Literature Review on Inequities in Reproductive Health Access
Substitute Senate Bill 6219, Chapter 119, Laws of 2018
January 1, 2019

Staff Contact: Caitlin Lang-Perez
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EXECUTIVE SUMMARY

Substitute Senate Bill 6219 (SSB 6219) passed the Washington State Legislature in 2018. The bill required the Governor’s Interagency Council on Health Disparities to conduct a literature review on disparities in access to reproductive healthcare in Washington State, and to propose recommendations to reduce those disparities. The bill defines reproductive healthcare broadly as the “care necessary to support the reproductive system, the capability to reproduce, and the freedom and services necessary to decide if, when, and how often to do so, which can include contraception, cancer and disease screenings, abortion, preconception, maternity, parental, and postpartum care.”

Methods

Identification of priority populations

The bill required the Council to examine inequities “based on socioeconomic status, race, sexual orientation, gender identity, ethnicity, geography, and other factors.” Additional populations were identified through staff expertise and experience, conversations with key informants, and a preliminary review of literature. In total, Council staff identified 14 populations likely experiencing inequities in accessing reproductive health services:

1. Age (Adolescents/young adults)
2. Age (Older adults)
3. Individuals with behavioral health disorders (Behavioral health)
4. Individuals with a disability (Disability)
5. Gender identity (Gender identity)
6. Sexual Orientation (Sexual orientation)
7. People who live in rural areas (Geography)
8. Individuals with unstable housing (Homelessness)
9. Immigrants and refugees (Immigration)
10. Individuals who are incarcerated (Incarceration)
11. Active duty military members and Veterans (Military, or Veterans)
12. People of color experiencing systematic racism (Racism)
13. Individuals of low socioeconomic status (SES)
14. Victims/survivors of violence (Violence, IPV, or Trafficking)

Review of literature

Council staff conducted a review of literature between May 2018 and August 2018 to identify barriers to accessing reproductive healthcare. Barriers served as a means to understand disparities in access in order to provide greater understanding of the potential root causes of disparities and to develop relevant, specific recommendations. The intent of the literature review was to develop a comprehensive and complete list of barriers. Therefore, staff reviewed articles until they reached a “saturation” in barrier identification (i.e., subsequent articles added no new or unique barriers). A separate literature review was conducted for each of the 14 populations identified, and a total of 271 references were
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included. Each research article was reviewed for barriers and recommendations, annotated for inclusion in the full report, and rated based on study design, execution, and generalizability to Washington State.

Key informant interviews and review
Key informant interviews were completed to gain additional context and background information and to refine staff understanding of the literature and recommendations for some population groups.

Recommendations
Council staff evaluated recommendations identified in the literature as well as reports from Washington State agencies and community-based organizations addressing reproductive health. Recommendations that could be addressed at the state level were then further evaluated to determine if they could be acted on by the Washington State Legislature or a state agency.

Recommendations were compared to identify areas of alignment and to determine which would likely address access barriers for multiple priority populations. A total of 13 recommendations are included in the final report. While not comprehensive, the recommendations represent actions that would reduce disparities in accessing reproductive healthcare for a number of individuals experiencing inequities in Washington State. Relevant key informants and state agencies reviewed and provided feedback on the proposed recommendations to ensure accuracy and applicability to Washington State.

Results
Overall, Council staff identified 45 unique barriers through the review of literature. Barriers were further grouped into three categories: Economic, Structural, and Social. The list of barriers was generated iteratively. After completing all population-specific reviews (available upon request), Council staff collaboratively determined whether each barrier was unique and combined barriers to include in the final report as appropriate. The report presents an overview of each barrier and a list of priority populations experiencing that barrier based on the literature. Additionally, examples highlight how the barrier impacted access for priority populations that experienced a particular barrier disproportionately or uniquely. For more detailed information, summaries of barriers by priority population and article annotations are available upon request. Note, barriers are numbered to improve readability and for easy reference. Numbering within the report does not indicate priority or severity compared to other barriers. See Appendix A for a comprehensive list of barriers experienced by different priority populations.

While findings from the review of literature are presented by priority population, an individual may identify with multiple factors. Therefore barriers in accessing reproductive health services may be compounded or exacerbated, furthering inequities in access. See the discussion of intersectionality on page 21 for further information.

Recommendations
DRAFT: Pending Review and approval by Council (13 September 2018)

Criminal Justice recommendations
1. The Departments of Corrections and Social and Health Services should cooperate with state prisons, county jail systems, and juvenile detention centers to create a continuum of care that spans incarceration and return to the community.
2. The Washington State Legislature should convene a workgroup to develop recommendations to reduce/eliminate barriers to healthcare services experienced by human trafficking victims and survivors.

**Education recommendations**

3. The Washington State Legislature should require (rather than make voluntary) that all public schools in Washington State teach age-appropriate, culturally-appropriate, comprehensive, medically accurate, and LGBTQIA-inclusive sexual health education.

4. The Washington State Legislature should allocate state funds for Department of Health to provide pass-through funding to community-based organizations to conduct sexual health education in community settings for adolescents and young adults, older adults, immigrants and refugees, individuals with limited English proficiency (LEP), individuals experiencing homelessness, and individuals with behavioral health disorders to expand health literacy related to reproductive health and navigating the healthcare system to access services.

**Provider recommendations**

5. *(Expected Bree Recommendation Adoption 9/22/18)* The Health Care Authority, Departments of Corrections, Labor and Industries, and Social and Health Services should fully implement the Dr. Robert Bree Collaborative’s “LGBTQ Health Care Report and Recommendations 2018” to improve healthcare and health equity for LGBTQ persons.

6. *(Pending Stakeholder Review)* The Washington State Department of Health should propose that the Dr. Robert Bree Collaborative identify and endorse separate sets of guidelines to improve the reproductive healthcare of: 1) people of color, 2) immigrants and refugees, and 3) victims and survivors of violence.

**Health Insurance recommendations**

7. The Washington State Legislature should work with the Office of Insurance Commissioner to determine how the agency can suppress (i.e., not send) explanation of benefit (EOB) statements for reproductive health services (e.g., contraception, pregnancy tests, Pap smears, sexually transmitted diseases (STD), HIV testing, PrEP, and HIV treatment), and grant the agency the authority necessary to implement and enforce the protocol.

8. The Washington State Legislature should develop and implement a health insurance option for lawfully present immigrants that do not meet the 5-year-bar, other immigrants not qualified for federal benefits, and for individuals who are undocumented.

9. The Washington State Legislature should grant authority to the Office of the Insurance Commissioner and Health Care Authority to update health insurance and medical forms to include non-gendered language and to allow individuals to indicate both sex assigned at birth and gender identity.

10. *(Pending Stakeholder Review)*: The Washington State Legislature should increase state Medicaid reimbursement rates to improve service and provider availability.

**State Funding recommendations**

11. The Washington State Legislature should dedicate additional state funds to provide family planning services in Washington State, and should replace federal Title X funding with state funding in the event that Title X is cut at the federal level or future requirements do not meet Washington State law.
12. **Community Health Worker Recommendation (Pending)**

13. Key Informants and subject matter experts shared opportunities for future research that the Washington State Legislature, state agencies, or universities should consider to improve access to reproductive health services in Washington State. See page 69 for a list of research proposals identified by key informants and subject matter experts.

**CONTEXT**

There are a number of current and ongoing factors at the state and federal level that may impact access to reproductive health services federally and in Washington State. This report is based on information available in August 2018, and may not capture recent or pending changes in state and federal policy. Table 1 details some of the contextual elements at the time of this report that may impact access to reproductive health services.

**Table 1. Federal and state-specific contextual factors that may impact access to reproductive health services in Washington State**

<table>
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<th>Contextual Factor</th>
<th>Potential impact on access to reproductive health services</th>
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<td>Affordable Care Act (ACA) and state Medicaid Expansion</td>
<td>The ACA was implemented in 2010, and Washington State was one of five states to expand Medicaid coverage early in 2011. However, the impacts of the ACA and Medicaid expansion are still not completely understood and data are still lagging. Available research also suggest that, although the ACA expanded coverage for reproductive health services (e.g., contraception), multiple populations continue to experience barriers in accessing services. 2,3</td>
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<td>Bills passed by the 2018 Washington State Legislature</td>
<td>A number of bills passed by the 2018 Washington State Legislature improved access to healthcare in the state. The following are bills that may improve access to reproductive health care for priority populations. <strong>Senate Bill 6580</strong> (SB 6580), Concerning human immunodeficiency virus (HIV) testing removes barriers to HIV testing by repealing previous legislation and making HIV testing subject to the same notification and consent requirements that apply to any other medical test. 4 <strong>Substitute House Bill 2016</strong> (SHB 2016), Concerning midwifery and doula services for incarcerated women required the Department of Corrections and jails to make reasonable accommodations for the provision of midwifery or doula services to women who are incarcerated who are pregnant or who have given birth in the last six weeks. 5 <strong>Substitute Senate Bill 5683</strong> (SSB 5683), Health care for Pacific Islanders residing in Washington under a compact of free association (COFA), increased access to healthcare services for the citizens of the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia living in Washington. 6 The bill provides premium and cost-sharing assistance for health coverage purchased through the Health Benefit Exchange if individuals are not eligible for federal or state health insurance and have an income less than 133% of the federal poverty level. 7</td>
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| Limited Service Pregnancy Centers | These individuals typically do not qualify for Medicaid due to their specific immigration status, and this bill improves access to care for these individuals. In addition to requiring this review, Substitute Senate Bill 6219 (SSB 6219) Related to improving access to reproductive health (Reproductive Health Parity Act) also expanded access to reproductive healthcare in Washington State by requiring:  
- Health carriers to cover contraceptives without cost-sharing; and  
- Health plans that cover maternity care or services to cover the voluntary termination of pregnancy (i.e., abortion services). |

| NIFLA v Becerra | In July 2017, the King County Board of Health adopted Rule & Regulation BOH 17-04, which required any limited service pregnancy center (or crisis pregnancy center) that is not a “health care facility” to post notices, both at the entrances of the facility and one additional area, reading: “This facility is not a health care facility.” The ordinance also requires that any print and digital advertising materials also include the notice in English, Spanish, Vietnamese, Russian, Somali, Chinese, Korean, Ukrainian, Amharic and Punjabi. The rule was the result of reports that some limited service pregnancy centers provide women little or no information regarding available comprehensive family planning and reproductive healthcare services. Moreover, some limited service pregnancy centers have reportedly provided misinformation to women about their health and healthcare options, thereby delaying access to comprehensive family planning and reproductive healthcare services and obstetric healthcare, which can increase health risks. The King County Board of Health determined that failure to notify a women that the facility is not a healthcare facility is a threat to public health. |

| Public Charge | In 2018, the Supreme Court of the U.S. (SCOTUS) heard the case National Institute of Family and Life Advocates, DBA NIFLA, et al. v. Becerra, Attorney General of California, et al. Two crisis pregnancy centers, one licensed and one unlicensed, and an organization representing crisis pregnancy centers filed the suit against the State of California’s FACT (Freedom, Accountability, Comprehensive Care, and Transparency) Act (2015). The FACT Act required licensed clinics to notify women that California provides free or low-cost services, including abortions, and give them a phone number to call. The stated purpose was to make sure that state residents know their rights and what healthcare services are available to them. Additionally, it required unlicensed clinics to notify women that California has not licensed the clinics to provide medical services. On June 26, 2018, The U.S. Supreme Court ruled in a 5-4 decision that the notices required by the California FACT Act violate the First Amendment by targeting speakers rather than speech. |

|   | The Department of Homeland Security (DHS) announced that it “will propose regulatory provisions guiding the inadmissibility determination on whether an alien is likely at any time to become a public charge under section 212(a)(4) of the Immigration and Nationality Act (INA), 8 U.S.C. 1182(a)(4). DHS proposes to add a regulatory provision, which would define the term public charge and would outline DHS’s public charge considerations.” In a letter to the Director of the U.S. Office of Management and Budget, Governor Inslee states, “the proposal disrupts settled law by making unprecedented changes to
### Literature Review on Inequities in Reproductive Health Access

Longstanding immigration policies that determine how an individual’s application to extend or change their immigration status is processed. It would allow the federal government to discriminate against individuals who have used, or whose families have used, public assistance programs including the Children’s Health Insurance Program (CHIP), Medicaid, the Supplemental Nutrition Assistance Program (SNAP), the ACA premium tax credits, the Women, Infant and Children (WIC) nutrition program, Section 8 housing vouchers, means-tested energy benefits, and even refundable tax credits.  

A 2018 Kaiser Family Foundation Data Note explains, “potential changes to public charge policies intended to reduce use of public programs by immigrant families, including their citizen children, could further increase strains on immigrant families and lead to losses in health coverage.” In his letter, Governor Inslee shares, “[b]y significantly expanding the scope and reach of ‘public charge’ rules, [Washington] State expects many eligible individuals to stop using their benefits or not apply for benefits at all,” which would result in people not accessing, among other things, necessary medical care (e.g., reproductive healthcare).

**Title X**

Title X is the only federal funding for family planning services, and represents the main source of funding for safety-net providers serving individuals regardless of income, insurance status, or immigration status. Washington State receives $13 million per year (approximately $4 million in federal Title X funding) to support family planning programs. In 2017, Title X providers served 91,250 clients across the state. In 2017, 90% of clients served in Washington were females of reproductive age (15-44 years), and an estimated 88% of female clients served were on some form of contraceptive method. This resulted in an estimated 18,140 fewer unintended pregnancies, 8,540 fewer unplanned births, and 6,130 fewer abortions, representing a net savings of over $141.4 million associated with maternal and birth-related care, miscarriages, ectopic pregnancies, and abortion services.

Currently, the funding requirements of Title X are being debated at the federal level. Proposed changes could increase barriers to accessing reproductive health services. If proposed changes are made, Washington State would be not be eligible to receive Title X funding based on state law (Cynthia Harris, Family Planning Program Manager, Washington State Department of Health [DOH], personal communication, August 2018). While this could limit funding available for family planning services in the state, it could also create opportunities to improve access under state law (Cynthia Harris, DOH, personal communication, August 2018).

**Upstream Washington**

Upstream Washington is a multi-year initiative launched by Upstream USA, a non-profit partnering with Department of Health, to ensure all women have access to the full range of birth control methods in a single visit. The initiative involves: 1) providing training and technical assistance to publicly funded and private healthcare providers to ensure they offer patients the full range of contraceptive methods in a single appointment at no or low cost; 2) working with state agencies to eliminate barriers preventing women from accessing same-day birth control methods; 3) increasing public knowledge and awareness of contraceptive options and where to
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<th><strong>Washington State Department of Licensing and Immigration and Customs Enforcement</strong></th>
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<td>access low or no cost contraception; and 4) creating a rigorous evaluation of the initiative’s impact.(^\text{16})</td>
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The Trump Administration has “intensified national debate about immigration and has implemented policies to enhance immigration enforcement and restrict the entry of immigrants from selected countries that the Administration believes may post a threat to the country.”\(^\text{17}\) Changing policies and enforcement priorities potentially affect 23 million non-citizens in the U.S., including both lawfully present and individuals who are undocumented, and have implications for the over 12 million children who are predominantly U.S. citizens living with a non-citizen parent.\(^\text{17}\) A study of 100 parents who are immigrants from 15 countries and 13 interviews with pediatricians in four states found that the current political environment has increased fear and uncertainty among immigrants, including those with lawful status.\(^\text{17}\) Feelings of fear and uncertainty increased following the rescission of the Deferred Action for Child Arrivals (DACA) program in September 2017.\(^\text{17}\) Interviewees also reported increased experiences of racism and discrimination.\(^\text{18}\) Additionally, immigrants reported increased difficulty in daily life (e.g., finding employment), and some reported decreased use of healthcare and participation in Medicaid and CHIP due to increased fear.\(^\text{17}\)

Moreover, the Washington State Department of Licensing (DOL) provided residents’ personal information (e.g., country of birth, address) to federal Immigration and Customs Enforcement (ICE) officers, which was then used to arrest and deport people.\(^\text{18}\) In January 2018, Governor Inslee announced policy changes to ensure "DOL will not turn over personal information for immigration-related investigations to federal immigration authorities without a court order signed by a federal judge or magistrate or under the requirement of state or federal law."\(^\text{19}\) Despite the policy change, DOL’s cooperation with ICE likely increased fear and uncertainty among immigrants in Washington State, which may have lasting impacts on individuals’ level of trust in state and local government agencies and institutions.

## METHODS

SSB 6219 passed the Washington State Legislature in 2018. The bill required the Governor’s Interagency Council on Health Disparities to conduct a literature review on disparities in access to reproductive healthcare in Washington State, and to propose recommendations to reduce those disparities. The bill defines reproductive healthcare broadly as the “care necessary to support the reproductive system, the capability to reproduce, and the freedom and services necessary to decide if, when, and how often to do so, which can include contraception, cancer and disease screenings, abortion, preconception, maternity, parental, and postpartum care.” The bill also called out a number of factors, or priority populations for consideration.
Identification of priority populations
SSB 6219 required the Council to examine inequities “based on socioeconomic status, race, sexual orientation, gender identity, ethnicity, geography, and other factors.” Council staff began this report by identifying additional priority populations that likely experience inequities in accessing reproductive healthcare. Additional populations were identified through staff expertise and experience, conversations with key informants, and a preliminary review of literature. In total, Council staff identified 14 populations likely experiencing inequities in accessing reproductive health services. See “Individuals experiencing inequities” for a list of these priority populations, as well as a summary of the health inequities experienced by these populations.

Review of literature
Between May and August, 2018, Council staff conducted a review of literature between May 2018 and August 2018 to identify barriers to accessing reproductive healthcare. Staff used barriers as a means to understand inequities in access in order to provide greater understanding of the potential root causes of inequities and to develop relevant, specific recommendations. The intent of the literature review was to develop a comprehensive, complete list of these barriers. Therefore, rather than using systematic review methodology, staff reviewed articles until they reached a “saturation” in barrier identification (i.e., subsequent articles added no new or unique barriers). A separate literature review was conducted for each of the 14 populations identified to ensure comprehensiveness. All articles were identified using MEDLINE/PubMed. A total of 271 references were included, and each research article was reviewed for barriers and recommendations, annotated, and rated based on study design, execution, and generalizability to Washington State (data not shown). See Appendix B for the number of articles included for each priority population; article annotations are available upon request.

Search terms and key words
Council staff used a standard search string to begin each population-specific literature review. The root of the search string was consistent across all priority populations and included the terms (US OR USA OR "U.S."\textsuperscript{1}) AND (equit* OR disparit* OR inequit*) AND (reproductive OR contracept* OR abortion* OR pregnancy OR prenatal OR mammogra* OR pap) AND access AND health. Unique search terms were then added to the string to identify articles relevant to each priority population. As needed, articles were also identified using additional key words if the initial search string did not include relevant articles or if staff identified gaps in articles related to access, reproductive health services (including all services outlined in SSB 6219) (e.g., cancer screening services), or subsets of the priority population (e.g., women experiencing intimate partner violence). See Appendix B for a breakdown of all search terms by priority population.

Inclusion criteria
While each search returned multiple articles, only articles that were published between 2008 and 2018 (within the past 10 years), focused on the U.S., and addressed access were included in the final review. In instances where there was limited relevant research published in the specified timeframe, staff used the most current research available prior to 2008.

Barriers
Overall, Council staff identified 45 unique barriers through the review of literature. Barriers were further grouped into three categories: Economic, Structural, and Social.\textsuperscript{1} The list of barriers was generated iteratively. After each population-specific review of literature, staff met to discuss identified barriers,
determine how they aligned with the existing list of barriers, and determine if barriers should be further refined or if new barriers should be added. Staff then summarized the barriers and results from each population-specific review of literature. Summaries of barriers by priority population are available upon request.

After completing all population-specific reviews, Council staff met again to determine whether each barrier was unique and combined barriers to include in the final report as appropriate. For each barrier, staff presented an overview of the barrier and a list of priority populations experiencing that barrier based on the literature. Staff further highlighted examples of how the barrier impacted access for priority populations that experienced a particular barrier disproportionately or uniquely. Therefore, a discussion of each population experiencing a barrier may not be included. Note, staff numbered barriers to improve readability and for easy reference. Numbering within the report does not indicate priority or severity compared to other barriers. See Appendix A for a comprehensive list of barriers experienced by different priority populations.

Limitations
This review is limited by available literature and data. Although articles published between 2008 and 2018 were included, there may be a publication lag in research and the most up-to-date data may not be presented in the literature. In addition, few published articles included research that was specifically conducted with people living in Washington State. National studies or studies conducted in other states may not be as generalizable to Washington. However, staff evaluated each article for generalizability and, whenever possible, data from the literature was supplemented with Washington State data.

While many articles and research studies evaluate reasons for inequities in health outcomes, fewer studies look at barriers to accessing reproductive healthcare. In addition, researchers discussed the difficulty in evaluating access barriers for individuals that do not access care at all because barriers are insurmountable. For this reason, the available literature may not fully capture all of the barriers individuals encounter when seeking reproductive healthcare. Similarly, available literature specific to accessing reproductive health services for some priority populations was limited or lacking.

Lastly, the majority of reproductive health related literature is related to women. Although barriers may also be relevant to men, transgender, or non-binary individuals, the findings in this report are limited to the study populations of published literature.

Terminology
Council staff recognize that preferred terminology may vary by communities and individuals. In writing the full report, staff used terminology referenced in the literature when discussing article findings. The Governor’s Interagency Council on Health Disparities is committed to using terminology that respects and honors the individuals to whom this research is concerned. While no single term is universally accepted by all peoples in a demographic group, the terms used in this report represent those used for data reporting purposes, and appear in the form the terminology was originally published. It is not meant to minimize, exclude, or generalize the individuals involved nor endorse one form of terminology over the other (Adapted from Futures Without Violence Report).

In addition, since the majority of published literature about reproductive health is focused on women, many findings refer specifically to women even if barriers could be applicable to men, transgender, or
non-binary individuals as well. To the greatest extent possible, staff attempted to specifically note whether findings are related to women, men, transgender, or non-binary individuals depending on the populations included in the original research article. Where possible, in general discussions, staff attempted to use phrasing recommended by key informants, stakeholders, or Council members. Specific terminology used when discussing inequities experienced by victims/survivors of violence; gender identity and sexual orientation; and immigrants and refugees can be found in Appendices C, D, and E, respectively.

**Key informant interviews and review**

Key informant interviews were completed to gain additional context and background information and to refine staff understanding of the literature and recommendations for some population groups. Interviews were conducted within time and process constraints, and informants were identified purposively or were recommended to staff by other informants or Council members. Staff also identified key informants using snowball methodology. While staff followed-up with many of these recommendations, they were not able to contact all individuals due to time limitations. In addition, staff did not hear back from or were unable to connect with all informants contacted within time constraints. Therefore, results should not be construed as comprehensive or representative of all perspectives.

