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# Journal of Midwifery & Women's Health

The Official Journal of the American College of Nurse-Midwives

SPECIAL CONTINUING EDUCATION ISSUE

## Gynecologic, Sexual, and Reproductive Health Care

Journal of Midwifery & Women's Health

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## Aims & Scope

The *Journal of Midwifery & Women's Health (JMWH)* is the official journal of the American College of Nurse-Midwives. This peer-reviewed journal includes new research and current knowledge across a broad range of clinical and interprofessional topics including perinatal care, gynecology, sexual and reproductive health, primary care, public health, health care policy, and global health. With a focus on evidence-based practice, *JMWH* promotes health equity and excellence in midwifery.

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## Editorials



## Commentaries



## Original Research and Reviews

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Editorial

# From *Here* to *Enough*: Fulfilling Midwives' Responsibility to Our Patients and Our Profession

One of the first lines in my recent acceptance speech for the 2021 Excellence in Leadership & Innovation Award was "I honestly never would have guessed I would have ended up here." And I meant it, deeply. *Here*, in that context, meant so much more than the virtual platform at which I, a transgender and nonbinary midwife, stood to accept my award. It meant so much more than the act of receiving an award. *Here* was having reached a point where loneliness was no longer the most defining feature of my career as midwife. *Here* was a moment of hope, even as I stumbled over the flood of grief, previously carefully buried, that that hope made space for.

With the launch of a new virtual issue of the *Journal of Midwifery & Women's Health* (*JMWH*) focused on health care for transgender and nonbinary individuals,[1] midwives find ourselves at a new *here*. When I started my midwifery education in 2010, *JMWH* had—in all its history—published only one article on the health needs of transgender and nonbinary people. Now, there is an online collection of *JMWH* articles highlighting a range of topics specific to providing care for transgender and nonbinary individuals, including gender-affirming care,[2,3] contraception care,[4,5] pregnancy care,[6] educational strategies to reduce bias in care provision,[7,8] and primary care.[9] Again, I never would have guessed we would have ended up here. That this is possible in a midwifery-focused space is the result of tremendous effort on the part of transgender and nonbinary midwives and our cisgender accomplices. I'm so glad we have made it this far. And, we must recognize that this is a jumping-off point rather than an end point. So where do we go next?

To address that question, I first take a step back to reflect on another notable thing about this issue of *JMWH*: it is the last issue under the long-standing editorial leadership of Dr. Francie Likis, a midwife and writer whom I count as one of the cisgender accomplices who has been so integral in getting us *here*. Francie has been a treasured mentor and friend to me throughout my career, and I have been continually heartened to see her bravery and graceful ferocity in advocating for lesbian, gay, bisexual, queer, and transgender and nonbinary communities.

Included in the health care for transgender and nonbinary individuals virtual issue are 2 editorials that Francie has written in the past 3 years regarding inclusive language in the Journal and in the midwifery field.[10,11] In 2018, Francie called me for a chat as she was working on her editorial "Intentional Inconsistency as Gender-Neutral Language Evolves." I agreed with her that this flexible and measured approach of intentional inconsistency was appropriate to the state of the profession at that time. And I said, "This is good enough for now. But we will soon reach a point where it is not enough, and we will have to do more." Francie and I had the same conversation about the title of the text *Women's Gynecologic Health*,[12] which is now—to this midwife's delight—simply and accurately titled *Gynecologic Health Care*.[13]

My life as a midwife has been sprinkled with such moments of delight and victory. But in the day-to-day tedium and intimacy of my career, I have lived primarily in spaces of *good enough*. I have settled and I have waited and I have endeavored to carve out little nooks and crannies where my patients from communities underrepresented in midwifery can feel understood and cared for. Then, recently, I had the opportunity to work with a couple of midwives who are both newer to midwifery and newer to articulating their nonbinary identities than I am. Without intentionally setting out to do so, they taught me that in this *good enough*, I am still operating out of a place of loneliness, fear, and scarcity—the legacy that my nearly 10 years as a midwife has gifted me. If what I had created in the professional space the 3 of us inhabit together was a tiny chain of beautiful islands, they looked at the ugliness of the polluted sea that surrounded them and said *this is not enough, this needs to change*. And they were right.

The field of midwifery has reached the point of *not enough*, and we have to do more. In truth we have always been at the point of not enough, but we must now—as a professional community—take accountability for that fact. We must take responsibility for the reality that we simply have not done what is required of us, or we have not done it well, and that the state of our profession is *not enough*, in so many ways.

It is *not enough* that there are still midwives and birth workers who insist that gender diversity is pathology and seek to demean and invalidate transgender and nonbinary people's knowledge of who we are as pregnant and birthing people and as parents. It is *not enough* that midwives are just now starting to really speak about the racism that is baked into our profession, and what it has cost midwives and midwifery patients of color. It is *not enough* that it is so hard—and often impossible—for patients of color to access culturally concordant midwifery care. It is *not enough* that fatphobia continues to be a cornerstone of what midwives call "health" or that we continue to both overtly and subtly deny the sexuality and autonomy of people with disabilities. It is *not enough* that access to safe and legal abortion is being eroded and that some midwives and other health care providers actively advocate for this terrible loss of safety and self-determination.

The *here* that the midwifery profession is operating within and that we cannot divorce ourselves from—the *here* in which crash surgical deliveries are performed in the intensive care unit rooms of pregnant people dying of COVID-19, in which Black birthing people are dying at unthinkable rates, in which many of the babies born into our midwife hands will live their lives under constant threat of police violence or hate violence—is *not enough*. It is not okay. But how do midwives move forward out of this place of pain and violence, taking responsibility from what is ours to attend to and make amends

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for? How do we face the transition phase of our collective labor?

