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COVER: Statewide contraceptive access initiatives offer new and innovative efforts to expand access to contraception, advance person-centered care, and improve health outcomes at the population and health systems levels. This supplemental issue of *AJPH* explores the implementation of statewide contraceptive access initiatives, describes intervention and evaluation components commonly implemented across initiatives, and discusses critical issues around reproductive justice, community engagement, scaling interventions, and future directions. Cover concept and selection by Aleisha Kropf. Image courtesy of bortonia/Getty images. Printed with permission.

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Note. The opinions expressed are those of the authors and do not necessarily represent the views of the Association of State and Territorial Health Officials.

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Reshaping Contraceptive Access Efforts by Centering Equity, Justice, and Autonomy

Policy plays an important role in both expanding and constricting contraceptive access, particularly in the current environment. This special issue focuses on how contraceptive access policy is shaped, how policy is translated into practice, and how a focus on equity, justice, and autonomy has reshaped the field's approach to contraceptive access efforts. Exploring the processes, outcomes, and evolution over the years of statewide contraceptive access initiatives (SCAIs) provides a unique opportunity to evaluate lessons learned, assess outcomes, test and measure impacts of innovations, and explore strategies to integrate person-centered care and equity-focused approaches. This special issue also offers broader intervention highlights beyond SCAIs, including considering wide-ranging policy implications for contraceptive access and how we get people the care they want, where and how they want it.

HOW THESE PAPERS ADVANCE THE FIELD

Public policy and public health programs must be informed by scientific evidence to ensure that they are effective, based in facts, and replicable. When grounded in evidence, innovation in service delivery has the potential to expand access to and improve quality of contraceptive care, especially in communities that face access barriers. Yet, implementation and access to innovative care delivery models varies greatly among states, and evidence on implementation, lessons learned, and impacts is limited.

Fostering research and innovative practices begins with sharing, disseminating, studying, and integrating best practices and lessons learned. Grounded in principles of equity and justice, strategies to move our work to expand contraceptive access forward include the following:

- Investing strategically at the federal, state, and local levels to ensure SCAIs are implemented and evaluated rigorously, with a particular focus on sexual and reproductive health equity;
- Engaging patients and communities to center the needs of those with greatest access barriers and most experiences of injustice, as more SCAIs and other interventions have begun to do, throughout the project design, implementation, and evaluation processes;
- Fostering innovative practices by communicating findings in a manner that facilitates action, and facilitating collective thinking to evolve the way we implement and evaluate projects to advance equity; and
- Ensuring public policy is consistent with scientific evidence and can redress the impact of historical and contemporary reproductive injustice through efforts such as this special issue, which starts to make the evidence base for SCAIs more current, reflecting new approaches to program implementation and evaluation.

CALL TO ACTION

We must continue to ask essential questions about what matters—including which processes, structures, and outcomes are deemed important and, thus, are considered worth funding and measuring. This special issue serves as a starting point to continue this conversation and our learning and to build and maintain equitable systems. We can maintain momentum by staying connected to colleagues and sharing the most up-to-date resources and best practices around contraceptive access efforts, even as projects are in progress, and by fostering deeper thinking about the principles and frameworks that guide our work and developing strategies for prioritizing and integrating them in our policies, research, and practice. AJPH

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7 Years Ago

Realizing Reproductive Health Equity for Adolescents and Young Adults

[T]he Affordable Care Act (ACA) has expanded health care coverage to certain vulnerable populations, including adolescents and young adults. Many preventive health services are required elements of the new insurance exchange plans, including contraceptives, at no additional cost. Therefore, by eliminating cost barriers to contraception for adolescents and young adults, the ACA may usefully abet increased use of LARCs [Long-Acting Reversible Contraceptions], which have high up-front but low overall cost, and ultimately even further decreases in unintended pregnancy and birth rates in this age group. LARC methods may be especially effective in decreasing unintended pregnancy rates among adolescent women who experience reproductive coercion, given that IUDs and implants are less susceptible to partner interference.

From AJPH, July 2015, p. 1284

6 Years Ago

Realizing Reproductive Health Equity Needs More Than Long-Acting Reversible Contraception (LARC)

Over the past 20 years, the reproductive justice movement has articulated a clear vision. . . . When fully realized, this vision offers people access to noncoercive, patient-centered reproductive health counseling and a range of contraceptive methods, and it offers, crucially, the right to have children free of stigma and shame. . . . A reproductive justice approach means reducing barriers to accessing LARC and making them readily available to all fully informed people who want them. However, it also means respecting the decision not to use these methods or to have these methods removed when they wish. The quality of contraceptive programs should be based not on how many LARC methods they distribute, how many adolescent pregnancies they prevent, or how much money taxpayers save, but by how many people feel truly respected and cared for when it comes to childbearing and family formation.

From AJPH, January 2016, p. 19

A Prologue to the *AJPH* Supplement: Using Evidence to Expand Contraceptive Access

Nikita M. Malcolm, MPH, Katrin V. Patterson, MPH, Ellen S. Pliska, MHS, CPH, Sanaa Akbarali, MPH, Susan B. Moskosky, MS, WHNP-BC, and Jamie Hart, PhD, MPH

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Expanding contraceptive access, within the broader goal of achieving sexual and reproductive health and well-being for all people, can support the attainment of individuals' personal goals. Evidence of the effects of initiatives to expand contraceptive access for individual, community, clinical, and health outcomes can support the scaling-up of initiatives. This special issue of *AJPH*, sponsored by the Association of State and Territorial Health Officials (ASTHO), highlights efforts to expand contraceptive access, particularly statewide initiatives, and features articles describing how these projects are conceptualized, implemented, and evaluated.

Over the past 15 years, statewide initiatives to expand contraceptive access have been implemented in multiple US states. Statewide contraceptive access initiatives are population-level approaches, typically serving large geographic regions, that require collaboration among multisectoral partners. In these initiatives, a coalition of organizations undertakes coordinated efforts to expand contraceptive access, such as providing clinical training and capacity building and mobilizing for policy change. A growing body of evidence suggests that these initiatives have the potential to expand access, improve health outcomes, and advance the provision of person-centered care.

This special issue, "Using Evidence to Expand Contraceptive Access," contextualizes the unique role contraceptive access initiatives play in addressing barriers to access, defines and demonstrates the application of common intervention and evaluation components across statewide initiatives, explores the evolution of these initiatives from approaches based on method effectiveness to person-centered approaches that support access to a broad range of contraceptive methods, and presents key lessons learned and early findings emerging from these initiatives. These initiatives offer a lens through which to critically examine how contraceptive access policy is shaped; how policy is translated into practice in communities, care delivery settings, and public health systems; and how advocacy for equity, justice, and human rights has reshaped, and continues to reshape, the field's approach to contraceptive access efforts.

The issue also features a set of invited articles that explore the importance of, and models for, integrating principles of person centeredness and reproductive health equity in contraceptive access initiatives; consider the role of the federal government in advancing contraceptive access and equity; and define a framework for sexual and reproductive health, equity, and well-being that can inform how the field approaches contraceptive access research, practice, and policy.

SHAPING THE SPECIAL ISSUE

ASTHO's efforts to engage statewide contraceptive access initiatives began in 2014, when the association convened the Long-Acting Reversible Contraception (LARC) Immediate Postpartum Learning Community, initially a collaborative of six states, to assist state health agencies in implementing LARC in the postpartum care delivery setting. As the goals and focus of the project expanded, along with the recognition of potential for coercion in LARC-centered initiatives, ASTHO broadened the scope of this effort and convened 27 states and territories to participate in the Increasing Access to Contraception Learning Community from 2016 to 2018, with funding and support from the Centers for Disease Control and Prevention (CDC), the Office of Population Affairs, and the Centers for Medicare & Medicaid Services. This expanded learning community generated key insights into strategies and best practices to implement statewide initiatives that increase access to the full range of contraceptive options and disseminate best practices. Estrich et al., featured in this special issue (p. S523), describe the implementation and evaluation approach for the Increasing Access to Contraception Learning Community and highlight lessons learned for future multistate learning communities.

During summer 2020, ASTHO partnered with the Coalition to Expand Contraceptive Access (CECA) to explore opportunities to disseminate findings of the ASTHO learning communities, the participating statewide initiatives, and broader efforts to expand contraceptive access. CECA is a group of stakeholders committed to ensuring access to contraception for all individuals, as a part of the broader vision of achieving sexual and reproductive health equity in the United States and sexual and reproductive health and well-being for all individuals. CECA's work involves identifying the evidence needed to influence policy and use federal executive branch scientific and administrative processes that influence contraceptive access. A critical federal process for supporting contraceptive access is the development and dissemination of clinical and programmatic guidelines on contraceptive care delivery and programming. In 2020, CECA engaged a broad group of stakeholders to consider actionable strategies to improve existing guidelines, with a focus on sexual and reproductive health equity and relevance in an evolving health care landscape. These experts emphasized the need for evidence-based clinical and programmatic guidelines focused on broader scale public health interventions, such as the statewide initiatives, to expand access.

Together, ASTHO and CECA conceptualized this special issue to feature innovations, lessons learned, and future directions for contraceptive access initiatives; generate a more current evidence base that reflects the evolution of these projects' approaches; and set the stage for a potential CDC Community Guide recommendation supporting statewide contraceptive access initiatives. In preparation for this issue, ASTHO and CECA engaged representatives from seven statewide contraceptive access initiatives selected based on their unique strengths and implementation approaches, robust efforts to analyze and disseminate project findings, and existing partnerships with our organizations. These partners participated in a series of meetings to share learnings from past and ongoing contraceptive access initiatives, discuss potential benefits of a Community Guide recommendation on contraceptive access initiatives, and concretize plans for this special issue. Representatives of the seven contraceptive access initiatives, along with a number of key stakeholders engaged throughout this process, contributed original articles to this issue.

FEATURED ARTICLES IN THIS SPECIAL ISSUE

The opening commentary in this issue explores the history and evolution of contraceptive access initiatives from approaches primarily focused on increasing access to LARC to approaches that expand access to the full range of contraceptive methods and emphasize person-centered care. Malcolm et al. (p. S473) present a conceptual framework that describes common implementation and evaluation components across initiatives and outline the benefits of an evidence-based, population-level programmatic guideline, such as a CDC Community Guide recommendation, for scaling up these initiatives.

Certain articles highlight implementation approaches for contraceptive access initiatives. White et al. (p. S478) describe the approach taken by Massachusetts, where the state-funded contraceptive access initiative is carried out by two technical partners, Partners in Contraceptive Choice and Knowledge and Upstream USA, that deliver direct training and technical assistance on person-centered contraceptive care to birth hospitals and outpatient primary care practices. Considering the challenges that may arise during implementation of contraceptive access projects, Simmons et al. (p. S528) underscore the importance of quality improvement and monitoring to address implementation challenges for Family Planning Elevated in Utah, such as low utilization of Medicaid reimbursement for services at partner clinics.

Evaluations of recently implemented projects are in progress, and early findings on implementation approaches, feasibility, and acceptability are emerging. Lessons learned from early contraceptive access initiatives, such as the Colorado Initiative to Reduce Unintended Pregnancy, shaped the implementation and evaluation of future projects. In this issue, Romer and Kennedy (p. S532) offer perspectives on evidence generated from the Colorado initiative, one of the first contraceptive access projects in the United States, and reflect on lessons learned and pitfalls of a "LARC-first" approach to contraceptive access.

Considering evaluations of more recent contraceptive access initiatives, Smith et al. (p. S484) describe the evaluation approach for the Choose Well initiative in South Carolina, the largest statewide contraceptive access initiative in the Southern United States. Two articles in this issue describe findings on individual and community outcomes of interest, specifically expansion of reproductive health service provision and contraceptive use, following the enactment of policy changes and clinical capacity–building activities to support expanded access in two states—Delaware and New Mexico (Boudreaux et al., p. S537; Burapa et al., p. S541). Darney et al. (p. S555) apply a broader lens, examining contraceptive provision in community health centers across the United States as a key access point for contraceptive care.

Given the major shifts in health care delivery and access spurred by the COVID-19 pandemic, Lindberg et al. (p. S545) report findings from the 2021 Guttmacher Survey of Reproductive Health Experiences to investigate trends in use and quality of telehealth for contraceptive care during the pandemic. This work expands the evidence base of telehealth use, quality, and equity as an approach to contraceptive care.

Another set of articles emphasizes the importance of integrating person centeredness, equity, and justice in contraceptive access initiatives. Dehlendorf and Perritt (p. S490) examine the historical and ongoing impact of coercion in the provision of reproductive health care and call for contraceptive access projects to explicitly center community voices to prevent the reenactment of past harms. Cadena et al. (p. S494), leaders of reproductive justice organizations in different parts of the United States, provide an account of the persisting problems in realizing contraceptive access and describe the innovative strategies their respective organizations have implemented to advance contraceptive justice. In an article that highlights the integration of these principles in programming, Lassar et al. (p. S500) describe the work of Illinois Contraceptive Access NOW, a new initiative to advance reproductive health equity by improving quality and coverage of contraceptive care. Similarly, Axelson et al. (p. S504) describe efforts to develop and implement a reproductive well-being framework in the place-based implementation model for contraceptive access projects at Power to Decide.

The special issue closes with articles that consider the future of contraceptive access initiatives and the field more broadly. Leaders in the federal government, representing the CDC and the Office of Population Affairs, describe the agencies' roles in expanding contraceptive access and future directions for these efforts (Pliska et al., p. S508; Marcella, p. S511). Gavin (p. S515) reflects on how an implementation science framework can support future scaling of evidence-based contraceptive access projects by posing key questions related to acceptability, adoptability, feasibility, and sustainability.

Finally, leaders at CECA and the National Birth Equity Collaborative describe two new frameworks that can advance progress toward the US sexual and reproductive health goals—sexual and reproductive health equity and sexual and reproductive health and well-being (Hart et al., p. S518). These two frameworks applied in tandem could provide a new paradigm for aligning sexual and reproductive health policy with individual and community needs for meaningful change.

FUTURE CONSIDERATIONS

The emerging evidence on contraceptive access initiatives has the potential to strengthen future population-health approaches to contraceptive access programming and policy, increase use of shared best practices for implementation and evaluation, foster engagement across health care silos within states, and demonstrate the impact of these approaches on advancing equity and improving access, affordability, satisfaction, person centeredness, and quality of care. The collection of articles in this special issue aims to contribute to and strengthen this body of evidence and set the stage for a potential future Community Guide recommendation on statewide contraceptive access initiatives. Our hope is that this special issue will equip the next generation of contraceptive access initiatives with a shared language and framework on which to build their efforts, inspire policymakers and practitioners to consider opportunities to support scaling up evidence-based initiatives to expand access, and encourage decision makers to pursue the full potential of person-centered, equitable, and accessible contraceptive access initiatives. AJPH

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Scaling Up Evidence-Based Practices in Contraceptive Access Initiatives

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Contraception can play a critical role in individuals' achievement of personal health, social, and financial goals.[1–3] Equitable, person-centered contraceptive access can promote reproductive autonomy and advance sexual and reproductive health equity so that people across the range of age, gender, race, and other intersectional identities have what they need to attain their highest level of health.[4,5] Yet, many people in the United States face barriers to accessing contraception, including cost, insurance gaps, and institutional barriers.[5] Discrimination and structural racism, both within and outside of the health care system, intensify these barriers for people of color, people living in poverty, people with disabilities, people who are immigrants, and others with marginalized identities.

STATEWIDE CONTRACEPTIVE ACCESS INITIATIVES

There is growing evidence that statewide contraceptive access initiatives can expand contraceptive access, advance the provision of person-centered care, and improve health outcomes.[6–8] Statewide contraceptive access initiatives are population-level approaches, typically serving large geographic areas within a state, that require collaboration across multisectoral partners such as state health departments, public and private payors, health and community systems of care, and community and advocacy groups. In these initiatives, a coalition of organizations undertakes coordinated efforts to expand contraceptive access, including providing training and capacity building within health care organizations; mobilizing for policy change to increase contraceptive access, affordability, and availability; and removing structural barriers to enhanced access. Since 2007, at least 28 states and local jurisdictions have implemented contraceptive access initiatives.

The reproductive health field has evolved considerably over the past 20 years, particularly in the increased adoption of approaches informed by reproductive justice and person-centered care frameworks. This evolution is reflected in the history of contraceptive access initiatives. Early interest in the potential of these initiatives was sparked by evidence generated by the Contraceptive CHOICE Project, implemented in St. Louis, Missouri, in 2006; this project documented the dramatic impact that long-acting reversible contraceptive (LARC) use can have on unintended pregnancies when barriers, including cost, are removed.[9] In response, state and funder interest prompted the implementation of several contraceptive access initiatives focused on addressing barriers specific to LARC access, including cost and logistical barriers (e.g., need for provider training on insertion and removal, lack of availability of devices in clinics and hospitals).

However, LARC-first or LARC-centered approaches, such as the tiered effectiveness contraceptive counseling model, ignored the many factors beyond method effectiveness that may shape a person's contraceptive preferences and decision making across the life span, as well as the long history of reproductive coercion in the United States.[10,11] Years of advocacy by reproductive justice leaders made clear that traditional "family planning" programs rest on culturally problematic assumptions regarding parenthood, pregnancy intention, and personal decision making. This activism was driven by the reproductive justice theoretical framework, developed by women of color, which asserts that it is a human right to maintain personal bodily autonomy, have or not have children, and parent in safe and sustainable communities.[12,13]

As a result, many contraceptive access initiatives shifted from LARC-first or LARC-centered approaches to focus on expanding access to a broad range of methods in which counseling approaches center individuals' preferences and promote reproductive autonomy.[14] This shift was accompanied by an increased focus on health and social outcomes that better represent the preference-sensitive nature of contraceptive care, such as access to care and individuals' reports that care was person centered, respectful, and noncoercive. Many initiatives are currently undergoing robust evaluations to document these outcomes.

SCALING UP EVIDENCE-BASED PRACTICES

To more concretely understand, support, and elevate efforts to build a more current and comprehensive evidence base for contraceptive access initiatives, the Coalition to Expand Contraceptive Access and the Association of State and Territorial Health Officials virtually convened representatives of seven contraceptive access initiatives in fall 2020 to explore the health and social effects of contraceptive access initiatives, outline program intervention and evaluation elements commonly applied across initiatives, consider opportunities to share successes and lessons learned, and support scaling of similar efforts by disseminating best practices.

One vehicle to disseminate best practices for population health interventions is the Centers for Disease Control and Prevention's Guide to Community Preventive Services (Community Guide), a collection of evidence-based findings from the Community Preventive Services Task Force. By detailing the feasibility of large-scale contraceptive access initiatives and their impact on sexual and reproductive health and well-being, a Community Guide recommendation on contraceptive access initiatives has the potential to expand access to contraceptive care, increase implementation of best practices, encourage cross-agency coordination, and inform funding proposals to support scaling of similar efforts. To that end, this article, and the collection of articles in this special issue, aims to contribute to and strengthen the body of evidence on the effects of contraceptive access interventions as a means of informing a future Community Guide recommendation.

ESTABLISHING A SHARED UNDERSTANDING

Here we describe intervention and evaluation components commonly implemented across contraceptive access initiatives and outline the potential benefits of an evidence-based population-level programmatic guideline for such initiatives.

Intervention Components for Contraceptive Initiatives

Eight multilevel core intervention components are commonly implemented across contraceptive access initiatives (Table 1). These intervention components include training or continuing education and ongoing technical assistance at the health care provider level; provision of low- or no-cost contraception, grants for contraceptive equipment or supplies, and quality improvement and monitoring at the health care organization level; public awareness campaigns and stakeholder engagement at the community level; and legislation or other policy changes at the public policy level. Implementation of these intervention components is interrelated and represents a theory-based, systems change approach wherein multiple interventions are implemented across levels (e.g., health care organization level, community level) to maximize effects across diverse and often fragmented systems of care in each state.

An expanded focus on access to a broad range of contraceptive methods and more person-centered approaches has often led contraceptive access initiative implementers and evaluators to modify program components. For example, some initiatives have integrated new strategies focused on principles of equity and justice, including acknowledging historical and contemporary racism, reproductive coercion, and how systems of care promote harmful program planning and implementation practices, particularly in communities of color; integrating training on bias and coercion for health care providers and staff; and convening community advisory boards in which members are empowered to influence program direction and compensated for their time.

Outcomes Examined Across Contraceptive Initiatives

Evaluations of contraceptive access initiatives typically involve assessments of various practice, policy, individual, community, health, and social outcomes, as depicted in the conceptual framework for statewide contraceptive access initiatives shown in Figure A (available as a supplement to the online version of this article at http://www.ajph.org). Practice and policy outcomes are relevant to care delivery and clinical practice, as well as institutional and public policy changes that may have an impact on contraceptive care. These outcomes include knowledge, skills, attitudes, and beliefs about contraception among providers; provision of person-centered counseling and contraceptive services;

TABLE 1— Core Intervention Components for Statewide Contraceptive Access Initiatives

Intervention Component	Description
Health care provider level	
Training/continuing education	Training for clinicians, support staff, and administrative staff through various modalities (e.g., small-group in-person training, one-on-one proctoring, virtual Webinar series) on topics including family planning; medical management of contraception; hands-on clinical skills (e.g., LARC insertion and removal); billing, coding, and reimbursement; and preventing coercion and bias
Ongoing technical assistance	Ongoing, targeted technical assistance to clinicians, support staff, and administrative staff through various modalities (e.g., coaching calls, in-clinic training specialists) on topics including hands-on clinical skills; purchasing, stocking, and billing for contraceptives; patient education materials; contraceptive access policies/procedures; contraceptive workflow; and data collection and reporting
Health care organization level	
Provision of low- or no-cost contraception	Direct funding or stocking for participating health centers across delivery settings (e.g., Title X clinics, Federally Qualified Health Centers, school-based health centers, hospitals for immediate postpartum contraception, abortion providers for immediate postabortion contraception[a]) to offer FDA-approved contraceptive methods and services to eligible individuals at low or no cost without per-client caps on use of contraceptive services and devices
Grants for equipment/supplies	Direct funding to participating health centers to purchase contraceptive supplies and equipment, other clinic supplies (e.g., examination tables, technology for patient education), and supplies for personnel
Quality improvement, data, monitoring, and evaluation	Continuous quality improvement and feedback to quickly identify implementation barriers and potential strategies to address barriers; ongoing measurement of aggregate, deidentified data on use of various contraceptives; provision of contraception services or person-centered counseling; and knowledge, skills, attitudes, or beliefs about contraception among providers
Community level	
Public awareness campaign	Digital media and marketing campaigns to increase awareness about the availability of reproductive health services and provide information and resources on reproductive health topics
Stakeholder engagement	Engagement in multistakeholder partnerships with public and private entities for effective implementation
Public policy level	
Legislation or other public policy change	Championing of enactment and implementation of legislation and public policy to support contraceptive access, including overall public and private insurance coverage for contraception, such as LARC coverage and reimbursement and multiple months of dispensing; expanded ability of providers (e.g., pharmacists, advanced practice clinicians) to prescribe and dispense contraception; ensured payment parity for providers; and over-the-counter contraception without a prescription

Note. LARC = long-acting reversible contraceptive; FDA = Food and Drug Administration.

[a] Two of the seven contraceptive access initiatives that participated in the virtual meeting series included postabortion contraception access in their programs.

and health system and clinic-level policies and procedures that support access to widespread person-centered contraceptive services (e.g., enabling stocking of a broad range of contraceptive methods at the clinical site).

Individual and community outcomes are affected by practice and policy factors and include individuals' reports that contraceptive care was provided in a person-centered manner, reproductive health service use, and contraceptive use that reflects individuals' needs and preferences. Effects on unintended pregnancy, births, and abortions are among the health and social outcomes of interest in some contraceptive access initiatives. Other outcomes of interest include maternal and infant health-related outcomes and reproductive well-being, defined as having the necessary access to information, services, and support to make decisions related to sexuality and reproduction and being empowered to act on those decisions.[15]

PUBLIC HEALTH IMPLICATIONS

Contraceptive access initiatives have the potential to greatly enhance the accessibility of this essential preventive service. Public funding plays a critical role in ensuring equitable access to contraception and other reproductive health services, but systems of care are often siloed and fragmented, requiring clinical and policy innovation and meaningful resource investments to facilitate expanded access. Contraceptive access initiatives have the potential to foster collaboration across a variety of stakeholders, provide needed training and capacity building within and across health care systems, and remove structural barriers to enhanced access through community-level interventions and public policy change.

Equitable, Person-Centered Contraceptive Care

Since the early interest in and implementation of these projects, many contraceptive access initiatives have expanded beyond LARC-first or LARC-centered approaches to focus on enhancing access to a broad range of contraceptive options and counseling approaches that center individuals' preferences, priorities, and autonomy. This focus on promoting person-centeredness in contraceptive care and advancing sexual and reproductive health equity presents an opportunity for these initiatives to examine and address broader issues in the field such as the influence of provider and partner coercion and bias on contraceptive choice; the association between person-centered care and contraceptive outcomes in diverse communities; racial inequities and rural gaps in contraceptive access; linkages to comprehensive sexual and reproductive health services, including sexual health services, fertility care, and pregnancy-related care (e.g., prenatal and postpartum care); and inequities in pregnancy and maternal health outcomes.

This equity-focused approach offers the ability to evaluate the extent to which contraceptive access initiatives focused on person-centeredness and equity lead to increased access, use, satisfaction, and quality of care. It also presents an opportunity to define, develop, and test measures to assess more holistic aspects of reproductive health such as reproductive well-being. A growing body of literature suggests that these alternative conceptualizations of reproductive health and well-being could balance, or even replace, the conventional population health measure of unintended pregnancy, a measure that has long been regarded as a proxy for women achieving their desired reproductive outcomes but has been increasingly called into question with respect to its validity.[16–19] The framework in Figure A reflects health and social outcomes assessed in some contraceptive access initiatives (e.g., effects on unintended pregnancy) as well as opportunities for integrating alternative person-centered measures in the future (e.g., reproductive well-being).

Impact of a Community Guide Recommendation

Experts in the field have identified the development and dissemination of evidence-based population health guidelines related to expanding contraceptive access, such as the Community Guide, as a priority.[20] However, the extent to which the Community Guide currently addresses contraceptive access is limited primarily to examining contraceptive use as an indicator of an intervention's success.

Currently, contraception is mentioned in the Community Guide in six instances; five interventions focus on educational programs for adolescents, with contraceptive uptake assessed as a measure of program effectiveness, and the sixth focuses on how school-based health centers can improve health equity in low-income communities. Although the school-based health center recommendation has a broader potential reach than the educational programs, it is still applicable only to the specific infrastructure around adolescent health care delivery. A Community Guide recommendation on contraceptive access initiatives would advance coordinated, population-based approaches to expand contraceptive access beyond individual-level educational interventions and promote evidence-based, multilevel systems change interventions with applicability to a broader group of individuals and communities.

Therefore, this special issue and the collection of articles within it set the stage for future consideration by the Community Guide. Consistent with the Community Guide's intent, statewide contraceptive access initiatives promote health within the realm of sexual and reproductive health. A Community Guide recommendation would confer great benefit to both research on and the practice of population health improvement and could help ensure that future contraceptive access initiatives include shared, evidence-based practices.

With the scientific evidence still accumulating, we hope that this special issue will encourage funders to support the evaluation of contraceptive access initiatives so that the body of evidence is robust, encourage program implementers to incorporate the core intervention components described here into their states' unique contexts to improve alignment across projects nationwide, and encourage program evaluators to align their evaluation strategies with those presented here and the accompanying conceptual framework so that evidence can be compared across states. These steps will help advance progress toward the goal of ensuring that all people have meaningful access to person-centered contraceptive care. AJPH

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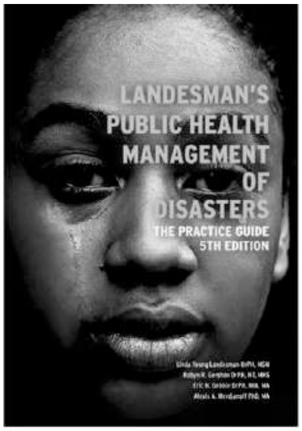
The authors have no potential or actual conflicts of interest to disclose.

REFERENCES

1. Bailey MJ, Hershbein B, Miller AR. The opt-in revolution? Contraception and the gender gap in wages. *Am Econ J Appl Econ.* 2012;4(3):225–254. https://doi.org/10.1257/app.4.3.225
2. Institute of Medicine. *Preterm Birth: Causes, Consequences, and Prevention.* Washington, DC: National Academies Press; 2007.
3. Stevenson AJ, Genadek KR, Yeatman S, Mollborn S, Menken J. The educational impact of expanded contraceptive access. Available at: http://paa2019.populationassociation.org/uploads/191070. Accessed June 24, 2020.
4. Hart J. CECA's commitment to sexual and reproductive health equity in our work. Available at: https://www.contraceptionaccess.org/blog/cecas-commitment-to-sexual-and-reproductive-health-equity-in-our-work. Accessed August 2, 2021.
5. Holt K, Reed R, Crear-Perry J, Scott C, Wulf S, Dehlendorf C. Beyond same-day long-acting reversible contraceptive access: a person-centered framework for advancing high-quality, equitable contraceptive care. *Am J Obstet Gynecol.* 2020;222(4):S878.e1–S878.e6. https://doi.org/10.1016/j.ajog.2019.11.1279
6. Goldthwaite LM, Duca L, Johnson RK, Ostendorf D, Sheeder J. Adverse birth outcomes in Colorado: assessing the impact of a statewide initiative to prevent unintended pregnancy. *Am J Public Health.* 2015;105(9):e60–e66. https://doi.org/10.2105/AJPH.2015.302711
7. Boudreaux M, Xie L, Choi YS, Roby DH, Rendall MS. Changes to contraceptive method use at Title X clinics following Delaware Contraceptive Access Now, 2008–2017. *Am J Public Health.* 2020;110(8):1214–1220. https://doi.org/10.2105/AJPH.2020.305666
8. Sanders JN, Myers K, Gawron LM, Simmons RG, Turok DK. Contraceptive method use during the Community-Wide HER Salt Lake Contraceptive Initiative. *Am J Public Health.* 2018;108(4):550–556. https://doi.org/10.2105/AJPH.2017.304299
9. McNicholas C, Tessa M, Secura G, Peipert JF. The Contraceptive CHOICE Project round up: what we did and what we learned. *Clin Obstet Gynecol.* 2014;57(4):635–643. https://doi.org/10.1097/GRF.0000000000000070
10. Brandi K, Fuentes L. The history of tiered-effectiveness contraceptive counseling and the importance of patient-centered family planning care. *Am J Obstet Gynecol.* 2020;222(4):S873–S877. https://doi.org/10.1016/j.ajog.2019.11.1271
11. Gomez AM, Fuentes L, Allina A. Women or LARC first? Reproductive autonomy and the promotion of long-acting reversible contraceptive methods. *Perspect Sex Reprod Health.* 2014;46(3):171–175. https://doi.org/10.1363/46e1614
12. Ross L, Derkas E, Peoples W, Roberts L, Bridgewater P. *Radical Reproductive Justice: Foundation, Theory, Practice, Critique.* New York, NY: Feminist Press at CUNY; 2017.
13. SisterSong. Reproductive justice. Available at: https://www.sistersong.net/reproductive-justice. Accessed September 3, 2019.
14. Dehlendorf C, Grumbach K, Schmittdiel JA, Steinauer J. Shared decision making in contraceptive counseling. *Contraception.* 2017;95(5):452–455. https://doi.org/10.1016/j.contraception.2016.12.010
15. Sealy G. Join us in building a nationwide reproductive well-being movement. Available at: https://powertodecide.org/news/join-us-building-nationwide-reproductive-well-being-movement. Accessed October 14, 2021.
16. Potter JE, Stevenson AJ, Coleman-Minahan K, et al. Challenging unintended pregnancy as an indicator of reproductive autonomy. *Contraception.* 2019;100(1):1–4. https://doi.org/10.1016/j.contraception.2019.02.005
17. Kost K, Zolna M. Challenging unintended pregnancy as an indicator of reproductive autonomy: a response. *Contraception.* 2019;100(1):5–9. https://doi.org/10.1016/j.contraception.2019.04.010
18. Aiken ARA, Borrero S, Callegari LS, Dehlendorf C. Rethinking the pregnancy planning paradigm: unintended conceptions or unrepresentative concepts? *Perspect Sex Reprod Health.* 2016;48(3):147–151. https://doi.org/10.1363/48e10316
19. Morse JE, Ramesh S, Jackson A. Reassessing unintended pregnancy. *Obstet Gynecol Clin North Am.* 2017;44(1):27–40. https://doi.org/10.1016/j.ogc.2016.10.003
20. Moskosky S, Hart J, Stern L. Expanding contraceptive access through clinical and programmatic guidelines. Available at: https://static1.squarespace.com/static/5d35f1b39760f8000111473a/t/5dab6b6555a5e02d24407e31/1571515239267/2.+Guidelines+Issue+Brief_10.19.pdf. Accessed December 18, 2020.



Massachusetts Initiative to Improve Contraception Services: A Tale of Two Programs

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In February 2018, the Massachusetts Executive Office of Health and Human Services issued a request for applications for the five-year Project to Increase Access to Contraceptive Counseling and Long-Acting Reversible Contraception in the Commonwealth. This initiative was intended to promote the availability of effective contraception to decrease the number of unintended pregnancies and improve maternal and infant health outcomes across Massachusetts. We identified specific needs for continued learning on patient-centered contraceptive counseling approaches, improved same-day access to all methods, provision of immediate postpartum intrauterine devices and implants, and increasing the number of contraceptive access points in the state. The objectives mirrored many of the core intervention components described in the introductory article of this special *AJPH* issue: Malcolm et al., "Scaling Up Evidence-Based Practices in Contraceptive Access Initiatives" (p. S473). The objectives are to address training, technical assistance, stakeholder engagement, and quality improvement, and to create a public information campaign similar to a previous national contraceptive training initiative.[1,2]

Two organizations successfully competed for the funding initiative. Partners in Contraceptive Choice and Knowledge (PICCK), a coalition of Massachusetts-based providers and advocates in a large public hospital, focuses on technical assistance and quality improvement for hospital-based providers already providing contraceptive care, encourages improvements in access and quality, and promotes expanded access to immediate postpartum contraception. Upstream USA (hereafter "Upstream") focuses their work on outpatient ambulatory care sites, especially Massachusetts's large network of federally qualified health centers, and encourages primary care sites to expand their contraceptive services.

We describe how the Massachusetts initiative capitalizes on the strengths of each team to reach both primary care and specialty providers at both the hospital system and community health center levels to maximize the program's reach. We present a detailed description of both teams, which are designed to optimally support their unique partners, as well as program evaluation strategies to assess the initiative's impact.

DESCRIPTION OF THE INITIATIVE

The Massachusetts initiative began in 2018 and will be conducted through 2023. Both teams in the Massachusetts initiative began their partner engagement by recruiting health care facility leaders. Teams presented their programs to the organizations' key stakeholders and subsequently executed memoranda of understanding to facilitate program implementation and data collection.

PICCK first approached the heads of obstetrics and gynecology departments at birthing hospitals to present their program and obtain their support. Each department selected onsite representatives, generally a physician and a nurse, to serve as champions and liaisons between the PICCK team and hospital management and staff. As the initiative progressed, PICCK expanded their programming to encompass select family medicine, pediatrics, and emergency medicine departments. In addition to hospital-based work, PICCK worked with select ambulatory practices, including community health centers strongly affiliated with these hospitals.

The PICCK Community Advisory Board, composed of a diverse membership of patients who utilize contraceptive care and statewide community stakeholders, constitutes an essential part of the PICCK program. The Community Advisory Board strengthens the program's activities by providing guidance to the core team, proposing innovative approaches for addressing gaps in contraceptive care and access, ensuring sustainability, and amplifying the diverse voices of Massachusetts residents receiving sexual and reproductive health care. Additionally, twice annually, PICCK convenes its Advisory Committee, composed of leaders from statewide health care organizations who advise PICCK on programming and impact.

Upstream selected clinical sites for recruitment based on patient volume, current state of contraceptive care, regional variation, patient demographics, and health center buy-in to implement Upstream's program with fidelity. With support from key stakeholders in the state, Upstream engaged community health center executives to solicit interest in participating and to secure its first set of partners. The executive sponsor at a health center then identified a day-to-day champion to coordinate internal practice change. To increase recruitment, Upstream has expanded beyond community health centers to include primary care networks and hospital-affiliated outpatient sites.

Upstream formed a Massachusetts council of advisors that is charged with supporting Upstream in its execution of a successful statewide initiative that meets ambitious goals related to scale, health center impact, and reproductive health outcomes for patients across the Commonwealth. The 10-member advisory group, which includes the first lady of Massachusetts, connects Upstream to key state and local leaders, advises Upstream on how to add value to the state's evolving health care and policy landscape, and champions Upstream across their professional circles.

The leadership teams from PICCK and Upstream met monthly throughout the duration of the project to coordinate recruitment, share strategies, and develop joint resources. They frequently communicated about intended recruitment at health facilities across the state and used their contacts to facilitate introductions for the other team when appropriate. With the onset of health facility changes in service provision because of the COVID-19 pandemic, both teams shifted to virtual programming; all programming during this initiative was conducted during the pandemic. In addition to creating individual resources to support contraception provision, they collaborated on a statewide webinar about providing contraceptive services after the COVID-19 pandemic and coproduced a resource for patients and providers about self-administration of the injectable contraceptive (subcutaneous depot medroxyprogesterone acetate).

Program Components

The Massachusetts teams tailored their programming to the needs of their facility partners to expand their practices' core capacities as well as to improve patient care standards related to contraceptive care. Programming content for both teams included the following:

1. educating and coaching clinicians and support staff on how to provide patient-centered contraceptive counseling that is free of bias or coercion;
2. providing technical assistance to stock the full range of contraceptive methods;
3. supporting billing and coding to optimize reimbursement of contraceptive services and methods;
4. revising or creating department or agency policies to enable high-quality, sustainable practice change related to contraceptive care;
5. incorporating a pregnancy intention screening or contraceptive needs assessment question, contraceptive counseling, and documentation of contraceptive method use into clinical workflows, often including the hospital's or agency's electronic health record (EHR) system;
6. establishing strategies to ensure that a patient can receive their desired contraceptive method on the same day as their visit, including long-acting reversible contraceptive (LARC) methods; and
7. enhancing emergency contraception services.

Technical assistance was provided through regular communication with key stakeholders with the partnered hospitals and agencies. By the conclusion of the initiative, PICCK will have partnered with 21 of the 40 Massachusetts birth hospitals, and the Upstream team aims to partner with 47 agencies of the 61 prospective community health centers and federally qualified health centers in Massachusetts.

Each team incorporated unique approaches to working with their partner organizations as well. PICCK programming with partner hospitals included providing the full range of contraceptive methods in the immediate postpartum period, including the adoption of immediate postpartum LARC provision and improved patient-centered counseling informed by the history of reproductive coercion. The PICCK team designed customized interventions, along with training and educational materials, with the needs of the individual hospitals determining programming topics and project management timelines. The audience for these interventions included pharmacy and administrative staff in addition to health care providers, nurses, operating room technicians, and medical assistants.

The additional programming areas and technical assistance of the Upstream intervention with partner health practices included: (1) training all agency staff on current best practices and clinical knowledge of high-quality contraceptive care; (2) coordinating clinician precepting for LARC placement and removal; (3) where necessary, providing funding to stock the full range of contraceptive methods; and (4) providing patient education materials for use during clinical visits.

Provider and Staff Training

Both teams conducted needs assessments and training surveys before program implementation to assess the type and level of technical assistance that was needed for each site to achieve high-quality contraceptive care service provision. Additionally, each team conducted posttraining surveys to capture the change in trainee knowledge and attitudes as well as satisfaction with the training. Provider and staff training was conducted through didactic and interactive presentations and included onsite training in LARC and (where appropriate) immediate postpartum intrauterine device insertion. PICCK conducted education at standing department meetings when possible, including grand rounds, resident education time, staff meetings, and nursing huddles. Before the COVID-19 pandemic, Upstream provided a two-day in-person training session for each individual agency. Beginning in June 2020, Upstream offered virtual training, which included e-learning modules that could be taken asynchronously as well as live virtual sessions. Hands-on skills for LARC placement were practiced with virtual clinical guidance. In addition, Upstream invited multiple agencies to training sessions, which enabled staff from different agencies to learn from one another.

At the end of hospital or agency engagement, each team conducted qualitative interviews with practice staff and key stakeholders to obtain a deeper understanding of participants' training experience. Both teams conducted internal training debriefs with instructors and administrative staff to assess lessons learned and improvements needed for future events.

EVALUATION STRATEGIES AND EARLY FINDINGS

At the outset of the Massachusetts initiative, both teams and representatives from the Massachusetts Department of Public Health and Massachusetts' Medicaid program worked collaboratively to design an evaluation plan for the five-year project. As described, the overall Massachusetts initiative was designed to include several of the key elements mentioned in "Scaling Up Evidence-Based Practices in Contraceptive Access Initiatives" and described as activities in the conceptual framework: training, technical assistance, stakeholder engagement, quality improvement, and a public information campaign. The overarching evaluation plan established a core set of process and outcome measures to be assessed across both teams and is intended to measure and evaluate the larger initiative across both teams to show overall progress toward increasing access to contraception in Massachusetts.

