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THE FUTURE OF REPRODUCTIVE CARE IN THE US
MARCH 6, 2024
1:00 P.M. EST

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>> YVETTE: Good afternoon. My name is Yvette Cozier. I serve as Associate Dean for Diversity, Equity, Inclusion, and Justice at the Boston University School of Public Health. On behalf of our school, welcome to today's Public Health Conversation. These conversations are meant as spaces where we come together to discuss the ideas that shape a healthier world. Through a process of open discussion, debate, and the generative exchange of ideas, we aim to sharpen our approach to building such a world. Guided by our speakers, we work towards a deeper understanding of what matters most to the creation of healthy populations. Thank you for joining us for today's conversation. In particular, thank you to the Dean's Office and the Communications team, without whose efforts these conversations would not take place. We are here today to discuss the landscape of reproductive health in the US. Together, we will talk about the range of services reproductive care encompasses. We will also discuss how public health can better navigate the politicization of reproductive health and better support equitable access to care. I look forward to engaging with our speakers and our audience for an informative and wide-ranging

conversation. I am now pleased to introduce today's moderator, Abigail Aiken. She is an associate professor at the LBJ School of Public Affairs at the University of Texas at Austin. Her research focuses on unintended pregnancy, evidence-based obstetric practice, and the impacts of laws and policies restricting access to abortion, including how and why people self-manage their own abortions outside the formal health care setting. She is currently the PI on Project SANA, examining self-managed abortion in the United States. She frequently testifies on reproductive health issues, and provided expert testimony to the Irish Parliament on the 2018 abortion referendum. She has consulted for the CDC, WHO and UN on various reproductive policy issues. Abigail, welcome the floor is yours.
>> ABIGAIL: Thank you, Dean Cozier, for that introduction. It is my pleasure to be moderating today's session which I don't think could come at a more important time for us all engaged in reproductive health. Now I would like to introduce our speakers for today. We are fortunate to hear from a range of experts in this field today and first we will hear from Lee Hasselbacher, Research Assistant Professor and Faculty Director At The Center for Interdisciplinary Inquiry and Innovation in Sexual and Reproductive Health at The University of Chicago. Lee leads Ci3's reproductive health policy research agenda, collecting data and translating research to inform policy debates and legislation. She collaborates with health providers, advocates, and UChicago researchers to achieve evidence-based policy reform. Next, we will turn to Whitney S. Rice, a Rollins Assistant Professor in the Department of Behavioral, Social and Health Education Sciences at the Emory University Rollins School of Public Health, and Director of the Center for Reproductive Health Research in the Southeast. Dr. Rice leverages training and transdisciplinary expertise from health care organization and policy, health services research, and maternal and child health disciplines in the pursuit of greater equity in sexual and reproductive health outcomes, care delivery, and scholarship. Then we will hear from Diane L. Rowley. Dr. Rowley is Emeritus Professor of the Practice of Public Health in the Department of Maternal and Child Health at the UNC Gillings School of Global Public Health and a Senior Researcher at the Sheps Center for Health Services Research. She has spent 30 years examining infant and pregnancy health disparities and is involved in conceptualizing health inequity and in creating tools to evaluate institutional equity. Then we will turn to Jody Steinauer, the Philip D. Darney Distinguished Professor of Family Planning and Reproductive Health in the Department of Obstetrics, Gynecology and Reproductive Sciences based at Zuckerberg San Francisco General Hospital. Dr. Steinauer is the

Director of the Bixby Center for Global Reproductive Health and the Director of the Kenneth J. Ryan Residency Training Program in Family Planning. She focuses her research on family planning training, professional identity formation in medical learners, and the experiences of students and residents learning to provide patient-centered care. Finally, we will hear from Rebekah Viloria, an obstetrics and gynecology physician at Fenway Health. Dr. Viloria's areas of expertise include abnormal pap smears, transgender gynecologic and obstetrics, and contraceptive management.
I'm so pleased to welcome these esteemed panelists today and I would like to turnover to Lee hassle backer to begin. Thank you, Lee.
>> LEE: Thank you. Let me get my slides going here. Thank you for the introduction and for this opportunity to join this group of public health experts I'm at the University of Chicago where I connect research to under the impact of reproductive health policy. I currently am at the time of Ci3 originally founded by Boston University's income president to address the barriers of sexual and reproductive health to ensure all young people have agency of their body as we gather today on the future of health care in the U.S. it's worth noting that many of our young people imagine what a truly health -- healthy future looks like. Participants are asked to build out a vision for a perhaps seemingly impossible future to reimagine pathways to achieve it. Given how dramatically the landscape of the policy has changed many have suggested there's a need to reframe the future of reproductive health. Some have been encouraging a radical reframing for many years, this term first emerged as Black leaders met in Chicago in the 90s and met about rights ground in social justice. Sister song an organization founded to advance reproductive justice defines it as the human right to maintain bodily autonomy, parent the children we have in safe and sustainable communities. In holding a vision of the future where this is true for all people perhaps, we can explore the steps needed to get there. We can look around for examples in policy and practice that move us closer to this goal. In Illinois where we focus much of our research at Ci3 advocates have pushed for policies that look at these goals. There's the act that establishes the fundamental right to make decision acting reproductive health including use and refusal of services the law defines reproductive health care as care relating to pregnancy, managing pregnant loss or improving maternal health and birth outcomes and provides examples such as sterilization, preconception care, assisted reproduction, abortion counseling. This must be accessible. Informed by the reproductive justice framework we must see that all folks have access. There's

