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INSIDE

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Research Shows Reproductive Health Nurses Needed in 2020s

Nursing pipeline affected by pandemic

The United States will soon need millions more nurses than are currently working in healthcare. But employers, including family planning centers and OB/GYN offices, likely will have a difficult time finding nurses. The American Nurses Association (ANA) predicts more registered nurse jobs will be available through 2022 than any other profession. A half-million nurses are expected to retire by the end of 2022.[1]

Nursing college educators and other experts say the COVID-19 pandemic has only made the nursing pipeline problems worse.[2]

To address ongoing nursing shortage issues, a three-pronged approach would include providing more opportunities for exposure to reproductive health nursing in nursing colleges, providing opportunities for nurses in other fields to learn more about reproductive healthcare, and preventing current and new reproductive health nurses from leaving the profession.

> NURSING COLLEGE EDUCATORS AND OTHER EXPERTS SAY THE COVID-19 PANDEMIC HAS ONLY MADE THE NURSING PIPELINE PROBLEMS WORSE.

"The pandemic has highlighted the pipeline and issues with it," says **Anna Brown**, BSN, RN, education program director with Nurses for Sexual & Reproductive Health (NSRH) in St. Paul, MN.

The nursing educational challenges make it difficult for student nurses to learn about the various reproductive health jobs in nursing. "You go to nursing school, and so much of the exposure is

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hospital-based nursing," Brown says. "There is not a lot of information about what specialties look like."

For example, Brown's first exposure to sexual and reproductive health experience and knowledge was not in nursing school — but when she volunteered with a sexual assault health hotline while in college.

"If people needed access to a sexual assault nurse, the hotline was a linkage to those resources," Brown says. "That was my first preview into what sexual and reproductive health means to people, outside of pregnancy planning."

After that volunteer experience, Brown decided to seek reproductive health training. For instance, she worked as a volunteer for an abortion fund, providing practical support, such as transportation to an abortion clinic. However, her entry into the field was too self-directed and limited in scope to be a model for attracting new reproductive health nurses.

"This is something NSRH aims to address," Brown notes. "If you're in, you're in, but there are not a lot of doors for entry into this kind of work. Coming at it from a multitude of angles is our focus."

Specialty nursing areas like reproductive health will not draw as much interest compared to inpatient and more traditional nursing settings, partly because of student nurses' personal interests and goals, notes **Susan H. Lane**, PhD, MSN, RN, associate professor in the department of nursing at Appalachian State University in Boone, NC.

"Undergraduate students often enter nursing programs with goals of becoming a hospital inpatient-based nurse or with long-term goals of becoming a nurse practitioner or CRNA [certified registered nurse anesthetist]," Lane explains. "Both of these educational tracks require experience in inpatient hospital critical care or emergency-type settings prior to admission to graduate programs, thereby contributing to the supply of nurses in these areas."

Advanced practice roles — including community-based roles or nursing education — for RNs are not as well-known or advertised to incoming nursing students, she adds.

"The pandemic may be a positive influence on developing more interest in community-based nursing roles because of the increased news media focus related to community and population health," Lane says.

The obstacles to familiarizing student nurses with reproductive health and other specialty areas

EXECUTIVE SUMMARY

The nursing pipeline in the United States has been affected by the COVID-19 pandemic. Nursing burnout increased, and nursing schools struggled to help students complete their practice experiences. The pandemic also highlighted problems in attracting more nurses to reproductive health practice.

- Nursing educational challenges make it difficult for student nurses to learn about various reproductive health positions.
- Most nursing students think about working for hospitals and inpatient settings and may know little about community nursing jobs.
- During the pandemic, some nursing schools resorted to virtual classes and simulated practice experiences.

include the role TV media plays in glamorizing hospital nurses and putting little focus on nurses working in community settings. Also, specialty-based nursing roles are not marketed to younger students during career planning sessions before entering nursing programs, she adds.

"For nursing programs, one avenue to support the interest in more specialty-based roles is exposure to these roles during clinical settings throughout the program vs. just in the community courses, which are typically only offered in baccalaureate programs," Lane says. "Additionally, offering specialty-based nursing roles as optional experiences during capstone courses in the final semester of nursing programs may provide another opportunity to strengthen the interest of new graduates in these types of nursing settings."

