

Background

Defining Reproductive Health

The World Health Organization defines reproductive health as *“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes...impl[ing] that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.”*¹ Reproductive and sexual health services are broad and include screening and treatment for sexually transmitted infections, screening and treatment of disorders of the genital organs (e.g., cancer, fibroids, endometriosis), and family planning including contraception, infertility treatment, pre-conception care, prenatal care, labor and delivery, and postpartum care. Further, reproductive and sexual health services can serve as an entry point into the health care system, helping to decrease disparities in access to care and potentially outcomes broadly.

The 2018 Guttmacher–Lancet Commission on sexual and reproductive health and rights argues for *“removing barriers that hinder...individuals’ [being] able to make decisions about their own sexual and reproductive lives, and exercise their sexual and reproductive rights...at policy, system, community, and societal levels.”*² These recommendations aim to improve quality, equity, and cultural appropriateness of reproductive and sexual health care services across the lifespan in Washington State especially for people of color, immigrants and refugees, victims and survivors of violence including of human trafficking, people with disabilities, American Indians/Alaska Natives, and those who are Lesbian, Gay, Bisexual, Transgender, and/or Questioning or Queer (LGBTQ). Autonomy is a hallmark of person-centered care and forms the foundation of these recommendations.

Measuring Disparities

Coercion and violation of human rights have marked the interaction of many minority groups with and within the medical system. The legacy of slavery, Jim Crow laws, non-consensual medical experiments including forced sterilizations, along with pervasive racism inform health disparities between black and white Americans today.³ This historical lens can and should be applied across population groups, from the impact of genocide, forced separation of children from parents and community, and again forced sterilizations among the American Indian and Alaska Native population on some of the poorest health outcomes of any racial group, to the forced sterilization of people with disabilities.⁴

These themes of lack of autonomy, respect, and reinforcing the value of all individuals as individuals run through the minority experience from the inception of the United States to current day. Interventions aimed at improving health of any population must be informed by that people’s history and include the voice and perspective of those people and the community organizations they lead.

Health disparities, preventable differences in health outcomes, are due to a multitude of intersecting factors including problematic interpersonal interactions and systematic inequality. The impact of shared social experiences such as slavery and segregation impact differences in health outcomes and access to resources (e.g., redlining) that in turn impact health outcomes. Recent research also points to the impact of shared social experiences as an environmental exposure impacting gene expression, or epigenetics. Cultural differences impact individual preferences or adherence to medication. Differential

access to health care insurance varies based on variation in state policy. Further, institutionalized racism and other -isms, societal allocation of access to or failure to provide access to resources or services, is pervasive through social structures.⁵

Health disparities exist in all the reproductive and sexual health services named earlier and have been specifically documented for many of this report's priority populations. Minority populations experience disproportionately high rates of unintended pregnancy and sexually-transmitted diseases and also experience lower rates of screening for common cancers.^{6,7} Minority women who report perceiving discrimination are less likely to use effective contraception.⁸ Disparities in screening for common cancers such as breast and cervical cancer are seen geographically as well in Washington State.⁹

Some disorders of the reproductive organs are more likely to be seen in and are more severe in people of particular ethnic and racial backgrounds as black women are more likely to have fibroid tumors and more likely to have larger and more numerous tumors and Asian women have been seen in some studies to have higher rates of endometriosis.¹⁰

More drastic health disparities are seen in differences in material mortality. The United States has the highest maternal death rate among developed nations with more than 50,000 mothers having life-threatening complications annually.^{11,12} Mortality differs greatly based on race with black mothers being three to four times as likely to die in childbirth than white mothers and more likely to suffer complications that lead to maternal death and injury.¹³

Washington State Demographics

Washington state is home to approximately 7.6 million people, of whom 78.9% identify as white; 4.3% as black or African American, alone; 1.9% as American Indian or Alaska Native, 0.8% as Native Hawaiian or other Pacific Islander, alone; 4.8% as two or more races; 12.9% as Hispanic or Latino; and 68% as white, alone (not Hispanic or Latino).¹⁴ The United States as a whole is moving to a minority-majority population, which is estimated to occur around 2050.¹⁵ Approximately 14%, 1.06 million people, reside in Washington State and were born abroad in 2017.¹⁶ Of that 1.06 million, 45% were born in Asia, 30% in Latin America, 15% in Europe, and 6% in Africa.⁴

Approximately 8.8% of Washingtonians under 65 report having a disability, defined as serious difficulty with one or more basic areas of functioning including hearing, vision, cognition, and ambulation.³ Approximately 4.6% of Washingtonians identify as lesbian, gay, bisexual, transgender or queer or questioning (LGBTQ), 4.8% of people in the Seattle-Tacoma-Bellevue metro area.^{17,18}

Violence is common, but more difficult to report at a state level. Of those surveyed, 51.9% of women and 66.4% of men report being physically assaulted as a child by a caretaker or assaulted as an adult.¹⁹ Approximately 33% of women and 17% of men have experienced contact sexual violence from an intimate partner some point in their lifetime and 25% of women and 11% of men have experienced contact sexual violence from any source, resulting in injury, fear, concern for safety, and needing additional health care services due to the trauma.²⁰ Further, more than half of women who have experienced contact physical violence report symptoms of post-traumatic stress disorder.⁶

2020 Workgroup

The Bree Collaborative was asked through the 2019 Senate Bill 5602 to develop a workgroup to “identify, define, and endorse guidelines for the provision of high quality sexual and reproductive health services in clinical settings throughout Washington...include[ing] the development of specific clinical recommendations to improve sexual and reproductive health care for: (a) People of color; (b) Immigrants and refugees; (c) Victims and survivors of violence; and (d) People with disabilities.”