There are so many answers to that question, and I am not the best person to provide most of them. But in the pages of the new virtual issue and this theme issue focused on gynecologic, sexual, and reproductive health care, my suggestion is: we honor the legacy of openness to change and movement toward justice and nurturing mentorship that Francie Likis has embodied in her tenure as Editor-in-Chief. And we take it further. We do what is required of us. We push the needle forward with courage and tenacity. We use inclusive language. We build a midwifery profession that centers the needs and leadership of those most deeply impacted by health disparities. We create for our patients what we truly want for them and for ourselves. We step back when that is what is needed, we step up when that is what is needed, we show up, we do better, we do the work, we change.

We do what midwives do: usher in the next generation of hope with loving hands and courageous hearts. And then we can discover all the beautiful *here*s that lie ahead.

Simon Adriane Ellis, CNM, MSN, ARNP
*Associate Editor*

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Editorial

# Looking Back, Looking Forward: Using Our Power for Good

As I undertook the daunting task of writing my final editorial as the Editor-in-Chief of the *Journal of Midwifery & Women's Health* (*JMWH*), I began by reading my inaugural editorial. In January 2008, I stated my primary goal as the incoming Editor-in-Chief was to maintain the high standards of this well-respected journal while supporting its continued evolution.[1] At the time, I had no idea how much change would take place in the years ahead. The Journal has grown in size and reach, its content and authorship have broadened, the midwifery profession has thrived in some areas and struggled in others, and scholarly publishing has become increasingly complex.

Some of the Journal's key metrics provide a sense of the growth that has occurred. Between 2008 and 2020, the number of new manuscripts received annually increased from 248 to 627. The number of peer reviewers has quadrupled with nearly 500 individuals now serving as reviewers. In my first year as Editor-in-Chief, the Journal contained 574 print pages, and there were 253,311 downloads of full-text articles from the Journal's website. Last year, there were 836 print pages and 744,887 downloads. The number of times articles in *JMWH* were cited by other articles in a given year increased from 514 cites in 2008 to 2622 cites in 2021.

These numbers are impressive but what is more meaningful to me is that the Journal is highly respected within and beyond the midwifery profession. The editors receive submissions from authors around the world who represent a wide range of professions and disciplines. The continued increase in downloads and citations demonstrates *JMWH* content is attracting attention from readers and considered a trustworthy source. There are articles in the Journal that have documented midwifery's advancement, and others that serve as a beacon for its future. Pioneering and dedicated editorial efforts to promote health equity[2,3] and intentional language[4–7] can be seen throughout the pages of *JMWH* and the Journal's website.[8,9] The editors have developed a virtual issue filled with resources to help authors navigate the contemporary publication process,[10] including avoiding unethical predatory publishers.[11] The Journal's editorial policies have been recognized as exemplars for other journals.[12]

The editorials I have written for *JMWH* have been a powerful opportunity for me to speak directly to midwives and our colleagues about a variety of subjects related to health and health care, the midwifery profession, and scholarly publishing. Having this platform to share ideas and calls for action has been a privilege, and I have sought to use this space to elevate topics that would benefit from more awareness and open discussion. It is very meaningful to have heard that some of the editorials I considered most important also resonated for readers, such as the ones about inclusive language[3] and images,[13] antiracism,[14] having a life beyond work,[15] mental illness,[16] and the many ways of midwifing.[17] There have also been instances in which the best use of my platform was to make room for other voices that needed to be heard.[18,19]

One of the fundamental commitments of the *JMWH* editors is mentoring authors and reviewers. I have always considered one of my best skills as an editor to be helping authors improve their writing while maintaining their voice, and the pride and joy authors have when their work is published is one of the most rewarding aspects of being Editor-in-Chief. The decades of mentorship by *JMWH* editors have helped grow the cadre of midwifery authors and reviewers, some of whom have gone on to become Editorial Board members and editors for both *JMWH* and other journals.

I certainly did not make all of the accomplishments and progress of the past 14 years happen myself, but I helped them happen and am proud of how the Journal has evolved during my tenure. I am deeply grateful to the extraordinary partners I have had in this work: the *JMWH* Deputy Editors Tekoa King, Patricia Aikins Murphy, and Ira Kantrowitz-Gordon; Managing Editor Brittany Swett; and Editorial Board members. Of course, *JMWH* could not exist without the authors whose scholarly work fills the Journal's pages, and the peer reviewers whose assessments and recommendations improve individual manuscripts and the Journal as a whole. The contributions of each of these individuals is sincerely appreciated. *JMWH* is the official journal of the American College of Nurse-Midwives (ACNM), and I am thankful that ACNM's staff and volunteer leaders have always respected the editorial independence that is necessary for the integrity of a society-owned journal.

As I step down as Editor-in-Chief, I want to part with what has become my mantra in this role and beyond: use your power for good. I came into this position not entirely comprehending the power that accompanied it. I knew I would have the weighty responsibility of making decisions to accept or reject manuscripts. What I did not anticipate was the larger influence I suddenly gained because I was an editor; people perceived me to be an authoritative source on many different topics and sought my input as such. This provided me with opportunities to make changes that positively affected not only the Journal but also the midwifery and editor professions. While I have had reservations about power because of its negative connotations, power is not inherently bad or good. Power is, as Dr. Martin Luther King, Jr. so eloquently stated, the ability to achieve purpose and effect change. Whether power is a positive or negative force is determined by how that ability is used and what the goals of change are. Each of us can choose how we use the power we wield. We can help or harm. We can lift or oppress. We can unite or divide. We can value or demean.