Each team developed its own evaluation plan, which feeds into the overall evaluation and tracks many other elements more specific to each program. Both evaluation plans include output, outcome, and impact measures and include data collection and follow-up during and after the intervention. This approach is designed to provide immediate quality improvement data, evaluate outcomes and impact, and assess the sustainability of the program. As of the writing of this article, the intervention is approximately midway through its five-year implementation; many of the output, outcome, and impact measures are scheduled for data collection at the end of the project. We have summarized the information available to date in Table 1 and describe data collection and evaluation strategies here.

Output Evaluation

Both teams collect qualitative and quantitative measures at multiple points in time throughout the intervention. Each team started with a needs assessment to inform program customization and identify existing gaps. Data collection during program implementation (e.g., attendance, participant evaluations, trainer evaluations, clinicians and nonclinicians trained) allowed teams to monitor whether the gaps identified during the needs assessment have been addressed and measure the level of proficiency achieved by the practice. Other elements of output evaluation include contraceptive methods stocked and number and type of coaching sessions. Output evaluation efforts that are specific to individual teams included evaluation of PICCK's Community Advisory Board through postmeeting surveys, an annual survey, and notes from meetings. Upstream

TABLE 1— Data Sources and Planned Measurements for the Massachusetts Initiative Programs: 2018–2023

Program Aspect	Data Sources/Measures	Outcomes to Date (as of Nov 1, 2021)
Output measures		
Partners	No. of engaged sites[a] or agencies[b] No. of referrals from partnered sites[a] No. of sites expected to sign MOUs[b]	Of 82 sites and agencies approached, 35 (43%) actively engaged in project activities
Trainings and technical assistance	No. of pretraining needs assessments No. of trainings provided No. of clinicians and staff trained No. of didactic and hands-on simulation trainings provided[a] No. of clinicians precepted[b] No. of CME/CNE credits provided No. of process notes[a] No. of site progress tracking[a] Dates of EHR integration and workflow changes completed and live data on contraceptive services sent to quality improvement teams for monitoring and evaluation[b]	24 organizational pretraining needs assessments completed 33 of 47 (70%) engaged sites and agencies have received clinical LARC insertion training (3 sites already provide) 86 trainings conducted[a] 84% of providers have received clinical LARC insertion training 2446 staff have received nonclinical training on contraceptive services 681 technical assistance meetings[b] 9 partner agencies with integrated EHRs sending live data[b]
Coaching	No. of champion calls[a] No. of coaching sessions on contraceptive counseling[b]	211 champion calls[a] 115 one-on-one contraceptive counseling coaching sessions[b]
Stocking/Pharmacy/Billing	• Changes in methods stocked • Improvement in billing capture for services provided	65% of engaged practices have provider-administered methods available onsite
Sustainability (proxy measures)	Number of • Adopted policies and procedures • Completed sustainability checklists • Sustainability interviews with site champions[a]	14 PPLARC and EC protocols adopted[a] 5 of 13 engaged agencies completed the intervention and have sustainable practices in place[b]
Stakeholder Engagement	Number of meetings with: • MDPH • Statewide Advisory Committee • CAB[a]	31 calls with MDPH[a] 5 Advisory Committee meetings[a] 9 CAB meetings[a]
Public Information Campaign	To be conducted within the project period	
Outcome measures		
Contraceptive Counseling and Provision	Changes in offered methods[a] EHR/billing data Counseling Services Methods (contraceptive care measures: National Quality Forum Nos. 2903 and 2904) Contraceptive needs assessment[a] Pregnancy Intention Screening Question[b] Patient satisfaction survey Patient interviews[b]	78% of engaged practices are providing LARC services 51% of engaged practices offer same-day LARC insertion 27% of visits with assigned female at birth patients of reproductive age included screening for pregnancy intention to assess desire for contraception
Impact evaluation		
Impact of Intervention	Trainings: Posttraining surveys Posttraining instructor evaluations[a] Posttraining staff interviews[b] Overall program: Champion interviews[a] Stakeholder interviews[a] Agency leader interview[b]	

Note. CAB = Community Advisory Board; CME = continuing medical education; CNE = continuing nursing education; EHR = electronic health record; LARC = long-acting reversible contraceptive; MDPH = Massachusetts Department of Public Health; MOU = memorandum of understanding. PICCK = Partners in Contraceptive Choice and Knowledge. Both the PICCK and Upstream teams collected listed measures except as indicated.

[a] Unique to PICCK.

[b] Unique to Upstream.

assesses clinicians targeted for precepting (based on a proficiency target) and progress toward that goal. Both teams include sustainability measures in their evaluation plans.

Outcome Evaluation

Both teams evaluate outcomes by using data from EHRs and billing systems. PICCK uses primarily information on services provided, counseling conducted, and method mix as they are provided by partners and by Massachusetts' Medicaid program. Upstream uses EHR-based family-planning measures to inform quality improvement activities and evaluation with each practice. Upstream funds the connection from each agency's EHR to Azara Healthcare Data Reporting and Analytics Solutions software (Azara Healthcare, Burlington, MA), a Health Insurance Portability and Accountability Act–compliant platform, before programmatic work begins. Upstream can view only nonprotected health information and aggregate results from these measures in the software, whereas practices can view their patient-level results in a user-friendly dashboard. Upstream examines a range of measures and indicators using EHR data: a pregnancy intention screening question, documentation of contraceptive counseling provision and patient's selected or expected method of contraception at end of the encounter, contraceptive method distribution, counts of implant and intrauterine devices placements and removals, and two National Quality Forum–endorsed contraceptive care measures of most and moderately effective contraceptive methods (no. 2903) and access to LARC (no. 2904).[3]

Impact Evaluation

Qualitative data collection is an important component of the impact evaluation. PICCK conducts champion and stakeholder interviews to assess program impact; Upstream conducts an agency leader interview one year after engagement to assess sustainability. To gain insight into patients' experiences with contraceptive services, both teams administer patient surveys via text or e-mail or with study staff (depending on the location of care) to patients receiving contraceptive services at participating practices and hospitals. When possible, the survey is conducted before, during, and after program engagement. The surveys include measures of shared decision-making, the University of California San Francisco Person-Centered Contraceptive Counseling measure (no. 3543),[4] delivery of contraceptive counseling, and questions about method use in the past year, at last sex, and before and after counseling.

PUBLIC HEALTH SIGNIFICANCE

At the time of publication, the Massachusetts initiative is midway through the five-year timeline, and many more process and outcome measures have yet to be collected. However, significant progress has already been made in partnering with a wide variety of health care providers in diverse geographic locations and providing training and technical assistance that is tailored to the needs of these varied providers. At the completion of the project, we expect that a key lesson learned will be the importance of a flexible set of interventions. The selection of two different teams, with different target partners and different approaches, has created both challenges and opportunities. Although the unique approach of each team has created heterogeneity in program design and data collection, engaging two different organizations has strengthened our ability to reach a broad variety of providers and practices across the state. We expect that the full implementation of the initiative will demonstrate the importance of a multifactorial approach to expanding contraceptive access, the importance of person-centered approaches to contraceptive provision, and the need for technical assistance to build the capacity of both experienced and emerging clinical providers.

Importantly, this statewide initiative did not stand alone but was implemented in the context of broader sexual and reproductive health clinical service delivery and programmatic efforts at the Department of Public Health and Massachusetts' Medicaid program. Both state agencies support the provision of quality sexual and reproductive health care and contraception at a wide variety of ambulatory care sites, including hospital-licensed primary care sites, federally qualified health centers, and independent nonprofit family-planning clinics. Both state agencies support the direct provision of contraception, and the Massachusetts Department of Public Health offers grant funding to providers to support the quality and sustainability of their clinical care. These agencies also work collaboratively to address public policy needs related to contraceptive care, facilitated in part by the multistate learning community mentioned in the introductory article of Malcolm et al. Thus, through a set of diverse initiatives, Massachusetts has addressed each of the elements mentioned in

"Scaling Up Evidence-Based Practices in Contraceptive Access Initiatives" for a comprehensive effort to improve access to and quality of contraceptive care in Massachusetts. AJPH

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K. O. White and N. M. Lerner designed and directed the Partners in Contraceptive Choice and Knowledge (PICCK) program. All authors analyzed the results and wrote the article.

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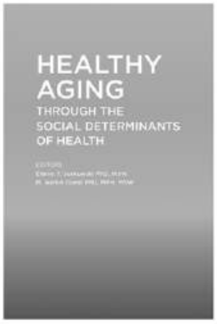
HUMAN PARTICIPANT PROTECTION

The PICCK program obtained approval for data collection from the Boston University Medical Campus institutional review board. The Upstream program obtained exempt status from the Sterling institutional review board.

REFERENCES

1. Harper CC, Comfort AB, Blum M, et al. Implementation science: scaling a training intervention to include IUDs and implants in contraceptive services in primary care. *Prev Med.* 2020;141:106290. https://doi.org/10.1016/j.ypmed.2020.106290
2. Harper CC, Rocca CH, Thompson KM, et al. Reductions in pregnancy rates in the USA with long-acting reversible contraception: a cluster randomised trial. *Lancet.* 2015;386(9993):562–568. https://doi.org/10.1016/S0140-6736(14)62460-0
3. Gavin L, Frederiksen B, Robbins C, Pazol K, Moskosky S. New clinical performance measures for contraceptive care: their importance to healthcare quality. *Contraception.* 2017;96(3):149–157. https://doi.org/10.1016/j.contraception.2017.05.013
4. Dehlendorf C, Fox E, Silverstein IA, et al. Development of the Person-Centered Contraceptive Counseling scale (PCCC), a short form of the Interpersonal Quality of Family Planning care scale. *Contraception.* 2021;103(5):310–315. https://doi.org/10.1016/j.contraception.2021.01.008



South Carolina's Choose Well Initiative to Reduce Unintended Pregnancy: Rationale, Implementation Design, and Evaluation Methodology

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We describe the implementation of Choose Well (CW), a statewide contraceptive access initiative ongoing in South Carolina, and the external evaluation of CW conducted at East Tennessee State University. The evaluation is well positioned to advance the evidence base surrounding contraceptive access initiatives, particularly given the uniqueness of CW in the southeastern United States.

DESCRIPTION OF THE CHOOSE WELL INITIATIVE

In 2017, the nonprofit organization New Morning (NM)[1] launched CW, a six-year statewide contraceptive access initiative. The mission of CW is to promote equitable access to contraception without judgment or coercion, aiming for a 25% reduction in statewide unintended pregnancy by 2023.

CW is informed by collective impact principles as a means to centrally coordinate geographically distributed stakeholders.[2] Its collective approach supports transformative change through ongoing communication among stakeholders, partner meetings and workgroups, and shared data collection standards. NM serves as the coordinating agency, managing all activities and funding all participating agencies.

CW is unique and innovative in key ways. It is the first and only contraceptive access initiative of its kind in the US Southeast. CW's efforts are systematically coordinated across various clinical sectors (federally qualified health centers, hospital inpatient and outpatient providers, rural health clinics, free clinics, college and university health centers, and Title X–funded public health departments), community organizations, and higher education institutions. These partners work collaboratively to improve access to high-quality, evidence-based, patient-centered contraceptive services. The inclusion of federally qualified health centers and rural health clinics (neither of which receive Title X funding in South Carolina) is particularly unique in seeking to expand access to contraceptive care at safety net clinics and to integrate contraceptive services into primary care. CW is also comprehensive in its approach with key interventions addressing determinants of contraceptive access and use at multiple levels (individual and community, provider and practice, and system and policy levels) and prioritizing patient and provider knowledge, attitudes, and experience of care. These interventions leverage community-reaching organizations in South Carolina and reputable training providers while generating a wealth of data for triangulation of evaluation findings.

Scope

CW is implemented statewide in South Carolina, with clinical sites in 45 of the state's 46 counties. Although the initiative is designed to address gaps in access among uninsured and underinsured people, all patients at CW clinics benefit from high-quality service provision, regardless of their insurance status or ability to pay. From 2017 to 2021, more than 300 000 people received contraceptive services at a CW clinic.

Core Components

Before the initiative's launch in 2017, a statewide needs assessment indicated that to meet the contraceptive needs of uninsured and underinsured patients in South Carolina, support should be directed to training and preparing the workforce, subsidizing the cost of expensive long-acting reversible contraceptive (LARC) devices (including intrauterine devices and contraceptive implants), hiring health care providers in shortage areas, and increasing consumer awareness. Also, results indicated more resources were needed to integrate contraceptive services into primary care clinics, which often referred contraceptive-seeking patients to Title X–funded public health departments. These funding priorities and needs assessment results were translated into CW's core components.

As the managing and fiscal agent of CW, NM directs funds to all clinical partners, community organizations, and educational institutions. In addition, NM manages a consumer-facing marketing engine; coordinates and creates trainings; hosts collaborative meetings; provides ongoing technical assistance; collects and interprets data; monitors grant compliance; and directs sustainability efforts through lobbying, advocacy, development, and fundraising. Every agency participating in CW agrees to garner leadership support for and make an organizational commitment to contraceptive access, implement evidence-based services, support data collection and evaluation, achieve sustainable service delivery, and work collaboratively with NM and other initiative partners to improve contraceptive access. These values are also infused through clinical workforce trainings. Messaging for the consumer-facing No Drama marketing campaign seeks to educate patients and empower them to make an appointment at a conveniently located CW-participating clinic. CW's primary efforts in four key areas are described below.

Infrastructure and workforce. Clinics use grant funds to purchase contraceptive methods to have available on-site, which can be provided to eligible patients at little or no cost. Clinics also use funds to buy equipment and pay for staff to deliver high-quality services. All clinics are expected to deliver contraceptive services aligned with the Centers for Disease Control and Prevention's Quality Family Planning Guidelines, offering same-day services (including placement of LARC methods) and noncoercive counseling on all methods.[3,4] Community agencies use funds for staff to conduct counseling and refer patients to clinics.

Capacity building and training. National and state-based consultants provide trainings in contraceptive counseling, LARC provision, shared decision-making, revenue cycle management, and other topics to clinical and nonclinical professionals in partner organizations. In addition to these trainings, NM provides ongoing technical assistance to clinical partners on topics including Medicaid billing and coding and electronic health record development. Partnering South Carolina institutions of higher education prepare nursing students to deliver quality services.

Integrated marketing and communications. Consumers are directed to services through the No Drama advertising campaign, which includes billboards, radio spots, and social media advertising.[5] All advertisements point consumers to a centralized Web site or phone line for additional information and appointment scheduling. Beginning in 2020, a patient advocate works directly with patients to answer any questions, facilitates scheduling appointments, and ensures qualifying patients have no out-of-pocket costs.

Strategic learning and sustainability. To improve CW service delivery, NM directs data collection and monitoring through shared measurement, quality improvement, and strategic learning projects. NM supports sustainable contraceptive services by integrating services at clinics and securing financial resources via public funds, grant seeking, and fundraising. NM also advocates for public and legislative support for policies that expand and promote access to reproductive health services in South Carolina.

DESCRIPTION OF THE CHOOSE WELL EVALUATION

Given the broad nature of the intervention and desire to translate evidence into practice, the RE-AIM Framework was used to guide the design of the independent external evaluation. RE-AIM offers a systematic means of evaluating CW across five key dimensions: reach, effectiveness, adoption, implementation, and maintenance.[6,7] Key evaluation components are mapped to the RE-AIM framework, as described in Table A (available as a supplement to the online version of this article at http://www.ajph.org), and align with the broader conceptual framework for statewide contraceptive access initiatives (Malcolm, p. S473).

The RE-AIM framework has been applied to this evaluation using Andersen's Behavioral Model for Health Service Use.[8,9] This model proposes that predisposing, enabling, and need factors at the individual, practice or provider, and policy or system levels influence health behaviors and outcomes. We adapted this model to characterize key constructs and relationships underpinning contraceptive use and reproductive health outcomes (Figure 1). We hypothesized that CW, by addressing multiple modifiable

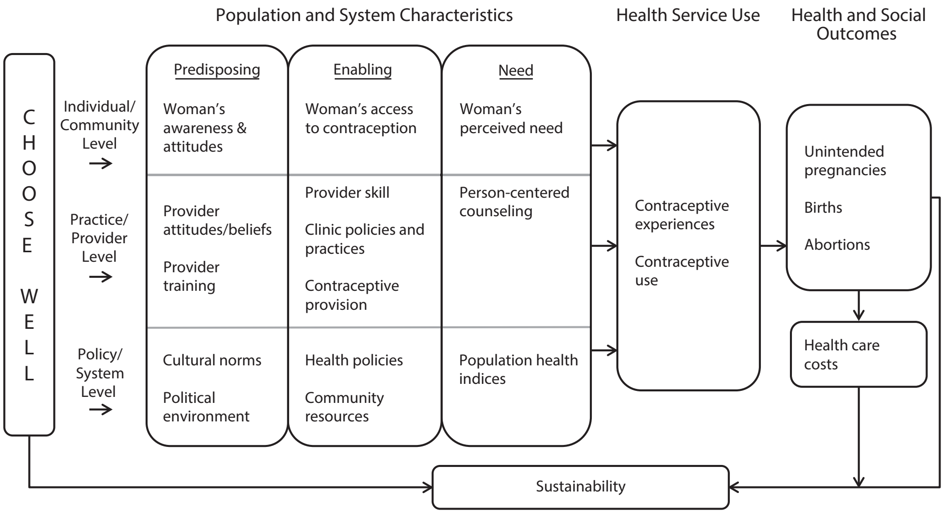

FIGURE 1— Conceptual Model for the Choose Well Evaluation

Source. This conceptual model is adapted from Andersen's Behavioral Model for Health Service Use.[8,9]

factors at the individual, practice or provider, and policy or system levels, will impact contraceptive experiences and use and subsequently health and social outcomes. We hypothesized that CW's key components and interventions will influence changes in population and system characteristics, including women's awareness and attitudes about contraception and their access to contraceptive services; provider attitudes, beliefs, skill, and provision of person-centered contraceptive counseling; clinic contraceptive policies, practices, and provision; and health policies in South Carolina, such as scope of practice and contraceptive reimbursement policy. These changes will translate into expanded contraceptive use and improved contraceptive experiences, resulting in lower rates of unintended pregnancy, births, and abortions in South Carolina, ultimately reducing health care costs and contributing to the sustainability of CW's efforts. This model guided development of evaluation surveys and examining appropriate outcomes at the right time and in the right sequence.[10]

Design and Methodology

The overarching evaluation design uses quasi-experimental studies with appropriate comparison groups for different outcomes and mixed-methods integrating survey and qualitative approaches. Key evaluation components follow a pre–post difference-in-differences design. Although the statewide studies survey probability-based population samples, other studies focus on priority populations for CW, including Medicaid beneficiaries, Title X users, the uninsured or underinsured, and safety net clinics.

The evaluation leverages state and national secondary data sets, and extensive primary data collection, including a longitudinal study of family planning patients; multiple statewide surveys of women, providers, and family planning clinics; and key informant interviews. Studies using secondary data incorporate different comparison groups within the Southeast region and nationally. Studies collecting survey data are conducted in South Carolina and a comparison state that is geographically and culturally similar to South Carolina but not implementing a statewide contraceptive access initiative. Both South Carolina and the comparison state are located in the Southeast and have centralized public health systems. The states are highly comparable at baseline, with population size, demographics, income levels, health insurance rates, unintended pregnancy and birth rates, Medicaid family planning policy, women's health indicators, and Title X contraceptive use patterns being similar.

These data sources are leveraged to examine a variety of programmatic outputs, practice and policy outcomes, individual and community outcomes, and health and social outcomes. These are summarized in Table B (available as a supplement to the online version of this article at http://www.ajph.org).

Programmatic Outputs

A robust process evaluation tracks activity and output measures across the duration of implementation. These measures examine the numbers of participating clinics over time, reach of training, reach and perceptions of the No Drama campaign, expansion of hospital postpartum contraception, and staff perceptions of CW implementation across participating organizations. The process evaluation uses programmatic notes, reports, and key informant interviews with CW partner staff, training organizations, and other participants.

Practice and Policy Outcomes

Knowledge, skills, attitudes, and beliefs about contraception among providers and provision of person-centered care. The evaluation assesses training and provider-related outcomes at the state level and also specifically among training participants. State-level data are derived from statewide surveys of providers conducted in South Carolina and a comparison state assessing provider attitudes, beliefs, skills, and practices related to contraceptive counseling and provision. The initial survey was conducted in 2017–2018, and the endline will be conducted in 2023. A regression-based difference-in-differences approach will be used to estimate the effects of CW on outcomes of interest. In addition, the process evaluation collected data from training participants across South Carolina in 2017–2019 to gauge the immediate impact of the training on intent to change practices, knowledge, and skills.[11]

Clinic-level policies and procedures to increase access to contraception. The statewide survey of family planning (health department and federally qualified health centers) clinics, conducted in South Carolina and a comparison state, assesses clinic-level contraceptive policies, practices, trainings, and service delivery. Three surveys are planned, The baseline and midline surveys were conducted in 2017 and 2020, respectively. The endline survey is planned for 2023. Survey methods and baseline data have been published elsewhere.[12] A regression-based difference-in-differences approach will be used to assess the overall effect of CW on contraceptive access and provision at clinics. Mixed models incorporating fixed and random effects will also be used to examine the effect of clinic characteristics and policies on changes in outcomes. Outcomes include the provision of the full range of contraceptive methods and patient contraceptive use.

Policy changes that enable contraceptive access. A policy monitoring protocol has been developed to track changes affecting contraceptive use during and after CW, including scope of practice laws for nurse practitioners and pharmacists, insurance coverage, and contraceptive reimbursement policies in South Carolina and comparison states. Such policies have implications for interpreting evaluation findings and for the sustainability of the initiative.

Medicaid expenditures on contraception. The evaluation assesses the economic impact of changes in contraceptive use and associated outcomes among Medicaid beneficiaries. Findings have implications for the Medicaid program, state budget, and the sustainability of CW.

Individual and Community Outcomes

Contraceptive use. Multiple studies examine state-level contraceptive use and among priority populations. Contraceptive use at the population level is estimated using the statewide Survey of Women (SoW). The SoW uses an address-based sample to derive population-level estimates of key reproductive health measures in South Carolina and a comparison state. Women of reproductive age were surveyed at baseline and followed longitudinally, with another cross-sectional survey conducted post-CW. The survey methods and select baseline results have been published elsewhere.[13]

Medicaid claims linked with vital records were used to construct a cohort of Medicaid-eligible women receiving family planning services spanning a 12-year period surrounding CW (2012–2024). Baseline data have been published elsewhere.[14] Changes in contraceptive use and associated outcomes will be examined using longitudinal analyses with fixed and random effects, time-to-event analysis, and mixed models for longitudinal panel-structured data.

To examine changes in contraceptive use over time among South Carolina Title X users compared with Title X users nationally and within the southeastern region, we use national Family Planning Annual Report data[15] beginning in 2012 and moving forward. This analysis uses an interrupted time-series design with a regression-based difference-in-differences approach and multiple nonequivalent comparison groups to examine changes over time.

We examine contraceptive use among patients of CW-participating clinics relative to those at nonparticipating clinics using data from the longitudinal study of family planning patients. This study uses a quasi-experimental design involving CW-participating clinics, pair matched with nonparticipating clinics. Eligible patients seeking contraceptive services at clinics are recruited and surveyed at recruitment and in follow-up surveys over two years. Surveys assess contraceptive decision-making, experiences, use, and outcomes. Analyses follow intention-to-treat methods using generalized estimating equations that account for clustering to estimate the effect of CW on outcomes of interest.

Contraceptive care experiences and receipt of person-centered care. Both the SoW and the longitudinal study of family planning patients assess women's experiences and satisfaction with contraceptive care, including contraceptive choice perceived control and receipt of person-centered counseling.[16]

Attitudes and beliefs about contraception among women of reproductive age. This outcome is examined at the state level, using data from the SoW, and also among women seeking services at CW-participating clinics using data from the longitudinal study of family planning patients.

Health and Social Outcomes

Unintended pregnancy. To analyze state-level changes in unintended pregnancy, we examine data from the Pregnancy Risk Assessment Monitoring System (PRAMS) for South Carolina and other southeastern states and data from the SoW. PRAMS is an ongoing population-based surveillance system of mothers who recently gave birth to a live-born infant.[17] A regression-based difference-in-differences approach will be used to estimate CW effects on unintended pregnancy and other outcomes.

Births, teen births, and abortions. To examine CW's impact on births, we use birth certificate data from all US states linked with the Area Health Services Resources File to account for the influence of social and community contexts on the outcomes.[18] Abortion is examined in vital records data at the state level. We will use an interrupted time-series study design with multiple nonequivalent or matched comparison groups to measure population-based shifts in these outcomes.

Reproductive well-being. Contraceptive decision-making and access to information, services, and supports to make these decisions will be examined within the longitudinal study of family planning patients.

PUBLIC HEALTH SIGNIFICANCE

Statewide contraceptive access initiatives have shown promise in increasing the availability of a full range of contraceptive methods, resulting in increased contraceptive use.[19–21] There is also evidence that these initiatives can impact outcomes, including abortions, teen births, and preterm births.[19,21,22] South Carolina is the first southeastern, politically conservative state to institute a statewide contraceptive access initiative of this magnitude.

CW continues under its current funding structure through the end of 2022. The evaluation of CW continues into 2025. The evaluation is well positioned to assess key outputs and impacts associated with CW and to contribute to the evidence base for contraceptive access initiatives. AJPH

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CONTRIBUTORS

M. G. Smith coordinated the development of the manuscript, wrote the first draft of the Choose Well evaluation components, critically edited all sections of the manuscript, and approved the final manuscript. S. Kelley and K. Satterfield wrote the first draft of the Choose Well implementation components, critically edited the manuscript, and approved the final manuscript. N. Hale contributed to the evaluation framework, critically edited all sections of the manuscript, and approved the final manuscript. K. E. Beatty critically edited all sections of the manuscript and approved the final manuscript. A. J. Khoury conceptualized and oversees the Choose Well evaluation, contributed to the evaluation framework, critically edited all sections of the manuscript, and approved the final manuscript.

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CONFLICTS OF INTEREST

S. Kelley and K. Satterfield are employed by New Morning, the nonprofit organization that is implementing Choose Well in South Carolina. The other authors have no conflicts of interest to declare.

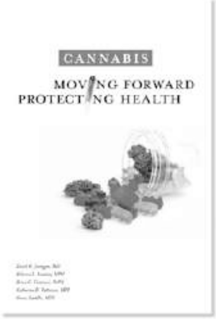
HUMAN PARTICIPANT PROTECTION

All evaluation efforts described have been reviewed and approved or exempted by the institutional review board at East Tennessee State University.

REFERENCES

1. New Morning. Homepage. Available at: https://newmorning.org. Accessed March 10, 2022.
2. Kania J, Kramer M. Collective impact. *Stanford Soc Innovation Rev*. Winter 2011. Available at: https://ssir.org/articles/entry/collective_impact. Accessed November 18, 2021.

3. Gavin L, Moskosky S, Carter M, et al. Providing quality family planning services: recommendations of CDC and the US Office of Population Affairs. *MMWR Recomm Rep.* 2014;63(RR-04):1–54. https://doi.org/10.15585/mmwr.mm6509a3
4. Gavin L, Pazol K. Update: providing quality family planning services — recommendations from CDC and the US Office of Population Affairs, 2015. *MMWR Morb Mortal Wkly Rep.* 2016;65(9):231–234. https://doi.org/10.15585/mmwr.mm6509a3
5. No Drama. Homepage. Available at: https://nodrama.org. Accessed March 10, 2022.
6. Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. *Am J Public Health.* 1999;89(9):1322–1327. https://doi.org/10.2105/AJPH.89.9.1322
7. Gaglio B, Shoup JA, Glasgow RE. The RE-AIM framework: a systematic review of use over time. *Am J Public Health.* 2013;103(6):e38–e46. https://doi.org/10.2105/AJPH.2013.301299
8. Aday LA, Andersen R. A framework for the study of access to medical care. *Health Serv Res.* 1974;9(3):208–220.
9. Andersen RM. Revisiting the behavioral model and access to medical care: does it matter? *J Health Soc Behav.* 1995;36(1):1–10. https://doi.org/10.2307/2137284
10. Andersen RM. National health surveys and the behavioral model of health services use. *Med Care.* 2008;46(7):647–653. https://doi.org/10.1097/MLR.0b013e31817a835d
11. Ariyo O, Khoury AJ, Smith MG, et al. From training to implementation: improving contraceptive practices in South Carolina. *Contraception.* 2021;104(2):155–158. https://doi.org/10.1016/j.contraception.2021.04.016
12. Beatty KE, Smith MG, Khoury AJ, Zheng S, Ventura LM, Okwori G. Accessibility of federally funded family planning services in South Carolina and Alabama. *Prev Med Rep.* 2021;22:101343. https://doi.org/10.1016/j.pmedr.2021.101343
13. Hale N, Smith M, Baker K, Khoury A. Contraceptive use patterns among women of reproductive age in two southeastern states. *Womens Health Issues.* 2020;30(6):436–445. https://doi.org/10.1016/j.whi.2020.08.005
14. Hale N, Manalew WS, Leinaar E, et al. Contraceptive use and pregnancy outcomes among women enrolled in South Carolina Medicaid programs. *Matern Child Health J.* 2021;25(12):1960–1971. https://doi.org/10.1007/s10995-021-03260-x
15. Fowler CI, Gable J, Lasater B, Wilson E. Family Planning Annual Report: 2018 National Summary. Research Triangle Park, NC: RTI International; 2019. Available at: https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html. Accessed October 8, 2021.
16. Dehlendorf C, Fox E, Silverstein IA, et al. Development of the Person-Centered Contraceptive Counseling scale (PCCC), a short form of the Interpersonal Quality of Family Planning care scale. *Contraception.* 2021;103(5):310–315. https://doi.org/10.1016/j.contraception.2021.01.008
17. Shulman HB, D'Angelo DV, Harrison L, Smith RA, Warner L. The Pregnancy Risk Assessment Monitoring System (PRAMS): overview of design and methodology. *Am J Public Health.* 2018;108(10):1305–1313. https://doi.org/10.2105/AJPH.2018.304563
18. Orimaye SO, Hale N, Leinaar E, Smith MG, Khoury A. Adolescent birth rates and rural-urban differences by levels of deprivation and health professional shortage areas in the United States, 2017-2018. *Am J Public Health.* 2021;111(1):136–144. https://doi.org/10.2105/AJPH.2020.305957
19. Ricketts S, Klingler G, Schwalberg R. Game change in Colorado: widespread use of long-acting reversible contraceptives and rapid decline in births among young, low-income women. *Perspect Sex Reprod Health.* 2014;46(3):125–132. https://doi.org/10.1363/46e1714
20. Boudreaux M, Xie L, Choi YS, Roby DH, Rendall MS. Changes to contraceptive method use at title X clinics following Delaware Contraceptive Access Now, 2008–2017. *Am J Public Health.* 2020;110(8):1214–1220. https://doi.org/10.2105/AJPH.2020.305666
21. Lindo JM, Packham A. How much can expanding access to long-acting reversible contraceptives reduce teen birth rates? *Am Econ J Econ Policy.* 2017;9(3):348–376. https://doi.org/10.1257/pol.20160039
22. Goldthwaite LM, Duca L, Johnson RK, Ostendorf D, Sheeder J. Adverse birth outcomes in Colorado: assessing the impact of a statewide initiative to prevent unintended pregnancy. *Am J Public Health.* 2015;105(9):e60–e66. https://doi.org/10.2105/AJPH.2015.302711



Statewide Contraceptive Access Initiatives: A Critical Perspective

Christine Dehlendorf, MD, MAS, and Jamila Perritt, MD, MPH

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The development of modern contraceptive methods has been heralded as an advancement in reproductive freedom and autonomy that plays a critical role in many individuals' achievement of personal health, social, and financial goals.[1] The production and distribution of contraceptive methods have, in fact, allowed many individuals to avoid pregnancies they did not want or could not carry and have, in some contexts, been associated with improved gender equality in the workforce and in families.[2] However, the development and use of these methods have been deeply shaped by population control theory and White supremacy values. Oppressive uses of these methods have included unethical testing, such as experimental use of oral contraceptive pills in Puerto Rico without obtaining informed consent in the 1950s; the coercive and involuntary sterilization of Black and Indigenous women, individuals living in poverty, and people with disabilities; and targeted counseling on contraception directed at people using substances and Black, Indigenous, and People of Color (BIPOC).[3,4]

Although the intent of the development and dissemination of these methods may have been grounded in the desire to expand access to and broaden the opportunity for reproductive freedom, the effect has been vastly different. Not all have shared equally in the promised liberation associated with contraceptive technologies, and many have, in fact, been harmed by contraceptive policies and practices.[5]

This complex reality of modern contraception reflects the context in which contraceptive technologies are being distributed and used. In the United States, and around the world, societal power structures and hierarchies dictate the value of one's reproduction, and control over reproduction has been a prominent way to manifest the relative valuing of people.[3] The increased availability of pregnancy control methods has reinforced and upheld harmful agendas on whose reproduction should be prioritized, allowing novel pathways of oppression to be enacted. Also, as we will describe, the increased availability of contraception, by providing the (imperfect) ability to control timing and frequency of pregnancies, has contributed to the development of new narratives about which pregnancies are viewed as positive outcomes.

Specifically, in the decades since the oral contraceptive pill was invented, a narrative has emerged about the importance of avoiding an unintended or adolescent pregnancy. Although much of this narrative was grounded in a desire to mitigate the economic and social impacts of unwanted childbearing, it served to reify dominant narratives about the value of pregnancy in some people and not others. Unintended and adolescent pregnancies have been and continue to be considered undesirable—in both clinical contexts and on a population level—despite a lack of robust evidence to support this belief.[6] Furthermore, an increasing body of scholarship has shown that the paradigm of intention does not align with the lived experience and desires of many individuals with respect to pregnancy.[7] The adolescent pregnancy prevention framework has also been problematized, with the recognition that sexual and reproductive decision-making is embedded in inequitable social resources and opportunities that influence both the occurrence of early childbearing and the impact it has on individuals and their lives.[8]

By centering adolescent or unintended pregnancy as the problem, attention is diverted from the real issues of inequality and structural oppression. In effect, the availability of technologies that increase the opportunity to control reproduction has enabled the narrative that people should control reproduction, especially when this reproduction is socially stigmatized. This narrative has provided another—albeit less explicit—pathway to devalue the reproduction of BIPOC and individuals living in poverty, who, because of the social and historical context in which reproduction occurs, are more likely to experience these stigmatized pregnancies.[9]

RECENT CONTRACEPTIVE INITIATIVES

As detailed in this special issue of *AJPH*, contraceptive access initiatives have proliferated over the past decade, driven in large part by the enthusiasm for what has come to be known as long-acting reversible contraceptive (LARC) methods. This enthusiasm, as well as the programmatic interventions born of it, failed to interrogate and instead reproduced the same concerns as previous generations of advancement in contraceptive technology. On one hand, having new, highly effective methods of contraception available provided new and more diverse means for individuals to realize their reproductive desires. On the other hand, the implementation and dissemination of programs focused on these methods provided another way to practice biases and priorities related to reproduction.

One of the earliest critiques of these initiatives was related to their emphasis on LARC methods over other methods. The Contraceptive CHOICE Project, based in St. Louis, Missouri, for example, was funded with the express goal to "promote and provide the most effective methods of contraception"[10(p635)] by increasing the uptake of LARC methods. This emphasis was manifested in a variety of ways, with perhaps the most prominent being the approach to counseling. CHOICE popularized the "tiered effectiveness" model of contraceptive counseling, in which patients are counseled on contraceptive options in a way that emphasizes effectiveness as the most important feature.[11] This achieved the desired effect of promoting the use of LARC methods.[10]

This approach to counseling was initially embraced—in large part because the high uptake of LARC methods was viewed as a positive outcome—and CHOICE was seen as a success. However, many pointed out the ways both the motivation for and the implementation of this counseling model were problematic. Specifically, they identified how a primary focus on contraceptive effectiveness values the project's focus on preventing unintended pregnancy over what each individual seeking contraceptive care may prioritize in their contraceptive method, such as control over their method or impact on menstruation.[12,13] In implementing this approach to counseling, CHOICE did not prioritize reproductive agency and autonomy by supporting participants in choosing methods that were the best fit for their own personal needs and preferences. Additionally, this approach is particularly problematic in that BIPOC are more likely to be subjected to directive contraceptive counseling and advised to limit or delay childbearing.[14] As a result, promoting directive counseling approaches will likely disproportionately burden those whose reproduction is already devalued.

The attention to CHOICE and its approach to counseling had a broad impact, including being adopted by a range of organizations such as the World Health Organization, the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics,[15] and state and local departments of health. This undoubtedly has influenced the contraceptive care experiences of innumerable people in the United States and beyond. This impact is beginning to recede, as demonstrated by the recent publication of the American College of Obstetrician Gynecologists' guidelines that explicitly reject this approach in favor of a person-centered, shared decision-making model.[16] However, the prominence of this approach to counseling still persists in many places more than a decade later. Its enduring nature, born of an early contraceptive access initiative, demonstrates how these initiatives and their LARC focus have the potential to contribute to contraceptive technologies' complicated and detrimental consequences, which go beyond access to methods.

An additional example of how these initiatives, particularly in the early phases, contributed to harm includes the focus on adolescent pregnancy prevention and advocacy for contraceptive access as a means of costs savings to public programs. The Colorado Family Planning Initiative began in 2009 with the laudable goal of expanding contraceptive access by providing LARC methods at the same level of support as other contraceptive methods available through the Title X program.[17] In media and scientific publications, however, the initiative and its supporters shifted from a focus on access—and the reproductive autonomy it can help to enable—as the end goal. Rather, the messaging on this initiative focused on its goal of—and seeming ultimate success at—reducing adolescent pregnancy and decreasing the costs of social support programs because of decreased births in families relying on these initiatives.[18] Therefore, the overarching message of this program was not about enabling people to achieve the families they wanted by providing the full range of contraceptive methods. Rather, it was clearly communicated that the goal was to decrease reproduction that is viewed as problematic on a societal level—specifically, reproduction among adolescents and those living in poverty.

Many working as part of the initiative no doubt felt themselves to be motivated to meet the needs of and support the reproductive autonomy of adolescents and adults being cared for in Title X clinics, and this initiative did address an unmet need in Colorado for improved contraceptive access. However, their actions ignored the context of these inequities in care and beliefs about reproduction. The broader narrative about why this work was being done, and how its success was being evaluated, contributed to ongoing problematic constructions of why reproductive health care is valuable and how reproductive health care can and should support societal, as opposed to individual, priorities.

A similar narrative that proposes contraceptive uptake as a means to address poverty has emerged as a motivation for more recent contraceptive access initiatives.[19] The now familiar beliefs that the reproduction of those living in poverty is the source of societal inequality and that providing and promoting contraception will therefore fix the problem ignores the true structural and contextual causes of poverty: systemic racism, economic inequity, and lack of social supports.[20] This narrative doubles down on the tendency to prioritize the provision of reproductive health as valuable specifically because of its purported benefit to those with greater social capital and institutional power, as opposed to its effects on individuals seeking care and their reproductive autonomy. Promoting these initiatives based on this rationale undermines human rights frameworks and social justice principles and instrumentalizes reproductive health to achieve societal goals rather than liberation.

These examples of directive counseling to use specific methods and the promulgation of problematic narratives about reproduction indicate that despite the many benefits that contraceptive access can provide to individuals, and the good intentions of many involved in these initiatives, their implementation has, in fact, caused harm—both in clinical practice and in the broader societal understanding of why it is important to invest in reproductive health care. Although those who prefer to view contraception as an inherently liberatory technology may find this surprising, these initiatives as they were conceptualized and embedded in existing structures and philosophies were unlikely to avoid this fate. Specifically, health care provision occurs in an ecosystem that does not value all bodies equally and that sees individual behavior as the primary driver of health care outcomes, as opposed to broader structural causes. These factors result in the well-documented biased and discriminatory care of minoritized groups, as well as structural inequities in providing health care services.[21]

In addition, as we described previously, reproduction control has been used as a tool to operationalize societal values throughout our nation's history, specifically related to White supremacy and the control of BIPOC bodies. Contraceptive service providers have been actively complicit in many of these efforts to limit the reproduction of these groups. Taken together, these realities—of biased and structural inequitable care focused on individual behaviors and the ongoing manifestation of societal values through the relative priorities placed on reproduction—mean that unless these types of initiatives are explicitly grounded in a commitment to addressing racial and economic injustices and reproductive oppression, existing prejudices and structural factors will inevitably lead to problematic implementation and consequences.

LOOKING FORWARD TO A NEW APPROACH

There is an opportunity to learn from these experiences in efforts to improve reproductive health care provision, including in the context of contraception, in the future. By centering equity, justice, and the voices and lives of those in communities being affected, future initiatives can create a new paradigm that acknowledges, addresses, and grapples with the recent and remote history of bias, discrimination, and structural inequities and foregrounds commitment to reproductive autonomy and reproductive justice,[22] rather than pregnancy prevention and societal goals.

