National
Family Planning
& Reproductive Health Association

HEALTH EQUITY

Resource Guide and Assessment Tool

An online version of this report can be accessed at tinyurl.com/6z3hjbaf.

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Background

The Title X family planning program is the nation's only program dedicated to providing access to high-quality family planning and sexual health care, including contraception, STI testing and treatment, HIV testing, cancer screenings and more, with a priority given to people with low or no incomes or who may otherwise lack access to health care.[1] While research shows that Title X has been an effective public health program,[2] if chronically underfunded,[3] many people still lack access to care, with a disproportionate impact on Black, Latinx, Indigenous, and other people of color, as well as the LGBTQ+ community, immigrants, youth, and people with disabilities.

The US Department of Health and Human Services' Office of Population Affairs (OPA), which administers Title X, has made a strong commitment to improving health equity in Title X-funded care. As a practice, family planning providers understand and aim to mitigate social determinants of health that may diminish access, quality, and patient experience in the communities they serve. Work to advance health equity is a logical extension of efforts to improve quality of care.

NFPRHA believes that health equity can only be achieved by recognizing and responding to systemic racism and all forms of oppression, including the unequal distribution of resources, which have created persistent health disparities. NFPRHA also believes that addressing health inequities requires an intersectional approach, a concept from civil rights advocate Kimberlé Crenshaw, that seeks to better understand how race, class, gender, and various other social identities shape a person's lived experience.[4] Understanding the intersectionality of people's lives can help expose structural inequities that lead to poor health outcomes for underserved communities. This understanding is essential when evaluating interventions that address racism, sexism, homophobia, ableism, and other forms of oppression.

> As Dr. Monica McLemore writes about operationalizing health equity, we need to "move toward the elimination of scientific racism, structural racism, and the historic exclusion of community wisdom that underpin the current evidence base for clinical care, teaching, and policy measures to address the social and structural determinants of health."[5]

Introduction

NFPRHA conducted an extensive literature review as the basis for this resource guide, which aims to assist family planning providers in identifying the work that is needed within their agency to address systemic barriers to care and advance health equity. While this document provides a preview of intervention examples, a comprehensive version with online access to recommended tools and resources can be found in the digital edition of this guide at: tinyurl.com/6z3hjbaf.

The Interventions by Population section of this guide, beginning on page 7, includes community-level interventions, policy-level interventions, recommended readings, and highlighted organizations with online access available at tinyurl.com/6z3hjbaf.

Accompanying the resource guide is an assessment tool that can support family planning providers as they conduct community needs assessments, program design and data collection, and seek to strengthen partnerships between the family planning network and collaborative organizations in their communities. NFPRHA recognizes that patients' health care experiences vary over time and by provider and advancing health equity can be addressed at multiple levels. Each agency should decide where and how to focus. Involving and taking the lead from the experience, perspective, interests, and needs of community members is essential to all efforts related to advancing sexual and reproductive health equity.

Note on Terminology

The language used throughout the various resources is not always inclusive for gender-expansive and nonbinary people. NFPRHA encourages all members to examine the language used in their health education materials, campaigns, and policies to increase belonging and respect for all people.

DEFINITIONS

Antiracism: The practice of identifying, challenging, and changing the values, structures, and behaviors perpetuating systemic racism. Dr. Ibram X. Kendi, author of "How to Be an Antiracist" and founding director of the Center for Antiracist Research at Boston University, defines it as a collection of antiracist policies and ideas that cause racial equity.

Barriers: Factors that prevent an individual or communities from accessing health care including family planning services. Barriers also include systemic factors such as racism and discrimination toward marginalized and racialized communities.

BIPOC: Black, Indigenous, and other people of color. The term "BIPOC" is intended to center the experiences of Black and Indigenous populations and the systemic racism that continues to still oppress and affect their everyday lives.

Cultural humility: A personal lifelong commitment of self-reflection and self-critique whereby the individual not only learns about another's culture, but starts with an examination of their own bias, beliefs, and cultural identities.[6]

Facilitator: Tools and resources that combat barriers to achieve better health outcomes.

Health equity: The opportunity for everyone to attain optimal health regardless of race, ethnicity, gender, income level or any social factors that create barriers. Health equity can only be achieved by responding to systemic racism and all forms of oppression that have created persistent health disparities.

Institutional racism: Refers specifically to the ways in which institutional policies and practices create different outcomes for different racial groups. The institutional policies may never mention any racial group, but their effect is to create advantages for whites and oppression and disadvantage for indivduals from groups classified as people of color.[8]

Interventions: The tangible tools and resources that can be used to assist with developing, revising, and evaluating policies and programs that advance health equity.

Oppression: The systemic and pervasive nature of social inequality woven throughout social institutions as well as embedded within individual consciousness. Oppression fuses institutional and systemic discrimination, personal bias, bigotry, and social prejudice in a complex web of relationships and structures that saturate most aspects of life in our society.

Organizational health literacy: The degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others[7].

Patient-centered care: Voluntary and non-coercive care that is respectful of the unique health needs and preferences of each patient and that allows those values to guide care decisions.

Racial justice: A core tenant of reproductive justice and an important movement in its own right. Racism permeates the nation's health care system, from discriminatory policies to inequities in resource distribution and underrepresentation in medical fields. These factors lead to widespread health disparities between people of color and their white peers. Racial justice movements push all Americans, including health care providers and administrators, to tackle these issues head-on and work for a more just future.

Reproductive justice: According to SisterSong: Women of Color Reproductive Justice Collective, reproductive justice is "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities." The term "reproductive justice" was coined by a group of Black women in June 1994, broadening the view of issues related to sexual and reproductive health far beyond that of white-led reproductive health and rights organizations.

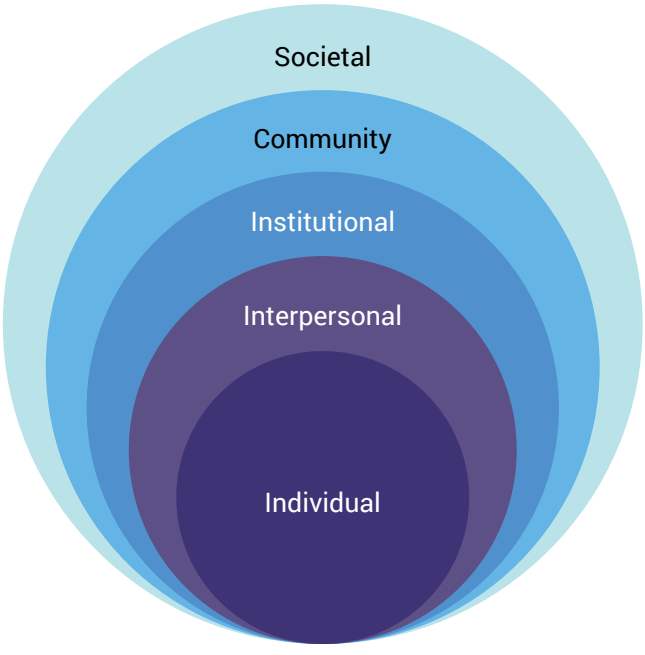
The Social Ecological Implications of Health Equity

The social ecological model is a framework that can be used to understand the interplay between a range of factors that influence the health of individuals and communities in which they live. This resource guide offers a range of interventions informed by a social ecological model that an organization can adopt to address health equity. The following are the five levels of factors that influence health behaviors and outcomes and, ultimately, health equity:

1. Societal (laws, public policies, and social norms)
2. Community (physical and social environment, schools, neighborhood conditions/amenities and income level)
3. Institutional (health care settings, organizational policies)
4. Interpersonal (relationships, family, social networks)
5. Individual (gender and gender identity and expression, sexual orientation, age, race, income)

As shown in **Figure 1**, the individual is at the center of these concentric circles, influenced by the interactions between factors at all levels. Health equity can be addressed at multiple levels, and it is up to each organization (with community engagement) to decide where and how to focus.