Key informant interviews were conducted in person or over the phone, as applicable, and questions were tailored to each informant to ensure full understanding of barriers to accessing reproductive health in Washington State. A total of XX key informant interviews were conducted. The majority of interviews were conducted with state agency staff (e.g., Washington State Health Care Authority), local health jurisdiction staff (e.g., Seattle-King County Public Health), healthcare providers (e.g., HealthPoint Community Health Center), community-based organization staff (e.g., Planned Parenthood Great Northwest and Hawaiian Islands), and researchers (e.g. University of Washington). Results from key informant interviews were used to inform background and contextual understanding, identify additional search terms that could help address gaps in the review of literature, and identify additional articles or resources to review for potential inclusion in the report.

Whenever possible, the comprehensive list of barriers and draft summaries of findings from population-specific literature reviews were sent to key informants to review for applicability to Washington State and to identify further barriers that may not have been captured in the published literature. Suggested changes were evaluated for alignment with the literature and included in the final report. In order to capture additional Washington State specific context, information from key informants is presented in summary as applicable. See Appendix F for a full list of key informants that were interviewed or provided review for this report; Council staff can be contacted for more information on how stakeholders were consulted.

**Recommendations**

Each article was reviewed for recommendations that would address barriers to accessing reproductive health services, and compiled into a comprehensive list. Council staff then evaluated each recommendation to determine if it would require action at the federal or state level. Recommendations that could be addressed at the state level were then further evaluated to determine if they could be acted on by the Washington State Legislature or a state agency.
In addition to vetting recommendations from the published literature, Council staff also reviewed reports and recommendations from Washington State agencies and community-based organizations addressing reproductive health. This list of reports was generated purposively based on suggestions from key informants, stakeholders, and Council members. See Appendix G for a list of relevant reports.

Recommendations from the published literature and Washington State agencies and organizations were compared to identify areas of alignment and to determine which recommendations would likely address access barriers for multiple priority populations. A total of 13 recommendations were included in the final report. These recommendations are not comprehensive, but represent actions that would reduce disparities in accessing reproductive healthcare for a number of individuals experiencing inequities in Washington State. Due to capacity limitations, staff were not able to fully evaluate recommendations for feasibility, cost, or alignment with existing federal and state law. Relevant key informants and state agencies reviewed and provided feedback on proposed recommendations to ensure accuracy and applicability to Washington State.

Other limitations
This report was subject to time constraints, which influenced the scope of work for this review. Articles included in the review are only a representation of the evidence and provide examples of current research. Since staff reviewed articles until they reached a “saturation” in barrier identification, articles may not address all possible reproductive health services or all possible sub-populations. In some cases only a few review articles or meta-analyses are referenced. One article may cite or provide analysis of dozens of other articles. Therefore the number of references included in the review does not necessarily reflect the full body of published literature. In addition, some articles provide evidence for more than one priority population and are referenced multiple times.

While Council staff sought to engage key informants to ensure the literature was applicable to Washington State, this report does not capture practice-based evidence, best or promising practices, or current and ongoing work to improve access to reproductive health services in Washington State. Similarly, this report does not capture community voices or stories from individuals attempting to access reproductive health services in Washington State. The majority of key informant interviews were conducted with staff and providers at state agencies, local health jurisdictions, health clinics, and community-based organizations rather than with individuals seeking care. The intent of this report is to provide the results from a review of literature on disparities in access to reproductive healthcare in Washington State, and to propose recommendations to reduce those inequities.

**ACCESS TO REPRODUCTIVE HEALTHCARE**

One of the contributing factors to inequities in reproductive health outcomes is differential access to reproductive healthcare. Access to reproductive healthcare is broadly defined in published literature as access to timely and appropriate care, and can be impacted by structural, institutional, financial, social, cultural, and sociodemographic factors. Larger reviews of published literature have identified inequities in access to reproductive healthcare for multiple priority populations, including adolescents and young adults, women of older reproductive age, individuals with behavioral health disorders, individuals with disabilities, individuals who identify as LGBTQIA, people living in rural areas, individuals experiencing homelessness, immigrants, individuals without health insurance, women
in the military, people of color who experience systematic racism and individuals of low socioeconomic status.

These populations experience worse reproductive health outcomes and have disproportionate access to numerous reproductive health services, including access to prenatal care, maternity care, contraception, assisted reproductive technology (ART) and infertility treatment, and many others.

**INDIVIDUALS EXPERIENCING INEQUITIES**

Council staff identified 14 populations likely experiencing inequities in accessing reproductive health services in Washington State, including inequities experienced by:

**Age (Adolescents/young adults)**
Adolescents (aged 13-18) and young adults (aged 18-26) account for a disproportionate number of unintended pregnancies and cases of sexually transmitted infections (STIs) in the U.S. While unintended teen pregnancy has declined, U.S. rates are still higher than many other high-income countries, and barriers to accessing care necessary to improve a variety of reproductive health outcomes remain. Structural barriers and social barriers are particularly limiting for adolescents and young adults due to their limited autonomy and related barriers (e.g. lack of transportation).

**Age (Older adults)**
Older adults (aged 65 and over) face unique challenges to accessing reproductive healthcare. Medicare helps to equalize insurance coverage among older adults, but inequities in access related to insurance remain. Furthermore, older adults struggle with access due to social barriers largely related to underlying perceptions about sexuality and risk in older age and the minimization of sexual health issues. However, evidence indicates older adults remain sexually active in their later years and are at risk for human immunodeficiency virus (HIV) and other STIs. Older adults may also lack appropriate knowledge of sexual health and underutilize protection.

**Individuals with behavioral health disorders (Behavioral health)**
Individuals with behavioral health disorders are at increased risk for STIs, HIV, Hepatitis B and C, human papillomavirus (HPV), having multiple sex partners, experiencing sexual violence, and being involved in sex work. Most women with substance use disorders are of reproductive age are less likely to use contraception or access preventive health services, and are more likely to experience unintended pregnancy and abortion. Although substance use during pregnancy is underreported, it is estimated that approximately 5.3% of pregnant women use illicit drugs at some point during their pregnancy. Substance use during pregnancy can have negative pregnancy, birth, and maternal health outcomes.

**Individuals with a disability (Disability)**
In 2015, an estimated 12.9% of Washingtonians were living with a disability. Approximately 12.6% of Washingtonians living with disabilities in 2015 were aged 18 to 34 years, and 40.6% were aged 35 to 64 years. Individuals with disabilities experience limitations and barriers to accessing healthcare, particularly reproductive healthcare. Many inequities experienced by individuals with disabilities are due
to misconceptions by society and providers that individuals with disabilities are unhealthy and asexual, unable to have sex, and not in control of their sexual desires.\textsuperscript{65} In addition, lack of facilities and care appropriate for individuals with disabilities has led to inequities in sexual healthcare access and outcomes (\textcolor{red}{\textbf{CITATION}}). Evidence indicates that women with disabilities are less likely to have received a mammogram during the past two years.\textsuperscript{66,67} Moreover, those living with disabilities in Washington experience high rates of financial poverty (19.5\% below 100\% of FPL and 43\% below 200\% FPL) compared to those without disabilities (10\% and 23\%, respectively)\textsuperscript{64} which further limits access to reproductive health.

**Sexual orientation (Sexual orientation)**

Lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA) individuals often face barriers to accessing necessary reproductive healthcare services and, as a result, can experience worse health outcomes. For example, gay and bisexual men have higher levels of both HPV infection and HPV-related disease than heterosexual men. Different subpopulations are also at increased risk of various cancers (e.g., anal cancer, breast cancer).\textsuperscript{1,68} Barriers to care include but are not limited to cost-related hurdles, gaps in coverage, and poor treatment from healthcare providers.\textsuperscript{1,69-77} Data from 2000-2007 show that women in same-sex relationships were less likely to have had a recent mammogram or Pap test.\textsuperscript{78} However, barriers are not experienced in the same way across these variable identities and can be improved or exacerbated by an individual's other identities or circumstances (race, socioeconomic status, etc.) (\textbf{CITATION}).

**Gender identity (Gender identity)**

Gender minorities face inequities in reproductive health access in the form of economic, structural, and social oppression. For example, the transgender population is more likely to live in poverty and less likely to have health insurance than the general population.\textsuperscript{1,79} Transgender people’s access to health services is further limited by high levels of mistreatment and stigma encountered when seeking health services.\textsuperscript{1,79} These barriers can contribute to worse health outcomes. This are less likely to have health insurance than cisgender people. Transgender women, particularly transgender women of color, are at high risk of HIV.

**People who live in rural areas (Geography)**

Women in rural areas have worse health outcomes than women in urban areas, as well as less access to healthcare in general and to obstetrics in particular.\textsuperscript{80} People who live in rural areas face numerous barriers in access to healthcare, including transportation infrastructure, population distribution, and configuration of facilities.\textsuperscript{81} Other geographic factors which are associated with inequities in access are rural closures of family planning clinics,\textsuperscript{82} increased travel time to clinics,\textsuperscript{83} shortages of providers in rural areas,\textsuperscript{84} increasing risk of malpractice litigation\textsuperscript{85}, and limited reproductive healthcare service availability due to Health System Directives.\textsuperscript{86}

**Individuals with unstable housing (Homelessness)**

Nationally, an estimated 20\% of individuals experiencing homelessness are women,\textsuperscript{87} and the number of families experiencing homelessness (mostly comprised of single women with one or more children) increased 20\% between 2007 and 2010.\textsuperscript{88} Women experiencing homelessness are less likely to receive pap smears or use contraception, and more likely to have abnormal pap smears, cervical cancer, STIs, HIV, pelvic inflammatory disease, multiple sex partners, unintended pregnancy, and adverse birth outcomes.\textsuperscript{87-89} A study with 205 women experiencing homelessness in Boston, Massachusetts found that
only 36% of women experiencing homelessness had received a pap smear in the past 12 months, compared to 55% of the U.S. general population. Approximately 50% of women experiencing homelessness who received a pap smear required follow-up treatment, compared to 2.3% of the U.S. general population. Seventy-three percent of pregnancies among women experiencing homelessness are unintended (compared to 50% of the general population), and experiencing homelessness during pregnancy is associated with lack of prenatal care, high-risk pregnancies, and poor birth outcomes.

 Immigrants and refugees (Immigration)
Individuals may enter and remain in the U.S. under a variety of circumstances and immigration statuses, including as lawfully-present aliens, refugees, migrants, detainees, asylum-seekers, Deferred Action for Childhood Arrivals (DACA) recipients, or as individuals who are undocumented. Access to healthcare varies by immigration status, and individuals and communities experience different barriers to care based on immigration status, nativity, length of time in the U.S., and level of acculturation. However, overall, immigrants in the U.S. are less likely to have health insurance (due to federal and state regulations and employment in jobs less likely to provide insurance), less likely to receive preventive care (including cancer screening and prenatal care), and more likely to delay seeking health services. Immigrants are also more likely to experience poor reproductive health outcomes, including unintended pregnancy, unintended birth, sexually transmitted infections, adverse birth outcomes, and longer durations of infertility than the general population. Individuals who are undocumented experience worse reproductive health outcomes than immigrants with legal status or the general population.

 Individuals who are incarcerated (Incarceration)
Between 2000 and 2013, the number of women who are incarcerated in the U.S. increased by 30%, while the number of men who are incarcerated increased by 13%. Women of color are incarcerated at rates higher than white women (e.g., black women are incarcerated at a rate 2.3 times that of white women), and the majority of women who are incarcerated (70%) are convicted of non-violent crimes. In addition, approximately 74% of women experiencing incarceration are of reproductive age. While pregnancy rates among women who are incarcerated are not available, most researchers estimate that approximately 10% of women who are incarcerated are pregnant. Approximately 6% of women are pregnant when they enter correctional facilities. Estimates suggest that an even higher percentage of adolescents in the juvenile justice system are pregnant.

Women who are incarcerated often have worse physical and mental health than the general population and experience higher rates of early sexual initiation; STIs; HPV; HIV; hepatitis B and C; chronic diseases; substance use; mental health disorders; and histories of physical, sexual, and psychological abuse and trauma. Pregnant women who are incarcerated are also more likely to experience unintended pregnancies, high-risk pregnancies, abortion, and poor birth and maternal health outcomes due to conditions before and during incarceration. In addition, cancer screening rates are lower among women who are incarcerated and the rate of cervical cancer among women in the criminal justice system is 4 to 5 times greater than the rate among non-incarcerated women. See discussions labeled Immigration for more information regarding barriers detainees experience in facilities operated by Immigration and Customs Enforcement (ICE).
Active duty military members and Veterans (Military or Veterans)
Women make up a growing number of active duty service members and Veterans. In 2014, 15% of active duty service members and 19% of reserves were women, and 97% of women in the military were of reproductive age. The Department of Veterans Affairs estimates that 11% of Veterans will be women by 2020. Women in the military experience unique risks to reproductive health, including low levels of contraceptive use during deployment, high levels of sexual assault and military sexual trauma, and high levels of unintended pregnancy. One study noted, “contraception access and use are critical, particularly given the high prevalence of sexual assault in the military and the benefits of menstrual suppression for deployment.” A 2010 survey found that 4.4% of active duty women in the military reported experiencing unwanted sexual contact, rape, or sexual assault compared to only 0.1% of women in the general population. Another study found that between 9.5% and 33% of women experience an attempted or completed rape while serving in the military. Lastly, pregnancy and unintended pregnancy rates were higher among women in the military than the general population, with 72 per 1,000 women in the military aged 18-44 versus 45 per 1,000 women in the general population aged 18-44 experiencing unintended pregnancy.

In 2015, the U.S. Department of Veterans Affairs completed a Barriers to Care survey with 8,532 female Veterans to identify barriers women face accessing healthcare through the Veterans Administration (VA). They identified nine main barriers to accessing healthcare in general, including comprehension of eligibility requirement and scope of services, effect of outreach, driving distance to access care, clinic location and hours, childcare, acceptability of integrated care, gender insensitivity, mental health stigma, and safety and comfort. Despite receiving universal health insurance through TRICARE, women in the military and female Veterans continue to experience unique barriers in accessing reproductive healthcare.

While most of available, published literature focuses on access to reproductive health for women in the military and female Veterans, men in the military and male Veterans also face barriers accessing reproductive healthcare services. For example, male Veterans have limited access to fertility treatment and assisted reproductive technologies (ART), even in cases where fertility outcomes can be linked to military service.

People of color experiencing systematic racism (Racism)
In 2017, an estimated 31% of Washington State’s population were people of color, an increase of 10% since 2000. According to Office of Financial Management April 1, 2017 data, Washington State’s population is estimated to be 80% White (69.2% non-Hispanic White), 8.4% Asian, 4.0% Black, 1.8% American Indian and Alaska Native (AI/AN), 0.8% Native Hawaiian and Other Pacific Islander (NHOPI), and 5.0% Two or More Races, and approximately 12.8% of the population is Hispanic or Latino. The state’s population is expected to continue becoming more racially/ethnically diverse as people migrate to the region. While the state population is becoming more diverse overall, diversity is not spread evenly through the state. “Currently, over 80% of individuals who identify as Asian, over 80% of individuals who identify as Black or African American, and 70% of individuals who identify as NHOPI reside in Pierce, Snohomish, and King Counties.” However, only 35% of individuals who identify as AI/AN and only 40% of those who identify as Hispanic live in these three counties.

The changing racial/ethnic composition of the state and counties is important to consider as “historic policies and practices have contributed to racial and ethnic disparities in health behaviors and
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outcomes and often continue to influence access to care, including reproductive health services. For example, in 2012, approximately 73% of pregnant Washingtonians entered prenatal care during the first trimester (first three months) of pregnancy. However, when disaggregated by race/ethnicity, inequities exist; 66% of Black, 66% of Hispanic, 60% of AI/AN, and 45% of Pacific Islander Washingtonians accessed prenatal services during their first trimester of pregnancy compared to 76% of White and 74% of Asian individuals. In particular, African American women are disproportionately affected by multiple sexual and reproductive health conditions compared to women of other race/ethnicities. “African American women accounted for 60% of the estimated new HIV infections that occurred among all women in 2014 and are 2.8-3.7 times more likely to die from pregnancy-related complications compared to women of all other race/ethnicities.” Furthermore, 2012 data show that African American women were more likely than white women to be diagnosed with having primary or secondary syphilis, gonorrhea, or chlamydia (16.3, 13.8, and 6.2 times, respectively). Additionally, evidence indicates that they are also twice as likely to be diagnosed with bacterial vaginosis, which is correlated with poor pregnancy outcomes including low birth weight.

Individuals of low socioeconomic status (SES)
Approximately 15% of people in the U.S. and 13% of people in Washington State lived below the Federal Poverty Level (FPL) in 2016, and approximately 12% and 10% of people lacked health insurance (respectively). In general, women, people of color, immigrants, and individuals living in rural communities were more likely to be low-income and lack health insurance. An estimated 40% of low-income women of reproductive age lacked health insurance. Women of low socioeconomic status were also more likely to experience poor reproductive health outcomes, including early initiation of sexual intercourse, unintended pregnancy, unintended births, abortion, teen pregnancy, HPV, longer duration of infertility, and late-stage breast cancer diagnosis. An analysis of federal data on unintended pregnancy collected from 2002 to 2006 estimated that women of low socioeconomic status experienced unintended pregnancy at five times the rate of women in the highest income level. Women living in high poverty census tracts had 1.3 times the odds of being diagnosed with late-stage breast cancer compared to women living in census tracts with less than 5% poverty. Those with low socioeconomic status were also more likely to have limited access to reproductive health services. For example, low-income men and women were less likely to get access to infertility treatment or assisted reproductive technology (ART), and “economic factors [were] the chief contributors to disparities in access to effective treatment.”

Research has also suggested that the relationship between access to reproductive healthcare and socioeconomic status is cumulative and cyclical. The Center for American Progress reported that access to contraception and abortion “has serious economic consequences for women, in both immediate costs as well as long-term effects on economic stability and progress.” The report concluded that, “women’s labor force participation, earnings, and [economic] mobility, [are] correlated with stronger measures of upholding reproductive rights and health care access.”

Victims/survivors of violence (Violence, IPV, or Trafficking)
Victims and survivors of violence face unique barriers to reproductive healthcare as well as exacerbated barriers (e.g., socioeconomic) related to their experiences of violence and exploitation. Published literature identified human trafficking (i.e., labor and sex trafficking), intimate partner violence (IPV), and sexual violence as detrimentally impacting access to reproductive health services. While most of the
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literature related to violence focuses on women, men and boys are also at risk for violence, especially trafficking.

Due to the underground nature of human trafficking, it is difficult to estimate the prevalence of victims and survivors. Key informants shared that many individuals being trafficked do not identify as victims and may not know that what is happening to them is unlawful (Office of Crime Victims Advocacy [OCVA], Department of Commerce [Commerce], personal communication, July 2018). According to a U.S. Department of State Report, “from July 1, 2014 to June 30, 2015, [U.S. Department of Justice (DOJ)] grantees providing [trafficking] victim services reported 3,889 open client cases, including 2,180 new clients.”

Fifty-one percent of victims served during the reporting period were U.S. citizens or lawful permanent residents and 49% were foreign nationals; the top three countries of origin of federally identified victims in fiscal year 2015 were the U.S., Mexico, and the Philippines. The report identifies particularly vulnerable populations in the U.S. as: “children in the child welfare and juvenile justice systems; runaway and homeless youth; American Indians and Alaska Natives (AI/AN); migrant laborers, including participants in visa programs for temporary workers; foreign national domestic workers in diplomatic households; persons with limited English proficiency; persons with disabilities; and LGBTI individuals.”

Additionally, according to 2010-2012 Washington specific data, 32% of men and 41% of women reported lifetime IPV. National data indicate that while men and women experience IPV at similar rates, women experience negative health impacts at higher rates than men do (27% and 11%, respectively). Intimate partner behaviors that prevent individuals from accessing health services (e.g., limiting access to transportation or finances, physical violence, reproductive coercion) interfere with the individual's ability to prevent, screen, and address IPV and adequately fulfill sexual and reproductive health needs.

INTERSECTIONALITY

Intersectionality, or the understanding that multiple systems of oppression interact in the lives of those with multiple marginalized identities, impacts the need, access, quality, and outcomes of reproductive health services. Since experiences of oppression are not mutually exclusive, individuals with multiple marginalized identities may have further reduced access to reproductive healthcare. Evidence suggests that intersecting oppressed identities (e.g., race/ethnicity, sexual orientation, gender, health status, and gender identity) influence individuals' healthcare experiences, often in disadvantageous ways. For example, "sexual minority women and LGBTQ people of color report worse health status, more unmet healthcare needs, and perceived and actual discrimination or substandard care than sexual minority men and White, LGBTQ people." In addition, youth who identify as lesbian or bisexual are more at risk for behavioral health disorders, homelessness, or experiencing violence; are less likely to access reproductive healthcare; and have higher rates of unintended pregnancy than youth identifying as heterosexual. While findings from the review of literature are presented by priority population, an individual may identify with multiple identities. Therefore barriers in accessing reproductive health services may be compounded, furthering inequities in access.

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oppression and lived experiences may further reduce an individual’s access to reproductive healthcare. While findings from the review of literature are presented by priority population, an individual may identify with multiple factors. Therefore barriers in accessing reproductive health services may be compounded or exasperated, furthering inequities in access.

**BARRIERS**

The 45 unique barriers identified through the review of literature are grouped into three categories: Economic, Structural, and Social. The following sections include an overview each barrier and a list of priority populations experiencing that barrier. The following discussion explains the barrier and highlights examples of how the barrier impacted access for priority populations that experienced a particular barrier disproportionately or uniquely. Therefore, a discussion of each population experiencing a barrier may not be included. Barriers are numbered to improve readability and for easy reference. Numbering within the report does not indicate priority or severity compared to other barriers. See Appendix A for a comprehensive list of barriers experienced by different priority populations.

