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INSIDE

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Reproductive Healthcare Workers Affected by Mental Health Stressors of Pandemic

Severe psychological distress can occur

Reproductive health providers are at increased risk of depression, anxiety, and stress as the COVID-19 crisis continues, according to researchers.[1]

Researchers studying frontline healthcare staff around the world consistently show that crises, like the COVID-19 pandemic, take a heavy toll on healthcare workers' mental health and can lead to increases in serious mental illness, as well as post-traumatic stress disorder (PTSD).[2,3]

But there is less evidence about the toll the pandemic has taken on other healthcare professionals. Investigators wanted to explore how outpatient reproductive healthcare workers have been affected by the stress and changed work conditions.

"TWO-THIRDS OF THE SAMPLE SAID THEY HAD BEEN HAVING INCREASED FEELINGS OF STRESS DURING THE PANDEMIC, AND ONE-THIRD HAD INCREASED FEELINGS OF ANXIETY AND DEPRESSION."

"I feel like this is something that needs to be talked about, and it's not addressed enough," says **Alison B. Comfort**, PhD, health economist at the Bixby Center for Global Reproductive Health at the University of California, San Francisco (UCSF).

A recent study revealed high levels of stress and mental health issues among reproductive health providers. "Two-thirds of the

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sample said they had been having increased feelings of stress during the pandemic, and one-third had increased feelings of anxiety and depression," Comfort says.[1]

The study's purpose was to draw attention to this issue. "The gap we're trying to fill is there is more attention given to the impact of the COVID-19 pandemic on healthcare workers on the frontlines — the emergency room and hospital settings," she explains. "We thought these [outpatient] providers may be affected, even if they're not on the frontlines."

"Research from previous epidemics has shown a high prevalence of severe psychological distress and mental health problems among healthcare workers, with some 50% to 60% having some severe psychological distress syndrome," says **Alexander Tsai**, MD, PhD, a psychiatrist at Massachusetts General Hospital and associate professor of psychiatry at Harvard Medical School. [2]

Severe psychiatric distress includes a positive screen for major depression, he adds. *(See story on moral injury and psychological distress during the pandemic in this issue.)*

"If you do structured interviews, you find major depressive disorder is around 5% to 6% in the overall population, so it's 10 times as many people [working in healthcare] with these disorders," Tsai explains.

These previous studies were centered around the severe acute respiratory syndrome outbreak in East Asia and the Ebola epidemic in Africa, he adds. For example, one review of 44 studies revealed that up to 73% of healthcare workers, including nurses, physicians, and auxiliary staff, reported PTSD symptoms during previous infectious disease outbreaks. Their symptoms lasted for more than three years in up to 40% of reported cases. The same review showed evidence of depressive symptoms in up to half of healthcare workers, and insomnia symptoms in more than one-third.[2]

If the experience in these 44 studies of previous epidemics/pandemics is comparable in the COVID-19 pandemic, we can anticipate extensive, long-term psychiatric problems in the months and years following current COVID-19 infections.

Emotional and Mental Health Toll

In the new COVID-19 study, researchers surveyed U.S. reproductive health providers, including

EXECUTIVE SUMMARY

New research explores how the COVID-19 pandemic has affected the emotional and mental health of reproductive healthcare workers.

- Investigators surveyed reproductive health providers, including nurses, physicians, administrative staff, and others. Two-thirds of respondents reported feelings of stress, and one-third experienced increased feelings of anxiety and depression.
- Previous studies have revealed that health crises can cause high levels of severe psychiatric distress.
- One stressor for reproductive health workers was being redeployed to provide COVID-19 testing.

physicians, nurses, advanced practice providers, administrative staff, health educators, and anyone who worked in a reproductive health setting, across different practice settings, from April 21, 2020, to June 24, 2020.[1]

"This population is interesting because reproductive healthcare providers practice in a variety of settings, including clinics, departments of health, family clinics, school-based health centers, outpatient hospital settings, and college-based health centers," says **Cynthia Harper**, PhD, professor of obstetrics, gynecology, and reproductive sciences and director of the UCSF-Kaiser Permanente Building Interdisciplinary Research Careers in Women's Health at UCSF. "The findings were similar in the different care settings. It was broad-based how the pandemic affected different types of clinics throughout the U.S. and the people working there."

