

**Minimizing Concern About Coercion:
A Critical Discourse Analysis of a Contraceptive Use Metric**

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“The way you made it, that’s the way it will be”

Gillian Welch

The Way It Will Be

The Harrow and the Harvest

Abstract

The field of public health has long named unintended pregnancy a problem concentrated in people of lower social class and associated with negative outcomes. A main strategy to reduce the unintended pregnancy rate is to increase women's use of specific contraceptive methods via contraceptive use metrics. However, scholars have criticized these metrics for a lack of attention to the issue of coercion. This study aimed to critically describe how policymakers constructed a contraceptive use metric targeting women with Medicaid insurance with attention to the discussion of contraceptive coercion. Using Critical Discourse Analysis and Reproductive Justice as guiding frameworks, I analyzed publicly available policy documents including meeting minutes, presentation slides, policy guidance texts, public testimonies, a stakeholder survey, and one audio recording. My analysis revealed healthcare system experts constructed the metric in alignment with mainstream public health discourse naming unintended pregnancy the cause of negative health outcomes and women's use of specific contraceptive methods, particularly long-acting reversible contraceptives, as the solution. Policymaker discourse reinforced the assumption that women are responsible for pregnancy prevention. Policymakers minimized stakeholder concerns about incentivizing coercion by changing the topic to improving access to contraception and through silence about the issue. Finally, a fertility reduction discourse was present naming certain people as being in no position to have children and children of impoverished people as high-cost children. Study results suggest a eugenic ideology and a mother-blame narrative may underpin contraceptive use metrics. These findings point to a need to focus policy on removing healthcare system barriers to contraceptive access for fertile people of all genders rather than increasing women's use of specific contraceptives.

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Chapter 1: Introduction

A long and widely held belief in public health is that unintended pregnancy is a problem associated with negative health outcomes for parents, children, and society. The United States Surgeon General described unintended pregnancy as a problem in the first Healthy People report published in 1979, and reducing the unintended pregnancy rate has been a United States policy goal since that time (Office of the Surgeon General, 1979). Despite this long-term policy focus, the unintended pregnancy rate has hovered at about half of all pregnancies in the United States since 1979 and has been described as a “stubborn problem” by prominent authors in the field (Finer & Zolna, 2014, p. S47).

One strategy to prevent unintended pregnancy is to increase women’s¹ use of contraceptives categorized as moderately and highly effective.² While some attempts to accomplish this increase in moderately and highly effective contraceptive use have involved removing barriers to access, other attempts have focused on the promotion of specific contraceptive methods, including setting policy targets for specific contraceptive use rates. Ensuring access to the full range of contraceptive methods is necessary for reproductive autonomy; however, the promotion of specific contraceptive methods has been criticized for a lack of attention to the issue of contraceptive coercion (Gomez et al., 2014).

Contraceptive coercion has been decried as a violation of human rights by organizations like the United Nations (United Nations Population Fund, 2014) and the American College of Obstetricians and Gynecologists (n.d.). Despite these declarations, there is a lack of research

¹ This study will use the term “women” and “female” but recognizes that these are exclusive and insufficient categories, that gender is a social construct and is not binary, that not all women have ovaries and uteruses, and that there are people who can become pregnant who would describe themselves with other words in other ways.

² Contraception is often categorized by effectiveness, and often into three categories: less effective, moderately effective, and highly effective. These categories are based on the typical use patterns pulled from aggregated data. At the individual level, a method placed in the less effective category could be highly effective depending on the individual skill level of the user and the ability of the user to implement the method.

specifically defining contraceptive coercion and clarifying how contraceptive coercion manifests. The extant research has, for the most part, focused on individual coercion by intimate partners or family members (Grace & Anderson, 2018; Grace & Fleming, 2016). While this type of coercion is an issue, the focus on individual-level coercion ignores the broader structural-level coercion that may exist within the healthcare system and family planning policy.

Recently, Senderowicz (2019) described how family planning policy may promote structural-level coercion by setting targets for specific contraceptive use rates. Senderowicz' (2019) research focused on a sub-Saharan African country where racialized women in colonized places are and have been the target of “contraceptive interventions and fertility reduction regimes” (p. 3). Senderowicz' theorizing about structured contraceptive coercion in the Global South proposes a framework with which to examine similar policies in the United States, especially policies that target racialized and gendered groups. Racialized women insured with the public Medicaid³ system may be particularly vulnerable to such coercion.

In 2014, policymakers in Oregon approved a contraceptive target policy called the Effective Contraceptive Use (ECU) metric. This policy created a financial incentive for the prescription of specific contraceptive methods to women with Oregon Medicaid health insurance. Oregon policymakers who created the ECU metric explicitly recognized its potential for coercion as it linked clinic financial incentives with use of specific contraceptives. Therefore, the Guidance Document for implementation of the ECU metric warned against coercive practice and gave a reminder that Medicaid patients must be free to choose their contraceptive method in accordance with federal law (Oregon Health Authority [OHA], 2014). These concerns about coercion echo a large body of Reproductive Justice theory that has documented the coercive practices of the medical establishment and the state; for example, coerced or non-consensual

³ Medicaid is public health insurance for United States citizens with low incomes.

sterilization or blocking access to reproductive healthcare for people with Medicaid insurance (Harris & Wolfe, 2014; Roberts, 2017, Chapter 3).

In a study that explored the potential of the ECU metric to promote contraceptive coercion, my research partner and I interviewed clinicians about their general approaches to contraceptive counseling with Oregon Medicaid patients and their interpretations of the ECU metric (Miller & Campbell, 2019). This evidence suggested that coercive contraceptive counseling practices were occurring, and included a firsthand account of a healthcare provider refusing a Medicaid patient's request to remove their contraceptive implant. These preliminary findings echo published literature, as research has documented healthcare provider resistance or refusal to remove contraceptive devices upon patient request (Amico et al., 2016). This finding suggests that despite reminding clinicians to avoid coercive practice, contraceptive coercion did occur and may have been incentivized by the ECU metric.

Although the Oregon ECU metric was retired in 2019, the National Quality Forum⁴ endorsed the “Contraceptive Care – Most & Moderately Effective Methods” measure in 2016 (National Quality Forum, 2016). The Office of Population Affairs⁵ (2019) cautioned states about financially incentivizing the Contraceptive Care measure because “performance on this measure is a function of a woman's preferences” (p. 1). However, because each state independently administers its Medicaid program, it is possible that the Contraceptive Care measure could result in a state opting to implement the measure linked with a financial incentive. Further, a recent study on the outcomes associated with the ECU metric published in the *Journal of the American Medical Association* suggested other states, “may want to consider similar incentive programs,”

⁴ The National Quality Forum is a not-for-profit, non-partisan, membership-based organization that evaluates and endorses quality measures for use by state and private sector payers.

⁵ The Office of Population Affairs is a federal agency that advises the Secretary of Health on reproductive health topics.

signaling incentivized contraceptive targets remain a policy option of interest (Rodriguez et al., 2020, p. 8).

Recent use of the Oregon ECU metric with subsequent National Quality Forum endorsement of a similar policy at the national level point to a need to critically analyze how contraceptive target policies are constructed and how structured contraceptive coercion is justified and resisted in the United States. This study will define the discursive injustice of contraceptive target policies by considering how policymaker discourses produced domination over women with intersecting marginalized social statuses (Van Dijk, 2009). The creation, implementation, and eventual discontinuation of the Oregon Medicaid ECU metric offers a useful case example.

Therefore, the overall purpose of this dissertation research is to critically analyze how policymakers and others constructed the Effective Contraceptive Use metric with attention to how the embedded coercion was justified and resisted using Reproductive Justice as a guiding framework. The specific aims of the study are to critically analyze and describe:

1. How the Effective Contraceptive Use metric was constructed, maintained, and retired
2. How concern about the structural contraceptive coercion embedded in the Effective Contraceptive Use metric was introduced, promoted, and minimized

This study will provide a significant contribution to our knowledge of how structural contraceptive coercion is embedded in Medicaid policy so that we can recognize the patterns people use to justify similar policies focused on increasing women's use of specific contraceptive methods. Once the patterns are clear, we can address them directly, and promote structures that support reproductive rights. This work will offer a foundation for the development and norming of policies grounded in Reproductive Justice that will support the reproductive

health of all, especially racialized and gendered people who have been the targets of reproductive oppression.

This introductory chapter provides background information about the Oregon ECU metric. I begin with an overview of Medicaid and the Medicaid population. Second, I describe the Oregon Medicaid system, including the incentive metric program with focused attention on the ECU metric. Third, I describe in more detail the problem of contraceptive coercion.

Medicaid

In 1965, the United States government created Medicaid to provide health insurance for low-income children, people who are pregnant, parents, seniors, and people with disabilities⁶ (Medicaid, n.d.). The creation of Medicaid was a significant expansion of federal funding for health insurance among people with low incomes. Medicaid particularly benefitted non-White⁷ children as mortality and poverty was significantly reduced in this population after initial policy implementation (Goodman-Bacon, 2018). Medicaid is a federal program with specific requirements. However, each state administers their Medicaid system differently, resulting in widely varying service delivery (Medicaid, n.d.).

The Affordable Care Act of 2010 was designed to expand Medicaid eligibility to include all adults with low incomes. The plan was for the federal government to fund Medicaid coverage for newly eligible recipients for several years in exchange for a state commitment to decrease per person spending and to gradually take more financial responsibility for funding Medicaid (Medicaid, n.d.). However, the Supreme Court ruled that Medicaid expansion was optional for states, thereby resulting in an even wider service accessibility variation and eligibility income levels and deepening racial disparities in access (Garfield et al., 2020; Grogan & Park, 2017).

⁶ Medicaid excludes undocumented immigrants.

⁷ For this dissertation, I will use the racial terms used by the study authors. I recognize that racial categories are fluid and their meaning contextual.

The Medicaid Population

Medicaid provides health insurance for more than one quarter of the United States population, 40% of whom have incomes below the federal poverty level⁸, and 61% of whom identify racially as Black, Hispanic, or Other (Medicaid and CHIP Payment and Access Commission, 2020). People who identify as Black or Hispanic are overrepresented in the Medicaid population, while people who identify as White are underrepresented (see Table 1). Women are also overrepresented in the Medicaid population. This means that the Medicaid population is a racialized and gendered group, which has implications for understanding the policies targeting them.

Table 1

Comparison of the Race and Gender Composition of the US and Medicaid Population

	US population percentage	Medicaid population percentage
Race		
Black, non-Hispanic	12.6	21.2
Hispanic	18.4	32.1
Other, non-White, non-Hispanic	7.7	7.8
White	61.3	38.9
Gender		
Female	51.1	55.7
Male	48.9	44.3

⁸ The Federal Poverty Level in 2021 is \$12,880 for a single person, with an additional \$4,540 added for each additional family member.

Oregon Medicaid and Coordinated Care Organizations

Oregon was one of the states that expanded Medicaid eligibility and committed to decreasing Medicaid per person spending over time. Part of this agreement included permission from the federal government to experiment with healthcare system accountability and alternative payment structures (McConnell, 2016). Oregon's approach to this experimentation included restructuring its Medicaid system into a network of Coordinated Care Organizations (CCOs). CCOs are geographically-based healthcare networks⁹ composed of groups of clinics and other healthcare facilities offering behavioral, oral, and physical health services for Medicaid patients (OHA, 2018). CCOs are designed to improve outcomes and decrease Medicaid spending by coordinating care (McConnell, 2016).

The Oregon Medicaid Incentive Metric System

The State of Oregon pays CCOs on both a per person basis and with a system of incentive metrics. Incentive metrics are a pay-for-performance model that rewards particular processes or outcomes. The Oregon Health Authority uses incentive metrics as a lever to make sure the CCOs are “improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of health care” (OHA, n.d.-a, para. 1). Examples of incentive metrics include: measuring the percentage of people who have timely prenatal care or the percentage of children immunized according to Centers for Disease Control and Prevention vaccination schedule.

The State of Oregon provides a bonus payment, called the “quality pool,” from the Oregon Health Authority budget if CCOs meet specific performance targets that shift from year to year (McConnell, 2016). The *Oregon Health System Transformation: CCO Metrics 2018*

⁹ CCOs may be for-profit or non-profit, and must be designated by the Oregon Health Authority.

Final Report published by the Oregon Health Authority (2019) described the quality pool payment methodology and final distributions for 2018. In 2018, CCOs earned quality pool dollars by meeting or exceeding the benchmark or improvement target on 12 of the 16 incentive metrics and by meeting a target for the Patient-Centered Primary Care Home enrollment metric. Once these funds were distributed, a second round of “challenge pool” dollars were available. The challenge pool consists of funds left over from the initial distribution and were distributed according to CCO performance on a subset of incentive measures. In 2018, the State of Oregon paid CCOs a total of \$188,264,693 in quality pool funds which represented 4.25% of the total CCOs were paid by the State (OHA, 2019).

The Metrics and Scoring Committee is the legislatively mandated public body that oversees Oregon’s incentive metrics. The Metrics and Scoring Committee is made up of nine members— three members-at-large, three members with expertise in health outcome measures, and three members representing CCOs. Members of the Metrics and Scoring Committee are appointed by the Director of the Oregon Health Authority and serve for two years. The Metrics and Scoring Committee is responsible for annually reviewing the incentive metric set which includes selecting, continuing, and retiring incentive metrics, as well as setting metric benchmarks (OHA, n.d-b).

Effectiveness of Incentive Metrics

Incentive metrics were intended to improve healthcare efficiency and quality by incentivizing specific outcomes or processes thereby shifting the payment structure of the healthcare system away from simply rewarding increased use of services (Sonfield, 2014). Determining the effectiveness of pay-for-performance programs is challenging because of the complex contexts in which these programs exist. In a systematic review examining the factors

that modify the effectiveness of pay-for-performance programs, Kondo and colleagues (2016) found immense heterogeneity in the studied programs and thus were unable to draw definitive conclusions about the general effectiveness of incentive metrics.

Kushner and colleagues (2017) evaluated the changes to Oregon Medicaid from 2012-2017 and found that the incentive metrics were associated with improvements in the incentivized outcomes. The evaluators defined improvement as movement towards the goal set by the Metrics and Scoring Committee. For example, improvement on the ECU metric was defined as increases in the prescription rates of specific contraceptives. Kushner and colleagues (2017) found that two-thirds of the incentive measures improved in two of the three years that data was available, while only one-third of non-incentivized measures improved. This report recommended that the State of Oregon increase the portion of CCO payments because the Oregon Medicaid incentive measures have been effective in creating targeted change.

Incentive Metrics and Health Equity

While incentive measures may be effective in creating targeted change, scholars have criticized the negative impact of pay-for-performance systems on health inequities along the axis of race (Demeester et al., 2017; Jung et al., 2016; Tao et al., 2016). Other research has found that linking clinic funding with quality measures may disadvantage safety-net clinics that serve patients most targeted by structural oppressions (Lewis et al., 2017; Shakir et al., 2018). Scant research has investigated how structured oppression appears in policy targeting oppressed communities.

Culhane-Pera and colleagues (2018) investigated how quality measures influenced patient care at safety-net clinics and non-safety-net clinics by interviewing healthcare providers to understand their perspectives on a new pay-for-performance system. This study reported that

healthcare providers perceive the selection of quality measures as embedded in and shaped by social inequities (Culhane-Pera et al., 2018). Specifically, Culhane-Pera et al. discussed how quality measures were originally selected by corporate executive officers concerned primarily with financial impacts. More recently, healthcare organizations and insurance plans have become involved in selecting quality measures. This means that quality measures are selected by those at the top of the healthcare system hierarchy, may be misaligned with patient-centered definitions of quality, and may re-inscribe social inequality (Culhane-Pera et al., 2018). To my knowledge no research exists that examines the incentive metric policymaking process for embedded structural inequality.

The Effective Contraceptive Use Metric

The Metrics and Scoring Committee approved the ECU metric in 2015 and retired the ECU metric at the end of 2019. The stated purpose of the ECU metric was to improve reproductive health outcomes via lowering the unintended pregnancy rate by increasing women's use of moderately and highly effective forms of contraception. The ECU metric was designed to be used with the One Key Question[®] initiative, which encourages clinicians to ask women the "one key question" at every clinical visit. The one key question is, "would you like to become pregnant in the next year?" If the woman is planning a pregnancy, the clinician prescribes prenatal vitamins. If the woman is not planning a pregnancy, the clinician initiates a conversation about contraception. If the woman is ambivalent, the clinician initiates a conversation about either prenatal vitamins or contraception (OHA, 2014).

To meet the ECU metric and be paid for their performance, clinicians were required to prescribe a specific contraceptive method to 50% of the CCO's female patients ages 15-50 (OHA, 2014). The contraceptive methods that counted for the ECU metric were those categorized as

moderately or highly effective and required the involvement of a healthcare provider with prescriptive authority. These methods included: female sterilization, intrauterine devices, diaphragms, implants, pills, patches, vaginal rings, and injections (OHA, 2014).

Contraceptive Coercion

Many scholars have expressed concern with any policy that promotes specific contraceptive methods in light of the history of race- and social class¹⁰-based reproductive oppression and violence perpetrated against women by both the United States and the medical establishment (Brandi & Fuentes, 2020; Mann & Grzanka, 2018; Senderowicz, 2019). Further, the contraceptive counseling visit is not a neutral space and power relations exist between clinician and patient, which this dissertation will explain in more detail in the second chapter. Informed by these concerns, the United States Office of Population Affairs will not set national benchmarks for specific contraceptive use rates and will not link incentive payments with specific contraceptives. The Office of Population Affairs website states that “the goal of providing contraception should never be to promote any one method or class of methods over women’s individual choices” (n.d. para. 13).

A Theory of Contraceptive Coercion

Despite the United States Office of Population Affairs’ stated commitment to avoid coercive practice, the concept of coercion in the contraceptive counseling visit is under-theorized. Research into contraceptive coercion often includes only intimate partners or family members as potential sources of coercion (Grace & Fleming, 2016), ignoring the larger structural processes such as state-level policies that may also contribute. Senderowicz investigated contraceptive coercion in a low-income country in sub-Saharan Africa that used a target-driven contraceptive

¹⁰ This dissertation will use the term “social class” to refer to the construct of “an individual or group’s relative position in an economic-social-cultural hierarchy...social class denotes power, prestige, and control over resources” (Diemer et al., 2013, p. 79)

uptake approach to family planning. Senderowicz interviewed 49 women of reproductive age and found evidence of contraceptive coercion in their stories.

From these interviews, Senderowicz theorized that coercion in contraceptive counseling occurs along a spectrum from subtle to more overt. For example, subtle coercion could be a clinician offering only limited contraceptive methods. An example of more overt coercion would be a clinician refusing to remove a contraceptive device. Further theorizing, Senderowicz named two types of coercion: downward and upward coercion. Downward coercion occurred when a person wanted a contraceptive method and their access was blocked. Upward coercion occurred when a person did not want a contraceptive method and was pressured into using one (Senderowicz, 2019). Senderowicz found that pressuring, upward coercion was the most common. This pressuring, upward coercion is the type of coercion potentially incentivized by the ECU metric.

Concern for Coercion in the ECU Metric

The Oregon Health Authority (2014) encouraged providers to be "cautious about bias," and expressly communicated the need to support Medicaid client autonomy (p. 16). Specifically, the Guidance Document stated,

while the Oregon Health Authority is incentivizing effective contraceptive use, it is important to remember that Oregon Health Plan clients must be free to choose the method of family planning that is to be used. Per federal law, health plans must provide that each member is, ‘free from coercion or mental pressure, and free to choose the method of family planning to be used.’” (OHA, 2014, p. 29)

This shows that concern about contraceptive coercion was present during the construction of the ECU metric. However, it is unknown how this concern was minimized enough to justify enacting the ECU metric.

Conclusion

In this dissertation, I question long and widely held assumptions about unintended pregnancy and the categorization of contraception, which will provide a nuanced understanding of how these concepts operate in the world today. In line with this, the next chapter reviews three central concepts necessary to critically analyze the ECU metric: the unintended pregnancy discourse, the effective contraception discourse, and the power relations in the contraceptive counseling visit.

Chapter 2: Background

As described in Chapter 1, the Oregon Health Authority identified that the Effective Contraceptive Use (ECU) metric created a coercive situation by linking clinic funding with women's use of specific contraceptives (Oregon Health Authority, 2014). Despite the recognition of this coercive situation, the measure was enacted for five years and has been recommended for use at the national level (Rodriguez et al., 2020). Therefore, the overall purpose of this dissertation research is to critically analyze how policymakers and others constructed the Effective Contraceptive Use metric with attention to how the embedded coercion was justified and resisted using Reproductive Justice as a guiding framework. The specific aims of the study are to critically analyze and describe:

1. How the Effective Contraceptive Use metric was constructed, maintained, and retired
2. How concern about the structural contraceptive coercion embedded in the Effective Contraceptive Use metric was introduced, promoted, and minimized

To accomplish these aims, it was necessary to conduct a review of the literature. I recognize that many hegemonic discourses shape our understanding of the phenomenon of the ECU metric, including discourses and ideologies around sexuality, pregnancy, motherhood, and parenthood. A nexus of intersecting social forces and ideologies including sexism, racism, eugenics, capitalism, and imperialism combine to constrain reproductive autonomy and create harm (Kuumba, 1999). I recognize the complexity of the forces that shape our ideas about reproduction and focus this chapter on information that is most central to this critical review. Specifically, I describe three central concepts necessary to critically analyze the ECU metric: (a) the unintended pregnancy discourse which forms the basis for the policy problem the ECU metric was constructed to address, (b) the effective contraception discourse which forms the

basis for the policy solution of promoting specific contraceptives, and (c) the power relation in the contraceptive counseling visit which is critical for a nuanced understanding of the social forces at work in the patient-clinician relationship. Considered as a whole, these three sections establish the background for a critical analysis of the ECU metric policy discourse.

Unintended Pregnancy Discourse

For decades, the public health field has constructed unintended pregnancy as a problem concentrated in populations of lower socioeconomic status,¹¹ and associated with negative health and social outcomes. In the first Healthy People report in 1979, the United States Surgeon General described how “unplanned births affect not only the health of children but also the social well-being of mothers” and are associated with “lower socioeconomic conditions and poverty” (p. 8-3). In 1995, the Institute of Medicine published a report titled *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*. This report associated unintended pregnancies with negative outcomes like insufficient participation in prenatal care, low birthweight, and consuming alcohol and nicotine during pregnancy (Brown & Eisenberg, 1995). Each Healthy People report since 1979 has included the policy goal of reducing unintended pregnancy, including the most recent Healthy People 2030 (“Healthy People 2030,” n.d.). In alignment with these policy goals, the ECU metric was designed to address the problem of unintended pregnancy (Oregon Health Authority, 2014).

The public health field commonly attributes the root of problem of unintended pregnancy to people’s ineffective use of or limited access to modern contraception (Wise et al., 2017). With ineffective use of or access to contraception proposed as the cause of unintended pregnancy, a commonly constructed solution to this problem includes policy and practice aimed at increasing

¹¹ This dissertation will use the term “socioeconomic status” to refer to the conceptualization and measurement of social class. This measure commonly includes indicators of power such as income, wealth, formal education level, and occupation (Diemer et al., 2013).

women's uptake of specific contraception (Finer & Zolna, 2014; Wise et al., 2017). The highly effective, long-acting reversible contraceptives (LARCs) such as the intra-uterine device (IUD) or the subcutaneous contraceptive implant are considered a "first-line" solution to the problem of unintended pregnancy (Gomez et al., 2014). The ECU metric was designed in alignment with this conventional interpretation of the root causes of unintended pregnancy, with unintended pregnancy named as a root cause of adverse outcomes (Oregon Health Authority, 2014).

The construction of unintended pregnancy as a problem is controversial. Scholars have identified concerns about how pregnancy planning is conceptualized (Aiken et al., 2016; Geronimus, 2003; Wise et al., 2017), how the unintended pregnancy rate is measured (Brown & Eisenberg, 1995; Kemet et al., 2018; Santelli et al., 2003), and how unintended pregnancy is associated with health outcomes (Gipson et al., 2008; Kost & Lindberg, 2015). In a recent commentary in *Contraception*, Potter and colleagues (2019) argued that the construction of unintended pregnancy as a problem caused by people's ineffective use of contraception can focus our attention on individual "failures" and allow society to blame the individual for their poor planning rather than consider the structural forces at play. This construction of pregnancy intention serves to obscure the structural forces of racism, sexism, and poverty, which contribute significantly to negative health and social outcomes (Bowleg, 2017).

In this section, I describe the unintended pregnancy discourse to develop a nuanced understanding of the construction of unintended pregnancy as a problem. First, I describe how pregnancy intention is currently conceptualized, critique assumptions embedded in this concept, and explore the meaning of the concept. Second, I describe how unintended pregnancy is measured. This includes the origin of measuring pregnancy intention, changes in measurement over time, how the unintended pregnancy rate is calculated, demographic trends in unintended

pregnancies, and novel measures of pregnancy preferences. Third, I consider what is known about the relationship between unintended pregnancy and outcomes. This includes a criticism of the lack of attention given to structural factors, like racism and poverty, in understanding the root causes of negative outcomes.

The Conceptualization of Pregnancy Intention

In the field of public health, pregnancies are commonly categorized as either “intended” or “unintended.” Kost and Zolna (2019) noted that common measures used to calculate the unintended pregnancy rate do not ask about intention but rather ask about pregnancy desires.¹² Thus, the definition of intended pregnancy is a pregnancy that happened at the desired time, or later than desired. The limitations of the binary categories of intended/unintended have been recognized; therefore unintended pregnancies are further split into two categories: “mistimed” and “unwanted.” The definition of a mistimed pregnancy is a pregnancy that occurred sooner than desired. The definition of an unwanted pregnancy is a pregnancy that was not wanted at any time, not now and not at a later time. The sub-categories of mistimed and unwanted pregnancies are commonly combined into the unintended category for analysis (Finer & Zolna, 2014). There is space for ambivalent feelings about pregnancy desire in commonly-used questionnaires; however, pregnancies that are not clearly intended or unintended are often combined with intended pregnancies for analysis (Finer & Zolna, 2014).

Assumptions about pregnancy intentions. In a commentary, Aiken and colleagues (2016) pointed out how this conceptualization of pregnancy intention assumes that people have clear pregnancy intentions or desires, specifically that women either want or do not want to be pregnant. Aiken and colleagues (2016) described how women’s pregnancy intentions do not

¹² Interestingly, mainstream discourse continues to refer to lack of pregnancy planning as the problem, even though the surveys used to determine the unintended pregnancy rate ask about pregnancy desire.

always fall neatly into these binary categories. Rather, women describe their pregnancy intentions as being on a continuum between intended and unintended. Some women may have a strong desire to avoid or achieve pregnancy, while others feel more ambivalent about these goals. These desires may fluctuate through time.

Aiken and colleagues (2016) also described how women's emotional orientation towards pregnancy is an important factor influencing outcomes. For example, a person may express a positive emotional response for a pregnancy that they clearly wanted to avoid, or a negative response for a pregnancy they desired. This seeming paradox is not captured by the pregnancy planning paradigm; an unintended pregnancy may not be perceived as a negative outcome, and an intended pregnancy may not be perceived as a positive outcome. Because of the multidimensional nature of pregnancy preferences, researchers created several novel measures that consider pregnancy preferences rather than intentions. These measures will be discussed in the measurement section of this chapter.

Pregnancy Meanings Which Contest the Dominant Discourse

A nascent body of research has explored pregnancy meanings and interpretations that contest the dominant discourse. This research has shown that women may resist the pregnancy intention discourse, may understand pregnancy intention terms differently than researchers, and suggests that the categorization of pregnancy by intention may not hold significant meaning in women's reproductive lives.

Unintended pregnancy as a positive event. Results from two studies with two distinct cultural groups showed similar feelings about unintended pregnancy which contest the dominant discourse holding unintended pregnancy as a negative event. Seeman and colleagues (2016) studied the role of religion and spirituality in pregnancy planning among African-American

women who lived in a Christian-oriented homeless shelter. Seeman and colleagues used an ethnographic approach with observations, focus groups, and life-history interviews with 16 out of 38 women who lived in the shelter. Seeman and colleagues found that most of the women did not intentionally become pregnant, and for some women becoming pregnant was a main reason they became homeless. However, the researchers found that the women interpreted their unintended pregnancy in a positive way as a “blessing” or as a catalyst for positive change (Seeman et al., 2016). Seeman and colleagues found that although the women interpreted their pregnancies as unintended to them, their pregnancies were “evidence of a caring and transcendent cosmic order” (Seeman et al., 2016, p. 42).

Seeman and colleagues discussed how the women’s interpretation of their pregnancies as blessings was at odds with the rational choice model that dominates the field of public health and considers unintended pregnancy to be a problem. Further, Seeman and colleagues suggested that the study participants’ resistance to the planning discourse was not related to a lack of access to or education about contraceptives, but “bound up with independent forms of vernacular moral and religious discourses of reproductive intentionality” (Seeman et al., 2016, p. 44). “Described as free and spontaneously given, the blessing of unintended children allowed some women... to reframe their experiences of homelessness, violence, and loneliness in powerfully redeeming ways” (Seeman et al., 2016, p. 46).

Hernandez and colleagues (2020) explored young, United States-born Latinas’ thoughts, feelings, and beliefs about unintended pregnancy and surrounding sociocultural factors. Hernandez and colleagues conducted 20 in-depth interviews with women who had a positive pregnancy test at a family planning clinic. Participants identified with a variety of Latina subgroups, were all under 25 years old, and were mostly single, unemployed, and uninsured.

Only women with a positive pregnancy test were interviewed. The research team assessed pregnancy intention with a single-item measure. Seventeen participants stated that they were not intending to become pregnant, two stated their intentions kept changing, and one person was intending to become pregnant.