The workgroup met from January to October 2020 to recommend system- and individual-level changes to build a health care system that truly meetings the needs of a diverse population. Differences in population disease burden, needs, and resilience necessitate different clinical services and care, and the workgroup seeks to base changes in a targeted universalism approach, universal goals pursued by targeted interventions.²¹ The workgroup also aspires to build a health care system that fits the needs of our specific population groups and the population at large.

Recommendation Framework

Disparities in population disease burden (e.g., uterine fibroids), outcomes such as higher material mortality for black gestational parents, access to care such as through insurance barriers for the immigrant population, and individual and population-level resilience necessitate multiple levels of intervention. Further, an individual has many intersecting identities, all of which contribute to overall health and that may not be apparent to an individual health care provider or be documented within a health care system.

The workgroup aims to create a health care system in which the four focus areas: access, appropriate care, patient-centeredness, and cultural humility, underpin all interactions, especially those involving sexual and reproductive health.

Table 1: Focus Areas and Clinical Steps

Focus Area	Clinical Step
Cultural Humility	<ul style="list-style-type: none"> • Understand the cultural background of your patient population • Provide culturally humble care, free of coercion or provider bias
Access	<ul style="list-style-type: none"> • Physical accessibility • Understand the insurance barriers for your patient population including those that may exist due to immigration status • Offer materials and services in languages appropriate to your population • Use easy to understand language and materials • Assess the person’s understanding of topics discussed using the teach back or show me method (demonstrate what they have been told)
Patient-centeredness	<ul style="list-style-type: none"> • Offer trauma-informed care and work to build trust • Reaffirm the confidentiality of conversations and any test results • Support • Involve family or friends if desired by the person • Understand needs of the patient
Appropriate care	<ul style="list-style-type: none"> • Educate and empower • Offer prevention, screening, treatment or referral for reproductive health conditions (e.g., USPSTF cancer screening, STIs) • Ask about parenting intention and offer family planning including contraception and infertility • Pre-conception care, prenatal care, labor and delivery, and postpartum care

Previous Bree Collaborative Recommendations

These recommendations seek to build on previous Bree Collaborative Recommendations, where relevant especially the following:

- [Hysterectomy Report and Recommendations](#), adopted January 2018, discuss racial and ethnic differences in the rate, route, including whether hysterectomy is minimally invasive, and probability of complications from hysterectomy.²² The Recommendations aim “to promote appropriate use of hysterectomy, including pre-surgical counseling, and evaluation, while recognizing individual variation based on clinical opinion and patient preference [through] three focus areas: 1. Assessment and medical management, by indication; 2. Uterine sparing procedures, by indication, 3. Surgical procedure including follow-up care, emphasizing the enhanced recovery after surgery protocol and use of a minimally invasive approach.”
- [LGBTQ Report and Recommendations](#), adopted September 2018, aim build a health care system allowing everyone to have a fair opportunity to be healthier understanding that LGBTQ persons experience elevated rates of depression, sexual abuse, smoking, and other substance use and that; that lesbian women are less likely to undergo certain screening tests for cancer (e.g., mammography to test for breast cancer, papanicolaou (pap) test for cervical cancer) and both men and women in same sex relationships are less likely to report insurance coverage; and that gay and bisexual men made up 70% of new HIV infections in 2016, with higher rates among those aged 25-34 and black and Hispanic/Latino gay and bisexual men.^{23,24 25,26 27} Recommendations are based in a whole-person care framework, taking into consideration a person’s multiple individual factors that make up health, wellness, and experience (e.g., behavioral health, past trauma, race/ethnicity) in such a way that is not identity or diagnosis-limiting. Focus areas include communication, language, and inclusive environments; screening and taking a social and sexual history; and areas requiring LGBTQ-specific standards and systems of care.
- [The Maternity Bundled Payment Model](#), adopted January 2020, discusses opportunities for clinical improvement including reducing cesarean section rates, increasing provision of care through appropriate providers in appropriate settings, reducing pre-term birth rates, reducing mortality rates for the gestational parents and for infants, and reducing health disparities.^{28,29} Clinical improvements in proactive identification and treatment of cardiovascular disease, increasing the rate of physiologic birth, and provision of more personalized postpartum care with a higher number of and more frequent visits also serve as areas for improvement. The guideline presents a payment model that includes prenatal care, labor and delivery, and postpartum care along with clinical components for internal quality tracking and performance metrics.
- [Prostate Cancer Screening](#), adopted November 2015, recommend that all men be evaluated by their provider for family history and factors that may elevate the risk of prostate cancer (e.g., sibling or parent with a prostate or breast cancer diagnosis, race). For average risk men under 55, over 70 years, who have significant co-morbid conditions, or who have a life expectancy less than 10 years, a PSA test is not recommend. Clinicians who believe there is overall benefit, should order this test for average risk men between 55-69 years old only after a formal and documented shared decision-making process. Clinicians who believe there is overall harm may initiate testing at the request of the patient after a formal and documented shared decision-making process.

Recommendations for Stakeholders

These recommendations are not intended to be used in lieu of health advice.

Patients and Family Members

- Find a health care provider that you feel comfortable talking with about your health care needs.
- If you are insured, talk to your health plan about what services are covered. If you are insured as a dependent on another person's health plan, talk to your health plan about any concerns about the confidentiality of the health care you receive.
- Talk to your provider about
 - Your past sexual history including the gender, sex of your sexual partners as well as types of sex and any history of sexually transmitted infections.
 - Whether you want or need screening for STIs.
 - Whether you want to become a parent in the next year
 - Any concerns that you might have about being down or depressed, especially if you have had thoughts of hurting yourself or others.
 - Your relationships with your partners including whether you have ever felt unsafe in the relationship(s) or experienced threats of harm or violence.
 - Tobacco, alcohol, or drug use.
 - How often to have regular cancer screenings.
 - Community resources that are available in your area.
 - How comfortable you feel in your provider's office including any feedback about access, and any other issues.
 - Any concerns about the confidentiality of the care you are receiving, including any concerns about communications from your provider or health plan.

