CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

Reproductive Health Care:

Conversations for Family Physicians and Their Patients

California Academy of Family Physicians | 2018

Shannon Connolly, MD

- Planned Parenthood
- Orange and San Bernardino Counties
- Los Angeles, CA

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This initiative is supported by a grant from the California Academy of Family Physicians Foundation.

Objectives

By the end of this session, participants will be able to:

- Open conversations with patients about reproductive life planning by asking One Key Question®.
- Engage patients in patient-centered counseling about their reproductive life planning, including prescribing appropriate contraceptive options and emergency contraception, and managing chronic medical conditions using evidence-based guidelines.
- Discuss and correct reproductive health myths.

Products discussed in this presentation

BRAND NAME PRODUCTS

Brand Name	Generic Name
Liletta and Mirena	Levonorgestrel 52mg
Kyleena	Levonorgestrel 19.5mg
Skyla	Levonorgestrel 13.5mg
ParaGard	copper IUD
Nexplanon	etonogestrel
Depo-Provera	medroxyprogesterone
Ella	Ulipristal
Plan B One Step	Levonorgestrel 1.5 mg

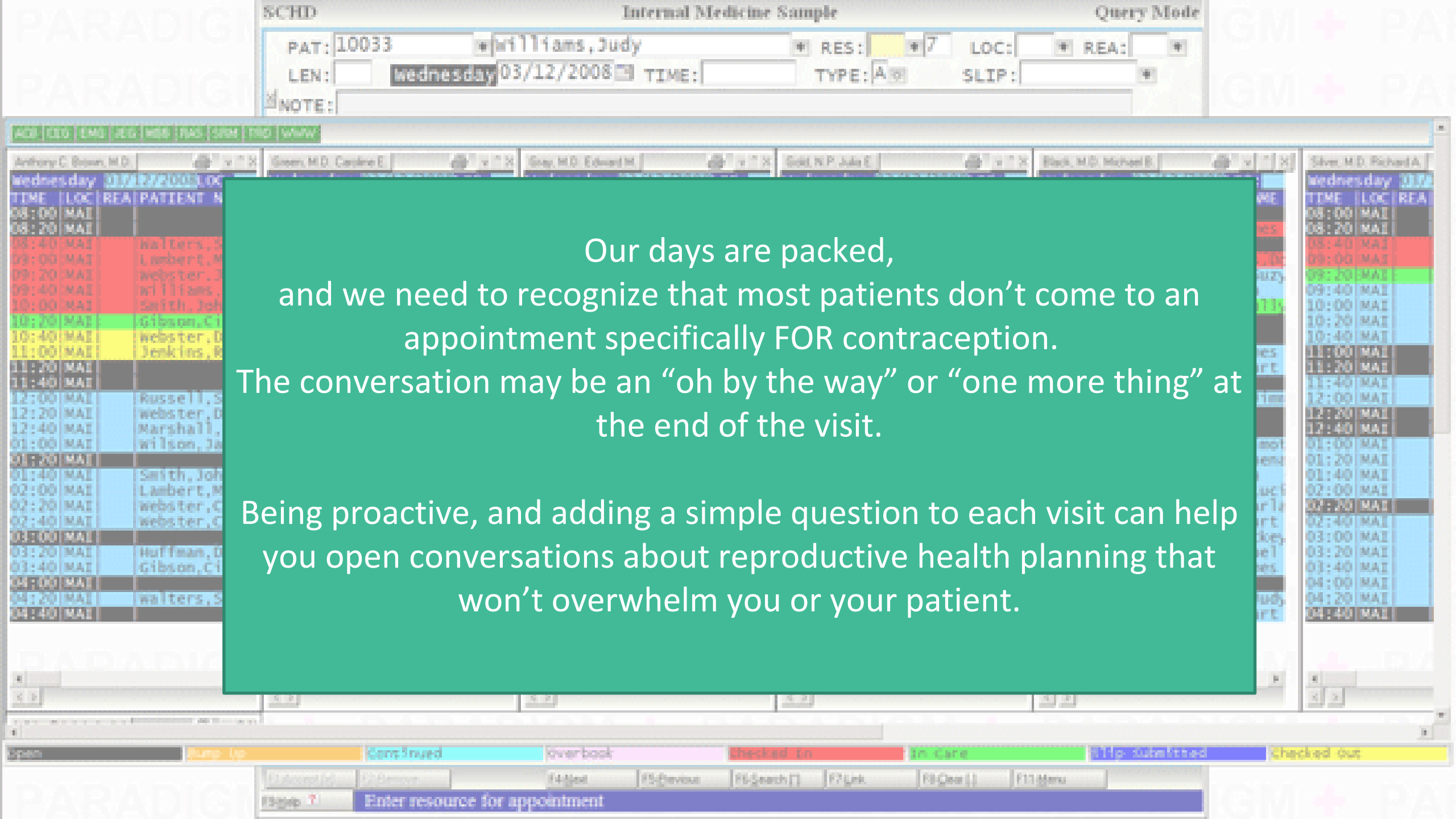
GENERIC PRODUCTS

Levonorgestrel

Etonogestrel

Medroxyprogesterone

Ulipristal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NOTE:
Our days are packed,
and we need to recognize that most patients don't come to an appointment specifically FOR contraception.
The conversation may be an "oh by the way" or "one more thing" at the end of the visit.
Being proactive, and adding a simple question to each visit can help you open conversations about reproductive health planning that won't overwhelm you or your patient.
Enter resource for appointment

Did You Know?

- **45%** of US pregnancies are unintended.
- **53%** of adolescents and **40%** of adult women at risk of unintended pregnancy are not using a most or moderately effective contraceptive method.

The average American woman becomes sexually active at age 17 and wants two children.

She will spend approximately 4 years of her sexually active reproductive life either pregnant or trying to get pregnant, and 25+ years trying to avoid pregnancy.

