

Reproductive Health & Wellness Program



THIS ISSUE

- *Dangerous trends after increased regulation of abortion clinics*
- *CDC Zika guidelines*

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Contraceptive Vending Machines: An EFFECTIVE Way to Reduce Unintended Pregnancies?

The use of contraception is a major factor affecting pregnancy, birth rates, and the ability of women and their partners to plan their pregnancies. There are several forms of contraceptives available including the implant (Nexplanon), IUDs (Mirena/Skyla/Liletta), pills, patch, shot (Depo-Provera), sponge, vaginal ring, diaphragm, female condom, male condom, and emergency contraceptives also known as the morning after pill. A recent study found that more than 99% of women aged 15–44 who have ever had sexual intercourse have used at least one contraceptive method.³ Based on this statistic, many sexually active women tend to be somewhat responsible with their sex life and family planning. However, accidents happen and even though there are many different contraceptives available, unplanned and unwanted pregnancies occur quite frequently.

In the United States, there are 61 million women in their childbearing years, and about 70% of these women are at risk of unintended pregnancy. This means they are sexually active and do not want to become pregnant, but could become pregnant if they and their partners fail to use a contraceptive method correctly and consistently.³ So what can we do to prevent these unplanned pregnancies? Well, what about contraceptive vending machines? The FDA approved a private liberal arts college in Pennsylvania, Shippensburg University, to offer contraceptives in vending machines on campus in their student health center.

Emergency contraceptive, condoms, and pregnancy tests are available in the vending machines for \$25. A recent study, based on a nationally representative sample of people ages 18 to 25 who have graduated from high school and completed at least one year of college, found that 59.3% of students reported having sex at least once a week. The proportion of women at risk who are not using a method is highest among 15–19-year-olds.³ If this is the case,

contraceptive vending machines on college campuses is a great start to reducing unplanned pregnancies among young adults. This is dependent on the availability of the vending machines and how easily accessible these contraceptives truly are.

Shippensburg University believes that dispensing birth control in vending machines helps make contraceptive methods directly available without an adult intermediary, which can make an immense difference for the teens and young adults who may be too embarrassed to ask a nurse or a pharmacist about it. While this may be true, everyone does not have access. The machines require students to swipe their IDs, which is an extra step to verify the person attends the college and that they are above the age of 17 years old. This also places a restriction on number of times each student is allowed to take advantage of this “perk.” Furthermore, the vending machines are only accessible when the student health center is open. Due to this, the contraceptives are not available on a 24/7 basis. Most adults, including young college-aged adults, usually have consensual sex late at night. This can be a problem, considering the student health centers may be closed. These vending machines are a delightful gesture, but they do not take care of the problem and they certainly do not benefit the general population who are affected more by unplanned pregnancies than college students are.

Most individuals and couples want to avoid unintended pregnancies for a range of social and economic reasons. As many of us in the health field know, unintended pregnancy has a public health impact.³ Births resulting from unintended or closely spaced pregnancies are associated with adverse maternal and child health outcomes, such as delayed prenatal care, premature birth, and negative physical and mental health effects for children, which can lead to higher infant mortality rates. Women more likely to experience unintended pregnancies are unmarried and have less education and income. Unintended pregnancies are also experienced

more by African American women.⁴ If unplanned pregnancy occurs most often among women with lower income and educational attainment, then why place contraceptive vending machine on college campuses, accessible to a population that is not impacted as often? This obviously is not making contraceptives more accessible to the women and even men most in need. Vending machines on college campuses are not beneficial to this at-risk population, but what would happen if contraceptives were dispensed in vending machines that the general public would have access to?

When used correctly, modern contraceptives are very effective at preventing pregnancy. If a pregnancy is not planned before conception, a woman may not be in optimal health for childbearing. For example, women with an unintended pregnancy could delay prenatal care that may affect the health of the baby.⁴ Many initiatives across the United States, including our very own program, *thebodyshop*, have provided access to contraceptives and reproductive health services, targeting the most underserved populations, to reduce the number of unplanned pregnancies, unwanted pregnancies, and poor pregnancy outcomes that may be due to these factors. However, most health centers across our city and the United States have limited hours. On average, a health center may close around 5pm. Therefore, even with the enormous amounts of efforts that we put into making contraceptives easily accessible, there are some people who still may not be able to take advantage of these efforts being made.

