, so there are no specific individuals for reproductive rights organizations to sue.

"We sued many individuals to get it blocked, but we haven't been able to [block the law]," Tejada says. "We were working on this before the law went into effect on Sept. 1, but the Supreme Court turned its back on the people in Texas and refused to block the law."

The Supreme Court's comment on its refusal to act was that the law presents complex procedural issues, Tejada adds.

"I think that with what happened in Texas, the United States has taken a huge step back — not just in abortion care, but in protection of gender equality and gender rights," says **Jina Dhillon**, JD, MPH, associate director for access with Ipas in Chapel Hill, NC. "Prior to what happened in Texas, the United States was similar to many other places in the world, in that abortion care gets regulated more restrictively than other healthcare. It's a political power wedge issue, and that's true in most places."

Whether people can access legal and safe abortion care depends on local laws and where they live. "That's true of *Roe*. There are many barriers in the U.S., including waiting periods, ultrasounds, and restricting access. We've exported this kind of political power dynamic associated with abortion in our foreign policy and foreign aid," Dhillon explains.

What happened in Texas with SB 8 was a huge step backward and out of step with what is happening in the rest of the world, Dhillon adds.

For instance, Argentina legalized abortion in 2020. In Septemher, Mexico's Supreme Court ruled the country's criminalization of abortion was unconstitutional. The Republic of Ireland legalized abortion Jan. 1, 2019, following a referendum supported by two-thirds of voters.[3-5]

"In Mexico and Argentina, feminist movements demanded accountability from the powers and the criminal justice system that abortion is decriminalized," Dhillon says. "It's concerning what's happening in the

United States. This is the beginning of bigger backsliding, and that's what we're all waiting and watching for."

When legal and safe abortion care is prohibited, vulnerable women completely lose access to care, Kokum says. Vulnerable people include those who live in medically underserved areas, in contraception deserts, and far from abortion providers. Also, people who are low-income, undocumented, uninsured, or underinsured will potentially lose access to care entirely.

"Those with higher means can access care by going out of state and navigating barriers to care, the costs related to child care, and staying overnight in another state when a waiting period is required," Kokum adds. "Those without means will not make the trip."

Abortion providers already are seeing this dichotomy between those who can still access care and those who cannot as it plays out in Texas. "We're seeing patients who, when they're told they're past the six-week limit and they'll have to travel out of state to get immediate access to abortion care, say, 'That's not an option' because they might be a single parent and have kids at home," Kokum says.

Before the Texas law took effect, 85% to 90% of abortions were performed after six weeks of pregnancy. "The vast majority of people who need access to an abortion are not able to access them at this time," Tejada says.

It might be too late even two weeks after a missed period, even if the person notices it, Tejada adds. Remaining options for those who cannot access legal abortions are self-managed abortions — some of which might be dangerous.

"You're more likely to see women do harmful things to their bodies," Dhillon says. "There are about 55 million abortions every year, globally, and 35 million of them are unsafe."

Although it is possible the Texas law will be blocked in court sometime in late 2021, its damage to reproductive healthcare clinics that provide abortion care is evident.

"At this point, standard abortion care has stopped beyond six weeks for most people because of a fear of lawsuits," Tejada says. "Everyone is afraid of those lawsuits, so providers have been forced to comply with these bans."

A notable exception came in September when Alan Braid, MD, provided a woman with an abortion after six weeks and made his action public through an opinion piece.[6]

As soon as his story was released, two people filed lawsuits against Braid. The plaintiffs do not live in Texas, and both are disbarred attorneys who are not actively involved with anti-abortion organizations.[7]

Braid's public stance on providing a banned abortion, followed by the two lawsuits, shows how damaging the law is to *Roe v. Wade* and its 50 years of legal abortion nationwide.

"The fact that he has been sued by multiple people shows how nefarious this law is, allowing any person to sue and collect a minimum of $10,000 if they succeed," Tejada says. "One individual is seeking $100,000 with no connection to the case."

