Progress Toward Comprehensive Contraceptive Access Through The Right Time in Missouri

Initiative Midline Report

July 31, 2022

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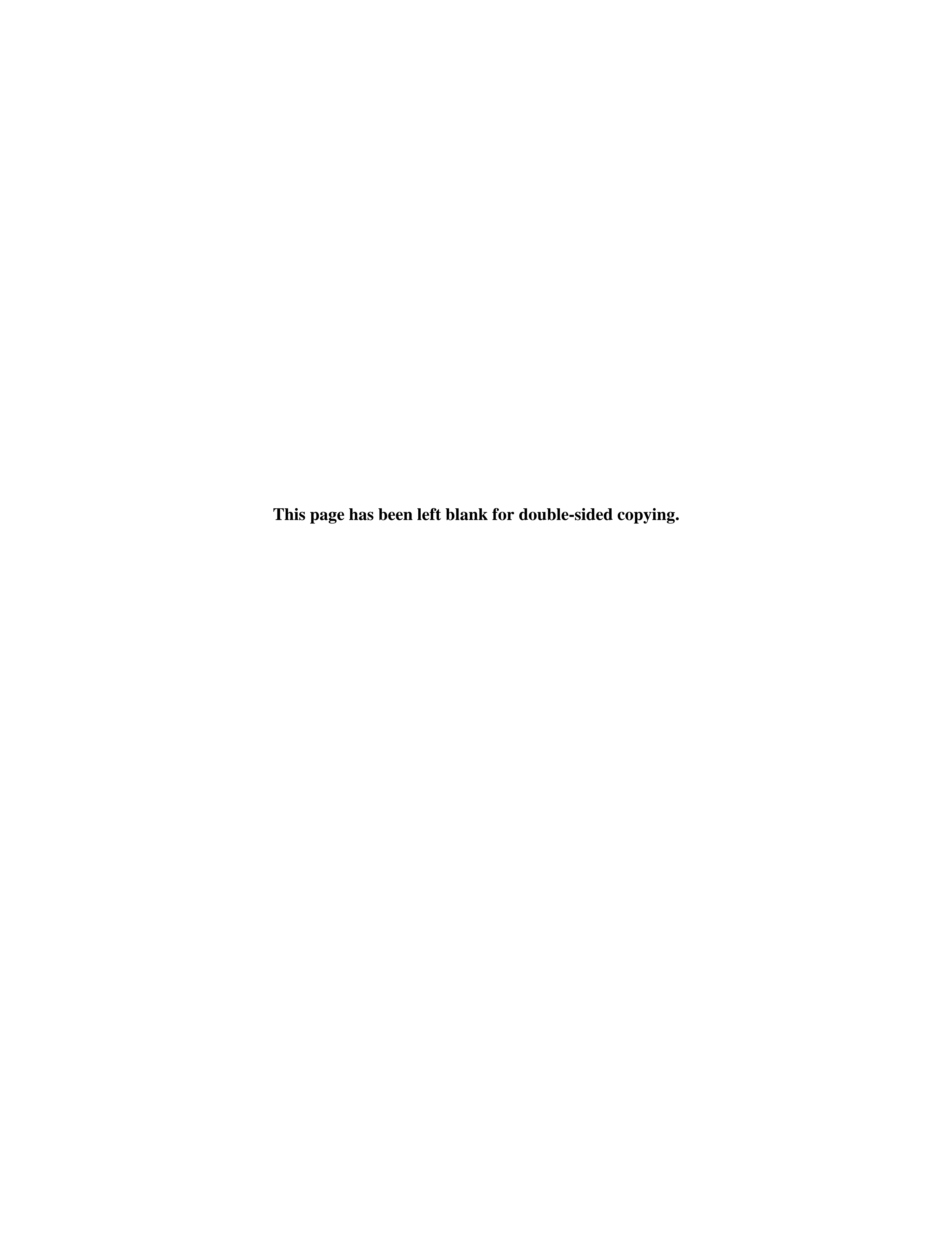

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We are indebted to the health center staff who took time out of their busy schedules to talk with us or complete our surveys, especially because combating the COVID-19 pandemic necessitated so much of their attention. Their on-the-ground insights elucidated a nuanced understanding of program implementation and the policy and political landscape in which they operate. We thank staff from Contraceptive Choice Center, Betty Jean Kerr People's Health Centers, Fordland Clinic, Columbia/Boone County Public Health and Human Services, Jefferson County Health Department, Planned Parenthood of the St. Louis Region and Southwest Missouri, Butler County Health Department, East Missouri Action Agency, Missouri Highlands Health Care, Pike County Memorial Hospital, Planned Parenthood Great Plains, and Spectrum Health Care.

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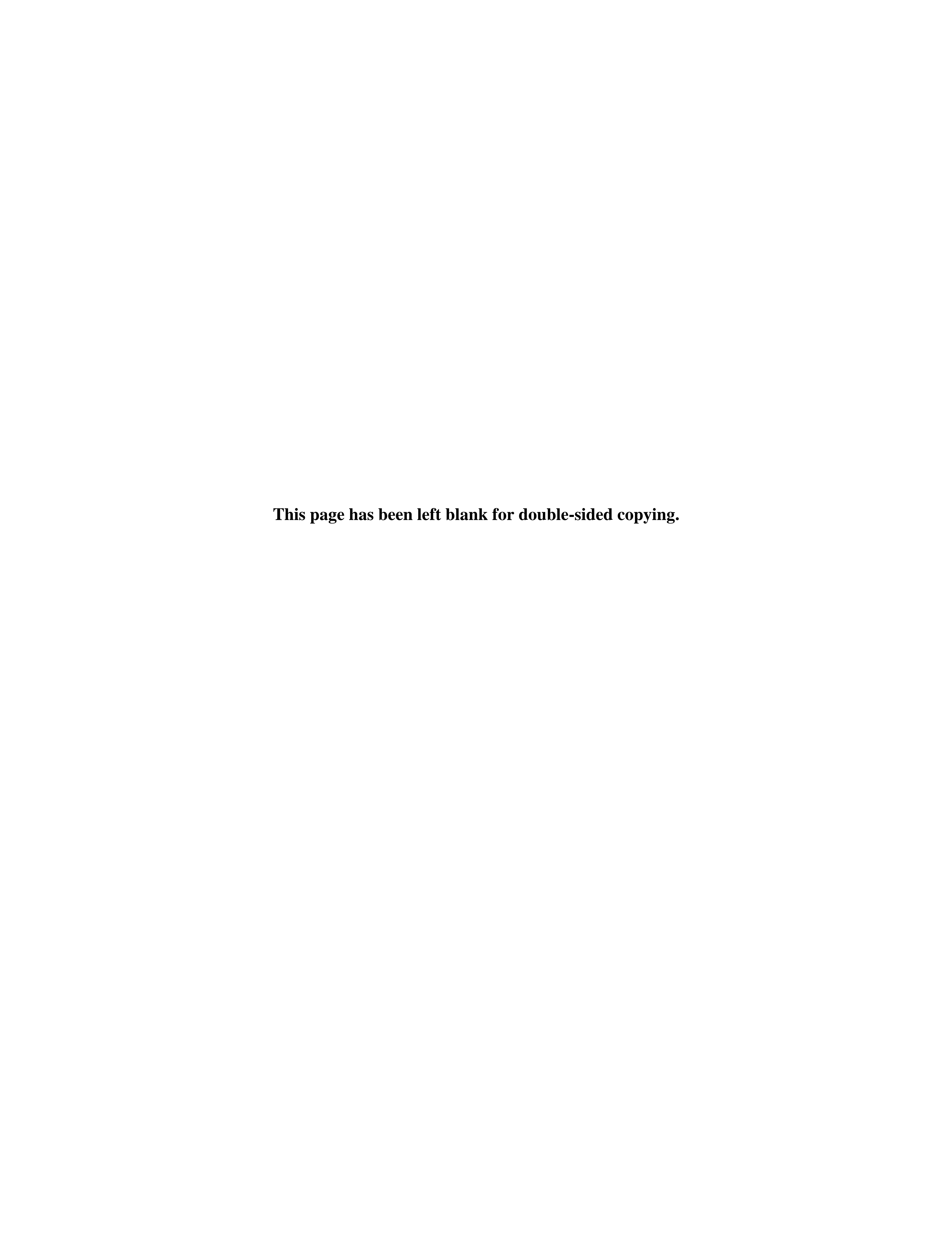

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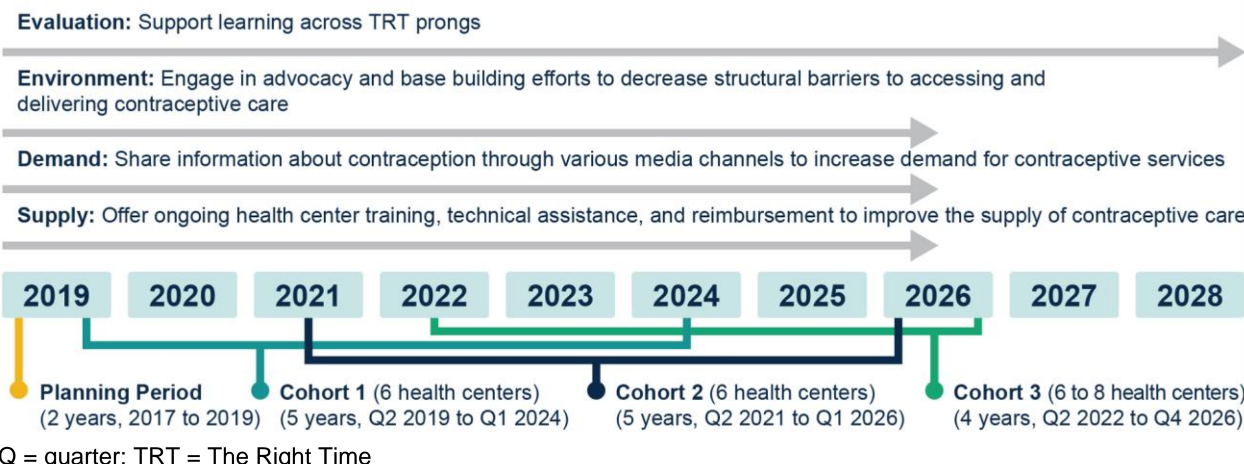
Executive summary

The Right Time (TRT) is an eight-year initiative that aims to improve reproductive health and rights in Missouri. TRT is premised on the belief that people—regardless of circumstance or characteristic—should be able to decide whether, when, and under what circumstances they become pregnant. To this end, TRT aims to equip health centers and their staff to offer and counsel patients on comprehensive contraceptive options, increase patients' self-efficacy and agency by disseminating quality reproductive health information and services, and reduce structural barriers to create an environment that offers people a safe space to decide what is best for them without judgement or shame. Influenced by the core tenets of reproductive justice, the initiative aims to foster an environment in which people have the freedom to have children, to not have children, and to raise their families in healthy and sustainable communities (SisterSong n.d.).

From when it launched in January 2019 to March 2022, TRT has engaged 12 health centers (34 clinic sites) in providing high-quality contraceptive services to nearly 40,000 TRT patients and shared information about contraception with about 100,000 people through online media and community outreach. TRT also partnered with coalitions and community mobilization organizations through 365 advocacy actions and 432 meetings with legislators to reduce barriers to accessing contraception—such as by requiring insurance companies to cover an annual supply of contraception all at once or allowing pharmacists to prescribe oral contraceptives. As we approach the midpoint of this project (Exhibit ES.1), it is a critical time to reflect on opportunities to further improve implementation to generate desired outcomes. In particular, this report seeks to describe what has worked, what needs improvement, and how to sustain efforts after TRT funding ends. This information is important because of the implications on reproductive health and rights from the overturning of *Roe v. Wade* in June 2022, especially for people from marginalized groups and because of the continued impact of the COVID-19 pandemic. In particular, information gleaned from this midline report will inform the recruitment strategy for a third cohort of health centers (anticipated to join the initiative in late 2022 or early 2023) and sustainability efforts as several health centers will leave the program in early 2024.

