The impact of US policy on contraceptive access: a policy analysis

Laura E. T. Swan*

Abstract

Background: Contraceptive access is influenced by policy decisions, which can expand and constrict the contraceptive options available. This study explored the impact of recent US federal policy on contraceptive access.

Methods: Federal policy changes impacting contraceptive access over the past decade were identified in grey literature. These policy changes were organized into a timeline and analyzed according to Levesque et al’s (2013) five dimensions of healthcare access (approachability, acceptability, availability/accommodation, affordability, and appropriateness), noting the most salient healthcare dimension impacted by the policy change and analyzing whether, according to this framework, the policy created a theoretical increase or decrease in contraceptive access.

Results: Of those policy changes coded as increasing ($n=42$) and decreasing ($n=28$) contraceptive access, most were related to the affordability (increasing $n=13$; decreasing $n=12$), physical availability (increasing $n=10$; decreasing $n=7$), and appropriateness (increasing $n=12$; decreasing $n=4$) of contraceptive care. Policy changes largely followed partisan divides, with contraceptive access increasing in years with a Democratic president and decreasing when a Republican president was in office. Many policy changes were related to the Affordable Care Act (ACA) and Title X of the Public Health Services Act. The implementation of the ACA and subsequent updates to it have increased the affordability of contraception, whereas changes to Title X have decreased the availability and appropriateness of contraceptive care.

Conclusions: This study highlights recent policy changes impacting contraceptive access, organizing them according to the five dimensions of healthcare access. It outlines specific policy barriers to contraceptive access and provides suggestions for policy and practice action that will improve contraceptive access and reproductive autonomy. Opportunities to ensure contraceptive access for all Americans include promoting comprehensive sex education, extending the Community Health Center Fund, increasing contraceptive care options for people with employers who are exempted from the ACA contraceptive mandate, addressing discrimination and building trust in contraceptive care, and amplifying outreach efforts to combat misinformation and confusion created by continuous changes to key family planning policies. Continued research on the role of policy in determining reproductive autonomy is warranted, and practice and policy action is needed to improve contraceptive access.

Keywords: Family planning, Reproductive health, Healthcare access, Grey literature, Contraceptive care

*Correspondence: lswan2@wisc.edu
Department of Population Health Sciences, University of Wisconsin-Madison, Madison, WI, USA
In the United States, nearly half of pregnancies are unintended [1–3], and a majority of reproductive-aged women are at risk of unintended pregnancy [4]. Although correct and consistent use of contraception reduces the risk of unintended pregnancy to 5% [5], many Americans face challenges to accessing contraception, citing barriers such as affordability [6–8], shame or embarrassment [9, 10], and difficulty physically reaching services [7, 11]. Furthermore, barriers to care disproportionately impact populations who are already marginalized based on factors such as age, income, race/ethnicity, rurality, education level, or exposure to violence [2, 11–13].

In addition, policy decisions expand and constrict the contraceptive options available. For example, in 1873, the Comstock Act limited contraceptive access by marking contraceptives as obscene and criminalizing their distribution [14] until nearly a century later in the 1965 Supreme Court decision in Griswold v. Connecticut [14, 15]. Meanwhile, eugenics practices flourished and were affirmed in the 1927 Supreme Court decision in Buck v. Bell which upheld the legality of forced sterilization [14, 16]. In 1942, in Skinner v. Oklahoma, the Supreme Court ruled against compulsory sterilization of convicted criminals but did not address the forced sterilization of other populations (e.g., based on income, minority status, or mental illness) [14, 15, 17]. These practices continued for many years, and reports of the forced sterilization of imprisoned populations and coercion involving incentives to promote permanent or long-acting contraception continue to emerge [16, 18]. The eugenics movement also helped propel the development and distribution of the contraceptive pill, which was tested on Puerto Rican women in the 1950s and has been used as a method of population control, targeting groups whose reproduction was considered "undesirable" [19, 20].

Other policies have increased contraceptive access by creating funding streams that help make family planning services more available and affordable. For example, Title X of the Public Health Services Act of 1970 (Title X) established federal funding for family planning services [14, 21]. This policy has increased contraceptive access by providing funds to community-based health facilities across the country, allowing for more affordable contraceptive care to be provided in convenient locations. Similarly, when Medicaid was expanded in 1972 to fund family planning services and supplies [22], contraceptive access increased by improving the availability and affordability of contraception.

In recent years, reproductive politics in the US have been at the forefront of polarized political debate, with many Democrats and Republicans differing significantly in their view on topics including abortion and contraception [23, 24]. Typically, Democrats are more aligned with progressive policies that promote family planning access, whereas Republicans often promote legislation that aligns with social and fiscal conservatism [25–28]. Debates over health policy have occurred amongst shifts in political power which influence the proposal and passage of family planning legislation [23, 29]. In roughly the past decade, the US presidential office has passed from Republican George W. Bush to Democrat Barack Obama in 2009, then to Republican Donald Trump in 2017, and most recently, to Democrat Joe Biden in 2021 [30]. In addition, the majority party in the US Senate and House
of Representatives shifts over time, most recently passing from a Democratic Senate majority from 2009 to 2015 to a Republican Senate majority from 2015 to 2021 and a from a Democratic House majority from 2009 to 2011 to a Republican House majority from 2011 to 2019 and finally to a Democratic House majority from 2019 to 2021 [31, 32]. These power shifts greatly influence policy decisions [29] which can create or prevent contraceptive access.

Current study
Earlier works [14] have reviewed and analyzed the history and impact of US reproductive politics prior to important recent changes in family planning legislation. To provide a comprehensive and overarching understanding of the state of contraceptive care in the United States and to identify needs for policy and practice action, there is a need for research that consolidates and analyzes the role of more recent policy changes in determining reproductive healthcare access and contraceptive access, specifically. Levesque et al.'s (2013) healthcare access framework can be applied to concretely examine the individual and system-level factors that determine contraceptive access [33]. This framework conceptualizes access to healthcare as determined by five dimensions (approachability, acceptability, availability and accommodation, affordability, and appropriateness) that interact to generate healthcare access. See Table 1 for a description of this healthcare access framework and application of its dimensions to contraceptive care.

Applying Levesque et al.'s (2013) healthcare access framework [33] to explore the role of US policy in determining contraceptive access, the following research question guided this study: How have federal US policy changes from 2009 to 2019 impacted contraceptive access? To answer this question, I identified relevant policy changes and organized them into a policy timeline, analyzing these policy changes according to Levesque et al.'s (2013) five dimensions of healthcare access [33].

