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Reproductive Health & Wellness Program



THIS ISSUE

- *Teenage Pregnancy Month!*
- *Polycystic Ovarian Syndrome: What is it? What can you do about it?*
- *Using Space Effectively in the Reproductive Health Clinic*

RECENT DEVELOPMENTS IN TEENAGE PREGNANCY IN THE U.S.

Over recent decades, trends in reproductive health related milestones for American men and women have shifted in many ways and social norms in regards to sex, marriage, and childbearing have changed dramatically. A recent study looked at the trends in reproductive milestones and the median ages at which each gender reached these milestones, in each generation. These milestones include age at first menstruation, first sexual encounter, first contraceptive use, first childbirth, and first union/marriage¹. By examining median ages of when people in each generation (born between 1937-1960, 1961-1971, and 1971-1995) reached these milestones, we can get a better picture of the shifts that have taken place over the years. This also allows for the comparison of different groups of people and can help us identify “important markers of social change that allow us to track and predict demographic trends, economic and social inequality, and changes in social norms”¹. Identifying when each gender and subpopulation reaches a given milestone allows for the development and improvement of reproductive health services and brings to light the effects of social and economic inequality. It also sheds light on cultural differences between groups of people.

Since most people have sex for the first time in their teens², it is crucial that we give all teens the opportunity to start using birth control. Considering the fact that many schools

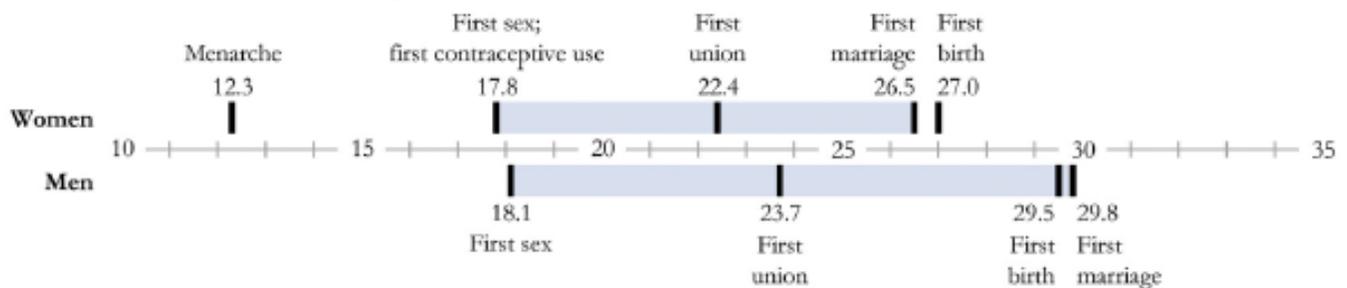
teach abstinence only, we have to assume that most students will not have the information they need to keep themselves protected. While we know that half of all pregnancies in the U.S. are unintended, almost all pregnancies are unplanned in the teen population³. The median age at which women start having sex is slowly declining and is now around the age of 17.8; for men the number has slowly gone up to about 18.1 years of age¹. In recent years, the number of women who were using some form of contraception at or before the first time they had sex has gone up to 75%, but it varies by race and ethnicity. Hispanic women are much less likely than their counterparts to be using contraception the first time they have sex. By 5 years after the first sexual encounter, 90% of women use some method of birth control¹.

Today, it is much more socially acceptable than it ever has been for a couple to live together and have children without being married. The average age that people begin to live with a partner, married or not, has not changed over the years, but the average age at which women start to have children increased, declined, and then increased again over time. For men, the age at which they have their first child has stayed around 29 years of age during the time frame that was studied. As is the case with contraception utilization, social factors such as family structure, race, and mother’s

amount of education play a role in determining likelihood and timing of marriage and childbearing. The study showed that black women born between 1972 and 1995 were “more than twice as likely to begin childbearing at any point in time as were white women,... mother’s education has and continues to be associated with delaying births,... and Hispanic women in particular lag behind women of other races in terms of initiating contraceptive use” but tend to want children earlier¹.