Finer LB and Zolna MR, Declines in unintended pregnancy in the United States, 2008–2011, *New England Journal of Medicine*, 2016, 374(9):843–852


General health
Career
Relationships
Education
Avoidance of teratogens
Finances
Prenatal care
Management of chronic medical conditions
Healthy pregnancy

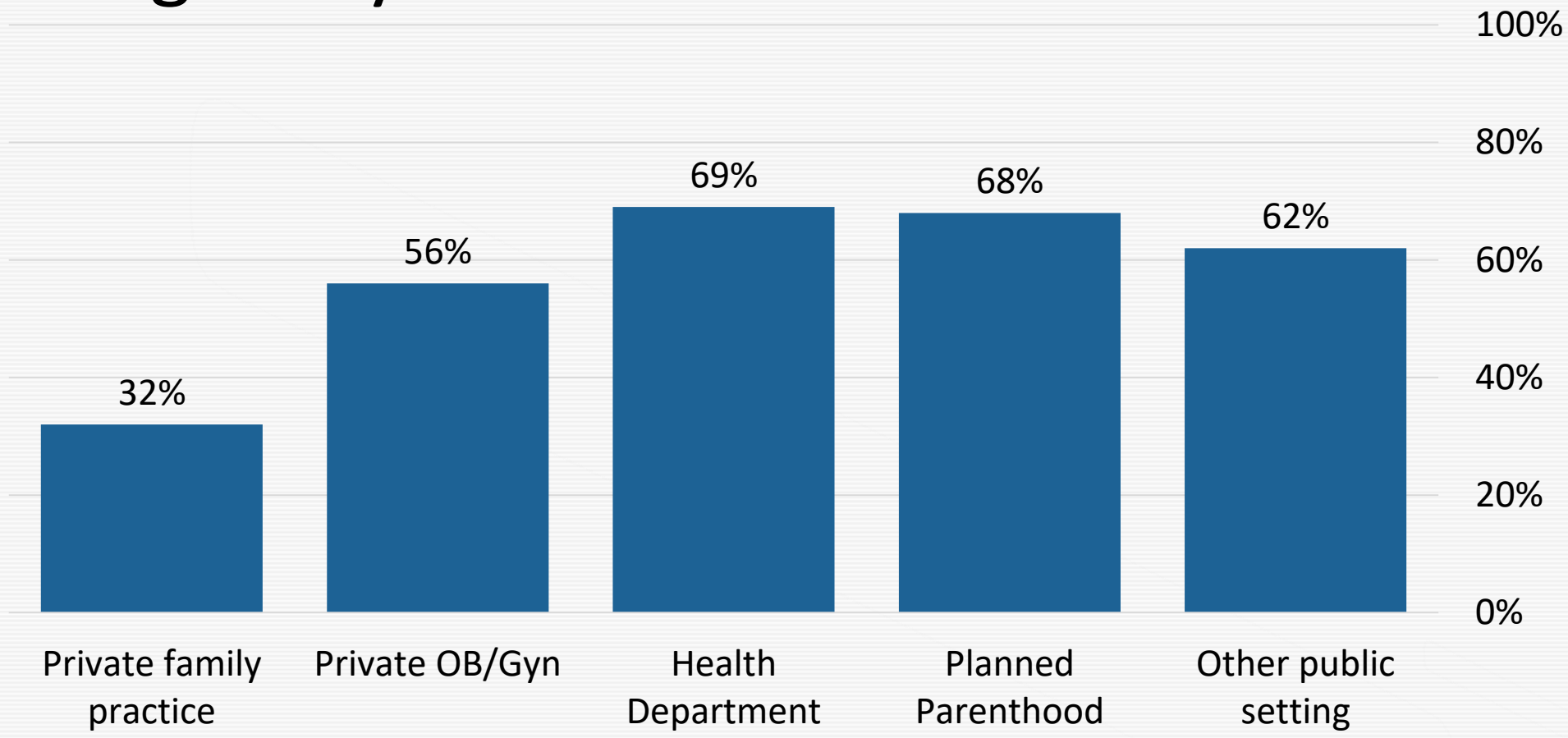
We Must Always Consider

- Culture
- Trust
- Community
- Ongoing relationships
- Legal obligations
- Our own biases

One Key Question®:

"Would you like to become pregnant in the next year?"

Provider Discussions about Pregnancy Intent



Percentage who often or always discuss pregnancy motivations during follow-up contraceptive visits.

Frost JJ, Darroch JE, Remez L, In Brief, 2008

Why don't doctors talk to patients about family planning?

- Not enough time
- Patients are there for other reasons/not on the patient's agenda
- Didn't think of it
- Lack of familiarity/comfort with methods
- Underestimate risk of pregnancy
- Discomfort with discussions about sex

Are You Planning a Pregnancy in the Next Year?

YES (preconception planning)

- Lifestyle modification
- Nutrition/weight management
- Chronic disease management
- Folic acid
- Avoidance of toxins
- Vaccines

NO

- Is there any chance that you might get pregnant in the next year?
- What are you doing to prevent pregnancy?

Katherine

25-years-old, presenting with cough and UTI.

Katherine is diabetic with prescribed insulin; she's not always under control.

Her latest A1C was 8.6.

You ask **One Key Question®**

Incidence of Congenital Anomalies by Exposure

Rate	Exposure
3.4%	Low dose methotrexate
8.2%	Carbamazepine
10.7%	Phenytoin
12.5%	ACE-I
5%	Hgb A1C 6.9-8.8
16.3%	Methamphetamine use
20.3%	Divalproex
16%	Hgb A1C >10.4
38%	Statin
46%	Isotretinoin

- http://www.nejm.org/doi/full/10.1056/NEJM200404083501524
- http://www.healthline.com/health-experts/fruit-womb/diabetes-pregnancy-11-hemoglobin-a1c-and-diabetic-control
- http://www.medpagetoday.com/Neurology/Seizures/3884
- http://emedicine.medscape.com/article/260725-overview#aw2aab6b8

Best Practices for Katherine

- Ask **One Key Question®** at all visits
- Preconception counseling
- Prenatal vitamins
- Harm reduction
- Discuss diabetes control
- Review of medications

Louise

42-years-old, with two teenagers who comes in for a routine visit and believes she is peri-menopausal.

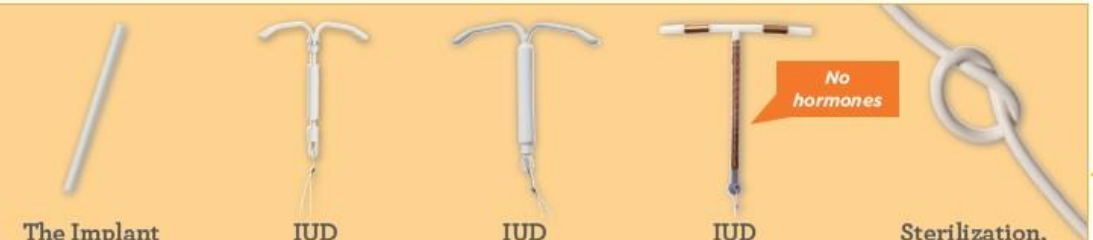
BP 148/92

You ask **One Key Question®**

HOW WELL DOES BIRTH CONTROL WORK?

What is your chance of getting pregnant?

