Since 2000, when the first hormonal intrauterine device (IUD) was approved in the United States, there has been growing enthusiasm for long-acting reversible contraceptive (LARC) methods (IUDs and implants). Because LARCs are highly effective at preventing pregnancy, increasing their use has become a primary focus of efforts to achieve public health goals related to reducing unintended pregnancy.

Efforts to expand contraceptive access have prioritized LARCs and have primarily focused on addressing cost, provider, and policy barriers to their provision. While this work has been, at least in part, motivated by the fact that these barriers have historically made LARCs disproportionately difficult to access, efforts have often gone beyond addressing barriers to promoting LARCs as first-line contraception through marketing campaigns and a tiered-effectiveness counseling model that emphasizes effectiveness as the most important method attribute.7–10

Many have raised concerns over unintended consequences of such a heavy emphasis on LARC promotion for people’s autonomy and trust in the health care system. This is particularly a concern among communities of color, youth, poor people, undocumented immigrants, and incarcerated individuals for whom the experience of being directed, or coerced, into using particular methods is nothing new but rather part of an ongoing legacy of reproductive oppression.11–13 Even when providers do not intend to be directive, an emphasis on LARCs in programmatic work or counseling can be experienced as pressure.14,15 Furthermore, promoting LARCs as the ideal methods (in counseling or marketing), and assuming that barriers to access are the only reason people do not use them, runs the risk of steering people away from methods that might be most effective for them and perpetuating understandable distrust in family-planning providers and programs.

The growing recognition of the need to move beyond a siloed focus on LARCs and financial barriers provides an opportunity for a next generation of contraceptive access efforts to do more. Such work can build on past programmatic and policy successes related to LARC provision and expand to addressing a
broader range of barriers people face in and out of the health care system. To help guide this next generation, we have defined a framework grounded in principles of person-centeredness and health equity as well as a recognition of the influence of structural and social contexts.

Patient-centeredness, as defined by the Institute of Medicine, refers to “providing care that is respectful of, and responsive to, individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.” Grounding contraceptive access initiatives in the principle of person-centeredness inherently leads to prioritization of individuals’ well-being and positive experiences with care, rather than a more narrow focus on preventing unintended pregnancy at the potential expense of people’s autonomy.  

Health equity refers to the goal that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential. An equity frame, including a focus on actively countering white supremacy and racism, is critical, given our long societal legacy of favoring the reproduction of affluent, able-bodied whites over other groups, a phenomenon termed stratified reproduction.

Our country has a long history of systematically attempting to control the reproductive lives of women of color, particularly black women, and limit or demonize their childbearing. It is imperative that contraceptive access efforts recognize and actively work to avoid perpetuating the harmful impacts this ongoing legacy of reproductive oppression can have on the autonomy and well-being of communities of color and other marginalized communities.

In defining this new framework (Figure), we also draw on social ecological theory, which describes how social, environmental, and policy contexts interplay to influence health, to depict multiple levels of influence on contraceptive care delivery and people’s engagement and experiences with the health care system. In the following text, we describe each part of the framework in detail.

**Contextual factors.** The historical, social, political, and economic context in the United States fundamentally influences health care delivery. Multiple oppressions, including racism, sexism, and economic injustice, intersect to create the reproductive oppression of people of color; poor people; lesbian, gay, bisexual, transgender, and questioning (or queer) people; and others. Furthermore, cultural and religious biases against contraception, and the stigma associated with sexuality and sexual and reproductive health care, are ever present and can interact with these oppressions. Without explicit attention to the ways in which certain groups are at a disadvantage in engaging with care, programs may inadvertently worsen disparities in sexual and reproductive health and autonomy.

In the policy and health systems context, the policies of public and private payers, including those related to the Affordable Care Act, Medicaid, and Title X, are well recognized as influencing contraceptive access, as are current clinical and public health priorities, such as a focus on reducing unintended pregnancy and abortions. However, it is also essential to pay attention to less recognized factors in the health system context that can impede women’s ability to have their contraceptive choices respected or their needs met, including the power imbalance between providers and patients stemming from a fundamentally paternalistic medical system and the lack of contraceptive methods with attributes that match individuals’ preferences. (Studies have shown that existing highly effective contraceptive methods are particularly ill suited to meet the preferences of many people of color.)

Contraceptive access initiatives should also recognize how they are embedded in community and social contexts, including family, peer, and partner relationships and norms, and work to build approaches that optimize access and quality within these networks. Particularly for adolescents, family norms related to the acceptability of communication about sexual and reproductive health and the permissibility of contraceptive use, shape individual health care seeking behavior. Notably, different forms of violence can also interfere with people’s ability to seek contraceptive care and follow-up support.

**Continuum of care.** Comprehensively meeting individuals’ contraceptive needs requires thinking across the continuum of care, before, during, and after individuals interact with the health care system, in an integrated manner. The continuum of care depicted in the framework is comprised of four components: outreach and trust building, access, quality, and follow-up support.

Outreach and trust building in the framework represents efforts to reach people outside the health care system with information and build trust. Importantly, this component is conceptualized as being distinct and more comprehensive than standard approaches to marketing services or LARCs to communities. Outreach and trust building mechanisms should be designed to meet people’s educational needs, provide social support to enable individuals to seek desired contraceptive care, convey people’s right to high-quality services, and cultivate dialogue and healing between communities and health care systems. Establishing robust referral networks among diverse multisector organizations is also critical to ensure individuals are informed about high-quality services. Access refers to efforts needed to address financial and other logistical barriers to accessing contraceptive care,

*(We use the term person-centered rather than patient-centered in recognition of the factors outside the health care system that influence whether individuals’ contraceptive needs are met. We recognize that there is also movement toward use of a frame of person-led health care and welcome further elaboration of this frame to deepen accountability of the health care system for prioritizing patient experience and autonomy.)*
such as transportation and child care. Ensuring clinics are stocked with the full range of contraceptive methods, and that they are all free or affordable for patients, is critical. Proactively addressing sustainability is particularly important to ensure people are not incentivized to choose LARCs because of a fear of losing access to contraception.