FIGURE 1. SOCIAL ECOLOGICAL MODEL



Addressing Barriers to Care

The social ecological model can assist with strategizing how to tackle the various forms of barriers to care. Below are examples of barriers that many individuals and communities face daily:

- **Societal barriers:** Restrictive state and federal laws and policies that limit sexual and reproductive health services negatively affect the health and well-being of all people seeking health care services. Adverse effects include increased rates of infant mortality among Black birthing people, negative economic outcomes, and poor mental health outcomes.[8] Laws and policies must prioritize a person's autonomy and their right to comprehensive and equitable health care.
- **Community barriers:** Equitable access to care includes addressing the lack of transportation, housing, economic instability, food insecurity, and systemic racism that under-resourced communities face. Interventions to support community care can include collaborating with local nonprofits that are composed of or seek to serve people who rely on safety-net family planning care removing cost barriers to support those who are uninsured or low income, and supporting initiatives such as pop-up clinics, mobile units, telehealth, etc.
- **Institutional barriers:** Organizational attitudes, beliefs, and activities, which include institutional racism, gender and sexual discrimination, cost, provider availability, culturally and linguistically appropriate care, and equitable access to care and treatment can impact health outcomes of patients. For example, a lack of provider availability can create long wait times or delay access to care. Providers must identify and address medical stigma, discrimination, and other inequitable practices.
- **Interpersonal barriers:** Social networks, which include family, friends, partners, and trusted members of the community can have a dual impact on health outcomes. The support and influence of social networks can not only promote health and reduce health stigma, but also exacerbate poor health outcomes and can be fueled by intimate partner violence, community/cultural stigma, and religious beliefs, for example.

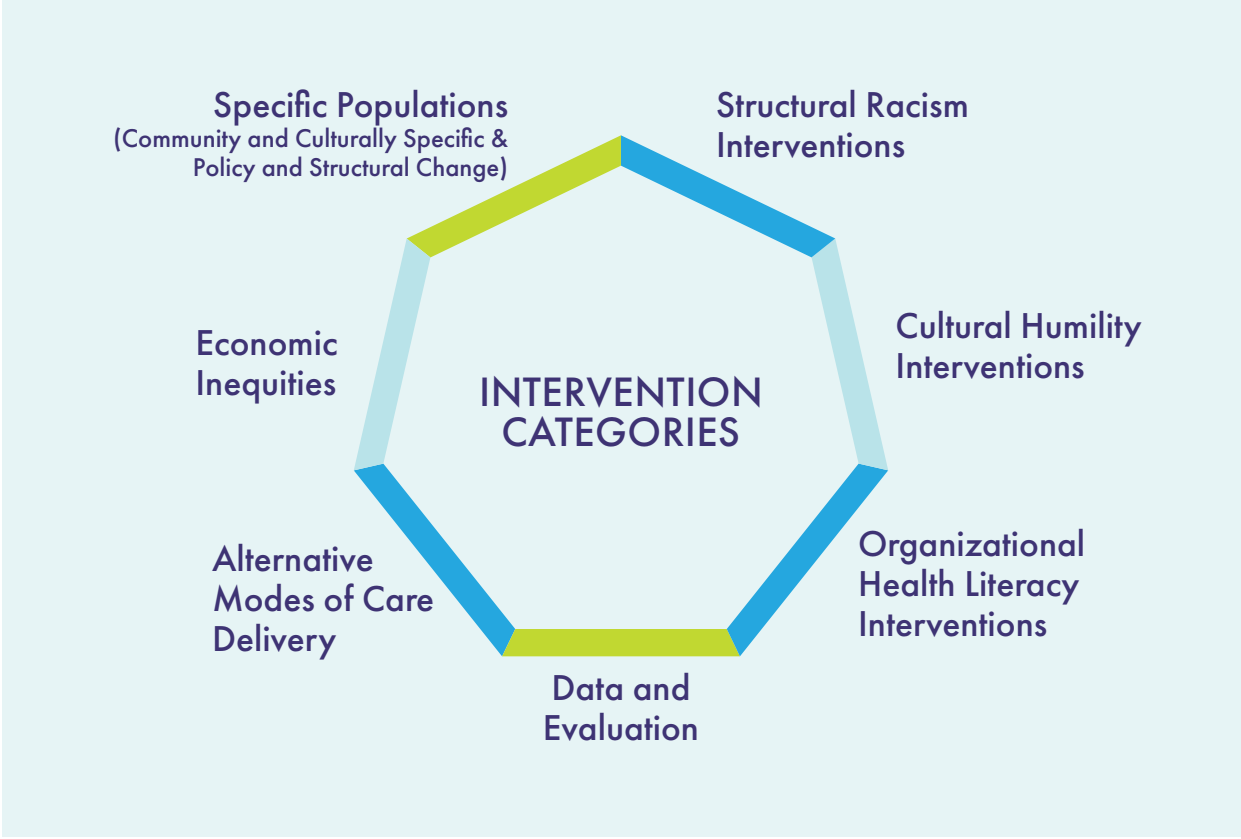
- **Individual barriers:** A person's race, ethnicity, age, gender, sexuality, and socioeconomic status will determine a person's attitudes, beliefs, knowledge, and skills pertaining to navigating the health care system. Due to various systems of power, many people lack access to care and education that prioritizes bodily autonomy, collaboration and offers patients the tools and skills needed to make informed decisions about their health care.

These barriers to care require interventions – at either the community or structural level – that aim to advance health equity by creating policy and structural changes.

Understanding Interventions

Based on research conducted by NFPRHA on health inequities and barriers to care, the following categories were identified as facilitators and evidence-based interventions that organizations are utilizing to implement equitable health care strategies:

- **Specific populations:** Prioritizing the needs of underserved communities, including populations that are socioeconomically disadvantaged, is key to advancing health equity. Many underserved communities face discrimination, lack access to resources, and fear institutions based on personal and/or collective trauma. Suggested interventions are organized by specific populations to help family planning providers determine which intervention is best for their communities. Many interventions will overlap due to the intersectional work being done in various communities. The interventions listed include organizational policies, programs, toolkits, and resources that are designed to advance health equity. Within this section, there will be examples of community and culturally specific interventions and policy and structural interventions.
  - **Community and culturally specific interventions:** Community-led health campaigns, culturally and linguistically appropriate materials, technology-based interventions such as text messaging or mobile applications, and various toolkits.



  - **Policy and structural change interventions:** Efforts by advocates and policymakers who aim to advance health equity on the policy and structural levels. Interventions include antiracist policymaking guidelines, reproductive justice toolkits, trainings and workshops for staff, and additional resources.

- **Structural racism interventions:** Services should be delivered in a manner that acknowledges a collective history and people's own lived experiences with structural and interpersonal racism.[9] Interventions must address systemic oppression and racism, and health disparities with Black, Indigenous, and other people of color (BIPOC) communities as well as aim to build community trust and improve the quality of care.
- **Cultural humility interventions:** A personal lifelong commitment of self-reflection and self-critique whereby the individual not only learns about another's culture but examines their own bias, beliefs, and cultural identities.[10] Cultural humility also includes "structural competency," which is based on the "understandings of the social determinants of health and related concepts such as structural violence and structural vulnerability."[11] Advancing health equity requires increasing access to culturally and linguistically appropriate materials and services, creating workforce retention and recruitment strategies, and ensuring that all people have access to an inclusive health care setting.
- **Organizational health literacy interventions:** The degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.[12] This includes implementing inclusive organizational processes, accessible educational modalities, and community-centered interventions.
- **Data and evaluation:** Equitable data collection requires updating health records and intake forms, etc. and using regional and local information to capture inclusive demographic data. Data and evaluation can be used to create interventions for priority populations, address systemic inequities, and provide approaches to increase access to care.
- **Alternative modes of care delivery:** Modes, such as telehealth, mobile units, and pop-up clinics, can serve to address economic inequities and improve health outcomes. These methods have been proven effective throughout the COVID-19 pandemic,[13] increasing access to medication abortion,[14] and increasing access to care for marginalized communities.[15]
- **Economic inequities:** Efforts to addressing economic inequities in health care, predominantly among communities that have been historically under-resourced, range from implementing a sliding fee scale, community education on insurance options, and improving access to affordable prescriptions and supplies.

Many interventions that are listed include a small summary or excerpts directly from the abstract, findings, or project summary to help users better navigate relevant resources. Many of the resources provided are intended to be used as a guide and can be adjusted based on the needs of the project, program, or policy.

Structural Racism Interventions

REPRODUCTIVE JUSTICE CIVIC ENGAGEMENT

Racial justice is a core tenant of reproductive justice. To improve health outcomes of marginalized communities, family planning providers, administrators, and policymakers can participate in civic engagement to make changes at the city, county, state, and federal levels and improve health outcomes.

Today, reproductive health, rights, and justice organizations work together to improve gaps in access and promote inclusive practices and policy solutions.

Examples of Organizations and Interventions

- The Alliance for Justice has created a **Reproductive Rights, Health, and Justice Resource Guide** to assist agencies engage in advocacy efforts.
- **Spark** has created trainings on leadership development and community mobilization through civic engagement.
- **Reproductive Justice as a Civic Engagement Framework** is an online training provided by Reproaction.
- **Contraception Justice Coalition** believes that all people should have access to contraception and pregnancy prevention care and is comprised of government officials, consumer advocates, and community members.