Really, really well



	The Implant (Nexplanon)	IUD (Skyla)	IUD (Mirena)	IUD (ParaGard)	Sterilization, for men and women
Works, hassle-free, for up to...	3 years	3 years	5 years	12 years	Forever

Less than 1 in 100 women

Okay

	The Pill	The Patch	The Ring	The Shot (Depo-Provera)
For it to work best, use it...	Every. Single. Day.	Every week	Every month	Every 3 months

6-9 in 100 women, depending on method

Not so well

	Withdrawal	Diaphragm	Fertility Awareness	Condoms, for men and women

For each of these methods to work, you or your partner have to use it every single time you have sex.

12-24 in 100 women, depending on method

FYI, without birth control, over 90 in 100 young women get pregnant in a year.

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Bixby Center for Global Reproductive Health

What is Needed Before Prescribing Combined Hormonal Contraceptives?

REQUIRED	RECOMMENDED	NOT REQUIRED
Medical history Blood pressure	BMI	Pap Pelvic exam STI testing Hemoglobin

US Selected Practice Recommendations for Contraception Use. CDC, 2016.

Stewart F, et al. Clinical breast and pelvic examination requirements for hormonal contraception: Current practice vs evidence. *JAMA.* 2001;285:2232-9.

Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

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

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Age		Menarche to <20 yrs:2		Menarche to <20 yrs:2		Menarche to <18 yrs:1		Menarche to <18 yrs:2		Menarche to <18 yrs:1		Menarche to <40 yrs:1	
		≥20 yrs:1		≥20 yrs:1		18-45 yrs:1		18-45 yrs:1		18-45 yrs:1		≥40 yrs:2	
						>45 yrs:1		>45 yrs:2		>45 yrs:1			
Anatomical abnormalities	a) Distorted uterine cavity	4		4									
	b) Other abnormalities	2		2									
Anemias	a) Thalassemia	2		1		1		1		1		1	
	b) Sickle cell disease‡	2		1		1		1		1		2	
	c) Iron-deficiency anemia	2		1		1		1		1		1	
Benign ovarian tumors	(*including cysts*)	1		1		1		1		1		1	
Breast disease	a) Undiagnosed mass	1		2		2*		2*		2*		2*	
	b) Benign breast disease	1		1		1		1		1		1	
	c) Family history of cancer	1		1		1		1		1		1	
	d) Breast cancer‡												
	i) Current	1		4		4		4		4		4	
	ii) Past and no evidence of current disease for 5 years	1		3		3		3		3		3	
Breastfeeding	a) <21 days postpartum					2*		2*		2*		4*	
	b) 21 to <30 days postpartum												
	i) With other risk factors for VTE					2*		2*		2*		3*	
	ii) Without other risk factors for VTE					2*		2*		2*		3*	
	c) 30-42 days postpartum												
	i) With other risk factors for VTE					1*		1*		1*		3*	
	ii) Without other risk factors for VTE					1*		1*		1*		2*	
	d) >42 days postpartum					1*		1*		1*		2*	
Cervical cancer	Awaiting treatment	4	2	4	2	2		2		1		2	
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		1		2		2		2		1		2	
Cirrhosis	a) Mild (*compensated*)	1		1		1		1		1		1	
	b) Severe‡ (*decompensated*)	1		3		3		3		3		4	
Cystic fibrosis‡		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy												
	i) Higher risk for recurrent DVT/PE	1		2		2		2		2		4	
	ii) Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	b) Acute DVT/PE	2		2		2		2		2		4	
	c) DVT/PE and established anticoagulant therapy for at least 3 months												
	i) Higher risk for recurrent DVT/PE	2		2		2		2		2		4*	
	ii) Lower risk for recurrent DVT/PE	2		2		2		2		2		3*	
	d) Family history (*first-degree relatives*)	1		1		1		1		1		2	
	e) Major surgery												
	i) With prolonged immobilization	1		2		2		2		2		4	
	ii) Without prolonged immobilization	1		1		1		1		1		2	
	f) Minor surgery without immobilization	1		1		1		1		1		1	
Depressive disorders		1*		1*		1*		1*		1*		1*	

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Diabetes	a) History of gestational disease	1		1		1		1		1		1	
	b) Nonvascular disease												
	i) Non-insulin dependent	1		2		2		2		2		2	
	ii) Insulin dependent	1		2		2		2		2		2	
	c) Nephropathy/retinopathy/neuropathy‡	1		2		2		3		2		3/4*	
	d) Other vascular disease or diabetes of >20 years' duration‡	1		2		2		3		2		3/4*	
Dysmenorrhea	Severe	2		1		1		1		1		1	
Endometrial cancer‡		4	2	4	2	1		1		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy†	(*see also Drug Interactions*)	1		1		1*		1*		1*		1*	
Gallbladder disease	a) Symptomatic												
	i) Treated by cholecystectomy	1		2		2		2		2		2	
	ii) Medically treated	1		2		2		2		2		3	
	iii) Current	1		2		2		2		2		3	
	b) Asymptomatic	1		2		2		2		2		2	
Gestational trophoblastic disease‡	a) Suspected GTD (immediate postevacuation)												
	i) Uterine size first trimester	1*		1*		1*		1*		1*		1*	
	ii) Uterine size second trimester	2*		2*		1*		1*		1*		1*	
	b) Confirmed GTD												
	i) Undetectable/non-pregnant ß-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	
	ii) Decreasing ß-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	
	iii) Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	
	iv) Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2*	4*	2*	1*		1*		1*		1*	
Headaches	a) Nonmigraine (mild or severe)	1		1		1		1		1		1*	
	b) Migraine												
	i) Without aura (includes menstrual migraine)	1		1		1		1		1		2*	
	ii) With aura	1		1		1		1		1		4*	
History of bariatric surgery‡	a) Restrictive procedures	1		1		1		1		1		1	
	b) Malabsorptive procedures	1		1		1		1		3		COCs: 3 P/R: 1	
History of cholestasis	a) Pregnancy related	1		1		1		1		1		2	
	b) Past COC related	1		2		2		2		2		3	
History of high blood pressure during pregnancy		1		1		1		1		1		2	
History of Pelvic surgery		1		1		1		1		1		1	
HIV	a) High risk for HIV	2	2	2	2	1		2*		1		1	
	b) HIV infection					1*		1*		1*		1*	
	i) Clinically well receiving ARV therapy	1	1	1	1	If on treatment, see Drug Interactions							
	ii) Not clinically well or not receiving ARV therapy†	2	1	2	1	If on treatment, see Drug Interactions							

Key:

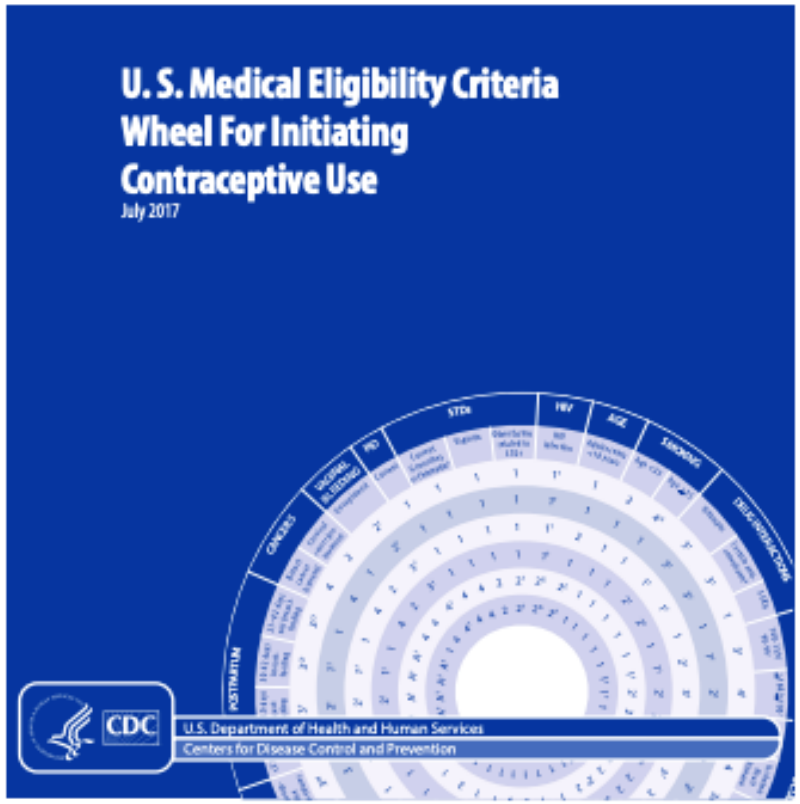
Abbreviations: C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and, ring); COC=combined oral contraceptive; Cu-IUD=copper-containing

Summary Chart of U.S. Medical Eligibility Criteria

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Hypertension	a) Adequately controlled hypertension	1*		1*		1*		2*		1*		3*	
	b) Elevated blood pressure levels (*properly taken measurements*)												
	i) Systolic 140-159 or diastolic 90-99	1*		1*		1*		2*		1*		3*	
	ii) Systolic ≥160 or diastolic ≥100‡	1*		2*		2*		3*		2*		4*	
	c) Vascular disease	1*		2*		2*		3*		2*		4*	
Inflammatory bowel disease	(*Ulcerative colitis, Crohn's disease*)	1		1		1		2		2		2/3*	
Ischemic heart disease‡	Current and history of	1		2	3	2	3	3		2	3	4	
Known thrombogenic mutations‡		1*		2*		2*		2*		2*		4*	
Liver tumors	a) Benign												
	i) Focal nodular hyperplasia	1											
	ii) Hepatocellular adenoma‡	1											
	b) Malignant‡ (hepatoma)	1											
Malaria		1											
Multiple risk factors for atherosclerotic	(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high	1											

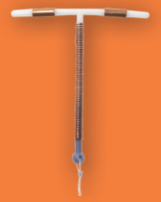
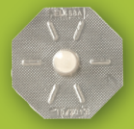
1	No restriction for the use of the contraceptive method for a woman with that condition
2	Advantages of using the method generally outweigh the theoretical or proven risks
3	Theoretical or proven risks of the method usually outweigh the advantages – not usually recommended unless more appropriate methods are not available or acceptable
4	Unacceptable health risk if the contraceptive method is used by a woman with that condition

https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/legal_summary-chart_english_final_tag508.pdf


U. S. Medical Eligibility Criteria
Wheel For Initiating
Contraceptive Use
July 2017
CDC
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

But, what about last night's unprotected sex?

OOPS! EMERGENCY CONTRACEPTION: BIRTH CONTROL THAT WORKS *AFTER* SEX

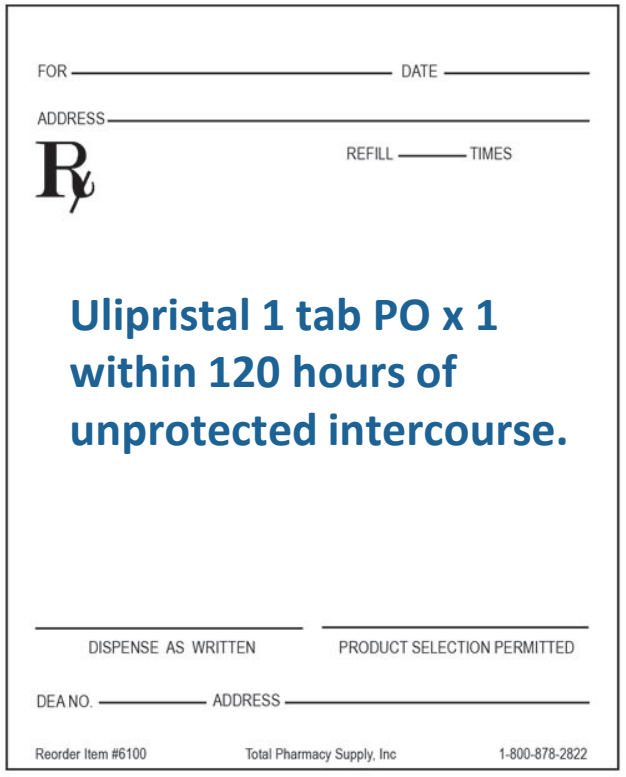
Types of emergency contraception	How well does it work?	How soon do I have to use it?	How do I use it?	Where can I get it?
 ParaGard IUD	Almost 100% effective 	Within 5 days	It's placed in the uterus by a doctor or nurse Keeps working as super effective birth control.	From a doctor, nurse, or at a clinic Say it's for EC so you are scheduled quickly.
  Ella	 Less effective if over 195 pounds. Try an IUD.	ASAP Works better the sooner you take it, up to 5 days.	Take the pill as soon as you get it Remember to use it every time you have unprotected sex.	From a doctor, nurse, or at a clinic Get an extra pack for future emergencies.
 Plan B One-Step or a generic	 Less effective if over 165 pounds. Try ella or an IUD.	ASAP Works better the sooner you take it, up to 3 days.	Take the pill as soon as you get it Remember to use it every time you have unprotected sex.	At a pharmacy, no prescription needed Get an extra pack for future emergencies.

