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INSIDE

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Reproductive Health Organizations Help Vaccinate Patients, Communities

Planned Parenthood targets minority populations

Planned Parenthood and other reproductive health organizations have initiated COVID-19 vaccine outreach for their patients and communities.

In addition to encouraging staff and patients to take the vaccine, the organizations have taken a positive COVID-19 vaccine message to minority communities and others hit hard by the pandemic.

"We have had some very successful vaccination events," says **Paul Dillon**, vice president of public affairs for Planned Parenthood of Greater Washington and North Idaho in Spokane, WA.

> THE ORGANIZATIONS HAVE TAKEN A POSITIVE COVID-19 VACCINE MESSAGE TO MINORITY COMMUNITIES AND OTHERS HIT HARD BY THE PANDEMIC.

Planned Parenthood started setting up mobile pop-up clinics in 2020 in response to COVID-19. "We did a little bit of outreach in 2019 before the pandemic hit," Dillon explains. "We reached out to farmworkers, but it wasn't really until 2020 that we expanded the program to include more healthcare and brought our clinical staff to sites."

With various grant funding, the organization helped meet a massive need. "There was nobody who was really going out there and doing this kind of work, travelling out to our farmworker sites and warehouses.

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This kind of outreach was a huge success," Dillon says. "We started working with partners, including tribal health centers and local organizations. In March 2021, there were two events in which almost 1,000 people were vaccinated."

Most of the Title X clinics in Arizona Family Health Partnership's network are providing the vaccine, says **Bré Thomas**, MPA, chief executive officer.

The clinics also are trying to maintain protective actions like handwashing and social distancing. "They are staying current on what the CDC says, [which is] if you have staff that are not vaccinated, they need to wear a mask," Thomas says.

In early June 2021, Planned Parenthood of Greater New York kicked off a major initiative to encourage COVID-19 vaccination across the United States.

"While we are turning the corner on the COVID-19 pandemic, we have to keep up the momentum to make sure everyone gets vaccinated," **Alexis McGill Johnson**, president and chief executive officer of Planned Parenthood Federation of America, said in a statement about the vaccination drive.[1]

Planned Parenthood's vaccination efforts include their Protect. Every. Body. campaign, which was launched in spring 2021 to build COVID-19 vaccination confidence among Black, Latino, and other communities of color.[2]

"We are on the ground, and folks turn to us for reliable, trusted information about their health," says **Monica Massamba**, manager of Black Campaigns with Planned Parenthood Federation of America in Tulsa, OK. "We have an organization that is already a part of these communities. We have been going door to door, canvassing and making calls with folks, letting them know where their closest vaccination site is and getting them the information they need to make that decision."

One advantage of family planning centers is they are well-known in their communities, especially among people who are at high risk of COVID-19 illness, including low-income populations and communities of color. This helps build trust, which has been essential

EXECUTIVE SUMMARY

Planned Parenthood, along with other reproductive health organizations, is leading the charge to vaccinate their patient population as well as rural populations, communities of color, and low-income populations.

- Planned Parenthood of Greater Washington and North Idaho has set up mobile pop-up clinics to service and educate their community, providing almost 1,000 vaccinations over the course of two events to immigrant, farmworker, and warehouse worker populations.
- Planned Parenthood in Tulsa, OK, has organized door-to-door canvassing and phone-banking, especially among low-income populations and communities to provide information and build trust.
- Reproductive health providers, already trusted in the community with clients, play a key role in busting vaccine myths and providing evidence-based information so patients can get vaccinated and healthy enough to focus on their reproductive health.

to increasing the vaccination rate in the United States.

"Building this kind of trust is a key to success," Dillon says. "We're educating people about the vaccination and COVID-19, and also incorporating family planning."

Planned Parenthood targeted Latino communities and immigrant populations in Greater Washington and North Idaho for outreach. The organization assembled a team to serve rural areas, starting with COVID-19 testing last year, says **Lili Navarrete**, director of public affairs and Raiz for Planned Parenthood of Greater Washington and North Idaho.

For example, the mobile clinic served about 120 people. Thirty-five percent tested positive for COVID-19. Most people served by the outreach were immigrants, farmworkers, and warehouse workers.