Part of NSRH's advocacy work is to provide exposure to reproductive healthcare in nursing schools. "We offer topics of reproductive health to provide them with exposure to a variety of what this career could look like," Brown explains. "The education we have in nursing schools is high-level labor and delivery. You come out and get a job, but there's more to reproductive healthcare than those three issues."

Nursing colleges handled disrupted education and limited nursing practice experiences as best they could since the pandemic shutdown of March 2020. Some resorted to virtual classes and simulated practice experiences for students.

"We were committed to progressing students on time and having them graduate on time, and had two major initiatives," says **Rhonda Maneval**, EdD, RN, senior associate dean of the College of Health Professions and the Lienhard School of Nursing at Pace University in New York City. "We moved to remote and virtual reality clinical [education]. We invested heavily in new technology around virtual clinical simulation. That was a major lift on the part of our faculty."

The college also provided telehealth for community and geriatric nursing. "Once we were able to have limited in-person presence on campus, we opened our simulation labs," Maneval adds. "We mocked up the hospital environment."

Other nursing colleges postponed practice experiences or found alternative, nonhospital sites for hands-on learning. "We experienced situations where clinical agencies were so strapped and overwhelmed with managing their patient population and the incredible influx of high-acuity patients with coronavirus that they suspended participation with nursing students because their staff couldn't manage that with everything else," says **Julie A. Manz**, PhD, RN, associate professor and assistant dean of the undergraduate program at the Omaha campus of Creighton University. "In some instances, here in Omaha, some of our practice partners were much quicker to allow our students to return. By June 2020, clinical partners welcomed us back because they recognized that if we want nurses, we need to help [the nursing college] with the learning."

The college also created virtual grand rounds, in which each student is assigned a patient and virtual case studies. "We managed to be creative and innovate and found ways to not hinder their professional development," Manz says. ■

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Pandemic Stress, Burnout Contribute to Nursing Pipeline Shortage

More nurses retired, not enough hired

Stress, burnout, turnover, and retirement have contributed to obstacles in the student-to-nursing workforce pipeline.

Nursing students and other healthcare professionals have experienced anxiety during the COVID-19 pandemic, research shows.[1] This affected both nursing and medical students as well as nurses working in any healthcare settings.

Students found their education altered by the nation's shutdown in the spring of 2020 and the continued strategies of remote learning and social distancing to reduce the spread of the virus.

Nursing students' and medical students' education was disrupted by the pandemic because of the emotional toll of worrying about their own health and their families' health, says **Allison Yu**, MD candidate, Class of 2022 at the University of California, Davis School of Medicine in Sacramento.

Yu studied the relationship between resilience and news monitoring with COVID-19 distress in students of health professions. She found that health science schools need to address the immense student stress with their curriculum disruptions during the pandemic.[1]

"We found that students were most concerned about their own family members and how things would change with school exams and societal responses to COVID," Yu says. "We didn't ask what they were looking for in societal responses, but we inferred discrepancy between [steps] the public was willing to take to adapt to the pandemic and how transmissible this virus was."

Yu and colleagues found that people who showed more resilience were better equipped to handle COVID-19 stress. They also noted that students who checked the news more than once a day were more likely to experience stress.

"It's interesting, because for a lot of health professionals, in general, knowledge is comforting and something they have control over," Yu explains. "But we're finding that maybe checking the news is not always the best way to go."

Hire Seasoned Nurses

It is important for reproductive health organizations to introduce seasoned nurses to the reproductive health field, says **Anna Brown**, BSN, RN, education program director with Nurses for Sexual & Reproductive Health (NSRH) in St. Paul, MN.

"One of our programs in training and abortion care is to take experienced nurses and train them on site," Brown says. "We bring education around any sexual and reproductive healthcare conversation."

The focus is to find nurses who are not already in the field, but who either want to work in sexual and reproductive health nursing or are open to expanding their nursing experience, she adds.

For instance, a medical-surgical nurse could be trained as a sexual assault examiner nurse. Or, ICU nurses could be trained to work in an abortion clinic or to work with patients at risk of HIV infection and in need of pre-exposure prophylaxis.

Other contributors to nursing shortages are turnover and nurses leaving the profession.

"At the root of this is burnout," Brown says. "There's not a conversation happening to prevent burnout — nurses leaving the profession within a couple of years."