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ADDRESSING SYSTEMIC OPPRESSION AND RACISM

To address systemic oppression and racism and create a more equitable workplace, agencies must examine its institutional policies through an equity lens. This could mean implementing DEI trainings for leadership and staff creating new opportunities for advancement, and an assessment of mission, vision, and values statement to center racial justice and health equity.[16,17]

Examples of Organizations and Interventions

- **A Racial Equity Framework for Assessing Health Policy** is a resource guide for policymakers seeking assistance on assessing policies and addressing racial equity in health policy.
- The **Equity, Inclusion & Engagement Policy Assessment Toolkit** provides exercises and tools to help organizations get started or review current policies.
- The **Reproductive Health National Training Center** has created an eLearning course for family planning organizations to address barriers to creating a diverse, equitable, and inclusive environment within their organization.
- The **California Improvement Network** created a guide to assist providers with translating their health equity efforts with improving data collection, determining key drivers of advancing health equity, and assessing current projects.

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INCORPORATING ANTIRACIST VALUES WITHIN HEALTH CARE

Antiracist interventions are key to improving the health and well-being of BIPOC patients and decision-makers and staff in health care settings have a responsibility to take antiracism action and improve health outcomes.[18] Organizations must assess, plan, implement, and monitor the progress of antiracism strategies that aim to support the community at large.

Examples of Organizations and Interventions

- **Race Equity Practices Spectrum Tool** is intended to review an organization's goals and strategies to incorporate racial justice practices within your organization.
- The National Juvenile Justice Network created **Anti-racist Organizational Development resources** to help organizations assess their policies and resources.
- **Equity in the Center** has additional racial equity organizational tools and resources

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ADDRESSING HEALTH DISPARITIES WITH BIPOC COMMUNITIES

Health disparities among BIPOC communities impact their sexual and reproductive health as well as their mental health.[19] Addressing these health inequities requires establishing strategies that target racial and ethnic disparities in family planning, including maternal mortality rates, HIV transmission, contraceptive access and counseling, and implementing person-led care.[20,21,22] Equitable practices include sustaining culturally specific health care settings with staff that reflect the BIPOC communities being served, increasing community outreach and collaboration to address cultural stigma and medical distrust, providing trauma-informed care, and increasing contraceptive access.

Examples of Organizations and Interventions

- **Hood Medicine Initiative** created a YouTube series to address health equity among BIPOC communities to expand access to care.
- Mental Health America has curated an online resource guide called **"Healthcare Disparities Among Black, Indigenous, and People of Color,"** with various resources on how to support BIPOC communities increase access to mental health services.
- The US Centers for Disease Control and Prevention (CDC) has created the **STD Health Equity** initiative with resources on sexual health cultural competency and reducing health disparities with additional tools and resources.
- The Kaiser Family Foundation (KFF) conducted a study to review COVID-19 and racial justice movements with a focus on health disparities: **Disparities in Health and Health Care: 5 Key Questions and Answers**
- The American College of Obstetricians and Gynecologists **Racial and Ethnic Disparities in Reproductive Health Services and Outcomes**[23] report on policy-level strategies to close the health equity gap.
- Also see: Interventions by Population

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BUILDING COMMUNITY TRUST

Building community trust is essential to engaging community members to seek health care services. Community trust can be developed by listening to and learning from employees, patients, and community members with marginalized identities, ensuring interventions are community-based and -led, establishing accountability interventions such as equity scorecards, and reporting progress and setbacks to staff and community members.[24,25,26]

Examples of Organizations and Interventions

- **The SHARE Approach: A Model for Shared Decision-making** is 5-step process to ensure that providers and patients work together to develop a health care plan that best meets the needs of the patient.
- The Guttmacher Institute published policy recommendations for long-acting reversible contraceptives (LARCs) to prevent coercive tactics while promoting LARCs. Some of the policy recommendations includes using a person-centered framework, reducing racial bias by building trust, and increase community engagement: **Powerful Contraception, Complicated Programs: Preventing Coercive Promotion of Long-Acting Reversible Contraceptives.**
- Learn more about non-paternalistic models to better support patient needs by building trust and supporting the autonomy of all patients: **Provider-Patient Relationship.**
- **Person-Centered Contraceptive Counseling (PCCC) measure** is a tool to evaluate patient experience of contraceptive care, and particularly how health care providers are supporting patients during the contraceptive decision-making process.
- ASTHO has created an introductory guide on **Multi-Sector Intersections and Collaborations to Advance Health Equity** to support coalition building and community collaboration.
- **The PATH Framework** is a person-centered model to encourage providers to engage in conversations with their patients about their sexual health needs.

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HEALTH EQUITY INTERVENTIONS
Cultural Humility Interventions

IMPROVING STRUCTURAL COMPETENCY WITHIN HEALTH CARE SETTINGS

Family planning providers can play a key role in bringing out institutional change by implementing policies and procedures that improve structural competency. This includes addressing unconscious and conscious racial bias and discrimination, on-going/continuing education requirements for medical professionals and other staff members, recruitment and retention strategies for inclusive staffing at all levels, DEI trainings and antiracist practices, and provider training in interpersonal skills and cultural competency.

Examples of Organizations and Interventions

- Access **NFPRHA's Racial and Reproductive Justice resources** and trainings.
- The World Health Organization (WHO) created a health promotion guide for increasing community engagement: **Community engagement: a health promotion guide for universal health coverage in the hands of the people.**
- Learn more about Seattle Children's Hospital's **Health Equity and Anti-Racism Action Plan** (HEAR), its 5-year effort to address racism and health disparities.
- The CDC has created a **Sexual Health Cultural Competence Resources** page for providers and organizations that serve culturally diverse communities.
- **Is Implicit Bias Training Effective?** is a report developed by the National Institutes of Health to discuss how implicit bias training alone does not eradicate bias; it must be paired with a comprehensive institutional strategy for change.

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WORKFORCE RETENTION, RECRUITMENT, AND ENVIRONMENT

Workforce retention, recruitment, and environment affect the safety and support of all staff and people seeking care. All institutions should focus on a recruitment and retention plan for BIPOC and LGBTQ+ staff, provide inclusive hiring practices for all levels of staff and providers, and provide hiring incentives for multilingual staff and providers.[27]

Examples of Organizations and Interventions

- **Confronting Racism in Health Care,** an article that discusses how organizations must examine their institutional policies, train all staff including leadership in antiracism policies, and develop and create relationships with Black and other-minority businesses within the community.
- The American Heart Association created a tool called **Driving Health Equity in the Workplace** to ensure that the workplace is a safe and supportive place for all employees.
- To reduce health disparities among transgender and gender non-conforming (TGNC) people, the Human Rights Campaign created a guide called **Transgender-Inclusive Benefits for Employees and Dependents** to support TGNC employees and their dependents.

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INCLUSIVE HEALTH CARE SETTINGS

All health care settings should be welcoming for those seeking services. To ensure the safety and well-being of patients, organizations should update their health records or electronic medical records to allow for preferred names and correct pronouns. Additionally, health centers should update intake forms include gender-neutral terms, create trans-inclusive policies (bathrooms, waiting rooms, etc.), foster shared decision making and power (patient advisory groups, staff support groups, etc.), provide culturally specific promotional tools and resources in all areas of the health center, and collaborate with faith-based communities for educational materials, outreach efforts, and community engagement.

Examples of Organizations and Interventions

- Planned Parenthood of the Southern Finger Lakes created a guide to improve health care services for transgender patients: **Providing Transgender-Inclusive Healthcare Services.**
- **Creating an Inclusive Environment for LGBT Patients** is a guide created by the National LGBT Health Education Center to improve institutional policies for LGBTQ+ patients.
- Also see: Intervention by Population

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HEALTH EQUITY INTERVENTIONS
Organizational Health Literacy Interventions

INCREASE PATIENT ACCESS TO CULTURALLY AND LINGUISTICALLY APPROPRIATE MATERIALS AND SERVICES

All people have the right to access information and education on their health-related needs. Culturally and linguistically appropriate materials must be developed with community involvement to support the health and well-being of all[28,29]. This includes translated materials with community input, patient education and access to medical translation services, culturally specific outreach efforts to include community health workers and patient navigators, culturally and linguistically appropriate education materials (eHealth, mobile apps, campaigns, etc.), and linguistically appropriate education materials for billing, telephone conversations, consent forms, etc.

ACCESSIBLE ORGANIZATIONAL PROCESSES AND EDUCATIONAL MODALITIES

Educational materials and organizational processes should also be accessible, which can range from offering ADA-compliant online and written communications, eHealth/mobile apps, peer-to-peer interventions, and culturally and linguistically appropriate materials. Digital literacy training may be needed to explain to staff how to use electronic health records, how to communicate online with a health care team, and how to use third-party apps for additional resources, for example.