"We also, at that time, provided assistance with food, and all the food boxes were culturally appropriate food," Navarrete says. "We also gave gift cards, sanitary products, and provided services that showed women how to take care of their bodies for reproductive health."

"It was really important for our community to be out there and for this population to see someone who speaks their language and looks like them, establishing trust," she explains. "I can speak their language and understand their background because I went through that when I immigrated from Mexico with my family and we had no healthcare."

Navarrete's family could not afford annual checkups or visits to clinics when they were ill.

"It was just unbelievable to see my dad struggle when we were sick. My mom did home remedies because we didn't speak the language and didn't have insurance," Navarrete says.

A team of five to 10 people visits the sites, usually between 11 a.m. and 3 p.m. "If we know that the workers or community members are working late, we will make our vaccine clinics from 1 p.m. to 6 p.m.," Navarrete says. "We always end up staying after hours because we have people who call in and say, 'I am just getting off work, can we stop by and get the vaccine/test/food box?' and we say that we will absolutely stay."

> "WE FUNDAMENTALLY BELIEVE THAT HEALTHCARE IS A HUMAN RIGHT AND HAS NO BORDERS. IT DOESN'T MATTER WHAT YOUR COUNTRY OF ORIGIN IS OR YOUR CITIZENSHIP STATUS."

This program will continue into the fall and incorporate flu shots as soon as those are available, she adds.

Vaccine hesitancy is an issue among many communities in the United States. This means healthcare providers must effectively educate patients and reach out to communities about the safety and science behind the COVID-19 vaccines.

"Providers are trusted in our community with our clients, so if the provider is able to tell the client that something is not actually true and bust the myth, it helps," Thomas says. "They can also provide information on what the vaccine does to protect people from COVID-19 and from the Delta variant."

Reproductive health providers are well-respected. When providers talk with clients about contraceptives, they also can help patients consider getting vaccinated against COVID-19, she says.

Vaccine hesitancy is real and a problem, but reproductive health providers can fill the gap and build trust through connecting with people in a way other providers cannot. "At Planned Parenthood, we do a lot to destigmatize different services, so we're well-positioned to help build trust with the vaccine," Dillon says. "We have a high rate of vaccination among our employees."

Providing vaccination outreach and access among disadvantaged communities fits in well with the organization's motto: "Care. No matter what."

"We fundamentally believe that healthcare is a human right and has no borders," Dillon says. "It doesn't matter what your country of origin is or your citizenship status."

Reproductive health providers should be culturally conscious of the population they serve. "They should educate themselves on the different cultures of patients who visit their offices," Navarrete says. "Also, they need to be open to going out into the community and offering services that are not in the office because these hard-to-reach communities need assistance and healthcare more than ever."

Planned Parenthood's vaccine outreach included phone banking, in which staff would ask people if they had received their COVID-19 vaccination, Massamba says.

"If they have gotten vaccinated, we thank them and move on," she explains. "If they haven't been vaccinated, then we share a little bit

of information about the vaccine and try to gauge their level of comfort with the vaccine. This determines how the conversation will go."

If the person does not seem hesitant about taking the vaccine, the outreach worker provides information about the closest vaccine site. If the person is very hesitant, the worker will give more evidence-based information and support.

The organization launched a COVID-19 fellowship this summer to provide peer-to-peer communication on the vaccine, encouraging young people to get vaccinated.

"For Black and brown communities, we've been doing door-knocking and having events that open up a space to have authentic conversations about where folks stand with the vaccine," Massamba explains.

For example, the organization held a virtual event in Michigan, called Real Docs and Real Talks. That event included a Black healthcare provider who shared accurate information about the COVID-19 vaccine and addressed some misinformation.

"This event was specifically targeted to Black communities in Michigan and was led by our Black organizer," Massamba adds.

The campaign quickly launched with more than 120,000 phone calls, and canvassers knocking on more than 40,000 doors. "We are hopeful that this will be successful and we are going to be able to get our folks vaccinated," she says.

