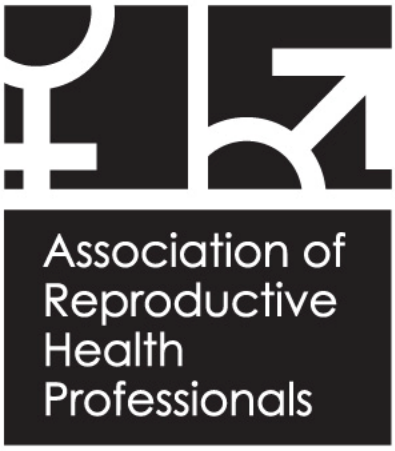
Association of Reproductive Health Professionals (ARHP)

Sexual Health Fundamentals for Patient Care Initiative
Report of a US Consensus Process

March 2010



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ABSTRACT SUMMARY

Title
Sexual Health Fundamentals for Patient Care: A report on 2010 consensus outcomes and guidance for women's health professionals

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Key Words
sexual health, sexual dysfunction, female sexual health, sexual medicine, consensus process, guidance, open access

Introduction
There is a significant practice gap in the delivery of high quality female sexual healthcare among primary care, frontline clinical professionals. A multi-disciplinary consensus panel of 16 sexuality specialists, from United States and Europe, developed evidence-based tools and recommendations to help healthcare providers improve patient care on female sexual dysfunction, health, and wellness.

Aims/Goals
1. To supplement expert guidelines with recommendations specifically designed to fill a practice gap for frontline women's healthcare providers on sexual function, health, and wellness.
2. To develop open-access assessment and practice tools for professional societies and advocacy groups.

Methods
An interdisciplinary consensus panel of 16 experts in female sexual health from diverse backgrounds and training was convened by the Association of Reproductive Health Professionals, who met for a series of professionally-facilitated consensus meetings in late 2009 and guided outcomes and recommendations through January 2010. A modified Delphi method was used in combination with nominal group technique to develop consensus definitions and recommendations. As part of the program needs assessment process, the Steering Committee guided a retrospective review of relevant behavioral and clinical research. A comprehensive review of the published literature was conducted, including a PubMed search for English-language studies with acceptably rigorous study design and standards. The resulting 77 articles were made available to the expert panel for their review and analysis prior to the consensus meeting series. To gather additional data about practice gaps, the committee also guided develop and analysis of a web-based attitude and perception survey of 1,209 women aged 18-50 regarding their experiences with healthcare providers, and developed content for informal interviews with professional groups and individual experts.

Results

After a retrospective literature review and two professionally-facilitated sessions over two and one-half days, the consensus panelists concluded that frontline healthcare providers require an increase in their medical knowledge, understanding of relevant psychosocial issues, and clinical skills on female sexual health to ensure highest-quality patient care. They concurred that there was a strong need for expert guidance for general practitioners who provide women's healthcare. Panelists agreed that clinicians from all disciplines and specialties can effectively and efficiently screen, diagnose, and initiate treatment on many common forms of female sexual dysfunction. Consensus was reached on nine key assumptions regarding female sexual healthcare in general practice environments and panelists identified an inventory of specific competencies required for expert care. In January 2010, the steering committee finalized a series of open access tools based on consensus recommendations, including a series of three provider fact sheets, a White Paper summary of the proceedings, and recommended algorithms and screening tools for frontline providers. Panelists will report these consensus findings in various ways to healthcare professionals in 2010. ARHP plans to reconvene the consensus group in mid-2010 to conduct further analysis and make additional recommendations; develop additional educational tools in partnership with medical societies and professional organizations; establish a shared information clearinghouse; conduct community meetings of providers, educators, and advocates on the topic of female sexual health; and work with organizations and academic institutions to raise awareness about outcomes from the *Initiative*.

Conclusion

Consensus experts agree that healthcare professionals need evidence-based guidance to effectively address sexual health with their female patients. Collaboratively developed expert guidance designed for the women's healthcare team can improve the quality of patient care. Freely accessible, evidence-based guidance can fill key women's healthcare practice gaps for primary care clinicians.

Support

Funding for this initiative was made possible by a consortium of grants from Boehringer Ingelheim, Pfizer, and Wyeth.

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COMPREHENSIVE REPORT

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Executive Summary

The Association of Reproductive Health Professionals (ARHP) recently hosted a series of consensus meetings of clinical and behavioral science experts in sexuality, focused on developing guidance for health care providers on improving patient care for female sexual dysfunction, sexual health, and wellness. The meetings specifically addressed decreased sexual desire in women and disorders that contribute to it, such as vaginal atrophy, dyspareunia, and other conditions. The explicit aims of this consensus process were: (1) To supplement expert guidelines with recommendations specifically designed to fill a practice gap for frontline women's healthcare providers on sexual function, health, and wellness. (2) To develop open-access assessment and practice tools for professional societies and advocacy groups.

Key Meeting Points

- Many women suffer from female sexual dysfunction; most want to discuss the issue with their health care provider.
- Frontline health care providers—clinicians, counselors, and patient advocates from all disciplines and specialties who care for women every day in their clinics across the country—can effectively and efficiently screen, diagnose, and initiate treatment on some of the most common forms of female sexual dysfunction.
- Sexual health care experts are available in most geographic locations for consultation or referral for complex cases or initial evaluation.
- To effectively help women with sexual health concerns, frontline providers must be familiar with sexual anatomy and physiology, common forms of sexual dysfunction, normative phases of the sexual response, normal changes associated with aging, and the effects of medical conditions and medications on sexual health.
- Effective and efficient communication and counseling skills are essential to the provision of sexual health care.
- Because sexuality is context-dependent, health care providers must be aware of the patient/client's lifestyle, cultural and relationship situation, and sexual history to diagnose and treat a sexual dysfunction or concern effectively.
- Practical tools are lacking and much needed to aid frontline providers in addressing female sexual health, concerns, and dysfunction.

Introduction

Female sexual concerns and dysfunction are commonplace and affect the lives of many women worldwide. Yet many women suffer in silence, reluctant to broach the subject with their health care providers. Unfortunately, providers often fail to ask about sexual health concerns. One reason for this communication gap is a lack of adequate formal medical sexual training for health care providers in the assessment and management of female sexuality and sexual dysfunction. There has also been an historic paucity of effective medication options for treating female sexual

dysfunction. Existing and potential future technologies may increase the interest of both patients and health care providers in addressing female concerns and sexual dysfunction. In general, frontline health care providers need to gain greater competency addressing sexual health concerns to help improve their patients' quality of life. (For a list of other barriers to ideal care in female sexual health, see pages 14-15.)

