

“I totally didn’t need to be there in person”: New York women’s preferences for telehealth consultations for sexual and reproductive healthcare in primary care

Silpa Srinivasulu^{1,*}, Meredith G. Manze¹, Heidi E. Jones^{2,3}

¹Department of Community Health and Social Sciences, The City University of New York, Graduate School of Public Health and Health Policy, New York, NY, United States

²Department of Epidemiology and Biostatistics, The City University of New York, Graduate School of Public Health and Health Policy, New York, NY, United States

³The CUNY Institute for Implementation Science in Population Health, New York, NY, United States

*Corresponding author: The City University of New York, Graduate School of Public Health & Health Policy, 55 W 125th Street, New York, NY 10027, United States. E-mail: Silpa.Srinivasulu18@sphmail.cuny.edu

Background: Expanding telehealth in the United States during the COVID-19 pandemic supported patients with needed sexual and reproductive healthcare (SRH) for continuity of care and reproductive autonomy. While telehealth for SRH is feasible and acceptable, studies have not explored patient preferences towards telehealth SRH from primary care settings.

Objective: We explore New York women’s preferences for telehealth SRH in primary care.

Methods: In 2021, we conducted 5 focus groups and 8 interviews with New York women of reproductive age who had a consultation with a primary care provider in the last year as part of a larger study on assessing SRH quality in primary care. We queried on experiences with telehealth for SRH and perceptions of measuring SRH quality in primary care telehealth consultations. We employed reflexive thematic analysis.

Results: We recruited 30 participants. They preferred telehealth for “basic” SRH conversations, such as contraceptive counselling, and desired in-person consultations for “complex” topics, like pregnancy and preconception, especially if nulliparous. Telehealth benefits included convenience, simplicity of some SRH needs, and alleviating power dynamics in patient–provider relationships. Challenges included lack of one-on-one connection, seriousness of pregnancy discussions, privacy, and internet access. Measuring quality of telehealth SRH should include fostering positive and engaging environments.

Conclusion: Participants find telehealth SRH in primary care preferable, underscoring the importance of offering and expanding this care. As telehealth SRH expands, providers should strengthen quality by building rapport to facilitate conversations on “serious” topics and their ability to help patients remotely.

Lay summary

The expansion of phone- and video-based consultations in the United States for sexual and reproductive healthcare (SRH) during the COVID-19 pandemic supported patients with needed continuity of care, while minimizing virus exposure. As COVID-19 becomes endemic, medical organizations and providers recommend sustaining and expanding telehealth for SRH and other primary care needs. No studies to date have explored patient acceptability of telehealth for SRH services broadly in primary care settings. This brief report explores preferences for telehealth for SRH in primary care among New York women of reproductive age through focus groups and interviews. Overall, participants preferred telehealth for “basic” SRH conversations, such as contraceptive options, and in-person consultations for more “complex” topics, like pregnancy and preconception. Benefits of telehealth services included convenience, simplicity of some SRH needs, and being able to minimize uncomfortable power dynamics in the patient–provider relationship. Challenges included the lack of one-on-one connection with a provider, the perceived seriousness of pregnancy-related conversations, privacy, and internet access concerns. Patients find telehealth for SRH in primary care preferable, especially for simple SRH conversations, which suggests the importance of continuing to offer services in this manner.

Key words: primary care, qualitative, quality, reproductive health, sexual health, telehealth

Background

In 2020, during the beginning of the COVID-19 pandemic in the United States, health, financial, and logistical barriers delayed access to sexual and reproductive healthcare (SRH), affecting patients’ abilities to exercise their reproductive autonomy, controlling when, if, and under what circumstances to have or avoid a pregnancy.^{1,2} In response, health centres rapidly adopted telehealth for SRH, and other primary healthcare, to provide needed and safe continuity of care.³

As the public health emergency waxes and wanes, professional medical organizations recommend expanding telehealth.⁴ Before the pandemic, numerous telehealth phone applications and online services existed, using videoconferencing, chatboxes, and calls to provide SRH; however patient utilization was low, and services were often unavailable at hospitals and health centres.⁵ Telehealth is well suited to providing SRH that focuses on counselling, prescribing, and self-testing such as contraceptive care, medication abortion, and