Planned Parenthood also offers video content that promotes vaccination. One example is a new hero video that tells one person's COVID-19 vaccine journey. Another one is titled "Every Second Counts."[3]

The organization also produced Vax Facts, which is a series of animated videos that provide facts and dispel myths about the vaccine. They are available on Planned Parenthood's Instagram and Twitter channels.[4]

"Our communities need to be safe and healthy to even be able to make a decision on whether or not they will be starting a family," Massamba says. "They need resources to make that decision, which is what we want to provide. It was always a given for us to step in." ■

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Researchers Study COVID-19 Vaccine Outreach to Pregnant Women

CDC expert offers clarity

The results of a recent study highlight the gaps in COVID-19 vaccination among pregnant women in the United States. Although pregnant women are at increased risk for severe illness and death from the disease, many remain unvaccinated.[1]

Contraceptive Technology Update asked **Hilda Razzaghi**, PhD, epidemiologist with the Immunization Services Division at the Centers for Disease Control and Prevention (CDC) to answer questions about the research. The transcript has been lightly edited for length and clarity.

CTU: Your study results suggest the need for improved outreach and engagement with pregnant women regarding the COVID-19 vaccine. How could OB/GYNs and family planning centers do a better job of reaching this population?

Razzaghi: We know that pregnant people are more likely to get severely ill with COVID-19, compared with non-pregnant people, and that getting a COVID-19 vaccine can help protect against severe illness. Pregnant people are eligible for and can receive a COVID-19 vaccine. When facing a decision about whether to receive a COVID-19 vaccine while pregnant, considerations might include the risk of exposure to COVID-19, risks of severe illness during pregnancy, the known benefits of vaccination, and the limited but growing evidence about the safety of COVID-19 vaccination during pregnancy. A discussion with a healthcare provider can help pregnant people make an

informed decision, but this is not required prior to vaccination.

The estimates from our study provide insight on COVID-19 vaccination during pregnancy, including among specific subpopulations. The availability of data regarding safety and efficacy of COVID-19 vaccines, as well as accurate and timely information about COVID-19 vaccination to pregnant people and women of reproductive age, including those who are younger and from some racial and ethnic minority groups, is important to allow them to make a more fully informed decision about COVID-19 vaccination.

We work closely with the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine, and other professional medical organizations. These organizations have been critical in disseminating CDC guidance about COVID-19 vaccines for pregnant and breastfeeding people, as well as ensuring that healthcare providers have the resources to help counsel pregnant and reproductive-age people. We know that healthcare professionals have pregnant people and infants at the forefront and regularly provide easy-to-understand information for pregnant people and people of reproductive age to make a fully informed decision. During prenatal care and other healthcare visits, healthcare professionals can continue to inform people about COVID-19 vaccination and encourage a safe space for people to ask questions and share their concerns. The CDC and others continue working rapidly to [collect] safety and effectiveness data for pregnant people so they have as much information as possible to make these decisions. Guidance will be updated as more data are available.

CTU: Should family planning centers and other reproductive health clinics begin offering COVID-19 vaccines to patients, both before and during pregnancy? What may be a model for doing this well?

Razzaghi: COVID-19 vaccination is recommended for all people 12 years [of age] and older. On an individual level, healthcare providers are vaccine recipients' most trusted source of information on vaccines. They play a critical role in helping vaccine recipients understand the importance of vaccination, and that COVID-19 vaccines are safe and effective. On a population level, the CDC is working with others across the federal, state, and local levels to ensure that COVID-19 vaccination is equitably distributed and easy to access.

At this time, all COVID-19 vaccines in the United States have been purchased by the government for administration exclusively by providers enrolled in the CDC COVID-19 Vaccination Program. Only healthcare professionals enrolled as vaccination providers directly through a health practice or organization can legally store, handle, and administer COVID-19 vaccines in the United States. If a provider is interested in enrolling in the CDC COVID-19 Vaccination Program, more information can be found on the CDC's website at: https://bit.ly/3jCIaUb. The CDC also offers multiple resources that might be useful when counseling a patient about COVID-19 vaccines: https://bit.ly/3qzQvJU. ■

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Disease-Specific Contraceptive Counseling Needed for Sickle Cell Disease Patients

Unintended pregnancy rate is high

Women with sickle cell disease (SCD) experience high rates of unintended pregnancy and low knowledge and use of long-acting reversible contraception (LARC), according to the results of a new study.[1]

In the study, four in 10 women with SCD reported becoming pregnant when they did not want to be. Eighteen percent experienced this repeatedly, says **Lydia H. Pecker**, MD, director of the Young Adult Clinic at Johns Hopkins Sickle Cell Center for Adults and assistant professor of medicine in the division of hematology at Johns Hopkins University.

