experiences, and we try to tell women you’re the problem for thinking that there’s a problem. It’s important for women to listen to themselves. Number 2 is that these are toxic experiences. If you’re in a relationship or a workplace that has harassment and assault happening, the best thing to do—if you can—is to either report the situation or get out of the situation.

Now, all of that is easier said than done. Oftentimes for women who are in harassing workplaces, for example, it’s not so easy to get out. Money is really quite important, and I don’t want to ignore that. And we saw in our own sample that the women who were more financially strained were more likely to report a history of sexual harassment. But getting help as best you can is important—not simply putting up with it and tolerating it. These are challenging situations to address.

JAMA: What can physicians do to support the health of women who may have experienced these events in their past?

DR THURSTON: Physicians have an important role to play. Number 1 is [knowing] the prevalence of these problems and just how common they are. Number 2 is [knowing] their implications for health. When you’re thinking about health [it’s important] to have a sense of a woman’s sexual assault history. It’s also the recognition that the woman may not report these experiences to the provider, even when asked. It really takes a lot of trust for people to come forward with these experiences, so it may mean developing a relationship over time, and not assuming that if you get a “no,” that [it’s] not happening.

So, to address that, have educational materials available and provide patients with materials to know where to go if it’s happening to them, regardless of disclosure. Partner with local agencies and support services to be able to refer people to appropriate care once they report a history of sexual assault or current sexual assault. And, ideally, have behavioral health care providers or victim services advocates on-site. That really reduces the tendency to lose people between referral and treatment. And then, finally, follow-up with people and maintain that ongoing relationship.

JAMA: Women and men are increasingly coming forward to talk about workplace sexual harassment and sexual assault. What do you want us to remember when we hear these accounts?

DR THURSTON: Remember that overreporting is rare. Underreporting is typically the rule. So, when people are reporting it, take it really seriously. Most likely you can trust their word for it. And understand that these experiences are important for their mental and physical health, not only at the time, but years down the road. The imperative is to try to help people to get out of these situations and receive appropriate care.

Note: Source references are available online through embedded hyperlinks in the article text.

The JAMA Forum

Title X: Moving Forward or Backward on Women’s Health?

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Twenty years ago, the Centers for Disease Control and Prevention (CDC) declared family planning and contraception services as 1 of 10 great public health achievements in the United States in the 20th century. Access to contraception is associated with reductions in teen pregnancy rates, improved health outcomes for women and their children, increased educational levels for women, enhanced economic security for women and their families, and other benefits that have led the US Agency for International Development (USAID) to declare family planning as a “best buy” for achieving the United Nations’ Sustainable Development Goals.

A new rule governing Title X of the Public Health Act is to be issued in January 2019. The proposed new rule that was available for public comment in 2018 suggests that federal policy makers may make it harder for women to access contraceptive services, despite evidence of the benefits to women, families, and the nation.

Rolling Back the Affordable Care Act

Recognizing contraception’s benefits, the Affordable Care Act included measures to make it easier to access contraceptive services. This included the requirement that all new private insurance plans cover comprehensive contraception services and products, without cost sharing. Exemptions were available for grandfathered plans and employers that are houses of worship, but the Supreme Court subsequently ruled in Burwell v Hobby Lobby Stores, Inc that this requirement violated the Religious Freedom Restoration Act, allowing expansion of eligible employers. The Obama administration developed rules for “accommodation” that would permit employers to object to offering contraception coverage but require their insurance plans to pay for women who wanted such coverage.

New rules issued by the Trump administration expanded access to exemption or accommodation to all nongovernmental employers and universities that have religious or nonreligious moral objections to contraception. These moral objections include “services which they [employers] consider to be abortifacient.” Note that what
constitutes “abortifacient” is determined by the employer.

The Trump administration has proposed that women who cannot get coverage for contraception from their employers can use Title X-funded programs. But the demand for Title X services already exceeds the $286 million in available funding, and there may no longer be a guarantee that these programs will offer comprehensive contraception options.

**Title X**

Title X is part of the Public Health Service Act that became law in 1970 to ensure that “no American woman should be denied access to family planning assistance because of her economic condition.” It is administered by the Department of Health and Human Services (HHS) Office of Population Affairs (OPA), which sets the rules for determining which organizations receive the available funding. The rules governing Title X have heretofore required most grantees to offer comprehensive family planning services.

In June, the Trump administration replaced acting OPA deputy assistant secretary Valerie Huber—the founder of Ascend, the largest US and global abstinence-only education organization—with Diane Foley, the former president and chief executive officer of Public Health Solutions (David). The Rise of “Crisis Pregnancy Centers”

A network of about 3000 religious-based crisis pregnancy centers stands ready to apply for Title X funding if the new rules eliminate the requirement for comprehensive contraception services. Crisis pregnancy centers provide pregnancy testing, ultrasounds, and free diapers. More than 200 Obria Medical Clinics advertise that they offer “well woman care” by physicians and nurse practitioners, but there is no mention of contraception. Although legal, crisis pregnancy centers’ approaches have been described as unethical. Crisis pregnancy center personnel are trained to not directly answer questions such as, “Do you provide abortions?” or “Can I get the birth control pill at your center?” Their answers are designed to have the woman come into the center, rather than provide specific answers. Once the woman comes in, the staff rely heavily on ultrasound images, strongly advocate that women continue their pregnancies, and try to delay a decision so that the women might go beyond the term when abortion is accessible.

What evidence is there that these non-clinics will receive Title X funding? The OPA just completed the 2018 proposal reviews and only awarded funding for 7 months. Although the 2018 grants went to only a few religious organizations, the limited award period will require a new competitive round of applications and the new Title X rule is expected to be finalized before the applications are reviewed. The OPA is trying to facilitate new applications by posting successful ones on its website. Religious organizations are also being encouraged to contact existing grantees to be included in their next applications.

**What’s Next?**

The final rule is expected in January 2019. If it includes key components of the proposed rule that are outlined herein, a legal challenge is likely to be filed immediately upon the rule’s issuance. The new House of Representatives could hold public hearings and increase the visibility of the potential impact of the rule changes.

Some states are codifying into legislation the requirement that insurance companies cover contraception with no co-pays. But in states in which access to contraception and reproductive health services are most challenged, the proposed rule changes would continue to erode access. Before 2010, there was bipartisan support for reproductive health services as good for women, good for families, and good for the US economy. Today, the organizations that rely upon Title X funding and the women and families they serve hang in the lurch.

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