Similar to Seeman and colleagues, Hernandez and colleagues (2020) found that the study participants who continued their pregnancy characterized their pregnancy as a “blessing” or part of “God’s plan.” The researchers provided participants with the Centers for Disease Control and Prevention’s definition of unintended pregnancy and asked the participants for their thoughts on the definition. Seventeen of the twenty women thought the term had negative connotations of blame and stigma and was not representative of their experience. Some participants thought that there was no right time to have a baby because “you’re never going to be financially [able to] fully support that child” (p. 928). These findings suggest that the current definition of unintended pregnancy does not fit women’s experiences and may be experienced as a positive event.

Unintended pregnancy and social norms around pregnancy timing. Neiterman and LeBlanc (2018) explored Canadian women’s perceptions about the timing of their pregnancies by interviewing 42 women who were pregnant or had given birth in the last 12 months. The women ranged in age from teens to over 40 years old. About half of the women were born in Canada, and the other half were immigrants. Five of the Canadian-born women identified as being part of a visible minority group. The study gave no further breakdown of the participants’ racial demographics. A few women described themselves as being in an upper income bracket, twelve described themselves as having no or low incomes, and the rest described themselves as having a moderate income.

Neiterman and LeBlanc (2018) considered how the women's perceptions and their own personal biographies related with social norms around pregnancy timing. The researchers described the concept of timing as "social expectations about when life events should occur" (p. 54). Major life events like childbearing are regulated by social expectations that categorize the event as either on-time or off-time. These authors also articulated that on-time events may be socially approved, while off-time events may be socially condemned.

Generally, Neiterman and LeBlanc (2018) defined an on-time pregnancy as one that is planned and an off-time pregnancy as one that is unplanned. They further defined an on-time pregnancy as one that happens for women after they "finish their education, achieve financial stability, (are) in their late 20's to early 30's, and have a meaningful relationship with a supportive partner" (Neiterman & LeBlanc, 2018, p. 59). The authors noted that while off-time life events are not necessarily socially condemned, pregnancy is often seen as a preventable event. Thus, women may be blamed for their irresponsibility in having an off-time pregnancy. Women in the study described their awareness of society's pregnancy timing norms and the relationship of those norms to their own lives. The researchers reported that women responded to pregnancy timing norms with a mixture of compliance, ambivalence, and defiance.

A nascent body of research has explored pregnancy meanings and interpretations that contest the dominant discourse. This research has shown that women may resist the pregnancy intention discourse, may understand pregnancy intention terms differently than researchers, and suggests that the categorization of pregnancy by intention may not hold significant meaning in women's reproductive lives.

This body of research reveals a complex picture of how women interpret the idea of pregnancy intentions. Not only does this research suggest some women understand pregnancy

intention terms differently than researchers or the way it is measured, but also the concept of pregnancy intention itself may not hold significant meaning in relation to how some women experience their pregnancies. The next section describes how pregnancy intention is measured to illuminate the origins and construction of the unintended pregnancy discourse.

The Measurement of Pregnancy Intention

Origin. Formalized inquiry into attitudes towards childbearing and factors affecting fertility began in the 1941 Indianapolis Study (Campbell & Mosher, 2000). The Indianapolis Study, also known as the study of Social and Psychological Factors Affecting Fertility, was funded by the Scripps Foundation for Research in Population Problems. The Indianapolis Study was rooted in concerns about the low fertility rate of White, married, Protestant women as compared with other ethnic groups (Campbell & Mosher, 2000) and Indianapolis was selected for the study site because of its large population of United States-born, White, Protestant women (Campbell & Mosher, 2000). Concern about the low fertility rate of white, Protestant women signals ideology in alignment with eugenics, a mainstream discourse of the time (Roberts, 2017).

The Indianapolis Study interviewed white, married, Protestant couples about their fertility history and categorized the couples into four groups. “Number and space planned” couples used contraception when they did not want a pregnancy, stopped using contraception to become pregnant, and had no surprises. “Number planned” couples planned their most recent conception but had earlier conceptions that began before or accidentally while contraception was being used. “Quasi planned” couples did not plan their most recent conception but wanted another child. “Excess fertility” couples had one or more pregnancies after their last wanted one (Campbell & Mosher, 2000).

The Indianapolis Study is notable for its narrow focus on white, Protestant, married couples and the exclusion of a large portion of the population. Also notable is that the Indianapolis Study included both mothers and fathers as interview subjects, unlike later measures that focused solely on the mother's perspective on intention (Campbell & Mosher, 2000). Additionally, the Indianapolis study did not account for "mistimed" pregnancies, which are pregnancies that are wanted but at a later time (Campbell & Mosher, 2000).

Changes in measurement over time. Since the Indianapolis Study, other studies have sought to understand attitudes towards childbearing and factors affecting fertility. The Growth of American Families Study in 1955 was rooted in concern about rapid population growth and designed to predict fertility trends (Campbell & Mosher, 2000). Similar to the Indianapolis Study, the Growth of American Families Study interviewed only White, married people about their reproductive behaviors (Campbell & Mosher, 2000). In contrast with the Indianapolis Study, the Growth of American Families Study did not interview husbands and instead asked wives for their interpretation of their husband's opinions (Campbell & Mosher, 2000). In 1960, the Growth of American Families Study was repeated and, for the first time, included interviews with women of color (Campbell & Mosher, 2000).

In the 1965 National Fertility Survey, researchers created the category of "mistimed" to account for those pregnancies or births that happened earlier than intended (Campbell & Mosher, 2000). The National Fertility Survey is also notable in that this study used each pregnancy or birth as the unit of measure. This marked a shift from the earlier focus on fertility history (Campbell & Mosher, 2000).

Current measures of unintended pregnancy. The National Survey of Family Growth (NSFG) began in 1973 and continues today (Centers for Disease Control and Prevention, 2020).

The NSFG is conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics and was originally designed to collect information from ever-married, women ages 15-44 about their reproductive health, including information about contraceptive use, pregnancy, and birth. There have been several notable changes to the NSFG since its inception. In 1982, the NSFG was expanded to include women of all marital statuses. In 1993, the NSFG added a new measure of ambivalence and also included a question measuring the strength of feelings about having children. In 2002, the NSFG was expanded to include a sample of men of the same age. In 2015, the NSFG expanded the age range of people interviewed to include people ages 15-49.

Figure 1 describes verbatim how the questions used to calculate pregnancy intention are asked in the 2017-2019 NSFG. The NSFG also asks each woman about how much she was trying to become pregnant, how happy she was to be pregnant, and her estimation of the father's pregnancy intention.

Figure 1

NSFG Pregnancy Intention Questions (Centers for Disease Control and Prevention, n.d., p. 112)

The next few questions are important. They are about how you felt right before you became pregnant. Right before you became pregnant (with your (NTH) pregnancy which ended in (DATE)/this time), did you yourself want to have a(nother) baby at any time in the future?

Yes; No; Not sure, don't know

[If the respondent answers affirmatively, the following question is asked]

So would you say you became pregnant too soon, at about the right time, or later than you wanted?

Too soon; Right time; Later; Didn't care

The Pregnancy Risk Assessment Monitoring System (PRAMS) is the other national survey used to measure pregnancy intention. Figure 2 describes verbatim how the current PRAMS survey asks the questions used to calculate pregnancy intention.

Figure 2

PRAMS Pregnancy Intention Question (Centers for Disease Control and Prevention, 2016, p. 5)

Thinking back to *just before* you got pregnant with your new baby, how did you feel about becoming pregnant?

I wanted to be pregnant later

I wanted to be pregnant sooner

I wanted to be pregnant then

I didn't want to be pregnant then or at any time in the future

I wasn't sure what I wanted

PRAMS added the “I wasn't sure what I wanted” option in Phase 7 of the questionnaire in 2012. PRAMS also asks about how women felt when they learned that they were pregnant and how their husband or partner felt about them becoming pregnant (Centers for Disease Control and Prevention, 2021). See appendix A for complete PRAMS questions related to unintended pregnancy and contraceptive use.

Calculation of the unintended pregnancy rate. The unintended pregnancy rate is calculated using data from several sources, including the above-mentioned questions. Finer and Zolna (2016) most recently calculated the unintended pregnancy rate in a study published in the *New England Journal of Medicine*. First, they determined the total number of pregnancies, including those that ended in birth, miscarriage, or abortion. For national level birth counts, they obtained the total number of births reported by the National Center for Health Statistics from birth certificate data. To estimate the total number of miscarriages, they used data from the NSFG to determine the ratio of reported miscarriages to births, and then used that ratio

multiplied by the total birth count to determine the population-level miscarriage rate. To estimate the total number of abortions, Finer and Zolna used data from a Guttmacher Institute census of abortion providers and used a similar process as with miscarriages to determine the population-level abortion rate.

Finer and Zolna used the 2009-2013 NSFG to determine the percentage of births and miscarriages that were unintended with the questions described above. The 2009-2013 NSFG included a nationally representative sample of 1975 pregnancies. The percentage of births and miscarriages that resulted from unintended pregnancies were applied to the total number of births and miscarriages. To determine the number of abortions that were unintended, Finer and Zolna used the 2008 Guttmacher Abortion Patient Survey, which included a nationally representative sample of 9493 women who had abortions. The percentage of abortions that resulted from unintended pregnancies were applied to the total number of abortions. Finally, the total number of unintended births, miscarriages, and abortions were summed to arrive at the total number of unintended pregnancies. In the next section, I will describe novel measures of pregnancy preferences that seek to more accurately represent peoples' experiences of pregnancy.

Demographic trends in the unintended pregnancy rate. Finer and Zolna (2014, 2016) described the trends and patterns in the national unintended pregnancy rate from 2001 to 2008 and 2008 to 2011. From 2001 to 2008, they found that the overall rate of pregnancy stayed approximately the same, with a small decrease in the intended pregnancy rate and a small increase in the unintended pregnancy rate. The increase in the unintended pregnancy rate corresponded with an increase in births resulting from unintended pregnancies, which shows a decline in the percentage of unintended pregnancies that ended with abortion.

Finer and Zolna (2014) further analyzed the data for patterns in the unintended pregnancy rate by demographics. They found that cohabitating women had higher unintended pregnancy rates compared with married women and that non-Hispanic Black women and Hispanic women had higher unintended pregnancy rates across all income levels compared with non-Hispanic white women. They found that non-Hispanic Black women with low incomes had the highest rates of unintended pregnancy of all women.

Finer and Zolna (2014) suggested the increase in unintended pregnancies may have been related to the economic recession which began in 2007. They theorized women might have been more likely to report their pregnancies as unintended because of economic insecurity. Finer and Zolna also considered a cultural shift towards later marriage and childbearing and lower fertility preferences may have contributed to the higher unintended pregnancy rate, as women spend more time avoiding pregnancy before bearing children and therefore have more opportunities to become pregnant unintentionally.

More recently, Finer and Zolna (2016) described national unintended pregnancy trends and patterns from 2008-2011. They found the unintended pregnancy rate decreased from a rate of 51% in 2008 to 45% in 2011. Further analysis by population subgroup showed cohabitating women had more than four times the rate of unintended pregnancy compared with married women in 2011. Lower incomes, particularly incomes below the federal poverty level, and people with lower formal educational attainment were both associated with higher rates of unintended pregnancy. Non-Hispanic Black women again had the highest rates of unintended pregnancy, followed by Hispanic women, and finally White women.

State-level trends in the unintended pregnancy rate. Finer and Kost (2011) estimated the unintended pregnancy rate by state using data from PRAMS and other similar state data

sources. Using data from 2006, Finer and Kost estimated the median state unintended pregnancy rate was 51 per 1,000 women aged 15-44. They found most states fell between 40-65 unintended pregnancies per 1,000 women. Oregon was estimated to have 47 unintended pregnancies per 1,000 women. In their discussion, Finer and Kost (2011) theorized that both state-level demographics and family planning policies may have influenced the state-level unintended pregnancy rate.

Kost et al. (2012) built on Finer and Kost's estimation of the state-level unintended pregnancy rate. Kost and colleagues used regression analysis to examine the relationship between the state-level unintended pregnancy rate and state-level characteristics from aggregated data, including demographics, socioeconomic status, contraceptive use patterns, and family planning services. The authors found although states with higher proportions of Black and Hispanic women had higher rates of unintended pregnancy, these differences were accounted for by age, marital status, proportion without health insurance, and proportion on Medicaid insurance. Kost and colleagues (2012) found that the proportion of women without health insurance and the proportion of women on Medicaid insurance were strongly associated with the state-level unintended pregnancy rate. The authors found the proportion of women without health insurance was associated with a higher unintended pregnancy rate, while the proportion of women on Medicaid insurance was associated with a lower unintended pregnancy rate. These findings suggest that health insurance status may play an important role in the unintended pregnancy rate.

Novel measures of pregnancy preferences. In response to limitations of the traditional way that pregnancy intention has been measured and calculated, researchers have proposed novel measures of pregnancy preferences. For example, Rocca et al. (2019) created the Desire to Avoid

Pregnancy (DAP) Scale, which is a prospective measure of pregnancy desire. The researchers created the DAP Scale in response to limitations such as retrospective measurement, limited categories, and the assumption that all people plan pregnancies.

Kemet et al. (2018) noted limitations to traditional measures of unintended pregnancy may be particularly relevant for Black and Hispanic women, citing research that found weak associations between unintended pregnancy and poor outcomes for these racialized groups. Therefore, these researchers aimed to address these criticisms with a novel strategy for measuring pregnancy perspectives during the pregnancy, rather than waiting until after the birth. Kemet and colleagues surveyed 161 women with pregnancies at less than 24 weeks gestation about the multidimensional aspects of their pregnancy context. The survey included context measures of pre-pregnancy perspective, including intention, wantedness, and planning, and measures of post-conception perspective, including timing, desirability, and happiness. Researchers placed measures of pregnancy context in one of three categories- favorable, ambivalent/neutral, or unfavorable perceptions.

Potential confounding demographic factors exist that could have confounded the relationship between race and pregnancy context. These demographic factors included:

“maternal age, gestational age, language that the study was conducted in (English or Spanish), level of educational attainment, employment status, relationship status, maternal health condition (e.g., depression, substance use), reproductive history (parity, previous miscarriage, and previous abortion), plans for the current pregnancy (abortion, adoption, parenthood) and study site (pregnancy testing or abortion clinic).” (Kemet et al., 2018, p. 314)

Kemet and colleagues (2018) used multivariable logistic regression and “found that neither race nor ethnicity was significantly associated with pregnancy intention, wantedness, planning, timing, or desirability after adjustment” (p. 315). The authors theorized the contradictory conclusions of prior work were due to methodological limitations commonly found in this body of research such as retrospective assessment of pregnancy intentions, exclusion of women whose pregnancies ended in miscarriage or abortions, and failure to account for confounding variables.

Unintended Pregnancy and Outcomes

Unintended pregnancy and fiscal outcomes. Research has examined the association of unintended pregnancy with financial outcomes such as public expenditures for births. Sonfield and Kost (2013) estimated the public expenditures on unintended pregnancy in the US to be \$21.0 billion in 2010. The authors noted 51% of US births were covered by public health insurance in 2010, and 68% of those births were unintended. Sonfield and Kost (2013) concluded the “substantial cost” of unintended pregnancies could be averted if “women and couples could be empowered to prevent these unintended pregnancies” (p. 15). They also estimated current support of family planning programs helped to prevent \$15.8 billion in costs related to unintended pregnancies in 2010.

Unintended pregnancy and health outcomes. In 1995, the Institute of Medicine (IOM) published *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* (Brown & Eisenberg, 1995). This report included a chapter entitled “Consequences of unintended pregnancy.” The authors synthesized research that examined the effect of pregnancy intention on health outcomes for children and parents. The report included a two-fold critique of the conceptualization and measurement of unintended pregnancy. First, the IOM report described

methodological challenges related to the accurate description of parental intention at the time of conception. For instance, the NSFG asked women about their pregnancy intentions months or years after the experience. Second, the IOM report described how researchers classified intention statuses differently across studies, making it difficult to synthesize the research. Despite these critiques, the authors of the IOM report concluded that unintended pregnancy was associated with negative health outcomes including insufficient participation in prenatal care, low birthweight, and consuming alcohol and nicotine during pregnancy (Brown & Eisenberg, 1995).

More recently, Cheng et al. (2009) used logistic regression to determine the relationship between unintended pregnancy and maternal behaviors. Cheng and colleagues used data from PRAMS, which surveyed a stratified random sample of 9048 mothers 2-9 months after they gave birth to a live infant between 2001 and 2006. The socio-demographic factors controlled for in their model included maternal age, race/ethnicity, Medicaid status, parity, marital status, and educational level. Cheng and colleagues placed women in one of three categories of pregnancy intention: intended (wanted now or earlier), mistimed (wanted, but later), and unwanted (not wanted at any time).

Overall, Cheng and colleagues found that unwanted and mistimed pregnancies were associated with unhealthy behaviors and negative outcomes. Specifically, study authors found women with unwanted pregnancy were more likely to consume inadequate folic acid, more likely to smoke cigarettes both before and after giving birth, and more likely to report postpartum depression than women with intended pregnancy. Further, women with unwanted pregnancy were less likely to have prenatal care during the first trimester and less likely to breastfeed past eight weeks compared to women with intended pregnancy. Finally, women with mistimed pregnancy were more likely to consume inadequate folic acid, delay prenatal care, and report

postpartum depression compared to women with intended pregnancy. However, the authors also found that women with mistimed or unwanted births were as likely as women with intended births to initiate breastfeeding, place their infant on their back to sleep, and use postpartum contraception. Considering these results, Cheng and colleagues (2009) observed, “the question of whether mistimed or unwanted pregnancies result in poor birth outcomes remains unanswered” (p. 197).

Critique of association of unintended pregnancy and health outcomes. In one of the more recent reviews on the effect of unintended pregnancy and health outcomes, Gipson and colleagues (2008) questioned the assumptions underpinning the conceptualization and measurement of unintended pregnancy, and were critical of the associations and causal links drawn between unintended pregnancy and many negative health outcomes. Most studies linking unintended pregnancy with poor outcomes have been cross-sectional, precluding researchers from drawing causal inferences about pregnancy intention and pregnancy outcomes (Gipson et al., 2008).

More recently, Kost and Lindberg (2015) investigated the relationship between pregnancy intention, maternal behaviors, and infant health. Citing the mixed evidence linking pregnancy intention with health outcomes, Kost and Lindberg theorized the conventional style of measurement and analysis of pregnancy intention may have contributed to the mixed results found in this body of research. The authors noted even studies using three pregnancy intention categories—intended, mistimed, and unwanted- have failed to account for the extent of the mistiming. This is important because research has shown a pregnancy mistimed by more than two years is distinct from a pregnancy mistimed by less than two years (Santelli, 2009).

Kost and Lindberg (2015) experimented with two new ways of measuring pregnancy intention to capture important variations in both wantedness and timing. For the first new way of measuring pregnancy intention, Kost and Lindberg started with conventional data from the National Survey of Family Growth then incorporated a measure of how mistimed the pregnancy was. Kost and Lindberg (2015) expanded on the conventional intention status categories to include four categories: “(1) wanted at that time or sooner, (2) mistimed by less than two years, (3) mistimed by two or more years, and (4) unwanted at any time” (p. 85). For the second new way of measuring pregnancy intention, they used a scale that measured pregnancy desirability rather than intention.

In their analysis, Kost and Lindberg used inverse propensity weights, a variation of propensity score analysis, to account for the complex factors influencing the probability of a woman being in one intention status group. Propensity scores are used as a balancing score to equalize the probability that a person was in a particular group (Austin, 2011). Researchers use propensity scores when studying a phenomenon in which a person may be more or less likely to receive a “treatment” based on their measured baseline characteristics. Propensity score analysis can increase the confidence that an observed “treatment” was the cause of an effect (Austin, 2011).

Kost and Lindberg used multinomial logistic regression to estimate the propensity scores used for weighting. Based on findings from previous research, the authors included factors such as demographic and socioeconomic factors in their regression model. Examples of these factors include age of the mother at conception and maternal union status at conception. Kost and Lindberg included all factors that potentially could affect intention status, even if the factor was

not significant in the regression model. Kost and Lindberg calculated a standardized bias to assess their propensity score estimation process.

Kost and Lindberg found several of the previously noted associations between unintended pregnancy and worse maternal/child outcomes were non-significant while others were. Significant findings were: 1) mistimed and unwanted births were still less likely to be recognized by mothers early in pregnancy than intended ones, 2) fewer unwanted births received early prenatal care or were breast-fed, and 3) unwanted births were also more likely than intended births to be of low birth weight. Additionally, in comparison with births at the highest level of the desire scale, all other levels of birth desire were significantly less likely to be recognized early in pregnancy and to receive early prenatal care. In the discussion of their results, Kost and Lindberg (2015) cautioned that public health research into the effects of pregnancy intention on health may not correctly account for the interaction of background characteristics with intention status, making claims about associations questionable.

Influence of structural factors on outcomes. Wise et al. (2017) reconsidered the common interpretation that women with less education have higher rates of unintended pregnancy because of a lack of knowledge or self-efficacy. In this study, researchers used multivariate regression to test whether early life educational advantage predicted unintended first birth. Educational advantage was measured with an educational advantage index made up of individual, household, and school characteristics shown to be predictive of college attainment. Data was collected from the 1979–1994 National Longitudinal Survey of Youth and analyzed a sub-sample of 3062 mothers. The authors hypothesized that women with early life educational advantage would be more likely to view their pregnancy as unintended compared with women with less early life educational advantage.

Similar to previous studies, Wise and colleagues found that early life educational advantage was associated with lower odds of having a first birth classified as unintended in their unadjusted model. However, when the model controlled for maternal race, the association was attenuated. Further, once the authors controlled for maternal race and age, the association flipped and the model showed early life educational advantage was associated with greater odds of reporting a mistimed first birth. Their findings suggest the concept of an unintended pregnancy is a cultural construction imposed on certain groups of women and that the structural factor of early life educational advantage influenced how women perceive the timing of their pregnancy or birth. Wise and colleagues (2017) concluded, “a birth is mistimed only relative to fertility-timing norms that themselves vary with overall structural advantage and race in the United States” (p. 10). In other words, educational inequities may condition how a woman classifies her pregnancy and whether it is interpreted as unintended.

Reproductive Justice scholars, Ross and Solinger (2017), have suggested ignoring or denying a pregnant woman’s context generates a premise that blames individuals for their supposed incorrect choices rather than naming and addressing the systemic causes of health inequities. Further, Bowleg (2017) explained:

willful ignorance is functional... Neglecting the historical legacy of how race (as well as the other marginalized social positions that intersect with race) has structured social inequality for people of color in the United States serves to center the health experiences of White people as normative, ‘color blinds’ White privilege to highlight positive health outcomes among White people as the product of their individual actions, and reifies negative stereotypes about the ‘irresponsible’ health behaviors of people of color. (p. 678)

Public health discourse has attributed the cause of the higher rate of unintended pregnancy among those with socioeconomic disadvantage to poor planning, low self-efficacy, or a lack of education. This, in turn, has obscured social inequality and systems that norm the White experience while casting the pregnancies of women of color, women of lower socioeconomic status, and women with lower formal educational attainment as deviant.

Summary

This section has examined the unintended pregnancy discourse including its origin, conceptualization, meaning, measurement, trends, and criticisms. An examination of the unintended pregnancy discourse was necessary to reveal the complexities underpinning the construction of unintended pregnancy, the problem Oregon policymakers designed the ECU metric to solve. This examination shows that the current conceptualization of unintended pregnancy as a problem ignores the influence of the broader social context while focusing on the intent of the individual. Ignoring the broader context blames people of lower socioeconomic status, a racialized, gendered, and classed group, for poor planning or lack of education. This, in turn, diverts attention away from the social contexts of poverty, racism, and classism. The deep and nuanced understanding of the construction of unintended pregnancy as a problem will serve as a foundation with which to analyze the ECU metric.

Effective Contraception Discourse

This section will focus on the discourse around effective contraception, particularly on the promotion of methods that are moderately or highly effective with typical use. In discussions of the promotion of specific contraceptives, one controversial issue has been reproductive autonomy. On the one hand, proponents of promoting specific methods argue people are free to choose their preferred method, and that increasing usage rates of highly effective contraception

will reduce unintended pregnancy, improve health, and save money (Northridge & Coupey, 2015; Rodriguez et al., 2014). On the other hand, critics have raised concerns that promoting specific methods ignores biased contraceptive counseling and other reproductive injustices towards women of color and women of lower socioeconomic status (Gubrium et al., 2016; Higgins, 2014), does not account for other aspects of contraception that matter to people (Alspaugh et al., 2020; Berglas et al., 2021), and constrains choice (Brian et al., 2020; Gomez et al., 2014; Mann & Grzanka, 2018; Senderowicz et al., 2021).

This section will explore the discourse around effective contraception. I will first outline how the mainstream medical establishment understands and describes effectiveness, then give an example of how contraceptives are commonly categorized by effectiveness. Finally, I will introduce other aspects of contraception that are important to people and why a person might choose a method that is less effective with typical use.

Contraceptive Effectiveness

How mainstream medicine describes effectiveness. Trussel and Aiken (2018) described the effectiveness of different contraceptive methods as the probability of pregnancy in one year for typical use and perfect use. Typical use is defined as “how effective methods are for the average person who does not always use methods correctly or consistently” (Trussell & Aiken, 2018, p. 829). Perfect use is defined as “how effective methods can be in preventing pregnancy when used *consistently and correctly* according to instructions (Trussell & Aiken, 2018, p. 829, italics in original). Trussel and Aiken (2018) described these probabilities as the percentage of women using the method predicted to experience unintended pregnancy in one year (see Table 2).

Table 2

Example of How Contraceptive Method Effectiveness is Described (Trussell & Aiken, 2018)

	Percentage of women who will become pregnant in one year	
Method	Typical Use	Perfect Use
Withdrawal	20	4
Implant (Nexplanon)	0.1	0.1

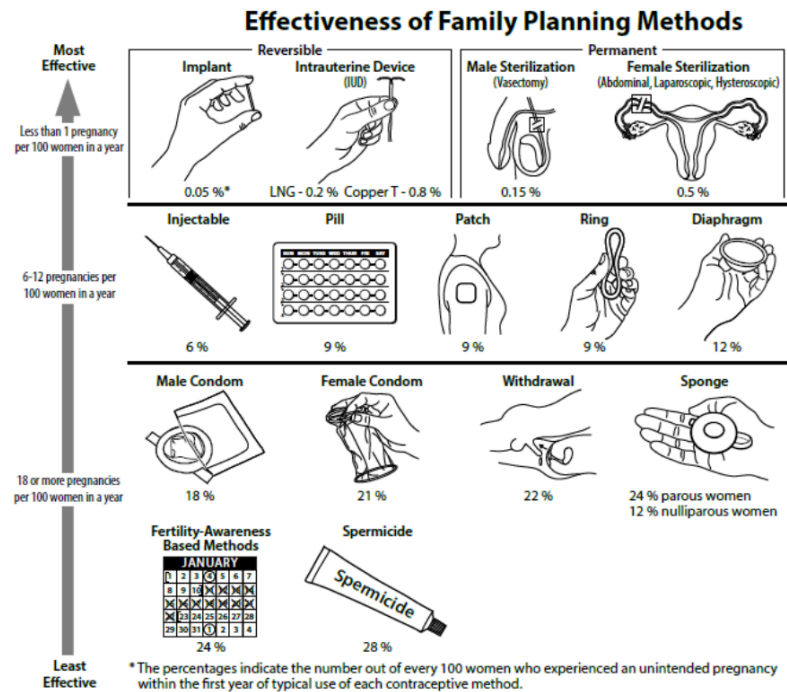
Contraceptive methods that require action at each heterosexual intercourse event on the part of the users, like withdrawal, tend to have more variability between typical and perfect use. In contrast, methods that do not require action at each heterosexual intercourse, like the contraceptive implant, have less variability (Trussell & Aiken, 2018). Trussell et al. (2018) added more published research exists on methods that are sold, like the contraceptive implant, because companies must prove their effectiveness in clinical trials. On the other hand, Trussell et al. (2018) state that methods that are not sold and cost nothing to use, like withdrawal, have less published research “because there is no financial reward for investigating this method” (p. 108).

Categorization of contraceptives by effectiveness. Patient education about contraception provided by health care providers commonly draws on charts, which rank different methods by effectiveness. The ECU metric Guidance Document (2014) used a chart based on a World Health Organization chart that categorizes contraception this same way using a tier system (see Figure 3). Sterilization and LARCs were tier 1. Methods involving injection, pill, patch, ring, and diaphragm were tier 2. Tier 3 methods included condoms, withdrawal, sponges, fertility awareness, and spermicide. The ECU metric financially incentivized healthcare providers to prescribe contraceptive methods from tier 1 and 2 but not tier 3.

Figure 3

Image of Contraceptive Methods Chart from ECU Guidance Document

Typical Effectiveness of Food and Drug Administrative (FDA)-approved Contraceptive Methods



Adapted from WHO's Family Planning: A Global Hand book for Providers (2001) and Trussell et al (2011).

(OHA, 2014, p. 10)

Beyond Contraceptive Effectiveness

Effectiveness is an important aspect of a contraceptive method because if a method did not work, it would not be useful. There is evidence that contraceptive effectiveness is important information for women during decision-making about preventing pregnancy (Donnelly et al., 2014). However, a singular focus on effectiveness may ignore other aspects of contraception that are important to people. For example, the route of administration, level of user control, and whether a method contains hormones or influences sexual pleasure are all considerations that may shape preferences (Dehlendorf et al., 2014; Fox et al., 2018; Gomez & Clark, 2014; Higgins

& Smith, 2016). Further, people may have a traumatic relationship with specific forms of contraception because of historical reproductive oppression and violence like sterilization abuse, non-consensual contraceptive experimentation, and contraceptive coercion (Roberts, 2017). The following studies illustrate aspects of contraception that are important to people and illuminate why a person might choose a less effective contraceptive method.