Key messages

- Primary care telehealth sexual and reproductive health is preferable to women.
- Telehealth may minimize power dynamics between patients and providers.
- More complex sexual and reproductive health conversations may be better suited to in-person consultations.
- Providers should foster positive, warm environments via telehealth.
- Telehealth sexual and reproductive health should continue expanding in primary care.

sexually transmitted infection testing. Moreover, primary care practices are crucial settings for comprehensive and patient-centred SRH, particularly for communities with barriers to reaching specialists, like obstetrician–gynaecologists.⁶

Patients find telehealth in primary care convenient, comfortable, and accessible^{7,8}; with similar perceptions for telehealth SRH.^{9–11} However, to date, no studies have explored patient preferences for SRH services broadly via telehealth in primary care. This brief report explores New York women's preferences for telehealth SRH consultations in primary care.

Methods

Study design and data collection

In October to December 2021, MM and SS conducted semistructured online video-based focus groups and in-depth interviews with a purposive sample of English-speaking women of reproductive age (18–45) currently living in New York who had a consultation with a primary care provider in the past year. Prior experience with SRH in primary care settings, in-person or telehealth, was not required. A third-party research firm recruited 80 respondents within each age group (18–25, 26–35, and 36–45 years) from online panels. We emailed and texted all respondents to join prescheduled focus groups. Interested respondents received an informed consent document with study information.

Due to recruitment challenges and not reaching saturation on themes related to younger ages, we transitioned to interviews with 18- to 35-year-olds. We recruited those who expressed interest in the study but did not attend a focus group, and nonresponders from initial outreach. All provided verbal informed consent. Focus groups lasted 50–120 min; interviews 25–60 min.

The semistructured topic guides queried on experiences with and thoughts about SRH quality in primary care, including telehealth consultations for SRH. We defined primary care providers to participants as “someone who you go to for general health care” and telehealth as “visits by telephone or videoconference instead of in-person at the clinic.” This analysis is part of a larger study exploring patients' perceptions of SRH quality metrics in primary care, as current measurements, like “unintended” pregnancy rates and contraceptive uptake, neglect to incorporate patients' perspectives.² We asked participants to review screenshared statements informed by patient satisfaction and reproductive autonomy frameworks.² Therefore, we present participants' perceptions of considerations for measuring SRH quality in telehealth.

Immediately after each data collection, we emailed participants an online demographics survey and wrote field notes, reflecting on data collection, personal biases, and patterns. Participants received \$30.

Analysis

We employed reflexive thematic analysis¹² MM and SS independently read and open-coded all transcripts to familiarize themselves with the data. Both identify as cis women and are reproductive health researchers with expertise in qualitative methods. MM is PhD-trained and SS is a PhD candidate. They developed an initial codebook and independently coded 1 focus group transcript from each age group. Together, they reviewed coding, explored and sense-checked discrepancies, and refined the codebook. This collaborative, reflexive engagement deepened interpretations of the data, which were captured through memos. SS coded remaining transcripts; MM served as second coder on interviews she did not conduct. They reviewed coding issues together. SS sorted and reviewed excerpts, memos, and field notes, deriving themes inductively from the data, though some deductive analysis was employed to ensure themes aligned with the research questions. The Institutional Review Board of the City University of New York approved this study.

Results

Thirty women participated (22 from 5 focus groups and 8 interviews). The majority lived in New York City (60%), identified as White (40%) or Black/African American (30%), and reported having a regular healthcare provider (83%). Overall, participants preferred having discussions related to contraception and other “basic” SRH concerns via telehealth, but desired in-person consultations for topics they viewed as more complex and unknown, like pregnancy and preconception (Table 1).

Benefits of telehealth for SRH

Participants found telehealth from primary care preferable for basic SRH due to the simplicity of conversation content, convenience, and alleviating interpersonal power dynamics that may emerge in-person. They felt basic SRH conversations were highly conducive for telehealth (Excerpt 1). They felt comfortable in simple situations, “if I was looking for information, or...trying to learn more about something I was experiencing” (focus group, FG, 2; age 25–34).

