Practical Ways to Incorporate Equity into SBHC Sexual and Reproductive Health Services

Elizabeth Cook, Child Trends, and Arin Kramer, La Clínica de La Raza

2022 National School-Based Health Care Convention

June 27, 2022

This project is supported by Grant Number 1 FPRPA006065-03-00 from the Department of Health and Human Services Office of Population Affairs. Contents are solely the responsibility of the authors and do not necessarily represent the official views of the Department of Health and Human Services or the Office of Population Affairs.

Poll #1

1) How are you connected to school-based health center work?

A. Non-clinical staff (SBHC administrator, site supervisor, front desk staff)
B. Clinical staff (provider, medical assistant, health educator)
C. School staff (teacher, principal)
D. Funder
E. Researcher
F. A role not listed here

2) How much do you know about health equity in sexual and reproductive health services?

A. Nothing
B. A little bit
C. Some
D. A lot

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Elizabeth Cook

Research Scientist

Child Trends

Baltimore, Maryland

- *Has 12 years research experience*
- *Focus is on adolescent sexual and reproductive health, SBHCs, and program evaluation*
- *Background in public health and social work*

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Arin Kramer

Family Nurse Practitioner
La Clínica de La Raza
Oakland, California

- *Has practiced for 14 years*
- *Focus is on adolescent reproductive health in SBHCs*
- *LARC provider trainer*
- *Developed a LARC doula curriculum for medical assistants and health educators*

La Clínica
a california health center

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Agenda

- What is health equity?
- Health equity in sexual and reproductive health services
- About our project
- Implementing a reproductive justice approach at La Clinica
  - Improved contraceptive counseling: *Shared decision making*
  - Improved access: *Provision of same-day contraception*
  - Improved experience: *Fostering a supportive environment for LARC procedures*
- Q&A – leave questions in the chat!

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What is Health Equity?

Health equity *means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.*

- Robert Wood Johnson Foundation

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Equality

Equity

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Why Does Health Equity Matter?

- Quality of life
- Duration of life
- Health care costs
- Economic costs

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Equity in Sexual and Reproductive Health Care

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Medical research on enslaved women

- Experimental surgeries
- No pain management
- Belief that Black people experience less pain

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Painting by Robert Thom, circa 1952. *J. Marion Sims: Gynecologic Surgeon, from "The History of Medicine."*

Black women's pain is still dismissed and minimized.

"… false beliefs about biological differences between blacks and whites continue to shape the way [Black people's pain is perceived and treated]."

Hoffman, Kelly M., et al. "Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites." *Proceedings of the National Academy of Sciences* 113.16 (2016): 4296-4301.

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Reproductive Coercion

- Fertility control
  - *Black, indigenous, and Latine people*
  - *Disabled people*
  - *Incarcerated people*
  - *People receiving public assistance*

“The legacy of medical experimentation and inadequate healthcare coupled with social determinants has exacerbated African American women's complex relationship with healthcare systems. The social determinants of health associated with institutionalized and interpersonal racism, including poverty, unemployment, and residential segregation, may make African American women more vulnerable to disparate sexual and reproductive health outcomes.

The development of innovative models and strategies to improve the health of African American women may be informed by an understanding of the historical and enduring legacy of racism in the United States. Addressing sexual and reproductive health through a historical lens and ensuring the implementation of culturally appropriate programs, research, and treatment efforts will likely move public health toward achieving health equity.

Furthermore, it is necessary to develop interventions that address the intersection of the social determinants of health that contribute to sexual and reproductive health inequities."

- Cynthia Prather, PhD, et al.

Prather, Cynthia, 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 2.1 (2018): 249-259.

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Joint Statement of Reproductive Justice Guiding Principles

Patients have the right to...

- choose any method of birth control (or to choose not to use birth control), free of persuasion
- prompt removal of an IUD or implant for any reason, without judgement or resistance from provider
- receive medically accurate, unbiased, and culturally relevant information about (and access to) the full range of contraceptive methods

Source: https://www.nwhn.org/wp-content/uploads/2017/02/LARCStatementofPrinciples.pdf

Joint Statement of Reproductive Justice Guiding Principles

Advocates & the medical community must…

- use training materials for contraceptive counseling that don't privilege LARCs over other methods.
- balance messaging about contraception being part of a healthy sex life with non-contraceptive reasons individuals seek methods.
- support other policies and programs that address the full scope of healthy sexuality.