Aims

To address this need for improved competency, ARHP hosted a series of consensus meetings of clinical and behavioral science experts in sexuality. The explicit aims of this consensus process were:
(1) To supplement expert guidelines with recommendations specifically designed to fill a practice gap for frontline women's healthcare providers on sexual function, health, and wellness; and
(2) To develop open-access assessment and practice tools for professional societies and advocacy groups.

Methods

ARHP designed and initiated an expert consensus process to address the relative absence of professional guidance related to women's sexual health care. The meeting series included a two-day assembly on August 29 and 30, 2009, followed by a one-day meeting on October 24, 2009. Both meetings were held in Washington, DC, in ARHP's Felicia Stewart Center. High-level experts with a variety of backgrounds in sexual health served as consensus process advisors and faculty (see Appendix 1).

This White Paper describing the *Sexual Health Fundamentals for Patient Care* program is a general summary of the expert consensus process, and will be used to inform the development of specific provider and patient education tools, including fact sheets, clinician guides, a web-based information center, and other outcomes and products. The *White Paper* and educational tools will be shared with professional organizations with constituents who can benefit. ARHP will promote and disseminate consensus process outcomes in early 2010 and throughout the year.

These consensus meetings build off of ARHP's long and successful history of convening experts who represent different stakeholders and areas of specialty for a targeted, fruitful dialogue that helps create forward momentum on key reproductive health issues. ARHP is a nonprofit professional education organization with 12,000 health care professional members, including physicians, advanced practice clinicians, nurses, pharmacists, researchers, educators, and counselors from many specialties. Since 1963, ARHP has served as an independent resource for trusted, evidence-based medical education and information on reproductive health topics, and has a history of convening experts from a range of disciplines and specialties to develop consensus on challenging issues that affect clinical practice. ARHP staff members and specially-appointed project leaders are responsible for all program content and direction. ARHP is accredited to provide continuing education credits to physicians and to pharmacists, and provides continuing education credits for nurses and other reproductive health professionals for ARHP-developed programs (please see Appendix 4 for more information).

This program was made possible by grants from a consortium of funders, including Boehringer Ingelheim, Pfizer, and Wyeth Pharmaceuticals. ARHP and the *Sexual Health Fundamentals for Patient Care* expert advisors are responsible for all program content and processes. The grantors did not participate in or influence any content associated with this project.

Development of the meeting series

To commence the process, ARHP leaders appointed a steering committee of leading experts in sexual health and women's health to plan and lead the consensus process. The steering committee provided key clinical guidance throughout the planning and execution of the meetings and served as key advisors and decision-makers throughout. ARHP staff also identified two professional facilitators to guide the process. As part of an extensive facilitator interview process, Glenn Tecker and Leigh Wintz, CAE, of Tecker Consultants LLC, were selected based their previous experience facilitating for national health care groups, including the American Medical Association, the American Hospital Association, the Association of Women's Health, Obstetric and Neonatal Nurses, among many others. The steering committee worked with the two professional facilitators prior to the meeting to finalize an agenda, set goals, and identify the most effective format for the meetings.

Prior to the first meeting, ARHP staff, working in partnership with staff from the National Women's Health Resource Center (now HealthyWomen), commissioned Harris Interactive to conduct a literature search on topics related to sexual health (see Appendix 2). This literature search informed current practice gaps related to sexual health and patient care and informed the agenda development.

The format of the first meeting was a series of small group discussions interspersed with whole group debriefings. Throughout the discussion, panelists were asked to consider the topic from the perspective of frontline health care providers, who are not experts in sexual medicine. The steering committee used a number of working assumptions for the meeting series (please see Appendix 3). The committee plans to use this collection of information to craft a variety of publications in the future on sexual health for patients/clients and health care providers. During the second meeting, the panelists reviewed the first draft of the summary document, created a prioritized list of items that frontline providers should know about sexual health, and drafted a list of "top-ten take-home points."

This summary document, which reflects the experts' discussions over the course of the two-meeting series, is divided into topic areas for convenience.

Discussion Topic Areas

- Clinical relevance and importance of female sexual health to patient care
- Needs, wants, and expectations of patients regarding female sexual health
- Common myths about female sexual health
- Medical knowledge, understanding of relevant psychosocial issues, and clinical skills required for clinicians to provide ideal female sexual health care
- Tools to help clinicians provide ideal female sexual health care
- Barriers to providing ideal female sexual health care
- Resources needed for providers
- Potential impacts of new technologies
- Creation of provider tools

Results

Topic 1: Clinical relevance and importance of female sexual health to patient care

Anticipating the hesitance of some health care providers to address sexual health, meeting panelists delineated the underlying reasons why female sexual health should be an important topic for frontline clinicians. The expert advisory panel identified several reasons why the topic is significant, including:

- Sexual health is an important quality-of-life issue;
- Sexual dysfunction has a profound effect on intimate relationships. An adage states that "bad sex" has a much greater impact on ruining a relationship (up to 70%) than "good sex" has on improving it (15%); [McCarthy 1997]
- Health care providers have a professional responsibility to address all health concerns (experts suggested that addressing sexual health should be similar to addressing smoking cessation or the need for immunization—health topics that the provider proactively addresses during routine health visits);
- Sexual health affects overall health and wellness;
- There is an important relationship between sexual dysfunction and co-morbid health conditions and inquiry about sexual health can serve as a portal for identifying underlying health problems, such as undiagnosed depression, cardiovascular disease and diabetes;
- Data have demonstrated that good relationships are associated with lower stress levels and better health outcomes;
- If sexual health concerns are not addressed, they may lead to other somatic concerns; and
- Increasing public interest in existing and any new potential technologies related to sexual health

Topic 2: Needs, wants, and expectations of patients regarding female sexual health

Based on the first line of inquiry ("What are the needs, wants, and expectations of our patients/clients related to female sexual function?"), group members discussed in small groups what patients/clients need, want, and expect in this area. The discussions included conversations about whether these needs, wants, and expectations were strictly from the perspective of the patient/client or from the perspective of the health care provider. For example, they wondered whether the needs to be considered are ones that the patient/client would identify or ones an informed clinician would identify. Group members discussed this dichotomy in both the small groups and the large group debriefing, and included both perspectives in their final lists. Recognizing the significant overlap between wants, needs, and expectations, the expert panelists generated lists of the three categories.