While being an editor comes with unique power, all midwives have power as highly educated professionals. Using power is not a new concept for our profession. Midwives

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have always been changemakers, and advocacy is woven into the fabric of the profession. The goal of effecting change is present throughout the hallmarks of midwifery that define and guide our profession. Advocacy of non-intervention in normal processes; promotion of person-centered care for all; empowerment of persons seeking midwifery care; and advocating for informed choice, shared decision making, and the right to self-determination are all ways midwives use our power.[20]

Power is both a tool and a responsibility. Across roles in practice, education, research, and the many other areas in which midwives work, there are countless ways to make a positive difference and create change. The scale of how people use their power varies. The world needs midwives who use their power for good by providing compassionate, evidence-based care to individual patients, as well as midwives who use their power for good at the systems level by helping to build structures that support populations and our profession. Most people can only change the world incrementally, but if we all do that, there will be real change. While the saying "midwives hold the future" is used to reflect the literal work of our hands guiding newborns into the world, midwives also help bring forth a better future for health care and the health of all the individuals we serve.

One of the best ways to use power for good is to share it with others. As midwives strive to build a more equitable and inclusive profession, sharing power is essential. A vital way that midwives can share power within the profession is by serving as clinical preceptors. Precepting falls within the broader category of mentorship, which is an important method of sharing our power with others. Mentoring does not need to be formal. Midwives are mentors every time we answer a colleague's request for help or advice with our time and input, or invite a colleague with less experience to join us in collaborative work. To paraphrase Michelle Obama, for every door that has been opened to you, open a door to others.

Finally, part of using power for good is knowing when it is time to give it to someone else. As I alluded to in my first editorial and fully understand now, one of the Journal's greatest strengths is that it is both enduring and ever changing. Editorial transitions are important for the continued development and betterment of a journal. Midwifing *JMWH* as its Editor-in-Chief has been one of the greatest honors of my career. As I step down from this position, it is my pleasure to welcome Melissa D. Avery, CNM, PhD, FACNM, FAAN, as the 14th Editor-in-Chief of *JMWH*. Melissa and I have been working together closely for the last few months, and she brings tremendous experience and enthusiasm to this role. I look forward to seeing the continued evolution of the Journal under her leadership.

Frances E. Likis, DrPH, NP, CNM
*Editor-in-Chief*

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### TEST ANSWERS

After reading the article, fill in the answers to the test questions on the reverse side of this page in the space provided below.

| | | | | |
|---|---|---|---|---|
| 1. | 2. | 3. | 4. | 5. |
| 6. | 7. | 8. | 9. | 10. |

### EVALUATION

The evaluation questions must be answered to receive CE.

1. Accuracy of content: Poor____ Fair____ Good____ Excellent
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1526-9523/09/$36.00 doi:10.1111/jmwh.13328

## OBJECTIVES

1. Recommend appropriate over-the-counter and prescription treatment options for individuals with genitourinary syndrome of menopause.
2. Diagnose hypoactive sexual desire disorder in women.
3. Contrast different approaches to abortion with pills in the United States.
4. Compare the role of health care providers, family, peers, and sexual partners in young women's decisions to initiate long-acting reversible contraception.
5. Describe strategies to improve health risk assessment.

## TEST QUESTIONS

Select the one best answer for each of the multiple-choice questions below.

1. Which of the following questions is most appropriate for the sexual history in a comprehensive midwifery patient health risk assessment?
   a. Are you having sex with women, men, or both?
   b. Are you sexually active?
   c. Are you using contraception?

2. Genitourinary syndrome of menopause:
   a. is progressive without treatment.
   b. occurs in 10% to 20% of postmenopausal women.
   c. usually lessens or resolves with time.

3. Which of the following statements about first-line treatment options for genitourinary syndrome of menopause is true?
   a. Vaginal moisturizers intended for long-term use require a prescription.
   b. Some vaginal lubricants are hyperosmotic and can cause epithelial damage.
   c. Vaginal moisturizers and lubricants improve health of the vaginal tissue.

4. Vaginal estrogen therapy:
   a. can be used in women using systemic estrogen therapy.
   b. reaches maximum efficacy within 6 weeks.
   c. is more effective in a cream compared to a pill, suppository, or ring.

5. The PLISSIT model used in screening for hypoactive sexual desire disorder includes:
   a. laboratory testing.
   b. permission.
   c. pelvic examination.

6. Flibanserin:
   a. can cause hypertension and somnolence.
   b. is approved for premenopausal women.
   c. should be stopped if no effect is noticed at 4 weeks.

7. Bremelanotide:
   a. is approved for postmenopausal women.
   b. may increase blood pressure.
   c. requires daily dosing.

8. According to research, the FDA-approved gestational age limit of 70 days for medication abortion can be extended to:
   a. 77 days.
   b. 80 days.
   c. 84 days.

9. In their systematic review of social network influences on young women's choice to use long-acting reversible contraception (LARC), Mahony et al found that:
   a. partners do not influence young women's decision to use LARC.
   b. peers are sources of primarily positive but often inaccurate information about LARC.
   c. young women find health care providers to be important in their decision to use LARC.

10. Individuals who are transgender and gender diverse and assigned female at birth:
    a. do not need contraception if they are on testosterone and amenorrheic.
    b. have the same contraindications for intrauterine device use as cisgender women.
    c. prefer amenorrhea and thus are not good candidates for a copper intrauterine device.

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# Bacterial Vaginosis

### What is bacterial vaginosis?

Many types of bacteria live in the vagina and keep the vagina healthy. Bacterial vaginosis (BV) happens when there are more unhealthy bacteria in the vagina than healthy bacteria. BV is the most common vaginal infection in women who are 15 to 44 years old.

### How do I know if I have BV?

Many women who have BV do not have any symptoms. You may have more vaginal discharge than usual. Your discharge may be gray or white and have a fishy smell. This smell is often worse right after having vaginal sex with a male partner. You also may have burning or itching in your vagina or burning during urination.