Exhibit ES.1. Anticipated implementation timeline for TRT



Q = quarter; TRT = The Right Time

A. Progress in implementation against baseline

TRT supports a multipronged approach to achieving overarching systems change. On the health care delivery front, TRT focuses on improving providers' skills, health centers' capacity to stock the full range contraceptive options, and the affordability and same-day access of contraception. Through online distribution channels and physical marketing materials, TRT delivers quality information to combat misinformation and promote people's agency in accessing and using contraceptive services. To make it possible and sustainable for the health care system to deliver and for people to access comprehensive contraceptive options, TRT also engages with legislators and mobilizes communities to support contraceptive-friendly policies and systems. From 2019 to 2022, TRT made progress toward its goals by enhancing health care delivery, increasing people's awareness and agency, and helping create an enabling environment that increases contraceptive access. Exhibit ES.2 shows the specific accomplishments of TRT.

Exhibit ES.2. Summary of TRT accomplishments from January 2019 to March 2022

Health care delivery

▲ **Provider awareness**
- ↑ Clinicians reporting delivering culturally competent care (increase from 50 to 60 percent delivering culturally competent care)
- ↑ Clinic administrators reporting being "very comfortable" with contraceptive counseling (increase from 67 to 83 percent being comfortable with contraceptive counseling)

▲ **Health center capacity**
- ↑ Health centers always having contraceptive methods in stock at clinic (increase from an average of 5 methods to an average of 8 methods [out of 14])

▲ **Accessibility**
- ↑ Contraceptive switching to LARC methods (3 percent increase in uptake)
- ↑ Health centers always offering same-day access to LARCs (increase of 4 health centers [5 total] offering same-day LARC access)
- ↑ Patients desiring LARCs and receiving same-day LARC placements (increase from 72 to 82 percent of visits)
- ↓ Cost barriers (decrease from 1 to 0 percent of patients indicating cost as a barrier to contraception)

Awareness and agency

▲ **High-quality information**
- More than 525,000 impressions on TRT Facebook and Twitter accounts
- More than 200,000 materials promoting TRT distributed
- More than 3,000 social interactions

▲ **Reach to underserved groups**
- ↑ Reach to state-wide audience, including rural communities, through paid, earned, and social media
- ↑ Engagement with Spanish-speaking populations through Spanish materials

▲ **Knowledge and positive attitudes**
- Contributed to increased knowledge about telehealth services for contraception
- Contributed to statewide increase in knowledge about methods of contraception, especially LARCs (increase from 30 to 66 percent for IUDs and increase from 24 to 55 percent for implants)
- Contributed to increased positive attitudes of birth control in Missouri (increase from 67 to 74 percent)

Enabling environment

▲ **Community outreach and engagement**
- ↑ Community mobilization to underserved communities (increase from 5 to 7 organizations)
- ↑ Outreach to potential TRT patients, community members, and organizations (2,040 events reaching >57,000 people)

▲ **Legislative action**
- Advocated for contraceptive legislation and defending the family planning safety net (through 432 meetings with legislators and staff)
- Spearheaded annual supply bills and supported pharmacist-prescribed bills (through 58 meetings with legislators and staff)
- Contributed to Missouri voters passing Medicaid expansion and legislators passing a clean FRA (61 advocacy actions with more than 23,000 people taking action; 43 legislators engaged through 59 meetings)

Notes: See Appendix A for more information about data sources and methods. The 14 contraceptive methods are IUDs, implants, Depo-Provera, oral contraceptive pills, cervical vaginal ring, contraceptive skin patch, male condoms, female condoms, diaphragm, sponge, cervical cap, spermicide, ulipristal acetate emergency contraception, and levonorgestrel emergency contraception. TRT does not reimburse for emergency contraception.

FRA = federal reimbursement allowance; LARC = long-acting reversible contraception; TRT = The Right Time initiative; IUD = intrauterine device.

Overall, contraceptive use among TRT patients (meaning patients receiving contraceptive services at clinics participating in TRT) increased from 93 percent at visit intake to 96 percent at exit. Contraceptive uptake increased the most among patients younger than age 18, Black patients, and patients with incomes below 250 percent of the federal poverty level (94 to 99 percent, 90 to 94 percent, and 89 to 92 percent, respectively). Switching to different contraceptive methods, which potentially serves as a proxy for people's ability to access their contraception of choice, was also observed. Use of the male condom and abstinence as the primary methods of contraception declined (by 8 and 3 percent, respectively), coinciding with increased uptake of the pill, Depo-Provera shot, and long-acting reversible contraception (LARC) methods (by 10, 5, and 3 percent, respectively). Increased uptake of LARC methods was particularly large among TRT patients younger than age 18 (8 percent).

B. Future of TRT

TRT's ability to reach people most in need of high-quality, affordable contraceptive services and education will determine whether it accomplishes its goal of improved reproductive health, rights, and justice in Missouri. As it progresses, TRT continues to function in an evolving and dynamic environment that creates opportunities and challenges, including COVID-19 and a polarized political climate around abortion, particularly with the overturning of *Roe v. Wade*, that affects the discourse around contraception because it falls under the umbrella of reproductive health and rights. To be successful in this environment, TRT will need to deliver steadfast support of health centers, providers, and implementing partners to enable them to continue delivering comprehensive contraceptive services, communications that cut through the noise of misinformation and politicized conversations about contraception, and persuasive messages to convince policymakers of the benefits of contraceptive-friendly policies and regulations. In recognition of this, TRT has extended health center participation from three to five years to allow more time to improve and sustain health systems' ability to deliver comprehensive contraceptive options. It has also approved a two-year extension of community mobilization activities and the addition of two more community mobilization partners to help address environmental barriers created by the pandemic, extend the reach of policy and regulatory work under the initiative, and provide linkages to TRT services through grassroots outreach and education. In addition, TRT plans to expand its wholesale digital outreach to include out-of-home advertising and community engagement events to improve reach among people who might have limited access to digital platforms and to increase access to quality contraceptive information and awareness of TRT services.

About this report

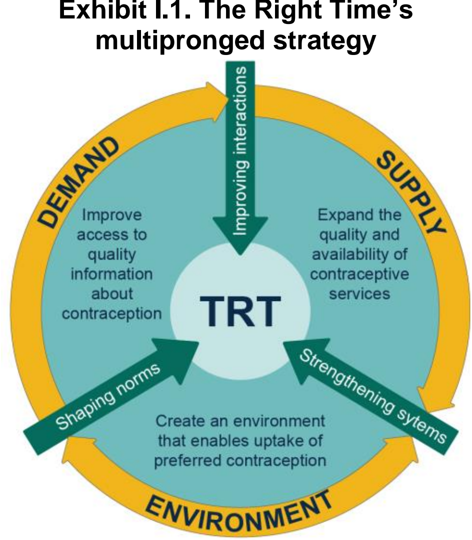
This midline report assesses the progress TRT made from its inception in early 2019 (as documented in the baseline evaluation and learning report) to March 2022, with a focus on progress toward outcomes related to reproductive health and rights. The authors analyzed and triangulated a diversity of quantitative and qualitative data sources to produce an accurate representation of findings. Partners, including Missouri Foundation for Health, Missouri Family Health Council, and Power to Decide, provided context and input to help interpret the results through routine meetings, discussion on semi-annual monitoring indicators, and review of this report. Consistent with equitable evaluation principles, implementing organizations provided community-centered insight through interpretations of key data points and discussions of implications in the community context.

To align with principles of reflexivity and equitable evaluation, we acknowledge the biases we might bring to this work and how our identities as parents, women, people of reproductive age, and people from underrepresented groups could influence our interpretation of the results. We put our best foot forward in synthesizing the data, writing this report, and incorporating feedback from TRT partners. We look forward to continued feedback from our partners and community members, decision makers, and others who have power to influence reproductive health.

I. Introduction

In 2019, Missouri Foundation for Health, together with Missouri Family Health Council, Power to Decide, and Mathematica, launched The Right Time (TRT), an initiative that aims to improve reproductive health and rights in the state. TRT is premised on the belief that people should be able to decide whether, when, and under what circumstances they become pregnant. Central to the initiative is a focus on equity. For TRT, equity means ensuring all people, regardless of circumstance or characteristic, have access to quality reproductive health information and services in an environment that offers them a safe space to decide what is best for them without judgement or shame. In its first few years of implementation, TRT shifted to better center equity; its ultimate goals changed from reducing unintended pregnancy to increasing reproductive freedom, and it de-emphasized a focus on certain methods in favor of promoting people's ability to choose their desired method (if any). [1]

Exhibit I.1. The Right Time's multipronged strategy

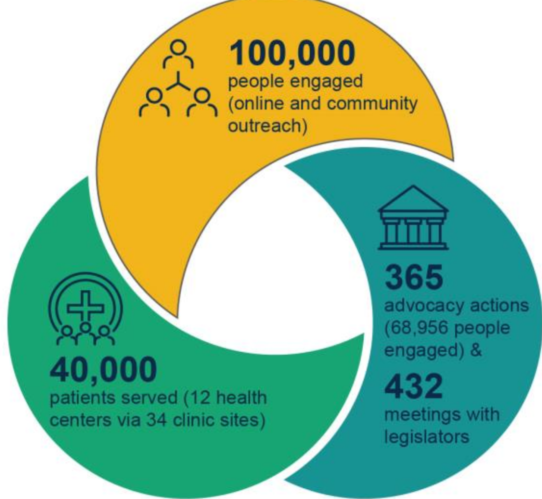


[1] Unintended pregnancy is often considered an indicator for poor reproductive health, but it is an imperfect measure because it assumes pregnancy intentions are binary.

Influenced by the core tenets of reproductive justice,[2] the initiative aims to foster an environment in which people have the freedom to have children, to not have children, and to raise their families in healthy and sustainable communities.

TRT seeks to meet its goal through a multipronged strategy that includes expanding the quality and availability of contraceptive services (supply prong); improving access to quality information about contraception (demand prong); and removing structural barriers to contraception, such as policies and systems that prevent people from accessing or using the contraception of their choice (environment prong) (Exhibit I.1). From January 2019 to March 2022, TRT has engaged 12 health centers (34 clinic sites) in providing high-quality contraceptive services to nearly 40,000 people over about 75,000 patient visits and shared information about contraception with about 100,000 people through online media and community outreach. TRT also partnered with coalitions and community mobilization organizations through 365 advocacy actions and 432 meetings with legislators and legislative staff to reduce barriers to accessing contraception (Exhibit I.2)—such as requiring insurance companies to cover a year's supply of contraception all at once or allowing pharmacists to prescribe oral contraceptives.

Exhibit I.2. The Right Time's progress, January 2019 to March 2022



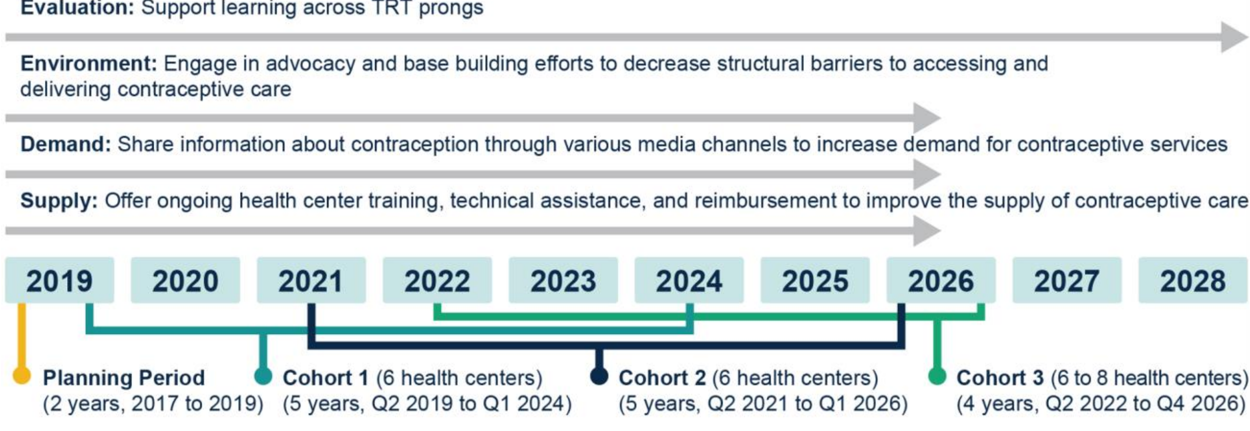
Source: Health center encounter data, April 1, 2019, to March 31, 2022; Power to Decide administrative data, January 1, 2019, to March 2022; Missouri Family Health Council and community mobilization advocacy and legislative data, January 1, 2019, to March 2022.