### ECONOMIC BARRIERS

1. Insurance status

<table>
<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
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<tbody>
<tr>
<td>28,31-33,49</td>
<td>53,54</td>
<td></td>
<td>141</td>
<td>1,76,140,142,143</td>
<td>1,74,76,78,140</td>
<td>14</td>
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<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military</td>
<td>Racism</td>
<td>SES</td>
<td>Violence</td>
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<td>89</td>
<td>3,14,91,94,95,98-100,144,145</td>
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<td></td>
<td>14,98,146-149</td>
<td>24,98,124,126,129-131,150-152</td>
<td>134,153-155</td>
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While the ACA expanded health insurance opportunities and coverage for reproductive healthcare for many individuals, multiple populations continue to experience barriers in accessing reproductive health services. In addition, some studies have found that type of insurance may impact access to reproductive healthcare, namely that public health insurance (i.e., Medicaid) provides greater access and more affordable care than private insurance. The Washington State TAKE CHARGE program was created in 2001 to expand Medicaid coverage for family planning services to families living at or below 200% of the FPL. In 2015, the program completed a survey of 338 women enrolled in TAKE CHARGE to determine the reasons women remained in TAKE CHARGE after the implementation of the ACA. Women reported staying on TAKE CHARGE because of the lack of employer-sponsored health insurance and cost of other insurance options. Women also had the perception that private insurance would not provide adequate coverage for birth control and other family planning services. Similarly, a study with low-income women accessing prenatal care in Appalachia found that women reported fewer out-of-pocket expenses and better access to services on Medicaid than private insurance.

**DISABILITY:** Multiple studies cited lack of health insurance as a barrier to individuals with disabilities receiving reproductive healthcare. In addition, 41% of women with disabilities live at or below the federal poverty line, exacerbating financial barriers to accessing care. A 2010 study in South Carolina
found that women with disabilities more frequently cited cost or lack of insurance as the reason for missing regular Pap smear testing compared to those who did not have a disability (31% vs 13%).

GENDER IDENTITY/SEXUAL ORIENTATION: Surveys conducted in 2016 and 2017 show high uninsured rates among LGBTQ emerging adults (43% uninsured) and transgender individuals (22%). The ACA, SCOTUS ruling on the Defense of Marriage Act (DOMA) [2013, U.S. v. Windsor], and SCOTUS ruling recognizing same-sex marriages [2015, Obergefell v. Hodges] increased access to care and insurance for LGBTQ individuals and their families. However, since these decisions are not binding for employers, "there remains some question about whether employers can legally limit spousal [health insurance] coverage to opposite-sex spouses." Key informants noted that connecting health insurance coverage to marriage still leaves many people uninsured or underinsured, and that equity requires access to quality medical insurance regardless of sexual orientation, gender identity, or marital status.

IMMIGRATION: Immigrant communities have restricted access to health insurance. Access is primarily restricted through federal and state legislation (see discussion under Federal and state restrictive legislation). An evaluation of Massachusetts's Commonwealth Care program (which served as a model for the federal ACA) concluded that immigrants continued to have less access to health services. Another study found that approximately 45% of noncitizen immigrant women of reproductive age in the U.S. were uninsured, compared to 24% of naturalized immigrants, and 18% of U.S. born women. In addition, immigrants are less likely to be employed in jobs that provide health insurance.

RACISM: A cross-sectional analysis of 2000 to 2010 Medical Expenditure Plan Survey data of women aged 40 years and older found insurance to be among the four most important factors leading to breast cancer screening inequities between Hispanics and non-Hispanic whites. Furthermore, an analysis of 2006 to 2010 National Survey of Family Growth data for 2,168 females aged 15-24 years found that having insurance significantly increased the odds of human papillomavirus (HPV) vaccination for Hispanics (US- and foreign-born).

SES: Lack of health insurance has been well-documented as a key barrier to accessing reproductive healthcare for individuals of low socioeconomic status. An estimated 40% of low-income women of reproductive age lacked health insurance. An analysis of the 2008 Michigan Special Cancer Behavioral Risk Factor Survey with women aged 40 or older about cancer screening found that having no health insurance reduced the likelihood of having a mammogram by 73% and was one of the primary barriers to mammography screening.

2. Cost of care

| Adolescents/Young Adults 27,30,42,49 | Older adults 50-52 | Behavioral health 63,159 | Disability 141,160-162 | Gender Identity 1,76,79,142,163,164 | Sexual Orientation 1 | Geography
<table>
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<tbody>
<tr>
<td>Homelessness 87</td>
<td>Immigration 91,93,94,96,98-100,144,145,158,165</td>
<td>Incarceration</td>
<td>Military 110,112</td>
<td>Racism 27,146,147,166</td>
<td>SES 20,24,98,100,124,126,128,130,131,151,152</td>
<td>Violence 134,153,167,168</td>
</tr>
</tbody>
</table>
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The cost of care (including clinical visits, procedures, and co-pays) is often cited as a barrier to care, and when cost is eliminated the barrier is also eliminated.\textsuperscript{27,28,49} While rates of health insurance coverage have increased since the passage of the ACA, studies have found that cost of care remained a barrier even for women with public or private health insurance coverage.\textsuperscript{20,151} A 2016 report to Congress by the U.S. Agency for Healthcare Research and Quality concluded that 70\% of care affordability measures have not changed since 2010 and inequities in care persist for low socioeconomic and uninsured populations in all healthcare priority areas.\textsuperscript{152} In addition, federal exclusions of coverage for infertility treatment under the ACA and the Hyde Amendment, which prohibits the use of federal funds for abortion services and requires health plans receiving federal money keep funds separate from any funds used for abortion services, make the cost of these services unattainable for many populations.\textsuperscript{98,100}

**BEHAVIORAL HEALTH:** Results from the national 2013 Health Reform Monitoring Survey found that 50.8\% of adults with mental health problems reported trouble affording healthcare, regardless of insurance status.\textsuperscript{159} The survey found that 29.8\% of uninsured adults with physical or mental health issues and 29.9\% with health insurance reported difficulty accessing care.\textsuperscript{159} Similarly, 80\% of uninsured adults with physical or mental health issues and 60\% with health insurance reported difficulty affording care.\textsuperscript{159} Adults with health issues that also had low socioeconomic status experienced more difficulties accessing care.\textsuperscript{63,159}

**GENDER IDENTITY:** Cost-related hurdles often affect both sexual and gender minorities.\textsuperscript{1} This barrier is particularly acute for the transgender population, which is much more likely to live in poverty and less likely to have health insurance than the general population.\textsuperscript{1,176} One study found the financial cost of care was the most commonly cited barrier to care among 256 transgender and gender nonconforming individuals pursuing or desiring to pursue gender-affirming care.\textsuperscript{142} According to 2015 U.S. Transgender Survey data, 32\% of transgender respondents in Washington State reported that in the previous year they did not see a doctor when needed because they could not afford it.\textsuperscript{164} National data indicate that transgender people of color experience greater economic inequities than white transgender respondents and the U.S. population.\textsuperscript{79} Overall, survey respondents were more than twice as likely as the U.S. population to be living in poverty and, transgender people of color were more than three times as likely as the U.S. population (12\%) to be living in poverty (i.e., Latino/a 43\%, American Indian 41\%, multiracial 40\%, and black 38\%).\textsuperscript{79}

**IMMIGRATION:** Immigrants may lack the financial capital and resources to pay for services and the cost of care, especially with restricted access to health insurance coverage.\textsuperscript{91,93,94,96,98-100,144,145,158,165}

**RACISM:** An analysis of data from the Rhode Island Pregnancy Risk Assessment Monitoring System, found that Hispanic women were more likely to have delayed prenatal care (AOR 1.84, 95\% CI 1.27-2.65) than their non-Hispanic white counterparts.\textsuperscript{166} Results indicated that income appeared to have the largest impact on disparities in prenatal care between non-Hispanic white women and Hispanic women.\textsuperscript{166} Similarly, studies have shown that income in an important factor in explaining inequities in cancer screening\textsuperscript{146} and HPV vaccination between Hispanic/Latinos and non-Hispanic whites.\textsuperscript{147} Conversely, analysis of 2006-2010 National Survey of Family Growth data found African-Americans remained less likely to have initiated HPV vaccination than whites after adjusting for socioeconomic covariates for both young women ages 15-18 years (AOR, .44; 95\% CI, .28—.68) and 19-24 years (AOR, .47; 95\% CI, .27—.82).\textsuperscript{147}
The Contraceptive CHOICE Project (CHOICE) eliminated the barriers of cost, service availability, and provider counseling practices as barriers for sexually active teenagers (age 15-19 years). Overall, CHOICE reduced inequities in unintended pregnancy experienced by non-Hispanic black teens. Participants’ unintended pregnancy rate was 18.2 per 1,000, compared to the national average of nearly 150 per 1,000. Black teens went from being 2.5 times as likely to experience unintended pregnancy as White teens to equally as likely, effectively eliminating the previous disparity due to racism.

SES: Cost of care is a barrier for women of low socioeconomic status to access reproductive health services. Various researchers have found that the cost of contraceptives, HPV vaccination, abortion, in vitro fertilization, ART, and prenatal care caused women to delay care or not seek care. A study with women presenting for infertility treatment in San Francisco concluded that, "women with insufficient income to pay for ART services experience an insurmountable gap in access to care...In the U.S., price is a barrier that separates those that are able to pay for standard of care treatment [versus] those that must accept substandard or no care in many cases."

The U.S. Agency for Healthcare Research and Quality report stated, "[low-income] people experienced worse access to care compared with high income people for all access measures except one" and "more than half of measures show that [low-income] households have worse care than high-income households." Further, the report concluded that "significant disparities continue for [low-income] people compared with high-income people who report they were unable to get or were delayed in getting needed medical care due to financial or insurance reasons."

VIOLENCE: Financial cost of care acts a as barrier to reproductive healthcare and medical care generally for victims and survivors of trafficking and IPV as traffickers and abusers often exert economic control to limit an individual’s power and self-determination.

### 3. Associated costs of care

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<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
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<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military</td>
<td>Racism</td>
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<td>20,24,128,131,169-171</td>
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<td>Violence 168</td>
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</table>

In addition to the direct cost of care, associated costs of care related to transportation, lost wages, child care, transportation, and travel expenses to and from services may limit access to care. In addition, costs related to recovery or follow-up practices may also add to the financial cost of care. Although the ACA eliminated cost-sharing for reproductive health services, routine vaccines, and STI screening, associated costs of care continue to limit access for those with low incomes and who lack financial support (e.g., adolescents and young adults with children).

GENDER IDENTITY: Transgender and non-binary individuals may face additional costs associated with care related to travel (e.g., to a competent provider), missed work, and other required services (e.g., therapist visits, lab work).

GEOGRAPHY: Lack of affordable transportation poses an added barrier, particularly for low-income
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people, accessing distant health services. States are required to arrange healthcare transportation for Medicaid-eligible pregnant individuals, a service which is termed Non-Emergency Medical Transportation (NEMT). While NEMT is a mandatory federal Medicaid benefit, federal waivers allow states to limit its availability. Medicaid’s NEMT benefit is important for helping low-income beneficiaries access care when they otherwise would not have been able to travel to healthcare appointments both reliably and affordably.

Through Washington’s First Steps program, Maternity Support Services (MSS) workers help Medicaid-eligible pregnant women arrange transportation through the brokerage system of contracted regional providers (Washington Health Care Authority, 2018). Since the implementation of the First Steps program in 1989, Washington women's prenatal care and birth outcomes have improved. In 2016, graduate students at the University of Washington completed a mixed methods survey of healthcare organizations (N=11) in Chelan, Douglas, Grant, and Okanogan Counties regarding transportation to healthcare appointments. Results from 16 interviewed participants found that NEMT service scheduling poses an added burden for patients and clinicians due to an inability to receive consistent information regarding the availability of and qualifications for services. Furthermore, participants shared that a NEMT ride must be schedule two days in advance, which may not meet patients emerging needs.

VIOLENCE: A report to the U.S. Department of Justice identified transportation costs as a barrier for AI/AN survivors and victims of sexual assault, particularly if necessary services (e.g., abortion, rape kits) were not covered by insurance or provided at local Indian Health Services (IHS) or tribal clinics.

4. Non-medical expenses and debts

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<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
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Non-medical expenses and debts limit an individual or family’s resources available to pay for reproductive healthcare services and associated costs of care.

IMMIGRATION: A study examining health status and healthcare access of DACA recipients found that individuals delayed seeking care due to competing financial priorities, including the cost of rent, food, and tuition.

SES: Survey results from women participating in Washington State’s TAKE CHARGE program found that non-medical debts and the cost of other bills and basic necessities were a barrier for women to pay for health insurance and the cost of care.

5. Underfunding

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<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
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Literature Review on Inequities in Reproductive Health Access

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<th>Homelessness</th>
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Issues of underfunding may limit health systems’ ability to offer the full spectrum of reproductive health services; sufficiently staff facilities; provide quality training opportunities; offer extended hours; or extend insurance coverage thereby limiting access to needed services.\textsuperscript{107,174,177-179}

**GEOGRAPHY:** Financial pressures have contributed to closures of rural family planning clinics and consequently reduced access to family planning services, STI testing, and cancer screenings.\textsuperscript{174,177} National data show that 9% of rural counties experienced the loss of all their obstetric services for the duration of 2004 to 2014 due to financial challenges that contributed to closures.\textsuperscript{174} Medicaid has an important role in financing 45% of all U.S. births, and 51% of rural births.\textsuperscript{175,176} Medicaid reimbursement rates for pregnancy healthcare services (e.g., prenatal care, delivery, labor, and post-partum care) are lower than rates paid by other commercial carriers. These disparate reimbursement rates contribute to financial problems in rural hospitals where obstetric care is dominated by Medicaid.\textsuperscript{174} Closure of obstetric units is associated with facilities’ location in counties with a lower median family income, which suggests that a local population’s overall financial status can influence whether a hospital can continue providing obstetric services.\textsuperscript{177}

**INCARCERATION:** Research with four correctional facilities found that some services, such as contraception are not routinely available due to cost.\textsuperscript{107} Some facilities have developed creative programs using Title X funding or partnerships with local health jurisdictions or academic institutions to provide family planning services.\textsuperscript{107} However, the American College of Obstetricians and Gynecologists (ACOG) has noted that correctional facilities often lack funding to provide health services since Medicaid funding cannot be used to provide care to adults or adolescents in secure confinement.\textsuperscript{178} In Washington State, Medicaid coverage is suspended while individuals are incarcerated, and suspended coverage only provides reimbursement for hospitalizations longer than 24 hours.\textsuperscript{178}

**RACISM:** The IHS is a federal agency that provides healthcare to 2.3 million AI/AN people (approximately 60% of the AI/AN population).\textsuperscript{179} \textbf{ADD Washington Specific Data} The provision of health services to members of federally-recognized Tribes is based on the government-to-government relationship between the federal government and Tribal Nations, established in the U.S. Constitution (Article I, Section 8) and grounded in treaties, laws, and U.S. Supreme Court Decisions.\textsuperscript{181} However, evidence indicates that IHS remains “significantly underfunded, receiving only about half of the funding needed to adequately care for the patients it serves.”\textsuperscript{180} In Fiscal Year (FY) 2017, IHS received $5 billion in budget appropriations, and its per capita expenditure was $3,851, significantly less than the U.S. National Health Expenditure ($10,348 per person) in 2016.\textsuperscript{179} In the face of limited federal funding, tribes and urban Indian health clinics in Washington State have been working formally for over a decade “to advance tribal-state collaboration on the delivery of health care services.”\textsuperscript{182}
STRUCTURAL BARRIERS
6. Health facility closures and mergers

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<th>Adolescents/Young Adults</th>
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Health facility closures and mergers reduce the availability of providers and services, often increasing the distance and time spent traveling to services.26,183

**GEOGRAPHY:** An analysis of three hospital closures in rural areas of the U.S. found closures decreased the level of access to care for local rural residents and led to an outmigration of healthcare professionals, exacerbating challenges in accessing specialty care.183

Increasing costs (e.g., medical services and contraceptive supplies) in the face of stagnant funding or cuts often contribute to closures. In 2012, Washington had 16 agencies operating 73 Title X family planning clinics (Cynthia Harris, DOH, personal communication, August 2018). From 2013 to 2017, three independent Title X family planning clinics closed and four local health jurisdictions stopped providing Title X family planning services at some or all their locations (Cynthia Harris, DOH, personal communication, August 2018).

7. Distance to services, travel time & transportation

<table>
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<tr>
<th>Adolescents/Young Adults</th>
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Distance to services, extended travel times, and limited transportation options (e.g., bus and ferry routes, schedules) pose significant challenges to accessing reproductive health services for those who lack or have limited access to a personal vehicle. For example, a study in Wisconsin found an association between long driving times to mammography facilities and lower mammography frequency.185 In particular, family planning clinic closures often resulted in increased distances and travel times to services, which reduced access to reproductive health services. Studies found that women whose closest clinic had shut down traveled four times the distance to obtain an abortion, as compared to women whose closest clinic remained open.186 In addition, this greater distance was nearly three times the average distance (i.e., 30 miles) according to a 2008 national survey.187 In Washington, closures in Okanogan County have caused patients to travel 35 miles to Twisp’s Room One-based Family Planning Clinic.188

**DISABILITY:** Along with the cost of transportation as an economic barrier, distance to services and availability of accessible transportation also pose challenges for individuals with disabilities,
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particularly those with mobility impairments and for whom fatigue is a major limitation in daily activities. Even if public transit is available, it is not necessarily accessible to people with visual and physical impairments, and these patients may need to schedule ahead of time for accessible transportation or rely on a family member.

**GENDER IDENTITY:** Travel-related challenges become a barrier to access for transgender and gender nonconforming people when appropriate services and/or competent providers are not available locally.

**GEOGRAPHY:** Travel and transportation barriers disproportionately affect those living in rural areas where long travel distances and times and limited public transportation options are common. In particular, older adults in rural communities experience long travel distances to services.

Nationally, rural closures have increased the travel time and distance to obstetric hospitals. Over half of rural women (18-39 years of age), compared to 7% of urban women, must travel more than thirty minutes to access the closest obstetric provider. Furthermore, fewer than half of women in rural areas of the U.S. live within a 30-minute drive of a hospital with perinatal services, while 87.6% of women in rural areas live within a 60-minute drive of a hospital with perinatal services. In 2010, 19.4% of women in Washington State lived in an area with longer than a 30-minute drive to the nearest hospital providing maternity and nursery care, and 5.5% lived in an area with longer than a 60-minute drive to these services.

Greater travel time can increase the risk of intrapartum complications for women rushing to the hospital for preterm labor delivery. Also, women in rural areas have to travel farther than women in urban areas to reach a hospital offering perinatal care, especially one offering higher acuity neonatal care services. Rural women therefore may face significant geographic barriers to receiving prenatal, delivery, and postpartum pregnancy healthcare services.

**IMMIGRATION:** Transportation to healthcare is a barrier for immigrants, regardless of immigration status. In addition, a qualitative assessment with recent Somali immigrants found cultural limitations that further restricted women’s ability to travel alone (i.e., women must be accompanied by a man) and limited their mobility to access prenatal and postpartum care. Distance to clinics providing reproductive health services was a barrier for male immigrants in rural communities in the Pacific Northwest.

**MILITARY/VETERANS:** Due to limited provider and service availability, women in the military often found it necessary to travel off-base to receive reproductive health services. Transportation was a barrier for women in the military who had to travel off-base to receive care. During deployment, women had limited mobility to travel off-base to receive care due to deployment setting (e.g. being on ship), unsafe conditions, or combat operations. The Department of Veterans Affairs found that 72% of women who use the VA do not use the nearest VA facility (due to provider and service availability), and that driving distance to access care was one of the nine main barriers female Veterans experience in accessing healthcare.

**RACISM:** AI/AN people who reside in rural areas or on tribal lands often must travel great distances to obtain medical care. Key informants shared that those who follow traditional seasonal migration
patterns face additional challenges accessing reproductive care. Additionally, key informants reported instances of local providers refusing to treat AI/AN pregnant individuals who initiate prenatal care late or are deemed high risk (e.g., diabetes, mental/behavioral health, substance use disorder). In such cases, individuals must choose whether or not to travel great distances to receive care.

VIOLENCE: In particular, individuals being trafficked and experiencing IPV often have severely limited access to transportation due to the closely controlled nature of their circumstances. Long distances and/or travel times and limited availability of public transportation to services represent a significant barrier to those being trafficked and experiencing more frequent and severe IPV. Lack of public transportation in rural areas is further exacerbated for IPV victims whose partner may control access to a vehicle or track when they leave or where they go. For example, one study found that travel distances greater than 20 miles negatively affected patient use of free mammogram services for women experiencing IPV.

8. Work, school, or childcare limitations

Challenges related to work, school, and childcare often act as barriers to accessing reproductive healthcare. For example, inflexible work schedules, limited time off work, time spent looking for work (if unemployed), or the need to bring children to medical appointments or find alternative childcare may pose significant barriers to accessing reproductive healthcare. These challenges are particularly pertinent for low-wage workers and those who have limited control over their work conditions.

MILITARY: Many researchers noted that working conditions for women in the military created a number of barriers to accessing reproductive healthcare, including work schedules, long work shifts, frequent travel, limited time before deployment, lack of annual leave, varying ability to use annual leave, and childcare. For example, one study found that women of higher rank were able to leave work to receive reproductive health services without requesting time off, whereas lower ranked women had to request time off through their chain of command before seeking services. Another study found that the amount of time required to get approved for care through military processes was a barrier that prevented or delayed women from seeking reproductive health services.

