

Report to the Legislature

Literature Review on Inequities in Reproductive Health Access

Substitute Senate Bill 6219; Chapter 119, Laws of 2018
January 1, 2019



P.O. Box 47990
Olympia, WA 98504-7990
Phone: (360) 236-4100
Fax: (360) 236-4088
healthequity@sboh.wa.gov

ACKNOWLEDGEMENTS

Our sincerest thanks to the community-based organization staff, healthcare providers, health clinic and systems staff, and local and state agency staff who shared their expertise in the development of this report. The depth and breadth of information presented in this report demonstrates the time and value each individual and organization invested in its development.

For more information:

Governor's Interagency Council on Health Disparities

P.O. Box 47990

Olympia, WA 98504-7990

Phone: (360) 236-4100

Fax: (360) 236-4088

healthequity@sboh.wa.gov

Staff contact:

Cait Lang-Perez

Phone: (360) 628-7342

caitlin.lang@sboh.wa.gov



TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	2
TABLE OF CONTENTS	3
EXECUTIVE SUMMARY	5
CONTEXT	9
METHODS	13
ACCESS TO REPRODUCTIVE HEALTHCARE	18
INDIVIDUALS EXPERIENCING INEQUITIES	18
INTERSECTIONALITY	25
BARRIERS	26
ECONOMIC BARRIERS	26
1. Insurance status	26
2. Cost of care.....	28
3. Associated costs of care	30
4. Non-medical expenses and debts	31
5. Underfunding	32
STRUCTURAL BARRIERS	33
6. Health facility closures and mergers	33
7. Distance to services, travel time & transportation	33
8. Work, school, or childcare limitations	35
9. Lack of medical home.....	36
10. Limited language access and lack of culturally and linguistically appropriate services	37
11. Service availability & provider availability	38
12. Limited services due to health system directives	41
13. Service/procedure requirements, or medically-unnecessary practices or procedures	43
14. Policy implementation and denial of services	44
15. Assumed heteronormativity and cisnormativity	45
16. Forms and procedures	46
17. Medically-accurate, culturally appropriate, comprehensive sexual health education and policy implementation	47
18. Clinic environment and conditions	48
19. Lack of formal provider training or medical education	49
20. State and federal legal rulings or legislation.....	50
21. Insurance coverage	54
22. Health plan communications	56

23. Difficulty navigating insurance system.....	56
24. Difficulty in obtaining medically-accurate information about services.....	57
25. Personal identification (ID) document requirements.....	57
26. Lack of data	57
SOCIAL BARRIERS.....	58
27. Intimate partner violence.....	58
28. Reproductive and pregnancy coercion	59
29. Physical and/or sexual violence	60
30. Mandatory reporting.....	62
31. Differential treatment, practices, or counseling by provider	62
32. Denial or delay of services	65
33. Fear, perception, or experience of bias, discrimination, stigmatization	66
34. Lack of social support.....	68
35. Individual health literacy.....	68
36. Patients' individual attitudes and beliefs.....	69
37. Parent/guardian/intimate partner's individual attitudes and beliefs	70
38. Providers' individual attitudes and beliefs.....	70
39. Misconception by providers/society regarding sexual activity and associated risks	71
40. Fear of deportation, separation from family, and other legal action.....	72
41. Mobility	73
42. Substance Use	73
43. Historical trauma and medical mistrust.....	73
44. Lack of actual or perceived confidentiality/privacy	74
45. Criminalization of individuals or behaviors, and fear of criminal justice involvement	75
RECOMMENDATIONS	76
APPENDICES	84
APPENDIX A: Barriers experienced by population group.....	84
APPENDIX B: Search terms and articles by population.....	89
APPENDIX C: Terminology specific to victims/survivors of violence	90
APPENDIX D: Terminology specific to LGBTQIA people.....	91
APPENDIX E: Terminology specific to immigrants and refugees	93
APPENDIX F: List of key informants.....	95
REFERENCES	99

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 (Council) 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, prenatal, 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*)
12. People of color experiencing systematic racism (*Race/Ethnicity*)
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 April 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 318 references were 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 14 recommendations were 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. Due to capacity limitations, staff were not able to fully evaluate recommendations for feasibility of implementation, cost, or alignment with existing federal and state law. 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.¹ The list of barriers was generated iteratively. After completing all population-specific reviews, 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, article annotations are available upon request. 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 exasperated, furthering inequities in access. See the discussion of intersectionality on page 25 for further information.

Recommendations

Criminal Justice recommendations

1. The Departments of Corrections and Children, Youth, and Families 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 victims and survivors of human trafficking.

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 age-appropriate, culturally-appropriate, comprehensive, medically accurate, and LGBTQIA-inclusive sexual health education in community settings for adolescents and young adults, older adults, immigrants and refugees, individuals with behavioral health disorders, individuals with disabilities, individuals experiencing homelessness, individuals with limited English proficiency (LEP), and tribes and urban Indian communities to expand health literacy related to reproductive health and navigating the healthcare system to access services.

Provider recommendations

5. The Health Care Authority and 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 LBGQTQIA persons.
6. The 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, 3) victims and survivors of violence, and 4) people with disabilities.

Health Insurance recommendations

7. The Office of the Insurance Commissioner should determine a common process and establish consistency of forms for health plans to redirect communications containing personal health information.

8. The Washington State Legislature should work with the Office of the Insurance Commissioner to determine a common process for health plans to automatically suppress communications containing personal health information related to 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.
9. 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.
10. The Washington State Legislature should grant authority to the Office of the Insurance Commissioner, Health Care Authority, Department of Social and Health Services, and other relevant agencies 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.
11. The Washington State Legislature should increase state Medicaid reimbursement rates for reproductive health services to improve service and provider availability.

State Funding recommendations

12. 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.
13. The Washington State Legislature should review the Community Health Worker Task Force final report regarding training and education recommendations (anticipated June 2019) and should identify opportunities and strategies for CHWs to address barriers in accessing reproductive healthcare.
14. Key Informants shared opportunities for future research that the Washington State Legislature or state agencies and institutions of higher education should consider to improve access to reproductive health services in Washington State. See page 82 for a list of research proposals.

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 November 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

Contextual Factor	Potential impact on access to reproductive health services
Affordable Care Act (ACA) and state Medicaid Expansion	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 suggests that, although the ACA expanded coverage for reproductive health services (e.g., contraception), multiple populations continue to experience barriers in accessing services. ^{2,3}
Bills passed by the 2018 Washington State Legislature	<p>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.</p> <p>Senate Bill 6580 (SB 6580), Concerning human immunodeficiency virus (HIV) testing, removed 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</p> <p>Substitute House Bill 2016 (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 and who are pregnant or have given birth in the last six weeks.⁵</p> <p>Substitute Senate Bill 5683 (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 State.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 These individuals typically do not qualify for Medicaid due to their specific immigration status,⁷ and this bill improves access to care for these individuals.</p>

<p>Bills passed by the 2018 Washington State Legislature (Continued)</p>	<p>In addition to requiring this review, Substitute Senate Bill 6219 (SSB 6219), Related to improving access to reproductive health (Reproductive Parity Act), also expanded access to reproductive healthcare in Washington State by requiring:⁸</p> <ul style="list-style-type: none"> • 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).
<p>Limited Service Pregnancy Centers</p>	<p>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.”⁹ 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.⁹ 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.⁹ 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.⁹ The King County Board of Health determined that failure to notify women that the facility is not a healthcare facility is a threat to public health.⁹</p>
<p>NIFLA v Becerra</p>	<p>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 Freedom, Accountability, Comprehensive Care, and Transparency (FACT) 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.¹⁰ 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 SCOTUS 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.</p>

<p>Proposed Rule: Protecting Statutory Conscience Rights in Health Care Notice of Proposed Rulemaking, RIN 0945-ZA03</p>	<p>In January 2018, the U.S. Department of Health and Human Services (U.S. HHS) published “Protecting Statutory Conscience Rights in Health Care; Delegation of Authority” (Proposed Rule). The 60-day comment period closed March 27, 2018 and the final rule announcement is expected in early 2019. In response, nineteen State Attorneys General, including Washington submitted comments urging U.S. HHS to withdraw the proposal.¹¹ The comments detailed how proposed rule changes "would allow individuals and entire institutions to deny lawful and medically necessary care to patients for 'religious, moral, ethical, or other reasons.'"¹¹ Authors emphasized the Proposed Rule would reduce access to medically-necessary care by allowing a broad set of individuals and institutions to opt out of providing care and unnecessarily decrease the information patients receive about their healthcare options.¹¹ Specifically, the Proposed Rule would "impose particularly onerous burdens on marginalized patients who already confront discrimination in obtaining [healthcare]."¹¹ As written, the Proposed Rule resembles the 2008 U.S. HHS final rule which was subject to legal challenges by multiple parties. In 2011, U.S. HHS rescinded aspects of the 2008 rule that were “unclear and potentially overbroad in scope,” while maintaining other portions which established an enforcement process and an initiative to increase awareness of protections available to healthcare providers.¹² Since 2008, “[Office for Civil Rights] has received a total of forty-four complaints [related to federal health care refusal laws], the large majority of which (thirty-four) were filed since the November 2016 election.”¹³</p>
<p>Public Charge</p>	<p>The U.S. 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.”¹⁴</p> <p>Under existing Public Charge tests, the federal government can consider four types of benefits in an individual’s application for lawful permanent residency, diversity visa applications, or applications to renew, change, or extend visas.¹⁵ Current benefits that can be considered include federal, state, local or tribal cash assistance for income maintenance; Temporary Assistance for Needy Families (TANF); Supplemental Security Income (SSI); and institutionalization for long-term care at government expense.¹⁵ Proposed changes would allow consideration of additional benefits, including: Medicaid; Medicaid Part D Low-Income Subsidy; Supplemental Nutrition Assistance Program (SNAP); Section 8 Housing Choice Vouchers; Section 8 Project-Based Rental Assistance; and Public Housing.¹⁵ In a letter to the Director of the U.S. Office of Management and Budget, Governor Inslee stated, “the proposal disrupts settled law by making unprecedented changes</p>

<p>Public Charge (Continued)</p>	<p>to longstanding immigration policies that determine how an individual’s application to extend or change their immigration status is processed.”¹⁶</p> <p>Although proposed changes would consider the applicant’s use of benefits, not benefits used by children or other family members,¹⁵ Kaiser Family Foundation has noted that, “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.”^{17,18} 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 could result in people not accessing necessary medical care” (e.g., reproductive healthcare).¹⁶</p>
<p>Title X</p>	<p>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.^{18,19} Washington State receives \$4 million per year in federal Title X funding (with an additional \$9 million from the state) to support family planning programs. In 2017, Title X providers served 91,250 clients across the state.²⁰ 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.²⁰ 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.²⁰</p> <p>Currently, the funding requirements of Title X are being debated at the federal level.²¹ Proposed changes could increase barriers to accessing reproductive health services.²¹ If proposed changes are made, Washington State may 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).</p>
<p>Upstream Washington</p>	<p>Upstream Washington is a multi-year initiative launched by Upstream USA, a non-profit partnering with DOH, to ensure all women have access to the full range of birth control methods in a single visit.²² 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</p>

Upstream Washington (Continued)	awareness of contraceptive options and where to access low or no cost contraception; and 4) creating a rigorous evaluation of the initiative’s impact. ²²
Washington State Department of Licensing and Immigration and Customs Enforcement	<p>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 pose a threat to the country.”²³ Changing policies and enforcement priorities potentially affect 23 million non-citizens in the U.S., including both individuals who are 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.²³ 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.²³ Feelings of fear and uncertainty increased following the rescission of the Deferred Action for Child Arrivals (DACA) program in September 2017.²³ Interviewees also reported increased experiences of racism and discrimination.²⁴ 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.^{18,23} Additionally, unaccompanied minors have been denied or delayed access to reproductive healthcare services, namely abortions, while in the custody of the federal government.²⁵</p> <p>Moreover, the Washington State Department of Licensing 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.²⁴ In January 2018, Governor Inslee announced policy changes to ensure “[Department of Licensing] 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.”²⁶ Despite the policy change, the agency’s cooperation with ICE likely increased fear and uncertainty among immigrants in Washington State, and may have lasting impacts on individuals’ level of trust in state and local government agencies and institutions.</p>

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, prenatal, 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” on page 18 for a list of priority populations and a summary of the health inequities experienced by these populations.

Review of literature

Council staff conducted a review of literature between April 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 review of literature 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 review of literature was conducted for each of the 14 populations identified to ensure comprehensiveness. All articles were identified using MEDLINE/PubMed. A total of 318 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. Article annotations are available upon request. See Appendix B for the number of articles included for each priority population.

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.") 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.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.

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. 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.²⁷ Furthermore, this review focused on access to reproductive healthcare. Available literature specific to accessing reproductive health services for some priority populations was limited or lacking, and individuals may experience barriers in accessing healthcare in general that do not appear in the reproductive health literature. For these reasons, the available literature may not fully capture all of the barriers individuals encounter when seeking reproductive health services or healthcare generally.

Terminology

Council staff recognize that preferred terminology may vary by communities and individuals. In writing the 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*).²⁸

Lastly, the majority of reproductive health related literature is related to cisgender women. Although barriers may also be relevant to men, trans women, trans men, and/or non-binary individuals, the findings in this report are limited to the study populations of published literature. To the greatest extent possible, staff attempted to specifically note 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. Staff spoke with approximately 80 key informants throughout the course of the review. The majority of interviews were conducted with state agency staff (e.g., 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 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 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 list of key informants that were interviewed or provided review for this report; Council staff can be contacted for more information on how individuals 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 and Council members.

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 14 recommendations were included in the 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 of implementation, 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, as outlined in SSB 6219, 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.²⁹ The Healthy People 2020 initiative stated that access to healthcare must be improved by increasing access to health insurance coverage, health services, and timeliness of care to promote and maintain health, prevent and manage disease, reduce unnecessary disability and premature death, and achieve health equity.³⁰ Access to reproductive healthcare is broadly defined in the published literature as access to timely and appropriate care³¹ and can be impacted by structural, institutional, financial, social, cultural, and sociodemographic factors.^{31,32} Larger reviews of published literature have identified inequities in access to reproductive healthcare for multiple priority populations, including adolescents and young adults,^{2,3} women of older reproductive age,² individuals with behavioral health disorders,² individuals with disabilities,² individuals who identify as LGBTQIA,² people living in rural areas,^{3,31,32} individuals experiencing homelessness,² immigrants,^{2,3} individuals without health insurance,^{29,33} women in the military,² people of color who experience systematic racism,^{2,29,31-33} and individuals of low socioeconomic status.³¹⁻³³

These populations experience worse reproductive health outcomes and have disproportionately limited access to numerous reproductive health services, including access to prenatal care,^{29,31} maternity care,³¹ contraception,² assisted reproductive technology (ART) and infertility treatment,^{32,33} 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 13-17) 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.³⁴⁻³⁷ 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.^{34-36,38} According to 2017 Washington State data, adolescents and young adults accounted for 67.8% of the state's Chlamydia cases (9.0% and 58.8%, respectively)

(DOH, personal communication, September 2018). Structural barriers^{34,35,37,39-50} and social barriers^{34-36,38,39,41-43,46-48,50-57} 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.⁵⁸⁻⁶² Furthermore, older adults struggle with access due to social barriers,^{58,60,63-68} largely related to underlying misperceptions about sexuality and risk in older age^{63,66} and the minimization of sexual health issues.^{66,67} Older adults may also lack appropriate knowledge of sexual health.⁶⁵ However, evidence indicates older adults remain sexually active in their later years^{65,67,68} and are at risk for human immunodeficiency virus (HIV) and other STIs.^{65,67}

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.^{69,70} Most women with substance use disorders are of reproductive age,⁷⁰ are less likely to use contraception or access preventive health services, and are more likely to experience unintended pregnancy and abortion.^{69,70} 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.⁷¹ Substance use during pregnancy can have negative pregnancy, birth, and maternal health outcomes.⁷¹

Individuals with a disability (*Disability*)

In 2015, an estimated 12.9% of Washingtonians were living with a disability.⁷² 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.⁷² 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.⁷³ In addition, lack of facilities and care appropriate for individuals with disabilities has led to inequities in reproductive healthcare access and outcomes.⁷³⁻⁷⁶ Evidence indicates that women with disabilities are less likely to have received a mammogram during the past two years.^{77,78} Moreover, those living with disabilities in Washington experience high rates of financial poverty (19.5% below 100% of Federal Poverty Level [FPL] and 43% below 200% FPL) compared to those without disabilities (10% and 23%, respectively)⁷² 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.¹ Different subpopulations are also at increased risk of various cancers (e.g., anal cancer, breast cancer).^{1,79} Barriers to care include but are not limited to cost-related hurdles, gaps in coverage, and poor treatment from healthcare providers.^{1,80-88} Data from 2000-2007 show that women in same-sex relationships were less likely to have had a recent mammogram or Pap test than those in heterosexual relationships.⁸⁹ Evidence indicates that barriers are not experienced in the same way across these variable identities and can be improved or exacerbated by an individual's other identities, experiences, or circumstances (e.g., race, socioeconomic status).¹

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.^{1,90} Transgender people's access to health services is further limited by high levels of mistreatment and stigma encountered when seeking health services.^{1,90} These barriers can contribute to worse health outcomes and unmet healthcare needs. For example, transgender women, particularly transgender women of color, are at high risk of HIV.¹

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.⁹¹ People who live in rural areas face numerous access barriers, including transportation infrastructure, population distribution, and configuration of healthcare facilities.⁹² Other geographic factors associated with inequities in access are rural closures of family planning clinics,⁹³ increased travel time to clinics,⁹⁴ shortages of providers in rural areas,⁹⁵ increasing risk of malpractice litigation⁹⁶, and limited reproductive healthcare service availability due to health system directives.⁹⁷

Individuals with unstable housing (*Homelessness*)

Nationally, an estimated 20% of individuals experiencing homelessness are women,⁹⁸ and the number of families experiencing homelessness (mostly comprised of single women with one or more children) increased 20% between 2007 and 2010.⁹⁹ 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.⁹⁸⁻¹⁰⁰ 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.⁹⁸ 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.⁹⁸ Seventy-three percent of pregnancies among women experiencing homelessness are unintended (compared to 50% of the general population),⁹⁹ and experiencing homelessness during pregnancy is associated with lack of prenatal care, high-risk pregnancies, and poor birth outcomes.⁷¹

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.¹⁰¹ The Migration Policy Institute estimates there are 11.3 million individuals who are undocumented living in the U.S., with approximately 229,000 individuals who are undocumented living in Washington State.^{102,103} In Washington, 88,000 children under the age of 18 live with at least one parent who is undocumented.¹⁰² In addition, 29,000 individuals are eligible for DACA, and 17,140 (67%) had DACA status in August 2018.¹⁰⁴

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.¹⁰⁵⁻¹¹¹ 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.^{18,19,105,108} 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.^{105,108,112-114} Individuals who are undocumented experience worse reproductive health outcomes than immigrants with legal status or the general population.¹⁰⁵

Individuals who are incarcerated (*Incarceration*)

Between 2000 and 2013, the number of women who were incarcerated in the U.S. increased by 30%, while the number of men who were incarcerated increased by 13%.¹¹⁵ 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.¹¹⁵ In addition, approximately 74% of women who are incarcerated are of reproductive age.¹¹⁵ While pregnancy rates among women who are incarcerated are not available, most researchers estimate that approximately 10% of women who are incarcerated are pregnant.¹¹⁶ Approximately 6% of women are pregnant when they enter correctional facilities.¹¹⁷ Estimates suggest that an even higher percentage of adolescents in the juvenile justice system are pregnant.¹¹⁶

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.^{115,117-120} 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.^{115-117,121} 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.^{119,122} See discussions labeled *Immigration* for more information regarding barriers detainees experience in facilities operated by ICE.

Active duty military members and Veterans (*Military*)

Women make up a growing number of active duty service members and Veterans.^{123,124} In 2014, 15% of active duty service members and 19% of reserves were women,^{124,125} and 97% of women in the military were of reproductive age.¹²⁶ The Department of Veterans Affairs estimates that 11% of Veterans will be women by 2020.¹²³ Despite receiving universal health insurance through TRICARE, women in the military and female Veterans continue to experience unique barriers in accessing reproductive healthcare.¹²⁷ Women in the military also 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.^{125,126,128-130} 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.”¹²⁹ 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 0.1% of women in the general population.¹²⁹ Another study found that between 9.5% and 33% of women experience an attempted or completed rape while serving in the military.¹²⁶ Lastly, pregnancy and unintended pregnancy rates were higher among women in the military than the general population,^{126,129} with 72 per 1,000 women in the military aged 18-44 versus 45 per 1,000 women in the general population aged 15-44 experiencing unintended pregnancy.¹²⁵

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.¹²³ While the VA has taken a number of steps to improve female Veteran’s access to healthcare, a 2018 report proposed additional recommendations to ensure that female Veterans receive appropriate, gender-sensitive healthcare through the VA.¹²⁴

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.¹³¹

People of color experiencing systematic racism (*Race/Ethnicity*)

In 2017, an estimated 31% of Washington State’s population were people of color,¹³² an increase of 10% since 2000.¹³³ According to Office of Financial Management April 1, 2017 data, however, Washington State’s population is estimated to be 80% White (69.2% non-Hispanic

White), 8.4% Asian (alone), 4.0% Black (alone), 1.8% American Indian and Alaska Native (AI/AN alone), 0.8% Native Hawaiian and Other Pacific Islander (NHOPI alone), and 5.0% Two or More Races, and approximately 12.8% of the population is Hispanic or Latino.¹³² The difference between these two data sets in the proportion of the state population who are people of color reflects how the Office of Financial Management directs state agencies to aggregate and report Census data for any individual who selects more than one racial category as “Two or More Races.” This methodology of reporting on race/ethnicity data undercounts or misclassifies people of color. For AI/AN people, this methodology misclassifies roughly half of Washington State’s AI/AN population as “Two or More Races.”

Reflecting a more accurate methodology, the National Indian Health Board (NIHB)/Centers for Medicare and Medicaid Services (CMS) Tribal Data Project presents data for AI/AN alone and in combination with another race. Using this methodology and data from the American Community Survey, NIHB estimates Washington’s AI/AN population in 2017 was 214,406 (or 2.9% of the total population).^{134,135} The Office of Financial Management’s methodology has broader impacts, as it potentially affects federal, state, and local resource allocation, which likely influences access to healthcare, including reproductive health services. Moreover, the reclassification prevents the consideration of specific communities of color as a whole when assessing health by race/ethnicity, which may mask inequities experienced by racial groups. The Governor’s Interagency Council on Health Disparities has identified a need for a review of the statewide standards for the collection, analysis, and reporting of disaggregated race/ethnicity data in order to address this and other data-related challenges.