The emotional/mental health toll can include PTSD and psychological distress disorders. Healthcare leaders should prepare for these problems to continue even as the nation becomes vaccinated. *(See story on helping staff cope with emotional/mental health in this issue.)*

The survey included open-ended questions about their experiences during the early part of the pandemic. Respondents talked about some of the obstacles and problems they faced.[1]

"We found that a lot of them mentioned concerns about quality of patient care and access to services," Comfort says. "They worried about whether their patients were avoiding coming into the clinic if they thought they couldn't get services, and what would that do to their other health conditions if they avoided coming in."

Stressors also included the quick job changes and constantly changing protocols, especially at the beginning of the pandemic. "Some people were responsible for running testing sites," Comfort says. "They had new responsibilities, and some mentioned the challenges of switching to telehealth visits that they were not used to doing."

For example, one reproductive health nurse told researchers that most of their staff assisted at COVID-19 drive-through testing centers, testing about 300 people within four hours in high temperatures. Then, they had to call all of the people who tested positive and perform contact tracing, mailing out both positive and negative results. They did not have volunteer help and had to perform this work in addition to their normal daily routines, including telemedicine visits with patients.

Other issues involved their colleagues' stress. "One provider mentioned the challenge of presenting a calm and supportive environment to patients and staff," Comfort says. This provider wrote, "This is exhausting … I have depleted my emotional reserves calming others."[1]

Reproductive healthcare professionals worried about becoming infected with the virus and potentially bringing it home to their families. "Some talked about the challenges of homeschooling and taking care of people in their homes," Comfort says. "There were financial concerns and [fears of] being fired."

Redeployment led to additional stress. "A lot of providers were redeployed outside of their own specialties to support the acute care response, especially during big surges," Tsai says.

Or they were asked to work with fewer staff members as patient visits declined and the economy collapsed. "It's like our healthcare workforce at large really kicked into high gear to help with things like testing," Harper explains. "There was so much to be done with the pandemic."

Preventive Care Is a Challenge

It was harder to provide preventive care and testing and treatment for sexually transmitted infections (STIs) during the pandemic. Plus, reproductive health providers' administrative responsibilities went through the roof as guidelines changed overnight.

"Things shut down, and they had to learn different ways to do reimbursement and interact with patients," Harper says. "They had to give high-quality counseling over the phone and use resources in a smart way."

For instance, clinics had to triage patients for in-person care. Those who could be counseled via telemedicine were handled remotely, leaving the clinic safer for those necessary in-person visits.

Telemedicine had shortcomings because not all patients had reliable internet connections, smartphones, or privacy in their households. "For reproductive health, privacy makes a big difference," Harper explains. "Maybe if you're calling a doctor for something not as stigmatized or private, you can do that with other family members around. But, generally, privacy and confidentiality are important."

According to survey respondents, this was particularly true of adolescent patients, who did not have the privacy in their households for telemedicine visits, Harper says.

The researchers also pointed to obstacles such as a lack of supplies, including personal protective

equipment (PPE). The worldwide PPE supply chain was disrupted, making day-to-day operations more difficult, Harper says.

Reproductive health staff also coped with the anxiety and depression of their patients. "You have patients arriving with depression, and healthcare providers are suffering, too," Harper says.

It is important for healthcare providers and leaders to acknowledge the sacrifices everyone has made during the pandemic, Tsai notes.

"Acknowledge the loss people experienced, perhaps in the kind of way that doesn't make people feel you are just papering over whatever difficulties they have encountered," he says. ■

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Watch Out for Moral Injury and Psychological Distress Among Staff

Staff need education, coping tools, therapy

Research into psychological distress and mental health issues during crises suggests that the world's healthcare workers will face challenges through the pandemic and for years afterward.[1,2]

New data from the Centers for Disease Control and Prevention (CDC) and an online survey revealed that one in 10 respondents seriously considered suicide within the past 30 days, and about one in five essential workers considered the same.[3]

Frontline professionals, and other healthcare workers to a lesser extent, are witnessing traumatic events that could lead to moral injury. As the authors of one new paper suggest, a big contributor to this problem is their frustration and sense of powerlessness. Nurses and others affected by the pandemic's trauma need education, coping tools, and therapy to help alleviate the adverse effects.[2]

The frontline workers in intensive care units (ICUs), caring for dying COVID-19 patients, are tired and swamped and may experience moral injury, says **Alexander Tsai**, MD, PhD, a psychiatrist at Massachusetts General Hospital, and associate professor of psychiatry at Harvard Medical School.