Patient Needs:

- To be educated about female sexual health, including:
    - Basic genital and pelvic anatomy, physiology, and pathophysiology;
    - Sexuality and biological functioning;
    - The effects of relationships on sexual wellness;
    - Normative changes associated with aging and how to respond to changes;

  - How chronic medical diseases (e.g., chronic heart disease) and other conditions affect sexuality;
  - How treatment of male sexual dysfunction can affect the female partner's sexual experience and the relationship.
- To know how to broach the topic with her health care provider;
- To have access to care from providers who are competent and well-educated about sexuality and sexual function and who will provide initial management or refer for detailed specialty care;
- To have access to referral services either in person or resource materials that can begin the treatment process;
- To engage in open communication with health care provider that is free from verbal or nonverbal judgments;
- To have all populations feel accepted and to create an environment accepting of all types of sexual expression (lesbian, bisexual, transgendered, etc)
- To receive care from health care providers who can recognize intimate partner abuse and are sensitive about verbal, sexual, emotional, physical abuse, whether present or past;
- To have the opportunity to choose whether their partner is present during evaluation;
- To have providers throughout the health care system who are aware of sexual health issues;
- To have health care providers view their sexual health concern in social context (self, family, partner) rather than in isolation; and
- To have providers help them see their role in self care (panelists suggested that providers could ask, "What types of things have you done to and for yourself to address this issue?" and recommend self-care steps to take (e.g., read patient education materials, research on Internet).

Patient Wants:

- To have effective and safe treatment options for male and female sexual dysfunction with low and tolerable side effect profiles;
- To engage with providers who are educated about sexual function and culturally sensitive about the potential effects of age, gender, orientation, disability, lifestyle, and religion on female sexual health;
- To have providers validate and legitimize the importance of their sexual health concerns;
- To have health care providers routinely initiate discussions about sexual health and lead management of identified issues, rather than assuming that the patient/client will ask if there is a problem (e.g., without direct yet sensitive inquiry, patients may not reveal (or even be aware themselves) that their arousal problem is a root cause of their relationship difficulties);
- To receive care from a single, consistent provider if possible (i.e., to avoid repeating their sexual history multiple times);
- To have adequate time with a provider and the opportunity to have an open conversation about sexual health;
- To have sexual dysfunction addressed to preserve a relationship and keep the family together (i.e., they may seek help to please a partner); and
- If patients choose to initiate a conversation with their provider about sexual health, to access help for prioritizing concerns before the visit so they can make the most efficient use of the visit. (Panelists suggested that providers might ask, "What is the one thing you want me to address for you today? We can address the other things on your list in a follow-up visit," and might

explain that a simple sexual health question can be answered with a simple answer but that more complicated problems may need more than one visit.)

Patient Expectations:

- To receive effective, safe treatment for sexual dysfunction that is a permanent fix (may be an unrealistic expectation);
- "One-stop shopping" for sexual health care as part of routine care (may be an unrealistic expectation);
- Reimbursement of care for sexual dysfunction by health insurance coverage, including counseling/therapy;
- Confidentiality and security of medical records (which holds implications for use of electronic medical records);
- That the solution to their sexual health issue will be biological and not interpersonal (may be an unrealistic expectation); and
- That treatment will restore their sexual functioning to a level that existed when they were much younger (an unrealistic expectation).

<u>Topic 3: Common myths about female sexual health</u>

Through small group work and large group discussions, panelists identified a number of myths that hinder ideal care for female sexual dysfunction. Myths held by health care providers (and possibly patients) include:

- *Pandora's Box:* There is a myth that asking about sexual health is akin to opening Pandora's Box. Several experts pointed out that while there *may* be a slight increase in the time needed to ask questions, often the problem is simple (e.g., drug side effect or vaginal dryness) and a few questions may lead to diagnosis and treatment. If the provider discovers that the problem is complex, he or she can refer the patient for specialty care;
- *Patient reluctance:* There is a myth that patients don't want health care providers to inquire about sexual health. The experts noted that most patients do want providers to ask about sexual health. Panelists also pointed out that in some instances, patients who finally find a health care provider who does ask them about their sexual health are often angry that no one asked them sooner. In addition, patients who find they can't discuss the topic with their provider may switch providers;
- *"Not my job":* A myth exists that sexual health is not an area for primary care providers to address. Panelists hypothesized that this myth reflects a larger problem—that of placing sex and sexual health in a different, unique, or untouchable category than other health problems, such that patients/clients feel the topic is not one they can or should talk about (e.g., urogenital atrophy often goes untreated because it is considered a "sexual" issue);
- *Ageism:* There can be a myth among patients and providers that people no longer engage in sex after a certain age (e.g., a patient who states, "I haven't had an orgasm in 7 years, but I'm 42 and so that's to be expected"); and
- *No treatments available:* The myth that there are no effective treatments available for female sexual dysfunction is pervasive. Panelists pointed out that a number of disorders, such as vaginal atrophy, can be effectively treated. There is an FDA-approved product, conjugated equine estrogen cream, which is available for the treatment of moderate to severe vulvovaginal atrophy, yet many providers are unaware of this new indication. In addition, some individuals (especially patients/clients, but providers as well) may be unnecessarily concerned about using local estrogen for treatment of vaginal atrophy because of the concern about potential systemic effects.

Topic 4: Medical knowledge, understanding of relevant psychosocial issues, and clinical skills required for clinicians to provide ideal female sexual health care

Medical knowledge

Throughout the course of the one-and-a-half day meeting, the experts identified a number of specific pieces of medical knowledge that clinicians must understand to provide ideal female sexual health care. These included both specific facts and broader conceptual ideas about female sexual health.

- Specific facts:
    - DSM IV diagnostic criteria (including the understanding that distress and marked interpersonal conflict are among the criteria for sexual dysfunction);
    - Basic female genital/pelvic anatomy and neurophysiology as they relate to sexual function (e.g., anatomy of clitoris, time to orgasm, etc.) across the life/reproductive cycle;
    - Basics of hormonal regulation including the role of estrogen and testosterone in the female sexual response cycle;
    - The models of the female sexual response;
    - Basic understanding of female sexual complaints, disorders, and dysfunction and the four broad categories of dysfunction (i.e., desire, arousal, orgasm, and pain);
    - Epidemiology of female sexual dysfunction;
    - The most common problems in each phase of life; and
    - Male sexual disorders.

- Broad concepts:
    - A great deal of heterogeneity exists in sexual response and satisfaction, and no one model explains all aspects of the response for all patients;
    - Orgasmic response is variable and as many as 60 percent of women do not reach orgasm through intercourse alone [Komisaruk BR 2006];
    - Intimacy or sexual behavior does not necessarily equate to vaginal intercourse, and vice versa;
    - Desire and arousal may not be synonymous; and
    - It is a myth that women's sexuality is finite and related to age or a specific condition (e.g., after childbearing, after menopause, or during the later years of life, after a medical illness diagnosis).