Psychological Burden Is High

Nursing burnout has worsened during the pandemic, new research shows.[2-4]

Answering a survey through the summer of 2020, healthcare workers reported high rates of anxiety, depression, burnout, and work overload.[4]

Burnout affected 49% of healthcare workers, while 43% reported work overload. Also, 61% of workers reported fear of exposure or transmission of COVID-19.[2]

Canadian researchers found nurses and other healthcare workers' psychological burden was high and rising as the pandemic persisted, and they needed ongoing support.[4]

One solution is to create a situation where nurses feel supported and can think about staying long-term. "In addition to focusing on providing a community and safe place for nurses, we need to address issues that come up in their workplace," Brown says. "You may be the only nurse providing that reproductive healthcare in that clinic or setting."

Current nursing burnout and stress was compounded by a pandemic that caused some family planning clinics to limit in-person visits and have nurses and other staff learn — literally overnight — how to help patients through telemedicine.

Frustrations Taken Out on Nurses

Nurses and other healthcare workers also dealt with the political and social frustration brought about by COVID-19.

"There was instability, lashing out, more yelling and name-calling, and refusal to wear masks," says **Crissy Hunter**, DNP, RN, CHSE, CNE, clinical nursing faculty and course coordinator for the nursing education track at Southern New Hampshire University in Manchester. "Some community members took it out on the profession of nursing. In some states, when people were anti-masks and thinking it was a conspiracy, they were taking it out on nurses because nurses were in the frontlines."

The closing of clinics — at least to in-person visits — also affected nurses' mental health and stress. "Hospitals and healthcare institutions went on lockdown," Hunter adds. "You couldn't have visitors, and I think a lot of it was taken out on nurses as a whole because we make up the largest sector of workers." This nationwide issue happened in every healthcare setting, she says.

For new nurses — those who graduated in late 2019 or early 2020 — the pandemic made their onboarding particularly challenging.

"COVID has shown us we can do so much from home, except practicing nursing," Hunter says. "I know, firsthand, people in the nursing profession who have quit their jobs over COVID and burnout."

Nursing schools also can help prevent nursing burnout through better preparing students for the emotional and social rigors of the profession.

"There are a lot of factors that lead into nurse burnout," says **Julie A. Manz**, PhD, RN, associate professor and assistant dean of the undergraduate program at the Omaha campus of Creighton University. "I think it's incumbent on all of us — academia and practice partners — to build resilience within our students and our employees. We have intentionally built in resilience, mental self-care, and reflective practice into our curriculum."

Some of the college's faculty conduct research on self-care and reflective practice, Manz says. They looked at these questions:

- How do you take time out?
- How do you recognize signs of stress?
- What are overwhelming feelings of burnout?
- What techniques can you employ to manage those feelings?

"We have to give individuals interested in nursing the skills they need to manage the stressors they face and the dynamic environment they work in," Manz says. ■

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New Oral Contraceptive Holds Promise of Few or No Blood Clots, Other Adverse Effects

Estetrol has low effect on breast tissue

Recent research has shown that a new combined oral contraceptive has high efficacy, cycle control, and safety, even among a diverse American population that included women with a body mass index of 35 kg/m^2. The medication contains estetrol (a novel estrogen) and drospirenone.

Estetrol is found in high levels in fetuses. Since fetuses do not develop blood clots, investigators hoped that using estetrol in a birth control pill also would prove safer than current oral contraceptives. Phase III clinical trial data suggested the theory was correct, although a Phase IV study will be conducted to confirm the findings.[1]

"Estetrol doesn't act in the body like all other estrogens," says **Mitchell D. Creinin**, MD, professor, director of family planning, and director of the Complex Family Planning Fellowship, at UC Davis Health in Sacramento.

Little Effect on Breast Tissue

Researchers found the efficacy of the new combined oral contraceptive was within the range of other available contraceptives. Ethinyl estradiol (EE) is the primary estrogen used in combined oral contraceptives. It has been used since the 1960s. While it has high potency, it produces adverse events in some women, including an increased risk of cardiovascular complications, thromboembolism, and breast tenderness.[1]

By contrast, estetrol (E4) has little effect on breast tissue — meaning no breast tenderness for most women — and on triglycerides.

"It inhibits breast cancer, so it's being studied for treatment of breast cancer," Creinin says. "It's not metabolized by the liver. All other estrogens taken as a pill go through the liver and are processed and stimulate the liver, causing changes in blood clotting, lipid factors, and triglycerides."