Examples of Organizations and Interventions

- The CDC has created a **Sexual Health Cultural Competence Resources** page for providers and organizations that serve culturally diverse communities, which includes a self-assessment check list, front desk assistance, and a guide to adapting culturally and linguistically competent health promotion materials.
- According to Community Language Cooperative, **Language Justice** is "a key practice used in social justice movements to create shared power, practice inclusion and dismantle traditional systems of oppression that have traditionally disenfranchised non-English speakers."[30]
- **Equity in the Center** has key resources on language justice and how to support communities.
- **Rural Health Literacy Toolkit** aims to provide evidence-based resources and tools to support the needs of rural communities in the United States.
- The Agency for Healthcare Research and Quality (AHRQ) **Health Literacy Universal Precautions Toolkit** is intended to support providers with helping their patients navigate the health care system and improve understanding of health information.
- Also see: Individuals with Limited English Proficiency (LEP)

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Data Collection and Evaluation Interventions

Equitable data collection requires updating health records and electronic health records (EHR) as well as intake forms to capture inclusive demographics such as race, age, gender identity, gender expression, or insurance status can reveal potential inequities and inform interventions for priority populations.

Best practices include collaborating with research groups, conducting patient satisfaction assessments that include demographic questions and measure barriers to care, and establishing or maintaining patient advisory groups to enable ongoing feedback.[31]

Examples of Organizations and Interventions

- NFPRHA focuses on quality improvement and measurement to promote greater recognition about the important role of family planning and its necessity in health care. NFPRHA has been working with accrediting agencies on policies to publicly measure and validate family planning and, specifically, contraceptive services. Review **NFPRHA's quality improvement and measurements resources** to support your health equity efforts.
- **AHRQ: Aspects of Patient Experience** is an online resource for developing surveys and trainings on improving patient experiences in health care settings.
- **Person-Centered Contraceptive Counseling (PCCC) measure** is a tool to evaluate patient experience of contraceptive care, and particularly how well healthcare providers are supporting patients during the contraceptive decision-making process.

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HEALTH EQUITY INTERVENTIONS
Addressing Financial Inequities

NFPRHA believes that all people should have timely and convenient access to high-quality, confidential, and affordable family planning and sexual health care. Financial inequities impact family planning decision making, especially for people with no or low incomes and communities that face systemic barriers to care, given that they "bear the financial responsibility and additional burden of finding a provider that accepts Medicaid."[32]

Interventions such as fee transparency, education on insurance options, and improved access to affordable prescriptions are imperative to reduce family planning and sexual health inequities.

Get Access to the Following Topics on the NFPRHA website:

- 5 ways to get help with prescription costs
- Mailing prescription medications to patients
- Medicaid & CHIP coverage
- Medicaid's Free Choice of Provider protections
- Patient Navigators
- Resources for the uninsured
- Sliding fee discount schedules aid

Get online access to these featured examples and other resources on the NFPRHA website: tinyurl.com/yc8a7n64

HEALTH EQUITY INTERVENTIONS
Alternative Modes of Care Delivery

By shifting where services are delivered, alternative modes of delivery can play a role in more effectively meeting patients' health needs and reducing health inequities. This might occur through leveraging technology, specifically telehealth, as well as using mobile health units, pop-up clinics, direct mail, and non-emergency medical transportation.

TELEHEALTH

Telehealth has been particularly beneficial for individuals living in rural and frontier health care deserts, as well as people in urban and suburban areas who encounter transportation barriers. Due to significant inequities in broadband and device access (smartphones, tablets), any intervention that leverages telehealth to advance health equity must account for varied levels of access to necessary technology.

Examples of Organizations and Interventions

- **NFPRHA's telehealth videos** explore how to leverage telehealth for providing access to patient-centered care in the family planning context. NFPRHA also has **sample telehealth workflows** that provide detailed steps for providing family planning and sexual health care via telehealth.
- Essential Access Health created a resource hub, called **Telehealth Essentials**, that includes clinical guidelines, a clinic operations guide, and various toolkits to support telehealth efforts.
- **Telehealth Services: Taking an Inclusive, Equity-Driven, and Trauma-Informed Approach** Job Aid, compiled by the Reproductive Health National Training Center, outlines six strategies to effectively communicate about telehealth services with patients.
- The Reproductive Health National Training Center's **Telehealth Etiquette for Family Planning** job aid assists providers to ensure a positive patient experience when conducting telehealth visits.
- **HITEQ Resources for Patients with Limited English Proficiency in Health Centers** provides health centers with strategies to increase their telehealth capacity for LEP patients.
- **Mailing Prescription Medications to Patients** is a NFPRHA resource that outlines considerations for health centers that are exploring the feasibility and permissibility of mailing medications to patients.

Get online access to these featured examples and other resources on the NFPRHA website: tinyurl.com/ynprj4t4

MOBILE HEALTH UNITS & POP-UP CLINICS

Mobile health units can take many forms, including buses, vans, and trailers, to provide clinical and health education services directly to communities in need. This intervention has been shown to reach a variety of populations that face barriers to accessing care, such as immigrants, individuals with substance use issues, and those without stable housing.[33] This is especially true in the post-*Dobbs* landscape, where mobile health units can provide abortion care and other sexual and reproductive health services.

Pop-up clinics are an opportunity for health care organizations to bring care directly into communities, extending the reach of their brick-and-mortar health centers. Pop-up clinics do not require upfront investments in mobile health units, making them a cost-effective approach to increasing a health center's reach in areas with limited access to care.

Examples of Organizations and Interventions

- **Pop It Up! A Guide to Pop-Up Clinics for Family Planning and Sexual Health Services** is a NFPRHA resource guide that introduces different models for implementing pop-up clinics for family planning and sexual health services. This resource guide includes examples and lessons learned from providers implementing this model.
- **Mobile Health Map,** a program of Harvard Medical School, is the only comprehensive database of mobile health clinics in the country. Members of this collaborative research network and learning community share information that health care organizations can reference when planning or implementing mobile health programs, including information about locations, services, priority populations, and costs.

- **The Case for Mobile,** published by Mobile Health Map, explores how health centers can leverage mobile health unit programs to sustain or expand their efforts to deliver health care in under-resourced communities.
- **Mobile Health Units: A Strategy to Increase Access to Family Planning and Sexual Health Services**[34] is a NFPRHA resource that provides an overview of mobile health units for family planning and sexual health services. To compile the guide, which includes examples and lessons learned from the field, NFPRHA conducted a literature review and interviews with several family planning and sexual health services providers that were operating or in the process of launching mobile health programs.

Get online access to these featured examples and other resources on the NFPRHA website: tinyurl.com/ynprj4t4

NON-EMERGENCY MEDICAL TRANSPORTATION

Access to free or low-cost and reliable transportation is essential to improving access to health care. BIPOC and low-income communities—whether urban, rural, or suburban—are more likely to rely on public transit systems and more directly affected by lopsided infrastructure investments (roads, bridges, and highways instead of public transit systems).[35] Health care organizations can help address this access barrier by implementing interventions to mitigate transportation barriers. These interventions extend well beyond the Non-Emergency Medical Transportation benefit for Medicaid enrollees to assisting all people with accessing transportation to and from medical appointments as needed.

Examples of Interventions

- The Rural Health Information Hub's **Rural Transportation Toolkit** contains modules with resources and information focused on developing, implementing, evaluating, and sustaining rural transportation programs.
- The Walsh Center for Rural Health Analysis at the University of Chicago published a report, **Promising Practices for Increasing Access to Transportation in Rural Communities,** that identifies 15 promising rural transportation program models.
- The Health Equity Project, in conjunction with Third Horizon Strategies, published **Getting from Here to There: Improving Non-Emergency Medical Transportation for the Underserved,** that suggests strategies that stakeholders can undertake to improve access to non-emergency medical transportation among Medicaid beneficiaries and Medicaid-eligible populations.
- **Ridesharing services** are developing partnerships with health systems to provide non-emergency medical transportation that has been shown to improve access to primary and preventive care. Lyft has partnered with Allscripts and Epic, two large EHR vendors, to enable health care organizations to use their EHR platforms to schedule rides for patients with transportation barriers; and Uber has partnered with Cerner Corporation, another large EHR vendor, to integrate the Uber Health app with Cerner's EHR platforms.[36] Health care organizations seeking to support patients with accessing transportation may wish to explore their EHR's current capabilities, if applicable. They also can explore how to work directly with ridesharing services to provide transportation to patients.

Get online access to these featured examples and other resources on the NFPRHA website: tinyurl.com/ynprj4t4

HEALTH EQUITY INTERVENTIONS

Interventions by Population

Get access to examples of interventions, examples of policy and structural change, recommended readings and highlighted organizations that provide a range of tools and resources specific to each population type.

