

## MEETING SUMMARY REPORT

# Multilevel Approaches to Achieving Equity in Family Planning and Teen Pregnancy Prevention Programs

MAY 24, 2022

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## Table of Contents

<b>Introduction</b> .....	<b>1</b>
Meeting Background and Purpose .....	1
Expert Panelists .....	1
Participants .....	2
<b>Part 1: Day 1 – February 10, 2022</b> .....	<b>2</b>
Session 1: Why health equity in Population Affairs programs? .....	2
Session 1 Summary .....	3
Session 2: Who is here? .....	3
Session 2 Summary (Panelists).....	3
Session 3: What are we missing?.....	3
Session 3 Summary .....	3
Session 4: What is the missing link? .....	4
Breakout Room #1: Family Planning .....	4
Breakout Room #2: Adolescent Health .....	6
<b>Part I: Day 2 – February 17, 2022</b> .....	<b>8</b>
Session 5: What are the gaps in Title X?.....	8
Session 5 Summary .....	8
Session 6: What are the Gaps in Teen Pregnancy Prevention (TPP) Programs? .....	11
Session 6 Summary .....	11
Part 1- Highlights.....	13
<b>Part II: Day 3 - March 2, 2022</b> .....	<b>15</b>
Session 7: Furthering the field of Family Planning and Teen Pregnancy Prevention Programs.....	15
Session 7 Summary .....	15
Q&A Summary .....	16
Session 8: Leveraging Community Assets .....	17
Session 8 Summary .....	17
Q&A Summary .....	19
<b>Part II: Day 4 - March 3, 2022</b> .....	<b>19</b>
Session 9: Solutions and Next Steps.....	19
Session 9 Summary .....	19
Q&A Summary .....	21

Session 10: Next Steps & Solutions: Opportunities to address previously identified gaps and leveraging knowledge .....	22
Session 10 Summary .....	22
Q&A Summary .....	24
Session 11: Next Steps & Solutions: Title X Program.....	25
Session 11 Summary .....	25
Q&A Summary .....	26
Part 2- Highlights.....	27
<b>Attachments .....</b>	<b>28</b>

## Introduction

### Meeting Background and Purpose

On behalf of the United States Department of Health and Human Services (HHS), Office of Population Affairs (OPA), NORC at the University of Chicago hosted a two-part, virtual meeting series to identify and understand historical contexts, current conditions, and strategies for addressing racial, social, gender, and geographic disparities and inequities in family planning and adolescent sexual and reproductive health education, services, and outcomes. The meeting took place over the course of three weeks on the following dates and times:

- Part I
  - Thursday, February 10, 2022 from 1:00-5:00pm ET
  - Thursday, February 17, 2022 from 1:00-4:00pm ET
- Part II
  - Wednesday, March 2, 2022 from 1:00-4:00pm ET
  - Thursday, March 3, 2022 from 1:00-4:00pm ET

Specifically, OPA’s aim for this two-part meeting series was to obtain input from expert panelists on:

- Historical contexts driving current racial, social, gender, and geographic disparities and inequities in family planning and adolescent sexual/reproductive health education;
- Gaps in training, research, knowledge, program policies/practices, and services related to equitable family planning services and adolescent sexual/reproductive health education;
- Strategies for addressing gaps related to equitable family planning services and adolescent sexual/reproductive health education; and
- Opportunities for policy development, innovation, programmatic guidance, training, and research to achieve equitable family planning service delivery and adolescent sexual/reproductive health education program implementation.

### Expert Panelists

Expert Panelists	Organizational Affiliation
Dr. Joia Crear-Perry, MD, FACOG	National Birth Equity Collaborative
Dr. Mara Decker, DrPH	University of California, San Francisco
Dr. Sonya Borrero, MD, MS	University of Pittsburgh School of Medicine
Dr. Paula Braverman, MD, FSAHM	Baystate Children’s Hospital
Dr. Kai Tao, ND, MPH, CNM	Illinois Contraceptive Access Now (ICAN!)
Dr. Maria Trent, MD, MPH	Johns Hopkins Pediatrics
Nia Mitchell, MPH	National Birth Equity Collaborative
Dr. Raegan McDonald-Mosley, MD, MPH	Power to Decide
Tanisha Clark, MPH	Association of University Centers on Disabilities
Usha Ranji, MS	Kaiser Family Foundation

## Participants

The meeting series participants included federal staff, researchers, clinicians, and public health personnel working to eliminate health disparities and advance health equity, antiracism, and improved access to sexual/reproductive health clinical services and education. Attendees represented the following organizations:

- Administration on Children, Youth, and Families (ACYF)
- Agency for Healthcare Research and Quality (AHRQ)
- Association of University Centers on Disabilities (AUCD)
- Baystate Health/ UMass Chan-Baystate
- Centers for Medicare and Medicaid Services (CMS)
- Clinical Training Center for Family Planning (CTCFP)
- Food and Drug Administration (FDA)
- Health and Human Resources (HHS), Office of Population Affairs (OPA)
- Illinois Contraceptive Access Now (ICAN!)
- Johns Hopkins University
- Kaiser Family Foundation (KFF)
- National Birth Equity Collaborative
- National Institute on Minority Health and Health Disparities (NIMHD)
- NORC at the University of Chicago
- Office of the Assistant Secretary of Health (ASH), Deputy Assistant Secretary for Women's Health
- Power to Decide
- Reproductive Health National Training Center (RHNTC)
- Substance Abuse and Mental Health Services Administration (SAMSHA); Office of Behavioral Health Equity (OBHE)
- University of California, San Francisco (UCSF)
- University of Missouri – Kansas City (UMKC)
- University of Pittsburgh

## Part 1: Day 1 – February 10, 2022

### Session 1: Why health equity in Population Affairs programs?

**Session Purpose:** To provide the expert panelists with an overview of the current goals of OPA with a health equity lens.

**Moderators:**

- Aisha Cody, MPA, CHES, Health Scientist, HHS Office of Population Affairs
- Richmond Pajela, MPH, Management Analyst, HHS Office of Population Affairs
- Shenena Merchant, MPH, DrPH(c), Public Health Advisor, HHS Office of Population Affairs

## Session 1 Summary

- Structural reproductive coercion in the U.S., such as forced sterilization and long-acting reversible contraception (LARC) coercion, has disenfranchised Black and Indigenous women.
- Federal programs for family planning and sexual/reproductive health services have increased access to care in recent decades.
- Racial, social, gender, ability, and geographical disparities arise when there are differences in health care quality, health care access, and exposures. Eliminating these disparities (racial, social, gender, ability, geographical) is key to achieving health equity.
- OPA's pathway to health equity is a multi-pronged approach focusing on program strategies, measurement, policy, and infrastructure.

## Session 2: Who is here?

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**Session Purpose:** To introduce panelists and their perspectives on health equity relating to family planning and Teen Pregnancy Prevention (TPP) programs.

**Moderator:** Noelle Miesfeld, MPH, Research Scientist, NORC at the University of Chicago

## Session 2 Summary (Panelists)

- Panelists (identified above) were introduced by the NORC team.

## Session 3: What are we missing?

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**Session Purpose:** To provide historical context driving the current landscape of health care and health disparities relating specifically to family planning service provision and sexual/reproductive health programs for adolescents.