Berglas and colleagues (2021) interviewed young women about why they chose less effective contraceptive methods. The study interviewed 22 women 15-25 years old who had accessed emergency contraception at family planning clinics. The clinics mainly served Latinx and African American communities in the San Francisco Bay Area. Berglas et al. (2021) found women in the study had used a mix of low, moderate, and highly effective contraceptive methods in the past. Participants' decided to use less effective methods out of a desire to be flexible and spontaneous with contraception, rather than rely on a continuous method. The authors also found women said they wanted to "protect" their bodies and were satisfied with their chosen method's effectiveness at preventing pregnancy. Finally, Berglas and colleagues found some women used a combination of contraceptive methods to reduce their risk of pregnancy. These findings suggest the participants' choice to use a less effective contraceptive method was based on personal preferences and needs.

Higgins and Smith (2016) conducted a narrative literature review on the sexual acceptability of contraception. The authors included 264 citations on the sexual aspects of contraception to construct a model that included macro-level factors of gender, social inequality, culture, and structure; relationship factors of dyadic influences and partner preferences; and individual factors including, for example, sexual functioning, pleasure, the sexual side effects, sexual identity, and pregnancy intention. Higgins and Smith then applied the model to 103

citations on the sexual acceptability of individual methods. The authors found contraception affects women's sexuality in positive and negative ways. While most literature focused on sexual functioning, Higgins and Smith suggested including a wider range of factors and addressing sexual acceptability could improve sexual well-being and promote user-friendly contraceptive practices. These findings suggest that sexual acceptability is a factor in the selection of contraceptive method.

Gomez and Clark (2014) conducted an exploratory analysis on the relationship between young women's preferences of contraceptive features and their interest in using an IUD. The study used an internet survey with 382 heterosexual women aged 18-29. The authors used chi-squared tests and logistic regression models to model the relationship between contraceptive preferences and interest in IUD. Gomez and Clark found preferences positively associated with interest in IUD were that the method did not interfere with sexual pleasure, was 99% effective without user action, or was 99% effective for five years without user action. Alternately, the authors found preferences that were negatively associated with interest in IUD were that the method was visible or that the method would allow them to resume fertility immediately after stopping use. These findings suggest that young women have a variety of preferences for contraceptive features that may influence their interest in IUD. Based on these findings, Gomez and Clark (2014) suggested women's preferences for contraception features, including but not limited to effectiveness, be integrated into contraceptive counseling.

Alspaugh et al. (2020) conducted a feminist post-structuralist review of the qualitative literature on women's and female-assigned-at-birth trans men's perspectives, beliefs, and attitudes towards contraception. The review included primary qualitative research conducted in the English language in the United States that studied peoples' perspectives on contraception.

The authors reviewed 19 studies with over 700 women and 39 trans men. The studies included people of a variety of races, primary languages, socioeconomic statuses, educational, and religious backgrounds. Alspaugh and colleagues (2020) found that discourses around gender norms, motherhood, pregnancy timing, and femininity influenced perspectives, beliefs, and attitudes towards contraception.

Alspaugh and colleagues also found the interplay of power between study participants and their sexual partners, as well as their health care providers, influenced contraception preferences. The review found many people in the considered studies preferred methods without hormones that were under their control. This finding may reflect that not many people in the considered studies used long-acting methods. Finally, the review suggested people perceive some types of contraception as being less safe than widely accepted scientific data have shown, and suggested further research is needed to understand and close this gap. The findings from this review suggest that gender roles and power dynamics influenced perceptions of contraception.

In total, these studies show there are aspects of contraception beyond effectiveness that are important to people, including: the ability to be spontaneous, the sexual acceptability of a method, the amount of user action a method requires, and the amount of control a user has over a method. Further, gender roles and power dynamics influence the perception of contraception and decision-making.

Summary

This section focused on the discourse of effective contraception, including descriptions of effectiveness and categorization of methods, and other aspects of contraception important to people besides effectiveness. A common argument from those defending the promotion of more effective methods is that people are free to choose. Critics of promoting specific methods suggest

otherwise. For example, despite the validity and importance of considering the complex aspects of contraception, studies show clinicians may dismiss patient concerns regarding side effects, and devalue or deemphasize tier 3 methods. The next section describes power relations in the contraceptive counseling visit to develop an understanding of the interpersonal and structural forces that may constrain contraceptive autonomy, especially for people with intersecting, subjugated social statuses, such as those with Medicaid health insurance.

Power Relations in the Contraceptive Counseling Visit

Van Dijk described how clinicians enact power by controlling the context of the clinic event; therefore the contraceptive counseling visit is not a neutral space (1993). Policy, social forces, and clinician and patient behavior intersect to form complex power relations around the contraceptive counseling visit and the contraceptive decision. In this section, I will first describe how the power over many forms of contraception came to be in the hands of clinicians with prescriptive authority. Second, I describe clinician behavior in the contraceptive counseling visit. Finally, I describe the evidence of contraceptive coercion at both the clinician and policy level.

Clinician Authority over Contraception

Clinicians have been involved in contraceptive access since the early 20th century. Prior to this time, people have been contracepting since ancient times (Tone, 2001). To understand how authority over some forms of contraception came to be in the hands of clinicians, it is necessary to consider a brief, recent history of contraception in the United States.

Early contraceptive practices in the United States. In a book on the history of the contraceptive market, Tone (2001) described how in the pre-industrial United States, people used techniques like prolonged lactation and male withdrawal, made their own vaginal suppositories and douching solutions out of common household ingredients, and purchased or made condoms

from linen or animal intestines. Also popular were abortifacients, which are compounds taken orally that induce miscarriage. Abortifacients can be made from many plants that grow wild; for example, pennyroyal (Tone, 2001).

Industrialization changed many aspects of life in the United States, including contraception, as people increasingly turned to the market to purchase contraceptive devices and compounds. The discovery of the vulcanization of rubber in 1839 revolutionized the manufacture of devices like condoms, intrauterine devices, diaphragms, and cervical caps. People purchased these devices, along with other contraceptives like commercially-prepared vaginal douches and abortifacients, by mail-order, from pharmacies, and from dry-goods or rubber merchants. Tone (2001) suggested the proliferation of advertisements for contraceptives, along with their proximity to sex-related items like dildos and printed pornography contributed to contraception being linked to the “vice trade” and becoming a target for anti-obscenity activists.

Anti-obscenity legislation. The United States congress passed the first anti-obscenity legislation in 1842, targeting imported printed pornography (Tone, 2001). Over the next 30 years, congress passed more laws targeting domestic printed pornography sent through the mail. In 1873, congress passed the Comstock Law, which expanded previous legislation in part by adding more “obscenities” to the forbidden list. This was the first time legislators named contraception an “obscenity” because Comstock, who Tone (2001) described as an anti-obscenity crusader, believed that “artificial” contraception could lead to immoral behavior. This legislation made it a crime to send contraceptive information, advertisements, or devices through the mail. Despite criminalization, the contraceptive market persisted, and few contraceptive makers, sellers, or buyers were prosecuted under the new law. Criminalization would, however, lay the groundwork

for clinician authority over contraception and the current paradigm of medicalized birth control (Tone, 2001).

The legalization of birth control. In the early 20th century, a home health nurse named Margaret Sanger, encountered poor, immigrant women suffering from unsafe abortion, contraception, and childbirth (Sanger, 2003). Sanger was determined to create contraceptive access for women, so she opened an illegal birth control clinic and lobbied the government to legalize birth control (Sanger, 2003). Sanger partnered with physicians, “to keep the movement strictly and sanely under medical auspices” as a tactic to gain legitimacy for contraception and keep the birth control movement middle-class and respectable (Sanger as quoted in Tone, 2001, p. 117). Physicians supervised the birth control clinics which focused on physician-fitted diaphragms with jelly, and Sanger lobbied the American Medical Association to rescind its ban on contraception (Tone, 2001) In 1936, the Supreme Court ruled that physicians could receive contraceptives by mail, and in 1937, the American Medical Association endorsed birth control (Tone, 2001).

Sanger also participated in the development of the birth control pill through fundraising and coalition-building with different groups. This included partnering with eugenicists, a popular pseudo-scientific movement in the United States at the time (Sanger, 2003). Sanger espoused ideologies in line with eugenic ideology when she wrote that society could be improved if those “unfit” to be parents had a way to reduce child-bearing (Sanger, 2003). Those considered by eugenicists to be “unfit” to be parents included people of color, people with disabilities, people with mental health issues, and queer people (Roberts, 2017).

Birth control pills by prescription. The Food and Drug Administration (FDA) approved the first birth control pill in 1950, not for contraceptive purposes, but to treat menstrual disorders

(Roberts, 2017). A few years later, the FDA approved the birth control pill for use as a contraceptive, but only for women who were legally married. In 1970, the FDA approved use of birth control pills for all women, regardless of marital status (Roberts, 2017). However, women needed to obtain a prescription for birth control pills from a physician with prescriptive authority.

Modern hormonal birth control may have significant side effects, like blood clots.¹³ Therefore, it is important for women to be screened to ensure it is safe for them to use modern hormonal birth control, and to ensure women understand the risks of the contraceptive method they use. Further, some contraceptive methods, like IUDs, the hormonal implant, and sterilization, require specialized knowledge and tools to complete the procedures and monitor women for safety concerns. There are many reasons why clinicians should be involved in contraceptive counseling for women. However, it is also important to remember the clinician-patient relationship is not neutral and complex power relations exist in which clinicians hold formalized power over patients' access to many forms of contraception.

Clinician Behavior in the Contraceptive Counseling Visit

In this section, I describe clinician behavior in the contraceptive counseling visit. This includes a description of tiered-effectiveness contraceptive counseling, in which tier 1 methods are offered first. Next, I consider how clinicians construct risk and uncertainty in the contraceptive counseling visit, and how clinicians may disregard patient concerns about side effects. Finally, I explore what is known about clinician behavior patterns along lines of gender, race, and class.

Tiered-effectiveness counseling. In an opinion piece, Brandi and Fuentes (2020) described and critiqued the practice of tiered effectiveness contraceptive counseling. Tiered-

¹³In 1970, the United States Senate held hearings on the hazards of oral contraceptives. This eventually resulted in a decrease of the amount of hormone put into oral contraceptives.

effectiveness contraceptive counseling means healthcare providers discuss the most effective methods first, and only discuss Tier 3 methods if the patient asks about them. Brandi and Fuentes (2020) described how prominent professional organizations, including the World Health Organization, Centers for Disease Control and Prevention, American College of Obstetrics and Gynecologists, and the American Academy of Pediatricians, have recommended tiered-effectiveness contraceptive counseling as best practice. This type of counseling is sometimes referred to as “LARCS first,” because LARC methods are discussed first in the contraceptive counseling visit.

Although these professional organizations remind clinicians about the importance of patient choice, they do not include guidance about how to behave when the promotion of specific methods conflicts with patient choice (Brandi & Fuentes, 2020). This issue of patient autonomy is an especially salient concern for women with Medicaid insurance who may have other intersecting, oppressed social locations (Gomez et al., 2014; Ross, 2017b). Brandi and Fuentes (2020) warned the effort to increase uptake of highly effective contraception can compromise patient autonomy

Senderowicz and colleagues (2021) investigated the quality of contraceptive counseling at five Tanzanian hospitals using a LARCS-first approach. This study interviewed 20 pregnant women seeking antenatal care. Senderowicz and colleagues found women reported that providers emphasized the benefits of IUDs, counseled them only about the IUD, and de-emphasized or disparaged other contraceptive methods. Findings from this study show that although tiered-effectiveness strategies may increase IUD uptake, they also may decrease access to person-centered contraceptive care and block access to evidence-based information about other contraceptive methods.

The construction of risk and uncertainty. Littlejohn and Kimport (2017) analyzed 102 recorded contraceptive counseling visits to understand how healthcare providers discursively constructed the risks associated with pregnancy and birth control. They found that many healthcare providers “differentially construct uncertainty” by suggesting to patients that negative side effects of birth control are unlikely and positive effects are likely. Further, they found many healthcare providers “contest uncertainty” by suggesting to patients that the potential serious side effects from birth control are controllable. Strikingly, in almost half of the analyzed visits, healthcare providers did not discuss serious side effects with patients. These findings reflect the social nature of the contraceptive counseling visit, and that medical knowledge does not exist objectively. Rather, healthcare providers may have a specific goal for the interaction and frame medical knowledge in support of their goals. Littlejohn and Kimport (2017) suggested the way healthcare providers construct the risk of side effects in a contraceptive counseling visit may be influenced by their focus on reducing unintended pregnancy and normative understandings of an “on-time” pregnancy.

Clinician attitudes about patient concerns. In further research into how clinicians may downplay side effects, Stevens (2018) interviewed 24 reproductive healthcare providers about their attitudes towards common complaints with hormonal birth control. Stevens (2018) found providers viewed patient concerns about non-life-threatening side effects as myths or misconceptions, and considered the embodied experiences of patients as unreliable. Although misinformation about contraception exists and clinicians may be a valuable source of factual information, Stevens (2018) suggested dismissal of patient concerns may contribute to an adversarial relationship. Further, some aspects of contraception patients found undesirable, like menstrual suppression, were considered to be “cultural superstition” by some clinicians (Stevens,

2018, p. 149). Stevens (2018) also found that providers considered negative side effects to be a normal part of contraception, and many clinicians reported urging patients with side effects to “stick with” methods they were dissatisfied with (p. 148).

Finally, Stevens (2018) considered provider attitudes along lines of race and class and found that providers constructed two types of racialized and classed patient who reject hormonal contraception. The first patient is ignorant of medical knowledge, ambivalent about pregnancy, of lower socioeconomic class, and Latina or African American. The second is highly educated and concerned with hormones being unnatural. While providers did not explicitly refer to race for this second patient type, they referred to the person being of higher socioeconomic status. Stevens’ (2018) findings suggest women’s experiences may be disregarded by reproductive healthcare providers, and women of marginalized social statuses are especially susceptible to this treatment. In the next section, I will explore the literature on clinician counseling and prescribing patterns along lines of different social statuses including gender, race, and class.

Clinician behavior patterns along lines of gender, race, and class. Social location influences the power relations between clinicians and patients insured by Medicaid. Clinicians hold power because they are likely to have intersecting dominant social statuses, such as being White, having a high level of formal education, or being from middle to upper class backgrounds. Clinicians also control the clinic space where the contraceptive counseling visit takes place, have power over when and where the visit occurs, and hold knowledge and skills about different contraceptive methods. In contrast, a person with Medicaid insurance by definition has a lower income, and is more likely to have intersecting subjugated social statuses, such as being a person of color, from a lower class background, not speaking English, and having less formal education (Medicaid and CHIP Payment and Access Commission, 2020).

Most research into clinician behavior during contraception counseling has focused on how clinicians counsel women. As noted in Chapter 1, I recognize sexual reproduction requires both a male and female component, and that contraception is within the purview of all fertile people who engage in heterosexual intercourse. However, because the ECU metric focused on increasing use of specific contraceptives in women, this section will explore the literature about clinician behavior during contraceptive counseling with female patients. I begin with a consideration of how clinician behavior may reinforce the conceptualization of contraception as a gendered phenomenon.

Along lines of gender. In the United States, contraceptive counseling is a gendered phenomenon in that contraception is often considered the responsibility of women and something that happens within women's bodies (Manzer & Bell, 2021). Kimport (2018) discussed the feminization of contraception in Western societies and considered how clinician behavior during contraceptive counseling may reinforce this process. Kimport (2018) examined transcripts from 101 recorded contraceptive counseling visits to describe how clinicians counseled female patients about male body-based contraceptives. The study found that clinicians devalued male body-based contraceptives by not considering these methods to be long-term contraception and by emphasizing the presumed negative aspects of these methods. Kimport (2018) stated, "these discursive patterns contribute to the feminization of responsibility for contraception and the retrenchment of the unequal gendered division of fertility work" (p. 1). Similarly, by only counting female body-based contraceptive methods, the ECU metric may have contributed to this discursive pattern, and therefore reinforced this division of fertility work.

Along lines of race and class. Studies into clinician behavior along lines of race and class have explored women's experiences of racism and classism (Gomez & Wapman, 2017;

Higgins et al., 2016; Thorburn & Bogart, 2005), clinician behavior in an experimental setting (Dehlendorf et al., 2010), and how clinicians navigate and minimize bias (Manzer & Bell, 2021). From these studies, the overall pattern that emerged is that women of color and women of lower social class may experience clinician behavior as discriminatory, and that clinicians may counsel patients differently along lines of race and class.

Women's experiences of racism and classism. Thorburn and Bogart (2005) investigated the frequency of African American women's experiences of "race-based discrimination" with family planning or contraceptive services, and whether the frequency varied with socio-demographic or reproductive health factors. They conducted phone surveys with a random sample of 326 United States-born, African American women aged 15-44 and asked about nine specific "race-based discrimination" experiences when accessing family planning services. They found that 79% of participants had used family planning services and that 67% of these participants had at least one of the race-based discrimination experiences. Thorburn and colleagues also considered whether the frequency of experiences of race-based discrimination varied by other socio-demographic factors¹⁴ or reproductive or sexual health factors.¹⁵ The only pattern they found was that African American women with lower incomes reported greater frequency of race-based discrimination, suggesting that the intersection of race and class played a role in clinician behavior.

Higgins et al. (2016) used a modified grounded theory approach to explore contraceptive-user perspectives on healthcare provider influence and bias related to LARC recommendations. The researchers conducted focus groups and interviews with 50 women aged 18-29 years old from different socioeconomic statuses. One-third of participants were university students, and

¹⁴ Marital status, education level, income level, religiosity, and employment status

¹⁵ Number of live births, sexual activity, sexually transmitted disease history, HIV testing history

two-thirds of participants were women on public assistance. Thirty-two participants identified as White, while 18 identified as Black, Latina, Asian, Native American, or biracial.

Higgins and colleagues found many participants considered clinicians a trusted source of information when considering a LARC method, with a higher proportion of White participants voicing trust than participants of color. Higgins and colleagues also found clinicians did not always heed participants' preferences for contraceptive method and minimized participants' experiences of side effects. Participants also identified the potential for racial and class bias on the part of clinicians in the recommendation of IUDs, linking historical injustice to current clinician behavior. The women of color in this study described how their awareness of these injustices in their communities made them wary of clinician recommendations for LARCs.

Gomez and Wapman (2017) sought to understand how young Black and Latina women experienced pressure from clinicians during contraceptive counseling. The researchers interviewed 38 women aged 18-24 as part of a larger study and then analyzed a subsample of 27 women who described experiences of pressure from clinicians. Gomez and Wapman (2017) found the pressure the women experienced was subtle, and therefore named the phenomenon *implicit pressure* because of the "under-the surface nature" of the experiences (p. 223). Participants described experiencing implicit pressure when clinicians preferred specific methods. Clinician preference was signaled by the selection of information provided, clinician tone of voice and affect, and de-emphasis or omission of information about potential side effects. Importantly, Gomez and Wapman found the experiences of implicit pressure could have an impact over time in that participants developed suspicion and mistrust of the healthcare system. Several women in the study described reluctance to access formal healthcare and reluctance around subsequent prescription contraceptive use.

Clinician behavior in an experimental setting. Dehlendorf et al. (2010) investigated how clinician recommendations for the hormonal IUD and perceptions of the patient varied by patient race/ethnicity and socioeconomic status. Dehlendorf et al. created 18 videos in which actors portrayed patients, and delivered a monologue inquiring about contraception. The actor/patients varied by race (Black, Latina, and White) and high/low socioeconomic status as signaled by dress and accent; actors delivered a standardized script. The researchers recruited 524 mostly White and physician healthcare providers who completed a questionnaire about their contraceptive recommendations and perceptions of the standardized patients.

Dehlendorf and colleagues used multivariate logistic regression to analyze the data and account for complex social factors. This included the interactions of the patient characteristics described above and healthcare provider factors such as age, sex, race/ethnicity, specialty, and provision of IUDs. The researchers found healthcare providers were more likely to recommend IUDs to Black or Latina women than to White women, but only when the women were of low socioeconomic status. Further, healthcare providers were less likely to recommend an IUD to White women of low socioeconomic status than White women of high socioeconomic status.

Regarding healthcare provider perceptions of patients, Dehlendorf et al. found healthcare providers were more likely to believe patients of low socioeconomic status were more likely than patients of high socioeconomic status to have a sexually transmitted infection or unintended pregnancy. Healthcare providers also perceived patients of lower socioeconomic status to be less knowledgeable about contraception. For Black and White patients, healthcare providers perceived patients of lower socioeconomic status to be less intelligent and less likely to follow up with medical care. Dehlendorf et al.'s findings suggest healthcare providers vary their contraceptive recommendations along lines of race and social class.

How clinicians navigate and minimize bias. Manzer and Bell (2021) studied how healthcare providers navigated and minimized bias in contraceptive counseling and decision-making. Manzer and Bell conducted semi-structured interviews with 51 healthcare providers, including nurse practitioners, physicians, nurse-midwives, and one nurse. Participants came from a variety of specialties, and 74% identified as being White.

Manzer and Bell found evidence of biased care from all specializations, ages, races, and genders of providers. Further, Manzer and Bell found healthcare providers used four main strategies to “justify, rationalize, minimize, and/or deny bias” (p. 124). First, healthcare providers used scientific rationale to justify their assumptions of who is at greater risk of unintended pregnancy and to make assumptions about aggregated data on contraceptive efficacy. Second, providers use “safe” biases, or euphemisms, to express racialized, classed, or gendered assumptions about patients. For example, providers used medically acceptable words like “*Medicaid, at risk, insured, or underserved*” to link pregnancy risk to women of low social class (p.126, italics in original). This strategy can also be described as an example of color-blind racism. Third, providers claimed to standardize their approach to contraceptive counseling regardless of race or class. However, when providers described their standard approach, they actually adjusted their approach based on patient characteristics. Finally, providers claimed to practice patient-centered care, but still described using persuasive techniques to influence patient choice. Overall, Manzer and Bell’s findings suggest while providers may not explicitly coerce women to use contraceptives, the use of strategies to justify their biased contraception counseling is evidence of contraceptive coercion. In the next section, I explore in more detail what is known about contraceptive coercion at the clinician and policy level.

Upward coercion. As I described in Chapter 1, upward coercion occurs when a person does not want a contraceptive method, but has the method. Several studies have described contraceptive counseling practices and contraceptive policies that demonstrate upward coercion ranging from more subtle to more overt. Using a grounded theory approach, Biggs et al. (2020) interviewed 20 community health center clinicians to understand how they approached contraceptive counseling about IUDs, and how they handled patient concerns. The researchers found some clinicians offered a full choice of methods and supported their patients' choices, while others focused on guiding women towards more effective methods, and several clinicians discouraged or refused to remove IUDs on patient request. Similar to research described above, many clinicians downplayed patient experiences of side effects like pain or bleeding with the IUD.

Brandi et al. (2018) explored contraceptive coercion by healthcare providers at the time of abortion, a time when women have reported pressure from healthcare providers to use a contraceptive method. The researchers used a modified grounded theory approach and the Integrated Behavioral Model and the Reproductive Autonomy Scale to create a framework for understanding contraceptive coercion by clinicians. Brandi et al. (2018) defined contraceptive coercion as “any behavior that interferes with contraception use in an attempt to either promote or discourage pregnancy” (p. 229). The researchers conducted semi-structured interviews with 31 women seeking abortion at a hospital-based clinic to explore their experiences of contraceptive coercion. Researchers included an event as an experience of coercion if the participant used a word that was a synonym for coercion, including “pressured,” “forced,” or “encouraged” to use a particular form of contraception. Brandi and colleagues found that 42% of the women interviewed had experienced contraceptive coercion by a healthcare provider. The

researchers identified themes relevant to the experiences of contraceptive coercion such as pressure to choose a method, pressure to choose a LARC, and healthcare provider motivation to prevent another abortion.

Barriers to IUD removal. Several studies have looked specifically at one of the more overt forms of upward coercion: clinicians refusing to remove an IUD upon a person's request and other barriers to IUD removal. Amico et al. (2016) used a modified grounded theory approach to describe the experiences of women who had discussed IUD removal with their clinicians within nine months of insertion. The researchers conducted semi-structured interviews with 16 women, nine of whom identified as Hispanic and 12 of whom had Medicaid insurance.

Amico et al. (2016) found that most participants wanted to have a successful IUD experience and waited for the side effects to resolve before seeking IUD removal. Three women described support in IUD removal from their clinician, while the other 13 women reported their clinician preferred they keep their IUD. All women reported clinicians advised them to wait and see if their symptoms resolved. Some women found this reassuring, while others interpreted this advice to mean clinicians did not want to remove their IUD. The women whose clinicians refused to remove their IUD expressed frustration, and some described this experience as hurting their relationship with their clinician. In an extreme case, one woman reported five visits with different clinicians to have her IUD removed. However, at the time of her interview, the IUD was still in place. These findings suggest some clinicians refuse to remove IUDs upon women's request. This has negative implications for the clinician-patient relationship, and may negatively influence patient satisfaction with their IUD experience.

In a related study, Amico et al. (2017) conducted semi-structured interviews with 12 physicians to understand their perceptions and experiences with patient requests for IUD removal.

The researchers found all of the physicians expressed preference for IUDs as a contraceptive method, and several described they would “sell” the IUD to patients (p. 108). Regarding patient request for IUD removal, the physicians reported having mixed feelings and most described encouraging patients to stick with the IUD longer. While many physicians acknowledged the importance of patient autonomy, most also described not removing patients’ IUDs because that was what they thought was best for the patient. These findings suggest that physicians may refuse to remove IUDs when patients request removal, which again has negative implications for the clinician-patient relationship and patient experience with IUDs.

Amico et al. (2020) also considered clinic-level barriers to IUD removal. The researchers called clinics offering family planning services in 10 mid-size cities in the United States. The researchers identified clinics through internet searches. Out of the 596 clinics identified, 229 clinics were included in the analysis because of inclusion criteria and logistics. One member of the study team called the clinics and acted as a 23-year-old woman requesting IUD removal. She asked several related questions, for example “how soon she could have the IUD removed?” and “how much would it cost?” The actor reported having health insurance through her parents.

Amico et al. (2020) found 60.7% of clinics could offer an appointment for IUD removal. Out of these clinics, 61.2% could offer an appointment within two weeks. Of the clinics that offered IUD removal, 17.3% required more than one visit for removal, while 43.2% stated that the IUD could be removed at the first visit. The range in cost for IUD removal at clinics that did not have a sliding scale pricing structure was \$50-\$1000, with a median out-of-pocket cost of \$262. Findings from this study suggest that IUD removal appointments are available, but that barriers to IUD removal exist, including cost and multiple visits.

The findings from these studies into barriers to IUD removal suggest that this type of overt upward contraceptive coercion occurs in the United States at both the clinician and clinic level. Although clinicians may believe they are doing what is best for the patient, their refusal to remove IUDs when patients request them removed constrains contraceptive autonomy, may contribute to mistrust in the patient-clinician relationship, and may discourage future use of some contraceptive methods, thus creating an access barrier.

Summary

This section has described power relations in the contraceptive counseling visit, including how the power over many forms of contraception came to be in the hands of clinicians with prescriptive authority, how clinician behavior patterns contribute to the construction of power relations, and information about contraceptive coercion at the clinician and policy levels. This section has shown that the contraceptive counseling visit is not a neutral space and how policy, social forces, and clinician and patient behavior intersect to form complex power relations around the contraceptive counseling visit and the contraceptive decision.

Chapter Summary

This chapter represents a review of the literature necessary to understand how the linking of financial incentives with the prescription of specific contraceptives for women with Medicaid insurances is coercive. This chapter has provided background about: (a) the unintended pregnancy discourse, which forms the basis for the policy problem the ECU metric was constructed to address, (b) the effective contraception discourse, which forms the basis for the policy solution of promoting specific contraceptives, and (c) power relations in the contraceptive counseling visit. The discussion of these three concepts informs our understanding of the problem of contraceptive coercion. Through this review, I have provided an overview of the

social forces that shape our understanding of the phenomenon of the ECU metric, such as sexism, racism, and classism. This understanding forms the background with which I will critically analyze the policy discourse around the ECU metric. In the next chapter, I describe how I will conduct a critical discourse analysis of the ECU metric with attention to how the embedded coercion was justified and resisted using Reproductive Justice as a guiding framework.

Chapter 3: Research Design and Methods

This chapter describes the research approach for the study. First, I describe the framework and theory guiding the approach. Second, I give a description of the study design, including setting, data collection methods, the analytic plan, and safety considerations. Third, I describe procedures to ensure methodological rigor. Finally, I discuss my position in relation to the study.

Framework and Theory

This study is grounded in a Reproductive Justice framework and in Senderowicz' theory of contraceptive coercion.

Reproductive Justice

Reproductive Justice is a human rights-based, intersectional framework that values reproductive autonomy and resists reproductive oppression (Ross, 2017a, 2017b; Ross & Solinger, 2017). Reproductive Justice theory, which is situated in the critical paradigm, provides a critical lens to study reproductive power relations, policies, and practices (Ross, 2017b). Reproductive Justice Theory draws on ideas from other critical theories, including Black feminist theory, critical race theory, disability theory, and queer theory. As a critical framework, Reproductive Justice attends to power relations and the greater socio-political contexts that give rise to contraceptive coercion. As such, Reproductive Justice supports scholars in taking an explicit ethical stance that resists and aims to dismantle structural inequality.

As a human rights-based framework, Reproductive Justice includes four basic rights: 1) the right to create family and kin, 2) the right to prevent or end pregnancy, 3) the right to parent with dignity free from violence by individuals or the state, and 4) the right to dissociate sex from

reproduction (Ross, 2017a; USC Annenberg, n.d.). Access to contraception as well as the option not to contracept is necessary to exercise these rights.

History. Reproductive Justice was named in 1994 by twelve Black women who were engaged in the reproductive health and rights movement (Ross, 2017b). These women came together at a pro-choice conference where they recognized that although abortion advocacy was an important aspect of reproductive rights, the pro-choice framework incompletely addressed the “intersectional oppressions of white supremacy, misogyny, and neoliberalism” (Ross, 2017b, p. 290). Reproductive Justice rejects the neoliberal discourse that claims all people have equal access to all reproductive health options and then blames women, especially women of color, for making an “irresponsible” choice if they experience unintended pregnancy. Reproductive Justice recognizes choice exists within a context in which both implicit and explicit pressures exist upon women, especially for women of color and women with other oppressed social statuses. Reproductive Justice also recognizes the long history of resistance to reproductive control.