Race and Ethnicity
- Asian American, Native Hawaiian, and Pacific Islander (AANHPI)
- Black Americans
- Indigenous Peoples
- Latinx/Latine

tinyurl.com/35z5jzf6

Adolescents and Young Adults
tinyurl.com/bde9m2ev

Immigrants/Refugees
tinyurl.com/4r7kcyvh

People Experiencing Intimate Partner Violence (IPV)
tinyurl.com/ykhwukjc

People with Intellectual, Developmental, or Physical Disabilities
tinyurl.com/yemrp6ra

People with Limited English Proficiency (LEP)
tinyurl.com/ynnhh4ff

People with Substance Use Disorders
tinyurl.com/4cwvtx2f

LGBTQ+ People
tinyurl.com/3kw72hwf

Low Income or Uninsured
tinyurl.com/6up4us3f

Men and Young Men
tinyurl.com/ymref8jb

People Living with HIV and HIV Prevention
tinyurl.com/5n6cxe3e

Religious Communities
tinyurl.com/mryp8eps

Rural/Frontier Areas
tinyurl.com/3vsp27ht

Sex Workers
tinyurl.com/4cypa42d

Unhoused Communities
tinyurl.com/y47n8fbf

National
Family Planning
& Reproductive Health Association

HEALTH EQUITY

Assessment Tool

Eliminating inequities in the health care system can be achieved only by responding to systemic racism and all forms of oppression, which are root causes of adverse social determinants of health, especially among historically oppressed communities and other peoples experiencing inequities. As providers strive to marry their intentions to dismantle racism and white supremacy and advance sexual and reproductive health equity in practice with action, they must examine their current practices, programs, and policies with a critical eye.

Navigating the Assessment Tool

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How to Use this Assessment Tool with the Resource Guide

The assessment tool can be used to obtain a baseline measure of progress to date and/or to identify activities and interventions that organizations may wish to prioritize. The assessment tool is comprised of six (6) different assessments based on the type of health equity intervention each organization is planning to implement.

The tool aims to assess the extent to which entities have implemented evidence-based and promising practices, programs, and policies to mitigate the negative impact of social determinants of health and advance sexual and reproductive health equity.

When conducting the assessments, remember that the audiences may include staff, community partners, and organizations/agencies that fund or deliver family planning and sexual health care and education. After completing the assessment tool, revisit the resources in this guide to explore the various interventions listed and how they can be adopted or adapted by your organization. Each section of the guide includes community- and policy-level interventions, recommended readings, and highlighted organizations that provide a range of tools and resources to assist with the implementation and evaluation of the organization's health equity efforts.

First, identify the level(s) of intervention that your organization may want to work on to advance sexual and reproductive health equity. These levels of intervention are informed by the social ecological model[37, 38, 39] which recognizes that multiple levels of influence impact health behaviors and health. By incorporating evidence-based programs and best practice strategies at each selected level into efforts to advance health equity, there is opportunity to mitigate those social determinants of health that have the biggest adverse impact on sexual and reproductive health outcomes. The levels in which to begin to strategize are as follows:

- **Interpersonal Level:** This level of the assessment seeks to ask staff, at all levels, about areas that may need improvement within the organization. This level aims to build knowledge and skills and shape the attitudes of people who interact with priority populations.
- **Institutional Level:** This level of the assessment targets the institutional environments in which individuals access health care, health information, and related social services.
- **Community Level:** Embedded in larger social and economic structures, this level of the assessment addresses the unique environments in which the individuals live, spend much of their time, and access services.
- **Societal Level:** This level of the assessment addresses larger, macro-level factors such as laws and policies that influence the behaviors of the individuals – with emphasis on people with low incomes, people of color, and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.

Depending on the needs of the organization, there may be multiple levels of the assessment that will be useful for the project, program, or policy. To find the assessment(s) that best suits your program, project, or policy goals, the assessment tool is divided into the following sections:

- **Interpersonal (All Staff):** Interactions that occur in institutional environments are, by nature, social.

At the same time, they are inherently different than those between friends or family members, particularly when considering issues of equality, power balance, and specific interests or expected outcomes. This area of the assessment relates to all individuals who work at the institution or the institution(s) that are funded, from the front lines of service delivery to executive leadership. The quality of these individuals' interpersonal interactions with patients has the potential to shape overall experience and ultimately can serve as facilitators or create barriers to access.

- **Interpersonal (Clinical Staff):** Power imbalances are especially pronounced during interpersonal interactions between patients and their clinical service providers. By their very nature, these interactions are asymmetrical: clinicians possess legitimized and expert power; patients are reliant on clinicians to receive the care and services they need. Furthermore, during exchanges, patients often need to hand over some level of control of their bodies and psyche. Such power imbalances can introduce bias into interpersonal interactions between patients and clinicians, especially when they are differences in race, culture, gender, gender identity, and religion. The section of the assessment will address the practices of clinical service providers that serve patients at your institution or the institution(s) funded by your agency. The kind of improved patient outcomes that can translate to advancements in health equity depend on successful communication between patients and clinicians. Quality interactions between a patient and their clinical providers rests on seven basic principles: mutual respect, harmonized goals, a supportive environment, appropriate decision partners, the right information, full disclosure, and continuous learning.[40]
- **Institutional:** Many institutions prioritize internal-facing activities, recognizing that meaningful external-facing work cannot occur until equity and justice are centered in their own environments, policies, and services. This section of the assessment will relate to your institution and the progress it has made to advance internal-facing health equity work.
- **Institutional (Health Center):** Another subset of institutional-level interventions focuses on the environments where individuals access health care, health information, and related social services. Both formal guidelines, such as written policies and rules, and informal guidelines, such as practices and environmental culture, in these spaces govern individuals' access to health care by shaping service availability, cost, and quality.[41] This area of the assessment may relate to the environments, policies, and services at a single health center, health system, or network of health centers. The social ecological perspective draws attention away from the intra-individual factors and processes to which health disparities historically have been attributed, shifting focus on environmental determinants.
- **Community:** "Community" is defined in many ways and used in different contexts. Within the social ecological model, "community" typically refers to relationships within and amongst organizations and groups in a civic or geographic region (neighborhood, political district) or social network (faith-based association, leisure association or club); it also may be defined in demographic terms (Black community, LGBTQ+ community).[42] Community-level interventions, therefore, typically focus on improving coordination between organizations and coalition building, with the goal of influencing political dialogue, public policies, and resource expenditures. They include interventions to increase the involvement of community members in larger civic and power structures; build social and organizing capital to address the social determinants of health; and implement changes to improve community environments, services, and capacities[43]. When assessing your work, consider the civic or geographic region where your institution resides, the organizations and groups your institution sits in community with, or a combination of both.
- **Societal (City, County, and State Public Policy):** Public policy interventions, including laws, regulations, and rules to improve population health, make up the broadest level of the social ecological model. To advance sexual and reproductive health equity, these interventions focus on the local, state, and national levels; maternal and child health-related services; and access to the full range of family planning and sexual health services, including contraception and abortion care.[44] There is an important link between the social ecological model's public policy level of intervention and concepts of community addressed at the community level. Communities serve as critical connections between individuals and larger social environments; without them, broad-based efforts to advance sexual and reproductive health equity cannot "trickle down" to the individual level and to smaller networks (e.g., families, friend groups) that influence individuals'

health-related behaviors. Therefore, to minimize issues of paternalism and coercion, public policy-level interventions should be designed to strengthen – and never to replace – the role of communities in advancing health equity.[45] In this section of the assessment, this is an opportunity to review both policies and the policymaking processes in your city, county, and state.

After completing the assessment tool, revisit the resource guide to explore the various interventions listed and how they can be adopted or adapted by your organization to advance health equity.

Assessment Instructions

1. Identify the level(s) of intervention that may want to work on to advance sexual and reproductive health equity.
   - **Interpersonal Level**
   - **Institutional Level**
   - **Community Level**
   - **Societal Level**
2. Next, which assessment best suits your needs? Descriptions are above.
   - **Interpersonal (All Staff)**
   - **Interpersonal (Clinical Staff)**
   - **Institutional**
   - **Institutional (Health Center)**
   - **Community**
   - **Societal (City, County, and State Public Policy)**
3. Next, identify key stakeholders that will be involved in the assessment process such as colleagues, partners, community leaders, patients, and community members.
4. Review each prompt and determine the **level of progress** based on where the organization is today. It is best to do this individually so that each person can see from various perspectives how they view the progress of the organization. Stakeholder and community involvement is key to gathering more accurate information.