### How would I get BV?

No one is sure why women get BV. Any woman can get BV, but it usually happens in women who have had sex with another person. Some women have a higher chance of getting BV than others. Women who have new sex partners, more than one sex partner, or female sex partners are more likely to get BV. Women who have genital herpes have a higher chance of getting BV. Douching also makes your chance of getting BV higher.

### How can I keep from getting BV?

Because it is not clear how BV is spread, no one knows the best way for women to prevent it. Some things you can do that may keep you from getting BV are:

- Only have sex with one person who agrees to only have sex with you.
- Do not douche. Douching removes healthy bacteria that protect your vagina.
- Use condoms every time you have sex. Women whose male partners use condoms have a lower chance of having BV.
- Do not have sex.

### How is BV treated?

BV is treated with antibiotics. You can take pills or use a medicine that you put in your vagina. Take all your medicine even if your symptoms go away. Your sex partners do not need to be treated if you have BV. Avoid having vaginal sex until you finish the medicine. The medicines that go in your vagina can cause latex condoms and diaphragms to get holes in them. That makes it easier for you to get pregnant or get a sexually transmitted infection (STI) if you have sex.

### How does BV affect my baby and me if I am pregnant?

Women who have BV have a higher chance of having their babies early, having a baby who weighs less than 5 1/2 pounds at birth, and getting an infection in their uterus. If you have symptoms of BV while you are pregnant, treatment is recommended. The antibiotics are safe for you and your baby during pregnancy.

### Does having BV cause other health problems?

Women who have BV have a higher chance of having other health problems such as:

- Getting another STI like gonorrhea or chlamydia if you have sex with someone who has an STI.
- Getting HIV if you have sex with someone who has HIV.
- Passing HIV to your partner if you have HIV and BV.

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## When should I see a health care provider?

You should call your health care provider if you think you might have a vaginal infection. Your provider will test your vaginal discharge to see if you have BV, a different vaginal infection, or an STI. All of these infections can have similar symptoms, but the treatment for each of them is different.

### For More Information

**Centers for Disease Control and Prevention**
https://www.cdc.gov/std/bv/stdfact-bacterial-vaginosis.htm

**Healthy Women**
http://www.healthywomen.org/condition/bacterial-vaginosis

Flesch-Kincaid Grade Level: 6.5
Approved November 2021. This handout replaces "Bacterial Vaginosis" published in Volume 60, Number 3, May/June 2015.

# Chlamydia and Gonorrhea

## What are chlamydia and gonorrhea?

Chlamydia and gonorrhea are infections that you get from someone else by having sex. These infections are caused by bacteria that are passed to you from your sex partner. It is common to have chlamydia and gonorrhea at the same time. These infections can move up from your vagina and cervix (the opening to your uterus) to infect your uterus and fallopian tubes (tubes that carry your eggs from your ovaries to your uterus). Chlamydia and gonorrhea can also cause infection in the rectum and rarely in the mouth, throat, or eyes.

## How do I know if I have chlamydia or gonorrhea?

Most women do not have any symptoms when they have chlamydia or gonorrhea. Some women have vaginal discharge, burning with urination, or bleeding between periods. Men who have chlamydia or gonorrhea may have a discharge from their penis or burning when they urinate. Your health care provider will use a cotton swab to get a small amount of fluid from your cervix or test your urine to see if you have chlamydia or gonorrhea.

## How would I get chlamydia or gonorrhea?

You can get chlamydia or gonorrhea by having vaginal, oral, or anal sex with a person who has the infection. A man does not have to ejaculate (release semen) to pass the infection. You can get chlamydia and gonorrhea again after you are treated if you have sex before your sex partner is treated.

## What are the risks of chlamydia and gonorrhea?

If you have chlamydia or gonorrhea and are not treated, you can get pelvic inflammatory disease (PID). This is a painful infection that can cause scarring in your fallopian tubes if it is not treated. The scarring can cause chronic pelvic pain or infertility (not being able to get pregnant). If you get pregnant after having PID, you can have an ectopic pregnancy (a pregnancy that is outside the uterus and can't live).

## When should I see my health care provider to be tested for chlamydia or gonorrhea?

You should see your health care provider to be tested for chlamydia or gonorrhea if you:

- Think or know you have had sex with a person who has chlamydia, gonorrhea, or another sexually transmitted infection.
- Think your sex partner was not treated for chlamydia or gonorrhea after you were treated.
- Have a male sex partner who has burning or discharge from his penis.
- Have sex with a new person.
- Are having sex with more than one person.
- Have had another sexually transmitted infection.
- Are younger than 25 years old. All women who are younger than 25 and having sex should have a test for chlamydia and gonorrhea once a year.

## How is chlamydia treated?

You will be given antibiotic pills to treat chlamydia infection. You may take pills for several days or be given a medicine where all the pills are taken at one time. Take all the pills you are given. You should be retested for chlamydia 3 months after you are treated. If you are pregnant, you should have another chlamydia test 4 weeks after finishing the medicine. Do not have sex until both you and your sex partner have taken all the medicine you have been given. If you take the pills for 7 days, wait to have sex until you are done taking all the pills. If you take the one-time dose of pills, wait 7 days to have sex.

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### How is gonorrhea treated?

You will be given a shot of an antibiotic to treat gonorrhea. Because chlamydia is often found with gonorrhea, you may also be given antibiotic pills for chlamydia if you are treated for gonorrhea. You should be retested for gonorrhea 3 months after you are treated. Do not have sex until 7 days after both you and your sex partner have been treated, and you do not have any symptoms.

### Does my partner have to be treated if I have chlamydia or gonorrhea?

Any sex partner you have had vaginal, oral, or anal sex with in the past 60 days should be tested and treated for chlamydia and gonorrhea. If it has been more than 60 days since you had sex, your last sex partner should be treated.