"The reason this matters in the sickle cell population is because women with sickle cell are at increased risks for complications in pregnancy," she explains. "No pregnancy event is casual for any woman, but the risks associated with sickle cell pregnancy are especially significant."

For instance, women with SCD are at at higher risk of maternal and fetal mortality, pre-eclampsia, and intrauterine growth restriction, Pecker says. These women also are at risk of preterm birth and sickle cell complications during pregnancy because there is no evidence-based treatment for SCD during pregnancy.

Women with SCD are also at increased risk for blood clots from some contraceptives, including most birth control pills. "The first line of contraception is progestin-only contraception, like intrauterine devices [IUDs] and nonhormonal contraception," she explains. "The problem is that there is a paucity of data with this, a lack of data on contraceptive safety. In the absence of strong data, women receive all different types of options."

Forty-six percent of the women participating in the study had used birth control pills, including those that contained estrogen and created a risk of blood clots.[1]

"Women with sickle cell disease need good, factual information about pregnancy risk, and they need access to high-quality, high-risk obstetrics and sickle cell disease expert care," Pecker explains. "Providers should know that women with sickle cell are at risk for a thrombosis event and should tailor their counseling about contraceptive choices to that fact."

Reproductive health providers should consider and counsel patients with SCD about potential complications if they use estrogen-containing birth control, Pecker adds. Often, people with SCD have experienced complications with estrogen options, including strokes, blood clots, or migraines with aura.

One important resource for providers to access is the U.S. Medical Eligibility Criteria for Contraceptive Use at: https://bit.ly/3w1YYXs.

The summary chart lists these contraceptives as safe for people with SCD:

- levonorgestrel-releasing IUD;
- implant;
- depot medroxyprogesterone acetate;
- progestin-only pill.

The study revealed that condoms, used by 87% of participants, and birth control pills were the most common contraception among the SCD population. LARC was used by 22% of subjects, and 21% reported a tubal ligation or partner vasectomy.

The lower level of LARC use among this population suggests there are barriers to IUDs and other LARCs, Pecker says.

"LARC is the reason women are controlling their reproduction, and we don't know what explains this finding [of low IUD use]," she says. "Is it inadequate access to high-

EXECUTIVE SUMMARY

Healthcare providers need to focus on educating women with sickle cell disease (SCD) about different types of contraception, efficacy, and risks while addressing disease-specific concerns.

- Women with SCD are at risk for pregnancy complications, such as higher risks for maternal and fetal mortality, pre-eclampsia, and intrauterine growth restriction.
- The first line of contraception for women with SCD is progestin-only contraception. Estrogen-containing contraception can create a risk for blood clots.
- Women with SCD may hold misconceptions about the efficacy of long-acting reversible contraception that need to be addressed.

quality care? At our center, we don't think that's the case."

One possible explanation is that women with SCD in the study held common misconceptions about the efficacy of LARC. "We did ask several questions about pregnancy risk with contraception, and we found that women with sickle cell disease reported a higher failure rate for IUDs than data show," Pecker says.

Another possibility is that providers are not addressing pregnancy prevention and possibly infertility risks early when some patients with SCD worry about that issue, she adds. This suggests reproductive health providers should focus on educating patients with SCD about the various contraception options, efficacy, and risks. They also should create opportunities for hand-on-the-door conversations, which are conversations about the patient's sexual and reproductive health that often happen just as the appointment is ending.

"Make sure these hand-on-the-door conversations about sexual and reproductive health become part of the sit-down conversation and not just when you're about to leave the patient and walk out of the room," Pecker says. "I think there's an opportunity when providers meet women with sickle cell disease to ensure they have proper sickle cell care because it's really important in guaranteeing [positive] reproductive health outcomes."

Reproductive health providers should focus on better contraceptive education for SCD patients and communicating the risks and benefits of the various contraceptive interventions, she adds.

