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Exploring Multiple Influences on Equity: A Mixed Methods Study of Low-income Women's Access to Family Planning Services in the South

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Doctor of Philosophy

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An abstract of

A dissertation submitted to the Faculty of the
James T. Laney School of Graduate Studies of Emory University
in partial fulfillment of the requirements for the degree of
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Abstract

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Background

Achieving equity in sexual and reproductive health (SRH) requires eliminating socially unjust and systematic health disparities in outcomes and access to SRH services. A female-bodied individual's ability to make decisions related to her sexual and reproductive health (SRH) is critical to her overall well-being and the well-being of her family. Disparities persist in poor SRH related outcomes and in access to SRH services among individuals who are lower socioeconomic status, people of color, and among those living in the Southern US.

Objective

To inform how equitable access can be measured and how it can be achieved, the studies included in this dissertation attempted to develop a complex understanding of what equity in access to SRH care means for low-income female individuals. Using a mixed methods approach, the studies included in this work explore multiple dimensions of access and how the care-seeking processes of low-income women in Southern states are influenced by: 1) individual access factors (e.g. insurance status, access to transportation), 2) the health care system (e.g. clinic location, cost of services), and 3) elements of their social context.

Results

We found that low-income women have different priorities in seeking SRH care and are likely influenced by complex combinations of demographic and individual access factors. Those seeking care at Planned Parenthoods often do so because the services are fast, trusted, and confidential. These studies demonstrate that "good access" is determined by alignment of individual and health system factors that met individual's needs in a particular moment.
A mismatch of these factors often produced inequities in access and contraceptive outcomes. Finally, social and structural forces including those related to systems of discrimination, economics, and health policy influenced both individuals and health systems and ultimately access.

Conclusion

These studies contribute to a broadened understanding of what "access" to SRH care is as well as the factors that influence the ability of low-income women in the Southern US to achieve it. Taken together these studies suggest that access may be understood as multi-dimensional, multilevel, interactive, fluid over time, and as a process.

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INTRODUCTION

A woman’s ability to make decisions related to her fertility and her sexual and reproductive health (SRH) is critical to her overall well-being and the well-being of her family; however, the ability to determine her reproductive goals is often not fully under her own control(Ross & Solinger, 2017). Unintended pregnancy (UIP), is one (imperfect) measure used to determine whether women are achieving their SRH goals, and young women, those of lower socioeconomic status, women of color, as well as women living in Southern U.S. states continue to bear the highest burdens of UIP (Kost, 2015b). In Georgia, one of the study locations, 60% of pregnancies are unintended and rates of teen pregnancy (TP) are higher than the US average(Centers for Disease Control and Prevention, 2016a; Frost et al., 2016). Existing literature indicates that these same populations also have lower rates of contraceptive use (Dehlendorf et al., 2010), particularly of highly effective methods,(Jackson et al., 2016; Shih et al., 2011) with lower rates attributed to unequal access to family planning (FP) care and specifically contraceptive services (Dehlendorf C et al., 2014; Dehlendorf et al., 2010; Hall et al., 2011, 2012a, 2012b; Martinez GM, 2013). Such populations also experience disparities in burdens of sexually transmitted infections (STIs) and high rates of maternal mortality (CDC,2016b; Molina & Pace, 2017). In fact, Georgia and Louisiana have the two highest rates of maternal mortality (72 and 66 per 100,000 respectively) (CDC WONDER 2017).

Better conceptualizations of equitable SRH

Health Equity may be defined as the elimination of socially unjust disparities in achieving health and is often understood as eliminating systematic disparities that act as underlying determinants of health (Braveman, 2014). Health equity is related to both achieving equitable outcomes and to equitable access to health care (Braveman, 2014). Achieving health equity in SRH care involves addressing socially unjust and systematic health disparities and necessitates a holistic approach that acknowledges the influence of multiple levels, including social and structural forces (Braveman, 2006; Braveman et al., 2011). Better conceptualization of equitable SRH access is needed. Although there is growing identification of barriers to FP care, much is unknown about how women themselves perceive and prioritize different factors in choosing to seek FP care (Brown et al., 2011; Hodgson et al., 2013; Hopkins et al., 2015; Wood et al., 2015). The influence of social context (e.g. social norms, systems of discrimination, and social capital) on women's care seeking and priorities is also often left out but has significant implications for understanding geographic disparities in access to and use of contraceptive care. Finally, there is limited understanding of which elements (individual, health system, social context) exert most influence on whether contraceptive care meets women's needs.

The current study

The goal of this study, as will be discussed, is to understand factors that help to support reproductive autonomy and that contribute to SRH equity in FP access and care seeking and that ultimately support individuals to achieve their highest level of SRH. Examining women's SRH behavior through a narrow lens is not sufficient. A more holistic approach—one that accounts for multiple interconnected influences-- is needed to support women in achieving their own highest level of SRH (Chrisler, 2014; Dehlendorf et al., 2018; Higgins, 2014; Price, 2010; Ross & Solinger, 2017). The dissertation moves beyond traditional health system approaches, which are often limited in scope, to identify intersecting elements that facilitate equitable access to FP services and to do so by taking women's perceptions of their lived experiences into account.

The studies included in this work explore how the care-seeking processes of low-income women in Southern states are influenced by: 1) individual access factors (e.g. insurance status, access to transportation), 2) the health care system (e.g. clinic location, cost of services), and 3) three elements of their social context (sociocultural norms, experiences of discrimination, and social capital). Employing Levesque's *patient-centered access framework (*Levesque *et al., 2013)* and informed by reproductive justice (RJ) perspectives, this dissertation will identify 1) how women articulate their priorities in seeking FP care, 2) the ways in which multiple factors intersect and influence whether and where women seek care, and 3) the implications of these intersections for meeting women's SRH needs.

This dissertation employs a transformative mixed methods approach to explore multilevel factors influencing low-income women's FP care seeking in the Southeast though the following three aims:

- **Aim 1:** Describe how multiple elements, including demographic factors and previous access to health services are associated with women's care-seeking behaviors for FP and SRH services at urban specialized FP clinics in two Southeastern states using patient surveys from two Planned Parenthood (PP) clinics from March 2016 - May 2017.

- **Aim2:** Identify and characterize the interplay between individual and health systems access factors that influence low income women's FP care seeking based on women's own perspectives, within one domain of access--affordability. Using life history interviews, in this aim we sought to better understand 1) women's conceptualizations of the affordability of FP in terms of health system and individual access factors, and 2) how health system and individual access factors shape low-income women’s contraceptive care-seeking and FP outcomes in the context of a state without a full Medicaid expansion.

- **Aim 3:** Characterize how elements in social context influence women’s care seeking as related to the access domain of “appropriate care”. Using mixed methods, we will assess how systems of discrimination, social capital, and social support shape women’s care-seeking processes and decisions as well as the implications for whether and where they go and whether their care meets their needs. In this aim we sought to understand: 1)what elements of appropriate care low-income women identify as important for their SRH services; 2) which elements of appropriate care are most salient in their SRH care-seeking; and 3) what influence women’s lives have on their experiences of and priorities for appropriate SRH care.

The rest of this chapter will include a review literature relevant to these aims and then will identify the gaps that will be addressed by these studies. It will conclude with a comment on the expected contribution of this dissertation. Chapters 2 through 4 will present findings relevant to each aim and Chapter 5 will provide an overall summary and discussion.

A. LITERATURE REVIEW

Overview of Literature Review

This review provides a summary of literature relevant to the dissertation aims. It will review relevant literature associated with 1) trends and disparities in FP outcomes; 2) trends and disparities in access to FP care; 3) the influence of social context on health; and 4) relevant theoretical framing. Behavioral and public health related research has increasingly recognized the importance of understanding behavior as the product of multiple “levels” of influences (Diez-Roux, 1998; Diez-Roux et al., 2000; Glass & McAtee, 2006; Golden & Earp, 2012; Merlo, 2003; Sallis J & Owen N, 2015; Trickett & Beehler, 2013). Multilevel thinking is not new conceptually and is often associated with Bronfenbrenner’s seminal work conceptualizing five ecologic systems with which individuals interact(Bronfenbrenner, 1979). In their seminal work, McLeroy et. al. adapted Bronfenbrenner’s psychology-oriented model for application in public health programs and described five levels of influence on individual health behavior. (McLeroy et al., 1988) The Social-Ecological Model is widely used in public health to conceptualize how individual’s health behaviors may be influenced by and interact with their context. Though increasing, fewer studies in behavioral health focus on implementing changes at higher levels of the SEF. Golden and Earp found that just 20% of behavioral interventions focused on community activities and only 6% on policy level changes(Golden & Earp, 2012). Given the recognition that individual factors and behaviors often do not fully explain variation in health, multilevel thinking is clearly needed in both explanatory research and intervention development. As will be discussed in this review, there are factors that shape women’s reproductive autonomy (including contraceptive access, use, and UIP outcomes) that are beyond their direct control and subject to influences at individual, interpersonal, clinic, societal, and policy levels.

This review will discuss the state of current literature for each section of the often theorized pathway (**Figure 1.1** below) relating UIP and other SRH outcomes to contraceptive use, access to FP services, and pregnancy intentions, with a particular focus on disparities highlighted in the literature (racial/ethnic, SES, geographic) in each of these behaviors and outcomes. Then drawing on an approach informed by the SEF, a review of multiple levels of contextual influence on these behaviors will be presented. Each section will close with a summary of the current gaps and challenges related to knowledge in each area. The review end with a discussion of access to FP services as this is the primary focus of the studies in this dissertation. After this, a discussion of social context, an influence not frequently addressed in research on access to FP services, will be presented. Finally, a discussion of prior theoretical framing will be presented along with an introduction to the *Patient Centered Access Framework* that will serve as the theoretical basis for the proposed dissertation research.

A.1 A Critical Goal: Reproductive Autonomy

Women's SRH remains a challenge in the United States, more so than in many other high-income countries (Hamilton BE and Ventura SJ, 2012; Heisler EJ, 2012; Molina & Pace, 2017; United Nations Statistics Division, 2016). Achieving equity in SRH outcomes such as those related to UIP is important but more so is the ability to make determinations about one's fertility and SRH. In SRH over the past decade a critical framework has been developed that calls for a more holistic and nuanced understanding of sexual and reproductive health. Reproductive Justice originated with women of color who felt that the dominant view of and approaches to addressing UIP did not adequately take their lives into account. The movement focuses on health equity and takes an intersectional (and systems oriented) view of SRH. RJ approaches have pushed the field of FP to go beyond issues of choice and the right to control fertility in order to take into account context and intersectional factors, like race and class, that influence SRH in minority populations (Asian Communities for Reproductive Justice (ACRJ), 2005; Price, 2010). Reproductive Justice (RJ) can be defined as: "*the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, and will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives. (ACRJ 2005, 1)(Asian Communities for Reproductive Justice (ACRJ), 2005; Price, 2010).*"

RJ theorists point out that having the right to control fertility is simply not enough and that there must be enabling conditions—networks of opportunities, supports, and services—that allow women to exercise that right (Ross & Solinger, 2017). Poor women and women of color are often caught between systems that are coercive about controlling their fertility and those that seemingly incentivize pregnancy through a lack of supportive resources for family planning (Bute & Jensen, 2010; Ross & Solinger, 2017). Additionally, as has been increasingly documented, women have different feelings about the experience of UIP and may experience an UIP as not necessarily a wholly negative outcome (Dehlendorf et al., 2018; Edin & Kefalas, 2011). The challenge that persists, therefore, is not only the continuing high rates of UIP and inequities in those rates, but inequities in women's autonomy with regard to their fertility (Dehlendorf et al., 2018). As will be discussed further, this study is informed by a RJ perspective, addresses issues of health equity, and takes an intersectional (and systems oriented) view of SRH. SRH equity in FP access and care-seeking means that women are able to achieve equal access to, use of, and receipt of quality FP services. This review will discuss the drivers of UIP, as well as other factors that influence inequities in women's overall ability to enact reproductive autonomy.

A.2 Unintended Pregnancy

UIP is one (imperfect) measure used to determine whether women are achieving their SRH goals. Reducing rates of UIP is recognized by many international and domestic organizations, and is among the established goals for Health People 2020 (U.S. Department of Health and Human Services (DHHS), 2010). In 2011, nearly half of the pregnancies in the U.S. were unintended (45% or 2.8 million) (Finer & Zolna, 2016). "Unintended" pregnancy is frequently defined as a pregnancy that is either unwanted at the time of conception or mistimed. If a woman did not want to become pregnant at the time of conception or at any time in the future her pregnancy is termed unwanted. If a woman wanted to become pregnant sometime in the future but did not want to become pregnant at the time of conception the pregnancy is termed 'mistimed'. The Guttmacher Institute estimates that in 2011, approximately 18% of pregnancies were unwanted and 27% of pregnancies were mistimed (Finer & Zolna, 2016). In 2011, it is estimated that unintended pregnancies resulted in unwanted births (58%), abortions(42%), and a small percentage were miscarried (Finer & Zolna, 2016).

Importance of UIP to health and welfare of woman, family, society

Experiences of UIP have significant implications for the health and welfare of women, their infants, their families, and society. Unintended pregnancies are often associated with delays in getting prenatal care (Mosher, 2012). Births resulting from unplanned or those not within appropriate birth spacing (18 months) can have significant health implications for mothers and infants, including higher rates of maternal and infant morbidity (Lindberg et al., 2015). Higher rates of UIP are especially concerning given the persistence of high rates of maternal mortality and morbidity among low-income women and women of color, particularly in rural areas and the Southeastern US. These rates often exceed those of some low- or middle-income countries

(Molina & Pace, 2017; United Nations Statistics Division, 2016). UIP also presents significantly negative social and economic implications for women and their families. Studies have shown that unplanned and unwanted births can result in lower economic earnings and less financial stability (Foster et al., 2018; Sonfield A et al., 2013). Unplanned births have also been associated with poor relationship health and poor mental health between couples, as well as poor parent child relationships (Sonfield A et al., 2013). Births from UIP also present additional financial costs to governments (Gipson et al., 2008; Kost, 2015b).

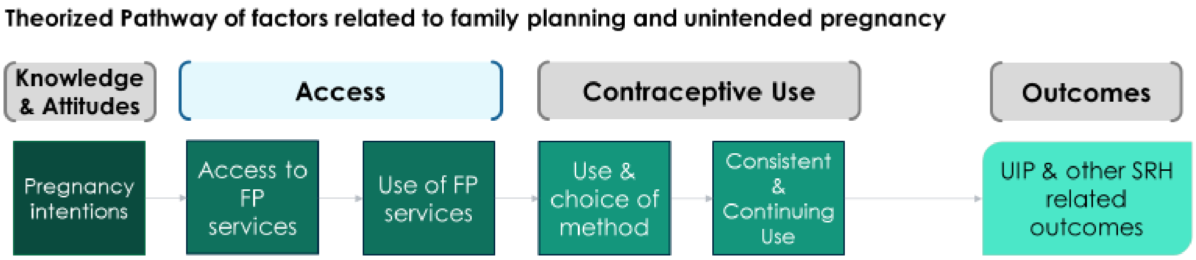
Trends & Disparities in UIP

Despite small declines in UIP in recent years --from 2008-2011 rates decreased from 51% to 45% and in 2011 reached an all-time 30 year low--rates of UIP remain high and are increasingly concentrated among lower-income women (Finer & Zolna, 2016). Young women, those of low socioeconomic status, and women of color continue to bear the highest burdens of UIP in the US (Finer & Zolna, 2016; Kost, 2015b). In 2011 it is estimated that the rate of UIP among low-income women (whose incomes were below the federal poverty level (FPL)) was more than five times the rate among higher income women (>200% FPL) (Finer & Zolna, 2016). Black women experience rates more than double that of their non-Hispanic white counterparts (Finer & Zolna, 2016; Sweeney & Raley, 2014). Geographic disparities also persist, with women living in Southern states often experiencing some of the highest rates of UIP (Kost, 2015a). In Georgia, the proposed study location for Aims 2 & 3, 60% of pregnancies are unintended and rates of teen pregnancy TP are higher than the US average (CDC, 2016a; Frost et al., 2016).

Drivers of UIP

Rates of UIPs (and related SRH outcomes) have been frequently associated with use of contraceptives, access to services, and pregnancy intentions. Contraceptive use, and consistent and effective method use, are considered to be the primary means of preventing UIP. UIP as a health outcome, therefore, may be conceptualized as a pathway that links pregnancy intentions, access to contraceptive services, use of contraceptives, and continuity of method use with the eventual pregnancy outcomes. The pathway below (**Figure 1.1)** illustrates a somewhat chronological series of associated behaviors. Access to and quality of FP services are seen as influencing whether an individual uses contraception as well as what method they choose. The initial choice of method (including its level of efficacy) and then consistent and correct use of the method are often associated with pregnancy outcomes.[*] Finally, an individual's pregnancy intentions may shape each step along the pathway. While not the focus of this study, it is important to acknowledge that pregnancy intentions may have both direct and indirect influence on contraceptive use and pregnancy outcomes.

Figure 1



Within this theorized pathway, disparities exist among certain sub-populations. These sub-populations (i.e. low-income women, young women, women of color) experience disparities in consistent use, types of methods chosen, particularly use of highly effective methods, as well as in access to and use of FP services. Disparities in UIP, use of contraception, and access are often

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[*] It is important to note that this framework deals only with unintended pregnancy and not births. The determinants of unintended births may vary slightly and may include differences in experiences of experiences of miscarriage and use of abortion, another form of family planning. Access to FP services, of course, would also determine access to abortion services and prenatal services.

assumed to be related and associated (Sadia et al., 2013). It is important to acknowledge however, that the pathway is missing consideration of larger contexts that shape women's attitudes and behaviors. The pathway outlined in Figure 1 therefore is incomplete, for there are multiple levels of context that shape women's attitudes and behaviors and that often produce inequities in outcomes and in providing services that meet women's needs.

A.3 Pregnancy Intentions

While not the focus of this research, it is important to acknowledge that decisions to use contraceptives, and to use them consistently, are often associated with an individuals' feelings about being pregnant. Significant research has shown that one's fertility desires are often a complex set of attitudes that may not be as simple as wanting or not wanting a child in the near future (Afable-Munsuz et al., 2006; Askelson et al., 2015; Borrero et al., 2015; Campo et al., 2012; Kendall et al., 2005; Lifflander et al., 2007). Many women feel ambivalent about whether they would like to have a child (often estimated at approximately 1/3 of women of reproductive age), sometimes feeling that they do not want a child at present but also feeling that it would not be a bad thing if it happened (Askelson et al., 2015; Schwarz et al., 2007). For many women, feelings of ambivalence may also be associated with perceptions related to their sense of control over their behaviors or fertility (locus of control). For example, many women, particularly in more religious areas, feel that whether they have children is 'up to God' or they may feel fatalistic assuming that having a child is inevitable, something that will eventually happen (Borrero et al., 2015). A significant body of research has found that attitudes like these are associated with contraceptive use and UIP outcomes, but it is clear that these attitudes are shaped by a complex set of social and structural factors (Afable-Munsuz et al., 2006; Askelson et al., 2015; Borrero et al., 2015; Campo et al., 2012; Kendall et al., 2005; Lifflander et al., 2007).

Further research is needed to determine the contextual influences on how women develop these attitudes.

A.4 Contraceptive Use

Contraceptive use is a major means of preventing UIP and is also associated with women's ability to achieve their RH goals. Contraceptive use is associated with positive health outcomes for women and their families as well as with socioeconomic outcomes relating to educational attainment and consistent employment (Sonfield A et al., 2013).

Trends & Disparities in Contraceptive Use

In 2014, approximately 60% of all women in the U.S. used a method of contraception. Ninety percent of women who were at risk of UIP also reported using a method of contraception at the time of survey (Kavanaugh & Jerman, 2018). Rates for consistent use of contraceptives are often lower, with data suggesting that only about two thirds of women at risk for UIP use contraceptives consistently and correctly through a given year (Sonfield A et al., 2014). Women who use contraceptives inconsistently or who do not use contraception at all experience UIP at far higher rates than women who are consistent in their use (Sonfield A et al., 2014).

While levels of use have remained relatively consistent, there has been a slight decline since 1995 (64%) to 2014 (61.4%). Existing literature indicates that young women, those with lower SES, and women of color also have lower rates of using any method of contraception (Dehlendorf et al., 2010). Age disparities are also present, with younger women less likely to use contraceptives. This disparity is more prominent for young women of color (Dehlendorf C et al., 2014).

Contraceptive Methods & Efficacy

The type and efficacy of the contraceptive method chosen also have implications for experiences of UIP (Gavin et al., 2014). Highly effective methods of contraception, especially long-acting reversible (LARC) methods, are effective at preventing pregnancy and are less prone to failure or user error. However, access to and use of these methods is not the same across income level, race/ethnicity, or age (Dehlendorf C et al., 2014; Jones J et al., 2012; Shih et al., 2011). In particular, women of color are less likely to use highly or moderately effective methods (Dehlendorf C et al., 2014; Jackson et al., 2016; Jones J et al., 2012; Shih et al., 2011). Growing use of highly effective methods indicate that this difference may be changing (Kavanaugh & Jerman, 2018). The reasons for disparities in choosing contraceptive methods may vary by minority group, suggesting a need to understand racial/ethnic differences more deeply. Such understanding is also crucial in meeting individual women's needs (Shih et al., 2011). There are growing concerns however, that LARC methods may be over emphasized and several have emphasized that they should not serve as a panacea for addressing UIP, particularly given women's ranging preferences for and comforts with such methods (Higgins, 2014). Indeed, there are increasing calls for caution in the field of FP given evidence of the tendency to push these methods on certain populations perceived to be at higher risk. Conceptualizing or measuring access thus must not focus solely on the uptake or availability of such methods (Dehlendorf C et al., 2015; Dehlendorf et al., 2018).

Multilevel Determinants of Contraceptive Use

A complex array of factors influences an individual's contraceptive use. These factors may yield different outcomes or be more important for certain individuals depending on personal factors such as SES or race/ethnicity. While personal factors account for some variation in contraceptive use, there is also evidence that personal factors such as race/ethnicity, age, parity and measures of socioeconomic status like income and education do not fully explain differences in it (Dehlendorf C et al., 2014; Grady et al., 2015; Sweeney & Raley, 2014). For example, among women who do not want any more children, black women were more likely than white women to not use any method of contraception, even when controlling for socioeconomic status (Grady et al., 2015). There is some evidence that socioeconomic factors may be partially associated with differences between Hispanic and white women's use of contraception (Grady et al., 2015). Still, it is likely that other experiences at both an individual level and at a level beyond an individual's control (context) most likely combine with personal factors such as race/ethnicity and SES to directly and indirectly influence behavior (Dehlendorf C et al., 2014; Grady et al., 2015). Current literature on these is discussed below:

Individual Level Influences

Knowledge & Attitudes

Women may have varying knowledge of and attitudes toward contraception that may explain some differences in use (Hodgson et al., 2013). Misconceptions about side effects or the effectiveness of methods, for example, may be influential. Some studies have found that women of color and women of lower SES may be more likely to underestimate the effectiveness of a variety of methods of contraception than white women or women of higher SES (Biggs & Foster, 2013; Hodgson et al., 2013). Women may also be less likely to use contraception if they believe that it is likely they are infertile or cannot get pregnant (Biggs et al., 2012). In one study of unplanned births, a little over one third of women who reported not using contraception at the time of conception reported that they believed they could not get pregnant at the time (Mosher, 2012). Another study found that Hispanic women experiencing unintended births were often more likely to believe they were not able to get pregnant (Mosher, 2012). Others have also noted that some women may prefer not using some methods because of dynamics related to intimacy or pleasure (Biggs et al., 2012; Higgins & Hirsch, 2008; Higgins et al., 2008).

Differences in attitudes toward pregnancy (and intention) may also be associated with use of contraceptives; however, there are mixed findings about whether race is related to desire to avoid pregnancy. Different pregnancy motivations may explain some race/ethnicity differences particularly in younger women. One study found that white young women are more likely to report they would be very upset if they got pregnant unexpectedly (Martinez GM, 2013). Though other studies have found that pregnancy intention is not significantly associated with contraceptive use (Bader et al., 2014). The relationship between pregnancy intention and contraceptive use is unclear and does not fully explain differences by race/ethnicity.

Health Status

Women may also have pressing health-related concerns such as depression and stress that can influence their ability or desire to use contraceptives consistently (Hall et al., 2014b; Hall et al., 2013; Moreau et al., 2013). There is also some evidence that women with chronic health conditions including obesity, hypertension, diabetes etc. use contraception differently than other women, but it is unclear whether these are simply associated (Chuang et al., 2005; DeNoble et al., 2014).

Side effects

Fear of, and negative experiences with, side effects also influence women’s use of contraception, particularly their use of hormonal methods (Frost et al., 2012b; Sweeney & Raley, 2014). There is a significant body of literature indicating that women of color experience and/or fear side effects from hormonal contraceptives more than white women (Coles et al., 2011; Guendelman et al., 2000; Hodgson et al., 2013). Black women are also more likely to report not using contraception because of a fear of side effects than White or Hispanic women (Mosher, 2012). Yet in some studies discontinuation rates related to side effects do not appear to be different by race when controlling for other factors (Littlejohn, 2012). It is unclear the extent to which beliefs about and experiences of side effects explain racial differences with respect to contraceptive choice (Sweeney & Raley, 2014).

Interpersonal Relations

Method choice and use is also determined by influences partly outside of women’s own control such as interpersonal relationships with family, friends, and partners (Hodgson et al., 2013). Close friend groups or trusted information sources can influence women’s perceptions of contraceptives and preferences for methods (Campo et al., 2012; Sadia et al., 2013). Intimate partners also influence women’s use of contraceptives (Campo et al., 2012; Matsuda Yui et al., 2014; Miller et al., 2010). Some women experience reproductive coercion when their partner prevents them from using a specific method (Borrero et al., 2015; Miller et al., 2010). Young women and teens, who are financially dependent on a partner are less likely to use contraceptives (Rosenbaum et al., 2012). Sexual networks or relationship dynamics may also explain inconsistent or non-use of methods. Women experiencing unintended births also reported not expecting sex as a reason for not using contraception (Biggs et al., 2012; Jones J et al., 2012).

Gaps & Remaining challenges in Literature on Contraceptive Use

Overall, though contraceptive use is relatively high, there are variations in contraceptive use by personal factors such as race/ethnicity, SES, and age. When these variations are considered alongside other influences, however, personal factors, particularly race/ethnicity, do not appear to play a determining role as clearly. The use of contraceptives is a complex behavior, shaped by both individual level and upper level factors. Many of these influences are likely to interact and are different because of one's social identity (race, SES etc.). For example, women may not want to use contraceptives because of their side effects and may be more likely to experience side effects given their experiences with discrimination. The extent to which these factors interact is not well understood. Some research indicates that variation in contraceptive use by personal factors, such as race/SES, may be in fact due to other influences commonly associated with being minority or low income. Little research, however, has explored how multiple factors within an individual's life may combine to produce behavior. Many of the disparities in use of contraceptives are assumed to be related to disparities in access to FP services, but the extent to which these are related remains unclear. The proposed study will address these gaps by examining the extent to which access comes into play in terms of initial use and continued use of methods. It will also begin to explore how multiple factors may overlap and combine to shape unique needs.