effort with policies that make it easier for pregnant people to qualify and enroll for medicaid and gain medicaid coverage and extend it to a full year postpartum. Set up pathway to reimburse doulas. And require private insurers to cover the full spectrum of pregnancy and health care equally. Illinois has also extended medicaid coverage for abortion since 2018 and we along with colleagues have researched the implementation and impact of this important policy change. We also know these barriers are experienced unevenly for instance the highest rates of poverty are experienced by women of color. While the hide amendment imposes restrictions for coverage at the federal level states can support this with their own funds A. policy choice. Given that 42% of births in the U.S. are covered by medicaid. While we reported challenges in Illinois over time the program has become more established and streamlined with eligible residents having access to immediate enrollment and the abortion costs covered. We have analyzed the clinical data. Our finding suggests that when abortion is more affordable access is more equitable. We found the number of people seeking abortion who reported having insurance grew significantly with the difference coming from public insurance coverage and as the quotes on this slide suggest abortion coverage reduced a significant financial barrier for those eligible for immediate enrollment. In addition to ensuring access we choose the preferred abortion including sedation without worrying about costs. And looking at the time before and after Medicaid abortion coverage we saw the gap narrow between those with and without public insurance who receive their abortion at or before eleven weeks which means more people have the option of choosing medication abortion furthermore in an analysis looking at zip code data showed that more patients received abortion services after implementation of medicaid abortion coverage. We learned from clinics and other stakeholders that these have allowed clinics and abortion funds to leverage support more efficiently to cover costs for those in need a benefit that has proven more valuable as more and more people come to Illinois for care post-Dobbs. On flip side medical access can have broader health effects. Over the last year our team at the University of Chicago have conducted three separate studies on how abortion on how folks want to pursue their careers. The reproductive policy of states where they might attend college or move in the future to raise families and where to get appropriate medical training and where to build their career and where they themselves will get the reproductive health care they may need. Physicians are reporting high levels of stress on how to treat their patients and if they must leave restrictive states to continue practicing medicine in the way they believe right. It's too soon to tell on the availability

and quality of maternal health care in those areas of the country where health care providers have concerns however we do know that many of the states that restrict abortion access already have worst outcomes than those states that protect access and they lack the expanded social programs that contribute to building healthy families. Given these concerns we can see how continuing to reduce equitable access to reproductive care can have consequences for many aspects of health care. So, as I conclude and reflect on how the public health community can take action with such a politicized environment my hope is that experts and researchers can see how their work is connected to reproductive health and justice and recognize that the goals of reproductive health and well-being are shared. I hope we can continue to center the people affected by shifts, share their stories and experiences, collect evidence and data on health outcomes and elevate proactive policies I think it can be helpful to take the time to imagine what it should be like for all people to have healthy, happy reproductive lives. Thank you.
>> ABIGAIL: Thank you. Whitney, over to you.
>> WHITNEY: It's such a pleasure to share key findings that we have found conducted relevant to health and social consequences that restrictive abortion policies and health equity implications of more equitable service access suggested by these findings. For anyone unfamiliar with RISE I hope you'll become more familiar today we're a center housed at Emery for those informing social systems and policy change surrounding reproductive health rights and justice in this region and we aim to do this through interrelated areas of focus, participatory research, research training and mentorship and critical actors who affect change, research dissemination and communication. Since 2017, RISE has supported research studies in a number of areas.
Many of which are reflected in categories and partnerships here. In a high level summary this work is sought to understand reproductive health policies including but also beyond abortion those on health services use, health outcomes, health systems operations and also highly importantly, what community grounded responses and solutions emerge in light of state policy climates in this region. And much of what I present today focuses on our abortion policy research. As many of you do not need reminding, the current abortion access reality in the southeast is one where over half of states have total abortion bans. The rest near total bans or other gestational age limits in addition to other policies that affect the ability to provide care.
And what would seem more obtain an abortion. And this is contributing or has contributed to substantial change in

abortion provision in clinical settings compared to before the Dobbs versus Jackson supreme court decision that allowed more extreme patchwork of state abortion access. Abortion bans in many states across the country also correspond with closures of some abortion clinics many of which are independent clinics, that provide the majority of abortion care in the U.S. and offer in some cases the only free or low cast access to reproductive health care in some communities. Some clinics also notably offer usual sources of preventive health care. Considering this environment, RISE teams have studied restrictive abortion policy environment even predating the Dobbs decision and have research along the way. Findings from this work like that, conducted in other settings like we just heard, in Illinois, have research -- so they suggest that restrictive abortion policies limit access to abortion particularly for people already facing structural and intersectional inequities especially by race, socioeconomic status, and age as we've already heard. In a study that estimated the potential consequences of the current Georgia policy limiting abortion access by gestation, informed by the numbers of abortions provided by year over a prior multiyear span, our research estimated that Black people, lower educated people and young people had a lower proportion of abortions that would likely, you know, not lower proportion of abortions that would not neat legal limit under Georgia's ban, for example, so we discussed findings from this work in conjunction with research of increased access have alleviated inequity for some disproportionately affected groups. Shifting to the next set of key findings on the topic of health care provider constraints and pills by restrictive abortion policies. Our team has conducted multiple studies to include Georgia but also neighboring states that speak to how providers navigate the restrictive and fluctuating abortion policy climate so even prior to our current around six week ban there was a 22 week plan in place and there continue to be other restrictive laws, have and continue to be other restrictive laws that require a waiting period, limit public funding of abortion among others. A RISE team looked at how providers perceived the gestational ban around 22 weeks, and interviewed providers inclusive of staff and administrative leadership from clinics and in the study providers report strict adherence to the ban and shared the care environment that included additional labor, service delivery restrictions, legally constructed risks for provider, intrusion on the patient/provider relationship among others. They also commonly reported mentioning disparities that they felt that they observed. That the ban was disproportionately affecting people of color, those experiencing financial insecurity and those with underlying medical conditions.