Methods
In May 2020, I used Google to systematically search grey literature (i.e., government, academic, business, and industry works not controlled by commercial publishers) [34] for websites, news articles, and reports that discussed recent (passed from 2009 to 2019) US federal policy influences on contraceptive access. Utilizing grey literature sources allowed me to capture policy-related landmarks that impact contraceptive access regardless of whether the policies themselves directly include language about contraception and healthcare access. This also allowed for the identification of incremental and recent policy changes not yet represented in peer-reviewed literature. I used keywords related to contraceptive access (i.e., “family planning” OR contraception OR “birth control”) and healthcare access, as conceptualized by

Table 1 Description of Healthcare Access Framework and Application to Contraceptive Care

| Dimension          | Description                                                                 | Application to Contraceptive Care                                                                 |
|--------------------|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| Approachability    | The ability to perceive the need for care. Related to community members’ health knowledge and health literacy, the transparency of available health services, and providers’ outreach endeavors. | - Sex education  
- Accuracy of contraceptive knowledge  
- Information about available family planning services and how and where to access this care |
| Acceptability      | The ability to seek care. Related to cultural and social factors that determine how people think and feel about healthcare services. | - Beliefs, social norms, stigma, and fear of judgment surrounding sex, contraceptive use, and pregnancy  
- Comfort with family planning conversations  
- Decision-making priorities  
- Trust in family planning providers and the confidentiality of care |
| Availability and   | The ability to physically reach care in a timely manner. Related to the geographic location of services, the hours of operation and availability of appointments, facility accessibility, and availability of transportation needed to reach care. | - Family planning clinics’ physical location and health center density  
- Shortages in family planning providers  
- Limited clinic hours of operation  
- Same-day, on-site availability of contraceptive services |
| Accommodation      |                                                                                                                                     |                                                                                      |
| Affordability      | The ability to pay for care. Related to the price of health services and community members’ income and other assets such as time, health insurance, and social capital. | - Cost and insurance coverage of contraceptive care  
- Patients’ income and access to health insurance  
- Local and federal family planning funding |
| Appropriateness    | The ability to engage with care. Related to the fit between patient needs and the care offered, how adequately providers are trained to meet patient needs, and the interpersonal quality of the care provided. | - Providers’ ability to meet the contraceptive needs and priorities of their community  
- Provider’s family planning knowledge and training  
- Provider preparedness to provide comprehensive and unbiased contraceptive care  
- On-site availability of multiple contraceptive options  
- Providers’ decision-making model |

* Adapted from Levesque et al. [33]
Levesque et al. (2013; e.g., transparency, transportation, insurance) [33]. I reviewed a total of 150 search results, including the first 30 results from a search with no year specified and the first 10 results from searches of sources published each year from 2009 to 2020. Of these, 65 sources were excluded for being duplicate sources, irrelevant to the topic at hand, not qualifying as grey literature, or discussing policies that were state-level, international, or passed before the target date of 2009. This left 85 grey literature sources (full list available upon request). Using these sources, I recorded any US federal policy change passed from 2009 to 2019 that was discussed as relevant to contraceptive access, and I noted a brief description of each policy. Then, I organized these policy changes into a timeline and coded them according to Levesque et al’s (2013) dimensions of healthcare access [33], noting the most salient healthcare dimension impacted by the policy change and analyzing whether, according to this framework, the policy created a theoretical increase or decrease in contraceptive access. Through this process, I identified, analyzed, and organized specific policy barriers to contraceptive access, allowing me to present suggestions for policy and practice action that should improve contraceptive access and reproductive autonomy.

Findings
Table 2 shows the policy timeline created using grey literature. This timeline provides the date and brief description of 77 US federal policy changes occurring between the years of 2009 and 2019, each described in grey literature as impacting contraceptive access. These policy changes were coded according to the most salient healthcare access category and according to whether they increased or decreased overall contraceptive access. Several (n=7) political changes and appointments (e.g., Donald Trump being inaugurated as US president in January 2017) are also included in the policy timeline as relevant policy landmarks but are not coded according to access category because they would likely only impact contraceptive access indirectly via subsequent policy changes. I coded 42 policy changes as increasing contraceptive access and 28 as decreasing contraceptive access. Policy changes thought to increase contraceptive access were most commonly coded as relevant to affordability (n=13), followed by appropriateness (n=12), availability and accommodation (n=10), approachability (n=5), and acceptability (n=2). Policy changes thought to decrease contraceptive access were most commonly coded as affordability (n=12), followed by availability and accommodation (n=7), appropriateness (n=4), approachability (n=3), and acceptability (n=2).

Approachability
Policy can impact contraceptive approachability by changing the way that community members perceive the need for contraceptive care and understand how and where such care can be accessed. The 2009 Health Information Technology for Economic and Clinical Health Act (HITECH), enacted as part of the American Recovery and Reinvestment Act, made changes to the administration of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 [35]. This change increased the privacy and security of health data and increased transparency when breaches occur [35]. Later, the Final Omnibus Rule of 2013 filled remaining security and privacy gaps in HIPAA and HITECH regulations [36]. These policy changes relate to contraceptive approachability because they impact the transparency and security of contraceptive care, potentially improving contraceptive approachability by growing trust in health systems and helping community members perceive contraceptive services as beneficial.

Additionally, the Title V Abstinence Education Grant Program, which had supported abstinence-only sex education since 1996, briefly expired in June 2009 [37]. However, it was resurrected in 2010 through the inclusion of Title V funding in the Affordable Care Act (ACA) [37]. It once again expired briefly in September 2017 and was reintroduced and renamed the “Sexual Risk Avoidance Education” program in the Bipartisan Budget Act of 2018 [37, 38]. Another stream of funding for abstinence-only sex education, the Community-Based Abstinence Education Grant Program, which was established in 2000, was eliminated through the Consolidated Appropriations Act of 2011 [37]. This program was later revived as the “Competitive Abstinence Education” program through the Consolidated Appropriations Act of 2012 and renamed the “Sexual Risk Avoidance Education” program in the Consolidated Appropriations Act of 2016 [37, 38]. These policy changes influence contraceptive approachability because they impact the contraceptive education and information available to community members which can change perceptions of the need for and usefulness of contraceptive care.

Acceptability
Policy changes can impact contraceptive acceptability by influencing the ways that people think and feel about seeking care. For example, changes to structural responses to sexual violence impact contraceptive acceptability by influencing survivors’ ability and willingness to seek care after victimization. In April 2011, the US Department of Education’s Office of Civil Rights sent a document known as the “Dear Colleague letter” to advise colleges and universities of new Title IX of the Education
Table 2  Policy Timeline: Changes in Federal US Policy (2009–2019) Impacting Contraceptive Access