Additionally, the state’s population is expected to continue becoming more racially/ethnically diverse as people migrate to the region.¹³⁶ While the state population is becoming more diverse overall, diversity is not spread evenly through the state, and “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.”¹³⁶ However, only 35% of individuals who identify as AI/AN and only 40% of those who identify as Hispanic live in these three counties.¹³⁶

Poor health outcomes are not inherent to an individual’s race/ethnicity, rather they are influenced by determinants of health like racism, which “contributes to social inequities (e.g., poverty) that shape health behaviors, access to healthcare, and interactions with medical professionals.”¹³⁷ Institutionalized racism results in differential access to resources, services, and opportunities, including access to healthcare, by race.¹³⁸ The changing racial/ethnic composition of the state and counties is important to consider as “historic policies and practices have contributed to [racial/ethnic] disparities in health behaviors and outcomes”¹³⁶ and often continue to influence access to care, including reproductive health services.^{137,139} For example, in 2012, approximately 73% of pregnant women in Washington entered prenatal care during the first trimester (first three months) of pregnancy.¹⁴⁰ 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.¹⁴⁰

African American women, in particular, are disproportionately affected by multiple sexual and reproductive health conditions compared to women of other races/ethnicities.^{139,141} “African American women accounted for 60% of the estimated new HIV infections that occurred among all women in 2014 and are 2.8 to 3.7 times more likely to die from pregnancy-related complications compared to women of all other races/ethnicities.”¹³⁹ 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).¹³⁹ 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.¹³⁹

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 in 2016, and approximately 12% and 10% of people lacked health insurance (respectively).¹⁴² In general, women, people of color, immigrants, and individuals living in rural communities were more likely to be low-income and lack health insurance.^{19,143} An estimated 40% of low-income women of reproductive age lacked health insurance.¹⁹

Women of low socioeconomic status were also more likely to experience poor reproductive health outcomes, including early initiation of sexual intercourse,¹¹² unintended pregnancy,^{112,143,144} unintended births,¹¹² abortion,^{112,145} teen pregnancy,¹¹² HPV,^{146,147} longer duration of infertility,^{32,114} and late-stage breast cancer diagnosis.¹⁴⁸ 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.^{143,144} 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.¹⁴⁸ Those with low socioeconomic status were also more likely to have limited access to reproductive health services.^{145,149} For example, low-income men and women were less likely to get access to infertility treatment or ART, and “economic factors [were] the chief contributors to disparities in access to effective treatment.”³²

Research has also suggested that the relationship between access to reproductive healthcare and socioeconomic status is cumulative and cyclical.^{74,112} 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.”⁷⁴ 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.”⁷⁴

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 detrimental to reproductive health service access. While most of the literature related to violence focuses on cisgender women and girls and/or trans women, cisgender men and boys and trans men are also at risk for violence, particularly 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.”¹⁵⁰ 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.¹⁵⁰ The report identifies particularly vulnerable populations in the U.S. as: “children in the child welfare and juvenile justice systems; runaway and homeless youth; [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.”¹⁵⁰ Evidence indicates that among the most common physical effects of sex trafficking and commercial sexual exploitation are STIs, pregnancy, substance use/misuse, and traumatic injury.¹⁵¹

Additionally, according to 2010-2012 Washington specific data, 32% of men and 41% of women reported lifetime IPV.¹⁵² 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).¹⁵² Transgender people experience IPV at particularly high rates. Fifty-four percent of respondents to the U.S. Transgender Survey experienced some form of IPV and 24% reported severe physical violence by an intimate partner, compared to 18% of the U.S. population.⁹⁰ 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.¹⁵³⁻¹⁵⁷

INTERSECTIONALITY

Intersectionality, or the understanding that multiple systems of oppression interact in the lives of those with multiple marginalized identities,¹⁵⁸ impacts the need, access, quality, and outcomes of reproductive health services.³¹ Since experiences of oppression are not mutually exclusive, additional systems of oppression and lived experiences may further reduce an individual’s 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."¹⁵⁹ 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.² 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.

BARRIERS

The 45 unique barriers identified through the review of literature are grouped into three categories: Economic, Structural, and Social.¹ The following sections include an overview of each barrier. Priority populations experiencing each barrier are bolded and highlighted, and citations from the literature related to the barrier for each population are provided. Barriers to access are not inherent to the priority populations discussed; rather, these inequities are the result of institutionalized structures of oppression that marginalize specific identities while prioritizing dominant identities for receipt of resources. 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 ease of reference. Numbering does not indicate importance, 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

Adolescents/ Young Adults 36,39-41,57	Older adults 30,61,62	Behavioral health	Disability 30,160	Gender Identity 1,30,87,159,161,162	Sexual Orientation 1,30,85,87,89,159	Geography 19,30
Homelessness 100	Immigration 3,18,19,105,108,109, 112-114,163,164	Incarceration	Military	Race/ Ethnicity 19,30,112,165-168	SES 30,32,74,112,143,145 ,148,149,169-171	Violence 153,172-174

Access to health insurance and healthcare varies by age, disability status, gender identity, sexual orientation, geography, race/ethnicity, and socioeconomic status.³⁰ Healthy People 2020 noted that access to health insurance is the first step to improving access to health services generally as it provides entry into the healthcare system.³⁰ Individuals who are uninsured are, “more likely to have poor health status, less likely to receive medical care, more likely to be diagnosed later, and more likely to die prematurely” than individuals with insurance.³⁰ A systematic literature review of 54 analyses (in 51 distinct studies) found that 43 analyses reported a statistically significant and positive relationship between health insurance or medical care use and health.¹⁷⁵ The author of the review concluded, “[t]here is a substantial

body of research supporting the hypotheses that having health insurance improves health and that better health leads to higher labor force participation and higher income.”¹⁷⁵

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.^{2,3,30} 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.^{170,176} 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 federal poverty level.¹⁷⁶ 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.¹⁷⁶ Women reported staying on TAKE CHARGE because of the lack of employer-sponsored health insurance and cost of other insurance options.¹⁷⁶ Women also had the perception that private insurance would not provide adequate coverage for birth control and other family planning services.¹⁷⁶ Similarly, a study of women with low-incomes accessing prenatal care in Appalachia found that women reported fewer out-of-pocket expenses and better access to services on Medicaid than private insurance.¹⁷⁰

DISABILITY: Multiple studies cited lack of health insurance as a barrier to individuals with disabilities receiving reproductive healthcare.¹⁶⁰ In addition, 41% of women with disabilities live at or below the federal poverty level,¹⁶⁰ 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%).¹⁷⁷

GENDER IDENTITY/SEXUAL ORIENTATION: Surveys conducted in 2016 and 2017 show high uninsured rates among LGBTQ emerging adults (43% uninsured) and transgender individuals (22%).^{87,159} The ACA, the SCOTUS ruling on the Defense of Marriage Act (DOMA) [2013, *U.S. v. Windsor*], and the SCOTUS ruling recognizing same-sex marriages [2015, *Obergefell v. Hodges*] increased access to care and insurance for LGBTQ individuals and their families.¹ 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."¹ 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.^{3,18,19,105,108,109,112-114,163,164} Access is primarily restricted through federal and state legislation (see discussion under *Federal and state restrictive legislation*).^{3,18,19,107,112,113,164,178} 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.³ 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.¹¹³ A 2016 report from the Guttmacher Institute found that 34% of noncitizen immigrant women of reproductive age in the U.S. were uninsured.¹⁸ Specific to Washington State, the Migration Policy Institute estimates that 46% of individuals who are undocumented are uninsured.¹⁰³ In addition, immigrants are less likely to be employed in jobs that provide health insurance.¹⁹ For example, while 68% of individuals who are undocumented in Washington are employed, most (22%) are employed in the agricultural sector.¹⁰³

RACE/ETHNICITY: 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.¹⁶⁵ 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 HPV vaccination for Hispanics.¹⁶⁶

SES: Lack of health insurance has been well-documented as a key barrier to accessing reproductive healthcare for individuals of low socioeconomic status.^{32,74,112,143,145,148,149,169-171} An estimated 40% of women with low-incomes of reproductive age lacked health insurance.¹⁹ 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.¹⁶⁹

2. Cost of care

Adolescents/ Young Adults 35,38,50,57	Older adults 58-60	Behavioral health 71,179	Disability 75,160,180,181	Gender Identity 1,87,90,161,182,183	Sexual Orientation 1	Geography
Homelessness 98	Immigration 105,107,108,110,112- 114,163,164,178,184	Incarceration	Military 125,128	Race/ Ethnicity 35,165,166,185,186	SES 27,32,74,112,114,143 ,145,147,149,170,171	Violence 153,172,187,188

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.^{35,36,57} 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.^{27,170} 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.¹⁷¹ 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 that 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.^{112,114}

BEHAVIORAL HEALTH: Results from the national 2013 Health Reform Monitoring Survey found that 50.8% of adults with mental health concerns reported trouble affording healthcare, regardless of insurance status.¹⁷⁹ 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.¹⁷⁹ Similarly, 80% of uninsured adults with physical or mental health issues and 60% with health insurance reported difficulty affording care.¹⁷⁹ Adults with health issues that also had low socioeconomic status experienced more difficulties accessing care.^{71,179}

GENDER IDENTITY: Cost-related hurdles often affect both sexual and gender minorities.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.^{1,87} 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.¹⁶¹ 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.¹⁸³ National data indicate that transgender people of color experience greater economic inequities than white transgender respondents and the U.S. population generally.⁹⁰ 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 to be living in poverty.⁹⁰

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.^{105,107,108,110,112-114,163,164,178,184} In Washington State, the Migration Policy Institute estimates that 54% of individuals who are undocumented have a family income level below 200% of the FPL.¹⁰³

RACE/ETHNICITY: 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 than their non-Hispanic white counterparts.¹⁸⁵ Results indicated that income appeared to have the largest impact on disparities in prenatal care between non-Hispanic white women and Hispanic women.¹⁸⁵ Similarly, studies have shown that income is an important factor in explaining inequities in cancer screening¹⁶⁵ and HPV vaccination between Hispanic/Latinos and non-Hispanic whites.¹⁶⁶ 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 and 19-24 years.¹⁶⁶

The Contraceptive CHOICE Project (CHOICE) eliminated the barriers of cost, service availability, and provider counseling practices as barriers to accessing contraception for sexually active teenagers (15-19 year olds).³⁵ 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 1,000.³⁵ 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.³⁵

In addition, a 2009 analysis of 24 urban Indian health organizations (UIHO) nationwide found that 10 (45%) of responding organizations reported out-of-pocket costs (e.g., co-pays) as barriers to care for children, women, or pregnant women at their site.¹⁸⁶

SES: Cost of care is a barrier for women of low socioeconomic status to access reproductive health services.^{27,32,74,112,114,143,145,147,149,170,171} Various researchers have found that the cost of contraceptives,¹⁴³ HPV vaccination,¹⁴⁷ abortion,^{112,145} in vitro fertilization,³² ART,¹¹⁴ and prenatal care¹⁷⁰ 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."¹¹⁴

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."¹⁷¹ 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."¹⁷¹

VIOLENCE: Financial cost of care acts as a barrier to reproductive healthcare and medical care generally for victims and survivors of trafficking¹⁸⁷ and IPV^{153,172,188} as traffickers and abusers often exert economic control to limit an individual's power and self-determination.

3. Associated costs of care

Adolescents/ Young Adults 50,51	Older adults	Behavioral health 71	Disability 180,181	Gender Identity 161	Sexual Orientation	Geography 189-191
Homelessness	Immigration	Incarceration	Military	Race/ Ethnicity	SES 27,32,74,147	Violence 188

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.^{27,32,74,147} In addition, costs related to recovery or follow-up practices may also add to the financial cost of care.²⁷ Although the ACA eliminated cost-sharing for reproductive health services, routine vaccines, and STI screening,⁴⁰ 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).⁵⁰

GENDER IDENTITY: Transgender and non-binary individuals may face additional associated costs of care related to travel (e.g., to a competent provider), missed work, and other required services (e.g., therapist visits, lab work).¹⁶¹

GEOGRAPHY: Lack of affordable transportation poses an added barrier, particularly for people with low-incomes, 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).¹⁹² Medicaid’s NEMT benefit helps low-income beneficiaries access care they otherwise would not have been able to receive by facilitating travel to healthcare appointments both reliably and affordably.¹⁹³ While NEMT is a mandatory federal Medicaid benefit, federal waivers allow states to limit its availability.¹⁸⁹

Through Washington’s First Steps program, Maternity Support Services workers help Medicaid-eligible pregnant women arrange transportation. Since the implementation of the First Steps program in 1989, Washington women's prenatal care and birth outcomes have improved.¹⁹⁰ 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.¹⁹¹ 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.¹⁹¹ Furthermore, participants shared that a NEMT ride must be schedule two days in advance,¹⁹¹ 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.¹⁸⁸

4. Non-medical expenses and debts

Adolescents/ Young Adults	Older adults	Behavioral health 71	Disability	Gender Identity	Sexual Orientation	Geography
Homelessness	Immigration 184	Incarceration	Military	Race/ Ethnicity	SES 176	Violence

An individual’s or family’s non-medical expenses and debts limit 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.¹⁸⁴

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.¹⁷⁶

5. Underfunding

Adolescents/ Young Adults	Older adults	Behavioral health	Disability	Gender Identity	Sexual Orientation	Geography 194-197
Homelessness	Immigration	Incarceration 121,198	Military	Race/ Ethnicity 186,199-201	SES	Violence

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.^{121,194,197-199}

GEOGRAPHY: Financial constraints have contributed to closures of rural family planning clinics and consequently reduced access to family planning services, STI testing, and cancer screenings.^{194,197} National data show that 9% of rural counties experienced the loss of obstetric services for the duration of 2004 to 2014 due to financial challenges that contributed to closures.¹⁹⁴ Medicaid has an important role in financing 45% of all U.S. births, and 51% of rural births.^{195,196} Medicaid reimbursement rates for pregnancy healthcare services (e.g., prenatal care, delivery, labor, and postpartum 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.¹⁹⁴ 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.¹⁹⁷

INCARCERATION: Research with four correctional facilities found that some services, such as contraception are not routinely available due to cost.¹²¹ Some facilities have developed creative programs using Title X funding or partnerships with local health jurisdictions or academic institutions to provide family planning services.¹²¹ 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.¹⁹⁸ In Washington State, Medicaid coverage is suspended while individuals are incarcerated, and suspended coverage only provides reimbursement for hospitalizations longer than 24 hours.¹⁹⁸

RACE/ETHNICITY: The IHS is a federal agency that provides healthcare to 2.3 million AI/AN people (approximately 60% of the population).¹⁹⁹ In 2017, an estimated 26.3% of AI/AN people living in Washington had access to IHS.²⁰² 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 SCOTUS decisions.²⁰¹ However, evidence indicates that IHS remains “significantly underfunded, receiving only about half of the funding needed to adequately care for the patients it serves.”²⁰⁰ 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 of \$10,348 per person in 2016.¹⁹⁹ Similarly, the 2009 analysis UIHOs nationwide found that 70% of responding organizations (N=16) reported shortages of resources/funding for providing maternal, infant, and child health services.¹⁸⁶ 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.”²⁰³

STRUCTURAL BARRIERS

6. Health facility closures and mergers

Adolescents/ Young Adults 34	Older adults	Behavioral health	Disability	Gender Identity	Sexual Orientation	Geography 204
Homelessness	Immigration	Incarceration	Military	Race/ Ethnicity	SES	Violence

Health facility closures and mergers reduce the availability of providers and services, often increasing the distance and time spent traveling to services.^{34,204}

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.²⁰⁴

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

Adolescents/ Young Adults 49-51	Older adults 60,63,205	Behavioral health	Disability 75,160,180,181	Gender Identity 161	Sexual Orientation	Geography 94,206-211
Homelessness 98	Immigration 107,108,110,111,163	Incarceration	Military 123,125,126	Race/ Ethnicity 188,212	SES 27,32,149,170,213	Violence 157,174,187

Distance to services,^{60,63,123,157,161,163,181,188,205,212} extended travel times,^{94,157,174,188,212,214} and limited transportation options^{60,75,107,108,110,111,125,157,160,174,180,215} (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.²⁰⁶ 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.²⁰⁷ In addition, this greater distance was nearly three times the average distance (i.e., 30 miles) according to a 2008 national survey.²⁰⁸ In Washington, closures in Okanogan County have caused patients to travel 35 miles to Twisp's Room One Family Planning Clinic.²⁰⁹

DISABILITY: Distance to services¹⁸¹ and availability of accessible transportation^{75,160,180} also pose challenges for individuals with disabilities, particularly those with mobility impairments and for whom fatigue is a major limitation in daily activities.¹⁶⁰ Even if available, public transit may not be accessible to people with visual and/or physical impairments, which may require these patients to schedule ahead of time for accessible transportation or to rely on a family member.¹⁶⁰

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.¹⁶¹

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.^{60,63,205}

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.⁹⁴ 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.^{94,214} 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.⁹⁴

Greater travel time can increase the risk of intrapartum complications for women rushing to the hospital for preterm labor delivery.²¹⁰ 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.⁹⁴ Rural women therefore may face significant geographic barriers to receiving prenatal, delivery, and postpartum pregnancy care services.²¹¹

IMMIGRATION: Transportation to healthcare is a barrier for immigrants, regardless of immigration status.^{107,108,110,111} 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.¹⁰⁸ Distance to clinics providing reproductive health services was also a barrier for male immigrants in rural communities in the Pacific Northwest.¹⁶³

MILITARY: Due to limited provider and service availability, women in the military often found it necessary to travel off-base to receive reproductive health services.^{125,126} Transportation was a barrier for women in the military who had to travel off-base to receive care.¹²⁵ 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.¹²⁶ 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.¹²³

RACE/ETHNICITY: AI/AN people who reside in rural areas or on tribal lands often must travel great distances to obtain medical care.^{188,212} Key informants shared that those who follow traditional seasonal migration patterns face additional challenges accessing reproductive care. Moreover, 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 concerns, substance use disorders). In such cases, individuals must choose whether or not to travel far 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.^{174,187} Long distances and/or travel times and limited availability of public transportation to services represent a significant barrier to those being trafficked¹⁷⁴ and those experiencing more frequent and severe IPV.¹⁵⁷ 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.¹⁵⁷ For example, one study found that travel distances greater than 20 miles negatively affected patient use of free mammogram services for women experiencing IPV.¹⁵⁷

8. Work, school, or childcare limitations

Adolescents/ Young Adults	Older adults	Behavioral health	Disability	Gender Identity	Sexual Orientation	Geography
Homelessness 98,99	Immigration 107,108,110,113,163	Incarceration	Military 123,125-129,216	Race/ Ethnicity	SES 27,32,146,147,170,217	Violence 187

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 under- or unemployed), or the need to bring children to medical appointments or find alternative childcare may pose significant barriers to accessing reproductive healthcare.^{163,215} These challenges are particularly pertinent for low-wage workers^{27,32,146,147,170,217} and those who have limited control over their work conditions.^{107,108,110,113,123,125-129,163,187,216}

MILITARY: Many researchers noted that working conditions for women in the military created a number of barriers to accessing reproductive healthcare, including work schedules,^{125,129,216} long work shifts,¹²⁸ frequent travel,¹²⁸ limited time before deployment,¹²⁷ lack of annual leave,^{126,127} varying ability to use annual leave,^{125,126} and childcare.¹²³ 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.^{125,126} 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.¹²⁶

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.¹⁸⁷

9. Lack of medical home

Adolescents/ Young Adults	Older adults	Behavioral health	Disability	Gender Identity 87,88,159	Sexual Orientation 89,159	Geography
Homelessness 98	Immigration 184,218	Incarceration 115,117,118,121	Military 127,128,216	Race/ Ethnicity	SES 169	Violence 187

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%.¹⁶⁹ Patients with a usual source of care experience better health outcomes, fewer health inequities, lower health costs, and better use of preventive health services.³⁰

HOMELESSNESS: Fragmented care is a large barrier to accessing reproductive healthcare for women experiencing homelessness.⁹⁸ 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.⁹⁸

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.¹⁸⁴ As a result, they are less likely to receive preventive screening and consistent access to contraception.¹⁸⁴ Detainees in facilities operated by ICE 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.²¹⁸

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.^{115,117,118,121} Additionally, lack of care continuity is a barrier to accessing contraception,¹¹⁵ for pregnant individuals who are incarcerated delivering at local hospitals,¹¹⁷ and for individuals upon release from incarceration.^{115,118} In addition, women in jails may not receive appropriate follow-up care because of short durations in facilities or unknown release dates.^{118,121}

MILITARY: Inconsistent or fractured care serves as a barrier for women in the military to access reproductive health services.^{127,128,216} 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 deployed.¹²⁷

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

Adolescents/ Young Adults 43	Older adults	Behavioral health	Disability	Gender Identity	Sexual Orientation	Geography 163,164
Homelessness	Immigration 3,106,107,109-112,163,164,178,184,218	Incarceration	Military	Race/ Ethnicity 112,146,168,185,219-221	SES 32,112,146,217	Violence 153,174,188

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.^{3,106,107,109-112,163,164,178,184,218} 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.^{168,219}

IMMIGRATION: The Migration Policy Institute estimates that 37% of individuals who are undocumented in Washington State speak English “not well” or “not at all.”¹⁰³ 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.¹⁶³ 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.¹¹⁰

VIOLENCE: A report from Amnesty International identified lack of training to provide culturally appropriate care for victims and survivors of sexual violence as a barrier to treatment.²²¹ 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.^{153,174,188} 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.¹⁷⁴ Moreover, providers may not be able to identify victims without the assistance of culturally responsive interpreters to gain the patient’s trust.¹⁷⁴

11. Service availability & provider availability

Adolescents 35,36,40,43-46,50	Older adults 62,205	Behavioral health 69,222	Disability	Gender Identity 1,81,82,85,86,161,223	Sexual Orientation 1,81,82,85,86,161,223	Geography 91,94,95,224-233
Homelessness 99	Immigration 107,110,163,178,218	Incarceration 116-118,234,235	Military 123,126,128,129,216	Race/ Ethnicity 186,212,236	SES 145,170,237	Violence 157,174,188

Limited service availability,^{62,145,170,186,205,224-227} provider availability,^{91,94,186,205,226,228,229} or lack of trained providers^{161,174,188} results in the provision of inadequate and inconsistent reproductive healthcare for multiple populations.^{35,36,43-46,50} These barriers may be exacerbated in rural areas¹⁵⁷ and Tribal nations¹⁸⁸ which often have significantly fewer primary care physicians and obstetrics/gynecology specialists and experience high staff turnover.¹⁸⁸ Healthy People 2020 noted that “future efforts [to improve access to care] will need to focus on the deployment of a primary care workforce that is better geographically distributed and trained to provide culturally competent care to diverse populations.”³⁰

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,²²⁸ low reimbursement rates adversely affect practice patterns.^{95,228,230} Provider availability has also been negatively affected by increasing risks of malpractice litigation and rising costs of medical insurance premiums.⁹⁶ 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.²³² After a lawsuit, 4% of obstetricians and gynecologists reported changing their insurer and 8% left their practice setting.²³² There is concern that professional liability challenges have disproportionately impacted access to obstetricians in rural areas.²³¹⁻²³³