A.5 Access to FP Services

Access to FP services is also widely considered to be linked to contraceptive use (and UIP) and is frequently discussed alongside the use of contraceptives. Understanding the distinctions, however, between the act of using contraceptives and the necessary pre-steps to this behavior is important. One's ability to get contraceptive methods is related to one's ability to find services and to use them. Thus, ‘access’ is a necessary prelude to contraceptive use. *Access to health care* can be broadly defined as “the ability to seek and have health care needs fulfilled (Levesque et al., 2013).” Access includes an individual’s preferences about where to get care, the process of seeking care, the ability to reach care, as well as the use of services (*realized* access). Though historically conceived as pertaining to the health system (i.e. provision of services), access to care consists of interactions among multiple streams of influence from both the supply and demand-sides(Andersen, 1995; Levesque et al., 2013). Though access has long been conceptualized as an interplay between health care system and individual factors (Aday & Andersen) it is most frequently measured and conceptualized in terms of the health care system (Aday & Andersen, 1974; Andersen, 1995). Similar trends can be observed in literature on access to FP services that deal with realized access (e.g. use of services) and factors within the health system (e.g. cost of services). Yet, as Levesque points out, access is complex and merits examination in terms of multiple influences (Levesque et al., 2013). An expanded, patient-centered definition of “access” that draws on Levesque’s framework serves as the framework for the proposed study and will be discussed later.

Trends & Disparities in Access

Access to services has been measured in several ways, including the availability of services and the extent to which they meet a given need, use of services, as well as particular attributes (e.g. *acceptability*, *availability*, *affordability*, and *effectiveness*) of services that enable (or serve as barriers) to access.

Publicly funded FP services provide an essential means for low-income women to avoid pregnancies they do not want and to plan pregnancies they do want. In 2014, women used these services to avoid two million unintended pregnancies, “which would likely have resulted in

900,000 unplanned births and nearly 700,000 abortions (Frost et al., 2016).” In 2014 publicly funded clinics met 39% of the need for publicly funded contraceptive services, a decline from years prior likely related to changes in insurance systems (Frost et al., 2016). In Georgia, only 16% of the need for publicly funded FP services were met by publicly funded centers in 2014, in contrast to 26% nationally (Frost et al., 2016). At the same time, between 2010 and 2014, despite increases in the number of women in need of publicly funded FP services (+ 7%), the need met by publicly funded services has decreased at rates higher than national (-26% compared to -14%) (Frost et al., 2016). Similar trends are apparent in other Southern states including Kentucky and Louisiana. The authors of this study point out that while decreases in met need may be expected because of changes in Medicaid expansion, these declines are at higher rates than increases in insured women (Frost et al., 2016). Further questions remain about where women are going to get services and what may be associated with these decreases. While need met cannot be interpreted as unmet need, some women may have received services from private services and the true number of women who received services is unknown, these estimates point to potential disparities in access to care.

Use of Services

In 2010, approximately 40% of women of reproductive age (15-44) received services from a medical provider in the past year. Of women aged 20-29, over half reported receiving services in the past year (Martinez GM, 2013). Though national estimates for 2013 indicate that use of services may be rising with 46% of women 15-44 reporting use of FP services in the past year (Pazol et al., 2017). Several studies have shown that use of FP services is lower among socially and economically disadvantaged women, minority and underinsured women (Hall et al., 2012b; Martinez GM, 2013; Pazol et al., 2017). Age, education, employment, insurance, immigrant status, religiosity have been also found to be associated with differences in use of FP services (Hall et al., 2011). Some studies have also found that differences in use of FP services are not driven by race/ethnicity but instead are more strongly related to income and insurance where inequalities appear to be widening between those with and without insurance coverage (Hall et al., 2011; Martinez GM, 2013). Compared to women receiving other SRH related medical services, one study found that black women received those services at a higher rate, but that disparities persisted for poorer women and women with gaps in insurance (Martinez GM, 2013). Another study also found no difference in rates of use of FP services by race/ethnicity, but did find differences in the types of method related counseling women received with more emphasis on sterilization methods for Hispanic women (Borrero et al., 2009). Additionally, one study found that young, poor, and minority women also experience higher rates of discordance between their preferred source of care and their actual source of care for SRH services (Hall et al., 2015).

Multilevel Determinants of Access to FP

Previous studies have examined multiple dimensions of the accessibility of FP services that serve as barriers or facilitators to access. The majority focus on the health system level but a few incorporate personal factors.

Health System factors

Existing literature on access primarily focuses on attributes of the health system that serve as barriers or facilitators to use of services (realized access). Studies using both survey and qualitative data have identified challenges for women in using FP services that are associated with the *acceptability* of seeking care. The confidentiality of available services has been shown to be particularly important in the use of FP services,(Wood et al., 2015) and continuity with clinician has been reported to be important in choosing care and in perceptions of quality (Becker & Tsui, 2008).

The *availability* of services also has influence on whether women access care, including the presence or physical location of services (particularly if they are along public transportation routes, close to work, etc.)(Frost et al., 2012a) as well as clinic hours and ease of scheduling an appointment (Frost et al., 2012a; Wood et al., 2015). Having a range of contraceptive methods on site as well as the ability to insert methods, influences service use as well as continuity of use (Frost et al., 2012a; Hodgson et al., 2013; Wood et al., 2015).

Recently a large body of literature, including the Contraceptive CHOICE project, has focused on *affordability* as a barrier. There is evidence that reducing cost of services is associated with increased use of contraception, with several studies seeing significant increases in use of LARC methods (Frost et al., 2012a; Peipert et al., 2012; Ricketts et al., 2014; Secura et al., 2010; Wood et al., 2015). Yet, these studies often focused on unique, controlled settings. It remains to be seen whether such interventions feasibly scale.

Significant research has already identified challenges for women in accessing and using FP services that are related to the *appropriateness of care* such as their interactions with providers and the *quality* of care they receive (Becker & Tsui, 2008; Wood et al., 2015). This includes staff and provider treatment (i.e. whether women perceive they are treated respectfully) and perceived autonomy in decision-making related to method choice, as well as cultural competency and language capacity (Becker & Tsui, 2008; Sweeney & Raley, 2014; Wood et al., 2015).

Individual factors

Far fewer studies have focused on individual factors that relate to the context of individuals' own lives or resources as they relate to access and to use of FP services, with one exception, insurance status. A number of studies have shown a clear association between women's insurance status and their ability to use or access care (as well as continuity in using contraception). Insurance status is strongly associated with the ability to use and pay for contraceptive services. Many studies have identified being uninsured, having a gap in insurance, or not having the right insurance as a barrier to receiving FP services (Hodgson et al., 2013; Hopkins et al., 2015). These factors are, of course, associated with national and local policy contexts. With changes in health care systems and insurance and with the passage of the Affordable Care Act in 2014, there have been some shifts in access related to insurance coverage. With shifts in access to private insurance and expansion of Medicaid, women are seeking services at a variety of providers. As mentioned, during this time Guttmacher estimates that the overall number of women being served by publicly funded contraceptive services fell, while the number of women receiving contraceptive services private sources of care rose (Frost et al., 2016). While changes related to ACA have enabled more women to access to a range of contraceptives these changes have not been felt uniformly, particularly in states where Medicaid was not expanded (including many in the South) (Frost et al., 2016). Georgia, for example, is one of five states where over 30% of women in need of publicly funded services were uninsured in 2014 (Frost et al., 2016).

In addition to insurance-related factors, access to FP services is also shaped by ability to reach services, particularly in terms of women's access to transportation (Hodgson et al., 2013; Wood et al., 2015). Several studies have also suggested that individual access to services may also be shaped by women's trust of the health care system and medical providers in general (Rocca & Harper, 2012; Thorburn & Bogart, 2005). Given a history of discriminatory and coercive practices within the U.S. health care system and within SRH (e.g. Tuskegee, forced sterilizations, Henrietta Lacks, etc.), it is not surprising that many poor and minority women distrust health care providers and are hesitant to seek services (Ross & Solinger, 2017; Stern, 2005).

Factors Associated with Preferences for Services

A few studies also examined how these factors are associated with women's preferences for a source of care, including why they choose a particular place to go. Studies have primarily focused on sources of care related to specialized FP centers, federally qualified health centers, and private doctors (Becker & Tsui, 2008; Frost et al., 2012a; Hall et al., 2015; Wood et al., 2015). These studies indicate that there are a variety of factors associated with why women choose particular sources of care, including: availability of multiple services on site (Frost et al., 2012a; Wood et al., 2015), cost and affordability of services (Frost et al., 2012a; Wood et al., 2015), ability to get an appointment (Frost & Lindberg, 2013; Wood et al., 2015), physical location of clinic (Frost et al., 2012a), hours and appointment availability (Frost et al., 2012a). Women also consider the quality of care they receive, particularly in relation to staff and provider expertise in women's health (Frost et al., 2012a; Wood et al., 2015), having continuity with a provider (Wood et al., 2015), and how staff treat them (Becker & Tsui, 2008; Frost et al., 2012a; Wood et al., 2015). Confidentiality and privacy of services was also universally important for women in choosing care (Frost et al., 2012a; Wood et al., 2015).

Preferences for care source and priorities appear to vary across (age, race/ethnicity, income) subgroups. For example, older women may prioritize consistency of care, women with children preferred having primary care or pediatric services also available (Hall et al., 2015; Hopkins et al., 2015; Wood et al., 2015). One study found that preference for and use of primary care services was more common among older, less educated, non-white, lower income, unemployed, and uninsured women (Hall et al., 2015).

Summary of Gaps and Remaining Challenges in Literature on Access to FP Services

Disparities persist in who is able to access FP services and there has been an overall decline in the use of publicly funded service providers. Much is unknown about the reasons for this decline. It may be explained in part by changes in the healthcare marketplace where more women are seeking care at different types of providers. It may also be explained by increases in the use of longer acting methods. However, much is unclear regarding the extent to which continuing disparities are also related to more restrictive policy environments with regard to contraception and funding for FP.

Women's ability to reach and use FP services is often shaped by factors beyond their control. There is some evidence that removing health system barriers to FP services can reduce disparities, but much less is known about the influence of other factors in women's own lives. Much less is also known about the extent to which care is fully meeting the diverse needs of low-income women. Disparities in access to services may also be linked to disparities in use of contraceptives but much remains unclear about how these are related and the extent to which access barriers drive disparities in use of contraceptives.

Critiques of the literature

There is much more to learn about how access contributes to disparities in reproductive autonomy and experiences of UIP. The current literature has several shortcomings and leaves many questions unanswered.

Methodological & Measurement challenges: Overall, literature on access is limited in scope. Current research predominantly focuses on measures of the health care system but not on measures of individual experiences of contexts, both of which may influence access. Quantitative assessments often focus on limited measures to represent access—mostly insurance status and use of services. Considerations about quality of services are often separated from other discussions related to access—thereby limiting conceptualizations of what realized access might mean.

Methodologically, the majority of studies are high-level assessments, using national data sets with few access specific measures. Qualitative studies often employ focus group discussions that, while useful for understanding general trends and identifying general barriers, are less useful for getting a detailed understanding of how various factors affecting access interrelate and/or vary among individuals. The majority of studies also use clinic- and hospital- based populations. Much less is known about the experiences of women who are not currently attending FP clinics for services. Finally, many studies use researcher driven, pre-specified notions of access, and very few studies have examined women's own reasoning about why they chose to go where they go.

Limited conceptualizations of access: The majority of studies treat the concept of access narrowly, not fully reflecting realities of women's lives. As RJ theorists have pointed out, understanding behaviors related to fertility control divorced from the context of women's lives often result in false assumptions related to women's means to achieve access (Ross & Solinger, 2017).

Focuses on method choice and efficacy as the end goal also miss part of the picture. Critiques of late have noted that counseling practices that emphasize the highest level of efficacy may also inadvertently be coercive and that effectiveness for avoiding unintended may not be the highest priority for all women when combined with their other experiences including experiences of side effects, perceptions of discrimination, or concerns related to removal (Dehlendorf et al., 2018; Higgins, 2014).

Finally, it is also important to note that access may not be a driver of contraceptive disparities for all women. Some, mainly qualitative, studies have also noted that access is not the issue for women in avoiding pregnancy or contraceptive use (Manze et al.). It is unclear the extent to which this is because access is narrowly defined or women's decision making about pregnancy is different. Further exploration of what it means to meet women's needs as it relates to access to services is needed.

A need for systems thinking: Taking a systems view of SRH recognizes that women's reproductive lives and choices are shaped by complex and interrelated factors that are inextricably linked (Roux, 2011). In fact, for many women, the idea of 'choice' in having a child is a far too simplistic and narrow a concept (Price, 2010). For poor women reproductive outcomes are often determined by systems that span the social ecological framework. Systems approaches also acknowledge interrelationships and feedback loops between levels (Kroelinger et al., 2014; Roux, 2011). Many elements in this model are interrelated and feed off of each other or create synergies. Culture and gender norms, for example, influence many levels of this framework. At a societal level policies are influenced by stereotypes about female promiscuity (McClelland & Frost, 2014). Price (2014)argues that contexts in which there is economic instability enforce patriarchal norms that subjugate women, in part by seeking to control their sexuality. Concerns about women's "promiscuity" leads to condemning them for using contraception. This, in turn, promotes policies that prevent women from controlling their fertility. Thus, to more fully understand the forces that shape women's access to FP services it seems essential to also examine contextual factors beyond the individual and the health system. A key area of influence is the social context that shapes both individuals and healthy systems.

A.5 Social Context

Defining Social Context

Social context describes sociocultural factors that influence women's daily lives and shape health behavior (Burke et al., 2009). Social context includes cultural and social norms, historical experiences and forces, socioeconomic forces such as poverty and education, systems of social exclusion such as racism and sexism, political and legislative influences, as well as interpersonal and community dynamics related to social capital and social support (Burke et al., 2009; Price & Hawkins, 2007). As Burke et al note, social context has been traditionally conceptualized in behavioral science in terms of its influence on individual beliefs but has largely been kept in the background (Burke et al., 2009). There is growing acknowledgement of the inextricable ways in which an individual's context influences behavior and an increasing emphasis on models that integrate multiple levels of influence. Drawing on Anthropology and Sociology, Burke et al expand notions of social context in relation to health behavior to demonstrate the ways in which it shapes an individual's behavior directly and indirectly. They argue that social context shapes daily life and behavior often in ways of which women are often not aware. The influence of social context also changes over time as one's own perceptions of it change and as one undergoes new experiences (Burke et al., 2009). Assessment of the dynamic interaction between a woman's social context and her health behavior, however, is often left on the margins. Burke et al point out, as do many RJ theorists, that only through understanding how an individual experiences multiple intersecting elements can we fully understand her health decisions (Burke et al., 2009; Ross & Solinger, 2017).

Elements of Social Context Related to Access & Disparities

The proposed study focuses on three key dimensions of social context: 1) social and cultural norms, 2) systems of exclusion, and 3) social capital (e.g. community trust and social support) that has been identified as having influence on reproductive health (Burke et al., 2009; Price & Hawkins, 2007). Each will be discussed further below.

Norms

Social and cultural norms have influence on behavior. Women's perceptions of what others are doing (descriptive norms) and their perception of what they feel others think they ought to be doing (injunctive norms) are established through a variety of channels including media messages, education, community—including faith communities, family, and peers. Social and cultural norms have been shown to influence pregnancy intention, (Bute & Jensen, 2010) contraceptive use (Bader et al., 2014; Frost et al., 2012b; Hodgson et al., 2013), behaviors related to UIP (Frost et al., 2012b; Kendall et al., 2005) and abortion (Rice et al., 2017; Whitney et al., 2016) but relatively little has been explored in terms of the influence of norms on whether and where women go for FP services. These norms are likely interrelated and influence both the health care system and care seeking but there may be other normative influences that come into play when women seek FP care. Additionally, there is likely to some variation in norms for individuals based on race, and these variations may be influenced by other factors within the social context such as experiences of discrimination. The influence of shame and stigma come into play significantly in terms of seeking services but may not be as powerful a driver in sexual behavior (acts that take place in very different spaces). The interplay between norms, larger social context, and factors in the health system may have important implications for health care providers, and for policy.

Systems of exclusion & discrimination

Systems of exclusion include discrimination including those related to racism, sexism, or homophobia (Price & Hawkins, 2007). Experiences of discrimination, historical and current, particularly within the health system, influence women's trust or lack of trust in medical services and their satisfaction with contraceptive counseling (Kossler et al., 2011; Ross & Solinger, 2017). Experiences of discrimination within the health care system have negative impacts on women's use of SRH care. Previous experiences of discrimination have also been shown to influence women's choice of method, often resulting in the selection of lower-efficacy methods (Kossler et al., 2011). Discrimination happens both within health care and outside of it. Yet much remains unclear about the degree to which such experiences both within and outside of health care systems influence women's process of seeking care.

Social capital

Social capital has been widely defined, and while there is no single consensus on the definition, it is commonly understood to describe phenomena having to do with social relationships at individual and societal levels. These phenomena have implications for a variety of benefits including community change and health outcomes (Islam et al., 2006; Macinko & Starfield, 2001). Social capital includes domains related to individual perceptions of interpersonal trust, sharing and reciprocity (*cognitive social capital)* and perceptions of social support (*bonding social capital)* (Islam et al., 2006; Murayama et al., 2012). Access to social capital has been shown to be associated with inequalities in health and health care access (Uphoff et al., 2013). Social capital has also been shown to influence SRH related outcomes (Crosby et al., 2003; Holtgrave & Crosby, 2003). Social capital, particularly community trust and social support, have been shown to be associated with pregnancy intention as well. In her seminal work on low-income single mothers, Edin notes how often extreme feelings of isolation and loneliness, experienced as a result of poverty, have influenced pregnancy decisions of young women (Edin & Kefalas, 2011). Isolation and loneliness may also influence into care-seeking. Further exploration is needed into these connections and into the ways in which low levels of social capital and social support shape some women's process of seeking care as well as their expectations and unique needs with respect to care.

Summary & Remaining Gaps in Social Context Literature

Previous literature has examined the influence of multiple dimensions of social context on unintended and teen pregnancy, use of contraceptives, as well as on seeking abortion services. However, little research has specifically focused on the influence of social context on seeking FP services. Additionally, while some research has begun to focus on the context of the South, little research has explored the ways in which localized context such as the social context influences access to FP care. Understanding these influences may provide further information on how to better provide services for women.

A.6 Theoretical framing

Prior Theories

Although a variety of health behavior theories have been used to address FP, a large majority of U.S. based studies and interventions related to UIP or contraceptive use for the past decade have been clinically based and a-theoretical (Kirby, 2008; Lopez et al., 2009). Some individual level behavioral theories have been applied to this area. The Theory of Planned Behavior (TPB) and the Health Belief Model (HBM), in particular, have been used to explain and to develop interventions for a range of health behaviors, including sexual behavior (Montano D & Kasprzyk D. , 2015). TPB has also been used to examine the choice and use of contraceptive methods (Hodgson et al., 2013; Peyman & Oakley, 2009) and provides a useful framework for understanding influences on women's access to contraceptive services.

Individual level behavioral theories, however, as is increasingly noted, often do not adequately address influences beyond the control of an individual. Individual level behavioral theories often assume individual autonomy in making a decision to perform a health behavior. While some theories do acknowledge the influence of environmental factors these are often grouped in a single construct that rarely specifies explicit influences or the mechanisms by which these operate. TPB, along with other individual level theories, have been widely critiqued for their views of behaviors as primarily rational and voluntary decisions (Glass & McAtee, 2006). While intention to use contraception is certainly associated with contraceptive use and access to services, access to services and actual use is more complex (Hanson et al., 2015).

By the same token, individual behavioral theories like TPB, often assume that an individual's intent is the most influential factor related to behavior. This is problematic in the context of fertility control. Accessing FP services does not solely lie with individual intent; deciding to seek services is just the beginning of access. The ability to use an effective method of FP comes from an interplay between a woman's own individual determinants and her experiences of environmental factors such as the health care system. This interplay has multiple phases that may affect her ability to achieve the end goal (using contraception). For example:

- The ability to seek care may be influenced by perceived norms, as well as health system policy.
- The ability to reach care may be affected by access to transportation, and on the health service level by the availability of services (e.g. appointment hours).
- The ability pay for care may be related to a woman's insurance status and the prices of methods at the clinic she chooses.

Few individual theories explore the influence of higher-level factors. While some individual theories acknowledge environmental factors, they do not delve into these influences or elucidate ways in which they interact. This dynamic interplay is lost when the focus is solely on individual level theories that often place too much emphasis on an individual agency that may in fact not be possible (Glass & McAtee, 2006). To date theories that encompass and explicate the interplay of multiple factors are still lagging.

Multilevel studies that explain or address health behaviors and outcomes are increasingly recognized as important to the field of public health research (Diez-Roux, 1998; Diez-Roux et al., 2000; Glass & McAtee, 2006; Golden & Earp, 2012; Merlo, 2003; Sallis J & Owen N, 2015; Trickett & Beehler, 2013). Multilevel thinking is not new conceptually and is often associated with Bronfenbrenner's seminal work conceptualizing five ecologic systems with which individuals interact (Bronfenbrenner, 1979). The Social-Ecological Model, as it is known, is widely used in public health to conceptualize how individual's health behaviors may be influenced by and interact with their context. This multilevel thinking, however, does not specify the mechanisms by which the levels interact or influence behavior. Developing interventions that address multiple levels have thus far been limited, including in the field of SRH. Some theorists have begun developing multilevel theories particularly in relation to experiences of discrimination (Krieger) or the influences of systems (Diez-Roux) but these theories remain few and often overly specific (Diez Roux, 2012; Krieger, 2011, 2012). This study seeks to expand understandings of the dynamic interplay between social context, health systems, and individual lived experiences on health behavior and health outcomes in order to more clearly understand the mechanisms by which these levels influence behavior'.

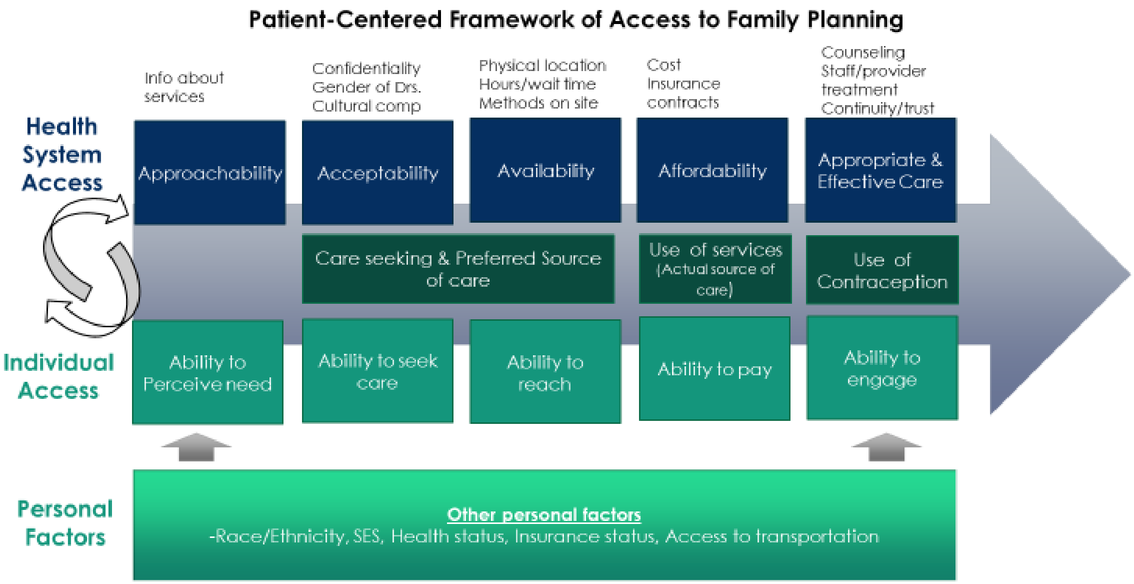
Finally, the majority of behavioral theories are problematic for understanding disparities in access to care, use of contraception, and UIP in that they assume that there is a specific desired behavior (e.g. using contraception), where increasingly in the field of SRH things are not so simple. The end goal here is not to promulgate a specific, paternalistic view of what individuals should be doing but rather to enable individuals to make informed decisions and to better access services that meet their needs. Rather than seeking a specific behavior, studies should enable women to use the services they need and to choose the method that is right for them. Given the history of reproductive coercion in public health practice, in particular, it is important not to identify a single best path but instead to encourage individual autonomy and decision making

To shift thinking and theorizing so as to address issues of coercion, power, and justice and to move from assuming that all individuals are similar in terms of their behavior and then "placing blame" on individuals who don't conform represents a challenge for our field. Theories must expand so as to understand individual behavior as a product of personal factors (race/ethnicity, SES) and time if they are to identify mechanisms that allow individuals the ability to make informed, autonomous decisions and to enact informed and autonomous behaviors (Glass & McAtee, 2006; Krieger, 2011, 2012).

Adapted framework for proposed dissertation

To address the issues noted above, this dissertation will not apply a specific behavioral theory but will make use of an access framework that encompasses multiple levels of influence on behavior. As this study is exploratory it makes use of a framework that encompasses these levels and constructs but does not yet specify how each of these influences behavior. The mechanisms by which these levels influence behavior will be explored during the course of the study. The proposed Patient Centered Framework for Access to FP (Figure 1.2), an adaptation of Levesque's "Patient Centered Access Framework" incorporates the influences of the health system, individual's perceptions of their lived experiences, and the social context (Levesque et al., 2013). Levesque's access framework provides an integrated and well-defined framework that clearly specifies determinants and dimensions of access.

Figure 1.2



These studies will employ a comprehensive concept of access (including preference for services, seeking and reaching care, using services, and ultimately having those services meet one's needs) and will explore how the process of accessing care is influenced by factors at multiple levels. The framework includes several components related to access. These domains are defined below and specific examples relevant for SRH are provided (**Table 1.1**).

Table 1.1: Patient Centered Access Domains*

Health Systems Access	Individual Access
Approachability The ability of individuals to identify the existence of FP services that are reachable and that they can help them achieve RH goals.	***Ability to perceive need*** An individual's own ability to perceive need for care can be shaped by knowledge, health literacy, health beliefs, (linkages with friends/networks), expectations of care - *SRH: Includes influences related to sex education, pregnancy intentions/beliefs, and expectations of what care can (cannot do) for them in preventing pregnancy (up to god)*
Acceptability Relates to cultural and social factors that determine whether it is possible for individuals to seek care. Are services provided in a way that makes it acceptable to seek them? - SRH: *Is there stigma attached with seeking FP only services, or services associated with abortion? Are services confidential? Is the gender of providers acceptable, race/ethnicity ok? What language services provided in?*	***Ability to seek care*** Includes the personal autonomy and capacity to choose to seek care, ability to realize right to seek care, including the expressing of an intention to seek care. - *SRH: The ability to realize reproductive rights to choose to control fertility and to seek care for FP. This could also include family/partner influence on ability to seek care.*
Availability (accommodation) Services are physically reachable including the physical clinic, as well as the presence of staff/providers, and services are able to be used in a timely manner. - *SRH: Are there FP services within a feasible distance to individuals, are there trained staff and providers present, are clinic hours helpful, and are there open appointments. Also are methods of contraception available same day on site?*	***Ability to reach care*** Refers to personal mobility in whether an individual is able to use and access transportation, as well occupational flexibility in taking time off of work etc. (these are shaped by their larger environment).
Affordability The costs of healthcare including the prices of services, medications (e.g. birth control), as well as time related costs of a clinic visit (length of appointment times).	***Ability to pay*** Related to the capacity to generate economic resources (pay for) health care through income, savings, loans, and insurance. - *SRH: Do individuals have insurance that covers their services and method of choice?*
Appropriateness (Effective care)	***Ability to engage***

Reflects the fit between services and client need, quality of care including time spent assessing health problems, and determining appropriate care/treatment, technical and interpersonal quality of care. • *SRH: How well do services meet clients' needs? Including: appropriate counseling, provider interactions and treatment. Is care effective in that it enables client's autonomy in selecting method that works for her. Is there cultural competency in care?*	The ability of individual to engage in health care related decisions including treatment decision, related to capacity and motivation to participate in care. • *SRH: Could also be shaped by previous experiences or trust of health care, norms related to how one should interact with a doctor*

*Adapted from Levesque et al 2013

This study, therefore, will attempt to more deeply explore the ways in which multiple influences impact systems and individual behavior with the aim of understanding ways in which women may have their needs more fully met.