Health Care Providers

- **Access**
- **Patient Centeredness**
 - Consider a patient's comfort level and be prepared to discuss how and why a sexual history is important and how patient confidentiality is ensured.
 - Ask about the patient's gender identity, chosen pronouns, and chosen name. This should ideally be done when the patient initially registers for care to facilitate inclusion of this information in the medical record and to ensure appropriate use of pronouns throughout the patient's care.
- **Appropriate Care**
 - **Parenting Intention:** Ask the patient about whether they want become a parent in the next year.
 - Discuss reproduction and contraception methods with patients as appropriate. Information on birth control across the gender spectrum is available [here](#).

Other topics relevant to reproduction include sperm/egg banking, fertility treatments and options, counseling on all options including abortion. Providers should also feel comfortable performing a preconception counseling visit or refer to a provider who is able to perform these services.

- Ask about plans for adoption and surrogacy. LGBTQ people should be asked about whether they want to have a family in the future as well. Providers should have some awareness around adoption options and steps in surrogacy.
- **Sexual History and STI:** Take a sexual history as part of an initial new patient visit that includes:
 - If patient has had sex with men, women, both men and women, and/or other/non-binary, or none.
 - Types of sex including oral, vaginal, and insertive and receptive anal sex (i.e., top, bottom, or versatile)
 - History of any previously sexually transmitted infections (STI) and concern about having contracted an STI (e.g., “Do you have any worry about having contracted an STI?”)
- Screen for the following during the medical history:
 - Behavioral health concerns including depression, suicidal ideation, and anxiety using a validated instrument (e.g., Patient Health Questionnaire 9 Item or 2 Item, Columbia Suicide Severity Scale, Generalized Anxiety Disorder 7-Item) annually.
 - Ideally behavioral health services should be integrated into primary care as outlined in the 2017 Behavioral Health Integration Report and Recommendations. If appropriate behavioral health services are not available onsite, develop a comprehensive referral network.
 - Intimate partner violence.
 - Tobacco use.
 - Alcohol and other drug use as outlined in the 2015 Addiction and Dependence Treatment Report and Recommendations following the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol.
 - Immunize all patients through age 26 for human papillomavirus (HPV). Monitor for changes to this recommendation from national organizations.
- **Cancer Screening:** Discuss regular, appropriate cervical cancer screening and breast cancer screening with patients with cervical and breast tissue for patients who are at higher risk of cervical and breast cancer including women who have sex with women or men and transgender men or genderqueer people who were assigned female at birth.

Discuss prostate cancer screenings with transgender women as outlined in the 2015 Bree Collaborative [Prostate Cancer Screening Report and Recommendations](#)

- **Cultural Humility**

Health Care Delivery Systems

- **Access**
 - Language. Review requirements to offer language services in healthcare settings from the Washington Coalition for language access [here](#) and from the Robert Wood Johnson Foundation [here](#).
 - Physical access
 - Telehealth: Improve TeleHealth access especially for populations who are staying home to avoid ICE.
- **Patient Centeredness**
 - Train all staff about using inclusive, non-stigmatizing language.
 - Revise forms and protocols (e.g., mission statement, employee materials) to reflect an open and affirming environment including non-discrimination in hiring practices.
- **Appropriate Care**
 - Configure your system's electronic health record (EHR) to accurately reflect the patient's chosen pronouns, chosen name, XXX
- **Cultural Sensitivity**

Health Plans

- Identify the patient's primary care provider and be sure the patient knows who this is.
- Ensure equity in infertility treatment coverage for subscribers with same and opposite sex partners (e.g., not requiring 12 months if under 35 and 6 months if over 35 of non-covered clinically-supervised insemination prior to reimbursement if not in an opposite-sex relationship).
- Ensure appropriate referral networks for XXX
- Include performance and quality metrics in contracts with providers and other purchasing agreements, that promote XXX
- Do not require a copay or deductible for XXX
- Allow information technology systems to include race/ethnicity
- Establish a simple process for individuals insured as dependents on another person's health plan (e.g., a minor using their parent's insurance) to access care confidentially using their insurance, and provide enrollees with clear and accessible information about how to access this process.

Employers

- Review recommendations to health plans and include similar language in your contracts.
- Consider benefits around infertility and improve language around leave for same sex couples who adopt or conceive through surrogacy.

Washington State Agencies (e.g., Health Care Authority, Department of Health)

- State agencies and government leaders should support and promote a robust public health infrastructure to meet the needs of all people in Washington State. This can be demonstrated through funding, legislation, communication, and advocacy.
- Consider developing a PEP Hotline to improve access to post-exposure prophylaxis. This was done in NYC. Senate Bill 6303 was introduced in 2020 but did not make it out of committee.

Culturally-Sensitive Care

A person is both an individual with distinct needs and has needs that are informed by cultural background. Our workgroup believes that understanding both is necessary to ensure high-quality care, starting with addressing bias present within individual health care providers and staff and bias that is systemic in our health care infrastructure.