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.³⁶ Yet, the quality and comprehensiveness of reproductive services provided varies substantially, with most pediatricians not providing the full range of appropriate services.³⁶ Additionally, adolescents seeking emergency contraception from a pharmacy experience barriers to access.^{43,44} 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, despite Washington State protections for adolescents.^{43,44}

BEHAVIORAL HEALTH: One study noted, "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,"²²² which suggests 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.⁶⁹

GENDER IDENTITY: A lack of competent providers willing to care for transgender and gender nonconforming patients is a barrier.¹⁶¹ Key informants shared that transgender individuals pursuing gender-affirming surgeries (e.g., chest reconstruction) experience difficulty finding providers in Washington State who accept Apple Health reimbursement rates. Moreover, they noted transgender clients have sought providers in neighboring states due to limited availability in Washington State. According to the Health Care Authority (HCA), the availability of trans-competent providers varies by surgical procedure. For example, there is only one provider in Washington State contracted with Medicaid to conduct full bottom surgeries (HCA, personal communication, August 2018). Limited provider availability can reduce timely access for procedures (e.g., 3-month to 2-year long 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 providing long-acting reversible contraceptives (LARC), including intrauterine devices (IUDs) and implants as compared to those that served more urban areas.²²⁶ For example, a retrospective cohort study of national data (2008-2013) found women delivering at urban-teaching hospitals were 20 times as likely to receive LARC devices.²³⁷ Similarly, a 2010 study found only 25% of Washington's male population live within a 60-minute drive of ART centers,²³⁰ suggesting that 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).²³³ In addition, inequitable distribution of specialty care (e.g., in vitro fertilization [IVF] clinics) can also limit access within rural communities.^{91,229} *Table 2* shows that there are fewer physicians providing reproductive health services in rural areas of Washington State compared to urban areas.⁹⁵ Nationally, there is 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.⁹⁴ Washington, Arizona, Utah, and Idaho are particularly vulnerable to this growing workforce imbalance as they already lack a sufficient supply of obstetricians and gynecologists.²²⁸ Furthermore, resident graduates tend to move to urban cities and counties,⁹⁴ which offer more specialty care and larger hospital settings.⁹⁵

Table 2. Number of physicians (by type) per 1000,000 people in urban and rural areas of Washington State⁹⁵

Physician type	Urban	Rural
Primary care	87.3	57.1
Family medicine	44.0	39.8
General Internal medicine	28.3	11.4
Obstetrics-gynecology	12.8	7.0

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.⁹⁹

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.¹⁷⁸ 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.²¹⁸ 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.²¹⁸ Additionally, immigrants may not have access to providers that understand their culture, language, or unique health situations.^{107,110,163,178} 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.¹¹⁰

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.¹¹⁶ ACOG also noted that facilities lacked opportunities for health education, preventive care, and women-specific health services.¹¹⁸ 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).²³⁴ 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.²³⁵ The authors found that counseling was significantly associated with type of facility ($p=0.001$), with “96% of providers from juvenile facilities, 82% of respondents from state prisons, and 64% of those from city or county jails” reporting counseling.²³⁵ 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.¹¹⁷

MILITARY: Studies have shown a lack of military providers trained to provide women’s reproductive health services (e.g., abortion),¹²⁶ a lack of female providers,¹²³ and a lack of women-only healthcare settings available to women in the military and to Veterans.¹²³ In general, women in the military also have inadequate access to contraception and condoms.²¹⁶ However, access to contraception options and supplies are even more inconsistent and limited during deployment.¹²⁷⁻¹²⁹ 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.¹²⁷ ACOG found women, depending on where they are deployed, may not have access to birth control pills or vaginal rings (due to climatic conditions) as contraceptive options.¹²⁸

The Department of Veterans Affairs’ Barriers to Care survey found that 16% of women who do not use the VA facility closest to them traveled farther because they felt “the women’s services I need are not available.”¹²³ The unacceptability of integrated care and gender insensitivity were two main barriers to accessing healthcare.¹²³ Forty-seven percent 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.¹²³ Despite these high percentages, the Department of Veterans Affairs also found a possible shortage of female providers and women-specific care.¹²³ 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.¹²⁷

RACE/ETHNICITY: A 2009 nationwide survey of UIHOs assessing the maternal, infant, and child health services available to urban AI/AN people found that 48% of surveyed sites reported shortages of providers or services.¹⁸⁶ Site representatives, clients, and providers all referenced the unmet need for obstetrician-gynecologists.¹⁸⁶ Some sites noted the difficulty of recruiting providers (e.g., lack of eligibility for Public Health Service and loan repayment incentives).¹⁸⁶

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.¹⁴⁵ Additional state licensing requirements for facilities and/or providers to perform abortions and limited malpractice insurance coverage for those performing abortions further reduced access to care.¹⁴⁵ 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.¹⁴⁵

12. Limited services due to health system directives

Adolescents/ Young Adults 49	Older adults	Behavioral health	Disability	Gender Identity	Sexual Orientation	Geography 238-241
Homelessness	Immigration	Incarceration 115,117,121,234	Military 125-130,216	Race/ Ethnicity	SES 32	Violence 242

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.^{115,117,121,127,234} Directives that limit reproductive options include religious directives,^{238,240,242} military culture and protocols,¹²⁷ and correctional facility policies.^{115,117,121,234} 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.²³⁸ ACOG stated that conscientious 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.²⁴² Moreover, such refusals may disproportionately impact individuals who already experience limited access to resources and services.²⁴² See discussion of Proposed Rule: Protecting Statutory Conscience Rights in Health Care Notice of Proposed Rulemaking, RIN 0945-ZA03 on page 11 for more information on how proposed U.S. HHS rule changes may affect access to reproductive healthcare services for marginalized populations.

GEOGRAPHY: In Washington State, the number of Catholic hospitals has increased in response to mergers with non-Catholic hospitals. Approximately, 40% of the state's hospital beds are in Catholic hospitals.²⁴¹ 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 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.²⁴⁰ This adds an additional barriers 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),¹¹⁷ limit the time women who are incarcerated have in medical appointments,²³⁴ and limit an individual's ability to take protective health actions (e.g., not permitting nutrition, work schedule, sleeping, or other accommodations during pregnancy).^{115,117} In addition, some facilities have policies that systematically delay necessary care.¹¹⁵ 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.¹¹⁵ 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).¹¹⁵

MILITARY: Military culture effectively restricts women's contraceptive and pregnancy choices through military abortion laws and decisions,^{125,126,128-130} lack of counseling or denial of preferred contraception,^{125,127} reporting through the chain of command,^{125-127,216} criminalization of sexual activity,^{126,127} and experience of military sexual trauma.^{123,126,128,129,216} 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.”¹²³

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

Adolescents/ Young Adults 34,38	Older adults	Behavioral health	Disability 73	Gender Identity 88,161,243,244,162	Sexual Orientation 223	Geography
Homelessness 99	Immigration 218	Incarceration 121	Military	Race/ Ethnicity	SES 27,143,145,147	Violence 187,245

Medically-unnecessary practices or procedures (e.g., mandating wait times to receive an abortion, requiring multiple appointments to start contraception or have an IUD placed, and limiting the number of refills) reduce access to services.^{34,38,99,145,147,187} ACOG found that practices such as requiring a pelvic exam, counseling, or testing for STIs prior to prescribing a contraceptive or placing LARC devices create unnecessary barriers to care.¹⁴³ Use of such medically unnecessary practices may require patients to overcome other economic, structural, and social barriers to access services^{27,147} which may result in patients either delaying or foregoing care.

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.^{80,161} 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 no 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.”¹⁶¹ Similarly, transgender and gender nonconforming individuals perceived requirements of a diagnosis (e.g., Gender Identity Dysphoria) to access care as an unnecessary barrier.¹⁶¹

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.^{88,161} 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).^{161,243} In addition, “despite [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). WPATH maintains standards to ensure referring clinicians are capable of distinguishing between co-existing mental health issues and gender dysphoria.⁸⁸ 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.

WPATH also recommends clinicians evaluate readiness using real life experience, or “a continuous period of living full-time as the gender which one identifies.”⁸⁸ However, there is a lack of evidence demonstrating an association between postsurgical outcomes and mastery of any particular aspect of real life experience.⁸⁸ 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.

The Informed Consent for Access to Trans Health (ICATH or “Informed Consent Model”) presents an alternative approach to providing care for transgender people. ICATH removes psychotherapy and/or gatekeeping requirements.²⁴³ 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.”²⁴³ Therapy is considered an option rather than a requirement or prerequisite to trans healthcare.²⁴³ 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.”²⁴⁴ “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.”²⁴³

14. Policy implementation and denial of services (e.g., age of consent, long-acting reversible contraception)

Adolescents <small>36,37,44,52,54,57</small>	Older adults	Behavioral health	Disability	Gender Identity	Sexual Orientation	Geography
Homelessness	Immigration	Incarceration	Military	Race/Ethnicity	SES <small>246</small>	Violence

Evidence from the literature as well as information shared by key informants indicates that the existence of a policy intended to increase access does not itself guarantee improved access. Barriers may persist in the absence of strategies to properly implement a new policy.^{246,247}

ADOLESCENTS: Washington State law allows, without parental consent or notification, minors at any age to access contraceptive and abortion services ([RCW 9.02.100](#)) and those aged 14 or over to access STI testing and treatment ([RCW 70.24.110](#)). However, 29% of Washington middle

and high schools require parental consent for the school nurse or clinic to provide reproductive health services, and 29% require consent for sexual reproductive health referrals.³⁷ In a review of 49 studies of pharmacies (23 of which were completed in the U.S.), up to 65% of the time adolescents were denied access to emergency contraceptive pills despite regulations allowing them access.⁴³ Misinformation about sexual reproductive health and dispensing guidelines resulted in some cases of incorrect denial of access. 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).

SES: Evidence from state Medicaid agencies that were early adopters of policies to reimburse for LARC insertion immediately after birth found that policy change alone was insufficient to increase women’s access to these services and devices.²⁴⁶ Implementation strategies (e.g., distributing education materials, establishing hospital/provider protocols) were necessary to expand access to immediate postpartum LARC placement.^{246,247} Key informants shared that although Washington’s Medicaid (Apple Health) program covers immediate postpartum LARC,²⁴⁸ as of November 2018 only two hospitals in Washington consistently provide access to immediate postpartum LARC. Therefore, Medicaid patients delivering at a hospital that does not provide the service do not have access to it.

15. Assumed heteronormativity and cisnormativity

Adolescents/ Young Adults 55	Older adults	Behavioral health	Disability	Gender Identity 85,161	Sexual Orientation 83,86	Geography
Homelessness	Immigration	Incarceration	Military	Race/ Ethnicity	SES	Violence

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.¹⁵⁸ Assumed heteronormativity acts as a barrier to individuals accessing necessary sexual healthcare as it contributes to an unwelcoming environment for LGBTQIA people.^{83,85,86,161} 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.^{83,86}

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.⁸⁶ 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 affect an individual's access to appropriate testing and treatment.⁸³

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.¹⁶¹ A systematic review identified the absence of gender neutral clinical practices as a barrier to accessing healthcare services.⁸⁵

16. Forms and procedures

Adolescents/ Young Adults	Older adults	Behavioral health	Disability	Gender Identity <small>86,249</small>	Sexual Orientation	Geography
Homelessness	Immigration	Incarceration	Military	Race/ Ethnicity	SES	Violence

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.^{86,249} Specifically, the common choice between 'male' and 'female' can prevent appropriate care for transgender and non-binary people.⁸⁶ 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."⁸⁶ Key informants confirmed that completing forms is a barrier to care for transgender and non-binary people 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 sex assigned at birth and current gender identity to adult surveys.²⁴⁹ GenIUSS states, "testing shows that the 'two step'

Table 3. The Two-Step Approach for asking about sex-assigned at birth and gender identity

<ol style="list-style-type: none"> 1. Sex assigned at Birth: What sex were you assigned at birth, on your original birth certificate? <ul style="list-style-type: none"> • Male • Female 2. Current Gender Identity: How do you describe yourself? (Check one) <ul style="list-style-type: none"> • Male • Female • Transgender • Do not identify as female, male, or transgender

approach appears the most likely to have high sensitivity, as well as high specificity, with adults.”²⁴⁹ 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.

17. Medically-accurate, culturally appropriate, comprehensive sexual health education and policy implementation

Adolescents 34,37,38,44,45,49,50, 250	Older adults 58,60,66-68	Behavioral health	Disability 76,251	Gender Identity	Sexual Orientation	Geography 49,250
Homelessness	Immigration 163	Incarceration	Military	Race/ Ethnicity	SES	Violence 153,156,174,252

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 nationally²⁵⁰ and in Washington State.⁴⁹ The prevalence and quality of sexual health education varies.^{34,37,45,49,250} Although Washington State requires any sexual health education taught in public schools to be medically-accurate and comprehensive, the reality of its implementation is varied.³⁷ 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).
66-68

ADOLESCENTS: Receipt of sexual education decreases later in high school when teens are more sexually active.³⁷ According to a report by the Office of Superintendent of Public Instruction (OSPI), just 19% of middle schools and 54% of high schools in Washington State taught all 16 of the critical sexual health education topics laid out by the Centers for Disease Control and Prevention (CDC).³⁷ 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.³⁷ 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.³⁷ Furthermore, only 55% of schools gave teachers all the materials they needed to teach sex education, less than half of all teachers received professional development on topics related to sex education, and 60% of teachers reported wanting more professional development in all areas of sex education.³⁷

OLDER ADULTS: Although sex education efforts rarely focus on older adults,⁶⁵ this population demonstrates a need for sexual health information.⁶⁶⁻⁶⁸ 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.⁵⁸ Additionally, some older adults believe they do not need certain sexual health services,⁶⁰ while others lack knowledge about appropriate and available services.⁶⁶ 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.⁶⁷

DISABILITY: A general lack of knowledge about the intersection of disability and sexuality among the healthcare community⁷⁶ as well as a lack of evidence and consensus on effective methods of sex education for adults with intellectual disabilities has resulted in gaps in appropriate sexual health education for adults with disabilities.²⁵¹ 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.²⁵¹ 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.^{73,251} Positive information about sex and training on sexuality is also lacking for caregivers of adults with intellectual disabilities.²⁵¹

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 IPV^{153,156,252} and trafficking.¹⁷⁴ In particular, adolescents may not recognize controlling behaviors in romantic relationships as abusive or coercive.¹⁵⁶

18. Clinic environment and conditions

Adolescents/ Young Adults 43,47,48,50	Older adults	Behavioral health	Disability 74-76,160,180	Gender Identity 85	Sexual Orientation 85	Geography
Homelessness	Immigration 110,163,184	Incarceration	Military 123	Race/ Ethnicity 188	SES 146,149,253	Violence

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),^{110,123,163,188} wait times,^{163,184} delays in getting appointments,^{184,188} and other environmental conditions (e.g., welcoming, safe, clean).¹²³

DISABILITY: The Americans with Disability Act (ADA) passed in 1990 setting guidelines for accessibility to places of public accommodation and commercial facilities for individuals with disabilities. However, lack of accessibility of clinics⁷³⁻⁷⁶ and medical equipment^{75,76,160,180} continue to pose significant barriers for people with disabilities, especially those with visual and physical impairments.¹⁸⁰ Challenges include difficulty navigating clinic parking lots¹⁸⁰ and buildings,¹⁸⁰ transferring to and from examination tables,⁷⁵ and difficulty standing to use standard mammography equipment.^{75,160}

19. Lack of formal provider training or medical education

Adolescents/ Young Adults 36,43,46	Older adults	Behavioral health 71	Disability 75,76,251	Gender Identity 1,81,82,85,86,161,22 3	Sexual Orientation 1,81,85,86,161,223	Geography 226
Homelessness	Immigration 108,110,111,184	Incarceration 121,234	Military 126,128,131,216	Race/ Ethnicity	SES	Violence 174,252

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).^{1,30,75,76,81,82,85,86,161,184,223,251} In addition, ACOG found that, in general, providers lack knowledge about the risks and benefits of contraceptives, which impacts their ability to counsel patients.¹⁴³ For example, in 2009 ACOG recommended LARC, including IUDs and the single-rod implant, as a “first-line contraceptive option, noting the few contraindications and suitability for nearly all women.”²⁵⁴ However, an analysis of surveys collected in 2011 from 587 medical directors at California’s Family Planning Access Care and Treatment program showed that 43% of respondents either “Strongly Agree or Agree” that IUDs can be inserted immediately postpartum.²⁵⁴ Whereas, 44% of respondents “Strongly Disagree or Disagree” and 13% reported “No Opinion” when asked whether they agree that IUDs can be inserted immediately postpartum.²⁵⁴ Authors concluded that providers’ lack of understanding of as well as their beliefs about LARC “may lead to limited contraceptive choices for women and a greater burden on patients and health care providers by unnecessarily requiring additional visits and procedures.”²⁵⁴

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.^{1,81,82,85,86,161,223} In part, this is due to the lack training provided in medical school curricula regarding LGBTQIA 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.⁸¹ Furthermore, 9 schools (6.8%) reported 0 hours during preclinical years, and 44 schools (33.3%) reported 0 hours during clinical years.⁸¹ 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.”⁸¹ For example, medical schools also were also 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, gender-affirming 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 16.⁸¹ 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.⁸²

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.¹⁸⁴ 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.^{108,110,111} 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 postpartum, from providers that are unfamiliar and lack training in female genital cutting.^{110,111} 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.^{110,111}

MILITARY: Studies noted that military providers lack training in women’s health and reproductive health services (e.g., abortion).^{126,216} Furthermore, evidence indicates that non-military providers lack understanding about reproductive health risks associated with military service,¹²⁸ understanding about the difficulty in hygienically managing menstruation during deployment,¹²⁸ and knowledge about contraceptive availability during deployment.^{126,128,216}

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.¹³¹ For example, data from male Veterans seeking infertility treatment within the South Florida Veterans Affairs healthcare system showed 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.¹³¹

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.¹⁷⁴ Evidence suggests that educational interventions can successfully increase knowledge and confidence in identifying and treating victims/survivors, yet further research is necessary to identify evidence-based effective training models.¹⁷⁴ Additionally, a review of IPV literature found a need to increase providers’ understanding and awareness of reproductive coercion to help identify at-risk individuals.²⁵²

20. State and federal legal rulings or legislation

Adolescents 39-41,43,44,52,54	Older adults	Behavioral health	Disability	Gender Identity	Sexual Orientation	Geography
Homelessness	Immigration 3,18,19,107,112,113, 164,178,255	Incarceration 115,117,118,120,121, 198,234,256-258	Military 125-130	Race/ Ethnicity 188	SES 19,32,74,112,114,143 ,145,149,259,260	Violence 174,187,261,262

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.^{19,74,149} Some federal and legislation limits access to contraception,¹⁴³ abortion service,^{112,145} and ART^{32,114} for all populations. See *Table 1* on page 9 for additional information regarding federal and state-specific contextual factors that may impact access to reproductive health services in Washington State.

Federally, the only funding for family planning is through Title X of the Public Health Service Act of 1970.¹⁹ It provides funding and family planning services through safety net providers, including federally qualified health centers, community health centers, and other community organizations.^{19,112} Title X funding often fills gaps in care by providing care regardless of insurance status, immigration status, or ability to pay.^{18,19}

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.¹¹² The ACA excluded abortion from public insurance coverage and restricted coverage through private insurance offered on the Health Exchanges.¹⁴⁵ 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.²⁵⁹ 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 2019.²⁶⁰

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.^{32,114}

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 safe and healthy relationship education for youth and adolescents.¹⁷⁴ 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 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.²⁶³ 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.³⁷

IMMIGRATION: Federal and state legislation restrict immigrant access to health insurance coverage and care, regardless of immigration status.^{3,18,19,107,112,113,164,178} 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).^{112,113,184} However, the Act specified that Medicaid would provide emergency coverage, including costs related to labor and delivery, regardless of immigration status.¹¹³ 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.¹¹³ 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, they 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.^{3,18,112,113,184} Since individuals who are undocumented and DACA recipients are excluded from coverage under 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.^{18,164}

HCA 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."²⁵⁵ 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.¹¹³ Pregnant women who are undocumented can receive a waiver from the state to receive Medicaid coverage during their pregnancy and two months postpartum.²⁵⁵ They can also continue to receive family planning services for one year after giving birth.²⁵⁵ Despite these options, individuals who are undocumented, especially adults who are undocumented, have the most restricted access to healthcare coverage in Washington State.²⁵⁵

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.^{115,117,118,120,121,234,256} Multiple national organizations provide recommended standards of care for women and adolescent girls who are incarcerated.^{115,120,121,256} However, non-mandatory national standards have created varying healthcare practices by states and facilities.^{117,256} 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.¹¹⁷ 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.^{115,234}

In Washington State, Department of Commerce provides healthcare to incarcerated individuals in state facilities.²⁵⁷ The Offender Health Plan (OHP) outlines services that are considered

medically necessary but does not guarantee these services to incarcerated individuals.²⁵⁷ The OHP states that Department of Commerce 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.²⁵⁷ 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).²⁵⁷ Under some circumstances, services that may also be considered medically necessary include fistula, mammography, gender dysphoria, and additional ultrasounds in pregnancy.²⁵⁷ Prohibited services include artificial insemination or IVF, 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).²⁵⁷

In addition, the ACA and state Medicaid expansion created additional opportunities for individuals who are incarcerated to obtain health insurance upon release. In 2017, Washington State enacted a law requiring HCA to suspend (rather than terminate) Medicaid coverage for incarcerated individuals.¹⁹⁸ While suspended, incarcerated individuals are still covered for inpatient hospitalizations longer than 24-hours, and full coverage is automatically reinstated upon release.¹⁹⁸ If individuals do not have insurance, they are enrolled in Medicaid prior to release, and HCA is required to expedite enrollment so that individuals who are incarcerated have insurance the date they are released.¹⁹⁸ City and county jail facilities may also allow individuals to apply for Medicaid depending upon resource availability (e.g., staffing).¹⁹⁸

Lastly, while many states still allow pregnant women to be shackled throughout their pregnancy and during labor and delivery,^{115,117,118} Washington State law has prohibited the use of restraints on pregnant women who are incarcerated since 2010 except under “extraordinary circumstances.”²⁵⁸ Washington 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.²⁵⁸ Washington State law also requires that correctional officers immediately remove all restraints if requested by medical personnel to provide care.²⁵⁸

MILITARY: While rates of unintended pregnancy and experiences of sexual violence are higher among women in the military compared to the general population,^{125,126,128-130} military abortion laws are more restrictive than U.S. federal abortion laws, creating disparate access to abortion for women in the military.¹²⁵⁻¹²⁹ Until 2013, “abortion services [could] only be provided at Department of Defense [DOD] facilities in cases of rape, incest, and life endangerment, and [could] only be paid for with DOD funds in cases of life endangerment.”¹²⁹ Between 1996 and 2004, approximately 3.8 abortions were performed per year at military facilities.¹²⁵ In 2013, the Shaheen Amendment expanded TRICARE coverage to include abortions in cases of rape and incest.¹²⁵ 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.¹²⁶

The military also has a policy of following laws of host nations and U.S. state restrictions. This places further restrictions on women seeking an abortion if they are stationed in a country that prohibits abortions,¹²⁶ or in states with restrictive abortion policies (e.g., appointment structures requiring additional travel and costs).¹²⁵

RACE/ETHNICITY: 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.^{188,264} 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.^{174,187,262} See *Fear of criminal justice involvement* for additional information.