Despite these efforts, TRT's progress is complicated by the concurrent political and environmental shifts affecting the reproductive health and rights landscape in Missouri. Although some changes have the potential to expand equitable access to reproductive health care—such as Missouri residents voting to expand Medicaid in August 2020 and the Biden administration rescinding the Trump administration's Title X family planning program rule, known as the "domestic gag rule," in November 2021—the political environment in Missouri has become increasingly hostile to reproductive health and rights since the initiative began in 2019. In addition to significant legislative attacks on birth control access that have dominated the political discourse throughout the initiative, the June 2022 overturning of *Roe v. Wade* significantly altered reproductive health care access, with abortion having become illegal in Missouri as of June 24, 2022. In addition, health systems, including TRT's facilities and providers, have been stretched thin by the COVID-19 pandemic. Missouri continues to trail other states in reproductive health (and overall health). Its ranking on reproductive health and rights—including contraceptive coverage,

[2] Reproductive Justice is a framework developed by Black women to emphasize the need for the reproductive health and rights movements to move beyond a narrow focus on abortion, contraception, and the concept of "choice," and to adopt a broader intersectional lens including social and economic justice, and human rights. SisterSong defines Reproductive Justice as the human right to maintain personal bodily autonomy, have children, not have children, and parent children in safe and sustainable communities (SisterSong n.d.).

access to abortion, and family planning through Medicaid—dropped from 44th in 2015 to 47th in 2021 (Institute for Women's Policy Research 2015, 2021).[3]

Exhibit I.3. Anticipated implementation timeline for TRT



Q = quarter; TRT = The Right Time

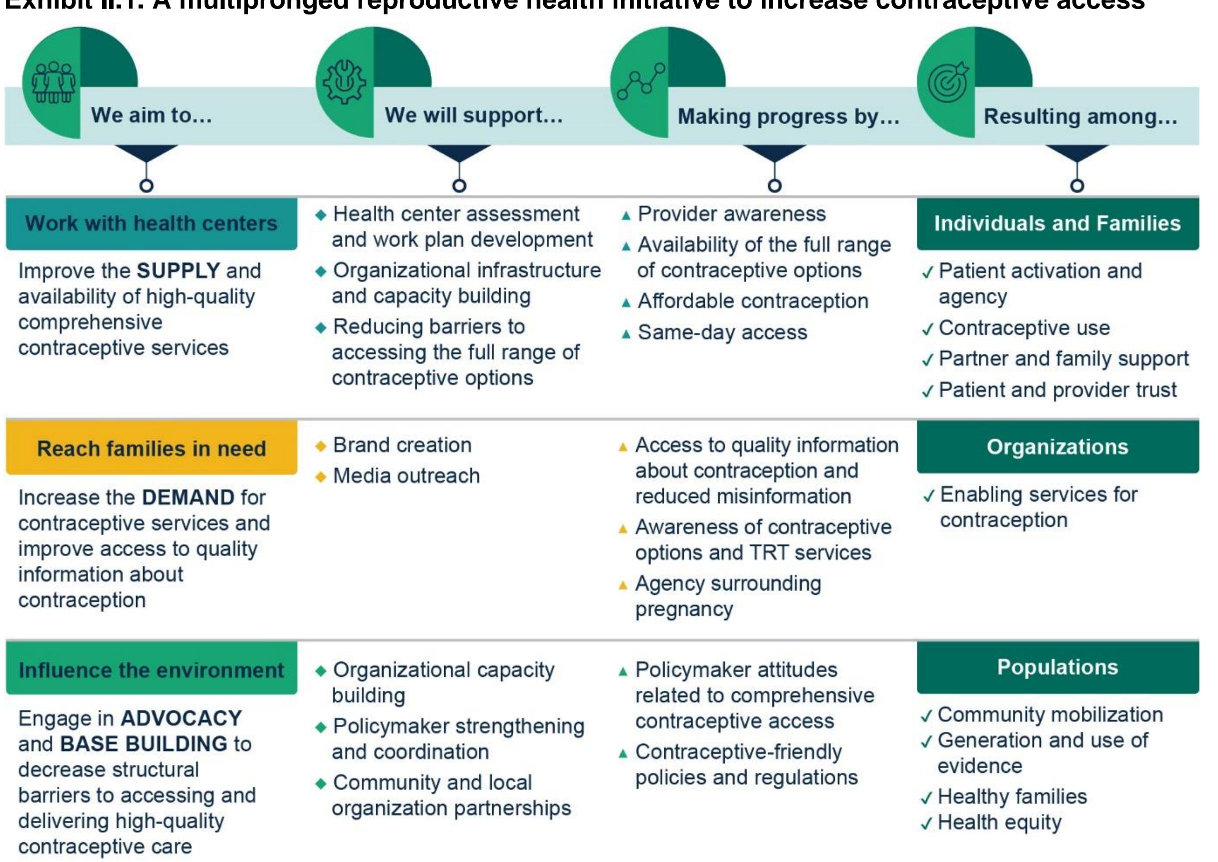
In this context, TRT's work is both imperative and deeply challenging. As the initiative approaches its midway point (Exhibit I.3), it is critical to take stock of progress that has been made and reflect on opportunities to further improve implementation to generate the desired outcomes. This report seeks to describe what has worked, what needs improvement, and how to sustain efforts after TRT funding ends. This information is especially important as the initiative considers recruiting a third cohort of health centers (anticipated to join the initiative in late 2022 or early 2023) and plans for sustaining efforts as Cohort 1 health centers transition out of the program in early 2024. TRT is now at an inflection point at which learnings generated from the first three years of implementation can serve to strengthen and adapt its strategy going forward.

[3] Out of 50 states, Missouri's ranking of overall health outcomes dropped from 39th in 2019 to 42nd in 2021; its ranking on low birthweight live births dropped from 31st in 2019 to 36th in 2021; and it has made little progress in reducing births among teenagers with a consistent ranking of 38th in 2020 and 2021 (America's Health Rankings 2019, 2020, 2021).

II. Achieving outcomes in the near-term

In the TRT baseline evaluation and learning report, the learning partner, Mathematica, identified lessons learned from implementing ***activities*** in the initiative's supply, demand, and environment prongs. With these activities in mind, this midline report assesses progress made over the first three years of the initiative toward achieving ***short-term outcomes*** for each prong. Findings from the midline report will set the stage for whether TRT is on track to achieve its ***long-term outcomes*** at the individual and family, organizational, and community levels. (Exhibit II.1 provides the logic model for TRT showing the activities described in the baseline report, short-term outcomes discussed in this report, and long-term outcomes to be assessed in future reports.)

Exhibit II.1. A multipronged reproductive health initiative to increase contraceptive access



Methods

To be inclusive in our approach and viewpoints, we used a variety of quantitative and qualitative methods and data sources in developing the midline evaluation. These data were collected from the Missouri Foundation for Health's five service regions—Northeast, Center, St. Louis Metro, Southwest, and Southeast—comprising 84 Missouri counties and the city of St. Louis.

Secondary data from implementing partners, health centers, and other publicly available sources provided information on health center participation, patients' contraceptive behavior, messaging, and community interactions and engagement.

Surveys fielded at baseline in May 2019 and June and July 2020 with 13 clinic administrators and 45 clinicians (representing 12 health centers) yielded information about operations, staffing, practitioners' behavior, and patients' demographics.

Surveys fielded 18 months into implementation from November 2020 to February 2021 and from January to April 2022 with 12 clinic administrators and 54 clinicians (representing the same 12 health centers) assessed progress since baseline in provision of contraceptive care.

Interviews conducted in summer 2021 with 11 initiative partners, promoters, and policymakers provided information on experiences with and insight about various aspects of boosting knowledge and support of reproductive health. Interviews with 32 clinic staff (representing 11 health centers) in summer 2021 shed light on experiences implementing TRT.

Interviews and focus groups with 74 TRT patients and people of reproductive age in summer 2021 and January 2022, respectively, provided information on individual decision making, preferences, and provider experiences related to birth control.

See Appendix A for more information about midline evaluation methods. ◢

TRT = The Right Time initiative.

This chapter discusses our key midline evaluation findings and learning by prong. Our goal is to provide action-oriented analyses that can support further enhancements to the initiative, help TRT reach its goals, and lead to improvements in reproductive health in Missouri.

A. Work with providers (supply)

TRT uses a multi-level approach to improve the supply of contraception. Specifically, it works at the provider, clinic, organizational policy, and systems levels to improve contraceptive care and access. Each of these levels has associated short-term outcomes:

- Increased provider awareness (provider level)
- Improved availability of the full range of contraceptive options (clinic level)
- Affordable contraception (organizational policy level)
- Increased same-day access (system level)

The first three outcomes enable providers to offer high-quality patient-centered counseling, a full range of contraceptive options, and patients' preferred method of contraception without cost barriers or delays. These outcomes together lead to improved same-day access to contraception, the fourth system-wide short-term outcome. We discuss progress toward these four short-term outcomes here.

Exhibit II.2. TRT health centers

TRT partners with health centers across Missouri to expand the quality and availability of contraceptive services. Six health centers (13 clinics) joined TRT in April 2019 (yellow circles) and six health centers (21 clinics) joined in July 2021 (teal circles), for a total of 12 health centers (34 clinics) across five regions of Missouri. Participating health centers include three Federally Qualified Health Centers, three health departments, two hospital-based clinics, and four not-for-profits. In all, 7 of the 12 health centers also participate in The Title X family planning program.

1. Increased provider awareness

TRT enhances providers' practices and capacity to deliver patient-centered and culturally competent contraceptive care.[4] Providers and clinic staff receive trainings and technical assistance on various contraceptive methods, placing and removal of long-acting reversible contraception (LARC) methods, and cultural competency to facilitate patient engagement and satisfaction in reproductive health experiences. In some cases, these trainings have led not only to increased provider awareness of comprehensive contraceptive options and culturally competent counseling but also to increased comfort level in their provision.

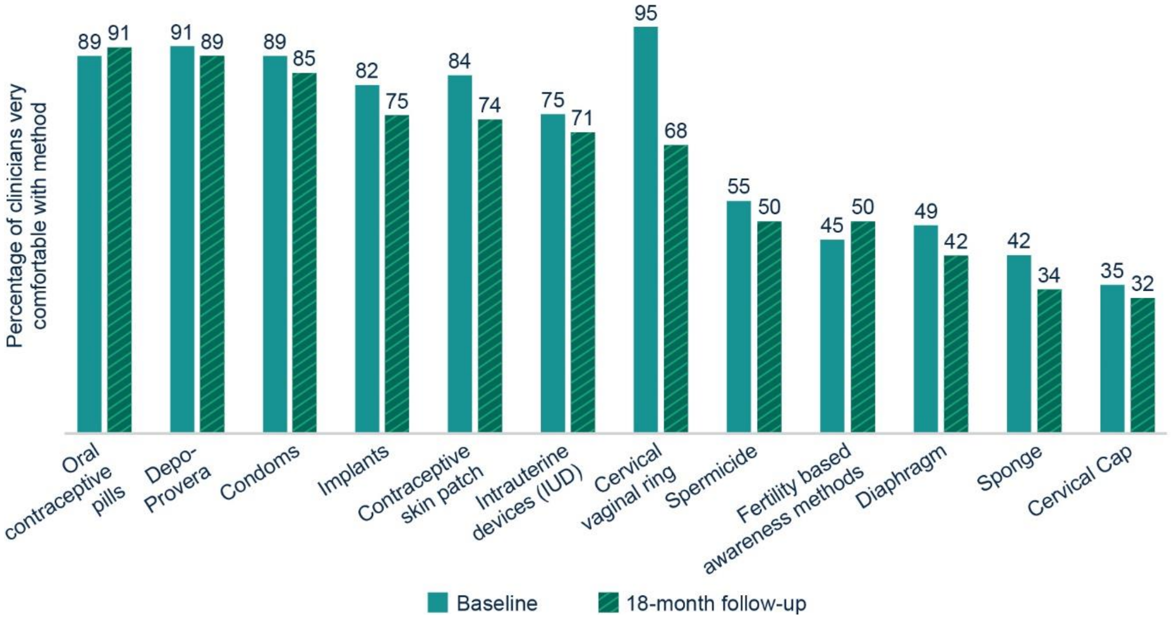
Although interviewed health center staff widely reported that they were already familiar with different contraceptive methods before TRT trainings, many also mentioned that TRT specifically helped increase their knowledge of different methods. In particular, interviewed staff stated that TRT trainings increased their awareness about the safety, efficacy, and appropriateness of LARCs in their patient population. The increased awareness about these methods and specialized training from a family planning clinical consultant enabled clinicians to confidently address myths related to LARCs, counsel patients on their options, and place and remove LARC devices.