The study revealed that headache was the most commonly reported adverse event and occurred in 5% of study participants. Abnormal uterine bleeding occurred in 4.6% of participants. No thromboembolic events were reported.

"In the U.S. study, we had zero blood clots," Creinin adds. "In the European study, there was one blood clot."

The findings suggest that at a population level, the new contraceptive would cause fewer blood clots. "It's very promising, a highly effective combination birth control pill with excellent cycle control, and it uses a natural estrogen that has more favorable effects in the body," Creinin says. "Also, with most products you get an increase in triglycerides, which is what we worry about with cardiovascular disease. You don't see that with this product."

Like other estrogens used in contraceptives, estetrol is derived from plant sources, he notes.

Could Be a 'Game-Changer'

If the contraceptive shows an extremely low blood clot rate in Phase IV, as is expected, then it could be a great option for many women seeking a very safe oral contraceptive.

Blood clots occur in pregnancy. Two COVID-19 vaccines were briefly paused due to rare blood clots, even though they were estimated to affect one in 1 million people. Offering a new contraceptive that does not cause a significant number of blood clots is vitally important, Creinin explains.

"To me, this is a game-changer," he says.

Although it will be a few years before Phase IV results are known, physicians in the United States, Canada, and Europe will be able to prescribe the contraceptive by fall 2021.

EXECUTIVE SUMMARY

A combined oral contraceptive with the novel estrogen, estetrol, showed high efficacy and safety and did not appear to put women at risk of blood clots, according to new research.

- Estetrol does not affect the body the same way as other estrogens.
- Headache was the most commonly reported adverse event.
- The contraceptive works equally well in women with high body mass index.

"It is highly effective, well controlled, has low side effects, and it works well in women of all ages, with no differences based on obesity," Creinin explains. "It is not weight-dependent in distribution; the only differences are related to compliance and prior hormone use."

Even with unscheduled bleeding — a common side effect with oral contraceptives — most cases reported with the combined estetrol/drospirenone pill involved spotting. "It was not the kind of bleeding that required sanitary protection," Creinin adds.

This new birth control option is important for the majority of American women who choose to use oral contraceptives. "It's highly effective and has low rates of side effects," Creinin says. ■

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Research Shows Low-Sensitivity Pregnancy Test Works Well After Medication Abortion

As more people access a medication abortion remotely — either through recent pilot studies or as part of temporary rules during the pandemic — a low-sensitivity pregnancy test can be used without in-person contact.

New research shows people can use both a 1,000 mIU/mL low-sensitivity pregnancy test or a five-level multilevel pregnancy test safely without visiting a provider's office or clinic.[1]

"I view the study and findings as an adjunct to what's going on right now in making mifepristone more accessible to women," says **Wing Kay Fok**, MD, MS, FACOG, clinical assistant professor of obstetrics and gynecology at Weill Cornell Medicine in New York City. "Our study demonstrates that in-person follow-up is not necessary, and women should have an array of options for how to confirm that their pregnancy has been terminated."

Traditionally, women who have obtained a medication abortion return to the clinic that provided the drugs for in-person follow-up. This could entail an ultrasound or blood test, Fok adds.

Traditional pregnancy tests purchased over the counter at a pharmacy are not accurate within the first few weeks following a medication abortion because the woman's pregnancy hormone levels still are decreasing.

"The pregnancy test at a pharmacy is a different type of pregnancy test, and it's not useful for following up on medication abortion until after four weeks," Fok says. "It's a much longer time frame than what [the low-sensitivity pregnancy test] can provide in terms of confirmation of pregnancy resolution."

This suggests that the low-sensitivity pregnancy test, which can be administered at home and without clinician help, would work better in cases of telemedicine abortion, especially if the goal is for someone to obtain quick confirmation that the abortion worked without having to drive to a clinic for follow-up.

"An alternative is that they have a telephone follow-up where they speak with a clinician and discuss symptoms after taking mifepristone, and if their symptoms are consistent with what we expect after medication abortions, they may be instructed to take a pregnancy test at home, four weeks after taking mifepristone," Fok says.

EXECUTIVE SUMMARY

New research shows using a low-sensitivity pregnancy test after a medication abortion is both accurate and safe.

- The 1,000 mIU/mL low-sensitivity pregnancy test or the five-level multilevel pregnancy test can be used safely without a visit to a provider's office or clinic.
- Traditionally, women had to return to the clinic that provided the medication abortion pills to confirm their pregnancy was terminated.
- This research suggests a way for women to undergo a medication abortion without having to visit a clinic afterward.