**Moderator:** Chandria Jones, PhD, MPH, Senior Research Scientist, NORC at the University of Chicago

## Session 3 Summary

**Question #1: What major findings in research and literature provide a deeper understanding of the equity gaps in family planning and TPP programs?**

- Higher rates of unintended pregnancy among people navigating the world with lower incomes.
- Higher STI rates among people of color.
- Inequities (lack of training for medical professionals, lack of access, accessibility issues) for individuals with disabilities is significantly less discussed than compared to those without disabilities.
- Lack of training and guidance for program providers of LGBTQ+ youth.
- Lack of focus on sexual and reproductive health and holistic, overall well-being.
- Lack of data (and then services/priorities) in all subgroups, for example, American Indian/Alaskan Native, individuals in unstable housing (transient individuals), and immigrant communities.

- Absence of patient-centered outcomes and lack of validated constructs and metrics.
- A lack of understanding of the historical and current context in which these inequities occur.
- Reproductive oppression intersecting with other forms of oppression in people's lives.

**Question #2: What are some of the examples of attempts or efforts to achieve health equity and address health disparities and inequities in sexual and reproductive services and programming?**

- Youth engagement through advisory boards/youth-centered design.
- Investment in novel models of care developed and implemented by communities most impacted; for example, when people can get access to contraception from their local drugstore.
- Creation and implementation of new points of access to meet users where they are, for example, there are currently seventeen (17) states plus the District of Columbia that are implementing the ability for pharmacists to prescribe medicine.
- Integration of sexual and reproductive health care into primary care settings.
- Implementation of structural competency training in the form of volunteer hours or service hours as a high school curriculum requirement (e.g., youth hired as mystery clients calling local clinics and reporting back on how they were treated and felt after they received services).
- Execution of novel measures that capture patient experiences of care; for example, hiring “secret shoppers” to provide feedback on their experience from care providers.

**Question #3: What barriers still exist in achieving health equity and addressing health disparities in sexual and reproductive services and programming?**

- Stigma related to sexuality and abortion.
- Lack of training in cultural and linguistic competence.
- Lack of patient-centered measures/insufficient data.
- Funding limitations to implement strategies.
- Lack of access to novel delivery methods for people with low incomes.
- Inequitable reimbursement under Medicaid.

**Session 4: What is the missing link?**

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**Session Purpose:** To connect with expert panelists via breakouts to further discuss gaps or barriers to achieving health equity in family planning and the adolescent health fields.

**Moderator:** Chandria Jones, PhD, MPH, Senior Research Scientist, NORC at the University of Chicago

**Breakout Room #1: Family Planning**

**Panelists:**

- Kai Tao, ND, MPhD, CNM, (Principal of Impact and Innovation, Illinois Contraceptive Access Now, ICAN!)
- Nia Mitchell, MPH, (Director of National Birth Equity Collaborative)
- Raegan McDonald-Mosley, MD, MPH (CEO of Power to Decide)
- Sonya Borrero, MD, MS (Professor of Medicine, University of Pittsburgh)
- Usha Ranji, MS (Associate Director, Women's Health Policy, Kaiser Family Foundation)

#### *Session 4, Breakout #1 Summary*

#### **Question #1: Where are some of the gaps in the understanding of racial, social, gender, ability, and geographical disparities in family planning services?**

- Misunderstanding of sexuality and gender among experts in the field; the complexities of understanding racial, social, gender, ability, and geographical disparities are often left out of data in many pivotal research because there are ongoing limitations in tools and resources to appropriately collect and interpret data for marginalized youth, including youth with disabilities and gender diverse youth. Terminology is problematic and may imply judgement (e.g., unintended pregnancy, teen pregnancy, pregnancy prevention, family planning).
- Lack of understanding among health care professionals of adverse side effects of family planning care (e.g., contraception) and the impact that has on health care decision making.
- Health care professionals can be too focused on contraception or preventing/treating STIs, but patients may have other health and non-health priorities.
- Patients sometimes lack the information or knowledge to make informed decisions about their health care, including their health and reproductive goals.
- Program performance measures are centered around narrow constructs of family planning (e.g., unintended pregnancies, teen pregnancies). Panelist referenced research conducted with low-income patients. Findings signified that some patients were not interested in contraception and were comfortable with the idea of planning around a pregnancy rather than preventing a pregnancy.

#### **Question #2: What are some of the gaps in practices/services of family planning services programs?**

- Barriers to accessing family planning programs among youth include requiring parental approval to receive care and consulting with them with parents/guardians present. These kinds of policies and practices restrict young patients' autonomy and make them hesitant to share information or ask questions.
- Health care systems are built for physicians to provide care, not around the people they are serving. (e.g., adolescent health clinics that are only open from 9am – 5pm on weekdays).
- Health care service structure limits physician and patient time together (e.g., 15 minutes for consultation) and therefore physicians must prioritize clinical decisions over educational and trust-building conversations. With limited communication between physician and patient, physicians may rely on implicit



biases and assumptions in the absence of nuanced information about their patient.

- **Potential solution:** Deliver care in a dynamic model that includes a variety of approaches for people to access care by phone, video conference, or by mail.

### **Question #3: How do policies and program practices miss the mark when addressing health equity?**

- Funding is often distributed to the health care systems, who then oversee sub-grantees to implement the work. This structure centers the health care system, rather than client needs at the community level.
- Title X is a wrap-around service, meaning it is not insurance coverage; but this may lead to gaps in billable services, such as counseling.
- Evaluation and metrics:
  - Importance of collecting data around quality care and satisfaction with care by race, ethnicity, age, etc. is important to understanding disparities in care.
  - Reconsideration of measurements will help better understand nuances in patient experience. For example, Person-Centered Contraceptive Counseling (PCCC) Measure, measuring contraception screening and health care needs.
- Destigmatizing Title X Family Planning services; many providers see Title X services as a direct funding stream.
  - **Potential solution:** Imbedding Title X funding in primary care settings.

### *Q&A Summary*

#### **Participant Question #1: How can you allow space and time for researching novel approaches?**

**Panelist Response:** Investment needs to be made at the macro level. Title X is not able to provide coverage to the same extent as Medicaid and private insurance. Being able to provide free STI testing would be impactful.

#### **Breakout Room #2: Adolescent Health**

##### **Panelists:**

- Mara Decker, DrPH (Assistant Professor of Epidemiology and Biostatistics, University of California, San Francisco)
- Paula Braverman, MD, FSAHM (Physician, Adolescent health, Baystate Children's Hospital)
- Tanisha Clarke, MPH (Senior Manager, Association of University Centers on Disabilities)

### *Session 4, Breakout #2 Summary*

#### **Question #1: Where are some of the gaps in the understanding of racial, social, gender, and geographical disparities in Adolescent Sexual Reproductive Health?**

- Describing the complexities of racial, social, gender, ability, and geographical disparities in evaluation research.
- Skewed data sets, for example, gender diverse youth or youth with disabilities are often not accounted for.
  - Critical sub-populations are often overlooked or forgotten (e.g., American Indian/Alaskan Native)
  - Inaccurate data categories (e.g., lumping all AAPI subgroups together)
- Gaps in educating the public and knowledge experts in the following areas:
  - Spreading awareness
  - Caring for youth
  - Evaluating programs

**Question #2: Where are some of the gaps in Adolescent Health program implementation?**

- Gaps in understanding research, for example, experts should have a full understanding of the program they are implementing before trying to evaluate it.
- Outdated programs (including obsolete technology) or programs being removed from direct providers.
- Lack of trainings and knowledge from providers in the care of youth patients.
- There is no standard for co-locating adolescent health services and/or family planning services with primary care physicians.
- Assumptions, attitudes and bias, and lack of representation in providers/services.