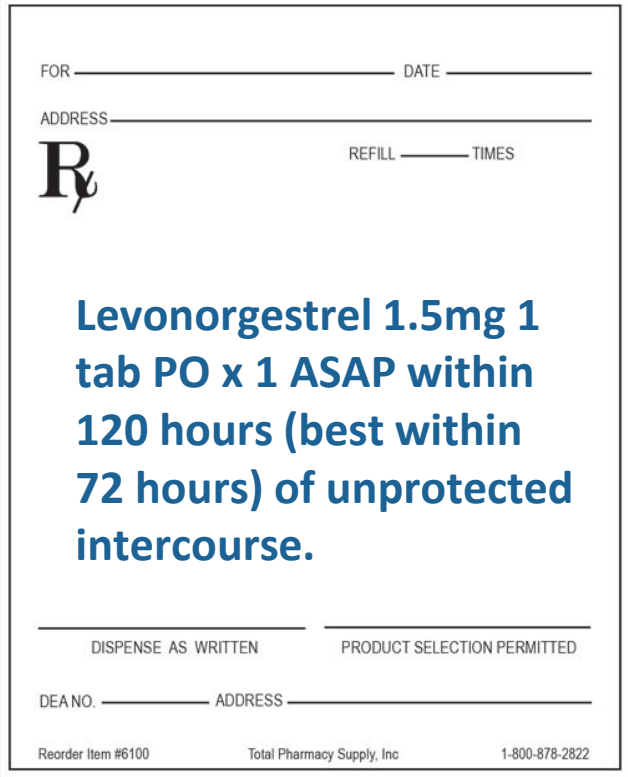
BEDSIDER Bedsider.org

Bixby Center for Global Reproductive Health

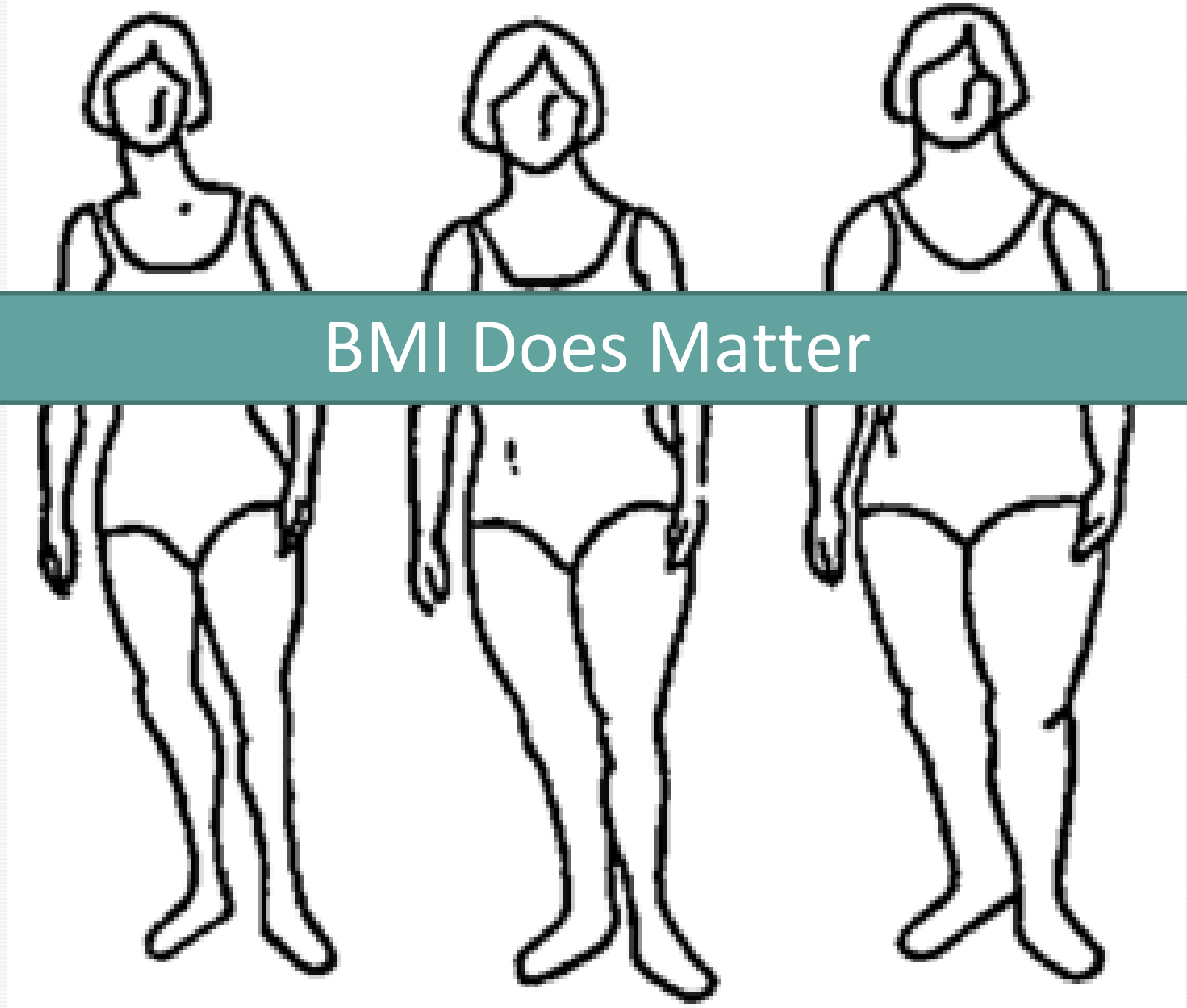
For more information, check out not-2-late.org

Emergency Contraception





BMI Does Matter



Efficacy of hormonal EC by BMI *

(Pregnancy rate (%)

BMI Kg/m2	Ulipristal Acetate (UPA)	LNG-EC*
<25	1.1	1.3
25-29.9	1.1	2.5
>30	2.6	5.8

* Average expected pregnancy rate with no EC = 6.2-7.4 percent.

Best Practices for Louise

- Ask **One Key Question®** at all visits
- Incorporate patient-centered counseling and, when appropriate, consider tiered-effectiveness when discussing contraceptive options for patients
- Always consult the MEC when prescribing birth control
- Don’t coerce her
- Offer emergency contraception and condoms

Michael

18-years-old, a high school student, who comes to you because his girlfriend of four months told him she tested positive for chlamydia.

After reviewing presumptive treatment and discussing ways to reduce future risk of STI transmission …

You ask **One Key Question®**

Why Should We Ask Men?

- Men who are educated about reproductive health issues are more likely to support their partners in decisions on contraceptive use and family planning.
- Men who are knowledgeable about reproductive health issues and can communicate about them with their partners, are more likely to be supportive during pregnancy and may make better health care decisions.