| Date    | Policy Change                                                                 | Theoretical Impact |
|---------|-------------------------------------------------------------------------------|--------------------|
| Jan 2009 | Barack Obama inaugurated as US president                                       | -                  |
| Feb 2009 | Health Information Technology for Economic and Clinical Health (HITECH) enacted as part of the American Recovery and Reinvestment Act of 2009, increasing Health Insurance Portability and Accountability Act (HIPAA) privacy/security | ↑ Approachability  |
| Apr 2009 | The Food and Drug Administration (FDA) lowers over-the-counter emergency contraceptive age to 17 years old | ↑ Availability/ Accommodation |
| Jun 2009 | Title V abstinence-only-until-marriage program expires                         | ↑ Approachability  |
| Dec 2009 | Mikulski’s Women’s Health Amendment to the Patient Protection and Affordable Care Act (ACA) passes, adding women’s preventive care as mandated services | ↑ Affordability    |
| Dec 2009 | Consolidated Appropriations Act of 2010 creates Teen Pregnancy Prevention Program | ↑ Appropriateness  |
| Mar 2010 | ACA signed into law                                                            | ↑ Affordability    |
| Mar 2010 | ACA amended through the Health Care and Education Reconciliation Act (HCERA) to include student loan reform, close the Medicare Part D donut hole, increase Medicaid payment rates, and expand Medicaid | ↑ Affordability    |
| Jun 2010 | US Medical Eligibility Criteria for Contraceptive Use published to provide recommendations on safe use of contraceptive methods | ↑ Appropriateness  |
| Dec 2010 | Healthy People 2020 establishes federal prevention agenda                       | ↑ Appropriateness  |
| Dec 2010 | Consolidated Appropriations Act of 2011 ends Community-Based Abstinence Education grant program and eliminates abstinence-only portion of the Adolescent Family Life Act | ↑ Approachability  |
| Jan 2011 | National Defense Authorization Act of 2011 creates TRICARE Young Adult, extending military member dependent coverage | ↑ Affordability    |
| Apr 2011 | “Dear Colleague letter” sent to colleges and universities regarding new Title IX guidance on student harassment | ↑ Acceptability    |
| Aug 2011 | ACA interim final rules announced in which the US Department of Health and Human Services (HHS) adopts IOM women’s preventive care guidelines, adding contraceptive coverage and preventive services to those covered by the ACA | ↑ Affordability    |
| Dec 2011 | HHS overturns FDA decision to make emergency contraception available over the counter regardless of age | ↓ Availability/ Accommodation |
| Dec 2011 | Consolidated Appropriations Act of FY 2012 revives federal funding for abstinence-only programs by establishing the Competitive Abstinence Education (CAE) grant program | ↓ Approachability  |
| Jan 2012 | Final rule church exemption from ACA contraceptive requirement announced        | ↓ Affordability    |
| Feb 2012 | Final rule ACA church exemption revised, extending it to other religious employers | ↓ Affordability    |
| Jun 2012 | National Federation of Independent Business v. Sebelius Supreme Court of the United States (SCOTUS) ruling upholding most ACA provisions but making Medicaid expansion optional for states | ↓ Affordability    |
| Aug 2012 | ACA contraceptive mandate implementation begins                                | ↑ Affordability    |
| Jan 2013 | Final Omnibus Rule fills gaps in existing HIPAA and HITECH regulations, increasing privacy/security | ↑ Approachability  |
| Jun 2013 | US Selected Practice Recommendations published to provide recommendations on how to use contraceptive methods safely and effectively | ↑ Appropriateness  |
| Jun 2013 | Safe Harbor rule announced, updating religious exemption to ACA contraceptive mandate | ↓ Affordability    |
| Mar 2013 | Campus Sexual Violence Elimination (Campus SaVE) Act integrated into the Violence Against Women Reauthorization Act of 2013, increasing requirements for colleges for sexual assault response and increasing survivors' rights | ↑ Acceptability    |
| Apr 2013 | Federal judge rules in Tummino v. Hamburg, removing age and point-of-sale restrictions on levonorgestrel-based emergency contraception, though 3-year market exclusivity was granted for Plan B® | ↑ Availability/ Accommodation |
| Jan 2014 | Medicaid expansion goes into effect                                             | ↑ Affordability    |
| Apr 2014 | Providing Quality Family Planning Services recommendations published, defining core services offered by family planning clinics | ↑ Appropriateness  |
| Jun 2014 | Burwell v. Hobby Lobby Stores, Inc. SCOTUS ruling that for-profit companies with a religious objection to birth control are exempt from ACA contraceptive mandate | ↓ Affordability    |
| Aug 2014 | Veterans Access, Choice, and Accountability Act of 2014 allows Veterans with specific burdens to receive healthcare with Choice contracted non-VA providers | ↑ Availability/ Accommodation |
| Jan 2015 | Navy increases availability of long-acting reversible contraception (LARC) during basic training and added walk-in contraceptive clinics | ↑ Availability/ Accommodation |
| Apr 2015 | Medicare and Children’s Health Insurance Program Reauthorization Act (MACRA) of 2015 passes, extending Community Health Center Fund for two years | ↑ Availability/ Accommodation |
| May 2015 | HHS clarifies contraceptive methods covered under the ACA as preventive services | ↑ Affordability    |
Table 2 (continued)