"'Moral injury' is a term coined by a psychiatrist who worked with combat veterans in the Vietnam War," Tsai explains. "He defined it as being party to the perpetration or not being able to transgress these acts, such as the Vietnam War atrocities."

People who have experienced moral injury are harmed for years after the event. They can include journalists, chaplains, healthcare workers, and others after large-scale disasters or mass violence, he adds.

Just as Vietnam War soldiers were helpless to prevent atrocities, healthcare workers in all settings have been helpless to prevent COVID-19 deaths. "Moral injury is an important issue that factors into distress among healthcare workers," Tsai says. "A study of healthcare workers in New York City, at the time of the surge, polled them about occupational hazards, what factors ranked highest in their mental health, and they identified 'not having control.'"

Other factors were the lack of support and being redeployed to do work outside of their specialty. "Those are the occupational factors. There were other things, like being fearful about being infected with COVID-19 or having to work despite having symptoms and not having personal protective equipment," Tsai says. "There is a long list of factors associated with mental healthcare in the epidemic, and working long hours is low on the list because they're used to long hours."

Burnout, anxiety, and depression among healthcare workers are caused by factors other than hard and long hours of work, he adds.

For all healthcare workers in the pandemic era, a big stressor involves anxiety about contracting the virus.

"We saw a lot of stress and anxiety around illness," says **Cynthia Harper**, PhD, professor of obstetrics, gynecology, and reproductive sciences, and director of the UCSF-Kaiser Permanente Building Interdisciplinary Research Careers in Women's Health at the University of California, San Francisco (UCSF).

In a study, Harper and co-investigators found that reproductive health professionals were worried about bringing illness home to their families. They also were worried about finding child care, which was scarce during pandemic surges. "Some were able to do telemedicine and have their shifts remote," Harper says.

Iconic images of the pandemic show healthcare workers with capes or being saluted by Superman — as an Ohio COVID-19 poster shows — or as masked hospital staff walk down a hallway, Marvel and Justice League superheroes bow to them. *(The images can be found at: http://bit.ly/31qZfpR.)*

"We see these health workers as heroes who can take on everything," says **Alison B. Comfort**, PhD, health economist with the Bixby Center for Global Reproductive Health at UCSF. "They have to show up for work, and we count on them for so much. In San Francisco, we have ads that say, 'Not all superheroes wear capes,' and they show healthcare workers."

But what these tributes to their work during the pandemic miss is the emotional health toll of their struggles during the pandemic. "We depend on them, and yet we're putting them under so much pressure. They're human and not sleeping and are constantly stressed and worried about their families," Comfort says. "We call them superheroes, but they're going through these very real, challenging situations."

Comfort says she was compelled, in part, to study this topic because of the tragic examples of physicians taking their own lives after months of caring for COVID-19 patients.

"We need to acknowledge [their difficulties], support them, and not make them do impossible jobs that put them under so much strain," she says. "They're not super human; they're human." ■

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Take Practical Actions to Help Employees Cope

Reducing stigma is first step

Employers sometimes offer staff tips on self-care to help them cope with stress and prevent depression and other mental health issues. But there also are actions leaders can take to help prevent their staff from becoming burned out or experiencing long-term mental health problems related to the COVID-19 pandemic:

• **Develop mental health resources for staff.** Organizations should propose resources that their staff can turn to for mental health counseling, treatment, and support, says **Alison B. Comfort**, PhD, health economist with the Bixby Center for Global Reproductive Health at the University of California, San Francisco (UCSF).