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

Adolescents/ Young Adults 44,57	Older adults 61	Behavioral health	Disability 73,76,181,265,266	Gender Identity 1,161,162,183,267	Sexual Orientation 1,161,162,183,267	Geography
Homelessness	Immigration 114,178	Incarceration	Military 127	Race/ Ethnicity	SES 19,32,74,112,114,143 ,145,149 215,237	Violence 221

Having health insurance coverage does not guarantee access to quality reproductive healthcare. Limitations in insurance coverage^{73,181,265,268} and insurance requirements^{73,76} may impact cost of care,^{19,74,149} complicate the process of finding a provider due to a limited number of providers accepting a specific insurance plan,¹⁸¹ or require a patient to see a primary care provider in order to be referred to a specialist.⁷³ People may also experience gaps in their coverage in the form of prohibitively high deductibles,¹⁶² service exclusions,^{1,161,162} or other practices that limit access to services. For example, ACOG reports difficulties encountered by hospitals and obstetrician-gynecologists in receiving reimbursement and payment for immediate postpartum LARC placement has slowed uptake of this evidence-based practice.²⁶⁸ Reimbursement for all delivery-related care is generally based on a global fee,^{268,269} which does not include the cost of LARC devices or insertions and thus disincentivizes hospitals to supply and dispense LARC devices immediately postpartum.²⁶⁹ Since 2012, 28 states, including Washington, have addressed the issue for Medicaid-covered patients by separating out reimbursement for LARC devices during delivery hospitalization.^{215,269} Medicaid policies are often later adopted by private insurance plans.

Low reimbursement rates and complex reimbursement processes may also make it difficult for providers to offer all services.^{76,114,178} Lastly, insurance may not cover all reproductive healthcare services, including contraception,¹⁴³ abortion,^{112,145} and ART.^{32,114} 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.¹¹⁴

GENDER IDENTITY/SEXUAL ORIENTATION: In addition to being less likely to have insurance than heterosexual, cisgender people, LGBTQIA individuals often experience gaps in insurance coverage.¹ 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.¹⁶¹ Insurance limitations described by respondents included a limited number of providers, policies containing transgender specific exclusions, and total expenditure limitations on transgender-related healthcare below the cost of procedures.¹⁶¹ 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.^{162,267} 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.¹⁶²

In 2015, "29% of [transgender] respondents [living in Washington State] experienced a problem in the past year with their insurance related to being transgender."¹⁸³ Individuals reported being denied coverage for care related to gender-affirming care or for routine care because they were transgender.¹⁸³ 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.

SES: While immediate postpartum contraception is uncommon (e.g. LARC, 13.5 per 10,000 deliveries; sterilization, 683 per 10,000 deliveries), evidence suggests that both LARC and sterilization are significantly more likely among women with low socioeconomic status, "with a widening gap in immediate postpartum LARC use in recent years."^{215,237} A retrospective cohort study found that "nationally from 2008-2013, women without private insurance [i.e., women with public insurance] received 57% of inpatient postpartum sterilizations and 85% of immediate postpartum LARC insertions—even though this group only comprises 45% of the delivering population."²¹⁵ Furthermore, women with public insurance were five times as likely as those with private insurance to receive immediate postpartum LARC.²³⁷ Findings predated changes in Medicaid reimbursement to facilitate inpatient postpartum LARC. In Washington, women enrolled in Medicaid experience better access to immediate postpartum LARC, provided the hospital where they are delivering offers the service, than women with private insurance. However, researchers have noted that efforts to improve access to this evidence-based option should be designed to promote universal availability to prevent coercion of women with low incomes, women of color, or otherwise marginalized women.²¹⁵ See discussion of *Historical trauma and medical mistrust* for additional context.

22. Health plan communications (e.g., explanation of benefits (EOB) and electronic health records)

Adolescents/ Young Adults 39-41	Older adults	Behavioral health	Disability	Gender Identity	Sexual Orientation	Geography
Homelessness	Immigration	Incarceration	Military	Race/ Ethnicity	SES	Violence 41

Health plan communications sent to the primary insurance policyholder (e.g., spouse, partner, parent, or guardian) for reproductive services pose unique barriers for adolescents/young adults and individuals experiencing IPV.³⁹⁻⁴¹ 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^{40,42} or receipt of EOBs sent to the primary insurance policyholder for services sought by an adult dependent.³⁹⁻⁴¹

In 2001, Washington State created the right for patients to limit disclosure by insurers of their health information.²⁷⁰ The regulation contains “protections for individuals who would be jeopardized by disclosure, for individuals receiving a range of sensitive health services, and for minors who may obtain health care without parental consent.”²⁷⁰ The text specifically requires insurers to refrain from disclosing information regarding services for which a minor has consented without first obtaining their authorization.^{270,271} Meanwhile, young adult and adult dependents must submit a request to limit disclosure. Sources found patients are largely unaware of the protections and their right to request to limit disclosure.^{41,270} Additionally, the requirement that patients initiate the process by contacting their insurance company poses a unique burden for individuals, particularly minors and those experiencing abusive, coercive relationships.⁴¹

23. Difficulty navigating insurance system

Adolescents/ Young Adults 34,43	Older adults 64,67	Behavioral health 71	Disability 181,272	Gender Identity	Sexual Orientation	Geography
Homelessness	Immigration 3,107,164	Incarceration	Military	Race/ Ethnicity	SES 27,176	Violence 174,273

Various populations have difficulty navigating complex administrative procedures, registration systems, and paperwork to apply for and receive health insurance coverage.^{3,64,67,107,164,174} 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.¹⁷⁶

24. Difficulty in obtaining medically-accurate information about services

Adolescents/ Young Adults 43	Older adults	Behavioral health	Disability	Gender Identity 85,161	Sexual Orientation	Geography
Homelessness	Immigration 111,218	Incarceration	Military 125,127	Race/ Ethnicity	SES	Violence

Lack of medically-accurate information regarding reproductive health services is a barrier to care.^{43,85,125,127,161}

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.¹²⁷ For example, because sexual intercourse 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.¹²⁷ 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.¹²⁵

25. Personal identification (ID) document requirements

Adolescents/ Young Adults	Older adults	Behavioral health	Disability	Gender Identity	Sexual Orientation	Geography
Homelessness	Immigration 107,163,164,184	Incarceration	Military	Race/ Ethnicity	SES	Violence 174,187

Many studies noted that the requirement to present personal identification and documentation to receive healthcare serves as a barrier to immigrants, regardless of status,^{107,163,164,184} and trafficked individuals^{174,187} seeking and accessing care. This requirement is especially restrictive for DACA recipients and individuals who are undocumented^{164,184} as well as trafficked individuals whose personal identification documents may be held by the trafficker.^{174,187}

26. Lack of data

Adolescents/ Young Adults	Older adults	Behavioral health 70	Disability	Gender Identity	Sexual Orientation	Geography
Homelessness	Immigration 106	Incarceration 115	Military 128,129,274	Race/ Ethnicity 28,186,200,221,264	SES	Violence 187

Researchers have noted the lack of research and data gaps related to the reproductive health of immigrants and refugees,¹⁰⁶ active duty women in the military and female Veterans,^{128,129,274} AI/AN tribal and urban Indian communities,^{28,186,200,221,264} and victims and survivors of violence.^{28,187} Key informants in Washington State confirmed that state-level data is also limited for refugees and trafficked individuals.

SOCIAL BARRIERS

27. Intimate partner violence

Adolescents/ Young Adults	Older adults	Behavioral health 70,71	Disability	Gender Identity 90	Sexual Orientation 1	Geography 157
Homelessness	Immigration	Incarceration	Military 128	Race/ Ethnicity 139,212	SES 27,149	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 (e.g., refusal to use a condom).¹⁵² IPV includes abusive behavior also referred to as domestic violence.¹⁵² Intimate partner behaviors that prevent individuals from accessing health services (e.g., limiting access to transportation or finances, physical violence, reproductive coercion) interfere with an individual’s ability to prevent, screen, and address IPV and adequately fulfill sexual and reproductive health needs.¹⁵³⁻¹⁵⁷ 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).¹⁵⁶

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.⁹⁰ Seventy-seven percent of those who did income-based sex work experienced IPV.⁹⁰ Additionally, data indicate that transgender respondents who are undocumented (68%) were more likely to experience violence than other respondents.⁹⁰ 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.^{70,71} 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.⁷⁰ Women who inject drugs are also more likely to be injected by others, including male sex partners.⁷⁰ 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.”⁷⁰

28. Reproductive and pregnancy coercion

Adolescents/ Young Adults	Older adults	Behavioral health 70	Disability	Gender Identity	Sexual Orientation	Geography 157
Homelessness 99,100	Immigration	Incarceration 115,117,121,234	Military 123,125-130,216	Race/ Ethnicity	SES	Violence 154,155,174,187,188, 252,275

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).^{188,275} Evidence indicates that reproductive coercion can affect people of any age, race/ethnicity, sexual orientation, or sociodemographic group.²⁵² 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.¹⁵⁵ Of those, 35% also reported experiencing reproductive coercion.¹⁵⁵ 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).²⁵² Examples of reproductive coercion include but are not limited to: removing condom during sex, destroying contraceptives, and preventing a partner from attending medical appointments.^{154,155,252} Literature also identified ways in which institutions enact reproductive coercion by limiting access to reproductive health services.^{115,117,121,123,125-130,216,234}

HOMELESSNESS: Women experiencing homelessness are at risk for reproductive coercion.⁹⁹ Women reported experiencing forced sex, engaging in sex work, or exchanging sex to secure housing, food, and money.⁹⁹ 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.^{99,100}

INCARCERATION: The culture and policies of correctional facilities' health systems may systematically limit women's access to reproductive health services.^{115,117,121,234} 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."¹¹⁵ 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."¹¹⁵ 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.¹¹⁵

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;^{125,126,128-130} lack of counseling or denial of preferred contraception;^{125,127} reporting through the chain of command;^{125-127,216} criminalization of sexual activity;^{126,127} and experience of military sexual trauma.^{123,126,128,129,216}

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).^{174,187} For example, grantees through Washington State’s Office of Crime Victim Advocacy (OCVA) 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

Adolescents/ Young Adults	Older adults	Behavioral health	Disability 251,276	Gender Identity 90	Sexual Orientation 1	Geography
Homelessness 98,100	Immigration 101,108	Incarceration 118	Military 123,126,128,129,216	Race/ Ethnicity 154,155,277	SES 27	Violence 174,187,245

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.”²⁷⁷ 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.²⁷⁷ Past and current experience with violence make women less likely to access reproductive healthcare.^{123,216}

GENDER IDENTITY: Nationally, 47% of U.S. Transgender Survey respondents were sexually assaulted at some point in their lifetime, and 10% were sexually assaulted in the past year.⁹⁰ Transgender individuals who have done income-based sex work were significantly more likely to have been sexually assaulted (72%).⁹⁰ 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.⁹⁰ Additionally, 61% of transgender respondents with disabilities had been sexually assaulted in their lifetime.⁹⁰

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.¹⁰¹ A study with female Somali and Congolese immigrants in Massachusetts found that female immigrants had prior experiences with sexual trauma and violence¹⁰⁸ 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.¹¹⁸

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.¹²⁸ The Department of Veterans Affairs requires screening of all Veterans for military sexual trauma, and 20% of female Veterans reported a history of trauma.¹²⁸ 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.¹²³ 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.²¹⁶ 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.¹²⁹ Another study found that between 9.5% and 33% of women experience an attempted or completed rape while serving in the military.¹²⁶ 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 Department of Defense estimates that 80% of servicewomen who experience unwanted sexual contact do not report it to a military authority.”¹²⁹

RACE/ETHNICITY: 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.²⁷⁸ 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%).²⁷⁸ 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.^{221,278} Available data show that AI/AN people 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.²⁷⁸ A comprehensive sexual violence survey administered by the Urban Indian Health Institute and the CDC found that, of 148 Native women interviewed in Seattle, 139 (94%) had been raped or coerced at some point in their lives.²⁶⁴ In addition, “of all the women who participated, 70% (104 women) reported that the first time they were sexually assaulted was by being raped or coerced,” and 82% of those 104 reported the incident happened before they were 18 years old.²⁶⁴ Key informants shared additional anecdotal information that indicates 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^{174,187} 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).¹⁸⁷ Study participants also described traffickers accompanying individuals or sending another trafficked woman with them to medical appointments for intimidation and control purposes.¹⁸⁷

30. Mandatory reporting

Adolescents/ Young Adults	Older adults	Behavioral health 222,279	Disability	Gender Identity	Sexual Orientation	Geography
Homelessness	Immigration	Incarceration	Military	Race/ Ethnicity 188,212	SES	Violence 174

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 trafficking¹⁷⁴ 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.^{222,279} Washington State law does not require healthcare providers to report substance use by pregnant women.²²² Washington State statute 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.²²²

31. Differential treatment, practices, or counseling by provider

Adolescents/ Young Adults 35,36,42,43,46,47,53, 55-57	Older adults 58,60,66-68	Behavioral health	Disability 160,177,180,181	Gender Identity 80,83,84,87,90,161,1 83	Sexual Orientation 80,83,84,87,90,161,1 83	Geography
Homelessness 99,100	Immigration 109,114,163,164,178, 184	Incarceration	Military 123,125,127,274	Race/ Ethnicity 112,138,139,146,168, 213,215,236,280,281	SES 32,114,146,149,213,2 15	Violence 156,252,282,283

Individuals seeking reproductive health services may experience differential treatment in a clinical setting from front office staff, medical staff, or providers.¹⁶¹ Identity-based discrimination in healthcare settings, harsh or abusive language,^{80,83,161} refusal of care,^{83,161} non-affirming care,^{80,161} heteronormative perspectives,^{83,86} substandard care,⁸⁰ and other differential treatment^{1,83,161} can result in decreased likelihood of individuals seeking care in the future.⁸³

Providers’ attitudes and implicit biases often influence how they counsel patients.^{112,146,168,213,280,281} For example, provider recommendations for HPV vaccination have been shown to increase vaccine uptake up to 18-fold.¹⁴⁶ However, a 2014 study found parents of Black and Latina girls reported lower rates of provider recommendation than did parents of white girls.¹⁴⁶ 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.^{58,60} 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, gender identity, and/or whether they deserved to be a parent or raise a child.^{32,114}

OLDER ADULTS: A British study of patients aged 50 to 92 years old 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."⁶⁶ None of the participants reported their general practitioner initiating a discussion about sexual health issues.⁶⁶

DISABILITY: A review of multiple studies found that providers often ignore routine female screening needs and fail to recommend mammograms for women with disabilities.¹⁶⁰ 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.^{177,181} Yet their analysis revealed that Pap test recommendations are relatively high among disabled women while screening rates remain low.¹⁷⁷ 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.¹⁷⁷

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.³ 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%).⁸⁷ 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.⁸⁷ Transgender people with disabilities report higher rates of mistreatment by healthcare providers (42%).⁹⁰ 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),^{83,161} displays of discomfort, and substandard care.⁸⁴

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 ($P = 0.001$).¹⁵⁹ 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.¹⁸³

HOMELESSNESS: Women reported being treated differently by providers based on their housing status.⁹⁹ Women with children experiencing homelessness in San Francisco, California,

reported that they were reluctant to disclose their housing status to providers for fear that they would receive substandard quality of care.⁹⁹ Women experiencing homelessness in Pittsburgh, Pennsylvania, also felt that providers shared biased or incomplete information with them about contraception options.¹⁰⁰ 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.¹⁰⁰

MILITARY: 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.¹²⁷ 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.¹²⁷ Similarly, a study with female Veterans found that LARC use was lower among Veterans than the general population.²⁷⁴

The Department of Veterans Affairs' Barriers to Care survey found that gender insensitivity was a main barrier to accessing healthcare.¹²³ 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."¹²³ 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.¹²³ The survey also found that women felt most respected by their provider, less respected by other providers, and least respected by office staff,¹²³ suggesting that the larger clinical environment influences their satisfaction with care.

RACE/ETHNICITY: Numerous studies identify racism, the differential treatment stemming from skin color or other individual characteristics, as a barrier to care.¹³⁸ Institutionalized racism results in differential access to resources, services, and opportunities, including access to healthcare by race.¹³⁸ A review of literature published from 2009 to 2015 examined the relationship between racial discrimination and adverse birth outcomes.¹³⁸ 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.¹³⁸ Another study of African American women (N=872) found that timing of prenatal care was not significantly associated with personal experiences of racism but was associated with group experiences (p>0.01).

Women of color experience differential contraception counseling.^{112,168,213,281} For example, self-reported evidence indicates that women of color and women with low-incomes may be more likely to experience pressure to limit family size.¹¹² 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 than white women.²⁸¹ 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."²⁸¹ Given the history of efforts to control the fertility of women with low-incomes and women of color, researchers

suggested that additional counseling may be indicative of providers’ implicit bias rather than quality care.²⁸¹

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,^{149,213} HPV vaccination,¹⁴⁶ and ART.^{32,114} 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 LARC than patients whose parents had more education.²¹³ 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.¹⁴⁹

32. Denial or delay of services

Adolescents/ Young Adults 43	Older adults	Behavioral health	Disability	Gender Identity 1,80,84,161,162,223, 284	Sexual Orientation 223	Geography
Homelessness	Immigration 218	Incarceration 218	Military	Race/ Ethnicity	SES	Violence

Denial or delay of services poses a significant barrier to accessing reproductive healthcare.^{1,43,80,84,161,162,218,284}

GENDER IDENTITY: Denial or delay of services is especially a barrier for transgender individuals.^{1,80,84,161} According to the Office of the Insurance Commissioner, “[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.”²⁸⁴ 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.¹⁶² 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).¹⁶² 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.¹⁶¹

In 2018, Office of the Insurance Commissioner 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.²⁸⁵ According to the press release, the companies issued blanket denials rather than considering individual cases.²⁸⁵ On August 1, 2018, Office of the Insurance Commissioner 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.²⁸⁵ Additionally, both are required to complete a review of all denials of this treatment since January 2016.

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

Adolescents/ Young Adults 47,50-52,286	Older adults 63,66	Behavioral health 70,71	Disability 160,180,251	Gender Identity 85,87,88,159,161,183 ,223,287	Sexual Orientation 85,87,88,159,161,183 ,223,287	Geography
Homelessness	Immigration 105,107- 111,163,164,178	Incarceration	Military 123,125-127,216	Race/ Ethnicity 54288,289	SES 27,32,112,144,253	Violence 153,174,188,245

Fear of or previous experiences of bias and discrimination within healthcare settings (e.g., from clinic staff, front desk receptionists, providers) can influence future use of services.^{85,87,88,110,159,161,163,183} A systematic review found evidence that fear of provider discrimination, homophobia, or differential treatment are a barrier to healthcare services,⁸⁵ and many populations experienced stigma and discrimination from society as well as healthcare providers.^{70,71,105,107-112,159,163,164,178,223,253} Multiple populations feared judgement or stigmatization for seeking reproductive health services or entering a reproductive health clinic (e.g., concern that others would assume they had an STI or were sexually promiscuous).^{47,48,50,51,107,108,123,125-127,163,216}

In addition, individuals also reported fear of stigmatization for seeking specific services, especially for abortion^{27,144} or infertility treatment.³² For example, women of low-socioeconomic status 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.²⁷ Generally, men and women seeking infertility treatment held an “aversion to being labeled ‘infertile.’”³² This aversion was a larger barrier among different racial/ethnic communities.³²

ADOLESCENTS/YOUNG ADULTS: Adolescents reported feeling disrespected and judged by providers due to their age and sexual activity,^{54,55} as well as fearing being seen as an incompetent teen mother.⁵⁰ In particular, adolescents and young adults of color reported these fears.^{47,48,50}

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.⁷¹ Women with substance use disorders reported additional feelings of stigmatization due to sex work, incarceration, and gendered social norms related to the role of women as caregivers.⁷⁰

DISABILITY: Patients with disabilities experience insensitivity from staff in every step of the healthcare process, from scheduling appointments to receiving procedures.¹⁸⁰ A review of multiple studies revealed that providers often treat women with disabilities in a condescending, insensitive, or oversensitive manner.^{75,160} As a result, women with disabilities are generally less satisfied with their care and more likely to delay or forgo care in the future.¹⁶⁰

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.⁸⁷ 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).¹⁸³

Similarly, queer/questioning participants reported delaying care more frequently than gay/lesbian and bisexual participants ($P=0.038$).¹⁵⁹ 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 ($P<0.001$).¹⁵⁹ Queer/questioning respondents also reported negative effects at higher rates than did gay/lesbian and bisexual participants ($P=0.001$).¹⁵⁹

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.²¹⁶ 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 sexual intercourse was “illegal” and a chargeable offense under Uniform Code of Military Justice.¹²⁷

34. Lack of social support

Adolescents/ Young Adults 50	Older adults	Behavioral health 71	Disability 160,180	Gender Identity 88,161	Sexual Orientation	Geography
Homelessness	Immigration 107-110,164	Incarceration	Military 125	Race/ Ethnicity	SES 27,149,170,217	Violence

Multiple populations experienced a lack of social support,^{108,109} partner support,¹⁶⁴ and social capital^{107,110} needed to access reproductive health services,¹⁴⁹ prenatal care,¹⁷⁰ cancer screening (mammograms and pap smears),²¹⁷ and abortion.²⁷

35. Individual health literacy

Adolescents 34-36,40,48	Older adults 58,60,66-68	Behavioral health 71	Disability 75,180,181,251	Gender Identity 88	Sexual Orientation	Geography
Homelessness 100	Immigration 3,105- 107,109,110,114,163, 164,184,290	Incarceration	Military 123,125,127,216	Racism 112	SES 112,114,143,146,149, 217	Violence

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.”²⁹¹ Lack of knowledge about available services,^{3,125,127,216} lack of knowledge about how to navigate the healthcare system,^{35,36,107,114,164,290} and limited health literacy^{3,100,105-107,110,114,163,164,184} also serve as barriers to receiving appropriate reproductive healthcare.