Obstacles to Test Remain

The current obstacle is that both the low-sensitivity pregnancy test and the five-level multilevel pregnancy test, which are similar in rapid and accurate results, are not marketed

commercially in the United States. The tests are available in parts of Europe, but typically are used in the United States only during research studies.

"The low-sensitivity pregnancy test is not commercially available in the United States, although it may be used under certain protocols in certain clinics," Fok says. "The five-level pregnancy test is not being used; it's not mass produced, and there's not a market for it."

One goal of studying these two pregnancy tests is to show they can be useful in the case of medication abortions. "Our goal as we attain more evidence of utility and value of both of these tests is it will become available in the United States in years to come," Fok says.

Clinics could order these tests if desired, but they likely would have to be ordered in bulk supply. "It doesn't change how mifepristone is dispensed — meaning, in the interim of managing the pandemic, it can be provided to people without an in-person visit," Fok says.

With more studies like this, it is possible manufacturers will pursue marketing the low-sensitivity pregnancy test in the United States.

"I think this study, along with others before it, confirms there are lots of ways of providing medication abortion safely," Fok says. "It's not a one size fits all; there are different ways to provide follow-up of medication abortion, which makes it easier in the pandemic as well as in the long run." ■

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Study Finds No Differences in Pregnancy Plans Between Young Black and White Women

But the unintended pregnancy rate is higher for Black women

Black and white young women share similar desires to avoid pregnancy and similar pregnancy plans, but Black women were much less likely to be pronatal, advocating for a higher birth rate, than were white women, new research revealed. The unintended pregnancy rate is 2.5 times higher for Black women than for white women, which raises questions about why this difference occurs.[1]

Investigators wanted to look for disparities in undesired pregnancies, says **Jennifer Barber**, PhD, professor in the department of sociology and a senior scientist at the Kinsey Institute at Indiana University.

"We were motivated by this huge disparity in what researchers call the unintended pregnancy rate, which is sort of a misnomer, because we're talking about whether women wanted to get pregnant when they got pregnant," Barber explains. "I called them undesired pregnancies."

There is a large race difference. In the study, two-thirds of Black women reported that their pregnancies were unintended, compared to 38% of white women.

"Our research was motivated by that huge difference," Barber says. "I was interested in learning whether Black women do not want to plan pregnancies or do they know what they want."

The investigators found that Black and white women are very similar. Both had concrete plans of what they wanted with pregnancy and contraception, she says.

LARC Not Responsible

The study took place between 2008 and 2012. Participants reported little use of long-acting reversible contraceptives (LARCs), so that was not the reason for the difference, Barber notes.

"LARC is more common now, but it was not very common among young women then," she says. "Back in 2008 to 2012, physicians didn't want to insert IUDs [intrauterine devices] in women who didn't have children."

Hypotheses Tested

Investigators assessed several hypotheses about what might cause the disparity in unintended pregnancy rates. Here are three of their hypotheses:

• **Hypothesis 1:** Black women have more desire for pregnancy during young adulthood than do white women.

Investigators interviewed more than 900 women, multiple times. They found almost no differences in pregnancy desire between Black women and white women. That theory was not the answer.

"A little over a third of them ever, in any interview, said they had any desire for pregnancy," Barber says.

• **Hypothesis 2:** Young Black women are more indifferent or ambivalent about pregnancy than are young white women.

In nine out of 10 weekly interviews, women reported zero desire for pregnancy and the strongest desire to avoid pregnancy. Black and white women showed similar patterns.[1] This hypothesis also was incorrect.

• **Hypothesis 3:** Young Black women have weaker pregnancy plans or are more fatalistic than are young white women.

Investigators found Black and white women had similar plans for future pregnancies. They often reported that their plan was to undergo tubal ligation when they discontinued contraceptives or gave birth.

They also held similar plans for education and careers. Only one Black woman and two white women suggested a fatalistic attitude or lack of planning for pregnancy. This hypothesis also was wrong.

"Not one size fits all is the story about why young women who don't want to get pregnant find themselves pregnant," Barber says. "One aspect of the story is they may find themselves with a partner who says, 'I want to have a baby with you.'"