Robert A. Hatcher, MD, MPH, chairman of the *Contraceptive Technology Update* editorial board, says, "Excellent education on all contraceptives, provision of contraceptives at low or no cost, and immediate access to contraceptives on the day you are first seeing a patient can lead to higher use of LARC. In St. Louis, the younger teenagers who chose to use LARC were more likely to choose an implant than an IUD. Providers should keep this in mind while prescribing contraceptives to teenage patients." ■

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Researchers Say It Is Time to Drop REMS Restriction on Mifepristone

Mifepristone found to be safe and effective

There is no medical reason mifepristone should carry the risk evaluation and mitigation strategy (REMS) restriction, according to the authors of recent paper.[1]

The commentary explains that REMS restrictions are supposed to be reserved for medications that are risky, such as opioids and other drugs that are addictive, says **Jenny Ma**, JD, MA, co-author of the commentary, senior staff attorney at the Center for Reproductive Rights, lecturer in law at Columbia Law School, and lecturer for the Sexuality and Gender Law Clinic in New York City.

Since 2004, mifepristone for abortion care in the first 10 weeks of pregnancy has been restricted by the FDA. "Mifepristone cannot be picked up in a pharmacy," Ma says. "You have to go to a certified healthcare provider and pick up the medication in person. Under the REMS, the provider has to be registered with the drug manufacturer."

This process is burdensome for providers, who have a lot of upfront costs and time constraints. "This drug is effective and safe. There are mountains of data on this," Ma adds.

It does not make sense for providers to encounter so many barriers to giving the pill to patients, she says.

"Because of the REMS and these restrictions, mifepristone is only available to certain providers, including those who want to be certified and have a system in place to allay some of these burdens," Ma explains. All of this means it is difficult for patients to access mifepristone, she adds.

Advocates and others who want the FDA to lift the REMS from prescribing mifepristone have seen some positive movement in that direction during the COVID-19

pandemic. The FDA decided there is no reason to require a person to visit a clinic to pick up the pill from their healthcare provider when they could obtain the pill safely through a mail order, just as they would with other drugs, Ma explains.

In May, the FDA said that it would undertake a full review of mifepristone restrictions. "That's incredibly exciting," Ma says.

The easing of restrictions during the pandemic is sensible because there are no scientific or medical reasons to require people to visit a clinic to take mifepristone home. "Of more than 20,000 FDA-approved drugs, mifepristone is the only one the FDA requires people to pick up in a clinical setting, even though they don't have to take it under clinical supervision," Ma notes. The FDA's announcement that it would review REMS for mifepristone is a positive sign, she adds.

State governments have continued to hinder access to abortion and miscarriage management, disproportionately affecting communities of color and young people. "We contend in our article that lifting the REMS is key to advancing equity to access to timely healthcare," she says. "When you look at who accesses abortion care in this country, 75% of those who access it are low-income, and six out of 10 are Black, Indigenous, or people of color."

Placing the REMS layer on top of existing barriers exacerbates discriminatory practices and creates a punitive landscape of abortion care, which is already heavily stigmatized. "The burdens land on communities that already have trouble accessing healthcare," Ma notes.

Lifting REMS would be a huge step in improving access for reproductive health patients. "In the pandemic, from our clients alone (and we represent individual abortion care providers), we have seen the impact this has made where state law allows," she explains. "The idea that people don't have to come pick up pills unnecessarily when they can be mailed to their home is incredible."

Even if REMS is eliminated for mifepristone, it will not mean that all barriers to the medication are gone. There are many different state laws that restrict access to this type of care. For instance, some states make an ultrasound and/or counseling mandatory before an abortion. Some states require abortion care patients to be counseled with debunked information, such as a correlation between abortion and oppression, or abortion and breast cancer.

"Lifting REMS on mifepristone would make it less of a barrier. But, unfortunately, it wouldn't be as seamless in those [abortion-restrictive] parts of the country, as in other areas where such state laws are not in place," Ma adds.

If REMS is lifted for mifepristone, it would have a huge effect on family planning clinic providers. "You wouldn't have to be certified anymore; you could have 10 pills in your small doctor's office," she explains. "If your patient is experiencing a miscarriage or desires an abortion, then you can provide this type of care without sending them to a different provider, as is currently happening in various places because of the burden of being certified."