EXPECTED CONTRIBUTION OF THE RESEARCH AIMS

As RJ theorists have pointed out, limited definitions of 'access' do not reflect the realities that exist for many women. In the context of abortion, for example, RJ theorists note that while women may have the 'right' to 'choose' they may not have the means. Better conceptualizations are needed to measure and improve equity in access to SRH care. Levesque's *patient-centered framework* focuses on the interplay between the supply and demand sides of care seeking as a process through which barriers or facilitators may arise at any point (Levesque et al., 2013). An adaptation of this framework serves as the theoretical framework for this study (**Figure 1.2)**. Taken together, the three aims of this dissertation will generate a new patient-centered access framework that can be used to identify new metrics for clinical quality improvement as well as for future research into strategies to promote equity.

The dynamic interaction between a woman's social context and her health behavior is often overlooked and is particularly missing from studies on access, but it has significant implications for fully understanding women's health decisions (Burke et al., 2009; Dehlendorf et al., 2018;

Price & Hawkins, 2007). This dissertation will explore three elements of social context that have relevance to the South: social norms, systems of discrimination, and social capital. It will also investigate the ways in which social context permeates the process of care seeking and consider how what specific implications the influence of social context has for clinical care, messaging, and policy.

With a focus on mixed methods and participant-centered methodology, these studies will move beyond traditional studies focused on naming barriers to care or on identification of disparities and will provide participant-driven narratives that acknowledge the complexity of women's lives and provide a deeper understanding of the many factors that influence women's contraceptive care seeking (Dehlendorf et al., 2018; Higgins, 2014; Ross & Solinger, 2017; Verbiest et al., 2016). In exploring these intersections, and in highlighting the way women describe their own needs and priorities, the dissertation will move the field closer to making recommendations for how better to meet marginalized women's needs, thereby reducing disparities in health and moving closer to SRH equity. It is the goal of this dissertation produce research that will generate actionable items that can be addressed by public health interventions, health systems, RJ groups, and policy makers in the future with significant implications for better meeting women's diverse needs and for UIP and other SRH related health outcomes.

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Chapter 2 : Influences on women's care-seeking at Planned Parenthood health centers in the South

ABSTRACT

Background

In the context of a shifting healthcare landscape, better understanding of the factors that motivate women to seek services from specialized family planning clinics (SFPCs) like Planned Parenthood (PP) can provide insights about potential changes in the role of SFPCs.

Methods

We surveyed 725 women seeking services at two PP health centers in Louisiana and Kentucky from March 2016 to May 2017. We examined differences in care-seeking between women who had varying levels of access including those who did and did not have insurance instability or a regular source of care (RSOC) besides the clinic.

Results

More than 60% of women attending the health centers did not have a RSOC and nearly 40% experienced instability in insurance. Women who experienced insurance instability and a lack of a RSOC more frequently sought primary preventive services such as pap and well-woman care at PP than women with better access. For women with better access, PP health centers also served important roles for those seeking contraceptive and STI related services. The most frequent reasons for choosing the PP were that it was faster to get an appointment, wanting to go to the PP clinic more than other clinics, and the confidentiality of services.

Conclusions

Our analysis suggests that PP health centers in Southern states still provide vital services for women with and without other sources of care and are critical for women needing access to timely services for preventative and STI related care.

INTRODUCTION

The importance of access to low-cost family planning services in achieving the sexual and reproductive health (SRH) goals of low-income and underserved women has been well documented (Frost et al., 2016; Frost et al., 2012a). Women with low incomes experience higher rates of unplanned pregnancy and sexually transmitted infections (STIs) and often have less access to health care than women with higher incomes (CDC, 2016b; Finer & Zolna, 2016; Kost, 2015b; Pazol et al., 2017). Specialized family planning clinics (SFPCs) offer an important and often unique source of SRH services. SFPCs are distinguished from safety net or primary care focused clinics in that they 1) are not connected with any broader health system, 2) specialize in providing comprehensive family planning and SRH care, including a full range of contraceptive methods and, 3) often have unique financial structures or sources of payment. (Frost et al., 2012a). Though women receive SRH care from a variety of sources, evidence suggests they often prefer providers who have SRH expertise (Hall et al., 2015). For some, SFPCs provide the only source of such services or act as a key point of entry into health care (Frost et. al., 2012). Planned Parenthood (PP) health centers, a type of SFPC, provide a significant portion of SRH care. In 2015, for example, PP health centers comprised only six percent of health centers offering publicly funded contraceptive services but provided 32% of care to clients seeking contraception from low-cost providers. Among Title X providers in 2015, PP health centers served 40% of all contraceptive clients (Frost et al., 2017).

In recent years, the health policy landscape has changed drastically which has many implications for access to SRH care. The passage and implementation of the Patient Protection and Affordable Care Act (ACA) in 2010 expanded access to contraception through mandated coverage of preventive services and expansion of insurance coverage, including Medicaid, in selected states, potentially increasing access to SRH services at providers other than SFPCs. Concurrently, increasing political moves have attempted to reduce state and federal funding to SFPCs, especially PP, which may have affected service delivery (Ranji et al., October 2019). Such policy changes have changed individuals' access to SRH care and may also change the role of SFPCs (Hopkins et al., 2015).

Access to health care can be broadly defined as "the ability to seek and have health care needs fulfilled" and includes an individual's preferences about where to get care, the process of seeking care, as well as the use of services (realized access) (Levesque et al., 2013). Two factors associated with women's SRH care seeking behaviors (use of and reasons for choosing a care source) are insurance status and having a medical home or "regular source of care" (RSOC).

Insurance status has been strongly associated with the ability to use and to pay for SRH related care and contraceptive services (Hodgson et al., 2013; Hopkins et al., 2015). With the passage of ACA, women with new access to sources of insurance and care may be seeking contraceptive and other SRH related services from a variety of providers. Declines in the use of publicly funded clinics for contraceptive services may be related to these changes. In 2014, the number of women served by publicly funded contraceptive clinics decreased and the number of women receiving contraceptive services via private providers increased (Frost et al., 2016).

Although changes related to the ACA have enabled more women to access a range of contraceptives, these changes have not been felt uniformly, particularly in states in the South where Medicaid was not expanded (Frost et al., 2016). The extent to which insurance changes have facilitated access to contraceptive care and SRH services more broadly, however, is not yet well-understood. Questions remain about sources of SRH care and care-seeking preferences among women in Southern states.

When implemented, the ACA was anticipated to improve access to regular preventative care (Kaiser Family Foundation, 2016). Having access to a RSOC has been shown to enhance use of and quality of experiences with contraceptive and primary prevention services (Caldwell et al., 2018; Corbie-Smith et al., 2002; Saultz & Lochner, 2005; VanGompel et al., 2015). SFPCs may play a different role for women with and without a RSOC.

A shifting healthcare landscape raises questions about the current role of SFPCs. Better understanding of the factors that motivate women to seek services from SFPCs like PP can provide insights about women’s needs and preferences for family planning services as well as provide insights about potential changes in the role of SFPCs.

This descriptive study seeks to understand how PP health centers may meet different needs for women depending on their access to health services in the Southeast. We analyzed data collected from women seeking services at PP health centers in two Southern states, Kentucky and Louisiana. Specifically we assessed: 1) why women choose PP health centers for care; 2) how women with different access factors differ in the services they seek and their reasons for choosing the health center; and 3) how use of services and reasons for choosing the clinic also differ by demographic factors.

METHODS

Study Sites & Recruitment

As part of a large evaluation project focused on family planning services in the southeastern United States, we surveyed patients seeking services at two PP health centers in Louisiana and Kentucky. The two PP health centers have many similarities including general clinic volume, services offered, and a predominantly low-income patient population (under 250% of FPL). Neither clinic received Title X funding during the survey period. These centers provide a wide range of SRH services (including a range of contraceptive methods on site, sexually transmitted infections (STI) testing and treatment, preventative care including well woman exams, pap testing, etc.), but not abortion services. These two sites also provide an interesting basis for comparison as at the time of survey, Kentucky had expanded Medicaid and Louisiana had not.

Surveys were collected in English from patients at two PP health centers during March 2016 - May 2017. Surveys were implemented over five rounds of data collection, occurring every two months. Surveys were distributed by health center staff to all patients for the period of one month or until 100 surveys were distributed. Patients were given the 5-minute paper survey upon check-in and completed it prior to their visit. The surveys were designed to be brief in order to reduce burdens on patients and staff. Staff collected all survey forms including refused or blank surveys. Response rates were generally high and ranged from 78% to 96% per round per site over the course of data collection. A total of 873 surveys were completed or partially completed by male and female patients across the two sites. The focus of this analysis is on surveys completed or partially completed by all patients identifying as female (n=725). The larger evaluation, including the current study, was reviewed by and received exempt status from the [Blinded Name] institutional review board given no identifying information was collected.

Measures

We examine women's[2] care-seeking through two primary measures: the *purpose for the visit* and the reasons women chose to come to the health center (*reason for choosing*). Since both survey questions were "check all that apply," each option is examined separately. Surveys also collected information about access factors such as insurance stability and sources of health care.

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[2] We use the word "woman" in this paper to refer to all clients who identified as biologically female. We were not able to assess gender identity more specifically in this analysis but recognize that individuals may have a variety of ways to identify themselves.

Demographic factors including age, race/ethnicity, gender, and sexual orientation were also collected.

Insurance stability is defined as not reporting any gaps (>1 month) in insurance in the past 3 years.

Regular Source of Care: Individuals with a RSOC are defined as those who report 1) having a particular doctor, clinic, or health center that they went to for health problems AND 2) having visited a doctor's office/clinic/health center (other than PP) in the last 3 years.

Care Source: A measure of the type of place used for routine care *("Care Source")* was developed from respondent answers to the question "what kind of place do you usually go to when you are sick or have questions about your health?" Respondents could check multiple sources or select "I do not usually get regular health care." Care sources were reduced into four categories: 1) **Doctor/Clinic** if respondents reported they attended a clinic, doctor's office, health department, school, or outpatient clinic at a hospital; 2) **ER/Urgent Care** if they did not report one of the previous sources and went to emergency rooms, urgent care centers or drug store clinics (e.g. CVS); 3) **PP Only** if care-seeking was from only PP health centers; or 4) **No Care Source** for those who indicated no source of care at all.

Previous use of services: Surveys also asked whether individuals had received a variety of SRH related services in the past 3 years. We used a 3-year time frame because of updated recommendations related to recommended pap testing.

Analysis

Data were analyzed in SAS 9.4 (Cary, NC). We compared women's care-seeking by access and demographic factors and among women who did and did not have a RSOC other than PP. Comparisons were conducted with Pearson's $\chi 2$ tests for significance. Data from both sites are presented together and stratified by site as well as in supplemental tables.

RESULTS

The majority of patients seeking care at these two sites were young, with almost half under age 25 (**Table 2.1**). The majority of female respondents identified as Non-Hispanic White (50%) or Black (36%). We present the demographics of survey respondents alongside the distributions of female Title X family planning users using 2016 Office of Population Affairs Family Planning Annual Report (FPAR) data in corresponding regions (IV & VI). Our sample appeared to include more individuals who were aged 20-29 and who identified as non-Hispanic-White and Black than national populations.

Access factors

Over a third of respondents experienced insurance instability, with 39% reporting they had experienced a gap in insurance over the past 3 years (**Table 2.2**). More than half of respondents (64%) reported not having a RSOC. The majority, however, said that when they were feeling sick or needed health advice they typically went to a doctor's office, health department, or health center (69%). Five percent of respondents answered that the PP health center was the only place they usually went to for their care, and a further 9% reported that they either had no identified place they turned to for care or did not get health care. Nearly 10% of respondents also said that they had not received any SRH services in the past 3 years.

Access factors differed across demographic groups.

Not having SRH care in the past 3 years was highest among Hispanic women (17% indicated no use), while fewer Black women this (5%). Hispanic women also more frequently had gaps in insurance (64%) and Black women least frequently reported the same thing (28%). While having a RSOC did not appear to vary by demographic factors, the types of places women usually went for care varied significantly. Almost a quarter (24%) of Black women said they primarily sought care from an ER or Urgent Care, much more frequently than other women. Women's care source was also associated with their previous use of services. Having a RSOC was significantly positively associated with having had any SRH services in the past 3 years. While women who reported no source of care received SRH care the least (83%), women who only used PP received SRH services most frequently (97%, $p<0.05$). Women who only went to PP also most frequently reported having received STI related care (81.6% vs. 50-64%, $p<0.05$), (data not shown).[3]

Purpose of visit

Respondents reported coming to a PP health center for an average of 1.5 services. Contraceptive and STI services were the most common purposes of visit for all women (**Table 2.3**). Women with access limitations more frequently indicated coming for a well woman exam though the difference was only significant for those without a RSOC (20%) compared to women who had a RSOC (13%). Respondents with insurance gaps more frequently reported coming to the PP health center for pap tests than those without gaps (21% vs 15%). Respondents with insurance gaps also more frequently reported coming in for problem visits (20% vs 13%). Conversely,

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[3] Data not presented in tables but available upon request.

individuals without access limitations more often reported coming for STI related services though this was only significant for those who had received SRH care recently (33.1%).

Black women indicated that they came for STI related services (42%) more than White women (28%) or other women of color (20%). Black women also less frequently reported coming for contraceptive services (43%), especially for insertion or placement of a long-acting method (27%) compared to white women or other women of color (36% and 38%).

Reasons for choosing the health center

Respondents were asked to indicate the reason(s) they chose to come to the PP health center rather than other health centers (**Table 2.4**). The most frequently cited reason (59%) for choosing the health center was that "it is faster to get an appointment scheduled here." Other leading reasons for choosing the health center included: being able to get confidential services (47%), being able to "get the services I want here compared to other clinics" (39%) and wanting to support PP health centers (57%). Women without a RSOC more frequently indicated that the health center being easy to get to was important for them than did women with a RSOC (42% vs 32%).

Though not top concerns, service cost and insurance coverage were often identified as reasons for care-seeking at PP health centers, and the importance differed by demographic and access factors. Women with access limitations frequently identified cost as a factor. The cost of services was more frequently identified as important for those with no source of care (56%) than for women who usually went to other sources (50-34%). Unsurprisingly, women who experienced insurance gaps chose PP because of cost more often than those who had not experienced gaps. White women (42%) tended to cite cost as a factor in their reasoning, but

Black women (45%) more frequently said that health center's taking their insurance was important for them.

Surveys also allowed patients to write in other reasons they chose the health center. We recoded reasons that aligned with the categories presented above (e.g. "cheaper" to "cost"). Written responses also highlight the importance of reasons cited above. That services uniquely meet women's needs, for example, was frequently alluded to in responses like "staff is friendlier than traditional OB/GYN" or "I feel comfortable here compared to other services including my PCP." Five percent of respondents also wrote that they came because they had experience with PP before such as "I've had positive experiences before."

While only a small percentage of respondents indicated that they chose the health center because a health care provider referred them, women of color indicated provider referral as a factor (8% of black women and 10% of 'other' race) much more frequently than white women (1%). Interestingly, "confidentiality of services" did not differ significantly by age and was important for both younger and older women.

Reasons for choosing health center by purpose of visit

Table 2.5 presents respondents' reasons for choosing the health center by the type of services they sought. Individuals coming for STI services more frequently indicated that they chose to come because it was faster to get an appointment (66%) and the services were confidential (57%) than those who were not coming for STI services. The health center accepting their insurance also appeared to be important for women coming for pap (47%) and well woman care as well as STI services (54%).

Site Differences

We also compared care-seeking, access factors, and demographics between the two state contexts (**Table 2.6, Supplemental Tables**). Patients attending the Kentucky health center tended to be white and younger than patients in Louisiana. Kentucky respondents more frequently reported usually going to a doctor or clinic for care (75% vs. 63%). Patients in Louisiana had more gaps in insurance. Kentucky respondents, however, more frequently reported receiving no recent SRH services than respondents in Louisiana (86 % vs. 95%).

Current care-seeking also varied by site. Women in Kentucky more frequently came to PP for pregnancy testing and contraceptive services, whereas in Louisiana they were more likely to report coming for problem or STI related care. The top reasons for choosing the health center were similar across sites. Cost and insurance related reasons, however, were more commonly cited by women in Louisiana.

DISCUSSION

Women's preferences and priorities in SRH care-seeking may be affected by changing U.S. policy, economic, and political environments. Our study highlights the role of PP health centers for women who have different determinants of access in two Southern states. Our analysis suggests that PP health centers provide vital services for women who have limited access (e.g., no RSOC, insurance instability) and that they are a critical source for them for providing routine preventative care. More than 60% of women attending these health centers did not have a RSOC and nearly 40% experienced instability in insurance. Women who experienced insurance instability and a lack of a RSOC more frequently sought primary preventive services such as pap and well-woman care at the PP clinics. Women with limited access also more frequently came for problem visits than women with better access, perhaps indicating that some women with barriers to care may tend to only seek SRH services for emergent needs. In line with findings from other studies, our study suggests that SFPCs may continue to provide an important opportunity for connecting women without a RSOC to other preventative health services (Frost et al., 2012a).

For women with better access, PP health centers also serve important roles for those seeking contraceptive and STI related services, providing faster access to care and confidential services. Forty percent of women attending the PP health centers had a RSOC but chose the PP health center for their SRH related needs, consistent with findings that women may prefer a provider that specializes in SRH care (Hall et al., 2015). Almost half of women with a RSOC came for contraceptive services.

PP centers may also provide an important source for STI related care. Our study found that a third of women seeking care at these PP centers indicated they were seeking STI services at their current visit. This is consistent with findings from previous studies that indicate that publicly funded and SFPCs are more likely to include STI counseling in SRH care than private providers (Frost JJ, 2013). This finding is of importance given the context of the two sites, Louisiana in particular has some of the highest STI rates in the country(CDC, 2018).

Similar to Frost et al’s study (2012a) of SFPCs, we found little overall variation in reasons that women chose to come to PP health centers regardless of their care source or access limitations. Our findings differed, however, in that the most prominent reason for choosing these centers was the ability to get a faster appointment. The ability to get a timely appointment is important for women who may have pressing health concerns, such as for problem visits, pregnancy testing, and STI and contraceptive services (Hoover et al., 2015; Johnston EM et al., 2017). Previous studies have found that providers have varying capacity to provide timely access to a full range of contraceptive methods and have found that PP clinics are frequently able to provide on-site contraceptives more readily than other safety-net providers (e.g., health departments or federally qualified health centers) (Zolna & Frost, 2016).

Women also frequently indicated that they chose PP health centers because they were trustworthy, confidential, and quick. As in the previous study by Frost et al (2012a), we found that many women chose PP for their SRH care even when they have access to other providers. Despite insurance changes in Kentucky, for example, women who usually went to a doctor or clinic for medical care still chose PP for their SRH care because they could get trusted services quickly. Women also chose PP health centers because they could get confidential services. Confidential services were particularly important for those seeking STI services. Different from previous studies, however, we found that the importance of confidentiality of services did not differ significantly for younger women (<25) as compared to older women (Frost et al., 2012a) . Confidential services are often critical for individuals seeking SRH related care, particularly for young adults and adolescents (Cuffe et al., 2016; Frost et al., 2012a; Wood et al., 2015). As changes to federal Title X policy have created concerns for providers related to confidentiality protections for minors, these clinics may serve an important role in continuing to provide confidential care (Congressional Research Service, 2019; Sobel et al., March 2019).

Women with limitations in access differed in some of their reasons for choosing the health center. Not unexpectedly, the cost of services was more important for women who had experienced a gap in coverage. ACA Medicaid expansion may account for the fact that fewer women cited cost and insurance as reasons for choosing PP in KY compared to patients in LA, though cost of services was significant for those who had experienced an insurance gap in both states.

Our study also indicates that women may have different patterns of care-seeking by demographics. Black women coming to PP health centers often had fewer gaps in insurance and were more likely to have received SRH services in the past 3 years. They also less frequently chose PP for cost-related reasons and instead more frequently indicated the health center taking their insurance was important. Hispanic women conversely more frequently had insurance gaps and were less likely to have received SRH services in the past three years. This suggests that the needs of women and their reasons for coming to PP centers may vary by complex combinations of individual factors such as race/ethnicity and access as well as the larger context of the state in which services are situated.

This analysis does have limitations. Due to the desire to limit the burden on patients and staff the surveys were short and did not include questions on income or insurance status. Clinic practice data however suggest the majority of patients seen at these health centers are low-income (<250% FPL). Check all that apply question formats may also yield different responses than rating each reason for choosing the health center independently. Our study also focuses on two sites in urban centers in the South and may not capture the experiences of women who live in less urban areas or in other states. Our study does have several strengths in that we are able to examine specifically why women choose a certain kind of SFPC (PP) in contexts where publicly funded providers also exist and that we are able to highlight perspectives of women in Southern states with different policy contexts.

Implications for Policy and Practice

Our study shows that for women with and without other care sources in Southern states, PP is a key provider for SRH care. The ability to provide services in a timely manner appears to be of high importance and may be an opportunity for leveraging these centers particularly in contexts with high rates of STIs. Demographic differences in care seeking may also speak to different access, priorities, and needs from the care system. Understanding these differences may be important for ensuring better equity in care that meets all women’s needs. This study demonstrates that despite a changing access landscape, SFPCs such as PP play an important role in that they are often a source of fast, trusted, and confidential care as well as comprehensive SRH services. Shifts in policy that provide access to insurance or other care sources may not change where women prefer to go for SRH health services. Further, recent policy changes, such as the new final rule for Title X, that further restrict providers like PP and that de-emphasize confidentiality protections and the provision of a range of contraceptive methods are likely out of line with women’s needs and preferences.

CH.2 TABLES

Table 2.1: Demographic characteristics of female respondents at KY and LA clinics in 2016-17 and of family planning program users from the 2016 Title X Family Planning Annual Report (FPAR)[†]

	Sample	FPAR 2016 Female Only	
	Only Female % (n=725)	**Region IV (KY) %**	**Region VI (LA) %**
Age			
Under 18	5	9	8
18 to 19	10	9	10
20 to 24	33	25	25
25 to 29	24	21	21
30 to 34	17	15	16
35 to 39	8	10	11
40-44	3	5	6
Over 44	1	6	4
Race			
White (non-Hispanic)	50	40	41
Black (non-Hispanic)	36	36	23
Other	9	3	4
Hispanic	5.8	20	16
Missing	0.4 (n=3)	3	3
Sexual Orientation			
LGBTQ	11	N/A	N/A
First Visit to Clinic (subset)[‡]		N/A	N/A
Yes	35	N/A	N/A
No	65	N/A	N/A

† FPAR data (Fowler, 2017) includes unduplicated family planning users during the reporting period. FPAR provides a useful comparison as it reflects users of subsidized family planning services which are similar to the population served by PP health centers. Neither PP health center in this study would be included in this data.

‡Subset of participants asked this question (n=342)

Table 2.2: Access barriers to SRH services among female respondents in KY and LA, 2016-2017 survey of Planned Parenthood health centers

	Total	Race/Ethnicity (%)				Age (%)	
	% (n)	**White**	**Black**	**Hispanic**	**Other Race**	**Age <= 25**	**Age >25**
SRH services in past 3 years							
No	9.5 (64)	**11.6**	**5.1**	**16.7**	**13.2**	**12.3**	**7.1**
Yes	90.5 (632)	**88.4***	**94.9**	**83.3**	**86.8**	**87.7**	**92.9***
Regular Source of Care							
No RSOC	64.3 (461)	62.7	65.1	78.6	67.1	64.6	63.5
RSOC	35.7 (256)	37.3	34.9	21.4	32.9	35.4	36.5
Insurance Stability							
Had Gap	39.3 (283)	**45.0**	**27.6**	**64.3**	**45.3**	**30.4**	**47.5**
No Gap	60.7 (436)	**55*****	**72.4**	**35.7**	**54.7**	**69.6*****	**52.5**
Care Source							
No Care Source	9.1 (66)	**12.4*****	**4.7**	**11.9**	**7.9**	7.3	10.9
Dr/Clinic	68.6 (494)	**70.5**	**66.0**	**63.0**	**68.4**	72.2	65.6
PP Only	5.1 (37)	**4.4**	**5.5**	**9.5**	**5.3**	3.5	6.4
ER/Urgent Care	17.2 (125)	**12.7**	**23.8**	**19.1**	**18.4**	17.0	17.2

* $p<0.05$, **$p<0.01$, *** $p <0.0001$

Table 2.3: Percentage of patients by purpose of current visit and demographic and access to care factors at health centers in LA and KY, 2016-2017 Survey of Planned Parenthood Health Centers

	Total % n=725	Race			Age		Use SRH of Services in past 3 years (n=720)		Had RSOC (n=717)		Insurance gaps in past 3 years (n=719)	
Purpose of Visit		**White**	**Black**	**Other**	**Age >25**	**Age <= 25**	**No SRH Serv**	**Any SRH Serv**	**No RSOC**	**RSOC**	**Had Gap**	**No Gap**
Pap Test	16.8	18.2	16.4	13.6	**23.3*** **	**9.7*** **	24.6	16.1	18.9	13.3	**20.9***	**14.5***
Well Woman	17.4	19.0	16.4	14.6	**22.5****	**11.7****	20.3	17.1	**20.0***	**12.5***	20.1	15.8
Pregnancy Test	11.9	**7.5****	**16.4****	**15.5****	10.1	13.7	15.9	11.5	12.6	10.9	9.9	13.1
Problem Visit	15.7	14.9	18.8	11.7	16.9	14.3	15.9	15.7	17.8	12.5	**19.8***	**13.3***
Any Contraceptive Services	51.7	**55.7****	**43.4****	**60.2****	48.7	55.6	53.6	51.5	53.2	49.6	51.2	52.3
BC method	*20.8*	*21.2*	*19.5*	*23.3*	_**17.2***_	_**24.9***_	*36.2*	*32.5*	*19.7*	*22.3*	_**15.9****_	_**24.1****_
LARC	*32.8*	_**36.1***_	_**26.6***_	_**37.9***_	*31.8*	*34.5*	*27.5*	*20.1*	*34.7*	*30.5*	*34.6*	*31.9*
STI	31.5	**27.6*****	**41.8*****	**19.4*****	30.2	32.2	**15.9****	**33.1****	30.4	33.6	28.6	33.3

* p<0.05, **p<0.01, *** p <0.0001

BC= birth control

Table 2.4: Reasons for choosing the health center by demographic and access factors at health centers in LA and KY, 2016-2017 Survey of Planned Parenthood Health Centers