They commented on the convenience of telehealth. They appreciated taking consultations from “the comfort of your own home” (in-depth interview, IDI, 7; age 18–25), not having “to worry about catching the bus” (FG 6; age 35–44), saving time spent in the waiting room, and staying safe from COVID-19 and other communicable diseases. The conveniences made telehealth preferable (Excerpt 2).

Telehealth also allowed participants more access to their providers, as health centres began to offer video consultations, phone calls, and improved chat functions for easy communication without requiring in-person appointments. For those

Table 1. Excerpts illustrating perceived benefits, challenges, and quality measures of telehealth for SRH in primary care settings among 30 New York women of reproductive age (2021).

Excerpt number	Theme	Illustrative quote ^a
Category: benefits of telehealth for SRH		
1	Basic SRH conversations, like menstruation-related concerns, and contraceptive counseling, are highly conducive for telehealth.	“I’ve gotten prescriptions for birth control from three different providers, and I totally didn’t need to be there in person, I could have just done that online.” (FG 1; age 18–24)
2	Convenience of telehealth made this mode of SRH preferable.	“I have three kids and sometimes it’s very difficult to drop them, get off work, drive to the doctor, wait there for 30 minutes, it just takes time... I do majority of my visits now virtually, ‘cause I can just step out of my work, take a 30-minute call and then I’m not wasting half of my day.” (FG 3; age 25–34)
3	Telehealth alleviated uncomfortable patient–provider power dynamics typically present when in-person.	“I prefer virtual communication between me and my primary doctor... Usually when I’m in person with my doctor, I don’t really think about all the questions that I need to ask them at the moment. But when I’m home, comfortable and virtual, having communication with her, I’ll probably think about all the questions that I do need answers to.” (IDI 1; age 26–35)
Category: challenges of telehealth for SRH		
4	Participants perceived a disconnect with their provider over telehealth and feared a lack of sincerity from their provider.	“Gestures or something out of screen that I might not be aware of and its sincerity, too. People sound different over the phone than they do in-person.” (IDI 5; age 18–25)
5	The youngest age group found pregnancy conversations difficult over telehealth and preferable for in-person consultations due to the unknowns and potential for many questions on this topic.	“Sometimes things just feel better in person and like something as serious as planning to have a child... I would have so many questions; I would want a bunch of stuff checked... I just would feel better, and I feel like it might go better if it’s there in person.” (FG 1; age 18–24)
6	Telehealth may not allow full privacy at home, especially for young patients with guardians less supportive of SRH conversations.	“I know that, like, their parents wouldn’t be okay with them, like, getting on birth control or being sexually active. Cuz I feel like, for some people, that it may not be, like, good for them to be over the phone or like at home and talking about it.” (IDI 6; age 18–25)
Category: quality of SRH in telehealth consultations		
7	Providers should create a warm environment and give off positive energy to encourage patients to open-up and feel comfortable on the new platform and in the remote space.	“Judging by their demeanor from the face, if it’s a smile, if it’s like a warm setting... and letting me know, ‘Hey, even through the video, you can be comfortable enough to share information with me.’” (IDI 2; age 26–35).

^aFG, focus group; IDI, in-depth interview.

who considered themselves shy and nervous around medical professionals, telehealth alleviated the patient–provider power dynamic participants perceived when in-person. They found it easier to talk openly to their provider via telehealth (Excerpt 3).

Challenges of telehealth for SRH

Several shared that telehealth consultations lack a “one-on-one connection, that in-person connection to just be in front of somebody and them to be looking at you. I don’t feel like they would be able sometimes to understand the full scope of what’s going on” (FG 4; age 18–24). This indicated that patient–provider communication via telehealth may not be as strong or clear as it could be in-person, resulting in both parties potentially missing essential information for the patient’s health. Participants also feared a lack of sincerity from their provider (Excerpt 4).