HOMELESSNESS: Interviews with women aged 18-24 years experiencing homeless in Pittsburgh found that women had low health literacy and lacked medically-accurate information about LARC.¹⁰⁰ 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.¹⁰⁰

IMMIGRATION: Low health literacy was a barrier for all immigrants, regardless of status.^{3,105-107,110,114,163,164,184} 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,¹⁸⁴ suggesting an intergenerational gap in health literacy.^{109,184} Multiple studies found that immigrants lacked knowledge of the U.S. healthcare system, which reduced their ability to navigate and access care.^{107,114,164,290} Immigrants also lacked awareness of available services³ and experienced confusion about healthcare policies and their options for

insurance and care.¹⁰⁵ A study with Somali immigrants found that they lacked knowledge about where to go for services and about insurance options and availability.¹¹⁰ 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.¹⁶³

MILITARY: Studies suggest women in the military lack knowledge and awareness about available reproductive healthcare services, contraception options, and abortion care.^{125,127,216} As a result, women avoided or delayed seeking care.¹²⁵ 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.¹²³

36. Patients' individual attitudes and beliefs

Adolescents/ Young Adults 50,55,57,286	Older adults 63,66,67	Behavioral health	Disability 75,180	Gender Identity 223	Sexual Orientation 88,223	Geography
Homelessness 98,100	Immigration 107-112,163,164	Incarceration	Military 127,129	Race/ Ethnicity 292	SES 32,112,143,149	Violence

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;^{75,108,112} moral, ethical, religious, or cultural beliefs;^{32,111,112,127,143,149,163} perception of risk;^{98,163} fear of procedures, diagnosis, or treatment;^{75,111,217,251,292} doubt about the necessity or efficacy of procedures;^{75,180} lack of trust of providers and the healthcare system;^{98,100,111} low self-efficacy;^{27,100,109} and overall personal motivation.¹⁴⁷

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.^{107,109-111,163,164} 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.^{108,112} Somali immigrants also held strong cultural beliefs (e.g., family size) that clashed with U.S. medical advice and practices.¹¹¹

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.¹⁶³ 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."¹⁶³

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.^{127,129}

RACE/ETHNICITY: Results of a qualitative study of 118 black women in New York found that fear and anticipation that screenings or well woman exams would likely finding bad news (e.g., breast cancer) deterred individuals from seeking care.²⁹² Authors noted women had an "embedded assumption of the probability of testing resulting in bad news."²⁹² 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."²⁹² For example, “not knowing” was described as protective from the knowledge of the disease and emotional consequences (e.g., depression, relational betrayal, relationship fallout).²⁹²

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

Adolescents/ Young Adults 37,46,57	Older adults	Behavioral health	Disability	Gender Identity 161	Sexual Orientation	Geography
Homelessness	Immigration 109,184	Incarceration	Military	Race/ Ethnicity	SES	Violence

Parental attitudes, beliefs, religious and cultural values, and understanding of the U.S. healthcare system serve as barriers for adolescents and young adults seeking reproductive health services.^{37,46,57,109,184} For example parental values may lead to decisions to delay HPV vaccination for young girls.⁵⁷ Parental citizenship and immigration status has also been identified as a barrier to accessing healthcare, even for children who are U.S. citizens.¹⁰⁵

38. Providers' individual attitudes and beliefs

Adolescents/ Young Adults 43,55,56	Older adults 58,60,66-68	Behavioral health	Disability 73,75,160	Gender Identity 1,80,223	Sexual Orientation 4,85,223	Geography
Homelessness	Immigration 107-110,114,164,184	Incarceration 121,234	Military 126	Race/ Ethnicity 138,139,188,236	SES 149,253	Violence 174,245

Provider attitudes, beliefs, biases, and religious or moral values affect how providers interact with, counsel, and treat their patients.^{85,126,234}

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.⁸⁵ 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%).⁸⁰ Moreover, studies show that up to 39% of transgender people have faced some type of harassment or discrimination in healthcare settings.¹

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 acted as barriers to women accessing contraception while incarcerated.²³⁴ 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.’”¹²¹ 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.”¹²¹ 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.¹²¹

RACE/ETHNICITY: Multiple studies with African American women described interpersonal experiences of racism (e.g., racial slurs directed at them) in healthcare settings.¹³⁸ Interpersonal racism refers to the attitudes and beliefs and actions of individuals that perpetuate racism.¹³⁸ 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.¹⁸⁸ 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.¹⁷⁴ A study by the U.S. HHS found that some healthcare providers stereotypically view commercial sexual exploitation and sex trafficking as primarily affecting young foreign adolescent girls.¹⁷⁴ 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.¹⁷⁴

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

Adolescents/ Young Adults 55,57	Older adults 66	Behavioral health	Disability 251,266	Gender Identity 86,161,287	Sexual Orientation 86,161,287	Geography
Homelessness	Immigration	Incarceration	Military 127	Race/ Ethnicity	SES	Violence

Cultural perceptions, misconceptions, or biases by society or providers about whether an individual is sexually active^{127,251,266} or at risk for STIs^{86,265} 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.^{55,57,66}

DISABILITY: Pervasive cultural attitudes include the belief that people with disabilities, especially intellectual disabilities,^{251,266} are asexual, unable to have sex, or are not in control of their sexual desires.^{251,266} Pregnancy is often not seen as an option for women with disabilities,⁷³ or it is assumed to be the result of sexual abuse and not the result of informed and intentional personal choice.²⁵¹ Many adults with intellectual disabilities, however, are capable of making an informed decision to have consensual sex.^{251,266} 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.²⁶⁵

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%, $p=.22$).²⁹³ 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,²⁹³ and women with intellectual disabilities have a history of experiencing forced or compulsory sterilization.²⁵¹

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.⁸⁶ For example, “physicians may inaccurately assume their [gender and sexually diverse] patients are not at risk of STIs if they do not report penetrative sexual intercourse.”⁸⁶ 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

Adolescents/ Young Adults	Older adults	Behavioral health	Disability	Gender Identity	Sexual Orientation	Geography
Homelessness	Immigration 3,105,107,109,163,164,184,218	Incarceration	Military	Race/ Ethnicity	SES	Violence 153,174

Immigrants, regardless of status, delayed seeking care or did not seek care for fear of deportation or other legal action.^{3,105,107,109,163,164,184,218} 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.¹⁸⁴ 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.¹⁷⁴ Female detainees at U.S. detention

centers did not access healthcare for fear of retaliation or negative consequences on their pending immigration status cases.²¹⁸ 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).¹⁵³

41. Mobility

Adolescents/ Young Adults	Older adults	Behavioral health	Disability	Gender Identity	Sexual Orientation	Geography
Homelessness 98	Immigration 109	Incarceration	Military 125,128	Race/ Ethnicity	SES	Violence 187

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.^{98,109,125,128,187}

42. Substance Use

Adolescents/ Young Adults	Older adults	Behavioral health	Disability	Gender Identity	Sexual Orientation	Geography
Homelessness	Immigration	Incarceration	Military	Race/ Ethnicity	SES	Violence 187,264

Substance use can be used as a tool by traffickers to control trafficked individuals or as a coping mechanism by victims/survivors^{187,264} making it difficult for individuals to act independently to seek reproductive health services.

43. Historical trauma and medical mistrust

Adolescents/ Young Adults	Older adults	Behavioral health	Disability 180,251	Gender Identity 88	Sexual Orientation	Geography
Homelessness	Immigration 108,112,294	Incarceration 115,119	Military	Race/ Ethnicity 50,57,139,236,286	SES	Violence

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.^{50,108,112,168,294} Communities of color have experienced histories of eugenics and, between 2006 and 2010 over 100 women in California’s prison system were unlawfully sterilized.¹¹⁵ 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.”¹¹⁹ In addition, some immigrant communities may also have experienced trauma in country of origin that may serve as a barrier to seeking care.¹⁰⁸

44. Lack of actual or perceived confidentiality/privacy

Adolescents/ Young Adults 36,38-43,47,48,51-54	Older adults	Behavioral health 71	Disability	Gender Identity 85,88	Sexual Orientation 85	Geography 295
Homelessness	Immigration 108,110,163,218	Incarceration	Military 125-127,216	Race/ Ethnicity	SES	Violence 174,188

Concerns about confidentiality or privacy were a barrier for many populations accessing reproductive health services.^{36,38,39,41,43,47,48,51-54,99,108,110,125-127,163,174,188,216,218} 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.^{43,47,48}

ADOLESCENTS/YOUNG ADULTS: The desire for confidentiality and privacy, and the associated fear of disclosure, is one of the most consistently cited barriers among adolescents asked about reproductive healthcare.^{36,38,39,41,43,47,48,51-54} Few adolescents and young adults are aware of their rights to confidentiality^{41,48} and many are uncertain about the ability of a healthcare provider to deliver confidential services without requiring parental consent.^{36,50,51} Healthcare personnel and providers contribute to this issue by providing incorrect information about availability⁴⁸ and age requirements for services.⁴³ Providers are sometimes uncertain about their own ability to maintain confidentiality for adolescents.³⁶

Although Washington State law does not require parental notification for prescribed contraception, research 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.^{36,43,50,51} 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.^{52,54} 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.^{52,54}

IMMIGRATION: One study with Somali immigrants found that women were concerned about confidentiality, especially with interpreters.¹¹⁰ Another study found that women did not seek reproductive health services, including pap smears, due to concerns about privacy and culturally-valued sexual modesty.¹⁰⁸ 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.¹⁶³ Lastly, female detainees in U.S. detention centers reported 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.²¹⁸

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.^{125-127,216} 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.¹²⁵ 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.¹²⁵

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

Adolescents/ Young Adults	Older adults	Behavioral health 70,71,222,279	Disability 251	Gender Identity	Sexual Orientation	Geography
Homelessness	Immigration 164	Incarceration	Military 125-127	Race/ Ethnicity	SES	Violence 174,187,245,262

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.^{70,71,222,251,279}

BEHAVIORAL HEALTH: Individuals with substance use disorders are more likely to become incarcerated or to experience recidivism, making it difficult to access regular and preventive care.^{70,71} Women who inject drugs are more likely to be involved in the criminal justice system than men who inject drugs.⁷⁰ For example, one study found that, “among prisoners with a sentence of more than 12 months admitted to [U.S.] 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 [U.S.] 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.¹²⁶ Additionally, under Uniform Code of Military Justice sexual relationships (except consensual relationships between members of the same rank) are an offense.¹²⁶ These policies create an environment of fear for women and “may prevent them from accessing the safe, legal care they are entitled to.”¹²⁶ 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.¹²⁷

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.^{125,126,216} 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.¹²⁶ Women also delayed seeking care because they did not want to leave deployment or impact their eligibility for promotion.¹²⁵

TRAFFICKING: Evidence shows “laws and law enforcement practices have resulted in the criminalization of domestic sex trafficking survivors.”¹⁸⁷ Women being trafficked 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).”¹⁸⁷

Study participants at Rikers Island women’s facility who had experienced trafficking reported fear of criminal justice involvement as a barrier to using emergency departments (e.g., arrest for prostitution or substance use).¹⁸⁷ 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.¹⁷⁴ 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.”²⁶² 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.”²⁶²

RECOMMENDATIONS

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 14 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 of implementation, 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.

Criminal Justice recommendations

1. **The Departments of Corrections and Children, Youth, and Families 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.²⁹⁶ Before returning to the

community, youth and adults need linkage to care, preferred method of contraception, insurance enrollment, housing, and other supports in order to access the reproductive care they need.²⁹⁶ Washington State has enacted policies to suspend (rather than terminate) Medicaid coverage for incarcerated individuals¹⁹⁸ and Department of Corrections is working to improve access to LARC (Cynthia Harris, DOH, personal communication, August 2018). However, literature shows that fractured care, especially between prison and community health systems, is also a barrier for women who experience incarceration to access consistent and appropriate reproductive health services.^{115,117,118,121} In addition, women in jails may not receive appropriate follow-up care because of short durations in facilities or unknown release dates.^{118,121} The American College of Obstetricians and Gynecologists recommends providing a continuum of care between initial screenings, in-house services, referrals, and release.¹¹⁸

2. **The Washington State Legislature should convene a workgroup to develop recommendations to reduce/eliminate barriers to healthcare services experienced by victims and survivors of human trafficking.** Victims and survivors of sex and labor trafficking experience complex healthcare needs (including reproductive services) related to their exploitation.²⁴⁵ 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, tribal representatives, 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.
 - 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 (OSPI) 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.”²⁹⁶ Preparing schools to be in compliance will require additional resources to train educators. Available evidence suggests the OSPI will require additional resources and mechanisms to monitor curricula in use and provide appropriate technical assistance to districts to support implementation of 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.”²⁹⁶ 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.²⁹⁶

- 4. The Washington State Legislature should allocate state funds for Department of Health to provide pass-through funding to community-based organizations to conduct age-appropriate, culturally-appropriate, comprehensive, medically accurate, and LGBTQIA-inclusive sexual health education in community settings for adolescents and young adults, older adults, immigrants and refugees, individuals with behavioral health disorders, individuals with disabilities, individuals experiencing homelessness, individuals with limited English proficiency (LEP), and tribes and urban Indian communities 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^{3,100,105-107,110,114,125,127,163,164,184,216} and health system navigation.^{35,36,107,114,164,290} 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. The Health Care Authority and 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 LGBTQIA 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.”²⁹⁷ The recommendations “seek to align care delivery with existing evidence-based, culturally sensitive standards of care”²⁹⁷ for LGBTQIA people in Washington State and to decrease health inequities. Focus areas include: communication, language, and inclusive environments; screening and taking a social and sexual history; and areas requiring LGBTQIA-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. **The 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, 3) victims and survivors of violence, and 4) people with disabilities.** 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.²⁹⁷ 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.²⁹⁸ Their approach to developing recommendations for LBGTQIA 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, victims and survivors of violence, and people with disabilities. Reducing health inequities for populations in Washington State also aligns with Department of Health’s strategic plan goal to promote health equity and improve population health.²⁹⁹

Health Insurance recommendations

7. **The Office of the Insurance Commissioner should determine a common process and establish consistency of forms for health plans to redirect communications containing personal health information.** Although Washington State law ([WAC 284-04-510](#)) protects patients’ rights to request limited disclosure of health information, patients and potentially providers are largely unaware of available protections.^{41,270} Moreover, there is no standard process by which patients can initiate such requests, making it difficult to navigate various health plans and prompting concerns that health plans may not actually follow the practice. California,³⁰⁰ Maryland,³⁰¹ and Oregon³⁰² have each adopted a common process and form, widely available online, by which patients may request confidential communication. Additionally, the Oregon Health Authority developed information for providers about the protections and outlined additional ways clinics/practices can support patients requesting confidential communications (e.g., have hard-copy versions of the standardized form available at the front desk, in exam rooms, and at check-out; ensure all staff are aware of and understand the new law).³⁰³ Office of the Insurance Commissioner can improve the use of existing Washington patient protections by establishing a common process and standardized form enrollees may use to request confidential communications be redirected. This procedural change is within the agency’s statutory authority and will help address concerns regarding privacy and confidential communications, especially for young people enrolled on their parents’ plans and individuals experiencing IPV enrolled on their abusers’ plans.
8. **The Washington State Legislature should work with the Office of the Insurance Commissioner to determine a common process for health plans to automatically suppress communications containing personal health information related to 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.** In September 2018, Office of the Insurance

Commissioner withdrew its notice of proposed rulemaking related to issuer disclosures, notices, and processes to protect privacy of healthcare information.³⁰⁴ They proposed the rule to “protect consumers from unauthorized disclosures about their health care services or payments by their insurance company to family members who are on the same health plan. These extra protections will be especially helpful to minors, victims of domestic violence and young adult children who are still on their parents’ health plans.”³⁰⁴ However, agency staff learned that “the language in [RCW 48.43.510\(2\)\(f\)](#) may prevent [Office of the Insurance Commissioner] from ensuring full protection of confidential health information because it requires insurance companies to provide an annual accounting upon request.”³⁰⁴ As legislative amendments are explored, automatic suppression of health plan communications related to reproductive health services should be considered to protect against privacy breaches related to sensitive services.

9. **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.^{3,18,112,113,184} 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);³⁰⁵ broadening the COFA Islander Health Care program to other immigrant communities;³⁰⁶ applying for a 1332 State Innovation Waiver (allowable under the ACA (for example, California considered a waiver to allow all immigrants regardless of status to purchase plans from the Health Exchanges));³⁰⁷ providing additional state funding for safety net providers and community health centers; or allowing for the development of county-based health insurance options.^{3,178,290}

10. **The Washington State Legislature should grant authority to the Office of the Insurance Commissioner, Health Care Authority, Department of Social and Health Services, and other relevant agencies 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.⁸⁶ 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.²⁴⁹ “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.²⁴⁹ 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

11. **The Washington State Legislature should increase state Medicaid reimbursement rates for reproductive health services to improve service and provider availability.** Health Care Authority is bound by Washington State law to remain budget neutral, and the agency has not received a budget increase for Medicaid services from the Legislature since 2007. Evidence indicates that low reimbursement rates for pregnancy healthcare services, relative to rates paid by other commercial carriers, contribute to financial problems in rural hospitals and under-resourced settings where obstetric care is dominated by Medicaid.¹⁹⁴ The Legislature should review options to increase Medicaid reimbursement rates for reproductive health services (i.e., specific Healthcare Common Procedure Coding system supply codes, patients, health centers, providers). In 2016, the Governor requested Health Care Authority increase reimbursement to qualified providers for insertion of LARC for Apple Health (Medicaid) clients.³⁰⁸ “The proposed fee increase intends to improve access for women enrolled in Apple Health who seek to prevent unintended pregnancy, and increase the number of providers performing LARC insertions (intrauterine devices [IUDs] or contraceptive implants).”³⁰⁸

Other Healthcare Related Recommendations

12. **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 an analysis of 2010 national and state-level data to estimate the total public costs from unintended pregnancies and the role of public insurance programs in paying for pregnancy-related care.^{309,310} Using the same approach, Department of Health found that publicly-funded family planning centers in Washington helped avert 18,140 unintended pregnancies in 2017, which have resulted in 8,540 fewer unplanned births and 6,130 fewer abortions.²⁰ 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.²⁰

13. **The Washington State Legislature should review the Community Health Worker Task Force final report regarding training and education recommendations (anticipated June 2019) and should identify opportunities and strategies for CHWs to address barriers in accessing reproductive healthcare.** Council staff acknowledge current work in Washington State related to community health workers (CHWs), promotores, Tribal Community Health Aides/Representatives, and community health representatives, and the value they add in helping patients overcome access barriers.^{18,311,312} The Community Health Worker Taskforce was reconvened in October 2018 to address training and education for CHWs with recommendations anticipated in June 2019. The prior 2016 Community Health Worker Taskforce recognized three unique roles for CHWs: 1. Develop relationships and build trust with communities of color and underserved, low-income populations; 2. Facilitate communication between patients and health care providers and decision-makers; and 3. Address social determinants of health at the individual and community level.³¹¹ CHWs, promotores, and Tribal Community Health Aides/Representatives serve as cultural mediators to help individuals and communities navigate the health care system; provide culturally and linguistically appropriate health education; conduct outreach; participate in care coordination and case management; provide social support; advocate for individuals and communities; build health literacy and community capacity; provide direct service (e.g., health screenings); conduct individual and community-level health assessments; and participate in evaluation and research.³¹¹

14. **Key Informants shared opportunities for future research that the Washington State Legislature or state agencies and institutions of higher education 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 women. The current evidence base does not meet requirements for “medical-necessity,” and therefore facial feminization is not currently not covered by insurance.
 - c. Identify the impact of limited service pregnancy centers (crisis pregnancy centers) on access to medically-accurate, timely reproductive healthcare.
 - 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. 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).

- f. Collect data to fill gaps in available state-level data to better understand and identify inequities in reproductive health access (e.g., data about reproductive health access for immigrants and refugees,¹⁰⁶ active duty women in the military and female Veterans,^{128,129,274} and victims and survivors of violence^{28,187}).
- g. Identify and evaluate policies and programs to increase representation and diversity of the healthcare workforce (e.g., race/ethnicity, sexual orientation, gender identity). Approaches for consideration may address the pipeline (high school to medical school), race-conscious admissions, requirements for internationally trained providers, or others.

APPENDICES

APPENDIX A: Barriers experienced by population group

Priority populations experiencing each barrier are highlighted. Barriers are numbered to improve readability and for ease of reference. Numbering within the reports does not indicate importance, priority, or severity compared to other barriers. While findings 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. These inequities are the result of institutionalized structures of oppression that marginalize specific identities while prioritizing others for receipt of resources. This review focused on access to reproductive healthcare. Available literature specific to accessing reproductive health services for some priority populations was limited or lacking, and individuals may experience barriers in accessing healthcare in general that do not appear in the reproductive health literature. For these reasons, the available literature may not fully capture all of the barriers individuals encounter when seeking reproductive health services or healthcare generally.