Oscar Stilley of Arkansas filed a suit asking for $100,000 and for an injunction prohibiting the defendant from performing any more abortions that violate SB 8. Stilley also acknowledged that he is disbarred as an attorney (convicted of tax evasion and conspiracy in 2010), and he is 12 years into a 15-year sentence under home confinement. His lawsuit claims the Texas law does not prevent out-of-state felons from filing civil suits against suspected abortion providers.[8]

"This goes to show how devastating this law would be," Tejada says.

There is no limit to the amount of people who can sue an abortion provider or other people who help a woman obtain an abortion, nor are there jurisdictional limits.

"We're at a difficult point with reproductive rights in the United States," Tejada says. "We have the Supreme Court turning its back on citizens in Texas, allowing this law to go into effect, and there's a direct challenge to *Roe v. Wade* with the Mississippi ban."

On a positive note, the ACLU has succeeded in blocking abortion bans in the past, and the current case also might eventually succeed.

"Every case we have brought that reached [the point of presenting] the merits, we have been able to get blocked. We're confident they'll all be struck down as unconstitutional," Tejada says. ■

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Effects of Texas Abortion Law Could Ripple Nationwide

The recent Texas law that banned abortions after six weeks gestation was written to be enforced by almost anyone, anywhere in the United States — creating a bounty hunter system. It could turn neighbors against neighbors, family members against family members, and incentivize strangers to spy on women.

The law's bounty hunter quality is reminiscent of authoritarian governments' secret police, says **Nada Stotland**, MD, MPH, professor of psychiatry at Rush Medical College in Chicago.

"What this new law sets up, in terms of psychiatry, I can only equate with what people in East Germany went through under the secret police," Stotland says. "Everyone is incentivized to report and spy on the most intimate life of other people, for profit."

The law gives people a big financial incentive to spy on women, see who is giving them a ride, and watch them closely.

"*Roe v. Wade* was based on privacy, and a lot of smart people have complained that this wasn't the best grounds for *Roe v. Wade* [to be decided]," Stotland explains. "Now, we have an action where we're going to a place where there's no privacy at all."

Stotland predicts the law could result in people suing those of whom they are suspicious, even without proof that anyone obtained an abortion.

"Any kind of transaction or behavior could be interpreted as intended to cause an abortion to happen," Stotland says. "If someone borrows $500 from somebody, and that's how much an abortion costs, then [the loaner] has to prove it was for something else; it pervades everything you do and everywhere you go."

Planned Parenthood centers have been flooded with calls from people trying to figure out what they can do and where they can turn for care, says **Lauren Kokum,** spokesperson and associate director of health media with Planned Parenthood Federation of America.

"All three Planned Parenthood affiliates in Texas are experiencing higher call volumes than normal," Kokum says. "The No. 1 question on Planned Parenthood's national Ask the Expert page is, 'How far along can you be to get an abortion?' It's up 102% compared to last year."

The Texas law also is affeceting reproductive health providers nationwide, but particularly in states near enough to Texas that people will drive there for safe and legal abortion care.

State laws that make legal abortion challenging already caused a migratory shift in which people crossed state lines to access abortion facilities. The Texas ban is expected to increase that trend.

"We provide abortions in Oklahoma, Louisiana, and New Mexico, through surrounding affiliates, and all of those states have seen Texas patients," Kokum says. "We even had one health center outside of New York City that saw a patient who flew from Texas immediately after the law went into effect."

Thousands of people go to California and other states to access abortions because they are unable to obtain a legal and safe abortion in their own state, says **Julie Rabinovitz**, MPH, president and chief executive officer of Essential Access Health in Berkeley, CA.

Since Texas SB 8 took effect, this number could increase significantly. "Now, we expect tens of thousands of people to come into California," Rabinovitz says. "From a capacity standpoint, that could be really difficult for a lot of centers if they don't have the ability to expand and serve these patients."

Essential Access Health wants to be a supportive ally to providers in Texas, but its chief mission is to support California reproductive health clinics, she notes.

"We're in active conversations with providers across the country to mobilize and do everything we can do in terms of abortion care," Rabinovitz says. "We're working with the California Alliance of Reproductive Freedom to see what we can do on our end to be supportive of both women and providers in Texas."