	Total n=725	Race			Age		Use SRH of Services in past 3 years (n=720)		Had RSOC (n=717)		Insurance gaps in past 3 years (n=719)		Care Source (n=720)			
	Total %	**White**	**Black**	**Other**	**Age >25**	**Age <= 25**	**No SRH Serv**	**Any SRH Serv**	**No RSOC**	**RSOC**	**Had Gap**	**No Gap**	**No Care Source**	**Dr/ Clinic**	**PP Only**	**ER/ Urgt Care**
Faster	59.4	**54.6****	**66.9**	**58.8**	57.8	61.1	57.4	59.7	60.3	57.8	**63.1***	**54.1**	50.0	39.8	40.5	38.4
Support PP	57.4	**66.2*****	**45.7**	**56.9**	**63.9****	49.9	***39.7****	**59.2**	*57*	*58.7*	**62.2***	**54.1**	*54.6*	*57.3*	70.3	55.2
Confidentiality ‡	47.3	45	51.7	43.9	45.6	48.3	**29.7***	**49.6**	48.5	45.4	48.2	46.7	40.7	44.4	61.1	57.7
Friends & Family	39.4	40.7	37.7	39.8	**30.4*****	**48.1**	47	38.6	40.3	37.4	39.6	39.4	37.5	39.5	35.3	41.4
Services wanted	39.3	40.2	37.4	42.2	36.9	41.9	**23.5****	**41.0**	41.5	35.4	40.6	38.1	39.4	38.6	46.0	40.0
Insurance	38.1	**34.1***	**45.3**	**35.3**	38.2	38.4	**23.5****	**39.6**	37.1	39.4	35	39.9	37.9	38.4	37.8	36.8
Cost	37.1	**42.4****	**29.9**	**37.3**	39.0	35.1	**22.1****	**38.7**	38.7	34.7	**46.3*****	**30.9**	**56.1***	**34.6**	**50**	**33.1**
Easy to get to	37.8	37.4	41.3	31.4	38.5	36.9	**25.0***	**39.1**	**41.5****	**31.5**	37.1	38.5	42.4	35.4	51.4	40.8
Staff understand needs	34.3	36.3	33.1	31.4	37.4	30.7	**13.2*****	**36.5**	35.6	32.3	38.5	31.6	42.4	32.1	46.0	35.2
Provider referred	5	**1.5****	**8.1**	**9.7**	4.8	5.4	4.6	5.1	4.74	5.7	4.7	5.3	**3.1***	**4.3**	**14.7**	**6.0**
Can bring children	4.9	**2.8***	**7.9**	**4.9**	4.8	5.0	1.5	5.2	5	4.3	**2.8***	**6.0**	1.5	4.7	8.1	6.4
Language	3.8	2.2	5.5	4.9	3.7	3.8	0	4.1	3.9	3.2	2.1	4.6	1.5	4.1	2.7	4.0

‡Subset of participants asked this question (n=313)

* p<0.05, **p<0.01, *** p <0.0001

Table 2.5: Percentage of patients reporting reasons for choosing the health center by purpose of current visit at health centers in LA and KY, 2016-2017 Survey of Planned Parenthood Health Centers

	Pap Test	Well-Woman	STI	Any BC	Pregnancy Test	Problem Visit
Faster	60.3	60.3	**65.8 ***	59.0	65.8	52.6
Confidentiality	59.3	56.1	**56.7***	41.3	52.0	52.5
Services wanted	43.8	40.8	44.3	42.1	33.3	36.0
Easy to get to	42.2	41.6	**43.9***	36.2	35.7	41.2
Cost	43.0	**45.6***	40.8	37.3	27.4	33.3
Insurance	**47.1***	**54.4*****	**45.6*****	40.8	**26.2***	39.9
Staff understands needs	**43.0***	41.6	**42.1****	33.2	**22.6***	42.1
Support PP	**73.6*****	**72.8*****	**63.2***	60.6	47.6	**69.3****
Language	3.3	1.6	5.3	3.0	4.8	2.5
Can bring children	7.4	4.8	7.1	4.8	3.6	2.6
Friends & Family	36.8	37.0	39.2	**46.1****	**27.5***	**29.41***
Provider referred	7.9	5.9	5.9	4.4	6.3	7.8

* $p<0.05$, **$p<0.01$, *** $p<0.0001$
Any BC= Any birth control related service

Table 2.6: access factor and Demographic Differences in female study population by health center site in Kentucky and Louisiana, 2016-2017 Survey of Planned Parenthood Health Centers

	KY % **(n=356)**	**LA %** **(n=369)**
Age* **		
Under 18**	7.3	3.3
18 to 19	12.7	6.8
20 to 24	35.3	29.8
25 to 29	21.8	26.8
>=30	22.9	33.3
Race* **		
White	60.7	40.2
Black	25.7	44.8
Hispanic	4.8	6.8
Other	8.8	8.2
LGBT	9.6	12.2
No SRH Service in past 3 years **	86.2	94.6
No RSOC	61.3	67.2
Care Source* **		
No Care Source	7.9	10.3
Dr/Clinic	74.7	62.6
PP Only	1.4	8.7
ER/Urgent Care	16.0	18.4
Had Insurance Gaps* **	32.0	46.6
Reason for Visit		
Pap Test	16.6	17.1
Well Woman	14.6	20.1
Pregnancy Test*	15.2	8.7
Problem Visit**	11.0	20.3
BC Any*	55.6	48.0
STI**	25.8	36.9
Why chose		
Faster	58.1	60.8
Confidentiality ***	34.5	58.3
Services wanted**	34.0	44.4
Easy to get to**	33.1	42.2
Cost**	31.2	42.8
Insurance**	31.2	44.7
Staff understand needs***	25.2	43.1
Support PP**	50.1	64.3
Language	2.6	4.9
Can bring children	3.4	6.3
Friends & Fam	42.3	36.6

* p<0.05, **p<0.01, *** p <0.0001

BC Any= Any birth control related services

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Chapter 3 : “I probably have access, but I can’t afford it”: Expanding definitions of affordability in access to contraceptive services among low-income women in a state without Medicaid Expansion

INTRODUCTION

Agency over one’s fertility is essential to the health of women and their families (Ross & Solinger, 2017; Sonfield A et al., 2013). Women who are of lower socioeconomic status, women of color, and those living in the Southeastern U.S. have lower rates of contraceptive use (Dehlendorf et al., 2010), particularly of highly effective methods (Jackson et al., 2016; Shih et al., 2011). Lower rates of contraceptive use are frequently attributed to unequal access to family planning (FP) care (Dehlendorf C et al., 2014; Dehlendorf et al., 2010; Hall et al., 2011, 2012a, 2012b; Johnston & McMorrow, 2020; Martinez GM, 2013). However, testing these assumptions is challenged by limitations in conceptualizing and measuring access.

“Access” has been broadly defined as “the ability to seek and have healthcare needs fulfilled (Levesque et al., 2013).” Access includes an individual’s preferences about where to get care, the process of seeking care, the ability to reach care, as well as the use of services (realized access). Though access has long been conceptualized as factors pertaining to both the healthcare system and individual, it is most frequently measured in terms of the healthcare system (i.e., provision of services) (Aday & Andersen, 1974; Andersen, 1995; Levesque et al., 2013). Yet, access is complex and consists of interactions among multiple streams of influence from both the supply (healthcare system) and demand (patient) sides (Andersen, 1995; Levesque et al., 2013). To illustrate this relationship between individual and health system, Levesque et al. proposed a patient-centered definition of access that includes five dimensions related to the health system (e.g. cost of services) as well as corresponding abilities of individuals to access care (e.g., ability to pay), which we term *individual access factors (Levesque et al., 2013).*

One key domain of access is affordability, which is defined as the costs of services for providers and consumers. Many studies of affordability focus solely on the health system or on insurance status (an element of individual access). The same is true of FP studies that focus on *realized* access to FP services (e.g., use of services) and health system factors (e.g., cost of services). Often left unexamined is the holistic measurement of both *health system characteristics* related to the direct and indirect costs of services, and *individual access factors* related to the ability to pay for services (Levesque et al., 2013; Penchansky & Thomas, 1981).

Select federal and state policies renewed attention to the issue of improving equity and affordability of FP services. The Patient Protection and Affordable Care Act (ACA), for example, eliminated cost-sharing for contraceptive services and allowed for expansion of access to insurance through subsidized insurance or state Medicaid expansion, thereby expanding lower-income women's access to FP services (Tschann & Soon, 2015). Although studies have shown dramatic increases in insurance coverage for women since 2014, critical gaps and challenges in accessing FP services remain among low-income and uninsured women and for women in states without Medicaid expansion (August et al., 2016; Jones & Sonfield, 2016; Moniz et al., 2018). In Southern states like Georgia, which did not expand Medicaid, there may be a greater need for publicly funded FP programs such as federally subsidized programs like Title X or state family planning expansion programs to fill these gaps (August et al., 2016; Jones & Sonfield, 2016). Georgia is one of many states that provides coverage via a Medicaid family planning waiver for FP services called *Planning for Healthy Babies* (P4HB). To be eligible, women must be ages 18-44, U.S. citizens, residents of Georgia, have household incomes at or below 211% of FPL and not be eligible to receive other Medicaid benefits. Despite these programs, in Georgia the number of women in need of publicly funded contraception is increasing while the number being served is decreasing at more than national rates (Frost JJ, 2019).

Thus, questions remain about the status of “access” in states without Medicaid expansion. Further, there is a need to better understand what access means in this context and whether common definitions of affordability of services that solely relate to cost or to insurance status capture the reality of women’s experiences. Studies so far have been primarily quantitative and have not deeply explored the experiences of low-income women and the reasons that affordability may still be a challenge.

As part of a larger mixed-methods study exploring women’s lived experiences to more holistically define access to contraceptive services, we examined both health system and individual factors related to one domain of access—the affordability of services. In this paper we sought to better understand 1) women’s conceptualizations of the affordability of FP in terms of health system and individual access factors, and 2) how health system and individual access factors shape low-income women’s contraceptive care-seeking and FP outcomes in the context of a state without a full Medicaid expansion.

METHODS

We recruited a sample of low-income, reproductive-aged adult women in suburban counties (outside the city center) within the Atlanta metropolitan statistical area, where public transportation and density of publicly funded FP services are less available than in urban settings. We sought a balance of individuals who identified as Black, White, and Hispanic. We also sought a range of care seeking experiences (e.g., private provider, community health center, specialized family planning provider, etc.), as well as non-care-seeking women. Women were classified as non-care-seeking if they had not received contraceptive services in the past three years and were not currently using a hormonal contraceptive or implant. Individuals were eligible to participate if they were: biologically female[§], aged18-34 years, sexually active, not currently pregnant, did not wish to become pregnant in the next year, had not had a hysterectomy or sterilization, spoke English, had an income below 250% FPL.

Recruitment Methods

Recruitment and data collection occurred from January 2019 to February 2020. We employed a mix of active and passive community-based (e.g., health fairs, local businesses, colleges) and clinic- based (e.g., state health department, Title X and Planned Parenthood clinics) sampling, as well as social media advertising (e.g., Facebook).

Data Collection

Eligible participants completed a survey and a semi structured life history in-depth interview (LHI) (Goldman et al., 2003). The self-administered survey assessed demographic factors and participants' social contexts. LHIs then assessed multiple influences on participants' FP care-seeking over the course of their lifetimes. LHI topics included health systems and individual factors (e.g., health, transportation, insurance & financial status, etc.), as well as their process of seeking care (e.g., preferred source of care, priorities, changes in source of care, use of contraception). Participants who were not currently seeking care for contraceptives were asked about previous experiences with sexual and reproductive health (SRH) services and the context related to decisions not to seek care. Interviews also incorporated several activities to elicit

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[§] We identify participants as women in this paper but acknowledge the range of gender identities that may be encompassed in individuals who are biologically female.

additional details related to care-seeking, including free-list and timeline drawing activities. Interviews, including the survey, lasted between 60 to 90 minutes and were conducted by the lead researcher (ANL). Interviews were audio recorded and transcribed verbatim. Participants received a $40 gift card for participating. The study was approved by the Emory Institutional Review Board.

Analysis

Interviews were coded using thematic analysis in MaxQDA 2020 (VERBI Software, 2019). Deductive codes were derived from the interview guide based on access literature, and inductive codes emerged from the interviews (Hennink et al., 2011). Three members of the research team double-coded one quarter (6) of the transcripts to refine coding definitions. Coders resolved discrepancies through discussion with the full coding team until they reached consensus. Themes were developed in a similar manner as described by Braun and Clarke (2006) through deep reading, annotation and memoing, and finally condensing and labeling. Themes were then grouped according to categories associated with the research questions. Descriptive statistics were analyzed using SAS 9.2 (Cary, NC).

Free list data were also tabulated. To start the LHI, participants were asked to list the any factors that came to mind in response to two prompts: 1) ‘Things that make it easier to use birth control or to prevent pregnancy when I want to’ and 2) “Things that make it harder to use birth control or to prevent pregnancy when I want to.’ Participants were then asked to circle the most important factor that they listed. Handwritten free list data from interview documents were compiled in Excel and tabulated. Participant lists were compiled then re-coded into categories of similar items (e.g., cost, insurance, etc.).

RESULTS

Participant Demographics

Twenty-five participants completed the study (**Table 3.1**); most identified as Black, Non-Hispanic. Less than half were employed full time.

Free-Listing Activity

Financial issues (e.g. ‘money’), healthcare costs, and insurance were some of the most frequently listed barriers or facilitators access and preventing pregnancy (**Table 3.2**). Many participants explained that they would not be able to get care or use contraception if they did not have insurance or money to pay for them; and through their interviews, participants referenced how these factors often affected the process by which participants sought care, shaping whether, when, and where participants went for care.

Thematic Overview

We organized major themes associated with affordability from LHIs into in five categories: 1) women’s experiences with individual ability afford care; 2) health system factors pertaining to affordability; 3) the implications of poor alignment between individual and health system factors on care-seeking and FP outcomes; 4) individuals’ strategies for navigating misalignments; and 5) experiences of shame and stigma produced through interactions between the individual and the health system.

Individual Access Factors

Several varying factors influenced participants’ ability to afford contraceptive services and were frequently in flux.

- ***Changes in insurance***. Most participants experienced some instability in insurance status. Participants reported an average of 2.5 changes in insurance in their lifetimes. The majority also experienced at least one period of being uninsured (churning). Insurance status changed with employment and finances, with changes in family situations, and immigration status. Mary, 24, an au pair, had insurance through her employer, but her insurance did not provide contraceptive coverage and so she and her coworkers had to find other ways to find affordable contraception.

- ***Changes in employment & financial status.*** Over their lifetimes, participants also experienced fluctuations in their financial situations. A few participants described how losing a job or being laid off resulted in losing their insurance or inability to pay for insurance and thus going without care.
  "I last had insurance in 2017. It's been like 2 years. I changed jobs, and the job that I moved to is a work from home job. They paid me less, but it was more out of pocket costs. Even though I knew I needed to get it I didn't sign up for the health insurance that they offered." (Shirley, 30, Black)

  Others described scrambling to get their contraceptive method before losing their insurance. Some participants had to change jobs or stop working because of their own health issues, the need to care for family, or deaths. These changes often resulted in changes in their financial status and thus their capacity for seeking care.

- **Individual factors supporting access during youth**: Access to insurance and/or support was a key facilitator for younger women to access FP care. Parental financial support in the form of helping to pay for contraception or service fees or helping to navigate insurance processes was also seen as crucial to accessing services. Parental support was not always a given, however, and many reported that they did not have it when they needed it. This included participants whose parents did not have insurance or went through periods of being uninsured. Blossom, 33, described how the lack of parental coverage (pre-ACA) meant that she no longer had access to contraception at age 18, resulting in an unwanted pregnancy: *"So I started a birth control pill. Then, I think, after I got older, I wasn't able to afford to get it, 'cause I think back then, with the insurance – I guess the child's on the parent's insurance – it was different. Like you could stay on it till you're 26 now, but back then, it wasn't like that…* So*, at 18, I didn't have any birth control. And then, I got pregnant at 18.*"

  College-based health centers were often identified as an important source of low-cost care that facilitated access when participants were in school. This was particularly useful as many participants mentioned that they had access to very little resources while a student and that they relied on these free services to be able to access care.

- ***Competing costs.*** The ability to pay for contraceptive care was not solely related to insurance status or to an individuals' employment. Participants also spoke about other competing 'costs.' These included transportation funds (e.g., gas money, bus fare, and ridesharing) or other health related expenses (e.g., diabetes care). Participants also frequently discussed time seeking care as a cost. This included taking time off work to go to appointments as well as the time required to navigate the health system. Alexandria, 32, White, described the difficulty she experienced with having to go back every month for a prescription: "s*o that's a thing that's been tough. I don't know why I had to go back every single month, but it was just their rule… I had to pay someone to watch my kid … Take off work, lose money.*"

Blossom described the complex series of financial considerations to be able to afford her care, including navigating transportation costs: "*Because after – when you go to certain places, you have to be there at a certain time and if you don't have a ride or if you're not on the bus line… If you don't have transportation then, you have to have money. You gotta pay someone or public transportation to get there… If I have to work in order for me to have the money to pay for the transportation, then sometimes, I don't have enough time.*"

Health System Characteristics

Participants cited several characteristics at both the clinic and system levels as being associated with affordability. These included the cost of methods and visit fees, insurance coverage policies, and the insurance billing process. For women with and without insurance, interaction with the health system was often complex. Participants frequently described a process of trying to find affordable care that was a match for needs that fluctuated with changes in their own lives as well as with the health system characteristics they encountered.

- ***Co-pays & visit fees:*** Most participants pointed out that 'cost' was more than just the price of a method. Often participants with and without insurance reported paying high co-pays or fees for visits so while their method might have been covered or affordable, the additional visit fees were still untenable. Thus, some women, especially those who did not have insurance, perceived that while they might have ‘access’ in the physical sense, they could not afford care.

“I feel like access is about the same. Not to every facility, but I feel like it’s about the same. Funds wise it is different. I probably have access, but I can’t afford it.” (Shirley, 30, Black, Non-Care-Seeking)

- ***Varying costs:*** Depending on where they went, women often encountered different costs. These costs were tied to unique combinations of individual and health system factors such as insurance status, the type and location of the service provider, the type of method desired and current insurance coverage for it, as well as other financial concerns. For example, while some found the health department to be useful for accessing low-cost services, others found that the fees were higher at health departments or community clinics than at private providers who accepted Medicaid. Kay, 24, Black, described going to the local health department to see if she could get contraception but discovered that they charged a copay: *“I think [the co-pay was] $35.00. And that was a lot to me at the time, 'cause I didn't have it.”* The private doctor she had been seeing did not charge anything, so she continued to drive an hour to the private provider for care.

Despite having Medicaid coverage Charlie, 25, Black, found that she could not get her desired method at her 6-week postpartum appointment with her private provider without high cost:

> *"And at that point, I was like, you know what? Give me the Nexplanon, because I had done my research on it, and I had gotten over all the horror stories. But since I had Medicaid, it wasn't covered… They wanted me to pay like $300.00 for it. I was like, I don't have that. And I don't want the pill. And she was like, well, you can get an IUD for free. I was still stuck on a hard no for IUD… So I ended up not getting birth control at all. […After four months] I ended up going to the Health Department, and they offered [the Nexplanon] for free…so I just got it there. But I still had Medicaid."*

Dilly, 19, Black Hispanic, described the process of trying to get an affordable birth control pill to help her with debilitating cramps: *"I know the first [pill] was $80.00, and then they switched me to a different brand, which was $65.00 just to get the whole pack… so now it's $40.00. Better than nothing… It's still a lot."* Although she found that she could get pills for less at the health department, the wait was also significantly longer resulting in other time costs.

High costs led some women (unknowingly) to crisis pregnancy centers (CPCs) for low-cost SRH related care. Though this care was often for sexually transmitted disease (STD) testing or pregnancy services, women did not distinguish CPCs as different from contraception providers: "*But I'd rather go to [CPC name] and get a whole bunch of STD testing for free than to go to the gynecological group, whatever it's called, and it's like they're really nice over there, but I literally cannot afford it.*" (Shay, 22, Black)

- ***Insurance & billing processes:*** Women also encountered difficulties with clinic billing which could involve long waits or confusion in order to determine what the insurer would cover for a certain method.

- ***Navigating public funding for FP:*** The enrollment process for publicly funded services was often overwhelming to navigate. Enrolling in Medicaid or P4HB required multiple steps and forms of documentation which could be difficult and time-consuming. If women found themselves in places where enrollment support was offered, they were often able to gain coverage; however, some participants encountered unhelpful staff or burdensome and confusing policies that ultimately prevented them from successfully navigating the process.

"Some months … if I'm not doing Door-Dash, I'm probably just doing Cash Ride… because I get cash, so I can't show them proof [of income]. And that's one thing that messes me up." (Goldie, 25, Black)

One participant described feeling as if she was caught in a catch-22 between working and needing health coverage. If she worked, she made too much to qualify for Medicaid, but could not afford insurance with her salary. Another participant described how P4HB was too burdensome to be worth using:

"I never used it. I just assume that I have it and I'll call. They say I don't have it or you need to update your income…We need your check stubs. We need your lease. It's just a

hassle. So, I just went to the health department and pay $20.00. It was just easier for me. With Medicaid, they'll ask you to come up there… That's taking off of work…You can't get an appointment so you're just waiting. There are people in line there for food stamps, for Medicaid, for daycare assistance. It's an all-day thing. It wasn't worth it.” (Yamia, 27, Black)

Participants were also often unaware of available support programs. Many did not know they were eligible for P4HB or about Title X funded health centers offering low-cost services near them. Others, especially some immigrants, were not eligible to receive benefits.

- ***Medicaid & pregnancy*****:** The experience of receiving Medicaid support while pregnant had positive and negative implications. When women were able to receive Medicaid during pregnancy, the process of seeking and receiving care often worked well and participants described experiencing “good care” that came with access to private doctors’ offices. Many women compared the differences they experienced while receiving Medicaid supported pregnancy care and the FP care they received at public or community health services. While receiving Medicaid pregnancy-related care, women were able to establish trusting relationships with providers who they reported gave quality care, in settings that were appealing and not overcrowded, while FP care often meant less appealing experiences at community health services.

  The postpartum transition off of Medicaid, however, could be difficult and experiences varied according to where a woman received care as well as with the level of assistance she had in navigating the next steps. Some women experienced gaps in insurance coverage or lost coverage completely and were not enrolled in P4HB, despite likely eligibility. Gaps in coverage meant that women missed opportunities to prevent future pregnancies. The six-week postpartum check-up was often tenuous in that if a woman missed this appointment, she then lost the ability to get coverage for contraception since her Medicaid expired soon after. Participants described being delayed in receiving their follow-up appointment as a result of emergencies, needing to take time to research their method, or because of issues with the cost of the method at a certain provider. Goldie, 25, described a harrowing process in trying to get postpartum contraception after experiencing an apartment fire that rendered her unable to keep her original follow-up appointment:

“*I tried to explain to them what happened… They still pushed me back 'cause, I guess, "Now that you're not having no baby no more, so we need to put pregnant people first in here." […so they delayed the appointment]. And by the time I went back, I didn't have no more Medicaid. 'Cause the Medicaid only lasted for a certain amount of time after you have the baby…I still have staples in my stomach. I've been plucking 'em out one by one, myself… They wanted to charge me [$300 to take out the staples]. I asked them would they be able to bill me later, and they was looking at me like I was crazy…I'm not working right not. I have no income… I did ask them how much it was just to get the birth control. They said I couldn't do anything basically until I get the staples taken out.*” (Goldie, 25, Black).

These struggles led to participants voicing perceptions that the government doesn’t care about you unless you are pregnant.

“but [then] at 3 months after you have your baby.' […Then] it's like, "You're on your own."…it seem(s) like they want you to keep having children.” (Blossom 33, Black)

- ***Most recent visit:*** By their most recent visit, most participants who wanted to be using contraception had found a way to get a method which they felt they could afford. Five individuals, with household incomes lower than the sample as a whole, still experienced difficulty with the cost of their chosen method at their most recent visit and were struggling with being able to afford it.

- ***Affordability as a process***: Affordability was thus something that changed over a lifetime and that often involved an intensive process of trial and error to find the right combination of individual access factors and the health system characteristics one encountered. Finding affordable care while low-income required being connected to the right resources including enrollment in programs such as Medicaid or P4HB, having knowledge of how such systems worked including knowledge of how to continue being enrolled, as well as finding a place that accepted the type of insurance or payment they had, and often needing to try multiple places before finding the right fit. Participants who reported fewer affordability concerns usually had stability in insurance status (private or Medicaid) and often used the same source of care.

Implications of Poor Fit between Individual and Health System

The unpredictable nature of navigating affordability had implications for women’s care-seeking and outcomes in several ways. **Figure 3.1** depicts the relationship between health system factors and individual factors and the implications of poor fit (in orange).

- ***Big, surprise bills:*** Many participants described how the process of trial and error in getting affordable care could be precarious financially. If women were not able to get up front information about costs or insurance acceptance they could be faced with large and unexpected bills as a result. Many commented that they were still paying off these expenses.

  "*I went to the gynecologist thinking that maybe I can establish myself with a gynecologist and I can keep going back. I was diagnosed with HPV, and I was slapped with a $1,200.00 medical bill... I can't even go to the gynecologist even though I have insurance because I just can't afford it… It's like I need birth control, but would I be able to afford it considering me having to pay for my master's degree out of pocket and other things*." (Shay, 22, Black, Non-care-seeking)

- ***"Weighing out" immediate vs. long term costs*:** For some women having no insurance or being in a difficult financial situation meant they had to "weigh out" the costs of using contraception against other more pressing expenses. Some participants without insurance described having to consider whether they 'really need' care. Others described how the immediate costs of contraception compared to other pressing costs and often prioritized immediate needs over contraception thereby risking a more costly unintended pregnancy. "*I was really broke and I didn't want to pay the online co-pay just to have the repeat visit, which I thought was kind of a rip-off because I'm not even visiting. I'm visiting you from the laptop in my living room. [The copay was] $15, which doesn't sound like much, but when you're living paycheck to paycheck, it is significant…I just couldn't justify the cost."* (Ruby, 23, White)

- ***Interruptions in care & non-use:*** Challenges with an individual's ability to pay and health system affordability ultimately led to interruptions in care and non-use of services or methods. When participants were uninsured or in difficult financial situations, they frequently reported not using contraception. Alexandria, 32, White, described the implications of insurance instability: *"I've had to go off birth control because I didn't have healthcare or like try to save all my pills just in case. And do every other day."*

  Changes in insurance coverage of methods could result in women being unable to afford their preferred contraceptive method and having to switch methods or stop use completely. Clinic billing processes such as needing to verify insurance coverage also resulted in gaps in receiving contraceptives or in women giving up. Jasmin, 24, Black, described a series of frustrating experiences in 2016 trying to get contraception and having to wait for insurance verification:

  "She was taking [the implant] out of my arm. And she was like, "Well, do you want to get new birth control?" and I was just like, "Well, yeah. You know, keep it going." But she was like, "Well, we'll have to run it by your insurance to see if they'll cover this style of birth control" …it was a lot of money… like $1,200. […My insurance] was through my mom's job, and so I guess like a private PPO… And then they never called me back either about the birth control to see if it was approved through my insurance… they're literally just not running my information… So I'm just like, "Whatever. I'll just give up." Because I literally don't have time to fight with these people."

  After never hearing from her first provider, Jasmin tried calling a specialized FP provider to see if she could get her contraception there, only to have the same thing happen again.

For Jasmin, this was too much to deal with, a waste of her time, and she ultimately gave up trying even though she strongly desired contraception.

Mitigating Unpredictable Affordability

Participants described strategies that they perceived could be helpful in mitigating the unpredictable nature of affordability, depicted in **Figure 3.1** undeath the care-seeking pathway.

- ***Upfront on costs*****:** Women highlighted the importance of being told "up front" about what costs would be. Many felt that providers were vague about costs of care and methods. A few participants described the frustration of having to wait to find out what the bill would be until after choosing a method or arriving at the pharmacy. Others related that they were told about generic versions or fully covered options that led to paying more.

- ***Payment plans:*** Some women also related that they didn't expect costs to be free, but at least wanted them to be reasonable for what they felt they could afford. Several participants mentioned that it was helpful to be able to do payment plans for high visit costs since they often did not have the money immediately to pay; however, it was difficult to find a provider willing to let them do such a plan.