	Adolescents/ Young adults	Older adults	Behavioral Health	Disability	Gender identity	Sexual orientation	Geography	Homelessness	Immigration	Incarceration	Military	Race/Ethnicity	SES	Violence
Economic barriers														
1. Insurance status														
2. Cost of care														
3. Associated costs of care														
4. Non-medical expenses, debts														
5. Underfunding														
Structural barriers														
6. Health facility closures and mergers														

	Adolescents/ Young adults	Older adults	Behavioral Health	Disability	Gender identity	Sexual orientation	Geography	Homelessness	Immigration	Incarceration	Military	Race/Ethnicity	SES	Violence
Structural barriers (continued)														
7. Distance to services, travel time, and transportation														
8. Work, school, childcare limitations														
9. Lack of medical home														
10. Limited language access, lack of culturally and linguistically appropriate services														
11. Service and provider availability														
12. Limited services due to health system directives														
13. Service or procedure requirements														
14. Policy implementation and denial of services														
15. Assumed heteronormativity and cisnormativity														
16. Forms and procedures														
17. Medically-accurate sexual health education														

	Adolescents/ Young adults	Older adults	Behavioral Health	Disability	Gender identity	Sexual orientation	Geography	Homelessness	Immigration	Incarceration	Military	Race/Ethnicity	SES	Violence
Structural barriers (continued)														
18. Clinical environment and conditions														
19. Lack of formal provider training or medical education														
20. State and federal legal rulings or legislation														
21. Insurance coverage														
22. Health plan communications														
23. Difficulty navigating insurance system														
24. Difficulty in obtaining medically-accurate information about services														
25. Personal identification document requirements														
26. Lack of data														
Social barriers														
27. Intimate Partner Violence														
28. Reproductive and pregnancy coercion														

	Adolescents/ Young adults	Older adults	Behavioral Health	Disability	Gender identity	Sexual orientation	Geography	Homelessness	Immigration	Incarceration	Military	Race/Ethnicity	SES	Violence
Social barriers (continued)														
29. Physical and/or sexual violence														
30. Mandatory reporting														
31. Differential treatment, practices, or counseling by provider														
32. Denial or delay of services														
33. Fear, perception, or experience of bias, discrimination, stigmatization														
34. Lack of social support														
35. Individual health literacy														
36. Patients' individual attitudes and beliefs														
37. Parent/guardian/intimate partner's individual attitudes and beliefs														
38. Providers' individual attitudes and beliefs														
39. Misconception by providers/ society about sexual activity and risks														

	Adolescents/ Young adults	Older adults	Behavioral Health	Disability	Gender identity	Sexual orientation	Geography	Homelessness	Immigration	Incarceration	Military	Race/Ethnicity	SES	Violence
Social barriers (continued)														
40. Fear of deportation, separation from family, and other legal action														
41. Mobility														
42. Substance use														
43. Historical trauma and medical mistrust														
44. Lack of actual or perceived confidentiality/privacy														
45. Criminalization of individuals or behaviors, and fear of criminal justice involvement														

APPENDIX B: Search terms and articles by population

Population	Search terms	Number of articles included
Adolescents/young adults	Adolescent Young Adult Teen	31
Older adults	sexually transmitted infection, STI, older adult, older men, older women, senior, postmenopausal, Medicare, nursing home	12
Behavioral Health	("mental health" OR "substance use" OR "behavioral health")	6
Disability	(disability* OR impairment*)	14
Gender identity	("gender identity" OR "gender nonconforming" OR transgender OR trans)	31
Sexual orientation	LGBTQ, Sexual orientation	14
Geography	Rural, Geography	11
Homelessness	("housing" OR "homeless")	4
Immigration	(immigra* OR detain* OR asylum OR citizen*)	26
Incarceration	incarcerat*, jail, prison*, criminal justice involved	16
Military and Veterans	(military OR ""active duty"" OR veteran) ("tricare")	11
Race/Ethnicity	(race OR ethnicity) ("racial disparities") People of color	40
SES	(socioeconomic OR SES)	22
Violence	(violence OR intimate partner violence OR "IPV") ("sex traffick" OR traffick*)	38

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.³¹³ Victims in the U.S. are entitled to protection and assistance, regardless of their immigration status.³¹⁴

- **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.³¹⁴ Labor trafficking has been found in diverse labor settings, including domestic work, small businesses, large farms, and factories.³¹³
- **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.^{314,315} Sex trafficking has been found in a wide variety of venues including residential brothels, escort services, massage businesses, strip clubs, and others.³¹³
- **Domestic trafficking** involves U.S. citizens, lawful permanent residents, and immigrants who are undocumented, and is often disproportionately perpetrated against vulnerable women and children.¹⁸⁷

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.¹⁵²

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).^{188,275} While the predominant form of RC involves a male partner's dominance over a woman, women, same-sex partners, and intergenerational relations (e.g., parents or in-laws) can also engage in RC.²⁵²

APPENDIX D: Terminology specific to LGBTQIA people

This appendix provides definitions for terms used in this report; it does not represent all possible or universally preferred language. Definitions are adapted from University of California, Davis LGBTQIA Glossary with review by relevant key informants.¹⁵⁸

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: 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

There are numerous immigration status designations defined by the federal government through the Immigration and Nationality Act.³¹⁶ Immigration status is fluid, and partially impacted by how and when an individual entered the country and their nativity. In addition, immigration status definitions refer to an individual's status at a particular point in time, and an individual may move through different statuses during their time in the U.S. For example, an individual may enter the U.S. as a refugee, adjust to become a legal permanent resident, and then become a naturalized citizen. Immigration status designations and terminology have legal, moral, and historical context, and are evolving.³¹⁷ This appendix provides definitions for terms used in this report and for health insurance eligibility; it does not represent all possible immigration statuses and designations.

Alien: An individual who is not a citizen or national of the U.S.³¹⁸

Immigrant: An individual currently in the U.S. who is not a citizen or national of the U.S., including both individuals that entered the U.S. legally and individuals that entered the U.S. without inspection.³¹⁸ This does not include individuals admitted into the U.S. for short or temporary periods of time, or for specific purposes.³¹⁶

- **Asylum-seekers**: An individual who petitions for asylum at a port of entry or after arrival in the U.S.^{101,316}
- **Deferred Action for Childhood Arrivals (DACA) recipient**: An individual brought to the U.S. as a child who has met certain qualifications and been granted temporary relief from deportation.³¹⁶ DACA eligibility is determined on a case-by-case basis.³¹⁶
- **Individual who is undocumented**: An individual who entered the U.S. without inspection.³¹⁸ Terms used to describe this designation include “illegal,” “non-citizen,” “unauthorized,” “undocumented,” “unlawfully present,” and “without status.”³¹⁷
- **Lawful permanent resident**: An individual who is not a citizen of the U.S. and is living in the U.S. under a legally recognized and recorded immigration status.³¹⁶
- **Refugee**: An individual located outside the U.S. who is legally admitted into the U.S. and is unable or unwilling to return to their country of origin due to persecution or fear of persecution based on race, religion, nationality, membership in a particular social group, or political opinion.³¹⁶ For the purposes of this report, staff used the term refugee broadly to include all populations eligible for benefits and services to assist in resettlement after arrival in the U.S. including refugees; asylees; Cuban/Haitian entrants; victims of trafficking; Iraqi or Afghan Special Immigrants; and Amerasians.

U.S. Citizen: An individual born in the U.S. or one of its territories; certain individuals born abroad to at least one U.S. citizen; or individuals who have become citizens through the naturalization process.³¹⁸

U.S. National: Individuals born in American Samoa or Swain Islands and residents of the Northern Mariana Islands who did not choose to become U.S. citizens.²⁵⁵

Immigration status groups for health insurance

For the purposes of health insurance coverage eligibility, Health Care Authority defines four citizenship and immigration status groups. In addition to “U.S. Citizen or U.S. National,” the terminology for the three immigration status groups is used in federal immigration law. The terms used do not necessarily indicate whether an individual is eligible for health insurance benefits since each group may include individuals with multiple immigration status designations. The three immigration status groups include:²⁵⁵

1. **Lawfully Present "Qualified Alien:"** While the ACA expanded health insurance options to many populations, it continued to exclude some immigrants from receiving Medicaid for five years (known as the 5-year-bar). Some immigration status designations under the “Qualified Alien” category must meet the 5-year-bar before becoming eligible for insurance, and some statuses are exempt from the 5-year bar. Lawfully Present “Qualified Aliens” are eligible to apply for federal health insurance (Medicaid and Children’s Health Insurance Program), to purchase and receive subsidies on the Exchanges, and to enroll in employer-sponsored health insurance.
2. **Lawfully Present "Non-qualified Alien:"** Children and pregnant women under this status are potentially eligible for federally-funded health insurance. Other adults with qualifying emergent conditions may be eligible to receive Alien Emergency Medical coverage. “Non-qualified aliens” are also eligible to purchase and receive subsidies on the Exchanges and to enroll in employer-sponsored health insurance.
3. **Undocumented Immigrant:** Individuals who are undocumented, including DACA recipients are not eligible for federal health insurance and cannot purchase coverage on the Exchanges. Individuals are potentially eligible for Alien Emergency Medical for certain qualifying emergent conditions. In Washington State, pregnant women and children who are undocumented can receive Medicaid coverage.

APPENDIX F: List of key informants

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. 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. Staff spoke with approximately 80 key informants throughout the course of the review. This list includes key informants that provided permission to include their name, title, and organization at the time this report was published, and may not include all individuals that contributed to this report.

Key informant	Title	Organization
Connie Cantrell	Executive Director	Cedar River Clinics
Darlene Packard	Financial Office Director	Cedar River Clinics
Mercedes Sanchez	Director of Development, Communications, and Community Education and Outreach	Cedar River Clinics
Kirstin Johnson	Certified Nurse Midwife	Community Health Association of Spokane
Coalition Members		Equal Start Community Coalition
Tobi Hill-Meyer	Health Equity Director	Gay City
Fred Swanson	Executive Director	Gay City
Shoshana Aleinikoff, MD		HealthPoint Midway Medical
Coalition Member Organizations		Health Equity & Reproductive Rights Organizations (HERRO) Coalition
Planned Parenthood Votes NW & Hawaii	Coalition member	HERRO Coalition
Karter Booher	Executive Director	Ingersoll Gender Center
Mattie Mooney	Healthcare Access Coordinator	Ingersoll Gender Center
Kasey Rivas	Director, Maternal-Child Health and Government Affairs	March of Dimes Washington
Staff member		NARAL Pro-Choice WA
Barbara Middleton, MSN, RN	Chief Operations Officer	NEW Health Programs Associations
Huma Zarif	Staff Attorney	Northwest Health Law Advocates

Key informant (continued)	Title	Organization
Dila Perera, MSW, MPH	Executive Director	Open Arms
Finn Cottom	Community Outreach Educator IN•cluded	Planned Parenthood of the Great Northwest and the Hawaiian Islands (Seattle)
Mollie Overby	Community Outreach Educator	Planned Parenthood of the Great Northwest and the Hawaiian Islands (Seattle)
Leslie Edwards	Public Policy Analyst	Planned Parenthood Votes Northwest Hawaii
Aley Joseph	Epidemiologist Assessment, Policy Development & Evaluation	Public Health—Seattle & King County
Heather Maisen, MSW, MPH	Family Planning Program Manager	Public Health—Seattle & King County
Erika Fardig	Nurse, Maternity Support Services	Public Health—Seattle & King County
Genya Shimkin, MPH	Founder and CEO	Q Card Project, LLC
Kirsten Harris-Talley	Board Member	Surge Reproductive Justice
Sarah Prager, MD, MAS	Professor of Obstetrics and Gynecology	University of Washington
Ying Zhang	Assistant Professor, Department of Family Medicine	University of Washington
Kelly Gilmore, MPH	Research Scientist, Family Planning; Clinical Instructor, Community-Oriented Public Health Practice	University of Washington
Allison Weaver	Special Projects Manager	Upstream Washington
Kelsey Liu, MPH	Program Manager	Urban Indian Health Institute
Eliza Ramsey	Project Associate	Urban Indian Health Institute
Tamaso Johnson	Public Policy Director	Washington State Coalition Against Domestic Violence
Stephanie Pratt	Victims of Crime Program Manager, Human Trafficking Lead, Office of Crime Victims Advocacy	Washington State Department of Commerce
Mary Colter, MD	Facility Medical Director, Washington Corrections Center for Women	Washington State Department of Corrections

Key informant (continued)	Title	Organization
Tiffani Buck	Women's Health Nursing Consultant	Washington State Department of Health
Lacy Fehrenbach	Director, Office of Family and Community Health Improvement	Washington State Department of Health
Andres Fernando	Rules and Legislation Implementation Manager, Health Systems Quality Assurance	Washington State Department of Health
Cynthia Harris	Program Manager, Family Planning	Washington State Department of Health
Tamara Jones	End AIDS Washington Coordinator	Washington State Department of Health
Mary Kellington	Family Planning Program Consultant	Washington State Department of Health
Blake Maresh, MPA, CMBE	Executive Director, Board of Osteopathic Medicine and Surgery, Health Systems Quality Assurance	Washington State Department of Health
Dorothy McBride	Family Planning Nurse Consultant	Washington State Department of Health
Paula Meyer MSN, RN, FRE	Executive Director, Nursing Care Quality Assurance Commission	Washington State Department of Health
Tracy Mikesell	Family Planning Specialist	Washington State Department of Health
Cynthia Morrison	Manager, Access, Systems and Coordination Section	Washington State Department of Health
Christie Spice, MPH	Deputy Assistant Secretary for Policy, Health Systems Quality Assurance	Washington State Department of Health
Kathy Weed	Program Manager, Health Systems Quality Assurance	Washington State Department of Health
Katie Wolt, MES	Health Policy Analyst – Midwifery Advisory Committee, Health Systems Quality Assurance	Washington State Department of Health
Alfie Alvarado-Ramos	Director	Washington State Department of Veterans Affairs

Key informant (continued)	Title	Organization
Heidi Audette	Communications and Legislative Director	Washington State Department of Veterans Affairs
Anaya Balter, RN, CNM, MSN, MBA	Clinical Director for Women's Health	Washington State Health Care Authority
Amy Dobbins	Section Manager, Office of Medicaid Eligibility Policy	Washington State Health Care Authority
Charissa Fotinos, MD, MSc	Deputy Chief Medical Officer	Washington State Health Care Authority
Francesca Matias	Eligibility Policy Representative, Office of Medicaid Eligibility Policy	Washington State Health Care Authority
Kyle Wood	Assistant Attorney General, Criminal Justice Division	Washington State Office of the Attorney General
Lonnie Johns-Brown	Legislative Director, Policy and Legislative Affairs Division	Washington State Office of the Insurance Commissioner
Jessica Houseman-Whitehawk	Program Officer, Health and Wellness	Yakima Valley Community Foundation

REFERENCES

1. Kates J, Ranji U, Beamesderfer A, Salganicoff A, Dawson L. Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S. In: The Henry J. Kaiser Family Foundation; 2015:1-27.
2. Casey F, Gomez-Lobo V. Disparities in contraceptive access and provision. *Semin Reprod Med.* 2013;31(5):347-359.
3. Dennis A, Blanchard K, Cordova D, et al. What happens to the women who fall through the cracks of health care reform? Lessons from Massachusetts. *Journal of Health Politics, Policy, and Law.* 2013;38(2):393-419.
4. Legislature WS. Senate Bill 6580 (SB 6580), Concerning human immunodeficiency virus (HIV) testing In:2018.
5. Legislature WS. Substitute House Bill 2016 (SHB 2016), Concerning midwifery and doula services for incarcerated women. In:2018.
6. Legislature WS. Substitute Senate Bill 5683 (SSB 5683), Health care for Pacific Islanders residing in Washington under a compact of free association (COFA). In:2018.
7. Advocates NHL. *Summary of Health Care Access Bills that Passed the 2018 Washington Legislature.* 2018.
8. *Final Bill Report SSB 6219.* Olympia, WA: Washington State Legislature;2018.
9. Health KCB. 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.
10. *Syllabus National Institute of Family and Life Advocates, DBA NIFLA, et al. v. Becerra, Attorney General of California, et al.* . Washington, DC: Supreme Court of the United States; 26 June 2018 2018.
11. Schneiderman ET, Jepsen G, Denn MP, et al. Comments Re: Proposed Rule: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority [Department of Health and Human Services, Office for Civil Rights RIN 0945-ZA03. In:2018:1-22.
12. Comment on Proposed Rule "Protecting Statutory Conscience Rights in Health Care NPRM, RIN 0945-ZA03". In. Washington, DC: National Family Planning & Reproductive Health Association; 2018:1-10.
13. Rights OoC. Protecting Statutory Conscience Rights in Health Care; Delegations of Authority. In: Services USDoHaH, ed. *RIN 0945-ZA03.* Vol 83 FR 3380. Proposed Rule ed. Washington, DC: Office of the Federal Register; 2018:3880-3931.
14. Security USDoH. Inadmissibility on Public Charge Grounds. 2018; <https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201804&RIN=1615-AA22>. Accessed August, 2018.
15. Health WSD. Public Charge Frequently Asked Questions. 2018; <https://www.doh.wa.gov/CommunityandEnvironment/HealthEquity/PublicCharge/FrequentlyAskedQuestions>. Accessed 11/27/2018, 2018.
16. Governor SoWOot. Gov Inslee ltr re Public Charge rules. In:2018.

17. Artiga S, Damico A. Nearly 20 Million Children Live in Immigrant Families that Could Be Affected by Evolving Immigration Policies. In. San Francisco, CA: Henry J. Kaiser Family Foundation; 2018.
18. Hasstedt K, Desai S, Ansari-Thomas Z. *Immigrant Women's Access to Sexual and Reproductive Health Coverage and Care in the United States*. Guttmacher Institute;2018.
19. Association NFPRH. *Policy Brief--Title X: Helping Ensure Access to High-Quality Care*. 2015.
20. Washington State Title X Family Plannint Network (Profile, 2016-17). In. 930-140 ed. Tumwater, WA: Washington State Department of Health; 2018.
21. Wohlfeil S. A Trump administration prposal would make it harder for women to get information on abortion. *Inlander*. September 6, 2018, 2018.
22. USA U. Washington. 2018; <https://www.upstream.org/campaigns/upstream-washington/>. Accessed August, 2018.
23. Artiga S, Ubri P. *Living in an Immigrant Family in America: How Fear and Toxic Stress are Affecting Daily Life, Well-Being, & Health*. Menlo Park, CA: Henry J. Kaiser Family Foundation; December 2017 2017.
24. Shapiro N. Washington state regularly gives drivers' info to immigration authorities; Inslee orders temporary halt. *The Seattle Times*. 11 January 2018, 2018.
25. Union ACL. *Garza v. Hargan- Challenge to Trump Administration's attempts to block abortions for young immigrant women*. 2018.
26. Inslee statement on Licensing policy changes to protect personal information of immigrants and refugees [press release]. Olympia, Washington: Governor Inslee's Communications Office2018.
27. Ostrach B, Cheyney M. Navigating social and institutional obstacles: Low-income women seeking abortion. *Qualitative Health Research*. 2014;24(7):1006-1017.
28. Violence FW. *The Facts on Violence Against American Indian/Alaskan Native Women*. Futures Without Violence;2012.
29. Anderson JE. Access to obstetric care in the United States from the National Health Interview Survey. *Social Work in Public Health*. 2014;29(2):141-147.
30. 2020 HP. Healthy People 2020: Access to Health Services. 2018; <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>. Accessed October 2018, 2018.
31. Kozhimannil KB, Hardeman RR, Henning-Smith C. Maternity care access, quality, and outcomes: A systems-level perspective on research, clinical, and policy needs. *Seminars in Perinatology*. 2017;41(6):367-374.
32. Ethics Committee of the American Society for Reproductive M. Disparities in access to effective treatment for infertility in the United States: an Ethics Committee opinion. *Fertil Steril*. 2015;104(5):1104-1110.
33. Kissin DM, Boulet SL, Jamieson DJ, Assisted Reproductive Technology S, Research T. Fertility Treatments in the United States: Improving Access and Outcomes. *Obstet Gynecol*. 2016;128(2):387-390.
34. Thaxton L, Espey E. Family Planning American Style Redux: Unintended Pregnancy Improves, Barriers Remain. *Obstet Gynecol Clin North Am*. 2017;44(1):41-56.

35. Goodman M, Onwumere O, Milam L, Peipert JF. Reducing health disparities by removing cost, access, and knowledge barriers. *Am J Obstet Gynecol.* 2017;216(4):382 e381-382 e385.
36. Ralph LJ, Brindis CD. Access to reproductive healthcare for adolescents: establishing healthy behaviors at a critical juncture in the lifecourse. *Curr Opin Obstet Gynecol.* 2010;22(5):369-374.
37. Instruction OoSoP. *Youth Sexual Health; Education, Youth Behaviors, & School Safety Fact Sheet.* 2017.
38. Gynecologists ACoOa. Committee Opinion: Committee on Adolescent Health Care - Adolescent Pregnancy, Contraception, and Sexual Activity. 2017;129(5).
39. Sedlander E, Brindis CD, Bausch SH, Tebb KP. Options for assuring access to confidential care for adolescents and young adults in an explanation of benefits environment. *J Adolesc Health.* 2015;56(1):7-9.
40. Tebb KP, Sedlander E, Bausch S, Brindis CD. Opportunities and Challenges for Adolescent Health Under the Affordable Care Act. *Matern Child Health J.* 2015;19(10):2089-2093.
41. Gold RB. *A New Frontier in the Era of Health Reform: Protecting Confidentiality for Individuals Insured as Dependents.* 2013.
42. Stablein T, Loud KJ, DiCapua C, Anthony DL. The Catch to Confidentiality: The Use of Electronic Health Records in Adolescent Health Care. *J Adolesc Health.* 2018;62(5):577-582.
43. Gonsalves L, Hindin MJ. Pharmacy provision of sexual and reproductive health commodities to young people: a systematic literature review and synthesis of the evidence. *Contraception.* 2017;95(4):339-363.
44. Ely GE, Dulmus CN. Disparities in access to reproductive health options for female adolescents. *Soc Work Public Health.* 2010;25(3):341-351.
45. Marques M, Ressa N. The Sexuality Education Initiative: a programme involving teenagers, schools, parents and sexual health services in Los Angeles, CA, USA. *Reproductive Health Matters.* 2013;21(41):124-135.
46. Santa Maria D, Guilamo-Ramos V, Jemmott LS, Derouin A, Villarruel A. Nurses on the Front Lines: Improving Adolescent Sexual and Reproductive Health Across Health Care Settings. *Am J Nurs.* 2017;117(1):42-51.
47. Lindberg C, Lewis-Spruill C, Crownover R. Barriers to sexual and reproductive health care: urban male adolescents speak out. *Issues Compr Pediatr Nurs.* 2006;29(2):73-88.
48. Galloway CT, Duffy JL, Dixon RP, Fuller TR. Exploring African-American and Latino Teens' Perceptions of Contraception and Access to Reproductive Health Care Services. *J Adolesc Health.* 2017;60(3S):S57-S62.
49. Winters A, Alson J. Development of a Socioecological Adolescent Sexual Health Index and Atlas: A Case Study in Washington State. *American Journal of Sexuality Education.* 2018:1-19.
50. Muzik M, Kirk R, Alfafara E, Jonika J, Waddell R. Teenage mothers of black and minority ethnic origin want access to a range of mental and physical health support: a participatory research approach. *Health Expect.* 2016;19(2):403-415.

51. Bender SS, Fulbright YK. Content analysis: a review of perceived barriers to sexual and reproductive health services by young people. *Eur J Contracept Reprod Health Care*. 2013;18(3):159-167.
52. Reddy DM. Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services. *Jama*. 2002;288(6).
53. Fuentes L, Ingerick M, Jones R, Lindberg L. Adolescents' and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services. *J Adolesc Health*. 2018;62(1):36-43.
54. Jones RK, Purcell A, Singh S, Finer LB. Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception. *JAMA*. 2005.
55. Charlton BM, Corliss HL, Missmer SA, et al. Reproductive health screening disparities and sexual orientation in a cohort study of U.S. adolescent and young adult females. *J Adolesc Health*. 2011;49(5):505-510.
56. Vadaparampil ST, Malo TL, Sutton SK, et al. Missing the Target for Routine Human Papillomavirus Vaccination: Consistent and Strong Physician Recommendations Are Lacking for 11- to 12-Year-Old Males. *Cancer Epidemiol Biomarkers Prev*. 2016;25(10):1435-1446.
57. Ferrer HB, Trotter C, Hickman M, Audrey S. Barriers and Facilitators to HPV vaccination of young women in high-income countries: a qualitative systematic review and evidence synthesis. *Bio Medical Center Public Health*. 2014;14(700).
58. Schueler KM, Chu PW, Smith-Bindman R. Factors associated with mammography utilization: a systematic quantitative review of the literature. *J Womens Health (Larchmt)*. 2008;17(9):1477-1498.
59. Trivedi AN, Leyva B, Lee Y, Panagiotou OA, Dahabreh IJ. Elimination of Cost Sharing for Screening Mammography in Medicare Advantage Plans. *N Engl J Med*. 2018;378(3):262-269.
60. Caban M, Kuo YF, Raji M, Tan A, Freeman J. Predictors of mammography use in older women with disability: the patients' perspectives. *Med Oncol*. 2011;28 Suppl 1:S8-14.
61. Ponce NA, Ku L, Cunningham WE, Brown ER. Language Barriers to Health Care Access Among Medicare Beneficiaries. *Inquiry*. 2006;43(Spring):66-76.
62. Gunderson A, Menachemi N, Brummel-Smith K, Brooks R. Physicians Who Treat the Elderly in Rural Florida: Trends Indicating Concerns Regarding Access to Care. *The Journal of Rural Health*. 2006;22(3):224-228.
63. Leach CR, Schoenberg NE. The Vicious Cycle of Inadequate Early Detection: A Complementary Study on Barriers to Cervical Cancer Screening Among Middle-Aged and Older Women. *Preventing Chronic Disease Public Health Research, Practice, and Policy*. 2007;4(4).
64. Marshall JK, Mbah OM, Ford JG, et al. Effect of Patient Navigation on Breast Cancer Screening Among African American Medicare Beneficiaries: A Randomized Controlled Trial. *J Gen Intern Med*. 2016;31(1):68-76.
65. Gedin TC, Resnick B. Increasing risk awareness and facilitating safe sexual activity among older adults in senior housing. *J Community Health Nurs*. 2014;31(4):187-197.