The Texas law is particularly stressful for women and abortion providers because someone could be sued based on suspicions, and their legal costs could not be recouped from the accuser.

"We don't know who is going to sue and how they're going to sue, and it's unclear how effective this law will be," Rabinovitz says. "I think it's terrifying."

The Texas abortion ban has mobilized organizations across the country to do more to expand and protect access to abortion care. "We're exploring ways to support partners across the country through telemedicine care," Rabinovitz says. "We're also exploring options to make California a haven for women from other states."

About two dozen states, including California, have publicly opposed the Texas abortion ban. As of press time, the ban was suspended by U.S. District Judge Robert Pitman. Texas officials are appealing this decision to the 5th Circuit Court of Appeals.[1]

SB 8 gives very little legal room for defense. For example, if one plaintiff files lawsuits against different clinics in Texas and loses the first case, the other providers cannot rely on the first case to stop the litigation. Also, ignorance is not a defense. If someone gave money to a woman, who used it to have an abortion, the person cannot win against the plaintiff based on their not knowing that the money would be used for the abortion. Defendants cannot recoup their legal costs, although they have to pay the plaintiff's attorney if they lose.[2]

"Had the Supreme Court just stayed the implementation of that law, then life could have gone on while people argued about this," Stotland says. "What the Supreme Court has added to the horror of this law is a method by which clinics have to shut down."

Meanwhile, pregnant women in Texas who are past six weeks of gestation are left with few safe options. One option is to travel to another state to obtain a safe and legal abortion. Another is to obtain abortion medications from overseas. This option is illegal nationally.

News reports suggest that some Texans have already engaged in self-administered abortions by ordering pills online from international entities.[3]

Undoubtedly, Texas women will face psychological repercussions from the law, Stotland notes.

"There are women who can't get a legal abortion. We know that women will resort to almost anything, including life-threatening interventions, to keep from having babies that they feel they can't be good mothers to," she adds.

The public's sentiment toward favoring legal and safe abortions and the actions of their elected officials who find creative ways to obstruct access to abortions is a cognitive dissonance that has made abortion a political wedge issue.

"The reason we have most people in the U.S. not wanting to outlaw abortion and yet they elect people who pass laws like this is because when you're not in that circumstance, you like to believe you will never be," Stotland says. "Women who belong to religions that condemn abortion get as many abortions as women who don't." ■

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Title X Program Saved by Biden Administration's New Final Rule

Title X organizations and other groups praised the Biden administration for reversing the draconian changes to the Title X family planning program that were enacted in 2019 under the Trump administration.

The 2019 changes, including a gag rule that prohibited Title X providers from discussing or referring patients to abortion services, resulted in one-fourth of Title X providers exiting the program. The number of patients served by Title X was cut in half nationwide. This left 1.6 million patients without care under the program that was designed to improve access to family planning services for low income and vulnerable women.[1]

"This is a very important development. We want to be clear that the Biden administration did the right thing by moving very rapidly to restore the Title X program and return it to its purpose of providing high-quality family planning care all across the country," says **Ruth Harlow**, senior staff attorney for the ACLU Reproductive Freedom Project in New York City.

In some states, the 2019 changes decimated the Title X program. "California's Title X network served nearly 1 million patients at 366 clinic sites across 38 California counties. But after the Trump rules took effect, the number of patients in California served by Title X dropped by 80%," says **Amy Moy**, chief external affairs officer for Essential Access Health in Berkeley, CA.

The Department of Health and Human Services (HHS) published the Title X final rule, "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," on Oct. 7, effective Nov. 8.[2]

"We are thrilled and relieved that with the release of the final rule, the Trump era regulations have been rescinded and replaced, and that opens the door for organizations that made the difficult decision to exit the program under the Trump rules to return," Moy says. "We are ready and eager to welcome those organizations and rebuild our Title X network in California."

The American Medical Association (AMA) also praised the latest action on Title X.