LEVEL OF PROGRESS						
1	2	3	4	5	N/A	UNK
1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree						

   - **Scoring your organization an N/A** means that it does not apply.
   - **Scoring your organization UNK** means that progress is unknown, which could be due to lack of knowledge or communication, it may apply to another department that is not represented in the assessment process, or more information is needed to fully answer the question.
5. **Stakeholder involvement** and additional comments will be at the bottom of each assessment to review.
6. The **Reference** column includes links to the resource guide that will direct you to various practices, programs, and/or policies referenced in each statement. It connects you with information to consider whether a specific intervention to advance sexual and reproductive health equity aligns with your needs, current resources, capabilities, and organizational culture.
7. After completing the self-assessment, reflect on responses using the **processing questions** on the next page.

Processing Questions

The following questions will provide a starting place for considering opportunities for improvement at your institution and/or the institution(s) you fund. After completing the assessment tool and reflecting on the following processing questions independently, compare your responses with a multidisciplinary team of colleagues, as well as patients, partners, community leaders, and community members. A structured approach to gathering feedback from individuals with different backgrounds and perspectives will ensure maximum impact on your health equity goals.

8. What was it like for you to assign values to each of the statements in the assessment?
   - What, if anything, was challenging about completing the assessment? Why do you think that is?
9. Which statements did you strongly disagree or disagree with (i.e., assign a "1" or "2" value)?
   - What factors might have contributed to your institution or the institution(s) you fund not being as far along with these opportunities to advance sexual and reproductive health equity? Why do you think that is?
10. What, if any, patterns did you see among the statements that you strongly disagreed or disagreed with?
    - To what extent were you more likely to strongly disagree or disagree with statements at some levels of intervention (e.g., interpersonal, institutional, community, public policy) than other levels? Why do you think that is?
    - To what extent were you more likely to strongly disagree or disagree with statements related to certain types of activities (e.g., structural racism interventions, cultural humility, organizational health literacy, data and evaluation)? Why do you think that is?
11. Which statements did you agree or strongly agree with (i.e., assign a "4" or "5" value)?
    - Moving forward, how might your institution or the institution(s) you fund leverage these areas of strength when implementing new priority activities and interventions?
12. To what extent do you need more information to complete this tool?
    - What steps might you take to gather this information?
13. To what extent do you predict that the values assigned on this assessment will vary among your colleagues and partners?
    - How will your institution or the institution(s) you fund benefit from these differences of opinion?

TIP: Consider making a priority matrix to determine which item to begin with. Here are some tools to get you started:

- Advancing Health Equity **Root Causes Analysis**
- Health Quality Innovation Network **Priority Matrix**
- Minnesota Department of Health **Prioritization Matrix**
- **Eisenhower Matrix Templates**

Access these tools at tinyurl.com/5em6tbzb

Health Equity Assessments

(Intentionally blank)

Interpersonal (All Staff)

Audience: Any institution that delivers or funds sexual and reproductive health services; any institution that funds or delivers and/or school- or community-based programming with a sexual and reproductive health component.

	LEVEL OF PROGRESS							REFERENCE
1. Health equity is incorporated in the organization's strategic plan as well as the mission, vision, and values.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
2. The organization has a plan for operationalizing the health equity strategy, tracking progress over time, and reviewing health equity data at the leadership and team levels.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural Humility • Data and evaluation
3. The organization created or provides training for staff and providers on antiracist strategies and skills to improve health equity.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
4. Equity is included in hiring decisions and improving health equity is included in job descriptions and responsibilities.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
5. The agency's leaders articulate the importance of addressing the health system's role in dismantling racism and other forms of oppression.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
6. Leadership provides formal opportunities for staff to engage in conversations about how racism and other forms of oppression impact their services, their lives, and the communities they serve.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
7. The organization reviews policies, practices, and norms in each organizational area to assess for potential inequitable impact on communities of color and other marginalized populations, and redesign where needed.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
8. The organization accepts Medicaid and other health insurance that serve predominantly marginalized populations.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Addressing financial inequities

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

STAKEHOLDER INVOLVEMENT

- ◯ **Yes.** Recommendations and input from those who are most impacted were involved throughout the entire process.
- ◯ **Somewhat.** Recommendations and input from those who are most impacted were involved in parts of the process.
- ◯ **No.** Stakeholders were not involved.

Please list those who were involved or need to be involved:

Who is missing?

COMMENTS

Note examples, achievements, challenges, questions, next steps, key supporting documents, etc.

Interpersonal (Clinical Staff)

Audience: Any institution that delivers or funds the delivery of sexual and reproductive health services.

The following statements relate to the practices of clinical service providers who serve patients at your institution or the institution(s) you fund.

	LEVEL OF PROGRESS							REFERENCE
1. All clinical staff have the necessary knowledge and skills to provide high-quality, evidence-based sexual and reproductive health services to all patients, including the most vulnerable populations in the community.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility • Organizational health literacy • Search by population
2. All clinical staff are comfortable providing care to all patients, including the most vulnerable populations in the community.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility • Organizational health literacy • Review by population
3. All clinical staff have received training aimed at raising self-awareness of their biases and their impact on patient experience and monitor progress.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
4. Clinical staff are committed to building patient trust, particularly among people of color and individuals from historically and currently marginalized communities; and recognize it as a process that requires long-term investment.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility • Search by population
5. Clinical staff express attitudes and behaviors that are consistent with person-centered care.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data collection • Structural racism • Cultural humility
6. Clinical staff have received training on how to meaningfully engage patients in their care.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
7. Clinical staff work to reduce stigma by reframing conversations with patients towards sexual health promotion.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Review populations • Addressing health disparities with BIPOC communities

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

	LEVEL OF PROGRESS							REFERENCE
8. The organization reviews policies, practices, and norms in each department, clinical care, and other organizational areas to assess for potential inequitable impact on communities of color and other marginalized populations, and redesign where needed.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
9. The organization collects and uses data to identify clinical areas where inequities exist, has set aims to address major gaps, and is implementing efforts to close those gaps.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data collection

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

STAKEHOLDER INVOLVEMENT

◯ **Yes.** Recommendations and input from those who are most impacted were involved throughout the entire process.

◯ **Somewhat.** Recommendations and input from those who are most impacted were involved in parts of the process.

◯ **No.** Stakeholders were not involved.

Please list those who were involved or need to be involved:

COMMENTS

Note examples, achievements, challenges, questions, next steps, key supporting documents, etc.

Institutional

Audience: Any institution that delivers or funds sexual and reproductive health services; any institution that delivers or funds school- or community-based programming with a sexual and reproductive health component. For example, a governmental agency/public institution or an advocacy organization

The following statements relate to your institution and the progress it has made to advance internal-facing health equity work.

	LEVEL OF PROGRESS							REFERENCE
1. My organization's leadership communicates, both verbally and in key organizational documents (e.g., strategic plan, annual report), that health equity is an organizational priority and inextricably linked to its mission and values.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Addressing systemic oppression and racism.
2. My organization's leadership model our commitment to health equity and antiracism work.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
3. My organization includes clients and community stakeholders with the identification, planning, implementation, and evaluation of health equity priorities.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Community engagement
4. My organization engages in discussions about its institutional history, including history of racism, and recognizes that it has a responsibility to remove any legacies of bias, discriminatory practices, and treatment without consent.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism
5. My organization has dedicated meaningful financial resources and staff time to understanding the negative impact of institutional and structural racism on communities.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Cultural humility
6. My organization has dedicated meaningful financial resources and staff time to building staff skills to engage in health equity and antiracism work.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
7. My organization's leadership ranks are familiar with the reproductive justice framework and can articulate the importance of advancing reproductive justice as part of our organization's health equity and antiracism work.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Anti-racism • Cultural humility

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

	LEVEL OF PROGRESS							REFERENCE
8. My organization has significant representation of people of color and individuals from historically and currently marginalized communities in leadership positions.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
9. My organization has significant representation of people of color and individuals from historically and currently marginalized communities on its Board of Directors, if applicable.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
10. My organization is committed to creating a more equitable workplace by evaluating hiring and advancement requirements that may ignore systems of inequities and reinforce white dominant culture and changing them	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Cultural humility
11. My organization is committed to creating a more equitable workplace by reviewing organizational practices and policies with an equity lens.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Cultural humility
12. My organization is committed to creating a more equitable workplace by establishing mechanisms to track and respond to discriminatory behavior in the workplace.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Cultural humility
13. During its recruitment, hiring, and promotion processes, my organization considers diversity, equity, and representation.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Cultural humility

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

STAKEHOLDER INVOLVEMENT

- ◯ **Yes.** Recommendations and input from those who are most impacted were involved throughout the entire process.
- ◯ **Somewhat.** Recommendations and input from those who are most impacted were involved in parts of the process.
- ◯ **No.** Stakeholders were not involved.