Understanding of relevant psychosocial issues

The experts identified a number of psychosocial topics that they believed to be essential for providers to understand in order to provide ideal female sexual health care. These include the following:

- Sexual function does not exist in a vacuum—it is influenced by the relationship, fatigue, stress, and other sociocultural factors in a woman's life;
- The health and stability/status of the women's relationship will affect her sense of sexuality and desire;
- Providers should not assume that all patients are heterosexual or that all engage in monogamy;

- There is an important difference between drive (primarily the biological components) and motivation (primarily the intrapsychic and interpersonal components) [Levine SB 2002];
- Providers often have inherent personal biases about sexuality or sexual health which are unrecognized. Panelists noted that providers should gain an understanding of their own viewpoints, assumptions, and biases about sexuality and how these may affect patient care;
- Sexual abuse (current or past) can play a very influential role in sexual dysfunction and its treatment; providers often neglect to consider or ask about history of sexual abuse in routine health care examinations;
- Cross-cultural issues can influence sexual health; sexuality is expressed differently in different cultures; and
- Differences in sexual orientation, ethnicity, or culture can affect the conversation about sexual health and whether a patient will introduce the topic at all.
- The patient/client may be trying to please her partner by seeking help for the sexual complaint or trying to please her health care provider by avoiding discussion of a potentially uncomfortable topic;
- Sexual dysfunction does not exist in a vacuum (i.e., relationship, lifestyle, financial and other factors profoundly affect sexual health) and understanding the patient/client's relationship status and the context within which the sexual complaint occurs are crucial to understanding the situation and making an accurate diagnosis; and
- A partner's sexual dysfunction will affect the patient/client's sexuality (i.e., male sexuality indirectly and directly affects female sexuality).

Clinical skills

Meeting attendees agreed that there are several skills that clinicians need to master to be able to provide ideal sexual health care. These skills fall into four categories: communication skills, diagnostic skills, clinical management skills, and practice-related skills. The expert group agreed that the PLISSIT model might be a helpful tool for health care providers to use when discussing sexual health or concerns with patients/clients (PLISSIT: Permission; Limited information; Suggestion; Therapy [Annon 1976]). Meeting attendees opined that when fully understood and properly applied, the model is an excellent foundation for providers to use when working with women around sexual concerns.

Communication skills

Panelists felt strongly that effective communication is essential for effective care of sexual health concerns. They believe that health care providers should be able to:

- Initiate a frank concise conversation about sexual health;
- Complete a detailed or directed sexual health history depending on time and complaint;
- Bring closure to a current appointment and segue to a subsequent appointment for further discussion without sending the wrong message to patient, such as being disinterested, insensitive or unconcerned;
- Use empathetic communication skills (i.e., PEARLS—empathetic education skills, partnership, empathy, apology, respect/reflect/ reinforce, legitimize, support);

- Recommend and refer a patient/client, either alone or with her partner, to a competent sexual health specialist without alienating her (i.e., be able to stop a discussion about a complex issue by saying, "It sounds like you have a lot to talk about" and refer to an appropriate expert);
- Use effective communication skills, including alternating between open- and closed-ended questions and using appropriate pauses, silence, and body language;
- Create and maintain an appropriate health care environment, including exam rooms, for questioning and examination (e.g., private space, door closed, provider sitting down and looking at patient, patient properly clothed, questions never asked during physical exam, intake forms with appropriate language that supports sexual diversity).

In addition, the experts felt that health care providers should appreciate the importance of sensitive use of terminology. Providers should understand the difference between the terms "common" and "normal," and appreciate that it is preferable to tell patients/clients that a concern or disorder is common, rather than to say it is normal, which may be interpreted as being dismissive. Providers also should appreciate that sexual health is not a "relative good"; for example, it is not appropriate to tell a cancer survivor seeking treatment for sexual dysfunction that they should just be appreciative of surviving cancer and "not to worry" about their sexual health.

Diagnostic skills

Meeting attendees identified several specific diagnostics skills that health care providers need to deliver sensitive, effective care for women with sexual health concerns. These skills include being able to:

- Perform age-appropriate screening via a sexual history;
- Conduct a contextual assessment;
- Use validated screeners or algorithms where available;
- Correctly diagnose each type of sexual dysfunction, recognizing that they often overlap;
- Diagnose challenges to basic sexual function through an initial evaluation and by asking probing questions. Examples include:
    - Does this problem present in every situation or only in certain situations?
    - Have you always had this issue or is it newly acquired?
- Identify multi-factorial contributing or precipitating factors (e.g., depression, urogenital atrophy, medications, bladder dysfunction, menopause) that affect sexual function;
- Appreciate that decreased sexual interest is a symptom rather than a diagnosis and that the underlying cause (e.g., medication side effect, hormonal issue, relationship issue) needs to be investigated;
- Know when a physical exam is necessary for diagnosis and management;
- Perform a respectful physical exam that is: as painless as possible; in a private environment with a comfortable temperature; free from interruptions; and includes a chaperone or patient advocate, as requested.

Clinical management skills

Meeting attendees felt that health care providers should be able to differentiate between the sexual disorders or concerns that they are competent to diagnose and treat and those which they need to refer for expert management. This is an especially sensitive issue because of the paucity of FDA-approved treatments for female sexual dysfunction and the resultant reliance on use of drugs approved for other indications. Meeting attendees proposed that vulvovaginal atrophy and SSRI-induced sexual dysfunction are common sexual complaints which frontline providers should be able to diagnose and treat.

There are also more complex disorders that should likely be referred to a specialist, such as sexual identity disorder, sexual aversion, fetishes, and treatment of sexual abusers. Between these two extremes are disorders for which frontline providers should be able to make an initial differential diagnosis and then refer the patient to an appropriate expert (examples of more complex treatments that should be referred include bioidentical hormone therapy, treatment with off label androgens, etc.). Expert panelists felt that the decision about which specific disorders an individual provider decides to manage should depend on the degree of training and the interest level of the practitioner. They emphasized that management should be guided by evidence-based medicine with the goal of avoiding misinformation, the perpetuation of myths, and heightened anxiety in patients. Each health care provider should recognize his or her limits and set their own personal and professional guidelines to which he or she ascribes too. Providers should refer patients out of their clinics if they feel ill-equipped or uninterested in treating disorders of a sexual nature. They should not deny the existence of sexual complaints but should recognize patient concerns and refer as needed.