The youngest group emphasized pregnancy conversations as challenging for telehealth (Excerpt 5). Due to the perceived seriousness of pregnancy planning for nulliparous young participants, they preferred in-person pregnancy and preconception conversations.

Some briefly discussed logistical concerns with telehealth, like internet quality delaying the process, and privacy concerns at home and work, especially around SRH. A younger participant noted concerns about parents/guardians overhearing telehealth consultations around contraception (Excerpt 6).

Quality of SRH in telehealth consultations

Overall, participants believed measuring SRH quality should not differ between in-person and telehealth primary care consultations. However, they highlighted that providers should spend extra attention engaging patients and fostering a positive environment. They should engage with their patient completely by asking relevant questions, demonstrating that they are listening, and fostering an environment that makes patients feel “connected”: “I feel like the provider should provide so much care that you don’t even notice that it’s virtual. And you actually prefer, and you feel comfortable” (IDI 4; age 18–25). Participants emphasized the importance of creating a warm environment and having a positive, kind demeanour (Excerpt 7).

Discussion

This exploratory study finds that New York women of reproductive age prefer telehealth for SRH in primary care, especially for simple conversations and questions. They highlighted convenience, improved access, and minimized power dynamics that impact patient–provider interactions, underscoring the importance of continuing and expanding primary care telehealth services.^{1,13–15} Providers can strengthen telehealth SRH quality by building trust and rapport with patients. They should acknowledge the seriousness of pregnancy-related conversations and discuss ways to provide this care remotely. Efforts to expand telehealth may enhance access and reproductive autonomy by offering opportunities to discuss comprehensive SRH needs in ways that work best for patients.

Telehealth alone will not address all barriers to accessing SRH. As indicated in this study, not everyone will feel comfortable with telehealth, nor will every SRH need be amenable to telehealth platforms. Privacy concerns may inhibit some from receiving SRH via telehealth.^{16,17} Those unfamiliar or uncomfortable with telehealth technology may also feel discouraged from using it for SRH. Moreover, the geographic and racial digital divide may make telehealth consultations logistically challenging, even impossible, in rural and urban underserved areas.^{18,19}

Further study is needed to investigate other gendered individuals' preferences towards telehealth SRH in primary care, as their experiences may differ. Online panels have sampling limitations, as well.²⁰ As recruitment and data collection took place online, participants represented a group of women familiar with the technology used in telehealth consultations. Our study excluded non-English speakers, whose telehealth SRH experiences may differ. Transitioning from focus groups to interviews may have resulted in different findings.

Overall, women in New York preferred telehealth for basic SRH in primary care settings. Incorporating patient considerations for high-quality telehealth SRH and addressing barriers may expand access and promote reproductive autonomy. Future studies should explore strategies to integrate patients' perceptions of metrics for high-quality telehealth for SRH in primary care.

Funding

This study was funded by the Professional Staff Congress of the City University of New York (PSC-CUNY), grant #TRADB-51-289.

Ethical approval

This study was approved by the Institutional Review Board of the City University of New York (Protocol #2021-2006-PHHP).

Conflict of interest

None declared.

Data availability

The data underlying this article cannot be shared publicly due to confidentiality and privacy of study participants. The data

will be shared on reasonable request to the corresponding author.