### What if I am pregnant and have chlamydia or gonorrhea?

If you have chlamydia or gonorrhea and you are pregnant, you need to be treated with antibiotics right away. These medicines will not hurt your baby. Being treated lowers your chance of giving birth early and giving the infection to your baby at birth. If you are not treated and your baby is exposed to the infection at the time of birth, your baby can get an eye infection, pneumonia (infection in the lungs), or a very serious blood infection.

### How can I keep from getting chlamydia and gonorrhea?

Some ways to prevent getting chlamydia and gonorrhea are:

- Use a condom every time you have vaginal, oral, or anal sex.
- Only have sex with one person who agrees to only have sex with you.
- Talk with your sex partner(s) about STIs and staying safe before having sex.
- Do not have sex with another person. This is the surest way to keep from getting chlamydia and gonorrhea.

### For More Information

**Centers for Disease Control and Prevention**
Chlamydia: https://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm
Gonorrhea: https://www.cdc.gov/std/gonorrhea/stdfact-gonorrhea.htm

**American Social Health Association**
Chlamydia: https://www.ashasexualhealth.org/chlamydia-101/
Gonorrhea: https://www.ashasexualhealth.org/gonorrhea/

**Office on Women's Health**
Chlamydia: https://www.womenshealth.gov/a-z-topics/chlamydia
Gonorrhea: https://www.womenshealth.gov/a-z-topics/gonorrhea

**Healthy Women**
Chlamydia: http://www.healthywomen.org/condition/chlamydia
Gonorrhea: http://www.healthywomen.org/condition/gonorrhea

Flesch-Kincaid Grade Level: 8.3
Approved November 2021. This handout replaces "Chlamydia and Gonorrhea" published in Volume 58, Number 5, September/October 2013.

# Genital Herpes

## What is genital herpes?

Genital herpes is an infection that you get from someone else by having vaginal, oral, or anal sex. About 1 out of 6 people have genital herpes. Herpes is caused by a virus called herpes simplex virus (HSV). Once you get HSV, the virus stays in your body for the rest of your life.

There are 2 types of HSV.

- Herpes simplex virus type 1 (HSV-1) usually causes sores in or around the mouth or lips. These are called cold sores. Almost all cold sores are caused by HSV-1.
- Herpes simplex virus type 2 (HSV-2) usually causes sores in the genital area on the vulva (area around the opening to your vagina), penis, or anus. HSV-2 can also cause sores in the vagina. Some genital herpes infections are caused by HSV-1.

## What are the symptoms of genital herpes?

Most people who have herpes do not know they have this infection because they have no symptoms or very mild symptoms. Some people who have genital herpes get sores that can cause pain, burning, tingling, or itching. Herpes sores start as one or more blisters on the skin. The blisters break open and leave an open sore. The sores may be very small or as large as one inch across. The skin around the sores may be red, swollen, and warmer than your other skin. Herpes sores can be very painful. Some people with herpes will feel burning, itching, or tingling in the area where the sore is going to be a few days before they have the sore. These are called prodromal symptoms.

## What is a genital herpes outbreak?

Any time you get a herpes sore, this is called a herpes outbreak. The first time you have an outbreak you may feel sick like you have the flu. You can have fever, body aches, pain when you urinate, and swollen glands in your groin area.

Although herpes is a lifelong infection, some people will only have one outbreak. Others will have more outbreaks after the first one. This is called recurrent herpes. Most people with recurrent outbreaks have a few per year. Some people have more than that, and some have less. Usually, people with recurrent herpes have outbreaks less often as the years go by.

## How do I know if I have genital herpes?

Your health care provider may be able to tell if a sore is herpes by just looking at it. A cotton swab can also be used to collect some of the fluid in the sore. This sample is tested to see if HSV is present. This test works better if the sores have just appeared within the last few days. Call your health care provider as soon as possible if you think you have a herpes sore. If you are worried you have herpes without any symptoms, a blood test for herpes can be done. The blood test does not tell you who you got herpes from or how long you have had herpes.

## How is genital herpes treated?

Antiviral medicine can help during outbreaks and between outbreaks. Antiviral pills for genital herpes are oral (go in your mouth). Antiviral pills are recommended for everyone with a first herpes outbreak. If you have repeat outbreaks, you can choose how often you take antiviral pills:

- Episodic therapy is when you take antiviral pills when you first feel prodromal symptoms or notice a sore. Episodic therapy can make the sores go away faster and make the outbreak less painful. Taking over-the-

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counter pain relievers like acetaminophen (Tylenol) or ibuprofen (Advil), soaking in warm water, and wearing loose clothing can also help make the outbreak less painful.
- Suppressive therapy is when you take antiviral pills every day to prevent outbreaks. If you stop taking the pills, you may start having outbreaks again.
- Talk with your health care provider to see if taking antiviral pills is right for you.

### How is herpes spread from one person to another?

Herpes is spread by skin-to-skin contact with a herpes sore or the genital area, mouth, or anus of a person who has the virus. People who have herpes are most likely to spread the virus when they have prodromal symptoms or a sore. People who have herpes can spread the virus even when they do not have any symptoms.

### How can I keep from getting herpes?

The only way to make sure you never get genital herpes is to not have sex with another person. There is no vaccine to keep you from getting herpes. If you are having sex, you can lower your chance of getting herpes by only having sex with one person who agrees to only have sex with you. Using a condom or dental dam every time you have vaginal, oral, or anal sex will also help prevent herpes. Do not have sex with a partner who you know or think has herpes during your last 3 months of pregnancy. You or your partner might have herpes but have no symptoms. You and your partner can get a blood test for herpes before you start having sex.