Practice-related skills

The group identified a few required skills that relate specifically to a provider's practice management. These include being able to:

- Identify sources for additional information when needed (e.g., Internet sites, organizations, textbooks, other health care providers);
- Create an effective means (i.e., triage patterns for both psycho-behavioral and medical management) for referring patients/clients to sexual health experts;
- Incorporate the management of female sexual dysfunction into routine practice (e.g., dealing with time allotment and billing); and
- Code for reimbursement for diagnosis and treatment of sexual dysfunction.

Topic 5: Tools that help clinicians provide ideal female sexual health care

Panelists identified a number of tools that would help frontline clinicians provide ideal care to women with sexual health concerns. These included diagnostic and treatment algorithms, sexual history-taking instruments, and quick reference tools. There was consensus that, due to the rigorous process necessary to develop algorithms that are specific enough to capture the expertise of the many disciplines involved in sexual health, customized algorithms are best developed by organizations representing specific types of care providers. Steering committee members agreed to work with

staff and consultants subsequent to the meeting to prioritize important existing screening tools and algorithms for use in guiding customized tools for specialized professional constituencies.

The experts identified several potential topic areas for quick reference tools or "Top Ten Lists" over the course of the meeting. Attendees felt strongly that providers would benefit from tools of this kind, which could include:

- Sexual health fundamentals (i.e., "the top 10 things you should know about sexuality");
- Ten questions to assess sexual health and conduct a sexual history-taking (including useful screening tools and algorithms—for more information, see Kingsberg 2006);
- Ten key points for intervention;
- Ten key points for diagnosis of female sexual dysfunction (for more information, see Kingsberg 2009);
- A framework of questions that the health care provider could adapt for his or her own communication style (for more information, see Kingsberg 2006).

In addition, panelists felt that an information clearinghouse would be extremely helpful. They identified several types of information that should be available in the clearinghouse, including:

- Information on sources of education and training for management of female sexual dysfunction. (The group noted several resources that should be included on this list: ISSWSH, which runs a course on treating female sexual dysfunction; NAMS, which has a treatment certification program; and www.femalesexualfunctiononeline.org, which offers online programs and tools, including a slide set on validated tools);
- List of appropriate algorithms;
- Fact sheets on topics related to female sexual dysfunction;
- A basic primer on sexual health covering epidemiology, labs results and interpretation, taking a sexual history, and issues related to confidential charting, treatment, and coding;
- A referral network tool that would provide information on where to locate sexual health experts;
- A DVD, downloadable video, or smart phone application describing how to conduct a sexual health interview;
- Concise cultural competency materials: perhaps a one-page document covering sexual health in the US, related to verbal and nonverbal language and troubleshooting (e.g., understanding that in Asian communities, it is not unusual for women to keep their eyes down when speaking to others); and
- Interactive computer-based tools for building communication skills.

Several attendees noted that there are ample resources on sexual health available but they are scattered, and that it would be very beneficial to health care providers if these materials were organized. They felt that resources should be screened and meet a minimum standard of quality to be included as a resource. ARHP Medical Director Beth Jordan noted that ARHP is interested in serving as a clearinghouse for these resources.

Topic 6: Barriers to providing ideal female sexual health care

Panelists listed the various barriers that thwart ideal care in female sexual health. The barriers they identified fall into three broad categories: provider-related, patient-related, and society-related.

Provider-related barriers

- Lack of knowledge about sexual health, function, and dysfunction;
- Inadequate training in history-taking;
- Inadequate training in diagnosis and management of female sexual dysfunction;
- Lack of competence and confidence in addressing sexual health concerns;
- Lack of communication skills;
- Lack of management guidelines;
- Reluctance to address female sexual dysfunction;
- Perception that female sexual health is strictly a biological issue (or conversely, perception that it is strictly a psychological or relationship issue);
- Perception that sexual health is not a medical priority;
- Reluctance to ask about female sexual dysfunction for fear of opening "Pandora's Box" or due to lack of time or skills;
- Lack of reimbursement (or knowledge of how to code for reimbursement);
- Perception that treatment options are limited;
- Perception that addressing sexual health is not "part of their job";
- Lack of infrastructure in office setting for ideal provision of sexual health treatment;
- Lack of referral resources or network; and
- Lack of understanding about which cases to refer.

Patient-related barriers

- Lack of awareness;
- Use of colloquial or non-clinical language to describe symptoms that are not readily understood or appropriately interpreted by providers;
- Assumption that if the health care provider doesn't ask about sexual health, it is not an important or valid issue to bring up;
- Discomfort talking about sexuality or lack of education and ease using terminology when talking about sexuality;
- Perception that treatment options are limited or nonexistent.

Society-related barriers

- Lack of reimbursement for treatment of sexual health concerns;
- Cultural barriers;
- Tension between provision of sexual health care as part of primary care or as a separate practice (panelists stated that most primary care providers who become sexual health experts cease practicing primary care or practice it separately from their sexual health practice); and
- Perception that seeking care for sexuality related issues means that a person is inferior; "strange" in terms of their sexual preferences or practices, or that something is "wrong" with them (e.g. a patient might be embarrassed for someone to know they go to such a clinic.)

The discussion of barriers sparked many conversations amongst the experts. For example, the group discussed the dichotomy of sexual complaints versus sexual wellness: that the difference between a patient/client who comes forward with a sexual health complaint and one who doesn't may be due to misinformation or a lack of understanding that the current situation could improve. The panelists proposed that it is important to keep the door open for future communication as "they may not be ready now, but might be later."

The experts emphasized the importance of health care providers talking with patients of all ages about sexual health, rather than assuming that once women reach a certain age they no longer needed sexual concerns to be addressed. Panelists proposed that providers incorporate questions about sexual health into their routine review-of-systems questioning.

The experts underscored the need to legitimize female sexual concerns that are biologically based. "We don't want to medicalize it, but we need to legitimize it. A lot of these women have urogenital symptoms, such as vaginal dryness, and that is uncomfortable." The experts proposed that educating providers to take effective sexual histories would help counter the tendency to "overmedicalize" female sexual dysfunction.

The group also discussed whether health care providers should have a chaperone present when evaluating a woman for female sexual dysfunction. Some asked whether it was necessary to have a chaperone present. ACOG guidelines state that "The request by either a patient or a physician to have a chaperone present during a physical examination should be accommodated regardless of the physician's sex."