| Date     | Policy Change                                                                                                                                                                                                 | Theoretical Impact |
|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
| Oct 2015 | Indian Health Service increases over the counter emergency contraception accessibility to Indigenous people                                                                                                   | ↑ Appropriateness |
| Dec 2015 | Consolidated Appropriations Act of 2016 renames “Competitive Abstinence Education” program to “Sexual Risk Avoidance Education” program                                                                                      | ↓ Approachability |
| Jan 2016 | Marines restrict availability of LARCs at basic training and begin promoting injectable contraceptives over other methods                                                                                           | ↓ Availability/ Accommodation |
| Mar 2016 | Providing Quality Family Planning Services recommendations revised                                                                                                                                             | ↑ Appropriateness/ Accommodation |
| Apr 2016 | Plan B® market exclusivity expires, allowing all generic emergency contraceptives to be available over the counter without age or point-of-sale restrictions                                                            | ↑ Availability |
| May 2016 | Zubik v. Burwell SCOTUS ruling sends 7 cases brought by religious nonprofits back to Courts of Appeal                                                                                                           | ↑ Affordability |
| Jul 2016 | US Medical Eligibility Criteria for Contraceptive Use updated                                                                                                                                                  | ↑ Appropriateness |
| Jul 2016 | US Selected Practice Recommendations updated                                                                                                                                                                 | ↑ Appropriateness |
| Dec 2016 | Title X eligibility requirements amended, prohibiting exclusion from subawards for reasons other than ability to provide services                                                                              | ↑ Availability/ Accommodation |
| Jan 2017 | Donald Trump inaugurated as US president                                                                                                                                                                       | - |
| Jan 2017 | Anti-birth-control Katy Talento appointed to the White House Domestic Policy Council                                                                                                                          | - |
| Apr 2017 | Neil Gorsuch confirmed as SCOTUS justice                                                                                                                                                                         | - |
| Apr 2017 | Joint Resolution of Disapproval nullifies Dec 2016 Title X eligibility amendment                                                                                                                              | ↓ Availability/ Accommodation |
| May 2017 | Antiabortion activist Teresa Manning appointed to lead Title X programs                                                                                                                                       | - |
| Jun 2017 | Abstinence-only advocate Valerie Huber appointed HHS chief of staff to the assistant secretary for health                                                                                                        | - |
| Jul 2017 | Funding for Teen Pregnancy Prevention Program cut two years before grants were scheduled to end                                                                                                               | ↓ Appropriateness |
| Sept 2017 | Title IX guidance on student harassment (established in 2011 “Dear Colleague letter”) eliminated                                                                                                              | ↓ Acceptability |
| Sept 2017 | Title V abstinence-only program expired briefly                                                                                                                                                                | ↑ Approachability |
| Oct 2017 | Interim rules released, extending religious exemption from ACA contraceptive mandate                                                                                                                        | ↓ Affordability |
| Dec 2017 | Interim rules (extending religious exemption from ACA contraceptive mandate) challenged and blocked from implementation pending litigation                                                                    | ↑ Affordability |
| Feb 2018 | Bipartisan Budget Act of 2018 extends Community Health Center Fund for two more years                                                                                 | ↑ Availability/ Accommodation |
| Feb 2018 | Bipartisan Budget Act of 2018 rebrands and renews Title V abstinence-only program under new name “sexual risk avoidance education” program                                                                     | ↓ Approachability |
| Feb 2018 | Call for Title X funding applications radically shifts Title X program, emphasizing natural family planning over comprehensive and evidence-based care                             | ↓ Appropriateness |
| Feb 2018 | Strategic Plan for 2018–2022, which states that life begins at conception, finalized as a guide for federal policy                                                                                               | ↓ Acceptability |
| Apr 2018 | Funding Opportunity Announcements shift Teenage Pregnancy Prevention Program to promote abstinence-only sex education                                                                                           | ↓ Appropriateness |
| Apr 2018 | District Court rules in Planned Parenthood of Greater Washington and North Idaho et al. v. HHS in favor of Planned Parenthood regarding Teenage Pregnancy Prevention grant termination   | ↑ Appropriateness |
| May 2018 | Domestic gag rule (AKA “Protect Life Rule”) announced, proposing ban on abortion referrals and abortion counseling for Title X recipients                                                                     | ↓ Availability/ Accommodation |
| May 2018 | Domestic gag rule challenged and blocked from implementation pending litigation                                                                                                                             | ↑ Availability/ Accommodation |
| Jun 2018 | VA Mission Act of 2018 provides continuing education for community providers who serve veterans                                                                                                               | ↑ Appropriateness |
| Jun 2018 | Department expands reach of Association Health Plans                                                                                                                                                         | ↓ Affordability |
| Jul 2018 | Circuit court blocks Interim Rules extending religious exemption from ACA contraceptive mandate                                                                                                                  | ↑ Affordability |
| Aug 2018 | HHS shortens Title X funding period from 3 years to 7 months                                                                                                                                                | ↓ Availability/ Accommodation |
| Aug 2018 | Centers for Medicare and Medicaid Services extends short-term health plan duration                                                                                                                          | ↓ Affordability |
| Aug 2018 | District Court dismisses Planned Parenthood case against HHS regarding Teenage Pregnancy Prevention Program shift                                                                                             | ↓ Appropriateness |
| Oct 2018 | Brett Kavanaugh confirmed as SCOTUS justice                                                                                                                                                                  | - |
| Oct/Nov 2018 | Final Rules extending religious exemption from ACA contraceptive mandate released                                                                                                                         | ↓ Affordability |
| Mar 2019 | Domestic gag rule finalized and immediately challenged                                                                                                                                                        | ↓ Availability/ Accommodation |
| Mar 2019 | Federal judge invalidates Association Health Plans expansion on the grounds that it violates federal tax law                                                                                                   | ↑ Affordability |
Amendments (Title IX) guidelines, requiring schools to take actions to eliminate campus student harassment and sexual violence [39]. Later, under the Trump administration, US Secretary of Education Betsy Devos eliminated this guidance, requiring a higher evidence standard in sexual assault cases [40]. Meanwhile, one of the original compliance policies established to regulate college handling of sexual assault and harassment, the Clery Act, was amended when the Campus Sexual Violence Elimination Act (Campus SaVE Act) was integrated into the Violence Against Women Reauthorization of 2013, increasing requirements for colleges for sexual assault response and improving survivors’ rights [41, 42]. These policy changes have changed expectations of the ways that colleges prevent and respond to sexual violence. As a result, students may feel differently about reporting sexual violence to university employees. Likewise, university employees have increased guidance in how to respond to reports of sexual violence and refer students to relevant services. Since students experiencing sexual violence often have an increased need for reproductive health services and contraceptive care, these changes are relevant to contraceptive acceptability because they could impact students’ ability and willingness to seek healthcare, including contraception, following victimization.

Additionally, in September 2017, the US Department of Health and Human Services (HHS) announced a draft of the Strategic Plan for 2018 to 2022 [43]. This plan imposed religiously based ideological views, mentioning multiple times that life begins at conception [43, 44]. Despite widespread concerns with this plan, which is meant to guide federal policy over this four-year period, the final version of the Strategic Plan remained largely unchanged and retained references to life beginning at conception [45]. This policy change demonstrates the ways that social norms and religious beliefs can influence policy decisions and ultimately contraceptive access. Furthermore, indoctrinating these values into federal legislation could impact how people view the norms and stigma around the contraceptive care that they seek.

### Availability and accommodation

By influencing the location and density of health facilities and their ability to provide adequate appointments and services, policy also impacts people’s ability to physically reach contraceptive care in a timely manner. For example, in April 2009, the Food and Drug Administration (FDA) lowered the age at which people can access over-the-counter emergency contraception to 17 years old [46]. In 2011, the FDA recommended that the age restriction be eliminated entirely; however, HHS overruled the recommendation, likely in an effort to appease conservatives prior to the announcement of ACA contraceptive mandate rules [46, 47]. In 2013, the emergency contraception brand, Plan B One-Step, was approved for over-the-counter sale regardless of age [46]. In April 2016, market protection for Plan B One-Step expired, allowing over-the-counter sale of all emergency contraception regardless of age [46]. These policy changes are relevant to contraceptive availability and accommodation because they impact when, where, and how people can physically access emergency contraceptive care.

The Neighborhood Health Centers program was developed in the 1960s to provide community-based primary care and was subsequently funded through policies such as the Health Care Safety Net Act of 2008 [48]. In 2010, the ACA established the Community Health Center Fund to expand and operate these community-based health
centers which serve many low-income Americans [48]. This fund was initially authorized through 2015 and was extended to 2019 through the Medicare and Child Health Insurance Program Reauthorization Act of 2015 and the Bipartisan Budget Act of 2018 [49]. In response to the COVID-19 pandemic, the fund was extended in 2020 through the Coronavirus Aid, Relief, and Economic Security (CARES) Act and in 2021 through the American Rescue Plan [50, 51]. These policy changes are relevant to contraceptive availability and accommodation because they impact community members’ ability to physically access contraceptive care conveniently, in their local communities.