TRAFFICKING: Victims of sex and labor trafficking may be barred by traffickers from accessing health services, or may have severely limited access due to daily financial quotas or inflexible forced labor hours.
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9. Lack of medical home

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<th>Adolescents/ Young Adults</th>
<th>Older adults</th>
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<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
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<tbody>
<tr>
<td>Homelessness 87</td>
<td>Immigration 165,195</td>
<td>Incarceration 101,103,104,107</td>
<td>Military 112,115,193</td>
<td>Racism</td>
<td>SES 150</td>
<td>Violence 167</td>
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Evidence shows that lack of a medical home or primary care provider serves as a barrier to reproductive healthcare. For example, an analysis of the 2008 Michigan Special Cancer Behavioral Risk Factor Survey with women aged 40 or older about cancer screening found that having no usual source of care reduced the likelihood of receiving a mammogram by 54%, and having no healthcare provider reduced the likelihood of receiving a mammogram by 68%. 150

HOMELESSNESS: Fragmented care is a large barrier to accessing reproductive healthcare for women experiencing homelessness. 87 A study with 205 women experiencing homelessness in Boston found that women lacked a medical home, visited multiple clinics to receive care, or sought care only in emergency rooms. 87

IMMIGRATION: Due to federal and state policies restricting DACA recipients from accessing health insurance coverage and care, many DACA-recipients lack a consistent medical home or primary care provider. 165 As a result, they are less likely to receive preventive screening and consistent access to contraception. 165 Detainees also face discontinuity of care. A study of women detainees in three detention centers in the U.S. found that women’s medical records were incomplete or were not provided when women moved to another facility or were released. 195

INCARCERATION: Fractured care, especially between prison and community health systems, is also a barrier for women who are incarcerated to access consistent and appropriate reproductive health services. 101,103,104,107 Additionally, lack of care continuity is a barrier to accessing contraception, 101 for pregnant women who are incarcerated delivering at local hospitals, 103 and for individuals upon release from incarceration. 101,104 In addition, women in jails may not receive appropriate follow-up care because of short durations in facilities or unknown release dates. 104,107

MILITARY: Inconsistent or fractured care also serves as a barrier for women in the military to access reproductive health services. 112,115,193 For example, one study found that lack of coordination between civilian and military providers made it difficult for women to get the care they needed, to continue receiving adequate reproductive health services, or to access their existing form of contraception once they were deployed. 115

10. Limited language access and lack of culturally and linguistically appropriate services

| Adolescents/ Young Adults 35 | Older adults | Behavioral health | Disability | Gender Identity | Sexual Orientation | Geography 144,145 |
Limited English proficiency, limited access to or lack of interpretation services, lack of translated materials and information in preferred or primary language, and lack of access to culturally-appropriate care and services are barriers to accessing reproductive health services for many populations.\textsuperscript{3,92,93,95-98,144,145,158,165,195} In turn, multiple organizations and researchers state that improving patient access to reproductive healthcare through providers’ use of culturally appropriate care can better meet the needs of individuals and communities.\textsuperscript{149,196}

**IMMIGRATION:** A study with male immigrants in rural communities in the Pacific Northwest found that male interpreters and bilingual providers were not often available, which restricted men’s access to reproductive healthcare, reduced their sense of privacy and confidentiality, and degraded their relationship with and trust of providers.\textsuperscript{144} Another study found that Somali men were excluded from prenatal education classes, rather than provided separate, culturally-appropriate options to learn about and support their partners through prenatal care, labor, and birth.\textsuperscript{96}

**VIOLENCE:** A report from Amnesty International identified lack of training to provide culturally appropriate care for survivors of sexual violence as a barrier to treatment.\textsuperscript{198} Limited language access resources can also act as a barrier to identifying trafficking and IPV victims and providing necessary reproductive health services in a clinical setting.\textsuperscript{134,155,168} For example, traffickers and abusers may accompany patients to health appointments under the guise of language support to ensure victims are unable to communicate accurate reproductive health information to the provider.\textsuperscript{155} Moreover, providers may not be able to identify victims without the assistance of culturally responsive interpreters to gain the patient’s trust.\textsuperscript{155}

### 11. Service availability & provider availability

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<th>Adolescents</th>
<th>Olders adults</th>
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<th>Disability</th>
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<th>Sexual Orientation</th>
<th>Geography</th>
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<tr>
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<td>61,199</td>
<td>1,70,71,74,75,142,20</td>
<td>1,70,71,74,75,142,20</td>
<td>138,155,168</td>
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<th>Homelessness</th>
<th>Immigration</th>
<th>Incarceration</th>
<th>Military/Veterans</th>
<th>Racism</th>
<th>SES</th>
<th>Violence</th>
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<tr>
<td>88</td>
<td>93,96,144,158,195</td>
<td>102-104,211,212</td>
<td>109,112,19364,66111</td>
<td>213</td>
<td>126,151</td>
<td>138,155,168</td>
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Limited service availability,\textsuperscript{54,126,151,184,201-204} provider availability,\textsuperscript{80,83,184,203,205,206} or lack of trained providers\textsuperscript{142,155,168} results in the provision of inadequate and inconsistent reproductive healthcare for multiple populations.\textsuperscript{27,28,35-38,42} These barriers may be exacerbated in rural areas\textsuperscript{138} and Tribal nations\textsuperscript{168} which often have significantly fewer primary care physicians and obstetrics/gynecology specialists and experience high staff turnover.\textsuperscript{168}

As obstetricians and gynecologists receive the highest proportion of their revenue from Medicaid and private insurance carriers, both of which are often linked to Medicare policies and reimbursement
formulas, low reimbursement rates adversely affect practice patterns.\textsuperscript{84,205,207} Provider availability has also been negatively affected by increasing risks of malpractice litigation and rising costs of medical insurance premiums.\textsuperscript{85} Malpractice suits are extremely common. According to a national malpractice survey conducted in 2017 with 4,137 obstetricians and gynecologists, 85\% of respondents had been named in a lawsuit.\textsuperscript{209} After a lawsuit, 4\% of obstetricians and gynecologists reported changing their insurer and 8\% left their practice setting.\textsuperscript{209} There is concern that professional liability challenges have disproportionately impacted access to obstetricians in rural areas.\textsuperscript{208-210}

**ADOLESCENTS:** Pediatricians are the main source or large source of care for adolescents ages 14 years or younger and remain a large source of care for teens older than 14 years who see a provider regularly.\textsuperscript{28} Yet, the quality and comprehensiveness of reproductive services provided varies substantially, with most pediatricians not providing the full range of appropriate services.\textsuperscript{28} Additionally, adolescents seeking emergency contraception from a pharmacy experience barriers to access.\textsuperscript{35,36} These barriers include misinformation (pharmacy personnel giving inaccurate medical information about emergency contraception and misinformation about age requirements), emergency contraception not being readily available, and outright denial of access due to age Washington State law protects access for adolescents.\textsuperscript{35,36}

**BEHAVIORAL HEALTH:** One study noted that “fewer than 20\% of substance use disorder treatment facilities nationally provide specialized care for pregnant or postpartum women, and estimates of unmet need for substance use disorder treatment range from 81\% to 90\% of women,”\textsuperscript{199} suggesting that women have limited access to pregnancy-specific treatment services. Surveys completed with 210 women and men receiving substance use treatment at clinics in Baltimore, Maryland found that 25\% of women surveyed and 33\% of men reported difficulty accessing family planning services in the past three years.\textsuperscript{61}

**GENDER IDENTITY:** A lack of competent providers willing to care for transgender and gender nonconforming patients acts as a barrier.\textsuperscript{142} Key informants shared that individuals who are transgender pursuing gender-affirming surgeries (e.g., chest reconstruction) experience difficulty finding providers in Washington State who accept Apple Health reimbursement rates. Key informants shared that individuals who are transgender have sought providers in neighboring states due to limited availability in-state. According to the Health Care Authority, the availability of trans-competent providers varies by surgical procedure; specifically, there is only one provider in Washington State contracted with Medicaid to conduct full bottom surgeries (Health Care Authority, personal communication, August 2018). Limited provider availability can reduce timely access for procedures (e.g., 3-month to 2-year waitlists).

**GEOGRAPHY:** Survey results from 1,615 administrators of publicly funded U.S. health centers that offered family planning showed that centers serving more rural areas had a lower chance of LARC, including IUDs and implants as compared to those that served more urban areas.\textsuperscript{203} Similarly, a 2010 study found only 25\% of Washington’s male population live within a 60-minute drive of ART centers.\textsuperscript{207} Therefore, the geographical unavailability of male reproductive health specialists may also impede access to care.

Surveys conducted by the Washington Academy of Family Medicine with rural members in 2003-2004 found a decrease in the proportion of family physicians practicing obstetrics (52\% to 44\% over 18 months).\textsuperscript{210} In addition, inequitable distribution of specialty care (e.g., in vitro fertilization [IVF] clinics)
can also limit access within rural communities.\textsuperscript{80,206} \textit{Table 2} shows that there are fewer physicians providing reproductive health services in rural compared to urban areas in Washington State.\textsuperscript{84} Nationally, there is also a significant geographic imbalance in the supply of obstetricians and gynecologists, and the national demand for services is expected to increase by 6\% in the next decade.\textsuperscript{83} Washington, Arizona, Utah, and Idaho are particularly vulnerable to this growing workforce imbalance as they already lack a sufficient supply of obstetricians and gynecologists.\textsuperscript{205} Furthermore, resident graduates tend to move to urban cities and counties,\textsuperscript{83} which offer more specialty care services and larger hospital settings.\textsuperscript{84}

\textbf{Table 2. Number of physicians (by type) per 1000,000 people in urban and rural areas of Washington State}\textsuperscript{84}

<table>
<thead>
<tr>
<th>Physician type</th>
<th>Urban</th>
<th>Rural</th>
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<tbody>
<tr>
<td>Primary care</td>
<td>87.3</td>
<td>57.1</td>
</tr>
<tr>
<td>Family medicine</td>
<td>44.0</td>
<td>39.8</td>
</tr>
<tr>
<td>General Internal medicine</td>
<td>28.3</td>
<td>11.4</td>
</tr>
<tr>
<td>Obstetrics-gynecology</td>
<td>12.8</td>
<td>7.0</td>
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\textbf{HOMELESSNESS:} In-depth interviews with 22 women with children experiencing homelessness in San Francisco, California found that lack of reproductive healthcare and access to contraception on-site at shelters was a barrier to receiving care.\textsuperscript{88}

\textbf{IMMIGRATION:} A report from the National Family Planning and Reproductive Health Association found that provider shortages were a barrier for immigrants to access healthcare in some areas.\textsuperscript{158} A study of female detainees in three immigration detention centers in the U.S. found that some detainees had indirect access to health clinics or that access was restricted by “gatekeepers,” namely security personnel who may or may not have training to assess when a situation is an emergency or warrants medical attention.\textsuperscript{195} The requirement to go through a gatekeeper to seek care may result in retaliation or mistreatment of women seeking care, delays in access to or denial of services, and worsening health conditions.\textsuperscript{195} Additionally, immigrants may not have access to providers that understand their culture, language, or unique health situations.\textsuperscript{93,96,144,158} Work with Somali immigrants in Minnesota found that a lack of providers who understood Somali culture and health needs, especially around female genital cutting, prevented immigrants from seeking care.\textsuperscript{96}

\textbf{INCARCERATION:} A number of nationwide surveys have been conducted with administrators and staff at state correctional facilities to determine how reproductive healthcare is provided to women who are incarcerated. In 2011, ACOG found that 38 states did not have adequate policies requiring prenatal care, 41 states did not require prenatal nutrition counseling or provide appropriate nutrition during pregnancy, and 48 states did not offer HIV testing for pregnant women who were incarcerated.\textsuperscript{102} ACOG also noted that facilities lacked opportunities for health education, preventive care, and women-specific health services.\textsuperscript{104} Similarly, in a 2009 survey of 286 correctional healthcare providers, 71\% of respondents said they asked about contraception at some point during incarceration, and 70\% stated they offered contraception counseling (although 57\% of these counseling sessions were at the request of the patient).\textsuperscript{211} Despite high levels of counseling, only 38\% of respondents reported providing women with contraception, and 55\% of respondents said that women were not allowed to continue a method of contraception they had been using prior to incarceration while they were incarcerated.\textsuperscript{212} The authors found that counseling was significantly associated with type of facility (p=0.001), with “96\% of providers
Literature Review on Inequities in Reproductive Health Access

from juvenile facilities, 82% of respondents from state prisons, and 64% of those from city our county jails" reporting counseling. Lastly, surveys with wardens at 19 state correctional facilities found that many facilities lacked equipment (e.g., fetal monitors), making it difficult for state prisons to provide necessary monitoring for high-risk pregnancies.

**MILITARY/VETERANS:** Studies have shown a lack of military providers trained to provide women’s reproductive health services (e.g., abortion), a lack of female providers, and a lack of women-only healthcare settings available to women in the military and to Veterans. In general, women in the military also have inadequate access to contraception and condoms. However, access to contraception options and supplies are even more inconsistent and limited during deployment. A 2013 survey with 281 women in the military who had been recently deployed found that 33% were unable to access the contraception method of their choice while deployed. ACOG found that, depending on where women are deployed, they may not have access to birth control pills or vaginal rings (due to climatic conditions) as contraceptive options.

The Department of Veterans Affairs’ Barriers to Care survey found that 16% of women who do not use the VA facility closest to them travelled farther because they felt “the women’s services I need are not available.” The unacceptability of integrated care and gender insensitivity were two main barriers to accessing healthcare. They found that 47% of female Veterans reported a preference for care provided in a women-only setting, 57% of female Veterans who had experienced military sexual trauma preferred care in a women-only setting, and 65% of female Veterans preferred a female provider. Despite these high percentages, the Department of Veterans Affairs also found a possible shortage of female providers and women-specific care. In addition, a survey of 281 women in the military who had been recently deployed found that women had limited access to a provider or healthcare overall.

**SES:** A 2011 summary of literature related to abortion access among women of low socioeconomic status found that 87% of counties in the U.S. lacked any facilities that could provide an abortion. Additional state licensing requirements for facilities and/or providers to perform abortions and limited malpractice insurance coverage for providers performing abortion further reduced access to care. These requirements disproportionately impacted provider availability at federally-qualified health centers and other safety net providers, which predominately serve low-income individuals and people of color.

### 12. Limited Services due to Health System Directives

<table>
<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military/Veterans</td>
<td>Racism</td>
<td>SES</td>
<td>Violence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>101,103,107,211</td>
<td>110-115,193</td>
<td></td>
<td>24</td>
<td>214-217</td>
</tr>
</tbody>
</table>

Health system directives that prohibit or limit the provision of reproductive health services (e.g., refusal to dispense contraception or perform abortion) serve as barriers to patients accessing the full range of services. Directives that limit reproductive options include religious directives, military culture and protocols, and correctional facility policies. For example, The Ethical
and Religious Directives for Catholic Health Care Services govern clinicians in Catholic facilities and prevent staff from providing common reproductive services related to contraception sterilization, abortion, and other assistive reproductive treatments. ACOG stated that contentious refusals or objections to provide requested services have the potential to impose religious or moral beliefs on a patient who may not share these beliefs and may disproportionately impact individuals who already experience limited access to resources.

**GEOGRAPHY:** In Washington State, the number of Catholic hospitals has increased in response to mergers with non-Catholic hospitals, and data reveal that 40% of hospital beds in the state are in Catholic hospitals. The rapid expansion of Catholic-affiliated hospitals in Washington may limit access to some family planning services such as abortion, tubal ligation, sterilization, and fertility treatments. Some regions, particularly in rural areas, lack non-religiously affiliated healthcare alternatives. For example, San Juan County has contracted with Peace Health to provide health services. As such, the hospital is limited in its ability to provide abortion-specific information and services. This adds an additional barrier to accessing the full range of reproductive health services for residents who already face obstacles to care (e.g., transportation costs of traveling on and off the island for care).

**INCARCERATION:** Correctional health systems often prioritize security over health (e.g., shackling during pregnancy), limit time that women who are incarcerated have in medical appointments, and limit the ability for individuals to take health protective actions (e.g., not permitting nutrition, work schedule, sleeping changes, or other accommodations during pregnancy). In addition, some facilities have policies that systematically delay necessary care. For example, some facilities require women to pay out-of-pocket and up-front for costs associated with medical care, transportation, or staff time to accompany them to medical appointments. Other facilities require women to obtain a court order from a judge to authorize release for treatment in community settings (e.g., specialist or abortion care).

**MILITARY/VETERANS:** Military culture effectively restricts women’s contraceptive and pregnancy choices through military abortion laws and decisions, lack of counseling or denial of preferred contraception, reporting through the chain of command, criminalization of sexual activity, and experience of military sexual trauma. The Department of Veterans Affairs notes that, for women who have experienced military sexual trauma, “given the historically male-dominated culture and patient base in VA facilities, women who already had misgivings about seeking care may be even more hesitant when faced with barriers of both mental health stigma and gender sensitivity issues.”

13. Service/procedure requirements, or medically-unnecessary practices or procedures

<table>
<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military</td>
<td>Racism</td>
<td>SES</td>
<td>Trafficking</td>
</tr>
<tr>
<td>26,30</td>
<td>88</td>
<td>195</td>
<td>107</td>
<td>77,142,219,220162</td>
<td>20,124,126,128</td>
<td>167</td>
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<tr>
<td>214</td>
<td>ACOG stated</td>
<td>214</td>
<td>218</td>
<td>217</td>
<td>216</td>
<td></td>
</tr>
</tbody>
</table>
Medically-unnecessary practices or procedures like mandating wait times to receive an abortion, requiring multiple appointments to start contraception or have an IUD placed, and limiting the number of refills reduced access to services.\(^{26,30,88,126,128,167}\) ACOG also found that practices such as requiring a pelvic exam, counseling, or testing for sexually transmitted infections prior to prescribing a contraceptive or placing long-acting reversible contraception create unnecessary barriers to care.\(^{124}\) Use of such medically unnecessary practices may require patients to overcome other economic, structural, and social barriers to access services.\(^{20,128}\) This may result in patients either delaying or foregoing care altogether.

**GENDER IDENTITY:** Many providers lack the necessary knowledge to provide appropriate care to their LGBTQIA patients, which can result in patients undergoing medically unnecessary practices or procedures (e.g., physicals, testing) or forced care.\(^{69,142}\) Not only can unnecessary procedures waste patients’ time and money, key informants shared that unnecessary exams of transgender patients are often motivated by a provider’s curiosity. For example, “unnecessary genital checks or breast exams or detailed questions about genitalia can cross the line into sexual harassment, especially when there is not warning or a request for consent beforehand” (Tobi Hill-Meyer, Health Equity Director, Gay City, personal communication, August 2018).

In a qualitative study, transgender and gender nonconforming participants shared that “requirements of speaking to and getting letters from a psychologist and psychiatrist were unreasonable and unnecessary”\(^{142}\) Similarly, transgender and gender nonconforming individuals perceived requirements of a diagnosis (e.g., Gender Identity Dysphoria) to access care as an unnecessary barrier.\(^{142}\)

Transgender and gender nonconforming individuals often face barriers in the form of procedure guidelines and requirements. For example, the World Professional Association for Transgender Health (WPATH) suggests in its Standards of Care (SOC) that patients obtain one referral from a mental health professional for hormone therapy and top surgery and an additional referral letter for bottom surgery from a clinician with at least a master’s degree or its equivalent in a clinical behavioral science field from an accredited institution.\(^{77,142}\) Evidence indicates that mental health providers may act as “gatekeepers” by not providing referral letters without transgender people participating in extensive psychotherapy (e.g., 12 or more months).\(^{142,219}\) WPATH maintains standards to ensure referring clinicians are capable of distinguishing between co-existing mental health issues and gender dysphoria.\(^{77}\) However, key informants shared that these recommendations are often used as requirements and present a significant barrier for transgender individuals in areas with limited access to trans-competent providers. Similarly, transgender and gender nonconforming individuals perceived requirements of a diagnosis (e.g. Gender Dysphoria) to access care as an unnecessary barrier.\(^{142}\)

WPATH also recommends clinicians evaluate readiness using real life experience, or “a continuous period of living full-time as the gender which one identifies.”\(^{97}\) However, there is a lack of evidence demonstrating an association between postsurgical outcomes and mastery of any particular aspect of real life experience.\(^{77}\) "Despite [the SOC] being set up as flexible guidelines, many providers or insurers use them as absolute requirements and will deny coverage if not established to the letter” (Tobi Hill-Meyer, Health Equity Director, Gay City, personal communication, August 2018). Key informants also shared that real life experience requirements often put transgender individuals who may not “pass” as cisgender at greater risk of experiencing violence at the hands of transphobic people.
The Informed Consent for Access to Trans Health (ICATH or “Informed Consent Model”) presents an alternative approach to providing care for transgender people. The Informed Consent Model removes psychotherapy/gatekeeping requirements.\(^{219}\) Instead, transgender patients decide whether they are ready for gender confirming care. In this model, the health practitioner's role is to “present transgender patients with information about risks, side effects, benefits, and possible consequences for undergoing gender confirming care, and obtain informed consent from the patient.”\(^{219}\) Therapy is considered an option rather than a requirement or prerequisite to trans healthcare.\(^{219}\) A community health center in Boston, Massachusetts, implemented a modified informed consent model that removed unnecessary barriers to hormone therapy, including restrictions specific to "real life tests."\(^{220}\) "Between 2007, when the Informed Consent Model was implemented, and the time of the data analysis in 2013, the number of active clients increased from less than 200 to over 1,000."\(^{219}\)

### 14. Parental consent and age requirements, policy implementation, and denial of services

<table>
<thead>
<tr>
<th>Adolescents</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
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<tbody>
<tr>
<td>28,29,36,44,46,49</td>
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<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military</td>
<td>Racism</td>
<td>SES</td>
<td>Violence</td>
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Washington State law allows, without parental consent or notification, contraceptive and abortion services to minors at any age (RCW 9.02.100) and STI testing and treatment to those aged 14 or over (RCW 70.24.110). However, 29% of Washington middle and high schools require parental consent for sexual and reproductive health services from the school nurse or clinic, and 29% for referrals.\(^{29}\) In a review of 49 studies of pharmacies (\(n\) = 23 in the US), incorrect denial of access occurred up to 65% of the time in some cases.\(^{35}\) Key informants in Washington highlighted anecdotal examples of front desk staff and pharmacists refusing adolescents access to reproductive health services (e.g., appointments and contraceptives).

### 15. Assumed heteronormativity and cisnormativity

<table>
<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
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<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
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<td>Racism</td>
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<td>Violence</td>
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Heteronormativity is defined as a set of societal norms, practices, and institutions that promote binary alignment of biological sex, gender identity, and gender roles; assume heterosexuality as a fundamental and natural norm; and privilege monogamous, committed relationships and reproductive sex above all other sexual practices.\(^{139}\) Assumed heteronormativity acts as a barrier to individuals accessing necessary sexual healthcare as it contributes to an unwelcoming environment for LGBTQIA people.\(^{72,74,75,142}\) Additionally, cisnormative practices, which assume an individual's gender identity matches their sex assigned at birth, create additional barriers for transgender and non-binary people.\(^{72,75}\)
SEXUAL ORIENTATION: Participants in a study conducted in Melbourne, Australia, identified physician discomfort and stigmatizing language or assumptions about a patient's sexual experiences as common barriers to developing rapport and receiving appropriate care. As this study was less generalizable to Washington's population and our review did not return U.S. specific research, Council staff vetted heteronormativity as a barrier to reproductive healthcare with organizations that serve gender and sexually diverse populations in Washington State. All agreed that heteronormativity serves as a structural barrier to care within the state, due to the institutionalized nature of practices. Further evidence suggest that heteronormativity can prevent individuals from disclosing their sexual orientation or gender identity to their provider, which can detrimentally affects an individual's access to appropriate testing and treatment.

GENDER IDENTITY: Transgender and gender non-conforming individuals face an additional barrier when confronted with cisnormative practices, when front office staff or providers assume an individual’s gender identity matches their sex assigned at birth. A systematic review identified the absence of gender neutral clinical practices as a barrier to accessing healthcare services.