Meeting facilitators led the group in an exercise that served as a first step in identifying potential solutions to the barriers that prevent widespread provision of sexual health screening by frontline providers. The exercise involved re-framing each barrier as a question, with the goal of fostering creative thinking about potential solutions. For example, the barrier "difficulty coding for sexual health visits" translated to "How do we partner with health care providers and teach them how to code for reimbursement?" Framing the barrier as a question helped panelists begin to consider action steps to address this barrier.

Topic 7: Resources needed for providers

Panelists identified several types of resources needed for frontline providers to have the competencies necessary to provide ideal sexual health care: in-person training opportunities, written materials, and web-based programs.

Written materials

- Treatment guidelines for diagnosing and managing female sexual dysfunction (incorporating useful sexual history-taking instruments and screening tools);
- Bibliography of relevant journal articles and books (one expert suggested surveying ARHP members for recommendations on books for patients, resources, and organizations);
- Compilation of web-based resources;
- Point of care resources (i.e., quick/convenient question-based algorithm; UpToDate.com/Epocrates.com; screening tools; Quick Reference Guide with algorithm);

- Process management/coding guides;
- Counseling tools;
- Brief validated screening tools for female sexual dysfunction (a panelist proposed that these might be obtained from Baylor's femalesexualdysfunctiononline.org slide set on validated tools);
- Patient education handouts printed in different languages;
- List of discreet, good resources for erotica; and
- How-to guide for integrating sexual health care into existing practice.

In-person training opportunities

- Training programs in medical school courses/residency programs, as well as programs to train family practice physicians, nurse practitioners, physical therapists, pharmacists, and social workers;
- One-time program with mock interviews with patients that includes questioning about female sexual dysfunction, evaluating specific complaints, such as low libido, and using hands-on clinical skills;
- Simulation sessions with critique (i.e., objective structured clinical examination [like the OSCE] or standardized patient programs);
- Ongoing "hands-on" programs, which include simulation sessions with feedback, opportunities to practice interview skills, and follow-up assessment in six months to evaluate whether practice and clinical outcomes have changed;
- Workshops based on slide presentations;
- Topics presented at conferences (one expert pointed out that health care providers are more likely to go to a comprehensive meeting than a meeting that focuses on sexual health alone);
- Certification programs (i.e., sexual health "designation" or "certification," with involvement from ISSWSH, AASECT, or others);
- Preceptorships;
- Mentoring programs (one expert noted that the American Association of Communication in Healthcare [AACH] has a model for no-cost mentoring that might be applicable); and
- A course on the business of sexual medicine (one expert described a half-day course that he developed on how to bring sexual medicine into practice, including advertising, marketing, coding and billing, networking in the community, how to find patients, place, program, personnel, and how to sell retail products if interested).

Web-based resources

- Web-based education and resource clearinghouse, perhaps sponsored by ARHP and similar to the Sex and a Healthier You program (experts discussed the issue of off-label information on such a website and one pointed out that discussion of off-label information is common in oncology; for example, the website of the National Comprehensive Cancer Network provides off-label instructions and expert opinion);
- Website (written with primary care provider-level language) to include algorithms with level of evidence cited (I, II, III);
- Referral database of sexual medicine experts;
- Webinar with a call-in team meeting (similar to the multidisciplinary tumor board meetings in oncology);
- Blog;

- List serve (one expert noted that a list serve could be problematic because information could be modified by anyone, thus the tool would need set criteria for inclusion/exclusion);
- Web-based demonstrations of exemplary patient counseling skills;
- Computer-based interactive programs; and
- Virtual standardized patient labs.

Sources for information and potential partnership

Group members brainstormed on potential sources for obtaining the resources needed for ideal sexual health care. Their list included advocacy and professional groups that could provide partnership opportunities, private organizations that could provide funding, and organizations and journals that could distribute educational resources.

Advocacy and professional groups

- Medical accreditation groups;
- Governmental agencies;
- Political groups;
- Hospitals and other institutions;
- Centers of Excellence in Women's Health;
- Sinclair Institute (an organization that creates educational videos);
- Panel of sexual health experts (to be convened);
- Foundations;
- Patient advocacy groups;
- Medical professional groups, including:
- AAFP (American Academy of Family Physicians)
- AASECT (American Association of Sexuality Educators Counselors and Therapists)
- ACOG (American College of Obstetricians and Gynecologists)
- ASRM (American Society for Reproductive Medicine)
- ESSM (European Society for Sexual Medicine)
- ISSM (International Society for Sexual Medicine)
- ISSWSH (International Society for the Study of Women's Sexual Health)
- NAMS *(*North American Menopause Society)
- NPWH (National Association of Nurse Practitioners in Women's Health)
- SMSNA (Sexual Medicine Society of North America)
- SSSS (Society for the Scientific Study of Sexuality)
- SSTAR (Society for Sex Therapy and Research)
- SUNA (Society of Urologic Nurses and Associates)
- WAS (World Association of Sexology)

Commercial Organizations

- Pharmaceutical companies;
- Foundations (e.g., Brisbane Foundation); and
- Sex toy companies that are interested in promoting sexual health (e.g., Good Vibrations, Adam and Eve).

Organizations and Journals

- Journal of Sexual Medicine;
- Journal of Sex and Marital Therapy;
- Archives of Sexual Behavior;
- Contraception;
- American Journal of Ob/Gyn;
- Obstetrics and Gynecology;
- Journal of Women's Health;
- Women's Health Care (NPWH); and
- Family medicine journals.

Potential roadblocks to developing resources

Panelists brainstormed on barriers that might prevent clinicians from receiving the resources needed to provide ideal sexual health care. Identified barriers include:

- Lack of funding for educational initiatives;
- Lack of training opportunities;
- The low priority status of sexual health;
- Presence of extreme opinions on sexual health; and
- Perception of sexual health as a sensationalized area.

Topic 8: Potential impacts of new technologies

The experts considered the following questions posed by the meeting facilitators, "Assuming that someday we may have more FDA approved pharmaceutical treatments for female sexual dysfunction, what essential resources should be provided to the frontline prescribers by the drug's manufacturer?" and "What actions would you like the company to take with regards to the launch of a new drug?"

Meeting attendees identified the following as resources or information that should be provided with any new drug:

- Materials that would help frontline providers identify appropriate patients for the drug (i.e., selection criteria) and information for patients that would help them "self-select" if they are potentially appropriate candidates for treatment;
- Information on the appropriate dosing/administration instructions and on realistic expectations for response;
- Patient educational materials on sexual well-being and function;
- Patient brochures on sexuality issues; and
- A balanced discussion of the limitations and benefits of the drug.