Addressing Bias

Implicit bias, nonconscious assumptions based on incomplete information such as a person's appearance, along with stereotyping are pervasive among American society. These biases are present among health care providers as well, contributing in part to disparities in health.³⁰ Implicit bias impacts the health care experiences and outcomes of all of populations of interest within this report. Some aspects of implicit bias in medical care have been well-documented, such as white medical students and residents, as well as those outside of the medical profession, reporting a belief that black patients feel less pain.³¹

Within sexual and reproductive health services, what a provider recommends for type of contraception, especially long-acting reversible contraception, have been shown to vary depending on a patient's race/ethnicity and their socioeconomic status (i.e., that long-acting reversible contraception is more likely to be recommended for low socioeconomic status black and Latina patients than low socioeconomic white patients.)³² To support health equity, the American College of Obstetricians and Gynecologists (ACOG) recommends practitioners raise awareness of health disparities among colleagues within their organization, support organizational quality improvement initiatives to target identified disparities, educate colleagues about relevant community resources, work with community partners such as local public health to address the social determinants of health, and advocate for policy changes to improve health and reduce disparities.³³

Cultural Humility

Competence, implying the "detached mastery of a theoretically finite body of knowledge," is problematic in the delivery of health care due to a "false sense of security [from] stereotyping" and issues in which behaviors or symptoms are ascribed to the person's specific cultural background rather than their individual disease or disorder.³⁴ Cultural awareness trainings are critiqued for their inability to effect meaningful change due to being short and often infantilizing, being unable to make up for the empathy-burnout that time-scare providers experience, and not showing any meaningful effect on a person or a population's health outcomes.^{35,36,37} Cultural humility relies on a life-long learning process in which a provider is "flexible and humble enough to assess anew the cultural dimensions of the experiences of each [person]."³⁰ Rather than having a static endpoint, self-questioning and self-critique, and active listening become part of the process.³⁸

Access to Care

Barriers to access inform many of the disparities seen across our priority populations. While some barriers to care are informed by state and national-level policy, others stem from physical barriers to the care delivery site or language and cognitive barriers that can hinder patient understanding of written or verbal material and therefore following recommendations or understanding diagnoses.

Insurance

Access to health insurance coverage determines access to health care delivery due to the high cost of medical care. Insurance coverage varies based on where people live and on their citizenship status. Foreign-born women are less likely to have health insurance when compared to those born in the United States and less likely to use sexual and reproductive health care services.³⁹ Lack of coverage stems mainly from systemic policy barriers.⁴⁰ The workgroup acknowledges that much of this is outside of the control of individual stakeholders and argues for understanding of how these barriers may impact a delivery system's patient population and advocacy for more inclusive coverage as a next step.

Language

Information by counties in Washington State on the prevalence of languages spoken in the home is available [here](#).

Physical Accessibility

Facilities should be physically accessible.

Cognitive Accessibility

The majority of American adults read at an 8th grade reading level while medical texts including instructions are written at a 10th grade reading level.⁴¹ This gap in understanding results in preventable poor health outcomes as people are unclear as to their next clinical steps.

Trauma-Informed Care

Abuse, violence, and other forms of trauma are widespread. The landmark 1998 study on adverse childhood experiences (ACEs) shows the high prevalence of ACEs and links these experiences to a lifetime risk of poor health outcomes such as alcoholism, depression, heart disease, cancer, and obesity.⁴² While children are highly sensitive to trauma, as seen through these later health impacts, trauma is also impactful for adults.

Trauma-informed care is built on understanding a person's individual life experiences (e.g., asking what has happened to you) and the need for a clinical encounter to empower rather than re-traumatize a person.⁴³ In many cases, providers operate under the assumption that someone has experienced trauma without directly asking whether this is so.⁴⁴ Key aspects include fostering a person's feeling of safety in the clinical encounter and developing a positive, trusting person-provider relationship. Trust is based in a one party being vulnerable, such as through having an illness or a lower level of knowledge, and believing the other party will care for their interests.⁴⁵ Fidelity, competency, honesty, and confidentiality are also dimensions of trust.³⁹

Reproductive and sexual health questions and services can feel especially invasive for a person who has experienced trauma. Establishing or reaffirming a person-provider relationship rests on developing interpersonal skills including being non-judgmental, providing reassurance, reaffirming that the person can and should ask questions, and talking about the person's goals of care or treatment.⁴⁶ This workgroup does not endorse a single guideline for trauma-informed care as this care philosophy cannot be operationalized through a checklist. Many entities have developed toolkits to support trauma-informed care.

The Centers for Disease Control and Prevention lists six principles to a trauma-informed approach:⁴⁷

- **Safety:** Staff and people receiving care feel physically and psychologically safe
- **Trustworthiness and transparency**
- **Peer support:** Those with lived experience of trauma as allies in recovery or using stories
- **Collaboration and mutuality:** Decision making is shared, power differentials among staff or between providers and people receiving care is reduced
- **Choice:** Empowerment and self-advocacy
- **Cultural, historical and gender issues:** Recognizing and addressing historical trauma, removing provider bias, care that is responsive to cultural background

The Substance Abuse and Mental Health Services Association uses the four Rs:⁴⁸

- **Realization** that anyone may have experienced trauma and their behavior can be understood as a coping strategy to address past trauma
- **Recognize** the signs of trauma
- **Respond** to the above through using a universal precautions approach
- **Resist Re-traumatization** by seeking to not create toxic or stressful environments

Appropriate Care

Family Planning

The *pregnancy intention* screening question, here changed to use the term *parenting intention* to be inclusive of those who cannot or may not intend to become pregnant, has been found by patients to be helpful in starting a conversation about family planning and related to contraceptive use.^{49,50} This question is typically well-received by patients and clinicians report felt the question should be included in routine reproductive health care.^{51,52} Patient centered contraceptive counseling allows the patient and provider to work together in talking about needs and preferences, is more likely to allow a person's preferences to be part of the eventual decision, and more likely to result in adherence to the chosen contraceptive method.^{53,54}

The Family Planning National Training Center provides four best practice recommendations to increase contraceptive access: stock a broad range of contraceptive methods, discuss pregnancy intention and provide patient-centered counseling, develop systems for same-visit provision of all contraceptive methods, and utilize diverse payment options to reduce cost as a barrier.⁵⁵ Patients switching from no method of contraception to any method results in a greater reduction in pregnancy than switching from to a moderately effective to most effective method. Women's decisions about which methods to use are less impactful than their decisions about whether to use contraception at all.⁵⁶