16. Forms and procedures

<table>
<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
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<tbody>
<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military</td>
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<td>Racism</td>
<td>SES</td>
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Structural heteronormativity also facilitates written miscommunication, resulting in patients experiencing difficulty completing forms to accurately communicate sex, gender, and relevant sexual behaviors with their provider. Specifically, the common choice between ‘male’ and ‘female’ can prevent appropriate care for transgender and non-binary people. Participants in one study identified challenges in regards to reporting “gender and sex – including having no options that describe them, not knowing how to ‘best’ respond to questions, and trying to balance providing accurate information with information that actually describes their experiences.” Stakeholder organizations confirmed that completing forms is a barrier to care in many healthcare settings in Washington State.

The Gender Identity in U.S. Surveillance (GenIUSS) group, a multi-disciplinary and multi-institutional collaborative, works to advance the development of sex and gender-related measures. GenIUSS recommends including measures of self-reported assigned sex at birth and current gender identity to adult surveys. GenIUSS states, “testing shows that the ‘two step’ approach appears the most likely to have high sensitivity, as well as high specificity, with adults.” The Two-Step approach (see Table 3) may prevent unnecessary denials of care and improve medical and insurance interactions for sexual and gender diverse clients.

Table 3. The Two-Step Approach for asking about sex-assigned at birth and gender identity
17. Medically-accurate, culturally appropriate, comprehensive sexual health education and policy implementation

Nationally the receipt of formal sexual health education in schools has been steadily declining for at least a decade, with the largest effects seen in non-metropolitan areas both nationally and in Washington State.\(^{41}\) The prevalence and quality of sexual health education varies.\(^{26,29,37,41,222}\) Although Washington State requires any sexual health education in public schools to be medically-accurate and comprehensive, the reality of its implementation is varied.\(^{29}\) There is also need for sexual health education outside of formal school settings to reach other populations demonstrating a need for sexual health information (e.g., older adults).\(^{58-60}\)

**ADOLESCENTS:** Receipt of sexual education decreases later in high school when teens are more sexually active.\(^{29}\) In Washington, just 19\% of middle schools and 54\% of high schools taught all 16 of the critical sexual health education topics laid out by the CDC.\(^{29}\) Additionally, 7\% of schools report using curricula that do not meet the state requirements, and only 53\% of schools had a curriculum consistent with 2005 DOH-OSPI guidelines.\(^{29}\) Just 20\% of schools in Washington reported teaching 10 or more hours of sex health instruction and 20\% reported either less than one hour or none at all.\(^{29}\) A lack of resources for teachers is an issue, and only 55\% of schools gave teachers all the materials they needed to teach sex education.\(^{29}\) Less than half of all teachers received professional development on topics related to sex education and 60\% wanted more professional development in all areas of sex education.\(^{29}\)

**OLDER ADULTS:** Although sex education efforts rarely focus on older adults,\(^{57}\) this population demonstrates a need for sexual health information.\(^{58-60}\) Evidence indicates that a lack of understanding about mammography screening procedures among women over age 65 has a larger negative impact on use than it does for younger women.\(^{50}\) Additionally, some older adults believe they do not need certain sexual health services,\(^{52}\) while others lack knowledge about appropriate and available services.\(^{58}\) For example, most adults 65 years and older never received formal education regarding HIV/AIDS when they
were younger as they were well into adulthood when HIV/AIDS was identified in humans and when the virus and its transmission became understood. 59

**DISABILITY:** A general lack of knowledge about the intersection of disability and sexuality among the healthcare community 223 as well as a lack of evidence and consensus on effective methods of sex education for adults with intellectual disabilities (ID) 224 has resulted in gaps in appropriate sexual health education for adults with disabilities. 224 In a review of studies, adults with intellectual disabilities were found to be more likely to lack information about sex than those without intellectual disabilities, despite expressing a desire for such information. 224 The authors pointed to a lack of access to the same kinds of formal education (e.g., through high school sexual health education) compared to those without intellectual disabilities. 65,224 Positive information about sex and training on sexuality is also lacking for caregivers of adults with intellectual disabilities. 224

**VIOLENCE:** Lack of comprehensive sexual health education that addresses healthy relationships (e.g., negotiating reproductive decision-making, identifying coercive behaviors), the full range of contraceptive options, and harm reduction strategies serves as a barrier to individuals experiencing or at risk of experiencing IPV134,137,225 and trafficking. 155 In particular, adolescents may not recognize controlling behaviors in romantic relationships as abusive or coercive. 137

### 18. Clinic environment and conditions

<table>
<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability 131,141,160,161,223</th>
<th>Gender Identity 74</th>
<th>Sexual Orientation 74</th>
<th>Geography</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelessness</td>
<td>Immigration 96,144,165</td>
<td>Incarceration</td>
<td>Veterans 109</td>
<td>Racism 168</td>
<td>SES 127,130,226</td>
<td></td>
</tr>
</tbody>
</table>

Clinic environment and conditions can either positively or negatively influence patient access to reproductive health services. Factors that impact access include hours of operation (e.g., limited or extended), 96,109,144,168 wait times, 144,165 delays in getting appointments, 165,168 and other environmental conditions (e.g., welcoming, safe, clean, etc.). 109

**DISABILITY:** Although the Americans with Disability Act passed in 1990, lack of accessibility of clinics 65,131,161,223 and medical equipment 141,160,161,223 continue to pose significant barriers for people with disabilities, especially those with visual and physical impairments. 160 This includes difficulty navigating clinic parking lots 160 and buildings, 160 transferring to and from examination tables, 161 and difficulty standing to use standard mammography equipment. 141,161

### 19. Lack of formal provider training or medical education

<table>
<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health 63</th>
<th>Disability 161,223,224</th>
<th>Gender Identity 170,71,74,75,142,200</th>
<th>Sexual Orientation 170,74,75,142,200</th>
<th>Geography 203</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelessness</td>
<td>Immigration 94,96,97,165</td>
<td>Incarceration 107,211</td>
<td>Military/Veterans</td>
<td>Racism</td>
<td>SES</td>
<td>Violence 155,225</td>
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</tbody>
</table>
It is well-documented that providers lack knowledge in providing culturally-appropriate, trauma-informed, patient-centered care for some populations, especially those with specific or unique healthcare needs (e.g., individuals with disabilities, transgender individuals, immigrants).

In addition, ACOG found that, in general, providers lack knowledge about the risks and benefits of contraceptives, which impacts their ability to counsel patients.

**GENDER IDENTITY/SEXUAL ORIENTATION:** Multiple articles discuss providers’ lack of necessary knowledge to provide appropriate care as a significant barrier to care for gender and sexually diverse people. In part, this is due to the lack of training provided in medical school and public health school curricula regarding LGBTQ health issues. A 2009-2010 survey of 132 medical schools (U.S. and Canada) found the median reported time dedicated to teaching LGBT-related content in the entire medical school curriculum was 5 hours. Furthermore, 9 schools (6.8%; 95% CI, 2.5%-11.1%) reported 0 hours during preclinical years, and 44 schools (33.3%; 95% CI, 25.3%-41.4%) reported 0 hours during clinical years. Researchers concluded that “the median reported time dedicated to LGBT-related topics in 2009-2010 was small across [U.S.] and Canadian medical schools, but the quantity, content covered, and perceived quality of instruction varied substantially.”

For example, medical schools also were asked to report the presence or absence of 16 LGBT-related topics either required or provided within the elective curriculum: sexual orientation, HIV, gender identity, STIs, safer sex, disorders of sex development/Intersex, barriers to care, mental health issues, LGBT adolescents, coming out, unhealthy relationships/IPV, substance use, chronic disease risk, sex reassignment surgery, body image, and transitioning. Of the 132 institutions that completed the questionnaire, 62.9% reported teaching at least half the 16 topics and only 8.3% reported teaching all 16. Key informants also noted that in many cases “LGBT related content” does not include transgender health topics. A subsequent analysis of medical education cites evidence that there remains a gap between information taught in health professional schools and postgraduate training programs and the needs of transgender individuals related to fertility and pregnancy.

**IMMIGRATION:** Providers often lack training around immigration laws, immigrant communities, the specific health needs of immigrants, and how to provide culturally sensitive and trauma-informed care. In addition, immigrants have noted that lack of provider training and medical knowledge around female genital cutting and circumcision is a barrier to seeking care. Studies with Somali immigrants in the U.S. have found that women who have experienced female circumcision often receive improper care and treatment, especially during labor, delivery, and post-partum, from providers that are unfamiliar and lack training in female genital cutting. Somali immigrants have expressed a desire for providers to understand the cultural reasons behind female genital cutting, as well as training in how to care for women who have experienced female genital cutting.

**MILITARY/VETERANS:** Studies noted that military providers lack training in women’s health and reproductive health services (e.g., abortion) and that non-military providers lack understanding about reproductive health risks associated with military service, understanding about the difficulty in hygienically managing menstruation during deployment, and knowledge about contraceptive availability during deployment.
Specific to male Veterans, one study found that military providers lack training on infertility evaluation and treatment and on potential occupational exposures resulting in infertility.\textsuperscript{116} For example, data from male Veterans seeking infertility treatment within the South Florida Veterans Affairs healthcare system found that a number of men with abnormal semen analysis were not referred for infertility diagnosis, and that a number of men diagnosed with infertility did not undergo semen analysis.\textsuperscript{116}

\textbf{VIOLENCE:} Results from two U.S. based studies and one Canadian study indicate that the majority of clinical providers did not feel confident in their ability to identify and assist victims or survivors of domestic sex trafficking.\textsuperscript{155} Evidence suggests that educational interventions can successfully increase knowledge and confidence in identifying and treating victims, yet further research is necessary to identify evidence-based effective training models.\textsuperscript{155} Additionally, a review of IPV literature found a need to increase providers’ understanding and awareness of reproductive coercion to help identify at-risk individuals.\textsuperscript{225}

\section*{20. State and federal legal rulings or legislation}

\begin{table}[h]
\begin{tabular}{|c|c|c|c|c|c|c|}
\hline
\textbf{Adolescents} & Older adults & Behavioral health & Disability & Gender Identity & Sexual Orientation & Geography \\
\hline
Homelessness & Immigration & 3,14,93,98,99,145,15 & 8,22737 & & & \\
RACISM & SES & 14,24,98,100,124,126 & 130,131,231,232 & & & \\
Trafficking & & 155,167,233,234 & & & & \\
\hline
\end{tabular}
\end{table}

Federal and state legal rulings or legislation can either positively or negatively impact access to reproductive healthcare. Legislation may impact cost of care, and have economic consequences, which may be especially burdensome for low-income individuals.\textsuperscript{14,130,131} Some federal and legislation limits access to contraception,\textsuperscript{124} abortion service,\textsuperscript{98,126} and ART\textsuperscript{24,100} for all populations.

Federally, the only funding for family planning in the U.S. is through Title X of the Public Health Service Act of 1970.\textsuperscript{14} It provides funding and family planning services through safety net providers, including federally qualified health centers, community health centers, and other community organizations.\textsuperscript{14,98} Title X funding often fill the gaps by providing care regardless of insurance status, immigration status, or ability to pay.\textsuperscript{14}

The federal Hyde Amendment restricts access to abortion and prohibits the use of federal funding to cover abortion services and care in the U.S.\textsuperscript{98} The ACA excluded abortion from public insurance coverage and restricted coverage through private insurance offered on the Health Exchanges.\textsuperscript{126} While Washington State must adhere to the Hyde Amendment, state law stipulates that “the state may not deny or interfere with a women’s right to choose to have an abortion prior to viability of the fetus, or to protect her life or health” and requires any health program receiving state funding (partial or full) to provide benefits, services, and information related to both maternity care and abortion services.\textsuperscript{231} In addition, the 2018 Reproductive Health Parity Act (SSB 6219) mandated that health insurance plans that provide coverage for maternity care services must provide equivalent coverage for abortion services beginning in January 2019.\textsuperscript{232}
Lastly, infertility treatment was also excluded from public insurance coverage through the ACA, and many county, state, and federal health programs do not cover basic infertility services, which are often cost prohibitive.24,100

**ADOLESCENTS:** Evidence indicates that local, state, and federal policies may limit the discussion of sexual health and risk of sexual exploitation in school-based programs, thereby acting as a barrier to safety and healthy relationship education for youth and adolescents.155 Washington’s Healthy Youth Act (RCW 28A.300.475) stipulates that if sexual health education is provided it must be medically-accurate. However, the provision of comprehensive, medically-accurate sexual health education is currently not required. For schools that provide sexual health education, the Office of Superintendent of Public Instruction (OSPI) rules (WAC 392-410-140) define sexual health education as including “the development of meaningful relationships and avoidance of exploitative relationships.” K-12 Health Education Standards provide age-appropriate grade-level learning outcomes that include developing students’ understanding of healthy relationships.235 However, a 2016 OSPI report found 7% of schools report using curricula that do not meet the state requirements, and only 53% of schools had a curriculum consistent with the 2005 DOH-OSPI guidelines.29

**IMMIGRATION:** Federal and state legislation restricts immigrant access to health insurance coverage and care, regardless of immigration status.3,14,93,98,99,145,158 The Personal Responsibility and Work Opportunity Act of 1996 restricted legal immigrants’ access to federally-funded health insurance for the first five years they have lawful status in the U.S. (known as the five-year bar).98,99,165 However, the Act specified that Medicaid would provide emergency coverage, including costs related to labor and delivery, regardless of immigration status.99 In 2002 and 2013, the federal government issued exceptions to the Act that allowed states to waive the five-year bar and provide Medicaid and Children’s Health Insurance Program (CHIP) coverage to immigrant pregnant women and children.99 While the ACA and corresponding Medicaid expansion increased health insurance access for many communities and enabled lawful immigrants to purchase and receive subsidies for private health insurance through the Health Exchanges, it continued to exclude some immigrants from receiving Medicaid for five years and made individuals who are undocumented and DACA recipients ineligible for public coverage or private insurance through the marketplace.3,98,99,165 Since coverage for individuals who are undocumented and DACA recipients is excluded from the ACA, safety net providers may face funding and reimbursement challenges through the ACA, which could result in further reduction in coverage and care for individuals who are undocumented.145

Washington State Health Care Authority defines four citizenship and immigration status groups for the purpose of health insurance coverage eligibility. In Washington State, the four eligibility groups include “Lawfully Present ‘Qualified Alien,’ Lawfully Present ‘Unqualified Alien,’ Not Lawfully Present (Undocumented) Immigrant, and Citizen or U.S. National.”227 Currently, Washington State offers Medicaid coverage to lawfully residing children and pregnant women without the 5-year wait period, and to all pregnant women regardless of their immigration status.99 Pregnant women who are undocumented can receive a waiver from the state to receive Medicaid coverage during their pregnancy and two months postpartum.227 They can also continue to receive family planning services only for one year after giving birth.227 Despite these options, individuals who are undocumented, especially adults who are undocumented, have the most restricted access to healthcare coverage in Washington State.227
**INCARCERATION:** While most state and federal prisons provide some level of healthcare, there are no national, mandated standards of care for women or adolescent girls who are incarcerated. Multiple national organizations provide recommended standards of care for women and adolescent girls in the justice system. However, non-mandatory national standards have created varying healthcare practices by states and facilities. Surveys with wardens at 19 state correctional facilities found that most facilities do not follow recommended standards of care for pregnant women who are incarcerated, and that women receive substandard care during pregnancy. Prior studies also found that as many as 70% of facilities do not have a formal policy on contraception and 30% lack a written abortion policy.

In Washington State, the Department of Corrections (DOC) provides healthcare to incarcerated individuals in state facilities. The Offender Health Plan (OHP) outlines services that are considered medically necessary, but does not guarantee these services to incarcerated individuals. The OHP states that DOC will provide "medically necessary maternity services" including pregnancy tests, prenatal care, delivery, postpartum care, care for complications, physician services, hospital services related to labor and delivery, and abortion. Other medically necessary care related to reproductive health includes treatment of hepatitis C, contraception (may be started 60 days prior to release or for scheduled extended family visits), opioid treatment during pregnancy, perinatal care, prenatal care, preventive care indicated by the U.S. Preventive Services Task Force (grade A and B only), abortion, and tubal ligation (at time of cesarean section if requested by patient in writing). Under some circumstances, services that may also be considered medically necessary include fistula, mammography, gender dysphoria, and additional ultrasounds in pregnancy. Prohibited services include artificial insemination or in vitro fertilization, circumcision (for non-medical reasons), erectile dysfunction, treatment of uncomplicated genital warts, infertility treatment, and reproductive sterilization or reversal (except tubal ligation following cesarean section).

In addition, the ACA and state Medicaid expansion created additional opportunities for incarcerated individuals to obtain health insurance upon release. Washington State enacted a law in 2017 that required Health Care Authority to suspend (rather than terminate) Medicaid coverage for incarcerated individuals. While suspended, incarcerated individuals are still covered for inpatient hospitalizations longer than 24 hours, and full coverage is automatically reinstated upon release. If individuals do not have insurance, they are enrolled in Medicaid prior to release, and Health Care Authority is required to expedite enrollment so that individuals who are incarcerated have insurance the date they are released.

Lastly, while many states still allow pregnant women to be shackled throughout their pregnancy and during labor and delivery, Washington State law has prohibited the use of restraints on pregnant women who are incarcerated since 2010 except under “extraordinary circumstances.” Washington State law stipulates that no restraints of any kind may be used during labor or delivery, and that no correctional personnel shall be present in the room during labor or delivery unless requested by medical personnel. Washington State law also requires that correctional officers immediately remove all restraints if requested by medical personnel to provide care.

**MILITARY:** While rates of unintended pregnancy and experiences of sexual violence are higher among women in the military compared to the general population, military abortion laws are more
restrictive than U.S. federal abortion laws, creating disparate access to abortion for women in the military. Until 2013, “abortion services [could] only be provided at Department of Defense facilities in cases of rape, incest, and life endangerment, and [could] only be paid for with DOD funds in cases of life endangerment.” Between 1996 and 2004, approximately 3.8 abortions were performed per year at military facilities. In 2013, the Shaheen Amendment expanded TRICARE coverage for abortions in cases of rape and incest, in addition to covering abortions for life-endangering situations. However, military providers are allowed to refuse to provide abortion services on moral or religious grounds in all circumstances, though they have an obligation to refer women to a provider who can perform an abortion.

The military also has a policy of following laws of host nations and U.S. state restrictions. This places further restrictions for women seeking an abortion if they are stationed in a country that prohibits abortions, or in states with restrictive abortion policies (e.g., appointment structures requiring additional travel and costs).

RACISM: Complicated criminal justice jurisdictional issues (i.e., federal, local, and tribal) specific to tribal lands present unique barriers to AI/AN women who have been sexually assaulted from seeking assistance from criminal justice authorities and healthcare providers. While criminal justice responses to the sexual exploitation and violence perpetrated by non-tribal members on tribal lands is beyond the scope of this literature review, it is important to recognize that failure to address these crimes adversely affects the reproductive, mental, and physical health of AI/AN women and girls.

TRAFFICKING: Federal and state regulations that allow the prosecution of trafficked individuals for other crimes related to their exploitation (e.g., substance use) deter individuals from accessing healthcare services, including reproductive care. See Fear of Criminal Justice Involvement.

21. Insurance coverage (services, reimbursement, and gaps in coverage)

<table>
<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
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</thead>
<tbody>
<tr>
<td>36,49</td>
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<td></td>
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<td>1,142,143,164,238</td>
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<td></td>
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<tr>
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<td>Immigration</td>
<td>Incarceration</td>
<td>Military</td>
<td>Racism</td>
<td>SES</td>
<td>Violence</td>
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<tr>
<td>100,158</td>
<td></td>
<td></td>
<td>115</td>
<td></td>
<td>14,24,98,100,124,126,130,131</td>
<td>198</td>
</tr>
</tbody>
</table>

Having health insurance coverage does not guarantee access to quality reproductive healthcare. Limitations in insurance coverage and insurance requirements may impact cost of care, complicating the process of finding a provider due to a limited number of providers accepting a specific insurance plan, or require a patient to see a primary care provider in order to be referred to a specialist. People may also experience gaps in their coverage in the form of prohibitively high deductibles, service exclusions, or other practices that limit access to services. In addition, low reimbursement rates and complex reimbursement processes may also make it difficult for providers to offer services. Lastly, insurance may not cover all reproductive healthcare services, including contraception, abortion, and ART. A literature review summarizing access to infertility care noted that patients’ access to reproductive health services not covered by any federal and state insurance can be especially limiting.
GENDER IDENTITY/SEXUAL ORIENTATION: In addition to being less likely to have insurance than heterosexual, cisgender people, LGBT individuals often experience gaps in insurance coverage. This experience is most pronounced for transgender people. Insurance was the second most commonly cited barrier to care in a study of transgender and gender nonconforming individuals surveyed. Insurance limitations described by respondents included having a limited number of providers, containing transgender specific exclusions, and limiting the total expenditures on transgender-related healthcare to amounts below the cost of procedures. For example, evidence shows that administering gonadotropin-releasing hormone (GnRH) analogues, commonly referred to as puberty blockers, causes the body to stop releasing puberty hormones, thereby pausing breast, testicle, and penis development. Despite the growing body of literature that shows puberty blockers help ameliorate mental health challenges faced by transgender adolescents, a retrospective review of medical records found only 29.6% of transgender adolescent patients prescribed puberty blockers received insurance coverage.

In 2015, “29% of [transgender] respondents [living in Washington State] experienced a problem in the past year with their insurance related to being transgender.” Individuals reported being denied coverage for care related to gender transition or for routine care because they were transgender. Key informants shared that even when transgender individuals find gender-affirming providers, gaps in coverage or insurance denials can prevent individuals from accessing medically necessary services or result in costly out-of-pocket expenditures.

22. Explanation of benefits (EOB) and electronic health records

<table>
<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
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<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
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<td>Racism</td>
<td>SES</td>
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<td>33</td>
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</tbody>
</table>

Detailed EOBs sent to the primary insurance policyholder (e.g., spouse, parent, guardian) for reproductive services pose unique barriers for adolescents/young adults and individuals experiencing IPV. For example, healthcare professionals have expressed concerns about unintentionally exposing sensitive healthcare information about services received by a patient to their family members through parental viewing of a minor’s electronic health record or receipt of EOB sent to the primary insurance policyholder for services sought by an adult dependent.

While Washington State law allows patients the ability to suppress an EOB upon request for sensitive services, few patients use it due to lack of awareness of this service. Additionally, the requirement that patients initiate the EOB suppression process by contacting their insurance company poses a unique burden for individuals, particularly minors and those experiencing abusive, coercive relationships.