Nonetheless, providers described a clear unrelenting commitment to providing quality patient-centered care and thus these and other restrictive laws as studies by our team and by others indicated can adversely affect other quality care such as equity of care provision.
Existing research does document evidence of the potential for improvement in these quality-of-care domains with increasing service access and then in my last highlight on policy consequences our team also explored outcome implications of shifting state. So namely existing policy or existing evidence around policy pointed to the idea that restrictive environments increase likelihood of miswanted -- mistimed and unwanted pregnancies going to term. Research has demonstrated that pregnancy and childbirth are related to pregnancy morbidity and mortality as compared to abortion. Further unable to access unwanted abortion care carries the risk of those pregnancy related morbidities such as preeclampsia and lastly the postpartum care environments characterized by inequities and insurance coverage, provider shortage also contributes to adverse outcomes. So, for those reasons we dove into exploring this relationship and findings revealed that Black people had disparities more than non-Black individuals and no college degree had a lower birthrate. And for all analyses, inequities worsened as state environments were increasingly restricted so this may contribute to rising rates to low birth weight as well as low equities in them also research also suggests that greater state restrictiveness of the abortion policy environment is associated with infant mortality, and these studies collectively find that less mortality and our team has also contributed to the knowledge base for service access that could alleviate or mitigate inequity or at least contribute to outcomes in that direction and even in the presence of restrictive abortion policies and in other relevant contexts. These studies include equitable doula access which notably in full spectrum doula care which can be provide for a range of health experiences including abortion. So this work includes research characterizing abortion funding support, a critical actor and not just the payment for abortion procedures for those procedures and or other methods of abortion for those who don't have access to needed resources. But also other costs like child care, travel, and other logistical needs. We've been able to provide descriptions over a multiyear span with our partner southeast fund and this informed programming in subsequent years. Some entities have included abortion fund support in their policymaking and budgets. My last note is around opportunities to more accessibly provide reproductive health education and in this climate where comprehensive sex education around abortion,

sex education including abortion has been restricted in some school settings. Future approaches necessitate innovative offerings and our RISE team has had some opportunity to both develop and evaluate some tools. So I'm happy to say more about any of these topics in Q&A. And I want to acknowledge those who supported, developed and informed this work.
>> ABIGAIL: Thank you very much. And now we will hear from Diane Rowley, Diane, over to you.
>> DIANE: I'm on my phone because I'm having internet problems and so my slides will be handled by the host and I can see if I can ask the host to get started. Assuming that everything is okay. Shall I go ahead and start? Talking? So that's not the first slide. I have a -- there we go. I have been working on issues of health equity for quite some time starting with looking at factors, risk factors and protective factors for infant mortality and maternal health and then spanning it to look much more clearly around what constitutes health equity. And so I'm going to have a slightly different focus from the rest of the group. First I want to acknowledge the current times that we're in. We had been encountering assault on reproductive care. And we heard this discussion already to some extent that -- and then more recently we've found out that Alabama supreme court thinks that frozen embryos are children. And while we need to think about how this might influence the future of reproductive care in the U.S., we need to continue to focus on our work and what our visions are of what care should be. And so that's going to be the nature of my few minutes that I have with you. When we think about reproductive care, we focus a lot on reproductive rights. Which is an individual's legal right and that is a lot of the issue around abortions. And other opportunities to access care. But there's also this need to look at what the national Institute of environmental health sciences calls the condition of the female and male reproductive systems during all stages of life this requires attention to a broad range of health conditions not just abortion, birth control and access to family planning and sex education. But a long list of conditions that require our attention. Some of those listed on the NIHS website include endometriosis, sperm count, erectile dysfunction and in addition to that we have got this other area that is much broader, equitable health and equitable health care and we have a vision in the U.S. that is commitment to developing equitable health. Simply put, health equity is the state in which everyone has a fair and just opportunity to attain the highest level of health. And many of us put this in the framework of pursuing social justice. So I want to talk about constructing future reproductive care that is comprehensive in scope and is

equitable and these frameworks are the life course framework that as envisioned by maternal and child health and reproductive justice framework. You've heard a little bit already about the reproductive justice framework and so I just won't elaborate on that a little bit. May I have the next slide, please. The life course framework as envisioned by maternal and child health defines the spectrum of factors that influence an individual's reproductive health through all stages of life. So, when an individual is in the womb through the postmenopausal period and it focuses on the experiences and exposures that happen throughout that time. On the time health pathways that are particularly affected during the critical periods as shown in the schematic and on the environment the broader community environment that strongly affects the capacity to be healthy, it focuses on equity and health. Assuming that hell reflects on more than genetics and personal choice and it focuses on protective and risk factors. The interplay of risk and protective factors that influence health. So, you've got this focus on what I would call biological behavioral social economic and environmental factors that contribute to health outcomes across a person's lifespan and why is this important because it needs to be dynamic over time.