Taking a Sexual History

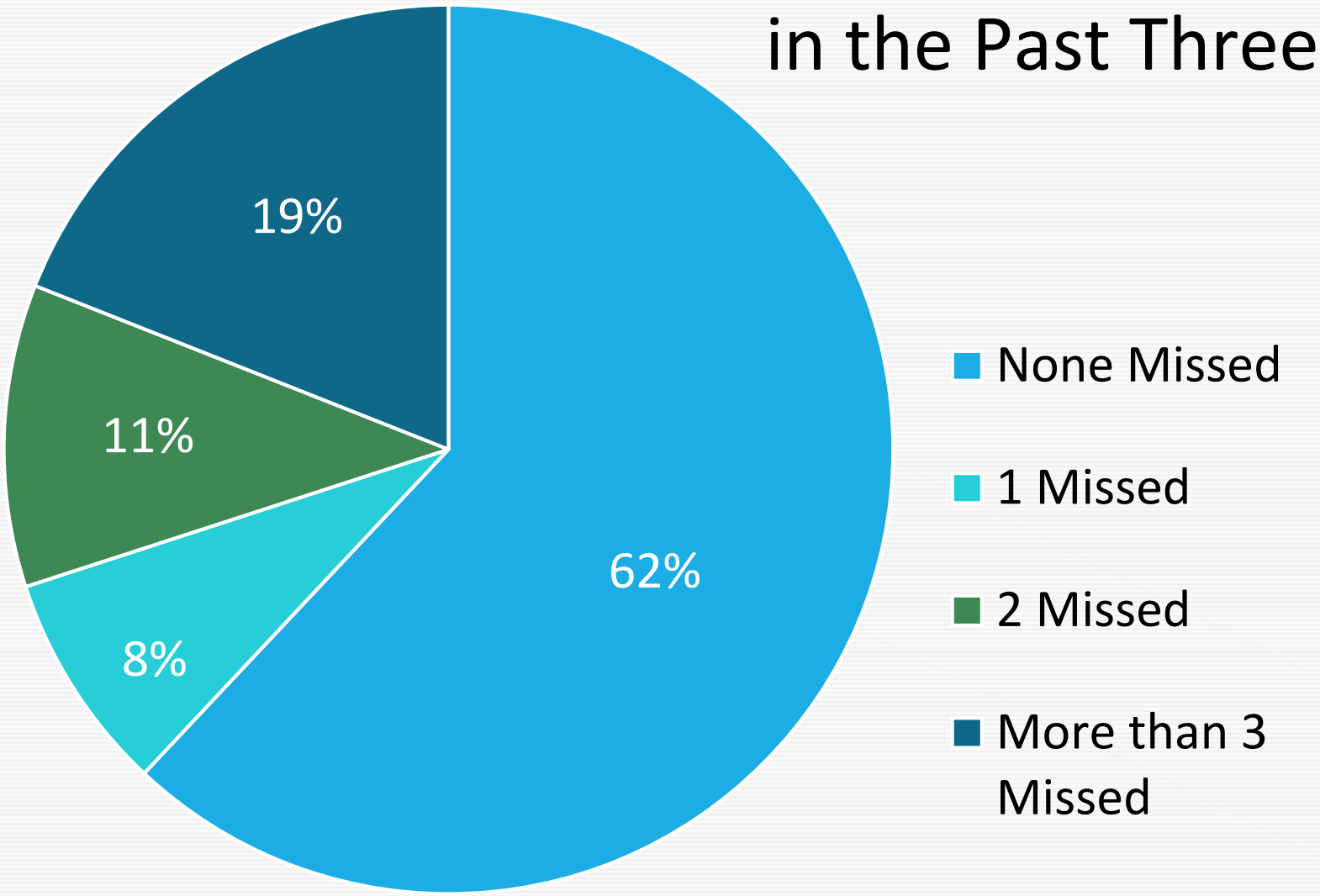
- If we know what kinds of behaviors our patients are engaging in, we can better address their health needs and provide them with individualized advice.
  - Engaging adolescent men is especially important as this age demographic rarely discusses sexual and reproductive health with their physicians.
  - Provides an important opportunity to provide accurate information, as well as guidance on everything from negotiating consent to decreasing risk of an unintended pregnancy or STI.

Anne

17-years-old, thinks she needed an appointment to renew her birth control prescription before she heads to college next month.

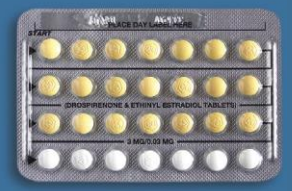
You ask **One Key Question®**

Pill-users Who Missed a Dose in the Past Three Months



FACT SHEET : THE PILL

Remember, the pill **does not protect you from Sexually Transmitted Infections or HIV.** Always use condoms to protect yourself!



HOW DO BIRTH CONTROL PILLS WORK?

- Birth control pills contain hormones like the ones your body makes. These hormones stop your ovaries from releasing eggs. Without an egg, you cannot get pregnant.
- No method of birth control is 100% effective. If you take all of your birth control pills on time, they are 99% effective. If you skip some pills, they are 91% effective.

HOW DO I START THE PILL?

- There are 2 ways to start the pill:
  - **Quick Start:** Take your first pill as soon as you get the pack.
  - **Next period:** Take your first pill soon after your next period begins.
- If you take your first pill *up to 5 days after the start of your period* , you are protected against pregnancy **right away**.
- If you take your first pill *more than 5 days after the start of your period* , you should **use condoms as back-up for the first 7 days.**

HOW DO I USE THE PILL?

- **Once you start using the pill** , take 1 pill each day. Take your pill at the same time each day.
- After you finish a pack of pills, you should start a new pack the next day. You should have NO day without a pill.

WHAT IF I MISS PILLS?

- **I forgot ONE pill:** Take your pill as soon as you can.
- **I forgot TWO pills or more:** Take your pill as soon as you can. Take your next pill at the usual time. **Use condoms for 7 days. Use emergency contraception (EC) if you have unprotected sex.**

WHAT IF I STOPPED TAKING THE PILL AND HAD UNPROTECTED SEX?

- Take Emergency Contraception (EC) **right away**. EC can prevent pregnancy up to 5 days after sex, and it works better the sooner you take it.