23. Difficulty navigating insurance system

| Adolescents/Young Adults | Older adults | Behavioral health | Disability | Gender Identity | Sexual Orientation | Geography |
|--------------------------|--------------|-------------------|------------|-----------------|-------------------|-----------|----------|
| Compliance              | 56,59        |                   | 162,239    |                 |                   |           |          |
Literature Review on Inequities in Reproductive Health Access

<table>
<thead>
<tr>
<th>26,35</th>
<th>63</th>
<th>SES</th>
<th>Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military</td>
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Various populations have difficulty navigating complex administrative procedures, registration systems, and paperwork to apply for and receive health insurance coverage. Women surveyed as part of Washington State’s TAKE CHARGE program also reported difficulty navigating and getting information about health insurance options through Washington Health Benefit Exchange.

24. Difficulty in obtaining medically-accurate information about services

<table>
<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
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<tbody>
<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military</td>
<td>Racism</td>
<td>SES</td>
<td>Violence</td>
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</tbody>
</table>

Lack of medically-accurate information regarding reproductive health services is a barrier to care.

MILITARY: A survey of women in the military who were recently deployed found that women had limited knowledge of and difficulty obtaining accurate information about what contraception was covered. For example, because sex is perceived to be “illegal” under the Uniform Code of Military Justice many women assumed that contraception was unavailable and only learned about contraception availability from other women in the military. In addition, in-depth interviews with 21 women in the military who had an abortion during active duty service, found that only half knew about the military’s abortion policy and only two knew that abortion was covered in cases of rape.

25. Personal identification (ID) document requirements

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<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
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<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
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<tbody>
<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military</td>
<td>Racism</td>
<td>SES</td>
<td>Violence</td>
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</table>

Many studies noted that the requirement to present personal identification and documentation to receive healthcare serves as a barrier to immigrants, regardless of status, and trafficked individuals seeking and accessing care. This requirement is especially restrictive for DACA recipients and individuals who are undocumented, and trafficked individuals whose personal identification documents may be held by the trafficker.

26. Lack of data

| Adolescents/Young Adults | Older adults | Behavioral health | Disability | Gender Identity | Sexual Orientation | Geography |


Researchers have noted the lack of research and data gaps related to the reproductive health of immigrants and refugees,\(^{92}\) active duty women in the military and female Veterans,\(^{112,113,241}\) and victims and survivors of violence.\(^{21,167}\) Key informants in Washington State confirmed that state-level data is also limited for refugees and trafficked individuals.

### SOCIAL BARRIERS

#### 27. Intimate partner violence

<table>
<thead>
<tr>
<th>Adolescents/ Young Adults</th>
<th>Older adults</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
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</thead>
<tbody>
<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military/ Veterans</td>
<td>Racism</td>
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</table>

IPV is any type of physical, sexual, or psychological harm done by a current or former partner or spouse (both heterosexual and same-sex); it also includes stalking, and loss of reproductive control (such as refusal to use a condom).\(^{133}\) IPV includes abusive behavior also referred to as domestic violence.\(^{133}\) Intimate partner behaviors that prevent individuals from accessing health services (e.g., limiting access to transportation or finances, physical violence, reproductive coercion) interfere with the individual’s ability to prevent, screen, and address IPV and adequately fulfill sexual and reproductive health needs.\(^{134-138}\) Evidence of the association between partner violence and unintended pregnancy suggests that providers need to consider the occurrence of reproductive coercion when counseling women regarding pregnancy prevention options (e.g., form of contraception).\(^{137}\)

**GENDER IDENTITY:** According to 2015 U.S. Transgender Survey data, 54% of respondents experienced some form of IPV, and nearly one-quarter (24%) reported severe physical violence by an intimate partner, compared to 18% in the general U.S. population.\(^{79}\) Seventy-seven percent of those who did income-based sex work experienced IPV.\(^{79}\) Additionally, data indicate that transgender respondents who are undocumented (68%) were more likely to experience violence than other respondents.\(^{79}\) Survivors of IPV face numerous unique barriers when accessing care (e.g., abusers controlling access to finances, transportation, and healthcare).

**BEHAVIORAL HEALTH:** Women with substance use disorders are more likely to experience sexual and physical violence from intimate partners, acquaintances, and strangers.\(^{62,63}\) In addition, one in three women who inject drugs are involved in sex work and are at an increased risk of experiencing violence from clients and law enforcement.\(^{62}\) Women who inject drugs are also more likely to be injected by others, including male sex partners.\(^{62}\) One study noted, “violence, or the threat of violence...undermine women’s ability to practice safe sex and safer drug use with intimate partners and during sex work.”\(^{62}\)
28. Reproductive and Pregnancy Coercion

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<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
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<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military</td>
<td>Racism</td>
<td>SES</td>
<td>Violence</td>
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Reproductive coercion is defined as attempts to promote pregnancy through verbal pressure and threats to become pregnant (pregnancy coercion), direct interference with contraception (birth-control sabotage), and threats and coercion related to pregnancy continuation or termination (control of pregnancy outcomes). Evidence indicates that reproductive coercion can affect people of any age, race/ethnicity, sexual orientation, or sociodemographic group. For example, a cross-sectional survey of English- and Spanish-speaking females ages 16 to 29 years seeking services in five family planning clinics in Northern California (N=1,278) found 19% reported experiencing pregnancy coercion and 15% reported birth control sabotage. Of those, 35% also reported experiencing reproductive coercion. While the predominant form of reproductive coercion involves a male partner's dominance over a woman, reproductive coercion can be enacted by women, same-sex partners, and intergenerational relations (i.e., parents or in-laws). Examples of reproductive coercion include but are not limited to: removing condom during sex, destroying contraceptives, and preventing a partner from attending appointments. Literature also identified ways in which institutions enact reproductive coercion by limiting access to reproductive health services.

**HOMELESSNESS:** Women experiencing homelessness are at risk for reproductive coercion. Women reported experiencing forced sex, engaging in sex work, or exchanging sex to secure housing, food, and money. Women also reported having male partners force pregnancy, refuse to use a condom, engage in birth control sabotage (e.g., poke holes in condoms), or retaliate with physical violence if women sought family planning services.

**INCARCERATION:** The culture and policies of correctional facilities' health systems may systematically limit women's access to reproductive health services. A 2015 commentary about reproductive health outcomes for women who are incarcerated noted that barriers are aggravated by "unique power dynamics, limited autonomy, and coercive conditions that are inherent in the prison and jail environment." For example, women who are incarcerated experience reproductive coercion by being "prevented from having abortions, pressured into using birth control or shackled to the rail of a hospital bed during childbirth." In addition, in many prison systems whether or not women are allowed to access care is dependent on corrections staff determination, and staff that serve as "gatekeepers" are often untrained in determining when medical attention is required, resulting in denied or delayed care.

**MILITARY:** Women in the military experience reproductive coercion due to military culture and male-dominated decision-making. Military culture effectively restricts women's contraceptive and pregnancy choices through military abortion laws and decisions, lack of counseling or denial of preferred contraception, reporting through the chain of command, criminalization of sexual activity, and experience of military sexual trauma.
VIOLENCE: Trafficked individuals experience reproductive or pregnancy coercion at the hands of traffickers who may choose to incentivize financial profit over safe sex (e.g., limiting access to or use of condoms, limiting or refusing healthcare visits) or control pregnancy outcomes (e.g., forced pregnancy or abortion).

For example, grantees through Washington State’s Office of Crime Victim Advocacy shared that “[p]imps often use pregnancy and children as a further way to control [trafficked individuals]” (OCVA, Commerce, personal communication, August 2018).

29. Physical and/or sexual violence

<table>
<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelessness</td>
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<td>Incarceration</td>
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<td>79</td>
<td>1</td>
<td>155,167</td>
</tr>
<tr>
<td>Immigration</td>
<td>90,94</td>
<td>Military/Veterans</td>
<td>104</td>
<td>135,136,243</td>
<td>20</td>
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<tr>
<td>Health</td>
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<td>Race/ethnicity</td>
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<td>Violence</td>
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Sexual violence includes “rape, being made to penetrate someone else, sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences such as harassment and flashing.”

While national data show some sexual minority and racial/ethnic groups are disproportionately impacted by sexual violence, Washington does not have state-level sexual violence data by race/ethnicity or sexual orientation. Past and current experience with violence make women less likely to access reproductive healthcare.

GENDER IDENTITY: Nationally, 47% of U.S. Transgender Survey respondents were sexually assaulted at some point in their lifetime, and one in ten (10%) were sexually assaulted in the past year. Transgender individuals who have done income-based sex work were significantly more likely to have been sexually assaulted (72%). Moreover, of those working in the underground economy at the time they completed the survey, 41% were physically attacked in the past year and 36% were sexually assaulted during that year. Additionally, 61% of transgender individuals with disabilities had been sexually assaulted in their lifetime.

IMMIGRATION: Refugees and asylum-seekers often enter the U.S. to seek protection due to persecution or fear of persecution due to race/ethnicity, religion, nationality, membership of a particular social group, or political opinion. A study with female Somali and Congolese immigrants in Massachusetts found that female immigrants had prior experiences with sexual trauma and violence, making women less likely to seek reproductive healthcare.

INCARCERATION: A 2012 report by ACOG states that rates of sexual assault and violence among incarcerated women are between 5.1% and 10.8% at some prisons, with women experiencing violence from other inmates or prison staff.

MILITARY/VETERANS: Military sexual trauma is defined as “the experience of sexual harassment or attempted or completed sexual assault during military service” and can be perpetrated by military personnel, civilians, commanding officers, subordinates, strangers, friends, or intimate partners. The Department of Veterans Affairs requires screening of all Veterans for military sexual trauma, and 20% of
female Veterans reported a history of trauma. According to the Barriers to Care survey, the Department of Veterans Affairs found that 19% of VA users and 8% of non-users avoided the VA because of past sexual trauma. Similarly, a literature review of articles published between 2008 and 2014 on the reproductive health of women in the military found that sexual trauma and assault prevented women from accessing reproductive health services. A 2010 survey found that 4.4% of active duty women in the military reported experiencing unwanted sexual contact, rape, or sexual assault compared to only 0.1% of women in the general population. Another study found that between 9.5% and 33% of women experience an attempted or completed rape while serving in the military. Researchers have noted that “true prevalence of sexual assault and rape are likely higher in the military (as in civilian populations) because of possible underreporting. The DOD estimates that 80% of servicewomen who experience unwanted sexual contact do not report it to a military authority.”

**RACISM:** According to the Bureau of Justice Statistics data (1992-2001), an annual average of 5,919 rape/sexual assaults were committed against AI/AN victims. AI/AN individuals were more likely to be victims of assault and rape/sexual assault committed by a stranger (41%) or acquaintance (34%) rather than an intimate partner or family member (21%). Unlike other race/ethnic groups, in which sexual violence is usually perpetrated by someone of the individual’s same race/ethnicity, 80% of sexual assault/rapes perpetrated against AI/AN women are committed by non-Native men. Available data show that AI/AN individuals disproportionately experience rape/sexual assault (5 victimizations per 1,000 persons age 12 or older) compared to White (2 per 1,000), Black (2 per 1,000), and Asian (1 per 1,000) people in the U.S. More recent data (2005-2010) indicate that AI/AN populations experience rape and sexual assault against females at a rate of 4.5 victimizations per 1,000 females age 12 or older (non-Hispanic White: 2.2; Black: 2.8; Hispanic/Latina: 1.4.; Asian/Pacific Islander (API): 0.7.). Anecdotal information shared by key informants indicates that AI/AN women in Washington also disproportionately experience sexual violence and assault.

**TRAFFICKING:** Individuals who are trafficked (labor and sex trafficking) experience greater risk of sexual and physical violence. In a study at Rikers Island’s women’s facility, trafficking survivors reported reproductive and sexual violence, both physical and psychological, including traffickers limiting or refusing healthcare visits and perpetrating physical violence for seeking services or receiving specific diagnoses (i.e., STI or pregnancy). Study participants also described traffickers accompanying survivors or sending another trafficked woman with them to medical appointments for intimidation and control purposes.

### 30. Mandatory reporting

<table>
<thead>
<tr>
<th>Adolescents/ Young Adults</th>
<th>Older adults</th>
<th><strong>Behavioral health</strong></th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
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<tbody>
<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military</td>
<td><strong>Racism</strong></td>
<td>SES</td>
<td>Violence</td>
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<td>199,245</td>
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<td>168</td>
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Fear of reporting requirements and the potential to violate a patient’s privacy and the provider-patient trust can prevent providers from asking questions to screen individuals for trafficking or behavioral health disorders. Mandatory reporting policies for pregnant women with substance use disorders are often seen as punitive by patients and providers and discourage women from seeking prenatal care and substance use disorder treatment. Washington State law does not require healthcare providers to report substance use by pregnant women. Washington State statute also requires the Department of Social and Health Services to provide prevention strategies that promote the use of alcohol and drug treatment services by women before, during, and immediately after pregnancy.

31. Differential treatment, practices, or counseling by provider

<table>
<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
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<td>69,72,73,76,79,142,1</td>
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<td>41,127,130,191</td>
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<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military/Veterans</td>
<td>Racism</td>
<td>SES</td>
<td>Violence</td>
</tr>
<tr>
<td>88,89</td>
<td>95,100,144,145,158,165</td>
<td>109,110,115,241</td>
<td>98,120,127,149,191,2</td>
<td>13,246-248</td>
<td>24,100,127,130,191</td>
<td>137,225,249,250</td>
</tr>
</tbody>
</table>

Individuals seeking reproductive health services may experience differential treatment in a clinical setting from front office staff, medical staff, or providers. Identity-based discrimination in healthcare settings, harsh or abusive language, refusal of care, non-affirming care, heteronormative perspectives, substandard care, and other differential treatment can result in decreased likelihood of seeking care in the future.

Providers’ attitudes and implicit biases often influence how they counsel patients. For example, provider recommendations for HPV vaccination have been shown to increase vaccine uptake likelihood up to 18-fold. However, a 2014 study found parents of Black and Latina girls reported lower rates of provider recommendation than did parents of white girls. Similarly, older women were less likely to receive a provider recommendation for a mammogram than younger women, despite the fact that provider recommendation is the strongest factor in mammography screening. The American Society of Reproductive Medicine reported that patients seeking infertility treatment and ART services received differential counseling and referrals due to providers’ biases and assumptions about an individual’s or couple’s socioeconomic status, marital status, sexual orientation or gender identity, and whether they deserved to be a parent or raise a child.

OLDER ADULTS: A British study of patients aged 50 to 92 years found many participants perceived their provider to be influenced by the stereotype that older people are asexual, or that sexual issues are a normal part of aging and should be accepted as the “natural progression.” None of the participants reported their general practitioner initiating a discussion about sexual health issues.

DISABILITY: A review of multiple studies found that providers often ignore routine female screening needs and fail to recommend mammograms for women with disabilities. The authors of a study attempting to improve rates of Pap smear testing in women with disabilities discuss previous research indicating that women with disabilities are less likely to receive a recommendation.
analysis revealed that Pap test recommendations are relatively high among disabled women while screening rates remain low. In fact, women with disabilities were 1.2 times as likely to receive a recommendation for a Pap test, but only 50% of those women actually went on to have a Pap test performed.

**GENDER IDENTITY/SEXUAL ORIENTATION:** A 2017 survey found 16% of LGBTQ Americans surveyed said they have been personally discriminated against when going to the doctor or health clinic because they are LGBTQ. Approximately a third of LGBTQ people surveyed said that transgender people in their area often experience discrimination when going to a doctor or health clinic (31%). Among transgender individuals, 20% said that transgender people often face discrimination when going to a doctor or health clinic and 10% report being personally discriminated against because they are transgender when accessing healthcare. Nationally, transgender people with disabilities report high rates of mistreatment by healthcare providers (42%). Evidence suggests that many transgender patients continue to face stigma and confusion by medical professionals, in the form of insensitivity to preferred gender pronouns (i.e., misgendering), displays of discomfort, and substandard care.

A 2012-2013 study of LGBTQ emerging adults in an urban Midwestern area found transgender patients were statistically significantly more likely than cisgender participants to experience denial of services or unequal treatment (P<0.001), and queer/questioning individuals reported them at higher rates compared to gay/lesbian and bisexual individuals (P=0.001). In Washington State, the 2015 U.S. Transgender Survey found 22% of transgender respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person.

**HOMELESSNESS:** Women reported being treated differently by providers based on their housing status. Women with children experiencing homelessness in San Francisco reported that they were reluctant to disclose their housing status to providers for fear that they would receive substandard quality of care. Women experiencing homelessness in Pittsburgh, Pennsylvania also felt that providers shared biased or incomplete information with them about contraception options. Specifically, women felt they received differential counseling from providers who tried to persuade them to use a particular method of contraception and pressure them to receive LARC.

**MILITARY/VETERANS:** A survey with women in the military who had been recently deployed found that 60% of respondents did not talk with a provider about contraceptive options prior to deployment and 78% did not talk about options for menstrual suppression. In addition, women who did talk with providers about contraceptives felt that providers discouraged them from using LARC or sterilization as a form of contraception. Similarly, a study with female Veterans found that LARC use was lower among Veterans than the general population.

The Department of Veterans Affairs’ Barriers to Care survey found that gender insensitivity was a main barrier to accessing healthcare. They reported that the “VA has historically been viewed as having a male dominated culture due to the preponderance of male patients (and providers) resulting from the fact that most Veterans are male.” The survey found that female Veterans are most satisfied with their provider and felt most respected if they receive care through a VA women-only clinic. The survey also found that women felt most respected by their provider, less respected by other providers and least respected by office staff, suggesting that the larger clinical environment influences their satisfaction with care.
Literature Review on Inequities in Reproductive Health Access

**RACISM:** Numerous studies identify racism, the differential treatment stemming from skin color or other individual characteristics, as a barrier to care.\(^{246}\) Institutionalized racism results in differential access to resources, services, and opportunities, including access to healthcare, by race.\(^{246}\) A review of literature published from 2009 to 2015 examined the relationship between racial discrimination and adverse birth outcomes.\(^{246}\) In one study reviewed, African American women discussed experiences of institutionalized racism (e.g., having to wait longer to be seen by a provider) while accessing prenatal care.\(^{246}\) Another study of African American women (N=872) found that timing of prenatal care was not significantly associated with personal experiences of racism (p=0.33) but was associated with group experiences (p>0.01).

Women of color experience differential contraception counseling.\(^{98,149,191,248}\) For example, self-reported evidence indicates that women of color and low-income women may be more likely to experience pressure to limit family size.\(^{98}\) An analysis of 2002 National Survey of Family Growth data found significant racial/ethnic differences in the specific services received. Results indicate that Black and Hispanic women received birth control counseling more often (AOR 1.5, 95% CI 1.2, 1.8, and AOR 1.3, 95% CI 1.1, 1.7, respectively) than white women.\(^{248}\) However, women of color did not actually obtain more birth control or prescriptions for birth control, which "suggests that the increased frequency of contraceptive counseling reported by [women of color] was likely not patient initiated."\(^{248}\) Given the history of efforts to control the fertility of low-income women and women of color, authors note that additional counseling may not be indicative of quality of care as much as reflective of provider implicit bias.\(^{248}\)

**SES:** A number of studies have found that women of low socioeconomic status are less likely to receive provider counseling or recommendations about reproductive health services, including contraception,\(^{130,191}\) HPV vaccination,\(^{127}\) and ART.\(^{24,100}\) One study found that patients whose parents had a high school education or less (used as a proxy for socioeconomic status) were significantly less likely to be counseled on long-acting reversible contraception than patients whose parents had more education.\(^{191}\) Similarly, a summary of literature examining the relationship between socioeconomic status and access to reproductive healthcare services found that lack of communication with healthcare providers was a barrier to accessing and starting contraceptive use.\(^{130}\)

### 32. Denial or delay of services

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<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
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Denial or delay of services poses a significant barrier to accessing reproductive healthcare.\(^{1,35,69,73,142,143,195,251}\)

**GENDER IDENTITY:** Denial or delay of services is especially a barrier for transgender individuals.\(^{1,69,73,142}\) According to the Washington State Office of the Insurance Commissioner website, “[i]f a health insurer
covers medically necessary services for its enrollees, it cannot exclude or deny those services for a transgender person because of the person’s gender identity. Health insurers are required to cover procedures that are part of a gender transition process if they’re covered for other policy holders for different reasons. Service examples include: hormone therapy, counseling services, mastectomy, breast augmentation and reconstruction. Key informants shared that insurance denials continue to disparately affect transgender individuals in Washington State. Automated systems designed to recognize both sex and gender as binary variables (male or female) may automatically deny claims for screenings or treatments that are not “gender appropriate” (e.g., trans man receiving a pap smear). Key informants shared that in most cases insurers will approve treatment after an appeal or pre-authorization. However, the extra steps and waiting period to receive routine care act as a significant barrier and lead patients to give up and forego care.

Despite the growing body of literature that shows puberty blockers help ameliorate mental health challenges faced by transgender adolescents, a retrospective review of medical records found 59.3% of transgender adolescent patients prescribed puberty blockers were specifically denied insurance coverage. Of those initially denied coverage, 4 subsequently received care; the median time between insurance denial and start date for hormone therapy was 9 months (range: 8-20 months). Additionally, transgender and gender nonconforming respondents in one study reported “feeling that their mental health was inappropriately used as rationale to deny care” and that mental health providers served as “gatekeepers” often interfering with obtaining recommended referral letters.

In 2018, the Washington State Office of the Insurance Commissioner (OIC) initiated an investigation into Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. in response to complaints that the companies specifically excluded breast augmentation as a treatment for gender dysphoria. According to the press release, the companies issued blanket denials rather than considering individual cases. On August 1, 2018, OIC announced that as a result of the investigation, “the companies will now cover chest reconstruction for transgender women” with a physician prescription for the treatment. Additionally, both are required to complete a review of all denials of this treatment since January 2016 by October 28, 2018.