Researchers recently studied mental health issues among reproductive healthcare staff during the pandemic and suggested that interventions should focus on reducing stigma as a barrier to health providers accessing treatment for mental illness.[1]

"Because it [can be] stigmatized to use those resources, we need leaders in organizations to be examples and say they benefited from those resources," she says. "You need leaders or key influencers within organizations to show it's OK to use those resources, saying, 'I really benefited from them, and you can, too.'"

It will take some work to make those resources available and destigmatize them, she adds. "Employers should offer mental health resources without penalty, and leaders should say, 'Why don't we all use it,'" says **Cynthia Harper**, PhD, professor of obstetrics, gynecology, and reproductive sciences, and director of the UCSF-Kaiser Permanente Building Interdisciplinary Research Careers in Women's Health at UCSF.

Everyone needs to become aware of how the pandemic may affect

employees' mental health and how they should seek as much help as they need. "All of us need a mind shift about mental healthcare," Harper says.

"Insurance is slightly more likely to cover mental health issues than it was 15 years ago," she adds. "We have a long way to go before everyone gets the help they need from this global pandemic."

• **Manage expectations.** A potential contributor to stress over the next year will be the expectation that everything will return to normal.

Continuous change and adaptations have been hallmarks of the pandemic. Reproductive health staff should know that these may continue. As one nurse practitioner told researchers, "This is going to be the new 'normal.' Not looking forward to how medicine will be done in the future."[1]

Reproductive health providers also need to manage patients' expectations as things continue with telehealth and other changes. "Healthcare workers had to completely change their workflow, and patients are thinking everything will be the same except for using Zoom, and it's not. That puts additional stress on clinical interactions," says **Alexander Tsai**, MD, PhD, a psychiatrist at Massachusetts General Hospital and associate professor of psychiatry at Harvard Medical School.

• **Make room for grief.** "There have been a lot of deaths that we as a country have experienced," Harper says. "We have a higher death rate than other countries."

According to researchers, the pandemic's overwhelming death toll and healthcare workers' fears of contracting the virus and infecting colleagues and family have harmed their emotional and psychological well-being.[2]

Many reproductive health staff personally experienced the trauma of these deaths and COVID-19 illnesses. Some workers' family members and/or people they knew were infected and harmed or killed by the disease.

"We've suffered this [crisis] together, and it has really been tremendous the way it has impacted all these different sectors of society," Harper says. "The first step is to say it really has affected people and to offer to help," Harper says.

• **Tell the truth: Things will not be the same.** Leaders should be frank about the situation and not offer false reassurance, Tsai says.

They can help their staff cope with moral dilemmas and the ever-changing work environment by expressing honesty about what the organization can and cannot do for them. "Don't present things in legalese or euphemism, but give it to people straight," Tsai says. "Whenever the epidemic subsides, that brings up anger and bitterness."

Staff will need ongoing support. "They can provide a regular discussion forum for healthcare workers to talk about the challenges they are experiencing, or some sense that employers are aware of these challenges and are trying to do something about it," Tsai explains. "If they feel like the big boss doesn't care, that doesn't feel good. It's better if the boss does care and there is more of a sense that we're in this together."

Healthcare workers recognize that their work during the pandemic will be difficult. But they want to know they will be supported as they experience sacrifice and losses. "Seeing employers trying to mobilize support in tangible ways also is appreciated," he adds.

For example, employers can try to arrange for safe child care for their employees during times when schools or daycare centers are closed. "To see an employer try to create safe child care would be greatly appreciated," Tsai says.

• **Provide aftercare.** "What happens when you put people under so much stress for so long is, even when we come out of the pandemic, there could be long-term repercussions for these healthcare workers, who have been under so much stress," Comfort says.

Employees who do not attend to their emotional health issues now and who delay care may end up with festering problems later.

"Providers are delaying taking care of themselves. In the next few years, we'll see repercussions of that," Comfort says.

Reproductive health sites that destigmatize mental health treatment and encourage staff to seek assistance can help them prevent long-term problems. "It goes back to the superhero idea, where they're treated as though they're super human and don't need help," Comfort explains. "But they [should] seek care, too."

All healthcare employees will need at least some aftercare when the pandemic ends. "Hopefully, employers and supervisors will mobilize some kind of appropriate response once the crisis is over," Tsai says. "With aftercare, the idea is to make sure the most common reaction to the issues that have come up during the pandemic is not simply avoidance."