The experts listed the following suggested actions for the manufacturer to take:

- Ensure that expectations are very clear for the patient, (e.g., patients need to take the medication every day for a few months before they can say it has failed);
- Explain clearly how the medication should be taken to avoid duplicating the experience with Viagra, where providers often failed to explain how to use the drug;
- Include information on sexual well-being;
- Include a patient education pamphlet;

- Educate health care providers on the specific details of the drug, the specific sexual dysfunction for which the drug is approved for treatment, and use of the drug;
- Ensure that the side effects of the drug are clearly communicated to avoid appearing to be less than forthright later;
- Include direct-to-consumer (DTC) marketing, which will encourage patients to ask their health care providers about sexual dysfunction, which in turn will encourage providers to assess dysfunction.

Panelists also were asked to consider the question, "What are the potential barriers that may limit the willingness of frontline providers to offer any new drug as an option to appropriate patients?" They listed several potential barriers, including:

- Reluctance of frontline providers to prescribe the drug and patients to take a drug due to the time involved, discomfort with an unfamiliar drug, lack of knowledge, and billing/cost issues associated with the drug;
- Cost (the experts noted that prescribers will need sufficient information to determine the cost-benefit analysis for an individual and partner);
- Lack of awareness about a drug's mechanism of action; and
- Cultural issues (e.g., myths and prohibitive cultural restrictions that affect treatment of female sexual dysfunction).

Topic 9: Creation of provider tools

During the second meeting, The panelists created lists to serve as the foundation for practical tools for providers. These include:

1. A Framework for Initiating Management of Sexual Dysfunction/Concerns (based on the PLISSIT Model)
2. Ten Key Take-Home Points About Sexual Health
3. Ten Open-Ended Questions to Consider
4. Ten Behavioral Strategies for Enhancing Sexuality that a Primary Care Provider Can Recommend
5. A Sex Therapy Primer for Non-Sex Therapist Providers
6. Case Studies in Sexual Health

A Framework for Initiating Management of Sexual Dysfunction/Concerns (based the PLISSIT Model):

1. Permission [all providers should be able to do]
    - Acknowledge that sexuality is a legitimate topic to discuss;
    - Empower a patient to speak with her partner about concerns and preferences;
    - Validate and legitimize the patient's complaint.

2. Limited information [most providers should be able to do]
    - Educate patient about:
        - Anatomy, perhaps using mirror exam or anatomical model
        - Physiology
        - Sexual response
        - Sexual changes associated with age
    - Provide relevant information about the range of normal sexual functioning;

- Discuss potential sexual side effects of medications;
- Discuss potential sexual effects of illnesses;
- Discuss depression and how its treatment can affect sexual function;
- Discuss how diet and exercise can affect sexual health;
- Educate patients that erotic reading/bibliotherapy can be effective;
- Explain that biological effects can be important (e.g., vulvovaginal atrophy is a biologically based problem that can be treated);
- Educate patients about the difference between lubricants, moisturizers, and estrogen therapy.

3. Specific suggestions with counseling [some providers will be able to do]
    - Recommend patient consider and address lifestyle or relationship issues (e.g., fatigue, stress, lack of private time with partner) that could be affecting sexual function;
    - Suggest use of erotic reading/bibliotherapy;
    - Suggest patients seek education on sexuality;
    - Recommend websites and books;
    - Suggest patients consider wooing/courtship behaviors [“What used to work?”];
    - Provide medical therapy directed to the sexual complaint (e.g., hormone therapy where needed);
    - Suggest self stimulation, stimulators, and sexual accessories;
    - Manage comorbid conditions and prescribe medications that affect sexual function;
    - Recommend pelvic floor management, such as Kegel exercises, if needed;
    - Recommend patient support groups for sexual abuse survivors (e.g., Sex and Love Addicts Anonymous [SLAA], survivor group).

4. Intensive therapy [most providers will refer]
    - Recommend medical and sexual devices (e.g., dilator, EROS device, electric stimulation unit);
    - Refer for therapy, including:
        - Sexual therapy;
        - Couples counseling;
        - Cognitive-behavioral therapy.
    - Refer for physical therapy;
    - Refer for expert management by medical or surgical subspecialists (e.g., gynecologist, psychiatrist, endocrinologist, urologist, urogynecologist);
    - Refer for expert management by sexual medicine specialists;
    - Refer patient or intimate partner for appropriate support services (e.g., in cases of violence/rape/family abuse);
    - Refer for expert treatment any patient with a sexual issue that exceeds the provider’s comfort level or expertise.

<u>Ten Key Take-Home Points about Sexual Health:</u>

1. Often, one open-ended question takes the same amount of time as several closed-ended questions.
2. Hypoactive sexual desire dysfunction (HSDD) is the most common female sexual dysfunction.

3. Use of the PLISSIT model for therapy can be helpful when working with women who have sexual dysfunction.
4. Vulvovaginal atrophy is common and can be treated.
5. There is a difference between coital and clitoral orgasms.
6. Both medications and disease can have profound effects on sexual function.
7. Depression and its treatment commonly affect sexual function.
8. Anger/resentment (or other relationship issues) often underlies sexual dissatisfaction and disorders.
9. It may be helpful to ask patients, "What have you tried so far?"
10. Most women welcome a provider initiating discussion about sexuality; they want their health care provider to bring up the topic of sexuality.

Open-Ended Questions

The experts recommended that before asking any questions, providers open with a normalizing statement such as, "It is now routine for us to ask about sexual health as part of the well-woman visit." Group members suggested three clinical settings in which it would be natural to include these questions: reproductive health visit, routine well-women care for women who are not of reproductive age, and routine screening/health maintenance visits. The questions also can be used when a patient/client presents with a specific sexual health problem.

<u>Ten Open-Ended Questions to Consider:</u>

1. What are you sexual concerns/problems/issues?
2. How does that affect your life/relationship(s)?
3. How does the concern manifest?
4. What is the most distressing part of this problem?
5. Tell me about your last sexual experience.
6. What "self-help" strategies have you employed to address your sexual concern so far?
7. How has your medical condition affected your quality of life, including your sexual health?
8. Are you interested in treatment?
9. What are your goals for your sexual health?
10. What kind of conversations have you had with your partner so far?