Please list those who were involved or need to be involved:

COMMENTS

Note examples, achievements, challenges, questions, next steps, key supporting documents, etc.:

Institutional (Health Center)

Audience: Any institution that delivers or funds the delivery of sexual and reproductive health services.

The following statements may relate to the environments, policies, and services at a single health center, health system, or network of health centers.

	LEVEL OF PROGRESS							REFERENCE
1. My health center is open during times that are convenient for patients, including evening and weekend hours.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
2. My health center offers timely access to advanced appointments and makes walk-in and same-day appointments available for sexual and reproductive health services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
3. My health center's facility is accessible to people with disabilities and systems are in place to ensure that additional reasonable modifications are available to people with disabilities.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• People with Intellectual, Developmental, or Physical Disabilities
4. My health center uses translated forms, signage, and educational materials that are culturally and language concordant for commonly spoken languages among patient populations.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Organizational Health Literacy • People with Limited English Proficiency (LEP)
5. My health center offers timely language access services though hiring bilingual/multilingual staff or accessible language services for patients with limited English proficiency.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Organizational Health Literacy • People with Limited English Proficiency (LEP)
6. My health center ensures that cost and ability to pay are not barriers to accessing sexual and reproductive health services, including contraception services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Financial inequities
7. My health center collects data to examine potential health inequities between patient populations.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data collection and evaluation
8. My health center regularly collects data about patients' experience of care, including qualitative data and the Person-Centered Contraceptive Counseling (PCCC) measure.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data collection and evaluation

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

	LEVEL OF PROGRESS							REFERENCE
9. My health center has quality improvement teams comprised of leaders, staff, and patients to review health equity data and creates time and resources for them to develop and implement equity-focused quality improvement efforts.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data collection and evaluation
10. My health center frames quality improvement goals from a strength-based perspective to avoid reinforcing racism and white supremacy.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
11. My health center communicates data effectively and respectfully to the broader community, balancing technical accuracy with community accessibility.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data collection and evaluation • Community engagement
12. My health center safeguards the privacy of patients that need confidential sexual and reproductive health services, including but not limited to adolescents; and has systems to ensure billing practices and use of electronic health records (EHRs) do not lead to confidentiality breaches.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
13. My health center uses standardized intake forms and EHR templates with prompts to facilitate the provision of person-centered care (e.g., prompts for each patient's correct name and pronouns, fields for disability documentation).	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
14. My health center is a physical space that is welcoming to patients across the gender spectrum.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• LGBTQ+ populations
15. My health center is a physical space that is welcoming to patients who identify as LGBTQ+.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• LGBTQ+ populations
16. My health center is a physical space that is welcoming to young people.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Adolescents and young adults
17. My health center is a physical space that is welcoming to patients with larger bodies.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	
18. My organization has adopted an approach for measuring health equity that includes indicators on the social determinants of health.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data and evaluation

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

	LEVEL OF PROGRESS							REFERENCE
19. My organization has adopted an approach for measuring health equity that includes indicators of unmet needs and the extent to which our programs address them.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data and evaluation
20. My organization has adopted an approach for measuring health equity that includes equitable access, high-quality clinical care and programming.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Data and evaluation

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

STAKEHOLDER INVOLVEMENT

◯ **Yes.** Recommendations and input from those who are most impacted were involved throughout the entire process.

◯ **Somewhat.** Recommendations and input from those who are most impacted were involved in parts of the process.

◯ **No.** Stakeholders were not involved.

Please list those who were involved or need to be involved:

COMMENTS

Note examples, achievements, challenges, questions, next steps, key supporting documents, etc.

Community

Audience: Any institution that delivers or funds sexual and reproductive health services; any institution that delivers or funds school- or community-based programming with a sexual and reproductive health component. For example, a governmental agency/public institution or an advocacy organization.

WHICH COMMUNITY ARE YOU PLANNING TO ASSIST, COLLABORATE WITH, OR CREATE POLICIES FOR (select all that apply):

- ◯ Asian American, Native Hawaiian, and other Pacific Islander
  Please specify:
- ◯ Black Americans
  Please specify:
- ◯ Indigenous Populations
  Please specify:
- ◯ Latinx/Latine
  Please specify:
- ◯ Adolescents and young adults
  Please specify:
- ◯ Immigrants/refugees
  Please specify:
- ◯ People experiencing Intimate Partner Violence (IPV)
  Please specify:
- ◯ People with intellectual, developmental, or physical disabilities
  Please specify:
- ◯ People with Limited English Proficiency (LEP)
  Please specify:
- ◯ People with substance use disorders
  Please specify:
- ◯ LGBTQ+ Populations
  Please specify:
- ◯ Low income or uninsured
  Please specify:
- ◯ Men and young men
  Please specify:
- ◯ People living with HIV and HIV prevention
  Please specify:
- ◯ Religious communities
  Please specify:
- ◯ Rural/Frontier Areas
  Please specify:
- ◯ Sex Workers
  Please specify:
- ◯ Unhoused communities
  Please specify:

	LEVEL OF PROGRESS							REFERENCE
1. Community leaders express a shared vision and value for advancing health equity.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism • Cultural humility • Organizational health literacy
2. Community leaders come together to identify common needs and build social and political capital to address the social determinants of health and advance health equity.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism • Cultural humility • Organizational health literacy
3. My community's publicly funded safety net can deliver no and low cost sexual and reproductive health services to all community members who need them.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Address financial inequities
4. My agency currently has relationships with the safety net organizations referenced above in #3.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population
5. My community has a network of community health workers and health support workers that connects individuals from historically and currently marginalized communities with health services, including sexual and reproductive health services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism • Cultural humility • Organizational health literacy • Language justice • People with Limited English Proficiency (LEP)
6. My community has a community-based service referral system to address social determinants of health, behavioral health, and social service providers.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism • Cultural humility • Organizational health literacy

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

	LEVEL OF PROGRESS							REFERENCE
7. My community has a coalition that works to advance health equity by addressing the sexual and reproductive health service needs of individuals from historically and currently marginalized communities. The coalition includes community members and leaders and reproductive justice advocates.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism • Cultural humility • Organizational health literacy
8. My community's sexual and reproductive health coalition has a strong, positive image in the community, a good track record, and a history of involvement of the broader community.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism • Cultural humility
9. My community has at least one multi-sectoral (e.g., health, labor, transportation, education, corrections, economic development, housing, philanthropy, public safety) coalition that addresses the complex factors that influence health equity in the community.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population • Structural racism
10. In community coalitions, there is understanding and acknowledgment of the history of racism and other forms of oppression in both the US and the community.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism
11. Community coalitions actively work with community leaders, elected officials, and policymakers to shift community norms that drive stigma and discrimination.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism
12. My community has evidence-based, program-level interventions in schools that can be leveraged to advance sexual and reproductive health equity.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism • Adolescents and young adults
12. My community has interventions in community-based settings that can be leveraged to advance sexual and reproductive health equity.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Search by population

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

STAKEHOLDER INVOLVEMENT

- ◯ **Yes.** Recommendations and input from those who are most impacted were involved throughout the entire process.
- ◯ **Somewhat.** Recommendations and input from those who are most impacted were involved in parts of the process.
- ◯ **No.** Stakeholders were not involved.

Please list those who were involved or need to be involved:

COMMENTS

Note examples, achievements, challenges, questions, next steps, key supporting documents, etc.

Societal: City, County, and State Public Policy

Audience: Any institution that delivers or funds sexual and reproductive health services; any institution that delivers or funds school- or community-based programming with a sexual and reproductive health component. For example, a governmental agency/public institution or an advocacy organization.

The following statements relate to both policies and the policymaking processes in your city, county, and state.

SOCIETAL (CITY OR COUNTY LEVEL)	LEVEL OF PROGRESS							REFERENCE
1. Elected officials and policymakers at the city and county levels reflect the diversity of the people they represent.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
2. Communities of color and other historically and currently marginalized communities play a key role in shaping policy discourse and ideas for elected officials and policymakers at the city and county levels.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
3. Policymakers at the city and county levels have taken steps to increase recruitment and retention of diverse local public health professionals that reflect the communities they serve.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
4. Policymakers at the city and county levels meaningfully engage and incorporate communities of color and other historically and currently marginalized communities in the policymaking and policy evaluation processes.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
5. Policymakers at the city and county levels target funding to communities and areas where it is needed most.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

STAKEHOLDER INVOLVEMENT

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Please list those who were involved or need to be involved:

COMMENTS

Note examples, achievements, challenges, questions, next steps, key supporting documents, etc.