Despite these qualitative findings, the percentage of clinicians who reported being "very comfortable" with varying contraceptive methods—including LARCs—declined from baseline to midline (Exhibit II.3). More likely, turnover in clinic staff from baseline to midline caused the reduction in comfort as about 40 percent of responses to the midline survey (representing 21 clinicians) were from clinicians hired between baseline and midline whose perspectives had not been captured at baseline and who likely had not yet participated in TRT-related trainings.[5]

[4] Patient-centeredness and cultural competency are components of quality of care. Patient-centered contraceptive care can be described as "treating each person as a unique individual with respect, empathy and understanding, providing accurate, easy to understand information about contraception based on the patient's needs and goals, and assisting patients in selecting a contraceptive method that is the best fit for their individual situation in a manner that reflects the patients' preferences for decision making" (Dehlendorf 2016). According to the Reproductive Health National Training Center, culturally competent care, also called culturally responsive care or cultural humility, intends to provide care that is responsive to the diverse cultural and other characteristics of the patient population (RHNTC n.d.)

[5] The 18-month clinician survey included responses from 54 clinicians; 33 of the 54 clinicians (61%) responded to both the baseline and 18-month survey, and 21 clinicians (39%) responded to the 18-month survey only.

Exhibit II.3. Clinicians reported decreased comfort with nearly all contraceptive methods



Source: Mathematica's analysis of baseline and 18-month clinician surveys for cohort 1 and cohort 2 health centers. Surveys fielded at baseline in May 2019 and June to July 2020 included 45 clinicians (representing 12 health centers). Surveys fielded 18 months into implementation from November 2020 to February 2021 and from January 2022 to March 2022 included 54 clinicians (representing 12 health centers).

In addition, interviewed clinicians reported that TRT trainings increased their confidence in recognizing implicit bias and coercive practices, serving LGBTQIA+ populations, and providing patient-centered counseling. Sixty percent of clinicians reported having knowledge and skills across multiple dimensions of culturally competent care at midline compared with just half of clinicians at baseline. Still, providers' responses indicated they might want and need more training, as less than half of providers reported comfort with contraceptive methods such as the diaphragm, sponge, and cervical cap. In addition, a few clinicians requested additional training on client-centered care. One of these clinicians said, "there is some degree of LARC first and LARC bias [at our health center]. [We] are trying to move away from that and focus on things like, 'What do you want your birth control to do for you?'"

2. Improved availability of the full range of contraception

TRT supports clinic operations and infrastructure that make offering the full range of contraceptive methods possible. Funding from TRT offsets some costs of onboarding staff, enables hiring of staff in key positions, and pays for initial stock of all contraceptive methods. Interviewed clinic administrators shared that this advance funding for contraceptive methods allowed them to increase the types of methods they have in stock; before TRT, many health centers limited their supply of more expensive contraceptive methods for financial reasons, including low reimbursement from insurance or Title X and inability to pay large lump sums up front to purchase stock.

With TRT's support, health centers expanded the range of contraceptive methods offered in stock at their clinic, moving from stocking an average of 5 of 14 potential methods in the clinic to 8 of 14 (Exhibit

II.4).[6] Health centers also expanded the number of methods either in stock at their clinic or through a prescription from 12 to 13 of the 14 potential methods (data not shown). Though the methods offered in stock at the clinic varied by health center, the most common methods in stock at baseline were intrauterine devices (IUDs), implants, Depo-Provera, male condoms, and female condoms. The most common methods in stock 18 months into implementation are the five methods commonly available at baseline, plus the oral contraceptive pill, cervical vaginal ring, and contraceptive skin patch.

Exhibit II.4. More health centers have contraceptive methods in stock at the clinic at midline

Method	Baseline	18-month follow-up	Change
IUDs	7	11	+4
Implants	9	11	+2
Depo shot	8	10	+2
Oral contraceptive pill	4	7	+3
Nuva Ring	2	9	+7
Patch	1	8	+7
Male condom	9	12	+3
Female condom	6	8	+4
Diaphragm	2	2	0
Sponge	1	3	+2
Cervical cap	0	2	+2
Spermicide	1	6	+5
EC (Ella)	3	6	+3
EC (Plan B)	4	5	+1

Source: Mathematica's analysis of baseline and 18-month clinic administrators surveys for cohort 1 and cohort 2 health centers. Surveys fielded at baseline in May 2019 and June to July 2020 included 13 clinic administrators (representing 12 health centers). Surveys fielded 18 months into implementation from November 2020 to February 2021 and from January 2022 to March 2022 included12 clinic administrators (representing 12 health centers).

Note: Emergency contraception (Ella and Plan B) are not reimbursed by TRT.

EC = emergency contraception; IUD = intrauterine device.

Financial support enabled 9 health centers (up from 2) to stock more expensive short-term methods (such as the ring) and 11 (up from 7 and 9) to stock IUDs and implants, respectively. Some methods still had low traction at health centers at midline, including the cervical cap, sponge, and diaphragm. Even with advance funding from TRT, providers shared that it was not worthwhile to stock these methods because they would expire before being used given how few patients were interested in them. Furthermore, clinic administrators cited not stocking the sponge because of a lack of provider comfort, provider concerns about the safety of the method, and provider concerns about the efficacy of the method in preventing pregnancy.

[6] The 14 methods include intrauterine devices (ParaGara, Mirena, Kyleena, Liletta, Skyla), implants (Nexplanon), Dep-Provera (the Depo shot, DMPA), oral contraceptive pills, cervical vaginal ring (Nuva Ring), contraceptive skin patch (Xulane), male condoms, female condoms, diaphragm, sponge, cervical cap, spermicide, Ulipristal acetate emergency contraception (Ella), and levonorgestrel emergency contraception (Plan B One Step, Next Choice One Dose, Take Action, My Way AfterPill).

"I wasn't allowed to stock [Nexplanon] in the office…because of the expense ahead of time and the terrible reimbursement. Now with the [TRT] grant, we can make all the options available to all people, whereas before you had to really see what their insurance would pay for." – Clinician at a Federally Qualified Health Center ◢

3. Provision of affordable contraception

"…[patients] have the ability to come in and make that change [of contraceptive method] and not just rely on whether or not their insurance will pay for that change. I think that that has allowed them the freedom to sometimes change their minds and decide if something's not working for them, which, if it's not working for them increases the unintended pregnancy rate."

– Clinician at a health department

TRT offers financial support that enables participating health centers to provide free or low-cost contraception to those who need it. This includes reimbursement for contraceptive services provided to uninsured and underinsured patients. As a result, encounter data show that very few patients cite cost as the barrier to using contraception, and nearly half of patients change their contraceptive method during a TRT visit. Contraceptive switching to more expensive methods was also observed, with a 3 percent increase in switching from other methods to LARC methods, as was switching to more effective methods, with 75 percent of TRT patients who switched methods moving to a method more effective in preventing pregnancy. Clinicians shared similar observations in interviews, saying that more patients were switching methods compared with before TRT as a result of the eliminated cost barrier. Provision of affordable contraception has had a positive complementary effect on TRT provider practices. Before the initiative, providers sometimes limited the options they offered based on what patients could afford or what their insurance would cover. Now, they offer a full range of options to patients without concern about cost. This freedom to offer all options has facilitated better patient-centeredness in contraceptive services, enabling patients to fully make their own decisions.

41%

of Missouri residents aged 18 to 45 say cost or insurance coverage is a barrier to obtaining the preferred method of contraception

"I would say cost [is the biggest barrier to obtaining contraception], then juggling the difference insurances I'm on. That has probably been the biggest pain for me is feeling like I can't just walk in and point [to my preferred method of contraception]."

– Focus group participant

Source: Mathematica's analysis of focus group data with TRT patients and non-TRT patients of reproductive age in January 2022. Focus group data represents 72 individuals. Power to Decide's poll of 750 Missouri residents ages 18 to 45, 2021.

4. Increased same-day access

"…not having to wait for Nexplanon to come in the mail based on the patient's insurance…just having it here on the shelf and being able to do same-day insertions is huge... in 45 minutes they come in, they're getting examinations done and they get their method and they're out the door."

– Clinic administrator at a health department

Together, providers' knowledge and skill, the ability to stock the full range of contraceptive methods, and all options being affordable creates a system that enables same-day access to any type of contraception, especially LARCs (Exhibit II.5). Furthermore, TRT provides technical assistance beyond provider and health center trainings to support same-day access. Family planning clinical consultants work with health centers to modify their clinic workflow as needed so they can provide same-day contraception. For example, a clinic administrator shared that technical assistance from the clinical consultant resulted in her clinic obtaining medical histories over the phone before appointments, allowing more time during the visit to deliver same-day services.

These efforts have contributed to an increase in same-day access across nearly all methods, particularly among LARC methods. Only 1 of 12 health centers surveyed always offered same-day access to IUDs or implants when they started TRT, but 5 of 12 health centers always offered same-day access at midline.[7] Similar trends were observed with the patch, Depo-Provera shot, and NuvaRing. In addition, among people requesting LARCs, TRT health centers accommodated same-day LARC placement for 84 percent of visits at midline compared with 72 percent after six months of TRT participation.

Exhibit II.5. Reduced administrative overhead improves same-day access

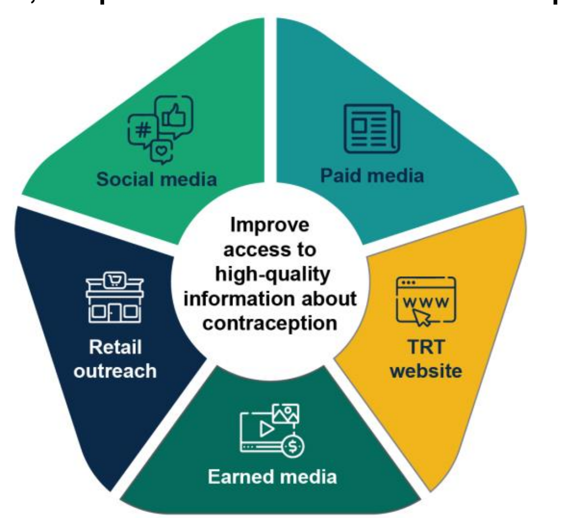
LARC = long-acting reversible contraception.

B. Reach families in need (demand)

TRT seeks to improve access to quality information about contraception as a mechanism to increase awareness of contraceptive services. To accomplish this, TRT partners created a TRT brand and deployed a multimedia communications strategy to ensure the quality of the information available, facilitate its reception, support its uptake, and help people exercise their agency (Exhibit II.6). The communications strategy aims to achieve:

- Increased access to quality information about contraception and reduced misinformation (information available)
- Increased awareness about contraceptive options and TRT services (uptake)
- Increased agency surrounding pregnancy (agency)

Exhibit II.6. Demand strategy provides ongoing, accurate, and positive information about contraception



TRT = The Right Time

Progress in achieving the first short-term outcome can be seen as the development of quality content and dissemination strategies to reach intended audiences, and progress in the second and third outcomes is reflected in the uptake and acceptance of the messaging to increase people's self-efficacy and agency regarding contraceptive decisions.