Shame & Stigma

Perceptions of stigma and experiences of shame[**] associated with insurance or financial status were also prevailing themes in the interviews. Both represented an emotional "cost" for participants.

[**] Stigma can be defined as attributing or labeling an individual as having undesirable characteristics. Stigma occurs in the public space and is manifest at a community or society level. Shame occurs at an individual level and has been defined as a negative emotion having to do feelings of failure in relation to personal or social standards. (M., 1998)

- ***Money and insurance key to better care*:** Having money and good insurance was often perceived as the gateway to good access and quality care.

  "*It all comes down to money, and resources… Money means better care. I think it means, um, better providers, you know, within your insurance network. Better insurance. Better coverage, you know. Access to a lot of other things."* (Von, 31, Black, Non-Care-Seeking)

- ***Stigma and shame if uninsured, on Medicaid, or poor*.** Women frequently experienced stigma attached to having no insurance or being on Medicaid. This resulted in their perceiving themselves or others as having less access to care in general and having to seek care in stigmatizing environments such as places that were overcrowded and unpleasant to be in. Blossom, 33, reflected on the atmosphere of low-income clinic spaces compared to her ideal care: *"[It] would be nice, clean, no security. Why do you need security at low income places vs high income places? Are we criminals 'cause we don't have any money?"*

  Participants also felt that women received lower-quality care because they were low-income or a Medicaid patient. Women also expressed feelings of shame. One participant described going to a large community health center as reminding her that she was "*poor and made a bad decision in life so that's why you ended up here*." Another participant began to cry as she described how bad it felt to come to a provider as a Medicaid patient:*" I don't know a lot of White women that grew up the way that I did, but I mean they can't even imagine what it feels like to think that you're bothering your doctor because you have subsidized healthcare.*

Ultimately, participants perceived that those who were low-income were not valued by providers or were perceived as a burden on the system.

> *"If you have insurance that you're paying for and that your company provides, you're going to receive a different experience… You're treated better. I'm pretty certain that if two people go into a facility and one has Medicaid and one has Aetna, then the person with Aetna is going to be treated better. It crosses racial lines. You're more valued when you're actually paying for the service that you receive."* (Yamia, 27, Black)

DISCUSSION

Our study demonstrates that affordability is associated with more than the pricing of services (health system) or insurance status (individual level) but is shaped by a dynamic relationship between individuals' ability to pay and the health system and that both are shaped by larger structural forces. Policies and processes, such as those verifying insurance or enrolling in programs, often proved to be barriers. Good access was determined by an alignment of individual and health system factors that met women's needs in a particular moment. A mismatch of these factors often produced inequities in access and contraceptive outcomes. While often conceptualized as static, affordability is a fluid and dynamic process that is shaped by an interplay among healthcare and individual factors over time. Our study found that low-income women experienced fluctuations throughout their lifetime that influenced their ability to afford and thus access services. Finding affordable care was an unpredictable process that involved trial and error, and participants often found stable affordability could be difficult to achieve often due to inefficiencies and inconsistencies across levels. The fluidity of affordability has implications for how we measure and conceptualize access. In measuring affordability researchers should consider that it is not static and that measuring affordability at only one point in time may miss a larger picture such as fluctuations in an individual’s ability to pay or churning in insurance status.

Public Health Implications

Our study also has several implications for practice and policy. It is crucial to note that the affordability barriers constraining individuals and health systems were not solely in the control of either. Structural forces including those related to economics or health policy influenced both individuals and health systems. Insurance policies for example, impacted both clinic processes and individuals’ ability to pay. Labor protections such as paid time off and insurance coverage influenced women’s ability to afford care both in terms of time costs as well as monetary ones. Addressing disparities in access and affordability thus must occur at multiple levels of influence beyond the individual (Ross & Solinger, 2017). To better support equity in access health systems, providers and policy makers should consider the following.

For participants in our study some provisions of ACA were helpful in attaining affordable care, including expansion of coverage for young women and full cost sharing for contraceptive methods. For insured and uninsured participants, method coverage did not always ensure that participants were consistently able to afford or use a method that they felt worked for them. Our data shows that providing a longer supply (e.g.,1 year) of oral contraceptives could help to alleviate additional visit fees encountered by participants.

Consistent with other studies, our findings suggest clarifications are needed for both insurance companies and medical practices about what services are mandated without cost sharing (Hall et al., 2014a; Politi et al., 2016). ACA requires coverage for patient contraceptive education and counseling without cost sharing, yet this is often not the experience of women. Many participants felt they wanted their provider to take their financial situations into account. Further studies could explore the role that providers could play as advocates for patients in relation to affordability. Improving health literacy is essential to support individuals in gaining better knowledge about their rights and what coverage they are entitled to both in terms of private insurance as well as in terms of publicly funded FP programs (Nelson et al., 2019). Strengthening the capacity of healthcare providers to navigate insurance and billing processes is also key to increasing affordability. Insurance verification processes should not mean that patients are lost. Providing quick access to contraceptives methods, preferably on the same day as the appointment is important for equitable access (Gavin et al., 2014). When at all possible, providers should also consider ways to provide up front information about the costs of methods to patients. Providing payment plan options is also a way to increase equity for individuals who are living paycheck to paycheck.

Several policies should be enacted in Georgia to address women's inability to pay for contraception. Subsidized FP programs, such as Medicaid, FP waivers, and Title X, are important for addressing these inequities, but complex systems combined with challenges in women's lives can mean that women do not get the help they need or are often unaware of available benefits. Improving individual knowledge of and the process by which individuals can engage with these systems is crucial to increasing access to FP services. Navigators or auto-enrollment processes could be further strengthened. Medicaid coverage should also be expanded to one year postpartum and for individuals below 138% FPL[††], thereby allowing women more

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[††] Georgia currently extends Medicaid eligibility for women who are losing insurance postpartum, but the system is not automatic nor streamlined.

time to get necessary care including access to contraception and to set up their next phase of coverage without experiencing gaps that endanger their health and well-being.

Experiences of stigma and shame are particularly concerning and highlight the often-internalized inequities that low-income women face in seeking care. Sensitivity and implicit bias training for providers and for staff could help to improve compassionate care.

Strengths and Limitations

This study was unique in that it focused on suburban women's lived experiences related to affordability and incorporated the use of LHIs to document experiences over the life course, enabling a deeper understanding of the process involved in finding affordable care. This study, however, was limited to one Metropolitan area and thus cannot be representative of all low-income women's experiences. State level policies may also have varied influence on affordability experiences. Studies have also shown challenges in self-reporting insurance status (Davern et al., 2008) and likely some women may have misidentified their insurance, particularly between Medicaid and P4HB. Despite this, individuals' perceptions and understandings of insurance are important to document. Finally, this study only includes the experiences of patients, but understanding challenges that providers face is also essential to understanding access.

CONCLUSION

Affordability is one domain of access that is shaped by the interplay between individual access factors and by health system characteristics as well as by larger structural forces that influence both. Assessments of affordability therefore must account for the interplay between these multilevel influences. Rather than being seen as static, it should be understood and measured as a fluid process. As we have shown, despite positive and important gains with ACA, low-income women in our study still struggled with affordability and disparities persist. Future research should address holistic conceptualizations of affordability that better reflect women's lives in order to better achieve equity in meeting women's needs.

CH.3 TABLES

Table 3.1:Demographic characteristics and individual access factors of individuals 18-34 participating in a study of women's experiences seeking family planning services in Georgia, 2019-2020

Characteristic (n=25)	(%)
Age	
<20	4
20-24	32
25-29	40
30-34	24
Race/Ethnicity	
White, Non-Hispanic	20
Black, Non-Hispanic	56
Hispanic, Black	12
Hispanic, Other	8
Education	
High School	8
Some College	29
Community College	25
4 Year College	38
Income (FPL)	
<150%	32
150-200%	40
200-250%	28
Employment	
Full-Time	42
Part-Time	32
Student	11
Homemaker	5
Unemployed	11
Insurance Status	
No Insurance	36
Medicaid/Peach Care/P4HB	24
Sponsored Private	40
Using a (prescribed) method of contraception	
Yes	48
No	52
Most Recent Care-Source	
Non-Care-Seeking for BC	28
Private MD	28
Community health center	20
SFPC	12
Other	12

Table 3.2: Percentage of participants with free-list answers related to "affordability" from answers to two prompts among low-income women 18-34 in Georgia (n=25).

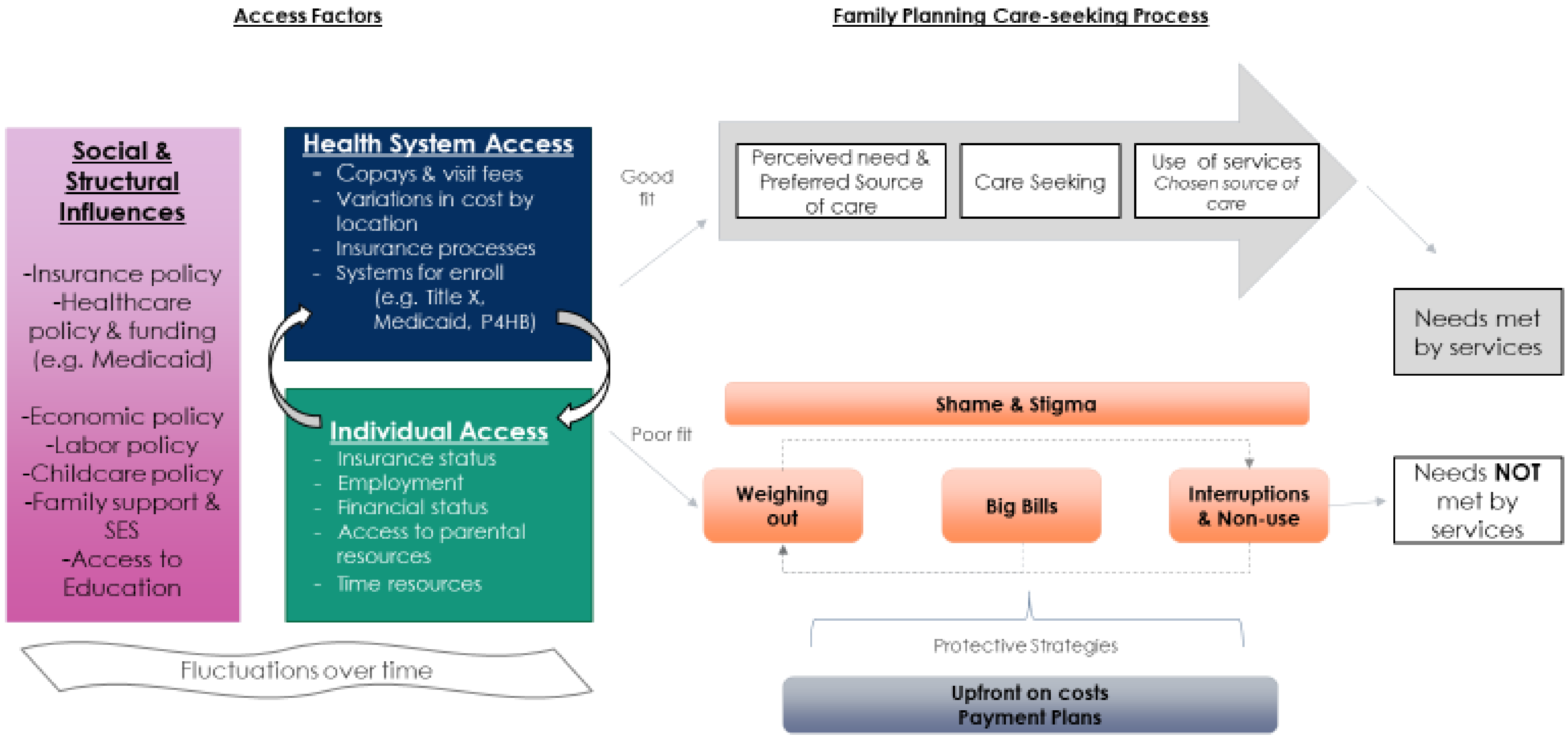
Item	Described As	Any time	Facilitator [1]	Barrier[2]	Listed as MIF
Health System Characteristics (Affordability)		**60%**			**12%**
Cost	*High out-of-pocket cost* *Lower cost appointments*	20%	27%	32%	
Time	*Being able to get time off for appointments;* *Having to go back every month for prescription refill* *Long wait times*	12%	27%	7%	
Insurance Policies	*When insurance does not cover it* *Testing requirements (yearly pap smears)*	12%	--	12%	
Individual Access Factors (Ability to Pay)		**84%**			**32%**
Insurance Status	*No insurance;* *Healthcare coverage*	60%	40%	20%	
Money	*Not having funds for birth control* *Can't afford it*	56%	40%	27%	

[1] Facilitators were responses to the prompt "*Things that make it easier to use birth control (or to prevent pregnancy) when I want to*"

[2] Barriers were responses to the prompt: "*Things that make it harder to use birth control (or to prevent pregnancy) when I want to*"

MIF= The percentage of participants who listed this as the most important factor in being able to use birth control or to prevent pregnancy

Figure 3: Conceptual framework of the domain of “affordability” in relation to FP care-seeking



Affordability is shaped by combinations of individual, healthy system, & social/structural factors that influence access to FP services. If there is poor fit between some of these, this produces negative implications for access & use. The "fit" between access factors is not static but fluid over time. Protective factors associated with the health system such as being up front on costs and providing payment plans help to mitigate affordability barriers.

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Chapter 4 How low-income women in Georgia understand "access" to appropriate sexual and reproductive health care: A life history analysis

INTRODUCTION

Low-income women, women of color, and women living in the Southeastern US continue to experience inequities in their access of sexual and reproductive health (SRH) services and in their experiences of SRH outcomes such as undesired pregnancy, maternal morbidity and mortality, and rates of sexually transmitted infections (STIs) (CDC, 2016a; Frost et al., 2016; Molina & Pace, 2017). *Health Equity* is often defined as the elimination of unjust disparities in achieving health and is often understood as eliminating systematic inequities in the health care system (Braveman, 2014). Rather than a narrow focus only on elements of the health care system, there is increasing recognition that achieving SRH justice and equity in access to services necessitates a more nuanced and holistic approach to addressing the systemic forces that influence these disparities (Dehlendorf et al., 2018; Holt et al., 2020; Ross & Solinger, 2017). How we measure and conceptualize SRH access and outcomes embodies what is valued in research and in health care and determines how we measure success and what health systems are held accountable to (Dehlendorf C et al., 2015; Dehlendorf et al., 2018). Key to achieving health equity is better definitions and measurement of concepts in order to better operationalize and measure progress toward them (Braveman, 2006). Though frequently considered separately from quality, access is multidimensional and is linked with quality of care.

In the fields of family planning (FP) and SRH, as related to contraceptive care in particular, there has been growing recognition that "quality of services" must be better defined and measured in order to more equitably address patient needs and facilitate better SRH outcomes (Dehlendorf et al., 2018; Holt et al., 2020). While traditionally measured in terms of population level metrics in terms of use of methods, particularly long-acting methods, quality FP care is increasingly seen as care that promotes patient autonomy, involves patient-centered care and counseling, shared-decision-making, and relationship building (Becker et al., 2009; Gavin et al., 2014; Holt et al., 2017). Patient-centered approaches push for solutions that prioritize the needs and experiences of the individual, not just to achieve a specific health goal but also to better meet the specific needs of clients (Holt et al., 2020; Institute of Medicine, 2001).

“Access” to healthcare may be understood as “the ability to seek and have healthcare needs fulfilled,”(Levesque et al., 2013) and is often defined as a multi-dimensional phenomenon (Aday & Andersen, 1974; Levesque et al., 2013; Penchansky & Thomas, 1981). While access to healthcare is frequently discussed as separate from quality of care, the use of quality services represents *realized* access. As Levesque et al assert, “the opportunity to utilize only services of poor quality […] is… a restriction of access to health care.” Equitable access should include the possibility of selecting and using effective and appropriate services (Levesque et al., 2013). In their patient-centered access framework, Levesque et al define five dimensions of access related to health care system characteristics (approachability, acceptability, availability, affordability, and appropriateness) and five dimensions corresponding to individual abilities to access care (ability to perceive, seek, reach, pay, and engage), herein referred to as *individual access factors*.

One dimension of health system access, a*ppropriateness*, which encompasses quality, is defined as the fit between health services and clients’ needs. It includes technical and interpersonal quality, time spent assessing health issues, as well as the services provided and the way they are provided (Levesque et al., 2013). *Ability to engage* describes the corresponding influences on the side of individuals that allow them to participate in their own health care.

An individual's experience of, and access to, SRH care, therefore, is influenced by both health system and individual factors, but it is also influenced by larger social and structural forces outside of their control. While Levesque et. al. and other access theorists acknowledge that individuals and health care systems are also influenced by macrosocial factors, these influences are not well defined or explored. Similarly, in FP studies of access it is often measured in singular terms associated with only the health care system. It is necessary, then, to ground our understanding of access and appropriate SRH care in the context of women's lives as well as in the context of the larger social and structural forces (e.g. social context including policies, systems of discrimination, and interpersonal social support) that influence them. Such an understanding may contribute to improved measures of access and quality that will better meet women's needs, and ultimately promote equitable SRH care.

This analysis is part of a larger mixed-methods study that aimed to better define equity in access to FP care by exploring low-income women's lived experiences with SRH care-seeking in Georgia. Specifically, this analysis sought to understand: 1)what elements of appropriate care low-income women identify as important for their SRH services; 2) which elements of appropriate care are most salient in their SRH care-seeking; and 3) what influence women's lives have on their experiences of and priorities for appropriate SRH care.

METHODS

Setting & Sample

This study focuses on women residing in suburban areas outside of Atlanta where public transportation and density of publicly funded FP services are less available than in urban Atlanta. We recruited a sample of sexually active, low-income adult reproductive age women (age 18-34) who currently did not want to become pregnant in the next year (Allen et al., 2017). We sought a balance of individuals who identified as Black, White, and Hispanic. We also sought a range of

SRH care-seeking experiences (e.g. with a private provider, a community health center, or a specialized family planning provider), as well as non-care-seeking women. Women were classified as not seeking SRH care if they had not received contraceptive services in the past year, were not currently using a hormonal contraceptive or implant, and did not plan to seek services in the near future (3 months). Individuals were eligible to participate in the study if they were: biologically female, sexually active, not currently pregnant, had no history of hysterectomy or sterilization, spoke English, had a household income below 250% FPL, and did not wish to become pregnant in the next year.

Recruitment and data collection occurred over the course of one year (January 2019 to February 2020). We employed a mix of active and passive recruitment strategies via social media advertising (Facebook, Instagram), in community settings (e.g. colleges, community events) and clinic-based settings (health departments, community health centers, Planned Parenthoods) to ensure a range of care and non-care seeking experiences in our sample. Interviews were audio recorded and transcribed verbatim. Participants received a $40 gift card for participating. The study was approved by the Emory University Institutional Review Board and informed consent was attained for all participants.

Data Collection

This study employed *convergent mixed methods design*. Convergent designs allow for the simultaneous collection of multiple types of data (quantitative and qualitative) to better answer a research question. Using both types of data allows for triangulation of results to provide a complex understanding of an issue (Creswell & Clark, 2011). Interviews were conducted by the lead researcher (ANL) who is an experienced qualitative interviewer. Eligible participants completed two forms of data collection during their in-person interview: 1) a self-administered survey to capture demographics and measures of their social context (e.g. social support, social capital, and experiences of discrimination) and 2) a life history interview (LHI).

Quantitative Tools

Three previously validated scales were used to measure elements of each participant's social context.

Perceived experiences of discrimination were measured using two previously validated scales, The Every Day Discrimination (EDD) Scale and the Major Experiences of Discrimination (MED) Scale. (Williams et al., 1997) The Everyday Discrimination scale (EDD) assessed participants' ratings of how frequently they experienced six examples of discrimination on a six-point likert scale ranging from 0 (never) to 6 (daily) with higher scores indicating more experiences with discrimination. Participants then indicated what they felt the main reason was for these experiences. Using the MED scale, participants also indicated whether they had experienced any major lifetime instances of discrimination (for 7 types of incidents) and the main reason they felt they experienced each. After receiving participant feedback, and recognizing the importance of intersectional experiences, the researchers added an extra question to allow participants to describe if they felt that there were multiple reasons they experienced discrimination.

Perceived social support (SS)was measured using the Multidimensional Scale of Perceived Social Support, a well-validated 11-item scale which asked participants to rate their perceptions of social support from friends, family, and a special person using a 5 point likert scale. (Dahlem et al., 1991) Higher scores reflect more social support.

Individual Social Capital (SC) was assessed using a modified version of the Social Capital Community Survey. (*Social Capital Community Benchmark Survey Short Form* 2006). The scale included domains related to social trust, civic/political engagement, and informal ties. Higher scores indicate higher levels of social capital.

Qualitative Tools

LHIs are semi-structured interviews that follow a narrative of a participant's life and emphasize the authority of participants to tell their own stories and name things that they view to be important. LHIs provide a useful approach for examining past and present contextual influences on individuals' experiences(Goldman et al., 2003). The LHI approach shifts power away from the researcher to the participant, a shift that is vital to understanding individual patterns of behavior in relation to personal history and broader environmental contexts as well (Goldman et al., 2003; Hatch & Wisniewski, 2014). The LHIs also incorporated a timeline visual elicitation activity to further evoke nuanced information about participants' SRH care-seeking and context and interviews were then structured to follow the timeline narrative (Kolar et al., 2015). Our tools draw on prior examples that focused on "moments" of experiences through a participant's life, and this case specifically focused on those associated with SRH related care-seeking as well as situating these moments within the broader life context of the participant (Johnston et al., 2014; Kolar et al., 2015). Participants were first asked to draw a timeline of their experiences in preventing pregnancy and in seeking FP related services. They could start with when they first learned about sex or contraception and then move through salient moments throughout their life up to the present. Participants were asked to include other significant events that influenced their feelings about pregnancy prevention including issues with family and friends, work or school, health, or sexual activity. After drawing the timeline, the interviewer and participant discussed the timeline together, moving through each event. Following the narrative of the timeline, the interviewer probed about participants' experiences with care-seeking, access domains, as well as their experiences with providers and staff at each time point of seeking services (**Appendix Table A.4.6)**. Participants were also asked what their ideal care would be and what they felt providers should know about their story.

Analysis

Quantitative and qualitative data were first analyzed separately and then combined for final reflection and comparison.

Quantitative

Descriptive statistics and social context scale scores were computed using SAS 9.2 (Cary, NC). Each participant received a score for each measure of social context (EDD, SS, SC). EDD sum scores were separated into tertiles (low, some, high) and by major reason (Race, Gender, or Other). Participants were considered to have experienced a major form of discrimination (MED) if they had experienced 1 or more events in their lifetimes. Mean scores were used to account for 'prefer not to answer' or 'don't know' responses in the SS and SC scales respectively. SC item scores were standardized using min-max scaling so that each question was scored from 0 to 1. The SC and SS scores were then divided into tertiles (Low, Medium, High) for use in comparing qualitative themes.

Qualitative

Verbatim, de-identified LHI transcripts were analyzed using MaxQDA 2020 (VERBI Software, 2019) by the first author (ANL) and two research assistants. Transcripts were first coded using thematic analysis with deductive themes derived from Levesque et al's patient-centered access framework and the interview guide (e.g. provider treatment, staff treatment) and inductive themes that arose from the data (e.g. 'Trust', 'Care about you'). An initial set of transcripts (6) were double coded to refine code definitions and to ensure consistency. Discrepancies in coding were resolved through discussion with the full coding team until consensus was reached. Themes were identified in a similar process to that described by Braun & Clarke (2006) through deep reading, annotating and creating memos, combining codes, and developing a thematic map to then develop an overall understanding in answer to the research questions. Themes were then organized into categories corresponding with the research questions.

Mixed Methods Analysis

A secondary holistic analysis was then conducted of each life history using a matrix analysis approach (Averill, 2002). Survey scores were incorporated as "document variables" in qualitative analysis such that each transcript had a set of attributes for comparison of themes. The lead author (ANL) reviewed each timeline visual and each LHI transcript in full. She created an annotated matrix timeline of each participant's care experiences and life events focusing on appropriate care experiences. Timeline matrices incorporated quantitative and qualitative data. For each event of SRH care-seeking, themes related to quality and appropriate care were noted as well as current life context and implications. The annotated timeline matrices were then independently reviewed by ANL and two research assistants to reflect four typologies of life history narratives that emerged. Discrepancies in categorization were then resolved through discussion.

RESULTS

Participants

Twenty-five individuals completed interviews. The majority identified as women (one participant identified as genderqueer) and as women of color (**Table 4.1**). Participants had received SRH care from a variety of sources over their lifetimes including private doctors and private hospital systems, health departments and community health centers (CHCs), specialized family planning providers (SFPs), school based health centers, mobile or internet based services, and crisis pregnancy centers (CPCs). Over half the participants (56%) were not currently using a method of birth control.

Quantitative findings: Social context

The sample had a mean EDD score of 8.1 (range 0 to 26) and experienced a mean of 1.7 lifetime major experiences of discrimination (**Table 4.2**). The major reasons indicated for discrimination were race, gender and age. A quarter of participants also reported intersectional experiences of discrimination whereby they felt the discrimination was the result of a combination of factors, often race, gender, and age. Some individuals reported experiencing low levels of EDD but did report incidents of lifetime MED. Others expressed discrimination fears through their perceptions of how their peers have been treated and while they did not report high levels according to the scale still considered and worried about discrimination in their medical care. Participants had relatively high levels of social support with an average SS mean score of 4 (range 1.2 to 5). The average standardized SC mean score was 0.4 (.18, .56). Nearly a quarter of participants disclosed experiences of sexual violence including molestation, rape, and intimate partner violence. Over half of the participants reported experiencing at least one episode of mental health difficulties usually involving depression and/or anxiety during their life history[7].

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[7] Mental health and sexual assault statistics were generated from quantizing codes in the LHI qualitative data.

Table 4.1: Demographic characteristics and access factors of individuals 18-34 who participated in a study of women's experiences seeking family planning services in Georgia, 2019-2020

	n or mean	(%)
Age	26	
<20	1	4%
20-24	8	32%
25-29	10	40%
30-34	6	24%
Race/Ethnicity		
White, Non-Hispanic	5	20%
Black, Non-Hispanic	14	56%
Hispanic, Black	3	12%
Hispanic, Other	2	8%
Education		
High School	2	8%
Some College	7	29%
Community College	6	25%
4 Year College	9	38%
Income (FPL)		
<150%	8	32%
150-200%	10	40%
200-250%	7	28%
Employment		
Full-Time	8	42%
Part-Time	6	32%
Student	2	11%
Homemaker	1	5%
Unemployed	2	11%
Insurance Status		
No Insurance	9	36%
Medicaid/Peach Care/P4HB	6	24%
Sponsored Private	10	40%
Current use of method		
Yes	12	48%
No	13	52%
Most Recent Care-Source		
Non-Care-Seeking for Contraception	7	28%
Private MD	7	28%
Community health center or Health Department	5	20%
SFPC	3	12%
Other	3	12%

Table 4.2: Social context of participants in a study of low-income women's experiences seeking family planning services in Georgia, 2019-2020

	mean (range) or % (n)
Experiences of Discrimination	
EDD	8.1 (0, 26)
Reasons for EDD among those with more than low (>6) levels	
Race/Ethnicity	40% (6)
Gender	13% (2)
Income	7% (1)
Age	20% (3)
Other	20% (3)
Experienced Intersectional EDD	24% (6)
MED	
Had any experiences	65% (16)
“*Have ever been unfairly denied medical care or provided medical that was worse than other people*”	32% (8)
Supportive Environments	
Social Support	4.0 (1.2, 5.0)
Social Capital	0.41 (0.18, 0.56)
Other traumas	
Sexual violence (e.g. rape, molestation, intimate partner violence)	24% (6)
Mental Health (e.g. depression, anxiety, etc.)	56% (14)

Qualitative findings

Themes are organized into four sections: 1) concepts of trust and appropriate care; 2) provider elements that facilitate trust and appropriate care; 3) staff elements that facilitate trust and appropriate care; and 4) trust in SRH care-seeking.