66. Gott M, Hinchliff S. Barriers to seeking treatment for sexual problems in primary care: a qualitative study with older people. --*Family Practice*. 2003;20(6):690-695.
67. Slinkard MS, Kazer MW. Older adults and HIV and STI screening: the patient perspective. *Geriatr Nurs*. 2011;32(5):341-349.
68. Nusbaum MRH, Singh AR, Pyles AA. Sexual Healthcare Needs of Women Aged 65 and Older. *Journal of the American Geriatrics Society*. 2004;52(1):117-122.
69. Terplan M, Lawental M, Connah MB, Martin CE. Reproductive Health Needs Among Substance Use Disorder Treatment Clients. *Journal of Addiction Medicine*. 2016;10(1):20-25.
70. Iversen J, Page K, Madden A, Mather L. HIV, HCV, and Health-Related Harms Among Women Who Inject Drugs: Implications for Prevention and Treatment. *Journal of Acquired Immune Deficiency Syndrom*. 2015;69(Supplement 2):S176- S181.
71. Sutter MB, Gopman S, Leeman L. Patient-centered Care to Address Barriers for Pregnant Women with Opioid Dependence. *Obstet Gynecol Clin North Am*. 2017;44(1):95-107.
72. *Disability & DVR Statistics Report*. Olympia, WA: Washington State Division of Vocational Rehabilitation;2017.
73. Nosek MA, Simmons DK. People with Disabilities as a Health Disparities Population: The Case of Sexual and Reproductive Health Disparities. *Californian Journal of Health Promotion*. 2007;5(Special Issue (Health Disparities & Social Justice)):68-81.
74. Bahn K, Kugler A, Mahoney M, Corley D, McGrew A. *Linking Reproductive Health Care Access to Labor Market Opportunities for Women*. Center for American Progress;2017.
75. Smeltzer SC. Preventive Health Screening for Breast and Cervical Cancer and Osteoporosis in Women With Physical Disabilities. *Fam Community Health*. 2006;29(1s):35s-43s.
76. Mitra M, Smith LD, Smeltzer SC, Long-Bellil LM, Sammet Moring N, Iezzoni LI. Barriers to providing maternity care to women with physical disabilities: Perspectives from health care practitioners. *Disabil Health J*. 2017;10(3):445-450.
77. Data File Documentation, National Health Interview Survey, 2010 (machine readable data file and documentation). In: Statistics NCfH, ed. Hyattsville, MD: Centers for Disease Control and Prevention; 2010.
78. Courtney-Long E, Armour B, Frammartino B, Miller J. Factors associated with self-reported mammography use for women with and women without a disability. *Journal of Women's Health*. 2011;2011(20):1279-1286.
79. Brewer NT, Ng TW, McRee A-L, Reiter PL. Men's beliefs about HPV-related disease. *Journal of Behavioral Medicine*. 2010;33(4):274-281.
80. Kosenko K, Rintamaki L, Raney S, Maness K. Transgender Patient Perceptions of Stigma in Health Care Contexts. *Medical Care*. 2013;51(9):819-822.
81. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, Gay, Bisexual, and Transgender-Related Content in Undergraduate Medical Education. *JAMA*. 2011;306(9):971-977.
82. Obedin-Maliver J, Makadon HJ. Transgender men and pregnancy. *Obstet Med*. 2016;9(1):4-8.

83. Rossman K, Salamanca P, Macapagal K. A Qualitative Study Examining Young Adults' Experiences of Disclosure and Nondisclosure of LGBTQ Identity to Health Care Providers. *J Homosex*. 2017;64(10):1390-1410.
84. Medicine ECotASfR. Access to fertility services by transgender persons: an Ethics Committee opinion. *Fertil Steril*. 2015;104(5):1111-1115.
85. Klein DA, Berry-Bibee EN, Keglovitz Baker K, Malcolm NM, Rollison JM, Frederiksen BN. Providing quality family planning services to LGBTQIA individuals: a systematic review. *Contraception*. 2018.
86. Carrotte ER, Vella AM, Bowring AL, Douglass C, Hellard ME, Lim MS. "I am yet to encounter any survey that actually reflects my life": a qualitative study of inclusivity in sexual health research. *BMC Med Res Methodol*. 2016;16:86.
87. *Discrimination in America: Experiences and Views of LGBTQ Americans*. National Public Radio, Robert Wood Johnson Foundation, Harvard T.H. Chan School of Public Health;2017.
88. Collazo A, Austin A, Craig SL. Facilitating Transition Among Transgender Clients: Components of Effective Clinical Practice. *Clinical Social Work Journal*. 2013(41):228-237.
89. Buchmueller T, Carpenter CS. Disparities in Health Insurance Coverage, Access, and Outcomes for Individuals in Same-Sex Versus Different-Sex Relationships, 2000–2007. *American Journal of Public Health*. 2010;100(3):489-495.
90. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi Ma. *The Report of the 2015 U.S. Transgender Survey* Washington, DC: National Center for Transgender Equality;2016.
91. Women CoHCfU. Committee Opinion 586: Health Disparities in Rural Women. In. Washington, DC: American College of Obstetricians and Gynecologists; 2014 (reaffirmed in 2016).
92. Delamater PL, Messina JP, Shortridge AM, Grady SC. Measuring geographic access to health care: raster and network-based methods. *International Journal of Health Geographics*. 2012;11(15).
93. Sobel L, Rosenzweig C, Salganicoff A. *Proposed Changes to Title X: Implications for Women and Family Planning Providers*. Henry J. Kaiser Family foundation; June 2018 2018.
94. Rayburn WF, Richards ME, Elwell EC. Drive times to hospitals with perinatal care in the United States. *Obstet Gynecol*. 2012;119(3):611-616.
95. Skillman S, Dahal A. *Washington State's Physician Workforce in 2016*. Seattle, WA: Center for Health Workforce Studies, University of Washington; February 2017 2017.
96. Hale R. Medical Professional Liability Revisited. *Obstet Gynecol*. 2006;107(6):1224-1225.
97. Stulberg D, Hoffman Y, Dahlquist IH, Freedman L. Tubal Ligation in Catholic Hospitals: A Qualitative Study of Ob-Gyns' Experiences. *Contraception*. 2014;90(4):422-428.
98. Bharel M, Casey C, Wittenberg E. Disparities in Cancer Screening: Acceptance of Pap Smears among Homeless Women. *Journal of Women's Health*. 2009;18(12):2011-2016.

99. Kennedy S, Grewal M, Roberts EM, Steinauer J, Dehlendorf C. A qualitative study of pregnancy intention and the use of contraception among homeless women with children. *Journal of Health Care for the Poor and Underserved*. 2014;25(2):757-770.
100. Dasari M, Borrero S, Akers AY, et al. Barriers to Long-Acting Reversible Contraceptive Uptake Among Homeless Young Women. *Journal of Pediatric and Adolescent Gynecology*. 2016;29(2):104-110.
101. Officials AoSaTH. *Immigration Status Definitions*. 2010.
102. Gelatt J, Zong J. *Fact Sheet: Settling In—A profile of the Unauthorized Immigrant Population in the United States*. Migration Policy Institute;2018.
103. Institute MP. Profile of the Unauthorized Population: Washington. 2018; <https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/WA>. Accessed 11/19/2018.
104. Institute MP. Deferred Action for Childhood Arrivals (DACA) Recipients and Program Participation Rate, by State. 2018; <https://www.migrationpolicy.org/programs/data-hub/deferred-action-childhood-arrivals-daca-profiles>. Accessed 11/19/2018.
105. Munro K, Jarvis C, Munoz M, D'Souza V, Graves L. Undocumented pregnant women: What does the literature tell us? *Journal of Immigrant and Minority Health*. 2013;15:281-291.
106. Thiel de Bocanegra H, Carter-Pokras O, Ingleby JD, et al. Addressing refugee health through evidence-based policies: a case study. *Annals of Epidemiology*. 2018;28(6):411-419.
107. Hacker K, Anies M, Folb BL, Zallman L. Barriers to health care for undocumented immigrants: a literature review. *Risk Management and Healthcare Policy*. 2015;8:175-183.
108. Mehta PK, Saia K, Mody D, et al. Learning from UJAMBO: Perspectives on Gynecologic Care in African Immigrant and Refugee Women in Boston, Massachusetts. *Journal of Immigrant Minority Health*. 2018;20(2):380-387.
109. Perez-Escamilla R, Garcia J, Song D. Health Care Access Among Hispanic Immigrants: ¿Alguien esta escuchando? [Is anybody listening?]. *NAPA Bulletin*. 2010;34(1):47-67.
110. International W. *Providing Culturally Appropriate Reproductive Health and Family Planning Services to Somali Immigrants and Refugees: A reference guide*. 2009.
111. Wojnar DM. Perinatal experiences of Somali couples in the United States. *J Obstet Gynecol Neonatal Nurs*. 2015;44(3):358-369.
112. Dehlendorf C, Rodriguez MI, Levy K, Borrero S, Steinauer J. Disparities in family planning. *American Journal of Obstetrics & Gynecology*. 2010;202(3):214-220.
113. Hasstedt K. Toward Equity and Access: Removing Legal Barriers to Health Insurance Coverage for Immigrants. *Guttmacher Policy Review*. 2013;16(1):2-8.
114. Ho JR, Hoffman JR, Aghajanova L, Smith JF, Cardenas M, Herndon CN. Demographic analysis of a low resource, socioculturally diverse urban community presenting for infertility care in a United States public hospital. *Contracept Reprod Med*. 2017;2:17.
115. Sufrin CB, Kolbi-Molinas A, Roth R. Reproductive Justice, Health Disparities, And Incarcerated Women in the United States. *Perspectives on Sexual and Reproductive Health*. 2015;47(4):213-219.

116. Gynecologists ACoOa. *Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females: Committee Opinion, Committee on Health Care for Underserved Women*. 2011.
117. Ferszt GG, Clarke JG. Health care of pregnant women in U.S. state prisons. *J Health Care Poor Underserved*. 2012;23(2):557-569.
118. Gynecologists ACoOa. *Reproductive Health Care for Incarcerated Women and Adolescent Females: Committee Opinion, Committee on HealthCare for Underserved Women*. 2012.
119. Ramaswamy M, Lee J, Wickliffe J, Allison M, Emerson A, Kelly PJ. Impact of a brief intervention on cervical health literacy: A waitlist control study with jailed women. *Prev Med Rep*. 2017;6:314-321.
120. Rizk R, Alderman E. Issues in gynecologic care for adolescent girls in the juvenile justice system. *J Pediatr Adolesc Gynecol*. 2012;25(1):2-5.
121. Sufrin CB, Baird S, Clarke JG, Feldman E. Family planning services for incarcerated women: Models for filling an unmet need. *International Journal of Prisoner Health*. 2017;13(1):10-18.
122. Kelly PJ, Hunter J, Daily EB, Ramaswamy M. Challenges to Pap Smear Follow-up among Women in the Criminal Justice System. *J Community Health*. 2017;42(1):15-20.
123. Affairs USDoV. *Study of Barriers for Women Veterans to VA Health Care: Final Report*. 2015.
124. DAV. *Women Veterans: The Journey Ahead*. 2018.
125. Grindlay K, Seymour JW, Fix L, Reiger S, Keefe-Oates B, Grossman D. Abortion Knowledge and Experiences Among U.S. Servicewomen: A qualitative study. *Perspectives on Sexual and Reproductive Health*. 2017;49(4):245-252.
126. Grindlay K, Yanow S, Jelinska K, Gomperts R, Grossman D. Abortion restrictions in the U.S. military: voices from women deployed overseas. *Womens Health Issues*. 2011;21(4):259-264.
127. Grindlay K, Grossman D. Contraception access and use among U.S. servicewomen during deployment. *Contraception*. 2013;87(2):162-169.
128. Gynecologists ACoOa. *Health Care for Women in the Military and Women Veterans: Committee Opinion*. 2012.
129. Holt K, Grindlay K, Taskier M, Grossman D. Unintended Pregnancy and Contraceptive Use Among Women in the U.S. Military: A systematic literature review. *Military Medicine*. 2011;176(9):1056-1064.
130. Witkop CT, Webber BJ, Chu KM, Clark LL. Contraceptive prescriptions for US servicewomen, 2008-2013. *Contraception*. 2017;96(1):47-53.
131. Halpern JA, Jue JS, Ramasamy R. Infertility evaluation and access to assisted reproductive technologies among male military veterans: analysis of the South Florida Veterans Affairs experience. *Translational Andrology and Urology*. 2018;7(Supplement 2):S188-S192.
132. ofm_pop_race_2000_and2017. In: Division FaR, ed. Washington State Office of Financial Management2018.

133. ofm_pop_race_2000_and2010. In: Division FaR, ed. Washington State Office of Financial Management 2010.
134. Fox E. 2017 ACS AIAN Population Estimate 5,286,404 with State Estimates Alone and In Combination; Nativity US. *National Indian Health Board/CMS Tribal Data Project (all data is for AIAN alone and in combination unless stated: AIAN "Alone")* 2018; <https://public.tableau.com/profile/edward.fox#!/vizhome/2017ACSAIANPopulationEstimate5286400withStateEstimatesAloneandInCombinationNativityUS/2017AIANPopulation5286404EstimateSourceAmericanCommunitySurveyOctober182018datarelease>. Accessed November, 2018.
135. Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2017. In. Washington, DC: U.S. Census Bureau, Population Division; 2017.
136. Health WSDo. *2018 Washington State Health Assessment*. March 2018 2018.
137. Prather C, Fuller TR, William L. Jeffries I, et al. Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity. *Health Equity*. 2018;2.1:249-259.
138. Alhusen JL, Bower KM, Epstein E, Sharps P. Racial Discrimination and Adverse Birth Outcomes: An Integrative Review. *J Midwifery Womens Health*. 2016;61(6):707-720.
139. Prather C, Fuller TR, Marshall KJ, IV WLJ. The Impact of Racism on the Sexual and Reproductive Health of African American Women. *Journal of Womens Health (Larchmt)*. 2016;25(7):664-671.
140. Health WSDo. *Prenatal Care*. 2014.
141. Eichelberger KY, Doll K, Ekpo GE, Zerden ML. Black Lives Matter: Claiming a Space for Evidence-Based Outrage in Obstetrics and Gynecology. *American Journal of Public Health*. 2016;106(10):1771-1772.
142. Selected Economic Characteristics: 2012-2016 American Community Survey 5-Year Estimates. 2016.
143. Gynecologists TACoOa. *Committee Opinion: Access to Contraception*. 2015.
144. Finer LB, Zolna MR. Unintended pregnancy in the United States: Incidence and disparities, 2006. *Contraception*. 2011;84(5):478-485.
145. Dehlendorf C, Weitz T. Access to abortion services: a neglected health disparity. *Journal of Health Care for the Poor and Underserved*. 2011;22(2):415-421.
146. Jeudin P, Liveright E, Del Carmen MG, Perkins RB. Race, ethnicity, and income factors impacting human papillomavirus vaccination rates. *Clinical Therapeutics*. 2014;36(1):24-37.
147. Niccolai LM, Mehta NR, Hadler JL. Racial/Ethnic and poverty disparities in human papillomavirus vaccination completion. *American Journal of Preventive Medicine*. 2011;41(4):428-433.
148. Henry KA, Sherman R, Farber S, Cockburn M, Goldberg DW, Stroup A, M. The joint effects of census tract poverty and geographic access on late-stage breast cancer diagnosis in 10 US states. *Health and Place*. 2013;21:110-121.
149. Zimmerman MS. Information Poverty and Reproductive Healthcare: Assessing the Reasons for Inequity between Income Groups. *Social Work in Public Health*. 2017;32(3):210-221.

150. State USDo. *Trafficking in Persons Report June 2016*. Washington, D.C.2016.
151. Greenbaum J. Child Sex Trafficking and Commercial Sexual Exploitation. *Advances in Pediatrics*. 2018;65(2018):55-70.
152. Health WSDo. Intimate Partner Violence has Serious Health Impacts in Washington State. In. Tumwater, WA: Washington State Department of Health.
153. Moya EM, Chavez-Baray S, Martinez O. Intimate partner violence and sexual health: voices and images of Latina immigrant survivors in southwestern United States. *Health Promot Pract*. 2014;15(6):881-893.
154. Holliday CN, Miller E, Decker MR, et al. Racial Differences in Pregnancy Intention, Reproductive Coercion, and Partner Violence among Family Planning Clients: A Qualitative Exploration. *Womens Health Issues*. 2018;28(3):205-211.
155. Miller E, Decker MR, McCauley HL, et al. Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*. 2010;81(4):316-322.
156. Miller E, Jordan B, Levenson R, Silverman JG. Reproductive coercion: connecting the dots between partner violence and unintended pregnancy. *Contraception*. 2010;81(6):457-459.
157. Peek-Asa C, Wallis A, Harland K, Beyer K, Dickey P, Saftlas A. Rural disparity in domestic violence prevalence and access to resources. *J Womens Health (Larchmt)*. 2011;20(11):1743-1749.
158. Center LR. LGBTQIA Resource Center Glossary. 2018.
159. Macapagal K, Bhatia R, Greene GJ. Differences in Healthcare Access, Use, and Experiences Within a Community Sample of Racially Diverse Lesbian, Gay, Bisexual, Transgender, and Questioning Emerging Adults. *LGBT Health*. 2016;3(6):434-442.
160. Todd A, Stuijbergen A. Breast Cancer Screening Barriers and Disability. *Rehabilitation Nursing*. 2012;37(2):74-79.
161. Puckett JA, Cleary P, Rossman K, Mustanski B, Newcomb ME. Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals. *Sexuality Research and Social Policy: Journal of NSRC*. 2017(August).
162. Nahata L, Quinn GP, Caltabellotta NM, Tishelman AC. Mental Health Concerns and Insurance Denials Among Transgender Adolescents. *LGBT Health*. 2017;4(3):188-193.
163. Harvey SM, Branch MR, Hudson D, Torres A. Listening to immigrant latino men in rural Oregon: exploring connections between culture and sexual and reproductive health services. *American Journal of Mens Health*. 2013;7(2):142-154.
164. Martinez O, Wu E, Sandfort T, et al. Evaluating the impact of immigration policies on health status among undocumented immigrants: a systematic review. *J Immigr Minor Health*. 2015;17(3):947-970.
165. Jadav S, Rajan SS, Abughosh S, Sansgiry SS. The Role of Socioeconomic Status and Health Care Access in Breast Cancer Screening Compliance Among Hispanics. *J Public Health Manag Pract*. 2015;21(5):467-476.
166. Gelman A, Miller E, Schwarz EB, Akers AY, Jeong K, Borrero S. Racial disparities in human papillomavirus vaccination: does access matter? *J Adolesc Health*. 2013;53(6):756-762.

167. James SE, Brown C, Wilson I. *2015 U.S. Transgender Survey: Report on the Experiences of Black Respondents*. Washington, DC; Dallas, TX: National Center for Transgender Equality, Black Trans Advocacy, & National Black Justice Coalition;2017.
168. Gynecologists ACoOa. Racial and Ethnic Disparities in Obstetrics and Gynecology. In:2007, 2015.
169. Akinyemiju TF, Soliman AS, Yassine M, Banerjee M, Schwartz K, Merajver S. Healthcare access and mammography screening in Michigan: a multilevel cross-sectional study. *International Journal for Equity in Health*. 2012;11(16).
170. Phillippi JC, Myers CR, Schorn MN. Facilitators of prenatal care access in rural Appalachia. *Women and Birth*. 2014;27(4):e28-35.
171. Quality AfHRa. *2016 National Healthcare Quality and Disparities Report*. Rockville, MD: U.S. Department of Health and Human Services;2017.
172. Brown MJ, Weitzen S, Lapane KL. Association between intimate partner violence and preventive screening among women. *J Womens Health (Larchmt)*. 2013;22(11):947-952.
173. Massetti GM, Townsend JS, Thomas CC, Basile KC, Richardson LC. Healthcare Access and Cancer Screening Among Victims of Intimate Partner Violence. *J Womens Health (Larchmt)*. 2018;27(5):607-614.
174. US CotCSEaStoMit. *Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States*. Washington, D.C.2013.
175. Hadley J. Sicker and poorer--the consequences of being uninsured: a review of the research on the relationship between health insurance, medical care use, health, work, and income. *Medical Care Research Review*. 2003;60(June 2003):35-75S.
176. 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.
177. Drew JA, Short SE. Disability and Pap smear receipt among U.S. Women, 2000 and 2005. *Perspect Sex Reprod Health*. 2010;42(4):258-266.
178. Rich E. *Policy Solutions to Improving Access to Coverage for Immigrants*. National Family Planning and Reproductive Health Association;2016.
179. Goin D, Long SK. *Health Care Access and Cost Barriers for Adults with Physical or Mental Health Issues: Evidence of Significant Gaps as the ACA Marketplace Opened their Doors*. The Urban Institute;2014.
180. Barr JK, Giannotti TE, Hoof TJV, Mongoven J, Curry M. Understanding Barriers to Participation in Mammography by Women With Disabilities. *American Journal of Health Promotion*. 2008;22(6):361-385.
181. Suzuki R, Krahn G, Small E, Peterson-Besse J. Multi-level barriers to obtaining mammograms for women with mobility limitations: post workshop evaluation. *Am J Health Behav*. 2013;37(5):711-718.
182. Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington: National Center for Transgender Equality, National Gay and Lesbian Task Force;2011.
183. *2015 U.S. Transgender Survey: Washington State Report*. Washington, DC: National Center for Transgender Equality;2017.