Emergency contraception may be “out of reach” geographically and economically for women in poverty, who are at a higher risk of unintended pregnancy. In an effort to target these women and teens, Sunshine Laundromat in Brooklyn, New York, now has emergency contraceptives and pregnancy tests in their vending machines at a lower price than the local pharmacy. The stigma surrounding buying contraceptives still exists. Hopefully contraceptive vending machines will eliminate some of the embarrassment associated with buying these items.

(Continued on page 2)

Vending Machines (Cont.)

As mentioned earlier, most people engage in sexual activities “after hours.” The Sunshine Laundromat stays open until 2am on most days during the week, which allows for access for an extended period of time.

One of the biggest questions that opponents have is whether contraceptive vending machines are allowing women to have more control over their reproduction and sexual practices, or if they are promoting promiscuity. Dispensing contraceptives through vending machines is very new, especially in the laundromat’s case. Therefore, the effectiveness has not truly been investigated. However, they may be on to something with making contraceptives more available to the general public and at risk communities.

Before advocating for contraceptive vending machines it is important to consider the safety of the targeted community. While accidents happen and emergency contraceptives are necessary, it should not be a woman’s only form of birth control. Frequent consumption of the morning after pill can be detrimental to a woman’s health. Therefore, some restrictions would have to be enforced to ensure the safety of women. Also, it may be worthwhile to make sure all people are well-educated about contraceptives before placing vending machines in public places. Knowledge about contraceptive methods is a strong predictor of use among young adults: In a 2012 study among unmarried women aged 18–29, for each correct response on a contraceptive knowledge scale, women’s odds of currently using a hormonal or long-acting reversible method increased by 17%, and their odds of using no method decreased by 17%.³ Sex education and access to contraceptive counselors would give women safe choices to ensure their reproductive health.

Contraceptive vending machines can potentially be costly, especially if they are not effective. It may be worthwhile to ask the community if these are even necessary or they feel that contraceptives are already easily accessible before making them available. It is one thing for people in high positions to “dictate” what they feel a community needs, but it is a completely different ball game when health care providers and centers caters to the specific needs and wants of the community. One thing for sure, we need to make sure we are targeting the correct communities, the people with highest risk for unintended pregnancies, when we talk about improving contraceptive access.

The Return of the “D.I.Y.” Abortion

The arguments over abortion provision, access, legality, and morality have only gotten more heated in the 44 years since *Roe vs. Wade* made abortion legal under federal law. Over the past few years, more laws restricting access to abortion have been passed at the state level than ever before. The number of new laws introduced by states peaked in 2011 at 92, and still more have been introduced in subsequent years. These laws have forced women to wait 24 hours after an initial visit before a procedure can be performed, required that physicians have admitting privileges at a nearby hospitals, legally obligated physicians to provide their patients with medically inaccurate information, and required surgical facilities to maintain unreasonable hospital-like building standards that no other kind of outpatient surgical facilities are required to maintain.

Between 2011 and mid-2014, more than 200 laws were passed, leading to the closure of 73 abortion facilities.¹ Many proponents of the restrictions insist that they are not intended to close clinics, but to protect women. However, the case currently before the U.S. Supreme Court (*Whole Woman’s Health v. Hellerstedt*) demonstrates the undeniable effect of the new wave of abortion regulations. During oral arguments at the Supreme Court, Justice Kagan pointed out that when one restrictive law went into effect in Texas, 12 clinics closed immediately upon its implementation. Then, when the laws were put on hold pending litigation, the clinics immediately reopened.² Given the nature of this specific regulations, requiring clinics to make the hallways of existing offices wide enough to accommodate 2 gurneys side by side, it is difficult to see how these regulations are not specifically intended to shut down facilities providing abortions. Having a clinic hallway that is the width of a hospital hallway is not necessary, especially since many terminations are medical abortions, induced by taking a series of pills.

The fact that most abortions are medical abortions, as opposed to surgical abortions, is not well known. Medical abortions involve taking two drugs while in the clinic: mifeprex and misoprostol. (Note: These pills are not the same as emergency contraception, or the “morning after pill,” which contain concentrated doses of the same hormones found in birth control pills and prevent ovulation). Given the mobility of this way of having an abortion, it is unsurprising that under conditions of extreme regulation of abortion, women find ways to access medical abortion that don’t depend on the medical institution.