Concepts of Trust and Appropriate Care

Nearly all participants discussed appropriate care in terms of finding a place that one could trust, and they also emphasized the importance of trust in seeking and receiving SRH care. Trust emblemized many elements of appropriate care such as being comfortable and familiar with a provider, knowing what to expect, establishing a relationship, having previous experiences with the providers, and being able to get information when needed. Trust was important in SRH care because, as many participants explained, they were trusting providers with their bodies.

Participants indicated that trust was particularly important in the context of their fears about being mistreated and they often alluded to the historical treatment of women, minorities, and low-income individuals in health care. One participant, for example, spoke of how she had not used contraceptive services because she was afraid of its negative effects and told the story of someone who went to get sterilized and died. Daniela, 32, a Hispanic woman whose family immigrated when she was young explained,

> *"… with the Hispanic community and the black community, we've been known for being tested on and … the hospital knows when you're legal or you're not or if you have documents… if they're doing practices and stuff, the most common thing if they're gonna do it is on people that they know [are] not gonna say anything. [We] don't have the resources…[we] have rights, but they know that we come from a community that's not informed.… That's just the reality, you know? And I guess that's the reason why, since I know that, I just kind of don't even try it (contraception). And I'm in a position where I'm different in … that I do have documents and I speak the language… but even then, it's not gonna get me anything. So, that's the reason why I kind of just stick to where I know they've treated me right."*

Provider elements that facilitate trust & appropriate care

Elements of appropriate care that participants associated with providers were categorized into eight sub-categories of themes: provider demographics, technical quality, feeling comfortable, communication, respectful & non-judgmental, being more than a number, and holistic care (**Table 4.3)**.

Provider Demographics: The first theme was that most participants preferred seeking SRH from a female provider. Secondarily, not have a preference in race or gender but only preferring to be treated well was common as well. Women of color and those who reported experiences of discrimination more frequently stated that they preferred a provider with a similar racial/ethnic background. A couple women of color, however, did not prefer this and instead wanted a provider who would not try to relate to them as closely because they felt that relatability could lead to judgement.

Technical quality: Though not as heavily emphasized as other elements of care participants also wanted providers who were knowledgeable about women's health and who provided care of high technical quality. Technical quality was often associated with a provider's having a specialty in Obstetrics & Gynecology, being an MD, and having good reviews. Providers who were thorough in addressing participants' concerns, in conducting testing or treatment, and in trying to find answers to their issues were perceived to be of better quality. One participant also reflected on the importance of having equitable access to quality care. Yamia, 27, Black, responded: "*Equitable care . . . means that everybody should have access to care that is quality*."

***Feeling comfortable**:* Participants regularly associated positive experiences with having providers who made them feel comfortable. Providers who were personable, friendly, and warm helped participants feel at ease in receiving SRH services. Comfortable care was often associated with not being rushed through a process and with the provider taking time to ensure that they were at ease. Feeling uncomfortable and unheard conversely was a reason that individuals avoided going to care.

Communication*:* Participants frequently discussed the importance of communication. They appreciated it when providers took time to answer all of their questions and provided information that they felt was necessary to make decisions clearly and in a straightforward manner. Providers who were open to communicating and were easy to access by phone, email, etc. also improved patients' trust.

Respectful and non-judgmental*:* Participants described wanting respectful care which meant having agency in decision making, not being belittled or brushed off, and not being judged. Participants stressed the importance of receiving non-judgmental care from their providers as well and expressed fears of being stigmatized for not previously getting care or for lacking insurance or for their sexuality or sexual behavior.

Agency meant having power in decision making related to fertility choices, contraceptive options, and procedures and was also critical. Receiving adequate information from providers facilitated agency. When providers did not give them options or were overly pushy about using birth control, participants felt their agency had been taken away or threatened. For several participants, though they experienced positive care and better provider relationships during pregnancy, they also experienced having their agency violated during labor and frequently associated this experience with discrimination.

Participants described other instances of disrespectful care, including being made to undergo embarrassing procedures, having their confidentiality broken, or having staff or providers make fun of them or be condescending. Several respondents also described negative experiences with, or fears about, providers belittling them or brushing off their concerns.

Compassion: Another theme that emerged from this study was that women had more positive experiences with their SRH care when providers expressed compassion and understanding of their lived experiences. Compassion included being understanding about costs of care, about the discomforts of physical procedures or exams, about life problems and fears. Compassion was also particularly important for individuals who had complex health issues. Providers' failure to deliver care with sympathy for participants' emotions or experiences often resulted in negative experiences that further eroded trust.

More than a number: Taking time and developing relationships: Participants voiced a desire to be seen and treated as a person and not simply as a number. When providers rushed through appointments and did not listen to their concerns, participants felt disheartened, frustrated, and unheard. Providers who listened, were patient, and who allowed the participants to take their time in asking questions and making decisions contributed to positive care experiences. Over half of the participants discussed the importance of feeling they knew the provider, or that the provider knew them (or their body). This was described as feeling cared about. Participants also felt that services were of better quality when their provider appeared to care about them and their well-being in contrast to places where they felt providers were "*just there*."

Holistic care*:* Finally, care that addressed women's entire set of experiences was also important to several participants. Respondents highlighted the importance of receiving SRH care that addressed their social and emotional concerns such as their mental health or other lived experiences. Others discussed the importance of a provider's understanding a patient's life and cultural background. Thus, equitable care meant taking women's lives into account and providing care attuned to unique needs and circumstances. Akia, 29, Black, explained this as she reflected on her ideal care, "*[Don't try] to put two different people in the same category… Because their stories can be similar but how their body reacts could be totally different or what they may be feeling could be just a little bit different. You can't treat …two different people the exact same way, they're going to be different in some shape, form or fashion."*

Staff elements that facilitate trust & appropriate care

Health care staff, including non-clinicians such as those at the front desk, medical assistants, etc., also influenced participants' experiences. We identified 3 major themes: providing help and information, creating a welcoming environment, and staff mirroring their environment (**Table 4.3**).

Providing help & information: Health services staff were often important in helping clients navigate care. Participants appreciated it when health services staff helped them to get through systems by providing information about costs and pricing, insurance, or about how to enroll in Medicaid or P4HB. Staff who were unhelpful, who provided incomplete information, or who never returned calls made for more frustrating experiences that often served as barriers to women receiving any care at all.

A welcoming environment, where you are wanted: When staff were friendly, participants felt they were in a welcoming environment and their experiences were more positive. Even more, staff who "wanted to be there" and who wanted you to be there contributed to positive experiences. Participants who had negative experiences described staff being rude or appearing to feel bothered by them.

Staff mirror their environment: Participants frequently associated negative staff interactions such as being rude, or not caring about them, with the staff having negative experiences themselves. Participants often recognized that clinics were understaffed or that staff appeared overworked and that this influenced the way staff treated patients. These negative experiences occurred most often in health departments or community health centers, but they also happened in other types of care settings. Nia, 26, Black, pointed out how internal dynamics associated with social and structural factors in the way staff are treated then influence patient care as well: "*Your internal staff needs to be on-point to have the best of services. If you're dealing with homophobia and racism inside, then you can't serve your population. If people feel like they're not getting paid enough for the work they do; they're overworked, underpaid, that they're feeling demeaned and belittled, then you need to fix that before you offer your services to the world.*"

Table 4.3: Provider & Staff elements that facilitate trust & appropriate care

Sub-Theme	Exemplar Quote
	Provider Elements
Provider Demographics	*“I actually feel more comfortable with a male doctor…Because they can say what they want, they can have their opinion on it, but at the end of the day, you have absolutely no clue what goes on with me… You can’t even relate, no matter how hard you really try to. Whereas a woman …I feel like it’s more judgement… it’s just way more intimate…women are… emotional. You know, we try to relate. And sometimes it’s good and bad, but I don’t want you to relate to me. I just want to be in and out, and I want to be done with it…when I’m looking for a doctor, I just want it to be business.”* (Laila, 28, Black)
Feeling comfortable	*“I think that’s the reason why … a lot of women may not go to the OB/GYN or they may not ask the questions that they should be asking is because they’re unaware and they’re uncomfortable … so sometimes you have to take a little bit longer with a patient than you may have to with a different patient. But no one’s going to really understand what it is that [providers] want us to learn if [providers] don’t understand what we’re feeling. […That means] patience, making them feel like they are being heard, that they’re not being rushed, that what they’re saying isn’t a burden.”* (Akia, 29, Black)
Respectful & non-judgmental	“I *went in saying that I wanted it to be a drug-free procedure. I didn't want to have an epidural or anything. I just felt like it was pushed on me. I think it was because of my race and my age. I was very adamant... They were like you're not going to be able to do this without drugs. You need this. It's going to be so much better. I didn't like the pressure. Luckily, I was able to get through it drug-free… I have looked into infant mortality and how there are such disparities between black childbirth and other races. It makes me question the system and the medical profession. Would you do that to a middle-aged white woman? If she came in and said I don't want to have any drugs. I feel like that would be a respected choice.”* (Yamia, 29, Black)
Having agency	*“Honestly, I feel like every time that I've been offered birth control, it's been pushed on me. Like you need to get something today…And even if I just say I'm not having sex actively right now, they'll [say] well, you still need birth control.”* Instead Von wished that providers would allow her to be the one to bring the subject up and then ask questions and provide answers about options without trying to influence her decisions. (Von, 31, Black)
Compassion	*“If you have any issues that are out of the normal in regards to women's health, you're probably gonna have to spend a long time searching for somebody who understands or cares… I think a lot of the reason is 'cause women are told to be quiet about their pain…we didn't realize how much of an issue this was until more recently when women are actually speaking up about how terrible the service is. So no one ever thought to do better about it. [Laughs]… women are told to be quiet about their women's issues.”* (Neena, 26, White)

More than a number & taking time	“*[The provider was] pretty good but rushed a bit. They make it seem like you’re not a person. Like you’re not welcome. They’re friendly but they’re not really taking the time to ask you questions.”* (Blossom, 31, Black) *“I do also feel like they're just there. I get kind of this eerie feeling that everybody's like just like a zombie in there… Like they don't really care as much as they would at a regular doctor.”* (Charlie, 25, Black)
Holistic Care	*“So, it's not that some of your patients are uneducated or some of them are poor... It's more like their environment and their experience has shaped what they have access to and what they're able to do with their lives and with their health… you as the health care provider, you have to know that so that when they come into your office… Because quality care isn't like just going to work and writing prescriptions and getting your bonuses and your checks and things like that. You actually have to care about the patient to give quality care.”* (Shay, 22, Black)
Understanding Background	“[*Providers] should be more empathetic with everyone's story. They should take a little bit of time to hear a little bit of your background and your experiences before moving forward. [I] have heard a lot of experiences of women that have experienced incredible, tremendous, crazy stories that you can't even imagine… And I don't even think that doctors know…like, for example, this one girl, she was from Honduras… her grandmother sold her to a man and sold her brother to someone else. So, she was sold at the age of seven…she's fine now with her kids and married, but I promise you that her ObGyn doesn't know that. Probably her ObGyn doesn't know that she got pregnant at, I don't know, 13… and they took the baby from her. Like, they yanked her baby from her. So, all of those stories and traumas – doctors should take that in, too. I think that should be more integrated in your health care.*” (Daniela, 32, Hispanic)
	Staff elements
A welcoming environment where you are wanted	*“…nobody was, like sorry for the inconvenience … or let me check their books and see if we can squeeze you in …And it was just so completely unprofessional... And then that’s a sensitive thing anyway…and if I was timid about it or up in the air about it I would completely have been, like, never mind. …But luckily this was the 26 year old me and not the 16 year old me… It wasn’t a receptive environment… It wasn’t cozy or welcoming, or soft music… whether it’s to get the birth control, you know, STD things, pregnancy things. To me, those are really intimate situations that a lot of us contemplate in our head while we’re parking, while we’re getting the visit…It was like, oh, I am here for STD, like, am I going to jail about this, or what’s happening? …So, that compared to the dentist’s office that has, like, soothing music, they’re happy to see you. It was, like, really, really dramatic difference.” (*Laila, 26, Black)
Staff Mirror their Environment	*“[The staff] were tired, I think, is the best way I could say. It's the County Health Department. What are you going to do? And [County] is one if not the poorest county in Georgia…Apart from they were not friendly, they were not happy to be there, it was just kind of like another day doing this… it was not the most welcoming atmosphere. It was really more of well we can't get rid of you.”* (Amy, 28, White)

Trust in Care-Seeking

Perceptions of trust and appropriate care also factored in to where and how individuals sought SRH care. Themes associated with the role of trust in care-seeking included: ways of finding trusted care, willingness to trust and return to care, weighing appropriateness vs. affordability.

Finding trusted care: Friends and family were often a source for identifying appropriate care, especially in relation to participants' first SRH related care-seeking endeavors. As they sought care later in life, individuals frequently described trying to determine if a provider was of quality or trustworthy through conducting their own research online, through reading reviews or looking at provider profiles. Prior experiences often informed many participants' priorities and how they went about seeking care.

Trust & returning to care: Participants returned to care sources they perceived to be familiar, reliable, trusted, and of high quality when they were able. Some individuals also described driving further or paying more for care that was trusted. For some participants not feeling they could find trusted care dissuaded them from seeking it at all.

"Lack of reliable servicers[sic]... It's not impossible to get good recommendations, but if you're just not comfortable and you don't know that you're going to be in good hands and treated well where you go, it's difficult to take that risk to even make the appointment." (Ruby, 23, White)

Appropriate vs. affordable care: Appropriate care, however, was also frequently intertwined with affordability. Indeed, participants generally fell into two groups when seeking care from a new provider--those who tried to find a trustworthy and quality provider and those who sought providers who were less costly or easily accessible. These two elements—appropriate care and cost—when weighed together could often be at odds. Participants often reported having to sacrifice quality for affordability when faced with high costs or lack of insurance coverage.

Even though they might have had a previously positive experience at a provider, if the costs were too high or their insurance changed, they often could not return. Many participants also commented that they would prefer a private provider if they could afford one.

Mixed Methods Findings: Lived experiences & care-seeking

In this section we describe mixed methods analysis using qualitative data from LHIs and quantitative survey data to describe participants' narratives of their life experiences and relate them to their experiences of, priorities for, and concerns about appropriate care. Though each life story is unique, we found that narratives tended to focus on different types of experiences with SRH care-seeking. As depicted in **Table 4.4**, we identify 4 types of narratives overall in relation to life experiences and access to appropriate care, these included narratives about: 1) negative experiences associated with trauma (including 2 sub-types --traumas having to do with a) race & gender and b) with economic stigma), 2) returning for positive experiences, 3) consistent care, 4) cost & logistics.

Table 4.4: Typologies of participant narratives in how their lived experiences relate to priorities for appropriate care in SRH access and care-seeking among low-income women in Georgia, 2019-2020

Typology (n=25)		EDD	MED	SS	SC	Mental Health	Appropriate Care Themes
Trust increasingly important in care-seeking	1) Negative experiences & trauma (n=8)						- Lack of agency - Holistic Care - Discrimination fears - Mental health struggles
	Race & Gender	Some/ High*	2.6	NT	NT	100%	
	Econ Stigma	All	1.25	NT	NT	75%	
	2) Returning for positive experiences (n=4)	Low/ Some	0.5	Medium* Low Family SS	Med/ High*	25%	- Fears of concerns being brushed off - Agency - Compassion - Discrimination fears
	3) Consistent care (n=3)	Low	0.3	High	NT	0%	- Larger discrimination fears - Feeling comfortable with care - Neutral or positive experiences
	4) Cost & logistics (n=6)	NT	2.3	NT	Low/ Med	33%	- Negative & positive experiences - Cost of services, logistics & ease of use reason for choosing care

NT= No clear trend
*All except one outlier (=Low)
EDD=Experiences of discrimination (score range)
MED= Major incidents of discrimination (score= average number experienced by group)
SS=Social support levels (range)
SC= Social capital levels (range)
Mental Health= % of participants noting mental health challenges

For each type of narrative, we include an exemplar life story to highlight the influence of lived experiences in seeking appropriate care. The importance of appropriate care and trust varied by typology, ranging from those who heavily emphasized appropriateness in their care seeking and were often driven by emotional experiences to those who did not emphasize appropriate care in their narratives and instead were motivated by other factors either out of ease or necessity. **Table 4.5** presents the frequency of overall themes associated with appropriate care endorsed by each typology.

Table 4.5: Percentage of participants discussing appropriate care themes by narrative typology among low-income women, 18-34 in Georgia

	Type 1		Type 2	Type 3	Type 4
Theme	**Gender & Race (n=8)**	**Economic Stigma (n=4)**	**Positive Return (n=4)**	**Consistent (n=3)**	**Cost Motivated (n=6)**
Trust	88	50	75.0	66.7	50.0
Trust with my body	13	25			17
Discrimination fears	63	25	25		17
Provider demographics					
Prefer same race & gender	38		25		
Prefer female	13			33	33
Prefer different	13				
Doesn’t matter	13	75	25	33	33
Provider Treatment					
Communication & questions	50	75	75	33	17
Technical Quality	38	50	50	33	17
Feel comfortable	63	50	50	67	67
More than a number	100	100	100	33	67
Compassion	38	25	50		17
Respectful	88	75	100	33	67
Agency	38	50	75		17
(Non) judgmental	50	25	50	33	50
Holistic approach	63	50			
Neg Provider Experiences	75	100	75		33
Pos Provider Experiences	88	100	100	67	83
Staff Treatment					
Just there	13	25			17
Giving info	50	75	25		50
Feeling welcome	63	100	50	33	83
(Non) Judgmental	38	50	50		
Staffing Overworked	38	50			33
Negative Staff Experiences	75	100	75		67
Positive Staff Experiences	75	100	50	33	67

Darker shading represents increasing frequency

Type 1: Narratives that emphasized negative experiences & trauma

One set of narratives more heavily involved negative emotional experiences than others. Participants in this group had stories that involved trauma and highlighted negative experiences with care. Though they had both positive and negative experiences in their lifetimes, the participants' care-seeking was influenced most by these negative life experiences. These participants described emotional traumas linked to social and structural influences having to do with race, gender, and class. Two sub-groups emerged within this type—those who had traumas associated with race and gender and those who had negative experiences because of class.

Trauma, for those who experienced it, often influenced needs in relation to care. Trauma, however, could also be reinforced by care. The majority of individuals in this group (75-100%) discussed the mental health struggles they encountered, while those in other typologies mentioned mental health far fewer times. Those who experienced negative emotional experiences also more frequently discussed feeling a lack of agency in relation to their care and most often discussed the importance of holistic care or care that took their background into account.

Experiences of Discrimination and Sexual Violence (Race & Gender)

Eight life histories involved experiences of emotional trauma related to discrimination and/or of sexual violence or abuse. Of the individuals in this group 5 identified as Black, 2 as White, and 1 as Hispanic. Three participants had negative experiences associated with race and gender, three with race, and two with gender only. One participant experienced trauma in relation to gender but did not emphasize appropriate care as much in her story as others did. All participants in this group reported experiencing discrimination in their surveys. The majority had high levels of everyday discrimination (EDD) and reported at least one major incident of discrimination

(MED). These life experiences correlated with the participants' fears of negative treatment which also were further exacerbated by traumatizing or stigmatizing care experiences.

Ruby's Story – Traumas associated with gender

Quantitative Life Context	
EDD	Some EDD (Gender)
SS	Med SS
SC	High SC
Insurance	Sponsored Private (Parent)
Contraceptive Care Seeking Status	Non-Care Seeking, OCP App

Ruby is 23 and identifies as White and as genderqueer. She has recently graduated college. She is currently on her parent's health insurance but still struggles to find care that is affordable and that meets her needs. Ruby grew up in a conservative and religious family. At the age of 13 she became involved in an abusive relationship and experienced multiple sexual assaults. She experienced a great deal of anxiety associated with these experiences.

"And then because of the unfortunate situation that I was in, I think that that started a lifetime thing of anxiety. So, I told my mother that I had this weird stomach pain going on. And I think, really looking back on it, that it was my anxiety about getting pregnant. Because at the time, everything was secretive, hidden from the family, hidden from the school."

Her first experiences with SRH care were associated with getting birth control for stomach pain that was attributed to menstrual cramps. Her first experiences were positive. After leaving home for college she returned to the same private provider to receive SRH care. One visit, however, led to a further traumatizing experience. Ruby described how her anxiety often led her to hold her urine in case the staff called her name and she missed her appointment. This time holding it in caused her stomach to become bloated.

"[The nursing staff] were like, why is your stomach so big for someone on a small frame? I was like, that's rude, first of all… they sent me in to another room to wait on a transvaginal ultrasound... as someone who had already been through uncomfortable bodily autonomy stuff, I really was not comfortable with that. And they told me that I might be pregnant [or have...] cysts on my ovaries. And that until this person came in and did the ultrasound with the wand up in me that they couldn't tell me what was going on... And it was the most terrifying half hour of my life. Pregnancy was the most scary thing that I had ever worried about up until then, which I guess is pretty privileged. I just feel like I was not treated with respect or with any consideration from the staff at multiple levels at that point. No one even stayed with me to reassure me as we waited for the ultrasound administrator.

After that… they made fun of me for not peeing… [It made me feel] pretty upset. Pretty embarrassed… So just bringing back bad feelings of shame that had hovered around my getting into acquiring birth control. That had been abated for a few years from good experiences… I think women's health is very stigmatized and often made into a joke. It's something that it's difficult to even just talk openly about because it has to be something that we're secretive about…So there was that kind of shame, just of needing women's health. And also, just shame about my own body."

Ruby’s Story – Traumas associated with gender

Ruby stopped using birth control sometime after that experience and instead used condoms. Throughout her life Ruby also had other negative care encounters in which staff or providers would use improper terminology for her body parts or would leave the door open during exams. These experiences further contributed to feelings of shame and discomfort and were disincentivizing for her care-seeking.

After the presidential election in 2017, Ruby experienced a decline in her mental health and grew depressed which influenced her sexual activity as well as her ability to seek SRH care and use birth control.

“*My mental health just took a big dive. And with that went a lot of the things that I used to be good at maintaining like paying my bills on time, going to classes regularly, being on time to things… [it wasn’t only] the results of the election but also just the feelings of constant tension in our environment and a feeling of general insecurity and lack of control. And the very triggering dialogue that was happening in our public sphere about the treatment of women and fems and sexual assault was extremely uncomfortable.”*

Since by then Ruby had graduated from college she also couldn’t return to her previously trusted source of care. She worried, *“where am I going to go where they're not going to treat me like they did then?”*

Ruby eventually found an app that allowed her to seek care from home. She found the care to be polite and efficient. She appreciated the fact that she could do it from home without scheduling an appointment or having to endure a pelvic exam, that they took her health concerns into account, and that she could get a three-month supply at once. Yet she stopped using the site after she felt she couldn’t afford the co-pay.

In reflecting on her ideal care, Ruby emphasized the importance of having agency in decision-making about her own body. She also reflected on how critical it is to have care that addresses her experiences fully and on how important having access to appropriate care is in being able to seek it in the future.

“*I want to be able to have control, you know. [That means] being able to pick my own method without automatically being talked into pills again. I would love it if someone would actually talk to me the way that you have today and emphasize the other options a little bit more, maybe, because I don't think anyone's ever done that with me before…*

I just feel like doctors sometimes have this tendency to forget that people's health and people's attendance at appointments can be difficult sometimes. It can be difficult for people to prioritize that at all. And I think the doctors need to recognize that it takes some people a lot of effort to even get there. Just make the whole process a little bit more encouraging and a little bit more patient-minded…I think that it's pretty indicative with my issues with not only past doctor experiences but maybe it's anxiety, maybe it's depression… that I haven't been … to a physician about my women's health in three years. So the next time that I do show up, if the process is not efficient and if the nurses and the doctors don't speak to me with respect and if they don't speak to me in a way that I can understand and all of that humanistic consideration stuff, then I'm going to be less incentivized the next time to show up. And it's going to have these effects that echo across my life and my behavior. And that's why it's so important that the process has the patient's wellbeing in mind.”

Ruby's story in context**:** Ruby dealt with challenging traumas associated with sexual assault during adolescence and generally shameful feelings related to her body and sexuality throughout her life. These experiences influenced how she received and engaged in care. Negative experiences dissuaded her from seeking care, whereas experiences that allowed her more bodily integrity and agency encouraged her to seek it. Ruby also struggled with the balance between using more comfortable sources of care and the associated cost. Her resilience in navigating these challenges was also influenced by her mental health overall.

Shay's Story– Traumas associated with race and gender

Quantitative Life Context	
EDD	High EDD (Race)
SS	Low SS
SC	Med SC
Insurance	Sponsored Private (Parent)
Contraceptive Care Seeking Status	Non-Care Seeking

Shay is 22 and identifies as a non-Hispanic, Black woman. She is currently pursuing a master's degree. Her family holds conservative values related to sexuality and though her mother talked with her about sex it was often unhelpful and stigmatizing. Shay has never used birth control. Her reasons for this are complex and include having seen her friends have many negative experiences.

"I've had a friend that took Depo and then her reproductive situation is like a complete mess... I have another friend that had an implant. I can't remember what went wrong with that... So, it's like, in my experience, I've never taken a form of birth control before… you can read things online but when you look at the experiences around you, it also affects your opinion and the way that you view things. Because online could list, you know, the benefits and the risk and things like that, but knowing somebody that actually experienced it and … it will definitely change your perception of whatever it is."

Since childhood and into her adult years, Shay also experienced various forms of sexual violence including rape and unwanted sexual advances.

During one of her first experiences seeking SRH care and STI testing her primary care provider was judgmental about her sexuality and this led Shay to seek care elsewhere. She found an Ob/Gyn office that met her needs and made her feel comfortable and welcome. The provider and staff were non-judgmental and sex positive. Despite having insurance, however, when Shay was diagnosed with HPV she had a $1200 bill that was completely unaffordable for her. Shay felt frustrated by the opposing pulls of trying to find trustworthy and affordable care:

"I was just disappointed because I was telling [my provider] about [graduating early and pursuing a master's degree and] he was so excited. But when it came to my care, [he] wanted to levy judgement. It's like that – to this day, I've never been back to that office…I'm just very particular about who I trust my body with health care and stuff. It's like, "You may give good care, but if I'm not comfortable with you, why are you my doctor?" Then I went to the gynecologist. They made me feel comfortable, but they're too damn expensive. So, back to square one."

Shay's Story – Traumas associated with race and gender

Even though her current school offers STD testing it is often hard to get an appointment, especially quickly. Most recently Shay (unknowingly) sought care from a crisis pregnancy center (CPC) that offered free STI testing. She returned for care several times because her experience was very positive. "A*t first they were amazing,"* and the care she received felt holistic, particularly in the context of her past experiences of sexual assault, as the staff addressed her experiences and provided emotional support.