"The Biden administration's final rule reversing drastic changes to the Title X family planning program is a major victory for physicians, healthcare professionals, and the millions of patients across the country who depend on Title X for access to essential reproductive care," AMA President **Gerald E. Harmon**, MD, said in a statement.[3] The AMA had challenged the Title X gag rule's inappropriate interference into the patient-physician relationship and physicians' ethical obligations, he added.

Before the Trump administration, Title X had widespread political support.

"What's been amazing about Title X up until the 2019 disaster is that it had bipartisan support, and it functioned everywhere across the country — red states and blue states," Harlow says. "Title X providers have healthcare uppermost in their minds and have worked very hard to implement the program and keep their eye on that rather than litigation and politics. I would expect that to continue."

When the rule takes effect Nov. 8, most family planning centers that left the program are expected to return and resume Title X care for patients.

"Initial conversations with [California] organizations that withdrew from the program show eagerness and excitement to come back into the program," Moy says. "Now, we can look forward to harmful restrictions being removed."

This is true of Title X programs in all parts of the country. For example, Planned Parenthood of the St. Louis Region and Southwest Missouri, which served 14% of all Title X clients in Missouri before 2019, had pulled out under the Trump era rule. It is expected to return, thanks to the Biden administration's reversal, says **Michelle Trupiano**, MSW, executive director of the Missouri Family Health Council, Inc.

"Planned Parenthood of St. Louis is the only abortion provider in the state," she notes. "We have one clinic in the entire state of Missouri."

Missouri Family Health Council will update its internal policies and work with Title X sites to update their policies and provide training and education in preparation for the 2021 final rule's changes.

"We want to ensure all providers know what they now are allowed to do vs. what they couldn't do over the past two years, and that's the majority of our work over the upcoming months," Trupiano explains.

In addition to eliminating the gag rule, the 2021 final rule includes these changes:

- It ends the requirement that providers maintain strict physical and financial separation of abortion services.
- It requires Title X-funded sites to offer a broad range of contraceptive methods or provide a prescription to clients for their method of choice.
- It clarifies that the program's income verification requirement should not burden patients or prevent them from accessing care.
- It provides adolescent confidentiality protections, including a prohibition on requiring consent or notification of parents or guardians for services.
- It allows more clinical service providers to direct Title X services and provide medical services consultation.
- It allows telehealth for Title X planning services.
- It advances the cause of health equity and requires family planning services to be client-centered, culturally and linguistically appropriate, inclusive, and trauma-informed.[4]

It is possible the 2021 Title X final rule could face a lawsuit from an anti-abortion organization. Any such legal challenge would run into problems because of solid data on how much the 2019 rule damaged the program

and reduced access to family planning services.

"If any suits are filed for rescinding the final rule, they would have an extraordinarily difficult path because the agency has documented how damaging the rule was to this program," Harlow explains. "The agency also has well-articulated reasoning for new changes, so any lawsuit will have a difficult time."

Many lawsuits were filed to challenge the 2019 rule, stating the Trump administration had not followed the procedure act and made sweeping amendments that were detrimental to the Title X program.

"These lawsuits had mixed results — in some places successful and in others, not," Harlow adds. "A number of the cases were on appeal to the Supreme Court by the time the Biden administration came in."

The Biden administration voluntarily withdrew the cases, Harlow says.

It is unlikely the 2021 rule would face similar legal challenges because the Biden administration followed a standard rulemaking process.

"The Trump administration's Title X regulations were in direct conflict with federal statute and medical ethics standards, and there is extensive evidence that they were harmful to the family planning safety net," Moy explains. "The Biden administration's final rule largely mirrors the regulatory framework that successfully governed the program for more than 20 years before the Trump-era regulations took effect in 2019. The rules are a reset, with important updates to advance health access and equity."

Regardless of possible challenges, Title X programs are celebrating the new final rule and the end of the Trump administration's rule.

"We are excited to able to once again offer the highest-quality care possible," Trupiano says. "It's been a long two years for our providers to operate under these onerous rules, and it will provide much needed relief not only to the network, but also to all Missourians seeking care." ■

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What Is New in Contraception?