Lifting REMS would increase the number of providers willing to provide medication abortion care. "If REMS is lifted, patients can pick these up like any other pills at a pharmacy and they can be mailed like any other medication," Ma says.

Also, providers could implement more flexible delivery models, especially in areas with healthcare access issues, she says.

Mifepristone is only available to patients for a limited window of time. Sometimes, the barriers of patients living hundreds of miles from a clinic severely affect their ability to use the abortion drug.

"Sometimes multiple weeks go by before a person can make it back to the clinic, and a lot of things happen in their lives," Ma explains. "Lifting REMS would be a huge step forward." ■

EXECUTIVE SUMMARY

The risk evaluation and mitigation strategy (REMS) restriction on mifepristone has been burdensome for providers and patients, researchers noted.

- Mifepristone has been shown to be safe and effective, while drugs under REMS restriction are supposed to be risky.
- The REMS restriction exacerbates the stigma around abortion care, which already disproportionately affects communities of color and young people.
- Since the pandemic, the FDA has begun to ease REMS restrictions, which will help advance equity to timely healthcare and increase the number of providers willing to provide medication abortion care.

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Changes to Medication Abortion Could Result in Pharmacy Dispensing of the Drug

Under the Biden administration, the FDA made it easier for women to obtain mifepristone for medication abortions in the United States.

The FDA's recent decision that it would not enforce the risk evaluation and mitigation strategy (REMS) until the pandemic ends might pave the way for a permanent relaxation of the restriction.

"In July 2020, a federal court ruled that mifepristone could be mailed out [due to the COVID-19 pandemic]," says **Rebecca H. Stone**, PharmD, BCPS, BCACP, FCCP, clinical associate professor at the University of Georgia. "Under the Trump administration, in January 2021, the Supreme Court ruled that mifepristone could not be mailed out. Then, the FDA addressed this issue again in April under the Biden administration and stated they would not enforce the in-person dispensing requirement of REMS until the pandemic ended. It can be mailed from a doctor's office or from a mail-order pharmacy, and that's a big change from what was previously allowed."

From a professional perspective, pharmacists are experts in medication, Stone says. "If we're talking about prescription medication, I believe pharmacists should have a seat at the table to disseminate all types of prescription medication," she adds.

Women who continue with a pregnancy experience many more baseline health risks than they do from taking mifepristone. "It's a relatively safe medication. Pharmacies could help make dispensing mifepristone more accessible to women in rural areas, who may not have physical access to a prescriber," Stone says. "Pharmacy-dispensed mifepristone may also make medication abortion more accessible to adolescents."

The ability to mail mifepristone makes telehealth care more affordable, Stone says. "In a telehealth care model, a woman could talk with her provider via videoconference, get any required ultrasound or bloodwork completed at her local health center, and then receive the medication in the mail from her provider or mail-order pharmacy," she explains. "However, it's important to realize that there are still complications with this model."

For instance, medical and pharmacy practice is regulated at the state level. Many states enacted specific telehealth abortion bans or further regulations on providing telehealth care across state lines.

"For a mail-order pharmacy, the patient would talk via phone to a pharmacist at the pharmacy, but some people may prefer to ask a pharmacist questions in person," Stone notes.

Even if mifepristone could be dispensed at pharmacies, that is not to say that every pharmacist will stock the drug and dispense it. Some pharmacists do not want to participate in providing a medication abortion.

"However, I don't think pharmacies should be excluded from mifepristone dispensing just because not every pharmacist wants to participate," Stone says. "That's not a reason to keep it out of all pharmacies."

Pharmacies already participate in abortion care by providing other medications like misoprostol, and nausea or pain medications. "Instead of getting medications from different sources, they can get everything from one source," Stone explains. "I think pharmacists are already accustomed to completing continuing education to learn about new drugs. so we're equipped to provide the education needed to dispense mifepristone."

It would be acceptable for pharmacists to dispense it just like any other new medication. "Pharmacists are experts in medication use and they help provide equitable access to medications," Stone says. "Putting medications in a widely dispersed network of

EXECUTIVE SUMMARY

The easing of the risk evaluation and mitigation strategy (REMS) restriction on mifepristone will make it easier for women to obtain the drug and could allow for pharmacy dispensing of the drug.