References

1. Lindberg LD, VandeVusse A, Mueller J, Kirstein M. Early impacts of the COVID-19 pandemic: findings from the 2020 Guttmacher survey of reproductive health experiences. Guttmacher Institute. Published June 2020 [accessed 2022 Jun 8]. <https://www.guttmacher.org/report/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health>
2. Potter JE, Stevenson AJ, Coleman-Minahan K, Hopkins K, White K, Baum SE, Grossman D. Challenging unintended pregnancy as an indicator of reproductive autonomy. *Contraception*. 2019;100(1):1–4.
3. Koonin LM, Hoots B, Tsang CA, Leroy Z, Farris K, Jolly T, Antall P, McCabe B, Zelis CBR, Tong I, et al. Trends in the use of telehealth during the emergence of the COVID-19 pandemic—United States, January–March 2020. *MMWR Morb Mortal Wkly Rep*. 2020;69(43):1595–1599.
4. American Academy of Family Physicians. Telehealth and telemedicine. Published December 2021 [accessed 2022 Jun 8]. <https://www.aafp.org/about/policies/all/telehealth-telemedicine.html>
5. Weigel G, Frederiksen B, Ranji U, Salganicoff A. Telemedicine in sexual and reproductive health. Kaiser Family Foundation. Published November 22, 2019 [accessed 2022 Jun 8]. <https://www.kff.org/womens-health-policy/issue-brief/telemedicine-in-sexual-and-reproductive-health/>
6. Manze MG, Romero DR, Sumberg A, Gagnon M, Roberts L, Jones H. Women's perspectives on reproductive health services in primary care. *Fam Med*. 2020;52(2):112–119.
7. Polinski JM, Barker T, Gagliano N, Sussman A, Brennan TA, Shrank WH. Patients' satisfaction with and preference for telehealth visits. *J Gen Intern Med*. 2016;31(3):269–275.
8. Predmore ZS, Roth E, Breslau J, Fischer SH, Uscher-Pines L. Assessment of patient preferences for telehealth in post-COVID-19 pandemic health care. *JAMA Netw Open*. 2021;4(12):e2136405.
9. Ender M, Lavelanet A, Cleeve A, Ganatra B, Gomperts R, Gemzell-Danielsson K. Telemedicine for medical abortion: a systematic review. *BJOG*. 2019;126(9):1094–1102.
10. Trent M, Thompson C, Tomaszewski K. Text messaging support for urban adolescents and young adults using injectable contraception: outcomes of the DepoText pilot trial. *J Adolesc Health*. 2015;57(1):100–106.
11. Thompson TA, Ahrens KA, Coplon L. Virtually possible: using telehealth to bring reproductive health care to women with opioid use disorder in rural Maine. *Mhealth*. 2020;6:41–51.
12. Braun V, Clarke V. Reflecting on reflexive thematic analysis. *Qual Res Sport Exerc Health*. 2019;11(4):589–597.
13. Manze M, Romero D, Johnson G, Pickering S. Factors related to delays in obtaining contraception among pregnancy-capable adults in New York state during the COVID-19 pandemic: the CAP study. *Sex Reprod Healthc*. 2022;31:100697.
14. Chattu VK, Lopes CA, Javed S, Yaya S. Fulfilling the promise of digital health interventions (DHI) to promote women's sexual, reproductive and mental health in the aftermath of COVID-19. *Reprod Health*. 2021;18(112).
15. Stifani BM, Smith A, Avila K, Boos EW, Ng J, Levi EE, Benfield NC. Telemedicine for contraceptive counseling: patient experiences during the early phase of the COVID-19 pandemic in New York City. *Contraception*. 2021;104(3):254–261.
16. Barney A, Buckelew S, Mesheriakova V. The COVID-19 pandemic and rapid implementation of adolescent and young adult telemedicine: challenges and opportunities for innovation. *J Adolesc Health*. 2020;67(2):164–171.
17. Simon MA. Responding to intimate partner violence during telehealth clinical encounters. *JAMA*. 2021;325(22):2307–2308.

18. Perrin A, Turner E. Smartphones help blacks, Hispanics bridge some—but not all—digital gaps with whites. Pew Research Center. Published July 16, 2021 [accessed 2022 Jun 8]. <https://www.pewresearch.org/fact-tank/2021/07/16/home-broadband-adoption-computer-ownership-vary-by-race-ethnicity-in-the-u-s/>
19. Vogels E. Some digital divides persist between rural, urban and suburban America. Pew Research Center. Published August 19, 2021 [accessed 2022 Jun 8]. <https://www.pewresearch.org/fact-tank/2021/08/19/some-digital-divides-persist-between-rural-urban-and-suburban-america/>
20. American Association for Public Opinion Research. Report on Online Panels. 2010 [accessed 2022 Jun 8]. <https://www.aapor.org/Education-Resources/Reports/Report-on-Online-Panels.aspx#ExecutiveSummary>