Some women might become pregnant if they think their partner wants this. Another possibility is that it is difficult to maintain discipline with contraceptive methods for years.

"For women with serious partners who want a pregnancy in the next several years, they don't want a LARC, so they end up with a method that takes serious effort," Barber explains. "They get tired of using condoms week in, week out. If you have a messy life, it's hard to remember to take a pill every day."

If a woman lets down her guard, even briefly, she may become pregnant. "My advice is we need better contraceptive methods and we need to support women to use the contraceptive methods they choose," Barber says. "I don't think any of these conclusions are new."

From a provider's perspective, it is important to know that both Black and white young women have clear desires to avoid pregnancy, and they have plans for how they will avoid or delay pregnancy, Barber says.

"But for some reason, they are not able to implement those plans in all cases — especially Black women," she adds. "It's not that they are wishy-washy about what they want or that they're unable to take steps, and it's not because they want different things. Providers should ask women what they want and help them put together a contraceptive plan." ■

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New Program for LGBTQ Youth Is Designed to Reduce Unintended Pregnancies

A researcher created a new program for LGBTQ (lesbian, gay, bisexual, transgender, queer, and questioning) youth based on the idea that this population experiences more difficulty accessing reproductive healthcare, partly because of problems related to their choice of pronouns and names.

The program addresses which contraceptives and intrauterine devices (IUDs) transgender boys can use, and which are effective and do not interfere with their hormone treatment, says **Ash Philliber**, PhD, senior research associate with Philliber Research & Evaluation in Accord, NY.

The IN-clued: Inclusive Healthcare — Youth and Providers Empowered program was designed to reduce unintended pregnancies and sexually transmitted infections (STIs) among youths who identify as LGBTQ.[1]

"This program is two-part: Half is for youth, and half is for clinics," Philliber says. "There was a strong desire from clinics and staff to be able to serve these youths and create more a more inclusive environment."

The program teaches ways to ask youths which names and pronouns they use. For instance, Philliber uses "they," "their," and "them" as personal pronouns.

"That makes a big difference," Philliber says. "Make sure brochures around the office reflect the whole spectrum of people, and not just heterosexual, cisgender couples. This makes a big difference when they go into the clinic and see something that looks like them."

Reproductive health clinicians also should be clear and open about confidentiality and what patients can expect. Some youths may not have told their parents about their sexual and gender identities, so the clinic's confidentiality and privacy guidelines should be posted publicly to show youths what to expect, they say.

With video/Zoom calls, clinicians should be aware of potential privacy issues when youths are speaking in the same room as a parent.

"UNDERSTAND THAT THERE IS A DIFFERENCE BETWEEN SEXUAL ORIENTATION AND SEXUAL BEHAVIOR, AND THEY'RE NOT AS CLOSELY LINKED AS WE THINK RIGHT NOW."

"One thing we've noticed is that, occasionally, doctors assume sexual orientation and sexual behavior are the same thing. If that were true, we wouldn't have [unintended] pregnancy among lesbians, but it's not true," Philliber says.

Clinicians always should ask women who identify as lesbian about contraception just as they would ask any other patient.

"Ask, 'Do you want to take condoms with you, just in case?' Not assuming that they aren't taking any kinds of risks," they add. "Understand that there is a difference between sexual orientation and sexual behavior, and they're not as closely linked as we think right now."

Another incorrect assumption is that someone who is transgender also is lesbian, gay, or queer. "This may not be the case," Philliber says. "You can't make assumptions about sexual behavior based on gender."

One way for physicians, nurses, and others working in reproductive health to view these issues is to think of how the world is constantly changing on so many levels, and they have to relearn how the world works.

"As kids, we're told to put everything into a box and to characterize everything," Philliber explains. "Now, we recognize that some things can't be put in a box. Sexual orientation can't be put in a box, and gender cannot be put in a box."

Use Preferred Names, Pronouns

The little things can make a big difference in building trust with LGBTQ patients. This trust can encourage patients to seek contraceptive care. Before, they might have avoided care because of the discomfort they felt in a clinic that did not recognize who they believe they are.

"Just because five years ago I said, 'My name is Ash,' to my doctor, my doctor still needs to ask me what name I use today," Philliber says. "Taking those little steps helps people feel more accepted and seen in that space. Being seen is a big thing."

A lot of LGBTQ people wander around in spaces where they need to fit into gender-normative space. They need to make sure they can

be seen as themselves in that space, because otherwise they will not get the care they actually need.