Although Reproductive Justice was named in 1994, the philosophies and activism underpinning this movement existed prior to that time. In the words of Loretta J. Ross, who participated in the creation of the Reproductive Justice framework, “reproductive justice simply finds new words for old ideas” (2017a, p. 177). For example, in 1981, Angela Davis wrote *Women, Race, and Class*, which contained a chapter entitled “Racism, birth control, and reproductive rights.” Davis (1981, Chapter 12) critiqued the White supremacist and eugenicist assumptions embedded in the modern birth control movement, laying the groundwork for Reproductive Justice and this dissertation.

Critique of White Supremacy. A critique of White supremacy is essential for work based in Reproductive Justice. Reproductive Justice defines White supremacy as the “lethal body

of ideas comprised of racism, Christian nationalism, homophobia, nativism, settler colonialism, transphobia, misogyny, and authoritarianism” (Ross, 2017b, p. 291). Reproductive Justice scholarship examines how White supremacy and reproductive politics intersect and provided the background framework for understanding how contraceptive target policies, like the ECU metric, are inherently coercive (Ross & Solinger, 2017). A main goal of Reproductive Justice is constructive social change. This goal is consistent with the policy focus of this dissertation, taking an explicit sociopolitical stance that challenges the ideology embedded in the pregnancy planning paradigm, and supports reproductive autonomy for the oppressed (Ross, 2017a). Although Reproductive Justice has a focus on racialization and racism, it is an intersectional framework. Therefore, power relations beyond race were included in this analysis.

Senderowicz’ Theory of Contraceptive Coercion

As discussed briefly in Chapter 1, I used Senderowicz’ (2019) theory of contraceptive coercion at the structural and interpersonal level. To refresh the reader, Senderowicz theorized two types of coercion: upward and downward coercion. Upward coercion occurs when a person does not want the contraceptive method, but has the method, while downward coercion occurs when a person wants a contraceptive method but does not have the method (see Figure 4). Both types of coercion can happen at the interpersonal or structural level. Interpersonal-level coercion could occur from intimate partners, family members, clinicians, or other healthcare workers. Structural-level coercion occurs at the level of policy or healthcare system structure.

Figure 4

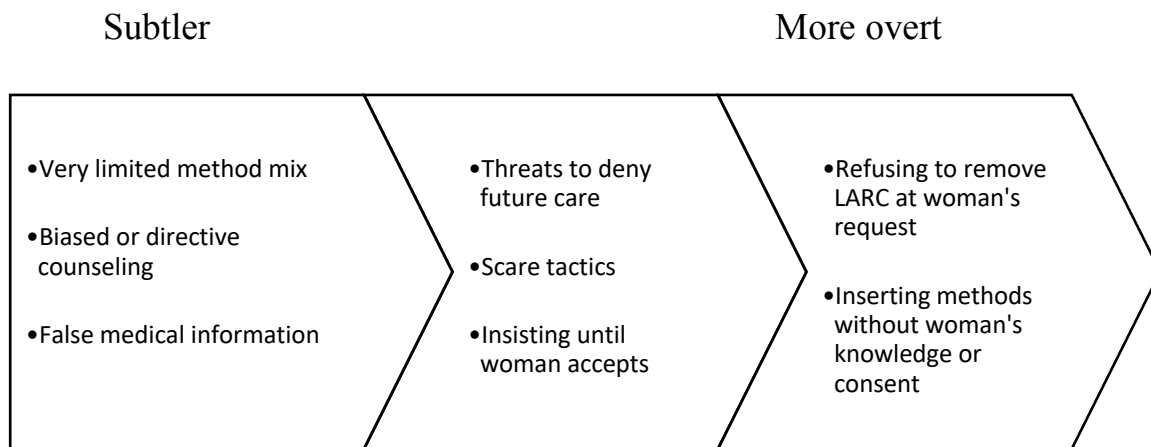
Bidirectional Conceptions of Coercion (Senderowicz, 2019, p. 3)

		Has contraceptive method	
		No	Yes
Wants contraceptive method	No	No coercion	Upward coercion
	Yes	Downward coercion	No coercion

Senderowicz (2019) further theorized that contraceptive coercion occurs along a spectrum from subtler to more overt (see Figure 5). Contraceptive target policies like the ECU metric may contribute to upward coercion along the spectrum. Clinicians may have been motivated to offer a limited method mix, use more directive counseling, or refuse to remove a LARC method because only these specific methods counted for the metric.

Figure 5

Spectrum of Coercion (Senderowicz, 2019, p. 6)



Analytical Approach: Critical Discourse Analysis

Critical Discourse Analysis (CDA) is a way of approaching textual analysis situated in the critical paradigm. CDA is aligned with the social constructionist view which assumes that reality is continually constructed through our interactions which may be mediated by symbol-making systems like language (Huckin, 1997). Therefore, the charge of CDA research is to describe and explain how discourse produces and reproduces one group's domination over another with the goal of constructive social change towards an equitable society (Van Dijk, 2009). This means that CDA, in alignment with Reproductive Justice, is openly ideological research and supports researchers in taking an explicit sociopolitical stance with a commitment to social equality, justice, and human rights (Van Dijk, 2015).

CDA acknowledges that texts are created and consumed in the complex real world. This means that attention to context, especially sociopolitical and historical contexts, are necessary for this type of analysis (Huckin, 1997). While CDA acknowledges the complexity of context, the goal of CDA is to unite analysis on three levels: the text itself, the discursive practice (how the text came to be and how it was interpreted and consumed), and the broader social context (Huckin, 1997). As Huckin (1997) wrote, "the meaning of a text derives not just from the words-on-the-page but also from how those words are used in a particular social context" (p. 79-80). Therefore, this study drew on the historical analysis of the discourse around unintended pregnancy, effective contraception, and contraceptive coercion described in Chapter 2 as well as the more local context of the Oregon Medicaid incentive metric program to understand the metric in its broader context.

Critical Discourse Analysis and Policy Analysis

Evans-Agnew et al. (2016) recommended nurse-scholars use CDA to examine the construction of health policy and how discourse, or “language-in-use,” constructs and reconstructs social issues (p. 138). Citing Foucault’s power/knowledge nexus, Evans-Agnew and colleagues (2016) linked policymaker discourses with the legitimation of knowledge and power noting, “people who wield greater power are able to control what type of knowledge is acceptable and what type is not” (p. 138). Consistent with this observation, Oregon policymakers and others who contributed to the ECU metric had power over how the ECU metric was constructed, which in turn influenced contraceptive counseling with low-income women with Medicaid insurance. States and other institutions have used “reproductive imperialism” to dominate people’s reproductive capacity through, among other ways, controlling access to contraceptives (Kuumba, 1999). Therefore, any policy document that seeks to influence people’s use of specific contraceptives, especially people structurally less powerful like people with Medicaid insurance, warrants analysis using a CDA approach.

Ideology. A central concept in CDA is ideology. Van Dijk (2000) defined ideologies as “the fundamental beliefs of a group and its members” (p. 7). In other words, ideologies are how a group understands the world and creates a base for the social practices of the group members. People may consider ideologies as positive or negative depending on their point of view. For example, both feminism and sexism are examples of ideologies because they both represent a set of general ideas, guide interpretations of the world, and form a basis for social practices of group members. Ideologies may be a way that dominant groups legitimize and maintain their power positions. For example, racist behavior is a form of dominance based on and justified by racist ideology which may be produced and reproduced through discourse (Kendi, 2016).

CDA also draws on the philosophy of Habermas and Lenhardt and seeks to “make unconscious elements conscious in a way which has practical consequences” (as quoted in Evans-Agnew et al., 2016, p. 138). Therefore, this dissertation focused on the language used by policymakers to expose the conscious and unconscious elements used to construct, maintain, and retire the ECU metric and to justify its embedded coercion. Ideologies may be so hegemonic they appear to people as truths. In this dissertation, I closely read the texts used to construct the ECU metric, described and explained the ideologies underlying the assumptions embedded in the text, and pointed out how the text legitimates unequal power relations.

Power relations. A second central concept in CDA is the idea that people discursively construct power relations. As described by Van Dijk (2015), “discourse structures enact, confirm, legitimate, reproduce or challenge relations of *power abuse (domination)* in society” (p. 467, italics in original). In other words, policymakers produce and reproduce power relations through their discussions and policy documents. These discussions are a way that society encodes our belief systems about what and how things should be done (Van Dijk, 2015). Therefore, policymaker discussion and policy documents were the main data source for this study.

Methodological Approach

To understand how policymakers constructed the ECU metric and how they discussed concerns about contraceptive coercion, I collected and analyzed policy documents related to the ECU metric. The primary document I considered was the ECU Guidance Document, which the Oregon Health Authority created to aid coordinated care organization understanding and implementation of the metric. I also collected and analyzed peripheral documents to ensure the broader context of the ECU metric’s construction informed analysis of the primary document.

Setting

The setting for this study was the Metrics and Scoring Committee of the Oregon Health Authority. The Oregon Health Authority is the governing body that oversees the Oregon Medicaid system. The Oregon Legislature created the Metrics and Scoring Committee within the Oregon Health Authority in 2012 to recommend outcomes and quality measures to coordinated care organizations (Oregon Health Authority, n.d.-b). The Metrics and Scoring Committee is a public body made up of nine members appointed by the Oregon Health Authority director for a two-year term. The nine-member body consists of three members with health outcome measurement expertise, three members representing coordinated care organizations, and three members-at-large, who are often healthcare professionals. Oregon Health Authority staff assist the Metrics and Scoring Committee with related duties such as assisting with metric development. The Oregon Health Authority created the Technical Advisory Group to assist the Metrics and Scoring Committee with metric development. The Metrics and Scoring Committee meetings are open to the public, and the documents used in each meeting are publicly available on the Oregon Health Authority website. These documents include presentation slides, meeting minutes, and public testimony, which I used in this study to give context to the conversation around the ECU metric. Technical Advisory Group meeting minutes are also publicly available on the Oregon Health Authority website and were included to give context to this study.

Data Collection and Organization Methods

I collected the data for this study from the public Oregon Health Authority Metrics and Scoring website, the public Oregon Health Authority Metrics Technical Advisory Group website, and through one Freedom of Information Act request to the Oregon Health Authority. All

archival records that referenced the construction, maintenance, or retirement of the ECU metric were included.

Data Sources

The document most central to the policymaker discourse is the ECU metric Guidance Document. Oregon Health Authority staff wrote the ECU Guidance Document for the coordinated care organization audience to aid in their understanding and implementation of the metric. The ECU Guidance Document contains the background and rationale for the metric, suggestions for metric implementation, and metric measurement specifications. Two documents referenced by the ECU Guidance Document were included in this study: the 1995 Institute of Medicine Report *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* (Brown & Eisenberg, 1995) and the research article “The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature” (Gipson et al., 2008). I collected these documents from the Institute of Medicine website and through the Oregon Health & Science University library.

I collected other more peripheral documents to give context to the broader discourse around the ECU metric. I read all Metrics and Scoring Committee meeting minutes from the inception of the Metrics and Scoring Committee in 2013 through the retirement of the ECU metric in 2019. In reading through these documents, I found all Metrics and Scoring Committee and Technical Advisory Group meeting minutes, presentation slides, audio recordings, public comments, and one *Stakeholder Survey* that referenced the ECU metric. I also analyzed documents used in Metrics and Scoring Committee or Technical Advisory Group meetings, such as presentation slides or Oregon Health Authority reports. I placed each of these documents in a

table in chronological order with document details and a brief description of the topics discussed (see Figure 6).

Figure 6

Table of Documents

Title	Date	Origin	Author	Audience	Purpose	Brief description	Contraceptive coercion mentioned (yes/no)

Analytic Process

Policy timelines. I began my analysis by creating a timeline of main events related to the construction, maintenance, and retirement of the ECU metric as I read through all documents mentioning the ECU metric from the Metrics and Scoring Committee website. I included the following main events in the timeline: introduction of the metric, presentations related to the metric, votes on inclusion of the metric in the incentive program, public comments related to the metric, and the setting of the benchmark. In all, I created three timelines: a one-page timeline, a brief timeline, and a detailed timeline. The timelines helped the research team understand the progression of the ECU metric and understand events related to the broader context of the policy.

Detailed discourse analysis. Next, I conducted a detailed discourse analysis as described by Huckin (1997) of the ECU Guidance Document. The ECU Guidance Document is a 40-page document separated into sections with headers. This detailed analysis began with an initial uncritical reading of the whole ECU Guidance Document in the position of the typical reader. I mentally assumed the role of the intended audience of the ECU Guidance Document, which was coordinated care organization and clinic staff who were responsible for implementing the ECU

metric. I imagined I was a person implementing the metric ready to accept the assumptions embedded in the text. This initial reading was analysis at the discursive practice level because I considered the text within its social context. During this first read-through, I considered the following questions outlined by CDA method: What does the audience have in common? Why does the audience care about this text? What is the purpose of the text? After the initial reading, I wrote a memo answering the questions and discussing my interpretations.

Next, I critically analyzed the text at increasingly microscopic levels. These subsequent readings were a close textual analysis at different levels: the whole text level, the sentence level, and at the word/phrase level. During these subsequent re-readings I kept the typical reader in mind to notice text features likely to influence the reader, or “have the potential to mislead the unwary reader” (Huckin, 1997, p. 81).

Whole text level. At the whole text level, I first considered the document genre. I considered what was typical about the genre of a policy implementation guidance document and questioned if the document manipulated genre, such as briefly taking an informal tone in an otherwise formal text. I considered how the authors framed the document with attention to what was described first or given priority, what was in the summary or title statement, what the headings were, and who in the document was depicted in a favorable or unfavorable light. This consideration of foreground and background contributed to an understanding of the framing of the text and what the authors thought were the most important issues. At the whole text level, I considered what the authors presupposed. In other words, what did the authors tacitly assume or take for granted? Finally, I looked for any discursive difference in the text, in which a different style of discourse entered the text. I created a document compiling every example of discursive

difference in the ECU Guidance Document. After reading at the whole text level, I wrote memos discussing my interpretations.

Sentence level. For the sentence and word/phrase level analysis, I conducted the analysis in four sections: (1) the Title Page, Table of Contents, Introduction, Executive Summary, and Acknowledgements, (2) Background, (3) Improving Effective Contraceptive Use, (4) CCO Incentive Measure, FAQ, Eligibility, Billing & Reimbursement, and For More Information. I sent the written analysis of each section to my committee.

At the sentence level, I re-read each whole section and memoed about the framing of the section. Then I went through the section sentence by sentence. First, I considered topicalization, noticed and listed out the topic of each sentence, and considered patterns of topics in the text. Topicalization is an example of foregrounding at the sentence level and showed what the author considered most important in the sentence. I considered how the pattern of sentence topics supported the overall framing of the text. From topics, I moved to consider the agent-patient relationship. Who acted and who is acted upon? The person who acted may be more powerful, while the person receiving the action may be passive or less powerful. Although an actor may be topicalized in a sentence, they may not be endowed with much power. At the sentence level, I also considered the omission of agents through nominalization and passive sentence construction. Nominalization is the creation of a noun from a verb or adjective and authors can use this device to erase the actor. Passive sentence construction makes the receiver of the action the subject of the sentence, again erasing the actor. This concealment may serve to background the responsibility of the agent. At the sentence level, I looked for presupposition, or what was assumed or inferred to be true in the sentence. Finally, I considered any insinuations, which are indirect suggestions that something negative is true.

Word/phrase level. The most detailed level of analysis is at the word/phrase level. At this level, I considered the connotations of specific words that may carry special meanings. Connotations may be communicated through metaphor. I also considered the register of the text, which is the level of formality or informality conveyed through word choice. Finally, I considered modality which is a way that certainty or authority is communicated with words like “may, most, without a doubt” (Huckin, 1997, p. 84). I created a document compiling every example of modals and every word for an agent used in the ECU Guidance Document. Like the sentence level analysis, I then wrote a memo describing and summarizing what I found.

Contextual level. After this increasingly detailed analysis, I considered the text in its broader context and wrote memos about my contextual interpretations guided by my aims. For example, how the texts constructed the concept of unintended pregnancy and how policymakers and stakeholders discussed the issue of coercion. These memos became the themes I present in Chapter 4.

Analysis of other texts. I also conducted a detailed analysis of the ECU Metric Brief, the ECU Metric Summary, public testimonies, and Metrics and Scoring Committee meeting presentation slides. There was one audio recording of the Metrics and Scoring Committee discussing the ECU metric. I transcribed verbatim the section of this recording in which policymakers discussed retiring the ECU metric and conducted a detailed analysis of the transcription. While conducting an “equity impact assessment” on the incentive metric program as an intern with the Oregon Health Authority, I found meeting minutes from a 2016 Oregon Health Authority staff meeting about unintended pregnancy. I obtained the minutes through a Freedom of Information Act request after my internship had ended and conducted a detailed analysis of these “closed door” meeting minutes. Finally, I closely read *The Best Intentions:*

Unintended Pregnancy and the Well-Being of Children and Families (Brown & Eisenberg, 1995), “The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature” (Gipson et al., 2008), and “Association of Implementing an Incentive Metric in the Oregon Medicaid Program with Effective Contraceptive Use” Rodriguez (2020) to give further context to the ECU Metric analysis.

Consultation with committee. I shared my findings from the detailed analysis with my committee and met with my full committee four times to discuss my findings and consider alternative interpretations.

Safety Considerations

I made a request for determination to the OHSU Institutional Review Board (IRB) to confirm that IRB oversight was not required. The data used for this study is publicly available. Therefore, the IRB determined no oversight was required for my dissertation.

Methodological Rigor

In this section I attend to the methodological rigor of this study to ensure the reliability, validity, and generalizability of the study findings to other contraceptive target policies (Morse, 2015). Ensuring that the study is reliable means that another researcher could follow similar steps and arrive at similar conclusions (Morse, 2015). Therefore, I kept an audit trail in the form of a research journal that documented my analysis decisions and process (Whittemore et al., 2001). I wrote the research journal in an accessible way by minimizing jargon and abbreviations so that a broad audience can read and understand the journal. Part of ensuring reliability was explaining not just my methodological process but also generating findings with sufficient granular detail to make them compelling and understandable.

Kvale (1995) described taking a “craftsmanship approach to validation” (p. 27). This means I continually checked, questioned, and interpreted my findings with my dissertation committee to ensure that my interpretations of the policy make sense to others. Lather (1986) suggested “seeking counterpatterns as well as convergences” during analysis (p. 67). Therefore, I considered a variety of possible patterns of textual interpretation in discussions with my committee. Lather (1986) further recommended triangulation of data sources to improve validity. I included varied data sources in my study— the policy guidance document, variety of MSC meeting materials, and the TAG meetings— to ensure consideration of context and triangulation of data sources.

Lather (1986) reconceptualized validity for research that is openly ideological in contrast to post-positivist research claims of neutrality. Lather (1986) argued rather than being more openly ideological than post-positivist research, critical research makes ideology explicit. Consistent with the approach, I have been explicit about Reproductive Justice theory and selected an analytic approach that makes space for the explicit expression of a value system which prioritizes human rights and human autonomy in reproductive decision-making. To enhance the rigor of this openly ideological study, I also practiced reflexivity and ongoing positionality as described below.

Reflexivity

Finlay (2002) defined reflexivity as “thoughtful, conscious self-awareness” (p. 532) in which the researcher recognizes that they are a participant in the process of knowledge construction. The process of reflexive analysis began during the pre-research stage in which I reflected on the topic as I selected it and my relationship to the topic. I examined the Reproductive Justice literature to aid in clarifying my research questions. Reflexive analysis

continued in the data collection and analysis stages. I kept a reflexive journal throughout my PhD journey, and I continued this journal through the data collection and analysis phases. During analysis, I reflected on my responses to the data and considered the assumptions and roots of my responses. Beyond considering my responses to the data in my analysis, I also practiced ongoing positionality through reflection in which I considered my social position in relation to the study (Walt et al., 2008).

Positionality

It is imperative to include understanding of my social position and continuously reflect upon the interplay between my social position and the research (Bourke, 1990; Finlay, 2002). I am a White cisgender woman of Anglo and western European descent who holds formal power in academia and the healthcare system. I grew up a settler colonist on Tana'ina Athapaskan land in Alaska, a borderland at the edge of the United States. The awareness of my formal power and of my family's colonial legacy led me to focus this study on how White supremacist and patriarchal ideologies underpin the public health policy discourse around reproduction and contraception. My goal is to use my power to transform the policy structures that create health disparities into policies that support health equity.

During the writing of this dissertation, I interned in the Office of Equity Inclusion at the Oregon Health Authority and assisted with an equity impact assessment of the incentive metric program. Conducting this project gave me insight into how the Metrics and Scoring Committee and Technical Advisory Group work, as well as the interplay between these committees and Oregon Health Authority staff. These insights impacted my work by helping me see the power relationships between the groups and learn about how those relationships have changed over

time. My internship also helped me see how these groups are made up of real people with all of their complexities which helped me humanize my interpretations of their work.

I have experienced contraceptive counseling as a patient and as a counselor working at a Planned Parenthood clinic in Oregon. I have heard stories from friends, coworkers, and patients about their experiences as patients in the contraceptive counseling visit. In these stories, I heard about pressure from healthcare providers to use a prescription method, especially an IUD or implant. The ubiquity of these stories coupled with my critical understanding of the ideologies underpinning the Effective Contraceptive Use metric are what led me to this research project.

My hope is that this research will be helpful for patients, clinicians, and policymakers to ensure that contraceptive counseling happens in a way that respects personal bodily autonomy and that policymakers design policy to support the accessibility of the tools people need to care for their fertility and reproductive health.

Chapter 4: Results

In this chapter I present findings regarding how policymakers constructed the contraceptive use metric which they named the Effective Contraceptive Use for Women at Risk of Unintended Pregnancy Incentive Metric. I put special focus on how policymakers and stakeholders¹⁶ discussed and justified its embedded coercion. The chapter has two parts. Part One outlines a brief history of the contraceptive use metric, followed by an in-depth, year-by-year description of how policymakers constructed, maintained, and retired the metric. Part Two consists of an analysis of the themes resulting from the detailed discourse analysis of the contraceptive metric policy texts.

Part One: Construction, Maintenance, Retirement

Several groups were involved in the construction, maintenance, and retirement of the contraceptive use metric. Figure 7 gives an overview of the government organizations involved: the Oregon Health Authority, the Health Plan Quality Metrics Committee, the Metrics and Scoring Committee, and the Metrics Technical Advisory Group. The main policymaking committee involved in the construction of the contraceptive use metric was the Metrics and Scoring Committee.

The Metrics and Scoring Committee is made up of nine members— three members-at-large, three members with expertise in health outcome measures, and three members representing Coordinated Care Organizations (Oregon Health Authority, n.d.-b). Members of the Metrics and Scoring Committee are appointed by the Director of the Oregon Health Authority and serve for two years. As per the Oregon State legislation that created the Metrics and Scoring Committee,

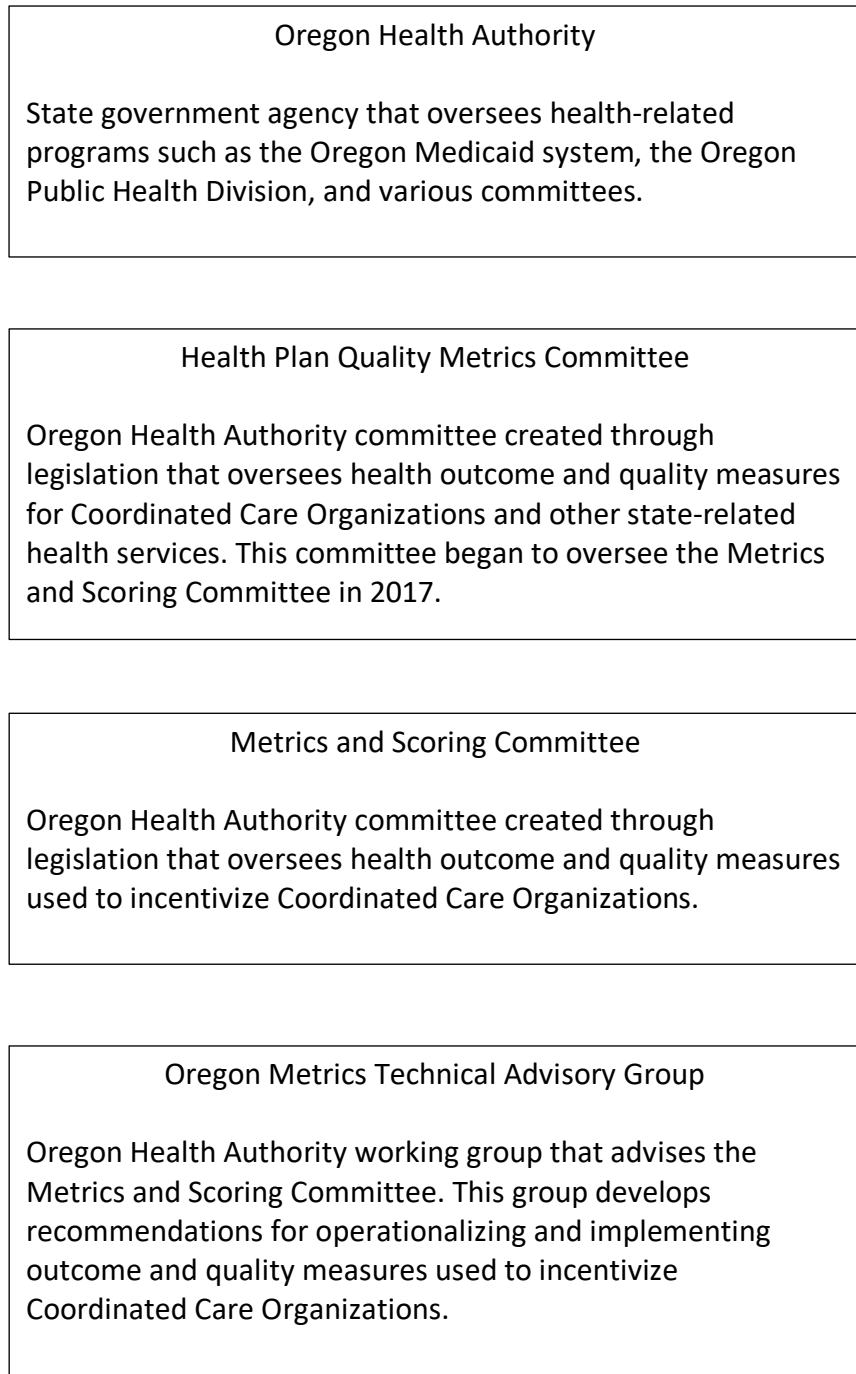
¹⁶ In this study, I use the word “stakeholders” to mean Coordinated Care Organization and health clinic staff because these staff were the people named as “stakeholders” by the Oregon Health Authority staff. Despite being the target population of the metric, no Medicaid members participated in the recorded discourse around the ECU metric and were not named as “stakeholders” by the Oregon Health Authority staff.

the State of Oregon may not financially compensate Metrics and Scoring Committee members for their participation in the committee, except for reimbursement of travel expenses related to attending Metrics and Scoring Committee meetings. This means to serve on the Metrics and Scoring Committee, a person would need to be available for three hours during a weekday once a month for unpaid service.

The Metrics and Scoring Committee meets on weekdays, usually from 9am-12pm, with an occasional all-day retreat. Before the COVID-19 pandemic, the Metrics and Scoring Committee met mostly in-person in Portland or Wilsonville, Oregon in different conference rooms. There was a call-in option available for people not able to attend the meetings in person. Although meetings were open to the public, most attendees besides Metrics and Scoring Committee members were Oregon Health Authority staff or representatives of professional organizations contributing to metric development. Anyone could submit public testimony to the Metrics and Scoring Committee. However, all public testimony regarding the contraceptive use metric was given by persons representing professional organizations such as the American Civil Liberties Union, Planned Parenthood, or a Coordinated Care Organization; no Medicaid member or organization representing Medicaid members gave testimony.

Figure 7

Description of Government Organizations that Influenced the Effective Contraceptive Use Metric



Brief History

This section outlines in brief the history of the contraceptive use metric (see Figure 8 for a visual timeline). Initially introduced in 2014, Metrics and Scoring Committee members voted to keep the contraceptive use metric in the Coordinated Care Organization Quality Incentive Program every year through 2019. The first mention of concern about coercion was noted in the September 2016 meeting minutes as occurring at the August 2016 Metrics and Scoring Committee. The author of the minutes did not state who brought up the concern about coercion. This 2016 coercion concern generated a response from the metric steward¹⁷, the person who initially introduced the idea of including the metric in the incentive set. The metric steward was a physician who worked for a Coordinated Care Organization as the Maternal Child Family Program Manager. The steward co-developed the One Key Question® Initiative and developed contraceptive metrics at the state and national level (Metrics and Scoring Committee [MSC] testimony Bellanca, 2014, August 22). The metric steward argued that the unintended pregnancy rate was highest for low-income women, low-income women have historically had less access to contraception, and the metric was a movement towards equal access to contraception. This 2016 moment of conflict regarding the potential for coercion embedded in the contraceptive use metric did not result in changes. The metric continued to be used and controversial, with ongoing questions from the Oregon Metrics Technical Advisory Group, Coordinated Care Organization staff, and clinicians about the intent of the metric and targeting low-income women for fertility control. In response to these ongoing concerns, the metric steward presented again in May 2017, stating the metric should not be changed to a pregnancy intention screen because the intent of the metric was to improve contraceptive access and prevent unintended pregnancy. Instead, the steward proposed lowering the metric benchmark to address concerns. The metric steward also

¹⁷ Each incentive metric had a metric steward responsible for overseeing the incentive metric.

noted the National Quality Forum had signaled approval of the ECU metric by endorsing a similar metric (MSC presentation, 2017, May 19, p. 28).