And the life -- current life course approach allows us to consider the health needs and desires of people at each stage of life. Including preconception care, prepregnancy care, pregnancy, infancy, childhood, adolescent, the reproductive years and post-reproductive years. And I think it's important to use frameworks rather than just think about what clinical services we need or what interventions might be valuable at each of these stages. Because frameworks can help policymakers synthesize and translate life course events and apply it to designing health services and delivery. And it allows us to extend beyond planning just for clinical services it guides public health programs to support healthy and equitable communities and ensuring that the broad array of protective and risk factors that are addressed in an integrated, coordinated and comprehensive manner. May I have the next slide, please. So while the life course framework is based on research. The other agreement I think we use in the future of reproductive care is the reproductive justice framework which you have heard evolved from Black women's activities who attended the 1994 international conference on population and development. This work is based on human rights rather than the legal rights that are associated with issues around reproductive rights and abortion. And on the need for social justice. You hear it has three primary principles that should guide the development of reproductive health care in the U.S. The human right not to

have a child, the human right to have a child, and the human right to parent children in safe and healthy environments. And as noted by Loretta Ross who is one of the major architects of this framework reproductive justice uses human rights frameworks to draw attention to and resist laws and public and corporate policies based on race, gender and class prejudices. An important point I want to emphasize is the reproductive justice demands that the state not unduly interfere with reproducting decision-making but it also insists that the state has an obligation to help create the conditions for people to exercise their decisions with social support it envisions a support for families of all configurations, it maintains that people should be able to have the number of children they want, when they want, and the way that they choose to have them. Furthermore, individuals should be able to raise their children with support systems that provides safety, health, and dignity. When we think about this issue of safety, health and dignity it expands the area that is the focus of reproductive care because it means that we need to look at communities and how communities exist. And how they can also be changed to provide safety, health and dignity we're talking not just about transportation but the whole -- but also education, broadly speaking, housing as well, for example, and so it reflects what we think of as the activities where people live, work, play, and sleep and it's my feeling that the future of reproductive care should take this into consideration that really primarily focus on that aspect of providing care and services. To people who -- before, during and after their reproductive lives. So, may I have the last slide, please? Health care extends far beyond what happens in clinical care. And that the future of reproductive care requires attention to the social context of people's lives and I know that we are very concerned about policy now but we also need to be willing to think very much in the future about our role and how we can change policy and how we can influence the process by which policy is made and I will leave it at that. Thank you very much for your attention.

>> ABIGAIL: Thank you very much, next we'll hear from Jody Steinauer to, Jody, over to you.

>> JODY: Thank you, let me just move my desktop around just a tiny bit. Thank you so much I want to appreciate Dr. Cozier for inviting me to be among this panel of amazing speakers.

I want to begin my remarks by sharing a quote by a gynecologist in Texas. She told us about a patient who presented with previable, preterm rupture of membranes at 19 weeks which is when the bag of water breaks and carries a high risk to the pregnant person, a very low chance of the pregnancy continuing to viability and a very low chance of neonatal survival. She

told us how horrible it was to not provide the patient the care they deserved and even though the patient wanted an abortion they had to wait until she became sick with bleeding or hemorrhaging the patient did develop severe infection over a few days, developed sepsis and was admitted to the intensive care and then and only then was she able to have her labor induced. I know many of you have heard these stories, we heard already about these experiences of moral distress but when I read this quote I want you to encourage you to think about this learner who is forming her identity as an OBGYN physician. And think about what it must be like as she's developing her skill in patient-centered care, communication and really trying to do what is right for patients. So she said, it was really hard, she said it's hard (reading). And so as we think about her, I want to position her where she's training, she's in Texas. She's one of about 1,300 O BGYN residents who are training in the states with the most extreme restrictions. Shown on the map in red. And in this map I show you the number of residency programs in each state. And on average a program has about 20 residents. In it. So in the next few minutes I want to -- I hope to convince you as you are engaging in this conversation and thinking about ways you can advocate I hope to convince you to not only think about the patients currently having a horrible time accessing the care they need but also about all the future patients who may be cared for by clinicians who are not prepared to provide the care they need either for abortion care or miscarriage care because those clinicians were trained in a state where they were unable to access the adequate training they need or I want you to think about -- or also I want you to think about the patients who may not be able to access the clinician because the clinician decided not to practice in the community because these bans are forcing them to violate their values and so I will talk a little bit about the workforce as well as Lee also mentioned earlier. So I wanted to start by saying undergraduate medical education must include abortion. The goal after all of medical school is to improve the health of all people by preparing physicians to meet the health needs of a country's population and as we are discussing today, abortion is an important health need of our country's population. All physicians will interact with people seeking abortion care. All physicians must be able to counsel and refer, care for people after accessing abortion care and uphold their professional obligations to values such as patient autonomy, confidentiality, putting the patient first, evidence-based medicine and patient-centered care. Also, medical schools prepare physicians to consider what they would like to do in their future and we know that physicians in many facilities provide abortion care