- Pharmacists should have a seat at the table in the conversation on dispensing prescription medication.
- Allowing pharmacies to dispense the drug might make mifepristone more accessible to adolescents as well as to women in rural areas without physical access to a provider.
- Pharmacists are medication-use experts, and putting mifepristone in a "widely dispersed network of pharmacies" will allow for more equitable access.

pharmacies makes it more equitable for women to get the medication. Pharmacists are medication experts and should be part of the process when prescriptions are involved." ■

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Research Suggests the Need for More Sexual Health Education Among Providers

Researchers found that more than half of OB/GYN resident physicians surveyed in a study lacked knowledge pertaining to sexual function disorders.[1]

Almost all the residents in the study felt comfortable obtaining a sexual history and providing counseling to a teenager seeking contraception. But fewer were comfortable counseling a young adult refugee or providing counseling to a teenager who is a victim of sex trafficking. Less than half of residents could handle working with a middle-age transgender patient.

"I think our study provided a very good assessment of the nation's sexual health training for OB/GYN resident physicians," says **Brett Worly**, MD, MBA, FACOG, lead study author, associate professor, and Learning Communities program director at The Ohio State University. "Important takeaways from our article are that resident physicians want to learn about sexual health and it is a priority to them," he says. "They understand how important sexual health is to a person's overall health."

Most OB/GYN residents are knowledgeable about topics like decreased sexual desire, sexual pain, orgasm problems, contraception, and sexual problems related to menopause. "We also learned that there are opportunities for improvement, including in transgender care, caring for sex trafficking survivors, and cultural competency in care," Worly says. For instance, residents may not know how to deal with patients who come from countries where they may have experienced something like female genital cutting.

EXECUTIVE SUMMARY

A new study revealed opportunities for improvement in OB/GYN knowledge of sexual health education.

- OB/GYN residents, while knowledgeable on subjects like decreased sexual desire, sexual pain, contraception, and more, could benefit from learning more about transgender care, caring for sex trafficking survivors, and cultural competency in care.
- The study results indicated these providers can become more competent through finding evidence-based information, learning about the care of LGBTQ+ patients, learning how to identify victims of sex trafficking, and by screening for intimate partner violence.
- It is important to screen patients for these issues and concerns at each visit to build provider-patient trust.

Worly offers these suggestions for how reproductive health providers can learn more about these sexual health issues:

• Find evidence-based information. The Association of Professors of Gynecology and Obstetrics created a series of videos to educate healthcare providers about topics such as transgender care and sex trafficking.

"There needs to be more recognition of that. Even more resources need to come to the forefront so that wherever you happen to be, you are able to have a specific resource to look up some of these conditions that can be rare for providers," Worly explains. "For instance, providers are seeing more patients that have survived sex trafficking than they might think."

• Learn about care of LGBTQ+ patients. "As far as transgender and different sexual orientations, there are many different perspectives. If you don't ask you'll never know," Worly says. "If you're respectful and take time to listen to patients, they'll tell you about their lives so you can have more background knowledge."

One important technique is for providers to screen everyone repetitively, regardless of the provider's opinion on whether the patient is having a certain type of sexual experience. It is essential for healthcare providers to build a trusting relationship with patients, he says.

When meeting with a patient who may be part of the LGBTQ+

community, the patient might not be ready to disclose information that is important to their sexual and reproductive health, Worly notes. The patient might have had negative experiences with providers in the past.

"Screening patients every time and talking and checking in with them from a contraceptive perspective helps ensure they have the contraception they need in order to accomplish the goals they have in their reproductive lives," he says.

For providers who have difficulty understanding transgender patients and the various ways people are describing their gender, Worly recommends they look at the history of transgender people.

"Transgender people have been in existence for 1,000 years — it's nothing new," he says. "There are references in every culture of transgender people."

In the past 50 years, transgender issues have not been discussed much in Western culture. People who have identified as transgender have been shamed by their family, friends, and even healthcare providers. They tend to keep their experiences private. However, in recent years, that cultural stigma has been changing. For example, openly transgender politicians, athletes, performers, and others are becoming role models for transgender youth.