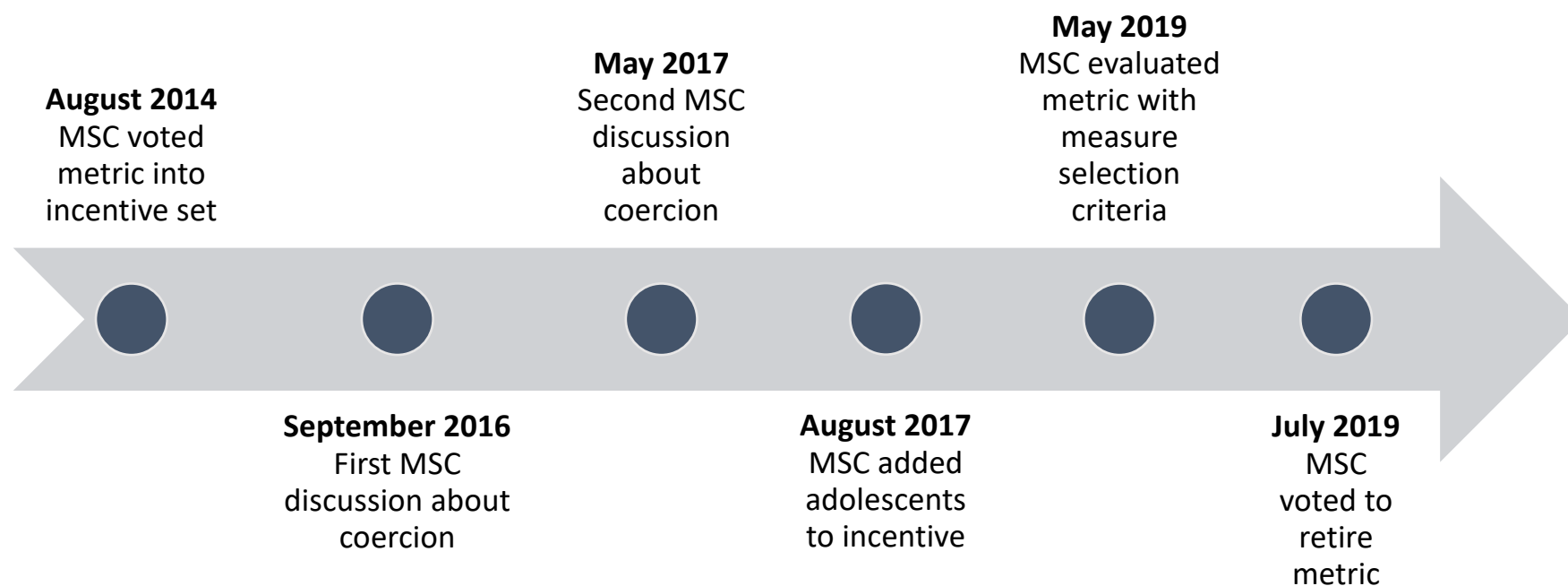
In August 2017, the Metrics and Scoring Committee voted to add 15–17-year-olds into the target population for the incentive. This prompted three Coordinated Care Organizations, the Health Plan Quality Metrics Committee¹⁸, and the Children’s Health Alliance¹⁹ to express concern about aiming to have half of female adolescents with Medicaid insurance prescribed one of the incentivized contraceptives. In 2019, the Metrics and Scoring Committee decided to retire five incentive metrics to simplify the Coordinated Care Organization Quality Incentive Program. In May 2019, the Metrics and Scoring Committee evaluated the contraceptive use metric with the measure selection criteria, and in July 2019, the Metrics and Scoring Committee voted to retire the contraceptive use metric for several reasons described in more detail below. Though retired from Oregon’s Coordinated Care Organization Quality Incentive Program, a similar metric continues as a quality metric at the national Medicaid level (National Quality Forum, 2016; United States Department of Health and Human Services Office of Population Affairs, 2019).

¹⁸ The Oregon Legislature formed the Health Plan Quality Metrics Committee in 2015 to oversee all health outcomes measures in Oregon. The Health Plan Quality Metrics Committee began to oversee the Metrics and Scoring Committee in 2017.

¹⁹ The Children’s Health Alliance is an alliance of pediatric providers in Oregon and Washington

Figure 8

Effective Contraceptive Use Metric Timeline



MSC=Metrics and Scoring Committee

In-Depth History

This section is an in-depth, year-by-year description of how policymakers constructed, maintained, and retired the ECU metric. Initially, the Metrics and Scoring Committee voted to adopt the ECU metric in August 2014. Each following year from 2015-2018, the Metrics and Scoring Committee voted to include the ECU metric in the Coordinated Care Organization Quality Incentive Program and set the target benchmark for the ECU metric. The following in-depth description includes instances when the Metrics and Scoring Committee or the Metrics Technical Advisory Group minutes contained substantial discussion about the ECU metric.

2014. In July 2014, the Metrics and Scoring Committee meeting minutes noted “contraception/unintended pregnancy” as a potential category for a new metric (p. 5). The first time the Metrics and Scoring Committee meeting minutes specifically mentioned the ECU metric was at the August 2014 Metrics and Scoring Committee meeting. The person who would become the metric steward submitted public testimony to the Metrics and Scoring Committee in support of moving the ECU metric from the demonstration metric set²⁰ to the Coordinated Care Organization Quality Incentive Program. The future metric steward spoke as a representative of a Coordinated Care Organization as their Maternal Child Family Program Manager. In addition to recommending the Metrics and Scoring Committee incentivize the ECU metric, the future metric steward also suggested draft measure specifications. After considering the testimony, the Metrics and Scoring Committee voted to adopt the ECU metric into the Coordinated Care Organization Quality Incentive Program and discussed the metric parameters. This discussion included the age range of the target population, the committee’s preference to include men in the metric, and that

²⁰ The demonstration metric set is a non-incentivized metric set intended to monitor health outcomes.

a “reasonable benchmark may be around 80%, because approximately only 5-10% of women are actively trying to get pregnant at any given time” (MSC minutes, 2014, August 22, p. 3).

In October 2014, the Oregon Metrics Technical Advisory Group notes on drafting the measure specifications stated: “inclusion of male sterilization diagnosis code is still under [Oregon Health Authority] review and may be removed from final version of specifications if not feasible for inclusion using claims data” (p. 3). The Oregon Metrics Technical Advisory Group also recommended setting the age range of the target population from 18-50.

At the November 2014 Metrics and Scoring Committee meeting, Oregon Health Authority staff formally introduced the ECU metric. The Oregon Health Authority staff member’s presentation described the numerator and denominator in the metric, gave background on low-income women’s usage rates of prescription contraception in Iowa, Oregon, and Washington DC²¹, suggested women’s nonuse or inconsistent use of contraception was the primary driver for unintended pregnancy, described the rates of unintended pregnancy broken out by all women, formal education level, race, and income, and suggested different benchmark options for the metric. After the presentation, the Metrics and Scoring Committee voted the ECU metric into the incentive metric set and discussed the target benchmark percentage.

At the November 2014 meeting, the Metrics and Scoring Committee discussed the age range of the target population for the ECU metric and decided women between the ages of 18-50 would be included. Regarding adolescents, the minutes included the following text:

The [Coordinated Care Organization] incentive measure will be focused on adults (ages 18+); adolescents ages 15-17 will be monitored, but not part of the quality pool [incentive] payment due to incomplete data and confidentiality issues. Committee members noted it

²¹ Iowa and Washington DC had also tracked women’s use of specific contraceptives and experimented with targeted interventions to increase women’s use of specific contraceptives.

is important to address the rate of teen pregnancy, especially among African-American and Latino and were encouraged that pediatric and family medicine practices will likely be implementing workflows to address effective contraceptive use for ages 18+ that will also affect adolescents. The Committee proposed adding adolescents to the incentive measure for 2016. (p. 2)

The Metrics and Scoring Committee also discussed setting the target benchmark, which included an absolute benchmark and an improvement target based on the Coordinated Care Organization's current rate of contraceptive prescriptions. The minutes stated "most [Coordinated Care Organizations] will likely earn their 2015 quality pool [incentive] payments for this measure based on the improvement targets, rather than the absolute benchmark" (p. 2). The Oregon Health Authority staff recommended the Metrics and Scoring Committee set the absolute benchmark at 60%, and the Metrics and Scoring Committee voted to set the absolute benchmark at 50%. The improvement targets were based on usage rates of incentivized contraceptive methods by members of the target population in 2014, resulting in different targets across Coordinated Care Organizations. The improvement percentage was the same across all Coordinated Care Organizations.

Several members of the public gave written and verbal testimony in support of the ECU metric, including the Legislative Director of the American Civil Liberties Union, the Executive Director of Planned Parenthood, the Medical Director and Executive Director of the Oregon Foundation for Reproductive Health, an Oregon State Representative, the Executive Director of Healthcare Coalition of Southern Oregon, and the Clinic Manager at Outside In, a health center serving youth experiencing homelessness. Regarding the ECU metric benchmark, the Oregon State Representative "noted the importance of having aspirational metrics in moving significant

public policy discussions forward and encouraged the Committee to not set the bar too low” (MSC minutes, 2014, November 20, p. 4). The Outside In Clinic Manager “recommended a higher benchmark in order to achieve the best results” (MSC minutes, 2014, November 20, p. 4). Also in November 2014, the Oregon Metrics Technical Advisory Group discussed the specific diagnosis codes that would count as numerator credits for the ECU metric. The minutes noted, “male sterilization has been removed because there is no good way to guarantee partnership with a female patient” (p. 4).

2015. In May 2015, the Oregon Health Authority Public Health Division Reproductive Health Section published an *ECU Metric Summary* entitled “CCO Incentive Metric: Effective Contraceptive Use among Women at Risk of Unintended Pregnancy” located in the Oregon Metrics Technical Advisory Group online meeting archive. The *ECU Metric Summary* provided information regarding who was included in the numerator and denominator of the metric and details about the incentive system. The *ECU Metric Summary* also described what is considered effective contraception, strategies recommended by the Oregon Health Authority to meet the metric, and suggested additional resources (Oregon Health Authority [OHA] Public Health Division Reproductive Health Section, n.d., p. 1).

2016. In August 2016, the Metrics and Scoring Committee discussed including the ECU metric in the 2017 Challenge Pool,²² meaning an extra incentive would be added. While still on the topic of the ECU metric, the Metrics and Scoring Committee minutes noted, “the Committee also considered clinic perspectives regarding the Effective Contraceptive Use measure” (p. 4). This is vague because the specific “clinic perspectives” were not named in the minutes. However,

²² The challenge pool is used to distribute any remaining quality pool funds if any Coordinated Care Organizations do not earn 100% of their incentive.

in the September 2016 Metrics and Scoring Committee meeting minutes, the word “coercive” was used to describe concerns raised at the August Metrics and Scoring Committee meeting (p. 2).

At the September 2016 Metrics and Scoring Committee meeting, the metric steward “presented on the Effective Contraceptive Use measure intent, messaging, and context to provide the Committee with more clarity following concerns raised at the August meeting about the measure being coercive” (MSC minutes, 2016, September 19, p. 2). The arguments the metrics steward gave in response to concerns regarding potential coercion in the ECU metric were: 1) unintended pregnancies are associated with negative outcomes for women and children; 2) most unintended births happen in the Medicaid population; and 3) the cause of unintended pregnancy is women’s nonuse or inconsistent use of contraception. The metric steward compared the lifetime risk of unintended pregnancy with diseases to convey the importance of screening for pregnancy intentions. One slide included the question: “Yes, but what about the perception that we are unfairly or unethically targeting poor women with our contraception efforts?” (MSC presentation, 2016, September 16, p. 67). The metric steward responded that the unintended pregnancy rate is highest for low-income women and that low-income women have less access to contraception. The slide included this assertion: “having a quality metric in contraception is a key step in giving low income women equal access to high quality primary care” (MSC presentation, 2016, September 16, p. 70). This shifted the topic of conversation from concern about coercion to improving access to contraception for low-income women. The Metrics and Scoring Committee discussion included:

Why the ECU metric was focused on tier 1 and 2 contraceptive use rather than pregnancy intention screening;

Why education or counseling was not included in the metric;

Tradeoffs between using claims and clinical data for measurement;

Whether the measure should be introduced as being about women's reproductive health rather than contraceptive use and other ways to frame the work with providers and clients (suggested framing: "helping women meet their own goals for reproductive health"); and

The need for training for providers, including addressing diversity. (MSC minutes, 2016, September 16, p. 2)

The Metrics and Scoring Committee discussed making the ECU metric one of the challenge pool metrics and "whether providers would have sufficient time to focus on ECU if it is added as a challenge pool measure, or whether making ECU a challenge pool measure would focus provider attention" (p. 3). The Metrics and Scoring Committee decided to make the ECU metric one of the challenge pool metrics for 2017.

Closed door meeting. On the same day as the September 2016 Metrics and Scoring Committee meeting, a group of Oregon Health Authority staff, including the Director of the Oregon Health Authority, held a meeting titled "Reducing Unintended Pregnancies." I will call this meeting the "closed-door meeting" to distinguish it from other meetings. The closed-door meeting was not open to the public and Oregon Health Authority did not post the meeting minutes online. I obtained the closed-door meeting minutes through a Freedom of Information Act Request. According to the closed-door meeting minutes, the purpose of this meeting was to involve "staff across [Oregon Health Authority] to coordinate [a] larger initiative" to reduce unintended pregnancy among people with Medicaid insurance (OHA, 2016). Elements of the discussion recorded in the minutes included eugenic, heteronormative, racist, and ableist language. For example:

[Oregon Health Authority staff member] is willing to have a conversation about people who shouldn't have babies. Have seen in own experience children who are abused, neglected, multiple partners, multiple children, children are tragically handicapped for life, etc. (OHA, 2016, p. 2)

The meeting minutes also included documentation of a person recognizing the potential for eugenic ideology and asserting a need to be sensitive to this perception: “If we are going to have any focus on this – have to be sensitive to perspective that dominant culture is trying to get non-dominant culture to have fewer children. Has to factor this into our research...Demographic factors” (OHA, 2016, p. 2). After this statement in the minutes, there was discussion of the Metrics and Scoring Committee meeting from earlier that morning with attention on how to frame and message the issue of reducing unintended pregnancies among people with Medicaid insurance. The minutes recorded, “health is better way to talk about these issues,” and that meeting attendees, “don't want this to be driven by [Oregon Health Leadership Council]²³/business community [as “business community” had discussed need for cost savings by reducing pregnancies of low-income people]” (OHA, 2016, p. 2-3).

2017. In March 2017, the Oregon Metrics Technical Advisory Group minutes stated, “[Technical Advisory Group] members feel that the current benchmark is too high and should be reviewed” (p. 3). The Oregon Metrics Technical Advisory Group discussed changing the ECU metric from claims data to clinical data from the electronic health record so the metric could exclude women who did not need contraception. Finally, the Oregon Metrics Technical Advisory Group discussed measuring “whether patient is offered contraceptives/contraceptive counseling, rather than contraceptive use” and “expressed a desire to better understand the intent of this

²³ The Oregon Health Leadership Council is an organization made up of “medical groups, hospitals, health systems or health plans that do business in Oregon” (Oregon Health Leadership Council, 2017).

measure before they could make a recommendation on potential modifications. Is the intent to reduce unintended pregnancy, increase access to contraceptives, screen with ‘one key question,’ etc?” (p. 3).

In May 2017, the Metrics and Scoring Committee discussed the intent of the ECU metric in response to the Oregon Metrics Technical Advisory Group questions. The metric steward gave another presentation similar to the one the steward gave in September 2016. The May 2017 presentation included the questions: “What is the intent of this measure? Do the current specifications address the intent? Are we having an impact? Should we consider a pregnancy intention screening metric instead?” (p. 19). The metric steward’s May 2017 presentation described the intent of the measure as: “1) Providing high quality primary care for woman by improving contraception access and 2) Preventing unintended pregnancy” (p. 20). The metric steward further asserted the metric was meeting these intents because “it focuses on the measurable outcome of contraception claims” (p. 24). The metric steward also addressed “shortcomings” in the measure specifications such as including women who don’t need contraception and not including vasectomies because “they are claims on someone else’s chart” (p. 24). The metric steward addressed these shortcomings by recognizing a “perfect score” for the ECU metric was not 100% of women but 70% of women (p. 24). It is not clear why a score of 70% was proposed as the new level of having reached a perfect score. One slide depicted who was included in the ECU metric denominator and suggested, without referencing any evidence for support, that 30% of women are either abstinent, partnered with women, or are trying to conceive (p. 25). The metric steward’s presentation included charts reporting data showing that from 2014 to 2015 there was a 9% increase in “effective contraceptive use among adults” (p. 26). The metric steward’s slides included that this meant “we are meeting expectations” and noted it

would take time to see a reduction in the unintended pregnancy rate (p. 28). The recommendation that more time would be needed to realize results was communicated via this statement: “will need several years of clear declines to get to at least a 10% reduction in births” (p. 28). The metric steward also stated the National Quality Forum endorsed a metric similar to the ECU metric, which showed “we are on the right track and setting a national standard!” (p. 28). Finally, the metric steward answered the question of whether the metric should be changed to a pregnancy intention screen. The metric steward did not think the ECU metric should be changed to a pregnancy intention screen because that would “move farther away from the intent of the metric” (p. 29). The metric steward gave several other reasons advocating against changing to a pregnancy intention screen, including that screening would be a process measure not an outcome measure, data collection would depend on chart review, there was no standard pregnancy intention screening, and there was no evidence screening improves outcomes. The metric steward’s May 2017 presentation then repeated slides from the September 2016 presentation describing the problem of unintended pregnancy and that low-income women have higher rates of unintended pregnancy as well as worse access to contraception compared with higher income women.

The May 2017 Metrics and Scoring Committee minutes reflect discussion about clarifying the intent of the metric per the metric steward’s presentation and acknowledged the new National Quality Forum contraceptive metric based on Oregon’s ECU metric. The Metrics and Scoring Committee discussed whether the metric should be a pregnancy intention screening rather than measuring women’s use of specific contraceptives. However, the Metrics and Scoring Committee expressed concern that “this would shift away from the intent of the measure (increasing access to contraception) and shift from an outcome to a process measure” (MSC

minutes, 2017a, May 19, p. 2). The minutes noted that Oregon Health Authority staff planned to send out a clinic self-assessment of contraceptive services tool to the Metrics and Scoring Committee.

In May 2017, the Metrics Technical Advisory Group meeting reviewed the information from the May Metrics and Scoring Committee meeting. The Oregon Metrics Technical Advisory Group again “expressed concern that the benchmark is set too high, and should be reviewed by the Committee,” and “expressed interest in moving toward an [electronic health record]-based measure in the future” (Oregon Metrics Technical Advisory Workgroup minutes, 2017, May 25, p. 2).

In July 2017, a pediatrician gave public testimony recommending the Metrics and Scoring Committee expand the financial incentive for the ECU metric to include 15–17-year-olds (MSC public testimony, 2017, July 21). The pediatrician gave two reasons for the recommendation: the high rate of unplanned pregnancy in the adolescent population, and the importance of access to contraception to have control of one’s reproductive health. The Metrics and Scoring Committee tabled further discussion until the metric steward “who has substantial expertise on this measure and women’s health in general” joined as a committee member in August (MSC minutes, 2017, July 21, p. 2).

In August 2017, the Metrics and Scoring Committee voted to expand the financial incentive for the ECU metric to include 15–17-year-olds. This vote was in opposition to the Oregon Health Authority’s prior recommendation²⁴ not to include adolescents in the incentive because of “privacy and confidentiality concerns” (MSC presentation, 2017, August 18, p. 9). During their discussion the Metrics and Scoring Committee noted some providers “have

²⁴ At times, Oregon Health Authority staff would give recommendations to the Metrics and Scoring Committee. However, the ultimate decision-making power over the metrics was held by the Metrics and Scoring Committee members.

expressed hesitation about adding adolescents to the incentivized part of this measure, while others are very supportive of the idea” (MSC minutes, 2017, August 18, p. 1). The minutes also stated, “the ECU is especially sensitive to racial and economic disparity, and contraception is one of the most important conversations a provider can have with a teen. Incentivizing metrics causes behavior to change” (p. 2). The metric steward reviewed the slide from the May 2017 presentation showing 70% of women need contraception and suggested teens were more likely than adults to be abstinent, so the benchmark could be lowered.

In September 2017, the Metrics and Scoring Committee became a subcommittee of the Health Plan Quality Metrics Committee. The Health Plan Quality Metrics Committee expressed “concern...about... the inclusion of adolescents in Effective contraceptive use [metric]” (MSC minutes, 2017, September 15, p. 1). Health Share of Oregon Coordinated Care Organization submitted written and verbal testimony with concerns about including adolescents in the incentive. These concerns included confidentiality and privacy, provider readiness to have a “culturally responsive conversation with their teen patients,” mixed messages because condoms didn’t count for the incentive, and the “social optics” of the measure because of the history of “targeting minority and low-income populations for fertility control” (MSC testimony Health Share, 2017, September 12, p. 1). A Metrics and Scoring Committee member representing Family Care Coordinated Care Organization indicated their organization shared these concerns. The Metrics and Scoring Committee responded to these concerns that “it is considered standard of adolescent care to suppress explanations of benefits,” that “the [National Quality Forum] effective contraceptive use measure includes adolescents,” and “while overall teen pregnancy has been decreasing, rates increased between 2014 and 2015 among African American and American Indian/Alaska Native teens” (MSC minutes, 2017, September 15, p. 1). The Metrics and Scoring

Committee voted against a motion to exclude adolescents from the financial incentive. The Metrics and Scoring Committee set the 2018 absolute benchmark for the ECU metric again at 50%. The rationale for not lowering the benchmark to account for the addition of adolescents was that women with tubal ligation were now included as a permanent numerator credit. The inclusion of women with tubal ligation as a permanent credit would increase Coordinated Care Organization performance on the measure, thus balancing out the inclusion of adolescents. The minutes indicated the Committee had a “preference for stability in benchmark” (p. 3).

2018. In February 2018, the Metrics and Scoring Committee reviewed the *CCO Incentive Metrics 2017 Mid-Year Deeper Dive* report prepared by Oregon Health Authority staff. This report showed the prescription rates for the contraceptives incentivized by the metric increased from 33.4% in 2014 to 41.8% in 2017 (MSC presentation, 2018, February 16, p. 11). Oregon Health Authority staff reported “effective contraceptive use” rates among adolescents and “adolescent well-care visit” rates in graphs broken out by the following categories: Coordinated Care Organization, age, race, percentage of members who are sexually active, teen pregnancy rates by region and race, and the percentage of adolescents whose contraceptives were billed by Planned Parenthood. There was no Metrics and Scoring Committee discussion recorded in the minutes.

In September 2018, two people gave verbal public comment at the Metrics and Scoring Committee meeting. One person spoke as a staff member from a Coordinated Care Organization. The minutes stated: “for the Effective contraceptive use...she would like the committee to consider what an ideal ceiling or goal would be” (MSC minutes, 2018, May 21, p. 2). The minutes recorded a person representing the Children’s Health Alliance noting, “the Effective Contraceptive Use measure target is more difficult for pediatric-only providers to meet, given the

nature of that population” (p. 2). The Metrics and Scoring Committee minutes do not reflect discussion of these comments. The Metrics and Scoring Committee voted to increase the absolute benchmark for the ECU metric to 53.9%, which was the 2017 90th percentile for all Coordinated Care Organizations.

In December 2018, the Eastern Oregon Coordinated Care Organization submitted public testimony with concerns about the ECU metric. These were concerns about the “narrow definition” of what methods counted as effective methods and the “possibility of introducing bias into the providers’ recommendations” (MSC public testimony, 2018, December 5, p. 1). The Eastern Oregon Coordinated Care Organization testimony also expressed concern about including adolescents in the incentive because “these girls are in a wide range of stages of physical and emotional development as well as maturity levels” and the ECU metric “doesn’t allow for the variety of and types of care these patients need” (p. 1). There was no discussion recorded in the Metrics and Scoring Committee minutes about the ECU metric or the public testimony from Eastern Oregon Coordinated Care Organization.

2019. The *ECU Metric Brief* was included in the February 2019 Oregon Metrics Technical Advisory Group meeting materials (OHA, n.d.-c). The *ECU Metric Brief* was written by Oregon Health Authority staff for use by Coordinated Care Organizations to communicate the ECU metric to clinics and healthcare providers. The *ECU Metric Brief* contains information about the ECU metric, strategies to implement the metric, resources to support implementation, and coding instructions.

In May 2019, Metrics and Scoring Committee members evaluated the ECU metric using the measure selection criteria. This was part of a process of evaluating all the metrics to determine which ones to retire. When the ECU metric came up for discussion in the Metrics and

Scoring Committee meeting, members joked about the controversy around it. One Metrics and Scoring Committee member said, “now we get to the fun stuff” followed by several people saying “yes” and laughing (MSC recording, 2019, May 17, 1:41:54). As a Metrics and Scoring Committee member introduced the topic of the ECU metric, they said, “effective contraceptive use... no controversy here” followed by laughter (MSC recording, 2019, May 17, 1:42:00). All Metrics and Scoring Committee members voted that the ECU metric met the criteria of “sufficient denominator,” which prompted more joking and laughter because the only thing the Metrics and Scoring Committee could agree on was that the metric had a large denominator: fertile women 15-50 years old. Only a few Metrics and Scoring Committee members voted that the ECU metric should continue to be included in the Coordinated Care Organization Quality Incentive Program based on the 11 measure selection criteria. About retiring the ECU metric, one Metrics and Scoring Committee member said,

Well and I think it's a question too of a few things? One is, y'know, home grown, home created measures. And y'know, whether that's right, wrong, bad, or good it's just one of those, I think it's an important thing to think about um.... And I think the second is, does effective contraception truly represent the ultimate goal of reproductive health and or y'know primary care for women and adolescents or whatever? And there was a strong preference in the past of a push for that but I think the feedback that folks are getting is that maybe there's some other things or other thoughts about how do you um define that that's beyond just contraception um. And I do think the [long-acting reversible contraceptive] issue is deeper than just—I don't agree with the [Centers for Medicaid Services] necessarily splitting it out, but I think, when you think of the practice, I mean

nobody's putting a NuvaRing²⁵ in (laugh), I mean, y'know what I mean, they're putting [long-acting reversible contraceptives] in... anyways. (MSC recording, 2019, May 17, 1:56:43)

Metrics and Scoring Committee members briefly brought up other issues with the ECU metric, including challenges for Coordinated Care Organizations around the surveillance codes and concerns that the metric didn't address sexually transmitted infections.

At the July 2019 Metrics and Scoring Committee meeting, the committee voted to retire the ECU metric. Included in the meeting notes was an Oregon Health Authority report from a stakeholder survey asking for feedback on the 2020 measure set (MSC, 2019c). Stakeholders were identified as, "coordinated care organizations (CCOs), providers, community partners, state programs, and other advocates with an interest in the CCO incentive measures" (MSC incentive measure selection packet, 2019, July 19, p. 62). OHA received 288 responses to the survey. One question on the survey asked for feedback on which five measures to retire. The ECU metric ranked 3rd out of all the measures. All comments in favor of retiring the ECU measure were included in the report. There were 10 comments from CCOs and 11 comments from "other respondents." Topics included that the metric was sexist and gendered, deemphasized condoms, an administrative and coding burden, inequitable, unjust, and infringed on patient autonomy. The arguments recorded in the Metrics and Scoring Committee minutes for retiring the ECU metric were:

Measure doesn't address sexually transmitted infections; has imperfect data gathering as measure is home-grown and claims-based (e.g., denominator includes women who are not at risk of unintended pregnancy, such as those whose partners have had vasectomies);

²⁵ NuvaRing is the trade name for the contraceptive ring

and, may not be the best avenue for improving reproductive health. In addition, there are concerns about potential inequities associated with the measure. (MSC minutes, 2019, July 19, p. 3)

Summary

I included this in-depth, year-by-year description of how policymakers constructed, maintained, and retired the ECU metric to provide context for the reader. The in-depth description demonstrates the presence of ongoing concerns about the intent of the metric, targeting low-income and socially marginalized women for fertility control, and including women in the denominator who do not need or want contraception. In response to these concerns, policymakers reframed the intent of the ECU metric as focused on improving women's health and improving contraceptive access. Policymakers contended that the issue of including women who did not need contraception in the denominator was addressed by lowering the benchmark. Policymakers also invoked the authority of the National Quality Forum's endorsement of a similar metric as evidence of the appropriateness of the ECU metric. The next section presents a detailed analysis of the themes resulting from the close reading of the ECU metric policy texts considered within the history of the ECU metric and the broader sociohistorical context.

Part Two: Analysis of Themes

Part Two is a detailed analysis of the themes resulting from the close reading of the ECU metric policy texts. The following themes are discussed:

1. Us and Them: A Discourse of Experts
2. Gendered Discourse: Contraception is for Women
3. Semantics of Unintended Pregnancy
4. More Effective Methods Preferred

5. Discussion of Contraceptive Coercion
6. Fertility Reduction Discourse: People in No Position to Have Children
7. Fertility Reduction Discourse: High-Cost Children

Us and Them: A Discourse of Experts

Analysis of the ECU metric policy documents reveals the primacy of a discourse of experts. The voices of experts, including Coordinated Care Organization staff, Oregon Health Authority staff, healthcare providers, and other healthcare professionals were present in the discourse, while the voices of people with Medicaid insurance, experts in their own needs and experiences, were absent. The inclusion of only healthcare system experts in the ECU metric policy discourse created a situation of unequal social power (Van Dijk, 2015). This section begins with a description of how the discourse of experts with social power was maintained through the setting and membership of the Metrics and Scoring Committee. Second, this section describes how the Guidance Document authors constructed Coordinated Care Organizations and healthcare providers in an active role while obscuring the agency of women with Medicaid insurance.

Metrics and Scoring Committee Membership

Profession. All Metrics and Scoring Committee members were employed in the healthcare field. Some examples of the professions Metrics and Scoring Committee members held were: Chief Medical Officer of a Coordinated Care Organization, Associate Professor at Oregon Health & Science University, and Data and Quality Improvement Director at the Oregon Primary Care Association. This means that Metrics and Scoring Committee members who created, maintained, and retired the ECU metric were primarily healthcare professionals. Therefore, the Metrics and Scoring Committee was a group with institutionalized social power

and dominant social statuses creating policy for a group with intersecting marginalized social statuses, devoid of institutionalized social power, and excluded from the policymaking process (Collins, 2019).