**Question #3: How do policies and program practices miss the mark when addressing health equity?**

- Putting pressure on youth to take full responsibility (e.g., “YOU need to make the right decision”) in addition to adolescent development and challenges they are facing.
- Institutional policies, for example, providing confidentiality for youth in the form of patient portals that do not permit access to parents or guardians.
- Understanding and awareness that every family structure is different (assumptions, attitudes, and bias), for example, attitude toward a multiple generation family of teen moms.
- Barriers to clinical resources in providing care for patients, for example, when caring for patients who cannot be weighed on a regular scale because they have a disability; providers need to recognize that patients have different experiences and abilities and that the lack of resources in a clinical setting should not prevent a patient from receiving care

*Q&A Summary*

**Participant Question #1: What are the most harmful or difficult challenges to sticking with fidelity?**

**Panelist Response:**

- Many people consider fidelity as meaning “word for word,” when in reality it means thinking about the core components of a program and what makes the

program work. (e.g., small groups, roleplay, etc.). The biggest concern is the assumption of what fidelity should mean; focus should be on what adaptations can be made to make the program more engaging and focused on the youth.

**Participant Question #2: What is your take on gaps regarding care for young men and their responsibility on the female (e.g., females become pregnant, males don't), is there a gap we are missing here?**

**Panelist Response:**

- In conducting focus group, it is often the first time that young men are allowed to, and even encouraged to, express their feelings. Alternatively, young women are far more often encouraged to express themselves and their feelings. We need to talk about young men, and their relationships, in a more inclusive way.

**Participant Question #3: Separate from administering grants, we have a body of work focused more broadly on adolescent health, do the panelists have any thoughts on adolescent health in general or about individual decisions adolescents make regarding their health?**

**Panelist Responses:**

- Positive youth development: a lot of the skills youth use to make decisions about healthy relationships and making sure they have the confidence they need are so important, the more we can see adolescent sexuality as a part of the whole is beneficial.
- The importance of provider relationships with youth because, in the long term, this helps build successful communication and trust. For example, panelist shared that she has had youth visit her just to show her their straight A report card because they are so proud of their grades and look forward to the provider showing an interest in the various parts of their life.
- The more we can provide more wholesome and comprehensive care for youth and teens (e.g., education, future goals, interests, etc.) the more we will see healthy and happy youth.

## Part I: Day 2 – February 17, 2022

### Session 5: What are the gaps in Title X?

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**Session Purpose:** To identify current gaps in Family Planning Service Provisions, including the Title X Program, and build off of previous sessions.

**Moderator:** Chandria Jones, MPH, PhD, Senior Research Scientist, NORC at the University of Chicago

### Session 5 Summary

**Question #1: What are some barriers to accessing Title X family planning services?**

- Patients have reported feeling overwhelmed with the administrative lift required to receive Title X family planning services (e.g., paperwork) and have disclosed that they would rather just pay cash out of pocket to avoid the hassle of filling out multiple forms. Likewise, some care providers have expressed a lack of interest in *being* a Title X provider due to the same administrative lift of completing required paperwork (e.g., income verification) and admit they just do not have the bandwidth to provide such services.
- Logistics (e.g., wait times, transportation, location, limited hours).
- Lack of trained youth friendly staff.
- Contraception deserts – i.e., upwards of 50% of Texas and Utah are limited in receiving Title X services.

**Question #2: How do current statutes and regulations of Title X exacerbate health inequity?**

- Allowance of religious objections leads to variability in services available depending on provider and area.
- Hierarchies and binaries (either/or): The current conversation feeds into the narrative that there are either/or choices to be made, but in order to solve inequities at the structural level, the conversation needs to be reimagined. For example, the conversation continues to center around the idea of men and women, without an acknowledgement of the range of addressing sexual identities.
- **Panelist quote:** “Race and gender were created at the same time, but we do not talk about gender in the same way [as race]. That is where the stigma comes from. We participate in stigma when we do not talk about it.”

**Question #3: What are some ways in which clinicians and other health service providers contribute to health disparities in family planning?**

- Title X services primarily focuses on family formation (e.g., avoiding pregnancy), which is a subset of sexual and reproductive health and wellbeing, and does not account for the broader spectrum of birthing, surrogacy, and adoption.
- Lack of acknowledgement of the spectrum of identities of patients. Health care professionals focus on “do you want to be pregnant or not,” this does not allow for treating the person as a whole.
- Programming that focuses narrowly on one component of health encourages siloed approaches to care and siloed solutions.

**Question #4: Who are the primary players that support health equity in family planning? How can partnerships grow with these players?**

- For youth involved with juvenile justice, health needs are often first identified when youth enter the system. There needs to be more engagement with correctional facilities to ensure youth living in a facility are not being denied services.
- Foster partnerships and connections through multiple perspectives and communities. People live and inhabit different communities, and each person brings a different perspective (e.g., provider, researcher, advocate).

**Question #5: How has COVID-19 affected the racial, gender, social, and geographic disparities in family planning services?**

- There is more public awareness of reproductive health in general but not for Title X program specifically.
- **Panelist quote:** “Increasing visibility is directly correlated to decreasing stigma.”
- When resources are low, it can feel like there is a tension between providing care to as many people as possible as comprehensively as possible.
- Title X and OPA may be able to leverage brand recognition to create an environment of trust, even when there is no personal rapport between patient and provider.
- Clinics can build a sense of community through health care teams. For example, there can be a system where a physician can provide a warm hand off to a health educator that can spend more time counseling the patient.

*Q&A Summary*

**Participant Question #1: Many people may not know about Title X. Is that a good thing? A bad thing? When we think of Health Equity advancing and being supportive of all, what role could Title X play more than what we have?**

**Panelist Responses:**

- Recommend that Title X office should be moved up in visibility.
- Visibility is also very connected with decreasing stigma. Underpins are woven into all of the issues that Title X works on, and also abortion. Sometimes you want to fly under the radar because of the practicalities in the administration, however decreasing the stigma is also the reason visibility is needed.

**Response Summary:** As noted during the discussion, visibility is strongly connected with decreasing stigma therefore, it is suggested Title X programs and/or services should be more visible in communities.

**Participant Question #2: How do you build connection with people when one of the other imperatives is to get people what they need, as quickly as possible, because we understand accessing healthcare is not easy in the context of the rest of our lives?**

**Panelist Responses:**

- When there is a high volume of clinical burden, there is a decreased priority to the patient. It is easy to feel like there are too many patients, and limited time to learn about them. “When there is adequate time and resources for providers to value their patients, improved methods to provide support and care emerge from those providers.”
- The current structure of medicine does not allow us to be our best selves, but it can be done when you create systems that allow for it. Patients need to know when they seek care that it will be non-judgmental care.