The Person-Centered Contraceptive Care framework, whose development was informed by the experience of previous state initiatives, provides a template that local, state, and national programs can use to guide their planning and implementation.[23] Innovations that programs can make to avoid falling into previous patterns include (1) ensuring robust community and stakeholder engagement from inception to evaluation, (2) ensuring that specific methods are not prioritized over others, and (3) specifically ensuring that counseling on and provision of often neglected methods, such as fertility awareness–based methods and diaphragms, are supported. In addition, these efforts must prioritize at all stages—including fundraising, implementation, and evaluation—outcomes that recognize the personal and contextualized nature of reproduction and that are aligned with reproductive autonomy.

It is essential to note, however, that none of these activities, together or in isolation, can protect against promulgating harm from contraceptive technologies in the absence of an authentic and deeply held commitment to reproductive autonomy and the undoing of oppressive structures and narratives, as well as the willingness to face the harms that have been done by the medical community and reproductive health providers. Our society has only begun to wrestle with deep, fundamental questions about the unjust origins and ongoing oppressive effects of our political, economic, and legal systems. We in health care and public health must ask similar questions and confront our own complicity in gendered and racialized oppression.

Only by confronting these truths will we have the opportunity to shift to programs and policies that center the lived experiences of those we seek to serve, especially those most harmed by previous efforts. In this way, we can manifest the reality we strive for, in which all people's reproduction is equally valued and their needs, values, and preferences for their reproductive lives are the guiding light for how contraceptive technologies are understood and provided. AJPH

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REFERENCES

1. Centers for Disease Control and Prevention. Achievements in public health, 1900–1999: family planning. *MMWR Weekly*. 1999;48(47):1073–1080.
2. Sonfield A, Hasstedt K, Kavanaugh ML, Anderson R. *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*. New York, NY: Guttmacher Institute; 2013.
3. Roberts D. *Killing the Black Body*. New York, NY: Vintage Books; 2000.
4. Morgan M. The payment of drug addicts to increase their sterilisation rate is morally unjustified and not simply "a fine balance." *J Obstet Gynaecol*. 2004;24(2):119–123. https://doi.org/10.1080/01443610410001645361
5. Stern AM. STERILIZED in the name of public health: race, immigration, and reproductive control in modern California. *Am J Public Health*. 2005;95(7):1128–1138. https://doi.org/10.2105/AJPH.2004.041608
6. Geronimus AT. Damned if you do: culture, identity, privilege, and teenage childbearing in the United States. *Soc Sci Med*. 2003;57(5):881–893. https://doi.org/10.1016/S0277-9536(02)00456-2
7. Aiken ARA, Borrero S, Callegari LS, Dehlendorf C. Rethinking the pregnancy planning paradigm: unintended conceptions or unrepresentative concepts? *Perspect Sex Reprod Health*. 2016;48(3):147–151. https://doi.org/10.1363/48e10316
8. Luker K. *Dubious Conceptions: The Politics of Teenage Pregnancy*. Cambridge, MA: Harvard University Press; 1996.
9. Troutman M, Rafique S, Plowden TC. Are higher unintended pregnancy rates among minorities a result of disparate access to contraception? *Contracept Reprod Med*. 2020;5(1):16. https://doi.org/10.1186/s40834-020-00118-5
10. McNicholas C, Madden T, Secura G, Peipert JF. The Contraceptive CHOICE Project round up: what we did and what we learned. *Clin Obstet Gynecol*. 2014;57(4):635–643. https://doi.org/10.1097/GRF.0000000000000070
11. Madden T, Mullersman JL, Omvig KJ, Secura GM, Peipert JF. Structured contraceptive counseling provided by the Contraceptive CHOICE Project. *Contraception*. 2013;88(2):243–249. https://doi.org/10.1016/j.contraception.2012.07.015
12. National Women's Health Network. LARC statement of principles. April 10, 2021. Available at: https://nwhn.org/larc-statement-of-principles. Accessed February 10, 2022.
13. Gomez AM, Fuentes L, Allina A. Women or LARC first? Reproductive autonomy and the promotion of long-acting reversible contraceptive methods. *Perspect Sex Reprod Health*. 2014;46(3):171–175. https://doi.org/10.1363/46e1614
14. Becker D, Tsui AO. Reproductive health service preferences and perceptions of quality among low-income women: racial, ethnic and language group differences. *Perspect Sex Reprod Health*. 2008;40(4):202–211. https://doi.org/10.1363/4020208
15. Brandi K, Fuentes L. The history of tiered-effectiveness contraceptive counseling and the importance of patient-centered family planning care. *Am J Obstet Gynecol*. 2020;222(4 suppl): S873–S877. https://doi.org/10.1016/j.ajog.2019.11.1271
16. American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women; Contraceptive Equity Expert Work Group; Committee on Ethics. Patient-centered contraceptive counseling. ACOG Committee Statement No. 1. *Obstet Gynecol*. 2022;139(2): 350–353. https://doi.org/10.1097/AOG.0000000000004659
17. Colorado Department of Public Health and Environment. Taking the unintended out of pregnancy: Colorado's success with long-acting reversible contraception. 2017. Available at: https://drive.google.com/open?id=1Bfk7CS8I5W92iCS0g8_COTBmi8a-JxZ4. Accessed February 10, 2022.
18. Ricketts S, Klingler G, Schwalberg R. Game change in Colorado: widespread use of long-acting reversible contraceptives and rapid decline in births among young, low-income women. *Perspect Sex Reprod Health*. 2014;46(3): 125–132. https://doi.org/10.1363/46e1714
19. Sanger-Katz M. Set it and forget it: how better contraception could be a key to reducing poverty. *New York Times*. December 18, 2018. Available at: https://www.nytimes.com/2018/12/18/upshot/set-it-and-forget-it-how-better-contraception-could-be-a-secret-to-reducing-poverty.html. Accessed February 10, 2022.
20. Black Mamas Matter Alliance. Contraception is not a remedy for poverty. *Essence*. October 23, 2020. Available at: https://www.essence.com/op-ed/black-mamas-matter-alliance-contraception-is-not-a-remedy-for-poverty. Accessed February 15, 2022.
21. Smedley BD, Stith AY, Nelson AR, eds; Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press; 2003.
22. Ross L, Solinger R. *Reproductive Justice: An Introduction*. Oakland, CA: University of California Press; 2017.
23. Holt K, Reed R, Crear-Perry J, Scott C, Wulf S, Dehlendorf C. Beyond same-day long-acting reversible contraceptive access: a person-centered framework for advancing high-quality, equitable contraceptive care. *Am J Obstet Gynecol*. 2020;222(4 suppl):S878.e1–S878.e6. https://doi.org/10.1016/j.ajog.2019.11.1279

Contraceptive Care Using Reproductive Justice Principles: Beyond Access

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As threats to sexual and reproductive health care spread, efforts toward meaningful access can feel like an uphill battle. Reproductive Justice[1] (RJ) leaders have long worked to improve access to care in the here and now while also weaving in openings for future systemic change.

Contraceptive access has profoundly shifted the lives of many. It has meant greater ability for people to decide if, when, and how they want to parent; reduced the possibility of sexually transmitted infections (STIs); provided autonomy to survivors of violence; built sexual freedom; helped manage medical conditions; and combated the default definitions of family that seek to control our bodies. Yet current contraception frameworks have a coercive and racialized foundation.[2–4] The development of modern contraception relied on coercive clinical research exploiting Black, Indigenous, and people of color (BIPOC) and people with disabilities.[2,4] Even the critical Title X federal program that provides affordable reproductive health care has a foundation in population control,[5] rooted in the eugenical ideologies and tactics of white supremacy.

The RJ movement has named the impact of colonialism on sexuality and reproduction, as well as the need to recognize sexual and reproductive health within the context of human rights and with an intersectional analysis.[6,7] As RJ organizations and leaders, we have worked in the nuanced and complex reality that BIPOC, people with disabilities, young people, immigrants, and LGBTQQIA+ (lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, plus) communities, especially those with low incomes, often experience the greatest barriers to accessing contraception and other sexual and reproductive health care, while simultaneously being targeted for control over our bodies and families.[8–10] Because of deep impacts on our communities alongside a desire to move care forward, EverThrive Illinois, Bold Futures (formerly Young Women United), and SisterReach have all worked to change the contraception field through multipronged paths. This has included reimagining how quality contraceptive care, state-based and national policy change, provider outreach and training, and counseling on contraceptive methods are conceptualized, implemented, and measured.

In this article, we critique some of the frameworks that exist in contraception policy and practice. We explore concrete ways that RJ leaders have worked to change access to contraception and the fields of sexual and reproductive health. Although our organizations and state-based initiatives have shifted contraception policy in significant ways over the past decade and beyond, there is still much work to be done to distance current contraception frameworks from their harmful origins and serve affected communities more fully from a person-centered approach. Finally, we highlight issues that remain to be explored. We look forward to continuing to transform the landscape of contraceptive care toward models that center affected communities and their decision-making.

PERSISTING PROBLEMS

Contraception frameworks have pathologized pregnancy and the pregnant person and constructed pregnancy as a disease to be prevented, with contraception as the remedy. In a 2016 article, Finer and Zolna promote contraception as a social good:

> In addition to supporting individual autonomy, there is also a clear public health justification for reducing the rate of unplanned pregnancy: [presumed cis] women and girls who have unintended pregnancies that result in births are more likely than those who intended to become pregnant to have inadequate or a delayed initiation of prenatal care, to smoke and drink during pregnancy, and to have premature and low-birth-weight infants.[11(p844)]

Focusing on expanding contraception through such public health frameworks centers pregnancy prevention over the needs of the person. It places the alleged negative health impacts as the result of an individual's decisions instead of the many systems affecting them, continuing to set up power imbalances between patients and providers. It also omits the diverse reasons people use contraception, such as prevention of STIs and management of medical conditions.

Assumptions and Ambiguity in Data

Unintended pregnancy data are not as straightforward as presented by reproductive health researchers and often make assumptions about the person. Unwanted and mistimed pregnancies are consistently lumped together as unintended even though they encompass two very different intentions. Because many young people's pregnancies are mistimed, they are included in unintended pregnancy data.[12]

A significant number of people experience pregnancy ambivalence.[13,14] As state-based data from the Pregnancy Risk Assessment Monitoring System has shown, the primary reason people who became pregnant gave for not using contraception was that they would not mind if they became pregnant.[15] Pregnancy planning and intention are equivocal concepts and not universal. However, contraception research and practice have largely ignored those insights. As expressed by Aiken et al.,

> . . . rather than evoking a binary distinction between whether a pregnancy was "intended" or "unintended" . . . [presumed cis] women often describe their pregnancies as falling on a continuum between the two.[14(p147)]

Even if a person identifies their pregnancy intention at a given point in time, it can fluctuate. Guttmacher reported that pregnancy intentions for over 40% of cisgender women have changed since the onset of the COVID-19 pandemic.[16]

Contraception and Coercion

Contraception as a preventive strategy is touted as a reason to convince people to do what is supposedly "best for them." But the assertion that unintended pregnancies necessarily lead to poor health outcomes is not a demonstrable claim because

> . . . there is little robust evidence that unintended pregnancy is an independent risk factor for poor maternal or neonatal outcomes. Many studies suggesting such a link are problematic in terms of their ability to control for potentially confounding influences.[14(p150)]

Within these conditions, contraceptive care is ripe for coercive practices. This has played out in state policy, creating a landscape in which certain types of contraception are valued over others, such as offering long-acting reversible contraception (LARC) for free while charging for other methods or not covering the cost of LARC removal.[17,18]

Narratives and practices that pathologize pregnancy are predominantly informed by people who are not part of the most affected communities. These policies and practices dehumanize people who become pregnant, criminalize people for how they take care of themselves or make decisions, and define success for people instead of with people.

LEADERSHIP OF REPRODUCTIVE JUSTICE ORGANIZATIONS

EveryThrive Illinois, Bold Futures, and SisterReach are key players within broader initiatives on contraceptive access. The following sections highlight some of our efforts and accomplishments in centering people and communities, using RJ frameworks.

EverThrive Illinois: Changing Frameworks

EverThrive Illinois is a champion for health equity, working to achieve RJ in the health care ecosystem through community-driven partnership, policy action, and systems change.

Contraceptive Justice (CJ) is a framework created with a coalition of reproductive health, rights, and justice advocates and community experts that operationalizes RJ for contraceptive care using 13 domains of high-quality health care (Box 1).[19] CJ is the concept that all people deserve the social, political, and economic power, rights, access, and resources to receive contraceptive care aligned with these domains of quality. Through the process of creating the principles of CJ with patients, the framework centers the experiences and concerns of those most affected by health inequities and seeks to prevent reproductive coercion. The CJ framework is a tool to rethink traditional approaches to contraceptive access and center a shared measure of success as defined by the person.

Contraceptive access initiatives are using more inclusive and person-centered language while still using the same problematic measures, such as unintended pregnancy and contraceptive use. Committing to justice requires consistent action, not just the correct language.

Seeing this gap, EverThrive Illinois and Converge: Partners in Access convened leaders in RJ and contraception to redefine quality and establish a new

BOX 1— Domains of High-Quality Health Care for Contraceptive Justice

Person-centered	Respectful of and responsive to each person's values, preferences, and needs and ensures that the person's values guide all health care decisions
Confidential	Keeping personal, identifiable medical information private and only sharing it with informed consent as a right of all people, including people younger than 18 years
Comprehensive	Providing complete information and the full range of services
Medically accurate	Providing information that is supported by scientific research
Developmentally appropriate	Providing information that is responsive to a person's age or stage of social, emotional, physical, and cognitive development
LGBTQQIA+ affirming	Affirming of and providing information and services relevant to lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual identities and communities
Accessible	Easily approached or obtained financially and physically
Trauma responsive	Acknowledging the reality and impact of trauma and responding with appropriate care
Culturally and linguistically affirming	Providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred language, health literacy, and other communication needs
Harm reduction grounded	Reducing the harm or risk associated with environments and experiences through policies, programs, and practices
Pro-choice	Affirming the basic human right to self-determination, including the right to use or not use contraception, choose a preferred method of contraception, or a pregnancy option such as abortion
Sex- and body-positive	Affirming and supportive of all sexual activity that is safe and consensual and of all bodies
Challenging of explicit and implicit bias, shame, and stigma	Recognizing that good intentions are not enough and actively working to reflect on and interrupt bias, shame, and stigma

Source. The EverThrive Illinois report.[19]

vision for success in person-centered contraceptive access initiatives using the CJ framework. The resulting sign-on statement lays out collectively defined principles. It sets the foundation for creating a patient-developed assessment of quality that clinics can utilize and an assessment of patient experience to provide an overall picture of quality from multiple perspectives.

Bold Futures: Policy Change

Bold Futures is an RJ organization by and for Indigenous people and people of color leading policy change, research, culture shift, and place-based organizing in New Mexico. Bold Futures improves contraceptive access through approaches informed by and reflective of the lived expertise of affected people.

New Mexico has some of the best contraception laws and regulations in the country; it is also a majority-people-of-color and rural state that remains stratified by income, race, and place. Bold Futures believes contraception access should focus on the contraceptive needs of people seeking care, not in preventing pregnancy as a disease or social burden. Bold Futures released the groundbreaking report *Dismantling Teen Pregnancy Prevention*[20] to undo some of the myths that often motivate contraception priorities for lawmakers, health officials, and state agencies.[21]

Bold Futures, together with partners, has led contraceptive advocacy through an access-centered and comprehensive approach to policy and rule change. In a 2017 example, New Mexico approved a pharmacy protocol that allows trained pharmacists to provide contraceptive counseling and prescribe most contraceptive methods. Through this collaboration with the New Mexico Pharmacists Association and the American Civil Liberties Union of New Mexico, Bold Futures focused advocacy on frontier and rural communities in a state affected by significant provider shortages, long wait times for care, and the need for working people to access care outside of traditional hours. Bold Futures organized nurses, physicians, and advanced practice clinicians to urge their respective boards to pass the protocol. Bold Futures then led meetings with local pharmacists to assess progress with the protocol. When pharmacists were not being reimbursed for their time, the New Mexico Pharmacists Association, Bold Futures, and their allies successfully advocated for a law requiring insurers to reimburse clinical services by pharmacists at amounts similar to those of other licensed providers.

Previously, Bold Futures was instrumental in enshrining the Affordable Care Act's "no-cost" contraceptive coverage requirements into state law; it then went further, requiring insurers to cover a six-month supply of contraception, over-the-counter contraceptive methods, and contraception regardless of an enrollee's gender. Bold Futures mobilized people from rural communities, students, members of the National Guard, and others to share with the legislature how multiple months of contraceptive dispensing meant their care would better meet their needs; queer and trans folks shared how over-the-counter coverage could limit invasive questions about their sexual health. Through implementation, Bold Futures reviewed and revised rules related to coverage, developed public education and marketing materials, and provided tangible guidance on establishing payment standards and billing mechanisms.

Bold Futures has continuously shifted contraception policy and implementation—based not on national playbooks but on the realities felt by people and providers—to make sure the intent of the policies matches their implementation and has real impacts on the lives of New Mexicans.

SisterReach: Advocating for Patient-Led Care

SisterReach is a Tennessee-based grassroots organization supporting the reproductive autonomy of women and adolescents of color, poor and rural women, LGBTQQIA+ and gender-nonconforming people, and their families through the framework of RJ. SisterReach's mission is to empower our base to lead healthy lives, raise healthy families, and live in healthy and sustainable communities. SisterReach works from a four-pronged strategy of education, policy and advocacy, culture shift, and harm reduction.

In Tennessee, access to comprehensive reproductive and sexual health education (CSE) is demonized by conservative and misinformed evangelicals, who are the political and economic majority in the state; they present LARC as the remedy to reduce abortion and adolescent pregnancy. Since 2012, SisterReach has advocated for public school youths' access to CSE through research informed directly by marginalized Tennessee youths, their parents, and teachers.[22] In 2015, we also launched our Vacation Body School program, which offers CSE in churches and has coordinated several local town halls, panels, and voter education opportunities for community dialogue and feedback. In 2022, SisterReach Youth Ambassadors will present a resolution to the Memphis school board requesting free barrier method contraception and accessible menstrual products on public school campuses county-wide.

SisterReach advocates for CSE on state and federal levels, and curates collaboration among state and national CSE advocates who understand the importance of increasing awareness, trust-building, and buy-in among people as the most effective prevention and intervention strategies. We provide free HIV and hepatitis C virus testing and connection to care, free of cost. Lastly, SisterReach's work to quell implicit bias among health care providers, sexual health educators, public health officials, and insurance providers by providing training on implicit bias concretizes our four-pronged approach to forward reproductive and sexual justice for the people we serve.

SisterReach envisions expanding the current person-centered[23] framework to person-led care: a more comprehensive and intersectional bridge to trust-building between providers, health care institutions, and patients.

SisterReach's CEO and founder, Cherisse Scott, teaches that person-led care recognizes that the person receiving care should be the utmost expert in the decisions they will make for themselves. Person-led care can curate opportunities for abundant life via abundant health outcomes informed by provider and patient.

REMAINING QUESTIONS

Although some of the wins mentioned here have been accomplished through multisectoral partnerships, none of them have come to fruition without great struggle, including clashes with partners who are closely aligned with our organizations on the issue of access and who—at least in theory—agree with RJ principles. The persisting problems discussed in this article are neither abstract nor remnants of the past, but are very much present and undermining a full expression of RJ.

The work of our three organizations, alongside the larger movements for RJ, is creating opportunities to shift contraceptive care toward a more just landscape with values rooted in community well-being and care.

Many of the issues that remain in contraception ideology and accessibility have inextricable ties to issues within the larger health care system. Although the public health field has recently shifted to examine racism as a public health issue, many of the racist and ableist foundations of these institutions remain unexamined.[24] Public health ideologies often assume that people need to be educated a certain way and convinced of what is in their best interest; they do not acknowledge the ancestral and historical ways that people have cared for themselves and their communities for generations despite the targeted neglect of colonial health care models. These foundational assumptions show up as ideas about “proper” family composition and size, pregnancy spacing, the “right” time to have a baby, and other prevailing ideologies that have become ingrained as public health methodologies.

But perhaps the greatest barrier that persists in public health for most affected communities—and that remains even with providers who intend to disrupt these patterns of harm—is the lack of space for provider–patient relationship formation. Western models of care continue to operate in a pressured, time-scarce structure[25] that, by its very nature, prevents full patient autonomy and decision-making from occurring. When visits last 15 to 20 minutes—and often even less—we cannot reasonably expect providers or patients to have meaningful and complete communication that disrupts harmful assumptions and stereotypes that drive the poor treatment and omission of full personhood from contraceptive care. In practice, the current health care structures lack a space for curiosity about what types of consent, informed decision-making, and lasting benefit can be gained from relationship formation with people seeking sexual and reproductive health care.

CONCLUSION

There is much that remains uninvestigated about how contraception frameworks can better serve populations most affected by systemic violence. The continued work of powerful RJ organizations, such as those featured in this article, creates an opportunity for established health care institutions, researchers, providers, and lawmakers to address the ways that current and past methodologies have resulted in harm for many communities—and an opportunity to instead adopt new frameworks and practices that emphasize self-determination in sexual and reproductive decision-making.

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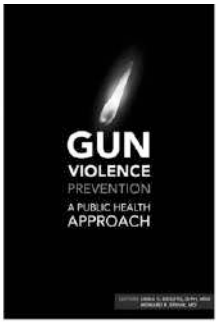
REFERENCES

1. Ross L, Solinger R. *Reproductive Justice: An Introduction.* Vol 1. Oakland, CA: University of California Press; 2017.
2. Briggs L. *Reproducing Empire: Race, Sex, Science, and US Imperialism in Puerto Rico.* Berkeley, CA: University of California Press; 2002.
3. Eig J. *The Birth of the Pill: How Four Crusaders Reinvented Sex and Launched a Revolution.* New York, NY: W.W. Norton & Company; 2014.
4. Roberts DE. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty.* New York, NY: Vintage Books; 1999.
5. Institute of Medicine. *A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results.* Washington, DC: National Academies Press; 2009.
6. Ross L, Roberts L, Derkas E, Peoples W, Bridgewater P. *Radical Reproductive Justice: Foundation, Theory, Practice, Critique.* New York, NY: The Feminist Press; 2017.
7. Women’s Earth Alliance, Native Youth Sexual Health Network. Violence on the land, violence on our bodies: building an Indigenous response to environmental violence. 2016. Available at: http://landbodydefense.org/uploads/files/VLVBReportToolkit2016.pdf. Accessed October 14, 2021.
8. Black Mamas Matter Alliance. Contraception is not a remedy for poverty. *Essence.* April 2019. Available at: https://www.essence.com/op-ed/black-mamas-matter-alliance-contraception-is-not-a-remedy-for-poverty. Accessed October 10, 2021.
9. SisterSong Women of Color Reproductive Justice Collective, National Women’s Health Network. Long-acting reversible contraception: statement of principles. 2016. Available at: https://www.nwhn.org/wp-content/uploads/2017/02/LARCStatementofPrinciples.pdf. Accessed October 13, 2021.
10. Romero D, Agénor M. US fertility prevention as poverty prevention: an empirical question and social justice issue. *Womens Health Issues.* 2009;19(6):355–364. https://doi.org/10.1016/j.whi.2009.08.004
11. Finer LB, Zolna MR. Declines in unintended pregnancy in the United States, 2008–2011. *N Engl J Med.* 2016;374(9):843–852. https://doi.org/10.1056/NEJMsa1506575
12. Santelli J, Rochat R, Hatfield-Timajchy K, et al. The measurement and meaning of unintended pregnancy. *Perspect Sex Reprod Health.* 2003;35(2):94–101. https://doi.org/10.1363/3509403
13. Gómez AM, Arteaga S, Villaseñor E, Arcara J, Freihart B. The misclassification of ambivalence in pregnancy intentions: a mixed-methods analysis. *Perspect Sex Reprod Health.* 2019;51(1):7–15. https://doi.org/10.1363/psrh.12088
14. Aiken ARA, Borrero S, Callegari LS, Dehlendorf C. Rethinking the pregnancy planning paradigm: unintended conceptions or unrepresentative concepts? *Perspect Sex Reprod Health.* 2016;48(3):147–151. https://doi.org/10.1363/48e10316
15. Illinois Dept of Public Health. Illinois Pregnancy Risk Assessment Monitoring System (PRAMS) 2010–2011 Report. Available at: https://dph.illinois.gov/content/dam/soi/en/web/idph/files/publications/il-prams-report-2010-2011.pdf. Accessed October 12, 2021.
16. 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.* New York, NY: Guttmacher Institute; 2020. https://doi.org/10.1363/2020.31482
17. Vela VX, Patton EW, Sanghavi D, Wood SF, Shin P, Rosenbaum S. Rethinking Medicaid coverage and payment policy to promote high value care: the case of long-acting reversible contraception. *Womens Health Issues.* 2018;28(2):137–143. https://doi.org/10.1016/j.whi.2017.10.013
18. Gubrium AC, Mann ES, Borrero S, et al. Realizing reproductive health equity needs more than long-acting reversible contraception (LARC). *Am J Public Health.* 2016;106(1):18–19. https://doi.org/10.2105/AJPH.2015.302900
19. Chaudhri A, Waligora K. *Contraceptive Justice: Policy and Community Assessment Report.* Chicago, IL: EverThrive Illinois; 2019.
20. Cadena M, Rivera R, Esparza T, Cadena D. *Dismantling Teen Pregnancy Prevention.* Albuquerque, NM: Young Women United; 2016.
21. New Mexico Legislative Finance Committee. Action plan: reducing unintended teen births. December 8, 2020. Available at: https://www.nmlegis.gov/Entity/LFC/Documents/Program_Evaluation_Reports/Action%20Plan%20-%20Reducing%20Unintended%20Teen%20Births.pdf. Accessed October 12, 2021.
22. SisterReach. Our voices and experiences matter: the need for comprehensive sex education among young people of color in the South. 2015.

Available at: https://www.sisterreach.org/uploads/1/3/3/2/133261658/2015_sr_our_voices_and_experiences_matte.pdf. Accessed November 19, 2021.

23. Holt K, Reed R, Crear-Perry J, Scott C, Wulf S, Dehlendorf C. Beyond same-day long-acting reversible contraceptive access: a person-centered framework for advancing high-quality, equitable contraceptive care. *Am J Obstet Gynecol.* 2020;222(4S):S878.e1–S878.e6. https://doi.org/10.1016/j.ajog.2019.11.1279
24. Bray SRM, McLemore MR. Demolishing the myth of the default human that is killing black mothers. *Front Public Health.* 2021;9:675788. https://doi.org/10.3389/fpubh.2021.675788
25. Linzer M, Bitton A, Tu SP, et al. The end of the 15–20 minute primary care visit. *J Gen Intern Med.* 2015;30(11):1584–1586. https://doi.org/10.1007/s11606-015-3341-3



Advancing Reproductive Health Equity Through a New Contraceptive Access Initiative

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Illinois has been a national leader in adopting progressive reproductive health policies that have expanded Medicaid coverage, reduced Medicaid abortion coverage restrictions, and protected minors' rights to many sexual and reproductive health services. Although these strides are significant, inequality in contraceptive access persists. Nearly one third of contraceptive users lack coverage for contraceptive services and supplies.[1] An estimated 800 000 women live in counties without health centers offering the full range of contraceptive methods.[2] One in three health care delivery networks in Illinois are religiously affiliated, with an even higher proportion among Medicaid recipients in Cook County, limiting patients' options for family-planning services.[3]

Where contraceptive care is accessible, quality varies widely and depends on the individual provider's training and biases and the health center's infrastructure.[4] Many Medicaid providers report offering birth control, but often the services are limited to birth control pills or Depo-Provera.[5] Among patients seeking contraceptive care at Illinois community health centers, only one in five receives contraceptive counseling.[1]

By training community health care providers to deliver patient-centered contraceptive care, by empowering patients to seize their right to the highest-quality care, and by removing financial barriers through innovative policy reform, Illinois Contraceptive Access Now (ICAN!) seeks to create an Illinois where every person can decide whether, when, and under what circumstances to become pregnant and parent. Lessons from this five-year initiative (2021–2025) will help to establish a new standard for contraceptive care in preventive and primary care.

TOWARD A NEW STANDARD OF CARE

ICAN! has adopted a three-pronged, systems-change approach to achieving our goals of (1) establishing screening for contraceptive needs and desires as a routine and essential component of preventive and primary care, (2) decreasing the number of people without health coverage for contraceptive care, and (3) expanding points of access to contraceptive care and education. Informed by the reproductive justice framework and guided by a 15-member community advisory board, ICAN! aims to center the specific lived experiences of Black women and women of color who may experience distrust of the health care system because of discrimination, racism, or contraceptive coercion.[6,7] Community advisory board members represent the communities served by our health center partners and guide all facets of ICAN! program development.

Partnering

In the United States, women of reproductive age (15–44 years) comprise the vast majority of federally qualified health center (FQHC) patients (63%) and adult Medicaid enrollees (65%).[8] They do not experience their contraceptive need in a vacuum but rather as an integrated part of their overall well-being. ICAN! partners with FQHC networks to build their capacity as contraceptive care quality hubs that provide same-day access to the full range of US Food and Drug Administration (FDA)–approved birth control methods at low or no cost. Through clinical training and technical assistance, we support health centers to screen all patients of reproductive age for contraceptive needs and desires, provide patient-centered contraceptive counseling, ensure accurate coding and billing for capturing maximum revenue, stock and prescribe all methods on the day of request, and enhance benefits enrollment procedures. ICAN! trainings promote a TRUER (Trauma-informed, Respectful, Unconscious bias aware, Evidence-based, and Reproductive well-being centered) care approach that places the individual and their unique life realities at the center of the provider–patient relationship. This model affirms the viewpoint that with education and unbiased information about the full spectrum of contraceptive options, people can be empowered to become experts on their own reproductive and sexual lives.

By contrast to many other statewide contraceptive access initiatives, ICAN! does not serve as a payer of last resort. Although we provide limited capacity-building funds for general operations, we are focused on achieving long-term sustainability by shifting payer practices to reward contraceptive care provision, expanding coverage for individuals with few resources, and supporting health centers in maximizing revenue from contraceptive care services through accurate billing and coding practices.

During ICAN!'s 2021 demonstration year, we partnered with three of the largest FQHCs operating in underserved communities throughout the greater Chicago area—Erie Family Health Centers, Near North Health, and PCC Community Wellness—for them to become contraceptive care quality hubs. More than 500 of their providers and staff participated in ICAN! trainings, and together they served 15 204 contraceptive patients, a 17% increase over the previous year. In coming years, ICAN! will expand its reach to FQHCs serving Central Illinois and rural Southwestern Illinois—regions with profound racial and economic inequities in reproductive health outcomes and great unmet contraceptive need.

Community Engagement

ICAN! empowers patients to seize their right to the highest-quality contraceptive care through digital innovation, community outreach, and youth education. ICAN!'s Web site, www.ican4all.org, provides accurate, unbiased birth control information and connects users to care at their local quality hub. Interactive features include a quiz to assess which methods might fit users' needs and preferences and a "phone-a-friend" option to speak directly with a trusted expert. Because of the social, financial, and practical barriers that people with limited access to care, such as Black women, women of color, and women with few resources, may face in accessing care at a health center, ICAN! has prioritized building out our digital platform to increase points of access through telehealth and to support users in understanding their coverage through an eligibility assistance function.

ICAN! partners with Chicago Public Schools, the Chicago Department of Public Health, the Illinois Department of Human Services, and local youth-serving organizations to provide birth control education and resources. Through training and educational resources, we also equip trusted, community-based maternal and child health providers—including case managers, home visiting nurses, and nutritionists—as well as staff of community-based organizations to screen clients for contraceptive needs and desires and make referrals to quality hubs. ICAN!'s foundational trainings will be adopted in the suite of professional development requirements for the state.

State Policy Research and Development

ICAN! pursues data-driven solutions to fundamentally transform the way contraceptive care is delivered, covered, and accessed by people with few resources. Our focus is not on new legislation but rather on optimizing existing policies by testing best practices for implementation to ensure maximum benefit. The cornerstone of this largely administrative agenda is a model family-planning state plan amendment, described in Figure 1, through which more than 70 000 individuals will become eligible for coverage.

To increase points of access, ICAN! is supporting the implementation of Illinois' new pharmacy prescribing law by drafting a state plan amendment that establishes high-quality care and referral protocols and by influencing pharmacist training standards. Furthermore, ICAN! is working with state Medicaid to enforce managed care organization member transparency and ensure adequate network coverage of family-planning services. Currently, there is no mechanism in place for informing patients that their care options may be restricted by religiously affiliated health providers, and payors are not held accountable for educating patients about the Centers for Medicare & Medicaid Services freedom of choice provision or for making timely referrals to contraceptive care. Together, ICAN!'s efforts have the potential to drive expansive and meaningful impact in removing barriers to high-quality contraceptive care for the people of Illinois.

MEASURING ACCESS AND QUALITY

The dominant outcome measures used by the field—sexually transmitted infection rates, unintended pregnancy rates, and adolescent pregnancy rates—fail to measure the extent to which individuals are able to exercise reproductive autonomy and achieve

- Increase eligibility for coverage from 138% FPL to < 213% FPL.
- Allow income eligibility to be based on individual income, rather than household income, to ensure young people and victims of intimate partner violence are treated as individuals.
- Allow coverage to be retroactive 90 days from the December 1, 2022, effective date.
- Not inquire about third party liability, thus allowing individuals with existing insurance to still apply for the SPA due to confidentiality concerns or restrictions from plans that don't cover contraception.
- Include medical presumptive eligibility for everyone regardless of immigration status. This ensures timely access to family planning services through a shortened application and access to same day coverage before a complete eligibility screening is processed.
- Include flexible auto-enrollment into the SPA for qualifying Medicaid applicants found ineligible for the full package of benefits.
- Include coverage for male reproductive health services, including vasectomy.

FIGURE 1— **ICAN! Proposed Model Family-Planning SPA Inclusions: Illinois**

Note. FPL = federal poverty level (as established by the US Department of Health and Human Services and adopted by the Centers for Medicare and Medicaid Services); ICAN! = Illinois Contraceptive Access Now; SPA= state plan amendment.

reproductive well-being. Rather than make assumptions about patients' reproductive goals (e.g., avoiding pregnancy), ICAN! measures the extent to which patients feel respected, supported, and informed enough to make decisions about whether, when, and under what circumstances to become pregnant or parent. Our leading measure of care quality is patient-reported experience metric data, as collected via the National Quality Forum–endorsed Person-Centered Contraceptive Counseling survey.[9] Our leading measures of access include the number of contraceptive encounters and method mix (which should reflect all FDA-approved birth control methods) at each health center.

Through our own evaluation process—which began in our 2021 demonstration year and will continue through 2026—we will work at the state and federal levels to define the core contraceptive access and quality metrics that will drive transformation at the health center level, exploring the merits and limitations of various data in upholding patient autonomy. We will use our relationships with our FQHC quality hubs, pharmacy allies, and managed care organization partners to glean patient feedback, method mix, and utilization patterns that will deepen the field's understanding of what it means to provide high-quality contraceptive care.

FIVE-YEAR IMPACT

By 2025, ICAN! aims to have developed 20 quality hubs in urban and rural communities statewide that have the ability, demand, and capacity to meet patient need for high-quality contraceptive care. An estimated 500 000 patients will have access to person-centered contraceptive counseling, and 250 000 individuals previously uninsured for contraceptive care will gain coverage. As Illinois democratizes access to high-quality contraceptive care, our hope is to serve as a replicable model for advancing reproductive health equity nationwide, paving the way for real and lasting culture change and new standards for reproductive health delivery in primary care. AJPH

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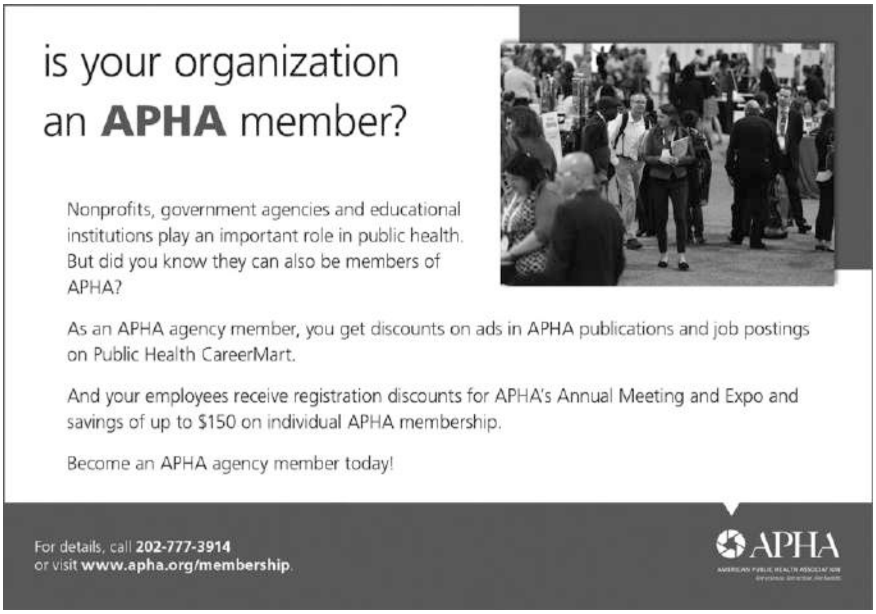
REFERENCES

1. Health Resources & Services Administration. National Health Center data. Table 3A and Table 6A. Available at: https://bphc.hrsa.gov/uds/datacenter.aspx?q=t4&year=2018&state=IL&fd=. Accessed February 1, 2022.
2. Power to Decide. Domestic gag rule reduces contraceptive access for more than 630,000 women living in Illinois. April 1, 2020. Available at: https://powertodecide.org/about-usnewsroom/domestic-gag-rule-reduces-contraceptive-access-for-more-630000-women-living. Accessed April 20, 2022.
3. Garcia-Ricketts S, Hasselbacher L, Hebert L, Stulberg D. The role of religiously-affiliated hospitals in reproductive health care for women with public insurance in Cook County, Illinois. 2019. Available at: https://ci3.uchicago.edu/wp-content/uploads/2020/09/The-Role-of-Religiously-affiliated-Hospitals-in-Reproductive-Health-Care-for-Women-with-public-insurance-in-Cook-County.pdf. Accessed April 20, 2022.
4. Chaudhri A, Waligora K. Contraceptive justice: policy and community assessment report. June 2019. Available at: https://everthriveil.org/wp-content/uploads/2021/01/2019_contraceptivejusticepolicyandcommunityassessmentreport.pdf. Accessed April 20, 2022.
5. Zolna MR, Frost JJ. Publicly funded family planning clinics in 2015: patterns and trends in service delivery practices and protocols. November 2016. Available at: https://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015. Accessed April 20, 2022.
6. Illinois Contraceptive Access Now. ICAN!’s TRUER Care Resource Center. Available at: https://ican4all.org/provider-resources. Accessed April 20, 2022.
7. In Our Own Voice: National Black Women's Reproductive Justice Agenda. April 2020. Available at: https://blackrj.org. Accessed April 20, 2022.
8. Kaiser Family Foundation. Medicaid coverage for women. February 17, 2022. Available at: https://www.kff.org/medicaid/fact-sheet/medicaids-role-for-women. Accessed April 20, 2022.
9. University of California, San Francisco. Person-centered contraceptive counseling survey. Available at: https://pcccmeasure.ucsf.edu/sites/g/files/tkssra3691/f/PCCC_instrument%20English.pdf. Accessed April 20, 2022.



Reproductive Well-Being: A Framework for Expanding Contraceptive Access

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Currently, more than 19 million women eligible for publicly funded contraception live in counties where they lack reasonable access to the full range of birth control methods. Around 1.2 million of these 19 million women live in counties without a single health center offering the full range of methods, compounding burden and inhibiting reproductive autonomy. These “contraceptive deserts” are defined as counties where the number of health centers offering the full range of methods is not enough to meet the needs of the county’s estimated number of people eligible for publicly funded contraception, defined as at least one health center for every 1000 people in need of publicly funded contraception. This calculation is based upon ratios developed by Richard Cooper, MD, of the University of Pennsylvania Wharton School, one of the leading physician utilization and supply experts in the United States.[1]

Access to the full range of contraceptive methods is critical given what is known about pregnancy desires and trends in contraceptive use over time. Most single young women (aged 18–29 years) report they do not want to get pregnant at this point in their lives, yet nearly half of these women are not using contraception reliably or at all.[2]

The ability to choose from among the full range of contraceptive methods encourages consistent and effective contraceptive use and leads to positive health, social, and economic outcomes. People who are satisfied with their current method are less likely to use the method inconsistently or incorrectly.[3] Using a method correctly allows people to avoid pregnancies that they do not want and to appropriately plan and space the pregnancies that they do want, reducing the risk of low birth weight and premature birth.[4] Contraceptive use enables people to achieve their educational and career goals and to support themselves and their families.[5] Perhaps most importantly, all people should have the right to choose the contraceptive methods they prefer—or no method at all. Protecting this right guards against explicit and implicit coercion within the health care system, which may occur if patients are only offered a limited selection of methods to choose from or if they feel pressured to select a particular method because of effectiveness, cost, or other factors.[6]

Despite these benefits, contraceptive access continues to be at risk because of geographic barriers, economic barriers (including the actual cost of the method as well as related costs like childcare, time off work, and transportation),[7] policy changes such as reductions to the Title X program,[8] and more. In the coming years, predicted shortages of health care providers able to offer contraception may exacerbate access gaps. The Association of American Medical Colleges predicts a shortage of between 46 900 and 121 900 physicians by 2032,[9] while the Health Resources and Services Administration predicts a shortage of approximately 293 800 registered nurses and 151 500 licensed practical nurses by 2030.[10] A similar shortage is anticipated in the “women’s health” workforce specifically, including a decrease in the number of obstetricians/gynecologists and an increase in demand for reproductive health care services by 2030.[11]

Power to Decide, a national reproductive health organization, works to build awareness about these contraceptive access gaps and to address people’s immediate contraceptive needs. We posit that the misalignment between pregnancy desires and contraceptive behavior is largely attributable to systemic inequities that exist in three interconnected areas: (1) knowledge about sexual health and contraception, (2) access to quality and comprehensive contraceptive services, and (3) sense of agency in decision-making and relationships. This hypothesis led to the development of a reproductive well-being framework, which shifts the narrative from personal intentions to supporting autonomy and recognizing and eliminating systemic barriers to reproductive health. In this article, we lay out that framework, describe efforts to implement this innovative approach at the community level, and identify the benefits of wide adoption of this framework to increase contraceptive access. Widespread adoption of this framework would result in measurable system changes in sectoral policies, positions, and practices.