Source: https://www.nwhn.org/wp-content/uploads/2017/02/LARCStatementofPrinciples.pdf

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About Our Project

- Child Trends, partnering with the School-Based Health Alliance
- Three-year grant (2019-2022)
- Funded by HHS Office of Population Affairs

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About Our Project: *Child Trends Principal Investigators*

Jen Manlove, PhD

Jenita Parekh, PhD

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About Our Project: *Goals*

1. **Identify innovative strategies** that programs or providers use to improve family planning service delivery to school-based populations.

2. **Explore facilitators and barriers** to developing and sustaining these innovative strategies.

3. **Develop and disseminate practical guidance** on implementing innovative practices for family planning programs in the United States.

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About Our Project: *Process*

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About Our Project: *Products*

Innovation Toolkit (forthcoming Fall 2022)

- Results of four process evaluations
- Includes site-level case studies & foundational approaches to providing family planning services to underserved populations in school-based settings

Research Briefs

1. Results of literature review on improving access to and quality of SRH services in school settings
2. Innovative strategies to use to reach students and remotely administer family planning services during COVID
3. Strategies for raising awareness and increasing use of family planning services offered by SBHCs
4. Strategies for using community partnerships to increase adolescents' access to reproductive health services

See here: https://www.childtrends.org/project/innovations-in-family-planning-clinical-service-delivery-for-underserved-school-based-populations

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Implementing a Reproductive Justice Approach at La Clinica

- **Improved contraceptive counseling**
  Shared decision making
- **Improved access**
  Provision of same-day contraception
- **Improved experience**
  Fostering a supportive environment for LARC procedures

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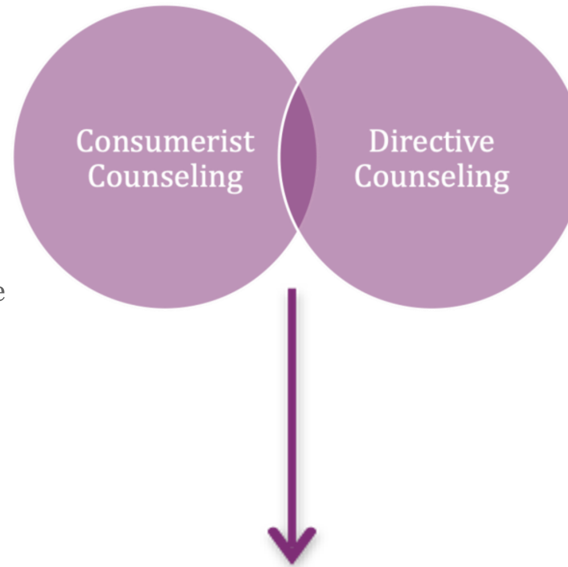
Improved contraceptive counseling: *Shared decision making*

- Patient-led counseling promotes patient autonomy
- Only information on methods asked about by the patient are discussed
- Fails to ensure accurate information about all methods



- Provider-led counseling prioritizes one-size-fits-all tiered effectiveness of methods
- Creates a biased presentation of options
- Fails to elicits priorities of the patient

Shared Decision Making

A collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences to make the best individualized care decisions.

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Dehlendorf, Contraception, 2015

Improved contraceptive counseling: *Shared decision making*

- Prioritize rapport above all else
- Remember that adolescent is expert on their life
- Elicit patient's priorities
- Use active facilitation
- Explain *during counseling* that patient has full control to discontinue
- Discontinue method for a patient when they want

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What this sounds like…

"You are in charge of your reproductive health, and I am here to support that decision."

“What is important to you about your method?”

“If you do not like your birth control, here are ways to follow-up.”

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“What is important to you about your method?”

- Efficacy
- Hidden method
- Frequency of using method (daily, weekly, monthly, or longer) or rather the desire to not remember something
- Specific side effects - acne control, weight gain, no hormones
- Bleeding patterns
  - lighter / less crampy menses
  - having a period (parents who monitor menses)
  - not having a period (trans youth)
  - predictable menses / no unscheduled bleeding

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Empower Choices Using Active Facilitation

"You mentioned that it is really important to you to have regular periods. The pill, patch, ring, 3-year hormonal IUD, and copper IUD are good options if you want to hear more about those."

"I am hearing you say that having a hidden method is the most important thing to you right now. In that case, the vaginal ring, the shot, the IUD, and the implant are good options. Can I tell you more about those methods?"