The pandemic will be with the United States and the rest of the world for a long time, but this cannot be an excuse to ignore its mental health repercussions among staff.

"It's important for supervisors, employers, and leaders to create space to reflect on the sacrifice made and the losses so the predominant story is some kind of meaningful story," Tsai explains. "Acknowledge the sacrifices, the difficulty, and the loss in a way that doesn't make people feel you are just papering over whatever difficulties that have been encountered." ■

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SAFE Intervention Brings Reproductive Health Services to Women in Treatment

Program reduces stigma for women who use opioids

One challenge of providing reproductive health services to women with opioid use disorder is stigma. Even women in treatment for opioid use often are afraid of judgment and might avoid visiting a family planning clinic or seeing an OB/GYN for contraceptives.

"There is a lot of reluctance to talk to a doctor," says **Hendrée E. Jones**, PhD, professor in the department of obstetrics and gynecology and executive director of UNC Horizons at the University of North Carolina at Chapel Hill. "Would they be discriminated against in some way? Would they be stigmatized? We found out that the women did not want to get pregnant, but were not actively trying not to get pregnant."

EXECUTIVE SUMMARY

Women with opioid use disorder may avoid visiting a family planning clinic or seeing a physician for contraceptive care and counseling because of their fear of stigma and judgment.

- The Sex and Female Empowerment (SAFE) intervention helps this at-risk group receive evidence-based contraceptive information safely and without risk of stigma.
- SAFE can be administered in one-on-one sessions with a trained educator or in a computer-adapted session.
- Both ways of delivering SAFE resulted in at least seven out of 10 women receiving long-acting reversible contraceptives after the intervention.

Jones and co-investigators created an intervention to help this at-risk group receive evidence-based contraceptive information in a way that was safe for them. The Sex and Female Empowerment (SAFE) intervention was vetted by women in the target population.

SAFE works in both face-to-face sessions and in a computer-adapted session. A study of the intervention revealed that both SAFE methods were more successful than usual care, with higher completion, higher satisfaction, and higher contraception consultation visit attendance.[1]

"We had positive retention in our study," Jones notes. "We were able to keep everyone in the study for the six months of their enrollment and follow-up. I thought that was fantastic."

In terms of primary outcomes, Jones and researchers found good

attendance to the interventions and good acceptance of reproductive health appointments. Also, the study participants who received the intervention acted on the information they received, and many received long-acting reversible contraception (LARC).

About 77% of the women who participated in the face-to-face intervention received LARC after the intervention. Seventy-three percent of the women who received the computerized SAFE intervention accepted LARC. By contrast, 23% of the women in the usual care group received a LARC.

Six months after the intervention, investigators asked women which contraceptive they were using. The results suggested that the majority continued with their LARC. "It didn't seem like we had a lot of discontinuation of it, but that was at six months, and it'd be important to do a larger follow-up study," Jones says. "I'd like to do a multisite trial with the SAFE intervention and follow people for a longer period of time to see it in the more global real world."

SAFE was designed to help a population of women with a 60% to 80% prevalence of unintended pregnancy. The high rate is driven by women with opioid use disorder with a high need for reproductive autonomy and low utilization of effective contraception because of their concerns about side effects, insertion, and removal of methods.

In designing SAFE, researchers spoke to women with opioid use disorder, to men who were not their partners, and to providers. "We wanted to understand what people already knew about contraception and contraceptive practices. That drove the intervention we designed," Jones explains. "I also was interested in seeing which providers would want to do something that takes 45 to 50 minutes to do in an office, or if an intervention on a computer would be more acceptable."

The researchers explored the possibility that some women with opioid use disorder also would prefer a computerized intervention. "Maybe women don't want to talk to anyone and would be more comfortable sitting at a computer and listening to vignettes and being interactive," Jones says.

When researchers asked women whether they would prefer group educational sessions or one-on-one sessions, they preferred the one-on-one sessions. The sessions occurred in the opioid use disorder clinic. "It was mixed, but overall they preferred we'd do the sessions one-on-one," she adds.