By Robert A. Hatcher, MD, MPH, Professor Emeritus, Department of Gynecology and Obstetrics, Emory University School of Medicine

In September, 500 people participated in a contraceptive technology virtual conference. The next day, 5,000 copies of the 16th edition of *Managing Contraception* were published. Below is some of the news from the new edition.

• The progestin-only pill providing 4 mg of drospirenone

As of early October, the most important change in oral contraception is Slynd, the progestin-only pill that provides 4 mg of drospirenone (DRSP). It is packaged with 24 active pills (DRSP 4 mg) and four inert pills. There is only one absolute contraindication (4 in U.S. Medical Eligibility Criteria [MEC]) for the use of this pill: It should not be prescribed to women with breast cancer. Breastfeeding women may use Slynd immediately postpartum. It is extremely effective, and it is not contraindicated for women at an elevated risk for blood clots (as are women using an estrogen-containing birth control pill).

Slynd is being called the first of the fourth generation of birth control pills. Its suppression of ovulation and its pregnancy rate are equivalent to combined pills. It does not cause increased blood pressure, and it carries no increased risk of venous or arterial clots.

While women who use Slynd experience more days of spotting in the first few cycles, only 3.3% discontinue this pill because of bleeding.

As with any new medication, the cost will be high to start with. But most insurance plans do cover DRSP, and women covered by the Affordable Care Act will not pay out of pocket.

• Self-administered subcutaneous Depo Provera (Depo-SubQ Provera)

Depo-SubQ is a way for women to inject Depo Provera themselves, eliminating the need for frequent office visits. This method has gained

popularity during the COVID-19 pandemic, since any healthcare that can be administered at home is encouraged. The U.S. MEC numbers for Depo-SubQ and Depo intramuscular (IM) are exactly the same.

For years, it has been apparent that Depo Provera provided by deep IM injections every three months has the highest discontinuation of any reversible contraceptive. A meta-analysis covering 4,000 women provided Depo IM or taught to inject Depo-SubQ over 13-15 weeks revealed higher continuation rates and lower pregnancy rates in the women who used Depo-SubQ.[1]

• Levonorgestrel intrauterine devices (IUDs) as emergency contraceptives

David Turok, MD, MPH, FACOG, of the University of Utah, was one of the stars of the Contraceptive Technology Conference. He discussed the use of 52 mg levonorgestrel IUDs as emergency contraceptives.

In one study, 706 women who had a negative pregnancy test were provided either a 52 mg levonorgestrel IUD (Mirena or Liletta) or a copper T 380A IUD. Women were provided a urine pregnancy test to perform after a month of IUD use. One pregnancy occurred in users of the levonorgestrel IUD, and no pregnancies occurred among users of the copper IUD. Turok and colleagues concluded that use of a 52 mg levonorgestrel IUD was noninferior to the use of a copper IUD in pregnancy prevention.[2]

Before this study, clinicians were reticent about providing a levonorgestrel IUD instead of a copper IUD, known for its extremely low pregnancy rate. Women using a Liletta or Mirena IUD are so likely to experience one of the non-contraceptive benefits attributed to levonorgestrel IUDs that insertion of a 52 mg levonorgestrel IUD may become the preferred method of emergency contraception for many women in the future.

The non-contraceptive benefits for women who use a levonorgestrel IUD may include any of the following: decreased menstrual cramping; as much as a 95% reduction in menstrual blood loss; protection against endometrial hyperplasia and endometrial cancer; protection against the growth of uterine fibroids; decreased endometriosis symptoms; and production of a thick mucus plug at the opening of the cervix, preventing sperm and many infectious agents from entering the uterus. The widespread knowledge of these remarkable non-contraceptive benefits, in addition to the effectiveness of Mirena and Liletta as emergency contraceptives and ongoing contraceptives, has led to more and more women (and their clinicians) choosing these for emergency contraception and ongoing contraception.

Innovation means nothing unless it leads to a change in practices. A continued focus on the questions "Now what must I do?" "What must we do?" "What is our next right step?" is important.