### If my sex partner or I have herpes, how can we keep it from spreading?

Being open and honest with your sex partner about having herpes is very important. If a person who has herpes takes antiviral pills every day, their chance of spreading the virus is much lower. Do not have sex when you or your partner has prodromal symptoms or herpes sores.

### What if I am pregnant and have genital herpes?

Your baby will not get herpes during pregnancy. If you have herpes and have a herpes outbreak near the vagina during the birth, there is a very low chance your baby will get herpes during birth. The chance your baby will get herpes is much higher if you have your first herpes outbreak around the time of birth. Your health care provider may recommend you take antiviral pills near your due date to prevent a recurrent outbreak. Cesarean birth may be recommended if you have a herpes sore or prodromal symptoms when you go into labor.

### For More Information

**Centers for Disease Control and Prevention**
https://www.cdc.gov/std/herpes/stdfact-herpes.htm

**American Sexual Health Association**
https://www.ashasexualhealth.org/herpes/

**Office on Women's Health**
https://www.womenshealth.gov/a-z-topics/genital-herpes

Flesch-Kincaid Grade Level: 6.1
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# Hepatitis C

## What is hepatitis?

Hepatitis is inflammation (swelling) of the liver. The most common types of hepatitis are A, B, and C. These types of hepatitis are caused by 3 different viruses.

Hepatitis C is caused by the hepatitis C virus that is in blood. You get hepatitis C from the blood of a person who has the hepatitis C virus. You cannot get hepatitis C from living in the same home with a person who has hepatitis C, touching them, or breathing in air from them.

## What are the symptoms of hepatitis C?

Most people with hepatitis C do not have symptoms and do not know they have the virus. Hepatitis C starts with an acute (short-term) infection that can become chronic (long-term) when the virus stays in your blood. Some people feel sick during the acute stage and may have nausea, fatigue, abdominal pain, or dark urine. You have chronic hepatitis if your body does not get rid of all of the virus in your blood within 6 months. If you have hepatitis C and are not treated, you can have long-term liver damage or die.

## Am I at risk for hepatitis C?

People who might get another person's blood in their body are at risk for getting hepatitis C. Use of injected drugs either now or in the past, even if it was just one time, puts you at risk for hepatitis C. Other risk factors include a needlestick injury at work, having HIV or hemophilia, and being born to a mother with hepatitis C. If someone close to you has hepatitis C, you can get the virus from using their personal items that might have blood on them, such as a razor or toothbrush. Getting a tattoo or piercing may also increase your risk if there is any blood from another person left on the needles used for you. It is rare but possible to get hepatitis C from having sex with a person who has the virus.

## How do I know if I have hepatitis C?

Many people who have hepatitis C do not know they have it. Even though they do not show signs of hepatitis C, they can still give it to others. You can find out if you have hepatitis C by having your blood tested for the virus. The back of this handout lists who should be tested for hepatitis C. If you have no risk factors, you should get the test once as an adult. If you have risk factors, you may need the test done more often.

## Are there vaccines for hepatitis?

There is no vaccine for hepatitis C. There are vaccines to protect people from getting hepatitis A and hepatitis B.

## Can hepatitis C be treated?

In some people, the acute hepatitis C infection will go away without treatment. Others will need medication to keep the acute hepatitis from becoming chronic, or to treat chronic hepatitis. There are different medications for hepatitis C. Your health care provider will help you choose which medicine is best for you.

## What if I am pregnant and have hepatitis C?

Pregnancy does not make hepatitis C worse. Pregnant women cannot take the medicines used to treat hepatitis C because they can cause birth defects. About 6 out of 100 babies whose mothers have hepatitis C will be born with the infection. If you have HIV, the chance your baby will get hepatitis C is higher. The baby gets the infection during birth, not during pregnancy. If you have hepatitis C, your baby should be tested when they are 12 to 18 months old. Babies who appear sick or whose mothers also have HIV can have an earlier test that is then checked again when the baby is 18 months old.

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### If the danger of giving hepatitis C to my baby happens during birth, should I have a cesarean birth?

Having a cesarean does not lower the chance of your baby getting the hepatitis C virus. You do not need to plan a cesarean birth if you have hepatitis C. Talk with your health care provider about the birth plan that is best for you.

### If I have hepatitis C, can I breastfeed?

Yes. Studies have found hepatitis C is not passed to your baby when breastfeeding. Giving your baby breast milk helps protect them from many diseases. Breast milk helps babies' bodies fight infection. If you have hepatitis C and your nipples are cracked and bleeding, you may not want to breastfeed your baby until your nipples have healed.

### Should I be tested for hepatitis C?

You should have a test for hepatitis C if you:

- Are 18 or older and have not had a hepatitis C test before.
- Are pregnant. This test is recommended every time you are pregnant.
- Have HIV.
- Currently use injected drugs.
- Have ever injected drugs in the past, even one time.
- Had a blood transfusion (got blood from another person) or organ transplant before 1992, or if you received a clotting factor before 1987.
- Have been told you got a blood transfusion from a person who later tested positive for hepatitis C.
- Have had long-term hemodialysis or a health problem that has caused liver damage.
- Are a health care, emergency medical, or public safety worker who has had a known exposure to hepatitis C-positive blood through a needlestick, sharp, or mucus membrane.
- Are a child born to a mother with hepatitis C.
- Want to have this test.

### For More Information

**American Liver Foundation**
https://liverfoundation.org/for-patients/about-the-liver/diseases-of-the-liver/hepatitis-c/

**National Institute of Diabetes and Digestive and Kidney Disease**
https://www.niddk.nih.gov/health-information/liver-disease/viral-hepatitis/hepatitis-c

**Centers for Disease Control and Prevention**
http://www.cdc.gov/hepatitis/hcv/cfaq.htm

Flesch-Kincaid Grade Level: 7.6
Approved November 2021. This handout replaces "Hepatitis C" published in Volume 62, Number 2, March/April 2017.