- Think about how you can create a system where people feel more supported. With high volume care, there is not enough time to provide quality care. Think about how Title X can use its power to invest in higher quality care and encourage lower volume patient services
- The connection of programs with the community is important to create an environment where adolescents feel comfortable coming in for services. There are so many opportunities within Title X and there are ways to do this in a really collaborative way to enhance the services and really help with the inequities.

**Response Summary:** Think about how you can create a system where people feel more supported. Lowering the volume of patients is one way to get patients to feel more connected. Title X can use its power to invest in higher quality care and encourage lower volume care. When there is adequate time and resources for providers to value their patients, improved methods to provide support and care emerge from those providers. Ultimately, the structure of medicine will encourage patient connection when you create systems that allow for it.

## **Session 6: What are the Gaps in Teen Pregnancy Prevention (TPP) Programs?**

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**Session Purpose:** To identify and better understand the gaps of evidence-based programs of Teen Pregnancy Prevention Programs, with a lens of innovation and key priority areas

**Moderator:** Chandria Jones, MPH, PhD, Senior Research Scientist, NORC at the University of Chicago

### **Session 6 Summary**

**Question #1: What implementation challenges do programs face in serving a diverse youth population (e.g., race, ethnicity, geography, gender, sexual orientation)?**

- Blaming and shaming youth versus supporting them.
- Assuming youth are uninterested when they are just busy. On the contrary, their parents/caregivers, and family are busy.
- Lack of holistic offerings that tackle a broader approach and support teens outside of typical services.
- Virtual opportunities: youth would be more engaged if they felt like they were not lectured.
- Community organizations, such as churches, may not be open to including programming about sexual and reproductive health.

**Question #2: How have curricula been developed/adapted so that they are inclusive for priority populations (e.g., LGBTQ youth, non-English speaking youth, rural vs urban youth)?**

- Panelists unanimously agreed that curricula are outdated.
- Creative approaches to standard learning (e.g., sex talk series, hiring an illustrator to draw different anatomical models).

- New programs that focus on familial communication.
- Newer programs are more likely to be co-created with youth.
  - Program example: sex talk series “we did a series that included a mixture of professionals and individuals with disabilities that led the conversation and touched on different topics, for example private spaces and safe touch, physical body and hygiene, interest in sex, people in different bodies, and sexual experiences that are not just sex.”

**Question #3: How have sexual reproductive health performance measures and definitions of “success” exacerbated inequity, health disparities or injustice?**

- Assuming that any pregnancy is a bad outcome when that is not the case.
- A lot of the evaluation questions are heteronormative.
- Outdated evaluation methods create barriers; for example, when program implementers focus on teen pregnancy, they are inherently creating a gap in other aspect of young persons’ life (e.g., school success, career goals, etc.)

**Question #4: Any suggestions for measuring and reporting outcomes without labeling as negative/positive, especially as we determine which programs are effective?**

- Definition of data should be considered. For instance, qualitative data is harder to use, and when we use leading questions and things that are deemed negative or positive, we are putting things in a box of what we want people to say. You can get some rich data from survey, but especially engaging youth with disability, everything takes more time, which often are challenging.
- Implementing outreach efforts in itself is a success. The outreach and communication for contraceptive use, for example, can avoid identifying and calling out specific contraceptives and brands to use or opinions on what contraceptives *not* to use and instead push forward with a positive general message to advocate for contraception in general.

**Question #5: Are schools’ facilitator or barrier for engaging youth?**

- The communities with the greatest need already have structural issues: poorly funded schools, poorly funded staff, poor internet connection, etc. Thus, the school system itself suffers from inequities and will struggle to effectively serve young people. Schools play an effective role in advocating for funding and recognizing resource barriers that hinder the engagement of youth.

*Q&A Summary*

**Participant Question #1: How can we promote prevention and encourage engagement?**

**Panelist Responses:**

- Meet people where they are at – make it as accessible and easy for them. Provide care without barriers. There should be infrastructure in place that makes it easy to, for example, get birth control or get condoms.

- From the sexual health education side: work with adolescents to identify their own priorities and goals. Recognize what opportunities are available for them in their communities: do they have a chance for quality education and careers? Adolescents make the decisions they make, often times because they do not have a sense of future opportunities. Go beyond the healthcare setting and explore what do we need to really strengthen their choices and opportunities.

**Response Summary:** One way to encourage participant engagement is to create infrastructure that makes patient care easy and accessible. Specifically for adolescent care, there needs to be systems in place that allow providers to work with adolescents to identify their needs and goals. The conversation between adolescents and providers needs to explore what we can do to strengthen their understanding of their choices.

**Participant Question #2: What is the role of schools to engage youth? Are schools serving as a barrier to providing equity in some cases? Not all kids are in a school, and school is not a safe place to receive this information for all students so just curious to know your thoughts.**

**Panelist Response:**



- The communities with the greatest need often have the most poorly funded schools. Schools have a huge potential and a huge role and absolutely more can be done, but we need to recognize that the way school funding is set up is a barrier for certain schools to receive the help that they need.

**Participant Question #3: Any suggestions for measuring and reporting outcomes without labeling as negative or positive specifically as we determine which programs are effective?**

**Panelist Responses:**

- Outreach: If you are a Title X clinic, determine how many how many people even came in your door, and use that as a measure of success. The fact that kids are getting in, and getting counseling, is a success.
- Determine how to define “positive” and “negative” and think about how we define data. A successful pregnancy could be considered a positive outcome. However, if you are doing teen pregnancy prevention programming, it could be seen as a negative outcome. We do not want to put people in a box, as far as what we are expecting people to say and what we are wanting them to respond.

## Part 1- Highlights

 <b>Gaps</b>	 <b>Opportunities</b>
<ul style="list-style-type: none"> <li>• Structural reproductive coercion in the U.S., such as forced sterilization</li> </ul>	<ul style="list-style-type: none"> <li>• Focus on eliminating health care disparities to achieve health equity</li> </ul>



and long-acting reversible contraception (LARC) coercion, disenfranchise Black and Indigenous women

- Higher rates of unintended pregnancy among people navigating the world with lower incomes
- Higher STI rates among people of color<sup>1</sup>
- Inequities related to patients with disabilities, gender, confidentiality concerns
  - These inequities are particularly evident among those experiencing disabilities - lack of training for medical professionals, lack of access, and not seen as individuals that should be a part of SRHE discussion
- Lack of training and guidance for program providers of LGBTQ+ youth.
- Lack of focus on sexual and reproductive health and well-being
- Lack of data (and then services/priorities) for certain subgroups (specifically, AI/AN population, transient individuals, and immigrant communities)
- Absence of patient-centered outcomes and lack of validated constructs and metrics
- A lack of understanding of the historical and current context in which health inequities occur
- Reproductive oppression intersecting with other forms of oppression in people's lives

- Youth engagement opportunities (e.g., Sex Talk series, logistics support, etc.)
- Invest in novel care models developed and implemented by communities most impacted by health inequities in sexual and reproductive services and programming.
- Integrate sexual and reproductive health care into primary care settings
- Integrate sexual and reproductive health programs in community organizations
- Provide structural competency training in the form of volunteer or service hours as a high school curriculum requirement (e.g., youth hired as mystery clients calling local clinics and reporting back on how they were treated and felt after they received services)
- Promote implementation of anti-racist principals and commitments at organizational levels
- Implement Novel measures that capture patient experiences with sexual health care services
- Increase visibility of Title X Service Delivery program
- Increase inclusivity in curricula (and technology used to implement curriculum) e.g., LGBTQ, non-English speaking youth, and youth in different geographical areas: rural vs. urban
- Recognize and address language habits of service providers (e.g., hetero normative discussions assuming that when speaking about sex that we are speaking about vaginal sex between woman and man)
- Implement holistic service offerings that address a broader approach of health care and service to support teens outside of typical (and outdated) services (e.g., goal setting)

<sup>1</sup> The term “people of color” encompasses a diverse array of individuals, races, and ethnicities. When analyzing data, OPA suggests analyzing based on more specific ethnicities and races as to acknowledge the disparities within and among different groups of color.