In December 2016, President Obama finalized an amendment to the Title X Family Planning program eligibility requirements, prohibiting exclusion from subawards for reasons other than the ability to provide services [52]. This amendment took effect in January 2017 but was promptly nullified under a Joint Resolution of Disapproval signed by President Trump [52]. Then, in 2018, HHS shortened the Title X funding period from three years to seven months [53]. Also in 2018, the Trump administration announced what they call the “Protect Life Rule” (known by pro-choice advocates as the “domestic gag rule”) which proposed a ban on abortion referrals and abortion counseling for Title X recipients [54, 55]. This rule was initially challenged and blocked from implementation but ultimately the Ninth Circuit Court of Appeals denied a stay in June 2019, allowing the domestic gag rule to go into effect [56]. In response, over 1,000 clinics withdrew from the Title X program in August 2019 rather than be forced to eliminate abortion referrals and counseling [56]. Recently, the Biden administration reversed the domestic gag rule in October 2021, potentially allowing withdrawn clinics to return to the Title X program [57]. Through funding that can make or break healthcare facilities, these policy changes impact contraceptive availability and accommodation by influencing where people can access contraceptive care and how many local options are available to them. When more facilities are forced to close or reduce their hours and services, community members face fewer options, greater wait times, and less convenient care.

There have also been changes in recent years to military guidelines on healthcare and contraception. The Veterans Access, Choice, and Accountability Act of 2014 expanded healthcare options for veterans with specific “burden[s]” to receive healthcare with “choice” contracted providers [58]. Specific branches of the military have also introduced new policies impacting the availability of contraception for service members. In January 2015, the Navy added walk-in contraceptive clinics and increased the availability of long-acting reversible contraception (LARC) during basic training. In contrast, in January 2016, the Marines restricted the availability of LARC at basic training and began promoting injectable contraceptives over other contraceptive methods [59]. These policy changes are relevant to contraceptive availability and accommodation because they impact when, where, and how military members and veterans physically access contraceptive care and which options are easily and conveniently accessible to them.

**Affordability**

By influencing the price of health care and people’s access to health insurance and other financial resources, policy changes can also greatly impact contraceptive affordability. Announced in February 2009 and signed into law in March 2010, the ACA is a US healthcare reform law establishing a new healthcare marketplace and requiring insurance coverage of preventive services, protections for pre-existing health conditions, and allowances for expanded dependent coverage [60–62]. Amendments, including the Women’s Health Amendment and the Health Care and Education Reconciliation Act, added additional protections such as Medicaid expansion and inclusion of women’s preventive care as mandated preventive services [61, 63]. The introduction of the ACA and these amendments that added additional protections are relevant to contraceptive affordability because they increased access to health insurance and reduced the cost of contraception and contraceptive care for many Americans.

The Institute of Medicine released recommendations for preventive services for women in July 2011, which were adopted into the ACA preventive care guidelines, adding contraceptive coverage as a required preventive service [62]. Shortly before implementation of the ACA contraceptive mandate began, an exemption for churches was announced in January 2012 and then extended in February 2012 to other religious employers [64]. Then, the Supreme Court ruled in June 2014 in *Burwell v. Hobby Lobby Stores, Inc.* that for-profit companies with a religious objection to birth control are also exempt from the mandate [65, 66]. Under the Trump administration, the religious exemption was further extended to the point that virtually any moral or religious objection can exempt an employer from the mandate [67]. This most recent change was challenged in court, culminating in the July 2020 Supreme Court decision in *Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania* which held that the religious and moral exemptions were lawful [65]. These restrictions on the ACA contraceptive coverage mandate are relevant to affordability because they increase the cost of contraception for Americans who work for exempt employers.
There was also resistance to the Medicaid expansion included in the ACA. In June 2012, the Supreme Court ruled in *National Federation of Independent Business v. Sebelius* to uphold most ACA provisions but made Medicaid expansion optional for states [22, 68]. Optional Medicaid expansion went into effect in January 2014 with 28 states and the District of Columbia participating [69]. This also changed the way that states utilize Section 1115 waivers and State Plan Amendments [70] to expand family planning Medicaid. These changes to Medicaid increased contraceptive affordability for some but left others, in states that did not expand Medicaid, with high contraceptive costs. Contraception was also made more affordable for some young Americans through the National Defense Authorization Act of 2011 which created TRICARE Young Adult, extending military member dependent coverage [71].

In June 2018, the Department of Labor expanded the reach of Association Health Plans which could have decreased consumer protections and allowed companies to sidestep benefit requirements [72]; however, this expansion was challenged and ultimately invalidated by a federal judge in March 2019 on the grounds that it violated federal tax law [72]. Also, under the Trump administration, in 2018 the Centers for Medicare and Medicaid Services extended the duration allowed for short-term health plans, which are not required to comply with the ACA [73]. This was also challenged in court, but a District Court ruled in 2019 to allow the extension [73]. This change was relevant to contraceptive affordability because it impacts the cost of contraception and contraceptive care by providing avenues for companies to sidestep ACA contraceptive coverage requirements.

**Policies and mandats that influence how providers are trained and prepared to meet patients’ needs can impact people’s ability to engage with evidence-based contraceptive care. The Teen Pregnancy Prevention Program (TPPP), providing competitive grant funding for programs that reduce teen pregnancy, was initially established in December 2009 in the Consolidated Appropriations Act of 2010 [74].** Subsequent appropriations laws continued funding this program until TPPP grant projects beginning in 2015 were shortened by two years, ending in 2018 rather than 2020 [74, 75]. In April 2018, a district court granted Planned Parenthood continued participation in the TPPP [76]. However, four days before this decision, an HHS Funding Opportunity Announcement shifted the TPPP to promote abstinence-only sex education and decrease focus on evidence-based approaches [74]. When Planned Parenthood sued HHS over this shift, a district court dismissed the case in August 2018 [77]. However, in January 2020, the US Court of Appeals for the Ninth Circuit ruled that these TPPP changes were unlawful because they are counter to the TPPP emphasis on evidence-based programming [78]. When rooted in evidence-based programming, the TPPP improves the appropriateness of contraceptive care by funding many initiatives that prevent unwanted pregnancies and increase understanding of barriers to care, ultimately helping providers and facilities better meet community contraceptive needs.

In the past decade, several guidelines and recommendations, including the US Medical Eligibility Criteria for Contraceptive Use (released June 2010, updated July 2016) [79], the US Selected Practice Recommendations for Contraceptive Use (released June 2013, updated July 2016) [80], and the Providing Quality Family Planning Services recommendations (released April 2014, updated March 2016) [81] were published, increasing the appropriateness of contraceptive care by providing healthcare providers with recommendations on the safe use of contraceptive methods. Similarly, in December 2010, the Healthy People 2020 initiative also increased the appropriateness of care by providing science-based national goals and objectives to guide national health promotion efforts in the United States [82]. Additionally, in 2015, updates to the Indian Health Service guidelines made emergency contraception more accessible to American Indian and Alaska Native community members [83]. These regulations have increased the appropriateness of contraceptive care by better preparing providers and facilities to meet patient and community contraceptive needs.