[7] The number of health centers always or very often offering same-day access to these methods increased from 7 health centers always or very often offering same-day access to IUDs when they started TRT to 8 health centers at TRT midline. Likewise, the number increased from 8 health centers always or very often offering same-day access to implants when they started TRT to 9 health centers at TRT midline.

1. Increased access to quality information about contraception

Findings from focus groups suggested that, despite receiving information about birth control from many sources, it can be challenging for people to find credible, digestible, and evidence-based information to inform their decision making. To address this gap, TRT disseminates high-quality and resonant information about contraception through its website, social media accounts, and marketing materials. TRT's messaging stands out by using a positive, approachable, and affirming tone to share information about birth control (Exhibit II.7). For example, its website not only provides evidence-based information about birth control but also shares supportive testimonial videos from birth control users. The messaging is also tailored to Missouri; the website provides a clinic finder so users can easily identify a health center near them, and it shares information about telehealth and home delivery of birth control for Missourians living in rural communities.

Exhibit II.7. Positive and affirming messaging in The Right Time marketing materials

All are welcome.

The Right Time partner health centers serve all people of childbearing age, regardless of income or insurance.

"The most alluring thing a woman can have is confidence."

—Beyoncé

We believe in you!

You have the right to pursue the future you want, including deciding if, when, and under what circumstances to get pregnant. Birth control gives you the power to make your own plans, on your own schedule, and on your own terms.

To complement this dissemination of quality information, TRT puts out messaging to explicitly combat misinformation. For example, there is a section of the website dedicated to fact-or-fiction articles, such as whether you can get pregnant while on your period or if using two condoms means extra protection or trouble. Palm cards, leaflets with contraceptive facts small enough to fit in a hand, also share reassuring messages that seek to reduce misinformation such as "Birth control does NOT hurt your chances of getting pregnant in the future."

"I think the biggest thing is just those misconceptions. People come in and they're like, 'I absolutely do not want the IUD.' And I ask why not and they're like, 'Because I know so and so, whose uterus fell out or something.' So, I think that requires a little bit of tact and a little bit of tailoring how you say things to meet the patient in the middle and try to explore those concerns."

– Clinician at Title X agency

Despite these efforts, qualitative data suggest that misinformation about contraception is still prevalent (although potentially waning)[8] and often spread through the Internet and social media. In interviews, providers described spending considerable time during their contraceptive counseling counteracting misinformation and myths about contraceptives (especially LARCs; Exhibit II.8).

[8] Power to Decide polling data suggests that fewer people noted concerns about safety and side effects of contraceptives among surveyed Missouri residents, from 50 percent in 2018 to 38 percent in 2020.

Exhibit II.8. Myths and misconceptions related to LARCs and strategies to promote reception of facts

Reason for these myths and misconceptions

- Lack of comprehensive sexuality education when younger
- Stigma and taboo around use of birth control (especially in rural areas)
- Provider's beliefs about who should offered certain methods and when
- Prevalence of online sources that share anecdotes of extremely rare outcomes (e.g., Reddit, Facebook groups)

Strategies providers can use to address myths and misconceptions

- Present alternative information rather than directly contradicting the patient
- Provide detailed but concise explanations of birth control
- Reframe the facts to avoid unintentionally amplifying myths
- Pre-bunk misinformation by sharing trusted information sources

Source: Mathematica's analysis of focus group data with TRT patients and non-TRT patients of reproductive age in January 2022. Focus group data represents 72 individuals.

Note: Myths and misconceptions related to LARCs include: they frequently migrate, fall out, get stuck, or are difficult to remove; they cause infertility; they cause weight gain; they are unsafe or ineffective for people over a certain weight.

LARC = long-acting reversible contraception; TRT = The Right Time.

2. Increased awareness of contraceptive options and TRT services

TRT's multimedia communications campaign includes a comprehensive approach of digital outreach, paid and earned media advertising, marketing materials, social media channels, and a robust website. From January 2019 to March 2022, the website reached nearly 100,000 unique users, and TRT's Facebook and Twitter accounts have generated more than 525,000 impressions. The initiative has also distributed more than 220,000 promotional materials (for example, brochures, postcards, posters, and palm cards). This outreach has increased the reach of quality information and combatted misinformation.

Getting the word out.

According to a state poll by Power to Decide, about 21 percent of Missourians were aware of TRT two years into the initiative, including 31 percent of Missourians ages 18 to 24.

TRT's outreach and education coordinators and community mobilization organizations play a key role in increasing the uptake of TRT's messaging. Outreach and education coordinators and community mobilizers participate in virtual and in-person outreach events to spread the word about TRT services to potential patients and organizations that serve potential patients. From January 2019 to March 2022, these groups have participated in more than 2,000 outreach events that reached nearly 60,00 people, primarily through online mediums (given in-person constraints because of the COVID-19 pandemic) or in the St. Louis metro area. The most common events involved dropping off TRT promotional materials (22 percent of events), one-on-one meetings with potential TRT patients or organizations that serve potential TRT patients (20 percent of events), and presentations about TRT and ancillary services (13 percent of events). About two-thirds of events were directed toward women of reproductive age and their partners (for example, outreach to students at local community colleges and workers at small businesses that do not offer health insurance), and the remaining one-third of events involved promoting TRT to organizations that work with potential TRT patients (for example, outreach to domestic violence shelters or correctional homes for teens). Oftentimes, TRT services were highlighted in the context of existing presentations; for example, in a

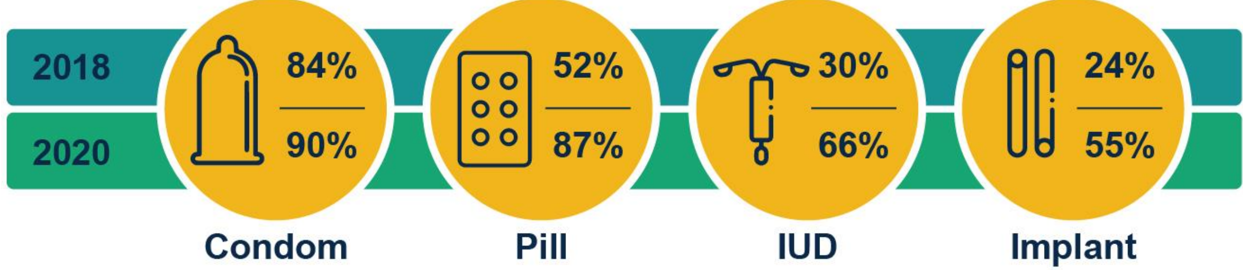
webinar session to build awareness about reproductive justice and ways to overcome challenges, a community mobilization organization shared opportunities to access TRT health centers.

Outreach and education coordinators and community mobilizers have also promoted TRT on social media through more than 3,200 social media posts resulting in nearly a million impressions. Similar to outreach events, these posts often highlight TRT in the context of other services (for example, increasing public awareness of the importance of the HPV vaccine, highlighting free pregnancy tests available at certain health centers, and debunking myths related to contraceptive methods). In addition, coordinators and mobilizers distribute printed educational materials to providers and educators. Educators feel able to use the materials in their classroom because—unlike other sources—materials produced by TRT are not politically charged or linked to an advocacy organization. Providers and patients alike find that TRT materials are easily used in a casual conversation; in interviews and surveys, providers shared that brochures on TRT-related services, palm cards that visually describe specific methods, and posters that list all available contraceptive options have all been helpful in discussing and informing decision making about birth control.

These efforts coincided with an increase in perceived knowledge about condoms, birth control pills, IUDs, and implants according to state polls in 2018 and 2020 by Power to Decide (Exhibit II.9). In 2018, poll results showed that about half the state population felt at least somewhat knowledgeable about birth control pills, and less than one-third felt at least somewhat knowledgeable about IUDs and implants. About two years later, knowledge about birth control pills, IUDs, and implants rose more than 30 percent. In addition, interviewed TRT providers have said more patients are coming into appointments with knowledge of the various contraceptive options.

Exhibit II.9. Knowledge about contraceptive methods has increased since 2018

Percentage of respondents who are knowledgeable about methods



Source: Power to Decide's poll of 700 Missouri residents ages 18 to 49, 2018; Power to Decide's poll of 750 Missouri residents ages 18 to 45, 2021. Respondents are considered knowledgeable if they indicated that they are "extremely," "very," or "somewhat" knowledgeable about each contraceptive method.

IUD = intrauterine device.

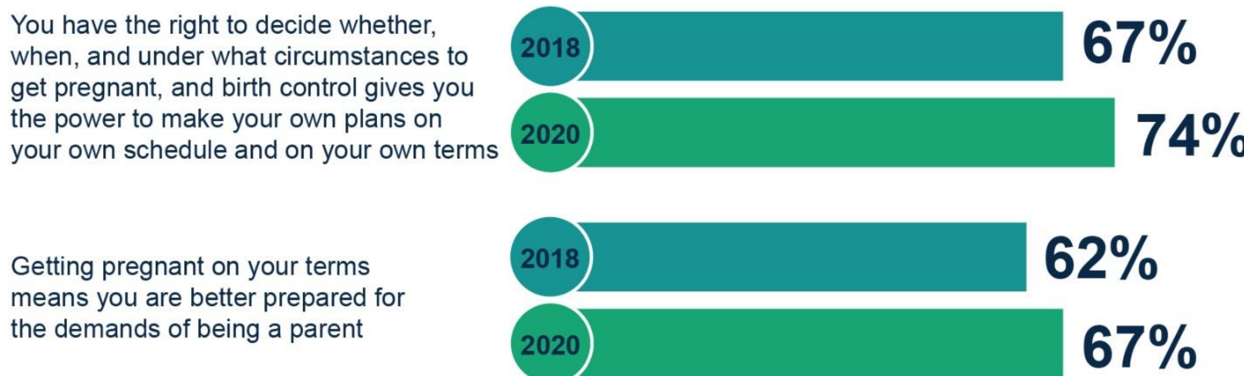
3. Increased agency surrounding pregnancy

> "I would say 99 percent of people are really grateful for the care we provide, because they can get in and be in a non-judgmental environment and ask questions and feel included."
>
> – Clinician at Title X agency

Ultimately, TRT messaging seeks to enhance people's agency surrounding pregnancy. Interviewed providers shared that they are now able to offer all contraceptive options without worrying about cost, which gives patients a greater feeling of choice or the right to choose. Several providers shared that patients are grateful for receiving non-judgmental and patient-centered care and the ability to select the method that is right for them. Although not directly attributable to TRT, polling data of Missourians show

a slight increase since TRT began in the proportion of residents agreeing that everyone has the right to decide whether and when to get pregnant (Exhibit II.10).

Exhibit II.10. Shifts in community norms around reproductive rights in Missouri



Source: Power to Decide's poll of 700 Missouri residents ages 18 to 49, 2018; Power to Decide's poll of 750 Missouri residents ages 18 to 45, 2021.

C. Support regional and statewide systems change (environment)

TRT seeks to create an enabling environment that empowers people to choose their preferred method of contraception without barriers. To accomplish this, TRT engages in advocacy and base building efforts together with coalitions and community mobilization organizations to ensure people have access to contraception (Exhibit II.11). The desired short-term outcomes of these activities include the following:

- Improved policymaker attitudes towards laws and regulations that support comprehensive contraceptive access (political will)
- Increased contraceptive-friendly policies and regulations (policy change)

The first short-term outcome creates the political will to make policy change. The second harnesses the political will to bring about policy change.

Exhibit II.11. TRT community mobilization efforts

TRT partners with seven community mobilization organizations across Missouri. These organizations engage key community leaders and influencers who help generate support and regulatory and legislative policy solutions. In particular, the community mobilization organizations seek to increase awareness of TRT, build support for TRT's advocacy goals, and build community solutions that reduce barriers to accessing and obtaining information about contraception. Three of the organizations work statewide, two work in St. Louis exclusively, one works in Southeast Missouri, and one works in St. Louis, southeast, and southwest Missouri.

1. Improved policymaker attitudes related to comprehensive contraceptive access

TRT regularly engages with policymakers to influence attitudes and mindsets related to contraception. From January 2019 to March 2022, partners had 432 meetings with legislators and legislative staff, one-third of which were with Republicans. These meetings involved cultivating relationships, promoting existing policies and programs that support contraceptive access, and discussing new policies and programs (Exhibit II.12).