Also, the one-on-one sessions were not held with physicians or nurses. "It was not the medical staff doing that," Jones says. "Ideally, it'd be great to have a nurse practitioner deliver it, but the behavioral health folks — bachelor's or master's level — did it."

SAFE involves the following:

• **Face-to-face sessions.** Using a desktop stand and flip board, the intervention leader meets with a woman to talk about various reproductive health topics. The flip board displays information about basic anatomy and reproductive health. The other side of each page contains information the interventionist sees.

"The patient sees the picture, and on the other side is a scripted analysis of what the picture shows," Jones explains. "The interventionist sees the written words, and can describe it or answer questions."

The woman and interventionist hold conversations on how to talk with the doctor, what questions she should ask, and how to stand up for her own decisions — especially if she had unpleasant experiences previously.

• **Reproductive health misconceptions.** The intervention covers misconceptions about pregnancy and different contraception practices.

"It covers basic reproductive biology, saying, 'This is how it works and how you get pregnant,' and 'Yes, you can get pregnant if you have sex standing up,' and 'Yes, you can get pregnant even if you wash immediately after having sex,' as examples," Jones says. "After we answer those questions, the next thing is to talk about whether they want to get pregnant in the next year. For those who didn't have intention of getting pregnant, what kinds of things do they want in their pregnancy prevention method?"

Another misconception is that if a hormonal method stops their period, it could cause problems. "They fear the blood will back up in their body and explode," Jones says.

• **Shared decision-making.** Interventionists can offer women information about different methods and explain how to maintain that method.

"We form an action plan, and women can go through that with their interventionist and talk about their worries," Jones says. "They can write down a couple of things and go through those with the interventionist. We used a shared decision-making tool."

They discuss pros and cons, the woman's fears, and what the woman and her partner think of various contraceptive methods. "The partner dynamic is important," Jones says. "Women might be reluctant to get an implant in their arm because their partner may be looking at it, or maybe they heard things about IUD strings interfering with sexual pleasure because men can feel it."

Bleeding also might be an issue. Interventionists should ask the woman if she wants to stop bleeding, or if having a period is important to her. "If the woman wants a period, let's use methods that ensure that happens," she says.

• **Computerized intervention.** "We [review] the same information, but it is self-guided in the computer-adapted intervention," Jones says. "It's a basic review of sexual anatomy, but they can click through it or slow down and listen to it."

They use videos and information from Bedsider, a nonprofit that provides information online about birth control methods and other issues related to reproductive health. For instance, if someone clicks on the picture of the birth control patch, they receive information about how it works, how much it costs, how to use it, side effects, and problems. It also includes two- to three-minute video testimonials from women who have used that particular method.[2]

At the end of the computerized intervention, women can decide which contraceptive methods they would like to use or learn more about. "The program provides a printout they can take to their [behavioral health professional], who will summarize things with them, talk about shared decision-making," Jones says. "If they want to make an appointment with a physician, they can."

The purpose of the intervention is to show how women with opioid use disorder can control their own decision-making process after they are given evidence-based information on contraceptives and their side effects. The process will suggest providers they could talk with. "It's not just gaining access, but getting access to providers who have compassion and empathy and are advocates for the patient population we serve," Jones says.

Although SAFE was studied with a population of women who had been treated in a methadone treatment program for at least 90 days, it could work well with another population with opioid use disorder. The key is the women need to be stable in their abstinence from active opioid use.

"An important question is, 'Do we have to wait 90 days, or would we get the same result if we did it sooner in treatment?'" Jones says. "I also think there are things we could do to build a better mousetrap. We could do an app, which is even more cost-effective." ■

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Ask Women if They Use More than One Contraceptive Method

Dual methods are common

Nearly one out of five women used two or more methods of contraception the last time they had sexual intercourse, researchers found.[1]

Specifically, 18% of women ages 15 to 44 years who had used some form of contraception at last intercourse said they used two or more methods. Condoms and another method were the most commonly used method among dual users (58%). But women also reported using the withdrawal method, or a long-acting reversible contraceptive (LARC) and another method that did not include condoms or withdrawal.[1]

The researchers also found a nearly linear relationship between dual use with condom and age. Younger people were using condoms at a much higher rate than older people, says **Megan L. Kavanaugh**, DrPH, MPH, principal research scientist at the Guttmacher Institute.