Several policy changes have also increased contraceptive appropriateness for military members and veterans. The VA Mission Act of 2018 increased the appropriateness of care by providing continuing education for community providers who serve veterans [58]. Similarly, in 2019, the Defense Health Agency [84] established procedures for comprehensive contraceptive counseling with Military Health System beneficiaries through the policy entitled Comprehensive Contraceptive Counseling and Access to the Full Range of Methods of Contraception. Each of these policies improved the appropriateness of contraceptive care through standardized training procedures that better prepare providers to engage in contraceptive counseling with veteran/military populations.

**Discussion**

These findings have suggested that over the past decade, federal US policies relevant to contraceptive access have largely followed partisan divides, with contraceptive access increasing in years with a Democratic president (President Obama) and decreasing while a Republican president (President Trump) was in office. This finding is
not surprising given the party-specific polarization present in reproductive politics in the US [23–28]. This study showed that there were more policy changes related to the affordability (e.g., ACA contraceptive mandate) and physical availability (e.g., Veterans Access, Choice, and Accountability Act; changes to Title X) of contraceptive care than other aspects of contraceptive access. This is likely, in part, a response to perceptions of these dimensions of access as primary barriers to care (e.g., [6, 7]).

There have also been many policy changes related to recent updates to the ACA and the Title X Family Planning Program, which largely impact the affordability and availability of contraceptive care. In fact, out of the 70 direct-impact policy changes identified in this analysis, 20 (29%) were related to the ACA and 9 (13%) were related to Title X. Both policies have enormous impact on contraceptive access in the United States, and the many changes to them throughout the past decade, which have largely ebbed and flowed with election cycles according to partisan divides, reflect the political polarization present in the American public [85]. This legislative back-and-forth carries real-world implications for contraceptive care, breaking down and reproducing barriers to care and creating confusion for both those seeking and providing contraceptive care. For example, research shows that policy complexity, frequent policy changes, and poor public communication, can lead to public confusion and misinterpretation of the law [86–88]. In the case of the ACA, this confusion can lead to delays in care [89], indicating a need for policy stability and campaigns to increase public understanding of healthcare policy.

Implications for practice and/or policy
This study identified policy needs and practice gaps that could be addressed to improve contraceptive access across the dimensions of healthcare access. First, eliminating abstinence-only sex education policies and Sexual Risk Avoidance Education programs and instead promoting comprehensive sex education would improve contraceptive access by increasing available contraceptive information and decreasing stigmatizing rhetoric. Additionally, continuing to extend the Community Health Center Fund would increase the availability and affordability of contraceptive care. The 2021 removal of the domestic gag rule may allow clinics including Planned Parenthood to reenter the Title X program, which would also greatly increase the availability, affordability, and appropriateness of care. Future policy action should continue to provide funding for these clinics to deliver comprehensive family planning care.

There is also a need for increased transparency regarding care options and costs of services as well as amplified outreach efforts to combat misinformation and confusion created by continuous changes to key family planning policies such as Title X and the ACA. Such efforts are key avenues for improving contraceptive access by increasing knowledge about healthcare policy and opportunities for care in local communities. Moreover, years of medical mistreatment of Black, Indigenous, and people of color (BIPOC) communities [16, 90] and continued implicit and explicit bias in healthcare [91, 92] has generated an earned distrust in medical systems among these communities (e.g., 93). This distrust represents a critical barrier to contraceptive access, impacting the ways that BIPOC perceive the need for care, seek or avoid care, and engage with healthcare systems [93]. With the possible exception of the 2015 update to the Indian Health Service guideline, which sought to increase emergency contraceptive access for American Indians and Alaska Natives, none of the policies reviewed in this study directly address the issue of discrimination and related distrust and decreased access in contraceptive care. As such, there is an immense and immediate need for policy and practice action that addresses both the interpersonal and structural presence of discrimination in healthcare and begins to inspire trust by developing culturally responsive community outreach and contraceptive care.

Finally, considering the Supreme Court decision upholding extensive moral and religious objections to the ACA contraceptive mandate, a focus on increasing options for those affected employees could increase contraceptive access. Creative solutions in both policy and practice arenas are needed to ensure contraceptive access for all Americans, including those with employers who are exempted from the ACA contraceptive mandate.

Limitations and future directions
One limitation of the current study is that it is possible and even likely that these methods did not identify all relevant federal policies that have recently influenced contraceptive access. The grey literature review was meant to capture the most salient policy changes related to recent contraceptive access, so any policy changes not described here may not be as relevant as those included in the current summary but could be investigated in future studies. Additionally, the current study was limited to examining contraceptive access, but many other recent policy changes have shifted the family planning policy landscape. It is often difficult to compartmentalize aspects of family planning care because true healthcare access requires the availability of comprehensive family planning services, including contraceptive, abortion, fertility, and pregnancy services [94]. Exploring the comprehensiveness of care rather than considering these services in silos can change the ways that policies are analyzed. For example, the Title X domestic gag
rule and the resulting clinic withdrawal from the Title X program [56] were coded in this analysis as “availability and accommodation” because they greatly impacted the physical availability of contraceptive care by reducing the funds available to providers and decreasing clinics’ ability to provide widespread contraceptive services. However, this policy change is also related to the appropriateness of overall family planning care. When clinics withdrew from the Title X program rather than eliminate abortion counseling and referrals, they were upholding family planning access by providing appropriately comprehensive services. Thus, future research could explore the role of recent policies on abortion access and the overall comprehensiveness of family planning care. Furthermore, the example of changes to Title X impacting both contraceptive availability/accommodation and appropriateness illustrates the overlap between the healthcare access dimensions, which can make it challenging to categorize policies into only one dimension. The current study sought to organize and analyze the identified policy changes according to the most salient healthcare access dimension. Future research could extend this analysis by narrowing the focus to a single policy and exploring its impact on multiple healthcare access dimensions. Additionally, whereas the current study focused on US federal policy, future research could investigate the role of state-level policies on contraceptive access and family planning access more generally. Finally, this study utilized grey literature and considered the theoretical impact of recent policy changes on contraceptive access. Future research could expand on these findings by reviewing, summarizing, and building on empirical research on this topic.