The answer is in the hands of everyone providing contraceptives, and students of this field. Moreover, the answer is, of course, in the hands of the individuals choosing a contraceptive.

Provide the best progestin-only pill, use the 52mg levonorgestrel IUDs as emergency contraceptives, and provide the subcutaneous contraceptive injection for women to use at home.

Dr. Robert A. Hatcher is the chairman of the Contraceptive Technology Update *editorial board. The 16th edition of* Managing Contraception *and the 21st edition of* Contraceptive Technology *can be ordered at: https://managingcontraception.com/* ■

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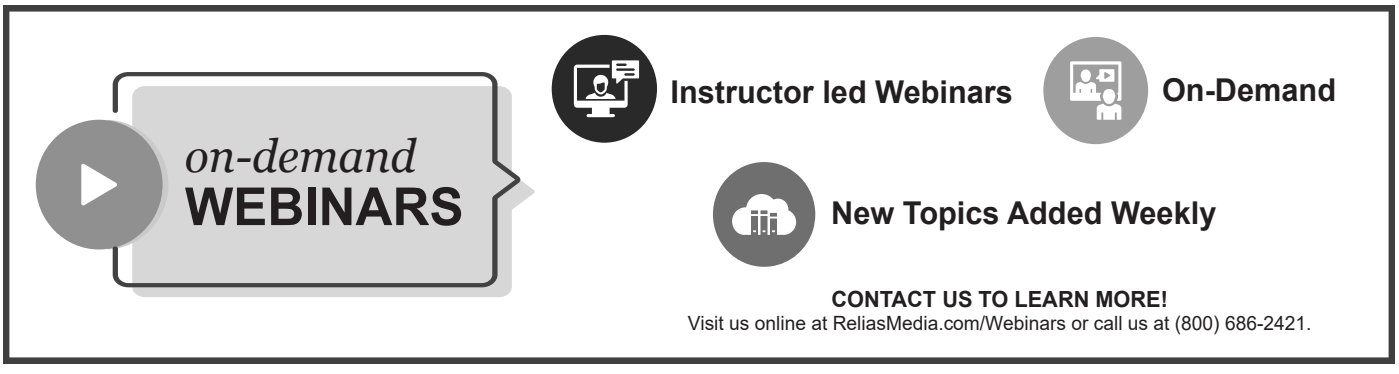

Research Shows Ultrasound Is Not Necessary for Medication Abortion

Researchers suggest reproductive health providers could offer patients a faster, less expensive medication abortion via telemedicine. Study findings show that omitting the pre-abortion ultrasound does not appear to compromise safety or result in more ongoing pregnancies.[1]

"This was secondary analysis of a large study that's been going on since 2016," says **Elizabeth Raymond**, MD, MPH, senior medical associate with Gynuity Health Projects in New York City.

The researchers studied the safety and feasibility of providing patients with a medication abortion without visiting an abortion clinic in person. Instead, they could meet with a provider via videoconference.

"If any tests are needed, providers could arrange for the person to get the test at any location convenient to the patient," Raymond says. "Then, the provider would dispense medications by mail to patients and follow up if further tests are needed."

While international organizations have made medication abortion available without in-person visits, this was the first time the U.S. government permitted an American research project to study tele-abortion, Raymond says.

"One reason we did this as a research study is because the FDA regulates mifepristone and has strict regulations that require the pills to be dispensed to patients in a clinic, office, or hospital," she says. "Mailing the drug was not allowed by the FDA."

The researchers wanted to see whether any safety or medical reasons exist for prohibiting abortion services via telemedicine. "Our main analyses from the study have found that there wasn't any problem with mailing the pills," Raymond says. "This approach of using direct-to-patient telemedicine with mailing the pills was safe, feasible, and highly acceptable to patients and clinicians."[1]

> "THIS APPROACH OF USING DIRECT-TO-PATIENT TELEMEDICINE WITH MAILING THE PILLS WAS SAFE, FEASIBLE, AND HIGHLY ACCEPTABLE TO PATIENTS AND CLINICIANS."

The study's relevance grew overnight when many reproductive health clinics reduced in-person appointments during the early months of the COVID-19 pandemic.