Absent voice of people with Medicaid insurance. Notably absent from the discourse around the ECU metric were the voices of people with Medicaid insurance, especially those targeted by the ECU metric. There were no members of the Metrics and Scoring Committee who represented the Medicaid patient point of view and no public testimonies from Medicaid members about the ECU metric. As the Oregon legislation that created the structure for the Metrics and Scoring Committee is written, it would be possible for a person with Medicaid insurance to serve on the Metrics and Scoring Committee as a member-at-large. However, the Metrics and Scoring Committee meeting schedule of three-hour meetings during weekdays and the lack of financial reimbursement for work related to committee involvement present barriers for participation for low-income people with Medicaid insurance. Further, the extensive use of healthcare and health insurance jargon in the Metrics and Scoring Committee meetings may also preclude involvement by those with Medicaid insurance. Metrics and Scoring Committee meetings are public, and meeting times are posted on the Metrics and Scoring Committee website. However, to my knowledge there is no specific outreach to engage people with Medicaid insurance in the policymaking process. The voice of people with Medicaid insurance is also absent in this analysis, which focused on the policymaker discourse. I will address the significance of the absent voice of people with Medicaid insurance in the limitations section of Chapter 5. In the next section, I describe how the linguistic structure of the ECU metric Guidance Document (OHA, 2014) contributed to this unequal power dynamic.

Sentence Subjects and Nominalization in the Guidance Document

The Guidance Document authors contributed to the unequal power dynamic described above by constructing Coordinated Care Organizations and healthcare providers in an active role, while obscuring or downplaying the agency of women with Medicaid insurance. This occurred by making Coordinated Care Organizations and healthcare providers most often the subject of sentences; evidence for this is most prominent in the “Improving Effective Contraceptive Use” section which included six ECU metric implementation strategies. It is important to note that Oregon Health Authority staff wrote the Guidance Document to communicate the ECU metric to Coordinated Care Organizations, clinics, and healthcare providers to aid in policy implementation. Therefore, it is not surprising that the Guidance Document authors frequently made Coordinated Care Organizations, clinics, and healthcare providers the subjects of the sentences. However, because the ECU metric was not solely focused on the actions of the healthcare system, but also on *women’s* use of specific contraceptives, this pattern of sentence subjects is problematic. The following paragraphs describe examples of these linguistic patterns in select portions of the Guidance Document.

In the “Improving Effective Contraceptive Use” section, the Guidance Document described six strategies Coordinated Care Organizations, clinics, and healthcare providers could use to increase women with Medicaid’s use of specific contraceptives. In this section, Coordinated Care Organizations, clinics, and healthcare providers were primarily the subjects of the sentences. In contrast, Medicaid members, patients, or women were infrequently the subject of sentences. Again, this pattern of sentence subjects was consistent with the intended focus, as the purpose of this section of the Guidance Document was to influence Coordinated Care Organization and provider behavior. For example, “Strategy 2: Remove barriers to

contraception” is focused on removing healthcare system-level contraceptive access barriers, such as dispensing limited amounts of contraceptive supplies and requiring unnecessary tests like pelvic exams prior to dispensing contraception (p. 17).

When women with Medicaid insurance were the subject of a sentence, the sentence tended to have a passive construction. For example, “Women should be given the opportunity to discuss their pregnancy intentions” (OHA, 2014, p. 15). Here, “women” are the subject of the sentence, yet their action is to be “given the opportunity” by someone else. This pattern of sentence subjects serves to conceptually exclude the Medicaid member from active participation in their contraceptive decision. In another example, the Guidance Document authors stated, “effective contraceptive use is not solely the responsibility of the clinician” (p. 21). Following this statement, various roles are listed that play a part in effective contraceptive use, including “administrative and other support staff, health educators, and clinicians” (p. 21). Excluded from this list are the users of the contraceptives themselves. Additionally, the phrase “effective contraceptive use” is a nominalization, in which a verb is turned into a noun, which also omits naming the person using the contraceptive.

Another example of nominalization was found in “Strategy 3: Improve availability and uptake of long-acting reversible contraception,” which included the unwritten but implied action of “uptake” by the women with Medicaid insurance (p. 21). This use of nominalization again served to omit the person who is taking up the contraception. Another example, “increasing the use of [long-acting reversible contraceptives] will improve effective contraceptive use across the Oregon Health Plan,” included the nominalization “increasing the use of [long-acting reversible contraceptives],” which again obscured the user of the long-acting reversible contraceptive (p. 21). This use of nominalization was evident throughout the Guidance Document and served to

obscure women's role as active participants in the decision to contracept or select their contraceptive method.

Summary

In summary, the setting and membership of the Metrics and Scoring Committee included healthcare system professionals, while excluding participation of Medicaid members. The authors of the Guidance Document constructed Coordinated Care Organizations, clinics, and healthcare providers in an active role imbued with power, while downplaying the agency of women targeted by the policy through sentence subjects and nominalization. This imbalance of social power reflected and reinforced the status quo in which a group of experts with institutionalized social power and dominant social statuses created and enacted a policy targeting the fertility of a group with intersecting marginalized social statuses.

Gendered Discourse: Contraception is for Women

Policymakers constructed the ECU metric as a metric for women, which presupposed that contraception is something women do and are responsible for. This presupposition is in line with prominent discourses of gendered divisions of contraceptive labor as well as the assumption rooted in biological determinism that women are responsible for preventing pregnancy because women carry the pregnancy (Littlejohn, 2021). Presupposing contraception as being the responsibility of women downplays the role of men and people of other genders in contracepting. This is significant because the stated intended outcomes of the ECU were a reduction in unintended pregnancies and potential associated negative consequences, which may have been more achievable with a more inclusive metric. In this section I document how policymakers constructed the ECU metric as being for women, thus continuing the gendered division of contraceptive labor while potentially reducing the measure's effectiveness. Policymakers

constructed the ECU metric as being for women in four ways: 1) by categorizing the ECU metric as a women's health metric; 2) including only women in the denominator; 3) not counting vasectomies; and 4) focusing on *women's* inconsistent or incorrect use of contraception as the reason for unintended pregnancy.

Categorizing the ECU Metric as a Women's Health Metric

Policymakers categorized the ECU metric as a "women's health metric." To illustrate this point, I provide two examples from the Metrics and Scoring Committee discourse. First, in the initial public testimony submitted in support of the ECU metric, the metric steward wrote: "[Coordinated Care Organizations] need a new women's health metric. This committee has already decided to retire the 'Elective Delivery before 39 weeks' metric, and it is important to replace it with another women's health metric" (MSC testimony Bellanca, 2014, August 22, p. 1). Second, at the September 2016 Metrics and Scoring Committee meeting, the minutes included: "whether the measure should be introduced as being about women's reproductive health rather than contraceptive use and other ways to frame the work with providers and clients (suggested framing: 'helping women meet their own goals for reproductive health')" (MSC minutes, 2016, September 16, p. 2). These examples demonstrate how the Metrics and Scoring Committee discourse constructed the ECU metric as being a metric for women through categorizing it as a women's health metric.

One member wondered about the construction of the ECU metric as being for women at the May 2019 Metrics and Scoring Committee meeting when the committee retired the ECU metric:

Does effective contraception truly represent the ultimate goal of reproductive health and or y'know primary care for women and adolescents or whatever? And there was a strong

preference in the past of a push for that but I think the feedback that folks are getting is that maybe there's some other things or other thoughts about how do you um define that that's beyond just contraception um. (MSC recording, 2019, May 17, 1:57:00)

This final example from the Metrics and Scoring Committee discourse demonstrates a questioning of the focus on women's contraceptive use as the metric representing women's primary care and reproductive health care. In the next section I describe how the Guidance Document authors also constructed the ECU metric as being for women.

In the Guidance Document (OHA, 2014), it is women's pregnancy intentions that are the focus of screening, women who try to avoid pregnancy, women who would benefit from knowing which methods of contraception are most effective, and women who use contraception inconsistently or incorrectly. The word *women* was used 180 times in the Guidance Document, while the word *men* was used seven times. Three of these uses of *men* were in relation to contraception, specifically in what contraceptive services the Oregon Health Plan covers for "men, women, and adolescents" (p. 34), in a suggested resource for counseling "women, men, and couples about contraceptive method choice" (p. 37), and in the "FAQ" (frequently asked questions) section of the Guidance Document. Even in those portions of the document where men are mentioned, the assumption that contraception is the responsibility of women remains, as evidenced in this example from the FAQ section of the Guidance Document:

What about men? Shouldn't they be involved in family planning?

Absolutely. It is a great idea to talk to men about their intentions for parenting and how it fits in with their life goals. Providers can ask them what they know about their partner's method of contraception, how it works and how effective it is. (p. 33)

Although this last example includes reference to men's role in family planning, this example presupposed that it is "their partner's method of contraception" providers need to discuss with men. This presupposition again reinscribed the idea that contraception is something that women do and are responsible for. The Guidance Document authors did not mention people of other genders besides men and women.

Only Including Women in the Target Population

The target population of the ECU metric was women. The Guidance Document defined the initial metric target population (denominator) as:

All women ages 18-50 who were continuously enrolled in a [Coordinated Care Organization] for the 12-month measurement period. Women who are not capable of becoming pregnant and women who were pregnant during the measurement year are excluded from the denominator. (p. 3)

In 2017, the Metrics and Scoring Committee expanded the ECU metric denominator to include women and female adolescents ages 15-50.

By targeting "women" with the ECU metric, policymakers ignored the social construction of gender, and reinscribed an essentialist idea of womanhood, which views women as a "natural, biological, and primarily-reproductive category" (Keyes et al., 2020, p. 25:5). This construction of the ECU metric presupposed not only that women's health was synonymous with reproductive health, but also that all people who can become pregnant were women. This analysis recognizes that policymakers were attempting to support the health of a gendered, marginalized group by including only women in the ECU metric denominator. In part, this may have been in response to the cis male as the "default body," which healthcare and health research often considers the norm (Keyes et al., 2020, p. 25:34). This may also have been in response to

the significant impact unwanted pregnancy has on the health and well-being of those with the capacity for childbearing, with women being disproportionately affected. For example, the Turnaway Study found that women denied abortion who gave birth were more likely to live in poverty and to raise the child alone, compared to those who received abortion care (Foster et al., 2018). Nonetheless, through the inclusion of only women in the ECU metric denominator, policymakers potentially reduced the measure's intended impact on unintended pregnancy rates. In the *ECU Metric Brief* (OHA, n.d.-c), the authors used the non-gendered word *patient* and did not use any gendered language. This may reflect Oregon Health Authority staff awareness of the limitations of targeting only women's contraceptive use. Despite this language shift, the numerator included only contraceptive methods prescribed to women.

Not Counting Vasectomies

In the initial planning stages of the metric, the Metrics and Scoring Committee considered including men in the metric. The meeting minutes reported that the Committee's "preference would be to include men in the measure; however, the only claims data available for men are vasectomy procedures" (MSC minutes, 2014, August 22, p. 3). Ultimately, the Oregon Metrics Technical Advisory Group abandoned the idea of including vasectomies early in the metric construction "because there is no good way to guarantee partnership with a female patient" (Oregon Metrics Technical Advisory Workgroup minutes, 2014, November 24, p. 4). This means that even if the Metrics and Scoring Committee had decided to include vasectomies, the ECU measure would still target women. In the metric steward's slide addressing "shortcomings in the [metric] specifications," the steward asserted, "we cannot count vasectomies as they are claims on someone else's chart" (MSC presentation, 2017, May 19, p. 24). By claiming that men with vasectomies are "someone else," the metric steward reiterated

that women were the target of the metric, and it is women's contracepting that the metric was focused on.

The Guidance Document authors restated these reasons in the "FAQ" or frequently asked questions section:

Is male sterilization included in the CCO incentive measure?

No. While male sterilization is a Tier 1 (most effective) method of contraception, the [Coordinated Care Organization] incentive measure is based on women. There is no reliable way to connect women in the denominator with men who have been sterilized.

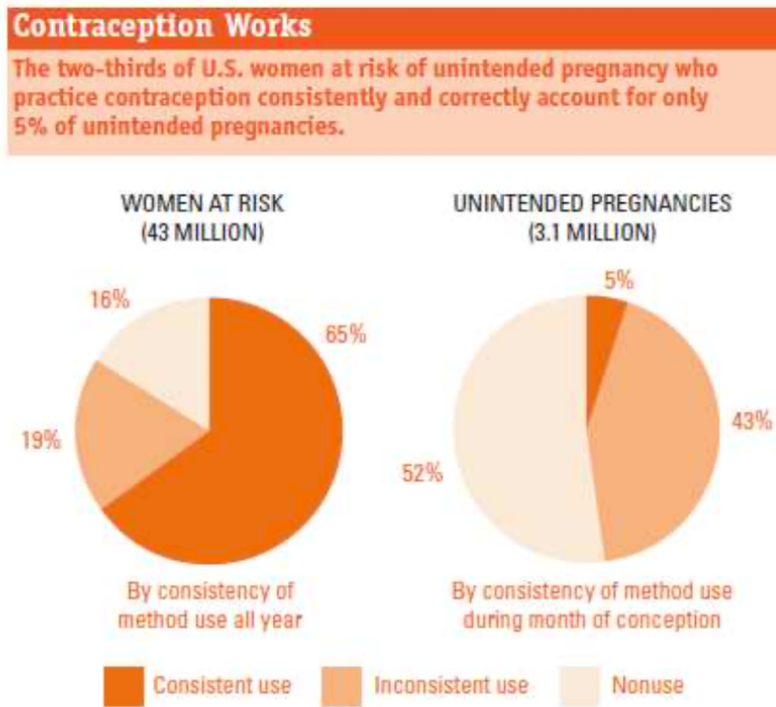
Even if there is administrative data for the woman that indicates the contraceptive method she uses is male sterilization, it cannot be determined from administrative data if the woman changes partners, or has multiple partners, and therefore she should still be considered 'at risk'. (OHA, 2014, p. 32)

This quote reveals that the ECU metric was "based on women" and reinscribed the discourse of biological determinism, which proposes that women are responsible for contraception because they are the ones who carry the pregnancy (Littlejohn, 2021).

Focus on Women Using Contraception Incorrectly or Inconsistently

Policymakers constructed women's inconsistent or incorrect use of contraception as the main reason for unintended pregnancy. For example, in each Metrics and Scoring Committee presentation, the metric steward included the following slide:

What we know about the need for ECU



11

(MSC presentation, 2017, May 19, p. 21)

The image compared the consistency in use of contraception by all women at risk of unintended pregnancy with consistency in use for women with unintended pregnancies. The image conveyed the message that women's inconsistent or nonuse of contraception was a major contributor to unintended pregnancy, and ignored how men or people of other gender's inconsistent or nonuse of contraception was also a contributor.

The Guidance Document authors reiterated this point with the statement, "among women with an unintended pregnancy, 43 percent reported using contraception, but they were using it incorrectly or inconsistently" (OHA, 2014, p. 3). Constructing the reason behind unintended

pregnancy as women's inconsistent or incorrect use of contraception ignores men and people of other gender's role in creating a pregnancy while failing to address the reasons that people may use contraception incorrectly or inconsistently.

Summary

In summary, analysis of these texts demonstrates how policymakers constructed the ECU metric as being for women. This analysis described how policymakers constructed the ECU metric as being for women in four ways: 1) by categorizing the ECU metric as a women's health metric; 2) including only women in the denominator; 3) not counting vasectomies; and 4) focusing on women's inconsistent or incorrect use of contraception as the reason for unintended pregnancy. The construction of the ECU metric as being for women reinscribed the dominant view and practice that contraception is a solely a women's health concern, contributing to the continuation of the gendered division of contraceptive labor.

Semantics of Unintended Pregnancy

The adjectives *unintended*, *unplanned*, *unwanted*, *unexpected*, and *mistimed* were used to describe similar concepts, and at times were used synonymously in the discourse around the ECU metric. Despite the similarity of use, these five adjectives have different meanings, both in common speech and within the research literature. Notably, the ECU metric discourse often conflated the terms *unintended* and *unwanted*, signaling that unintended pregnancies were assumed to be unwanted. In this section, I describe how the research literature defines these terms, conduct an etymological analysis²⁶ of the adjectives used to describe pregnancies, and give examples of how the words were used, distinguished, and conflated in the ECU metric discourse.

²⁶ Etymological analysis is an analysis of word origins to illuminate the deeper meanings and histories held by words.

Definitions of terms within research literature

Within the research literature, unwanted and mistimed pregnancies are subcategories of unintended pregnancies. Unwanted pregnancies are pregnancies that were not wanted when they occurred or at a future time. Mistimed pregnancies are pregnancies that occurred sooner than desired. Unwanted and mistimed pregnancies are often combined for analysis under the category of unintended pregnancies (Finer & Zolna, 2014). In general, researchers operationalize the rate of unintended pregnancy based on language used in research reports stemming from one of two large studies, the National Survey of Family Growth and the Pregnancy Risk Assessment Monitoring System. Both surveys use the word *want* in the survey question, however the words *intended* or *unintended* are used as the descriptors in dissemination of findings (Kost & Zolna, 2019).

Etymologies and Semantics

First, I describe the etymologies and consider the semantics of the words *unintended*, *unplanned*, *unwanted*, and *mistimed*. *Unexpected pregnancy* is a rarely used term both in the unintended pregnancy literature and in the discourse around the ECU metric, therefore I will not analyze this word.

Unintended. The word *unintended* is formed by the prefix *un* and the adjective *intended*. The prefix *un* is added to adjectives to express a negative sense (Oxford English Dictionary [OED], n.d.-h). The root of the adjective *intended* is the verb *intend*, which comes from the French verb *entendre* or *intender*, and means “to stretch, extend, strain, direct one's thoughts or faculties, to hear, understand, expect, occupy oneself” (OED, n.d.-a) The verb *intend* also comes from the Latin verb *intendere* and means “to stretch out or forth, to strain, direct, spread out, increase, turn one's attention, purpose, endeavour, maintain, assert” (OED, n.d.-a). The adjective

intended means “purposed to be done or accomplished; designed, meant; designed to be what is denoted by the noun; done on purpose, intentional” (OED, n.d.-b). Taken together, the word “unintended” describes an action not done with (future) purpose. Having a future purpose is one way the word *intend* differs from the word *want*.

Unplanned. The adjective *unplanned* is formed by the prefix *un* and the adjective *planned*. The root of the adjective *planned* is the noun *plan*, which means a “design or proposal” and suggests “an intention or ambition for the future” (OED, n.d.-e). The English noun *plan* comes from the French and means a “drawing, sketch, or diagram made by projection on a horizontal plane showing the layout of a building, city, area, etc.” (OED, n.d.-e). Taken together, the word *unplanned* means “not planned...not organized or anticipated; unconsidered, spontaneous” (OED, n.d.-i). Like the word *unintended*, the word *unplanned* suggests a future orientation.

Unwanted. The adjective *unwanted* is formed by the prefix *un* and the adjective *wanted*. The etymology of the verb *want* comes from the Scandinavian adjective *vanta* and means “to be lacking” (OED, n.d.). The adjective *wanted* means “lacking, missing; needed; sought after; wished for, desired” (OED, n.d.-j). Taken together, *unwanted* means not lacking or not desired. In contrast to the word *unintended* or *unplanned*, the word *unwanted* does not suggest a future orientation.

Mistimed. The adjective *mistimed* is formed by the prefix *mis* and the adjective *timed*. The prefix *mis* means “‘amiss’, ‘wrong(ly)’, ‘bad(ly)’, ‘improper(ly)’, ‘perverse(ly)’, ‘mistaken(ly)’” (OED, n.d.-c). The adjective *timed* means “done, made, or occurring at an opportune (or inopportune) time” (OED, n.d.-g). Together, *mistimed* means “ill-timed, unseasonable, untimely” (OED, n.d.-d).

These etymologies and definitions show that the words *unintended* and *unplanned* have similar meanings and suggest a purpose for the future. In contrast, the word *unwanted* refers to something not desired, but does not suggest something in the future or have anything to do with time. The word *mistimed* refers to something that happened at the wrong time, thus also holds a time component. The words *unintended* and *unplanned* both suggest a conceptualization of linear time, in which there is a future to be planned for, to be stretched towards, to be drawn abstractly and then made real.

Use of Terms in the Guidance Document

Policymakers named the metric “Effective Contraceptive Use among Women at Risk of Unintended Pregnancy,” which used the word *unintended* to describe the type of pregnancy that the policy was aimed at preventing. Guidance Document authors used five different adjectives to describe the pregnancy concept. The word *unintended* was used 38 times, *unplanned* was used once, *unwanted* was used six times, *unexpected* was used once, and *mistimed* was used once. These counts include use only in the main body of text and exclude use of the terms in references or resources.

It is not surprising that the word *unintended* is used most often to describe the type of pregnancy the policy is designed to help women avoid. This word is common in the public health literature and researchers have used the word *unintended* to describe and categorize pregnancies since the 1941 Indianapolis Study into White Protestant women’s pregnancy intentions (Campbell & Mosher, 2000). Indeed, the Guidance Document authors state in the Introduction that one of the purposes of the Guidance Document is to include “strategies for addressing pregnancy intentions” (OHA, 2014, p. 3). This usage suggests the assumption that people have clear pregnancy intentions.

The phrase *unintended pregnancy* was used mostly in a negative sense. Numerous times in the Guidance Document the phrase *at risk of unintended pregnancy* was used, including in the full title of the metric. The phrase *at risk* suggests danger or “the possibility of loss, injury, or other adverse or unwelcome circumstance” (OED, n.d.-f). For the most part, the phrase *unintended pregnancy* was described as something to be reduced or prevented. In the “Unintended Pregnancy” section of the Guidance Document, the authors recognized that not all unintended pregnancies may be negative events. This is one place in the text that distinguished between the categories of unintended and unwanted pregnancies:

It is important to note that not all unintended pregnancies are unwanted pregnancies.

Sometimes an unintended pregnancy is a welcome surprise. Even in these cases, the fact that the pregnancies were unintended and unexpected means that there were missed opportunities for preconception care. (OHA, 2014, p. 8)

The second place in the Unintended Pregnancy section of the Guidance Document, the phrase *unwanted pregnancy* was distinguished as a subcategory of *unintended pregnancy*:

For women whose unintended pregnancies are unwanted, approximately forty percent end in abortions, the remainder result in births. For these families, an unintended and unwanted pregnancy can lead to an increased likelihood of complications for both the mother and infant. (OHA, 2014, p. 7)

The final place where *unwanted* was distinguished from *unintended* was in the Strategy 4 section: “helping women plan healthy pregnancies (and avoiding those that are unwanted or mistimed) is a core component of primary care” (OHA, 2014, p. 23). In this example, the word *unwanted* is used in contrast to *mistimed* as a sub-category of *unintended*, as it is in the research literature. This sentence also uses the adjective *healthy* to describe planned pregnancies and

contrasts these *healthy pregnancies* with unwanted or mistimed pregnancies. This use of the adjective *healthy* implies that unwanted or mistimed pregnancies are not healthy, which is possible but not necessarily true.

The other times the word *unwanted* was used in the Guidance Document this term was not clearly distinguished from the word *unintended* and was used in a way that could be interpreted as being interchangeable with the word *unintended*. One of these uses was in the Background section in a quote from the Institute of Medicine report *Clinical Preventive Services for Women: Closing the Gaps*. The “[Institute of Medicine] recommended that preventive services for women include ‘a fuller range of contraceptive education, counseling, methods, and services so that women can better avoid unwanted pregnancies and space their pregnancies to promote optimal birth outcomes’” (p. 5). Guidance Document authors use the word *unwanted* again in the Unintended Pregnancy section without clearly distinguishing it from the word *unintended*. “Women and adolescents who carry an unwanted pregnancy to term and give birth may also have their education or jobs derailed by the pregnancy” (OHA, 2014, p. 7).

The Guidance Document authors recognized that not all people may be sure about their pregnancy intentions. In the section “Strategy 1: Screen women for their pregnancy intentions on a routine basis” the Guidance Document authors stated:

The One Key Question®²⁷ initiative encourages primary care providers to routinely ask women of reproductive age “Would you like to become pregnant in the next year?” The purpose of asking the question is to ensure that women who answer ‘yes’ receive preconception care to improve the health of their pregnancy, and those women who answer ‘no’ or ‘unsure’ receive contraception care that meets their needs.

²⁷ For information on the One Key Question® see: Allen, D., Hunter, M.S., Wood, S., & Beeson, T. (2017). One Key Question®: First things first in reproductive health. *Maternal Child Health Journal*, 21(3):387-392. doi: 10.1007/s10995-017-2283-2

Pregnancy intention should be assessed within the primary care medical home and workflows for both ‘yes’ and ‘no’ responses will help ensure that the woman’s wellness is addressed. (OHA, 2014, p. 15)

Although this text allowed that some women may have answered “unsure” to the question about whether they would like to become pregnant in the next year, women who answered “unsure” were combined with those who answered “no” and placed in the category of needing contraception. The subsequent sentence only included the binary option of “yes” or “no” as answers to the question of pregnancy intention, which showed there was not a workflow option for people who were unsure about their pregnancy intentions.

Use of Terms in Other Texts

In the *ECU Metric Summary*, the word *unintended* was the only word used to describe the pregnancies that the policy was designed to prevent. In the *ECU Metric Brief*, the words *unintended* or *intentions* were the two words used to describe pregnancies. For example, “as a health care provider, you play a key role in helping patients understand their options, take control of their reproductive health, and prevent unintended pregnancies” (OHA, n.d.-c, p. 1). Another example was as a strategy for the implementation of the metric, which was to “screen patients for their pregnancy intentions on a routine basis” (OHA, n.d.-c, p. 1).

In the Metrics and Scoring Committee presentations about the ECU metric, *unintended* was the main word used. The word *unwanted* was used on two slides that described why it was important to prevent these pregnancies.

Why is this important?

Goal is to prevent unintended (unwanted) pregnancy

A woman with an unintended pregnancy is:

- less likely to seek early prenatal care
- more likely to expose the fetus to harmful substances
- at greater risk of depression
- at greater risk of physical abuse
- at greater risk of having her employment, education and relationship with her partner derailed

Brown, S. S., & Eisenberg, L. (Eds.). (1995). The best intentions: Unintended pregnancy and the well-being of children and families. Washington, DC: National Academies Press

(MSC presentation, 2016, September 16, p. 60)

Why is this important?

Goal is to prevent unintended (unwanted) pregnancy

A child of an unintended conception is at greater risk of:

- being born at low birthweight
- dying in his/her first year of life
- being abused or neglected
- not receiving sufficient resources for healthy development

Brown, S. S., & Eisenberg, L. (Eds.). (1995). The best intentions: Unintended pregnancy and the well-being of children and families. Washington, DC: National Academies Press

(MSC presentation, 2016, September, p. 61)

The rest of the presentation used only the word *unintended* to describe pregnancies. This use of the two words, with *unintended* first and *unwanted* next to it within parentheses, suggests a conflation of these two terms, calling into question the accuracy and precision of the risks

outlined in the slides. In other words, when the discourse around the ECU metric used the word *unintended*, it assumed that the pregnancy was also unwanted.

Summary

This section described the etymologies and semantics of the adjectives *unintended*, *unplanned*, *unwanted*, and *mistimed*, and gave examples of how these words were used in the ECU metric discourse. Overall, my analysis of these texts demonstrates the frequent conflation of the words *unintended* and *unwanted*. This conflation suggests policymakers assumed unintended pregnancies were also unwanted.

Specific Methods Preferred

Conflicting perspectives regarding preferences for specific methods of contraception are evident within the Guidance Document. This could be described as “a dueling discourse,” with one voice advocating for expanding access to the full range of contraceptive methods, while another voice advocating for women to use contraceptive methods more effective at the population, typical-use level. The Guidance Document authors included a recommendation from an Institute of Medicine report that preventative health services for women should include giving women access to a “fuller range of contraceptives” (OHA, 2014, p. 5). The Guidance Document authors also asserted that “it is important to provide women at higher risk of unintended pregnancy with contraceptive options” (p. 7). These statements suggest ensuring women have access to the full range of contraceptives is important. However, these statements both occurred within a policy that preferred women use specific methods, creating tension between patient autonomy and increasing women’s use of specific methods.

In this section, I examine how the discourse around the ECU metric constructed some contraceptive methods as effective and minimized women’s contraceptive preferences.

Focus on Contraceptive Effectiveness

The preference for specific contraceptive methods was built into the metric in two ways: in the name of the metric and by what contraceptive methods were counted. A name is a semantic macrostructure that informs and controls how the reader interprets and understands the concepts that follow the name (Van Dijk, 2009). The full name of the metric was the “Effective Contraceptive Use among Women at Risk of Unintended Pregnancy” metric, while the more commonly used shortened name was the “Effective Contraceptive Use” metric. The name of the metric shows the focus was on the effectiveness of contraceptive methods and their use by women at risk of unintended pregnancy. This semantic macrostructure shaped understanding of the rest of the policy by focusing the reader on contraceptive effectiveness.

The preference for specific methods was also shown by the prominence of the topic of contraceptive effectiveness in the Guidance Document. “Effective Contraceptive Use” was the first subheading under the “Contraceptive Use” section. This section included a visual depiction of contraceptive methods organized in a three-tiered system ranked by effectiveness. Organizing the methods by effectiveness signaled that this was a defining quality. Further, the word *effective* or *effectiveness* was used 51 times as a descriptor for contraception in the Guidance Document.

The metric numerator categorized specific contraceptive methods as effective for the incentive. The inclusion of limited contraceptive methods in the ECU metric was due in part to policymaker preference for women to use contraceptive methods more effective at the population level. This preference reveals the focus on realizing population-level reduction in unwanted pregnancy. This focus created conditions that, at best, ignored or minimized potential for contraceptive coercion at the individual level and, at worst, was a vehicle for maintaining eugenic, heteronormative, racist and ableist social structures.