DEVELOPING THE FRAMEWORK

In 2017, Power to Decide convened leaders and practitioners from more than 50 national, state, and local organizations including March of Dimes, the American College of Obstetricians and Gynecologists, the Association of Maternal and Child Health Programs, National Birth Equity Collaborative, Nurse Family Partnership, and the University of California–San Francisco, among others. The goal was to address the gap between people's stated desires to prevent pregnancy and their contraceptive decision-making and use. As part of this effort, we conducted focus groups across a range of sectors, geographies, backgrounds, and lived experiences, including in-depth interviews with experts and providers in reproductive justice, reproductive health, and reproductive rights. In total, we spoke with more than 300 people as part of this research effort.

We heard clearly that to align one's contraceptive behaviors with one's pregnancy desires, including the desire not to have a child, access is critical, and it is one piece in a larger context. We have long understood that contraceptive use is influenced, in part, by individual factors, such as knowledge, attitudes, and behaviors (e.g., desires to avoid or achieve pregnancy, concerns about side effects),[2] as well as interpersonal influences (e.g., relationships with partners, peers).[12] In our research, we learned that many people, young people in particular, do not feel like they have the power, agency, or self-efficacy to set their intentions related to contraceptive use, pregnancy, and reproduction, largely because of systems barriers. These include organizational factors, such as the availability and accessibility of services as well as the type of services offered; community factors, such as sociocultural norms and expectations and interactions with the built environment; and societal factors, such as systems of oppression (e.g., racism in the health care system), health insurance policies, and the state policy context.

The stakeholder group used this feedback to create the reproductive well-being framework, which aims to design systems of support that surround individuals and help them align their reproductive desires with their actions. This framework is intersectional in nature, touching all levels of the socio-ecological model while also illustrating the complexities of personal, community, and institutional factors (Figure A, available as a supplement to the online version of this article at https://ajph.org). Reproductive well-being means that all people have equitable access to the information, services, systems, and support they need to have control over their bodies, and to make their own decisions related to sexuality and reproduction throughout their lives. In a culture of reproductive well-being, all people are

1. **Respected:** People are seen, heard, and understood by their provider, family, and society. They are trusted to be able to make the decision that is best for them. Their unique experiences, beliefs, and cultures, as well as the complexity of their decisions, are respected.
2. **Autonomous:** Decision-making power sits with the individual. Providers prioritize shared decision-making, even when a patient's decision may feel counter to their own training or beliefs, or when the system they work in makes that difficult.
3. **In control:** People receive access to all the information and options available so they can make informed decisions. They can create a healthy future for themselves and a healthy start for the next generation if they choose to have or raise children.
4. **Surrounded by communities and systems of support:** Reproductive well-being is an essential component of overall health and well-being, not only in the health care system but also in society in general. It is understood, discussed openly, and pursued by all.

The stakeholder group identified four key systems-level domains that serve as "levers" to achieve reproductive well-being at the place-based level: (1) policy, (2) education and communication, (3) health care and social services delivery, and (4) health equity. We also developed an implementation toolkit that identifies key actions communities can take to catalyze change in each of these domains. The implementation of the actions within this toolkit, as well as the integration of the reproductive well-being framework in the field's approach to clinical practice, programs, research, and policy, will support the design and maintenance of more holistic service systems that reflect the realities of complex decisions and circumstances people face related to reproductive well-being, including contraceptive access.

PLACE-BASED IMPLEMENTATION TO INCREASE ACCESS

Power to Decide understands that communities themselves are best positioned to determine the specific approach for increasing reproductive well-being where they live. As such, we support various place-based reproductive well-being initiatives, outlined here, to increase contraceptive access through strategies across the four domains (policy, education and communication, health care and social services delivery, and health equity). We use a reproductive well-being assessment tool to assess contraceptive access and other key reproductive well-being indicators within the domains at baseline and annually throughout the project period.

All Access Eastern Kentucky

Since 2017, Power to Decide has worked in partnership with Kentucky Health Justice Network and Appalshop to implement a contraceptive access initiative in a 10-county region in eastern Kentucky. The goal is to build a sustainable policy, services, and program environment so that all people have awareness of and access to the full range of contraceptive methods.

Within the policy domain, the team has developed a state-specific online advocacy training to build stakeholders' capacity to advocate for policies that increase contraceptive access. Within the education and communication domain, the team trained youth participants to develop and disseminate media pieces about contraceptive access and health care services in the region to influence change in the health care system as well as change norms across the region. Within the health care and social service delivery domain, the team partnered with clinics to provide training, disseminate Bedsider educational materials, and increase best practices in contraceptive services delivery. Finally, within the health equity domain, the team contributed to the knowledge base on contraceptive access in rural communities.

Evaluation efforts indicate an increase in the number of clinical providers in the region certified in One Key Question, a pregnancy desire screening tool that is recognized as a promising practice by medical and public health groups such as the American College of Obstetricians and Gynecologists, the American Public Health Association, the American Medical Association, and the Association of Maternal and Child Health Programs, and an increase in the number of best practices for youth-friendly contraceptive care at partner clinics.

Shared Learning Collaborative

In 2020, Power to Decide launched a place-based reproductive well-being shared learning collaborative to improve reproductive well-being, disseminate lessons learned, and build the evidence base at the community level. We currently work with seven communities across the country: Detroit, Michigan; Omaha, Nebraska; Syracuse, New York; Austin, Texas; Oklahoma City, Oklahoma; Harrisonburg, Virginia; and the Commonwealth of the Northern Marianna Islands. Each multisectoral team completed a reproductive well-being assessment, identifying best practices within the key domains to increase contraceptive access and enhance reproductive well-being in their communities. Implementation activities range from offering free provider education and training to advocating for policy change to hosting social media campaigns. Teams complete the reproductive well-being assessment annually to measure progress over time in the four domains.

MEASURING REPRODUCTIVE WELL-BEING

During the early stages of the reproductive well-being work, an expert measurement group was convened to discuss measurement considerations for the framework, as well as the future development of a reproductive well-being index. The index will include (1) both population and individual measures, (2) domains identified by the expert measurement group as critical to measuring this complex topic, and (3) existing data along with gaps related to measuring reproductive well-being, including contraceptive access. In short, the tool will measure social determinants of health as well as other factors that influence a person's ability to achieve reproductive well-being. Development and adoption of a such a reproductive well-being index could fundamentally shift the way the sexual and reproductive health field approaches priority setting, measurement, outcome indicators, and more.

ENCULTURATING THE REPRODUCTIVE WELL-BEING NARRATIVE

Power to Decide envisions a culture in which there is a system of support that makes it possible for every person—no matter who they are or where they live—to achieve reproductive well-being. In such a culture, all people have equitable access to the information, services, systems, and support they need to have control over their bodies and to make their own decisions related to sexuality and reproduction throughout their lives. Certainly, access to contraception does not equate to the totality of reproductive well-being; however, reproductive well-being cannot be achieved without practical, equitable access to contraception. The ability to identify one's own pregnancy desires and to use contraception to achieve those desires is fundamental to feeling respected, autonomous, in control, and supported.

Expanding contraceptive access requires innovation and a collective commitment to address the broader inequities and social determinants of health that stand between many people and their overall well-being. The reproductive well-being framework leverages institutional, policy, and practice change to build and scale a system of support that increases access to contraception and makes reproductive well-being possible for every person. Transforming reproductive well-being from an aspiration to reality will require everyone to support a paradigm shift to a culture that values people's empowerment, agency, and autonomy for their own reproductive well-being. Join the reproductive well-being movement.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

REFERENCES

1. Power to Decide. Birth control access. Available at: https://powertodecide.org/what-we-do/access/birth-control-access. Accessed February 22, 2022.
2. Frost JJ, Lindberg L, Finer L. Young adults' contraceptive knowledge, norms and attitudes: associations with risk of unintended pregnancy. *Perspect Sex Reprod Health*. 2012;44(2):107–116. https://doi.org/10.1363/4410712
3. Guttmacher Institute. Improving contraceptive use in the United States. May 2008. Available at: https://www.guttmacher.org/report/improving-contraceptive-use-united-states. Accessed February 18, 2022.
4. Kavanaugh ML, Anderson RM. Contraception and beyond: the health benefits of services provided at family planning centers. Guttmacher Institute. July 2013. Available at: https://www.guttmacher.org/report/contraception-and-beyond-health-benefits-services-provided-family-planning-centers. Accessed February 19, 2022.
5. Sonfield A, Hasstedt K, Kavanaugh ML, Anderson R. The social and economic benefits of women's ability to determine whether and when to have children. Guttmacher Institute. 2013. Available at: https://www.guttmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children. Accessed February 20, 2022.
6. Sonfield A. Why family planning policy and practice must guarantee a true choice of contraceptive methods. *Guttmacher Policy Review*. November 1, 2017;20. Available at: https://www.guttmacher.org/gpr/2017/11/why-family-planning-policy-and-practice-must-guarantee-true-choice-contraceptive-methods. Accessed March 1, 2022.
7. Wise A. Access to birth control is about more than where you live. Bedsider Providers. December 23, 2019. Available at: https://providers.bedsider.org/articles/access-to-birth-control-is-about-more-than-where-you-live. Accessed March 1, 2022.
8. Swan LET. The impact of US policy on contraceptive access: a policy analysis. *Reprod Health*. 2021;18(1):235. https://doi.org/10.1186/s12978-021-01289-3
9. Association of American Medical Colleges. New findings confirm predictions on physician shortage. April 23, 2019. Available at: https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage. Accessed February 20, 2022.
10. US Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. Supply and demand projections of the nursing workforce: 2014–2030. July 21, 2017. Available at: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nchwa-hrsa-nursing-report.pdf. Accessed April 10, 2022.
11. US Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. Projections of supply and demand for women's health service providers: 2018–2030. 2021. Available at: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/projections-supply-demand-2018-2030.pdf. Accessed February 20, 2022.
12. Yee L, Simon M. The role of the social network in contraceptive decision-making among young, African American and Latina women. *J Adolesc Health*. 2010;47(4):374–380. https://doi.org/10.1016/j.jadohealth.2010.03.014

Connecting the Dots: Public Health, Clinical, and Community Connections to Improve Contraception Access

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Reproductive well-being and equity require systems working together to develop trust and authentic, power-sharing relationships with communities, particularly those that have been historically marginalized. This includes addressing structural racism and healing from it; promoting equity, including equitable access to health care services; and engaging communities as decision makers in policy development, program design, and quality care.[1,2] Appropriate contraception access that includes receiving the desired care and support that one needs is critical for promoting optimal and equitable reproductive health.[3]

Public health leaders have demonstrated the unique role their agencies bring to cross-sector contraception access collaborations with clinical and community partners. Statewide and jurisdiction-wide contraception access initiatives are great opportunities for such collaborations. The Association of State and Territorial Health Officials Increasing Access to Contraception Learning Community project, conducted in collaboration with the Centers for Disease Control and Prevention's Division of Reproductive Health, implemented a series of learning communities with 27 multidisciplinary teams (from 26 states and one territory) between 2014 and 2018 to improve access to the full range of contraceptive methods. These communities required public health and clinical partnerships, with team memberships representing state and territorial public health agencies, state Medicaid agencies, clinical champions, and other essential partners including community organizations, to collaboratively implement policies, programs, and evaluations to increase access to contraception.

Growing these internal networks provided an opportunity for structured cross collaboration.[4] In many cases, this was the impetus for public health, clinical, and community partners to work on contraceptive access through common goals. These cross-sector partnerships enhanced existing work. One state incorporated reproductive justice messaging into long-acting reversible contraception (LARC) communications as a result of the input of local and community partners. Several states' public health and clinical partners enriched clinical provider training with youth-friendly, motivational interviewing and client-centered counseling.[5]

Similarly, the Zika Contraception Access Network, in place from May 2016 to September 2017, was a program designed to increase access to contraception services among women in Puerto Rico who chose to prevent pregnancy during the 2016–2017 Zika virus outbreak as a primary mitigation strategy to reduce the risk of Zika virus–related pregnancy and birth outcomes. The program incorporated a removal inclusive design, with access to removals 10 years beyond the program period, to maximize women's reproductive autonomy and access to LARC removal when desired.[6,7] Among the 29 221 women who participated in the program, 69% received same-day provision of a contraceptive method, 70% chose an LARC method, and 4% selected LARC removal. Principles of ethics, shared decision-making, and multidisciplinary collaboration helped to make the project a success for the women of Puerto Rico.

The COVID-19 pandemic has shown the role that public health can play in improving access, particularly in communities that have been marginalized, by growing the community health workforce and heightening digital access to enhanced telehealth services, both of which can benefit statewide and jurisdiction-wide contraception access initiatives. In 2021, the Centers for Disease Control and Prevention provided $2.25 billion in COVID-19 grants to help states and territories improve health equity in populations that have been marginalized and are at higher risk for COVID-19 than others. Working with communities to build their capacity will help sustain this funding into the future.

The Association of State and Territorial Health Officials, the National Association for County and City Health Officials, and the National Association of Community Health Workers will partner to build the community health workforce through collaboration with community-based organizations.[8] In this next phase of "life with COVID," the expanded community workforce has an opportunity to pivot to addressing other public health priorities such as contraception access with trusted frontline workers in communities serving as a link between health and social services.

During the COVID-19 pandemic, public health, clinical, and community organizations have been leading data collection activities to better understand the digital literacy and telehealth experiences of patients and providers and have been working closely with providers to expand services and the capacity of communities to deliver them.[9] Examples include public health efforts to accomplish digital inclusion and telehealth equity assessments, the creation of "heat maps" identifying barriers and access points for unavailable specialty services,[10] and training and employment of community members in places such as libraries as digital navigators to support telehealth services.[11]

Early in 2020, the Office of Population Affairs of the US Department of Health and Human Services authorized telehealth as an option for Title X family planning clinics across the country and announced $35 million in grants for the Title X program to support telehealth as a means of sustaining access to contraceptive health services.[12] Including contraception access within such endeavors can enhance access to services, support clinical reach, and build capacity within communities.

Partnerships to improve statewide and jurisdiction-wide contraceptive access have seen many changes in the past few years, including expanded use of telehealth and the opportunity to strengthen the deployment of community health navigators such as community health workers. Understanding a community's history and challenges in the context of social determinants can help in developing solutions to disparities in access and fostering equity. Public health has a bright future ahead in supporting and advancing the integration of public health and clinical services and enhancing community connections through cross-sector work to advance innovative evidence-based efforts, improve health, and increase equity.

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REFERENCES

1. Coalition to Expand Contraception Access. Why CECA focuses on SRHW and SRHE. Available at: https://www.contraceptionaccess.org/blog/why-ceca-focuses-on-srhw-and-srhe. Accessed February 25, 2022.
2. Association of State and Territorial Health Officials. Achieving optimal health for all by eliminating structural racism. Available at: https://www.astho.org/globalassets/pdf/policy-statements/achieving-optimal-health-for-all-eliminating-structural-racism.pdf. Accessed February 25, 2022.
3. Zapata LB, Pazol K, Curtis KM, et al. Need for contraceptive services among women of reproductive age—45 jurisdictions, United States, 2017–2019. Available at: https://www.cdc.gov/mmwr/volumes/70/wr/mm7025a2.htm?s_cid=mm7025a2_w. Accessed February 25, 2022.
4. DeSisto CL, Estritch C, Kroelinger CD, et al. Using a multi-state learning community as an implementation strategy for immediate postpartum long-acting reversible contraception. *Implement Sci.* 2017;12(1):138. https://doi.org/10.1186/s13012-017-0674-9
5. Association of State and Territorial Health Officials. Increasing Access to Contraception Learning Community project summary. Available at: https://legacy.astho.org/Maternal-and-Child-Health/Increasing-Access-to-Contraception/Learning-Community-Close-Out-Meeting-Summary-Report-Year-Four. Accessed February 25, 2022.
6. Lathrop E, Hurst S, Mendoza Z, et al. Final program data and factors associated with long-acting reversible contraception removal: the Zika Contraception Access Network. *Obstet Gynecol.* 2020;135(5):1095–1103. https://doi.org/10.1097/AOG.0000000000003835
7. Lathrop E, Romero L, Hurst S, et al. The Zika Contraception Access Network: a feasibility program to increase access to contraception in Puerto Rico during the 2016–2017 Zika virus outbreak. *Lancet Public Health.* 2018;3(2):e91–e99. https://doi.org/10.1016/S2468-2667(18)30001-X
8. Plescia M. The historic opportunity COVID-19 presents to address health equity. Available at: https://www.astho.org/communications/blog/historic-opportunity-covid-19-presents-to-address-health-equity. Accessed February 25, 2022.
9. Association of State and Territorial Health Officials. Using lessons from the COVID-19 response to inform telehealth activities. Available at: https://www.astho.org/globalassets/brief/using-lessons-from-the-covid-19-response-to-inform-telehealth-activities.pdf. Accessed February 25, 2022.
10. Georgia Department of Public Health. State health improvement plan 2016–2021. Available at: https://dph.georgia.gov/document/document/gadph-ship-2017-final/download. Accessed February 25, 2022.
11. State of Hawaii Department of Health. Department of Health to bring health/digital navigators and telehealth support services to underserved communities. Available at: https://health.hawaii.gov/news/newsroom/department-of-health-to-bring-health-digital-navigators-and-telehealth-

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support-services-to-underserved-communities. Accessed February 25, 2022.

12. US Department of Health and Human Services. HHS announces $35 million for telehealth in the Title X Family Planning Program. Available at: https://www.hhs.gov/about/news/2021/11/23/hhs-announces-35-million-telehealth-title-x-family-planning-program.html#:~:text=ashmedia%40hhs.gov-,HHS%20Announces %20%2435%20Million%20for%20Telehealth%20in%20the%20Title%20X,Title%20X%20family %20planning%20providers. Accessed February 25, 2022.

The Title X Program: Setting Standards for Contraceptive and Health Equity

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For more than 50 years, the Title X family-planning program has provided federal funding to ensure access to family-planning and related preventive care for people with low incomes, uninsured people, people living in areas with provider shortages, young people, people who otherwise would not have access to care, and people who simply want to receive care from expert, evidence-based, family-planning providers. The US Department of Health and Human Services, Office of Population Affairs (OPA), the agency administering the Title X program, has established standards and best practices and invested in research and quality improvement initiatives that have benefited more than just Title X–funded projects. The program's investments in infrastructure have helped sustain health clinic operations to serve people regardless of insurance coverage, employer, or geographic location, among other factors, with equitable, high-quality family planning and preventive care services. And it is important to note that the family planning and preventive care services covered are wide ranging. Among other services, they provide sexually transmitted infections screenings and treatment, HIV testing and referral, human papillomavirus vaccines, and screenings for breast and cervical cancer, drug and alcohol use, mental health, and intimate partner violence.

Specifically, as it relates to contraceptives, the Title X program has played a leading role in providing access without regard to insurance, ability to pay, geographic location, immigration status, or other factors. Importantly, the program sets quality standards and serves as an example to other programs on how to deliver client-centered contraceptive care, counseling, and education. For this reason, Title X is often an important complement to other initiatives to expand contraceptive access, including state contraceptive access initiatives. Moreover, Title X funding enhances the capacity of state and local providers to offer an array of contraceptive methods, improving both access and choice.

Without a doubt, Title X is currently at a critical inflection point. The program has undergone intense, drastic changes in recent years, which has necessitated rebuilding the program to ensure that it continues to meet its mission. As a result, OPA has the strategic imperative to restore and modernize the program so that it reflects current population needs and an evolving understanding regarding family planning. Even more, building on lessons learned from decades of providing care primarily to underserved populations, the program is uniquely situated to advance health equity and serve as a model for state and other federal programs.

PROVIDING CONTRACEPTIVE ACCESS

The structure of the Title X family-planning program uniquely positions it to be a collaborator on and supporter of contraceptive access. The program is implemented through competitively awarded grants to state and local public health departments and family-planning, community health, and other private nonprofit agencies—which means the program has a wide reach across the country and through various settings. Health clinics receiving Title X funds are required to offer a range of reproductive and other preventive health services, including a "broad range of acceptable and effective family planning methods."[1(p31)] In 2020, nearly 75% of the females and 60% of the males served were using or adopted a contraceptive method during their last visit.

Title X complements other federal and state coverage and access policies. The demand for contraceptive services at Title X clinic sites has remained consistently high, despite federal coverage expansions (i.e., expanding Medicaid eligibility and increasing the affordability of private insurance) through the Affordable Care Act, state family-planning programs, and other policy changes in the federal and state health care systems; this demonstrates that the need for low- or no-cost contraceptives remains, especially given the remaining number of uninsured people and people who do not have insurance plans covering contraceptives, as well as the insured who continue to prefer to access contraceptives for high-quality, confidential care. Recognizing the ability to uniquely use these federal dollars, states—including those that have enacted statewide contraceptive initiatives—rely on Title X to afford real-world access to clinic sites and staff.[2] Some states and localities receive Title X funding directly. Still others partner with and provide additional state funding to Title X grantees to advance the state's goals to increase access to contraceptives.

Beyond direct service delivery, Title X provides critical investments in health clinics' infrastructure, including salaries and building overhead, often serving as a necessary complement to other family-planning resources. As a result, the program has been instrumental in supporting the availability of family-planning services in underserved areas. Illustratively, OPA recently awarded $35 million in grants to improve and expand telehealth infrastructure and capacity for Title X grantees.[3] Title X investments in infrastructure also increase health clinics' capacity to offer certain contraceptive methods. For example, Title X funding allows some providers to stock the most effective contraceptive methods, that is, long-acting reversible contraceptives (i.e., intrauterine devices and implants), which have higher upfront costs than do other forms of contraceptives.[4]

Because Title X funding provides investments in the grantee organization's infrastructure, as opposed to providing insurance coverage or direct services to a defined population, the program equitably offers high-quality care to people regardless of health insurance status or level of coverage. Title X grantees are required to prioritize clients who have low incomes, and 87% of clients in 2020 had family incomes that qualified them for subsidized services or services without cost.[1] Many of these clients are uninsured. Even so, Title X remains important for people who have insurance. Since 2015, the percentage of clients with health insurance has exceeded the percentage without insurance, and nearly 60% of Title X clients have either public or private insurance.[1] Illustratively, Medicaid is the largest public funder of family-planning services and supplies,[5] but Medicaid beneficiaries frequently turn to Title X clinics to access these services.[1] Title X has also played an important role in filling the gaps between reimbursement and the actual cost of services. Additionally, people who are insured might not want to use their coverage to access contraceptives or other family-planning services, particularly if they share an insurance policy with family or others, and Title X–funded health centers provide no- or low-cost confidential health care services.

SETTING FAMILY-PLANNING STANDARDS

Title X is a key driver nationwide in encouraging high-quality care for family-planning services and supplies, including contraceptives, because of the program's participation requirements for its diverse array of grantees. In fact, recently finalized regulations governing the program require that the family-planning projects aim to ensure "equitable, affordable, client-centered, quality family-planning services."[6] Many Title X grantees align their projects across funding streams to improve consistency and efficiency in administering care; subsequently, Title X program standards can affect other non–Title X–funded health care services or activities that grantees oversee.

In addition to the statutory and regulatory standards to which Title X grantees must adhere, grantees are required to implement quality standards that are aligned with nationally recognized standards of care. OPA and the Centers for Disease Control and Prevention (CDC) led the process to develop and publish "Providing Quality Family Planning Services: Recommendations from CDC and the US Office of Population Affairs," and these standards have been adopted by Title X participants and other providers.[7] The document provides guidance to primary care providers to help patients achieve pregnancy as well as obtain basic infertility services, preconception health services, contraceptive services, pregnancy testing and counseling, and sexually transmitted infections services.

OPA also funds the Reproductive Health National Training Center[8] and the National Clinical Training[9] Center for Family Planning, which provide trainings to Title X grantees and clinicians on a range of topics, such as supporting LGBTQI+ (lesbian, gay, bisexual, transgender/-sexual, queer or questioning, and intersex) clients with gender-affirming language and incorporating health equity into family-planning visits. Title X is also unique among other health care delivery programs in that the Title X program issues research grants and contracts related to family planning to ensure continued learning and improvements in the delivery of family-planning and other related preventive health services.

SETTING STANDARDS FOR HEALTH EQUITY

Building on the program's long history, Title X clinics can position themselves to serve as an example of how health centers and providers can provide equitable, culturally sensitive care. The Biden–Harris administration has made separate commitments that guide OPA and, subsequently, the Title X program, including the following two. First, in October 2021, the White House released the first ever National Strategy on Gender Equity and Equality as a part of "efforts to ensure that all people are treated fairly and equitably and have the opportunity to reach their full potential."[10(p8)] Second, within the first month that President Biden assumed office, the White House issued the executive order Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, which tasked agencies across the federal government with reviewing systems, data, funding, and policies to consider the impact on health disparities.[11] Consequently, OPA has enacted new policies and standards to ensure that the program is best serving the clients who seek care at Title X health clinics. Title X's program priorities for the next five years include (1) advancing health equity through the delivery of Title X services, (2) improving and expand access to Title X services, and (3) delivering Title X services of the highest quality.

Title X clinics already disproportionately serve medically underserved and underrepresented communities. In 2020, 86% of the clients served identified as female,[1] meaning Title X clinics' provision of contraceptives plays a significant role in helping women prevent and plan pregnancies, which has proven to affect women's ability to seek and maintain educational and career advancements. Even so, Title X is serving an increasing number of young men. The Title X program also disproportionately serves people of color. In particular, in 2020, 26% of clients identified as Black or African American, and 35% identified as Hispanic or Latino ethnicity.[1]

More than 40% of immigrant women who accessed contraceptives did so at a safety net family provider such as a Title X clinic.[12] In addition, because Title X grantees provide confidential services and because eligibility for no-cost or subsidized services is based on an unemancipated minor's income rather than family income, adolescents frequently seek a range of health care from Title X programs. Some LGBTQI+ organizations have also noted that Title X serves as an important resource to ensure that LGBTQI+ people, particularly youths, can obtain unbiased and, as needed, gender-affirming care.[13] However, there is more that can be done to purposely center these communities' unique health needs and preferences and provide culturally and linguistically appropriate care to other historically underserved communities, such as people with disabilities.

The Title X program is currently rebuilding the network's capacity with a focus that places health equity at the center. A regulation governing the program that was finalized in 2019 led to 19 grantees withdrawing their participation, whereas 18 additional grantees continued use but reported losses of clients, subrecipients, or sites.[1] There were no Title X–funded services in Hawaii, Maine, Oregon, Utah, Vermont, or Washington, and there were substantially reduced services in Alaska, Connecticut, Illinois, Massachusetts, Minnesota, New Hampshire, and New York. It follows that this reduced participation led to reduced access to reproductive and preventive health care services, including contraceptives. COVID-19 further impaired Title X clinics' ability to provide services—an impact that is still being evaluated. The 2019 rule and the COVID-19 pandemic together accounted for 1.6 million fewer family-planning users between 2019 and 2020 and nearly 3.0 million fewer clients from 2018 to 2020.

In late 2021, OPA finalized a rule rescinding the 2019 rule and restoring the program's focus on providing evidence-based reproductive health care, including nondirective options counseling for people who are pregnant.[14] Once the 2021 final rule is implemented and additional health centers are added to the program, it is estimated that Title X clinics will serve more than four million women using contraception annually. The rule includes new standards, including newly considering prospective grantees' ability to achieve health equity, and defines such terms as "client-centered care," "culturally and linguistically appropriate services," "inclusivity," and "health equity."

OPA is also enhancing its data collection, reporting, and analysis in the Title X program, including collecting more disaggregated data to better understand clients served and resources needed.[15] OPA will also continue to more broadly ensure that various tools, such as performance measures and surveys, are employed to assess whether and how client preferences in the provision of family-planning services—including but not limited to contraceptives—are being met.

The Title X program has historically been structured to provide necessary resources to states and localities, organizations, and health clinics in exchange for these entities agreeing to deliver care that is high quality and evidence based. This has led to the program being not only a resource but also an example for how to deliver equitable contraceptive care. Moving into the future, the program can play even more of a role in serving as a resource for and example of health equity more broadly. Because the program funds contraceptives provision and a wide range of preventive services, such an example would positively benefit a range of public health issues. Even more, efforts to more intentionally center health equity will improve health outcomes among the people that entrust Title X clinics with their health. AJPH

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REFERENCES

1. Office of Population Affairs. *Title X Family Planning Annual Report: 2020 National Summary*. US Department of Health and Human Services: Rockville, MD; 2021. Available at: https://opa.hhs.gov/sites/default/files/2021-09/title-x-fpar-2020-national-summary-sep-2021.pdf. Accessed May 28, 2022.
2. Sawhill I, Guyot K. Preventing unplanned pregnancy: lessons from the states. 2019. Available at: https://www.brookings.edu/wp-content/uploads/2019/06/Preventing-Unplanned-Pregnancy-2.pdf. Accessed May 28, 2022.
3. US Department of Health and Human Services, Office of the Assistant Secretary for Health. Family planning telehealth infrastructure enhancement and expansion grants. Available at: http://www.grants.gov/web/grants/view-opportunity.html?oppId=334704. Accessed January 20, 2022.
4. Boudreaux M, Xie L, Choi YS, Roby DH, Rendall MS. Changes to contraceptive method use at Title X clinics following Delaware Contraceptive Access Now, 2008–2017. *Am J Public Health*. 2020;110(8):1214–1220. https://doi.org/10.2105/AJPH.2020.305666
5. Ranji U, Salganicoff A, Sobel L, Gomez I. Financing family planning services for low-income women: the role of public programs. October 25, 2019. Available at: http://www.kff.org/womens-health-policy/issue-brief/financing-family-planning-services-for-low-income-women-the-role-of-public-programs. Accessed January 25, 2022.
6. National Archives and Records Administration; US Government Publishing Office. What requirements must be met by a family planning project? 42 CFR § 59.5(b)(3). Available at: https://www.ecfr.gov/current/title-42/chapter-I/subchapter-D/part-59/subpart-A/section-59.5. Accessed May 28, 2022.
7. Gavin L, Pazol K, Ahrens K. Update: providing quality family planning services—recommendations from CDC and the US Office of Population Affairs, 2017. December 22, 2017. Available at: http://www.cdc.gov/mmwr/volumes/66/wr/mm6650a4.htm. Accessed January 25, 2022.
8. Reproductive Health National Training Center. Resources. Available at: http://rhntc.org/resources. Accessed January 21, 2022.
9. National Clinical Training Center for Family Planning. Online training. Available at: http://www.ctcfp.org/online-training. Accessed January 21, 2022.
10. White House. National strategy on gender equity and equality. 2021. Available at: http://www.whitehouse.gov/wp-content/uploads/2021/10/National-Strategy-on-Gender-Equity-and-Equality.pdf. Accessed May 28, 2022.
11. White House. Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. Signed January 20, 2021. Available at: http://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government. Accessed May 28, 2022.
12. Hasstedt K, Desai S, Ansari-Thomas Z. Immigrant women's access to sexual and reproductive health coverage and care in the United States. November 20, 2018. Available at: http://www.commonwealthfund.org/publications/issue-briefs/2018/nov/immigrant-womens-access-sexual-reproductive-health-coverage. Accessed January 20, 2022.
13. Brief of Amici Curiae *State of California v. Azar, Essential Access Health v. Azar*. July 3, 2019. Available at: http://www.glad.org/wp-content/uploads/2019/08/TITLE-X-NCLRetal.pdf. Accessed May 28, 2022.
14. Federal Register. Ensuring access to equitable, affordable, client-centered, quality family planning services. 42 CFR, Part 59. April 15, 2021. Available at: http://public-inspection.federalregister.gov/2021-07762.pdf. Accessed May 28, 2022.
15. US Department of Health and Human Services, Office of Population Affairs. Family planning annual report (FPAR) 2.0. Available at: http://opa.hhs.gov/research-evaluation/title-x-services-research/family-planning-annual-report/fpar2. Accessed January 25, 2022.

Steps Needed to Scale Up Statewide Contraceptive Access Initiatives

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Approximately 28 states and local jurisdictions have implemented statewide contraceptive access initiatives (SCAIs), and there is an emerging body of evidence supporting their ability to increase access to client-centered care. In recognition, the Coalition to Expand Contraceptive Access (CECA) and the Association of State and Territorial Health Officials (ASTHO) have crafted this supplement issue of *AJPH* to set the stage for scaling up SCAIs and thereby expanding client-centered contraceptive access to the 73 million women and other people of reproductive age in the United States.

One action recommended by CECA and ASTHO is to seek a Centers for Disease Control and Prevention (CDC) Community Guide recommendation for SCAIs once several ongoing evaluations have been completed. A Community Guide recommendation would indicate whether SCAIs are effective at expanding access to client-centered care.[1] Since Community Guide recommendations are used by states, local governments, schools, and other community organizations to select public health interventions, it is a key step in scaling up SCAIs. Yet, because it has taken an average of 17 years to turn 14% of original research to the benefit of health care, other steps are likely needed.[2,3] In this editorial, I draw on implementation science and World Health Organization (WHO) recommendations for scaling up to highlight some of these other steps.

IMPLEMENTATION SCIENCE AND ACCESSIBILITY

Implementation science extends the traditional focus of evaluation on effectiveness by asking questions designed to increase successful replication of interventions, such as those listed here. In some cases, these questions are addressed in existing evaluations, and I have referenced examples from articles included in this *AJPH* supplement.

What Is the Intervention?

To ensure successful replication, the intervention must be clearly defined. Malcolm et al. (p. S473) describe a workshop convened by CECA and ASTHO of seven SCAI program and evaluation teams, during which a core set of activities (e.g., stakeholder engagement, provider training, provision of low- or no-cost contraception, public awareness, policy change, quality improvement) and outcomes (e.g., access to client-centered contraceptive care) were identified. Other articles included in this supplement build on the CECA and ASTHO framework to provide more detailed information about the interventions in specific states. For example, White et al. (p. S478) show that in Massachusetts, there was a focus on the collaboration between two health systems: primary care and hospitals.

What Was the Process of Implementation?

Monitoring implementation of SCAIs under real-life conditions is essential for identifying any unintended consequences and documenting any program modifications made along the way. For example, Cadena et al. (p. S494) describe how early implementation approaches by SCAIs contributed to coercive contraceptive practices and provide concrete examples of how this harm can be mitigated by integrating reproductive justice and equity principles, being informed of the lived experience of affected people, and engaging them in intervention design and implementation. As described by Smith et al. (p. S484), the evaluation of the Choose Well initiative in South Carolina is documenting the process of implementation (e.g., training, reach of the intervention, change in clinic level procedures, Medicaid expenditures) and contextual factors that may affect the SCAI (such as changes in political leadership, natural disasters, economic fluctuations, changes in competing programs).

How Effective Is the Implementation?

Implementation outcomes are critical to understanding whether individual SCAI activities are having the desired effect. The evaluation of the Choose Well initiative in South Carolina, for example, tracks the impact of provider training on participants' knowledge, attitudes, and behaviors; the impact of changes in clinic procedures on contraceptive use; and the impact of the public awareness campaign on programmatic reach and public perceptions.

What Types of Adaptations Can Be Made?

Adaptation is the degree to which an innovation is modified to different settings in the process of adopting an intervention, while preserving fidelity and effectiveness.[4] The article by Simmons et al. (p. S528) on the Family Planning Elevated Contraceptive Access Program in Utah illustrates how adaptation can be tested through a programmatic monitoring system that identified implementation challenges, designed adaptations to address the challenges, and assessed the outcomes of the adaptation.

How Does the Intervention Reduce Inequity?

An examination of how well the intervention addressed inequities is critical, especially inequities based on race/ethnicity, LGBTQIA (lesbian, gay, bisexual, transgender, questioning or queer, intrasex, asexual), youth, and income.[5] In their article about the ICAN! initiative in Illinois, Lassar et al. (p. S500) illustrate how SCAIs may approach this—for example, by integrating reproductive justice principles and establishing a 15-member community advisory board to oversee the implementation. Other ways that equity concerns should be integrated into SCAI evaluations is to conduct subgroup analyses to determine whether all people had improved access to care and report that the care they received was client centered.

Is the Intervention Sustainable?

Sustainability is an understudied area of implementation science, but it's important for any effort to scale up SCAIs.[6] Ideally, existing SCAI evaluations will document the duration of impact on access to client-centered care over a defined period of time, the amount of funding needed to sustain them, and whether there is a point at which additional efforts are no longer needed.

DEVELOPING A SCALING-UP STRATEGY

The WHO has noted that scaling up successful health interventions requires "focused attention, strategic planning and management as well as resources allocation,"[7] and it has funded the development of a series of technical resources designed to help countries develop a scaling-up strategy. A nine-step process is proposed, which includes the following: planning actions to increase the scalability of the intervention, building the capacity required to implement the SCAI, advocating for needed changes in policies and regulations, and making decisions about dissemination, organizational processes, cost and resource mobilization and monitoring and evaluation.[7]

Ideally, an approach like this would be used to plan efforts to scale up SCAIs throughout the United States. However, a key challenge in the US context has been the lack of an organizational entity that could coordinate the development of a scaling-up strategy. SCAIs do not fit neatly into the scope of any single federal program, and contraceptive care is provided in a siloed, fragmented, and highly variable way across a number of programs such as the Office of Population Affairs' (OPA) Title X program, the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC), and the Center for Medicaid and CHIP Services (CMCS), among others. However, a new Department of Health and Human Services Reproductive Healthcare Access Task Force was created in 2022 to "identify and coordinate activities across the Department to protect and bolster access to essential sexual and reproductive health care," and could assume responsibility for developing a cross-agency vision for scaling up SCAIs.[8] This might include asking the CDC's Community Guide to consider a recommendation for SCAIs, authorizing use of OPA's Title X funds to fund aspects of SCAI implementation, requiring the HRSA's BPHC to support the engagement of federally qualified health centers in SCAIs through funding and performance measurement, and having the CMCS endorse innovative payment models developed in states implementing SCAIs.

SUMMARY

This editorial proposes steps that public agencies, private funders, program staff, and evaluation teams might take to support scaling up SCAIs. This includes expanding evaluation efforts to address questions about implementation and better coordination of federal agencies. I hope that the opportunity to achieve impact at scale will motivate public and private support of SCAIs so that all people of reproductive age in the United States may benefit from improved access to client-centered contraceptive care. AJPH

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REFERENCES

1. Centers for Disease Control and Prevention. About the Community Guide. Available at: https://www.thecommunityguide.org/about/about-community-guide. Accessed April 25, 2022.
2. Balas EA, Boren SA. *Managing Clinical Knowledge for Health Care Improvement. Yearbook of Medical Informatics.* Stuttgart, Germany: Schattauer; 2000:65–70.
3. Division of Cancer Control and Population Sciences, National Institutes of Health. Overview of implementation science and trans-NIH initiatives. Available at: https://www.nichd.nih.gov/sites/default/files/inline-files/Neta_NICHD_2021-02-24_slides.pdf. Accessed April 25, 2022.
4. Rogers E. *Diffusion of Innovations.* New York, NY: Simon & Schuster; 1995.
5. Baumann AA, Cabassa LJ. Reframing implementation science to address inequities in healthcare delivery. *BMC Health Serv Res.* 2020;20(1):190. https://doi.org/10.1186/s12913-020-4975-3
6. Shelton R, Lee M. Sustaining evidence-based interventions and policies: recent innovations and future directions in implementation science. *Am J Public Health.* 2019;109(suppl 2):S132–S134.
7. World Health Organization and ExpandNet. Nine steps for developing a scaling-up strategy. 2010. Available at: https://apps.who.int/iris/bitstream/handle/10665/44432/9789241500319_eng.pdf?sequence=1. Accessed April 25, 2022.
8. US Dept of Health and Human Services. Fact Sheet: HHS Reproductive Healthcare Access Task Force. Available at: https://www.hhs.gov/about/news/2022/01/21/fact-sheet-hhs-reproductive-healthcare-access-task-force.html. Accessed April 25, 2022.