and I have the QR code our international specialty organization to just point out that FIGO have made a strong statement that all medical schools must include abortion worldwide. OBGYN is unique that we require training, all programs must include training and that's been in place since 1996. We have to really have to have the skill to safely empty the uterus, care for people with pregnancy loss, and it is our professional obligation to provide abortion care no matter what we personally feel about abortion in the setting of saving someone's life so we are obligated to train every OBGYN. It turns out that many studies have shown both in family medicine and OBGYN that abortion training also increases competence in many skills used beyond abortion care for example pregnancy loss care or what we call miscarriage care. This is the journey of abortion training in the United States. The purple line is considered routine training where it's completely integrated and expected in a program the green line is no training and this shows the proportion of programs over time. And you can see that in 1992 there was a year where only 20% of programs had routine training and I will pause and say the difference between these -- the ones that are not routine or no training are programs with optional or opt in training but many studies have shown that routine training is better for many reasons and of course it's required by our accreditation council. That is what inspired the requirement for training and that also inspired the doctor to found the Ryan Program which I now get to direct and what we do is we support OBGYN programs to develop relationships with clinics and really integrate abortion training in their programs and you can see since then we've been steadily increasing over time it also shows you how hard it is and reminds us also that there were many, many restrictions -- restrictive state laws before Dobbs of course and so many programs have had a hard time far long time training in the last study 72% of programs did have routine training and only 8% did not have available so that was the pre-Dobbs state I also want to go out way beyond OBGYN and family medicine even though it's not required it's definitely within the scope of practice. There's a sister program called the ready program to support family medicine training. There are many initiatives beyond family medicine and other primary care specialties, emergency medicine, et cetera. There are a few fellowships for people once they're done with residency. Complex family planning and maternal fetal medicine and some fellowships in family medicine and of course physicians are not the only part of the workforce. We have many different disciplines that need to have integrated abortion training. We beyond medicine. To give you a scope -- a sense of the numbers of programs, identify I've put these two maps side by side.

They're a little different and we're in different points of time. Each dot is a residency program. On the left you see OBGYN programs and the green states at the time that these papers were published represented states that had worse or severe restrictions and you can see that there are more -- the main point of this is I want to show you that there are a lot more family medicine programs than OBGYN programs and to give you a scale, there's about 1300 OBGYN, training in the banned states and there are four thousand residents being trained in those red states.

If I then put medical schools and nursing schools on a map, it would be shocking to you how many people there are about 30,000 medical students training in states with bans. And in the back of my calculation I'm guessing there are at least 60,000 nursing students so this is a huge group of people who are at risk of not learning the core skills they need to provide care. Lee I believe already mentioned workforce concerns and just to give you a snapshot of applications by residency.

On the left this is a publication of the association of medical colleges. This is a percent difference to OBGYN compared to the previous year and on the right it's the percent difference in applications to family medicine. So you can see that overall, there was a significant drop in the medical -- the number of medical students who wanted to go into these specialties. Because of abortion bans and not being able to provide health care and you can see the many fewer, twice as many fewer applied to abortion bans. Programs in abortion ban states in both groups. This is concerning and also adds to the concerns about the number of clinicians who we worry will leave the state after training so not only are we worried about applications we're worried about people leaving and we're worried that many of these states already have significantly higher morbidity and mortality associated with pregnancy care, large disparities in care by patient race and ethnicity and so when you are forced to continue pregnancies and fewer clinician to provide them we are facing a significant health care crisis. Quickly to try to uplift you a little bit on this I wanted to tell you some of the things we're working onto improve training so one thing a lot of groups are trying to do is to develop really comprehensive standardized curricula that we can require for everyone. There's a national collaboration with innovative health and along with the organization that oversees the Ryan Program to create an online curriculum and there's a lot of work to develop simulations in areas both procedural simulations and communication simulation to prepare the workforce to be able to provide care with fewer direct patient clinical experiences. And I was excited to hear Dr. Rice's description of the Emery

online materials I also want to offer this website to you all because it's an amazing open-source resource for you to learn all about abortion care and other topics. The last training strategy I want to highlight is out of state travel so we've been actively working very hard to try to match programs in restrictive states with programs in less restrictive states for residents to travel for training. Right now, there are 17 very strong partnerships that exist. Actually 16. With a few more on the way. And you can see each arrow represents a program that is sending their residents to these different states. And I can tell you more about it if you want to hear about it but this is a very challenging process. It takes 6-9 months to establish a project but it is exciting and successful and more than one hundred residents have travelled and it's overall beginning to meet the needs and there are 59 programs in these states and we have only solved the problem for 16. Finally I mentioned moral distress right at the beginning. We're seeing impacts on learners and I wanted to close with an uplifting quote. People have talked about how hard people are working to do the right thing for patients and in our study this was a quote by a resident from South Carolina. She said, I feel like I'm willing to jump through hoops to help patients to get the help they deserve, and we've heard that from all the residents in our study and in our programs across the country. So I hope that you all -- demand that health professionals are ready to learn and to think creatively about it. I hope you'll support organizations that support training and include -- I want you to hold the workforce and training issues in your advocacy because I feel this will be a long-term effect of the bans. We will have a large group of health professionals that can't provide the care they should be able to provide. Feel free to reach out to me. I want to highlight on the top right we have the Ryan Program and innovating education, I included their web links. Medical Students for Choice is an organization I've been involved with for a long time. American medical students association are doing incredible work.
Nurses for sexual and reproductive health have incredible trainings and the three down here are medicine based programs that have incredible training materials available and reach out if you have any questions, thank you.
>> ABIGAIL: Thank you so much for an excellent presentation. And finally we will hear from Dr. Rebekah Viloria.
>> REBEKAH: So my name is Rebekah Viloria. I am an OBGYN who does 100% clinical practice I hope I will provide another perspective in discussing the future of reproductive care. It's wonderful to be here with everyone because I think this collaboration with both the public health, the social health,