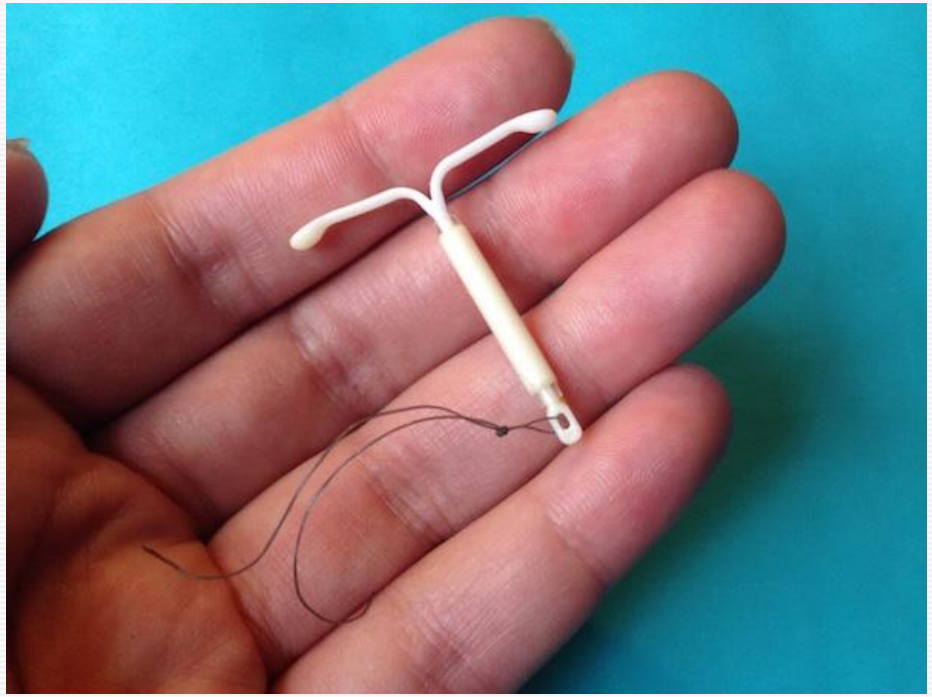
HOW DOES THE PILL HELP ME?

- The pill is safe and effective birth control.
- Your periods may be more regular, lighter, and shorter. You may have clearer skin.
- The pill lowers your risk of getting cancer of the uterus and ovaries.
- The pill has **no effect** on your ability to get pregnant in the future, after you stop taking it.

HOW WILL I FEEL ON THE PILL?

California Academy of Family Physicians | 2018

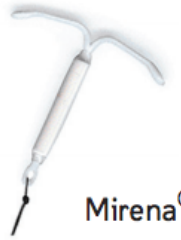
https://www.reproductiveaccess.org/wp-content/uploads/2014/12/factsheet_pill.pdf



- 1 IUD used for 3 years = 1,095 pills
- 1 IUD used for 5 years = 1,826 pills
- 1 IUD used for 10 years = 3,650 pills

One Year Failure Rates

Effectiveness	Contraceptive	Typical-Use Pregnancy Rate
Ineffective	Chance	85%
Less effective	Condoms	18%
More effective	Pill/patch/ring	9%
	Injectable	6%
Highly effective	IUDs	0.2-8%
	Sterilization	0.15-0.5%
	Implant	0.05%

	Copper IUD	Progestin IUDs
	 ParaGard®	 Mirena®, Skyla®, Liletta® and others
Brand names	ParaGard®	Mirena®, Skyla®, Liletta®, and others
When does the IUD start working?	The copper IUD starts working right away.	The progestin IUDs start working 7 days after they are inserted. Use condoms or another back-up method of birth control for the first 7 days after the IUD is inserted to prevent pregnancy.
How long can you use it?	ParaGard® works for 12 years. Your health care provider can remove your IUD at any time.	May be left in place from 3 to 7 years, depending on which IUD you choose. Your health care provider can remove your IUD at any time.
Does it contain hormones?	No.	Yes. There is a low dose of progestin but no estrogen.

A Word about IUD Costs …

Based on full price, without insurance assistance *

IUD	Full Price Range	Cost/month for one year	Cost/month for five years
Mirena® or Kyleena®	$500-$858	$41-$72	$8-$14
ParaGard®	$500-$739	$41-$62	$8-$12 $4-$6 (Cost/month for 10 years)
Skyla®	$650-$714	$54-$60	$18-$20 (Three Years)
Liletta®	$50-$684	$4-57	$1-$19 (Three Years)

Liletta® can be purchased by FQHCs and other clinics who use 340B pricing for ~$50. Mirena® can cost upwards of $600 even with 340B pricing. https://www.bedsider.org/methods/iud#costs

Best Practices for Anne

- Ask **One Key Question®** at all visits
- Use patient-centered counseling to identify barriers and solutions for patients
- Offer same-day LARC insertion

Wrapping Up

Rapid Fire Myth-Busting: Is it a Fact or a Myth?

It is evidence-based to place an IUD in a nulliparous non-monogamous teen.

FACT

A history of PID (such as Gonorrhea and/or Chlamydia) is an absolute contraindication to IUD insertion.

MYTH

Contraceptive use does not affect fertility and will not make it "harder" to get pregnant in the future.

FACT

Intrauterine contraceptives increase the risk of ectopic pregnancy.

MYTH

Amenorrhea caused by continuous use of contraception is associated with major depressive disorder.

MYTH

Continuous use of OCPs is safe for patients.

FACT

It’s important to check a patient’s blood pressure before prescribing birth control pills.

FACT

Long term use of depot medroxyprogesterone acetate (DMPA) is associated with an increased risk of femoral neck fractures.

MYTH

42% of family planning providers use IUDs, compared to 12% of the general population.

FACT

Depot medroxyprogesterone acetate (DMPA) is too dangerous for teens.

MYTH

Transgender men and women have sexual and reproductive healthcare needs that can be met in a family medicine clinic.

FACT

The placement of IUDs increase the risk of abortion.

MYTH

The CDC MEC provides evidence-based recommendations about birth control prescriptions.