Education and Screening

Screening for diseases and disorders impacting reproductive health organs should follow guidelines of the US Preventive Services Task Force and relevant specialty societies, except for intimate partner violence. Universal education about healthy relationships and intimate partner violence are recommended over screening. Non-structured discussions on parenting or healthy relationships are more likely than structured screening tools to result in a person's disclosure of having experienced intimate partner violence.⁵⁷ Other practitioners recommend case finding, offering services to those showing signs or symptoms of violence over universal screening.⁵⁸

Cervical, breast, and prostate cancer screening should follow the age-specific guidance of the USPSTF and be individualized based on risk factors (e.g., family history). People with cervical tissue should be screened if age 21-29 every three years, if 30-65 every three years with cervical cytology alone or every five years with high-risk human papillomavirus alone or in combination with cervical cytology alone, if over 65 screening is not recommended if previous screening has been adequate.⁵⁹ People with breast tissue should be screened for breast cancer with a mammography every other year if aged 50-74, base a decision to screen 40-49 on the risks and benefits of screening.⁶⁰

For people who have receptive anal sex, clinicians should follow the 2015, the Washington State Department of Health and Public Health Seattle and King County PrEP Implementation Guidelines⁶¹ with more specific definitions that allow for easier adoption. The workgroup endorses these guidelines and recommends their use across Washington State. The guidelines are available [here](#). For HIV treatment, follow the United States Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV, available [here](#) (updated March 2018).

Measurement

Most nationally recognized measures focus on maternity care. Many of these are discussed in the 2020 Maternity Care Bundled Payment Model.

The National Quality Forum [Perinatal and Reproductive Health 2015-2016 Final Report](#) includes two contraceptive care measures not related to postpartum contraception:

2903 Contraceptive Care – Most & Moderately Effective Methods

Description: The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved methods of contraception.

2904 Contraceptive Care - Access to LARC

Description: Percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices or systems (IUD/IUS)). It is an access measure because it is intended to identify situations in which women do not have access to the long-acting reversible methods of contraception (LARC), i.e., contraceptive implants and intrauterine devices.

Appendix C: Guideline and Systematic Review Search Results

	<i>Year</i>	<i>Title</i>	<i>Summary</i>
<i>AHRQ: Research Findings and Reports</i>	2019	Can Physical Activity Improve the Health of Wheelchair Users? A Systematic Review	In-progress
	2018	Achieving Health Equity in Preventive Services: Systematic Evidence Review	In populations adversely affected by disparities, evidence is strongest for patient navigation to increase colorectal, breast, and cervical cancer screening; telephone calls and prompts to increase colorectal cancer screening; and reminders including lay health workers encouraging breast cancer screening. Evidence is low or insufficient to determine effects of barriers or effectiveness of other interventions because of lack of studies and methodological limitations of existing studies.
	2012	Closing the Quality Gap Series: Quality Improvement Interventions To Address Health Disparities	The literature on QI interventions generally and their ability to improve health and health care is large. Whether those interventions are effective at reducing disparities remains unclear. This report should not be construed to assess the general effectiveness of QI in the health care setting; rather, QI has not been shown specifically to reduce known disparities in health care or health outcomes. In a few instances, some increased effect is seen in disadvantaged populations; these studies should be replicated and the interventions studied further as having potential to address disparities.
<i>Cochrane Collection Reviews</i>	2019	Interventions for sexual dysfunction following stroke	Use of sertraline to treat premature ejaculation needs to be tested in further RCTs. The lack of benefit with structured sexual rehabilitation and pelvic floor physiotherapy should not be interpreted as proof of ineffectiveness. Well-designed, randomised, double-blinded, placebo-controlled trials of long-term duration are needed to determine the effectiveness of various types of interventions for sexual dysfunction. It should be noted, however, that it may not be possible to double-blind trials of complex interventions.
	2015	Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience	Intensive advocacy may improve everyday life for women in domestic violence shelters/refuges in the short term and reduce physical abuse one to two years after the intervention. There is no clear evidence that intensive advocacy reduces sexual, emotional, or overall abuse, or that it benefits women’s mental health. It is unclear whether brief advocacy (mostly given in healthcare settings) is effective, although it may provide short-term mental health benefits and reduce abuse, particularly in pregnant women and those suffering less severe abuse. We considered the results of several studies to be potentially biased because of weak study designs. There was little consistency between studies, with variations in the amount of advocacy given, the type of benefits measured, and the lengths of follow-up periods. As a result, it was hard to combine their results, and we cannot be certain of how much advocacy interventions benefit women or the impact of the

	intimate partner abuse	type of advocacy, the place it was given, or the severity of the abuse experienced by the women receiving the intervention.
2015	Screening women for intimate partner violence in healthcare settings	The evidence shows that screening increases the identification of women experiencing IPV in healthcare settings. Overall, however, rates were low relative to best estimates of prevalence of IPV in women seeking healthcare. Pregnant women in antenatal settings may be more likely to disclose IPV when screened, however, rigorous research is needed to confirm this. There was no evidence of an effect for other outcomes (referral, re-exposure to violence, health measures, harm arising from screening). Thus, while screening increases identification, there is insufficient evidence to justify screening in healthcare settings. Furthermore, there remains a need for studies comparing universal screening to case-finding (with or without advocacy or therapeutic interventions) for women's long-term wellbeing in order to inform IPV identification policies in healthcare settings.
2014	Interventions for preventing or reducing domestic violence against pregnant women	There is insufficient evidence to assess the effectiveness of interventions for domestic violence on pregnancy outcomes. There is a need for high-quality, RCTs with adequate statistical power to determine whether intervention programs prevent or reduce domestic violence episodes during pregnancy or have any effect on maternal and neonatal mortality and morbidity outcomes.