- Include up-to-date and accurate critical sub-populations in data sets and evaluations (e.g., AI/AN and AAPI groups)

## Part II: Day 3 - March 2, 2022

### Session 7: Furthering the field of Family Planning and Teen Pregnancy Prevention Programs

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**Session Purpose:** To identify the gaps in data collection and research processes used in Family Planning and Teen Pregnancy Prevention programs and to identify approaches for applying an equity lens to data collection and research.

**Moderator:** Brandon Coffee-Borden, MPP, NORC at the University of Chicago

#### Session 7 Summary

#### Question #1: What does it mean for research and evaluation to be equity driven?

- Self-reflection and organizational reflection about biases.
- Understanding the differences between equality and equity.
- Considering the needs of our communities.
- Being intentional with theoretical approaches in regard and to research and evaluation methods.

#### Question #2: What are some barriers to implementing these strategies?

- The data burden of performance measures which are at an individual level, and not structural level.
- Conflicting responsibilities that hinder youth involvement in programs (e.g., familial responsibilities, jobs, school, etc.).
- Contingent valuation (CV) research focusing on one strategy and a limited set of factors. Currently, there are massive data sets collected from critical care and that only provides *one* strategy for collection. Researchers and providers need to be permitted to develop numerical values for more thoughtful and aggressive care, for example, parents who are made aware of children with STD's are more than willing and available to provide support in the form of time and/or money/payment to ensure their children receive the care they need.

#### Question #3: How does mistrust of research and evaluation among marginalized communities affect their participation?

- Participants have low expectations of being provided the logistical resources and timely payment to participate during the research effort and after the research effort. For example, participants often need transportation services (i.e., metro bus card/fare or ride pickups) to get to their destination where the research is being conducted. At the conclusion of the research, participants do not want to

provide additional time completing a satisfaction survey especially when they have not received payment for their time yet.

- Getting participants paid quickly and adequately for their time and participation.

**Question #4: What additional support is needed to implement strategies for conducting research and program evaluation with an equity lens?**

- Increased funding opportunities to enhance current programs, such as expanding personnel.

**Question #5: What are some examples of performance measures that address health equity?**

- Person-Centered Contraceptive Counseling Measure (PCCC).
- Title X sliding fee discount schedule (SFDs) for grantees, sub-recipients, service sites.

**Question #6: What are some OPA (Title X or Teen Pregnancy Prevention program) performance measures that aggregate data in a way that disguises disparities and inequities?**

- Contraceptive options: the data being reported out from patients is skewed.
- Collecting demographic information in a valuable and intentional way and recognizing the data is not serving the research.
- Excluding data from youth and gender diverse people and avoiding other components of sexual and reproductive health (e.g., healthy relationships, unhealthy relationships, and violence).
- Language services are not being provided within all funded sites.

## Q&A Summary

**Participant Question #1: Can the expert panelists provide additional details on how OPA (the funder of Title X and Teen Pregnancy Prevention program research) can support organizations to achieve common goals?**

**Panelist Responses:**

- Providing additional means of open discussion and learning like these panel series where OPA shows interest and is receptive to understanding and making progress.
- OPA being receptive and in agreement to include sub-populations (e.g., Asian American/Pacific Islander data set should be disaggregated).

**Participant Question #2: Are there other agencies at the federal level or state level that are at least appear that they are moving in the right direction in terms of evaluation and/or research and how OPA can shift the paradigm to be more inclusive and responsive to the needs of the community?**

**Panelist Responses:**

- CMS has shown great progress in research in the maternal health field.
- STD Control Branch and CDC partners are working to destigmatize and change terminology around "risk" and "at-risk".

## Session 8: Leveraging Community Assets

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**Session Purpose:** To discuss how to identify and leverage community assets to maximize Family Planning and Teen Pregnancy Prevention programs.

**Moderator:** Brandon Coffee-Borden, MPP, NORC at the University of Chicago

### Session 8 Summary

#### **Question #1: What are some strategies for engaging youth in Teen Pregnancy Prevention programs?**

- Youth Participation Strategies include:
  - Youth advisory councils where youth can help develop curricula, design logos and programs, and receive credit hours for the work they provide.
  - Engaging loyal and trusted community partners who have youth, and the community, in their best interest.
  - Community service/work models where through serving others and participating in programs, youth will perceive a need that is beneficial to them and/or their families.
  - Being more creative in the personnel, which should include people who can connect and identify with the youth.
  - Service provider centers where youth willingly want to go to receive services as a trusted location and providing incentives for youth to get there and seek services (e.g., metro cards for transportation). Often times youth do not have travel options to be able to travel to a trusted location to receive services.
  - Engaging youth when they are not in school. For example, Youth Educator Program in Maryland provided peer to peer education programming over the duration of a six-week summer course.
  - Providing care in a location that is also a social outlet for teens; it provides freedom for youth to be able to seek care without their parents /guardians questioning them.

#### **Question #2: What are examples of organizations or individuals that grantees can partner with in the community?**

- The United States Department of Justice (DOJ).
- Child Protection Services (CPS) and other child welfare agencies, especially foster care.
- Faith-based organizations (churches, charities, etc.).
- National and/or local child advocacy centers.

#### **Question #3: How might grantees encourage buy-in from community partners?**

- Child Protection Services (CPS) or services that help youth in crisis. The organizations are available and willing, the next step would be to provide them formal training.
- Juvenile justice systems: the DOJ has an interest in providing programming for youth and should be an environment where youth can grow and forge

partnerships with other community-based organizations. The staff can be trained to have a different role within the facility or in the foster care system.

- “At a systems level, there are so many areas siloed based on funding, so if national funders could become more transparent in why some organizations are receiving funding and others are not then we can begin to fit the pieces together for whole-person care.” –Dr. Kai Tao, ND, MPH, CNM(ICAN!)

**Question #4: How can Title X grantees be empowered to include sub-recipient organizations that are inclusive and reflective of their community?**

- Providing information about the decision factors in those Title X recipients who are frequently awarded funding year after year so there is a level understanding.

**Question #5: What are some challenges to recruiting sub-recipient organizations?**

- In locations with minimal Title X programs, there is often a limited supply of government funds that leads to increased competition amongst service providers. This ultimately leads to a loss of services for providers who cannot maintain sufficient funding levels. This leads to gaps in sub-recipients and the services they are able to provide for adolescents and their families.