"They just ask you how you're doing...If you don't want to share, you don't have to. But I just tell them whether I have multiple partners or not, or my relationship status, or my symptoms, of course. … But yeah, they just have a conversation with you and see what's going on. I feel like they're good with the emotional support side …. making sure that you're okay…I can't really remember specific things that they said, but they are just like, "We're always here if you need to call up here and ask questions or if you need to talk to us or what's going on with you," and stuff like that. I also told them about me being raped ... They were sympathetic with that. They understood, and they didn't make me feel like I was a victim. They actually wanted to empower ... I felt like that was probably the most uplifting thing out of that entire situation… [I feel like it's different than other care I've received] I feel like that's more well-rounded care, I feel like. I feel like with other doctor's offices, in my personal opinion…I feel like everything is transactional. It's more like, "Oh, you're sick. What do you need? You have these symptoms? …. Here is your prescription." Then you just go."

At the CPC, however, they took a lot of time to pray and preach during her visit, which felt frustrating and reminiscent of negative experiences in her upbringing. She wished that they would just get to her actual medical care. When she was diagnosed with HPV at another doctor's office, she began to feel her treatment at the CPC change. She began to feel judged by the staff, who made comments about her sexual activity. Ultimately, they said they couldn't see her because they couldn't treat her for the HPV.

Shay has also experienced high levels of everyday discrimination throughout her life, including weekly instances of being treated with less courtesy or respect than others, of people thinking she is not smart, and of being threatened or harassed. She perceives this treatment as being associated with her race as well as her gender and age. Shay regularly thinks about the potential for experiencing further mistreatment in the healthcare system. In reflecting on the importance of trust in relation to SRH care, Shay described the perils of care-seeking that black women face:

"I think it's very important that you actually trust the doctor that's giving you medicine or prescriptions, treatment, whatever it is. I think that – well, to loop it all together, especially considering my race, too, among my friend group and just the people that I interact with, we just naturally have this fear or being sterilized because of what has happened in the past. So, it's like we can go to the doctor and get an abortion or get birth control and then something terribly wrong could happen to us. Because we are black women, people don't empathize with us the same way if it was someone else. Even with birth rates, we are three times more likely to die during childbirth. So, there's so many different factors that are going into play here. Then, again, I go online. You look up and black women are more susceptible to all these different things. Then we don't trust the doctor, so it's like – how can we get help?"

Shay's story in context: Shay experienced traumas both in terms of discrimination and sexual assault. Feeling comfortable and not judged by her provider was important for her and drove her care-seeking. Finding a place that was validating was important as was finding holistic care that addressed her life experiences past and present. Because of financial concerns, however, she was not able to find a place that fully met her needs.

Experiences of Economic Stigma (Class)

Four participants' stories centered on challenges with economic factors in their lives as well as with seeking and navigating SRH care. Of these individuals, three identified as Black and one as White. These participants struggled to afford care, have insurance, and/or maintain a job. For some, getting time off work and having childcare were also factors. All had lower incomes and were uninsured or on Medicaid. In their SRH care seeking, these challenges combined with experiences of stigma and poor treatment that were associated with their income. Individuals in this group often said they preferred a provider who knew and cared about them and who did not judge them for not having insurance or for being on Medicaid. While a majority of study participants commented on stigma associated with their income, the influence of this stigma on their care-seeking was not as pronounced as other influences and thus they are not included in this group.

Alexandria's Story – Traumas associated with class

Quantitative Life Context	
EDD	High EDD (Other)
SS	Low SS
SC	High SC
Insurance	Medicaid or (Subsidized)
Contraceptive Care Seeking Status	OCPs from Private MD

Alexandria is 32 and identifies as a White, Non-Hispanic woman. She grew up in a Northeastern state in poverty with a teen mother. At 16 she got pregnant and sought an abortion. Even though her mother was not supportive, she was finally able to get the procedure she desired. At 17 she moved out. After college she moved to Georgia. She didn't have insurance and was not using birth control. She got pregnant but had a miscarriage and had to seek care in the emergency room because she had no other access to care.

"I went to the ER because I didn't have healthcare… [I didn't get birth control after because] at that point I couldn't afford it... I had to scrounge up $150.00 to get a pregnancy test... I was always talking about how I couldn't afford birth control. The $30.00-a-month for birth control … So I distinctly remember not being on birth control then even after I had a miscarriage because at the hospital they didn't you know offer it to me. It just was kind of like 'You're here in the ER.'"

Alexandria continued to struggle to afford healthcare and birth control. Receiving no support from her partner to pay for it, she soon became pregnant again. She decided to keep her pregnancy and was able to enroll in Medicaid after scraping together another $150 for her pregnancy test at a nearby clinic. She really liked her private Ob/Gyn provider but still felt she lacked agency during delivery "*So she was really great. I actually still see her but, I ended up having to get induced when I had my son so … there were a lotta decisions made on my behalf that, I think that if I would've had private healthcare it would've been a different experience."*

After her pregnancy, Alexandria made sure to get birth control right before she lost her pregnancy-associated coverage. She returned to her prenatal care provider but because of her job and lack of childcare, she found the experience extremely difficult. The appointment process was challenging, and she faced stigma associated with her insurance.

"[The appointment] hours were very limited.…I was actually working in a warehouse until like the day before I had my son… moving things and in fumes and it was crazy because it's a 'Right to Work' state and so I couldn't get a job anywhere because I was visibly pregnant even though, I'm a certified paralegal … so I went back to work when my son was 21 days old… I had to take off work early … it was 9 to 4 and that was it and they didn't have any other time …. They wouldn't call me in medicine so … [So I left him] with a caregiver, I had to pay more money. Going to the appointment you know they were always just, like, gruff and just not happy to be there and I always internalized it as because I had Medicaid"

" [The provider's office was] super-sketchy about bringing kids there… because they were a private doctor's office and they only saw a very small number of Medicaid patients, they were just like kind of like, 'Medicaid patients don't make too much noise,' kinda thing…I saw them treat other people much poorly than treated me… and especially people that [brought their kids]"

Alexandria's Story – Traumas associated with class

After this Alexandria got a job working for a law office and was able to get health insurance for a period of time. Because she liked the doctor, she chose to return to the same provider for SRH care. During this time her doctor had also changed offices and focused more on providing care to low-income women. Alexandria perceived a marked difference in how she experienced her care especially from staff.

[My provider] moved her offices and so it was better, like, the people were better… she found her passion and so she wanted to serve low-income people. And so it was more like "we're happy, we know that you need care, we're happy you're here," … it was definitely better… they were, like, we're in this to benefit women, you know? It wasn't like "this is our doctor's office, how dare you come here?" You know "with your government insurance?" It was definitely more, like, this is something to help women so that was really helpful and good."

When Alexandria decided to start her own business, however, she lost her insurance and stopped taking birth control. She finally found out she was eligible for subsidized insurance through the ACA exchange and was able to get a form of Medicaid again. But using Medicaid made her self-conscious about how she was perceived by her providers. Even though the care was nicer in the new office, she still felt tremendous shame:

"So I was back on Medicaid, back on my same mindset of, like, feeling bad for being there and feeling like I'm taking up too much time with the provider...I still feel like bad because I'm on government-subsidized insurance…I think because I grew up on it, you know? I mean I don't know if I've paid enough taxes to cover it all though I would. [Starts Crying] You know I would pay for anyone to get healthcare but I dunno…every message that I've heard since I was a child is, like...about taking care of yourself. And why would you be getting people to help you? When it's, like, we've been, like, socialized to think this. "

In describing her ideal care, Alexandria emphasized the importance of receiving holistic care from a provider and staff that knew her.

"I feel like they're helping me so and if I knew something about them, then I could connect with them more … I just think … then that means that we're all, like, in this care thing together."

Alexandria's story in context: Alexandria experiences highlight challenges associated with structural and contextual factors such as labor and family care policies. Her ability to access care was influenced by the difficulties she experienced in securing insurance and having access to affordable childcare. Her experiences also highlight the challenges women may face in being able to get a job or insurance during pregnancy and the health risks they may also encounter. Alexandria felt shame and guilt at needing to have subsidized healthcare and felt the quality of her care suffered because of it.

Type 2: Positive Experiences

Four individuals had narratives that focused on returning to trusted care. Of participants in this group two identified as Black, one as Black Hispanic, and one as White. While some individuals experienced both positive and negative care experiences, they described positive aspects of their experiences that motivated them to return to a preferred provider. All were also willing to drive further, sometimes up to an hour, and/or to pay more for their preferred source of care.

Individuals in this group often felt they were known by their providers and that their providers cared about their needs. One participant, however, said that she did not want her provider to know her too well as she was concerned this might result in receiving more personally biased care. All participants in this group expressed varying apprehensions about not being taken seriously or not having their concerns addressed by their providers including concerns related to their contraceptive choices, reproductive health issues, as well as concerns about judgment, or discrimination. These individuals all returned to their preferred sources of care, however, because their provider did not dismiss them and instead addressed their concerns. These individuals also encountered fewer obstacles having to do with insurance when they returned to their preferred care source. Most of the participants in this group also had higher levels of social capital than those in other groups, though one participant had low social capital. All participants described experiences of family stigma associated with SRH, a stigma often aligned with conservative religious values. While some individuals in this group had medium levels of SS, all scored lower on family specific SS.

Juju's Story– Positive Experiences & Returning

Quantitative Life Context	
EDD	Some EDD (Other)
SS	Med SS
SC	High SC
Insurance	Planning for Healthy Babies
Contraceptive Care Seeking Status	IUD from Private Hospital

Juju is 27 and identifies as a Black Hispanic woman. She works in the food industry and has a partner and a new child. Her Hispanic family was Catholic and held conservative values about sexual activity and so in her teen years Juju planned to wait until marriage to have sex. When she met her current partner, they used condoms for a while and then eventually did not use anything. Her feelings about pregnancy changed. "…i*n my mind, I'm like, 'If I have a kid, this would be awesome' kind of thing… Like, if this happens, this happens."* Since her periods were irregular, Juju didn't realize it when she became pregnant. She attributed feeling strangely to stress and long hours with work. She injured her shoulder, however, and sought care at aa private hospital that was close by and there found out she was pregnant. She and her partner were both surprised and happy. She continued to get prenatal care within the same private health system even though her friends told her she should go to a different one. She continued because she appreciated the kind of care she received, *"[since] they were so nice when they were telling me the process and doing the sonograms and everything."*

After giving birth, Juju did not want to become pregnant again too soon and decided to try using contraception. She discussed options with her OB, but also visited three other locations close to her home to compare pricing and methods before making her decision. She appreciated the treatment she received at the health department as they took time to give her information about each method and about pricing. Her visit to a specialized family planning clinic, in contrast, felt unhelpful.

"The health department was the nicest about it and sat down, talked about it and everything. They answered my questions more. They weren't just like, "Here, you have this, this, and this. This is the price" and like, gave me some paper. 'Cause when I went to [SFPC], they just gave me a paper and they were just like, "Here are the prices and everything and just let me know what you want to do."

Juju appreciated having more information about her options: *"[The health department] talked to me about it, 'cause I wasn't aware. I've really never been on birth control my whole life span, so, I needed to know what was gonna be best."*

Juju's Story– Positive Experiences & Returning

In the end however Juju felt most comfortable returning to her previous provider who she felt most comfortable with and who knew her: *"But I just feel like, more comfortable [there]. They took care of my baby…they're gonna take care of me… [My OB] knows my situation. She has my whole record in front of her. . . She's been here this whole time. So, I feel like, super comfortable."* In addition, the staff and atmosphere in general made her feel welcome. *"[The staff are] amazing, as always…I just feel like they care…Whether you're paying in cash or have no insurance – whatever it is, it's just like, they care."*
She also chose to return to her previous provider even though it cost more. Juju paid out of pocket for her IUD insertion $275 and drove further (~25 min) from her home compared to the health department (only 12 min away).

"There should have been no reason why I went with [Preferred Provider] over the health clinic, because I paid way more [there]... but then, I just felt secure, 'cause the last year and a half of my life has like, been here. So, then, I was just like, I'd rather pay a little bit more to like, just make sure.

In reflecting on her ideal care, Juju emphasized the importance of having humanizing care and a provider who was attentive to her concerns: *"Just attentive to my questions and…know that I'm here and I'm a person and that I have questions and concerns. That was my major thing. Like, I don't want my questions to be like, bypassed or like, '[that's] a stupid question' or my concerns don't matter."*

Her experiences with her preferred provider mirrored these priorities. "[*Whether I had any concerns] was the first thing [my provider] asked me. Like, 'What do you want to know before we decide?' And then, even with placement –, "What do you want to know before we put this in?' And at that time, I was like, "I don't know. I can't think of anything.' She's like, 'Well, let me give you the rundown-- it's gonna feel like this. It's gonna take this long.'– and then, even the after care of taking it out. Like, that I might bleed now, I might bleed in three months. …Like, if there's any issues or pains to come back. 'Here's the contact. Here's the e-mail. Here's my personal number.' Just verifying everything like, my pharmacy, making sure that's correct – having a backup pharmacy. Like, they're so on it with making sure that everything's in a row so then, you feel secure about it.*

Juju also commented on the importance of having a provider who was also a person of color, who could relate to her*: "I would definitely rather have someone of ethnic background…They can relate, I feel like. And it's not as judgy. I mean, I've had white doctors who don't. I've had Asians who don't. But it's less common.*

At her preferred private source of care, Juju had two providers one was white male and her primary provider was a black female. She noticed an immediate difference in how she was treated.

"I feel like he was kind of like, rushy with everything, and she was kind of like, "You're not gonna leave here until you feel absolutely comfortable." … my boyfriend comes to most of my appointments, so, it'd make him feel more comfortable…[he said], "She's actually listening to you." …He noticed it a lot before I did. [It made me feel more] comfortable."

Juju's story in context: Despite having breaks in her insurance coverage, Juju prioritized trusted sources of care for her SRH needs so much that she was willing to pay more and drive further for that care. Though she did not report high levels of discrimination in her survey, she was aware of the potential for poor treatment and prioritized provider who she felt would relate and take their time with her to make sure she was comfortable.

Type 3 Consistent Care & positive/neutral experiences

Three participants gave narratives that mainly highlighted positive or neutral experiences but did not as heavily emphasize the way they were treated as being motivation for why they sought care. All participants were women of color (2 identified as Black, and 1 as Hispanic). They discussed their general perceptions and feelings about the presence of discrimination and the potential for poor treatment in healthcare but did not describe experiences of their own care that were negative. Instead, participants in this group were largely able to find care that met their needs. They had generally stable insurance and a consistent ability to return to sources of trusted care. At the time of interview, though they were low-income. All had sponsored private insurance as well.

Akia's Story – Consistent Good Care

Quantitative Life Context	
EDD	Low EDD
SS	High SS
SC	Low SC
Insurance	Sponsored Private
Contraceptive Care Seeking Status	Non-care-seeking, Condoms

Akia is 29 and identifies as a black woman. She is married and is in a polyamorous relationship. Her family was in the military and she grew up on a base. When she was in high school, a family friend took her to get birth control for the first time. She couldn't remember to take the pills regularly though and ended up stopping and just using condoms with her boyfriend. At 17, in her next relationship she didn't use condoms or birth control and got pregnant unintentionally. She used either her parent's military insurance or Medicaid to go to a private Ob/Gyn. She had positive experiences with her Ob/Gyn who she felt didn't judge her for being pregnant so young.

"[At the hospital] they were …very attentive, very clean, like I said, very patient. They really made me feel taken care of."

After her pregnancy, Akia kept using condoms; it was easier and less scary than birth control: *"I think because I was afraid of birth control … I guess the pill was just kind of the first thing on my mind, … I didn't want anything implanted in me. And so I just thought condoms are easy, you can go to the corner store and get them so I think it was more of a lazy thing."*

Akia's Story – Consistent Good Care

She met her husband in a Midwestern state and then with him to moved Georgia. They are polyamorous and are careful to get tested for STIs regularly and always use condoms. Her husband is also infertile, so she worries less about getting pregnant.

"[Being Poly] just kinda means that you have, multiple loves. And with being poly, you do have the freedom to have those connections with other people…whether it be spiritual, physical, including sex, mental, whatever. So with us having that freedom of course our Number 1 priority is to protect ourselves. And definitely condoms is a huge thing on our list for both of us."

She and her husband have insurance through his military coverage. They sometimes go to free testing events but now she usually sees her private Ob/Gyn. Akia found her Ob/Gyn when she started having bad pelvic pain related to fibroids. She did her research, looking at reviews to find a doctor whom she felt she could trust.

"I tend to like to find African-American doctors. And she listened, you know? Sometimes you find doctors that don't really listen, they just kind of try to tell you what you're feeling or what is going on but everything that I asked her to do, [she did]…. And so my history with that is kind of long so she wasn't trying to rush me along."

Akia also reflected on her preference for African American providers.

"Because healthcare is different across-the-board and some things that I may deal with as a black woman may be different from someone who is white or Indian, Native American, whatever [crosstalk] --Where our bodies are all made differently and sometimes we, as black women, go through things that other races may not go through. So it's always important for me to have someone who can relate to me."

Though she personally has not experienced mistreatment in her SRH care, she feels that it is important that providers understand the importance of each individual's unique experience.

"Because their stories can be similar but how their body reacts could be totally different or what they may be feeling could be just a little bit different. You can't treat … two different people the exact same way, they're going to be different in some shape, form or fashion. So if… the patient starts to feel like they're not being heard or that they're feeling is not important, it's of course it's gonna leave a bad taste in their mouth, they're not gonna wanna come back."

***Akia's Story in Context*:** Akia discussed many elements of positive care in her experiences and stressed the importance of attentive care including being listened to and not being rushed. Of the 3 individuals in this group, she emphasized elements of appropriate care the most. Akia discussed only positive care-seeking experiences though she acknowledged that other women had much more negative ones. She never discussed difficulty in gaining access to care largely due to her consistent insurance.

Type 4: Not as emotionally tied to care-seeking and more motivated by cost

The narratives of six participants did not emphasize trust or the importance of appropriate care despite undergoing both positive and negative experiences. Instead, these individuals mainly emphasized the importance of cost or insurance or time and convenience in their priorities for where they sought care. Of the participants in this group two identified as Black, two as Black Hispanic, and two as White. Individuals in this group appreciated appropriate care including respectful and non-judgmental treatment, but the pressing concerns of cost or ease in accessing services was a more important and immediate concern.

Ashley —Cost & Logistics Motivated

Quantitative Life Context	
EDD	Low EDD
SS	Med SS
SC	Med SC
Insurance	Not Insured
Contraceptive Care Seeking Status	OCPs from Health Department

Ashley is 24 and identifies as a white non-Hispanic woman. In high school, when she started having sex, she asked her mom to get birth control, but she didn't take it regularly because she was just being 'young and crazy.' Six months before graduation, she became pregnant. She received prenatal care from a private hospital system. After giving birth she kept going to private hospital for her OB/GYN care but switched to a woman provider because it made her more comfortable. At 21 she moved out and wasn't able to maintain access to care or contraception due to financial struggles.

"That's when I moved out and I was not employed, and I wasn't on birth control or anything. I just wasn't even going to the doctor …I wasn't on birth control for a while though, till I was 23. [I didn't use it] I think just because the money situation. No insurance and no money help. Just got expensive. And I didn't even know about low income clinics or health departments."

Around 24, Ashley was finally able to get birth control again despite not having insurance. She got help from her Aunt who was a nurse who helped her figure out a where to get it for less cost.

"My aunt is a nurse in [County] and she called me. I told her I was really struggling getting my birth control and she was like, well, they have these low-income clinics and health departments… She gave me a number and I called, and they were like yeah, you can come in, it's cheaper."

Ashley —Cost & Logistics Motivated

The health department was short staffed, and the staff were rude, but she got what she needed. The next time she got a refill she went to a different place, a community health center (CHC) that her aunt told her about because she needed sleep medication. At the CHC, the staff were friendly and cheerful and made her feel welcome. The provider was male however, which made her feel uncomfortable.

"Everybody is friendly. [The staff] were nice in there and it's not a long wait. I mean, it's not like, I don't know, fifteen, twenty minutes in the waiting room but just like an hour and a half. Yeah, I liked it there… [The provider] was a man. I didn't really like that… He didn't really speak that great of English at all so I was just like I really can't understand him. I think that was the only thing that bothered me, a very hard time connecting…that was rough. Especially when you're trying to talk to a man already about birth control and I'm like you don't understand me either…. The nurses were really nice and they were quick…They were just cheerful and just happy, cheerful person. I feel like everyone at a nurse and a doctor's office should be like that."

Ashley went on and off pills. Occasionally, she would forget or would not prioritize them, but then when she got into a relationship, she was more consistently sexually active and wanted to get pills immediately. She chose to return to the health department because it was easier-- she had been before, it was close by, and the pills were cheaper than the CHC ($5 vs $20). Her experiences at the health department were not great, however.

"The front desk is always rude I feel… they're just very unhappy in there… I think they just don't really want to talk to you and they don't really want you in their face…But I feel that the doctors were okay…. Not like top notch. But… I could deal with them… they're just not rude or fast with you. They're like okay, we need to talk about it or figure out what's going on and I like that in a doctor."

Ashley also felt that the care she received could be judgmental, *"I think that they are very judgmental in there… they make you just feel really awkward talking about things… it's always been like that. It's like I don't really want to tell you this stuff…[like] having sex with no condom… Or having sex with more than one person or whatever, having sex with the [same] sex, it's like you're going to look down a little bit. ... But other than that, it's good.*

Even though Ashley got what she needed from the health department and will likely return, her preferred source of care would be a private provider.

[I probably wouldn't recommend it to my friends] I would say get health insurance and go see a real doctor. No, they're real doctors, I shouldn't say that... I think they take better care of you, they're more friendly, they more than want you in there...like you're not rushed at all. I just like private doctors, I think. And I haven't been able to see one in a while (chuckles)…I don't know. It's just a little different than a health department."

Ashley's story in context: Ashley's narrative focused on the logistical and financial challenges to accessing birth control services. She noted that staff and provider treatment could result in more negative experiences, but her priorities associated with cost and convenience outweighed these concerns. Her ideal care still involved having a provider who cared about her which she associated with private providers, but she felt this was not possible without having health insurance.

DISCUSSION

Low-income women in Georgia conceptualized appropriate SRH care as care that can be trusted, and they identified many elements that facilitate such trust. Our findings align with other work in the area of quality FP services and identified many similar themes such as the importance of communication, compassion, taking time, personalization, and autonomy (Becker et al., 2009; Holt et al., 2017). Adding to this literature, individuals in this study emphasized the importance of being understood and highlighted how their personal histories influenced their perceptions of appropriate/quality care. More than previous studies, we also found that health services staff, not just providers, contributed to women's experiences of appropriate care.

As others have increasingly recognized in family planning, "access" to SRH care must be centered in the context of an individual's lived experiences as well as within larger historical and current social and structural forces. Holt et al for example, conceptualize contraceptive care in this way (Holt et al., 2020). Measuring equitable access thus involves determining whether individuals have the ability to use appropriate services that meet their unique needs. Our findings demonstrate that elements of trust and appropriate care are essential to the conceptualization of access. SRH care-seeking, including whether and where to seek care, was frequently influenced by considerations of both. For some, however, issues of cost and time were more important than appropriateness. Low-income women in our study also had to frequently trade quality for cost. As our study illustrates, access to appropriate care may be understood as the interplay between health system characteristics and individual factors that are both influenced by the context of larger social and structural environments. Access to appropriate care, for example, involved not only the training and expertise of the provider, but also the interpersonal interactions between provider and patient, and was shaped by individual factors such as insurance status, race, as well as the participants' lived experiences including those of discrimination and trauma.

Achieving health equity involves both equitable outcomes and equitable access (Braveman, 2014). Inequities were evident in participants' varied abilities to have access to the same level of appropriate care and were often associated with challenges related to discrimination, trauma, or affordability. Participants recurrently voiced the desire to have care that acknowledged and was sensitive to their unique experiences. For many, experiences of direct discrimination as well as awareness of mistreatment in their peers or communities filtered into participants' overall engagement with healthcare. Several participants also pointed out that women's health is often stigmatized and felt they had to be quiet about their issues. Our study highlights how the presence and history of societal discrimination filters into the ways female-bodied individuals, particularly those of color, must frequently be vigilant to protect themselves from mistreatment in their SRH care experiences. Participants' experiences were also intersectional (Bowleg, 2012; Crenshaw, 1990). Many participants had multiple individual social identities and underwent intersecting experiences of oppression at the structural level, such as those associated with not only race but gender, class, as well as age. Trusted care was also desired to be intersectional as well, as for some women it was important not only to have a black or female provider, but a black and female provider.

Lack of equitable access to appropriate care has implications for care-seeking and SRH outcomes. As our findings indicate, when care does not meet women's needs, they may be dissuaded from returning or may not be able to get all the information they feel is necessary to make SRH decisions. This may result in care-seeking from other sources, such as CPCs, that may seem to meet women's needs but fail to provide quality information. CPCs often provide free services that focus on social and emotional support. It is not surprising, as we found in our interviews, that some women may initially feel that CPCs provide elements of appropriate care and appear to meet their needs more than other services. CPCs, however, often provide ineffective care and inaccurate information that can further undermine women's ability to achieve positive SRH outcomes (Kimport, 2020; Swartzendruber et al., 2019; Swartzendruber et al., 2018a; Swartzendruber et al., 2018b). Further research should investigate how FP and SRH services can better meet women's needs more holistically by addressing social, structural, and emotional factors. Lack of access to appropriate SRH care, finally, is also likely to influence multiple SRH outcomes, including those related to maternal health. As our data indicate, low-income women, particularly women of color, often encounter a lack of agency in their delivery care, even when they have positive prenatal care experiences.

Recommendations for public health

This study has several implications for public health practice and policy. Our findings highlight the need not only for patient-centered but also trauma informed SRH care (Holt et al., 2017; Institute of Medicine, 2001; SAMHSA, 2014). Mental health also plays a role in many participants' ability to seek care and should be integrated into SRH services more holistically. Strong referral linkages to care sources not provided on site are important for holistically addressing patient needs. Our findings also confirm the importance of assuring that individuals feel they are being heard by giving them time to process information and to raise concerns. Measures of patient experiences (such as those that assess whether they feel that they had enough time with the provider or the extent to which they feel they received enough information to make decisions) could be helpful to assess whether sufficient attention to such issues is achieved.

As others have emphasized, our findings also point to the need for providers to be trained not just in cultural humility but in structural competency. Such training can help providers understand structural and social factors such as racism and economic policy that influence the lives and health of their patients, as well as the healthcare system itself (Holt et al., 2020; Metzl & Hansen, 2014). Continued engagement with community and patient stakeholders is also necessary to rebuild trust and to address historical injustices against black, indigenous, and other people of color in medicine and in SRH. Finally, our study also highlights the important role of healthcare staff in providing appropriate care. As our participants acknowledged, services suffered when staff were overworked or did not feel connected to their work or the mission of providing quality care. Additionally, in many settings, especially those that provide publicly funded services, staff often come from the communities that are being served. Achieving justice and equity for patients thus likely requires attending to justice and equity for staff as well.

Strengths and limitations

Our study has several strengths. By using a life history approach, we were able to collect rich data that demonstrate how experiences may build on each other throughout an individual's life course and how the context of women's lives comes in to play in their seeking care. Our study also explored the perspectives of women in suburban communities who use a range of services. This allowed us to examine a more diverse range of experiences than similar studies focusing on women attending urban family planning clinics. Our study, however, is limited by what participants may have been willing to share. It may be that some were more likely to disclose trauma than others, for example. Life history approaches also include complexity and this complexity may make it hard to fully untangle which experiences had the most influence on a participants' care seeking. Finally, our study findings are not generalizable, although they do offer an understanding of one set of low-income women's experiences in the Southeast.