SOCIETAL (STATE LEVEL)	LEVEL OF PROGRESS							REFERENCE
1. State agencies and policymakers apply reproductive justice in their messaging and do not use language that undermines or devalues the reproduction of low-income individuals and individuals from historically and currently marginalized communities.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
2. Elected officials and policymakers at the state level reflect the diversity of the people they represent.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
3. Communities of color and other historically and currently marginalized communities play a key role in shaping policy discourse and ideas for elected officials and policymakers at the state level.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
4. State policymakers have taken steps to increase recruitment and retention of diverse public health professionals.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
5. State policymakers meaningfully engage and incorporate communities of color and other historically and currently marginalized communities in the policymaking and policy evaluation processes.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
6. State policymakers target funding to communities and areas where it is needed most.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
7. State policymakers have invested in telehealth infrastructure, prioritizing projects in unserved and underserved areas in the state and at "anchor institutions" including health centers, schools, and libraries.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
8. State policymakers promote income stability for individuals and families by increasing eligibility for and facilitating enrollment in public benefit programs.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
9. My state has adopted the Affordable Care Act's (ACA's) Medicaid expansion.	◯ Yes				◯ No			• Structural racism: Reproductive justice civic engagement

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

SOCIETAL (STATE LEVEL)	LEVEL OF PROGRESS							REFERENCE
10. My state has expanded eligibility for coverage of family planning services under Medicaid.	◯ Yes				◯ No			• Structural racism: Reproductive justice civic engagement
11. In my state, Medicaid covers all contraceptive methods, including over-the-counter methods, without quantity or time limits.	◯ Yes				◯ No			• Structural racism: Reproductive justice civic engagement
12. In my state, Medicaid covers all pre-exposure prophylaxis (PrEP) services without cost sharing.	◯ Yes				◯ No			• Structural racism: Reproductive justice civic engagement
13. My state has enacted laws to increase access to contraception (e.g., pharmacist dispensing, 12-month supply coverage).	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
14. My state requires commercial insurers and Medicaid to provide reimbursement for services delivered via telehealth (when those services would have been covered if delivered in person).	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
15. State policymakers dedicate state funding for sexual and reproductive health services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
16. State policymakers do not impose restrictions on the allocation of public funds for sexual and reproductive health services (e.g., restrictions that prohibit abortion providers or their affiliates from receiving funds, age restrictions).	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
17. My state has enacted policies to secure individuals' right to abortion care without gestational age limits.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
18. My state does not impose restrictions on abortion coverage by commercial health insurance plans.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
19. My state provides state funds for abortion care for Medicaid enrollees.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

SOCIETAL (STATE LEVEL)	LEVEL OF PROGRESS							REFERENCE
20. My state provides state funds for Medicaid coverage for people who are undocumented.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
21. In my state, pregnant and postpartum people do not face criminal charges for experiencing miscarriages and stillbirths, self-managing abortions, using both criminalized and lawfully prescribed substances, or engaging in other acts perceived as creating a risk of harm to their pregnancies.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
22. Minors in my state have the explicit authority to consent to family planning and sexual health services, including contraceptive services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
23. Minors in my state have the explicit authority to consent to family planning and sexual health services, including STI services.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
24.My state has laws that protect the confidentiality of sensitive health care information for all patients, including minors.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement
My state promotes access to best practice medical care for transgender individuals, including transgender youth.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ N/A	◯ UNK	• Structural racism: Reproductive justice civic engagement

1- Strongly Disagree 2- Disagree 3- Neutral 4- Agree 5- Strongly Agree

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Endnotes

1 Office of Population Affairs (OPA), "Title X Turns 50."

2 Darney et al., "Title X Improved Access To Most Effective And Moderately Effective Contraception In US Safety-Net Clinics, 2016–18."

3 Institute of Medicine (IOM), "A Review of the HHS Family Planning Program."

4 Crenshaw, Kimberle (1989) "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," University of Chicago Legal Forum: Vol. 1989, Article 8.

5 McLemore, "Connecting the Dots: Reproductive Justice + Research Justice = Health Justice - Bill of Health."

6 University of Oregon, "What Is Cultural Humility? The Basics."

7 U.S. Department of Health and Human Services, "Health Literacy in Healthy People 2030."

8 Foster, The Turnaway Study: Ten Years, a Thousand Women, and the Consequences of Having--Or Being Denied--an Abortion.

9 Grossman et al., "Trauma-Informed Care: Recognizing and Resisting Re-Traumatization in Health Care."

10 University of Oregon, "What Is Cultural Humility? The Basics."

11 Melino, "Structural Competency in Health Care."

12 U.S. Department of Health and Human Services, "Health Literacy in Healthy People 2030."

13 Shaver, "The State of Telehealth Before and After the COVID-19 Pandemic."

14 Koenig et al., "The Role of Telehealth in Promoting Equitable Abortion Access in the United States: Spatial Analysis."

15 Levy et al., "From Pandemic Response to Portable Population Health: A Formative Evaluation of the Detroit Mobile Health Unit Program."

16 Michener, "A Racial Equity Framework for Assessing Health Policy."

17 University of Wisconsin–Madison, "Equity, Inclusion & Engagement Policy Assessment Toolkit."

18 Hassen et al., "Implementing Anti-Racism Interventions in Healthcare Settings: A Scoping Review."

19 Mental Health America, "Healthcare Disparities Among Black, Indigenous, and People of Color."

20 Sutton et al., "Racial and Ethnic Disparities in Reproductive Health Services and Outcomes, 2020

21 Sutton et al., "Vital Voices: HIV Prevention and Care Interventions Developed for Disproportionately Affected Communities by Historically Underrepresented, Early-Career Scientists."

22 Santana et al., "How to Practice Person-Centered Care: A Conceptual Framework."

23 Sutton et al., "Racial and Ethnic Disparities in Reproductive Health Services and Outcomes, 2020

24 Agency for Healthcare Research and Quality, "The SHARE Approach: A Model for Shared Decision Making."

25 Senderowicz, "Contraceptive Autonomy: Conceptions and Measurement of a Novel Family Planning Indicator."

26 Gullo et al., "Creating Spaces for Dialogue: A Cluster-Randomized Evaluation of CARE's Community Score Card on Health Governance Outcomes."

27 Rosales, León, and León-Fuentes, "Recommendations for Recruitment and Retention of a Diverse Workforce: A Report from the Field."

28 Vujcich et al., "Translating Best Practice into Real Practice: Methods, Results and Lessons from a Project to Translate an English Sexual Health Survey into Four Asian Languages."

29 Juckett, Gregory, and Kendra Unger. "Appropriate use of medical interpreters." American family physician 90, no. 7 (2014): 476-480.

30 Community Language Cooperative, "Language Justice."

31 Boyd et al., "Equity and Bias in Electronic Health Records Data."

32 Dehlendorf et al., "Disparities in Family Planning."

33 Stephanie W. Y. Yu, et al., "The scope and impact of mobile health Units in the United States: a literature review," *International Journal for Equity in Health* 16, no. 178 (2017).

34 NFPRHA, "Mobile Health Units: A Strategy to Increase Access to Family Planning and Sexual Health Services."

35 Monica Anderson, "Who relies on public transit in the U.S.," (Washington, DC: *Pew Research Center*, 2016).

36 Emiko Atherton, Emily Schweninger, and Margo Edmunds, "Transportation: a community driver of health," (Washington, DC: American Public Health Association, AcademyHealth, and Kaiser Permanente, 2021).

37 Kenneth R. McLeroy et al., "An Ecological Perspective on Health Promotion Programs," Health Education Quarterly 14 (1988), no. 4: 351-377.

38 Kobi V. Ajayi et al., "Using the Social-Ecological Model to Understand the Current Perspective of Contraceptive Use in the United States: A Narrative Literature Review," Women 1 (2021), no. 4: 212-222.

39 Shelley D. Golden and Jo Anne L. Earp, "Social Ecological Approaches to Individuals and Their Contexts: Twenty Years of Health Education & Behavior Health Promotion Interventions," Health Education & Behavior 39 (2012), no. 3: 364-372.

40 Lyn Paget et al. Patient-Clinician Communication: Basic Principles and Expectations, Discussion Paper. *NAM Perspectives.* Washington, DC: The National Academies Press, 2011.
Hacker, Diana and Nancy Sommers. A Writer's Reference, 7th ed. Boston: Bedford/St. Martin's, 2011.

41 Kenneth R. McLeroy et al., Health Education Quarterly, 1988.

42 Ibid

43 Shelley D. Golden et al., "*Health Education & Behavior,* 2012.

44 Jamie Hart, Joia Creer-Perry, and Lisa Stern, "US Sexual and Reproductive Health Policy: Which Frameworks Are Needed Now, and Next Steps Forward," American Journal of Public Health 112 (2022), no. S5: S518-S522.

45 Ibid

National

Family Planning

& Reproductive Health Association

An online version of this report can be accessed at https://tinyurl.com/6z3hjbaf.