Studies have shown that countries in which there is no legal abortion, there are significant ‘black market’ purchases of medical

abortion drugs.¹ Women can buy them over the internet, or through an unlicensed source. The problem is that this way of acquiring the drugs this exposes them to the dangers of an unregulated pharmaceutical market. The “danger” to women of a licensed provider prescribing controlled medications from a regulated source is much less than buying an unknown pill from a stranger, with no knowledge of where the pill came from. In Texas, where abortion is nearly illegal in practice, unregulated medical abortions are occurring with more frequency. This is thanks, in part, to the fact that in Mexico medical abortion drugs are sold as ulcer medication over-the-counter. When one journalist traveled to Texas to see what unregulated medical abortion looked like, she found many of these pharmaceutical products being sold at a flea market.

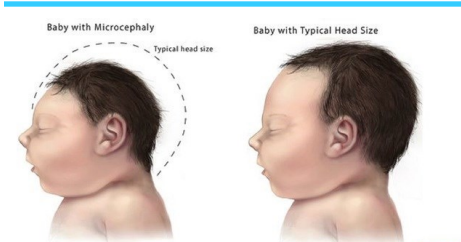
Many women use these (and other drugs) in an attempt to self-abort. Although it is not as effective as using misoprostol with mifeprex, and not as safe as being under the supervision of a medical provider, women who need to avoid pregnancy will find ways of doing so. This kind of underground economy of abortion is prevalent in Latin America, where abortion is illegal. The normalization of “back-alley” medical abortion in Latin America has meant significantly fewer reports of botched “back alley” surgical abortions. These botched surgical abortions are what we commonly think of as do-it-yourself (DIY) abortion. They often result in fallen intestines, infection, and were often caused by women inserting sharp objects into their own uterus.¹

The rise of do-it-yourself (DIY) abortions is no coincidence after so many restrictions and so many clinics closed. While it is a gruesome expression, a ‘coat hanger abortion’ is not a euphemism. Before safe and legal abortions were available, women took desperate measures to obtain the procedure they needed, even if that meant trying to self-abort. We don’t have data on the exact number of women who have tried to self-abort in recent years, partly because people fear giving honest answers when these kinds of questions are asked. However, we do have a newer kind of data that doesn’t require surveys; records of Google searches. Researchers have collected data on related search terms such as “how to self-abort,” “how to have a miscarriage,” and a number of other concerning things like “how to do a coat hanger abortion,” “buy abortion pills online,” and searches related to bleaching the uterus or being punched in the stomach to lose a pregnancy.² The New York Times reports that search rates for topics like these were relatively steady between 2004 and 2007, rose slightly during the recession, and jumped (Continued on page 3)

DIY Abortions (Cont.)

significantly in 2011 when the restrictive laws started passing across the country. In 2015, there were 3.4 million Google searches for abortion clinics, and Guttmacher Institute estimated that there were close to 1 million legal abortions in the same year. There were over 700,000 searches for the combined self-aborting related search terms, and specifically 4,000 of those were for instructions on how to perform a coat hanger abortion.

Unsurprisingly, the state with the most Google searches (Mississippi) has only one abortion clinic after all the legal restrictions.² Additionally, “eight of the ten states with the highest search rates for self-induced abortions are considered by the Guttmacher institute to be hostile or very hostile to abortion, [and] none of the ten states with the lowest search rates for self-induced abortion are in either category”.² However, in the states with the fewest abortion clinics, 54% fewer legal abortions were performed. Live birth rates were higher in these states, but not high enough to account for the lower number of legal abortions. This means that there are pregnancies that can’t be accounted for in the states where it is hardest to get an abortion.² This is not definitive proof that women are self-inducing abortion, but it is suggestive. Passing laws to “end abortion” will not put an end to abortion. They only put an end to safe abortion.



the virus, received ultrasounds to examine the health of their fetuses. Ultrasounds allowed researchers to detect fetal abnormalities in 12 of the 42 fetuses (or 29%) of infected women.⁵ As the babies are being born, the issues are being explored further.