<u>Ten Practical Suggestions a Primary Care Provider Can Recommend:</u>

1. Make sex priority
    - Get lock on bedroom door;
    - Hire babysitter;
    - Schedule date nights;
    - Change time of day for sex.
2. Stress management
3. Time management
4. Exercise and consider the Mediterranean diet
5. Smoking cessation
6. Address sexual boredom
7. Consider the sexual environment (i.e., ask patient/client to consider the question, "What makes you feel sexual?")
8. Erotic reading/bibliotherapy

9. Sensate focus education
10. Mindfulness

Recommended Contents for a Sex Therapy Primer for Non-sex Therapist Providers:

- When and how to refer for sex therapy;
- What sex therapy is and what it isn't;
- Links to relevant websites; and
- Possible interventions a sex therapist might suggest:
    - Exploration of sexual fantasies
    - Cueing exercises
    - Helping a patient develop realistic and appropriate goals

Case Studies in Sexual Health:

Proposed topics:

- Diagnosis and management of hypoactive sexual desire dysfunction
- Diagnosis and management of postmenopausal vulvovaginal atrophy

Conclusion

This consensus process of experts in sexual health identified key challenges to the provision of ideal care for female sexual dysfunction. The expert group members focused on the competencies that frontline providers need in order to deliver ideal care and listed resources required to establish and maintain these competencies. Based on this information, ARHP will partner with other organizations to distribute information, create educational materials, and serve as a clearinghouse for the tools and resources that health care providers need to effectively identify and treat female sexual dysfunction. The steering committee will begin this work by translating and repackaging the information gleaned from the series of expert meetings for use in patient education, curriculum for providers, and other tools (including web-based, print, and video materials and simulation experiences) to facilitate improved patient care in sexual health. In addition, ARHP will make the information available to other organizations for use in crafting their own educational materials.

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Appendix 2: Bibliography

In April 2009, the Association of Reproductive Health Professionals (ARHP), in partnership with the National Women's Health Resource Center (NWHRC), commissioned Harris Interactive to conduct research to explore women's sexuality and sexual function.

This literature review covers articles related to general female sexual function, as well as various sexual disorders, including:

- Hypoactive Sexual Desire Disorder
- Sexual Arousal Disorder
- Sexual Aversion Disorder
- Sexual Pain Disorders (Vaginismus, Dyspareunia)
- Orgasmic Disorder

Other conditions such as vulvodynia, including vulvar vestibulitis syndrome (VVS), were included in this review as well, as they are very closely related to difficulties with female sexual function.

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Appendix 3: Assumptions for Meetings

Working Assumptions

Purpose: Assist "frontline" members of the reproductive health care team with expert guidance on sexual health and wellness for their female patients

Assumptions:

- Primary focus: "frontline" members of the reproductive health care provider team (MD, NP, PA, CNM, PhD, pharmacist, nurse, educator, front office staff, etc) who are not primary female sexuality experts and need evidence-based information and training to answer pressing patient questions regarding female sexual health and, if needed, to provide referrals
- Key nonprofit medical societies, education groups, and advocacy organizations will be notified about the process, asked to be "associates" of the project, and invited to (1) freely use all project outcomes (other than scholarly journal article) in any way that they believe will benefit their constituents and to (2) add their contact information to a "sexual health clearinghouse" that is under development
- ARHP is a resource and service organization committed to open access, and will not issue ARHP copyrights or ownership claims for program outcomes—they will be freely shared with associated organizations
- Outcomes for this phase of the project will focus on content that can be adapted and used for subsequent projects, and will not include specific products, such as brochures, interactive web tools, curricula, etc.

Substance of the Meeting Discussions:

- Develop "non-official guidance" for the reproductive health care team about sexual function, health, and wellness care
    - Prepare health care team for the future upsurge of patients in response to forthcoming FDA approval of medical interventions
    - Create awareness of the need and steps/resources for providing appropriate patient interventions and potential referrals
    - Create clinical pearls for the frontline health care provider team for addressing patient function and wellness
- Discuss documented and lesser-known barriers to operationalizing this guidance
    - Known barriers
        - Lack of interventions available to patients
        - Patient and provider discomfort discussing sexuality
        - Complexity of sexual function and wellness
        - Systems issues/barriers: coding, reimbursement, administrative, other systems barriers
    - Other lesser-known barriers

Intended outcome/product: Content developed by high level experts in the field to arm frontline health care provider teams with guidance to treat and refer patients, available to all health care providers and associated organizations

Likely Platforms for Dissemination of Content for Use by All Associates and Individuals

- Scholarly summary article written by some member of the working group (TBD) published in an academic journal, such as the Journal of Sexual Medicine
- Use/dissemination by associates in any way they think will benefit their constituency
- Introduction/link for associates to potential female sexuality program funders for their future projects
- Development of an open access *"sexual health clearinghouse"* of organizations involved in sexuality and reproductive health research, education, and practice
    - Web-based list of organizations, with a subset of companies as part of a clearinghouse—an expansion of the sex and sexuality resource center on ARHP's site: http://www.arhp.org/Topics/Sex-and-Sexuality
- [Pending further funding] Work with associates to further develop/supplement existing *"sexual health professional referral network*"

Appendix 4: About ARHP

Since 1963, ARHP has established itself as the leading source for trusted medical education and information on reproductive and sexual health. ARHP educates health care providers, informs consumers, and impacts public policy. Through convening teams of organizational colleagues and respected experts, ARHP advocates for reproductive health advances and educates professionals across specialties. The organization's multidisciplinary and multispecialty membership, strong strategic partnerships, broad educational focus, and four-plus decades of experience are its strengths. ARHP is well-positioned as the leader in providing credible, evidence-based programs on all that is current in reproductive health.

Over the past 46 years, ARHP has planned and implemented thousands of accredited didactic lectures, hands-on trainings, clinical consensus meetings, scientific forums, and publications. ARHP's international peer-reviewed journal, *Contraception*, is widely circulated and well-respected. ARHP-sponsored programs, conferences, and publications have successfully reached hundreds of thousands of health professionals with the latest research, emerging technologies, applied training, and useful information for health care practice. ARHP was the first medical organization to offer continuing medical education credits online in 1994—more recently, ARHP has implemented a series of Webinars and PDA-based educational activities, allowing individuals who are unable to travel to attend educational sessions to learn about the latest clinical information available. Information about ARHP's many accredited programs is available at www.arhp.org/cme.

All ARHP programming is rigorously designed based on the latest scientific evidence to meet the standards of the Accreditation Council for Continuing Medical Education, which accredits ARHP to offer continuing medical education credit for physicians. ARHP is also accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. ARHP partners with accredited nonprofit colleague organizations, such as the National Association of Nurse Practitioners in Women's Health and other groups to offer nursing contact hours, pharmacology credits, family medicine credits, ACOG cognates, and others as needed. The organization also adheres to the guidelines of the Federal Drug Administration, Pharmaceutical Research and Manufactures of America, and the Office of the Inspector General of the National Institutes of Health.