FACT

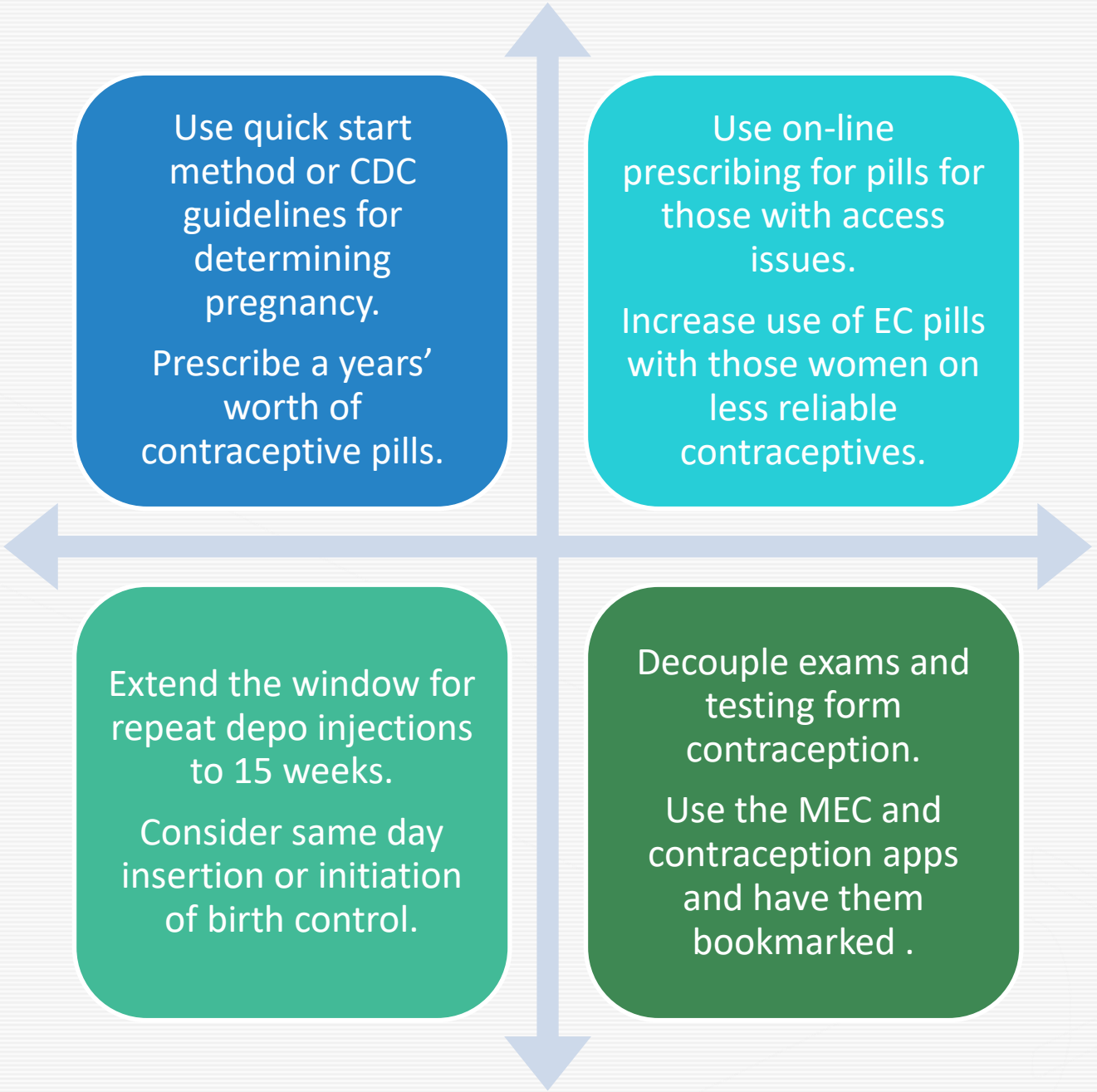
Liletta® does NOT have bio-equivalency to Mirena®.

MYTH

Scheduled bleeding every four weeks on combined hormonal contraceptives is the same thing as a period.

MYTH

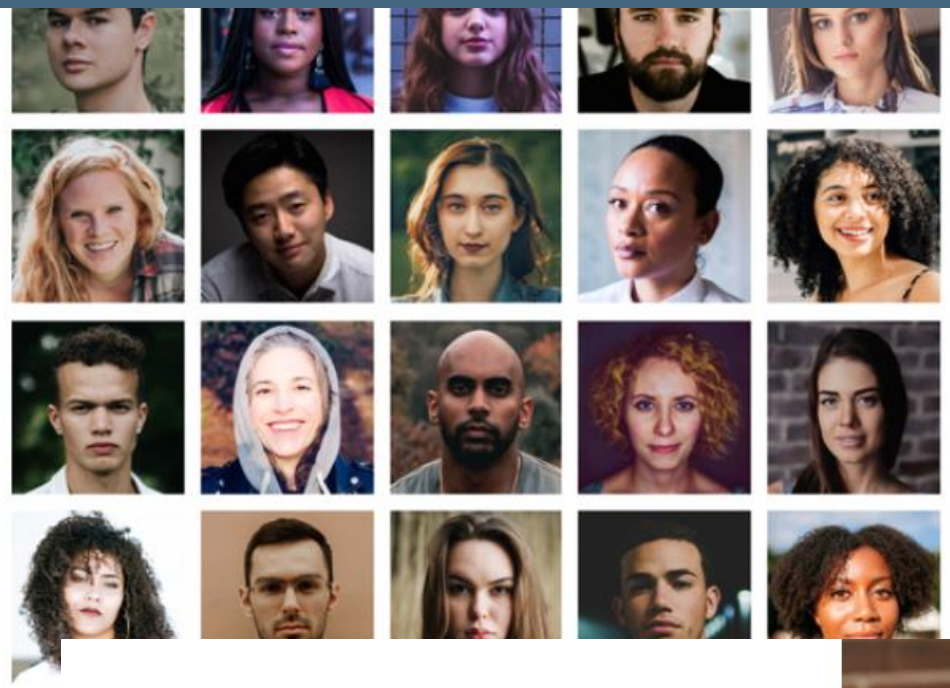
Best Practices



LEARNER SELF-ASSESSMENT

You are encouraged to participate in this online assessment. The knowledge and attitude assessment will give you a sense of practice gaps and assist you in planning educational interventions to close the gaps. Colleagues from every state will be participating, and you'll be able to see where you fall in the scoring. The assessment also includes the correct answers and all citations and rationales. The LSA is sponsored for .25 AAFP Prescribed or *AMA PRA Category 1 credits™* and is free to all health care clinicians.

GO TO ASSESSMENT



California Academy of Family P

Designed

for family physicians … by family physicians

www.familydocs.org/rhi

MAINTENANCE OF CERTIFICATION

CAFP, in partnership with Interstate Postgraduate Medical Association, has developed an ABFM Part IV Improving Performance in Practice module. This module is designed to increase the use of One Key Question® for reproductive health planning, enhance physician-patient communication, and improve team approaches to care. The module is approved for ABFM Part IV credit, includes 30 AAFP Prescribed credits upon completion and is based on a team-approach [*AMA PRA Category 1™* credit also is available]. The Part IV module is appropriate for any family physician, family medicine resident or other primary care physician plus your teammates. Questions? Contact Shelly Rodrigues at srodrigues@familydocs.org.

GO TO MODULE

What Tools and Resources are Available?

Start at **www.familydocs/rhi**

- OneKeyQuestion
- Bedsider.org
- www.reproductiveaccess.org
- Contraception Point-Of-Care app (Android and IOS)
- CDC US Medical Eligibility for Contraceptive Use
- https://wwwn.cdc.gov/pubs/CDCInfoOnDemand.aspx?ProgramID=195 (for add'l free handouts)

Thank You

Questions?

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Repro Health Happy Hour

NMAFP Winter Refresher

February 23 @ 5:00pm

Garduño's Restaurant | Hotel Albuquerque

Please join the New Mexico Cluster of the Reproductive Health Access Network for a social hour at NMAFP's Winter Refresher.

This is a great opportunity to connect with supportive colleagues, discuss Academy activities, and gear up for an energized 2019!

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new mexico

Sponsored by the Reproductive Health Access Project