184. 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.
185. Bromley E, Nunes A, Phipps MG. Disparities in pregnancy healthcare utilization between Hispanic and non-Hispanic white women in Rhode Island. *Matern Child Health J*. 2012;16(8):1576-1582.
186. *Urban American Indian/Alaska Native Maternal, Infant, and Child Health Capacity Needs Assessment*. Seattle, Washington: Urban Indian Health Institute, Seattle Indian Health Board;2009.
187. Ravi A, Pfeiffer MR, Rosner Z, Shea JA. Identifying Health Experiences of Domestically Sex-Trafficked Women in the USA: A Qualitative Study in Rikers Island Jail. *J Urban Health*. 2017;94(3):408-416.
188. Bachman R, Zaykowski H, Kallmyer R, Poteyeva M, Lanier C. *Violence Against American Indian and Alaska Native Women and the Criminal Justice Response: What is Known*. August 2008 2008.
189. Adelberg M, Simon M. Non-Emergency Medical Transportation: Will Reshaping Medicaid Sacrifice An Important Benefit? In. *Health Affairs Blog*. Vol 2018. 20 September 2017 ed. Health Affairs2017.
190. Cawthon L, Salazar E. *The First Steps Program: 1989-1997*. Olympia, WA: Department of Social and Human Services; July 1999 1999.
191. Ander K, Black S, Bullock A, et al. Report prepared by: University of Washington MPH Candidates. In:2016.
192. Arnold L, Perkins J. Non-Emergency Medical Transportation for Pregnant Women. In. Chapel Hill, NC: National Health Law Program; 2008.
193. Musumeci M, Rudowitz R. *Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers*. Menlo Park, CA: The Kaiser Commission on Medicaid and the Uninsured; February 2016 2016.
194. Hung P, Henning-Smith CE, Casey MM, Kozhimannil KB. Access To Obstetric Services In Rural Counties Still Declining, With 9 Percent Losing Services, 2004-14. *Health Aff (Millwood)*. 2017;36(9):1663-1671.
195. Markus AR, Rosenbaum S. The role of Medicaid in promoting access to high-quality, high-value maternity care. *Womens Health Issues*. 2010;20(1 Suppl):S67-78.
196. Kozhimannil KB, Casey MM, Hung P, Han X, Prasad S, Moscovice IS. The Rural Obstetric Workforce in US Hospitals: Challenges and Opportunities. *J Rural Health*. 2015;31(4):365-372.
197. Hung P, Kozhimannil KB, Casey MM, Moscovice IS. Why Are Obstetric Units in Rural Hospitals Closing Their Doors? *Health Serv Res*. 2016;51(4):1546-1560.
198. Authority HC. *Health Care Services and Supports- Incarceration Overview*. 2017.
199. Service IH. IHS Profile. In. Indian Health Service2018.
200. Sequist TD, Cullen T, Bernard K, Shaykevich S, Orav EJ, Ayanian JZ. Trends in quality of care and barriers to improvement in the Indian Health Service. *J Gen Intern Med*. 2011;26(5):480-486.
201. Service IH. Agency Overview. <https://www.ihs.gov/aboutihs/overview/>.

202. Fox E. 2017 AIAN Insurance Status and Uninsured Rate. *National Indian Health Board/CMS Tribal Data Project (all data is for AIAN alone and in combination unless stated: AIAN "Alone")* 2018;
<https://public.tableau.com/profile/edward.fox#!/vizhome/2017AIANPopulationInsuranceStatusandUninsuredRatebyAccesstoIHS/2017AIANPopulationInsuranceStatusandUninsuredRatebyAccesstoIHS> . Accessed November, 2018.
203. Health WSDo. Tribal Public Health: Our Partnership with Federally Recognized Tribes. <https://www.doh.wa.gov/AboutUs/PublicHealthSystem/TribalPublicHealth>. Accessed September, 2018.
204. Wishner J, Solleveld P, Rudowitz R, Paradise J, Antonisse L. *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies*. Menlo Park, CA: Henry J. Kaiser Family Foundation; June 2016 2016.
205. Towne SD, Jr., Smith ML, Ory MG. Geographic variations in access and utilization of cancer screening services: examining disparities among American Indian and Alaska Native Elders. *Int J Health Geogr.* 2014;13:18.
206. Jewett PI, Gangnon RE, Elkin E, et al. Geographic access to mammography facilities and frequency of mammography screening. *Annals of Epidemiology.* 2017;28(2018):65-71.
207. Gerdts C, Fuentes L, Grossman D, et al. Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of a Restrictive Law in Texas. *Am J Public Health.* 2016;106(5):857-864.
208. Jones RK, Jerman J. How far did US women travel for abortion services in 2008? *J Womens Health (Larchmt).* 2013;22(8):706-713.
209. Andrews E. This little clinic is tackling the big problem of rural teen pregnancy. 28 May 2015, 2015.
210. Grzybowski S, Stoll K, Kornelsen J. Distance matters: a population based study examining access to maternity services for rural women. *BMC Health Serv Res.* 2011;11:147.
211. Gjesfjeld CD, Jung JK. How far?: Using geographical information systems (GIS) to examine maternity care access for expectant mothers in a rural state. *Soc Work Health Care.* 2011;50(9):682-693.
212. *Healthy Communities: A Tribal Maternal-Infant Health Strategic Plan*. Sequim, Washington: American Indian Health Commission for Washington State;2010.
213. Dehlendorf C, Anderson N, Vittinghoff E, Grumbach K, Levy K, Steinauer J. Quality and Content of Patient-Provider Communication About Contraception: Differences by Race/Ethnicity and Socioeconomic Status. *Womens Health Issues.* 2017;27(5):530-538.
214. Group WSAp. *The Obstetrician-Gynecologist Distribution Atlas*. Washington, DC: The American Congress of Obstetricians and Gynecologists;2013.
215. Moniz MH, Spector-Bagdady K, Heisler M, Harris LH. Inpatient Postpartum Long-Acting Reversible Contraception: Care That Promotes Reproductive Justice. *Obstet Gynecol.* 2017;130(4):783-787.
216. Braun LA, Kennedy HP, Womack JA, Wilson C. Integrative Literature Review: U.S. Military Women's Genitourinary and Reproductive Health. *Military Medicine.* 2016;181(1):35-49.

217. Nonzee NJ, Ragas DM, Ha Luu T, et al. Delays in Cancer Care Among Low-Income Minorities Despite Access. *J Womens Health (Larchmt)*. 2015;24(6):506-514.
218. Watch HR. *Detained and Dismissed: Women's struggles to obtain health care in United States Immigration Detention*. 2009.
219. Health WSDo. *Access to Prenatal and Preconception Care*. 2007.
220. Son J. Perceptions and Challenges: Postpartum Care Among Korean Americans Through an Online Community. *J Transcult Nurs*. 2016;27(3):241-248.
221. *Maze of Injustice: The failure to protect Indigenous women from sexual violence in the USA*. New York, NY: Amnesty International USA;2007.
222. Jarlenski M, Hogan C, Bogen DL, Chang JC, Bodnar LM, Van Nostrand E. Characterization of U.S. State Laws Requiring Health Care Provider Reporting of Perinatal Substance Use. *Womens Health Issues*. 2017;27(3):264-270.
223. Mansh M, Garcia G, Lunn MR. From Patients to Providers: Changing the Culture in Medicine Toward Sexual and Gender Minorities. *Academic Medicine*. 2015;90(5):574-580.
224. Mehta A, Nangia AK, Dupree JM, Smith JF. Limitations and barriers in access to care for male factor infertility. *Fertil Steril*. 2016;105(5):1128-1137.
225. Elkin EB, Atoria CL, Leoce N, Bach PB, Schrag D. Changes in the Availability of Screening Mammography, 2000-2010. *Cancer*. 2013;119(21):3847-3853.
226. Bornstein M, Carter M, Zapata L, Gavin L, Moskosky S. Access to long-acting reversible contraception among US publicly funded health centers. *Contraception*. 2017;97(5):405-410.
227. Bearak JM, Burke KL, Jones RK. Disparities and change over time in distance women would need to travel to have an abortion in the USA: a spatial analysis. *Lancet Public Health*. 2017;2(11):e493-e500.
228. Rayburn WF. *The Obstetrician–Gynecologist Workforce in the United States: Facts, Figures, and Implications*. Washington, DC: The American Congress of Obstetricians and Gynecologists; 2017 2017.
229. Association RTNI. State Fertility Scorecard: Washington. 2018; <http://familybuilding.resolve.org/fertility-scorecard/>. Accessed August, 2018.
230. Nangia AK, Likosky DS, Wang D. Distribution of male infertility specialists in relation to the male population and assisted reproductive technology centers in the United States. *Fertil Steril*. 2010;94(2):599-609.
231. Xiao H, Tan F, Goovaerts P. Racial and geographic disparities in late-stage prostate cancer diagnosis in Florida. *J Health Care Poor Underserved*. 2011;22(4 Suppl):187-199.
232. Levy S, Kane L. Medscape Ob/Gyn Malpractice Report 2017: Real Physicians. Real Lawsuits. In. Medscape2017.
233. Benedetti TJ, Baldwin LM, Skillman SM, et al. Professional liability issues and practice patterns of obstetric providers in Washington State. *Obstet Gynecol*. 2006;107(6):1238-1246.
234. Sufrin CB, Creinin MD, Chang JC. Contraception services for incarcerated women: a national survey of correctional health providers. *Contraception*. 2009;80(6):561-565.

235. LaRochelle F, Castro C, Goldenson J, et al. Contraceptive use and barriers to access among newly arrested women. *J Correct Health Care*. 2012;18(2):111-119.
236. Gynecologists TACoOa, Gynecologists TACoOa. ACOG Statement of Policy on Racial Bias. In. Washington, DC: The American College of Obstetricians and Gynecologists; 2017.
237. Moniz MH, Chang T, Heisler M, et al. Inpatient Postpartum Long-Acting Reversible Contraception and Sterilization in the United States, 2008-2013. *Obstet Gynecol*. 2017;129(6):1078-1085.
238. Bishops USCoC. Ethical and Religious Directives for Catholic Health Care Services, 6th ed. In. Washington, DC: Committee on Doctrine of the United States Conference of Catholic Bishops (USCCB); 2018.
239. Foster AM, Dennis A, Smith F. Do religious restrictions influence ectopic pregnancy management? A national qualitative study. *Womens Health Issues*. 2011;21(2):104-109.
240. Bouchtia N. ACLU calls on San Juan to comply with Washington's Reproductive Privacy Act. 2015; <https://www.aclu-wa.org/blog/aclu-calls-san-juan-comply-washington-s-reproductive-privacy-act-0>. Accessed July, 2018.
241. Stone J. Healthcare Denied At 550 Hospitals Because Of Catholic Doctrine. 2016; <https://www.forbes.com/sites/judystone/2016/05/07/health-care-denied-at-550-hospitals-because-of-catholic-doctrine/#3d27fda55ad9>. Accessed July, 2018.
242. Ethics ACo. The Limits of Conscientious Refusal in Reproductive Medicine. In. Vol November 2007: The American College of Obstetricians and Gynecologists; 2007.
243. Schulz SL. The Informed Consent Model of Transgender Care: An Alternative to the Diagnosis of Gender Dysphoria. *Journal of Humanistic Psychology*. 2017;58(1):72-92.
244. Reisner SL, Bradford J, Hopwood R, et al. Comprehensive Transgender Healthcare: The Gender Affirming Clinical and Public Health Model of Fenway Health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. 2015;92(3):584-592.
245. Judge AM, Murphy JA, Hidalgo J, Macias-Konstantopoulos W. Engaging Survivors of Human Trafficking: Complex Health Care Needs and Scarce Resources. *Annals of Internal Medicine*. 2018;168(9):658-663.
246. DeSisto1 CL, Estrich C, Kroelinger CD, et al. Using a multi-state Learning Community as an implementation strategy for immediate postpartum long-acting reversible contraception. *Implementation Science*. 2017;2017(12):138.
247. *Long Acting Reversible Contraception (LARC) Learning Community Launch Report*. Arlington, Virginia: ASTHO; 19 August 2014 2014.
248. Washington Apple Health Family Planning Provider Guide. In. Olympia, Washington: Washington State Health Care Authority; 2016.
249. Group TG. *Best Practices for Asking Questions to Identify Transgender and Other Gender Minority Respondents on Population-Based Surveys*. Los Angeles, CA: The Williams Institute;2014.
250. Lindberg LD, Maddow-Zimet I, Boonstra H. Changes in Adolescents' Receipt of Sex Education, 2006-2013. *J Adolesc Health*. 2016;58(6):621-627.
251. Greenwood NW, Wilkinson J. Sexual and reproductive health care for women with intellectual disabilities: a primary care perspective. *Int J Family Med*. 2013;2013:642472.

252. Park J, Nordstrom SK, Weber KM, Irwin T. Reproductive coercion: uncloaking an imbalance of social power. *Am J Obstet Gynecol.* 2016;214(1):74-78.
253. Browne DR, Hackett S, Burger A. Employing Community Voices: Informing Practice and Programming through Camden Healthy Start Focus Groups. *Maternal and Child Health Journal.* 2017;21(Supplement 1):S101-106.
254. Biggs MA, Harper CC, Malvin J, Brindis CD. Factors influencing the provision of long-acting reversible contraception in California. *Obstetrics and Gynecology.* 2014;123(3).
255. Authority WSHC. Citizen and immigration status definitions. 2018; <https://www.hca.wa.gov/health-care-services-supports/program-administration/citizen-and-immigration-status-definitions>. Accessed June 2018.
256. Union ACL. *State Standards for Pregnancy-Related Health Care and Abortion for Women in Prison.* 2012.
257. Corrections WSDo. *Offender Health Plan.* 2018.
258. Legislature WS. RCW 72.09.651- Use of restraints on pregnant women or youth in custody--Allowed in extraordinary circumstances. In:2010.
259. Legislature WS. Chapter 9.02 RCW: Abortion. In.
260. Legislature WS. RCW 48.43.073-Required abortion coverage--Limitations. In:2018.
261. Student Sexual Abuse Prevention Curriculum, RCW 28.A.300.160 Revised Code of Washington(2018).
262. Committee CSECSC. *Commercially Sexually Exploited Children Statewide Coordinating Committee 2016 Report to the Washington State Legislature.* 28 November 2016 2016.
263. Instruction OoSoP. Health Education. <http://www.k12.wa.us/HealthFitness/Standards/HealthEducationK-12LearningStandards.pdf>. Accessed July, 2018.
264. --. *Our Bodies, Our Stories | Sexual Violence Among Native Women in Seattle, WA.* Seattle, Washington: Urban Indian Health Institute;2018.
265. Swaine JG, Dababnah S, Parish SL, Luken K. Family caregivers' perspectives on barriers and facilitators of cervical and breast cancer screening for women with intellectual disability. *Intellect Dev Disabil.* 2013;51(1):62-73.
266. Friedman C, Owen AL. Sexual health in the community: Services for people with intellectual and developmental disabilities. *Disabil Health J.* 2017;10(3):387-393.
267. Children's S. Puberty Blockers. In: Seattle Children's AM, ed2016.
268. Gynecologists TACoOa, Gynecologists TACoOa. Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy. In: Group CoGPL-ARCW, ed. Washington, DC: The American College of Obstetricians and Gynecologists; 2018.
269. Sridhar A, Salcedo J. Optimizing maternal and neonatal outcomes with postpartum contraception: impact on breastfeeding and birth spacing. *Maternal Health, Neonatology, and Perinatology.* 2017;3(1).
270. English A, Lewis J, Morales M, Coleman C. *Protecting Patients' Privacy in Health Insurance Billing & Claims: A Washington Profile.* Washington, DC: National Family Planning & Reproductive Health Association; September 2016 2016.
271. Right to limit disclosure of health information, Washington Administrative Code(2003).

272. Peterson JJ, Suzuki R, Walsh ES, Buckley DI, Krahn GL. Improving cancer screening among women with mobility impairments: randomized controlled trial of a participatory workshop intervention. *Am J Health Promot.* 2012;26(4):212-216.
273. Authority WSHC. Take Charge (Family Planning non-Medicaid). <https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/take-charge-family-planning-non-medicaid>. Accessed July, 2018.
274. Gawron LM, Redd A, Suo Y, Pettey W, Turok DK, Gundlapalli AV. Long-acting Reversible Contraception Among Homeless Women Veterans With Chronic Health Conditions: A Retrospective Cohort Study. *Medical Care.* 2017;55(9, Supplement 2):S111-S120.
275. Miller E, Silverman JG. Reproductive coercion and partner violence: implications for clinical assessment of unintended pregnancy. *Expert Review Obstetric Gynecology.* 2010;5(5):511-515.
276. Harrell E. *Crime Against Persons with Disabilities, 2009-2013 - Statistical Tables.* Washington, DC: U.S. Department of Justice; May 2015 2015.
277. Health WSDo. Sexual Violence Impacts Health Outcomes in Washington State. In.
278. Perry S. *American Indians and Crime.* Bureau of Justice Statistics: U.S. Department of Justice; December 2004 2004.
279. American College of Obstetricians and Gynecologists CoHCfUW. *Substance Abuse Reporting and Pregnancy: The role of the Obstetrician-Gynecologist.* 2011.
280. Burdette AM, Webb NS, Hill TD, Jokinen-Gordon H. Race-specific trends in HPV vaccinations and provider recommendations: persistent disparities or social progress? *Public Health.* 2017;142:167-176.
281. Borrero S, Schwarz EB, Creinin M, Ibrahim S. The impact of race and ethnicity on receipt of family planning services in the United States. *J Womens Health (Larchmt).* 2009;18(1):91-96.
282. MacMillan HL, Wathen CN, Jamieson E, et al. Screening for Intimate Partner Violence in Health Care Settings. *JAMA.* 2009;302(5):493-501.
283. Moracco KE, Cole TB. Preventing Intimate Partner Violence: Screening Is Not Enough. *JAMA.* 2009;302(5):568-570.
284. Office of the Insurance Commissioner WS. Transgender medical coverage rights. Accessed August, 2018.
285. Kreidler prompts Kaiser to write new policy to treat transgender women fairly [press release]. 1 August 2018 2018.
286. Oakley LP, Harvey SM, Lopez-Cevallos DF. Racial and Ethnic Discrimination, Medical Mistrust, and Satisfaction with Birth Control Services among Young Adult Latinas. *Womens Health Issues.* 2018.
287. Whitehead J, Shaver J, Stephenson R. Outness, Stigma, and Primary Health Care Utilization among Rural LGBT Populations. *PLoS ONE.* 2016;11(1).
288. Roman LA, Raffo JE, Dertz K, et al. Understanding Perspectives of African American Medicaid-Insured Women on the Process of Perinatal Care: An Opportunity for Systems Improvement. *Matern Child Health J.* 2017;21(Suppl 1):81-92.

289. Clark CR, Baril N, Hall A, et al. Case management intervention in cervical cancer prevention: the Boston REACH coalition women's health demonstration project. *Prog Community Health Partnersh.* 2011;5(3):235-247.
290. Advocates NHL. *County-Based Health Coverage for Adult Immigrants: A proposal for counties in Washington State.* 2018.
291. Prevention CfDCa. What is Health Literacy? 2016; <https://www.cdc.gov/healthliteracy/learn/>. Accessed 6 September 2018.
292. Golden AG, Pomerantz A. Interpretive Repertoires That Shape Low-Income African American Women's Reproductive Health Care Seeking: "Don't Want to Know" and "Taking Charge of Your Health". *Health Communications.* 2015(30`746-757).
293. Haynes RM, Boulet SL, Fox MH, Carroll DD, Courtney-Long E, Warner L. Contraceptive use at last intercourse among reproductive-aged women with disabilities: an analysis of population-based data from seven states. *Contraception.* 2018;97(6):538-545.
294. McCloskey LA, Doran KA, Gerber MR. Intimate Partner Violence is Associated with Voluntary Sterilization in Women. *J Womens Health (Larchmt).* 2017;26(1):64-70.
295. Ohl ME, Richardson K, Kaboli PJ, Perencevich EN, Vaughan-Sarrazin M. Geographic Access and Use of Infectious Diseases Specialty and General Primary Care Services by Veterans With HIV Infection: Implications for Telehealth and Shared Care Programs. *The Journal of Rural Health.* 2014;30(2014):412-421.
296. *End AIDS Washington 2020.* Olympia, WA: Washington State Department of Health; August 2016 2016. DOH Pub 410-069.
297. Collaborative DRB. *LGBTQ Health Care Report and Recommendations.* Dr. Robert Bree Collaborative;2018.
298. Reviewing New Topic Proposals and Selecting New Topics. In:2017.
299. *Department of Health Strategic Plan September 2016-August 2019.* Tumwater, WA: Washington State Department of Health; November 2016 2016.
300. Confidential Communications Request (CCR). In. Sacramento, California: California Department of Insurance; 2015.
301. Request for Confidential Communications Form. In. Baltimore, Maryland: Maryland Insurance Administration; 2014.
302. Oregon Request for Confidential Communication. In. Salem, Oregon: Department of Consumer and Business Services; 2016.
303. Protecting Patient Privacy: The Oregon Confidential Communication Request What Providers Need to Know. In: Authority OH, ed. Salem, Oregon: Oregon Health Authority; 2016:1-6.
304. Issuer disclosures, notices and processes to protect privacy of health care information (R 2013-11). 2018; <https://www.insurance.wa.gov/issuer-disclosures-notices-and-processes-protect-privacy-health-care-information-r-2013-11>. Accessed September, 2018.
305. Medicare CfMa. Basic Health Program. 2018; <https://www.medicaid.gov/basic-health-program/index.html>. Accessed August 2018.
306. Authority WSHC. COFA Islander Health Care. 2018; <https://www.hca.wa.gov/about-hca/apple-health-medicaid/cofa-islander-health-care>. Accessed August 2018.

307. Services CfMaM. Section 1332: State Innovation Waivers. 2018; https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html. Accessed August 2018.
308. Policy Level PL-P0 Long-Acting Reversible Contraceptives Rates Increase. In: Authority WSHC, ed. Vol 2016 Supplemental Request. Olympia, Washington: Washington State Health Care Authority; 2016.
309. State Facts About Unintended Pregnancy: Washington. In. New York: Guttmacher Institute; 2017.
310. Sonfield A, Kost K. *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*. New York: Guttmacher Institute; 2015.
311. Force CHWT. *Community Health Worker Task Force Recommendations Report for Healthier Washington*. Olympia, WA 2016.
312. Service IH. Community Health Representative: About Us. No date; <https://www.ihs.gov/chr/aboutus/>. Accessed November 5, 2018, 2018.
313. Commerce WSDo. Washington State Clearinghouse on Human Trafficking. <https://www.commerce.wa.gov/serving-communities/crime-victims-public-safety/office-of-crime-victims-advocacy/human-trafficking/>. Accessed July, 2018.
314. Health WSDo. Human Trafficking. <https://www.doh.wa.gov/AboutUs/ProgramsandServices/HealthSystemsQualityAssurance/HumanTrafficking>. Accessed July, 2018.
315. Trafficking, RCW 9A.40.100 (2017).
316. Services USCal. Glossary. 2018; https://www.uscis.gov/tools/glossary?topic_id=a#alpha-listing.
317. Kashyap MB. "Illegal" vs. "Undocumented:" A NWIRP Board Member's Perspective. In. Vol 2018: Northwest Immigrant Rights Project; No date.
318. Officials AfSaTH. Immigration Status Definitions. 2010.