None

<https://www.cdc.gov/sexualhealth/>

None

Health
Technology
Assessment
Program
Centers for
Disease Control
and Prevention

Institute for
Clinical and
Economic
Review

Bree Collaborative Reproductive and Sexual Health Workgroup

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<p><i>Veterans Administration Evidence-based Synthesis Program</i></p>	<p><u>2013</u></p>	<p><u>Intimate Partner Violence: Prevalence Among U.S. Military Veterans and Active Duty Servicemembers and a Review of Intervention Approaches</u></p>	<p>We also identified six SRs that evaluated interventions aimed at decreasing exposure to IPV. None of these SRs assessed primary IPV prevention strategies; all summarized literature on secondary prevention strategies such as screening for IPV. Overall, screening in health care settings increases identification of IPV victimization and appears to be feasible and acceptable. Screening alone, however, does not decrease rates of IPV victimization. Other secondary prevention strategies (behavioral interventions, advocacy interventions) provide insufficient evidence to demonstrate significant changes in IPV or IPV-related mental or physical harms.</p>
<p><i>The American College of Obstetricians and Gynecologists</i></p>	<p><u>2015</u></p>	<p><u>Racial and Ethnic Disparities in Obstetrics and Gynecology</u></p>	<p>Reducing racial and ethnic disparities in health and health care should be a priority for all obstetrician–gynecologists and other women’s health care providers. Obstetrician–gynecologists can help to meet this objective by</p> <ul style="list-style-type: none"> • raising awareness among colleagues, residents, staff, and hospital administrators about the prevalence of racial and ethnic disparities and the effect on health outcomes • understanding the role that practitioner bias can play in health outcomes and health care • strongly encouraging the adoption of federal standards for collection of race and ethnicity information in clinical and administrative data to better identify disparities • promoting research that not only identifies structural and cultural barriers to care but also tests the effectiveness of interventions to address such barriers • educating patients in a culturally sensitive manner about steps they can take to prevent disease conditions that are prevalent in their racial and ethnic groups • supporting and assisting in the recruitment of obstetrician–gynecologists and other health care providers from racial and ethnic minorities into academic and community health care fields
	<p><u>2012 (reaffirmed 2019)</u></p>	<p><u>Intimate Partner Violence</u></p>	<p>Obstetrician–gynecologists are in a unique position to assess and provide support for women who experience IPV because of the nature of the patient–physician relationship and the many opportunities for intervention that occur during the course of pregnancy, family planning, annual examinations, and other women’s health visits. The U.S. Department of Health and Human Services has recommended that IPV screening and counseling should be a core part of women’s preventive health visits. Physicians should screen all women for IPV at periodic intervals, including during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup), offer ongoing support, and review available prevention and referral options. Resources are available in many communities to assist women who experience IPV.</p>
	<p><u>2017</u></p>	<p><u>Domestic Violence</u></p>	<p>FAQs</p>

<u>2014</u>	Interactive site for clinicians serving women with disabilities	<ul style="list-style-type: none">• Part 1 includes an overview of the program, The Scope of Disability in Women, and Psychosocial Issues.• Part 2 includes The GYN Examination, GYN Health Screening, Sexually Transmitted Disease and Skin Examination• Part 3 encompasses Medical and Reproductive Considerations. Modules include: Contraception; Menses and Abnormal Uterine Bleeding; Pregnancy and Parenting; Urinary and Bowel Considerations; Diet, Physical Activity and Weight; Adolescent Health; and Aging and Osteoporosis.• Part 4 encompasses Reproductive Health Specific to Disability. Modules include: Spinal Cord Injury, Spina Bifida, Multiple Sclerosis, Cerebral Palsy, Intellectual and Developmental Disabilities, and Sensory Disabilities.• Part 5 encompasses Access to Health Care. Modules include: ADA Requirements and Incentives, Disability Culture, and Universal Design/Office Practice Solutions• Part 6 is the Resources Section with links to resources for providers, patients and those who care for them.
<u>2001</u>	Abuse Assessment Screen	<p>Many women with disabilities are at risk for abuse, however standard screening tools may not unveil abuse common to women with disabilities such as with holding assistance or treatment.</p> <p>McFarlane, J, et al. Abuse Assessment Screen-Disability (AAS-D): Measuring frequency, type, and perpetrator of abuse toward women with physical disabilities. J of Women's Health and Gender-Based Medicine 2001;10(9):861-866.</p>
<u>2015</u>	Health Care for Unauthorized Immigrants	<p>Unauthorized (undocumented) immigrants are less likely than other residents of the United States to have health insurance. The American College of Obstetricians and Gynecologists has long supported a basic health care package for all women living within the United States without regard to their country of origin or documentation. Providing access to quality health care for unauthorized immigrants and their children, who often were born in the United States and have U.S. citizenship, is essential to improving the nation's public health.</p>
<u>2018</u>	Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care	<p>The American College of Obstetricians and Gynecologists makes the following recommendations for obstetrician-gynecologists and other health care providers to improve patient-centered care and decrease inequities in reproductive health care:</p> <ul style="list-style-type: none">• Inquire about and document social and structural determinants of health that may influence a patient's health and use of health care such as access to stable housing, access to food and safe drinking water, utility needs, safety in the home and community, immigration status, and employment conditions.• Maximize referrals to social services to help improve patients' abilities to fulfill these needs.• Provide access to interpreter services for all patient interactions when patient language is not the clinician's language.• Acknowledge that race, institutionalized racism, and other forms of discrimination serve as social determinants of health.

- Recognize that stereotyping patients based on presumed cultural beliefs can negatively affect patient interactions, especially when patients' behaviors are attributed solely to individual choices without recognizing the role of social and structural factors.
- Advocate for policy changes that promote safe and healthy living environments.