the other physicians is really how we're going to move forward. So I have no -- I have one disclosure that I'm a content advisor. So to define what reproductive health and this is a definition from the WHO it is a state of complete physical, and mental and social well-being not merely the absence of disease (reading). I put this here because reproductive health is a lot. And I think in the environment that we are now, it is incredibly important to see that it's not just abortion but it is seeing the whole person as themselves. So where I am in Boston, I do have to acknowledge that I've been practicing for twenty years and in a state that has unreproducted access to abortion, contraception, gender affirming care, fertility care. It is hard for me. I realize I am so lucky and grateful and I understand how delicate of a balance it is with the other residents I have trained with who are in states that are incredibly restrictive. I also wanted to acknowledge that most of the history of obstetrics and gynecology in the U.S. really comes from the enslaved persons who had who participated without consent in a lot of the learning about how our bodies work. So, in my clinical practice, I do see reproductive health with three really major pillars and the CDC adds this additional pillar which is infant and family health where I practice. We have primary care physicians and family medicine physicians and they really are helping with infant health aspect as well but it is very much part of the reproductive health view. Okay? So reproduction and when I say reproduction we're talking about the ability to either not have a child or have a child during a reproductive years but then also I add menopause because you're going to see in my next cum slides why I do think talking about health care beyond just reproduction is going to be important we also talk about sexual health in terms of, again, if the rise in STDs and specifically syphilis, gonorrhea is really important because that affects our health and finally what I just say, wellness, this is where asking about sexual orientation is really, really important in everybody's life and talking about work and inventory and if you look at this we both get paps we do part of our training as physicians is not making assumptions about what body parts we have, what we use and choices about fertility or not getting pregnant and again part of the workforce and planning and medicine is thinking about immunizations, our mental health and our social health and that picture I put as we both get paps is a reminder that we are seeing a change in gender identity and treating patients that may not present as female but yet they have organs in which when they're used could result in pregnancy whether that's desired or not desired. And I do put this slide in here to remember that gender diverse populations are similar in that they have not

been -- that while they're a very small part of the population in most studies, in the U.S., it's about 0.5% but in my health center we see about 17% of patients who are in the LGBTQ population and also this is a population that is very much underrepresented in any type of research or statistics because we're not asking gender identity. And it's maybe missing a population but it does come under and I would say in the past 10 years probably it is incredibly relevant because patients who may not identify as female or may not be female presenting but are a -- assigned female at birth who are choosing gender affirming therapy it is important to talk about fertility. And transgender and again that is an umbrella term to say that your gender identity does not match with assigned sex at birth. That retain gonads may result in sexual activity that results in pregnancy and testosterone are not reliable forms of contraception and, again, like I said, there are besides racial and ethnic disparities this group of transgender individuals we have seen in literature just recently that, yes, there are extreme barriers to accessing reproductive health care. And so, there are two points that I want to go over that kind of shape my view as how we approach reproductive care in the future. And one of these is this population projections from 2020-2060 based on the 2020 census. And there are three points to keep in mind. 2030 is a demographic turning point. Older women will continue to outnumber older men although that gap is becoming more narrow. That the population will continue to grow but it is going to be driven by immigration influx and then that -- our population by 2030 is going to be much more racially and ethnically diverse.
>> We can see kind of the side of your screen I just wanted to let you know in case you want to go into presenter.
>> REBEKAH: Thank you so much for that. When I looked at that I thought how does that affect OBGYN you see people are able to get pregnant for a little bit longer, through assistive reproductive therapy. Our older population of women, we're going to start engaging in conversations, talking about how your body works and how to feel comfortable about it in menopause and then these last three are my own ideas is as our population changes we must look at the more racial -- include racial statistics in there about the change in population. Anyone who has children or teenagers we know that social media is part of the daily lives. I think this will be part of reproductive care and also artificial intelligence for data gathering, telehealth innovations that will improve outcomes for a lot of the diverse population. So this is the second thing I want us to think about about shaping the future of reproductive care. And this is, again, from the maternal mortality rates in the U.S. which

everyone I think has pretty much eluded to is that in 2021 we did see that maternal mortality increased dramatically, so from 2019 you went from 21 maternal deaths to 32.9. And that is staggering. And the majority of these have been through postpartum complications that could have been prevented the other really important part is that the maternal death rate among Black Americans is much higher than other racial groups. And so there's a lot that is probably driving one, the increase in maternal mortality, both age, chronic disease but also probably preexisting health disparities and access and this is where we got to be looking at what we can do in the future to help decrease this.

So where are we at now? So this is just a kind of quick slide with approximate numbers I'm sure everyone can probably be more specific. And that -- and we're looking at where we can change the reproductive outcomes, you know, or improve them. I think there are three areas so contraceptive access. Abortion, and then fertility. About two-thirds of women are using contraception right now while we do have unintended pregnancies they are decreasing about one in five will end in abortion with a majority of those abortions being from African American or Black Americans than followed by white women and Non-Hispanic the majority of abortions are not just procedural but they are medication meaning someone takes the medication and the pregnancy can pass. And then talking about the right to have a family or build a family and we will get into what recently happened in Alabama is that 2.3% of infants are born through assistive reproductive technology and right now there are at least 400,000, some people in some studies it says a million, frozen embryos in the U.S. the majority of those being formed simply for fertility preservation and male factor. So where do we go from here? I think increasing contraceptive access is a good starting point. That meaning having funding for persons who want it. Giving through social media or even in school that we have age appropriate, medically accurate comprehensive education. And at the end of this month we have the over-the-counter birth control pill and looking and advocating as providers and research. And with the emerging contraception that there's a lot of hope. And that the 15% of persons who are where it is contributing to a pregnancy. So this holds for future contraception so either in a daily pill or gel but more exciting there's a pill that a male body person would take before having sex. It inhibits that helps sperm move and makes them immobile and provides about 24 hours of contraception. There's also a lot of emerging contraception that is using immunocontraception so nonhormonal which is a big plus for a lot of persons in which there are antibodies to sperm or certain