# Sexually Transmitted Infections

### What is a sexually transmitted infection (STI)?

An STI is an infection that you get from someone else by having sex. You can get an STI from having vaginal, oral, or anal sex. STIs are common infections in the United States. More than a million people get STIs every year.

### What are the most common STIs?

**Chlamydia** causes an infection in the vagina and cervix (opening to your uterus). Most women who have chlamydia have no symptoms and do not know they have chlamydia. Some women have burning with urination or vaginal discharge. If chlamydia is not treated, it can cause a painful infection in the pelvic organs (uterus, tubes from the uterus to the ovaries, and ovaries) called pelvic inflammatory disease (PID). Chlamydia is treated with antibiotics. Both you and your partner will need to be treated. If you have chlamydia, you should get retested 3 months after you get treatment.

**Genital herpes** causes painful sores on the vulva (area around the opening to your vagina), in the vagina, and around the anus. The sores last several days and may burn or itch. The first time a person gets the sores, they may also have fever, headaches, and pain with urination. The herpes virus stays in your body for the rest of your life. Some people get the sores often, and some do not get them very often. There are antiviral medicines that can make the sores go away faster. You can also take medicine daily to keep from getting sores.

**Genital warts** look like bumpy growths on your vulva, in your vagina, or around your anus. Warts often go away on their own but can be removed if needed. Genital warts are caused by the human papillomavirus (HPV). There are many different types of HPV. Most people who have sex will get HPV at some point in their lives. For women, the biggest concern is that some types of HPV cause cancer of the cervix. Getting regular Pap tests can help to prevent cancer of the cervix. You can get an HPV vaccine to protect you against the types of HPV that cause genital warts and cancer.

**Gonorrhea** causes an infection in the genital area or mouth. Many women will not have symptoms or know they have gonorrhea. Some women will have vaginal discharge, vaginal bleeding between periods, or burning with urination. Gonorrhea is treated with antibiotics. Both you and your partner will need to be treated. If you have gonorrhea, you should get retested 3 months after you get treatment.

**HIV/AIDS** is an STI that can cause serious illness in many parts of the body. HIV cannot be cured. If you have HIV, you can take medicines to help keep the disease from making you very sick.

**Syphilis** causes different symptoms over time. The first stage causes one or more painless sores near the genitals, anus, rectum, or mouth. The second stage can cause a rash, fever, and swollen glands. The final stage can cause damage to other parts of the body without symptoms. Syphilis is treated with penicillin. You should not have sex until the sores are gone.

**Trichomoniasis,** which is also called "trich, " causes an infection in the vagina. Women may have a bad-smelling vaginal discharge, and vaginal itching or burning. Some women have no symptoms. Trich can be treated with antibiotics. Both you and your partner need to take the medicine.

### I have only had sex with one partner. Do I have to worry about STIs?

Anyone who is having vaginal, oral, or anal sex can get an STI. If you have only one partner during your life, you are at less risk. It is important to remember that you may not know for sure if your partner has had other partners.

### How do I keep from getting an STI?

Some ways to prevent getting an STI are:

- Get a vaccine for HPV if you are between 11 and 26 years old. If you are 27 to 45 years old and have not had an HPV vaccine, talk with your health care provider about whether you should get one.

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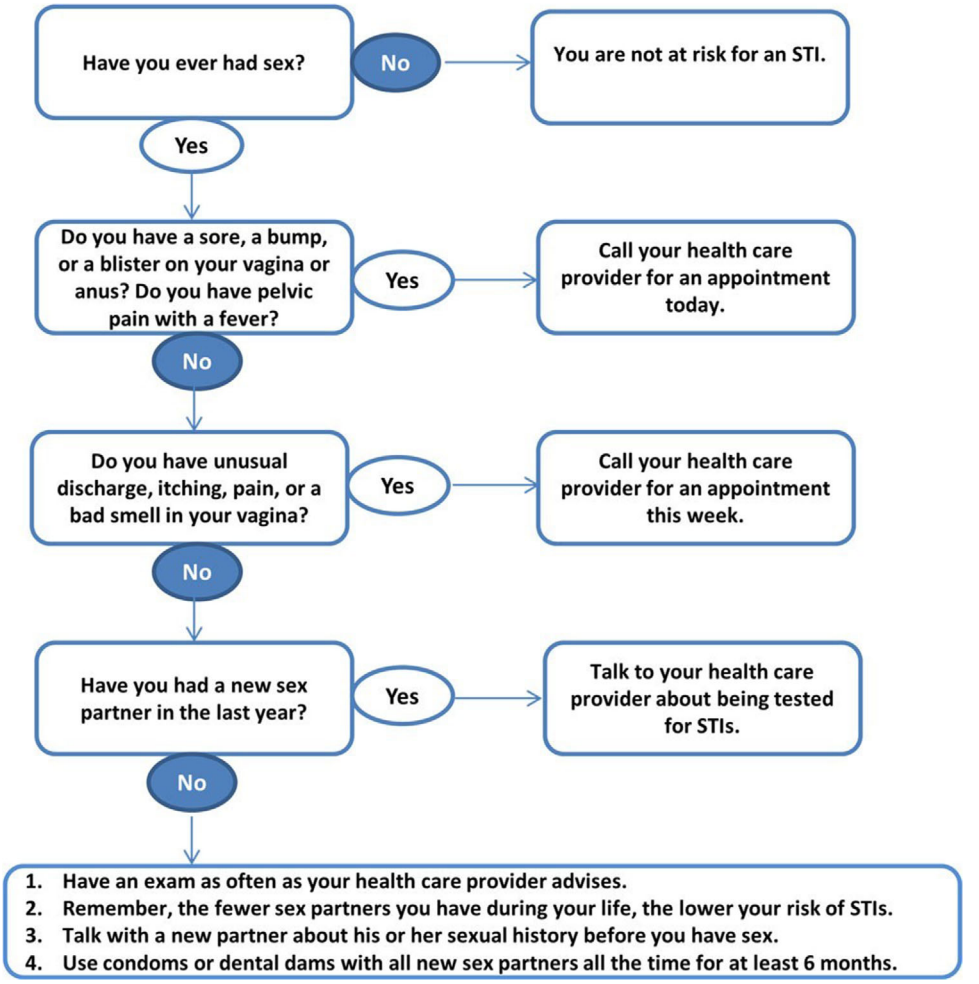
- Get a vaccine for hepatitis B if you have not already had one.
- Do not have sex with another person. This is the surest way to avoid STIs.
- Use a condom every time you have vaginal, oral, or anal sex.
- Only have sex with one person who agrees to only have sex with you.
- Talk with your sex partner(s) about STIs and staying safe before having sex.