Empower Choices Using Active Facilitation

- Provide accurate information about side effects, how to manage them, and how to follow-up
- Address patient concerns about side effects respectfully

"That's too bad your friend had that experience. I haven't heard of that before, and I can tell you it definitely doesn't happen frequently. My guess is that if you were to use this method, it would not happen to you."

Poll #2

What are some of the barriers to the provision of same-day contraception in SBHCs?

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Improved access: *Provision of same-day contraception*

- Quickstart methods
- Same-day Emergency Contraception
- Same-day LARC procedures

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Reproductive Health National Training Center Toolkit, 2020

Improved access: *Provision of same-day contraception*

How to implement:

- Stock devices, make supplies readily available, pre-assemble the materials in kits or in a portable caddy.
- Adjust the clinic schedule to enable flexibility.
- Engage, train, and support all staff.

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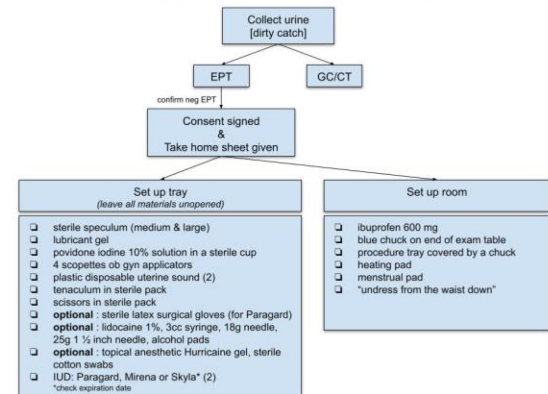
Improved access: *Provision of same-day contraception*

Stock device and pre-assemble materials



IUD Insertion: Tray Setup

- Sterile or nonsterile speculum - two sizes: recommend graves (wide/short) and pederson (long/narrow)
- lubricant gel
- povidone iodine 10% solution in a sterile cup
- 4 scopettes ob gyn applicators
- plastic disposable uterine sound (2)
- tenaculum in sterile pack
- scissors in sterile pack
- **optional** : sterile latex surgical gloves (for Paragard)
- **optional** : lidocaine 1%, 3cc syringe, 18g needle, 25g 1 ½ inch needle, alcohol pads
- **optional** : topical anesthetic Hurricaine gel, sterile cotton swabs
- IUD: Paragard, Mirena or Skyla* (2)

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Improved access: *Provision of same-day contraception*

Engage, train, and support all staff

- Cultivate staff buy-in for same-day provision.
- Train clinicians to insert and remove LARCs.
- Provide job aids for clinicians
  - *How to Be Reasonably Certain a Woman is not Pregnant*
  - *Quickstart Algorithm*
  - *Paragard/Mirena/Liletta IUDs as Emergency Contraception*
- Train and support front desk staff and medical assistants to answer basic questions about obtaining contraception same-day.

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Improved access: *Provision of same-day contraception*

How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- is ≤7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

In situations in which the health-care provider is uncertain whether the woman might be pregnant, the benefits of starting the implant, depot medroxyprogesterone acetate (DMPA), combined hormonal contraceptives and progestin-only pills likely exceed any risk; therefore, starting the method should be considered at any time, with a follow-up pregnancy test in 2-4 weeks. For IUD insertion, in situations in which the health-care provider is not reasonably certain that the woman is not pregnant, the woman should be provided with another contraceptive method to use until the health-care provider can be reasonably certain that she is not pregnant and can insert the IUD.

When to Start Using Specific Contraceptive Methods

Contraceptive method	When to start (if the provider is reasonably certain that the woman is not pregnant)	Additional contraception (i.e., back up) needed	Examinations or tests needed before initiation[1]
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection[2]
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	Bimanual examination and cervical inspection[2]
Implant	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	None
Injectable	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	None
Combined hormonal contraceptive	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	Blood pressure measurement
Progestin-only pill	Anytime	If >5 days after menses started, use back-up method or abstain for 2 days.	None

Abbreviations: BMI = body mass index; IUD = intrauterine device; STD = sexually transmitted disease; U.S. MEC = U.S. Medical Eligibility Criteria for Contraceptive Use

[1] Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (U.S. MEC 1) or generally can be used (U.S. MEC 2) among obese women. However, measuring weight and calculating BMI (weight [kg]/height [m²] at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

[2] Most women do not require additional STD screening at the time of IUD insertion. If a woman with risk factors for STDs has not been screened for gonorrhea and chlamydia according to CDC's STD Treatment Guidelines (http://www.cdc.gov/std/treatment), screening can be performed at the time of IUD insertion, and insertion should not be delayed. Women with current purulent cervicitis or chlamydial infection or gonococcal infection should not undergo IUD insertion (U.S. MEC 4).