This and other studies have shown that teen pregnancy rates have gone down in conjunction with an uptake of contraception use in the same group. One of their most important findings was the “clear shortening of the time from first sex to contraceptive use, which bodes well for prevention of unintended pregnancy”¹. The growing spaces between first sex and first union, and first sex and first birth seems to have been caused by changes in society such as the fact that more women participating in the work force, the acceptance of premarital sex, and a higher prevalence of cohabitation before marriage. This makes it clear that we need to provide easy and affordable access to the most effective methods of contraception to both teens and adults. More and more people are making their decisions about having children based on when they feel ready to take on the responsibility – providing access to contraception will only make those decisions easier.

Current Median Ages at Reproductive Events¹



Shaded area represents period of high risk for nonmarital birth.

THE PCOS PROBLEM

Polycystic Ovary Syndrome (PCOS) is a hormonal imbalance disorder. Roughly 1 in 20 women of reproductive age has PCOS⁴. As many as 5 million women in the United States are affected⁴. The cause is unknown and there is no cure. Yet, PCOS is the most common reason for infertility.

Here are three additional reasons PCOS is an important public health issue:

PCOS increases risk for health complications.

Many women with PCOS are insulin resistant and overweight or obese, raising their risk for type 2 diabetes and heart disease. More than 50% of women with PCOS will have diabetes or pre-diabetes before age 40⁴. Their risk of heart attack is 4 to 7 times higher than women of the same age without PCOS⁴. Also, women with PCOS have higher rates of miscarriage, gestational diabetes, pregnancy-induced high blood pressure, and premature delivery.

PCOS can be difficult to diagnose.

PCOS is a combination of different symptoms and signs of varying severity. There is no single test for PCOS. To be diagnosed with PCOS, a woman must have at least two of the following: irregular menstrual cycles, elevated

levels of androgens, or ovaries with numerous small cysts⁴. PCOS is believed to be underdiagnosed. Women with PCOS are more likely to have a sister or mother with PCOS.

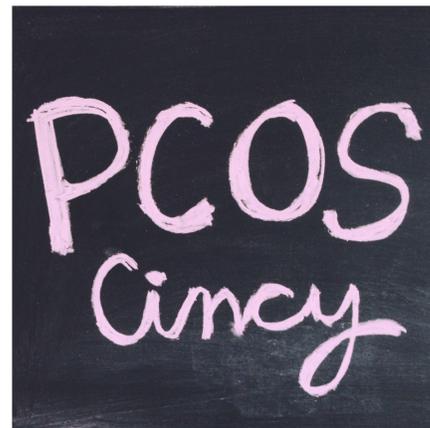
PCOS symptoms are mild.

Since many women do not consider problems such as increased hair growth, oily skin, and acne to be serious symptoms, they may not inform their healthcare providers. Three out of four women with PCOS are unaware that PCOS is the cause⁴. A woman may mistakenly attribute her irregular periods to her new diet, major weight loss, or high stress levels. Consequently, many women are not diagnosed until they have trouble getting pregnant.

Public health professionals, healthcare providers, and community members can work together to address the PCOS problem. Increased awareness can result in early diagnosis, treatment (healthy diet, exercise, and medication), and prevention of adverse health effects. We encourage you to read about PCOS through sites like womenshealth.gov and speak to a certified endocrinologist or gynecologist.

PCOS Cincy is a community outreach initiative that aims to raise awareness about PCOS among young professionals in Greater

Cincinnati through social media campaigns and awareness events. Since coping with PCOS can be difficult, PCOS Cincy provides mental and emotional support to women with PCOS. PCOS Cincy hopes to empower young professionals to take control of their health.



For additional information about PCOS Cincy, please visit www.facebook.com/PCOS.Cincy or contact Alyssa Llamas at PCOS.Cincy@gmail.com.

ADOLESCENT MEN & TEENAGE PREGNANCY

The public health discourse surrounding teenage pregnancy has long been concerned with the determinants and effects of this outcome on adolescent women, but little research has focused on the perceptions of teenage pregnancy among adolescent men. How do adolescent men conceive of teenage fatherhood? Does the fact that society presumes women to be responsible for pregnancy and child-rearing affect how adolescent men perceive the risk associated with teenage pregnancy?