US Sexual and Reproductive Health Policy: Which Frameworks Are Needed Now, and Next Steps Forward

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Sexual and reproductive health (SRH) is a key component of people's overall health and quality of life. A variety of policies, programs, and services support individuals' and communities' attainment of SRH, including public health interventions at the national, state, and local levels; maternal and child health–related services; and access to the full range of SRH services, including contraception and abortion. Yet despite private and public investments in SRH, individual- and population-level outcomes in the United States continue to lag behind those of other nations and are marked by persistent and pervasive inequities.[1]

The current US approach to SRH policy is inadequate to solve these problems. Well-intentioned efforts often fail, achieve only limited impact, are easily rolled back during times of political change, or even occasionally perpetuate harms.[2] Improving health outcomes and achieving equity will require a fundamental and holistic shift in how policymakers, clinicians, researchers, and the public understand and address these issues.

This article introduces two linked frameworks—sexual and reproductive health and well-being (SRHW) and sexual and reproductive health equity (SRHE)—that are intended to link and improve upon existing frameworks, including sexual and reproductive health, reproductive justice, and health equity.[3] SRHW and SRHE frameworks bring a particular focus on patient-centered approaches and de-siloing of systems and issues, both necessary for achieving goals like enhancing reproductive autonomy and reducing maternal mortality.[4,5]

Adopting SRHW and SRHE frameworks could provide a new paradigm for SRH policy in the United States, catalyze these needed changes, and ensure their durability as political winds and priorities shift. This article describes the initial development of these frameworks, their application to policy interventions, and next steps for improving public policy.

HOW THE FRAMEWORKS WERE DEVELOPED

The working definitions of SRHW and SRHE were framed as part of efforts to develop the Coalition to Expand Contraceptive Access (CECA) Recommendations for Achieving Universal, Equitable Access to Quality Contraception.[6] Through reviews of the evidence and expert consultations, CECA determined that guiding principles, such as SRHW and SRHE, would be necessary to connect contraception to a larger US government purpose and mission, as well as to advance the goal of universal, equitable access.

To shape these new frameworks, CECA first conducted a comparative analysis of the foundational constructs that currently shape SRH care and policy. CECA reviewed relevant literature and compiled a crosswalk of key terms and frameworks, including health disparities, health equity, person-centeredness, and reproductive justice, and described definitions of these constructs, how they were developed, and the context in which they are currently used.[7–10]

CECA then convened an interdisciplinary technical expert panel in spring 2020. Twenty-seven experts with relevant, diverse expertise—including SRH, reproductive justice, health equity, disability rights, LGBTQ+ (lesbian, gay, bisexual, transgender, queer, plus) health, public health, and familiarity with federal executive branch processes to expand contraceptive access—were selected to participate. Technical expert panel participants analyzed the relevance of various frameworks to federal policy, explored past and present federal actions to advance equity, and worked to develop a common framework for integrating reproductive health equity into government processes. Technical expert panel participants highlighted the important role that systems and structures play in equity, and in integrating a sexual health framing, particularly with respect to incorporating the perspectives and experiences of LGBTQ+ people. This resulted in CECA's definitions of SRHE and SRHW presented in the next section, and the identification of these as key frameworks to develop and implement.

DEFINING THE FRAMEWORKS

SRHW is a self-defined state that includes reaching one's individual sexual and reproductive goals. An SRHW approach necessitates framing aspects of policy and health care broadly, including a wide range of health services and social supports to de-silo clinical care, public health programming, and policy to reflect how people live and envision their health and well-being. The relevant policies, programs, and services that help people achieve SRHW include areas traditionally associated with SRH, including contraception and abortion, and also maternal and child health, fertility, childcare, paid leave, and housing, among others. Aligning work across these areas is consistent with how people envision their own health: a recent survey of 900 women regarding their health care priorities found that "Women view 'women's health' as more than just reproductive health—it encompasses physical, mental, and emotional wellbeing."[11] This approach is consistent with the reproductive justice focus on "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[7]

SRHE means that systems ensure that all people, across the range of age, gender, race, and other intersectional identities, have what they need to attain their highest level of sexual and reproductive health, and includes self-determining and achieving their reproductive goals. Government policy, health care systems, and other structures must value and support everyone fairly and justly.[12] An SRHE lens must be applied to all SRHW efforts, meaning that policies, programs, and services must account for historical and current forces that lead to inequities based on race, location, income, and other factors and center the needs of those who have been most harmed. SRHE would mean that these forces no longer limit individuals' attainment of SRHW and that everyone is treated fairly and justly.

CECA's technical expert panels and evidence analyses resulted in the call for an SRHW framework, focused on ensuring that all people have access to health care services that enable them to prevent and treat illness, experience the best health outcomes possible, and make the reproductive decisions that are right for them. Yet disparities in access to needed supports persist, exacerbated by the siloing of SRHW policies, funding streams, and infrastructure. Supports can be difficult to understand and navigate for federal agencies, states, health care systems, providers, and people seeking services.

HOW THESE FRAMEWORKS CAN BE APPLIED

How do we get to a place where historical and current forces that lead to inequities no longer limit individuals' attainment of their highest level of SRH, which includes self-determining and achieving their reproductive goals?

Reframing Our Goals

In reframing national goals as SRHW and SRHE, a new paradigm for SRH policy would focus on (1) improving health outcomes and reducing inequities, including maternal mortality; (2) increasing bodily autonomy for all people, including those whose autonomy has historically been restricted, particularly Black, Indigenous, and people of color (BIPOC); and (3) reshaping the national conversation to define well-being holistically and not by the absence of disease and distress, but by the presence of sexual and reproductive fulfillment, pleasure, healing, and joy. Global models like The World Health Organization Framework for Ensuring Human Rights in the Provision of Contraceptive Information and Services offer promising models for integrating a systems approach but are still inadequate for achieving the changes needed, including a holistic understanding of well-being.[13]

Four principles can help guide such a fundamental paradigm shift.

Principle 1. Existing structures, systems, and processes must be examined and changed. To fundamentally change processes to reflect equity, we must reconsider the questions we ask and how we design, measure, interpret, and share the results. As part of this process, we need to redefine "evidence" in a way that emphasizes a broad range of voices, fields, and outcomes and does not reinforce systemic bias. We must also alter structures to enhance collaboration and communication. An equity-informed approach to research requires that we critically examine and confront research practices and structures rooted in systemic racism and oppression, and center the experiences, priorities, and needs of communities. One promising example that could be adapted to other areas is the work done to "decolonize" research with Indigenous communities.[14]

Principle 2. Inclusion must be prioritized. We must engage more diverse and new voices in a meaningful way that includes the power to make decisions. This means that professional and expert organizations, academic partners, and the federal government must invite end users and others not traditionally invited from the beginning, rather than as an afterthought. This includes patient partners, community-based organizations, and those who do adjacent work (e.g., reproductive health advocates partnering with doula organizations). This also includes demonstrating the value of stakeholders' time by compensating participants and equitably dividing resources and funding among partner organizations. For many, this will be a cultural shift that can be supported by explicit guidance about who should be at the table and how they can be involved during every stage of the process.

Principle 3. Accountability must be built into the system and processes. Systems must be held accountable for demonstrating results and effectiveness that center equity. Guidelines, performance measures, and funding streams can be leveraged to drive equity, for example, through development of clinical guidance that centers the principles of SRHE and aligns patient-centered performance measures with payment. This would include involving patients and families in all phases of guideline development, consistent with best practices. Identifying patient and family values, preferences, and goals better enables guidelines to meet the needs of the individuals for whom they are intended and to avoid harm.[15]

Principle 4. Language and definitions must follow values. We must explicitly acknowledge historical context and harms and how they manifest today, be clear in our values and intention, and prioritize alignment between language use and behavior change. Contextualizing our work in history and within the context of people's lives begins with consistent use of inclusive, equity-focused language and principles that resonate with diverse groups—particularly those historically marginalized, such as BIPOC, adolescents, people with disabilities, and LGBTQ+ people—and address issues in an intersectional way. In the case of CECA's work, engagement with LGBTQ+ communities and experts in LGBTQ+ health led to the inclusion of "sexual" alongside "reproductive" in our conceptualization of SRHE. Similar engagement would likely lead to linguistic and framing adjustments in other organizations and efforts.

Translating the Frameworks Into Action

Translating SRHW into action requires a "whole systems thinking" and "health in all policies" approach that expands beyond a biomedical model of health to include aspects of life, such as economic stability and freedom from discrimination. Access to comprehensive health services, including noncoercive sexual health services, contraception, fertility care, and full-spectrum pregnancy-related care (i.e., abortion, miscarriage management, prenatal care, birth services, and postpartum care), is essential to an individual's ability to exercise reproductive autonomy and improve health outcomes, as a recent National Academy of Medicine report emphasized.[16] Social supports, such as quality child care and comprehensive paid family leave, are needed as well and have been shown to improve maternal and infant health, including physical health and well-being.[17] Governments could adapt its structures to better apply an SRHW approach. At the federal level, this would necessitate sharing goals, norms, and progress across the many agencies and departments currently responsible for aspects of reproductive and sexual health and social supports, with oversight from the highest levels of government (i.e., Congress and the White House).

Translating SRHE into action requires acknowledging and understanding the multidimensional historical context of how inequity has structured the experiences of people with marginalized identities. Sexual and reproductive coercion has driven racial and gender oppression throughout US history, beginning with the violence of slavery, including forced procreation and sexual assault.[18] Other examples include oral contraceptive trials on Puerto Rican people without informed consent and the state-sanctioned eugenic sterilization of Black, Latinx, and Indigenous people, and people with physical and intellectual disabilities.[19,20] These oppressions are not only in the past: coercive sterilization practices continue in both detention and correctional settings.[19] Although there are limited examples of reflection on this history, such as Planned Parenthood's reconsideration of Margaret Sanger's legacy, the racist history of "family planning" has yet to be fully acknowledged; authentic truth and reconciliation has never taken place despite decades of scholarship, historiography, and advocacy.[21] We must work to understand and redress the root causes of SRH inequities—particularly patriarchy, racism, colonialism, and capitalism—if SRHE is to be achieved.

To be in service of advancing SRHW and SRHE, we must shift the work away from some of the frameworks that have traditionally guided SRH work to more meaningful ones. This includes asking essential questions about what matters—which processes, structures, and outcomes are deemed important and thus considered worth funding and measuring. In the case of contraception, this has historically been the reduction of unintended pregnancy, which has been regarded as a proxy for women achieving their desired reproductive outcomes. A growing body of literature has questioned the validity of the unintended pregnancy framework and suggested alternative ways of conceptualizing reproductive health and well-being.[22,23] The unintended pregnancy framework should be replaced by more patient-centered outcomes and recognition that a spectrum of outcomes may be acceptable to people, dependent on their personal and social context. Measurement frameworks in contraceptive care are important for assessing quality and ensuring that this service is prioritized, as in other areas of health care, such as chronic disease management and preventive health screenings. Yet careful attention to centering bodily and reproductive autonomy in care delivery, with specific attention to inequities in care experience, is required. New measures to better understand sexual and reproductive well-being are in development and must be fully integrated to prioritize people's experience of reproduction in a holistic and comprehensive manner.

These frameworks should also be integrated into the training and clinical care models adopted. Clinical practice, when (re)designed with an SRHW and SRHE approach, can both increase equitable access to SRH care for all people and improve the experience and expand the power of people who have experienced harm in the health care system and face the greatest barriers to care. The full scope of SRH services must be offered in as many settings as possible, and clinicians and clinical teams should be competent to provide patient-centered and trauma-informed SRH care broadly, not just contraception.

CONCLUSION

In the absence of new frameworks, public and private work to improve health outcomes and reduce inequities will continue to miss the mark. Frameworks provide an opportunity to ground our work in shared values and evidence and enable transparency and accountability. CECA's experience has demonstrated the feasibility of applying the principles of SRHW and SRHE to policy work, and these models also have the promise to transform research and clinical practice. Fully developing and adopting SRHW and SRHE frameworks could catalyze needed changes, enhance their relevance and accountability to communities, and lead to enduring impact. As all aspects of health care, including SRH, seek to minimize harm and maximize justice, it is necessary to continually examine the underlying frameworks that guide all work.

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CONTRIBUTORS

J. Hart, J. Crear-Perry, and L. Stern conceptualized and designed the article. J. Hart, L. Stern drafted the article. J. Hart, J. Crear-Perry, and L. Stern critically revised the article for important intellectual content. J. Hart approved the final version to be published.

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REFERENCES

1. Tikkanen R, Gunja MZ, FitzGerald M, Zephyrin L. *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries.* New York, NY: The Commonwealth Fund; 2020. https://doi.org/10.26099/411v-9255
2. Gomez AM, Fuentes L, Allina A. Women or LARC first? Reproductive autonomy and the promotion of long-acting reversible contraceptive methods. *Perspect Sex Reprod Health.* 2014;46(3):171–175. https://doi.org/10.1363/46e1614
3. Coalition to Expand Contraceptive Access. Definitions and measures of reproductive and sexual health-related constructs: agency, autonomy, empowerment, equity, quality of life, and well-being. 2021. Available at: https://static1.squarespace.com/static/5d35f1b39760f8000111473a/t/60b7da8b32aaff26f59ee3c6/1622661771409/2.+Definitions+and+ Measures+of+Social+Outcomes_Environmental+Scan.pdf. Accessed January 10, 2022.
4. Chappel A, DeLew N, Grigorescu V, Smith SR. Addressing the maternal health crisis through improved data infrastructure: guiding principles for progress. Health Affairs Blog. August 11, 2021. Available at: https://www.healthaffairs.org/do/10.1377/hblog20210729.265068/full. Accessed November 12, 2021.
5. National Quality Forum. Maternal morbidity and mortality measurement recommendations final report. National Quality Forum; 2021:81. Available at: https://www.qualityforum.org/Publications/2021/08/Maternal_Morbidity_and_Mortality_Measurement_Recommendations_Final_Report.aspx?utm_source=informz&utm_medium=email&utm_campaign=maternal+final+report. Accessed November 12, 2021.
6. Coalition to Expand Contraceptive Access. CECA Recommendations for Achieving Universal, Equitable Access to Quality Contraception. May 2021. Available at: https://www.contraceptionaccess.org/framework-resources. Accessed November 12, 2021.
7. SisterSong. Reproductive Justice. Available at: https://www.sistersong.net/reproductive-justice. Accessed September 3, 2019.
8. Upadhyay UD, Dworkin SL, Weitz TA, Foster DG. Development and validation of a reproductive autonomy scale. *Stud Fam Plann.* 2014;45(1):19–41. https://doi.org/10.1111/j.1728-4465.2014.00374.x

9. Braveman P, Arkin E, Orleans T, Proctor D, Plough A. What is health equity? Robert Wood Johnson Foundation. 2017. Available at: https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html. Accessed October 27, 2020.
10. Stern L, Hart J, Danaux J. Conceptualizing sexual and reproductive health equity: key terms and frameworks. November 2021. Available at: https://static1.squarespace.com/static/5d35f1b39760f8000111473a/t/618eb3fe963bfb53486bfd15/1636742142643/SRHE+Key+Terms+and+Frameworks_11.2021.pdf. Accessed November 12, 2021.
11. Witte C, Yost F, Suennen L, Craven M. Dear future president—what women want for healthcare in America. Ask Tia. Available at: https://www.asktia.com/article/dear-future-president-what-women-want-for-healthcare-in-america. Accessed February 28, 2022.
12. Hart J. CECA's commitment to sexual and reproductive health equity in our work. Coalition to Expand Contraceptive Access. June 5, 2020. Available at: https://www.contraceptionaccess.org/blog/cecas-commitment-to-sexual-and-reproductive-health-equity-in-our-work. Accessed August 2, 2021.
13. World Health Organization. 2010. Framework for ensuring human rights in the provision of contraceptive information and services. Available at: https://apps.who.int/iris/bitstream/handle/10665/133327/9789241507745_eng.pdf. Accessed April 29, 2022.
14. Datta R. Decolonizing both researcher and research and its effectiveness in Indigenous research. *Res Ethics.* 2018;14(2):1–24. https://doi.org/10.1177/1747016117733296
15. Institute of Medicine (US) Committee on Standards for Developing Trustworthy Clinical Practice Guidelines. *Clinical Practice Guidelines We Can Trust.* Graham R, Mancher M, Miller Wolman D, Greenfield S, Steinberg E, eds. Washington, DC: National Academies Press; 2011.
16. Fuentes-Afflick E, Perrin JM, Moley KH, Díaz Á, McCormick MC, Lu MC. Optimizing health and well-being for women and children: commentary highlights interventions and recommends key improvements in programs and policies to optimize health and well-being among women and children in the United States. *Health Aff (Millwood).* 2021;40(2):212–218. https://doi.org/10.1377/hlthaff.2020.01504
17. Coombs S. Paid leave is essential for healthy moms and babies. National Partnership for Women & Families; 2021:6. Available at: https://www.nationalpartnership.org/our-work/health/moms-and-babies/paid-leave-is-essential-for.html. Accessed November 12, 2021.
18. Roberts DE. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty.* New York, NY: Vintage; 1999.
19. Ko L. Unwanted sterilization and eugenics programs in The United States. Independent Lens. January 29, 2016. Available at: https://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-states. Accessed September 14, 2021.
20. Blakemore E. The first birth control pill used Puerto Rican women as guinea pigs. History Stories. March 11, 2019. Available at: https://www.history.com/news/birth-control-pill-history-puerto-rico-enovid. Accessed September 14, 2021.
21. Johnson AM. I'm the head of Planned Parenthood. We're done making excuses for our founder. *New York Times.* April 17, 2021. Available at: https://www.nytimes.com/2021/04/17/opinion/planned-parenthood-margaret-sanger.html. Accessed September 14, 2021.
22. Aiken ARA, Borrero S, Callegari LS, Dehlendorf C. Rethinking the pregnancy planning paradigm: unintended conceptions or unrepresentative concepts? *Perspect Sex Reprod Health.* 2016;48(3):147–151. https://doi.org/10.1363/48e10316
23. Gomez AM, Arteaga S, Ingraham N, Arcara J, Villaseñor E. It's not planned, but is it okay? The acceptability of unplanned pregnancy among young people. *Womens Health Issues.* 2018;28(5):408–414. https://doi.org/10.1016/j.whi.2018.07.001

Use of a Learning Community to Expand Access to Contraception

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The Increasing Access to Contraception Learning Community was established to disseminate strategies and best practices to support 27 jurisdictions in the development of policies and programs to increase access to the full range of reversible contraceptives. We describe Learning Community activities and identify those that were most useful to participants. Although participation in Learning Community provided jurisdictional teams with structured activities such as virtual learning and peer networking opportunities, some teams struggled with full participation because of staffing turnover and shifts in priorities. (*Am J Public Health*. 2022;112(S5):S523–S527. https://doi.org/10.2105/AJPH.2022.306823)

Learning collaboratives are a strategy to improve knowledge dissemination and practice, but evidence of their effectiveness remains mixed.[1,2] Some learning communities have shown substantial impact on policies, practices, and clinical outcomes, including use of most and moderately effective contraception methods,[3] whereas others have demonstrated no significant effect. Evidence is limited about which learning community components are useful to participants.

INTERVENTION AND IMPLEMENTATION

From 2014 to 2016, in partnership with the Centers for Disease Control and Prevention, other federal agencies, and maternal and child health organizations, the Association of State and Territorial Health Officials (ASTHO) convened the Immediate Postpartum Long-Acting Reversible Contraception (LARC) Learning Community.[4] In 2016, ASTHO called for letters of interest from more jurisdictions, and this collaborative expanded to become the Increasing Access to Contraception Learning Community (henceforth, the "Learning Community").[5]

PLACE, TIME, AND PERSONS

The Learning Community included 27 US jurisdictions and centered on nine focus areas (Table A, available as a supplement to the online version of this article at http://www.ajph.org).[6] The jurisdictional teams included representatives from public health, Medicaid, and clinical care leadership. In October 2016, the Learning Community began with an in-person meeting, which included the creation of jurisdictional action plans that outlined team goals. Throughout the Learning Community, ASTHO provided technical assistance, hosted virtual learning sessions, and sent additional communications to teams, including updates to available resources, which could be accessed on the ASTHO Web site. The Learning Community concluded in person in May 2018. Funding was not provided to Learning Community jurisdictions; the in-person meetings were funded by ASTHO.

PURPOSE

Evaluations of other learning communities have demonstrated their feasibility, but participation has been primarily oriented toward clinical care.[1,7,8] By contrast, the Learning Community focused on public health and included representatives from a wide array of backgrounds. Participants in the earlier years of the Learning Community reported that its framework provided structure, accountability, and perceived validity, and prepared participants for potential challenges and opportunities.[9] This article builds on those findings by describing participant experiences with the activities of the Learning Community and evaluating which specific components (e.g., action planning, technical assistance, virtual learning sessions) were considered most useful.

EVALUATION AND ADVERSE EFFECTS

Evaluation data were collected at multiple time points by tracking technical assistance requests, administering Web-based polling to measure participant knowledge and usefulness of content immediately after virtual learning sessions, and semistructured telephone interviews with members of all 27 jurisdictional teams. Interviews were conducted during June through August 2018 and included an average of three participants per team. Interviews were audio-recorded, transcribed, and coded based on the nine focus areas and key activities.

The most common uses of the action plan were to coordinate teamwork, prioritize next steps, structure work and responsibilities, provide accountability, and guide the team when facing barriers or momentum challenges. Teams used the action plan to inform new team members, document activities for reports, and remind others in the jurisdiction that increasing contraception access was a formal priority. The majority of teams (70.4%) identified the process of developing an action plan as helpful (Table 1). Teams reported that having dedicated time at the in-person meeting to discuss the plan as a group, with a facilitator to guide the process, was also helpful. However, some teams did not think the action plan was helpful; two teams (7.4%) had existing action plans, and three (11.1%) were frustrated by ambitious action plans with achievements expected in a relatively short time-frame, or issues outside of team control such as administrative transitions and accompanying shifts in jurisdictional priorities.

Technical assistance requests were primarily related to the focus areas of reimbursement and financial sustainability, and provider awareness and training. Eleven teams (40.7%) reported that technical assistance helped further goals. Having scheduled calls for technical assistance helped keep teams accountable for action plans. Technical assistance resources were developed to be broadly applicable to all Learning Community teams. However, eight teams (29.6%) reported a need for more detailed resources customized to individual jurisdictions. Multiple teams suggested pairing with teams at similar stages of development, in similar regions, or working within similar payment systems to enable focused discussion and problem-solving.

Twenty-three teams (85.2%) participated in the virtual learning sessions, which enabled progress in their work. Based on polls after each session, 86% to 100% of participants reported increased knowledge of session subject matter (data not shown). Teams reported appreciating the sharing of resources such as LARC toolkits and how to train and support health system billing staff. Sessions were used as forums to contact experts, and teams reported peer-to-peer learning as the most beneficial component. Teams referenced using strategies from other jurisdictions to reduce barriers or facilitate progress to address challenges. Difficulty in finding time to attend the virtual learning sessions was mentioned by 11 teams; they suggested shortening sessions to one hour. Archiving sessions made it possible for teams to access the material and review sessions as needed.

The Learning Community encouraged both structured and unstructured peer-to-peer and expert-to-peer communication. The diversity in team structure enabled regular, informal connection with others of disparate areas of expertise (e.g., public health, Medicaid, and clinical care) and facilitated problem-solving. Seventeen teams (63.0%) reported increasing connections to other teams, individuals, and potential collaborating organizations in other jurisdictions. The most frequently shared resources addressed two barriers: (1) reimbursement and (2) logistical, contraceptive stocking, and administrative barriers. Teams reported that such resources increased progress, confirmed activity direction, supported success, and maintained motivation. The remaining 10 teams did not report any specific barriers to communication.

No adverse events occurred during the Learning Community, although more than half the teams (14 teams, 51.9%) reported less than full participation. Seven of these teams identified personnel changes as the main barrier. The other seven teams identified competing priorities and projects or too few resources to fully participate. Individual team members felt “stretched a little thin,” compounded by the need to coordinate with multiple team members and conflicting schedules. Thirteen teams reported being able to fully participate, and one team member reflected on facilitating factors:

> I appreciate that there were actual resources . . . . We were flown to meetings. We were provided technical assistance . . . . We were provided some evaluation tools . . . . That’s all very important, so I would love to see that model continue.

TABLE 1— Jurisdictional Team Experiences With Increasing Access to Contraception Learning Community (IAC LC) Activities: 2016–2018

Team #	Technical Assistance (TA)	Virtual Learning	Action Plan	Communications Within IAC LC Increased?	Fully Able to Participate?
1	Had barriers no TA could help	Rarely participated, did not use them	Helpful	No	No
2	Don’t remember	Participated, helpful	Helpful	No	No
3	TA they wanted was not available	Participated, not helpful	Unclear	No	No
4	Not asked	Not asked	Not asked	Increased	No
5	TA helpful	Participated, helpful	Helpful	Unclear	No
6	Not asked	Couldn’t remember participating	Helpful	No	No
7	TA helpful	Participated, helpful	Helpful	Increased	Yes
8	“Somewhat” helpful, TA they wanted was not available	Participated, helpful	Helpful	Increased	Yes
9	TA helpful	Participated, helpful	Helpful	Increased	Yes
10	TA they wanted was not available	Participated, did not use	Helpful	Increased	Yes
11	Had barriers no TA could help	Participated, helpful	Not helpful	Increased	No
12	TA helpful	Participated, helpful	Helpful	No	Yes
13	TA helpful	Participated, helpful	Not helpful	Increased	No
14	TA helpful	Participated, helpful	Helpful	Increased	No
15	TA helpful	Participated, helpful	Helpful	No	No
16	TA helpful	Participated, helpful	Unclear	Increased	No
17	TA helpful	Participated, helpful	Helpful	No	Yes
18	TA not helpful	Participated, helpful	Helpful	Increased	Yes
19	TA helpful	Participated, helpful	Helpful	Increased	Yes
20	TA not helpful	Participated, helpful	Helpful	No	Yes
21	Don’t remember	Participated, helpful	Helpful	No	Yes
22	TA not helpful	Participated, helpful	Helpful	No	No
23	Had barriers no TA could help	Did not participate	Not helpful	No	No
24	TA helpful	Participated, helpful	Helpful	Increased	Yes
25	Did not get wanted TA, not helpful	Participated, helpful	Not helpful	Increased	Yes
26	TA helpful	Participated, helpful	Helpful	Increased	Yes
27	Got all requested TA, no mention of helpful versus not helpful	Participated, helpful	Unclear	Increased	No

Note. Participating jurisdictional teams include the following: Alabama, Alaska, California, Colorado, Commonwealth of the Northern Mariana Islands, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, Montana, New Mexico, New York, North Carolina, Oklahoma, South Carolina, Texas, Washington, West Virginia, and Wyoming.

SUSTAINABILITY

By the end of the Learning Community, 44% of goals had been achieved by jurisdictions.[6] One year following the Learning Community, jurisdictions were continuing efforts for 87% of goals, with all jurisdictions still working on at least one goal, indicating sustainability of the activities.[6] Additionally, the Learning Community was an important precursor for the Coalition to Expand Contraceptive Access and ASTHO collaboration, as described in “Scaling Up Evidence-Based Practices in Contraceptive Access Initiatives” in this issue (Malcolm et al., p. S473). Six of the seven states involved in that collaborative were also part of the Learning Community.

PUBLIC HEALTH SIGNIFICANCE

Nearly every team found participation in the Learning Community to be helpful in developing programs and policies. Teams identified the opportunity to engage in a structured planning process as useful and reported that peer learning, both within and across teams, generated new ideas and effective strategies to overcome barriers, particularly those related to reimbursement. Other learning communities have also found that coordinated, structured planning by multidisciplinary teams,[1] and learning from both experts and peers,[8] are useful.

The interviews identified several challenges inherent to multiyear learning communities, including the need for organizations to continue momentum despite participant turnover. For some teams, maintaining momentum was challenged by unachievable action plan goals. Organizations planning learning communities may consider proposing activities to prioritize goals while establishing specific, measurable, actionable, and time-limited objectives.

Experiences of jurisdictional early adopters of Medicaid contraceptive reimbursement policies demonstrate that policy change alone is insufficient to increase access to the full range of effective contraceptive methods.[10,11] Implementation strategies are needed to bridge the gap between policy and access to contraception. Interviews suggested that participation in a multisectorial learning community composed of jurisdictional officials and providers can serve as a useful strategy to overcome implementation barriers and increase the effectiveness of health care systems change. Participating in a learning community can add to perceived credibility and prioritization of efforts to improve contraceptive access. When actual policy use has stalled, policymakers may find value in encouraging participation in a learning community to discover and share policy-development best practices.[9,12]

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The authors do not have any potential or actual conflicts of interest to disclose.

HUMAN PARTICIPANT PROTECTION

This project was determined to be exempt by the University of Illinois at Chicago institutional review board. At the Centers for Disease Control and Prevention, the project was determined to be public health practice and did not require human participant approval.

REFERENCES

1. Nix M, McNamara P, Genevro J, et al. Learning collaboratives: insights and a new taxonomy from AHRQ's two decades of experience. *Health Aff (Millwood)*. 2018;37(2):205–212. https://doi.org/10.1377/hlthaff.2017.1144
2. Wells S, Tamir O, Gray J, Naidoo D, Bekhit M, Goldmann D. Are quality improvement collaboratives effective? A systematic review. *BMJ Qual Saf*. 2018;27(3):226–240. https://doi.org/10.1136/BMJQS-2017-006926.
3. Loyola Briceno AC, Kawatu J, Saul K, et al. From theory to application: using performance measures for contraceptive care in the Title X family planning program. *Contraception*. 2017;96(3):166–174. https://doi.org/10.1016/J.CONTRACEPTION.2017.06.009
4. Kroelinger CD, Waddell LF, Goodman DA, et al. Working with state health departments on emerging issues in maternal and child health: immediate postpartum long-acting reversible contraceptives. *J Womens Health (Larchmt)*. 2015;24(9):693–701. https://doi.org/10.1089/jwh.2015.5401
5. Association of State and Territorial Health Officials. Increasing access to Contraception Learning Community year three project summary. 2018. Available at: https://www.astho.org/globalassets/pdf/iac-y3-final-report.pdf. Accessed May 10, 2022.
6. DeSisto CL, Estrich CG, Kroelinger CD, et al. Increasing access to contraception in the United States: assessing achievement and sustainability. *J Womens Health (Larchmt)*. 2021;30(9):1217–1224. https://doi.org/10.1089/jwh.2021.0414
7. Ebert L, Malte C, Hamlett-Berry K, Beckham J, McFall M, Saxon A. Use of a learning collaborative to support implementation of integrated care for smoking cessation for veterans with posttraumatic stress disorder. *Am J Public Health*. 2014;104(10):1935–1942. https://doi.org/10.2105/AJPH.2013.301776
8. Bunger AC, Hanson RF, Doogan NJ, Powell BJ, Cao Y, Dunn J. Can learning collaboratives support implementation by rewiring professional networks? *Adm Policy Ment Health*. 2016;43(1):79–92. https://doi.org/10.1007/s10488-014-0621-x
9. DeSisto CL, Estrich C, Kroelinger CD, et al. Using a multi-state learning community as an implementation strategy for immediate postpartum long-

acting reversible contraception. *Implement Sci.* 2017;12(1):138. https://doi.org/10.1186/s13012-017-0674-9

10. Okoroh EM, Kane DJ, Gee RE, et al. Policy change is not enough: engaging provider champions on immediate postpartum contraception. *Am J Obstet Gynecol.* 2018;218(6):590.e1–590.e7. https://doi.org/10.1016/j.ajog.2018.03.007
11. Rankin KM, Kroelinger CD, DeSisto CL, et al. Application of implementation science methodology to immediate postpartum long-acting reversible contraception policy roll-out across states. *Matern Child Health J.* 2016;20(suppl 1):173–179. https://doi.org/10.1007/s10995-016-2002-4
12. Kroelinger CD, Morgan IA, DeSisto CL, et al. State-identified implementation strategies to increase uptake of immediate postpartum long-acting reversible contraception policies. *J Womens Health (Larchmt).* 2019;28(3):346–356. https://doi.org/10.1089/jwh.2018.7083

Implementation and Monitoring of the Family Planning Elevated Contraceptive Access Program, Utah, 2018–2019

Rebecca G. Simmons, PhD, MPH, Jami Baayd, MPH, Alexandra Gero, MPH, Caitlin Quade, MPH, Madeline Mullholand, MPA, Erica Torres, MPH, David K. Turok, MD, MPH, and Jessica N. Sanders, PhD, MSPH

Family Planning Elevated (FPE) is a contraceptive access initiative in Utah. FPE designed and utilized a comprehensive monitoring system to identify and respond to challenges implementing our initiative as they arose. Here, we describe the components of our monitoring system, and highlight how FPE's monitoring system successfully identified that Utah's Medicaid expansion was not widely adopted by eligible individuals. We then describe how FPE adapted to this challenge. (*Am J Public Health*. 2022; 112(S5):S528–S531. https://doi.org/10.2105/AJPH.2022.306935)

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Family Planning Elevated (FPE) is a statewide contraceptive access initiative in Utah.

INTERVENTION AND IMPLEMENTATION

The FPE initiative has two main objectives: (1) to improve clinic capacity to provide comprehensive, person-centered contraceptive care across the state and (2) to make no-cost contraceptive care available to individuals falling in Utah's contraceptive "coverage gap," which exists for individuals who fall between the newly expanded Medicaid eligibility parameters and 250% of the federal poverty level (FPL). The US Department of Health and Human Services defines the FPL.

FPE's Contraceptive Access Program (CAP) launched in February 2019 and will end in April 2022. Three cohorts of clinics enrolled in FPE CAP, with each clinic participating for two years. A total of 28 clinics from eight health organizations participated. Clinics were eligible to apply if they served uninsured or low-income Utahns, had 340B pricing, accepted Medicaid, and were willing to participate in the program for two years with additional pre- and postintervention data provision. Once accepted, participating clinics received six program benefits:

1. a cash grant,
2. in-person trainings,
3. reimbursement for family planning services for FPE-eligible individuals at the Medicaid reimbursement rate,
4. no-cost stocking of contraceptive devices and reimbursement for other contraceptive methods,
5. ongoing technical assistance from family planning experts, and
6. a tailored media campaign to increase client awareness of contraceptive services at participating clinics.

PLACE, TIME, AND PERSONS

FPE was designed to augment a Medicaid Family Planning Waiver that passed through the Utah Legislature in March 2018 and was scheduled to begin in January 2019.[1] However, in November 2018, a full Medicaid expansion to individuals earning less than 138% FPL was passed through a statewide ballot initiative.[2] Because this coverage would have included contraceptive services as part of the health care services covered by Medicaid, the Family Planning Waiver was absorbed into this larger bill.[2]

Ultimately, the Utah legislature rolled back the Medicaid Adult Expansion to 100% FPL. This new legislation included work requirements and a per-capita cap, further limiting the number of covered individuals and increasing application requirements and administrative burden.[3] With the expansion, approximately 70 000 to 90 000 Utahns were newly eligible. The new legislation delayed the start of any expansion to April 2019. FPE shifted its own program eligibility in response to these policy changes, covering contraceptive care for individuals with incomes 0% to 100% FPL from February to April 2019, then 100% to 250% FPL from April 2019 to February 2020, and finally 139% to 250% FPL beginning in March 2020.

PURPOSE

FPE's goal from the outset was to provide contraceptive coverage to individuals who fell in the coverage gap. The mission of FPE is equitable access to all methods, for all communities, at all times. Rather than prioritizing any particular method or class of methods, this approach emphasizes comprehensive, person-centered contraceptive care for anyone who desires it, and supports switching and discontinuation as normal parts of the contraceptive process. FPE's monitoring system, as described here, helped ensure that adaptations to programmatic challengers were consistent with our mission.

EVALUATION AND ADVERSE EFFECTS

FPE designed and implemented an ongoing monitoring system to identify and respond to implementation challenges as they occurred and to help track clinics' progress toward the final outcome measures (increased service provision to individuals within the coverage gap, and expanded method mix offered at participating clinics[4]). At program outset, the monitoring system had three components: (1) a comprehensive process evaluation,[5] (2) quarterly update calls with all clinic sites, and (3) a quarterly monitoring report that measured clinics' programmatic compliance using components of service delivery and client exit data. Ultimately, we introduced two additional monitoring components to help us adequately evaluate program implementation: (4) our data tracker, which surveils the monthly provision of both FPE-eligible and -ineligible contraceptive services, and (5) in-situ simulation trainings at all clinical sites. A detailed description of each monitoring component is provided in Box 1 (see Table A, available as a supplement to the online version of this article at https://ajph.org, for a list of all indicators collected). Throughout implementation of FPE, we discovered that each component of the monitoring system meaningfully contributed to our understanding of various program implementation challenges. Here we describe how we used our

BOX 1— Monitoring Elements of the Family Planning Elevated (FPE) Contraceptive Access Program

Monitoring Component	Description	Rationale for Use	When Initiated
Process evaluation	Comprehensive evaluation to monitor and analyze how FPE was implemented, the ongoing impact of the program, and the community, state, and national contexts in which FPE was delivered.	The process evaluation allows us to identify which components of the program contribute to the success or failure of the initiative and understand how the context impacted the intervention.	December 2018
Clinic update calls	Quarterly calls between FPE program team and clinic champions and administrators to discuss progress, collect program indicators, and identify need for support.	Ongoing clinic conversations with administrators are necessary to ensure that program roll-out occurs, to address any needs, and to identify and resolve problems early in the implementation process.	February 2019
Monitoring report	Quarterly report compiled by evaluation team and presented to implementation team summarizing key program indicators of project progress for each participating health organization.	Ongoing monitoring data summaries identify challenges to implementation and keep track of clinic progress toward outcome objectives.	November 2019
Data tracker	Monthly tracker of both service delivery data and billing data to assess the number and type of contraceptive services provided by individual organizations.	Ongoing assessment of contraceptive service provision and total number of services provided gives an understanding of how the program is integrated into the existing clinical practice.	April 2020
Simulation	A three-hour training provided to each clinic at their one-year point in the program consisting of two simulated patient scenarios replicating a real visit using a patient actor and clinic staff who participate in their respective clinic roles. Each training concludes with a facilitated debrief and action planning with clinics.	Simulation allows us to see contraceptive care in action, identify areas where implementation of the program remained difficult for sites, and brainstorm solutions about how to optimize the program into each clinic's individual culture and workflow.	January 2020

monitoring system to identify a particular implementation challenge: lower-than-anticipated Medicaid enrollment numbers.

One of the goals of FPE CAP was to support clinics in helping newly eligible patients enroll in Medicaid. Trends in monthly service delivery data highlighted that the proportion of Medicaid-eligible clients seen at FPE CAP clinics remained largely unchanged before and after FPE CAP implementation: 77.2% and 83.8% of clinics' reproductive-aged client volume, respectively (it should be noted that relying on oft-missing client-reported income is an unreliable metric). As the FPE team noticed the stalling enrollment trends, we utilized other components of the monitoring program to contextualize the data. Through quarterly update calls and process evaluation interviews with clinics and FPE's stakeholders, we identified application burden, enrollment requirements, and lack of presumptive eligibility as significant barriers to Medicaid utilization. In addition, we learned that Medicaid enrollment at FPE CAP clinics mirrored a similar statewide trend in Medicaid enrollment rates, which were lower and grew more slowly than anticipated by the Medicaid office and advocates.[6]

In response to low utilization of Medicaid reimbursement for family planning services at FPE CAP clinics, we increased discussions about available strategies for linking clients to Medicaid enrollment assistance. We encouraged clinics to use FPE CAP grant funds to staff in-clinic Medicaid navigators. No clinics opted for full-time onsite navigators, however, largely because of the constraints of the COVID-19 pandemic. Documentation of Medicaid applications and enrollment was not specifically part of the FPE evaluation, but based on anecdote; very few individuals successfully navigated Medicaid enrollment at the point of contraceptive care.

Despite FPE's efforts to remove Medicaid expansion barriers, utilization of Medicaid was lower in the FPE-eligible population than predicted. The full Medicaid application includes 20 pages of self-reported information and documentation of family assets, employment history, and earnings; engaging in this lengthy process both challenges and stigmatizes people. These burdens highlight the importance of low-barrier approaches to augment coverage with programs like FPE and Title X.

We did not observe any adverse effects from the FPE program on individuals' ability to enroll in Medicaid.

SUSTAINABILITY

Our findings demonstrate the significant gap between passing a policy and uptake of that policy. While policy change, such as Medicaid expansion, can provide potential improvements in access to care, such policies must also include sufficient budgeting and planning for their successful implementation to truly sustain change.

PUBLIC HEALTH SIGNIFICANCE

While contraceptive initiatives have become common in recent years,[7–10] details of how these interventions are executed remain underreported, which results in new initiatives "reinventing the wheel" around programmatic development and implementation. Transparency around programmatic implementation offers learning opportunities for other contraceptive initiatives and identifies best practices through experience. Ultimately, our program required multifaceted monitoring using qualitative and quantitative data, as well as in-situ clinical visits to fully identify and address program implementation challenges. This finding is consistent with other contraceptive and public health initiatives that have attempted to scale up or adapt.[11,12] Including multiple monitoring components, particularly those that allow for in-clinic visits to explore implementation experientially, should be a consideration when developing new initiatives.