proteins on the sperm that will render sperm immobile as well and that will be in the form of a vaginal gel and when we talk about reproductive health what does it encompass is STD prevention. There's a lot of good contraception research going on that while both contraception but also incorporating antiretrovirals as we see STDs increase and this will be a great option as well and then abortion, I do think is obvious we've been talking about it. We know about Dobbs versus Jackson and what has happened since then and we count as a national organization I think it's through this society of family planning I think the doctor knows about this. This is what I got recently was a publication that was just out or a news release in February that since April 2022, about fifteen months -- there was a drastic decrease and you see a large increase in abortion in Illinois, Florida and California and telehealth abortions so you have a remote telehealth consult and medication is mailed to you represented about 16% of abortions as well and legal induced abortion is markedly safer than childbirth is safer than outpatient dental procedures. Whether it is a procedure abortion or a medical abortion, it is still markedly safer than childbirth. And then finally just talking about what's happening in Alabama in February, basically the Alabama supreme court has defined an embryo which is literally a 6-10 cell entity as an extra uterine unborn child and that in this case, they define that the wrongful death of a minor act applies to all unborn children regardless of their location. And so subsequently all of IV used in preborn embryos have stopped in Alabama and they condemn this court decision. In that they -- the see three major things happening. Modern fertility care is unavailable for the people of Alabama. Again, what we talked about by Dr. Steinauer is young physicians will not come to Alabama for training or begin their practice which gives you a deficit of well-trained OBGYN providers in Alabama and then existing clinics will be forced to choose between providing suboptimal patient care or shutting their doors. When you see who is using assistive technology a lot of it is for fertility preservation so either egg preservation or embryo preservation. So using an egg immediately fertilizing it and then using those embryos and the majority of IVF is used by white women but remember that parent person who is have a uterus who want to single parent or in patients who are in a same sex who use a surrogate, those are also patients who are utilizing IVF. And so the future of IVF very much in the -- in a limbo state especially if Alabama's restrictive laws then go to other states. And it will limit very much who is able to family build, it will also increase the risk of building a family or increase the -- I apologize -- of fertility care in general.

And then finally, one thing that Dr. Steinauer also talked about is that the post-Dobbs providing training is going to change dramatically. And that 44% of OGBGYN residents are currently in states that have very restrictive abortion rules and that even though it looks like applicants either decreased or have decreased in states that are restricted, remember that our work force in general of all specialties in medicine is that nearly half of all residents regardless if they're in OBGYN are women right now in this world. Not only are they trying to help provide care but these women are also going to be subjected to some of these restrictive rules. So just in closing what I see as the clinical future of reproductive care is I do think there'll be friendly states that will provide the majority of abortion care, assistive reproductive technology, gender affirming care and high risk obstetrics the population changes in the next couple of years are going to result in an aging population of female bodied people which will change kind of the scope and spectrum of reproductive care. I am very hopeful that there'll be other forms of birth control available to us that will be reasonable and then finally I do think research is going to start including looking at very specific populations in the diversity and how health care can be improved, health care outcomes can be improved through social media and artificial intelligence. So I am happy to take any questions and I appreciate everyone's attention.

>> ABIGAIL: Thank you for that insightful presentation and I would like to thank all of our speakers for being with us, for giving their time and for these really excellent and information packed presentations this afternoon. So across our presentations we've heard about the future of reproductive care in the U.S. from the policy impact perspective, the life course perspective, the clinical provider perspective and the patient perspective and really our speakers have given us so much to think about and I would like to open up discussion in the 13 minutes that we have left and I would like to ask all speakers if they could to join me on camera so that we can turn now to our Q&A part of the event. Now in the interest of time, I will ask one question as the moderator to all of our panelists and then I will turn it over to the audience Q&A because I see already several very interesting questions there I would like to be able to address many of those. So let's just start off with one question. In an overarching sense for our panelists, and you know I think we've heard in the presentations that at times improving equity and reproductive health care can feel like a really big if not insurmountable challenge and so I'm wondering what, for you, is one thing we could do now in your area of policy research, training, clinical practice or expertise that

could improve reproductive health care here in the U.S. or at least set us on the right path when we look at the current policy limitations that we have in so many different states? So that's a question for everybody. And I just invite our panelists to go ahead and share any thoughts they might have on that.
>> DIANE: I don't mean taking a stab at this because I think my perspective is a health perspective and primarily clinical services and medical services. And so, my first reaction to this was we need to take care of the children that are being born by providing good care for them and responding to this idea that a child or a childhood begins with an embryo, who is taking care of those kids who would not have been born if there weren't restrictions in abortion? So that's the other part of this scenario that we have not addressed. But I see it as part of providing adequate reproductive care as well.
>> ABIGAIL: Thank you so much, absolutely. Anybody else want to chime in?
>> LEE: One thing that comes to mind is everyone can donate to abortion funds I think they're doing a lot of the work right now to make sure people have access and I know the Chicago abortion fund also provides care for folks if they're being evicted from their homes. Lots of other wraparound services. That's an easy thing that anybody can do right now.
>> ABIGAIL: Absolutely, thank you. Thank you.
>> WHITNEY: I guess my addition is about, I think there's an opportunity for folks to be aware of what their reality is in their state context. And I think that awareness has the ability to contribute to, you know, I think there are a lot of assumptions and research has shown, you know, misinformation about that policy realities and so I feel like that information is, you know, powerful and can be engaged -- folks can engage in conversation within their professional communities and other communities about what the current context is and I think it also has a role in some abortion stigma reduction as well as it relates to abortion. Of course, I think this is a broader reproductive health conversation but I think there is a tendency to, like, sort of minimize and/or leave that part out of conversation so I am glad to see just how much we've been saying abortion here today.
>> ABIGAIL: Yes, certainly. Anybody else before we move to audience Q&A? Please.
>> JODY: I will add to Dr. Rice's comment I feel everyone can hold their health professionals in their community accountable for providing the best care possible keeping patient's experiences confidential, not the law enforcement, via web access, provide postabortion care for people, and can even long