A 2010 literature review of 50 research studies focusing on adolescent men's conceptions about pregnancy showed that most young men see teenage pregnancy "as a negative event because of the adverse effect having a baby will have on their future aspirations and life goals, as well as on current freedoms"⁵. However, it also showed that a small minority of men had positive feelings toward the idea of pregnancy. These men saw pregnancy as a means to prove their manhood or as a means to turn one's life around⁵. With respect to birth outcomes deemed acceptable by adolescent men, one U.S. study showed that 61% of men would choose to keep the baby, 19% would choose to abort, and 12% would choose to put the baby up for adoption⁵. Despite their

feelings towards adolescent pregnancy, adolescent men are aware of their lack of agency with respect to a pregnancy that has already started. Their control over the birth outcome has been shown to be mediated by the quality of their relationship with the woman whom they impregnated. The literature also shows that adolescent men who are of Black and Hispanic origin and those who have low socioeconomic status are predisposed to having positive attitudes towards teen pregnancy⁵. Poor neighborhood quality, greater religiosity, and specific masculine identities also seem to be involved in producing positive attitudes towards teen pregnancy among teenage men⁵.

More research should be done to understand perceptions of unintended pregnancy among adolescent men in the United States and in urban settings specifically. It is likely that adolescent men with positive attitudes towards teen pregnancy play a large role in increasing risk of adolescent pregnancy in their peers. Due to the gendered burdens of pregnancy and childbearing, these attitudes can result in unwanted outcomes for young women who find themselves pressured into having unprotected sex or carrying an unwanted pregnancy to term at their male partner's behest.

CORNER FOR QUALITY IMPROVEMENT ECOLOGY AT THE SEXUAL HEALTH CLINIC

Due to the highly politicized nature of reproductive health care in the United States, issues of privacy are paramount in patients' minds when experiencing care in the reproductive health setting. One recent study examined how the ecology of a publicly-funded reproductive health clinic affected African American patients' experiences of privacy when seeking services⁶. They found that African-American women's access to reproductive health care was largely determined by their perception of the organization providing care and by their concerns about privacy breaches that may occur from attending a given clinic.

Women were more likely to attend the clinic if they had trust in the staff that worked there – even if there were increased chances of having their identity discovered by other members of their community that frequented the clinic. However, the trust that the patients had in their providers came from the non-judgmental stance that clinic staff had towards patients. The clinic's public image as a non-judgmental source of comprehensive reproductive health care produced approbation among more conservative members (cont. on Page 3)

INTERSECTIONALITY & POPULATION HEALTH RESEARCH

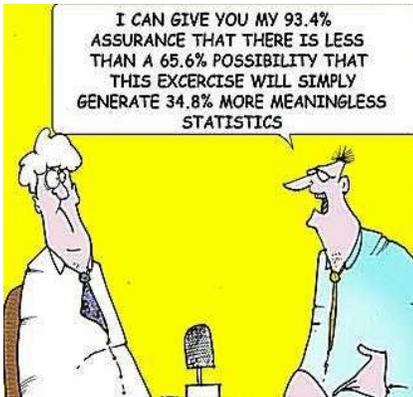
Over the past few years we have seen an ever amassing mountain of evidence about the relationship between social inequality and inequality in health outcomes. This population level data has shown us that there is severe inequality in the city of Cincinnati itself. Either by infant mortality rates or by life-expectancy rates, we see, time after time, that the poorest residents, the poorest areas, have the worst health outcomes. But how does this information help to inform interventions that would resolve health disparities? How can we translate this rich literature on health inequality into research on “intervenable factors that might be candidates for potential solutions”⁷?