"Now, we're in a society that I think really believes people deserve our respect, attention, and care, and they don't deserve to be treated improperly or insulted," Worly says. "Transgender people have a much higher rate of depression, suicide, and interpartner violence."

Healthcare providers can help save transgender patients' lives and health by respecting them and their situations, he notes.

"Helping [LGBTQ] individuals in the area of contraception, future fertility, and stated desire to become pregnant is confusing for reproductive health providers," says **Robert A. Hatcher**, MD, MPH, chairman of the *Contraceptive Technology Update* editorial board. "Listening carefully to patients is always important and cannot be stressed too much when providing services to LGBTQ clients."

• Identify victims of sex trafficking. It is rarely obvious that a particular patient is a victim of sex trafficking. Reproductive health providers need to be aware that anyone might be in that situation.

After moving to Columbus, Worly became more aware of sex trafficking situations and sought education.

"I went to a national conference and I started thinking about it more, realizing that I didn't recognize situations of sex trafficking before," he says. "There was a situation I had with a personal translator that made me uncomfortable because the translator would only talk with me and wouldn't let me talk to the patient."

Looking back at some of his earlier experiences as a new physician, Worly realized he might have missed opportunities to help a patient who was a victim of sex trafficking.

"Now, I know it exists and I know what to look out for," World explains. "If you don't go out of your way as a healthcare provider to find out about these things, then you will not know about it because it's not well covered in medical training."

For this reason, Worly believes it is important to speak with patients without a family member, including a family translator, present.

"It is important for practitioners who are on their own or in private practice to figure out a translation system that works for them," Worly says.

• Screen for intimate partner violence (IPV). "Screen every patient in a nonjudgmental way," Worly says.

For example, providers can ask these questions:

- Is someone touching you in a way you don't want?
- Are you sexually active?
- Are you sometimes afraid during sexual relations?
- Have you ever been hit or hurt by your partner?

"It's important to screen patients at every visit to continue to build trust," Worly explains. "Oftentimes, you can't have a full conversation about some of these different situations. For some patients, you need to set up another appointment on a subsequent day to really get into these issues."

The study is designed to help practicing OB/GYNs reflect on their training, strengths, and opportunities for improvement, Worly says. It might motivate some OB/GYNs to look up their old residency program (or a program nearby) and offer to provide a lecture on topics that need to be addressed better.

"Sexual health is challenging in that there are many social taboos, and these topics are not usually covered in residency education," Worly says. "Few people feel like experts in these areas. OB/GYN physicians sometimes feel overwhelmed with clinical and academic work, so taking on a new topic may seem onerous."

Now that the coronavirus pandemic has helped everyone learn how to obtain information via digital formats, providers can learn about these sexual health topics at their own pace and in places and at times that are convenient for them, Worly adds. ■

REFERENCE

1. Worly B, Manriquez M, Stagg A, et al. Sexual health education in obstetrics and gynecology (Ob-Gyn) residencies — a resident physician survey. *J Sex Med* 2021;18: 1042-1052.

CONTRACEPTIVE TECHNOLOGY UPDATE®

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CME/CE QUESTIONS

1. **Which has been used by the Planned Parenthood Federation of America to increase vaccination rates among their communities and patient populations?**

   a. Offering gift cards to local restaurants and stores
   b. Mobile clinics, phone-banking, door-knocking
   c. Setting up vaccine booths at community centers
   d. Listing vaccine sites through social media and advertising on local radio and TV

2. **What type of birth control is the safest for women with sickle cell disease, according to Lydia H. Pecker, MD?**

   a. Spermicidal jelly
   b. Estrogen-containing pills
   c. Progestin-only contraception
   d. Rhythm method

3. **According to Brett Worly, MD, MBA, FACOG, it is important for providers to screen for which of the following at every reproductive health visit to build trust?**

   a. Intimate partner violence
   b. HIV
   c. Substance use disorder
   d. Depression/anxiety disorder

4. **Why is it important for the FDA to remove the risk evaluation and mitigation strategy restriction from mifepristone, according to Jenny Ma, JD, MA?**

   a. It reduces the amount of government spending.
   b. It limits medication abortion distribution.
   c. It improves equity in access to healthcare.
   d. It requires more training for physicians.

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.