before Dobbs we knew that gynecologists, primary care providers did not actually provide to the extent that the laws allowed because of stigma. And so I feel like many places now still thank God still have exceptions even in these abortion ban states and so we really need to hold the hospitals and providers accountable for taking care of all the people who can access legal abortion in their state so we're not taking people out-of-state who have medical problems, pregnancy complications, et cetera. So that's what I would say is talk to your local clinicians, find out what's happening.
>> ABIGAIL: Great. Thank you. So many practical and actionable responses there. Thank you, everybody. I would like to turn to our audience Q&A to make sure we address some of the interesting questions. Thanks, audience members for putting these into the Q&A function. And the first question I have here is how can we appeal to our population of the U.S. who believe that abortion contraception is, for example, biblically forbidden without infringing or threatening their religious freedoms I find one of the toughest battles is finding ways to speak with these folks. Does anyone in this conversation have any thoughts, advice, suggestions for tackling this conversation as public health professionals since we are so active, usually in the sphere of public health education.
>> WHITNEY: I can try one attempt at responding to that. I think there has been a dominant of conversation at the intersection of, like, religion and reproductive justice that takes sort of that approach or kind of like it's a loud part of the conversation. But there's also a lot of religious groups, experts, organizations that really center in this conversation, you know, reproductive autonomy and reproductive freedom as part of their -- what they see as entwined within their religious values about, you know, just what people should be able to experience in terms of their, you know, well-being that they see that as tied to their faith and so there are -- I can try and drop a few organizations in the chat that I am aware of that kind of, you know, center that in their work and so I think perhaps the call to action is just not continuing to perpetuate as the loudest narrative around, you know, kind of religion and reproductive health, that is a part of it to be clear but certainly not all perspectives.
>> LEE: I can also add based on our research with religious health hospitals and health settings that I think you can also talk about a distinction between individual held beliefs and then whether those beliefs should apply to entire systems, states, communities and I know it's a tough needle to thread but I think recognizing that, you know, and honoring people's individual beliefs and whether it should govern access within

institutions and within policy is one way to talk about it.
>> JODY: I will add I have done some work in effective conversations. It's toward training clinicians to talk about abortion but some principles is to not be afraid to talk about it and to -- the one way you can change people's opinions and make people more open and compassionate is by communication. Very few people are actually on the polar ends of this discussion. Many people have conflicting feelings. And a lot of emotional feelings about abortion and if you have a journey story, to share it, especially for people who are coming to this from a faith-based lens of having concerns about abortion. People who do have a faith and have decided within their faith that abortion should be available and to share that experience, especially if someone has grappled with it. Sharing your own journey is really helpful because people can really relate to you. It messes with their mental template a little bit of oh, this person is of this faith identity and went through this and shared some of the concerns that I have and has come to a different conclusion than I have. So I encourage people to talk about it.
>> ABIGAIL: Thank you, thank you, all, so much. I was just going to move to the next but if there's another comment I can wait. No? Okay. So the next question I wanted to put to the panel, what strategies could the community help establish in our communities that are experiencing maternal deserts so where we look across the U.S. and maternal deserts and the idea of that has been mentioned, are there strategies that the community could help establish locally to help combat some of that?
>> REBEKAH: Do you mean provider deficit for maternal care? This is probably my own thing. I do think a lot of telehealth has been available in medicine where there may be low resources but there is kind of a hub where someone is available 24/7 to say, all right, I'm seeing this strip, like it's basically telehealth labor and delivery. While in the middle of, like, a rural Massachusetts, you know, there's someone in Boston who is covering multiple labor and deliveries in these rural places that can have access to the monitoring know what is the resources are and that is your backup to say, it's time to transfer this person to tertiary care and I do have -- I know of several things that are being set up. You can think of it in terms of there are ICU providers that sit again in a hub and they monitor ICUs in rural parts of the U.S. that don't have resources and they say it's time to transfer or you don't have enough blood products or anything like that and I do think this intercommunication of telehealth is able to at least help a low resource place transfer to higher resource to prevent maternal deaths and infant deaths.

>> WHITNEY: One other quick note, our team has been engaged in and I have seen research around community rooted providers. The potential to support a broader range of providers in this climate. Whether they be doulas, whether they be community midwives, there's just a history of their ability to, you know, reach communities in a really community rooted and reverent way so I will just add that as a supplement to the telehealth options.
>> ABIGAIL: Thank you to all our panelists. We are at time. And thank you for the panelists for giving their team and to Dean Cozier for hosting this wonderful event today I'm so glad to have been a part of it and I will now pass it back to Dean Cozier to conclude the event.
>> YVETTE: I want to thank all our panelists for the rich conversation and to thank the audience for engaging in today's program. I wish everyone a good afternoon. Thank you.