Exhibit II.12. Types of engagement with Missouri legislators

"…the issue around sexual and reproductive health in the Missouri legislature often just gets boiled down to this false pro-life and pro-choice debate."

– Community partner

"If we can't convince our lawmakers that masks are beneficial or vaccines prevent viruses during global health pandemics, how are we going to convince our policymakers that contraceptive equity is important or bodily autonomy at the core of contraceptive equity is an imperative?"

– TRT partner

For example, partners have met with legislators about the annual supply of birth control bill, the pharmacist-prescribed contraception bill, bills related to preventing sexually transmitted infections, and other reproductive health bills. [9,10,11,12] These activities have helped to build relationships with legislators and identify champions to lead reproductive health legislation, but the polarizing political environment that centers reproductive health discourse around abortion has stalled progress.

"I think the culture and the legislature makes [discussing contraception] very hard. There are people in the legislature who say they're strongly pro-life and that to them means limiting access to birth control as well as limiting access to abortions and I don't see that changing anytime soon. A lot of Missourians would have to understand politics and pay more attention for that to change." – Policymaker ◢

[9] This legislation would require insurance companies to cover up to 13 months of birth control dispensed at one time, reducing barriers to contraception.
[10] This legislation would allow pharmacists to prescribe and dispense oral contraceptive pills.
[11] For example, pharmacists' prescribing of HIV pre- and post-exposure prophylaxis (PrEP/PEP), HIV testing and treatment legislation, and statewide syringe access program
[12] For example, family paid leave policies, LGBTQIA+ legislative issues, transgender youth bills, maternal mortality bills, and advanced practice nurse and telehealth legislation.

2. Increased contraceptive-friendly policies and regulations

Partners have also engaged in efforts to remove policies that impede contraceptive use. For example, partners advocated for permanently relaxing restrictions on advanced practice registered nurses, including waiving mileage restrictions for these nurses to allow them to reach patients in rural or underserved areas.

In addition to interacting directly with legislators, TRT partners build support for comprehensive contraceptive-friendly policies and regulations through participation in statewide coalitions. Partners lead the Healthy Families Coalition[13] and strategize on issues related to reproductive health with the Missouri Health Partnership Coalition, the Missouri Kids Win Coalition, the HIV Justice Coalition, and the Women's Health Council. From January 2019 to March 2022, TRT partners engaged in 365 actions (resulting in nearly 69,000 people taking action through emails, action alerts, and phone calls and testimonies to legislators) related to improving access to health insurance as a means of increasing contraceptive coverage and expanding access to contraceptive methods through new policies and regulations (Exhibit II.12). This includes efforts related to the federal reimbursement allowance, a "…must-pass funding mechanism responsible for one-third of the current state Medicaid program" (MFHC 2021). In the 2021 legislative session, the legislature failed to pass a federal reimbursement allowance —for the first time since 1992—as state legislators attempted to attach amendments to the legislation that would prohibit Medicaid funding for abortion providers and affiliates and restrict Medicaid from covering certain family planning services, such as emergency contraception and IUDs, by incorrectly designating them as abortifacients. In the context of a contentious political environment, Missouri Family Health Council and community mobilization organizations engaged in advocacy activities, mobilized grassroots support, and educated lawmakers to increase their understanding of how emergency contraception and IUDs work. These efforts contributed to Governor Parson signing a three-year extension of the federal reimbursement allowance into law, which did not restrict Medicaid funding of abortion providers or of different birth control methods, a major victory for reproductive health and rights in Missouri.

Despite these efforts and policy victories, community partners shared that working on legislative issues is "a long, long slog," with legislation often spanning multiple sessions before passing. For example, despite partners prioritizing the annual supply birth control legislation during the 2021 legislative session—with partners and mobilizers facilitating several strategy meetings about the legislation, meeting with 8 legislators over 17 meetings to discuss the legislation's benefits, and mobilizing more than 800 people to call and provide testimony to their legislators—the bill did not even receive a public hearing. During the 2022 legislative session, partners were heavily engaged in defending against efforts to reverse Medicaid expansion and prevent Medicaid recipients from receiving care at Planned Parenthood, further complicating partners' ability to make progress on contraceptive equity legislation.

[13] This is a statewide group of community partners, advocacy organization, and provider networks that collaborate to increase access to family planning, improve infant and maternal health, reduce sexually transmitted infections, remove barriers to care, and strengthen family security.

Exhibit II.13. Illustrative advocacy efforts to increase contraceptive-friendly policies and regulations

Goal	Program	Outcome
• Increase **support for Medicaid expansion** to improve access to care, including contraception. • Mobilize around the **FRA renewal** to require Medicaid to cover most birth control methods.	**Medicaid expansion**	• Missouri voters **approved Medicaid expansion**. • Legislators **passed a "clean" version and fully funded the regular Medicaid program** in the 2021 legislative session, but the bill did not allocate funding for the expanded program.
• Extend **Medicaid coverage for new mothers from 60 days to 12 months postpartum** to facilitate postpartum birth control access and reduce short interval pregnancies.	**Extension of postpartum Medicaid coverage**	• Missouri Family Health Council and partners **mobilized verbal and written testimony supporting extended Medicaid coverage 1115 waiver** (2019 and 2020) and submitted verbal and written testimony in support of house and senate bills (2021 and 2022). • Bill **introduced with bipartisan sponsorship** in 2022 legislative session.
• Remove **restrictions on which providers can be reimbursed for family planning services** (that is, abortion providers) to increase access to care.	**Women's Health Service Program/Budget**	• Submitted **verbal and written testimony against restrictions** and promoted calls to action.
• Provide **12-month postpartum coverage for enrollees** to increase access to health care services, including contraception, for people not eligible for MO Health Net for pregnant women.	**Missouri Medicaid-Show-Me Healthy Babies Program[a]**	• Provided **testimony and made phone calls** to encourage a committee hearing on the relevant legislation.
• Require **insurance companies to cover an annual supply** of contraception all at once to reduce barriers to accessing contraception.	**Annual supply birth control**	• Engaged in **28 meetings with 14 policymakers** related to legislation, including soliciting a Republican co-sponsor, and mobilized more than 800 people. • Submitted **written and verbal testimony** at hearings during 2022 legislative session.
• Allow p**harmacists to prescribe oral contraceptives** to reduce barriers to accessing contraception.	**Pharmacist-prescribed birth control**	• Engaged in **30 meetings with 11 policymakers**, including 5 meetings supporting a bill that allows pharmacists to dispense oral contraceptive with a prescription from the provider regardless of whether the prescription expired. • **Bill introduced in committee** in 2022 legislative session.

Source: Missouri Family Health Council, community mobilization advocacy, and legislative data, January 1, 2019, to March 31, 2022.

[a] This provides health coverage to pregnant women who are not eligible for Missouri's Medicaid program, do not have access to employer-sponsored insurance, and do not have affordable private insurance with maternity benefits.

FRA = federal reimbursement allowance; IUD = intrauterine device.

D. Indicators signaling achievement of longer-term outcomes

Core indicators of TRT's long-term goals include increased uptake of contraception of choice and reduced mistimed or undesired pregnancy (an unintended pregnancy does not necessarily indicate that it is mistimed or undesired).[14] Shifts in trends for these indicators at the community level will likely take at least a decade to observe. In the meantime, data from TRT patients on increasing uptake overall and switching contraception provide early signals. To center equity, these data should be examined in the context of whether the uptake and switching to contraception of choice is happening among those who disproportionately experience poor reproductive health outcomes and are underserved by the health care system.

> Black patients and patients with incomes below 250 percent of the federal poverty level had the lowest rates of contraceptive use at intake (90 and 89, respectively). Despite increasing their uptake of contraception at visit exit (94 and 92, respectively), these contraceptive rates are still lower than TRT patients overall.

At visit intake, rates of contraceptive use for TRT patients were already higher than rates of contraceptive use among all Missourians in 2017 (93 percent for TRT patients versus 69 percent among Missouri women ages 18 to 49) (Douglas-Hall et al. 2018). These rates were even higher at visit exit, with 96 percent of TRT patients on some form of contraception. Higher rates of contraceptive use at visit exit were especially prevalent among TRT patients younger than age 18 (99 percent versus 39 percent nationally) and Hispanic patients (97 percent versus 61 percent nationally; Daniels and Abma 2020). The high rates of contraceptive use among TRT patients (compared with those of Missouri residents and the United States population) suggests further potential for TRT to continue reaching new populations who need contraception the most (that is, those without any access to contraception).[15]

As for switching contraceptive methods, 45 percent of TRT patients switched methods, and 75 percent switched to a method that is more effective in preventing pregnancy. Overall, use of the male condom and abstinence as the primary methods of contraception declined (by 8 and 3 percent, respectively), coinciding with increased uptake of the pill, Depo-Provera shot, and LARC methods (by 10, 5, and 3 percent, respectively). The increased uptake of LARC methods was particularly salient among TRT patients younger than age 18 (8 percent). These findings suggest TRT might be contributing to people obtaining their contraception of choice by improving their knowledge about different methods and reducing barriers to access.

[14] We acknowledge that although pregnancy might be undesired at the time of conception, it is not necessarily undesired after conception.

[15] In all, 61 percent of TRT patients are White. Comparatively, 82 percent of people in the state identify as White (Missouri Census Data Center 2019). One health center in central Missouri serves a primarily Black population (81 percent of patients served), and another health center in the St. Louis metro area serves a large Hispanic population (21 percent of patients served). Across the board, roughly half of TRT patients are uninsured (52 percent), reflecting a large uninsured population that seeks care from safety-net health centers.

III. Progress in context and implications for the next phase of TRT

From its launch in 2019 to March 2022, TRT has seen progress across each of its prongs. Yet the initiative continues to function in an evolving and dynamic environment that creates challenges to and offers opportunities for its success. Most recently, COVID-19 caused the diversion of health center resources from contraceptive services to COVID-19 testing, vaccination, and contact tracing efforts. In some cases, staff furloughs and layoffs have further limited health centers' capacity to provide services. At the same time, the pandemic has created space for innovation; several health centers adopted telehealth and contraceptive mailings during the pandemic and plan to continue them even after the public health emergency ends. Expanded regulations at the federal and state level—such loosening of restrictions on the Health Insurance Portability and Accountability Act and waivers to bill telehealth services at the same rate as in-person visits—increased uptake of contraceptive service provision via telehealth (Beatty et al. 2022).

In addition, the political climate in Missouri and the discourse around abortion—including the overturning of *Roe v. Wade* in June 2022—fosters a polarized environment around reproductive health care and limits the initiative's ability to pursue proactive contraceptive legislation. A monthly news scan from January 2019 to March 2022 showed that most of the conversation around reproductive health heavily skewed toward the topic of abortion. Of the 1,578 articles related to reproductive health published in local and national news outlets, nearly 90 percent (1,369) mentioned abortion. For example, articles covering the reauthorization of the Federal Reimbursement Allowance included quotes from Missouri legislators calling emergency contraception and IUDs "abortifacients" in an attempt to prohibit Medicaid funding for them. Despite the initial pushback on the Federal Reimbursement Allowance reauthorization, Governor Mike Parson ultimately signed a three-year extension into law that does not restrict Medicaid funding of abortion providers or of different birth control methods. A Power to Decide poll revealed that more than half of surveyed Missourians in 2020 thought that birth control has become too polarizing of a topic in the state even with the inroads TRT has made to policymakers.

> "I've tried to be an advocate for being really happy with my IUD, and so trying to talk to friends of mine and say, "Hey, you should look into this, I've been really happy with it because at least my perception before starting to use one was that it was scary to have this thing poked up inside me," and so have tried to for what it's worth, at least share my anecdotal success."
>
> – Focus group participant

Because of this environment, the current progress of TRT will require steadfast support of health centers, providers, and implementing partners to enable them to continue delivering comprehensive contraceptive services, communications that cut through the noise of misinformation, and persuasive messages to make the case to legislators of the benefits of contraceptive friendly policies and regulations. Mixed comfort among providers with counseling on certain contraceptive methods, using trauma-informed and culturally competent techniques that take patient needs and preferences into account, and addressing common myths about contraception highlight the need for ongoing health center trainings. Similarly, continued high-quality contraceptive information online *coupled with* in-person outlets for dissemination will increase reach of quality contraceptive information. Broader dissemination of quality information can help counteract distrust of birth control services among people with past negative experiences and exposure to myths and anecdotes of extremely rare negative outcomes, especially regarding LARC methods. Legislators' defensive posturing on contraception will require community mobilizers to continue nimble adjustments to their tactics (for example, rather than seeking legislators' explicit support for contraception legislation, instead asking for silence from anti-abortion legislators).