33. Fear, perception, or experience of bias, discrimination, stigmatization

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<th>Disability</th>
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<td>Racism</td>
<td>SES</td>
<td>Violence</td>
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<td>109-111,115,193</td>
<td>54255,256</td>
<td>20,24,98,125,226</td>
<td>134,155,168</td>
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Fear of or previous experiences of bias and discrimination within healthcare settings (e.g., from clinic staff, front desk receptionists, providers) can influence future utilization of services. A systematic review found evidence that fear of provider discrimination, homophobia, or differential treatment acts as a barrier to healthcare services, and many populations experienced stigma and discrimination from society as well as healthcare providers. Multiple populations feared judgement or stigmatization for seeking reproductive health services or entering a
reproductive health services (e.g., concern that others would assume they had an STI or were sexually promiscuous). 39,40,42,43,93,94,109-111,115,144

In addition, individuals also reported fear of stigmatization for seeking specific services, especially for abortion 20,125 or infertility treatment. 24 For example, low-income women seeking care at an abortion clinic in Oregon reported receiving social stigma and judgement; hostility from a partner, friend, or family member about their decision to seek an abortion; harassment from anti-abortion protesters outside clinics; and unresponsive case workers. 20 Generally, men and women seeking infertility treatment held an “aversion to being labeled ‘infertile.’” 24 This aversion was a larger barrier among different racial/ethnic communities. 24

ADOLESCENTS/YOUNG ADULTS: Adolescents reported feeling disrespected and judged by providers due to their age and sexual activity, 43,47 as well as fearing being seen as an incompetent teen mother. 42 Adolescents and young adults of color in particular reported these fears. 39,40,42

BEHAVIORAL HEALTH: Women with substance use disorders reported that providers treated them with lack of empathy, resulting in a disconnection from care and worse treatment outcomes. 63 Women with substance use disorders reported additional feelings of stigmatization due to gendered social norms, the role of women as caregivers, sex work, and incarceration. 62

DISABILITY: Patients with disabilities experience insensitivity from staff in every step of the healthcare process, from scheduling to the actual procedures. 160 A review of multiple studies revealed that providers often treat women with disabilities in a condescending, insensitive, or oversensitive manner. 141,161 As a result, women with disabilities are generally less satisfied with their care and more likely to delay or forgo care in the future. 141

GENDER IDENTITY/SEXUAL ORIENTATION: A nationally representative survey found that 18% of LGBTQ respondents and 22% of transgender respondents report they have avoided doctors or healthcare out of concern they would be discriminated against. 76 Washington specific data from 2015 shows that 38% of transgender people surveyed reported at least one negative experience related to being transgender (e.g., refused treatment, verbally harassed, physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care). 164 Similarly, queer/questioning participants reported delaying care more frequently than gay/lesbian and bisexual participants (P=0.038). 140 Of those participants who reported disclosing their LGBTQ identity to their provider, those who identified as transgender were more likely to report a negative outcome than cisgender participants (P<0.001). 140 Queer/questioning respondents also reported negative effects at higher rates than did gay/lesbian and bisexual participants (P=0.001). 140

MILITARY: A literature review of articles published between 2008 and 2014 on women in the military accessing reproductive health services found that women avoided seeking care due to lack of confidence in healthcare providers, previous negative experiences with military medical providers, and stigma for seeking services. 193 A survey of women in the military who had been recently deployed found that women were afraid to ask for contraception due to the belief that sex was “illegal” and a chargeable offense under Uniform Code of Military Justice. 115
34. Lack of social support

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<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
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<td>42</td>
<td>93-96,145</td>
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<td></td>
<td>20,130,151,194</td>
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Multiple populations experienced a lack of social support, partner support, and social capital needed to access reproductive health services, prenatal care, cancer screening (mammograms and pap smears), and abortion.

35. Individual health literacy

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<th>Adolescents</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
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<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military/Veterans</td>
<td>Racism</td>
<td>SES</td>
<td>Violence</td>
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<tr>
<td>26-28,32,40</td>
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<td>109,110,115,193</td>
<td>98</td>
<td>98,100,124,127,130,194</td>
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Health literacy extends beyond sexual health education as previously described. The ACA defines health literacy “as the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.” Lack of knowledge about available services, lack of knowledge about how to navigate the healthcare system, and limited health literacy also serve as barriers to receiving appropriate reproductive healthcare.

**HOMELESSNESS**: Interviews with women aged 18-24 experiencing homelessness in Pittsburgh found that women had low health literacy and lacked medically-accurate information about LARC. For example, women did not know that an IUD could be removed early, believed that an IUD could lead to infertility, perceived that partners would be able to feel an IUD during intercourse, and had incorrect information about the process of placing and removing an IUD.

**IMMIGRATION**: Low health literacy was a barrier for all immigrants, regardless of status. DACA recipients’ understanding about the U.S. healthcare system was especially low if their parents were not U.S. citizens or were undocumented and lacked access to insurance and healthcare, suggesting an intergenerational gap in health literacy. Multiple studies found that immigrants lacked knowledge of the U.S. healthcare system, which reduced their ability to navigate and access care. Immigrants also lacked awareness of available services and experienced confusion about healthcare policies and their options for insurance and care. A study with Somali immigrants found that they lacked knowledge about where to go for services, and about insurance options and availability. Specific to male immigrants from Mexico, one study found that men lacked knowledge about family planning, available services, clinic locations, care and treatment options, and available financial assistance.
MILITARY/VETERANS: Studies suggest women in the military lack knowledge and awareness about available reproductive healthcare services, contraception options, and abortion care. As a result, women avoided or delayed seeking care. The Department of Veterans Affairs’ Barriers to Care survey also found that female Veterans did not understand the scope of services available or the eligibility requirements to receive care through the VA.

36. Patients' individual attitudes and beliefs

| Patients’ individual attitudes and beliefs may cause individuals to delay or avoid seeking care. Attitudes and beliefs may include definitions of health or when to seek healthcare, moral, ethical, religious, or cultural beliefs; perception of risk; fear of procedures, diagnosis, or treatment; doubt about the necessity or efficacy of procedures; lack of trust of providers and the healthcare system; low self-efficacy; and overall personal motivation. |

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<th>Adolescents/Young Adults</th>
<th>Older adults</th>
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<tr>
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<td>113,115</td>
<td>259</td>
<td>24,98,124,130</td>
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IMMIGRATION: Depending on immigration status, nativity, length of time in the U.S., and level of acculturation, immigrant individuals and communities experience multiple cultural differences that impact their attitudes and beliefs about seeking reproductive health services in the U.S. Overall, immigrants experienced culturally-based myths and misinformation; cultural and familial differences in communication, attitudes, and practices related to reproductive health; and cultural beliefs about when to see a doctor and what constituted pain/discomfort. Somali immigrants also held strong cultural beliefs (e.g., family size) that clashed with U.S. medical advice and practices.

A study with Hispanic, male immigrants in the Pacific Northwest found that men adhered to cultural norms, and held strong cultural beliefs, including machismo-related beliefs. This led men to have a low-perception of risk related to sexual and reproductive health and believe that reproductive health is not a responsibility for men to address. The authors state, "when combined with a cultural history that has not embraced the male role in sexual and reproductive health, the cultural belief of machismo perpetuates the idea that Latino men do not have to be responsible for their own sexual health or that of their partner."

MILITARY: Military culture discouraged sexual activity and labeled it as “illegal,” causing many women to believe that they would not be sexually active during deployment and therefore would not need contraception.

RACISM: Results of a qualitative study of 118 self-identified black women in New York indicate fear and anticipation of screenings or well woman exams likely finding bad news (e.g., breast cancer) deterred individuals from seeking care. Authors noted women had an "embedded assumption of the probability of testing resulting in bad news." Unlike the traditional biomedical premise that more
knowledge is always preferable to less, participants described the uncertainty of “thinking” something might be wrong was preferable to "knowing" definitively whether they had a health problem (e.g., breast cancer, HIV). Participants felt confirmation of a health problem could be "tremendously problematic because of the subsequent consequences." For example, not knowing was described as protective from the knowledge of the disease and emotional consequences (e.g., depression, relational betrayal, relationship fallout).

37. Parent/guardian/intimate partner's individual attitudes and beliefs

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<th>Adolescents/Young Adults</th>
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<th>Behavioral health</th>
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Parental attitudes, beliefs, religious and cultural values, and understanding of the U.S. healthcare system serves as a barrier for adolescents and young adults seeking reproductive health services. For example parental values may lead to decisions to delay HPV vaccination for young girls. Parental citizenship and immigration status has also been identified as a barrier to accessing healthcare, even for children who are U.S. citizens.

38. Providers' individual attitudes and beliefs

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<th>Adolescents/Young Adults</th>
<th>Older adults</th>
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Provider attitudes, beliefs, biases, and religious or moral values affect how providers interact with, counsel, and treat their patients.

GENDER IDENTITY/SEXUAL ORIENTATION: A systematic review found LGBTQIA individuals report provider attitudes toward clients (e.g., uncaring, unsupportive, and judgmental attitudes) act as a barrier to care. For example, a survey of 152 transgender adults found the most frequently reported problematic healthcare interactions with healthcare services related to gender insensitivity (31.46%), displays of discomfort (28.67%), and denial of services (20.97%). Moreover, studies show that up to 39% of transgender people have faced some type of harassment or discrimination in healthcare settings.

INCARCERATION: A 2009 survey of 286 correctional healthcare providers found that provider attitudes about the importance of contraception and the belief that other health needs were more important were barriers to women accessing contraception while incarcerated. Similarly, research with Rhode
Island Department of Corrections found that, “various administrators and staff initially expressed resistance to providing contraception during incarceration because of the potential suggestion that women were at risk for pregnancy while in custody and because they believed ‘it is not our problem.’” The Rhode Island Department of Corrections found that, “when the facility started providing contraceptives on-site [using Title X funding], women were 12 times more likely to start a [contraception] method than when given a referral for release.” This finding, along with additional understanding about pregnancy rates among women who are incarcerated, recidivism, and barriers women experienced accessing family planning services after release caused provider attitudes to shift.

**RACISM:** Multiple studies with African American women described interpersonal experiences of racism (e.g., racial slurs directed at them) in healthcare settings. Interpersonal racism refers to the attitudes and beliefs and actions of individuals that perpetuate racism (CITATION). A qualitative study of AI/AN women found evidence that negative experiences with providers (e.g., showing superior attitudes, using confusing terminology, and avoiding the reservation during non-work hours) deter women from accessing services. Additionally, key informants working with AI/AN populations in rural and urban areas of Washington State confirm that dehumanizing interactions (e.g., derogatory comments, assumptions based in negative stereotypes) serve as a significant barriers to care.

**VIOLENCE:** Provider-held stereotypes and misperceptions can affect the likelihood of screening a patient for experiences of violence. A study by the U.S. Department of Health and Human Services found that some healthcare providers stereotypically view commercial sexual exploitation and sex trafficking as primarily affecting young foreign adolescent girls. This stereotype may influence whether they screen or recognize victims with identities also at risk of sexual exploitation and trafficking, including U.S. citizens, boys and men, or transgender individuals.

### 39. Misconception by providers/society regarding sexual activity and associated risks

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<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral Health</th>
<th>Disability</th>
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Cultural perceptions, misconceptions, or biases by society or providers about whether an individual is sexually active or at risk for STIs may lead to differential treatment and counseling. For example, providers may not believe that adolescents or older adults should be sexually active and may not counsel or recommend contraception.

**DISABILITY:** Pervasive cultural attitudes include the belief that people with disabilities, especially intellectual disabilities, are asexual, unable to have sex, or are not in control of their sexual desires. Pregnancy is often not seen as an option for disabled women, or it is assumed to be the result of sexual abuse and not the result of informed and intentional personal choice. Many adults
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with intellectual disabilities, however, are capable of making an informed decision to have consensual sex.\textsuperscript{224,237} These misconceptions about sexuality and risks for women with intellectual disabilities are pervasive enough that caretakers report the most common reason for not receiving a pelvic exam or Pap test was their belief that the test was unnecessary for women with intellectual disabilities.\textsuperscript{236}

Researchers who looked at women with disabilities more generally found that rates of sexual activity are no different between women with disabilities and women without disabilities (90.0\% vs. 90.6\%, p=.76). Contraceptive use at last intercourse is also not significantly different between these two groups (70.1\% vs 74.3\%, p=.22).\textsuperscript{260} Although women with disabilities use contraception at the same rate, this is nuanced by the fact that they tend to use permanent forms of birth control at a higher rate,\textsuperscript{260} and women with intellectual disabilities have a history of experiencing forced or compulsory sterilization.\textsuperscript{224}

**SEXUAL ORIENTATION:** If providers do not understand gender and sexually diverse people’s unique health needs, influenced by both sexual orientation and behavior, they may make inaccurate assumptions that influence the care they provide.\textsuperscript{75} For example, “physicians may inaccurately assume [gender and sexually diverse] patients are not at risk of sexually transmissible infections (STIs) if they do not report penetrative sexual intercourse.”\textsuperscript{75} Alternatively, patients may be treated as if they are at high risk for STIs when their actual behavior is very low risk, which can be stigmatizing.

### 40. Fear of deportation, separation from family, and other legal action

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<th>Adolescents/Young Adults</th>
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Immigrants, regardless of status, delayed seeking care or did not seek care for fear of deportation or other legal action.\textsuperscript{3,91,93,95,144,145,165,195} A study with DACA-recipients found that immigrants, even when in the U.S. legally, did not seek care for fear of deportation or consequences for future citizenship.\textsuperscript{165} Similarly, trafficked minors born in the U.S. but whose parents lack documented legal status in the U.S. did not seek care or assistance for fear of causing their family (e.g., parents) to be deported.\textsuperscript{155} Female detainees at US detention centers did not access healthcare for fear of retaliation or negative consequences on their pending immigration status cases.\textsuperscript{195} Lastly, a study of Latina immigrants who were victims/survivors of IPV described partners using their immigration status and fear of deportation and/or separation from children as a form of manipulation (e.g., denied access to health services).\textsuperscript{134}

### 41. Mobility

<table>
<thead>
<tr>
<th>Adolescents/Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelessness</td>
<td>Immigration</td>
<td>Incarceration</td>
<td>Military</td>
<td>Racism</td>
<td>SES</td>
<td>Violence</td>
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<tr>
<td></td>
<td>87</td>
<td>95</td>
<td>110,112</td>
<td></td>
<td></td>
<td>167</td>
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</table>
Literature Review on Inequities in Reproductive Health Access

Studies have found that housing instability, homelessness, transiency, military deployment, and constantly moving around make it difficult to access regular, consistent, and preventive reproductive health services, treatment, and follow-up.\(^{87,95,110,112,167}\)

### 42. Substance Use

<table>
<thead>
<tr>
<th>Adolescents/ Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
</tr>
</thead>
</table>
| Homelessness | Immigration | Incarceration | Military | Racism | SES | Violence  
\(^{167}\) |

Substance use can be used as a tool by traffickers to control trafficked individuals or as a coping mechanism by victims/survivors,\(^{167}\) making it difficult for individuals to act independently to seek reproductive health services.

### 43. Historical trauma and medical mistrust

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<tr>
<th>Adolescents/ Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelessness</td>
<td>Immigration (94,98,261)</td>
<td>Incarceration (101,105)</td>
<td>Military</td>
<td>Racism (42,49,120,213,253)</td>
<td>SES</td>
<td>Violence</td>
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</table>

Mistrust of the healthcare system due to legacies of oppression and reproductive health coercion, including forced sterilization and coercive family planning programs, served as a barrier of care for some populations.\(^{42,94,98,149,261}\) Communities of color have experienced histories of eugenics and, between 2006 and 2010 over 100 women in California’s prison system were unlawfully sterilized.\(^{101}\) In general, research has found that “[incarcerated] women’s long trauma histories tend to impact on their beliefs about Pap screening- that is, an expectation of fear, discomfort, and questionable safety during gynecological exams.”\(^{105}\) In addition, some immigrant communities may also have experienced trauma in country of origin that may serve as a barrier to seeking care.\(^{94}\)

### 44. Lack of actual or perceived confidentiality/privacy

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<th>Adolescents/ Young Adults</th>
<th>Older adults</th>
<th>Behavioral health</th>
<th>Disability</th>
<th>Gender Identity</th>
<th>Sexual Orientation</th>
<th>Geography</th>
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</thead>
<tbody>
<tr>
<td>Homelessness</td>
<td>Immigration (94,96,144,195)</td>
<td>Incarceration</td>
<td>Military (110,111,115,193)</td>
<td>Racism</td>
<td>SES</td>
<td>Violence (155,168)</td>
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</tbody>
</table>

Concerns about confidentiality or privacy were a barrier for many populations accessing reproductive health services.\(^{28,30,31,33,35,39,40,43-46,88,94,96,110,111,115,144,155,168,193,195}\) Other studies have also found concerns about the lack of privacy in the clinic or pharmacy environment, from accessing the clinic to the check-in process to the waiting room.\(^{35,39,40}\)
ADOLESCENTS/YOUNG ADULTS: The desire for confidentiality and privacy, and the associated fear of disclosure, is one of the most consistently cited barriers when adolescents are asked about reproductive healthcare. Few adolescents and young adults are aware of their rights to confidentiality, and many are uncertain about the ability of a healthcare provider to deliver confidential services without requiring parental consent. Healthcare personnel and providers contribute to this issue by providing incorrect information about availability and age requirements for services. Providers are sometimes uncertain about their own ability to maintain confidentiality for adolescents.

Although Washington State law does not require parental notification for prescribed contraception, the research on this subject highlights the salience of confidentiality and the consequences of misinformation, both of which are highly influential even in the absence of parental notification laws and age requirements. Studies both in Wisconsin and nationwide found nearly half of adolescent girls reported they would stop seeking contraceptive services if they believed their parents would be notified. Respondents indicated they would resort to less effective contraception or none at all, and surprisingly many would also stop seeking reproductive health services that do not require parental notification such as STI testing and Pap tests.

IMMIGRATION: One study with Somali immigrants found that women were concerned about confidentiality, especially with interpreters. A study found that women did not seek reproductive health services, including pap smears, due to concerns about privacy and culturally-valued sexual modesty. A study with Hispanic, male immigrants identified the importance of confianza or privacy, confidentiality, and trust when interacting with providers and front desk staff at clinics. Lastly, female detainees in US detention centers reported the lack of confidentiality or privacy when receiving health services, including instances where male guards were present during examinations and at appointments where the results of a pregnancy test were communicated.

MILITARY: Most concerns about privacy and confidentiality among women in the military were due to the fact that military protocol requires active duty military members to explain why they need medical attention to their chain of command and to seek permission to access care. Women were concerned about disclosing their need for reproductive health services and feared that their medical status would be reported to their chain of command, their commanding officer would find out the results of medical tests, the results of pregnancy tests would go into their military record, and medical staff would gossip. For example, among women in the military who had an abortion during active duty service, three out of 21 women interviewed said that their commanding officer found out they were pregnant without their disclosing the information.

45. Criminalization of individuals or behaviors, and fear of criminal justice involvement

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<th>Adolescents/Young Adults</th>
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<th>Gender Identity</th>
<th>Sexual Orientation</th>
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<td>Homelessness</td>
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<td>145</td>
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<td>155,167,234</td>
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</tbody>
</table>

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Research has found that some populations are less likely to seek care due to concerns about criminal justice involvement, legal action, removal of their children (i.e., involvement from child protective services), and incarceration.\textsuperscript{62,63,199,224,245}

**BEHAVIORAL HEALTH:** Individuals with substance use disorders are also more likely to become incarcerated or to experience recidivism, making it difficult to access regular and preventive care.\textsuperscript{62,63} Women who inject drugs are more likely to be involved in the criminal justice system than men who inject drugs.\textsuperscript{62} For example, one study found that, "among prisoners with a sentence of more than 12 months admitted to US state prisons in 2012, 1 in 3 women were admitted for drug offences compared with 1 in 7 men. Further, more than two thirds of women in the US federal prisons are serving sentences for nonviolent drug offences."

**MILITARY:** Military policies punish unmarried members of the opposite sex spending the night in the same living quarters, sexual relationships between unmarried people, and pregnancy.\textsuperscript{111} Additionally, under Uniform Code of Military Justice sexual relationships (except consensual relationships between members of the same rank) are an offense.\textsuperscript{111} These policies create an environment of fear for women and "may prevent them from accessing the safe, legal care they are entitled to."\textsuperscript{111} A study evaluating access to abortion during deployment found that confusion and concern about military policies criminalizing sexual relationships led women to fear seeking services and delay care.\textsuperscript{115}

Women in the military also reported that fear of reprimand, disciplinary action, or punishment as well as fear of potential impacts on their career or promotion led them to avoid or delay seeking reproductive health services.\textsuperscript{110,111,193} Women in the military who became pregnant during deployment were concerned about being punished, being "kicked out" of the military, going to military prison, losing rank, or losing their source of income.\textsuperscript{111} Women also delayed seeking care because they did not want to leave deployment or impact their eligibility for promotion.\textsuperscript{110}

**TRAFFICKING:** Evidence shows "laws and law enforcement practices have resulted in the criminalization of domestic sex trafficking survivors."\textsuperscript{167} Trafficked-women are often arrested for "charges associated with drugs (forced drug use by traffickers to maintain control over victims), weapon possession (for protection from potentially violent buyers), various types of fraud including using a false identity (created by the trafficker), and theft or robbery (through force by the trafficker or buyer)."\textsuperscript{167}

Trafficked participants at Rikers Island women’s facility reported fear of criminal justice involvement as a barrier to using emergency departments (e.g., arrest for prostitution or substance use).\textsuperscript{167} Moreover, fear of criminal justice involvement (e.g., prostitution charge) acts as a barrier to accessing health services in jurisdictions where individuals 16 to 18 years of age can be tried in criminal courts as adults.\textsuperscript{155} According to the Commercially Sexually Exploited Children Statewide Coordinating Committee (CSEC), youth in Washington continue to be adjudicated for crimes related to “child pornography, burglary, drugs, and various probation violations, which can reinforce cycles of exploitation."\textsuperscript{234} Even if a youth enters a diversion program, “the original charge may still be disclosed publically as result of internet information sharing, therefore the subsequent risk of discrimination remains."\textsuperscript{234}
RECOMMENDATIONS

DRAFT: Pending Review and approval by Council (13 September 2018)

Recommendations from the published literature and Washington State agencies and organizations were compared to identify areas of alignment and to determine which recommendations would likely address access barriers for multiple priority populations. These 13 recommendations are not comprehensive, but represent actions that would reduce disparities in accessing reproductive healthcare for a number of individuals experiencing inequities in Washington State. Due to capacity limitations, staff were not able to fully evaluate recommendations for feasibility, cost, or alignment with existing federal and state law.

Criminal Justice recommendations
1. The Departments of Corrections and Social and Health Services should cooperate with state prisons, county jail systems, and juvenile detention centers to create a continuum of care that spans incarceration and return to the community. An assessment by End AIDS Washington concluded that a comprehensive approach is needed to ensure access to care for adults and youth while incarcerated and upon release. In order to access the reproductive care they need. Washington State has enacted policies to suspend (rather than terminate) Medicaid coverage for incarcerated individuals and Department of Corrections is working to improve access to long-acting reversible contraception. However, literature shows that fractured care, especially between prison and community health systems, is a barrier for women who experience incarceration to access consistent and appropriate reproductive health services. In addition, women in jails may not receive appropriate follow-up care because of short durations in facilities or unknown release dates. The American College of Obstetricians and Gynecologists recommends providing a continuum of care between initial screenings, in-house services, referrals, and release.