"These data help us understand there is more to dual use than we thought about in the past," Kavanaugh says. "When people are combining methods, they're combining condoms with hormonal methods. Clinicians should recognize that people's contraceptive strategies are more complicated than we thought about in the past. Clinicians should orient their counseling sessions to acknowledge the complexity of these strategies so individuals can choose the best method or methods for their own life circumstance."

The researchers drew on national data on reproductive health metrics in the United States, reviewing women's answers to questions in the National Surveys of Family Growth. They looked at two periods: 2006-2010 and 2013-2017.

They presented data from the years 2008 and 2015. Samples were 6,601 women in 2008 and 5,562 in 2015. Data came from women who had had penile-vaginal intercourse in the three months prior to the interview and who reported some form of contraceptive use at last sex. When the researchers compared the earlier group to the later group, they found that the percentage of people using dual contraceptives had increased from 14% to 18%.

Overall, contraceptive use has remained steady in the United States. The increase in people reporting using dual contraceptive methods could be the result of how contraceptive strategies are measured and how some methods have become more acceptable in recent years. "Some contraceptive methods are becoming more widely accepted as viable," Kavanaugh says.

For example, the withdrawal method has received more talk and literature in recent years. Also, people may have reported it less in previous decades.

"Ten to 15 years ago, people may have practiced withdrawal, but they didn't report it as a contraceptive method or behavior, and now it's a bit more widely adopted as a contraceptive method," Kavanaugh says.

Also, single-method contraceptive surveillance reports may not mention the withdrawal method because they report only the most effective method that people use. This would mean a couple that uses both birth control pills and the withdrawal method would be listed only as using the withdrawal method. "In this study, we're reporting all the methods people use," Kavanaugh says.

Previous research showed that people felt more confident or better able to meet their goal of pregnancy prevention when they layered their contraceptive methods.[2] "It was, 'I just wanted to make sure I was fully protected, and combining withdrawal and a hormonal method makes me feel extra protected,'" she explains.

The study's findings also suggest that reproductive health providers should ask patients about dual contraceptive use because it will provide them with better information as they make recommendations.

"Whenever contraceptive methods are being discussed, whether in a clinical encounter or health education setting, we want to do a better job of recommending contraceptive use," Kavanaugh says.

This means clinicians should acknowledge that contraceptive use is more complex than a single method.

"When people are preventing pregnancy, it's not just using one method; there may be several methods or one method combined with another method," she says. "To have an encounter that's fully informed, providers should understand how patients are protecting themselves against pregnancy. The best [patient-provider] encounter is where everyone is on the same page to achieve the patient's goals." ■

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Study Reveals Increased IUD Expulsion Rate After Vaginal Delivery

Obesity is another factor

Physicians sometimes worry that women who have not given birth will have more difficulty with an intrauterine device (IUD), experiencing a higher expulsion rate. But the results of a recent study show that the opposite is true.

"For many years, IUDs were withheld from women who never had babies because of mythological concerns about infection, and the thought they had smaller uteruses and were more likely to expel the device," says **Mitchell D. Creinin**, MD, professor of family planning and director of the Complex Family Planning Fellowship at University of California, Davis Health. "Instead, it's the opposite: The more deliveries you have, the more likely you'll expel IUDs. We know that if an IUD is not

placed correctly, it will increase risk of expulsion, but it's just more likely to occur if [someone] had a vaginal birth."

Overall, the risk of expulsion is low — 3.8% over six years. Three-quarters of those expulsions occur in the first year.[1]

"After the first year, expulsion is very uncommon, and overall it's uncommon," he adds.

For every vaginal childbirth, the risk of IUD expulsion increases by 30%.[1]

The researchers found that women who had only vaginal delivery were more than twice as likely to experience IUD expulsion over 72 months as women who had not given birth, or who underwent a cesarean delivery. Women with a body mass index (BMI) of 30 or greater also experienced an IUD expulsion rate 2.6 times greater than the expulsion rate for non-obese women.

"People who had a baby before were more likely to have expulsion than those who did not have a baby," Creinin says. "People who ever had a c-section had an expulsion rate pretty similar to those who never had a baby."