The inclusion of limited methods in the ECU metric was also due to the way data was collected for the metric. Coordinated Care Organizations used claims data to count the number of contraceptive prescriptions. This data collection method precluded collecting data on non-prescription methods (condoms, withdrawal, sponge, fertility awareness). This incomplete data collection was further worsened by the Metric and Scoring Committee's decision not to count vasectomies. This reveals that ECU metric definitions may have been influenced in part by what methods could be tracked with current data collection methods rather than an exclusive focus on population level efficacy for preventing pregnancy. By counting only specific contraceptives more effective at the population level, the policymakers also placed a value judgment on contraceptives, thus ignoring other aspects of contraception that may factor into a person's contraceptive choice.

Brief Mentions of Other Aspects of Contraception Besides Effectiveness

Guidance Document authors discussed other aspects of contraception besides effectiveness, including "satisfaction" and "side effects" specifically in relation to women's use of long-acting reversible contraceptives. For example, "Clinics can promote patient follow-up, including scheduling recheck visits for [long-acting reversible contraceptives] at 6-8 weeks, and asking follow up questions about satisfaction with method and side effects" (OHA, 2014, p. 23). The Guidance Document authors also stated that Coordinated Care Organizations, clinics, and providers could help with "side effect management" (p. 26). In this section, the authors included direction for clinicians to discuss "efficacy, benefits and side effects of method chosen," and noted "counseling should also cover the duration of use, hormonal versus non-hormonal methods, and barrier versus non-barrier methods" (p. 25). This last phrase briefly recognized three other aspects of contraceptives that matter in people's contraceptive decision-making.

The public testimony from the Eastern Oregon Coordinated Care Organization mentioned potential side effects in a non-essential clause. A non-essential clause is a clause that can be removed from the sentence without resulting in an incomplete sentence. This means that the authors thought the topic of side effects was important to include, but not important enough to be the main topic of the sentence. In their letter, the Eastern Oregon Coordinated Care Organization stated, “while we agree with the principle of the ‘One Key Question,’ incentivizing such limited treatment options, which are not without potentially significant side effects, undermines the patient/provider relationship, and diminishes alternative treatments which may be more appropriate for some patients” (MSC testimony, 2018, December 5, para. 3). This was the only mention in any of the policy documents that side effects may influence contraceptive choice and use.

Assumption That Increasing Women’s Use of Specific Contraceptive Methods is Good

Throughout the Guidance Document, the words “increase” and “improve” were used interchangeably in relation to “women’s use of specific methods.” The word *increase* refers to getting more of something, while the word *improve* refers to making something better, an inherent value judgement. The frequent conflation of these terms served the purpose of reiterating the presuppositions that contraceptive methods are valued by effectiveness, and more women using highly effective methods is good for them and society.

Focus on Long-Acting Reversible Contraceptives

Although the ECU metric incentivized women’s use of many contraceptive methods, the Guidance Document authors focused on increasing long-acting reversible contraceptive use more than any other methods. Long-acting reversible contraceptives were mentioned 32 times in the body of the Guidance Document. In contrast, the pill was mentioned eight times, the patch five,

the ring five, the injection four, and the diaphragm four. The Guidance Document authors' emphasis on long-acting reversible contraceptives was also demonstrated by their focus on strategies to increase long-acting reversible contraceptive use: "Strategy 3: Improve availability and uptake of long-acting reversible contraception" (OHA, 2014, p. 21). In addition, "Strategy 5: Build provider awareness and capacity around effective contraceptive use" is primarily focused on increasing long-acting reversible contraceptive use (p. 25).

One member considered the emphasis on long-acting reversible contraceptives at the May 2019 Metrics and Scoring Committee meeting when the committee retired the ECU metric. The following excerpt referenced "the [long-acting reversible contraceptive] issue." This reference was to the controversy around the public health goal of increasing women's use of long-acting reversible contraceptives.

And I do think the LARC [long-acting reversible contraceptive] issue is deeper than just—I don't agree with the CMS [Centers for Medicaid] necessarily splitting it out, but I think, when you think of the practice, I mean nobody's putting a NuvaRing in (laugh), I mean, y'know what I mean, they're putting [long-acting reversible contraceptives] in... anyways. (MSC recording, 2019, May 17, 1:57:26)

When the Metrics and Scoring Committee member laughed about how "nobody's putting a NuvaRing in" because "they're putting in [long-acting reversible contraceptives]," they interpreted that the ECU metric was influencing healthcare providers to increase placement of long-acting reversible contraceptives rather than other methods like the NuvaRing. This example from the Metrics and Scoring Committee discourse further underscores the overall emphasis of the ECU metric on long-acting reversible contraceptives, despite including other methods in the incentive.

Silence Around Sterilization

Although sterilization is a tier 1 method incentivized by the ECU metric, there was silence around strategies to improve access to this method. The Guidance Document authors named sterilization seven times in the Guidance Document. Three of these uses were in descriptions of the metric numerator, three were in relation to the question in the “Frequently Asked Questions” section about why male sterilization was not included, and the final use was in a list of services covered by Oregon Medicaid health insurance. Tubal ligation was mentioned under “Strategy 5: Build provider awareness and capacity around effective contraceptive use,” with direction to healthcare providers that “counseling should be patient-focused and clear about the effectiveness of various methods, emphasizing Tier 1 methods (vasectomy and tubal ligation as permanent methods, [intrauterine devices] and implants as long-acting reversible methods)” (OHA, 2014, p. 25).

Silence Around Tier 3 Methods

There was also silence in the Guidance Document about tier 3 methods. Fertility awareness-based methods, sponges, withdrawal, and spermicide were not discussed beyond being listed as tier 3 or less effective methods. Guidance Document authors mentioned condoms five times in the Guidance Document. Two of these mentions were in lists of tier 3 methods. Two of these mentions were in relation to how condoms “provide barrier protection against disease” (p. 5) and to “help reduce the risk of sexually transmitted infections” (p. 19). The final mention was in a list of what services the Oregon Medicaid health insurance covers.

Summary

In this section, I examined how the Guidance Document authors constructed a dominant narrative favoring use of contraceptive methods with population level efficacy for preventing

pregnancy and constructed a preference for women to use specific contraceptive methods. While the authors of the Guidance Document expressed the importance of ensuring people's access to the full range of contraceptive options, they also expressed a clear preference for specific contraceptive methods. This was accomplished by focusing primarily on contraceptive effectiveness, conflating the terms *increase* and *improve*, and focusing most of the text on increasing women's use of long-acting reversible contraceptives. Excluding condoms, fertility awareness-based methods, withdrawal, and spermicide from methods considered "effective" served to de-emphasize these methods. This may have constrained people's contraceptive choice and undermined the stated commitment to promote access to the full range of contraceptives.

Discussion of Contraceptive Coercion

Policymakers brought up the issue of contraceptive coercion soon after the ECU metric was enacted and policymakers and stakeholders continued to raise this issue for the duration of the policy. This section begins with a focused description of the Metrics and Scoring Committee discussion of how the issue of coercion was introduced, promoted, and minimized, including both direct and indirect mentions of coercion. Next, this section assesses the two main ways policymakers minimized concerns about coercion: 1) silence around what contraceptive coercion is; and 2) reframing the metric as "improving access" when the nearly singular focus on LARC use signals policymakers' interest in population level efficacy for preventing pregnancy and the fully singular focus on Medicaid-supported women dangerously intertwines with longstanding racism and eugenics within reproductive health policy.

In-Depth Review of the Discussion of Contraceptive Coercion

The first references to coercion were indirect and were included in the Guidance Document (OHA, 2014). These references to coercion were indirect in that they did not

explicitly mention coercion, but reminded clinicians that women must be free to choose their contraceptive method. The next time policymakers raised concerns about coercion occurred more directly at the August 2016 Metrics and Scoring Committee meeting. The metric steward presented a response to the “concerns that were raised... about the measure being coercive” at the September 2016 Metrics and Scoring Committee meeting (MSC minutes, 2016, September 16, p. 2). In the presentation at the September 2016 Metrics and Scoring Committee meeting, the metric steward included the question, “Yes, but what about the perception that we are unfairly or unethically targeting poor women with our contraception efforts?” (MSC presentation, 2016, September 16, p. 67). The metric steward’s answer to this question was the “lowest income women” (p. 68) have the highest rates of unintended pregnancy and “poor women (have) less access to contraception than their higher-income peers” (p. 70). Therefore, this “quality metric in contraception is a key step in giving low-income women equal access to high quality primary care” (p. 70). At the May 2017 Metrics and Scoring Committee meeting, the metric steward presented another response to concerns about the intent of the metric. Although the origin of these concerns is unknown, it is possible they came from the Metrics Technical Advisory Group because this group also worked closely with the metrics. The May 2017 minutes described that “the intent of the measure is twofold: 1) Providing high quality primary care for women by improving contraception access and 2) Preventing unintended pregnancy. The first intent (improving access to contraception) is the shorter-term and primary aim” (p. 2). In December 2018, a Coordinated Care Organization raised concern about several issues with the metric including provider bias, the narrow definition of what counted for effective contraception, and concern about including adolescents (MSC public testimony, 2018, December 5).

In May 2019, the Metrics and Scoring Committee evaluated the ECU metric using the measure selection criteria. This recorded discussion included a joke about how there was “no controversy here” followed by laughter, implying that the ECU metric was controversial (MSC recording, 2019, May 17, 1:42:00).

In July 2019, the Metrics and Scoring Committee voted to retire the ECU metric. Meeting materials contained a *Stakeholder Survey* with comments about the ECU metric from Coordinated Care Organization and clinic staff. These comments included several voicing concern about coercion in the metric. For example:

The effective contraceptive use measure raises medical-ethical concerns with many providers. My opinion is this measure perpetuates reproductive injustice by creating a financial incentive to health care providers to promote contraceptives among a defined population of Oregonians, who are also most likely to be persons of color. (MSC incentive measure selection packet, 2019, p. 89)

The July 2019 minutes stated that there were “concerns about potential inequities associated with the measure” (p. 3). This overview of how policymakers discussed the issue of contraceptive coercion related to the ECU metric between 2014 and 2019 demonstrates that policymakers were concerned about coercion throughout the duration of the ECU metric.

How Policymakers Minimized the Issue of Coercion

Policymakers predominantly minimized the issue of coercion in two ways: 1) silence around what contraceptive coercion is; and 2) reframing the metric as “improving access.”

Silence. Guidance Document authors indirectly signaled concern about incentivizing coercion in the Guidance Document yet did not explicitly name the issue. In the “Strategy 5 Build provider awareness and capacity around effective contraceptive use” section under the sub-

heading “Provide effective counseling,” the third part of the recommended counseling approach is to:

3. Provide time for client to review and sign informed consent form for LARC procedure

[Coordinated Care Organizations] and clinics should ensure that all providers have an informed consent form and training, or a script for how to talk to a member in a way that promotes clear understanding by a woman of her choices and any risks involved.

Members should not be given forms to sign without discussion: patient participation in these decisions must be voluntary and they must be provided adequate, appropriate information to make decisions. (OHA, 2014, p. 27)

This excerpt shows the Guidance Document authors recognized the issue of contraceptive coercion, signaled by the inclusion of verbiage about ensuring clients have time to review contraceptive information, an understanding of their choices, and that decisions must be voluntary. That the authors thought it was necessary to include these topics signals they knew people may not have adequate time for or information about contraceptive decisions and may be given forms to sign without discussion. The authors’ use of one of the strongest modals²⁸ in the phrase “must be voluntary” conveyed a strong necessity for the voluntariness of patient participation in contraceptive decisions and suggests they were concerned about coercion.

Similarly, content in the “Measure Specifications” section also suggests the authors of the Guidance Document were aware of the potential for coercion. The Guidance Document authors stated:

While the Oregon Health Authority is incentivizing effective contraceptive use, it is important to remember that Oregon Health Plan clients must be free to choose the method

²⁸ A modal is word indicating degree of likelihood or obligation.

of family planning that is to be used. Per federal law, health plans must provide that each member is ‘free from coercion or mental pressure, and free to choose the method of family planning to be used.’ (OHA, 2014, p. 29)


The use of the conjunction “while,” which began the prepositional phrase, indicated a contrast between the incentivizing of specific contraceptive use and clients being free to choose their method. This section also included two more uses of the strong modal “must,” and the modal phrase “it is important.” Both of these uses of strong modals gave added gravity to the idea that Medicaid members have the freedom to choose their contraceptive methods. The direct quote in the excerpt is from the Code of Federal Regulations, which are rules published in the Federal Register by the departments and agencies of the Federal Government. The inclusion of this rule signals Guidance Document authors knew people had been exposed to coercion or mental pressure in contraceptive decision-making. Despite this implied concern, the authors did not explicitly explain contraceptive coercion, reference historical examples of this practice, or mention the distrust it has engendered in marginalized populations.

Changing the topic to improving access. The second way policymakers minimized concern about contraceptive coercion was by changing the topic to “improving access” for people who have historically had less access to contraception. The metric steward reframed the ECU metric this way in both presentations given in response to concerns about contraceptive coercion. This effectively redirected attention away from the issue of coercion. In this section, I describe and give examples of how the metric steward avoided the issue of targeting the contraceptive choices of low-income women by shifting the conversation to improving contraceptive access for this population.

In the September 2016 presentation, the metric steward began with a two-slide definition of the ECU metric:

Effective Contraception Use Metric


Proportion of women at risk for unintended pregnancy
who are using an effective method of contraception



(MSC presentation, 2016, September 16, p. 58)

Denominator: Women age 15-50 who are physiologically capable of pregnancy

Numerator: Women with evidence of Tier 1 or 2 contraception during the measurement period (tubal ligation, IUD, implant, pills, patch, ring, shot, diaphragm)




(MSC presentation, 2016, September 16, p. 59)

This definition showed that the ECU metric was a financial incentive for increasing women's use of the specific contraceptives described as the "numerator."

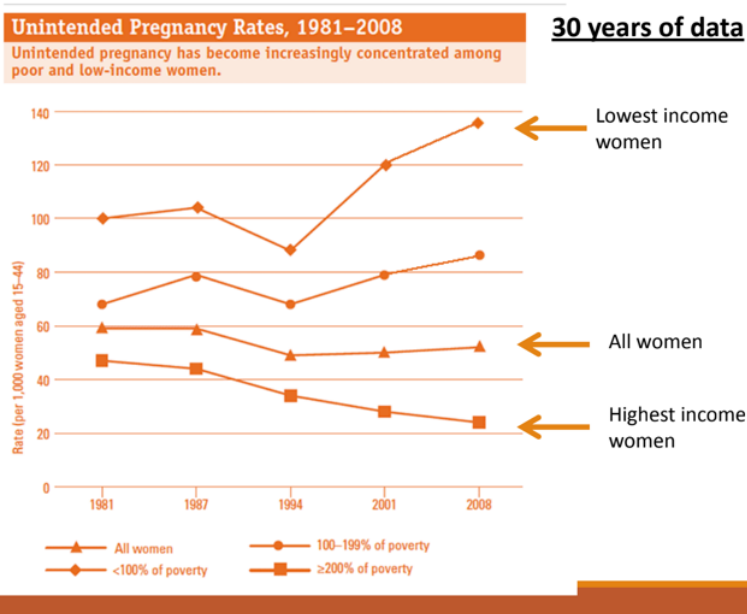
Towards the end of the presentation, the metric steward asked the question:

Yes, but what about the perception
that we are unfairly or unethically targeting poor women
with our contraception efforts?



(MSC presentation, 2016, September 16, p. 67)

The metric steward then moved to a slide with a graph of unintended pregnancy rates by income level from 1981-2008, with the subtitle that “unintended pregnancy has become increasingly concentrated among poor and low-income women”:



(MSC presentation, 2016, September 16, p. 68)

Next, the metric steward described the need for publicly funded contraceptive services and named two access barriers to contraception:

Access to contraception for low-income women

- More than half of women who need contraception need publicly-funded services
- The number of women needing publicly funded contraception services increased by 17% from 2000 to 2010
- Failing to cover contraception was ruled as a violation of the federal Civil Rights Act as amended by the 1978 Pregnancy Discrimination Act
- The Federal ACA includes contraception care as a core preventive service that all women are entitled to without cost sharing or co-pays.

(MSC presentation, 2016, September 16, p. 69)

Finally, the metric steward summarized the argument with a final slide:

All of these speak to the long history of poor women having less access to contraception than their higher-income peers.

Having a quality metric in contraception is a key step in giving low income women equal access to high quality primary care.

(MSC presentation, 2016, September 16, p. 70)

In this presentation, the metric steward shifted the audience's attention. At the start of the presentation, the metric steward defined the ECU metric as financially incentivizing women's use of specific contraceptives. At the end of the presentation, the metric steward summarized the metric as improving access to contraception for poor women and addressing an inequity. The metric steward did not discuss the issue of coercion, instead she changed the topic to focus on contraceptive access inequities. This exemplifies how inherent tensions and contradictions within the ECU metric were managed and dismissed.

While some of the strategies outlined in the Guidance Document may have addressed structural access barriers to contraception, at its core the ECU metric was a policy focused on increasing women's use of specific contraceptives. By shifting the conversation from the issue of

coercion to the issue of contraceptive access, the metric steward avoided addressing the issue of coercion.

Summary

This section described how policymakers discussed the issue of contraceptive coercion throughout the duration of the ECU metric, and the two main ways policymakers minimized concern about coercion: 1) through silence around what contraceptive coercion is; and 2) by reframing the metric as “improving access” as a strategy to misdirect attention away from the issue of coercion. Overall, this section contributes to our understanding of how coercion may be justified in contraceptive policy.

Fertility Reduction Discourse: People in No Position to Have Children

Policymaker discourse around the ECU metric constructed specific groups as targets for fertility reduction. Overall, the target of the ECU metric was to reduce births resulting from unintended pregnancies in low-income women with Medicaid insurance. At times, policymakers described more specific groups as being at highest risk of unintended pregnancy and therefore in most need of contraception for fertility control. In this section, I describe the specific groups that policymakers named as being at highest risk of unintended pregnancy and how this construction aligns with the eugenic ideology of “stratified reproduction” in which people’s fertility is valued differently based upon social hierarchies of race and class (Harris & Wolfe, 2014).

Policymakers constructed specific groups as being of higher risk of unintended pregnancy

Throughout the ECU metric discourse, policymakers discussed specific groups as being at higher risk of unintended pregnancy. Policymakers did not invent these groups, but rather used historically constructed groups without further question. This information was used to advance an argument regarding who was most in need of specific contraceptives for fertility reduction.

The following examples demonstrate how policymakers constructed racialized and classed groups of women and adolescents and labeled them as being at higher risk of unintended or problematic pregnancy and from there, assumed these groups needed specific contraceptive methods. The following examples show how on the surface, the arguments made by policymakers about the importance of addressing the issue of unintended pregnancy in these groups have merit.

Most broadly, policymakers constructed the group most at risk of unintended pregnancy as being “poor” or “low-income.” For example, the Guidance Document authors stated, “unintended pregnancies disproportionately affect poor women, whose rates of unintended pregnancy are 5.5 times higher than higher-income women” (OHA, 2014, p. 7). Policymakers also constructed the racialized groups of African American and Hispanic women as being at higher risk of unintended pregnancy than White women. For example, the Guidance Document authors continued from the previous quote with the statement “similarly, African American and Hispanic women have rates two to three times higher than whites” (p. 7). Policymakers further minimized these populations by grouping their rates together in the Guidance Document. Finally, policymakers constructed women with less formal education as being at higher risk of unintended pregnancy compared with women with more formal education. The Guidance Document authors again continued from the previous quote with the statement, “women who did not graduate high school are 2.3 times more likely to have an unintended pregnancy than college graduates” (p. 7).

The first Metrics and Scoring Committee presentation on the ECU metric in 2014 by an Oregon Health Authority staff member constructed the specific groups most at risk of unintended pregnancy in a similar way as the Guidance Document authors. The presentation included the

following slide:

What we know about the need for ECU

Characteristic	Rate of unintended pregnancy per 1000 women	Increased likelihood of unintended pregnancy
All women ages 15-44	52	
Not a HS grad	80	Women without a high school education are 2.7 times more likely
College graduate	30	
White, non-Hispanic	36	Black women are almost 3 times as likely as white women, and Hispanics are 2.3 times as likely
Black, non-Hispanic	91	
Hispanic	82	
Income <100% FPL	132	Poor women are 5.5 times as likely
Income ≥200% FPL	24	

12



(MSC presentation, 2014, November 23, p. 12)

This slide demonstrated how policymakers constructed women without a high school education compared with college graduates, Black and Hispanic women compared with White women, and “poor” women with incomes below the Federal Poverty Level compared with women with higher incomes as having an increased likelihood of having an unintended pregnancy.

Policymakers constructed racialized adolescents as having problematic rates of teen pregnancy. For example, at the November 2014 Metrics and Scoring Committee meeting, the minutes recorded:

Committee members noted it is important to address the rate of teen pregnancy, especially among African-American and Latino and were encouraged that pediatric and

family medicine practices will likely be implementing workflows to address effective contraceptive use for ages 18+ that will also affect adolescents. (MSC minutes, 2014, p. 2)

In another example, during the discussion about including adolescents in the incentive, the Metrics and Scoring Committee minutes stated, “while overall teen pregnancy has been decreasing, rates increased between 2014 and 2015 among African American and American Indian/Alaska Native teens” (MSC minutes, 2017, September 15, p. 1).

Putting aside for a moment the issues with the measurement of unintended pregnancy, the statistics do suggest these groups are indeed at higher risk. Policymakers cited the unintended pregnancy research by Finer and Zolna (2011) as evidence for the higher rates of unintended pregnancy in these groups and this evidence was one way policymakers justified the need for the ECU metric. However, it is critical to call out the sub-text to these statistics and how they were presented. Notably, the statistics were presented without attention to historical context. The policymaker discourse gave no attention to how the racialized and classed groups targeted by the ECU metric overlapped with racialized and classed groups who had historically been targeted for fertility control. This silence around this overlap was problematic because of the co-occurring silence about the issue of coercion. The policymakers constructed racialized and classed women as the site of the problem of unintended pregnancy and constructed a solution that targeted them with specific contraceptives. This is not only stigmatizing, but further undermined the reproductive autonomy of these groups.

Essential drivers of the fertility reduction discourse were revealed in the 2016 Oregon Health Authority closed-door meeting on reducing unintended pregnancy. To remind the reader, this meeting was not open to the public, and meeting participants were Oregon Health Authority staff members including the Director of the Oregon Health Authority. That the closed-door

meeting was not open to the public may have contributed to the more overt way staff members discussed reducing the fertility of Medicaid members.

For example, in the closed-door meeting the Director of the Oregon Health Authority was recorded as saying, “it would be great to identify parents on Medicaid who are having too many children, could use that data to improve performance (OHA, 2016, p. 1). Other questions the minutes recorded were: “How many children are women on Medicaid having? What are the circumstances of having these children? What are the health status of these children?” (OHA, 2016, p. 1). The minutes described how “on the [Maternal Health] side – we saw acutely mentally ill women having 5 babies with 5 different fathers, extremely high cost children. Issues compounded by drug and alcohol use (OHA, 2016, p. 1). Also, “[Director of Oregon Health Authority] is willing to have a conversation about people who shouldn’t have babies. Have seen in own experience children who are abused, neglected, multiple partners, multiple children, children are tragically handicapped for life, etc.” (OHA, 2016, p. 2). And finally, the minutes noted the goal to “stop people who are in no position to have children from having children. Especially important in a state like ours” (OHA, 2016, p. 2).

The statements captured in the closed-door meeting minutes reflect eugenic ideology, which in some cases may underpin fertility reduction policies. Staff overtly stated normative beliefs about the appropriate number of children a person should have and how many sexual partners a person should have. These minutes further reveal stigma towards people with mental illness and people who use drugs and alcohol having children. Although the harms to children that often occur in the context of parental drug and alcohol abuse can be severe and rightly deserve the attention of policymakers, targeting the fertility of socially marginalized people is an overly simplistic and potentially harmful approach to addressing this important concern.

In summary, the way policymakers constructed socially marginalized women as being most at risk of unintended pregnancy justified targeting these women for fertility control. Although most of the language used in the discourse around the ECU metric may not appear on the surface to have roots in eugenic ideology, the more overt discourse in the closed-door meeting reveals these roots which will be further discussed in the following chapter.

Fertility Reduction Discourse: High-Cost Children

A second fertility reduction discourse was present in the discourse around the ECU metric, as one of the stated purposes for the ECU metric was to reduce Medicaid costs by reducing the number of births to women with Medicaid insurance and the “high-cost children” resulting from these births (OHA, 2016, p. 1). This cost reduction discourse aligns with one of the overall goals of the incentive metric program to reduce Medicaid costs. The Metrics and Scoring Committee website includes the statement that the Oregon Medicaid incentive metrics “are used by the Oregon Health Authority to determine whether Coordinated Care Organizations are effectively and adequately improving care, making quality care accessible, eliminating health disparities, and controlling costs for the populations that they serve” (OHA, n.d.-a, para. 1). Throughout the discourse around the ECU metric, the high cost of birth and high cost of the children from these births were noted as a central concern. This section describes this cost-savings discourse.

In the metric steward’s 2014 public testimony to the Metrics and Scoring Committee, the steward proposed incentivizing the ECU metric for several reasons, including the need to reduce costs. In the testimony, the metric steward wrote:

“[Coordinated Care Organizations] need to reduce costs. While Medicaid pays for about 43% of all births in our state, Medicaid pays for 61% of the births that result from

unintended pregnancies. That amounts to more than 10,000 births per year. If we conservatively spend \$8500 per birth, those unintended births result in \$85 million in Medicaid spending per year for prenatal and delivery costs alone. Reducing unintended pregnancies by just 10% would produce \$8-10 million in cost savings, and it would help families meet their own goals for the number and spacing of their children.” (p. 2, bold and underline in original)

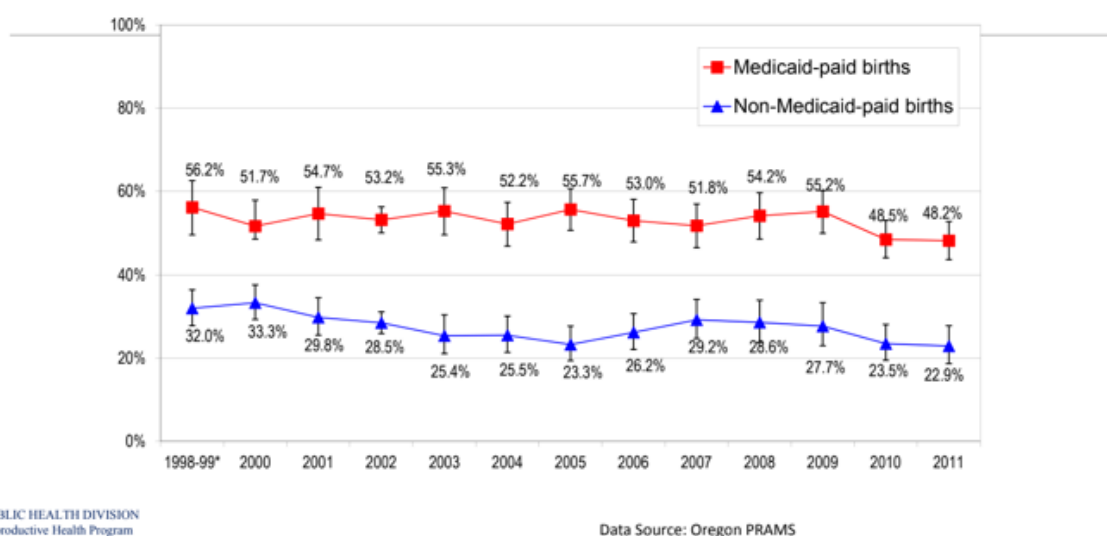
The metric steward presented the result of reducing unintended pregnancies as a systems-level cost savings by reducing the number of Medicaid-paid births. Interestingly, she intertwined this goal with the presupposition that reducing unintended pregnancies would also help families meet their reproductive goals. Possibly the inclusion of this presupposition was to minimize the cost-savings emphasis and return to a seemingly more patient-centered assertion.

Cost was mentioned twice in the Guidance Document. In the “Unintended Pregnancy” section, the Guidance Document authors repeated similar numbers to the metric steward’s testimony: “a study published in 2013 found that approximately 63 percent of unintended births in Oregon were paid for by Medicaid” (OHA, 2014, p. 6). The other place Guidance Document authors mentioned cost was in the section “Strategy 3: Improve availability and uptake of long-acting reversible contraception (LARCs).” The Guidance Document included the statement that “[Coordinated Care Organizations] can provide strong leadership in support of [long-acting reversible contraceptives] by highlighting their effects on unintended pregnancy and their potential cost effectiveness and adopting policies and practices that support [long-acting reversible contraceptive] uptake” (p. 22).

In the metric steward’s September 2016 presentation in response to concern that the ECU metric targeted poor women, the steward included a graph showing the proportion of unintended,

term pregnancies whose births were paid for by Medicaid as compared with non-Medicaid-paid births. This graph communicated that since 1998, Medicaid has paid for many more births that were the result of an unintended pregnancy compared with non-Medicaid-paid births. This graph repeated the initial cost-savings discourse the metric steward presented in the steward's 2014 public testimony:

Proportion of Births that were Unintended



(MSC presentation, 2016, September 16, p. 62)

At the 2016 Oregon Health Authority closed-door meeting on reducing unintended pregnancy, the meeting minutes indicate a clear focus on decreasing Medicaid cost by reducing births by women with Medicaid insurance:

Culminated a month ago with a meeting with Oregon Business Council doing work on what is happening and Oregon and what the costs are. Loud and clear that the # of

unwanted pregnancies and the data / extension of what happens to people having these babies and the babies themselves. On MH [maternal health] side – we saw acutely mentally ill women having 5 babies with 5 different fathers, extremely high cost children. Issues compounded by drug and alcohol use. (OHA, 2016, p. 1)

These excerpts show that one of the reasons for the ECU metric was to reduce Medicaid costs by reducing the number of births by people with Medicaid insurance, and by reducing the births of “high-cost children” (OHA, 2016, p. 1).