The implementation challenge identified here demonstrates how important programmatic flexibility and adaptation are when implementing a contraceptive initiative. Furthermore, while our monitoring processes successfully identified implementation and access barriers, FPE was not always able to address them programmatically. Programmatic components cannot always fully address external environmental forces, which further underscores the importance of including policy elements in contraceptive initiatives. Long-term and system-wide sustainability depends on implementation, evaluation, and policy efforts working synergistically to remove unnecessary burdens and to support access to reproductive health care for all people at all times. AJPH

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The authors have no conflicts of interest to disclose.

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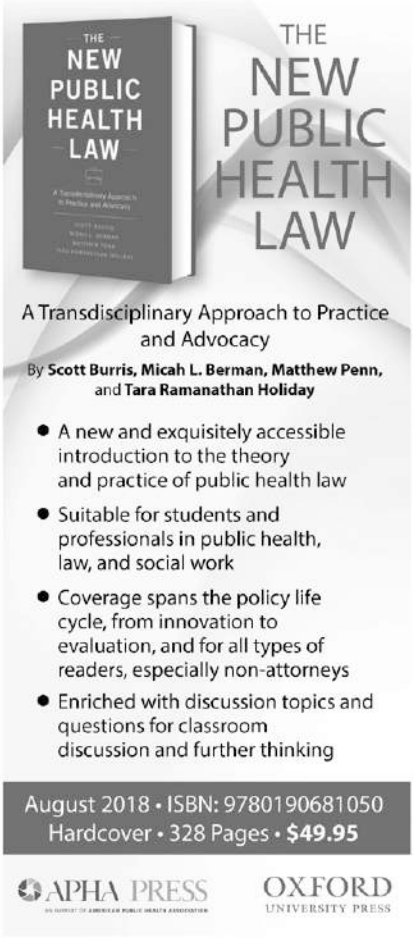
This study was deemed “exempt” by the University of Utah Institutional Review Board (IRB 00117213).

REFERENCES

1. Utah State Legislature. H.B. 12 Family Planning Services Amendments. 2018. Available at: https://le.utah.gov/~2018/bills/static/HB0012.html. Accessed June 2, 2022.
2. Musumeci M, Guth M, Rudowitz R, Hall C. From ballot initiative to waivers: what is the status of Medicaid expansion in Utah. San Francisco, CA: Kaiser Family Foundation, Health Policy Analysis, Polling, and Journalism; 2019.
3. Utah State Legislature. S.B. 96 Medicaid Expansion Adjustments. 2019. Available at: https://le.utah.gov/~2019/bills/static/sb0096.html. Accessed June 2, 2022.
4. Simmons RG, Myers K, Gero A, et al. Evaluating a longitudinal cohort of clinics engaging in the Family Planning Elevated Contraceptive Access Program: study protocol for a comparative interrupted time series analysis. *JMIR Res Protoc.* 2020;9(10):e18308. https://doi.org/10.2196/18308
5. Baayd J, Simmons RG. Protocol for a process evaluation of Family Planning Elevated: a statewide initiative to improve contraceptive access in Utah (USA). *BMJ Open.* 2020;10(10):e038049. https://doi.org/10.1136/bmjopen-2020-038049
6. Utah Health Policy Project. Medicaid adult expansion report. 2021. Available at: http://www.healthpolicyproject.org/medicaid-enrollment-data/expansion-report_20210908. Accessed June 2, 2022.
7. McNicholas C, Tessa M, Secura G, Peipert JF. The contraceptive CHOICE project round up: what we did and what we learned. *Clin Obstet Gynecol.* 2014;57(4):635–643. https://doi.org/10.1097/GRF.0000000000000070
8. Biggs MA, Rocca CH, Brindis CD, Hirsch H, Grossman D. Did increasing use of highly effective contraception contribute to declining abortions in Iowa? *Contraception.* 2015;91(2):167–173. https://doi.org/10.1016/j.contraception.2014.10.009
9. Welti K, Manlove J. Unintended pregnancy in Delaware: estimating change after the first two years of an intervention to increase contraceptive access. Bethesda, MD: Child Trends; 2018.
10. Moskosky S, Malcolm N, Stern L, Cross A, Hart J. Priority roadmap for policy-ready contraceptive research: draft environmental scan report. March 2021. Available at: https://static1.squarespace.com/static/5d35f1b39760f8000111473a/t/60b7ddb85a8993514873e6ee/1622662584455/6.+Statewide+Contraceptive+Access+Initiatives_Environmental+Scan.pdf. Accessed June 2, 2022.
11. Igras S, Sinai I, Mukabatsinda M, Ngabo F, Jennings V, Lundgren R. Systems approach to monitoring and evaluation guides scale up of the Standard Days Method of family planning in Rwanda. *Glob Health Sci Pract.* 2014;2(2):234–244. https://doi.org/10.9745/GHSP-D-13-00165
12. Steyn PS, Cordero JP, Gichangi P, et al. Participatory approaches involving community and healthcare providers in family planning/contraceptive information and service provision: a scoping review. *Reprod Health.* 2016;13(1):88. https://doi.org/10.1186/s12978-016-0198-9



The Colorado Initiative to Reduce Unintended Pregnancy: Contraceptive Access and Impact on Reproductive Health

Sarah E. Romer, DNP, FNP-C, and Kathy I. Kennedy, DrPH, MA

The Colorado Initiative to Reduce Unintended Pregnancy, including its largest subproject, the Colorado Family Planning Initiative, had a significant impact on contraceptive access during and after the project period. This coordinated and multilevel initiative improved reproductive health outcomes by driving change in public health systems, advancing statewide policies, building capacity through training and technical assistance, and increasing public awareness and education. Lessons learned from the implementation and outcomes of the Colorado Initiative to Reduce Unintended Pregnancy continue to inform contraceptive access efforts. (*Am J Public Health*. 2022;112(S5):S532–S536. https://doi.org/10.2105/AJPH.2022.306891)

The Colorado Initiative to Reduce Unintended Pregnancy (hereafter "Colorado Initiative") was a multiyear project involving multilevel interventions and implemented by a broad range of partners across Colorado with the goal of increasing access to contraception. The Colorado Initiative was conducted between 2008 and 2016 and focused on four strategies: (1) increasing access to quality family-planning services, (2) increasing the availability of IUDs (intrauterine devices) and implants, (3) promoting healthy decisions and planning, and (4) improving public policy and practices.[1] We describe the implementation and long-term impact of the Colorado Family Planning Initiative (CFPI) project, the largest project of the Colorado Initiative, and highlight lessons learned that may inform the implementation and evaluation of future contraception access projects.

INTERVENTION AND IMPLEMENTATION

In Colorado, a large network of stakeholders was identified to inform Colorado Initiative activities during the project period. The Colorado Initiative distributed funding to 17 grantee organizations, reaching 110 public health centers, advocacy coalitions, and reproductive justice and community-based organizations (Figure A, available as a supplement to the online version of this article at http://www.ajph.org).

The largest grantee funded by the Colorado Initiative was the Colorado Department of Public Health and Environment's Title X Family Planning Program. This program formed the CFPI and used an existing network of 69 family-planning clinics located in public health departments, community health centers, hospitals, and urban and rural school-based health centers to implement clinic-based strategies to address the four priority areas for the Colorado Initiative. Before the CFPI, access to long-acting reversible contraceptive (LARC) methods was limited because of constraints such as device cost[2] or lack of provider proficiency with device insertion.[3] The CFPI aimed to reduce such barriers and increase access through the Title X network by increasing capacity, providing LARCs at no cost, improving community outreach and health education through a public awareness campaign, and supporting state policy changes to family planning.

PLACE, TIME, AND PERSONS

Colorado was selected as a site for this initiative because it (1) is a midsized state with a diverse population, (2) had an established family-planning network, and (3) had a high unintended pregnancy rate before the start of the project period.[1] In Colorado, the Colorado Initiative supported the CFPI from 2009 to 2014. The CFPI network of Title X family-planning clinics covered all 37 counties with Title X family-planning clinics in the state. These counties, 13 designated as urban, 14 as rural, and 10 as frontier, include 95% of Colorado's population.[4] Finally, we assembled CFPI data through 2019 to identify long-term trends in the outcomes of interest, including changes in family-planning service utilization, contraceptive provision, adolescent birth, and abortion rates.

In 2008, the Colorado Title X Program reached 52 645 clients (46 348 women and 6297 men), with more than half of clients younger than 25 years. The racial and ethnic diversity of the clientele was mostly representative of Colorado's overall population (77% White, 4% Black, 3% other), with the exception of 40% of clients who identified as Hispanic, which was nearly double the number of Hispanic residents in Colorado (21%). Finally, more than 70% of clients reported an income below 100% of the federal poverty level (as determined by the US Department of Health and Human Services for that year).

PURPOSE

To implement Colorado Initiative strategies, all 69 Title X clinics received CFPI funds. Participation required clinics to provide LARCs at no cost. Most clinics purchased and stocked LARC devices onsite. Smaller clinics contracted with local providers to provide devices and sterilizations. Clinics also engaged in activities related to hiring and training staff, extending clinic hours, purchasing equipment or electronic health records, and expanding community outreach and education to reduce barriers and increase access to quality family-planning services.

CFPI activities also included training and technical assistance on contraceptive counseling, clinic workflows, and billing and coding practices through annual conferences and quarterly meetings. In 2015, these annual trainings were expanded to include LARC device insertions, training 550 clinicians statewide over a four-year period.[1] After the CFPI received criticism for prioritizing LARCs and using tiered counseling methods, trainings were modified in 2016 to ensure that program activities were patient centered, focused on reproductive autonomy, and provided equitable access to all methods.

Two coalitions emerged that engaged Title X clinics participating in the CFPI in advocacy efforts to influence statewide policies and practices, including improvements to Medicaid reimbursement, confidentiality protections, and state funding for family planning.

Additional community education and outreach activities were launched through a public awareness campaign focused on normalizing sexual and reproductive health topics among individuals, families, and communities.

EVALUATION AND ADVERSE EFFECTS

We compared reproductive health indicators at three points—the year before the initiative (2008), at the end of the CFPI (2014), and five years after the project ended (2019). During the CFPI, the total number of women seen in Title X clinics increased by 2.5%. Table 1 also shows that the improvements in reproductive health indicators were sustained through the five years after the intervention. From 2008 to 2019 the proportion of female contraceptive clients using a LARC increased from 6% to 32%, whereas the proportion using combined hormonal methods (i.e., pills, patches, and rings) decreased from 48% to 25%. Female clients using Depo Provera and other methods remained unchanged from 2008 to 2019. Although the intervention reached people across the state, the outcomes we report here focus on adolescents and young adults. Statewide, large declines were seen in the adolescent birthrate (from 11.2 per 1000 in 2008 to 3.9 per 1000 in 2019), the adolescent abortion rate (from 39.6 per 1000 in 2008 to 13.5 per 1000 in 2019), and the number of second-order or higher births to adolescents (from 1258 in 2008 to 290 in 2019). We did not identify any adverse effects during the CFPI or during the five-year follow-up period.

SUSTAINABILITY

The Colorado Initiative created momentum to build statewide contraceptive access initiatives across the country and provided lessons and recommendations for future programs:

1. Integrate principles of person centeredness and equity into program planning, implementation, and evaluation at the outset.
2. Partner with a diverse group of stakeholders, including advocates and reproductive justice organizations. Engage communities in identifying their strengths and opportunities, then codesign programs and solutions together, building strategic priorities, goals, and metrics that are nonstigmatizing, culturally relevant, and person centered.
3. Share the success of the project through publications[1,3,4,6] and advocacy efforts. In Colorado, this increased the visibility of the

TABLE 1— Selected Characteristics and Reproductive Health Indicators of Title X Female Clients: Colorado, 2008, 2014, 2019

Characteristic[a] or Reproductive Health Indicator[b]	2008, No. (%)	2014, No. (%)	2019, No. (%)
Total	46 348	47 513	43 774
Age, y			
< 15–19	12 256 (26.4)	11 392 (24.0)	9 801 (22.4)
20–24	13 381 (28.9)	13 237 (27.9)	10 599 (24.2)
25–34	14 423 (31.1)	15 238 (32.1)	14 228 (32.5)
≥ 35	6 288 (13.6)	7 646 (16.1)	9 146 (20.9)
Race			
White	35 565 (76.7)	32 696 (68.8)	30 855 (70.5)
Black	2 043 (4.4)	3 387 (7.1)	4 263 (9.7)
Other/more than 1 race	1 479 (3.2)	1 730 (3.6)	2 380 (5.4)
Unknown/not reported	7 261 (15.7)	9 700 (20.4)	6 276 (14.3)
Ethnicity			
Hispanic or Latino	18 589 (40.1)	22 321 (47.0)	23 017 (52.6)
Not Hispanic or Latino	25 638 (55.3)	22 216 (46.8)	19 123 (43.7)
Unknown/not reported	2 121 (4.6)	2 976 (6.3)	1 634 (3.7)
% of FPL[c]			
≤ 100	38 577 (73.3)	41 743 (74.9)	38 387 (71.6)
101–150	7 657 (14.5)	6 853 (12.3)	6 611 (12.3)
151–200	2 959 (5.6)	3 207 (5.8)	3 729 (7.0)
201–250	1 381 (2.6)	1 584 (2.8)	1 722 (3.2)
> 250	1 684 (3.2)	2 316 (4.2)	3 165 (5.9)
Unknown/not reported	387 (0.7)	0 (0.0)	0 (0.0)
Insurance type[c]			
Public	4 578 (8.7)	16 002 (28.7)	18 926 (35.3)
Private	4 483 (8.5)	6 825 (12.3)	8 347 (15.6)
Uninsured	38 257 (72.7)	29 271 (52.5)	25 666 (47.9)
Unknown/not reported	5 327 (10.1)	3 605 (6.5)	675 (1.3)
Overall method mix	46 348	47 513	43 774
IUDs	2 653 (5.7)	6 237 (13.1)	7 347 (16.8)
Implants	263 (0.6)	5 262 (11.1)	6 755 (15.4)
Injections	6 082 (13.1)	6 945 (14.6)	5 908 (13.5)
Pills	18 765 (40.5)	12 412 (26.1)	9 247 (21.1)
Vaginal ring	1 812 (3.9)	1 938 (4.1)	1 170 (2.7)
Patch	1 759 (3.8)	670 (1.4)	303 (0.7)
Female clients using all other contraceptive methods[d]	6 511 (14.0)	6 619 (13.9)	6 641 (15.2)
Female clients who were pregnant, seeking pregnancy, not using a method for another reason, or whose method was unknown/not reported	8 503 (18.3)	7 430 (15.6)	6 403 (14.6)
Female clients using IUDs, by age, y	2 653	6 237	7 347
< 15–19	190 (7.2)	771 (12.4)	958 (13.0)
20–24	642 (24.2)	1 810 (29.0)	1 766 (24.0)
25–34	1 261 (47.5)	2 425 (38.9)	2 735 (37.2)
≥ 35	560 (21.1)	1 231 (19.7)	1 888 (25.7)

Continued

TABLE 1— Continued

Characteristic[a] or Reproductive Health Indicator[b]	2008, No. (%)	2014, No. (%)	2019, No. (%)
Female clients using hormonal implants, by age, y	263	5 262	6 755
<15–19	111 (42.2)	1 973 (37.5)	2 264 (33.5)
20–24	65 (24.7)	1 793 (34.1)	1 913 (28.3)
25–34	66 (25.1)	1 162 (22.1)	1 736 (25.7)
≥35	21 (8.0)	334 (6.3)	842 (12.5)
Female clients using pills, by age, y[e]	18 765	12 412	9 247
<15–19	5 233 (27.9)	2 813 (22.7)	2 002 (21.7)
20–24	not reported	3 589 (28.9)	2 445 (26.4)
25–34	not reported	4 084 (32.9)	3 035 (32.8)
≥35	not reported	1 926 (15.5)	1 765 (19.1)
Female clients using 3-mo hormonal injectables, by age, y	5 482	6 945	5 908
<15–19	1 194 (21.8)	2 061 (29.7)	1 688 (28.6)
20–24	1 754 (32.0)	1 821 (26.2)	1 392 (23.6)
25–34	1 775 (32.4)	1 972 (28.4)	1 659 (28.1)
≥35	759 (13.8)	1 091 (15.7)	1 169 (19.8)
Reproductive health indicator			
Adolescent abortion rate: induced terminations of pregnancy among females 15–19 y per 1000 females 15–19 y	11.2	5.5	3.9
Adolescent birthrate: births to females 15–19 y per 1000 female population in the age group	39.6	19.8	13.5
No. second or higher order births to adolescents 15–19 y	1 258	511	290
Rapid repeat births: % of all repeat births among women of all ages that occur <24 mo after the previous delivery	24.0	20.7	21.6
Average age at first birth, y	25.7	27.1	27.9

Note. FPL = federal poverty level; IUD = intrauterine device. We used FPL as determined by the US Health and Human Services in the specific year.

[a] US Department of Health and Human Services, Office of Population Affairs, "Family Planning Annual Report 2021" (https://opa.hhs.gov/research-evaluation/title-x-services-research/family-planning-annual-report/family-planning-0).
[b] Colorado Department of Public Health and Environment (https://drive.google.com/file/d/1eoY53hAMOaUiQ5_-iQU0H84I-vkPJRq9/view).
[c] Male plus female Title X family-planning users.
[d] Female sterilization, cervical cap, diaphragm, sponge, female condom, spermicide (used alone), fertility awareness method, lactational amenorrhea method, abstinence, withdrawal, other, vasectomy, male condom.
[e] In 2008 there were 18 765 reported oral contraceptive users, including 5305 aged <15–19 y. In the 2008 "Family Planning Annual Report" for those aged 20–39 y, there are 10 616 cases of missing data on age.

program and led to an increase in state funding for family planning. However, the project was criticized for highlighting costs that governmental programs avoided through reductions in adolescent birthrates as a reason for expanding funding for the program.

4. Recognize the importance of language and messaging. Provide context when describing outcomes and successes to avoid stigma and marginalization.
5. Create an ongoing culture of continuous improvement. Provide flexibility to shift priorities as the field of reproductive health evolves and allow local approaches to implementation.

PUBLIC HEALTH SIGNIFICANCE

By increasing access to contraception broadly, the CFPI profoundly affected women's reproductive health in Colorado, and the impact was sustained after the initiative ended. Access to contraception matters to the lives of individuals and families and makes a measurable public health impact. The Colorado Initiative expanded contraceptive access and opportunity in Colorado and inspired other states[7] to implement similar models. AJPH

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REFERENCES

1. Colorado Department of Public Health and Environment. Taking the unintended out of pregnancy: Colorado's success with long-acting reversible contraception. 2017. Available at: https://drive.google.com/file/d/1Bfk7CS8I5W92iCS0g8_COTBmi8a-JxZ4/view. Accessed October 8, 2021.
2. Pritt NM, Norris AH, Berlan ED. Barriers and facilitators to adolescents' use of long-acting reversible contraceptives. *J Pediatr Adolesc Gynecol.* 2017; 30(1):18–22. https://doi.org/10.1016/j.jpag.2016.07.002
3. Phillips J, Sandhu P. Barriers to implementation of long-acting reversible contraception: a systematic review. *J Am Assoc Nurse Pract.* 2018;30(4):236–243. https://doi.org/10.1097/JXX.0000000000000019
4. Ricketts S, Klingler G, Schwalberg R. Game change in Colorado: widespread use of long-acting reversible contraceptives and rapid decline in births among young, low-income women. *Perspect Sex Reprod Health.* 2014;46(3):125–132. https://doi.org/10.1363/46e1714
5. Goldthwaite LM, Duca L, Johnson RK, Ostendorf D, Sheeder J. Adverse birth outcomes in Colorado: assessing the impact of a statewide initiative to prevent unintended pregnancy. *Am J Public Health.* 2015;105(9):e60–e66. https://doi.org/10.2105/AJPH.2015.302711
6. Stevenson AJ, Genadek KR, Yeatman S, Mollborn S, Menken JA. The impact of contraceptive access on high school graduation. *Sci Adv.* 2021;7(19):eabf6732. https://doi.org/10.1126/sciadv.abf6732
7. Skračić I, Lewin AB, Roy KM. Evaluation of the Delaware Contraceptive Access Now (DelCAN) initiative: a qualitative analysis of site leaders' implementation recommendations. *Contraception.* 2021;104(2): 211–215. https://doi.org/10.1016/j.contraception.2021.03.015

Delaware Contraceptive Access Now and Contraceptive Initiation Among Medicaid Enrollees, 2015–2020

Michel Boudreaux, PhD, Katie Gifford, PhD, MS, Mary Joan McDuffie, MA, Rebecca McColl, MA, Taehyun Kim, MS, and Erin K. Knight, PhD, MPH

Delaware Contraceptive Access Now was a statewide contraceptive access program implemented in Delaware between 2015 and 2020. We evaluated the association of the program with contraceptive initiation in Delaware's Medicaid program using a difference-in-differences design that compared changes in Delaware to changes in Maryland. Results suggest that program implementation was associated with increased initiation of long-acting reversible methods, particularly among adolescent patients aged 15 to 18 years. We found less-consistent evidence for changes to any contraceptive method. (*Am J Public Health*. 2022;112(S5):S537–S540. https://doi.org/10.2105/AJPH.2022.306938)

Delaware Contraceptive Access Now (DelCAN) was a statewide intervention that sought to improve access to contraceptives, including long-acting reversible contraceptives (LARCs).[1]

INTERVENTION AND IMPLEMENTATION

The multisectoral intervention included changes to Medicaid payment for LARC devices in outpatient and inpatient (postpartum) settings, direct financial support of clinics, clinical training in patient-centered counseling and contraceptive care, business operations support, and a public awareness campaign that alerted the public about where they could obtain affordable same-day services. Trainings involved all Title X–supported clinics in the state, the largest outpatient clinics and medical groups, and five of the six maternity hospitals. The program was implemented by the State of Delaware in partnership with Upstream USA.[2]

Previous work suggests that the program increased attendance at Title X clinics and increased the share of Title X patients that used a LARC.[3,4] However, there is no existing evidence about how the intervention affected other patient groups, including those participating in the Medicaid program, which covers 20% of all reproductive-age women in Delaware and finances about half of all births. While Title X is an important provider in Delaware Medicaid, fewer than one in four Medicaid contraceptive patients obtain contraceptive services via Title X. Previous results may not generalize to the entire Medicaid population.

PLACE, TIME, AND PERSONS

Implementation activities occurred between 2015 and 2020. The intervention was implemented across the state.

PURPOSE

The primary objective was to reduce the rate of unintended pregnancy in Delaware by ensuring that all reproductive-aged women, regardless of insurance or ability to pay, have same-day access to the full range of contraceptives.

EVALUATION AND ADVERSE EFFECTS

We evaluated the association of the program with contraceptive claims in Delaware Medicaid. We used a difference-in-difference design that compared changes in contraceptive claims from before (2013–2014) versus during program implementation (2015–2019), in Delaware compared with Maryland. The purpose of the comparison state (Maryland) was to account for changes in contraceptive provision that would have likely occurred in the absence of the program. Maryland was chosen because it did not implement a comprehensive program and covariate levels were similar across the state (Appendix Table A, available as a supplement to the online version of this article at https://ajph.org). In addition, data from the American Community Survey suggested that race, age, and socioeconomic status indicators among reproductive-age women with Medicaid evolved in a similar pattern in Delaware and Maryland from before to after Del-CAN implementation (data not shown). We were also concerned about differential adoption of the Affordable Care Act's Medicaid expansion.[5] In a robustness test, we examined a subgroup of parents who were eligible at similar income levels in both states throughout our study period.

We assessed changes in outcomes across the early implementation period (2015–2017) in which payment reforms were implemented and most training was completed, and the late implementation period (2018–2019) in which the major activity was technical assistance.

Data came from Medicaid enrollment, inpatient, outpatient, and pharmacy files. To be eligible, participants must have been aged 15 to 44 years, identified as female in the enrollment record, had 11 months of continuous full-coverage enrollment in a calendar year, lacked an indication of infecundity and pregnancy, and not had a live birth in the calendar year. We excluded postpartum enrollees because the program included a number of activities specifically targeting the postpartum population.[1] The estimates presented here pertain to the preconception population, which allowed us to isolate the effect of the clinic-based program components from the hospital-based components that targeted postpartum patients. Future work will examine the postpartum population in detail. Analyses were stratified by age (15–18 and 19–44 years).

We examined LARC insertion (implants and intrauterine devices) and any contraceptive initiation (female sterilization, LARC, or short-acting prescription methods). We considered LARC insertion because many program activities attempted to mitigate the unique challenges of delivering same-day LARC services.[6] Initiation for LARC and sterilization was identified from procedure coding in the claims. Short-acting initiation was defined as a claim for a short-acting method that followed at least six months of no short-acting method claim. Initiation is a meaningful metric for capturing how well the program met its goal of expanding access in ways that would facilitate first-time adoption for those with unmet demand or switching to a method that better met patient preferences. Initiation is also more feasible than measuring ongoing use because many patients do not obtain continuation services for long-acting or permanent methods.

We estimated difference-in-differences comparisons with linear probability models. The coefficients of interest were interactions between Delaware and the early implementation period, and Delaware and the late implementation period. Models also included state fixed effects, calendar year fixed effects, age, any chronic condition, parental status, and time-varying community characteristics obtained from the US Census Bureau (public-use microdata area race, age, sex, poverty, employment, and nativity). Regressions used robust standard errors.

Figure 1 describes LARC trends for adolescents. LARC use was similar by state before implementation, but increased in Delaware in the implementation periods, relative to Maryland. Outcome graphs for all outcomes and subgroups can be found in the Appendix, Figure A.

Table 1 presents difference-in-differences results. For adults, there was no significant change in LARC in the early intervention period and a 0.26-percentage-point increase in the late intervention

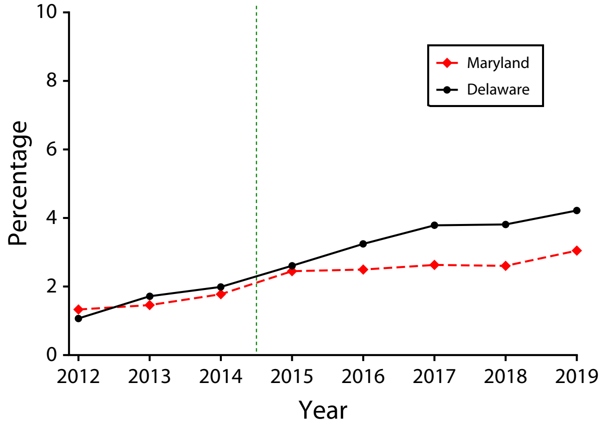

FIGURE 1— **Long-Acting Reversible Contraception Initiation by State, Among Adolescents Aged 15–18 Years: Maryland and Delaware, 2012–2019**

Note. Long-acting reversible contraceptives include intrauterine devices and implants. The vertical line demarks the pre- and postimplementation periods. Eighteen was chosen as the maximum adolescent age to align with the child eligibility pathway in Medicaid.

Source. Delaware and Maryland Medicaid administrative data.

TABLE 1— Difference-in-Differences Results for Long-Acting Reversible Contraceptive (LARC) and Any Method Initiation by Subgroup: Maryland and Delaware, 2012–2019

	LARC		Any Method Initiation	
	Percentage Point Estimate (SE) or Mean	*P*	Percentage Point Estimate (SE) or Mean	*P*
Reproductive-aged adults (aged 19–44 y)				
DE*early intervention period	−0.08 (0.10)	.42	−1.08 (0.22)	< .001
DE*late intervention period	0.26 (0.11)	.021	−0.50 (0.23)	.032
Mean Delaware outcome before intervention	2.5		15.0	
Adolescents (aged 15–18 y)				
DE*early intervention period	0.59 (0.18)	.001	0.18 (0.47)	.71
DE*late intervention period	1.24 (0.22)	< .001	0.70 (0.51)	.17
Mean Delaware outcome before intervention	1.8		18.8	

Note. Eighteen years was chosen as the maximum adolescent age to align with the child eligibility pathway in Medicaid. Models are adjusted for the community characteristics described in the text, and individual-level age group, a chronic condition indicator, number of Medicaid enrolled children in the household, and (for the adult subgroup) an indicator of parental status. All models include state and year fixed effects. Standard errors are robust. Sample sizes are 1 221 377 for adults and 297 006 for adolescents.

Source. Delaware and Maryland Medicaid administrative data.

period—a 10% increase from the baseline rate ($P = .021$). In both the early and late intervention period, there was evidence of a decline in any method initiation, but of relatively small magnitudes (relative to the baseline rate of 15.0) of 1.08 percentage points in the early intervention period ($P \leq .001$) and 0.50 percentage points in the late intervention period ($P = .032$). This might reflect substitution from shorter-acting methods to LARC.

For adolescents, there was a statistically significant increase in LARC adoption of 0.59 percentage points ($P \leq .001$) in the early intervention period and 1.24 percentage points ($P \leq .001$) in the late intervention period. On a relative basis, this represents a 33% and 68% increase, respectively. There was no statistically significant evidence of a change in any method initiation for adolescents.

We found similar results in a subsample of adult parents (Appendix, Table B), suggesting that results for adults were not confounded by differential expansion under the ACA. Appendix Table C also examines short-acting methods and any contraceptive claim, which included initiation and continuation.

This study did not consider adverse effects. However, any contraceptive access program, particularly those with strong LARC components, must center patient autonomy to counteract the history of provider biases and policy arrangements that have shaped contraceptive provision in the United States.[7–10] Ongoing work that is part of the broader DelCAN Evaluation considers patient-reported experiences of care and its variation across groups.[11]

SUSTAINABILITY

An important goal of the program was to build system capacity that could be sustained. Future work will examine that.

PUBLIC HEALTH SIGNIFICANCE

Many states are engaged in interventions and reforms meant to increase access to contraceptives (Malcolm et al., p. S473). These programs have the potential to remove barriers that prevent patients from attaining their reproductive goals. In this study, we found that a relatively comprehensive effort in Delaware resulted in increased adoption of LARC among preconception Medicaid enrollees, particularly among adolescents. Future work is needed to more fully understand why effects were larger among adolescents. Furthermore, more work is needed to examine if the associations we observed are the result of changes in access or changes in provider counseling style. AJPH

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CONFLICTS OF INTEREST

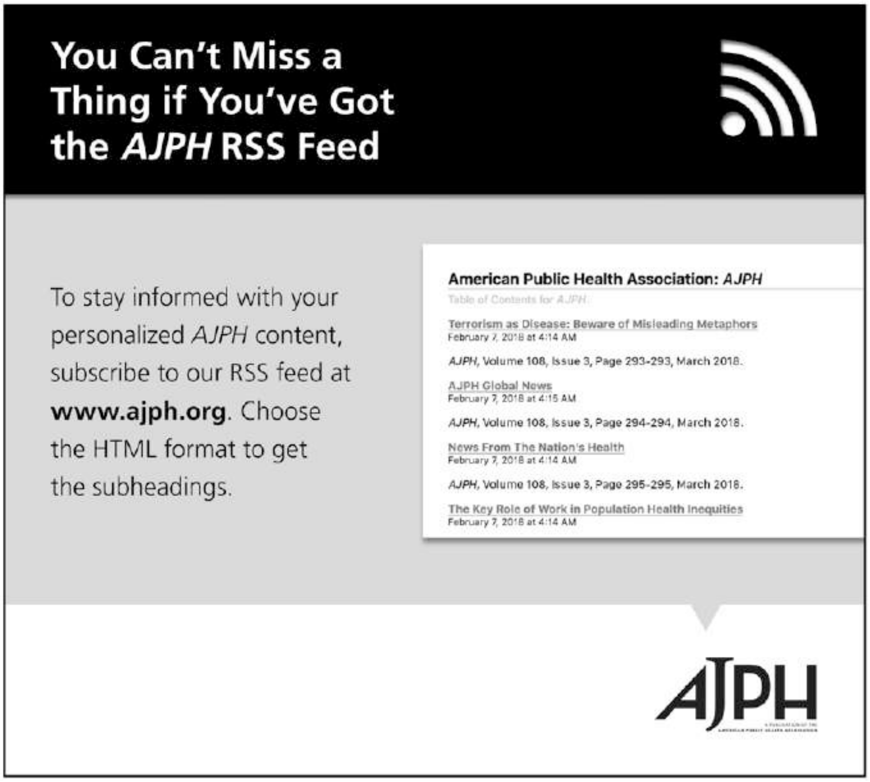
We have no conflicts of interest.

HUMAN PARTICIPANT PROTECTION

This study was approved by the University of Delaware institutional review board (#930265; expedited review) and the State of Delaware's Health and Social Services institutional review board (#16-09A).

REFERENCES

1. Choi YS, Rendall MS, Boudreaux M, Roby DH. Summary of the Delaware Contraceptive Access Now (DelCAN) initiative. Delaware Contraceptive Access Now. 2020. Available at: https://popcenter.umd.edu/delcaneval/summary-init. Accessed July 2, 2021.
2. Upstream USA. Improving care across the nation. 2021. Available at: https://upstream.org/our-work. Accessed July 1, 2021.
3. Marthey D, Rashid H, Xie L, Boudreaux M. An evaluation of the Be Your Own Baby public awareness campaign. *Health Serv Res.* 2021;56(5):766–776. https://doi.org/10.1111/1475-6773.13698
4. Boudreaux M, Xie L, Choi YS, Roby DH, Rendall MS. Changes to contraceptive method use at Title X clinics following Delaware Contraceptive Access Now, 2008–2017. *Am J Public Health.* 2020;110(8):1214–1220. https://doi.org/10.2105/AJPH.2020.305666
5. Darney BG, Jacob RL, Hoopes M, et al. Evaluation of Medicaid expansion under the Affordable Care Act and contraceptive care in US community health centers. *JAMA Netw Open.* 2020;3(6):e206874. https://doi.org/10.1001/jamanetworkopen.2020.6874
6. Biggs MA, Harper CC, Brindis CD. California family planning health care providers' challenges to same-day long-acting reversible contraception provision. Obstet Gynecol. 2015;126(2):338–345. https://doi.org/10.1097/AOG.0000000000000969
7. Gomez AM, Fuentes L, Allina A. Women or LARC first? Reproductive autonomy and the promotion of long-acting reversible contraceptive methods. Perspect Sex Reprod Health. 2014;46(3):171–175. https://doi.org/10.1363/46e1614
8. Brandi K, Fuentes L. The history of tiered-effectiveness contraceptive counseling and the importance of patient-centered family planning care. *Am J Obstet Gynecol.* 2020;222(4S):S873–S877. https://doi.org/10.1016/j.ajog.2019.11.1271
9. Manzer JL, Bell AV. "We're a little biased": medicine and the management of bias through the case of contraception. *J Health Soc Behav.* 2021;62(2):120–135. https://doi.org/10.1177/00221465211003232
10. Dehlendorf C, Ruskin R, Grumbach K, et al. Recommendations for intrauterine contraception: a randomized trial of the effects of patients' race/ethnicity and socioeconomic status. *Am J Obstet Gynecol.* 2010;203(4):319e1–e8. https://doi.org/10.1016/j.ajog.2010.05.009
11. DelCAN Evaluation Team. Evaluation of the Delaware Contraceptive Access Now initiative. 2022. Available at: https://popcenter.umd.edu/delcaneval/evaluation. Accessed April 15, 2022, 2022.



Impacts of a Statewide Effort to Expand Contraceptive Access in New Mexico, 2014–2020

Wanicha Burapa, MD, MPH, Jeremy R. Martinez, MBA, and Katharine Winkel Daniel, MS, CHES

Two New Mexico state agencies implemented a statewide contraceptive access initiative in a sizable rural border state through the provision of low- or no-cost contraception, provider training and technical assistance, public awareness campaigns, and policy changes. These interventions resulted in successful expansion of reproductive health services provision and contraceptive use among Medicaid-enrolled adolescents and young women of reproductive age between 2014 and 2020. These findings demonstrate how multilevel interventions can expand contraceptive access, even in rural limited-provider settings.

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New Mexico is a border state where half of the multicultural population reside in the metro Albuquerque area and the rest are in sparsely populated large rural and frontier counties. Expanding contraceptive access across New Mexico to meet varying reproductive health needs and to assist New Mexicans with achieving planned and preventing unplanned pregnancy requires coordinated statewide action.

INTERVENTION

A long-standing collaboration between the New Mexico Department of Health Family Planning Program (the New Mexico Title X[1] grantee) and the Medical Assistance Division of the New Mexico Human Services Department, which administers the Medicaid Program, led to the implementation of a multilevel statewide initiative to expand contraceptive access, through the provision of low- or no-cost contraception, provider training and technical assistance, and policy changes. The New Mexico intervention components were aligned with the conceptual framework proposed by the Association of State and Territorial Health Officials and the Coalition to Expand Contraceptive Access (Malcolm et al., p. S473).

PLACE AND TIME

This article describes ongoing efforts to implement a statewide contraceptive access initiative across the state of New Mexico between 2014 and 2020.

PERSONS

While the initiative reached individuals across the state, our analysis assesses the impact on reproductive health services provision and contraceptive use among Medicaid-enrolled adolescents and young women who generally reported high rates of unplanned pregnancy.

PURPOSE

The purpose of the New Mexico statewide initiative is to expand access to a broad range of reproductive health services and contraceptive methods across the state.

IMPLEMENTATION

The four main strategies are contraception cost, training and technical assistance, public awareness campaigns, and policy changes.

Provision of Low- or No-Cost Contraception

Sixty New Mexico Title X clinics, including 30 New Mexico Department of Health public health clinics that are both Title X and Medicaid providers, provide all US Food and Drug Administration–approved contraceptives on site at low or no cost, and receive Medicaid reimbursements when applicable.

In 2013, Medicaid allowed for separate reimbursement of long-acting reversible contraceptive (LARC) devices and procedures provided during the immediate postpartum period.[2] To expand access in an outpatient setting, Medicaid unbundled LARC devices from the encounter rate, effective September 1, 2016, to ensure that clients served at federally qualified health centers and rural health clinics have access.[3] This was followed by a 100% or greater increase in Medicaid LARC device and procedure payment rates in all clinical settings on January 1, 2020.[4]

Training and Technical Assistance

In December 2016, the New Mexico State Legislature appropriated funds to a University of New Mexico LARC Mentoring Program. This program offered statewide training, including publicly funded clinics, on contraceptive counseling and provision to clinicians and clinic staff, and Webinars on shared decision-making and reimbursement. With Medicaid administrative matching funds, the LARC Mentoring Program provided procedure trainings to 148 Medicaid clinicians on implants, 174 clinicians on intrauterine devices, and 18 clinicians on immediate postpartum LARC.

In the same year, the Family Planning Program and University of New Mexico launched the virtual reproductive health clinic using the Extension for Community Healthcare Outcomes model. The bimonthly, one-hour didactic presentations and case-based discussions are geared toward clinicians and other health care professionals to disseminate best practices, increase reproductive health service provision knowledge and self-efficacy, and improve access to resources in the practitioner's community. Trainings also promoted client-centered approaches to reproductive health services. In 2020, the clinic offered 19 sessions, had 37 attendees per session on average, and awarded more than 400 continuing education credit hours to 246 multidisciplinary professional attendees.

Public Awareness Campaign

Between October 2016 and June 2019, the Family Planning Program conducted statewide LARC public awareness campaigns intended to reach young adults aged 13 to 19 years about the availability and appropriateness of the contraceptive implant (six multiple modality campaigns that ran at least one month each). The campaigns used Internet ads on popular Web sites and mobile games, advertisements before movies showing in theaters, and geo-tracking cell phones belonging to adolescents entering specific, adolescent-popular spaces, such as malls, movie theaters, and schools. The ads were designed by Bedsider with "tag lines" that appealed to adolescents and young adults about LARC with racially/ethnically diverse models that looked like New Mexico young adults.[5]

Policy Changes

Over the past two decades, New Mexico implemented public policies to improve reproductive health that include service learning and positive youth development programs, comprehensive sex education, adult–adolescent communication programs,[6] Medicaid Family Planning Expansion, Medicaid expansion (beginning in 2014), confidential contraceptive services for minors in Title X and Medicaid settings, pharmacist-prescribed hormonal contraception, extended supply of some prescription contraceptives, codifying the Affordable Care Act contraceptive coverage provision,[7] and a combination of clinic- and telemedicine-based family-planning services at some public health clinics.

EVALUATION

We examined trends in quarterly unduplicated numbers of Medicaid-enrolled women aged 24 years or younger who had full benefits and claims reflecting either moderately effective (MOD; injectable, pill, patch, vaginal ring, and diaphragm) contraception or noncumulative LARC (intrauterine device and implant) use from 2014 to 2020. A client was counted only once as either using a LARC or a MOD (with no LARC claim) in each quarter. We also examined trends in quarterly numbers of Medicaid providers who rendered services to these clients. Figure 1 reports data on both outcomes.