When clinicians attended the IN-clued program, some said they were uncomfortable with the discussion about pronouns and did not need to learn about it, Philliber notes.

"Within our own company, we had some staff, when we said, 'You need to talk about pronouns,' who said they weren't comfortable with it, largely based on religious beliefs," Philliber explains. "Instead of focusing on how they need to do this because it's the right thing to do, it's instead that they need to do this to do their jobs right. In order to serve youths and provide them with the healthcare they need, we need to make them seen so they'll talk with us."

If young people feel unheard or uncomfortable in a doctor's office or clinic, they will be unable to ask for the care they came for, and clinicians are not doing their job. For instance, a youth who presents to a clinic to be screened for an STI might leave if the staff made the patient feel uncomfortable.

Make Youths Feel Seen, Heard

During the IN-clued clinic curriculum, the leaders heard anecdotes about youths who said they did not start a contraceptive they sought because the doctor did not listen when they asked for it, or the youths did not ask for it because they already were uncomfortable, Philliber says.

Examples of how LGBTQ youth may feel unheard and unseen include:

- only two choices for gender on the clinic's health history form;
- the front office staff calling out the patient by a name the patient no longer uses;
- the nurse using an assumed pronoun for the patient, instead of the correct pronoun.

"If I give a survey, and there are only two gender options on it, I feel unseen, and I won't finish the rest of the survey," Philliber explains. "For us to collect data, we have to make you feel seen in those forms."

One important tactic in ensuring every patient is acknowledged and respected is to ask each person the same question about sexual activity, regardless of sexual identity.

"No matter what, treat everyone exactly the same," Philliber says. "Don't make assumptions based on whatever boxes you were taught to put people in."

Practice Inclusivity

Another technique is to practice gender/sexual identity inclusivity. "We do practice within the clinic. Peer educators come in and train in the clinic, and they practice role-playing," Philliber says. "They give feedback to doctors and staff and say, 'This made me feel great,' 'This made me feel uncomfortable,' and 'I came in for this and left with this, so this is a problem.'"

Patients can use a resource called a Q card, which is a tiny card that can fit in someone's wallet. People can write the names and pronouns they use and why they came to the doctor's office and give it to the doctor or nurse.[2]

"A lot of clinics are using those cards at their front desk," Philliber says. "You hand it to people when they come in, so they won't have those missteps."

When patients visit a clinic, the front staff are very important to how patients perceive their care. The staff set the tone and can make patients feel comfortable and understood by asking each person which name they want to use.

"It sets a better tone for the whole time. They are the ambassadors of the clinic, making sure people feel comfortable and safe there," Philliber explains. "I can't place too much value on these ideas; as someone who grew up not having this kind of care, I truly believe this kind of care is incredibly important." ■

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CME/CE QUESTIONS

1. **Why are nursing students less interested in specialty nursing areas like reproductive health?**

   a. Nursing students would prefer working in emergency department or ICU settings.
   b. Undergraduate students often enter nursing programs with goals of becoming a hospital inpatient-based nurse, nurse practitioner, or certified registered nurse anesthetist.
   c. Nursing students tend to be children of nurses, and they select the same field of interest as their parents.
   d. Undergraduate nursing students select their nursing focus based on the courses they like best, and there are too few reproductive health classes.

2. **Results of a recent study revealed a new combined oral contraceptive shows high efficacy, cycle control, and safety even among people with higher body mass index. Which estrogen does this contraceptive contain?**

   a. Estrone
   b. Estriol
   c. Estetrol
   d. Estradiol

3. **Researchers found that people can use which pregnancy test after a medication abortion without visiting a provider's office or clinic?**

   a. 1,000 mIU/mL low-sensitivity pregnancy test or five-level multilevel pregnancy test
   b. Over-the-counter early result pregnancy test
   c. ClinicalGuard Pregnancy urine test
   d. Pregmate test

4. **Black and white women hold similar desires to avoid pregnancy and similar pregnancy plans, but what is very different in their reproductive health?**

   a. Two-thirds of Black women reported their pregnancies were unintended, vs. 38% of white women.
   b. Unintended pregnancy rates are much lower in Black women than white and Hispanic women.
   c. Black women report 60% fewer sexual partners than do white women.
   d. The sexually transmitted infection rate among Black women is 30% lower than among white women.