In summary, a second fertility reduction discourse was present in the discourse around the construction of the ECU metric. Policymakers constructed fertility reduction in the Medicaid population to reduce Medicaid costs and justify the ECU metric.

Conclusion

Considered as a whole, these themes suggest a policymaking process that reinscribed unequal power divisions and targeted the fertility of low-income women with Medicaid insurance, thus continuing the historical thread of reproductive oppression. The focus on increasing *women's* use of specific contraceptive methods served to constrain contraceptive autonomy and exclude people of other genders from the policy. The conflation of *unintended* with *unwanted* pregnancies oversimplified people's experience of pregnancy and reinforced the focus on individual women's intentions. Finally, the closed-door meeting revealed aspects of eugenic ideology underpinning the ECU metric. In the next chapter, I will situate these findings within the literature and suggest future contraceptive policy directions in line with Reproductive Justice principles and in support of people's contraceptive and reproductive autonomy.

Chapter 5: Discussion

Contraceptive coercion and the construction of contraceptive uptake policies by policymakers are understudied phenomena. Therefore, I sought to critically analyze policymaker discourse around the Effective Contraceptive Use Metric with special attention to the issue of coercion in this dissertation. First, I synthesized literature describing complexities in three discourses: 1) discourse around unintended pregnancy, 2) discourse around effective contraception, and 3) discourse around contraceptive coercion (Chapter 2). Second, I described how language and power operate in policymaking (Chapter 3). Taken together, these two chapters provided the background with which to critically analyze policymaker discourse around contraceptive uptake policies.

Results from this analysis revealed that healthcare system experts constructed the ECU metric in alignment with the mainstream public health discourse naming unintended pregnancy the cause of negative health outcomes and women's use of specific contraceptive methods as the way to prevent these outcomes. Policymakers justified the ECU metric using fertility reduction discourses, based on the assumption unintended pregnancies are negative events. Some policymakers expressed concern about incentivizing coercion and unfairly targeting "poor" women in early policy discussions, while others responded to these concerns and justified the policy by silencing dissent around the issue of coercion and shifting the focus to women's contraceptive access.

This final dissertation chapter presents a discussion of these findings. First, I discuss the seven themes found in my discourse analysis relevant to the construction of the ECU Metric and the discussion of contraceptive coercion in the context of the literature. Second, I discuss

implications of this research for policymaking, strengths and limitations of this study, and suggestions for future research.

Us and Them: A Discourse of Experts

ECU Metric analysis revealed a discourse dominated by the voices of healthcare system experts. Absent from the ECU Metric discourse were the voices of women with Medicaid insurance who were the ultimate targets of the policy. This “discourse of experts” was created by the legislatively mandated structure of the Metrics and Scoring Committee which set the rules for the setting and membership of the committee. Friel and colleagues (2021) labeled this type of power “structural power” (p. 3). This structural power gave healthcare system experts the capacity to set the policy agenda and shape how the ECU Metric was conceptualized. As healthcare systems experts possessed the power to set the agenda and framework of discourse, they had “discursive power,” which is a type of structural power identified by Friel and colleagues (2021, p. 3). People with Medicaid insurance were not included in the policymaking process, nor were there mechanisms in place to make people with Medicaid insurance aware of the policy which subsequently shaped their healthcare experiences. This finding demonstrates an imbalance of social power. Considered broadly, this social power imbalance was used to justify the fertility reduction discourse.

This is not to suggest, however, that people with Medicaid insurance were without power. The literature demonstrates how those who are structurally less powerful nonetheless assert themselves within these constrained contexts. In their analysis of how power operates in public policy, Friel and colleagues (2021) described how “health equity actors” creatively exerted their power to influence public policy despite structurally unequal power distributions through strategic use of particular policymaking processes, building relationships with powerful allies,

and using their discursive power to shift the framing of the issue (p. 9). McKenzie and colleagues (2022) studied Indigenous Canadian peoples' experiences of reproductive injustice and found one of the ways participants asserted their power in the face of clinicians "pressuring, rushing, or tricking" them into reproductive health decisions was by refusing to fill the contraceptive prescription and avoiding further discussion (p. 1039).

Although the examples offered above demonstrate creative and strategic use of power by the structurally less powerful, they simultaneously highlight the unequal power distribution present both in institutional policymaking and reproductive healthcare contexts. Rather than rely on creativity and refusal, structural redistribution of power is needed to restore the balance. In a critical ethnography of Aboriginal people's maternity experiences in British Columbia, Varcoe and colleagues (2013) found: "Aboriginal women and members of their communities wanted choice and control...to restore a sense of power after centuries of losses in the wake of colonization, and also to move beyond tokenism to authentic participation and leadership in research, planning, and decision-making" (p. 7). To restore the balance of power, policymakers should meaningfully include those affected by policy in the policymaking process. Although examples are scant in the research literature of policymakers meaningfully including those affected, the reproductive health research group Ibis Reproductive Health values "collaboration and shared power" and has partnered with groups like SisterSong Women of Color Reproductive Justice Collective to conduct research that "shifts power to communities" (Ibis Reproductive Health, 2023, para. 5).

Gendered Discourse: Contraception is for Women

Policymakers constructed the ECU Metric as a metric for women, signaling their presupposition that contraception is something women do and are responsible for. This

construction downplayed the role that people of other genders play in contracepting. Thus, the ECU metric contributed to wide and longstanding feminization of contraception (Littlejohn, 2021). The feminization of contraception impedes the goal of reducing unwanted pregnancies because it excludes fertile people of other genders from participating and also disproportionately burdens women with the side effects, responsibility, and cost of contraception (Littlejohn, 2021).

Recent literature has explored the feminization of contraception. Caddy et al. (2023) conducted a literature review to understand how reproductive responsibilities were divided between heterosexual couples. They identified several barriers to men's engagement with reproductive work which included the feminization of family planning services such as only targeting women as people who use contraception. El Ansari and colleagues (2023) conducted a scoping review to map the research literature regarding Middle Eastern and North African men's sexual and reproductive health. They found that most studies focused on HIV/AIDS and sexually transmitted infections, few studies focused on contraception, and no studies focused on pre/intra/postnatal care or on abortion care. The findings from these studies demonstrate how policy and research biases, norms, and focus may contribute to the exclusion of men from reproductive responsibilities.

Other research demonstrates the beneficial impacts of including men and boys in contraceptive decision-making and implementation. In a review, Aventin and colleagues (2023) found including men and boys in family planning improved contraceptive use and suggested contraceptive policy should include men and boys in the roles of contraceptive users. Averbach and colleagues (2023) conducted a cluster randomized controlled trial focused on gender equity in family planning by using of a contraceptive counseling style that included husband/wife couples. They found the inclusive contraceptive counseling style resulted in increased use of

contraception within the couple and improved couples' perceptions of care quality. Both studies suggest including men in reproductive policy and counseling results in positive outcomes.

Beyond contraceptive counseling, other health policies apart from the ECU metric also deemphasize men's role in pregnancy prevention through policies for payment for vasectomy, which is a highly effective method for preventing pregnancy. For example, the Affordable Care Act mandated health insurance cover prescription contraceptive methods including female sterilization. However, the Affordable Care Act does not mandate that health insurance cover vasectomy (Healthcare.gov, n.d.). This policy may contribute to differences in vasectomy rates along economic gradients. For example, Bertotti (2013) used data from the National Survey of Family Growth to examine how racial and socioeconomic factors predict male or female sterilization in cohabitating or married heterosexual couples. Bertotti (2013) found that White and more socioeconomically advantaged women were more likely to have a male partner with a vasectomy compared to women with less social advantage. The ECU metric's deemphasis of vasectomy as a contraceptive method for people with low incomes may have reinforced this inequality.

Semantics of Unintended Pregnancy

The discourse around the ECU metric constructed unintended pregnancy as a negative event targeted for reduction through the policy. While it is common in the public health discourse to name unintended pregnancy as a problem, use of the word "unintended" is imbued with meaning about the pregnant person's assumed plan. This focus on the individual's plan or lack of a plan as the root of negative outcomes allows blame for the negative outcomes to be on the individual, thus obscuring the unequal social conditions in which these pregnancies occur (Bowleg, 2017; Potter et al., 2019). The focus on peoples' lack of planning represented by

naming “unintended pregnancy” as a core problem can shift the responsibility of global issues from communities to individuals.

Nandagiri (2021) engaged a feminist perspective in a critique of the voluntariness of global family planning programs and described how:

By focusing on individual behavioural change, the responsibility for current and future conditions (e.g. the climate emergency) is assumed to be held by women and couples instead of by global economic and governance structures. Linking increased contraceptive use to economic growth or climate change mitigation thus instrumentalizes their reproductive behaviours. (p. S224)

By creating an argument proposing the problem of unintended pregnancies can be solved through policies focused on women’s contraception choices, we ignore the structural inequities that substantially contribute to the negative outcomes often linked with unintended pregnancies. For example, the structural inequity of racism contributes significantly to negative parental, fetal, and infant outcomes through unequal environmental exposures (Miranda et al., 2009), unequal access to paid family leave (Goodman et al., 2021), breastfeeding disparities (Morrow et al., 2021; Petit et al., 2021), and unequal conditions in home and hospital neighborhoods (Howell et al., 2018; Janevic et al., 2021).

Similarly, Winett et al. (2016) described how discourses in public health can hold individual mothers responsible for their children’s chronic diseases and leave out the social context in which the pregnancy occurred. As noted by Winett et al. (2016):

When we portray causal factors as maternal “choices” (e.g., what she eats, her physical activity level, whether she seeks sufficient prenatal medical care), we exclude from the

frame the many contextual factors—often determined by shared societal decision-making—that shape mothers’ actions. (p. 1370)

The “maternal choices” described by Winett et al. could also include whether the parents chose to use contraception or whether the parents planned their pregnancy. Again, use of the phrase “unintended pregnancy” to explain negative parental and infant outcomes reinforces the focus on individuals while obscuring societal factors. By not including systemic causes for negative parental and fetal outcomes, we reduce our ability to envision systemic solutions, thus perpetuating and possibly exacerbating these issues.

Kost and colleagues (2023) published an article on pregnancy desires in the journal *Demography* that signaled a shift in the terminology used to describe pregnancies. Rather than using the terms “unintended,” “intended,” and “mistimed” to categorize pregnancies, the authors used five categories of “pregnancy desire” that align closely with how the survey questions were asked. The researchers also changed the unit of measurement from counting pregnancies to counting individual pregnancy desires. As a result, people who wanted to become pregnant but did not were also included in the data set, reflecting a fuller view of reproductive autonomy. Kost and colleagues also included a separate category for those who expressed ambivalence about pregnancy desires, rather than combining them with some other category as has been done historically. This approach to the conceptualization and measurement of pregnancy intention/desire contrasts sharply with dominant approaches in this area which tend to focus on the prevention of pregnancies not thought of as planned.

Specific Methods Preferred

Policymakers expressed a preference for specific contraceptive methods, especially for long-acting reversible contraceptives (LARCs) which are either an intra-uterine device (IUD) or

a hormonal implant placed in the subcutaneous tissue in a person's upper arm. This preference is in alignment with the tiered-effectiveness model used by medical and public health associations as described in Chapter 2. LARCs are reversible contraceptive methods that are highly effective in preventing pregnancy with typical use, and thus were ranked as "tier 1" in the tiered-effectiveness model. For example, in one year of typical use only 0.1% of people using a hormonal implant will become pregnant (Trussell & Aiken, 2018). Comparatively, in one year of typical use 20% of people using withdrawal will become pregnant (Trussell & Aiken, 2018). Because of how highly effective LARCs are for preventing pregnancy with typical use, clinicians commonly recommend LARCs when a person wishes to preserve their future fertility capacity but does not currently wish to become pregnant.

McNicholas et al. (2014) conducted a prospective cohort study to investigate how the removal of barriers like cost and access influenced LARC usage rates. They also measured rates of satisfaction, continuation, and pregnancy with different contraceptive methods. The researchers found most women chose a LARC method and had higher satisfaction and continuation rates compared to women who chose other methods. Strikingly, the study found "non-LARC users were more than 22 times as likely to experience an unintended pregnancy compared to their LARC counterparts" (p. 4). Another study found similarly high rates of satisfaction with LARC methods suggesting that this highly effective contraceptive is an appropriate choice for many people (Ela et al., 2022). Although LARCs are an excellent contraceptive for many people, too much emphasis or insistence on LARCs may be coercive.

The focus on promoting a narrow range of contraceptive options has been critiqued for constraining contraceptive autonomy. For example, Nandagiri (2021) questioned how "voluntary" voluntary global family planning programs can be when they focused on a narrow

range of reproductive options. Nandagiri (2021) argued the voluntariness of contraceptive choices occur within a socio-political context and is shaped by social institutions which influence and may constrain the available contraceptive choices. Policies such as the ECU Metric that focus on a narrow range of contraceptive options based solely on population-level effectiveness are an example of the sort of social institutions that restrict access to the full range of contraceptive options, thereby constraining individual autonomy. Further, the system of ranking contraceptives by effectiveness has also been critiqued.

Bertotti and colleagues (2021) investigated the assumptions underlying the system of ranking contraceptive methods by tier. To investigate this topic, the researchers conducted a critical discourse analysis of gynecology textbooks and medical recommendations and named this discourse the “efficacy discourse.” Similar to what was described in Chapter 2 of this dissertation, Bertotti et al. found the tiered model prioritized contraceptive failure over other aspects of contraception such as side effects and reproductive autonomy. Specifically, Bertotti et al. criticized the tiered model’s “selective reliance” on typical-use rates because it “ignores data suggesting that some third-tier methods can be used very effectively” (p. 8).

The authors also found the “efficacy discourse define[d] the adverse effects associated with pharma-contraceptives as worth-the-risk by framing these medical risks as less serious than the embodied risks posed by pregnancy” (p. 5). In other words, the gynecology textbooks and medical recommendations compared the risks of pregnancy with the risks of contraceptives, thus minimizing contraceptive risks. Further, the analyzed texts equated the efficacy of contraceptives with safety for both women and broader society because of the dangers of unintended pregnancy. “Efficacy discourse then downplay[ed] pharma-contraceptive side effects by suggesting that they are worth the risk in order to solve social and health problems supposedly caused by women’s

risky bodies and behavior” (p. 4). In summary, Bertotti et al. critiqued the “efficacy discourse” for its focus on a narrow range of contraceptive options and how this discourse minimized reasons people may have for choosing tier 2 or 3 contraceptive methods.

Fertility Reduction Discourse

People in no position to have children. Targeting socially marginalized women for fertility control through public discourse and policy is not new, but rather a continuation of a historical thread present in the United States since its inception (Roberts, 2017). Eugenic ideology or “stratified reproduction” is when a society values the fertility of some more than others and believes that social problems can be solved by preventing the “unfit” from reproducing (Harris & Wolfe, 2014). A classic example comes from the Supreme Court case *Buck v. Bell* in which the Supreme Court permitted the forced sterilization of Carrie Buck because she was “feeble-minded” (*Buck v. Bell*, 1927). The Justice who wrote the decision stated “three generations of imbeciles are enough” (*Buck v. Bell*, 1927). Scholars later found Carrie Buck did not have an intellectual disability, but was from a poor family and had little formal education (Powell, 2021). This shows how “eugenic practices occur at the intersection of ableism, racism, xenophobia, classism, and other systems of oppression,” and how eugenic ideology may be used to justify state control of a person’s fertility based on any one or a combination of these oppressions (Powell, 2021, p. 623).

High-cost children. The discourse of “high-cost children” is another example of how policymakers suggested social problems may be solved by reducing the fertility of low-income people. Put another way: “some must not be born so that future others might live more abundantly (consumptively)” (Murphy, 2017, p. 041). The discourse of cost-savings ignores the fact that birth is part of the human life cycle, and the birth process requires effort and support.

The discourse also perpetuated a mother-blame narrative in which the high cost of unintended births and “high-cost children” are blamed upon mothers, who were then targeted for fertility reduction to reduce costs.

Discussion of Contraceptive Coercion

The ECU Metric was controversial throughout the duration of the policy due to concern about contraceptive coercion. Policymakers and stakeholders who gave feedback on the policy brought up concern that the ECU Metric incentivized coercion, targeted poor women for fertility reduction, and undermined reproductive autonomy. In response, other policymakers and Oregon Health Authority staff involved in the policy minimized the issue of contraceptive coercion in two main ways: 1) with silence around or only indirect reference to the issue; and 2) by changing the topic from coercion to improving contraceptive access.

Silence. In the ECU Guidance Document, policymakers stated “health plans must provide that each member is ‘free from coercion or mental pressure, and free to choose the method of family planning to be used’” (Oregon Health Authority, 2014, p. 29). However, no definition of contraceptive coercion or mental pressure, nor historical examples of contraceptive coercion were offered to make the meaning of these abstract phrases more clear, despite availability of these examples from Reproductive Justice scholars (Davis, 1981, Chapter 12; Roberts, 2017; Ross & Solinger, 2017). Risk for coercive practice could arise in a situation in which the patient’s contraceptive preference differed from the push of the policy, however no guidance was offered for a clinician in this situation beyond the statement patients must be free to choose their contraceptive method.

The ECU Metric was designed to increase women’s use of specific contraceptive methods, while clinicians were expected to respect patient choice. Mann and Grzanka (2018)

named this dilemma “agency without choice” in their critique of LARC promotion materials. People ostensibly had free access to the full range of contraceptive options, but some options were “right” and some were “wrong” choices. Morison (2022) interviewed clinicians about how they understood the conflict when their priorities on contraception differed from their patients’ priorities. The author found although clinicians supported the idea of respecting patient choice, they:

expressed frustration, concern, and worry about patients who [did] not comply with their advice, or when they [were] unable to ‘get’ patients to use/keep using high-efficacy contraceptives. This was especially evident in talk about targets for decreasing unintended pregnancy, teenage pregnancy, and (repeat) abortion rates as indicators of successful practice. (p. 5)

Similarly, in interviews with clinicians about their approaches to contraceptive counseling, Mann et al. (2022) found clinicians described patient behavior problematic when patients did not choose a highly effective contraceptive method. Finally, from the patient perspective, Senderowicz (2019) explained how women felt “obligated to accept” specific contraceptive methods in a country with contraceptive uptake targets, again showing the link between policies promoting specific methods and constrained contraceptive autonomy.

Taken together, these studies show how the issue of coercion can arise in the clinical encounter. By not acknowledging this issue of coercion beyond the admonition to respect patient choice, and by offering no guidance on how to approach a clinical situation in which the patient’s preference differed from the push of the policy, policymakers minimized the issue of structured contraceptive coercion embedded in the ECU Metric.

Changing the topic to improving access. The second way policymakers minimized the issue of contraceptive coercion was by changing the topic from coercion to improving contraceptive access. Both times when the Oregon Metrics Technical Advisory Group raised issues about coercion in Metrics and Scoring Committee meetings, the metric steward responded by changing the topic to the importance of improving contraceptive access for “poor” women who historically had “less access to contraceptives than their higher income peers” (MSC presentation, 2016c, September 16, p. 70). It is true access to contraceptives is an issue. Access barriers include requiring unnecessary tests or clinic visits before a person may begin a method, lack of trained clinicians, especially on LARC insertion and removal, and financial constraints (Oregon Health Authority, 2014; Secura et al., 2010). Prior to the Affordable Care Act, insurance companies were not required to cover the cost of contraceptives, and people who did not have insurance coverage for contraceptives relied on an ever-changing web of funding programs to cover the cost or paid out-of-pocket. Cost presents an access barrier, especially for LARC methods with high up-front costs. For example, the self-pay price for an IUD ranges from \$500-\$1300 (Planned Parenthood, n.d.).

Much scholarship has focused on contraceptive access. For example, the Contraceptive CHOICE project studied what happened when all contraceptive methods were offered at no cost, and found significantly more people chose to use a LARC relative to other methods (Secura et al., 2010). However, a singular focus on contraceptive access without attention to contraceptive agency minimizes the issue of coercion. Gomez et al. (2018) named this issue “the contraception paradox [because] contraception can be both a source of empowerment and agency for women who wish to control their fertility and a source of oppression for women deemed socially undesirable reproducers” (p. 2). Proponents of the ECU Metric focused only on the empowering

aspect of contraception and was promoted by those with structural power as a policy lever to improve access to contraception while minimizing issues of coercion.

Implications for Policymaking

Likely based on the evidence that LARCs are effective in preventing pregnancy, contraceptive policy has focused on LARC access and promotion. Research findings strongly recommend reconsideration of this approach. To ensure people's access to the full range of contraceptive methods while avoiding contraceptive coercion, several recommendations are aimed at all levels of policymaking. The first recommendation is to acknowledge that contracepting is the responsibility of all fertile people who engage in heterosexual intercourse but do not desire pregnancy and to ensure policies reflect this. The ECU metric only targeted women, which reinscribed the patriarchal notion based in biological determinism that women bear the responsibility of contracepting (Littlejohn, 2021). Future contraceptive policies should be inclusive of people of all genders.

The second recommendation is to ensure contraceptive policies do not hold specific contraceptives as "better" than any other contraceptive. When people may access the full range of contraceptive options in the context of receiving clear, current evidence regarding the risk and benefits of each option, they will make the best decision for themselves about the type of contraceptive best suited to their life and needs. The ECU metric only incentivized specific forms of contraception considered "moderately and highly effective" and aimed to increase women's use of these specific methods. This excluded many safe and effective methods of contraception that may be preferred by people for many reasons, and thus constrained people's choice and limited their access to the full range of contraceptive options.

The third recommendation is to create policy that removes healthcare system-level barriers that block people's access to contraceptives. Strategies could include dispensing more supplies of contraceptives at a time, communicating with the public to ensure people know they can access free contraceptive services in Oregon, uncoupling unrelated tests like pelvic exams from the provision of contraceptives as is standard care (Committee on Gynecologic Practice, 2019), and assessing clinic-level contraceptive access barriers. For example, the Oregon Preventive Reproductive Health Advisory Council tool provides guidance for clinics to assess domains of contraceptive access, such as appointment or clinician availability (2017).

The fourth recommendation is to use quality measures that measure people's access to contraception and satisfaction with contraceptive services rather than contraceptive uptake. Measures that focus on the performance of the healthcare system will ensure contraceptive measures are focused on access issues rather than personal decisions. For example, Oregon Medicaid is piloting the Person-Centered Contraceptive Counseling measure, a patient-reported outcome measure (Dehlendorf et al., 2021). This metric empowers patients to evaluate clinician performance in discussing and honoring their contraceptive preferences, and the respectful provision of care and information (Dehlendorf et al., 2021).

The fifth recommendation is to end the policy focus on reducing the unintended pregnancy rate. Research has described flaws in these classic measures in that they do not accurately capture people's experience with avoiding or pursuing pregnancy. As alternatives, both the Desire to Avoid Pregnancy scale or a measure of contraceptive autonomy that holds autonomous nonuse of contraception as a positive outcome better reflect people's experiences and do not perpetuate the stigma of lack of planning as the root cause of negative health outcomes (Rocca et al., 2019; Senderowicz, 2020). Webster et al.(2022) found policies ensuring

access to paid family leave when a family has a child, breastfeeding support, childcare support, and high-quality prenatal, birth, and postpartum care were associated with improvements in perinatal and infant outcomes. These findings suggest rather than changing the focus to desire alone, we need to expand our focus and recognize pregnancy and parenting as complex processes embedded in cultural and structural contexts with differing impacts over the life course.

Strengths and Limitations

Strengths

The study had several strengths and limitations. A strength of this study was the use of publicly available policy records as the analytical approach. This approach enabled the use of already-existing data sources, which was efficient and eliminated the need for the production of new data or participant effort. The use of publicly available records that can be accessed by any person through public websites means interested persons can examine the primary sources for this study and create their own interpretations of the policy discourse. To facilitate this access, I created an Open Science Framework page and used an archivist approach to organize all policy documents included in this study in one publicly accessible location. The Open Science Framework page will be linked with a Digital Object Identifier in future publications, thus facilitating access to the primary data sources used for this study.

A second strength of this study was the use of Critical Discourse Analysis as the approach. Critical Discourse Analysis has seldom been used in nursing research or in healthcare policy analysis. This is due in part to the complexity of the approach and lack of clear guidance on how to structure this approach. Careful documentation of the process in my research journal, included in my Open Science Framework page, may help other nursing and policy researchers successfully use Critical Discourse Analysis to examine other policy texts.

The use of Critical Discourse Analysis ensured the analysis went deeper than just a consideration of topics, but also included consideration of semantics, argumentation strategies, and conceptual framing, among others. This type of linguistic analysis allowed for a deeper understanding of *how* the policy messages were communicated beyond simply naming that they were communicated. This type of analysis can help other researchers and policymakers identify elements of policymaker discourse that may promote contraceptive coercion and limit reproductive autonomy, which in turn increases awareness and helps future policymakers avoid similar issues.

Another strength of the study was the reading of all policy documents and analysis by my dissertation committee. The input from my committee ensured my interpretation of the policy texts was challenged and confirmed. I also connected with researchers in the field of global contraceptive policy who are similarly focused on ensuring reproductive autonomy for socially marginalized people. These connections facilitated my understanding of the complex dynamics at play in the creation and maintenance of these policies.

Limitations

This study used meeting minutes to reconstruct the timeline of the ECU metric. The meeting minutes represent an Oregon Health Authority staff person's interpretation of the meeting proceedings, which influenced the topics recorded and chosen words. The minutes were approved by the committees at each subsequent meeting, suggesting they are a close representation of the proceedings. However, the timeline should be interpreted with caution, and is not a complete representation of the ECU metric. Metrics and Scoring Committee meetings began to be audio-recorded towards the end of the time the ECU metric was in effect, but only one recorded meeting contained substantial discussion of the ECU metric. Audio recordings of

all Metrics and Scoring Committee meeting discussions would have been a more accurate source for exact topics, word choices, tones of voice, and other verbal information, and would have given more depth and nuance to the timeline.

The policymaker discourse included in the study was limited to the discourse of policymakers in Oregon. A similar policy based on the ECU metric was approved by the National Quality Forum and is in use at the national Medicaid level. Research into the discourses of the National Quality Forum and at the national Medicaid level could reveal further insights into how policymakers discussed concern about coercion into Medicaid policy.

Another limitation of the study was the study did not include the voices of women with Medicaid insurance who were the target of the policy. This limitation continued the exclusion of these marginalized voices in the discourse around the ECU metric.

Suggestions for Future Research

While the current study illuminates how policymakers justified the embedded coercion in the ECU metric, more research is needed to inform the creation of quality metrics to improve access to the full range of contraceptive methods and support contraceptive autonomy. Future research should explore people with Medicaid's experiences of accessing contraceptives to ensure policies are informed by the people they target. Future research into what reproductive health concerns are most salient for people with Medicaid insurance should expand beyond contraception and unwanted pregnancy to consider issues such as sexual pleasure, healthy menstruation, polycystic ovarian syndrome, endometriosis, infertility, and sexually transmitted infections.

Future research is also needed into how to best frame issues of contraceptive access, reproductive freedom, pregnancy desires, etc. New ideas for what language to use and how to

frame these issues is needed from a communications lens, such as the research done by the Berkeley Media Studies Group. This organization studies how the media portrays public health issues and provides suggestions for framing and language choices focused on structural drivers rather than individual choices.

Finally, despite years of criticism, the unintended pregnancy rate continues to be used as a proxy measure for women's reproductive autonomy (Potter et al., 2019). Future research should focus on the creation of valid and reliable measures of reproductive autonomy for people of all genders to ensure we are accurately measuring this concept. Senderowicz' (2020) recent creation of a contraceptive autonomy indicator reflects a major shift towards measuring contraceptive autonomy rather than pregnancy intentions.

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Appendix A

PRAMS Questions

Core question 12 (p. 5)

Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant? Check ONE answer.

- I wanted to be pregnant later
- I wanted to be pregnant sooner
- I wanted to be pregnant then
- I didn't want to be pregnant then or at any time in the future
- I wasn't sure what I wanted

[if answer "I wanted to be pregnant later," ask Q4]

Standard question Q4 (p. 33)

How much longer did you want to wait to become pregnant?

- Less than 1 year
- 1 year to less than 2 years
- 2 years to less than 3 years
- 3 years to 5 years
- More than 5 years

Standard question E5 (p. 9)

When you got pregnant with your new baby, were you trying to get pregnant?

- No
- Yes

[If no ask E6]

Standard question E6 (p. 9)

When you got pregnant with your new baby, were you or your husband or partner doing anything to keep from getting pregnant? Some things people do to keep from getting pregnant include having their tubes tied, using birth control pills, condoms, withdrawal, or natural family planning.

- No
- Yes

[If no ask E7]

[If yes ask E3]

Standard question E7 (p. 9)

What were your reasons or your husband's or partner's reasons for not doing anything to keep from getting pregnant? Check ALL that apply.

I didn't mind if I got pregnant

I thought I could not get pregnant at that time

I had side effects from the birth control method I was using

I had problems getting birth control when I needed it

I thought my husband or partner or I was sterile (could not get pregnant at all)

My husband or partner didn't want to use anything

I forgot to use a birth control method

Other → Please tell us: _____

Standard question E3 (p. 9)

What method of birth control were you using when you got pregnant? Check ALL that apply

Birth control pills

Condoms

Shots or injections (Depo-Provera®)

Contraceptive implant in the arm (Nexplanon® or Implanon®)

Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)

IUD (including Mirena®, ParaGuard®, Liletta®, or Skyla®)

Natural family planning (including rhythm method)

Withdrawal (pulling out)

Other → Please tell us: _____

Standard question Q6 (p. 33)

How did you feel when you found out you were pregnant with your new baby?

Very unhappy to be pregnant

Unhappy to be pregnant

Not sure

Happy to be pregnant

Very happy to be pregnant

Standard question E4 (p. 9)

Before you got pregnant with your new baby, had you ever heard or read about emergency birth control (the “morning-after pill”)? This combination of pills is used to prevent pregnancy up to 5 days after unprotected sex.

No

Yes