Bar graphs show MOD and LARC claims data. The magnitude of changes in numbers of adolescent (aged ≤ 18 years) and young woman (aged 19–24 years) users observed during this period are as follows: adolescent LARC users increased from 11 to 368 per quarter (33-fold), and adolescent MOD users increased from 43 to 1815 per quarter (42-fold). For young women, LARC users increased from 87 to 420, and MOD users increased from 350 to 1369 (both approximately four-fold increases).

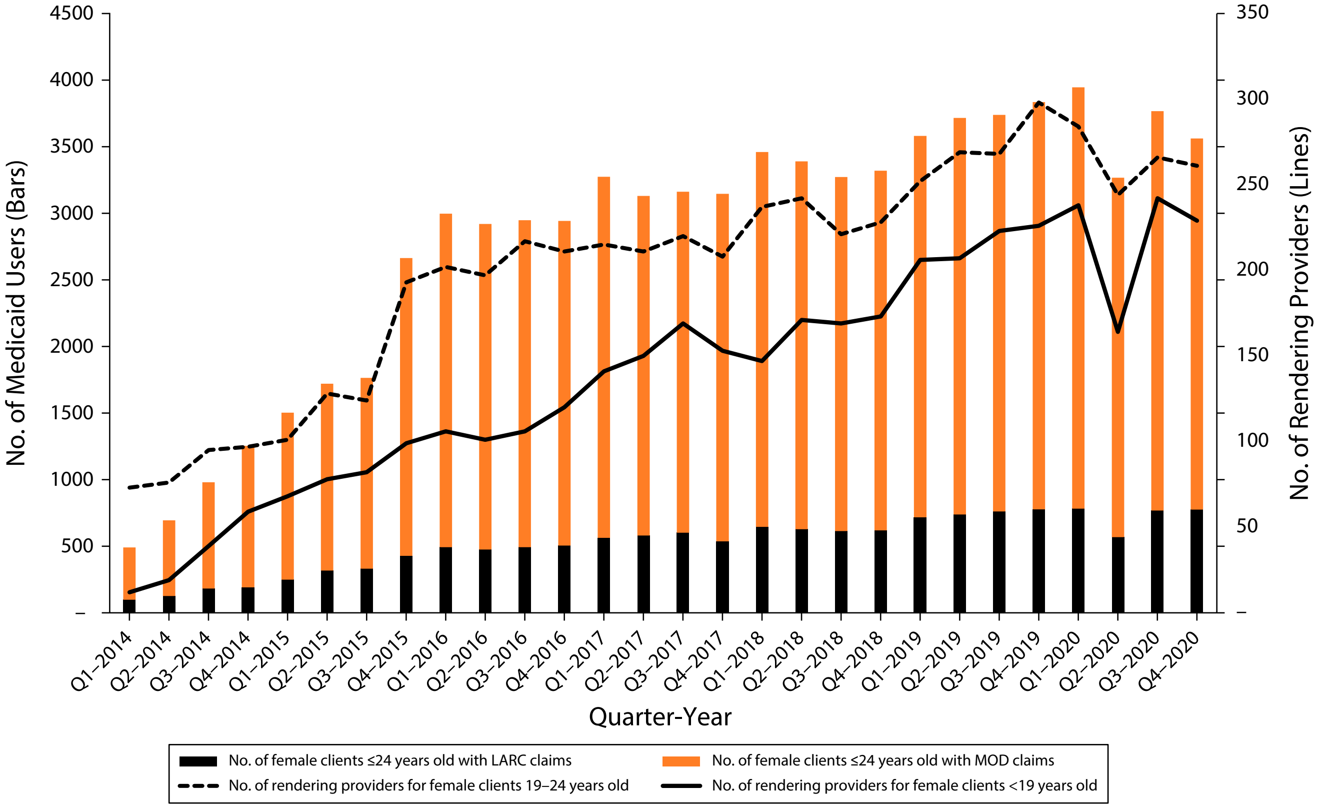

FIGURE 1— **Combined Numbers of New Mexico Medicaid-Enrolled Adolescent and Young Female Clients Who Received Long-Acting Reversible (LARC) and Moderately Effective (MOD) Contraceptive Methods and Numbers of New Mexico Medicaid Providers Who Rendered These Services to Each Group: 2014–2020, Quarterly**

Note. Numbers shown separately in two line-graphs. The solid line represents providers who rendered services to adolescents, and the dashed line represents providers who rendered services to young women. LARC and MOD contraceptive methods are shown in black and orange bars, respectively.
Source. New Mexico Medicaid Management Information System, New Mexico Human Services Department, Medical Assistance Division.

A decrease in LARC and MOD use in the second quarter of 2020 may have been an effect of limited nonessential clinical services during the COVID-19 pandemic.

The numbers of rendering providers to adolescents have increased 20-fold, from 12 to 242 per quarter and to young women from 73 to 298 per quarter (a four-fold increase).

A separate analysis of quarterly LARC usage rate among public health clinic clients through the billing and electronic health record system was conducted during the digital advertising campaign. The use of LARC in the public health clinics increased in the quarter following the campaign activities: usage in females aged 15 to 19 years increased from 12% in July–September 2016 to 21% in July–September 2019 (a 75% increase) with considerably higher rates during the quarters with the advertising campaigns.

ADVERSE EFFECTS

No adverse effects were assessed in this evaluation. However, potential risks may include that non–Title X community providers prioritize Medicaid clients in provision of costly contraceptive methods. In New Mexico, this risk is mitigated with the availability of safety-net Title X clinics providing comprehensive family-planning services in almost all 33 counties.

SUSTAINABILITY

Statewide contraceptive access initiatives can offer a sustainable method to expand contraceptive access when a coalition of committed organizations are engaged and client-centered approaches are prioritized. With continued funding from the state legislature and commitment from Medicaid and University of New Mexico, new and existing providers acquired and maintained the skills and appropriate reimbursements necessary to provide essential services statewide. An increase in Medicaid-rendering providers, especially in rural areas, helped expand access to contraceptive services.

PUBLIC HEALTH SIGNIFICANCE

Title X and Medicaid have played a critical role in ensuring access to a broad range of contraceptives for individuals with limited access.[1] Our findings demonstrated an increase in the number of young Medicaid-enrolled clients who used an effective contraceptive method, either a MOD or LARC, following implementation of a statewide contraceptive access initiative. Statewide initiatives involving multilevel interventions, including clinical support and changes in public policy, can act in concert to expand contraceptive access, even in rural settings with limited numbers of providers. AJPH

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CONTRIBUTORS

W. Burapa originated, supervised, and assisted with the study and analyses, and collaborated with the writing. J. R. Martinez queried for the data and completed the analyses. K. W. Daniel supervised the study, completed the analyses, and led the writing.

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The authors wish to use this publication to describe, record, and share with the public the New Mexico initiative that could not have happened without the support and hard work of many New Mexicans. We would like to specifically thank the following staff for their dedicated work to implement the initiative over the study period: Kari Armijo, BA, New Mexico Human Services Department, Santa Fe; Robert Stevens, RPh (retired), Erica Archuleta, MEd, and April Neri, RN, Medical Assistance Division, New Mexico Human Services Department; Peg Ickes, FNP-BC, and Susan Lovett, MPH (retired), Family Planning Program, Public Health Division, New Mexico Department of Health, Santa Fe.

CONFLICTS OF INTEREST

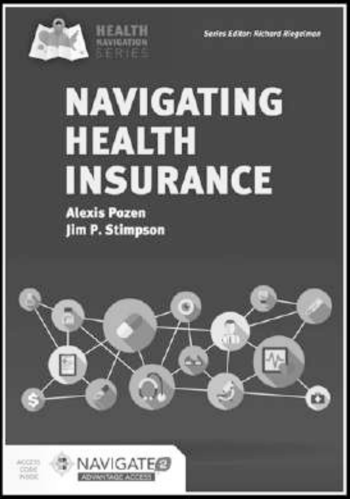
The authors have no potential or actual conflicts of interest to disclose.

HUMAN PARTICIPANT PROTECTION

The authors of this article did not obtain an institutional review board approval because of the nature of the data collected and analyzed. All data were aggregated, and no individually identifiable information was reported.

REFERENCES

1. US Department of Health and Human Services Office of Population Affairs. About Title X Service Grants. May 18, 2021. Available at: https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants. Accessed September 23, 2021.
2. New Mexico Human Services Department. Medicaid Supplement Number 13-05. April 1, 2013. Available at: https://www.hsd.state.nm.us/wp-content/uploads/FileLinks/c78b68d063e04ce5adffe29376ff402e/MAD_SUPP_13_05_Supplement__Hyst_Consent_Form_91213_final__2_.pdf. Accessed February 11, 2022.
3. New Mexico Human Services Department. Medicaid Supplement Number 16-09. September 16, 2016. Available at: https://www.hsd.state.nm.us/wp-content/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/Supplements%20for%20MAD%20NMAC%20Program%20Rules/Supplement-16-09.pdf. Accessed February 11, 2022.
4. New Mexico Human Services Department. Medicaid Letter of Direction Number 28-1. November 23, 2020. Available at: https://www.hsd.state.nm.us/wp-content/uploads/FileLinks/63e11e4bdee34c68b133c1607f22bc54/LOD28_1_Medicaid_Provider_Payment_Rates_FINAL.pdf. Accessed February 11, 2022.
5. Power to Decide. Whoops proof birth control: increasing awareness and positive regard for IUDs and the implant through an advertising campaign. 2017. Available at: https://powertodecide.org/sites/default/files/resources/primary-download/whoops-proof-birth-control-2017.pdf. Accessed February 14, 2022.
6. As-Sanie S, Gantt A, Rosenthal MS. Pregnancy prevention in adolescents. *Am Fam Physician*. 2004;70(8):1517–1524.
7. Power to Decide. Key state policies at a glance as of September 1, 2020. October 2022. Available at: https://powertodecide.org/sites/default/files/2020-10/Key%20State%20Policies%20at%20a%20Glance.pdf. Accessed September 23, 2021.



Telehealth for Contraceptive Care During the COVID-19 Pandemic: Results of a 2021 National Survey

Laura D. Lindberg, PhD, Jennifer Mueller, MPH, Madeleine Haas, BA, and Rachel K. Jones, PhD

Objectives. To investigate trends in the use and quality of telehealth for contraceptive care during the COVID-19 pandemic in the United States.

Methods. The 2021 Guttmacher Survey of Reproductive Health Experiences is a national online survey of 6211 people assigned female at birth, aged 18 to 49 years, and that ever had penile–vaginal sex. We used weighted bivariable and multivariable logistic regressions to analyze the use of telehealth for contraceptive care and the quality of this care.

Results. Of the respondents, 34% received a contraceptive service in the 6 months before the survey; of this group, 17% utilized telehealth. Respondents who were uninsured at some point in the 6 months before the survey had greater odds of using telehealth for this care. Respondents had lower odds of rating the person-centeredness of their care as "excellent" if they received services via telehealth compared with in person (25% vs 39%).

Conclusions. Telehealth has helped bridge gaps in contraceptive care deepened by COVID-19. More work is needed to improve the quality of care and reduce access barriers to ensure telehealth can meet its full potential as part of a spectrum of care options. (*Am J Public Health*. 2022;112(S5):S545–S554. https://doi.org/10.2105/AJPH.2022.306886)

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The disruption of the COVID-19 pandemic exacerbated logistical barriers to obtaining sexual and reproductive health care, including restrictions on and concerns about providing in-person care.[1,2] Early in the pandemic, 1 in 3 women reported cancellations or delays in getting sexual and reproductive health care or contraceptive methods. These barriers to care disproportionately affected groups already experiencing systemic inequities based on race, sexual orientation, and income.[3] Providers sought strategies to meet patients' needs, and telehealth emerged as a means to increase access to contraceptive care by delivering services that do not rely on patients meeting with a health care provider in person at the same physical location.[4,5]

While there is no firm agreement on terms, generally, telemedicine refers to patient–provider visits delivered virtually. In contrast, telehealth goes beyond the provider–patient dyad, including direct-to-consumer platforms that enable patients to obtain medical advice and treatment without a previous doctor–patient relationship.[6,7] We rely on the phrase "telehealth" here to encompass a range of service modalities used to provide aspects of contraceptive care, including contraceptive counseling, a related checkup or medical test, or a prescription for a method or the contraceptive method itself.

Before the pandemic, telemedicine in contraceptive care was limited in frequency and scope because, in part, of complicated billing requirements and other regulations.[8] The pandemic catalyzed these systems to be simplified and improved, with significant changes to the complex rules for online prescribing, licensing, reimbursement, and coverage that have been barriers to telehealth. The 2020 Coronavirus Aid, Relief, and Economic Security Act introduced many regulatory changes,[9] and state Medicaid programs and commercial insurance plans temporarily modified policies to support the expansion of telehealth.[10–12] These changes allowed many providers and family planning clinics, including the publicly funded Title X clinics providing care to about 3 million women in 2019 before the pandemic,[13] to implement new telemedicine services for contraceptive care without an in-person office visit.[14]

By June 2020, a study of office-based obstetricians/gynecologists found that 84% were conducting telehealth visits for a range of services, compared with 12% before March 1, 2020.[4] In addition, the number of direct-to-consumer platforms for contraception and demand for their services also increased, including sites such as The Pill Club, Pandia, and GoodRx.[15–17] However, most online platforms do not accept insurance or Medicaid and do not offer sliding fee scale options for uninsured individuals.[14] Despite these shifts in the provider landscape, the Kaiser Family Foundation Women's Health Survey conducted online in late 2020 found that only 5% of women who reported using a contraceptive method in the past 12 months obtained their contraception through a phone or video visit, Web site, or app.[18] Even with this relatively low level of use, one estimate is that almost half of those using telehealth for contraceptive care were new users since the pandemic.[19] Information on demographic differentials on who uses telehealth for contraceptive care is lacking, raising questions about how telehealth can reduce the existing inequities in health care.

Even as access to telehealth for contraceptive care has increased, there is limited information on the quality of this care or patient satisfaction. A 2020 systematic review of telemedicine for contraceptive care found limited assessments of its quality.[20] One study during the pandemic found that two thirds of young women surveyed agree that telehealth is an acceptable way to get birth control.[21] An online platform surveyed users and found that nearly all planned to continue to get contraception through telehealth after the pandemic ended, suggesting satisfaction with this form of care.[22]

Patient-centeredness has been increasingly recognized as a critical component of the quality of family planning.[23] Patient-centeredness prioritizes patients' preferences through a high level of interpersonal care, support of patients' decision-making, and information sharing.[24] Previous research has examined patient-centered care as a quality indicator of in-person contraceptive care. However, rapid changes in the health care system mean there is little information on the extent to which telehealth offers patient-centered care. While there are other domains of health care quality, such as its safety, timeliness, and efficiency,[25] focusing on patient-centeredness as a quality metric is of particular importance for reproductive autonomy.[26,27]

The Coalition to Expand Contraceptive Access led a recent multidisciplinary effort that identified telehealth as a priority area for health policy–focused contraceptive research.[28] Comprehensive and timely study of the prevalence and patterns of telehealth for contraceptive care is lacking. Most research in this area has focused on providers, but it is vital to incorporate patient experiences and perspectives. While the 2020 Kaiser Family Foundation study provided a valuable snapshot of utilization, low rates resulted in many issues that could not be investigated, including characteristics of those using telehealth and their evaluation of the quality of this care.[18]

Given the need for timely research about this modality of care from patient perspectives, we used national data collected from respondents in July and August 2021 to examine their recent use of telehealth for contraceptive care. We identified characteristics of those using telehealth and used a validated scale of patient-centered care to examine respondents' self-evaluation of the quality of the care.[24] This work helps expand the evidence base around telehealth use, quality, and equity as an emergent approach to contraceptive care.

METHODS

Secondary data for these analyses came from the 2021 Guttmacher Survey of Reproductive Health Experiences, an online survey conducted in July and August 2021 to focus on contraceptive behaviors and service utilization.[19] NORC at the University of Chicago managed survey recruitment and fielding. They recruited through a dual-sampling approach using NORC's AmeriSpeak panel, a probability-based panel designed to be representative of the US household population, and Dynata's nonprobability online opt-in panel, which uses enrollment targets for age, race/ethnicity, and education to ensure the sample composition aligned with the US census population. This dual-sampling approach maximizes sample size to permit robust analysis of less-prevalent behaviors like telehealth use.

Eligible study participants were those assigned female at birth, aged 18 to 49 years, residing in a US household, who had ever had penile–vaginal sex, and who could complete surveys in English. Participants provided informed consent and received a nominal incentive. The final analytic sample for this analysis consisted of 6211 complete responses (3129 AmeriSpeak, 3082 Dynata).

Measures

Respondents reported contraceptive services received within the 6 months preceding the survey including a contraceptive method, prescription for a method, or refill of a method; counseling or information about contraception; or a checkup, medical test, or other service related to using a contraceptive method. The survey asked source of care for the most recent service from the following categories: in-person visit with health care provider, telehealth visit with health care provider, online contraception Web site or app (e.g., The Pill Club, Pandia Health, GoodRx), or pharmacy or drug store (13 respondents who obtained care from another or an undetermined source were excluded from the analysis). For clarification, the survey stated, "A telemedicine or telehealth visit is an appointment with a provider conducted by telephone or video conference in place of an in-person visit." Those who had a telehealth visit with a provider reported if the visit occurred by video, phone only, or some other mode. Unless otherwise specified, we used a composite telehealth use measure that includes telehealth with a health care provider, online contraceptive Web site, or app. We adapted this strategy to maximize the number of respondents for relevant analyses; in addition, it addressed concerns that respondents may not consistently distinguish between telehealth from a health care provider versus an online Web site or app, such as if online care included provider–patient interaction.

Respondents who received a contraceptive service reported how they paid for their most recent contraceptive service and could select more than 1 option; we created a combined variable prioritizing self-pay, then insurance, and then free. Type of provider was identified as a private provider or other providers (family planning clinic, community health center, public health clinic, school-based clinic, urgent care center, emergency department).

Among those reporting telehealth for their most recent contraceptive service, respondents were asked their reasons for use compared with in-person services; they could identify multiple reasons, which we combined thematically.

Respondents rated the contraceptive care they received from a provider, whether in-person or telehealth, using the Person-Centered Contraceptive Counseling (PCCC) scale. (We did not ask the PCCC scale for contraceptive care received from a pharmacy or drug store, as this may not have included counseling from a pharmacist.) This scale has respondents evaluate provider performance across 4 items: "respecting you as a person," "letting you say what mattered to you about your contraception," "taking your preferences about your contraception seriously," and "giving you enough information to make the best decision about your contraceptive method."[24] Following the approach suggested by Dehlendorf et al.,[24] we created a dichotomous indicator of respondents reporting "excellent" on all 4 items versus all other response combinations.

We collected self-reported demographic information for respondents and measured race/ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic, non-Hispanic Asian/Pacific Islander, and non-Hispanic other/multiple races), marital status (married/living with partner, other), education level (high school or less, some college, college graduate or above), and uninsured in the 6 months before the survey (yes or no). We calculated household income as greater than or equal to 200% or less than 200% of the federal poverty level.[29] Respondents were asked to report their sexual orientation with 1 or more of the following responses: straight, lesbian or gay, bisexual or pansexual, and other; we combined all responses other than straight into a single "LGB+" category. Respondents were asked to report their gender identity with 1 or more of the following responses: woman, man, nonbinary, transgender, and other; those who solely answered "woman" were coded as cisgender, while all others were coded as "transgender/nonbinary/other." Other characteristics included metropolitan area status (metro area, nonmetro area) and penile–vaginal sex the 6 months before the survey (yes or no).

Analysis

We estimated the proportion of respondents who received a contraceptive service in the 6 months before the survey and examined variation in provider modality by payment method and type of provider by using the χ^2 test. We also examined variation in the use of telehealth and the PCCC scale by provider modality in this narrowed population. For both outcomes, we used bivariable logistic regression to examine variation by demographic characteristics and multivariable logistic regression, including variables associated with the outcomes at $P < .10$ in the bivariable models. The PCCC models were limited to respondents who received contraceptive care from a provider, whether in person or through telehealth. In the multivariable model, we tested for an interaction between Internet quality and modality of care to examine if respondents' Internet quality differentially influenced the PCCC scale.

For all analyses, we used Stata version 17.0 (StataCorp LP, College Station, TX) with panel weights provided by NORC that combine the completed AmeriSpeak panel and nonprobability online interviews using their TrueNorth calibration weighting service to be representative of the US population of women aged 18 to 49 years who have ever had penile–vaginal sex.

RESULTS

Overall, 34% of the sample received a contraceptive service during the 6 months preceding the interview; 6% of the overall sample used telehealth for their most recent visit (Table 1). Among respondents receiving a contraceptive service, 17% reported using telehealth (8% with a provider, 9% online) at their most recent visit, 50% saw an in-person provider, and 33% received a contraceptive service from a pharmacy or drug store.

In both the overall sample and among the subsample of respondents who received contraceptive care, about half lived in a household with an income greater than or equal to 200% of the federal poverty level, were non-Hispanic White, were married or living with a partner, and had graduated college. Most identified as straight, identified as cisgender, were insured in the 6 months before the survey, lived in metropolitan areas, and had penile–vaginal sex in the 6 months before the survey.

Among the 367 respondents who had used telehealth for contraceptive care, respondents gave a range of responses for why they used telehealth, with "It was easier to go online than visiting a health care provider in-person" as the most common response (45%). One third indicated that their or their provider's concerns about COVID-19 motivated their use of telehealth. Of users, about 20% gave lower cost and increased confidentiality as reasons for their telehealth use, and 11% used telehealth because they did not have a regular provider (Figure A, available as a supplement to the online version of this article at https://ajph.org).

TABLE 1— Percentage Distribution of Respondents by Receipt of Services and Demographic Characteristics: United States, 2021

Characteristics	Among Full Sample (n = 6211), % (95% CI)	Among Those Who Received a Contraceptive Service (n = 2079), % (95% CI)
Receipt of services		
Received any contraceptive service in the 6 mo before the survey	34 (32, 35)	100
Type of provider for most recent contraceptive service		
In-person	17 (15, 18)	50 (47, 52)
Telehealth	6 (5, 6)	17 (15, 19)
With provider	3 (2, 3)	8 (6, 9)
Online platform	3 (3, 4)	9 (8, 11)
Pharmacy	11 (10, 12)	33 (31, 36)
Demographic characteristics		
Age, y		
18–27	16 (15, 18)	27 (25, 30)
28–38	35 (33, 36)	38 (35, 40)
39–49	49 (48, 51)	35 (33, 38)
Household income[a]		
< 200% of the federal poverty level	43 (42, 45)	46 (43, 48)
≥ 200% of the federal poverty level	57 (55, 58)	54 (52, 57)
Race/ethnicity		
Non-Hispanic White	55 (54, 57)	50 (47, 53)
Non-Hispanic Black	14 (13, 15)	17 (15, 18)
Hispanic	21 (19, 22)	24 (21, 26)
Non-Hispanic Asian/Pacific Islander	5 (5, 6)	5 (4, 6)
Non-Hispanic other/multiple races	5 (4, 6)	5 (4, 6)
Marital status		
Married/living with partner	62 (61, 64)	55 (52, 57)
Other	38 (36, 39)	45 (43, 48)
Education		
High school or less	28 (27, 30)	27 (25, 30)
Some college	29 (28, 31)	28 (26, 31)
College graduate or above	43 (41, 44)	45 (42, 47)
Sexual orientation[b]		
Straight	85 (84, 86)	82 (80, 84)
LGB+	15 (14, 16)	18 (16, 20)
Gender[c]		
Cisgender	98 (98, 99)	97 (95, 98)
Transgender/nonbinary/other	2 (1, 2)	3 (2, 5)
Health insurance status in the 6 mo before the survey		
Insured	80 (79, 81)	74 (72, 76)
Uninsured	20 (19, 21)	26 (24, 28)
Metropolitan statistical area status		
Nonmetro	14 (13, 15)	11 (9, 12)
Metro	86 (85, 87)	89 (88, 91)

Continued

TABLE 1— Continued

Characteristics	Among Full Sample (n = 6211), % (95% CI)	Among Those Who Received a Contraceptive Service (n = 2079), % (95% CI)
Internet access quality		
Excellent	76 (75, 77)	76 (73, 78)
Good/average/poor	24 (23, 25)	24 (22, 27)
Had penile–vaginal sex in the 6 mo before the survey		
No	9 (8, 10)	3 (2, 3)
Yes	91 (90, 92)	97 (97, 98)

Note. CI = confidence interval; LGB+ = lesbian, gay, bisexual, and others (includes all responses other than straight).

[a] Federal poverty level according to US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.[29]
[b] Respondents were asked to report their sexual orientation with 1 or more of the following responses: straight, lesbian or gay, bisexual or pansexual, and other. We combined all responses other than straight into a single "LGB+" category.
[c] Respondents were asked to report their gender identity with 1 or more of the following responses: woman, man, nonbinary, transgender, and other. Those who solely answered "woman" were coded as cisgender, while all others were coded as transgender/nonbinary/other for analysis.

Respondents' payment methods differed significantly by the source of care. More telehealth users paid out of pocket for care than those receiving contraceptive care in person or from a pharmacy (36% vs 22% vs 23%; Table 2). Respondents were less likely to pay with insurance for telehealth than in-person or pharmacy-provided care (45% vs 62% vs 61%). In addition, there was significant variation by type of provider. Telehealth was relatively evenly divided between private (53%) and other providers (47%). In contrast, about two thirds of in-person care was from private providers. Among those receiving telehealth from a provider, a similar proportion of respondents used video (52%) or phone (48%; not shown).

Receiving Services by Telehealth

In bivariable models, use of telehealth compared with other sources of care had significantly higher odds among respondents who were uninsured in the 6 months before the survey; had incomes less than 200% of the federal poverty level; were non-Hispanic Black, Hispanic, or non-Hispanic Asian/Pacific Islander; or were living in a metro area, compared with their peers (Table 3). In the bivariable model, there was some evidence that transgender/nonbinary/other respondents had higher odds than cisgender respondents of using telehealth than other sources of care for their contraceptive care (odds ratio [OR] = 2.36; 95% confidence interval [CI] = 0.95, 5.86). There was no variation in the likelihood of using telehealth compared with other sources of care by education, age, sexual orientation, Internet quality, or sexual activity.

In the multivariable model, only uninsured respondents had significantly higher adjusted odds of using telehealth (adjusted odds ratio [AOR] = 2.59; 95% CI = 1.92, 3.51) than those with insurance after controlling for

TABLE 2— Payment Method and Type of Provider Among Those Who Received a Contraceptive Service in the 6 Months Before the Survey: United States, 2021

Characteristics	Total (n = 2079), %	In-Person (n = 1001), %	Telehealth (n = 367), %	Pharmacy (n = 651), %	*P*
Payment method					< .001
Self-pay	25	22	36	23	
Insurance	59	62	45	61	
Free	16	16	19	16	
Type of provider					.01
Private	65	67	53	NA	
Other provider[a]	35	33	47	NA	

Note. NA = not applicable.

[a] Other provider includes family planning clinic, other clinic (community health center, public health clinic, school-based clinic), some other place (urgent care center or emergency room), and any other place.

TABLE 3— Use of Telehealth for Contraceptive Services Among Those Who Received a Contraceptive Service in the 6 Months Before the Survey, by Demographic Characteristics

	%	OR (95% CI)	AOR (95% CI)
Total	17		
Health insurance status in the 6 mo before the survey			
Insured	12	1 (Ref)	1 (Ref)
Uninsured	29	2.93 (2.18, 3.93)	2.59 (1.92, 3.51)
Household income[a]			
< 200% of the federal poverty level	20	1 (Ref)	1 (Ref)
≥ 200% of the federal poverty level	15	0.69 (0.53, 0.91)	0.90 (0.67, 1.22)
Race/ethnicity			
Non-Hispanic White	13	1 (Ref)	1 (Ref)
Non-Hispanic Black	23	1.91 (1.34, 2.72)	1.36 (0.94, 1.97)
Hispanic	21	1.76 (1.24, 2.52)	1.35 (0.93, 1.98)
Non-Hispanic Asian/Pacific Islander	23	1.92 (1.15, 3.21)	1.59 (0.91, 2.76)
Non-Hispanic other/multiple races	11	0.85 (0.40, 1.83)	0.77 (0.34, 1.75)
Metropolitan statistical area status			
Nonmetro	11	1 (Ref)	1 (Ref)
Metro	18	1.66 (1.05, 2.61)	1.56 (0.97, 2.50)
Gender[b]			
Cisgender	17	1 (Ref)	1 (Ref)
Transgender/nonbinary/other	32	2.36 (0.95, 5.86)	1.66 (0.67, 4.09)
Education			
High school or less	17	1 (Ref)	
Some college	18	1.11 (0.75, 1.64)	
College graduate or above	16	0.98 (0.68, 1.42)	
Age, y			
18–27	18	1 (Ref)	
28–38	16	0.82 (0.59, 1.15)	
39–49	17	0.94 (0.66, 1.34)	
Sexual orientation[c]			
Straight	17	1 (Ref)	
LGB+	18	1.12 (0.80, 1.57)	
Internet access quality			
Excellent	16	1 (Ref)	
Good/average/poor	19	1.21 (0.89, 1.66)	
Had penile–vaginal sex in the 6 mo before the survey			
No	18	1 (Ref)	
Yes	17	0.97 (0.42, 2.21)	

Note. AOR = adjusted odds ratio; CI = confidence interval; LGB+ = lesbian, gay, bisexual, and others (includes all responses other than straight); OR = unadjusted odds ratio. The sample size was n = 2079.

[a] Federal poverty level according to US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.[29]

[b] Respondents were asked to report their gender identity with 1 or more of the following responses: woman, man, nonbinary, transgender, and other. Those who solely answered "woman" were coded as cisgender, while all others were coded as transgender/nonbinary/other for analysis.

[c] Respondents were asked to report their sexual orientation with 1 or more of the following responses: straight, lesbian or gay, bisexual or pansexual, and other. We combined all responses other than straight into a single "LGB+" category.

household income, race/ethnicity, metropolitan status, and gender. These findings were similar in models that separately examined telehealth from a provider and care from a contraceptive Web site or app (not shown).

Patient-Centered Quality of Care

Overall, 37% of respondents rated their most recent contraceptive care provider as "excellent" on all 4 person-centered contraceptive counseling items. There is evidence that respondents were less likely to rate the patient-centeredness of their contraceptive counseling as "excellent" if they received care by telehealth compared with in person in both bivariable (OR = 0.51; 95% CI = 0.31, 0.82) and multivariable (AOR = 0.57; 95% CI = 0.35, 0.92) models (Table 4). The pattern was similar for the 4 component items (not shown). In the multivariable models, respondents without health insurance (AOR = 0.37; 95% CI = 0.24, 0.58); non-Hispanic Black (AOR = 0.53; 95% CI = 0.34, 0.82), Hispanic (AOR = 0.64; 95% CI = 0.41, 0.98), and non-Hispanic Asian/Pacific Islander (AOR = 0.32; 95% CI = 0.16, 0.66) respondents; and respondents with poorer Internet access (AOR = 0.35; 95% CI = 0.23, 0.53) had significantly lower odds than their peers of uniformly excellent scores on the PCCC scale. Household income and education were associated with the PCCC in the bivariable, but not multivariable, models. An interaction test indicated that telehealth's PCCC score did not vary by respondents' Internet quality (not shown).

DISCUSSION

This study demonstrates the extent to which individuals obtained contraceptive services using telehealth during the second year of the COVID-19 pandemic. Nearly 1 in 5 survey respondents used telehealth for contraceptive care. Respondents rated their telehealth from a provider as being less patient-centered than those receiving services in person, highlighting the need to improve telehealth experiences. Telehealth appears to have increased access to contraceptive care during a public health crisis, especially for individuals who are lower-income, Black, Hispanic, Asian/Pacific Islander, living in metro areas, and uninsured. The investment in and development of telehealth infrastructure, and users' initial experiences with this care, may promote this care even as the constraints of the pandemic recede.

The changing health care landscape of the pandemic showed that, for many people, telehealth offers benefits for their contraceptive care. Policies should reflect that telehealth can safely and effectively provide contraceptive care and other sexual and reproductive health services.[20,30] It is essential that sustainable reimbursement rates continue even after the pandemic. Legislation around telehealth is complex and rapidly changing; according to the Center for Connected Health Policy, all 50 states currently have pending telehealth legislation under consideration.[31] Given this dynamic policy environment, providers need support in adapting to the changing policy environments, and potential users need information and education about shifts in service availability and attributes.

These data offered uneven evidence of telehealth's role in improving access to contraception for traditionally underserved groups. Low-income respondents and respondents of color were more likely to use telehealth, but LGB+ respondents and rural respondents were not. This last finding is particularly noteworthy, given the expectation that telehealth could offer opportunities in settings where in-person care is less available. It may reflect difficulties in pivoting to telehealth during the pandemic among rural providers. We did not find evidence that reduced Internet quality was a distinct barrier to obtaining telehealth contraceptive care; this has been raised as a potential barrier for rural communities for telehealth for other health care issues, especially with older populations.[32]

The greater use of telehealth among transgender and nonbinary respondents than among cisgender respondents suggests the need for more research in this area. As gender-affirming care becomes increasingly challenging to access, transgender people may find telehealth an available mechanism to access a broad range of health care needs, including contraception.[33] Beyond gender identity, some individuals seeking services will value that telehealth can provide care from a more diverse pool of providers than is available from nearby providers.

Similarly, there is an ongoing need to better understand the challenges and opportunities that online contraceptive platforms and apps afford. For example, these services may feel more confidential, or clients may feel less stigma than with in-person care. Online platforms offer convenience, but a tradeoff may be affordability as most do not accept insurance for all or part of the costs, and costs can vary widely.

Two related findings—that telehealth contraceptive care use was more common among respondents without health insurance and those who self-pay—raise questions about publicly funded clinics in this new landscape. These clinics are designed to offer free or low-cost services to low-income individuals, many of

TABLE 4— "Excellent" Person-Centered Quality of Care Among Those Who Received a Contraceptive Service in the 6 Months Before the Survey, by Demographic Characteristics

	%	OR (95% CI)	AOR (95% CI)
Total	37		
Source of care			
In-person	39	1 (Ref)	1 (Ref)
Telehealth	25	0.51 (0.31, 0.82)	0.57 (0.35, 0.92)
Health insurance status in the 6 mo before the survey			
Insured	44	1 (Ref)	1 (Ref)
Uninsured	17	0.26 (0.17, 0.39)	0.37 (0.24, 0.58)
Household income[a]			
< 200% of the federal poverty level	30	1 (Ref)	1 (Ref)
≥ 200% of the federal poverty level	44	1.86 (1.37, 2.51)	1.33 (0.93, 1.91)
Race/ethnicity			
Non-Hispanic White	46	1 (Ref)	1 (Ref)
Non-Hispanic Black	27	0.43 (0.29, 0.65)	0.53 (0.34, 0.82)
Hispanic	29	0.47 (0.32, 0.71)	0.64 (0.41, 0.98)
Non-Hispanic Asian/Pacific Islander	20	0.29 (0.14, 0.58)	0.32 (0.16, 0.66)
Non-Hispanic other/multiple races	41	0.81 (0.42, 1.55)	0.95 (0.49, 1.83)
Internet access quality			
Excellent	43	1 (Ref)	1 (Ref)
Good/average/poor	19	0.31 (0.21, 0.46)	0.35 (0.23, 0.53)
Gender[b]			
Cisgender	38	1 (Ref)	1 (Ref)
Transgender/nonbinary/other	15	0.30 (0.08, 1.13)	0.61 (0.18, 2.07)
Education			
High school or less	28	1 (Ref)	1 (Ref)
Some college	38	1.53 (0.99, 2.37)	1.31 (0.83, 2.07)
College graduate or above	42	1.85 (1.24, 2.77)	1.09 (0.69, 1.72)
Age, y			
18–27	34	1 (Ref)	
28–38	36	1.09 (0.73, 1.62)	
39–49	41	1.34 (0.89, 2.02)	
Sexual orientation[c]			
Straight	39	1 (Ref)	
LGB+	35	0.84 (0.57, 1.24)	
Metropolitan statistical area status			
Nonmetro	32	1 (Ref)	
Metro	38	1.32 (0.87, 2.01)	
Had penile–vaginal sex in the 6 mo before the survey			
No	31	1 (Ref)	
Yes	37	1.33 (0.58, 3.09)	

Note. AOR = adjusted odds ratio; CI = 95% confidence interval; LGB+ = lesbian, gay, bisexual, and others (includes all responses other than straight); OR = unadjusted odds ratio. The sample size was n = 2079.

[a] Federal poverty level according to US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.[29]
[b] Respondents were asked to report their gender identity with 1 or more of the following responses: woman, man, nonbinary, transgender, and other. Those who solely answered "woman" were coded as cisgender, while all others were coded as transgender/nonbinary/other for analysis.
[c] Respondents were asked to report their sexual orientation with 1 or more of the following responses: straight, lesbian or gay, bisexual or pansexual, and other. We combined all responses other than straight into a single "LGB+" category.

whom are uninsured, and should provide contraceptive care that is less costly than online platforms. Further research is needed on how patient preferences shaped patterns of use and preferences for care and the long-term impacts on demand for publicly funded services, as contraceptive care options diversify.

It is concerning that this study found that respondents had lower odds of reporting that their care was patient-centered when they saw the provider through telehealth than in person. This difference diminished in multivariable models but remained at a level to suggest that patients considered care provided through telehealth to be less patient-centered. It will be essential to support telehealth providers in improving and prioritizing patient-centered approaches, whether through training or other interventions. Furthermore, respondents of color reported overall lower PCCC scores when controlling for the modality of care, suggesting that inequities in quality of care were unchanged by telehealth. More research on this and other aspects of the quality of telehealth care is needed.

Limitations

This study has a few relevant limitations. Although the online methodology allowed for timely data collection, there may be selection biases not addressed by the sampling weights. The 2021 Guttmacher Survey of Reproductive Health Experiences does not include adolescents aged younger than 18 years, for whom telehealth for contraceptive care may pose unique challenges and opportunities. Many online platforms require individuals to be aged at least 18 years or require parental consent.[14] Adolescent telehealth may raise additional privacy concerns. However, telehealth offers opportunities for adolescent care, including the potential to more easily receive confidential care without alerting caregivers and reducing geographic and travel-related barriers to care.[34] More clinical guidelines addressing telehealth for this population are needed.

In addition, we could not identify validated measures of contraceptive telehealth for the survey. Although we developed our survey items for telehealth based on recent work in the field,[18,21,35] we may not have accurately or thoroughly measured respondents' care experiences or consistently identified distinctions among telehealth from a provider, Web site, or app. There is a need to develop robust measures of telehealth to allow for surveillance and research of the changing care landscape. As providers further develop models of care that challenge conventional categorizations of telehealth, future efforts should examine how telehealth and in-person care may work in concert with one another.

Public Health Implications

The provision of contraceptive care through telehealth can help to increase access and provide services with fewer barriers and constraints. Attention to the quality of this care is needed. Policies should support and expand access to telehealth for contraceptive services while ensuring that people have the full range of options available to them, including in-person visits with a health care provider.

Conclusions

Telehealth is helping to bridge gaps in sexual and reproductive health care resulting from the upheaval of COVID-19, but work remains to ensure it is equitable and high-quality.

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CONTRIBUTORS

L. D. Lindberg was the lead contributor to the conceptualization of the work. L. D. Lindberg, R. K. Jones, J. Mueller, and M. Haas designed the survey; L. D. Lindberg, J. Mueller, and M. Haas analyzed and interpreted the data; and all contributed substantively to the writing of the article. All authors read and approved the final article.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare that are relevant to the content of this article.

HUMAN PARTICIPANT PROTECTION

Study procedures were approved by the Guttmacher Institute and NORC institutional review boards. All respondents provided informed consent to participate.