TRT has responded to this context by extending health centers' participation from three to five years to allow more time to improve and sustain health systems' ability to deliver comprehensive contraceptive options. The extension of health center participation will align with a two-year extension of community mobilization activities and the addition of two more community mobilization partners to allow space to address environmental barriers created by the pandemic, extend the reach of policy and regulatory work under the initiative, and provide linkages to TRT services through grassroots outreach and education. TRT also plans to expand its digital outreach to include out-of-home advertising, community engagement events, and outreach through community colleges to improve reach among people that might have limited access to digital platforms and increase access to quality contraceptive information and awareness of TRT services.

Conclusion

At midline, TRT has made progress in supporting individual knowledge, organizational competencies, community mobilization, and political will to deliver comprehensive options that contribute to Missourians' access, rights, and agency in using their contraception of choice. These changes enable patients to visit health centers with trust in their provider and know they have the right and ability to access their method of choice. Clinic administrators at two health centers shared that at least two health centers will permanently change how they operate and reach clients, sustaining outreach and education coordinator roles introduced by TRT even after TRT funds that support the roles end. Medicaid expansion has paved the way to coverage for comprehensive contraception.

Ultimately, comprehensive contraceptive access and use represents a key mechanism to reduce unwanted pregnancies and, more generally, improve reproductive and maternal health. These outcomes promote healthy pregnancies, births, and development of the next generation. At a community level, changes in these longer-term indicators will likely only be observed years after the end of the initiative. The endline report will provide further insight into the promise of TRT to catalyze its vision for a world in which people have the freedom to choose to have children, to not have children, and to raise their families in healthy and sustainable communities.

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Appendix A:

Midline Evaluation Methods

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Our evaluation approach uses quantitative and qualitive methods to understand The Right Time's impact on reproductive health and rights in Missouri. Adhering to principles of equitable evaluation, including inclusivity in approach and viewpoints, we solicited feedback from implementing partners to ensure our methods were sound, our approach did not unintentionally harm or exclude certain groups, and we compensated participants fairly. The methods used in the midline evaluation are the same as those described in the baseline evaluation and learning report, which allows us to assess TRT's progress over the last three years. Specific methods include a descriptive study; qualitative interviews, focus groups, and analysis; and provider surveys and analysis. We asked research questions across multiple sources to solicit varying perspectives and triangulate an accurate representation of findings. The study received approval from Health Media Lab's institutional review board (606MPR19) to protect human subjects.

The number of people, clinics, and health centers represented through each data collection and analysis approach varied. Therefore, the number contributing to a specific finding in the report depend on the method used to collect and analyze the data. Here, we briefly summarize the methods, highlight changes that reflect contextual shifts such as the COVID-19 public health emergency, and provide links for further reading of these methods in our baseline report.

A. Descriptive analysis

The descriptive analysis leverages secondary data from implementing partners, health centers, and other publicly available sources (Exhibit A.1). With an eye toward equity, we analyzed data with regard to structural drivers affecting contraceptive uptake (supply), lived experiences that influence interpretation and utility of messages (demand), and trust of institutions and community groups that promotes or hinders engagement (environment). Additional stratification of health center data by socioeconomic status, racial identity, and geography sheds light on potential implementation barriers affecting TRT's reach, as does analyzing over time to assess how contextual factors such as COVID-19 have stalled progress.

Exhibit A.1. Secondary data sources

Data source	Description	Strategy and research question(s)
MFHC programming tracker	Data on training and technical assistance provided to participating TRT health centers	**Supply**: How many and what types of health centers participated in the intervention?
Health center encounter data	Data on patient-level encounters at participating TRT health centers, including patients' characteristics and contraceptive behavior	
Power to Decide TRT administrative data	Data on digital outreach, paid and earned advertising, and marketing materials	**Demand**: How many people were exposed to TRT's messages?
Outreach and education trackers	Data from MFHC, community mobilization organizations, and outreach and education coordinators on advocacy, engagement, media, and legislative efforts	**Environment:** Which state policies are relevant to reproductive health? What was the extent of community outreach to community organizations and policymakers?
LexisNexis and Cision	Data on local and national news related to family planning	
MFH legislative tracker	Data on the Missouri legislative session and health-related bills	

Notes: Health center encounter data available from April 2019 to September 2021. All other data sources available from January 2019 to September 2021. LexisNexis and Cision are web-based databases. All other data sources are electronic files.

MFHC = Missouri Family Health Council; TRT = The Right Time initiative.

B. Qualitative interviews, focus groups, and analysis

The qualitative methods relied on information from interviews with state and community leaders, health center staff from participating TRT sites, and TRT patients, as well as focus groups with TRT patients and Missouri women of reproductive age[16] who are not TRT patients (Exhibit A.2). Interviews with state and community leaders, health center staff, and TRT patients took place from June to August 2021. Focus groups with TRT patients and non-TRT patients of reproductive age took place in January 2022. To improve the quality and credibility of our evaluation findings, qualitative data comprised a diverse group of participants recruited intentionally with support from TRT implementing partners and a local research group.

Exhibit A.2. Qualitative data sources

Category (N)	Participant type (N)	Topics discussed
State and community leaders (11)	• Community partners (4) • Implementing partners (3) • Advisory committee members (2) • Foundation staff (1) • Policymaker (1)	• Successes and challenges of deploying TRT • Factors that promote or impede contraceptive and reproductive health care • Perceptions of contraception and state policies relevant to reproductive health • Other programs or services to increase access to reproductive services • Influence of COVID-19 on TRT implementation, outcomes, and sustainability
Health center staff (32)	• Front desk or billing staff (10) • Outreach and education coordinators (8) • Clinicians (7) Clinic administrators (7)	• Health center practices • Key challenges in service delivery • Operational procedures that support providing contraceptive care • Delivery of contraceptive counseling and education to patients • Health center organizational policies • Specific approaches used to implement TRT • Influence of COVID-19 on TRT implementation, outcomes, and sustainability
TRT patients and non-Missouri women of reproductive age (72)	• TRT patients (interviews) (4) • TRT patients (focus groups) (27) • Non TRT-patients (focus groups) (41)	• Knowledge, attitudes, and intentions related to contraception • Types of information received from various sources • Contraceptive behavior and decision making processes • Influence of COVID-19 on reproductive health experiences and decision making

Notes: Clinic staff interviewees represent 11 health centers. Interviews with implementing partners and foundation staff lasted 90 minutes and included two participants; all other interviews were one- hour and included one participant.

TRT = The Right Time initiative.

The study team made minor changes to the protocols and data collection procedures used at baseline. Protocol revisions include adding questions to learn about the pandemic's effect on implementation and adding questions to assess the initiative's sustainability. Process revisions include collecting all data

[16] Although we understand that not all people in need of reproductive health services identify as women, to simplify recruitment procedures, we recruited participants who identified as women and were ages 18 to 44.

virtually using web-conferencing technology because of pandemic-related health concerns, conducting more individual interviews instead of clinic focus groups given limitations in staff availability, and adding two new participant types (outreach and education coordinators and front desk or billing staff) to capture a diversity of clinic staff perspectives.

Consistent with the methods used at baseline, trained facilitators collected qualitative data using a semistructured guide. Facilitators used empathy interview techniques to take a human-centered approach to build rapport and trust, understand feelings and perspectives of interviewees, and encourage open and authentic conversation about experiences related to contraception. Facilitators obtain verbal consent from all participants before proceeding. Interviews and focus groups were recorded with permission and transcribed to facilitate analysis. TRT patients and Missouri women of reproductive age received a $100 Visa, Amazon, or Walmart gift card to defer costs associated with participation.

We used the same process to select and recruit participants as we did at baseline except that we did not recruit for clinic staff focus groups for the reasons mentioned above (refer to Exhibit A.3 in the baseline evaluation and learning report for our detailed recruitment process). We also used the same process for coding and analyzing the qualitative data as we did at baseline except that we added analysis codes for COVID-19 and sustainability (refer to Exhibit A.5 in the baseline evaluation and learning report for our categories for qualitative coding).

C. Provider survey and analysis

Survey data and analysis provide insight from administrative and clinical providers on reproductive and contraceptive services offered; training experiences, needs, practices, and procedures related to providing contraception; and perceptions of TRT (Exhibit A.3).

Exhibit A.3. Provider surveys and analysis

Period	Cohort	Fielding dates	Responses (health centers)	Topics covered
Baseline	• Cohort 1	• May to June 2019	• 7 clinic administrators (6 health centers) • 21 clinicians (6 health centers)	• Health center offerings, operations, staffing, and training needs • Providers' behavior • Patients‘ demographics
	• Cohort 2	• June to July 2020	• 6 clinic administrators (6 health centers) • 24 clinicians (6 health centers)	
18-month follow-up	• Cohort 1	• November to March 2021	• 6 clinic administrators (6 health centers) • 24 clinicians (6 health centers)	• Health center offerings, operations, staffing, and training needs • Providers' behavior • Patients' demographics • Perceptions of The Right Time • COVID-19 impacts
	• Cohort 2	• January to April 2022	• 6 clinic administrators (6 health centers) • 30 clinicians (6 health centers)	

The baseline survey captures health center information before launch, and the 18-month follow-up survey captures changes in these domains since baseline; an endline survey will capture additional changes. The 18-month follow-up survey also included questions to learn how the COVID-19 pandemic affected clinics, the extent to which providers' characteristics aligned with patients served, feedback on TRT's marketing materials, and the perceived sustainability of the initiative. Both surveys underwent descriptive

analyses to assess baseline clinic infrastructure, capabilities, staff training needs, and changes since baseline. Information on how we developed the surveys, the number of questions across modules, pre-testing procedures, burden estimates, and recruitment and fielding processes are available in Appendix A of the baseline evaluation and learning report. Exhibit A.4 provides the response rate for these surveys.