### When should I see a health care provider?

The following guide can help you decide when you need to see your health care provider about STIs.




### For More Information

**Centers for Disease Control and Prevention**
General Information: https://www.cdc.gov/std/general/default.htm
The Lowdown on How to Prevent STIs: https://www.cdc.gov/std/prevention/lowdown/
National STI Hotline: 800-232-4636 (English and Spanish)

**American Social Health Association**
http://www.ashastd.org

Flesch-Kincaid Grade Level: 6.8
Approved November 2021. This handout replaces "Sexually Transmitted Infections (STIs) " published in Volume 58, Number 5, September/October 2013.

# Vaginal Candidiasis (Yeast Infection)

### What is vaginal candidiasis?

Women normally have some yeast cells and other bacteria that live on their skin, in their intestine (gut), and in their vagina. When there is too much yeast in your vagina, you can have a thick, whitish discharge and vaginal itching, burning, and redness. This is called vaginal candidiasis or a vaginal yeast infection.

### How would I get a yeast infection?

You can have too much yeast in your vagina for many reasons. Yeast grows best in dark, moist areas. Tight clothes, wet clothes, and nylon underwear keep the vagina moist, which helps yeast grow. Yeast can also grow when the normal bacteria in the vagina change, which can happen if you take antibiotics. Hormone changes during pregnancy or when you take birth control pills can also make yeast infections more likely. Yeast infections can be passed between sex partners, but sex is not a common way for women to get a yeast infection.

### How can I keep from getting yeast infections?

Wear cotton underwear to keep moisture out of your vagina. Materials like nylon pantyhose, polyester pants, and wet bathing suits can keep the vagina moist. Avoiding using panty liners may also help prevent yeast infections. Do not use scented soap or scented powder around your vagina, or take bubble baths. These products can irritate your vagina. Do not douche. Douching removes healthy bacteria that protect your vagina from having too much yeast.

### What is the difference between uncomplicated and complicated yeast infections?

Many healthy women get a yeast infection a few times during their life. An uncomplicated yeast infection does not occur often and does not cause severe pain. You can get medicine over the counter at a drugstore to treat this kind of yeast infection. Complicated yeast infections are a yeast infection that happens 3 or more times in a year, one that does not get better after being treated, or one that causes severe pain. Women who have some health problems, such as diabetes or HIV, have a higher chance of getting a yeast infection that is complicated.

### How do I treat a yeast infection?

Most yeast infections are treated with a cream, suppository, or tablet that is inserted in your vagina. The medicines are used for 1 to 7 days depending on which one you get. One-day treatments should only be used for mild infections. If you are having a lot of burning or itching, get a medicine that is used for 3 or 7 days. Sometimes a yeast infection medicine that goes inside the vagina comes with a cream to put on your vulva (area around the opening to your vagina). The back of this handout has a list of yeast infection medicines you can buy over the counter.

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## How should I use the medicine for a yeast infection?

Wash your hands before and after you use these medicines. Insert the medicine high into your vagina. It may be easier to do this while you are lying down. Many yeast infection medicines are used at night just before you go to sleep. This helps the medicine stay in your vagina for several hours. Use the medicine for the entire time, even if you feel better before all the medicine is gone. Stopping the medicine too soon can cause the yeast infection to come back.

A slight burning of the skin or vagina is normal the first few times you use the medicine. It is also common to have more discharge while you are using the medicine. Many of the yeast infection medicines can cause latex condoms and diaphragms to get holes in them. That makes it easier for you to get pregnant or get a sexually transmitted infection if you have sex.

## When should I see a health care provider?

You should see a health care provider if you:

- Have symptoms of a yeast infection for the first time.
- Are not sure if the symptoms you have are from a yeast infection.
- Have severe pain or your vulva has a lot of swelling or redness.
- Used an over-the-counter treatment and still have symptoms.
- Treated a yeast infection less than 2 months ago and have symptoms again.
- Have 3 or more yeast infections in less than 1 year.
- Are pregnant.
- Have diabetes, HIV, or another health problem that affects your immune system.

**Over-the-Counter Medicines for Yeast Infections**

| Medicine | How Long it is Used |
|---|---|
| Clotrimazole 1% cream | 7-14 days |
| Clotrimazole 2% cream | 3 days |
| Miconazole 2% cream | 7 days |
| Miconazole 4% cream | 3 days |
| Miconazole 100 mg vaginal suppository | 7 days |
| Miconazole 200 mg vaginal suppository | 3 days |
| Miconazole 400 mg vaginal suppository | 1 day |

## For More Information

**Centers for Disease Control and Prevention**
https://www.cdc.gov/fungal/diseases/candidiasis/genital/index.html

**Office on Women's Health**
https://www.womenshealth.gov/a-z-topics/vaginal-yeast-infections

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