Providing flexible options for care delivery modalities through innovative solutions such as telemedicine, pharmacy and over-the-counter access, and online ordering of contraceptive supplies is critical to expanding access to people living in rural communities, people living with disabilities, and others who face barriers to visiting clinics. Ensuring easy scheduling through online portals, call centers, same-day access, and extended office hours are also strategies to improve access.

Quality refers to the processes of contraceptive care and the degree to which services equitably respect and meet individuals’ needs. Training related to evidence-based contraceptive provision and providing same-day access to the full range of methods are aspects of quality that have received much attention. However, given the historical context and ongoing research showing that women of color receive lower-quality family planning care and are more likely to be pressured to use contraception and have LARC methods recommended than white women (specifically among low-income groups), it is also critical that a focus on quality includes attention to equity and racism.

Trainings for all clinical staff on these issues, intentionally led by experts from...
the women-of-color—led reproductive justice movement, can provide a necessary foundation for a sustained commitment to providing care that does not perpetuate injustices and actively seeks to repair historical and ongoing oppressions. Training in structural competency, a framework for assessing how health care systems can recognize and address social structures that influence patients’ health behaviors and health care seeking, is also an area for more work to facilitate the provision of high-quality services that repair harms and engender trust.35

With respect to contraceptive counseling, it is essential that training include how to elicit and respond to patients’ needs and values, as opposed to providers’ priorities. While the tiered-effectiveness model has dominated past initiatives, recent recognition of the importance of patient-centeredness in contraceptive care has led to a growing emphasis on shared decision making as an alternative approach. This model of counseling, which is consistent with patient preferences26 and associated with improved patient experiences,37 is designed to elicit patients’ contraceptive priorities and support them in finding a method that is the best fit for these preferences.

Counseling training should also emphasize the importance of providing information about noncontraceptive benefits of different methods, including their ability to prevent sexually transmitted infections and their benefits for conditions such as fibroids or dysmenorrhea, so that individuals can consider the full range of features relevant to their overall well-being.

In cases in which contraceptive care is provided at sites that do not provide other clinical services, and particularly other reproductive health services such as abortion, prenatal care, and infertility services, attention should be paid to having robust referral networks and processes for facilitating care coordination. Finally, leveraging and enhancing quality improvement efforts is necessary to sustain high-quality, person-centered services. Focusing on patient experience, through tools such as patient surveys and engagement with patient stakeholder groups, and systematically incorporating findings into quality improvement efforts, can ensure that patient-centeredness is continuously foregrounded.

The final component of the care continuum, follow-up support, refers to ongoing support for contraceptive use, switching, or discontinuation. Patient concerns about side effects are often perceived by clinicians as nuisances to effective contraceptive use, as opposed to legitimate concerns, which can manifest in a tough-it-out approach to counseling and reluctance to remove LARCs.38,39 Clinical systems should instead develop person-centered support services and robust systems for ongoing communication with patients.

Follow-up modalities should be integrated with easy scheduling of follow-up appointments and method switching, including LARC removal, on request. Support for side effect management can include availability of clinical advice through flexible means (eg, patient portals, drop-in clinics, texting) and online materials to support people’s ability to assess and understand their own needs. Clinical systems must also have systematic approaches to ensuring patient confidentiality, including staff training on respecting patient preferences for communication. Finally, recognizing that no contraceptive prevents all pregnancies, offering person-centered pregnancy options counseling is an essential aspect of high-quality contraceptive care.40

As depicted along the bottom of the framework, authentic community engagement to design programs, and provide feedback as programs evolve, is critical to ensure efforts are responsive to the unique needs of the communities they aim to serve.

2. Call to action: think broadly about how to ensure high-quality contraceptive care for all

The goal of this framework is to provide a blueprint for policymakers, program implementers, and researchers working on the next generation of contraceptive access initiatives to ground their efforts in person-centeredness and health equity and consider structural and social contexts that shape people’s experiences.

This framework, like other models grounded in social ecological theory, illustrates the complexity of a social environment and the multiple levels of influence on health outcomes. We recognize that initiatives will almost always be constrained by availability of resources in their ability to include the full range of programmatic elements and limited in their ability to tackle underlying oppressions.

An additional constraint in the ability to operationalize this framework is that, for certain components, such as ensuring same-day access through revising facility billing, well-tested approaches exist,41,42 whereas in others, such as referrals and training in race equity and structural competency, there is a need to develop evidence-based best practices.

These limitations should not interfere with future contraceptive access initiatives engaging with the broad range of factors and components described in the Person-Centered Contraceptive Care Framework. Initiatives can intentionally consider how programmatic efforts align with framework components and strive to incorporate additional components across the care continuum where possible. They can proactively be cognizant of broader structural and social factors that will influence their success and the likelihood of negative unintended consequences for certain groups.

In this way, future efforts to expand contraceptive access can deliberately work to design programs that meet all people’s contraceptive needs, with the ultimate goal of supporting individuals’ reproductive autonomy and advancing health equity.

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