**Question #6: What additional support is needed to engage sub-recipient organizations?**

- “Transparency for why some organizations receive Title X funding. From someone on the outside looking in, it appears that the same organizations receive funding year after year without program change; the awarding of funds is too routine. We need understanding for the review of the merits of the Title X applicants.” - Dr. Kai Tao, ND, MPH, CNM (ICAN!)
- Support in scenarios where organization migrate to private funding for money and private funders do not understand how or why to build in meaningful engagement, so organizations are often taking that on themselves and provide insight to funders that engagement is built from inception to implementation to evaluation.
- Additional support is needed in the form of increased marketing and communications to young people especially where adolescent health-specific services are being provided. Specifically, when specialized care is implemented (e.g., LARC centers). Oftentimes, young people travel hours to get to a service provider, so the more communication provided up front, and in more creative methods like social media, then the patient is more informed to receive the services they are seeking.

**Question #9: How might grantees engage their partners in the decision-making process during program design and implementation?**

- Openly discuss funding, like Title X dollars, engaging partners, and stakeholders in creative options like telehealth contraceptive visits for those people with no other coverage or options
- Implementing long-lasting relationships, partnership who have seen programs built from the bottom up and are invested in its success.

- Hosting a "listening" stakeholder needs assessment at the beginning of a program. Beyond direct implementing partners, we can help to identify local priorities from different perspectives. (Qualitative interviews/focus groups, mapping, etc.)

## Q&A Summary

**Participant Question #1: Including those who have lived experiences in the research and evaluation process, can any of the panelists share experiences where examples have worked particularly well or been completed in a meaningful way (not just 'check the box' type of way). Conversely, any examples it was not conducted in a meaningful way.**

### Panelist Responses:

- Providing a safe place for education like at a 'Living with HIV' conference and providing beneficial research to building better programs to serve young people.
- Receiving health care from someone that looks like you helps provide a support system to avoid internalizing intrusive thoughts.

## Part II: Day 4 - March 3, 2022

### Session 9: Solutions and Next Steps...

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**Session Purpose:** To identify best practices, innovative guiding principles, and opportunities to enhance the knowledge base for family planning and teen pregnancy prevention programs to aid in the elimination of health disparities

**Moderator:** Brandon Coffee-Borden, MPP, NORC at the University of Chicago

### Session 9 Summary

**Question #1: If you had a magic wand, how would you use it to address issues in health equity, especially in family planning / TPP programs?**

- Eliminating the cost and coverage barriers are a necessary step but it does not get us to health equity on its own; there is a need to provide equitable distribution of funds.
- Providing healthy relationship education at an earlier age in school systems and school-based clinics is important, but there is also a need to support patients and youth in their lives and their family's lives outside of education, employment, and housing.
- Rebuild the system with a human centered design that increases accessibility to meet people where they are at (e.g., integrating family planning into primary care, using telehealth options in place of and in addition to brick-and mortar locations, increasing care/education that can be provided through pharmacies, using digital solutions to reach teens).

**Question #2: How can we further the health equity discussion with other leaders?**

- Health equity focus must be universally and uniformly implemented across all service providers viewed as trusted resources (e.g., WIC, early education, family case management).
- While there is a focus on health equity, we must simultaneously focus on contraceptive access in order to provide a life-course perspective.

**Question #3: What are some examples of marketing/communication campaigns or other methods that have increased support for health equity?**

- The change in perception of LGBTQ rights and acknowledging fairness (e.g., gay marriage is not taking anything away from anybody, it is creating a level playing field). This messaging has generated the rapid change of acknowledging differences in gender and sexual orientations.
- The platform of communication matters as well. Communication platforms need to reach people where they are and social media (e.g., TikTok and Instagram) and podcasts have made it easier to talk about issues that are traditionally private.
- **Panelists shared the following successful campaign examples:** Think Pink (increasing access to contraception), Talking is Power (facilitating conversations about youth health), Black Mamas Matter (increasing visibility of the black maternal health crisis), and Black Maternal Health Week.
- There is a need to talk about the origin of Title X and the current cultural shifts (e.g., moving away from linkages to personal choice and moving towards discussing the structural roots of health inequities and the ways in which family formation occurs). Additionally, male voices may be minimized. True inclusivity represents the spectrum of community members.
- In addition to challenging dominate narratives, it has been important to uplift narratives and stories about what *is* working, particularly for services or models of care that are from predominantly Black and indigenous spaces. It is about bringing more visibility, awareness, and support into our entities.
- **Resource shared in the chat:** Contraceptive services in the year before conception and routine exams for women with chronic disease are associated with decreased odds of severe maternal morbidity or death for Medicaid enrollees. [https://www.ajogmf.com/article/S2589-9333\(21\)00245-7/pdf](https://www.ajogmf.com/article/S2589-9333(21)00245-7/pdf)

**Question #4: Preparing for the future, how do you anticipate health equity in reproductive health evolving?**

- The terminology “Sexual Health” has replaced “Reproductive Health,” (e.g., there are lots of reasons to be healthy beyond having a baby, specifically healthy relationships, and violence in relationships).
- Abortion will continue to be an important topic, and upcoming supreme court decisions will have a disproportionate impact across communities.
- Policies will need to center on access (in part dependent on geography and socio-economic status) and center on the people from communities (instead of being designed *for* communities).

## Q&A Summary

**Participant Question #1: If you are talking to policy makers, we discussed moving from a policy frame around providers to people, would not it be great if Title X followed the person not creating point of entry into care. Do you all have examples of people-centric vs. infrastructure-centric that might be a good bridge to have those connections? Is there an example of how that has worked?**

### Panelist Responses:

- Home and community-based waivers where the money follows the person (even if they are in homecare) and those people have flexibility in where those dollars are used (e.g., medically fragile children who are dependent, the money will follow them whenever and however needed to support them).
- The Veterans Affairs tries to do this as they have to outsource OB care and other services to the community.
- From a service delivery perspective, private companies like Aurora Health focus on community-based care (e.g., support for someone with diabetes to get up and workout in the morning).
- There may be something about these policies that can be fleshed out and supported at a national level and then spread to consumers.