Conclusion

Achieving health equity in SRH care involves addressing socially unjust and systematic health disparities and necessitates a holistic approach that acknowledges the influence of multiple levels of influence, including social and structural forces (Braveman, 2006; Braveman et al., 2011). A better conceptualization of equitable SRH access, one that acknowledges the complex and multifaceted nature of access, enables more effective measurement and intervention. Our study highlights the multifaceted nature of one dimension of access, that of appropriate care. We found that low-income women in Georgia place value on trusted care that is respectful, promotes agency, does not rush, is compassionate, and that recognizes the unique and holistic experiences of individuals. Those who have experienced discrimination, trauma or mental health challenges may be in particular need of care that is tailored to their needs. For low-income women, however, the need for appropriate care is all too often at odds with other dimensions of access such as affordability of care, a conflict which may perpetuate inequities.

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APPENDIX

Table A.4.6: Life history interview research domains, constructs & sample probes

Research Domain	Constructs	Example Probes
Care-Seeking Process	• Deciding to go • Decision making & priorities for care • Seeking care • Experiences of & satisfaction with care • Result of care (e.g. use of contraception) • Barriers & Facilitators	*"How did you know where to go for care?"* *"What made it easier/harder to get care this time?"*
Access Domains	• Approachability • Acceptability • Availability • Affordability • Appropriateness/quality	
Life & Social Context	• Work/school • Partners • Friends & Family • Financial situation • Health status	*"What else was going on in your life related to _______ at this time?"*

Figure A.4: Sample Timeline Tool

PERSONAL BIRTH CONTROL SERVICE USE TIMELINE

Please draw a timeline of your use of birth control services starting with the first time and ending with the last time you went.

Consider including:

- Where you went to get services
- Type of method you got
- Other health issues
- Side effects
- Any times you decided **NOT to get services** (or couldn’t get them)
- **Other places you went** to get help preventing pregnancy (medications, herbs, mail order, talking to a friend or community member)
- Sexual activity
- Jobs or school
- Living situation
- Issues with family/friends/partner
- Other life events that you think were important

Please use the space below to draw your timeline

Chapter 5 : Summary & Conclusion

5.1 SUMMARY OF FINDINGS

Striving to attain the highest possible standard of health for all people requires special attention to the needs of those at “greatest risk of poor health” and necessitates a focus on a variety of factors that shape inequalities in access to health care (Braveman, 2006, 2014). Attaining reproductive justice means that individuals are able to achieve a holistic well-being that supports them in making healthy decisions about their bodies and reproduction. This requires addressing a holistic set of influences including social, economic, and political (ACRJ, 2005; Ross & Solinger, 2017). The studies included in this dissertation attempted to develop a complex understanding of what equity in access to FP care means for low-income women to inform both how equitable access is measured and how it can be achieved. Each of my three dissertation aims contributes to a broadened understanding of what “access” to SRH care is and the factors that influence the ability of low-income women in the Southern US to achieve it.

My first study, comprising Aim 1, examined why, in the context of the ACA and Medicaid expansion, many women still chose to receive services at a particular type of SRH provider, Planned Parenthood (PP), in two southern states, Louisiana and Kentucky. Employing patient surveys, this study explored women’s priorities in choosing PP, examining the relation between these priorities and individual access factors such as insurance status and having a regular source of care (RSOC). The study found that overall women chose PP health centers because they were quick, confidential, and trustworthy. Sixty percent of survey respondents indicated that they did not have a RSOC, indicating that these centers served as an important source of care for many individuals without other avenues to care. Despite having other options, women who had another source of care also came to PP for their SRH care, often for STI or contraceptive services. While cost of services was of some importance to respondents, it was more frequently identified as a reason for choosing PP by those with insurance instability. Our findings suggest that women may have different priorities in care-seeking depending on elements of individual access (insurance status, having a RSOC) as well as on demographic factors such as race/ethnicity. The study found that women's care-seeking at PP health centers, including the type of services sought and reasons for choosing PP (e.g. those associated with cost and insurance status), also varied by demographics factors such as race/ethnicity, suggesting that the needs of women and their reasons for coming to PP centers may be influenced by complex combinations of individual and demographic factors, as well as by the larger context of the state in which services were situated. Finally, this study also indicates that access to FP services may be influenced by policy restrictions such as those to Title X funding that may prevent some women from being able to use their preferred care source or that limit confidentiality protections for minors (Sobel et al., March 2019). This too has implications for how we conceptualize access.

In the second mixed methods study comprising Aims 2 & 3, we used a combination of surveys and LHIs to examine the priorities of low-income women in Georgia's with respect to seeking FP care and how their priorities and care-seeking processes were influenced by the health care system and individual access factors, as well as by elements of their social context (e.g., experiences of discrimination, social support, and social capital). More specifically, we sought to document the ways in which multiple factors intersect and influence whether and where women seek care and the implications of these intersections for meeting women's SRH needs. Aim 2 elucidated how participants conceptualized one specific domain of access, affordability, and identified how health system characteristics (such as high co-pays, varying costs, and difficult systems), as well as individual factors (such as such as variations in insurance, financial, and employment status) determined what was “affordable” for participants over their life course. The study also found that low-income women frequently experienced shame and stigma in relation to their insurance or financial status in trying to access SRH care. Our findings suggest that to access to SRH care, low-income individuals must often go through a process of trial and error before they find the right “fit” between individual factors and the characteristics of the health care provider.

Aim 3 examined another domain of access, appropriate care, and explored how low-income women define appropriate care in relation to SRH services. The study also explored how the desire for appropriate care influenced care-seeking in the context of participants’ lived experiences. As with other studies, we found that participants frequently conceptualized appropriate care as trusted care, a concept that involved communication, compassion, respect, taking time, personalization, and autonomy. Individuals in this study also emphasized the importance of being understood. Their life histories also illustrated how experiences with discrimination, mental illness, and other traumas influenced their priorities for SRH care-seeking. More than previous studies, this study found that health services staff, not just providers, contributed to women’s conceptualizations of appropriate care.

Taken together, all three studies demonstrate that “access” to SRH care is multi-dimensional and that an individual’s ability to access SRH services is influenced by <u>both</u> health system and individual factors and that both, in turn, are shaped by larger social and structural forces that may vary over time. While much of FP research focuses on solely use of services, or on cost, our findings indicate that measuring access in terms of the health system alone is not sufficient.

5.2 BROADENING UNDERSTANDINGS OF ‘EQUITABLE ACCESS’

The goal of this dissertation was to develop a more holistic understanding of access to SRH care and how equitable access is shaped by the interplay between health system and individual factors, as well as by larger social and structural contexts. Building on prior access work, this study employed a patient-centered framework for understanding access in relation to FP (Levesque et al., 2013). Drawing on our research we expand this framework and propose that access may be understood as multi-dimensional, multilevel, interactive, interactive, fluid, and as a process. Each concept is described below.

- *Multi-dimensional*

  Though many have proposed that access be understood as having multiple dimensions, in practice, FP research often treats access as something singular and often as tied to health system factors such as the cost of methods or use of services. Our studies thus far highlight several major domains of access such as availability or ease of appointments (Aim 1), affordability (Aim 2), and appropriateness (Aim 3). Each domain was influential in women’s ability to realize access (use services), though the importance of each domain varied for different individuals. Each domain was also comprised of multiple elements. “Appropriate care,” for example, involved. compassion, respect, technical quality etc.

- *Multilevel:*

  Access is influenced by factors at multiple levels of a socioecological framework. Health system characteristics (i.e., clinic or organization level) are most frequently identified as elements of access, but, as proposed and as we have shown, individual level access factors are also greatly influential in whether an individual can access care. In addition, social and structural contexts involving discrimination, healthcare policies, and economic forces may influence both health systems and individuals. Thus, each access domain is influenced by health system and by individual, and socio-contextual factors.

- *Interactive:*

  As was proposed, SRH access is determined by an interplay between levels (e.g. health system and individual factors). In Aim 2, for example, the affordability of services was often determined by the fit between health center pricing and insurance processes and an individual's insurance status. SRH access also involves interplay between or among domains. Our findings showed, for example, that for low-income women, the domains of affordability and appropriate care often had to be weighed against each other. While participants were motivated by affordability, they often preferred to return to a place that they were familiar with, that they trusted and that they felt provided quality care. Some individuals in our study were able to accept more costs in terms of paying more for care (financial) or driving further (time) to ensure they received trusted services. Others, however, reported having to sacrifice appropriate care for affordable care

- *Being fluid*:

  As with emerging conceptualizations of health behavior such as that illustrated by Glass & McAtee (2006), SRH access is not static but instead fluctuates over an individual's lifetime. At various life stages, an individual's SRH access needs, priorities, and experiences differ. Access also varies with changes in the environment (e.g. ACA, policy change, etc.). Protective factors that support access also fluctuate. During adolescence, for example, some individuals in our study had additional resources such as parental financial support or insurance that allowed them to better access care. At the same time, their need for confidential care may have been higher. Other individuals had access to affordable and easy to use SRH care at colleges that provided campus health services. Pregnancy also represented a time when individuals were often better connected to SRH care and to existing resources that helped with affordability (e.g. Medicaid, P4HB, etc.). For participants in our study, pregnancy often provided the only opportunity to receive care that balanced needs across domains of access. Participants sometimes received quality care at an appropriate cost from a provider they trusted. Post pregnancy however, access could change again and "good access" was frequently dependent on current policies and existing systems within health centers.

- *A Process:*

  As our studies have shown, securing access, particularly for those who are socio-economically disadvantaged, is often a process that requires finding a fit between individual needs and health system characteristics. This process, moreover, must often be restarted as factors change across levels and the life-course.

As our findings demonstrate, 'access' to SRH care is a complex phenomenon. Systems approaches that acknowledge complexity including the presence of interrelationships between levels, feedback loops, and macro level patterns that result from the interplay between multiple factors are helpful in further conceptualizing and measuring access and in developing interventions (Kroelinger et al., 2014; Roux, 2011).

5.3 STRENGTHS & LIMITATIONS

A major strength of this dissertation is the use of a range of mixed methods data to assess "access" in a holistic way. The use of the LHI methodology allowed for rich contextual data that accounts for multiple experiences over time rather than simply taking a cross-sectional snapshot. Another strength of the methodology is that it centered on participants' own experiences and involved multiple activities that allowed them to identify salient influences. Examining the experiences of care-seeking and non-care seeking women allowed for further understanding the relationship between care-seeking and access and helped to illustrate what barriers women may face. The second study focused on the perspectives of suburban women (those living outside of urban Atlanta) which is different from many FP studies that draw on urban, clinic-based populations.

There are also limitations to this work. We were not able to include non-English speaking participants in this study and so may have missed some of the challenges that non-English speakers or immigrants face in navigating access to SRH care. Similarly, we are likely to have missed experiences of the most marginalized individuals, although we made efforts to include women who were not currently connected to care. Our sample mostly represents the experiences of cis-gendered individuals, and further studies are needed on the SRH healthcare access experiences of those who have other gender identities and who may have unique needs and life experiences. Finally, we have focused solely on the experiences of individuals seeking care (i.e., patients) and recognize that providers face challenges to facilitating equitable access. Working with healthcare providers and staff is essential to understanding access. Although this dissertation combines research from multiple Southern states, we are not able to draw conclusions about the Southeast in general or to fully capture how different social contexts may influence access to SRH care.

5.4 FUTURE RESEARCH

The studies presented here are the beginning of a more in-depth examination of access to SRH care. Further analyses are needed to fully describe other domains of access such as availability of services. The interplay between domains of access will also need to be further explored. In our second study, some pregnancy-related decisions and experiences, such as unintended pregnancies, did not influence care-seeking priorities as strongly as we anticipated and will be the subject of future analyses. Participants' reasons for not using contraceptive care were also complex and also merit further study. Though our second study focused on individuals who did not want to become pregnant in the near future, the decision to use or not use contraception was not solely associated with one type of care experience. Some decisions were linked to care-seeking and some were associated with personal preferences, lived experiences, and the influence of family and friends. Future papers will explore variations in the reasons for not using care and will suggest how SRH care providers may better meet the needs of nonusers. Finally, intervention and measurement research should also be conducted to address inequities in access.

5.5 IMPLICATIONS FOR PUBLIC HEALTH PRACTICE & POLICY

In conceptualizing equitable "access" and in more fully bringing it to realization, it is critical to act across socioecological levels. As illustrated in **Figure 5.1,** our studies have implications that are important to address at multiple levels of the social ecological framework, beyond simply the individual and health system (Golden et al., 2015).

- *Individual*

  Improving health literacy is essential to supporting individuals in gaining better knowledge of their rights and of the coverage they are entitled to both in terms of private insurance and in terms of publicly funded FP programs (Nelson et al., 2019). Participants in our second study were often overwhelmed when trying to navigate insurance systems and frequently unaware of the benefits they were entitled to.

- *Health System/Clinic*

  Collectively, our studies demonstrate that the ability to provide affordable, appropriate and timely care are all important to supporting access to SRH services. Timely care may be of high importance particularly in the contexts of Southern states with high rates of STIs. Providing quick access to contraceptives methods, preferably on the same day as the appointment, is also important for equitable access (Gavin et al., 2014).

  To increase affordability, health systems should support and strengthen the capacity of healthcare providers to help patients navigate insurance and billing processes. Insurance verification processes should not lead to patients giving up or never receiving care. When at all possible, health systems should also consider how to provide up front information about costs. Providing payment plan options is one way to increase equity for individuals who are living paycheck to paycheck.

  To better support appropriate care health systems should adopt and prioritize patient centered as well as holistic SRH services (Gavin et al., 2014; Holt et al., 2017; Holt et al., 2020). Our studies highlight the need not only for patient-centered, but also for non-stigmatizing and trauma informed SRH care (SAMHSA, 2014). Integrating trauma informed care protocols could help providers to ensure their practices are not unintentionally triggering or re-traumatizing. Such protocols could involve providers asking patients if it is ok to touch them, preparing them with details about what a physical exam will consist of, and telling them it is ok if they don’t want certain parts of the exam. Mental health also plays a role in many participants’ ability to seek care and should be integrated into SRH services more holistically. Mental health screenings (such as those for depression and anxiety) should be integrated into clinical protocols and strong and easy to navigate referral systems to connect patients with follow-up care should be developed. As others have emphasized, our findings also point to the need for providers to be trained not just in cultural humility but in structural competency. Such training can help providers understand structural and social factors such as racism and economic policy, that influence the lives and health of their patients, as well as the healthcare system itself (Holt et al., 2020; Metzl & Hansen, 2014).

Our studies demonstrate the important role of healthcare staff in facilitating access to care including helping to navigate systems associated with insurance and cost such as P4HB and Medicaid as well as in creating a welcoming environment that promotes trust. As our participants acknowledged, services suffered when staff were overworked or did not feel connected to their work or the mission of providing quality care. As one participant pointed out, when staff were connected to the mission of providing services to low-income women the quality of care improved. Additionally, in many settings, especially those that provide publicly funded services, staff often come from the communities that are being served. Staff working in publicly funded FP settings in the Southeast already experience challenges associated with low pay and high work load, and conservative communities, they often deal with stigma, which can lead to turnover and burnout (Higdon & Newton-Levinson, 2019). Achieving justice and equity for patients requires attending to justice and equity for staff as well. Supporting staff to help make the atmosphere more welcoming by including them in the mission and by increasing efforts to support staff may promote better access for patients.

- *National and State Policy*

Since socio-contextual forces influence individual and health system factors, this work has several policy implications as well. Some provisions of ACA helped participants in these studies attain affordable care. The expansion of coverage for young women and full cost sharing for contraceptive methods are two examples. For insured and uninsured participants, method coverage did not always ensure that participants were consistently able to afford and therefore use a method that they felt worked for them. Our data shows that providing a longer supply (e.g.,1 year) of oral contraceptives could help avoid additional visit fees encountered by participants. Consistent with other studies, our findings suggest that clarifications are needed for both insurance companies and medical practices about what services are mandated without cost sharing (Hall et al., 2014a; Politi et al., 2016).   ACA requires coverage for patient contraceptive education and counseling without cost sharing, yet this is often not the experience of women. Many participants wanted their provider to take their financial situations into account. Further studies could explore the role that providers could play as advocates for patients in relation to affordability.

Specific to Georgia, several policies should be enacted to address women's inability to pay for contraception and FP care. These policies include expanding the Medicaid program for individuals at or below 138% FPL as well as expanding pregnancy Medicaid (Right from the Start) to 12 months post-partum, [8] thereby allowing women more time to get necessary care including access to contraception and to set up their next phase of coverage without experiencing gaps that endanger their health and well-being. Though Georgia has recently passed an expansion of pregnancy Medicaid to six months post-partum, a full year provides additional benefits. This allows for sufficient time to try a method of contraception and to adjust or change the method if needed. Pregnancy associated mortality can also occur up to a year after birth. Subsidized FP programs, such as Medicaid, FP waivers, and Title X, are important for addressing inequities, but complex systems combined with challenges in women's lives meant that individuals often did get the help they needed or were often unaware of these programs and the availability of their benefits. Navigators or auto-enrollment processes could also be strengthened for P4HB and Medicaid enrollment. Several organizations offer these services but the ease of engaging with these systems is still varied.

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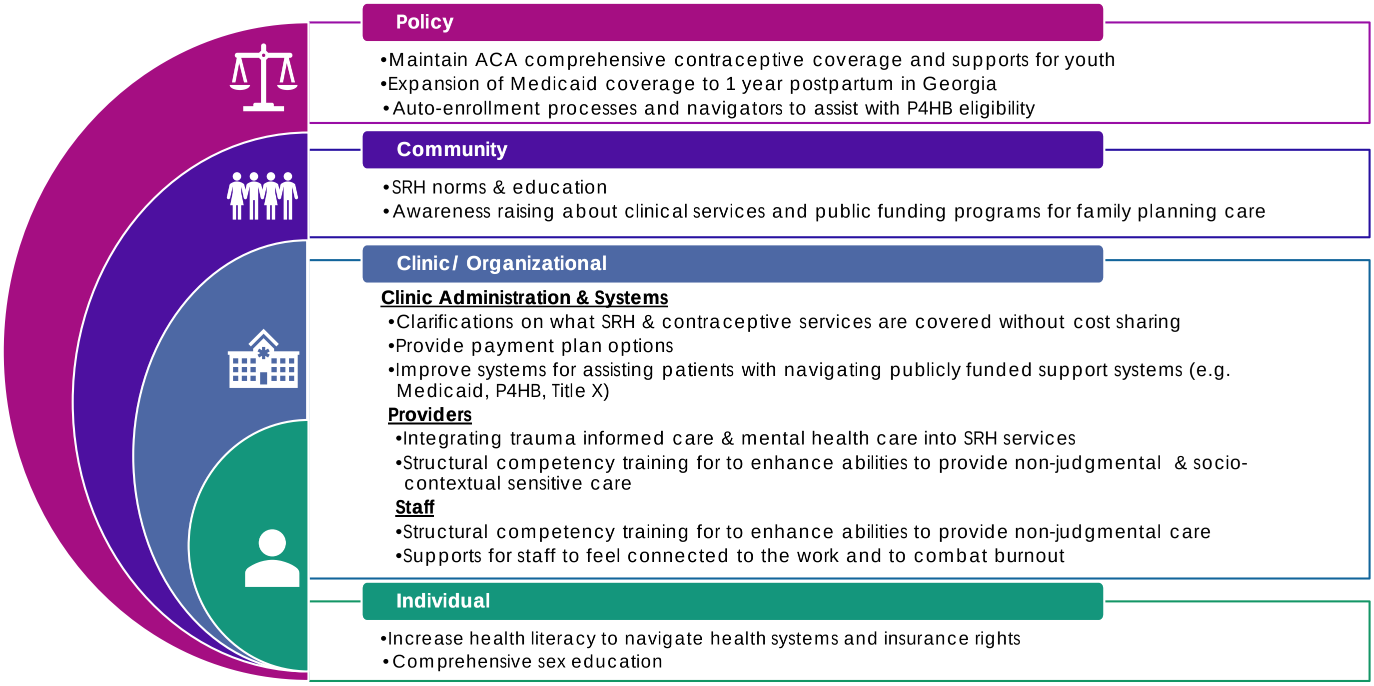
[8] Georgia currently extends Medicaid eligibility for women who are losing insurance postpartum, but the system is not automatic nor streamlined.

Our studies are situated within a dynamic SRH policy landscape. Shifts in policy that provide more access to insurance or a wider selection of care sources may not change where women prefer to go for SRH health services. Our findings point to a need for a diverse cadre of care sources so that individuals are able to find care that meets their unique needs. Recent policy changes, such as the new final rule for Title X, that further restrict who can provide services (such as PP) and that de-emphasize confidentiality protections and the provision of a range of contraceptive methods or policies that reduce requirements for comprehensive contraceptive coverage are likely to be out of line with women's needs and preferences(Congressional Research Service, 2019; Sobel et al., March 2019).

Other studies of equity in access to primary care have found a dearth of interventions that target individuals' abilities to access care (demand) or that have targeted both health system (supply) and individual (demand) influences (Richard et al., 2016). Addressing access from multiple levels shifts the burden solely from individual and serves to recognize that access is shaped by multilevel determinants. Further work is needed to develop interventions that address multiple levels together such as addressing policies associated with P4HB enrollment processes, promoting in-clinic interventions to support women in connecting to care, and improving health literacy among individuals in relation to their insurance rights.

Figure 5



Understanding equitable access: implications for practice & policy across multiple levels of influences

Policy

- Maintain ACA comprehensive contraceptive coverage and supports for youth
- Expansion of Medicaid coverage to 1 year postpartum in Georgia
- Auto-enrollment processes and navigators to assist with P4HB eligibility

Community

- SRH norms & education
- Awareness raising about clinical services and public funding programs for family planning care

Clinic/ Organizational

Clinic Administration & Systems

- Clarifications on what SRH & contraceptive services are covered without cost sharing
- Provide payment plan options
- Improve systems for assisting patients with navigating publicly funded support systems (e.g. Medicaid, P4HB, Title X)

Providers

- Integrating trauma informed care & mental health care into SRH services
- Structural competency training for to enhance abilities to provide non-judgmental & socio-contextual sensitive care

Staff

- Structural competency training for to enhance abilities to provide non-judgmental care
- Supports for staff to feel connected to the work and to combat burnout

Individual

- Increase health literacy to navigate health systems and insurance rights
- Comprehensive sex education

Strategies to support changes at all levels:

Enacting the changes suggested above requires concerted efforts across sectors. Two strategies involve addressing time-limitations of providers and enhancing measurement to incentivize progress toward equity. Creative solutions to support providers in sufficiently addressing patient needs even when short on time are required. Health care staff may provide an opportunity to address these needs. Involving staff in providing emotional and social support for patients and in connecting them with additional resources addresses gaps in ensuring affordable and appropriate care as well as provides pathways for further engagement and growth for staff.

Measurement is also key to supporting health systems to enact changes to enable more equitable access. Measurement can help to identify where issues exist and help to maintain accountability.

As others have pointed out, measurement is important in shaping the lens through which we understand our work (Dehlendorf et al., 2018). Researchers who study SRH and those involved in public health quality assessment should also consider measures of access that better reflect its complexity. Health systems should also integrate measurement of access into their internal assessments. Finally, quality measures are often linked with incentives such as funding and insurance contracts. Expanding nationally recognized measures of quality to include measures of access that promote equity (as illustrated below) could help to support progress toward SRH equity within the health system.

Measures of access:

To move toward equity, access measures should serve as an assessment of whether the system as a whole is functioning properly. Simply measuring the individual or the health care system alone may miss issues associated with a poor fit between individual factors and health system factors. While socio-contextual influences are difficult to impact directly, measuring them also allows for deeper understanding of how they function as well as possible means of intervention. **Table 5.1** provides some illustrative examples of how measures could be expanded in various contexts, but further research is needed to better operationalize measurement. Measures of SRH access should also account for complexities such as its being multi-dimensional, multilevel, as well as account for how it is influenced by interplay between levels and dimensions. Measures of access should also account for changes over time (fluidity) and assess the difficulty or ease of the process to realize it. To account for these complexities, a variety of data sources including electronic health records, patient satisfaction surveys, feedback from community stakeholders, community or national surveys, and policy data should also be used. Measurement should also integrate equity-based assessments such as those proposed by health equity researchers that assess the extent to which individuals from disadvantaged groups have the same opportunity to realize access to quality services and ultimately attain the highest standard of SRH (Braveman, 2006; Levesque et al., 2013)

Table 5.1: Illustrative examples for expanding measurement of equitable access to SRH care

		Examples	
Characteristics	**Description**	**Measures**	**Data Source**
Multi-dimensional	When measuring access include measurement of multiple domains such as availability, affordability, and appropriateness.	• Checklists of whether care is available, affordable, and appropriate, etc. for health system assessment or multiple measures of access for individual factors (insurance status, wait time for getting last appointment, perceptions of treatment, etc.) • Measuring multiple elements within a dimension, such as those within appropriate care: - Did you have enough time with your provider to make a decision? - Did interactions with staff make you feel comfortable or welcome? - Clinic staff turn-over rate - How much do you agree with the following: “I don’t have further questions or need more information about my method or procedure”	Clinic or organization practice data & patient surveys
Multilevel	Measures should also assess access at multiple levels including individual, health system, and larger social context. Placing access measures “in context” acknowledges the larger forces that act on both the individual and health system.	• Health system measures of postpartum contraceptive uptake *Considered in the context of* • % enrollment of patients in health system in P4HB post delivery	Clinic or health system data
Interplay & Fit	Beyond capturing multiple dimensions and multiple levels, access measurement should	• “Do you feel like the care you are able to afford is of: poor, fair, or high quality?”	Patient surveys or national surveys

	strive to assess the interrelationship between them. This also involves assessing the functioning of the system as a whole.		
Fluidity	Measures of access should also account for changes over time and the influence they may have on access overall.	• Individual use of SRH services in last 3 years • *Considered in the context of* Individual continuity of insurance coverage over time period (e.g. 3 years)	Community or national surveys
Process	Measures should acknowledge the process involved and seek to identify ways in which this process can be less burdensome.	• Number of failed attempts to accessing services • % of pregnant women on Medicaid who are connected to follow-up contraceptive care or P4HB	Community or national surveys
Promoting of Equity	Measures should attend to the extent to which disadvantaged groups are able to attain the highest standard of health and have the same opportunity to realize access to quality services.	• Demographic breakdowns of access measures above by race/ethnicity, income, insurance status, etc. • “To what extent do you feel like your experience today fully met your needs?”	

5.6 CONCLUSION

Persisting disparities in SRH outcomes among those who are low-income, persons of color, or who live in the Southern U.S. necessitate further attention. Achieving health equity in SRH care involves addressing systematic and socially unjust health disparities and necessitates a holistic approach that acknowledges the power of multiple levels of influence (Braveman, 2006; Braveman et al., 2011). Better conceptualization of equitable SRH access, one that acknowledges its complex, fluid, and multifaceted nature, enables more effective measurement, intervention, and accountability.

SRH access cannot be conceptualized in terms of health systems alone, but must also include individual abilities to access services, demographic factors such as gender and race/ethnicity, as well as social, economic, and political influences. As evidenced in these studies, SRH access is shaped by intersecting structural influences such as policies related to labor protections and benefits, family care support, and by social influences such as historical and current systems of discrimination that yield trauma and mistrust. Disparities will persist unless we are able to address larger social and structural forces that also influence this process though multilevel intervention

SRH services access is one component of the vision to support all indviduals in attaining the highest level of SRH. As emphasized by reproductive justice scholars and advocates, it is essential to acknowledge that achieving this necessitates an extension beyond the clinic to support women’s ability to have make autonomous decisions about their fertility, have healthy pregnancies, and to parent children without fear. Collaboration and integration with other efforts in the realms of social justice , environmental justice, and criminal justice, are also essential to achieving this vision.

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