Source: For full recommendations and updates, see the U.S. Selected Practice Recommendations for Contraceptive Use webpage at http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usspr.htm.

CDC
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

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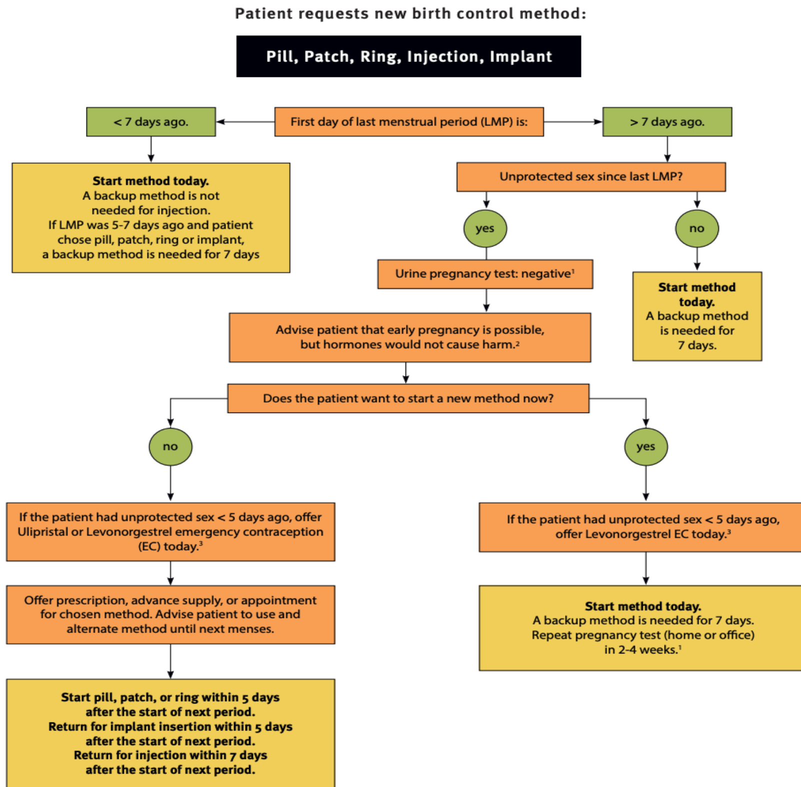
Quick Start Algorithm for Hormonal Contraception[2]

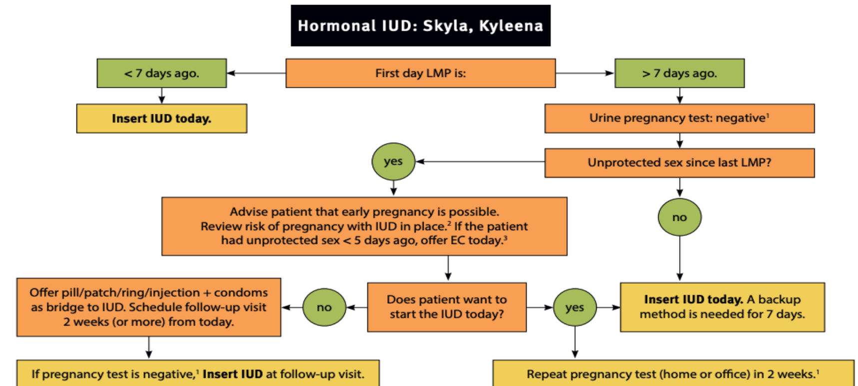


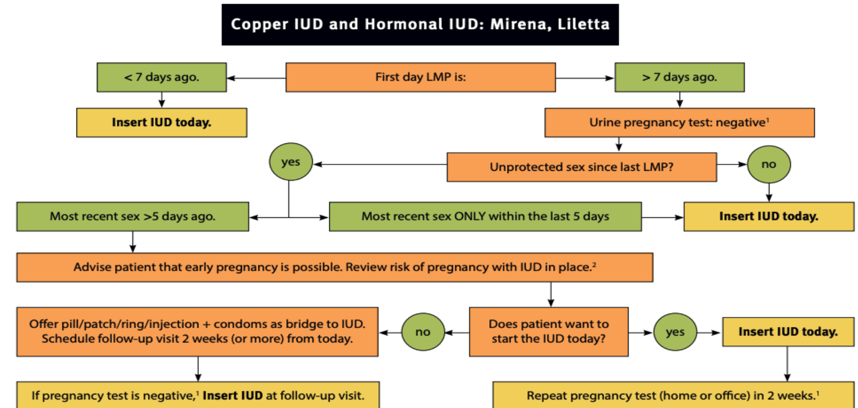
1 If pregnancy test is positive, provide options counseling.