References

- ¹ World Health Organization. Reproductive Health. Available: <https://www.who.int/westernpacific/health-topics/reproductive-health>
- ² Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. *Lancet*. 2018 Jun 30;391(10140):2642-2692.
- ³ Prather C, Fuller TR, Jeffries WL 4th, et al. Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity. *Health Equity*. 2018;2(1):249–259. Published 2018 Sep 24. doi:10.1089/hecq.2017.0045
- ⁴ Blue Bird Jernigan V, Peercy M, Branam D, et al. Beyond health equity: achieving wellness within American Indian and Alaska Native communities. *Am J Public Health*. 2015;105 Suppl 3(Suppl 3):S376–S379. doi:10.2105/AJPH.2014.302447
- ⁵ Hardeman RR, Murphy KA, Karbeah J, Kozhimannil KB. Naming Institutionalized Racism in the Public Health Literature: A Systematic Literature Review. *Public Health Rep*. 2018;133(3):240–249. doi:10.1177/0033354918760574
- ⁶ Haider S, Stoffel C, Donenberg G, Geller S. Reproductive health disparities: a focus on family planning and prevention among minority women and adolescents. *Glob Adv Health Med*. 2013;2(5):94–99. doi:10.7453/gahmj.2013.056
- ⁷ Centers for Disease Control and Prevention. STDs in Racial and Ethnic Minorities. Accessed: <https://www.cdc.gov/std/stats17/minorities.htm#ref1>
- ⁸ Kossler K, Kuroki LM, Allsworth JE, Secura GM, Roehl KA, Peipert JF. Perceived racial, socioeconomic and gender discrimination and its impact on contraceptive choice. *Contraception*. 2011;84(3):273–279.
- ⁹ Washington Health Alliance. Community Checkup. <https://www.wacommunitycheckup.org/compare-scores/measure-detail/?Measure%20Name=Breast%20cancer%20screening>
- ¹⁰ Jacoby VL, Fujimoto VY, Giudice LC, Kuppermann M, Washington AE. Racial and ethnic disparities in benign gynecologic conditions and associated surgeries. *Am J Obstet Gynecol*. 2010;202(6):514–521. doi:10.1016/j.ajog.2010.02.039
- ¹¹ Centers for Disease Control and Prevention. Pregnancy-Related Deaths. Accessed: April 2019. Available: www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm
- ¹² Save the Children. State of the World’s Mothers 2015. 2015. Accessed: May 2019. Available: www.savethechildren.org/content/dam/usa/reports/advocacy/sowm/sowm-2015.pdf
- ¹³ Tucker MJ, Berg CJ, Callaghan WM, Hsia J. The Black-White disparity in pregnancy-related mortality from 5 conditions: differences in prevalence and case-fatality rates. *Am J Public Health*. 2007 Feb;97(2):247-51. doi:10.2195/ajph.2006.011111
- ¹⁴ <https://www.census.gov/quickfacts/WA>
- ¹⁵ <https://www.pewsocialtrends.org/2012/11/07/a-milestone-en-route-to-a-majority-minority-nation/#>
- ¹⁶ <https://www.migrationpolicy.org/data/state-profiles/state/demographics/WA>
- ¹⁷ <https://news.gallup.com/poll/203513/vermont-leads-states-lgbt-identification.aspx>
- ¹⁸ https://news.gallup.com/poll/182051/san-francisco-metro-area-ranks-highest-lgbt-percentage.aspx?utm_source=Social%20Issues&utm_medium=newsfeed&utm_campaign=tiles
- ¹⁹ <https://www.ncjrs.gov/pdffiles1/nij/183781.pdf>
- ²⁰ <https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf>
- ²¹ <https://belonging.berkeley.edu/targeteduniversalism>
- ²² Jacoby VL, Fujimoto VY, Giudice LC, Kuppermann M, Washington AE. Racial and ethnic disparities in benign gynecologic conditions and associated surgeries. *Am J Obstet Gynecol*. 2010 Jun;202(6):514-21.
- ²³ The Centers for Disease Control and Prevention. HIV Among Gay and Bisexual Men. September 2017. Accessed: March 2018. Available: <https://www.cdc.gov/hiv/pdf/group/msm/cdc-hiv-msm.pdf>
- ²⁴ Centers for Disease Control and Prevention. Diagnoses of HIV Infection in the United States and Dependent Areas, 2016. Volume 28. Published November 2017. Available: <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2016-vol-28.pdf>
- ²⁵ Russell ST, Fish JN. Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth. *Annu Rev Clin Psychol*. 2016 Mar 28; 12: 465–487.