2. The Washington State Legislature should convene a workgroup to develop recommendations to reduce/eliminate barriers to healthcare services experienced by human trafficking victims and survivors. Victims and survivors of human trafficking (sex and labor) experience complex healthcare needs (including reproductive services) related to their exploitation. Persons experiencing or exiting trafficking face economic barriers (e.g., financial costs), structural barriers (e.g., criminalization and collateral impacts on eligibility for publicly funded services, employment), and social barriers (e.g., reproductive coercion, stigmatization) to care. Reducing and eliminating identified barriers for trafficked people requires a collaborative, multidisciplinary response between survivors, advocates, organized labor representatives that represent workers in industries with a high prevalence of potential labor trafficking (e.g., farm work, domestic work, other low-wage service industries), social service providers, healthcare providers, law enforcement, public defenders, and prosecutors. The workgroup should:
   a. Review existing state and federal laws related to human trafficking.
   b. Identify opportunities to: improve access to trauma-informed medical care; reduce other barriers to healthcare; increase awareness among first responders that survivors are victims and are not complicit in criminality; reduce criminalization and prosecution of trafficked people.
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c. Provide a report that includes any findings, recommendations, and draft legislation to the Governor and appropriate committees of the legislature, within one year of the effective date.

Education recommendations

3. The Washington State Legislature should require (rather than make voluntary) that all public schools in Washington State teach age-appropriate, culturally-appropriate, comprehensive, medically accurate, and LGBTQIA-inclusive sexual health education. In addition, the Legislature should fund Office of Superintendent of Public Instruction to develop enforcement mechanisms and provide funding and training to school districts to ensure compliance. Evidence indicates that comprehensive sexual and relationship health education is critical to improving individual knowledge and capacity to access reproductive health services. End AIDS Washington recommended that Washington State build on the Healthy Youth Act (HYA) “to ensure that all young Washington residents are receiving comprehensive, medically accurate, and LGBT-inclusive sexual and relationship health education that includes the most current science on STDs, HIV, and prevention methods.” Preparing schools to be in compliance will require additional resources to train educators. Available evidence suggests the Office of Superintendent of Public Instruction (OSPI) will require additional resources and mechanisms to monitor curricula in use and enforce full compliance with the HYA. “This effort should seek to decrease HIV/STDs, unintended pregnancy, and stigma experienced by sexual minorities, and should foster greater understanding and acceptance of all sexual and gender identities among all Washington State youth and staff in public schools.” In addition to OSPI’s current efforts, the mandate is necessary to ensure equitable access to medically-accurate information and expanded access to reproductive health resources.

4. The Washington State Legislature should allocate state funds for Department of Health to provide pass-through funding to community-based organizations to conduct sexual health education in community settings for adolescents and young adults, older adults, immigrants and refugees, individuals with limited English proficiency (LEP), individuals experiencing homelessness, and individuals with behavioral health disorders to expand health literacy related to reproductive health and navigating the healthcare system to access services. These priority populations all experience lower health literacy related to reproductive health services and health system navigation. Many of these individuals may not be reached through formal sexual and reproductive health education in public school settings. Therefore, providing sexual health education in community settings for these populations may improve their access to information and resources.

Provider recommendations

5. (Expected Recommendation Adoption 9/22/18) The Health Care Authority, Departments of Corrections, Labor and Industries, and Social and Health Services should fully implement the Dr. Robert Bree Collaborative’s “LGBTQ Health Care Report and Recommendations 2018” to improve healthcare and health equity for LGBTQ persons. Based in a whole-person care framework, the Bree Collaborative’s recommendations address structural and social barriers to care. Recommendations take into consideration “a person’s multiple individual factors that make up health, wellness, and experience (e.g., behavioral health, past trauma, race/ethnicity) in such a way that is not identity or diagnosis-limiting.” The recommendations “seek to align care delivery with existing evidence-based, culturally sensitive standards of care for LGBTQ people in Washington State.
and through that effort to decrease health disparities. Focus areas include: communication, language, and inclusive environments; screening and taking a social and sexual history; and areas requiring LGBTQ-specific standards and systems of care. The report includes specific actions (e.g., use of the patient’s chosen pronouns, name, and gender identity) as well as resources to support providers and health systems to successfully implement recommendations.

6. **(Pending Stakeholder Review)** The Washington State Department of Health should propose that the Dr. Robert Bree Collaborative identify and endorse separate sets of guidelines to improve the reproductive healthcare of: 1) people of color, 2) immigrants and refugees, and 3) victims and survivors of violence. The Bree Collaborative’s “LGBTQ Health Care Report and Recommendations” exemplify the benefits of applying a whole-person framework to develop evidence-based, culturally sensitive recommendations to improve standards of care and health equity. As such, the Bree Collaborative’s review, recommendations, and guidance is trusted to advance health equity, ensure quality care, and support the healthcare delivery system to address the unmet needs of priority populations. Their approach to developing recommendations for LGBTQ persons can be adapted to develop recommendations to address structural and social barriers to care for other priority populations, including people of color, immigrants and refugees, and victims and survivors of violence. Reducing health inequities for populations in Washington State also aligns with DOH’s strategic plan goal to promote health equity and improve population health.

Health Insurance recommendations

7. The Washington State Legislature should work with the Office of Insurance Commissioner to determine how the agency can suppress (i.e., not send) explanation of benefit (EOB) statements for reproductive health services (e.g., contraception, pregnancy tests, Pap smears, sexually transmitted diseases (STD), HIV testing, PrEP, and HIV treatment), and grant the agency the authority necessary to implement and enforce the protocol. Recommendations to label reproductive healthcare as “preventive health services” is helpful but insufficient, especially for the most vulnerable clients (e.g., victims and survivors of violence). An EOB that shows “preventive health service” still alerts the primary policyholder that a service was provided, placing the burden on the client to explain what type of service they received to their partner or parent. This will protect the privacy of enrollees, including young people enrolled on their parents’ plans and individuals experiencing IPV enrolled on their abusers’ plans, and remove a barrier in accessing care.

8. The Washington State Legislature should develop and implement a health insurance option for lawfully present immigrants that do not meet the 5-year-bar, other immigrants not qualified for federal benefits, and for individuals who are undocumented. While the ACA and corresponding Medicaid expansion increased health insurance access for many communities and enabled lawful immigrants to purchase and receive subsidies for private health insurance through the Health Exchanges, it continued to exclude some immigrants from receiving Medicaid for five years and made individuals who are undocumented and DACA recipients ineligible for public coverage or private insurance through the marketplace. Insurance options that may improve access to reproductive healthcare for immigrant communities include establishing a state-funded program to cover comprehensive reproductive health services; creating a State Basic Health Plan (allowable under the ACA) (Centers for Medicare & Medicaid Services 2018); broadening the COFA Islander Health Care program to other immigrant communities (HCA 2018); applying for a 1332 State Innovation Waiver (allowable under the ACA; for example, California considered a waiver to allow all
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immigrants regardless of status to purchase plans from the Health Exchanges) (Centers for Medicare & Medicaid Services 2018); providing additional state funding for safety net providers and community health centers; or allowing for the development of county-based health insurance options.\(^3\),\(^1\),\(^5\),\(^7\)

9. The Washington State Legislature should grant authority to the Office of the Insurance Commissioner and Health Care Authority to update health insurance and medical forms to include non-gendered language and to allow individuals to indicate both sex assigned at birth and gender identity. Evidence from the literature and key informants in Washington indicate that binary sex/gender options on medical and insurance forms present challenges to sexual and gender diverse people, particularly for gender non-conforming and transgender individuals.\(^7\) The Gender Identity in U.S. Surveillance (GenIUSS) group, a multi-disciplinary and multi-institutional collaboration, works to advance the development of sex and gender-related measures. GenIUSS recommends including measures of self-reported assigned sex at birth and current gender identity to adult surveys.\(^2\) Testing shows that the ‘two step’ approach appears the most likely to have high sensitivity, as well as high specificity, with adults.” Researchers found it “unclear whether assigned sex at birth should precede or follow current gender identity on population-based surveys” and recommend future studies investigated the ordering effects of the two questions.\(^2\) The Two-Step approach may prevent unnecessary denials of care and improve medical and insurance interactions for sexual and gender diverse clients. Williams Institute Recommended Measures for “Two-Step” Approach includes questions that ask:

- **Sex Assigned at Birth:** What sex were you assigned at birth, on your original birth certificate?
  - Male
  - Female

- **Current Gender Identity:** How do you describe yourself? (Check one)
  - Male
  - Female
  - Transgender
  - Do not identify as female, male, or transgender


Other Healthcare Related Recommendations

11. The Washington State Legislature should dedicate additional state funds to provide family planning services in Washington State, and should replace federal Title X funding with state funding in the event that Title X is cut at the federal level or future requirements do not meet Washington State law. The Guttmacher Institute conducted analyses of 2010 data, national and state-level, to estimate the total public costs from unintended pregnancies and the role of public insurance programs in paying for pregnancy-related care.\(^2\),\(^6\) Using the same approach, DOH found that publicly funded family planning centers in Washington helped avert 18,140 unintended pregnancies in 2017, which have resulted in 8,540 unplanned births and 6,130 abortions. In addition, by averting unintended pregnancies and other negative reproductive health outcomes, publicly funded family planning services provided by safety-net health centers in Washington helped
save the federal and state governments $141.4 million in associated costs of maternal and birth-related care, miscarriages, ectopic pregnancies, and abortion services.\textsuperscript{15}

12. \textbf{Community Health Worker Recommendation (Pending):} Council staff is currently contacting stakeholders to determine the most appropriate recommendation to increase access to community health workers who can facilitate patients accessing necessary reproductive health services.

13. Key Informants and subject matter experts shared opportunities for future research that the Washington State Legislature, state agencies, or universities should consider to improve access to reproductive health services in Washington State, including:
   a. Conduct spatial analysis of reproductive health service and provider availability (e.g., county, zip code, census tract) to identify areas with service or provider shortages.
   b. Evaluate facial feminization procedures as means to reduce sexual and physical violence perpetrated against transgender people. The current evidence base does not meet requirements for medical-necessity and therefore facial feminization is not currently not covered by insurance.
   c. Determine the appropriateness, feasibility, and application of collecting additional health information for refugees at ports of entry to provide refugees with timely, appropriate health services (e.g., access to contraception).
   d. Conduct an in-depth analysis of state unintended pregnancy data to gain a more nuanced understanding of populations with high rates of unintended pregnancy and to identify effective strategies and interventions to increase access to contraception for those populations.
   e. Identify impact of limited service pregnancy centers (crisis pregnancy centers) on access to medically-accurate, timely reproductive healthcare.
# APPENDICES

## APPENDIX A: Barriers experienced by population group

<table>
<thead>
<tr>
<th>Economic barriers</th>
<th>Adolescents/Young adults</th>
<th>Older adults</th>
<th>Behavioral Health</th>
<th>Disability</th>
<th>Gender identity</th>
<th>Sexual orientation</th>
<th>Geography</th>
<th>Homelessness</th>
<th>Immigration</th>
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<th>Military</th>
<th>Racism</th>
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<tbody>
<tr>
<td>1. Insurance status</td>
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<td>3. Associated costs of care</td>
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<td>4. Non-medical expenses, debts</td>
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<td>5. Underfunding</td>
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## Structural barriers

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<th>Structural barriers</th>
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<td>6. Health facility closures and mergers</td>
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<td>7. Distance to services, travel time, and transportation</td>
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<td>8. Work, school, childcare limitations</td>
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<td>9. Lack of medical home</td>
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<td>10. Limited language access, lack of culturally and linguistically appropriate services</td>
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<td>11. Service and provider availability</td>
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<td>12. Limited services due to health system directives</td>
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<th>Military</th>
<th>Racism</th>
<th>SES</th>
<th>Violence</th>
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<tr>
<td>13.</td>
<td>Service or procedure requirements</td>
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<td>14.</td>
<td>Parental consent and age requirements, policy implementation, denial of services</td>
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<td>15.</td>
<td>Assumed heteronormativity and cisnormativity</td>
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<td>16.</td>
<td>Forms and procedures</td>
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<td>17.</td>
<td>Medically-accurate, comprehensive sexual health education and policy implementation</td>
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<td>18.</td>
<td>Clinical environment and conditions</td>
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<td>19.</td>
<td>Lack of formal provider training or medical education</td>
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<td>20.</td>
<td>State and federal legal rulings or legislation</td>
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<td>21.</td>
<td>Insurance coverage</td>
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<td>22.</td>
<td>Explanation of benefits and electronic health records</td>
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<td>23.</td>
<td>Difficulty navigating insurance system</td>
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### Literature Review on Inequities in Reproductive Health Access

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<th>Adolescents/Young adults</th>
<th>Older adults</th>
<th>Behavioral Health</th>
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<th>Sexual orientation</th>
<th>Geography</th>
<th>Homelessness</th>
<th>Immigration</th>
<th>Incarceration</th>
<th>Military</th>
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<th>SES</th>
<th>Violence</th>
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<td>24.</td>
<td>Difficulty in obtaining medically-accurate information about services</td>
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<td>25.</td>
<td>Personal identification document requirements</td>
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<td><strong>Social barriers</strong></td>
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<td>27.</td>
<td>Intimate Partner Violence</td>
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<td>Reproductive and pregnancy coercion</td>
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<td>Physical and/or sexual violence</td>
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<td>30.</td>
<td>Mandatory reporting</td>
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<td>31.</td>
<td>Differential treatment, practices, or counseling by provider</td>
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<td>32.</td>
<td>Denial or delay of services</td>
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<td>33.</td>
<td>Fear, perception, or experience of bias, discrimination, stigmatization</td>
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<td>Lack of social support</td>
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<td>Individual health literacy</td>
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<td>36.</td>
<td>Patients’ individual attitudes and beliefs</td>
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<td>37. Parent/guardian/intimate partner’s individual attitudes and beliefs</td>
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<td>38. Providers’ individual attitudes and beliefs</td>
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<td>39. Misconception by providers/society about sexual activity and risks</td>
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<td>40. Fear of deportation, separation from family, and other legal action</td>
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<td>41. Mobility</td>
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<td>42. Substance use</td>
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<td>43. Historical trauma and medical mistrust</td>
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<td>44. Lack of actual or perceived confidentiality/privacy</td>
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<td>45. Criminalization of individuals or behaviors, and fear of criminal justice involvement</td>
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APPENDIX B: Search terms, articles, and key informants by population

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<tr>
<th>Population</th>
<th>Search terms</th>
<th>Number of articles included</th>
<th>Number of key informant interviews</th>
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<tr>
<td>Adolescents/young adults</td>
<td>Adolescent, Young Adult, Teen</td>
<td>29</td>
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<tr>
<td>Older adults</td>
<td>STI, sexually transmitted infection, postmenopausal, older adult, older men, older women, senior, Medicare, nursing home</td>
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<tr>
<td>Behavioral Health</td>
<td>(&quot;mental health&quot; OR &quot;substance use&quot; OR &quot;behavioral health&quot;)</td>
<td>6</td>
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<tr>
<td>Disability</td>
<td>(disability* OR impairment*)</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Gender identity</td>
<td>(&quot;gender identity&quot; OR &quot;gender nonconforming&quot; OR transgender OR trans)</td>
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</tr>
<tr>
<td>Sexual orientation</td>
<td>LGBTQ, Sexual orientation</td>
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<td>4</td>
</tr>
<tr>
<td>Geography</td>
<td>Rural Geography</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Homelessness</td>
<td>(&quot;housing&quot; OR &quot;homeless&quot;)</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Immigration</td>
<td>(immigra* OR detain* OR asylum OR citizen*)</td>
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<tr>
<td>Incarceration</td>
<td>incarcerat*, jail, prison*, criminal justice involved</td>
<td>16</td>
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<tr>
<td>Military and Veterans</td>
<td>(military OR &quot;active duty&quot; OR veteran) (&quot;tricare&quot;)</td>
<td>10</td>
<td>2</td>
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<tr>
<td>Racism</td>
<td>(race OR ethnicity) (&quot;racial disparities&quot;) People of color</td>
<td>37</td>
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<tr>
<td>SES</td>
<td>(socioeconomic OR SES)</td>
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<tr>
<td>Violence</td>
<td>(violence OR intimate partner violence OR “IPV”) (“sex traffick” OR traffick*)</td>
<td>33</td>
<td>4</td>
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</table>

**Literature Review on Inequities in Reproductive Health Access**
APPENDIX C: Terminology specific to victims/survivors of violence

**Human trafficking** is a form of modern-day slavery in which traffickers use force, fraud or coercion to control victims for the purpose of engaging in commercial sex acts or labor services against their will.\(^\text{269}\)

Victims in the U.S. are entitled to protection and assistance, regardless of their immigration status.\(^\text{270}\)

**Labor trafficking** is using force, fraud or coercion to recruit, harbor, transport, provide or obtain a person for labor or services in involuntary servitude, peonage, debt bondage or slavery.\(^\text{270}\)

Labor trafficking has been found in diverse labor settings, including domestic work, small businesses, large farms and factories.\(^\text{269}\)

**Sex trafficking**, under Washington State law, is a commercial sex act induced by force, fraud, or coercion or in which the person induced to perform such act is under the age of 18.\(^\text{270,271}\)

Sex trafficking has been found in a wide variety of venues including residential brothels, escort services, massage businesses, strip clubs, and others.\(^\text{269}\)

**Domestic trafficking** involves US citizens, lawful permanent residents, and immigrants who are undocumented, and is often disproportionately perpetrated against vulnerable women and children.\(^\text{167}\)

**Intimate partner violence (IPV)** is any type of physical, sexual, or psychological harm done by a current or former partner or spouse (both heterosexual and same-sex); it also includes stalking, and loss of reproductive control such as refusal to use a condom. IPV includes abusive behavior also referred to as domestic violence.\(^\text{133}\)

**Reproductive coercion (RC):** attempts to promote pregnancy in an individual who can become pregnant through verbal pressure and threats to become pregnant (pregnancy coercion), direct interference with contraception (birth-control sabotage), and threats and coercion related to pregnancy continuation or termination (control of pregnancy outcomes).\(^\text{168,242}\)

While the predominant form of RC involves a male partner’s dominance over a woman, women, same-sex partners, and intergenerational relations (i.e., parents or in-laws) can also engage in RC.\(^\text{225}\)
APPENDIX D: Terminology specific to LGBTQIA people

Adapted from UC Davis LGBTQIA Glossary\(^{139}\)

**Cisgender**: a gender identity that society deems to match the person’s assigned sex at birth. The prefix cis- means "on this side of" or "not across."

**Cissexism/Genderism**: The pervasive system of discrimination and exclusion that oppresses people whose gender and/or gender expression falls outside of cis-normative constructs. This system is founded on the belief that there are, and should be, only two genders & that one’s gender or most aspects of it, are inevitably tied to assigned sex.

**Gender**: A social construct used to classify a person as a man, woman, or some other identity. Fundamentally different from the sex one is assigned at birth.

**Gender Identity**: A sense of one’s self as trans, genderqueer, woman, man, or some other identity, which may or may not correspond with the sex and gender one is assigned at birth.

**Gender Non Conforming (GNC)**: people who do not subscribe to gender expressions or roles expected of them by society. More commonly a way to describe a demographic or experience rather than a term someone may identify themselves as.

**Heteronormativity**: A set of societal norms, practices, and institutions that promote binary alignment of biological sex, gender identity, and gender roles; assume heterosexuality as a fundamental and natural norm; and privilege monogamous, committed relationships and reproductive sex above all other sexual practices.

**Intersectionality**: A term to describe the way that multiple systems of oppression interact in the lives of those with multiple marginalized identities.

**Misgendering**: Attributing a gender to someone that is incorrect/does not align with their gender identity

**Non-binary**: A gender identity and experience that embraces a full universe of expressions and ways of being that resonate for an individual. It may be an active resistance to binary gender expectations and/or an intentional creation of new unbounded ideas of self within the world. For some people who identify as non-binary there may be overlap with other concepts and identities like gender expansive and gender non-conforming.

**Sexual Orientation**: Sexual Orientation is an enduring emotional, romantic, sexual or affectional attraction or non-attraction to other people. Sexual orientation can be fluid and people use a variety of labels to describe their sexual orientation

**Transgender**: Adjective used most often as an umbrella term, and frequently abbreviated to “trans.” This adjective describes a wide range of identities and experiences of people whose gender identity and/or expression differs from conventional expectations based on their assigned sex at birth – including non-binary people. Not all trans people undergo medical transition (surgery or hormones). Another commonly held definition:

1. Someone whose determination of their sex and/or gender is not universally considered valid; someone whose behavior or expression does not “match” their assigned sex according to society.

**Trans man**: A person may choose to identify this way to capture their gender identity as well as their lived experience as a transgender person.

**Trans woman**: A person may choose to identify this way to capture their gender identity as well as their lived experience as a transgender person.
APPENDIX E: Terminology specific to immigrants and refugees

Draft pending key informant review
APPENDIX F: List of key informants

*Draft pending key informant review*

APPENDIX G: Relevant Washington State specific reports and recommendations

- Bree Collaborative LGBTQ recommendations (2018)
REFERENCES

4. Legislature WS. Senate Bill 6580 (SB 6580), Concerning human immunodeficiency virus (HIV) testing In:2018.
9. Health KCBo. Signature Report R&R BOH17-04.2. In. A rule and regulation relating to disclosure of information by limited service pregnancy centers; adding a new Title 4A to the BOH Code; enacted pursuant to RCW 70.05.060, including the latest amendments or revisions thereto. Vol BOH17-04. Seattle, WA: King County Courthouse; 2017.
Literature Review on Inequities in Reproductive Health Access


Literature Review on Inequities in Reproductive Health Access


Literature Review on Inequities in Reproductive Health Access


76. *Discrimination in America: Experiences and Views of LGBTQ Americans.* National Public Radio

Robert Wood Johnson Foundation
Literature Review on Inequities in Reproductive Health Access


Literature Review on Inequities in Reproductive Health Access

121. Health WSDo. Prenatal Care. 2014.
Literature Review on Inequities in Reproductive Health Access


156. Cawthon L. *TAKE CHARGE: Health Insurance Survey.* Washington State Department of Social and Health Services, Services and Enterprise Support Administration, Research and Data Analysis Division.;2015.


Literature Review on Inequities in Reproductive Health Access


165. Raymond-Flesch M, Siemons R, Pourat N, Jacobs K, Brindis CD. "There is no help out there and if there is, it's really hard to find": a qualitative study of the health concerns and health care access of Latino "DREAMers". *J Adolesc Health.* 2014;55(3):323-328.


Literature Review on Inequities in Reproductive Health Access

188. Andrews E. This little clinic is tackling the big problem of rural teen pregnancy. 28 May 2015, 2015.
Literature Review on Inequities in Reproductive Health Access


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