2 Based on Select Practice Recommendations – Benefits of starting contraceptive likely exceed risk of early pregnancy.

3 For patients with body mass index over 25, levonorgestrel EC works no better than placebo. Ulipristal EC has higher efficacy than levonorgestrel EC for those who had unprotected sex 3-5 days ago. Because ulipristal EC may interact with hormonal contraceptives, the new method should be started no sooner than 5 days after ulipristal. Consider starting injection/IUD/implant sooner if benefit outweighs risk.

Quick Start Algorithm for IUDs[2]





1 If pregnancy test is positive, provide options counseling.

2 CDC advises ruling out pregnancy before IUD insertion. Clinicians may discuss the benefits of same-day insertion (improved access/patient convenience), balanced against a small risk of early pregnancy, which would be complicated by IUD insertion.

3 For patients with body mass index over 25, levonorgestrel EC works no better than placebo. Ulipristal EC has higher efficacy than levonorgestrel EC for those who had unprotected sex 3-5 days ago. Because hormones may decrease the efficacy of ulipristal, the new method should be started no sooner than 5 days after ulipristal. Consider starting injection/IUD/implant sooner if benefit outweighs risk.

Poll #3: *Teens identify which of the following as their primary deterrent to choosing an IUD?*

a. Cost

b. Fear that IUDs cause reproductive problems in the future

c. Concerns about changes in their menstrual cycle

d. Fear of a painful procedure

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Poll #3: *Teens identify which of the following as their primary deterrent to choosing an IUD?*

a. Cost

b. Fear that IUDs cause reproductive problems in the future

c. Concerns about changes in their menstrual cycle

d. Fear of a painful procedure

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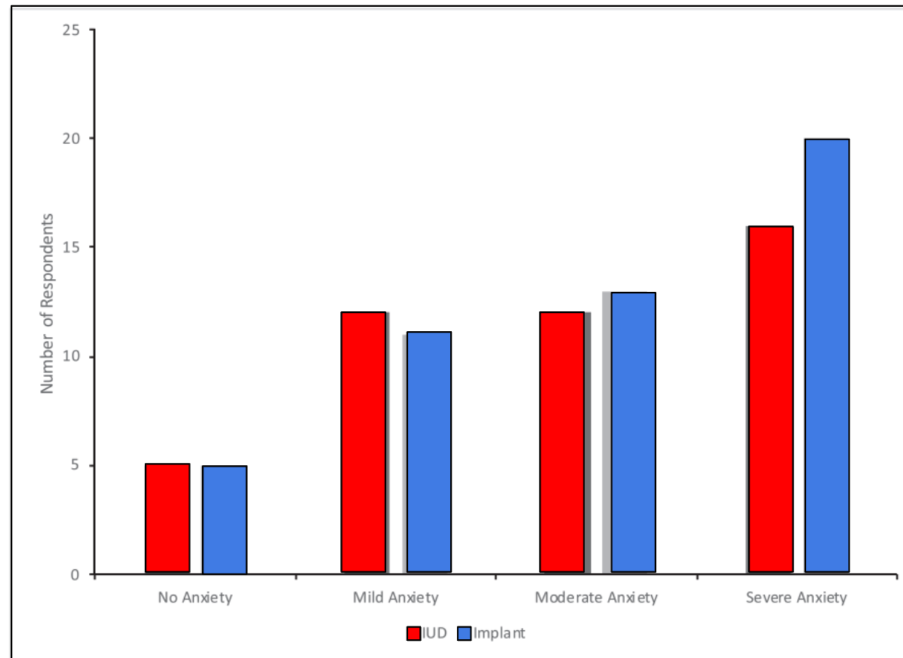
Preprocedural Anxiety in Adolescents