**Participant Question #2: When thinking about individuals with disabilities, are there examples you can share or perspectives you have in advancing access to person-centered and reproductive health and clinical services. How might TPP and evidence-based curricula address the needs of adolescents with disabilities and autism-spectrum disorder?**

### Panelist Response:

- “Being cognizant and what we are teaching is going back to the community, whether [the disability] is visible or invisible. We push for training on individuals on how to [provide] for training with people with disabilities. People with disabilities should be part of the decision making, whether professionals or parents, we talk about people with disabilities as if they are not there. People with disabilities are susceptible to violence and know what is good, what is safe is important for anyone.” – Tanisha Clark, MPH, Association of University Centers on Disabilities

### Resource shared in the chat:

- <https://www.ctcfp.org/clinician-cafe-providing-inclusive-family-planning-care-to-patients-with-disabilities/>
- Health Connected has a sexuality ed curriculum adapted for youth with different learning abilities: <https://www.health-connected.org/teen-talk-aaa>

**Participant Question #3: How do we do draw connections between access to contraceptive care and family planning services to maternal healthcare without just “jumping on the bandwagon” or undermining the importance of maternal healthcare.**

### Panelist Responses:



- Noted at times we're divided (maternal health vs. pre-health) and there are often times political differences and positioning in reproductive justice, which is inclusive to the right to have children, but those relationships/partnerships are being formed now, which takes time and trust, so we have to understand it takes time and patience and realizing it's happening now, in real time.
- We tend to get very siloed in the areas that are actually interconnected. It happens, and we have disciplinary perspectives vs. research perspectives.
- **Resource shared in the chat:** <https://pubmed.ncbi.nlm.nih.gov/33416289/>

## Session 10: Next Steps & Solutions: Opportunities to address previously identified gaps and leveraging knowledge

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**Session Purpose:** To search for opportunities to address previously identified gaps and leveraging knowledge obtained during Day Three

**Moderator:** Brandon Coffee-Borden, MPP, NORC at the University of Chicago

### Session 10 Summary

#### **Question #1: How might we (OPA) better support our grantees to ensure delivery methods and modalities are equitable and inclusive?**

- If equity and inclusivity are not required, grantees may not do it. Training is necessary, but insufficient. There needs to be built-in accountability for the programs/clinics not incorporating [equitable] practices including consequences, how they will be reprimanded, and how their funding may be affected.
- The field needs to collect and analyze data in a different way to inform decision making (e.g., learning from consumers and administrators). The field also needs capacity and funding to conduct data collection work.

#### **Question #2: How might we apply best practices of engaging youth and community members in health equity? How might we apply best approaches to gaining buy in from youth and community members in health equity?**

- Helping grantees in the Title X setting in meaningful community engagements and making sure people can analyze data by race and ethnicity and income. If additional requirements are being added onto our providers, then other requirements may (or should) be de-prioritized.

#### **Question #3: What are three key priority areas for reducing racial, gender, social, and geographic health care, and health disparities in access to services?**

- **Ideas generated from the panelists included:** pros and cons of technology (e.g., telehealth) particularly for vulnerable youth (e.g., children in foster care), self-care (what services can youth do for themselves or via mail (e.g., at-home STD testing), refugee/unaccompanied minors or recent immigrants with difficulty navigating American health care system, and building local capacity to conduct research and evaluation, including doing research in a meaningful way with community partners.

- “In certain communities there is still the impact of immigration restrictions on safety-net providers, in general. OPA serves these populations but would like to know the emphasis and support for grantees that do the outreach to these communities, so OPA can provide additional support or funding to those populations and let them know they are safe and protected.” – Usha Ranji, MS, Kaiser Family Foundation

**Question #4: How can OPA better assist grantees in equitable research design in the various components of research (research question, population groups, methods, sampling)?**

- Increase awareness that there are research design resources available in conjunction with increased communication of where to find the resources. Components of research should be made available in one location so that researchers are not sent to multiple locations (e.g., websites, documents, toolkits) to find the information and guidance they are seeking. here is where you can go to get everything that you need (one stop shop to decrease loss to follow-up and care).
- More time is needed to do research and grants often ask for research details in the proposal (which is at least 6 months if it is a truly genuine, community, engaged process). Funders may consider providing thorough expectations in the time allotted to conduct the work. Multiple levels of evaluation, data collection, and iterations of IRB may not be feasible.
- Organizations lack the necessary research and evaluation infrastructure in order to do participatory or community engaged work which requires additional time and resources.
- “Reiterating the division of services between contraceptive care and abortion care is problematic. The knots [in which] people tie themselves to provide separate documentation and abortion care and contraceptive care on the backend takes time away from those things we actually care about and want to provide research for.” - Dr. Raegan McDonald-Mosley, MD, MPH, Power to Decide

**Question #5: What are some examples of new/adapted services that were helpful in addressing health equity in adolescent health (e.g., telehealth)?**

- Providers have implemented one-on-one interaction through telehealth allowing for additional time beyond the appointment requirements and simply just interacting and asking questions about the patient’s personal life (e.g., How is school going?). By providing a private and dedicated interaction, adolescent patients have been more forthcoming in providing health information insight to their provider. Often times this is a challenge because parents may lurk over adolescent shoulders; in those cases, adolescents are quiet and withdrawn during appointments and may not be receiving the information that they were seeking.
- One service provider has conducted training for providers (on making interpersonal interaction, asking to move the camera, ask if it is still a good time)

and make those interpersonal interactions. Young people like the ability to use virtual interfaces versus call and wait on hold for someone they have never met.

- Increase in pharmacist prescriptions of birth control but the rise of telehealth can hinder equity (people using Title X services would not be able to use those services).
- Issues of confidentiality in rural settings persist as people can easily run into people they know.

#### **Question #6: How has COVID-19 changed the landscape of service delivery for TPP and adolescent health programs?**

- “In some ways COVID-19 has provided opportunities to become more creative with pivots to online sexual health education (e.g., asking questions via chat and increases in telehealth); however, there is no doubt COVID exacerbated inequities. The children benefiting most are the ones who were already ahead with advantages. We may never address the inequities of the youth lost over the last two years (i.e., who moved between school systems or left school).” – Mara Decker DrPH, University of California, San Francisco
- Once the public health emergency is declared “over,” states will be allowed to terminate Medicaid enrollment for those who no longer qualify. It will not happen at once and will increase the pressure on Title X clinics.
- Panelists noted missing the social aspect of being in person with clients.
- This tragedy that has been a blessing in disguise, but it has been a great learning curve and showed us we *can* and *should be* doing more.

#### **Q&A Summary**

**Participant Question #1: Thinking about the history in the U.S. as it relates to medical mistrust in research and/or services received, what are your thoughts about the practical implications or implementation for sexual and reproductive health services in health education curricula? Novel models (like telehealth) tend not to be available to communities in need. Many are seeking care in places like CVS, which do not provide the cozy, warm, and welcoming environment the panelists spoke about yesterday. How do we engage adolescents who do not have access to technology, how do we engage them to make sure they are part of the process?**

#### **Panelist Responses:**

- “I worked with Bedlam and Rising – a domestic violence program in native American populations that uses the framing of “nothing about us, without us.” The organization and their work are led by Native American groups and helps recognize their history, front and centered. When we speak about domestic violence in Native American populations, we just really need to start with the history and structural issues: 1) changing the narrative and 2) being trauma-informed and trauma care and providing people with the safe spaces they need.”
- **Response from the Chat:** Tribal areas also have abysmal rates of broadband access (<50%).