Exhibit A.4. Survey respondents' response rate

Period	Cohort	Type	Complete	Partial complete	Incomplete	Total	Response rate
Baseline	• Cohort 1	• Clinic administrator	7	0	0	7	100%
		• Clinician	18	3	9	30	73%
	• Cohort 2	• Clinic administrator	6	0	0	6	100%
		• Clinician	22	2	4	28	86%
18-month follow-up	• Cohort 1	• Clinic administrator	6	0	0	6	100%
		• Clinician	22	2	2	26	92%
	• Cohort 2	• Clinic administrator	6	0	0	6	100%
		• Clinician	28	2	2	32	94%

Appendix B:

Supplemental Exhibits

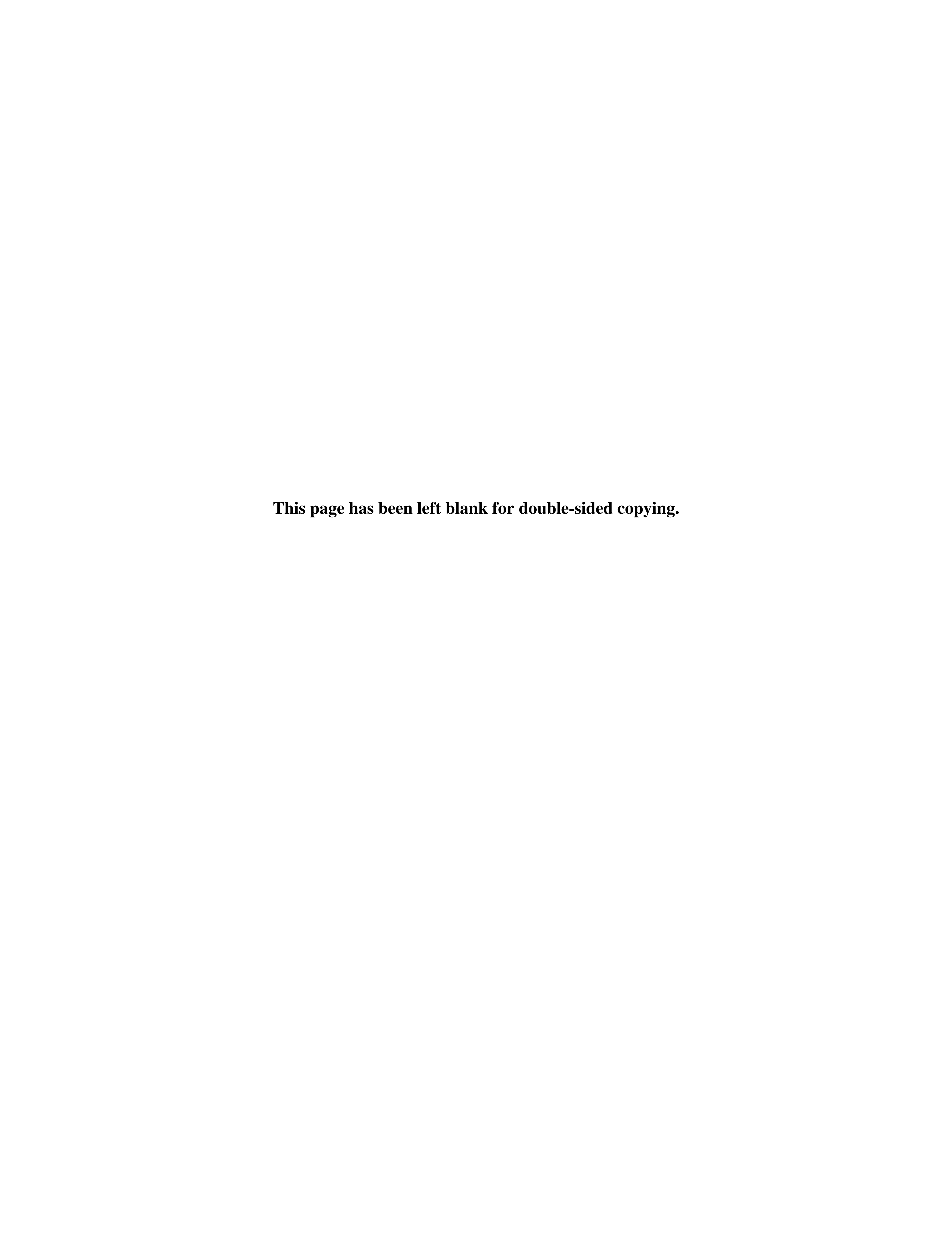

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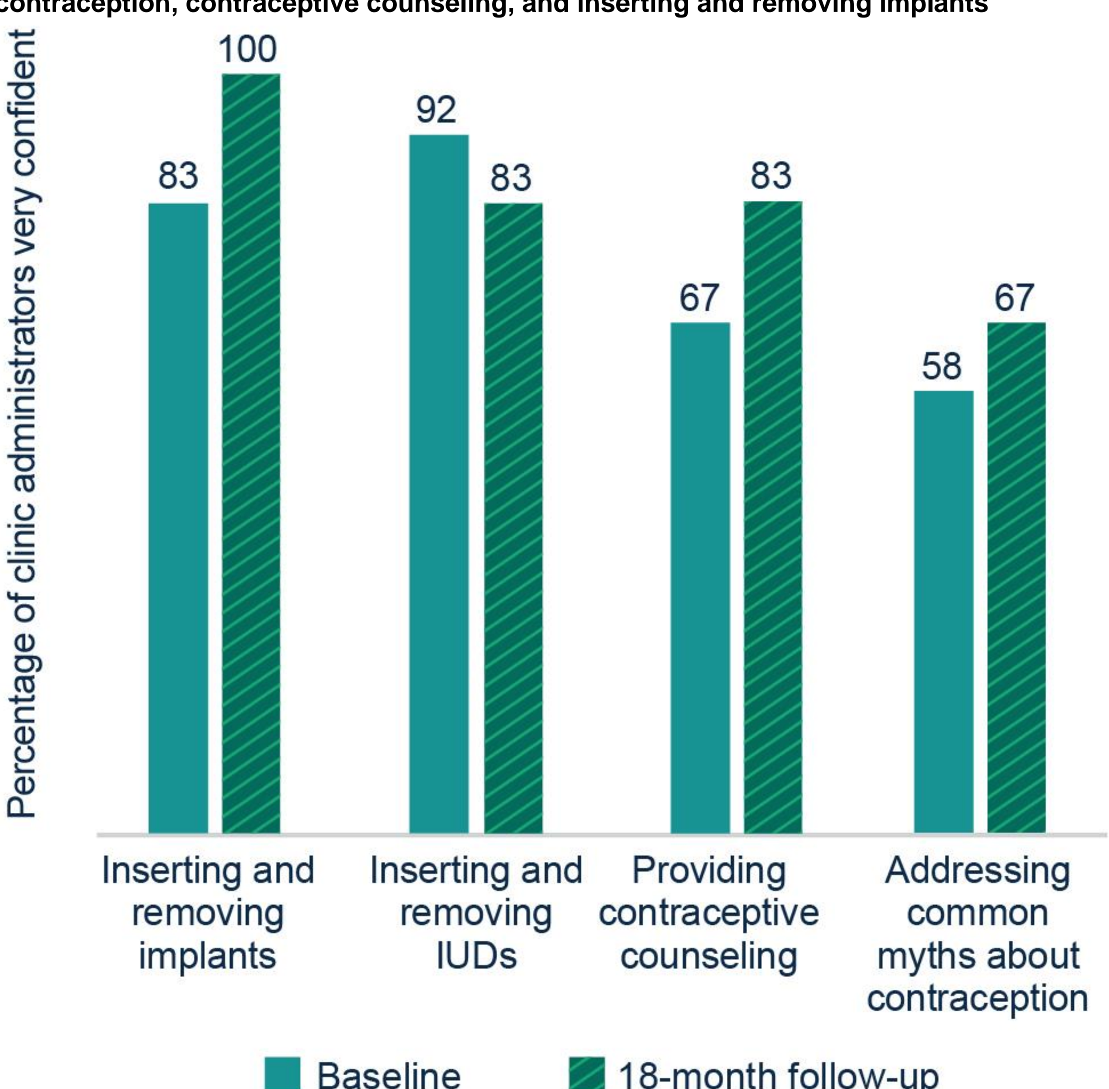
Exhibit B.1. Clinic administrators reported increased confidence in addressing myths about contraception, contraceptive counseling, and inserting and removing implants



Source: Mathematica's analysis of baseline and 18-month clinic administrators surveys for cohort 1 and cohort 2 health centers. Surveys fielded at baseline in May 2019 and June to July 2020 included 13 clinic administrators (representing 12 health centers). Surveys fielded 18 months into implementation from November 2020 to February 2021 and from January 2022 to March 2022 included 12 clinic administrators (representing 12 health centers).

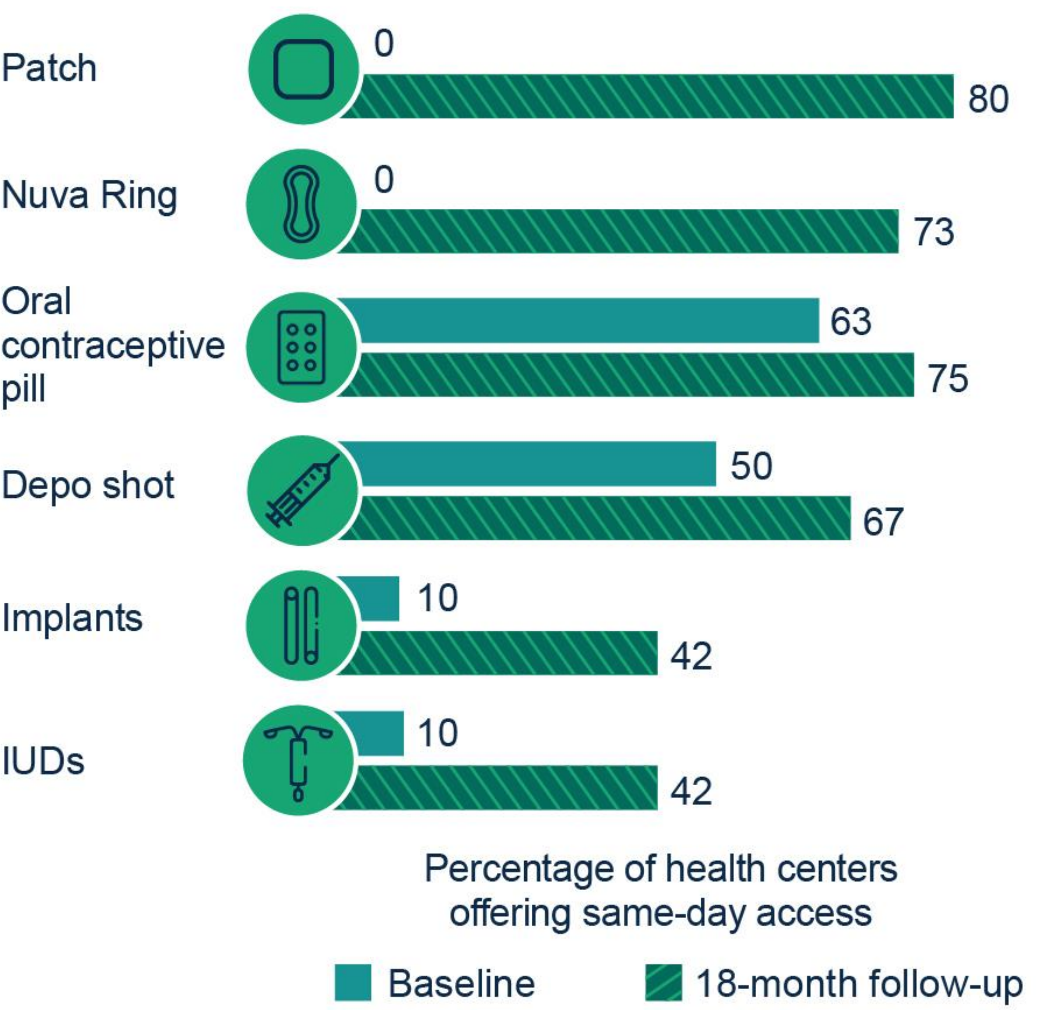
IUD = intrauterine device.

Exhibit B.2. Most clinicians increased their knowledge and skill in cultural competency

Percentage of clinicians very knowledgeable or skilled	Baseline	18-month follow-up
Eliciting the patient's perspective about contraception	49	67
Greeting patients in a culturally sensitive manner	36	58
Identifying and addressing a misunderstanding between yourself and a patient with different background	27	56
Working with medical interpreters	32	49
Providing culturally sensitive patient about contraception	36	47
Recommending culturally sensitive choices for contraception	31	45
Health disparities experienced by diverse cultural, racial, ethnic, or religious groups	44	42
Historical and contemporary impact of racism, bias, prejudice, and discrimination in reproductive healthcare	33	42
Sociocultural characteristics of diverse cultural, racial, ethnic, or religious groups	20	38

Source: Mathematica's analysis of baseline and 18-month clinician surveys for cohort 1 and cohort 2 health centers. Surveys fielded at baseline in May 2019 and June to July 2020 included 45 clinicians (representing 12 health centers). Surveys fielded 18 months into implementation from November 2020 to February 2021 and from January 2022 to March 2022 included 54 clinicians (representing 12 health centers).

Exhibit B.3. More health centers always offer same-day contraception



Source: Mathematica's analysis of baseline and 18-month clinic administrators surveys for cohort 1 and cohort 2 health centers. Surveys fielded at baseline in May 2019 and June to July 2020 included 13 clinic administrators (representing 12 health centers). Surveys fielded 18 months into implementation from November 2020 to February 2021 and from January 2022 to March 2022 included 12 clinic administrators (representing 12 health centers).

IUD = intrauterine device.

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