One researcher, Greta R. Bauer, suggests that we borrow from intersectionality theory to inform population health research. Intersec-

tionality theory was first posited by Kimberle Crenshaw as a term to understand the unique experience of oppression for minority women. This oppression is not merely the additive oppression of being, for example, Black and a woman, but instead it is the unique experience of oppression associated with being a Black woman. Bauer suggests that oppressed intersectional identities such as “Black woman” be considered in conjunction with privileged identities such as “White men” to better elucidate “the effects of privilege as well as marginalization and the health impacts for those at positions that are both privileged and marginalized... without neglecting the study of those at multiply marginalized intersectional locations”⁷. She stresses that this kind of research paradigm should

focus on processes or policies that can be sites of intervention – without this focus, research will continue to reproduce the idea that inequity is fixed and unchangeable.

Much of Bauer’s argument focuses on specific statistical techniques that can be used to understand population-level data through an intersectional framework – clearly this is beyond the scope of this context. But work such as this is exciting because it serves to push social epidemiology beyond the mere identification of racial disparities or gender disparities in health outcomes. By utilizing advanced statistical techniques for understanding the effect of intersectional subject positions, we can better serve the public’s health.



the body shop CCTST RESEARCH PROJECT!

The research staff of the body shop is beginning its first funded research project focusing on contraceptive use among CHD clients. We are currently submitting our project proposal to University of Cincinnati’s Institutional Review Board for *Barriers to Long-Acting Reversible Contraceptive Choice among Black Women Seeking Contraception: Focus Groups*. This is the first phase of our project made possible by a \$15,400 grant from the Center for Clinical Translational Science and Training. We will be holding focus groups with Black/African American women recruited from CHD health centers to try and better understand the barriers to long-acting reversible contraceptive (LARC) access and use in our community. The information we receive from participants in this phase of the study will inform a later study that will involve semi-structured interviews with women who are potential contraceptive users within the CHD system. We expect that the information provided by participants in both phases will inform improvements to the CHD system that will improve the quality of care we provide.

We are focusing on LARC specifically because of racial disparities within the RHWP population that are prevalent with

respect to these highly effective methods. A recent analysis of contraceptive choices of women attending the Cincinnati Health Department’s Reproductive Health and Wellness Program (RHWP) from March 2012 through February 2013 showed that, while controlling for age, education, health insurance status, and birth history, Black/African American women had significantly lower odds of choosing a LARC method compared with non-Black/African American women (AOR: 0.36, 95% CI: 0.23 – 0.57, p <.001). Mediation analysis showed that provider counseling on contraception had no effect on the odds of LARC choice. Further understanding of the barriers to LARC choice in the local context will allow administrators to redesign program features to address disparities and ensure that women are able to choose the method that is best for them.

Our project is unique in that it uses mixed quantitative and qualitative methods to investigate the health disparities affecting a specific intersectional identity: Black/African American women. The focus of this research is the policies and procedures of contraceptive care provision in the RHWP; thus, this research project is an important step in translating intersectional theory into public health practice

ECOLOGY AT THE SEXUAL HEALTH CLINIC

CONTINUED FROM PAGE 2

of the public who saw women accessing services there as morally irresponsible. Thus, the clinic’s commitment to privacy in turn increased the risks to patients associated with breaches of privacy.

Publicly-funded reproductive health clinics find themselves in this double bind time after time, but clinic managers must do their best to ensure that their staff members are non-judgmental and discrete caregivers. Without these sources of empowering care, it is likely that many vulnerable members of our community will lose trust in the health care systems that are accessible to them.

MEN’S HEALTH

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



DON’T BE CONDUMB, USE A CONDOM

The Men’s Health Initiative has started seeing young men on a one-on-one basis at specific CPS School-Based Health Centers! Young men coming in for sexual health check-ups will get to chat about STI and pregnancy prevention with our Men’s Health Coordinator, Eric Washington.

thebodyshop

REPRODUCTIVE HEALTH & WELLNESS PROGRAM

Reproductive Health Suite
Clement Health Center
Cincinnati Health Department
3101 Burnet Avenue
Cincinnati, OH 45229

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 over 5,000 individuals, and continue to grow, learn, and serve.

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

jennifer.mooney@cincinnati-oh.gov

May 11 is Mother's Day!

Thank your Mom for having that uncomfortable "birds and the bees" talk with you!
Remember, safe sex starts with parental involvement!

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