"It became difficult for people to go to doctors, so this [tele-abortion] service we had started became really relevant during the COVID-19 pandemic," Raymond notes. "It meant the patient didn't have to travel to the abortion clinic."

Standard practice required patients to undergo ultrasounds. This also became more challenging during the pandemic.

"We had been doing research to see whether that ultrasound test was necessary or whether eligibility could be determined by talking to patients, asking them about their last menstrual period," Raymond says.

"The key thing is to determine whether the patient was pregnant, the gestational age, and whether the pregnancy is in the uterus vs. ectopic," she adds. "The research made it clear that most patients could do a pregnancy test to determine pregnancy, and we could reasonably assess gestational age by asking questions."

Abortion provider organizations reviewed the data and concluded that an ultrasound was not necessary for most patients. "Providers started offering medication abortion without a prior ultrasound," Raymond says. "For most patients, the ultrasound could be eliminated, and the patient would not need to go out of the house; she could talk to the provider by video. Some providers began to implement that option."

Some clinics enrolled in the tele-abortion study continued to perform an ultrasound on every patient after the pandemic began. Other clinics required an ultrasound on a case-by-case basis. All the enrolled clinics were in states where the ultrasound was not required by state law and tele-abortions were not prohibited.

"There are about half the states where this tele-abortion approach would not be legal, and Texas is one of them," Raymond says.

Still, tele-abortion can be helpful to people who live in states that allow the practice, especially when driving to an abortion provider is a long trip. For many women who live in states where abortion medication cannot be mailed to them because of state laws, a workaround might be to travel to another state to pick up the mailed package. That happened with some women enrolled in the tele-abortion study.

"We had patients from 34 different states who got tele-abortions because they could travel," Raymond explains. "We had patients crossing state lines to pick up their pills."

Researchers compared tele-abortion patients who received ultrasounds to those who did not to look for differences in safety, medical care, costs, and other outcomes.

"We took data from those clinics and compared the patients who did get the ultrasound with those who did not get the ultrasound," Raymond says. "It was not a randomized trial because clinicians were deciding about an ultrasound for each patient."

The researchers tried to adjust for patient differences. For example, some patients may have had a last menstrual period that placed them closer to 10 weeks gestation. Others might have had their last menstrual period six weeks earlier, or the patient did not remember when the last period took place.

"The groups of patients are different, and those differences could affect the outcome, so we used statistical techniques to adjust for those differences," she says.

Requiring patients to undergo an ultrasound increases cost and introduces a delay in abortion care, she notes.

Investigators also found that patients who did not get the ultrasound had a higher chance of the medication not working optimally. Some needed additional treatment, like an aspiration, to complete the abortion.

"But we also found they did not have a higher chance of serious problems — not a higher chance of being in the hospital or getting a transfusion," Raymond explains. "We also found that abortions were much faster and cheaper without the ultrasound, so those are big advantages."

The clinicians who participated in the study and who offered the medication abortion without an ultrasound thought this tradeoff was definitely beneficial for the patient, if it was what the patient wanted.

Because of the pandemic, the government lifted restrictions on mailing mifepristone to patients who sought a tele-abortion, and more clinics started using this approach outside of the study.

"They couldn't do that before because it was not consistent with FDA restrictions, but because of the pandemic, the restrictions were lifted," Raymond explains. "The lifting of the prohibition on mailing is only during the pandemic and will technically end."

The FDA is reviewing regulation of mifepristone and may decide to lift restrictions permanently. "Regardless of the pandemic, the restrictions placed on mifepristone make no sense. This is a very safe drug, and there's no reason why this medicine should not be mailed," Raymond says. "The tele-abortion approach is highly convenient for some people, but it's not going to solve all the problems of abortion access. What we need in abortion care is a range of options so that at least one thing will be suitable for a particular person, whatever the situation is."

It is not ideal for people to cross state lines to access abortion care. But if they can receive abortion care while sitting in their homes, it is a good option, Raymond adds. ■

REFERENCE

1. Anger HA, Raymond EG, Grant M, et al. Clinical and service delivery implications of omitting ultrasound before medication abortion provided via direct-to-patient telemedicine and mail. *Contraception* 2021;S0010-7824(21)00342-5.