## Session 11: Next Steps & Solutions: Title X Program

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**Session Purpose:** To search for opportunities to address previously identified gaps and leveraging knowledge obtained during Day Three

**Moderator:** Meghan Woo, ScD, ScM, NORC at the University of Chicago

### Session 11 Summary

**Question #1: What are some opportunities to leverage existing resources (partnership, federal or provider-level agencies) that can focus attention on achieving health equity?**

- There are opportunities to leverage telehealth, but telehealth is not grounded in health equity (e.g., challenges related to the digital divide, digital literacy, privacy limitations). Title X investments and strategies need to leverage community-based resources (e.g., digital literacy programs, decision support tools in multiple languages, health care summary sheets that can be printed off and taken to a healthcare visit). Patient-facing resources should support value-concordant decision making and consideration of contraceptive methods.
- Related to issues of telehealth – in addition to the digital divide, digital literacy, and privacy limitations – then grounding telehealth in a health equity strategy by centralizing marginalized groups in the development of technological and creative solutions. If we accommodate the most disenfranchised then we will reap the most benefits and that can be done through community-based programs like digital literacy programs, pharmacist provisions, and decision support tools (e.g., Bedsider has a selection of decision support tools).
- **Resource shared in the chat:** for people with lack of access or privacy, connect people with alternate Wi-Fi spots in the area  
<https://www.converge.pitt.edu/femtech-collaborative>
- Many resources have already been developed from experience in other marginalized communities. To reduce the duplication of resources (and efforts), panelists suggested connecting with existing community and professional organizations.
- There is still a need to define **equity** and **inequality**, as well as a need to provide communities of practice, safe spaces, and trainings in which people can advance their understanding of equity, close the gaps, and address all ends of achieving equity.

**Question #2: What types of trainings and resources are available to address these biases? Other than training and resources, how else can provider and organizational biases be minimized?**

- National Birth Equity Collaborative provides training through health agencies and are currently focused on working through institutional changes that prevent consistent training implementation. These trainings focus on implicit bias, anti-racism, birth equity assessments, and technical assistance assessments. Georgetown University has a Center for Excellence (the National Center on Cultural Competence).

- Training programs are most effective with diverse teams (e.g., lived experiences, Black trainers, and clinicians) that integrate social science and research, so panelists pull from a variety of documentation and texts to really be able to navigate outside of public health medicine.
- Training programs need to reflect what consumers and trainees need, and what communities are experiencing. Having good metrics for community needs (e.g., on complication and continuation rates) can improve training design and delivery.
- **Resource shared through chat:** Reproductive Health National Training Center (RHNTC) has several relevant resources which were developed for staff working in Title X and TPP settings, including the podcasts [Power to Decide] mentioned <https://rhntc.org/search?keys=equity>.

**Question #3: What are some suggestions for how to approach these key players? Please provide examples of successful or unsuccessful outreach. How do we facilitate support in the community for health equity?**

- Approach individuals who have lived expertise; programs are quick to provide an honorarium for a speaker with years of education behind their name, but we go into communities and dissect information from so many and they are never incentivized for the value they bring to our systems on which we will ultimately capitalize.
- Go to the heads of county agencies. In Ohio, this has been successful for specific projects for the care of kids in juvenile justice and kids who were receiving services from organizations in the community and overall, the mental health abuse agencies.

## Q&A Summary

**Participant Question #1: Is there a kernel of advice or something new you heard that OPA should also hear and be aware of, not necessarily toward these topics, but in general? We would love some insight into the minds of our expert panelists.**

**Panelists' Responses:**

- Panelists thanked OPA for holding this space and expressed that they felt lucky to be in communication with peer experts. Panelists reflected on the first hormonal IUD in early 2000's as a family planning provider and has followed the LARC (long-acting, reversible contraception) enthusiasm. Panelists encouraged OPA to be bold and center the energy on individuals versus the health care system and eliminating things that are not evidence based and focusing on equity and person-centered care.
- Panelists expressed that they wanted to allow the program to focus on people while maintaining a focus on coverage, but Title X and Medicaid (whether intentionally or not) go hand in hand.
- Panelists recognized a great opportunity to involve OPA to align programs in changing socio-political realities in addition to new and cultural, social norms.

- There are a considerable number of challenges, but also opportunities, for OPA to do things we have never even touched on before. Do not avoid innovation, new paradigms, or approaches to tackle these issues in a different way. We cannot keep doing what we have been doing and expect to have different results.

Response summary: Panelists encouraged OPA to be bold and center the energy on individuals versus the health care system and eliminating things that are not evidence based and focusing on equity and person-centered care. There is opportunity to involve OPA in changing socio-political barriers and updated cultural/social norms. Panelist stated that “We can’t keep doing what we’ve been doing and expect to have different results” while explaining that there are a considerable number of opportunities for OPA to do things we have never touched on before. Panelists encouraged innovation, new paradigms, or approaches to tackle these issues in a different way.

## Part 2- Highlights

 <b>Gaps</b>	 <b>Opportunities</b>
<ul style="list-style-type: none"> <li>• Gaps related to data collection and evaluation include capacity and funding needs to collect and analyze data to inform decision making.</li> <li>• Gaps related to health equity persist, especially as they relate to COVID-19 (e.g., Medicaid enrollments that are covered by the public health emergency, children changing school systems and missing health education), increased use of telehealth, and the need for grantees to be held accountable for not incorporating health equity into their services (including consequences, how they will be reprimanded, and how their funding will be affected).</li> <li>• There is still a need to define <b>equity</b> and <b>inequality</b>, as well as a need to provide</li> </ul>	<ul style="list-style-type: none"> <li>• Equitable distribution of funds can support health equity goals</li> <li>• Engage youth outside of institutions and systems (e.g., education and employment)</li> <li>• Focus on contraceptive access in order to provide a life-course perspective</li> <li>• Provide one stop shop models to decrease lost to follow-up</li> <li>• Provide grantees with more time to do research and grants often ask for research details in the proposal (which is at least 6 months if it is a truly genuine, community, engaged process). Funders can provide thorough expectations of what is required in the time allotted to conduct the work. Multiple levels and iterations of evaluation, data collection, and IRB may not be feasible</li> <li>• Title X investments and strategies need to leverage community-based resources (e.g., digital literacy)</li> </ul>

communities of practice, safe spaces, and trainings in which people can advance their understanding of equity, close the gaps, and address all ends of achieving equity

- There are opportunities to leverage telehealth, but telehealth is not grounded in health equity (e.g., challenges related to the digital divide, digital literacy, privacy limitations).

programs, decision support tools in multiple languages, health care summary sheets that can be printed off and taken to a healthcare visit). Patient-facing resources should support value-concordant decision making and consideration of contraceptive methods

- Training programs are most effective with diverse teams (e.g., lived experiences, Black trainers, and clinicians) that integrate social science and research, so panelists pull from a variety of documentation and texts to really be able to navigate outside of public health medicine
- Training programs need to reflect what consumers and trainees need, and what communities are experiencing. Having good metrics for community needs (e.g., on complication and continuation rates) can improve training design and delivery

## Attachments

- Attachment 1. Agenda
- Attachment 2. PowerPoint Slides
  - Attachment 2a. Part I - Day 1 – February 10
  - Attachment 2b. Part I - Day 2 – February 17
  - Attachment 2c. Part II – Day 3 – March 2
  - Attachment 2d. Part II – Day 4 – March 3
- Attachment 3. Panelist Onboarding Packet
- Attachment 4. Registration Report
- Attachment 5. Closed Captioning Transcripts
- Attachment 6. Zoom Chat Transcript
- Attachment 7. Jamboard and Word Cloud Graphics
- Attachment 7a. Jamboard – Part I – Day 2 – Session 5
- Attachment 7b. Jamboard – Part I – Day 2 – Session 6
- Attachment 7c. Mentimeter – Part I – Day 2 - Icebreaker