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DG Callahan et al. / J Pediatr Adolesc Gynecol 32 (2019)

Improved experience: *Fostering a supportive environment for LARC procedures*

- Meet the patient fully clothed before the procedure.
- Review the steps of the procedure and give them an opportunity to ask questions
- Provide hands-on Nexplanon/IUD models before the procedure
- Do not show the instruments. Keep the exam tray covered with a chuck (And cover after the procedure!)
- Use trauma-informed language
- Train clinic staff to be LARC doulas

Trauma-informed Language for IUD Procedures

INSTEAD OF:	TRY:	Why?
"I'm going to do the exam now."	"Before we start, I want to you to be aware that you are in control of the pace today. If you want me to slow down, repeat myself, explain anything more, please let me know. Or, if at any point, you want me to stop the procedure, I will."	Discuss the signal to pause. Model consent & build autonomy.
"Scoot your bottom down on the bed."	"When you're ready, move your hips to the edge of the exam table."	Use "exam table" not "bed"
"Open your legs." "Spread your legs."	"Let your knees fall to the sides or towards the walls."	Be mindful of triggering language. Let the patient move into position without any touching from you.
"Now you'll feel the speculum, which can be uncomfortable."	"Are you ready for the speculum exam? You'll feel some pressure from the speculum. Let me know if you have any discomfort so that I can try to fix that right away."	Again, ask for consent. Set expectations and model the words pressure vs pain.
"Everything looks good/feels good/beautiful."	"Everything looks normal and healthy."	Remove the focus on image.
"I am going to clean your vagina now."	"I'm going to swab with antiseptic now."	Insinuates that the vagina is not clean.
"You're going to feel a pinch, cramp, pain..."	"You may feel some sensation now. Practice those slow deep breaths we did before through your nose, and out your mouth…"	Studies show that anticipatory guidance describing pain makes it more likely for the patient to feel pain, as opposed to neutral descriptors of what the clinician is doing.

Improved experience: *Train clinic staff to be LARC doulas*

A LARC doula is...
someone who provides emotional, physical, and informational support before, during and after a LARC procedure.

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Improved experience: *Train clinic staff to be LARC doulas*

A LARC doula's work is focused entirely about the well-being and experience of the patient, paying attention only to their comfort, as well as ***their sense of control, participation, and understanding***.

Retaining a patient's sense of control is key. Empower them to have a shared role in the procedure -- that this is not done "to" the patient but "with" the patient.

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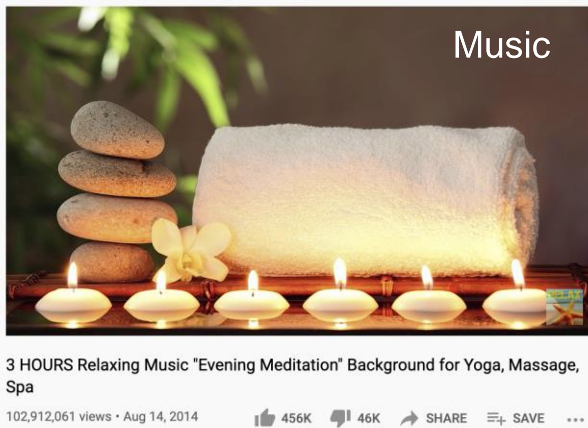
Improved experience: *Train clinic staff to be LARC doulas*



Deep Breathing

Temperature Regulation

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Improved experience: *Train clinic staff to be LARC doulas*

Create a LARC doula kit to store materials for supporting patients during LARC procedures:

- IUD/implant models
- lavender eye pillow
- stress ball
- instant heat packs
- fan

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Resources

Patient Resources

- Bedsider's Method Explorer
- Reproductive Health Access Project: contraception patient handouts and take home sheets
- Beyond the Pill education materials for patients

Clinician Resources

- SisterSong: LARC Statement of Principles
- Improving Contraception Counseling Through Shared-Decision Making Curriculum
- Reproductive Health National Training Center: Same-Visit Contraception: A Toolkit for Family Planning Providers
- Talking Points for Front Desk Staff
- Quick Start Algorithm for Contraception
- National Clinical Training Center for Family Planning's LARC Link
- Beyond the Pill's Clinic and Provider Toolkit & Implant/IUD Protocols
- ACOG LARC procedure video series

Resources Published through this Project

- Innovations in Family Planning Clinical Service Delivery for Underserved School-Based Populations

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Thank you!

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