Reproductive Health Is Important Among Communities with Opioid Use Disorder

Pregnancy-capable individuals with a history of opioid use disorder (OUD) hold an inherent distrust of the healthcare system. This is one reason why contraceptive counseling could be a challenge for this population.[1]

"They have an understandable distrust, so it's really on providers to learn more about their experiences and acknowledge the lens through which they make these decisions," says **Lauren Sobel**, DO, MPH, complex family planning fellow at Brigham and Women's Hospital.

New research through Boston Medical Center shows that individuals with OUD exhibit similarities to individuals with other chronic medical conditions when they are choosing a contraceptive method.[1]

"One thing our study strived to do is to talk about their experience with contraception and not make any recommendations for the type of contraception," Sobel says. "When women and pregnancy-capable individuals with OUD choose a contraceptive, they actually consider

many of the same factors that others choose, like weight gain, bleeding, and whether it affects their chronic medical condition."

Pregnancy-capable individuals with OUD consider various factors that also go into their contraception decisions. These include potential relapse and protecting their future fertility.

This study and other research have serious implications for clinical practice. For instance, pregnancy-capable individuals with OUD have some unique experiences at the intersection of their disorder and their reproductive health.

"There's certainly some unique association with women who have opioid use disorder trying to protect their future fertility, but they're not always interested in long-acting reversible contraceptives," she says. "They may or may not have a stable relationship with the healthcare system for things like an IUD removal."

Essentially, while many persons with OUD have standard concerns like weight gain, some also carry unique concerns that are due to their history of OUD.

"The main thing clinicians need to do is acknowledge that individuals come to contraceptive counseling with unique experiences," Sobel adds. "If we don't factor in the impact of opioid use disorder on the method they use, we risk missing important cues as providers, asking uninformed questions, and we risk perpetuating stigma." ■

REFERENCE

1. Sobel L, Lee YW, O'Connell K, et al. Contraceptive decision making among pregnancy-capable individuals with opioid use disorder at a tertiary care center in Massachusetts. *Contraception* 2021;104:355-360.

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.

CME/CE QUESTIONS

1. **New research suggests that reproductive health providers could offer patients a telemedicine abortion without requiring every patient to get a pre-abortion ultrasound because:**

   a. the pre-abortion ultrasound does not appear to compromise safety or result in more ongoing pregnancies.
   b. the pandemic proved that a pre-abortion ultrasound is not needed for any patient seeking a medication abortion.
   c. not ordering the pre-abortion ultrasound resulted in fewer medical complications.
   d. it proved safe and effective to exclude the pre-abortion ultrasound through 12 weeks of pregnancy.

2. **A study of women who used either Depo Provera intramuscular (Depo IM) or subcutaneous Depo Provera (Depo-SubQ) revealed:**

   a. no difference in continuation and pregnancy rates between the two groups.
   b. higher continuation rates in those who used Depo-SubQ, but lower pregnancy rates in those who used Depo IM.
   c. higher continuation rates and lower pregnancy rates for those who used Depo-SubQ.
   d. lower continuation rates for those who used Depo-SubQ.

3. **Senate Bill 8, which became effective in Texas on Sept. 1:**

   a. banned all abortions after 15 weeks and left enforcement to local police and sheriff's departments.
   b. banned all abortions after six weeks and gave people anywhere in the United States the power to enforce the bill through civil lawsuits.
   c. threatened jail time for women obtaining any abortion.
   d. prohibited medication abortions.

4. **Pregnancy-capable individuals with opioid use disorder might worry about their future fertility and also might not be interested in certain contraceptives. Which contraceptives could be of concern to this group?**

   a. Condoms
   b. Birth control pills
   c. Vaginal barriers
   d. Long-acting reversible contraceptives

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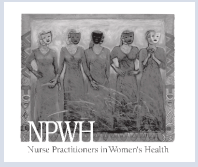

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