Conclusion
This study has provided an overview of recent US policy changes related to contraceptive access and analyzed their theoretical impact on contraceptive access. Using Levesque et al’s (2013) five dimensions of healthcare access [33], findings indicated that most policy changes impacted the affordability, physical availability, and appropriateness of contraceptive care and that recent policy changes have largely fluctuated with election cycles according to partisan divides. In particular, many policy changes were related to the ACA and Title X. The implementation of the ACA and subsequent updates to it have increased the affordability of contraception, whereas changes to Title X have decreased the availability and appropriateness of contraceptive care. Opportunities to ensure contraceptive access for all Americans include promoting comprehensive sex education, extending the Community Health Center Fund, increasing contraceptive options for people with employers who are exempted from the ACA contraceptive mandate, addressing discrimination and building trust in contraceptive care, and amplifying outreach efforts to combat misinformation and confusion created by continuous changes to key family planning policies. Continued research on the role of policy in determining reproductive autonomy is warranted, and practice and policy action is needed to improve contraceptive access.

Abbreviations
ACA: Affordable Care Act; Title X: Title X of the Public Health Services Act; HITECH: Health Information Technology for Economic and Clinical Health Act; HIPAA: Health Insurance Portability and Accountability Act; Title IX: Title IX of the Education Amendments; HHS: US Department of Health and Human Services; FDA: Food and Drug Administration; LARC: Long-active reversible contraception; TPPP: Teen Pregnancy Prevention Program; BIPOC: Black, Indigenous, and people of color.

Acknowledgements
I thank my dissertation chair, Dr. Sarah Kye Price, and dissertation committee members Dr. Youngmi Kim, Dr. Shelby McDonald, and Dr. Sarah Jane Brubaker for their support and guidance in preparing this project.

Authors’ contributions
LETS analyzed and interpreted the information in this study and wrote this manuscript. The author read and approved the final manuscript.

Authors’ information
LETS was a Ph.D. Candidate at Virginia Commonwealth University when this analysis was completed. She is now a Postdoctoral Research Associate in the Department of Population Health Sciences at the University of Wisconsin-Madison.

Funding
No funding was provided for this research.

Availability of data and materials
The grey literature sources used to create the policy timeline for this study are available from the corresponding author on reasonable request.

Declarations
Ethics approval and consent to participate
Not applicable as this study does not contain data from any individual person.

Consent for publication
Not applicable as this study does not contain data from any individual person.

Competing interests
The author declares that they have no competing interests.

Received: 15 July 2021 Accepted: 10 November 2021
Published online: 22 November 2021