In every analysis of the expulsion data, vaginal deliveries stood out as a chief risk factor. "What's driving increased expulsion risk is people who had vaginal deliveries," Creinin says. "The expulsion risk to people who had only vaginal deliveries was 7%; it was 5% at one year, and 7% at six years."

Investigators conducted the study to give physicians more information about this IUD risk factor. "There are still doctors and providers out there who won't give an IUD to women who have not had a baby, and their risk of expulsion is not higher than for those who had a baby," Creinin says.

When women make decisions about which contraceptive method to use, they need these data to better inform their decisions. "It's giving more information, being realistic," he says.

Investigators analyzed data from the ACCESS IUS multicenter, Phase III, open-label clinical trial of the Liletta levonorgestrel 52 mg intrauterine system (IUS). The trial included 29 clinical sites that enrolled healthy, nonpregnant, sexually active women, ages 16 to 45 years, beginning in December 2009. Some had given birth previously, and some had not. There were follow-up visits three times in the first six months, and every six months after that. Participants were called at three-month intervals between visits.[1]

"We wanted to understand why expulsion occurs," Creinin says. "If I place an IUD correctly in a woman with two vaginal deliveries and in a woman with a c-section, the woman who had vaginal deliveries may still expel the IUD. Obesity also comes into play — both independent."

Clinicians need data to better inform patients. "When someone goes through the [IUD] procedure, you would hate for it to come out and for the woman to start bleeding and cramping," Creinin says. "It'd be great to say to a patient, 'These are the reasons why, and here are the factors associated with expulsion.'"

Expulsions also are much more common when the IUD is placed within minutes of a vaginal birth. For instance, when the IUD is placed right after a vaginal delivery, there is a 25% risk it will expel in the next six months. "There's a one in four risk of expulsion," Creinin adds. "If a woman shows up to every [prenatal] visit, you're better off putting the IUD in after the follow-up visit than right away."

But this depends on the woman's social determinants of health and her commitment to returning to the clinic after she has given birth, he says.

The research also may suggest an opportunity for IUS companies to improve their products by developing IUDs for women who had a vaginal delivery. "As new IUDs are brought to market, they may need to design IUDs for this population," Creinin says. "I hope further development of IUDs will take into account ways to minimize expulsion."

As a woman's BMI increases, so does the IUD expulsion risk. "It's good for patients to know that if they're obese and had vaginal deliveries in the past, their risk of expulsion is a little higher, and the doctor should let them know that," Creinin says. "Be honest with patients, and tell them what the risk is, understanding that it changes based on patient characteristics." ■

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COMING IN FUTURE MONTHS

- Unintended pregnancies increased worldwide during pandemic
- Provide contraceptive counseling when women seek pregnancy testing
- Prevention services for sexually transmitted infections can reduce overall costs
- Study confirms legal abortions are safe medically and for mental health

CONTRACEPTIVE TECHNOLOGY UPDATE

Contraceptive Technology Update is endorsed by the **National Association of Nurse Practitioners in Women's Health** and the **Association of Reproductive Health Professionals** as a vital information source for healthcare professionals.

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **During the pandemic, reproductive health providers experienced high levels of stress and:**

   a. suicidal thoughts.
   b. anxiety and depression.
   c. post-traumatic stress disorder.
   d. obsessive-compulsive symptoms.

2. **The Sex and Female Empowerment (SAFE) intervention resulted in what percentage of women receiving long-acting reversible contraceptives after the one-on-one intervention?**

   a. 23%
   b. 44%
   c. 73%
   d. 77%

3. **Women with which characteristics are more likely to experience an intrauterine device expulsion, according to Mitchell D. Creinin, MD?**

   a. Women who have undergone abortions
   b. Women who have undergone one or more cesarean deliveries
   c. Women who are malnourished or have substance use disorder
   d. Women who are obese or who had one or more vaginal deliveries

4. **Because of feelings of helplessness to prevent COVID-19 deaths, healthcare workers are at risk of developing:**

   a. grief.
   b. pandemic fatigue.
   c. moral injury.
   d. post-traumatic stress disorder.

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.