REFERENCES

1. Maier M, Samari G, Ostrowski J, Bencomo C, McGovern T. "Scrambling to figure out what to do": a mixed method analysis of COVID-19's impact on sexual and reproductive health and rights in the United States. *BMJ Sex Reprod Health.* 2021;47(4):e16. https://doi.org/10.1136/bmjsrh-2021-201081
2. Diamond-Smith N, Logan R, Marshall C, et al. COVID-19's impact on contraception experiences: exacerbation of structural inequities in women's health. *Contraception.* 2021;104(6):600–605. https://doi.org/10.1016/j.contraception.2021.08.011
3. 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. New York, NY: Guttmacher Institute; 2020. https://doi.org/10.1363/2020.31482
4. Weigel G, Frederiksen B, Ranji U, Salganicoff A. How OBGYNs adapted provision of sexual and reproductive health care during the COVID-19 pandemic. Kaiser Family Foundation. 2020. Available at: https://www.kff.org/womens-health-policy/issue-brief/how-obgyns-adapted-provision-of-sexual-and-reproductive-health-care-during-the-covid-19-pandemic. Accessed February 18, 2022.
5. Keller LH, Dawson R. Family planning providers show creativity and resilience in response to the COVID-19 pandemic. Guttmacher Institute. June 2020. Available at: https://www.guttmacher.org/article/2020/06/family-planning-providers-show-creativity-and-resilience-response-covid-19-pandemic. Accessed September 24, 2021.
6. What is telehealth? How is telehealth different from telemedicine? HealthIT.gov. October 17, 2019. Available at: https://www.healthit.gov/faq/what-telehealth-how-telehealth-different-telemedicine. Accessed February 28, 2022.
7. What is telehealth? *NEJM Catalyst*. February 1, 2018. Available at: https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0268. Accessed February 28, 2022.
8. Kane CK, Gillis K. The use of telemedicine by physicians: still the exception rather than the rule. *Health Aff (Millwood).* 2018;37(12):1923–1930. https://doi.org/10.1377/hlthaff.2018.05077
9. Moss K, Wexler A, Dawson L, et al. The Coronavirus Aid, Relief, and Economic Security Act: summary of key health provisions. Kaiser Family Foundation. 2020. Available at: https://www.kff.org/coronavirus-covid-19/issue-brief/the-coronavirus-aid-relief-and-economic-security-act-summary-of-key-health-provisions. Accessed February 23, 2022.
10. Chu RC, Peters C, De Lew N, Sommers BD. State Medicaid telehealth policies before and during the COVID-19 public health emergency. Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy. 2021. Available at: https://aspe.hhs.gov/reports/state-medicaid-telehealth-policies. Accessed February 18, 2022.
11. Guth M, Hinton E. State efforts to expand Medicaid coverage & access to telehealth in response to COVID-19. Kaiser Family Foundation. 2020. Available at: https://www.kff.org/coronavirus-covid-19/issue-brief/state-efforts-to-expand-medicaid-coverage-access-to-telehealth-in-response-to-covid-19. Accessed February 18, 2022.
12. Hudman J, McDermott D, Shanosky N, Cox C. How private insurers are using telehealth to respond to the pandemic. Peterson-KFF Health System Tracker. 2020. Available at: https://www.healthsystemtracker.org/brief/how-private-insurers-are-using-telehealth-to-respond-to-the-pandemic. Accessed February 18, 2022.
13. Frost JJ, Frohwirth LF, Blades N, Zolna MR, Douglas-Hall A, Bearak J. Publicly funded contraceptive services at US clinics, 2015. Guttmacher Institute. 2017. Available at: https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015. Accessed February 25, 2022.
14. Frederiksen B, Gomez I, Salganicoff A. A look at online platforms for contraceptive and STI services during the COVID-19 pandemic. Kaiser Family Foundation. April 23, 2020. Available at: https://www.kff.org/coronavirus-covid-19/issue-brief/a-look-at-online-platforms-for-contraceptive-and-sti-services-during-the-covid-19-pandemic. Accessed May 29, 2020.
15. Free the Pill. Who prescribes the pill online? 2022. Available at: https://freethepill.org/online-pill-prescribing-resources. Accessed February 18, 2022.
16. Weigel G, Frederiksen B, Ranji U, Salganicoff A. Telemedicine in sexual and reproductive health. Kaiser Family Foundation. 2019. Available at: https://www.kff.org/womens-health-policy/issue-brief/telemedicine-in-sexual-and-reproductive-health. Accessed February 18, 2022.
17. Hope H. Telehealth providers report increase in requests for birth control. *CBS8*. May 7, 2020. Available at: https://www.cbs8.com/article/news/health/increase-requests-birth-control-california/509-84c8f7b2-f7ef-4e31-9fb7-800e3d9b5687. Accessed February 23, 2022.
18. Frederiksen B, Ranji U, Salganicoff A, Long M. Women's sexual and reproductive health services: key findings from the 2020 KFF Women's Health Survey. Kaiser Family Foundation. 2021. Available at: https://www.kff.org/womens-health-policy/issue-brief/womens-sexual-and-reproductive-health-services-key-findings-from-the-2020-kff-womens-health-survey. Accessed February 18, 2022.
19. Lindberg LD, Mueller J, Kirstein M, VandeVusse A. The continuing impacts of the COVID-19 pandemic in the United States: findings from the 2021 Guttmacher Survey of Reproductive Health Experiences. Guttmacher Institute. 2021. Available at: https://www.guttmacher.org/report/continuing-impacts-covid-19-pandemic-findings-2021-guttmacher-survey-reproductive-health. Accessed February 18, 2022.
20. Thompson TA, Sonalkar S, Butler JL, Grossman D. Telemedicine for family planning: a scoping review. *Obstet Gynecol Clin North Am.* 2020;47(2):287–316. https://doi.org/10.1016/j.ogc.2020.02.004
21. Power to Decide. Survey says. Telehealth. 2020. Available at: https://powertodecide.org/sites/default/files/2020-08/Survey%20Says_Telehealth_2020.pdf. Accessed February 25, 2022.
22. Twentyeight Health. Survey of 1,400 women offers insights into telehealth preferences, birth control access, and pregnancy planning. 2021. Available at: https://www.twentyeighthealth.com/newsroom/twentyeight-survey-2021-release. Accessed February 25, 2022.
23. Gavin L, Moskosky S, Carter M, et al. Providing quality family planning services: recommendations of CDC and the US Office of Population Affairs. *MMWR Recomm Rep.* 2014;63(RR-04):1–54.
24. Dehlendorf C, Fox E, Silverstein IA, et al. Development of the Person-Centered Contraceptive Counseling scale (PCCC), a short form of the Interpersonal Quality of Family Planning Care scale. *Contraception.* 2021;103(5):310–315. https://doi.org/10.1016/j.contraception.2021.01.008
25. Institute of Medicine Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academies Press; 2001:10027. https://doi.org/10.17226/10027
26. Dehlendorf C, Reed R, Fox E, Seidman D, Hall C, Steinauer J. Ensuring our research reflects our values: the role of family planning research in advancing reproductive autonomy. *Contraception.* 2018;98(1):4–7. https://doi.org/10.1016/j.contraception.2018.03.015
27. Diamond-Smith N, Warnock R, Sudhinaraset M. Interventions to improve the person-centered quality of family planning services: a narrative review. *Reprod Health.* 2018;15(1):144. https://doi.org/10.1186/s12978-018-0592-6
28. Coalition to Expand Contraceptive Access. Priority roadmap for policy-ready contraceptive research. September 2021. Available at: https://static1.squarespace.com/static/5d35f1b39760f8000111473a/t/61522c6a6fcfb305b44e8d6a/1632775275078/Research+Roadmap_September+2021.pdf. Accessed February 25, 2022.
29. Office of the Assistant Secretary for Planning and Evaluation. 2020 poverty guidelines. Available at: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2020-poverty-guidelines. Accessed April 11, 2022.
30. Williams RL, Meredith AH, Ott MA. Expanding adolescent access to hormonal contraception: an update on over-the-counter, pharmacist prescribing, and web-based telehealth approaches. *Curr Opin Obstet Gynecol.* 2018;30(6):458–464. https://doi.org/10.1097/GCO.0000000000000497
31. Center for Connected Health Policy. Pending telehealth legislation in the United States. 2022. Available at: https://www.cchpca.org/pending-legislation. Accessed February 18, 2022.
32. Sachs JW, Graven P, Gold JA, Kassakian SZ. Disparities in telephone and video telehealth engagement during the COVID-19 pandemic. *JAMIA Open.* 2021;4(3):ooab056. https://doi.org/10.1093/jamiaopen/ooab056
33. Grasso C, Campbell J, Yunkun E, et al. Gender-affirming care without walls: utilization of telehealth services by transgender and gender diverse people at a federally qualified health center. *Transgend Health.* 2022;7(2):135–143. https://doi.org/10.1089/trgh.2020.0155
34. Evans YN, Golub S, Sequeira GM, Eisenstein E, North S. Using telemedicine to reach adolescents during the COVID-19 pandemic. *J Adolesc Health.* 2020;67(4):469–471. https://doi.org/10.1016/j.jadohealth.2020.07.015
35. Jones R. Continuity and change in contraceptive use, United States, 2012–2014: Version 1. *ICPSR: Data Sharing for Demographic Research*. Published online 2018. https://doi.org/10.3886/ICPSR37067.V1

US “Safety Net” Clinics Provide Access to Effective Contraception for Adolescents and Young Women, 2017–2019

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Objectives. To describe patterns of providing moderately effective versus the most effective contraception and of providing implants versus intrauterine devices in US community health centers.

Methods. We conducted a historical cohort study (2017–2019). Outcomes were woman-level receipt of most effective contraception (long-acting reversible contraception; implants and intrauterine devices) or moderately effective contraception. We used logistic regression to identify patient and clinic factors associated with providing (1) most versus moderately effective methods, and (2) implants versus intrauterine devices. We calculated adjusted probabilities for both outcomes by age group.

Results. We included 199 652 events of providing contraception to 114 280 women in 410 community health centers. Adjusted probabilities were similar across age groups for moderately versus most effective methods. However, the adjusted marginal means for receiving an implant compared with an intrauterine device were highest for adolescents (15–17 years: 78.2% [95% confidence interval (CI) = 75.6%, 80.6%]; 18–19 years: 69.5% [95% CI = 66.7%, 72.3%]). Women’s health specialists were more likely to provide most versus moderately effective contraception.

Conclusions. Community health centers are an important access point for most effective contraception for women of all ages. Adolescents are more likely to use implants than intrauterine devices. (*Am J Public Health*. 2022;112(S5):S555–S562. https://doi.org/10.2105/AJPH.2022.306913)

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Ensuring access to choice of effective forms of contraception is fundamental to supporting individuals in achieving their reproductive goals. The most effective contraception includes long-acting reversible contraception: the implant and the intrauterine device (IUD). Understanding patterns of providing the most effective contraceptive methods and how they may vary by clinic type and population served are important indicators of access to contraceptive care and risk of pregnancy. It is similarly meaningful to examine use of IUDs and implants separately. Each method has distinct medical eligibility criteria, mechanism of action, and side effect profile, and each requires different types of skill to insert and remove.[1] However, research often examines access to the most effective methods overall, without disaggregating IUDs and implants, thus masking important differences that affect service delivery.[2,3]

Subdermal contraceptive implants are effective forms of contraception, but use is still relatively low because of lack of awareness, misperceptions about safety and efficacy by both providers and users, and high up-front costs.[4] Although data on implant use are limited, the available reports[5] suggest that younger women (i.e., adolescents aged 14–17 years) are likely to choose the implant over an IUD, perhaps because it does not require a pelvic examination. Previous reports also suggest that implant users tend to have lower incomes and have Medicaid coverage or are uninsured (compared with having private coverage).

Community health centers (CHCs) play a vital role in providing access to contraceptive care for low-income and medically underserved populations, regardless of insurance status or ability to pay.[6] CHCs vary in the scope of family-planning services they deliver, but most health centers offer contraceptive methods onsite to facilitate access to care.[7] However, barriers persist to delivering the most effective contraceptive services in CHCs, including stocking devices onsite and availability of staff trained for IUD or implant insertions or removals.

We describe patterns of moderate and most effective contraceptive provision over a 3-year period (2016–2019) in a national network of CHCs. We describe patient and clinic characteristics of contraceptive provision, describe method mix by age group, and identify patient and clinic characteristics associated with providing the most effective (i.e., long-acting reversible contraception) methods versus moderately effective methods and providing implants versus IUDs.

METHODS

We used individual-level electronic health record (EHR) data to conduct a historical cohort study using the Accelerating Data Value Across a National Community Health Center Network (ADVANCE) clinical research network, a member of the National Patient-Centered Outcomes Research Network.[8] ADVANCE is a multicenter collaborative led by OCHIN in partnership with the Health Choice Network, Fenway Health, and Oregon Health & Science University. Outpatient EHR data from CHCs in the 4 data-sharing partner organizations are integrated and standardized into a common data model.[8] ADVANCE data include information from more than 7 million patients from CHCs across 31 states, represent 25% of all CHC patients nationwide, and are demographically similar to the national profile of CHC patients.[9] ADVANCE data are collected under a waiver of authorization because of minimal risk to patients and the practical issues of getting consent from the number of patients included. EHR data from ADVANCE are not originally developed for research but have been validated by multiple validation studies.[10,11]

Sample

We selected CHC clinics (i.e., brick-and-mortar care locations) when meeting certain care-type characteristics and patient volume criteria. We applied exclusions at the clinic level and then the patient level. We used data from CHC clinics that were live on the EHR system by September 1, 2016 (4 months before study start, i.e., January 1, 2017), and through the study end of June 30, 2019 (we chose to end the study before the implementation of the 2019 Trump–Pence Title X rule changes, which could have affected service delivery).[12,13] We excluded clinics that did not provide primary care services (e.g., dental clinics) or provided fewer than 50 visits to women of reproductive age (12–49 years) per study year (for details, see the Appendix [available as a supplement to the online version of this article at http://www.ajph.org]).

In included clinics, we first identified people documented as female in the EHR with at least 1 ambulatory visit between January 1, 2017 and June 30, 2019 (n = 745 979 patients). We were unable to comprehensively assess gender identity and will use the term "women" throughout the article to refer to these patients. We identified 118 022 patients' receipt of a most or moderately effective contraceptive method. We included all contraceptive methods except for those provided to women after evidence of sterilization (n = 381) or to women with infecundity (n = 2433). We excluded the less than 1% of the study population with no data in the EHR for age (n = 83) or payor (n = 812; see Figure A in the Appendix for a study flow diagram). We did not observe any contraceptives provided to individuals aged 12 to 14 years in our sample, so our final study sample is 114 280 women aged 15 to 49 years who received contraceptive services. These women were seen at 410 CHCs.

Variables

Our outcomes were woman-level contraceptive method type: moderately effective (i.e., short-acting hormonal contraception methods of injectables, oral contraceptives, patch, vaginal ring)[14] versus most effective (i.e., IUDs and implants) and then within most effective, IUD versus implant, following Office of Population Affairs metric specifications.[15] We extracted contraception information from several structured EHR fields, including prescription orders, as identified by medication code and name searches, records of medical procedures using Current Procedural Terminology, the Healthcare Common Procedure Coding System, and the *International Classification of Diseases, 10th Revision* (Geneva, Switzerland: World Health Organization; 1992 [*ICD-10*]) procedure codes, as well as *ICD-10* diagnosis codes (Table A in the Appendix). We captured contraceptive methods at the woman visit level (n = 198 734), and some visits (n = 918) included more than 1 method (e.g., both IUD and oral contraceptives). We assigned women to their highest efficacy contraceptive over the study period; therefore, we chose to describe our unit of analysis as "contraceptive provision" (hereafter "provision").

We assigned patient demographic characteristics based on their first contraceptive visit in the study period. We included age (15–17 years at first study visit, 18–19, then 5-year age bands to 49), race/ethnicity (Latina, non-Latina White, non-Latina Black, non-Latina other [including Asian, American Indian/Alaska Native], or non-Latina missing race), patient income as a proportion of the federal poverty level (FPL) category (< 100% FPL, 101%–150% FPL, 151%–200% FPL, > 200%, or missing income), payor or insurance (private, public, or uninsured; additional details on insurance are in the Appendix), and medical provider (whether they were a women's health specialist or not). If we encountered missing data, we used the next most recent contraceptive visit with known data. Data were not missing at random for missing patient race/ethnicity (5.5%) or for income category (11.6%; Tables B and C in the Appendix); therefore, we chose to include missingness as its own level in categorical variables and did not perform multiple imputation.

We identified clinics' Title X funding status, which is known to be associated with providing the most effective methods,[13] by cross-referencing CHC addresses with a list of Title X–funded clinics that we obtained from the Office of Population Affairs.[6] We classified clinics as rural using 2010 Rural–Urban Commuting Area codes; we categorized small towns and lower as rural.[16] We also included state-level indicators: presence of a state family-planning program (1115, State Plan Amendment, Family Planning waiver) status[17] and Medicaid expansion status (as of January 1, 2016).[18]

Statistical Analysis

We described patient-, provider-, clinic-, and state-level characteristics at the woman level, stratified by receipt of the most effective versus moderately effective contraceptive during the study period. We next described contraceptive provision by individual method type and age by the age distribution in each method type and by the method mix in each age group. Finally, to identify the patient-, clinic-, and state-level factors associated with the most versus moderately effective methods and the provision of implants versus IUDs, we fit 2 generalized logistic linear models with logit link function and binomial distribution, clustered on the clinic with an exchangeable correlation structure. We excluded women with evidence of having both implant and IUD during the study period (n = 499) from the second model. We calculated predicted population absolute probabilities (marginal means) of each outcome for all age categories.

To assess the robustness of our model results, we performed the following sensitivity analyses. We tested models without either payor or income, models with 1 and then the other singly, and a model with both; results were unchanged (data not shown). We present the full model in this article. We tested the interaction of age and payor and of age and clinic Title X status; the interaction terms were not statistically significant (data not shown), and we present the models with fixed effects. We conducted all analyses in SAS version 8.3 (SAS Institute, Cary, NC).

RESULTS

We identified 199 652 events of contraceptive provision to 114 280 women in 410 CHCs between January 1, 2017, and June 30, 2019. Nearly 14% were aged 15 to 17 years, 10% were aged 18 to 19 years, slightly more than 41% were aged 20 to 29 years, and slightly more than 35% were 30 years or older (Table 1). The largest proportion of contraceptive visits were by Latina women (39%), followed by non-Latina White (30%), and then Black (19%) women. The majority (63%) of the sample had incomes less than 100% FPL, and 21% were uninsured. The provider on record for contraceptive provision was most often a general practitioner (71.2%), and 29% of women with contraceptive provision had their first study visit to a Title X clinic. There were no meaningful differences in age by whether a woman received any most effective method compared with only moderately effective contraception during the study period. Other bivariate differences between use of only moderately and any most effective methods can be seen in Table 1.

Table 2 shows the age distribution of specific contraceptive methods. The largest proportions of injectable, patch, and ring users were aged 20 to 29 years; the age distribution was more even for oral contraceptive pill users. Among implant users, the largest proportion were aged 20 to 24 years (22% of implant users) and 15 to 17 years (19% of implant users). The population of IUD users skewed older, with the largest age groups aged 25 to 29 years and 30 to 34 years.

Table 3 displays method mix in each age category. The oral contraceptive pill and injectable were the most common methods across all age groups. In the

TABLE 1— Client and Clinic Characteristics of Women With Contraceptive Provision Visits in US Community Health Centers: 2017–2019

Characteristics	All Patients, No. (%)	Any Most Effective Contraceptive During Study, No. (%)	Only Moderately Effective Contraceptive During Study, No. (%)	*P*
Women	114 280	88 167	26 113	
Woman-level characteristics at first contraceptive visit during study period				
Age, y				<.001
15–17	15 672 (13.7)	12 205 (13.8)	3 467 (13.3)	
18–19	10 966 (9.6)	8 718 (9.9)	2 248 (8.6)	
20–24	23 710 (20.7)	18 414 (20.9)	5 296 (20.3)	
25–29	23 271 (20.4)	17 572 (19.9)	5 699 (21.8)	
30–34	18 094 (15.8)	13 763 (15.6)	4 331 (16.6)	
35–39	12 224 (10.7)	9 359 (10.6)	2 865 (11.0)	
40–49	10 343 (9.1)	8 136 (9.2)	2 207 (8.5)	
Race/ethnicity				<.001
Latina	44 754 (39.2)	33 370 (37.8)	11 384 (43.6)	
Non-Latina White	34 354 (30.1)	26 692 (30.3)	7 662 (29.3)	
Non-Latina Black	21 535 (18.8)	17 881 (20.3)	3 654 (14.0)	
Non-Latina other	7 388 (6.5)	5 604 (6.4)	1 784 (6.8)	
Missing	6 249 (5.5)	4 620 (5.2)	1 629 (6.2)	
Income as % of federal poverty level[a]				<.001
<100	71 937 (62.9)	55 297 (62.7)	16 640 (63.7)	
101–150	15 185 (13.3)	11 589 (13.1)	3 596 (13.8)	
151–200	6 203 (5.4)	4 754 (5.4)	1 449 (5.5)	
>200	7 973 (7.0)	6 258 (7.1)	1 715 (6.6)	
Missing	13 220 (11.6)	10 327 (11.7)	2 893 (11.1)	
Payor				<.001
Private	23 846 (20.9)	18 756 (21.3)	5 090 (19.5)	
Public	66 008 (57.8)	50 045 (56.8)	15 963 (61.1)	
Uninsured	24 426 (21.4)	19 366 (22.0)	5 060 (19.4)	
Provider				<.001
Women's health MD/APC	32 873 (28.8)	23 477 (26.6)	9 396 (36.0)	
Other provider	81 407 (71.2)	64 690 (73.4)	16 717 (64.0)	
Clinic-level characteristics				
First study visit to a Title X clinic	33 570 (29.4)	24 310 (27.6)	9 260 (35.5)	<.001
First study visit at a rural clinic	4 675 (4.1)	3 860 (4.4)	815 (3.1)	<.001
State-level characteristics				
State Family Planning/1115 Waiver as of January 2016	90 606 (79.3)	69 857 (79.2)	20 749 (79.5)	.43
Medicaid Expansion under ACA as of January 2016	84 312 (73.8)	61 880 (70.2)	22 432 (85.9)	<.001

Note. ACA = Affordable Care Act; MD/APC = persons with MD, DO, or advanced practice nursing (advanced practice registered nurse, certified nurse–midwife, doctor of nursing practice, physician assistant) degree. Contraceptive provision is captured from prescription records and administrative diagnosis and procedure codes. Most effective contraceptive methods are implant and intrauterine device. Moderately effective contraceptive methods are injection, oral pill, patch, and vaginal ring.

[a] As determined by the Department of Health and Human Services in the year of the patient's clinic visit or the year that the most recent patient data were available.

TABLE 2— Age Distribution in Each Contraceptive Method in US Community Health Centers: 2017–2019

	Most Effective Contraceptive Methods, No. (%)		Moderately Effective Contraceptive Methods, No. (%)[a]			
Age, Years	**Implant**	**IUD**	**Injectable**	**Oral Pill**	**Patch**	**Vaginal Ring**
All	14 079 (12.3)	12 034 (10.5)	26 980 (23.6)	54 516 (47.7)	3 428 (3.0)	3 243 (2.8)
15–17	2 700 (19.2)	767 (6.4)	4 469 (16.6)	7 089 (13.0)	454 (13.2)	193 (6.0)
18–19	1 589 (11.3)	659 (5.5)	2 756 (10.2)	5 448 (10.0)	325 (9.5)	189 (5.8)
20–24	3 165 (22.5)	2 131 (17.7)	5 448 (20.2)	11 556 (21.2)	706 (20.6)	704 (21.7)
25–29	2 878 (20.4)	2 821 (23.4)	4 960 (18.4)	10 920 (20.0)	751 (21.9)	941 (29.0)
30–34	1 945 (13.8)	2 386 (19.8)	3 982 (14.8)	8 486 (15.6)	590 (17.2)	705 (21.7)
35–39	1 125 (8.0)	1 740 (14.5)	2 859 (10.6)	5 812 (10.7)	356 (10.4)	332 (10.2)
40–49	677 (4.8)	1 530 (12.7)	2 506 (9.3)	5 205 (9.5)	246 (7.2)	179 (5.5)

Note. IUD = intrauterine device. Sample size was n = 114 280. An individual woman is assigned age at first study visit and is assigned the most effective methods received if more than 1 method was received during study period.

[a] Percentage of all contraceptive provision.

youngest age category (15–17 years), 17% used an implant. Use of implants decreased as a proportion of all contraceptive method use by increasing age: by 30 to 34 years, implants accounted for 11% of contraceptive use. The pattern was reversed for IUD use: IUD use as a proportion of contraceptive use was 5% among those aged 15 to 17 years and increased to 15% among women 40 to 49 years.

Finally, we examined 2 multivariable models controlling for patient, clinic, and state factors (Table 4): most effective versus moderately effective method and implant versus IUD. Adjusted probabilities were similar across age groups for any most effective method compared with moderately effective methods, ranging from 19.3% (95% confidence interval [CI] = 16.6%, 22.4%) among those aged 25 to 29 years to 17.5% (95% CI = 14.9%, 20.4%) among those aged 18 to 19 years.

The adjusted absolute probability for receipt of an implant rather than an IUD was highest for adolescents (aged 15–17 years: 78.2% [95% CI = 75.6%, 80.6%]; aged 18–19 years: 69.5% [95% CI = 66.7%, 72.3%]) compared with older women (aged 25–29 years: 51.0% [95% CI = 48.1%, 53.8%]; aged 40–49 years: 30.4% [95% CI = 27.1%, 33.8%]).

The type of provider seen was associated with both receipt of any most effective method and receipt of an IUD and not an implant. Overall, women's health providers were more likely than were general practitioners to provide any most effective method (adjusted odds ratio [AOR] = 2.92; 95% CI = 2.33, 3.65; Table D in the Appendix). Provider type (women's health provider vs general practitioner) was negatively associated with receipt of implant compared with IUD (AOR = 0.67; 95% CI = 0.58,

TABLE 3— Contraceptive Method Mix in US Community Health Centers by Age: 2017–2019

	Most Effective Methods, No. (%)		Moderately Effective Methods, No. (%)			
Age, Years	**Implant**	**IUD**	**Injectable**	**Oral Pill**	**Patch**	**Ring**
15–17	2 700 (17.2)	767 (4.9)	4 469 (28.5)	7 089 (45.2)	454 (2.9)	193 (1.2)
18–19	1 589 (14.5)	659 (6.0)	2 756 (25.1)	5 448 (49.7)	325 (3.0)	189 (1.7)
20–24	3 165 (13.3)	2 131 (9.0)	5 448 (23.0)	11 556 (48.7)	706 (3.0)	704 (3.0)
25–29	2 878 (12.4)	2 821 (12.1)	4 960 (21.3)	10 920 (46.9)	751 (3.2)	941 (4.0)
30–34	1 945 (10.7)	2 386 (13.2)	3 982 (22.0)	8 486 (46.9)	590 (3.3)	705 (3.9)
35–39	1 125 (9.2)	1 740 (14.2)	2 859 (23.4)	5 812 (47.5)	356 (2.9)	332 (2.7)
40–49	677 (6.5)	1 530 (14.8)	2 506 (24.2)	5 205 (50.3)	246 (2.4)	179 (1.7)

Note. IUD = intrauterine device. The sample size was n = 114 280.

TABLE 4— Adjusted Probabilities of Most Versus Moderately Effective Contraception and of Implant Versus IUD Use by Age: United States, 2017–2019

Age, Years	Most Effective (26 113) vs Moderately Effective (88 167) Contraception, Probability (95% CI)	Implant (13 580) vs IUD (12 034), Probability (95% CI)
15–17	17.7 (15.1, 20.7)	78.2 (75.6, 80.6)
18–19	17.5 (14.9, 20.4)	69.5 (66.7, 72.3)
20–24	17.9 (15.3, 20.9)	59.7 (56.8, 62.6)
25–29 (Ref)	19.3 (16.6, 22.4)	51.0 (48.1, 53.8)
30–34	18.6 (16.0, 21.5)	44.7 (41.8, 47.6)
35–39	18.2 (15.7, 21.1)	38.5 (35.4, 41.7)
40–49	16.8 (14.5, 19.4)	30.4 (27.1, 33.8)

Note. CI = confidence interval; IUD = intrauterine device. Probabilities are adjusted and absolute. Moderately effective contraceptive methods are vaginal ring, patch, oral pill, and injectable. Most effective contraceptive methods are IUD and implant. Generated from the full model in Supplemental Table D (available as a supplement to the online version of this article at https://www.ajph.org). Models are adjusted for age, race/ethnicity, income, payor, provider type, Title X clinic visit status, rural clinic visit status, State Family Planning/1115 waiver status, and state Medicaid expansion status.

0.78), indicating that women's health care providers are more likely to provide IUDs (rather than implants) than are general practitioners. Other factors associated with implant use compared with IUD use were Latina ethnicity (AOR = 1.51; 95% CI = 1.39, 1.65, compared with non-Latina White women), low income (< 100% FPL: AOR 1.28; 95% CI = 1.14, 1.43, compared with > 200% FPL), and public insurance (AOR = 1.12; 95% CI = 1.03, 1.23, compared with private). Supplemental Table D provides the full models and AORs.

DISCUSSION

The CHC network is an important access point for contraception for women of all ages. In 2016, more than 6 million low-income women of reproductive age received care in CHCs or other safety net settings.[19] We show, in a large sample of CHC clinics, that adolescents, young women, and older women have similar proportions of most effective contraception (i.e., long-acting reversible contraception) provision compared with moderately effective contraception provision, but that variations exist in the use of individual most effective methods (i.e., IUDs vs implants) by age. We found that the probability of receiving an implant compared with receiving an IUD was highest for adolescents. As hypothesized, we found that patient (e.g., age) and provider (e.g., provider type) level factors were associated with provision of the most effective contraception overall and with type of the most effective methods (i.e., IUDs or implants).

In-line with previous research,[5,20–22] we found that younger (15–17 years) and older (18–19 years) adolescents have a much higher probability of using implants over IUDs than do older women, controlling for patient, clinic, and state factors that could influence method provision (e.g., insurance status, provider type, Title X, or insurance). Also similar to previous reports,[21] implant use decreased as a proportion of all contraceptive method use with increasing age. Higher implant use among younger women may be attributed to their desire for the most effective contraception without a pelvic examination,[23] lower maintenance and chance of user error, or implants' availability at publicly funded clinics.

Adolescents have been shown to choose and continue most effective methods when cost barriers are removed.[22,24] However, provider bias and lack of provider training can pose barriers to adolescent access to the most effective methods,[25] despite medical organizations' endorsement of the safety of implants for adolescents.[4,26] In addition, young women and women of color are more likely to report experiences of coercion or lack of autonomy in contraceptive decision-making. It is critical that all contraceptive counseling be centered in a reproductive justice framework that is developmentally appropriate and uses patient-centered counseling; shared decision-making can emphasize attention to the needs and preferences of adolescents.[27,28]

At the clinic level, we found that provision by a women's health care specialist (i.e., physician or advanced practice provider) was positively associated with provision of the most effective methods overall (i.e., IUD and implant) compared with moderately effective methods, which supports previous research.[29] However, provision by a woman's health care specialist was negatively associated with receiving an implant compared with an IUD, showing that women's health care specialists do the bulk of IUD provision and that implants are provided by a wider range of providers, which expands access. However, barriers exist to the provision of the most effective methods, including implants, in safety net settings, because of a lack of awareness, lack of staff training for required insertion and removal, and logistical and cost-related difficulties stocking devices onsite.[30,31]

Strengths and Limitations

Previous findings have often focused on the effectiveness or the use of the most effective methods overall[2,36,32] or have focused on commercially insured women,[3,33] aggregate clinic-level reports,[7] small samples of clinics, or population-based prevalence data,[2] which do not allow us to see where care is provided. Our data using individual-level clinical data from CHCs across the United States support and improve on previous work.

Our study has limitations. First, our sample of CHCs may not be generalizable to all patients in CHCs, CHC clinics, or states. However, our data came from the largest national set of data from people accessing care in safety net settings, and the ADVANCE patient population is demographically and clinically similar to the overall CHC population.[8] Second, our EHR data source precluded information about patient experience of care or content of counseling. Third, we did not know whether women sought contraceptive services outside our CHC network; however, our study question focused on provision, not on population-level prevalence of method use. Fourth, we did not have consistently available data for gravidity or parity, which are known to influence contraceptive use patterns. Finally, we chose to end our study in June 2019, before the Trump–Pence administration weakened the federal Title X program, which provides funding for family planning services for uninsured women. Contraceptive use patterns may have changed after the implementation of these changes, which have since been reversed under the Biden–Harris administration. Future work is necessary to evaluate this period.

Public Health Implications

Access to effective contraception, including the most effective methods, is key to supporting individuals in achieving their reproductive goals, including avoiding unintended pregnancy. CHCs are an important access point for the most effective contraception for women of all ages, including women with low incomes or without insurance, who bear the largest burden of unplanned pregnancy.[34] We have shown that CHCs provide access to adolescents and young women to the most and moderately effective contraceptive methods, including the implant and IUDs. CHCs rely on diverse funding streams from the fragmented public family-planning service delivery system to provide contraceptive services, regardless of insurance status or ability to pay. Medicaid expansion under the Affordable Care Act,[6] the federal Title X family-planning program,[13] and state family-planning programs[35] all contribute to expanding access to contraceptive services in the safety net. CHCs must be supported to provide high-quality, developmentally appropriate, noncoercive, and confidential contraceptive services to adolescents and young women. AJPH

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CONTRIBUTORS

B. G. Darney and F. M. Biel conceptualized the study and conducted the analysis. B. G. Darney, F. M. Biel, and J. Oakley drafted the article. All authors participated in data interpretation and revised the article for intellectual content.

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Note. The funders had no role in data conceptualization, analysis, or interpretation.

CONFLICTS OF INTEREST

B. G. Darney's institution receives research support from Merck/Organon, and B. G. Darney serves on the Society of Family Planning board of directors. M. I. Rodriguez has served as a contraceptive trainer for Merck and the American Congress of Obstetricians and Gynecologists. She has served on a Bayer advisory board. She has served as a consultant for the World Health Organization. Her institution has received research funding from the Laura and John Arnold Foundation, the National Institutes of Health, Merck, and the Robert Wood Johnson Foundation on projects on which she is the PI. OHSU has reviewed and managed M. I. Rodriguez's potential conflicts of interest.

HUMAN PARTICIPANT PROTECTION

This study was reviewed by the Western institutional review board.

REFERENCES

1. Hatcher RA. *Contraceptive Technology.* 21st ed. New York, NY: Ayer; 2018.
2. Kavanaugh ML, Pliskin E. Use of contraception among reproductive-aged women in the United States, 2014 and 2016. *F S Rep.* 2020;1(2):83–93. https://doi.org/10.1016/j.xfre.2020.06.006
3. Law A, Yu JS, Wang W, Lin J, Lynen R. Trends and regional variations in provision of contraception methods in a commercially insured population in the United States based on nationally proposed measures. *Contraception.* 2017;96(3):175–182. https://doi.org/10.1016/j.contraception.2017.05.011
4. Committee on Adolescence. Contraception for adolescents. *Pediatrics.* 2014;134(4):e1244–e1256. https://doi.org/10.1542/peds.2014-2299
5. Ricketts S, Klingler G, Schwalberg R. Game change in Colorado: widespread use of long-acting reversible contraceptives and rapid decline in births among young, low-income women. *Perspect Sex Reprod Health.* 2014;46(3):125–132. https://doi.org/10.1363/46e1714
6. Darney BG, Jacob RL, Hoopes M, et al. Evaluation of Medicaid expansion under the Affordable Care Act and contraceptive care in US community health centers. *JAMA Netw Open.* 2020;3(6):e206874. https://doi.org/10.1001/jamanetworkopen.2020.6874
7. Wood S, Beeson T, Bruen B, et al. Scope of family planning services available in federally qualified health centers. *Contraception.* 2014;89(2):85–90. https://doi.org/10.1016/j.contraception.2013.09.015
8. DeVoe JE, Gold R, Cottrell E, et al. The ADVANCE network: accelerating data value across a national community health center network. *J Am Med Inform Assoc.* 2014;21(4):591–595. https://doi.org/10.1136/amiajnl-2014-002744
9. National Association of Community Health Centers. Community Health Center chartbook. January 2021. Available at: https://www.nachc.org/wp-content/uploads/2021/04/Chartbook-Final-2021.pdf. Accessed August 5, 2021.
10. Angier H, Gold R, Gallia C, et al. Variation in outcomes of quality measurement by data source. *Pediatrics.* 2014;133(6):e1676–e1682. https://doi.org/10.1542/peds.2013-4277
11. Heintzman J, Marino M, Hoopes M, et al. Supporting health insurance expansion: do electronic health records have valid insurance verification and enrollment data? *J Am Med Inform Assoc.* 2015;22(4):909–913. https://doi.org/10.1093/jamia/ocv033
12. Kaiser Family Foundation. The status of participation in the Title X Federal Family Planning Program. December 20, 2019. Available at: https://www.kff.org/11b08e1. Accessed February 10, 2020.
13. Darney BG, Biel FM, Hoopes M, et al. Title X improved access to most effective and moderately effective contraception in US safety-net clinics, 2016–18. *Health Aff (Millwood).* 2022;41(4):497–506. https://doi.org/10.1377/hlthaff.2021.01483
14. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Effectiveness of family planning methods. 2014. Available at: https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/family-planning-methods-2014.pdf. Accessed February 12, 2021.
15. Office of Population Affairs. Contraceptive care measures. Available at: https://www.hhs.gov/opa/performance-measures/index.html. Accessed October 18, 2018.
16. US Department of Agriculture. Rural–urban commuting area codes. 2019. Available at: https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx. Accessed March 30, 2019.
17. Guttmacher Institute. Medicaid family planning eligibility expansions. January 1, 2022. Available at: https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions. Accessed February 2, 2022.
18. Henry J Kaiser Family Foundation. Status of state action on the Medicaid expansion decision. September 11, 2018. Available at: https://www.kff.org/907f6c5/\. Accessed October 2, 2018.
19. Wood S, Strasser J, Sharac J, et al. Community health centers and family planning in an era of policy uncertainty. March 15, 2018. Available at: https://www.kff.org/womens-health-policy/report/community-health-centers-and-family-planning-in-an-era-of-policy-uncertainty. Accessed November 21, 2021.
20. Prescott GM, Matthews CM. Long-acting reversible contraception: a review in special populations. *Pharmacotherapy.* 2014;34(1):46–59. https://doi.org/10.1002/phar.1358
21. Guttmacher Institute. Contraceptive use in the United States by method. 2021. Available at: https://www.guttmacher.org/fact-sheet/contraceptive-method-use-united-states. Accessed November 9, 2021.
22. Mestad R, Secura G, Allsworth JE, Madden T, Zhao Q, Peipert JF. Acceptance of long-acting reversible contraceptive methods by adolescent participants in the Contraceptive CHOICE Project. *Contraception.* 2011;84(5):493–498. https://doi.org/10.1016/j.contraception.2011.03.001
23. Turok DK, Gawron LM, Lawson S. New developments in long-acting reversible contraception: the promise of intrauterine devices and implants to improve family planning services. *Fertil Steril.* 2016;106(6):1273–1281. https://doi.org/10.1016/j.fertnstert.2016.09.034
24. Diedrich JT, Klein DA, Peipert JF. Long-acting reversible contraception in adolescents: a systematic review and meta-analysis. *Am J Obstet Gynecol.* 2017;216(4):364.e1–364.e12. https://doi.org/10.1016/j.ajog.2016.12.024
25. Murphy MK, Stoffel C, Nolan M, Haider S. Interdependent barriers to providing adolescents with long-acting reversible contraception: qualitative insights from providers. *J Pediatr Adolesc Gynecol.* 2016;29(5):436–442. https://doi.org/10.1016/j.jpag.2016.01.125
26. Committee on Practice Bulletins-Gynecology, Long-Acting Reversible Contraception Work Group. Practice Bulletin No. 186: Long-acting reversible contraception: implants and intrauterine devices. *Obstet Gynecol.* 2017;130(5):e251–e269. https://doi.org/10.1097/AOG.0000000000002400
27. Higgins JA. Celebration meets caution: LARC's boons, potential busts, and the benefits of a reproductive justice approach. *Contraception.* 2014;89(4):237–241. https://doi.org/10.1016/j.contraception.2014.01.027
28. Gomez AM, Fuentes L, Allina A. Women or LARC first? Reproductive autonomy and the promotion of long-acting reversible contraceptive methods. *Perspect Sex Reprod Health.* 2014;46(3):171–175. https://doi.org/10.1363/46e1614
29. Thompson KMJ, Rocca CH, Stern L, et al. Training contraceptive providers to offer intrauterine devices and implants in contraceptive care: a cluster randomized trial. *Am J Obstet Gynecol.* 2018;218(6):597.e1–597.e7. https://doi.org/10.1016/j.ajog.2018.03.016
30. Boudreaux M, Xie L, Choi YS, Roby DH, Rendall MS. Changes to contraceptive method use at Title X clinics following Delaware Contraceptive Access Now, 2008–2017. *Am J Public Health.* 2020;110(8):1214–1220. https://doi.org/10.2105/AJPH.2020.305666
31. Janiak E, Clark J, Bartz D, Langer A, Gottlieb B. Barriers and pathways to providing long-acting reversible contraceptives in Massachusetts community health centers: a qualitative exploration. *Perspect Sex Reprod Health.* 2018;50(3):111–118. https://doi.org/10.1363/psrh.12071
32. Daniels K, Daugherty J, Jones J, Mosher W. Current contraceptive use and variation by selected characteristics among women aged 15–44: United States, 2011–2013. *Natl Health Stat Rep.* 2015;(86):1–14.
33. Bearak JM, Finer LB, Jerman J, Kavanaugh ML. Changes in out-of-pocket costs for hormonal IUDs after implementation of the Affordable Care Act: an analysis of insurance benefit inquiries. *Contraception.* 2016;93(2):139–144. https://doi.org/10.1016/j.contraception.2015.08.018
34. Finer LB, Zolna MR. Declines in unintended pregnancy in the United States, 2008–2011. *N Engl J Med.* 2016;374(9):843–852. https://doi.org/10.1056/NEJMsa1506575
35. Rodriguez MI, Darney BG, Elman E, Linz R, Caughey AB, McConnell KJ. Examining quality of contraceptive services for adolescents in Oregon's family planning program. *Contraception.* 2015;91(4):328–335. https://doi.org/10.1016/j.contraception.2014.12.008