References
1. Ahrens KA, Thoma ME, Copen CE, Frederiksen BN, Decker EJ, Moskosky S. Unintended pregnancy and interpregnancy interval by maternal age. National Survey of Family Growth. Contraception. 2018. https://doi.org/10.1016/j.contraception.2018.02.013.
2. Finer LB, Zolna MR. Declines in unintended pregnancy in the United States, 2008–2011. N Engl J Med. 2016. https://doi.org/10.1056/NEJMsa1506575.
3. Holliday CN, McCauley HL, Silverman JG, Ricci E, Decker MR, Tancredi DJ, et al. Racial/Ethnic differences in women’s experiences of reproductive...
coercion, intimate partner violence, and unintended pregnancy. J Women's Health. 2017. https://doi.org/10.1089/jwh.2016.5996.
4. Jones RK, Tapales A, Lindberg LD, Frost J. Using longitudinal data to understand changes in consistent contraceptive use. Perspect Sex Reprod Health. 2015;47(3):131–9.
5. Guttmacher Institute. Contraceptive use in the United States [Internet]. 2015 https://www.guttmacher.org/sites/default/files/pdfs/pubs/fb_contr_use.pdf. Accessed 4 Jan 2021.
6. Madden T, Secura GM, Politi MC, Peipert JF. The role of contraceptive attributes in women’s contraceptive decision making. Am J Obstet Gynecol. 2015;213(5):566.e1–9. https://doi.org/10.1016/j.ajog.2015.01.051.
7. Sundstrom B, DeMaria AL, Ferrara M, Smith E, McNair S. “People are struggling in this area”: a qualitative study of women’s perspectives of telehealth in rural South Carolina. Women Health. 2020. https://doi.org/10.1080/03630242.2019.1643814.
8. Zimmerman MS. Information poverty and reproductive healthcare: assessing the reasons for inequity between income groups. Social Work in Public Health. 2017;32(3):210–21.
9. Hickey MT, White J. Female college students’ experiences with and perceptions of over-the-counter emergency contraception in the United States. Sex Reprod Healthc. 2015. https://doi.org/10.1016/j.srhc.2014.09.008.
10. Hill NJ, Swatu M, Robinson AK. “My Religion Picked My Birth Control”: the influence of Religion on Contraceptive Use. J Relig Health. 2014. https://doi.org/10.1007/s10943-013-9678-1.
11. Beeson T, Wood S, Bruen B, Goldberg DG, Mead H, Rosenbaum S. Accessibility of long-acting reversible contraceptives (LARCs) in Federally Qualified Health Centers (FQHCs). Contraception. 2014;89:91–6.
12. Miller E, Decker MR, McCauley HL, Tancedj DJ, Levenson RR, Waldman J, et al. Pregnancy coercion, intimate partner violence and unintended pregnancy. Contraception. 2010. https://doi.org/10.1016/j.contraception.2009.12.004.
13. Swan LET, Auerbach SL, Ely GE, Agbemenu K, Mencia J, Araf NA. Family planning practices in Appalachia focus group perspectives on service needs in the context of regional substance abuse. Int J Environ Res Public Health. 2020;17:119.08.
14. Solinger R. Reproductive politics: Who everyone needs to know. Oxford: Oxford University Press; 2013.
15. Lombardo PA. Medicine, eugenics, and the Supreme Court: from coercive sterilization to reproductive freedom. J Contemp Health Law Policy. 1996;3(1):1–25.
16. Price K. What is reproductive justice? How women of color activists are redefining the pro-choice paradigm. Meridians. 2010;10(2):42–65.
17. Lawrence J. The Indian health service and the sterilization of Native American women. Am Indian Q. 2000;24(3):400–219.
18. Al-Arshani S. A whistleblower complaint alleging hysterectomies being performed on women from an ICE detention center recalls the ugly history of forced sterilization in the U.S. Business Insider [Internet]. 2020. https://www.businessinsider.com/here-ugly-history-forced-sterilization-us-2020-9 Accessed 3 July 2020.
19. Ege J. The birth of the pill: How four crusaders reinvented sex and launched a revolution. New York: W. W. Norton & Company; 2014.
20. SIECUS. A history of federal funding for abstinence-only-until-marriage guidelines on campus sexual assault [Internet]. 2017. https://www.siecus.org/our-work/abstinence-only-university-guidelines-campus-sexual-assault.
21. Clinton S, et al. Pregnancy coercion, intimate partner violence and unintended pregnancy. Contraception. 2014;89:91–6. https://doi.org/10.1016/j.contraception.2009.12.004.
22. Swan LET, Auerbach SL, Ely GE, Agbemenu K, Mencia J, Araf NA. Family planning practices in Appalachia focus group perspectives on service needs in the context of regional substance abuse. Int J Environ Res Public Health. 2020;17:119.08.
23. Aiken RA, Scott JG. Family planning policy in the United States: the influence of Religion on Contraceptive Use. J Relig Health. 2014. https://doi.org/10.1007/s10943-013-9678-1.
24. Hare C, Poole KT. The polarization of contemporary American politics. Polity. 2014;46(3):111–29.
25. Diffen. Democrat vs. Republican [Internet]. https://www.diffen.com/difference/Democrat_vs_Republican. Accessed 30 Sep 2021.
26. Swers ML. Gender and party politics in a polarized era. In: Straus JR, Glassman ME, editors. Party and procedure in the United States Congress. Rowman & Littlefield, 2016. p. 279–300.
27. Carmines EG, Gentry JC, Wagner MW. How abortion became a partisan issue: Media coverage of the interest group-political party connection. Politics Policy. 2010;38(6):1135–58.
28. Devins N, Baum L. Split definitive: How party polarization turned the Supreme Court into a partisan court. Supreme Court Rev. 2017. https://doi.org/10.1086/691096.
29. Gostin L. The formulation of health policy by the three branches of government. In: Bulger RE, Bobby EM, Fineberg H, editors. Society’s choices: Social and ethical decision making in biomedicine [Internet]. 1995. p. 335–57. https://www.ncbi.nlm.nih.gov/books/NBK231979/.
30. The White House. Presidents [Internet]. https://www.whitehouse.gov/about-the-white-house/presidents/. Accessed 30 Sep 2021.
31. History Art & Archives. Party divisions of the House of Representatives, 1789 to present [Internet]. History, Art & Archives. https://history.house.gov/Institution/Party-Divisions/Party-Divisions/. Accessed 30 Sep 2021.
32. United States Senate. Party division [Internet]. https://www.senate.gov/history/partydiv.html. Accessed 30 Sep 2021.
33. Levesque J, Harris MF, Russell G. Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. Int J Equity Health. 2013;12(8):1–9.
34. The New York Academy of Medicine. What is grey literature? [Internet]. https://www.greylit.org/about. Accessed 22 Feb 2021.
35. University of Chicago. HIPAA background. 2010. https://case.edu/medicine/admission/sites/case/medicine/files/2018-12/HIPAA-knowingly-sharing PHI.pdf. Accessed 14 May 2020.
36. HIPAA. JIPAA history [Internet]. 2014. https://www.hipaajournal.com/hipaaj/d/vol3-2010-hipaa-history/. Accessed 3 Jul 2020.
37. SIECUS. A history of federal funding for abstinence-only-until-marriage programs [Internet]. 2018. https://siecus.org/wp-content/uploads/2018/08/A-History-of-AOUM-Funding-Final-Draft.pdf. Accessed 14 May 2020.
38. Boyer J. New name, same harm: Rebranding of federal birth-availability programs. Guttmacher Policy Rev. 2018;21:11–6.
39. Larkin M. The Obama administration reimade sexual assault enforcement on campus. Could Trump unmake it? Boston University Radio [Internet]. 2016. https://www.wbur.org/edify/2016/11/25/title-ix-obama-trump. Accessed 14 May 2020.
40. Rosenblatt L. Secretary of Education Betsy DeVos rescinds Obama-era guidelines on campus sexual assault [Internet]. 2017. https://www.latimes.com/politics/washington/la-ra-essential-washington-update-2017-09-21story.html#secretary-of-education-betsy-devos-rescinds-obama-era-guidelines-on-campus-sexual-assault. Accessed 4 Jul 2020.
41. Campus Clarity. The Campus Sexual Violence Elimination Act of 2013 [Internet]. [http://campussaveact.org/]. Accessed 3 Dec 2020.
42. Violence Against Women Reauthorization Act. Pub. L. No. 113–4 [Internet]. 2013. https://www.gpo.gov/fdsys/pkg/BILLS-113s47enr/pdf/BILLS-113s47enr.pdf.
43. Letter from US Senators to Eric Hargan, Acting Secretary, Department of Health and Human Services. 2017. https://www.help senate.gov/imo/media/doc/102/71%20-%20HHS%20Strategic%20Plan.pdf. Accessed 14 May 2020.
44. U.S. Department of Health and Human Services. HHS Strategic Plan FY 2018–2022, Draft [Internet]. 2017. https://www.hhs.gov/images/stories/2017-2018/hhs-strategic-plan-fy2018-2022.pdf. Accessed 14 May 2020.
45. U.S. Department of Health and Human Services. Strategic Plan FY 2018–2022 [Internet]. 2017. https://www.hhs.gov/about/strategic-plan/index.html. Accessed 14 May 2020.
46. NARAL Pro-Choice America. Emergency contraception (EC): An important and underutilized contraceptive option [Internet]. 2017. https://www.prochoiceamerica.org/wp-content/uploads/2017/01/1-EmergencyContraception-EC-An-Important-and-Underutilized-Contraceptive-Option.pdf. Accessed 14 May 2020.
47. Brady D. Ruling on contraception draws battle lines at Catholic colleges. The New York Times [Internet]. 2012. https://www.nytimes.com/2012/01/30/health/political-law/10contraception-controversy-on-catholic-campus.html. Accessed 14 May 2020.
48. Hall MA, Rosenbaum S. The health care safety net in a post-reform world. Rutgers: Rutgers University Press; 2012.
88. Hughto JMW, Meyers DJ, Mimiaga MJ, Reisner SL, Cahill S. Uncertainty and confusion regarding transgender non-discrimination policies: implications for the mental health of transgender Americans. Sex Res Soc Policy. 2021. https://doi.org/10.1007/s13178-021-00602-w.

89. Tipirneni R, Politi MC, Kullgren JT, Kieffer EC, Goold SD, Schoer AM. Association between health insurance literacy and avoidance of health care services owing to cost. JAMA Netw Open. 2018. https://doi.org/10.1001/jamanetworkopen.2018.4796.

90. Osakwe C. Explaining reproductive health disparities: Violence in the "colorblind" institution of medicine [Internet]. 2021. https://opencommons.uconn.edu/srhonors_theses/822.

91. Maina JW, Belton TD, Ginzberg S, Singh A, Johnson TJ. A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. Soc Sci Med. 2018. https://doi.org/10.1016/j.socscimed.2017.05.009.

92. Stepanikova I, Cook KS. Effects of poverty and lack of insurance on perceptions of racial and ethnic bias in health care. Health Serv Res. 2007. https://doi.org/10.1111/j.1475-6773.2007.00816.x.

93. Logan RG, Daley EM, Vamos CA, Louis-Jacques A, Marhefka SL. “When is health care actually going to be care?” The lived experience of family planning care among young black women. Qual Health Res. 2021. https://doi.org/10.1177/1049732321993094.

94. Johnston J, Zacharias RL. The future of reproductive autonomy. Hastings Cent Rep. 2017;47(6):56-11.

**Publisher’s Note**
Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.