While Zika is primarily transmitted through mosquito bites, new reports indicate that it is also transmitted sexually. Preliminary CDC recommendations issued at the end of March suggest that men who have traveled to or reside in areas with active Zika transmission protect their male and female partners by consistently and correctly wearing a condom during, or abstaining from, vaginal, anal, and oral sex. This is especially important if the man’s partner is pregnant, as active infection could be transmitted to the fetus in utero.⁶ All reported cases of sexual transmission were with a man who displayed symptoms of the virus disease, either just before onset of symptoms or just after resolution of symptoms. CDC does not yet know if the virus can be transmitted by men who never display symptoms of Zika virus disease. Timelines are changing as we learn more about the virus, but currently it is suggested that infected people practice abstinence or correct condom use for 6 months after onset of illness, for 8 weeks after departure from areas known to have active Zika infections if symptoms do not develop, for as long as active transmission persists if the couple lives in an area with active transmission of Zika, and for the duration of a pregnancy if the female partner is pregnant.

MEN’S HEALTH

Interested in the Men’s Health Initiative for your organization? Contact the program coordinator: eric.washington@cincinnati-oh.gov

The Men’s Health Initiative performs health education seminars at local community-based organizations. We currently have seminars on the following topics:
Reproductive Anatomy, Pregnancy, and Sexuality • STIs and Protecting Yourself • Relationships and Communication • Family Planning • Fatherhood • Puberty • Bullying

TEAM MEMBER SPOTLIGHT: LYNNISSA HILLMAN

Name: Lynnissa Hillman

Hometown: Cincinnati, OH

Favorite movie/book:

Movie: Lean on Me

Book: Invisible Man by Ralph Ellison

What do you do for thebodyshop?

I currently enter data for the Fetal and Infant Mortality Review. I will eventually work with the entire Maternal and Infant Division as a whole assisting in any way that I can. I am also in the process of constructing literature reviews of a variety of reproductive health disparities to understand the trends and to further the understanding of what direction we need to go in the future.

What do you love about working in reproductive health?

I love everything about working in reproductive health. It allows me to think outside the box and also gives me a chance to do things for others. I thought I wanted to be an OBGYN until I realized I was more interested in health disparities than the actual practicing of medicine. Working in reproductive health gives me the rewarding feeling of providing health services and health education to underserved populations.

When you're not at work, where might we find you?

When I'm not at work, you will most likely find me at home or somewhere with my family.



New CDC Guidelines: Zika

In recent months, the Zika virus has been a big concern for health care providers in Central and South America. While there haven’t been nearly as many cases in the U.S, it is still a concern that is on the radar. Zika is not terribly harmful for adults, but the concern springs from the fact that it seems to be causing severe birth defects, most commonly microcephaly, and poor pregnancy outcomes for women who have contracted the virus. NPR reports that the link between Zika and microcephaly, which causes babies to be born with deformed heads and damaged brains, is still circumstantial at this point.⁵ The observed connection between the virus and the congenital condition stems from the fact that the number of cases of microcephaly have increased since the outbreak began, but much more research must be done to verify the link between the virus and these birth defects and poor pregnancy outcomes. However, a very small study of just 88 women in Brazil demonstrated that in addition to microcephaly, Zika can potentially increase the chance of miscarriage, inhibit fetal growth, cause potential blindness and deafness, cause the placenta or amniotic fluid to be insufficient to support the fetus. Of the 88 women studied, 72 had confirmed cases of Zika. 42 of those women, plus 16 who did not have the virus, received ultrasounds to examine the health of their fetuses. Ultrasounds allowed researchers to detect fetal abnormalities in 12 of the 42 fetuses (or 29%) of infected women.⁵ As the babies are being born, the issues are being explored further.

thebodyshop

REPRODUCTIVE HEALTH & WELLNESS PROGRAM

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RHWP Hotline:
513-357-7341

Appointment scheduling through the CHD Call Center:
513-357-7320

The Reproductive Health and Wellness Program (RWHP) or the body shop, is a five-year grant awarded by the Ohio Department of Health to the Cincinnati Health Department and is funded by the federal Title X program. The primary objective of this program is to provide access to contraceptives and reproductive health services to the men and women of Hamilton County, especially to the most underserved populations, so as to reduce the number of unplanned pregnancies, unwanted pregnancies, and ultimately, the number of poor pregnancy outcomes. Through these direct services, education and outreach, the program also hopes to cultivate a culture of responsibility, well-being, and empowerment in regards to sexuality and reproductive health. To date, we've enrolled thousands of individuals, and continue to grow, learn, and serve.

For additional information regarding the project, please contact Dr. Jennifer Mooney at:

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If you don't want
April showers to bring May babies...

Wear a condom and use your favorite
method of birth control!

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