- ²⁶ Mayer KH, Bradford JB, Makadon HJ, Stall R, Goldhammer H, Landers S. Sexual and Gender Minority Health: What We Know and What Needs to Be Done. *American Journal of Public Health*. 2008;98(6):989-995.
- ²⁷ Buchmueller T, Carpenter CS. Disparities in Health Insurance Coverage, Access, and Outcomes for Individuals in Same-Sex Versus Different-Sex Relationships, 2000–2007. *American Journal of Public Health*. 2010;100(3):489-495. doi:10.2105/AJPH.2009.160804.
- ²⁸ MacDorman MF, Matthews TJ, Declercq E. Trends in out-of-hospital births in the United States, 1990-2012. *NCHS Data Brief*. 2014 Mar;(144):1-8.
- ²⁹ Howell E, Palmer A, Benatar S, Garrett B. Potential Medicaid cost savings from maternity care based at a freestanding birth center. *Medicare Medicaid Res Rev*. 2014;4(3):mmrr2014-004-03-a06. Published 2014 Sep 9.
- ³⁰ Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington (DC): National Academies Press (US); 2003.
- ³¹ Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proc Natl Acad Sci U S A*. 2016;113(16):4296–4301.
- ³² Dehlendorf C, Ruskin R, Grumbach K, et al. Recommendations for intrauterine contraception: a randomized trial of the effects of patients' race/ethnicity and socioeconomic status. *Am J Obstet Gynecol*. 2010;203(4):319.e1–319.e3198. doi:10.1016/j.ajog.2010.05.009
- ³³ ACOG
- ³⁴ Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved*. 1998;9(2):117-125.
- ³⁵ Shepherd SM. Cultural awareness workshops: limitations and practical consequences. *BMC Med Educ*. 2019;19(1):14. Published 2019 Jan 8.
- ³⁶ Horvat L, Horey D, Romios P, Kis-Rigo J. Cultural competence education for health professionals. *Cochrane Database Syst Rev*. 2014;(5):CD009405. Published 2014 May 5. doi:10.1002/14651858.CD009405.pub2
- ³⁷ Truong M, Paradies Y, Priest N. Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC Health Serv Res*. 2014;14:99. Published 2014 Mar 3.
- ³⁸ Chang ES, Simon M, Dong X. Integrating cultural humility into health care professional education and training. *Adv Health Sci Educ Theory Pract*. 2012;17(2):269-278. doi:10.1007/s10459-010-9264-1
- ³⁹ Tapales A, Douglas-Hall A, Whitehead H. The sexual and reproductive health of foreign-born women in the United States. *Contraception*. 2018;98(1):47–51.
- ⁴⁰ Hasstedt K, Desai S, Ansari-Thomas Z. Immigrant Women's Access to Sexual and Reproductive Health Coverage and Care in the United States. November 20, 2018. The Commonwealth Fund. Available: <https://www.commonwealthfund.org/publications/issue-briefs/2018/nov/immigrant-womens-access-sexual-reproductive-health-coverage>
- ⁴¹ Health Literacy: The Gap Between Physicians and Patients
<https://www.aafp.org/afp/2005/0801/p463.html#:~:text=Health%20literacy%20is%20basic%20reading,at%20a%2010th%20Dgrade%20level>.
- ⁴² Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245-258.
- ⁴³ https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf
- ⁴⁴ <https://www.health.harvard.edu/blog/trauma-informed-care-what-it-is-and-why-its-important-2018101613562>
- ⁴⁵ Dang BN, Westbrook RA, Njue SM, Giordano TP. Building trust and rapport early in the new doctor-patient relationship: a longitudinal qualitative study. *BMC Med Educ*. 2017;17(1):32. Published 2017 Feb 2. doi:10.1186/s12909-017-0868-5
- ⁴⁶ Dang BN, Westbrook RA, Njue SM, Giordano TP. Building trust and rapport early in the new doctor-patient relationship: a longitudinal qualitative study. *BMC Med Educ*. 2017;17(1):32. Published 2017 Feb 2.
- ⁴⁷ https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm
- ⁴⁸ Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. October 2014. Accessed: June 2020. Available: <https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf>

- ⁴⁹ Stulberg DB, Dahlquist IH, Disterhoft J, Bello JK, Hunter MS. Increase in Contraceptive Counseling by Primary Care Clinicians After Implementation of One Key Question[®] at an Urban Community Health Center. *Matern Child Health J.* 2019;23(8):996–1002.
- ⁵⁰ Wolgemuth T, Judge-Golden C, Callegari L, Zhao X, Mor M, Borrero S. Associations between Pregnancy Intention, Attitudes, and Contraceptive Use among Women Veterans in the ECUUN Study. *Womens Health Issues.* 2018;28(6):480–487.
- ⁵¹ Baldwin MK, Overcarsh P, Patel A, Zimmerman L, Edelman A. Pregnancy intention screening tools: a randomized trial to assess perceived helpfulness with communication about reproductive goals. *Contracept Reprod Med.* 2018;3:21. Published 2018 Dec 17. doi:10.1186/s40834-018-0074-9
- ⁵² Manze MG, Calixte C, Romero DR, et al. Physician perspectives on routine pregnancy intention screening and counseling in primary care. *Contraception.* 2020;101(2):91–96. doi:10.1016/j.contraception.2019.11.004
- ⁵³ Dehlendorf C, Krajewski C, Borrero S. Contraceptive counseling: best practices to ensure quality communication and enable effective contraceptive use. *Clin Obstet Gynecol.* 2014;57(4):659–673. doi:10.1097/GRF.0000000000000059
- ⁵⁴ Rivlin K, Isley MM. Patient-centered Contraceptive Counseling and Prescribing. *Clin Obstet Gynecol.* 2018;61(1):27–39. doi:10.1097/GRF.0000000000000337
- ⁵⁵ Family Planning National Training Center. Contraception Toolkit. 2018 (Family Planning National Training Center) https://www.fpntc.org/resources/increasingaccess-contraceptiontoolkit?utm_source=eNews&utm_campaign=February
- ⁵⁶ Thomas A, Karpilow Q. The intensive and extensive margins of contraceptive use: comparing the effects of method choice and method initiation. *Contraception.* 2016;94(2):160–167.
- ⁵⁷ Jack SM, Ford-Gilboe M, Davidov D, MacMillan HL; NFP IPV Research Team. Identification and assessment of intimate partner violence in nurse home visitation. *J Clin Nurs.* 2017;26(15-16):2215-2228. doi:10.1111/jocn.13392
- ⁵⁸ Wathen CN, MacMillan HL. Health care's response to women exposed to partner violence: moving beyond universal screening. *JAMA.* 2012;308(7):712-713.
- ⁵⁹ <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening#:~:text=The%20USPSTF%20recommends%20screening%20for%20cervical%20cancer%20every%203%20years,should%20be%20with%20cytology%20alone.>
- ⁶⁰ Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement.
- ⁶¹ Washington State Department of Health and Public Health Seattle and King County. Pre-Exposure Prophylaxis (PrEP) Implementation Guidelines. 2015. October 2015. Source: www.kingcounty.gov/depts/health/communicable-diseases/hiv-std/patients/pre-exposure-prophylaxis.aspx