Examples of New Sexual and Reproductive Health (SRH) Measures in Development

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The measures that are used to track and evaluate public health programming and clinical services are powerful tools that allow the identification of gaps in access and quality of care and experience and allow us to determine the impacts of interventions. The availability of measures that reflect what we care about, including experience of care and people's lived experience, is particularly important in contraception due to the personal nature of decisions related to reproduction, as well as the well-documented inequities in contraceptive care by race/ethnicity. By improving and implementing existing, endorsed contraceptive measures and developing new SRH measures we can better capture whether people are having their needs met. The examples described below can help to expand the "suite" of measures – and move the needle toward quality and equity in SRH care

An expanded "suite" of SRH measures could potentially assess:

- A person's need for services, determining whether they accessed the care they wanted to receive
- Contraceptive provision and patient satisfaction with services
- Patients' SRH outcomes, such as pregnancy, fertility, and the ultimate outcome of sexual and reproductive wellbeing (SRWB)

Measuring Person-Centered Contraceptive Need

A population-level measure of person-centered contraceptive need aims to better reflect the contraceptive care needs of the people potentially accessing services by shifting who is centered in producing that knowledge and making decisions about who needs contraceptives.

Rationale. This measure of need is guided by the framework of person-centered health care access, which conveys different dimensions of health care accessibility and a person's ability to access those dimensions, expanding beyond traditional health care environments and considering individuals who could not access or continue services. There has been a focus in contraceptive measurement on utilization and engaging individuals who access health care settings, creating a gap in measuring how people perceive, seek, reach, and need services, including in community-based and nontraditional settings.

Items. The measure items include:

1. **Use of preferred method of contraception:** This item helps determine if there is a method of contraception a person wants to use, centering the preferences of people who want to use contraception and excluding people who do not want to use contraception (who would otherwise be categorized as a potential user).
2. **Use of preferred service delivery approach:** This item can be used to compare how a person wants to access service versus how they are actually receiving it to advance our understanding of people's orientation toward services.
3. **Experienced challenge or delay in getting contraception in past year:** This item looks at access barriers to determine who is not supported by policies and systems and where support is needed.
4. **Has enough information to choose best contraception of them**: Information is a critical component of achieving sexual and reproductive wellbeing. This item can highlight who is lacking information and where support is needed.

Development Updates. Historically, denominators of contraceptive measures – the populations who need contraception – were defined by demographics and for reasons related to pregnancy prevention. Part of developing this measure includes thinking deeply about appropriate denominators and specific subpopulations, including teens. There is interest in how this measure can apply at the facility or health care plan level, but as of now it is designed to be a population measure.

Team: Sexual Health and Reproductive Equity (SHARE) Program at the UC Berkeley School of Social Welfare.

The Self-Identified Need for Contraception (SINC) Screening Question

SINC is a standardized data element that helps identify patients in need of contraceptive services at the time of their visit. This screening question is designed to be asked at least once a year, with programmable options within EHR systems to prompt more or less frequently, depending on patient responses and preferences. SINC may be used to refine the denominator of the Electronic Clinical Quality Measures of Contraceptive Access (eCQMs), to only include patients who are interested in contraceptive care, as described above. Currently, work is being conducted to evaluate adequacy of screening for contraceptive need using a performance measure that assess the percentage of women aged 15-44 who are asked SINC within a calendar year.

Rationale. Improvement in the frequency of identifying people in need of contraceptive services, especially in primary care settings, is recognized as a critical opportunity to enhance the health care systems' ability to meet reproductive needs. Previously developed questions related to reproductive health needs assessment have utilized a pregnancy-intention framework, where patients are screened using a question soliciting desire for pregnancy within a year; patients who report not wanting to become pregnant within a year are counseled on contraceptive methods. Research shows this approach does not resonate with patients, as many patients do not have a binary view of pregnancy intention and it has the capacity to miss a significant portion of patients interested in using a contraceptive method even though desiring pregnancy in the next year. The SINC screening tool utilizes a service-needs model, as this approach helps to more accurately identify patients who are interested in contraceptive services at the time of their visit.

Items. The SINC measure consists of a single question (shown below), with several answer options.

Self-Identified Need for Contraception (SINC)
EHR standardized data element

We ask everyone about their reproductive health needs. Do you want to talk about contraception or pregnancy prevention during your visit today?

If **yes**:
- *Mark yes and refer to provider for contraceptive counseling.*

If **no**:
- Clarification Prompt: "There are a lot of reasons why a person wouldn't want to talk about this, and you don't have to share anything you don't want to. Do any of these apply to you?" *(mark all that apply)*
  - **I'm here for something else**
  - **This question does not apply to me / I prefer not to answer**
  - **I am already using contraception (and what)**
  - **I am unsure or don't want to use contraception**
  - **I am hoping to become pregnant in the near future**

Development Updates. SINC utilization data is currently being collected as part of the project collecting data for the contraceptive use eCQMs (for which SINC is a critical data element, allowing refinement of the denominator). Once completed at the end of 2023, this data will allow for validity and reliability testing of a SINC screening performance measure. This measure will consist of the percentage of women 15-44 at a given facility that receive SINC screening in a calendar year.

Team: The Person-Centered Reproductive Health Program (PCRHP) at the University of California, San Francisco.

Applying the Person-Centered Contraceptive Counseling (PCCC) Measure in Peripartum Contexts

PCCC is an existing NQF-endorsed measure with 4-items applied at the health care plan level. It was developed for non-pregnant people receiving care in ambulatory settings. Work to modify the measure for use in peripartum settings is underway, which requires modifying the domains to better reflect specific peripartum medical contexts.

Rationale. There are several factors related to medical considerations, ambulatory care provision, and reproductive harms that need to be considered when modifying PCCC to a peripartum context. These aspects of care, which make application of PCCC more complicated, must be recognized and measured as not to create unintended consequences, such as directive counseling, worsening known disparities, and exacerbating reproductive injustices to prevent pregnancy outcomes. Attention to one area of care can negatively impact the quality of another area of care. There is currently no measure of contraceptive care experience for peripartum settings to balance the existing measures of use and provision.

Development Updates. Preliminary findings of an internet survey showed that positive PCCC scores in peripartum settings ranged from 5-8%, compared to 35-99% in ambulatory settings, and there were notable disparities by race. The measure will be modified for research purposes and will lead to a performance measure.

Team. The Person-Centered Reproductive Health Program (PCRHP) at the University of California, San Francisco.

Measuring Self-Assessed Pregnancy Acceptability (SAPA)

SAPA (formerly post-conception pregnancy acceptability) is a novel person-centered, population-level measure of how people feel and think about pregnancy and assess their options once they are confirmed to be pregnant. It captures cognitive, emotional, and circumstantial factors that influence pregnancy-related decision making and health outcomes.

Rationale. The measure of unintended pregnancy is limited and does not reflect the diversity of pregnancy experiences, especially in marginalized communities and for individual to whom pregnancy planning does not resonate. Qualitative research shows that people make determinations about their pregnancy after they are confirmed pregnant. Correlations between pregnancy intention and maternal and infant outcomes are weak and affected by unmeasured confounding variables. Additionally, unintended pregnancy does not center reproductive autonomy nor holistically evaluate sexual and reproductive health efforts. A measure of SAPA can provide information to support person-centered pregnancy and abortion services. Intended outcomes and policy implications include better understanding the role and needs of supports and services in the context of acceptability, including among people who did not desire pregnancy at this time and determining how abortion serves as a mediator.

Items. The measure captures three levels of acceptability (highly acceptable, mixed acceptability, and unacceptable) across the following four domains:

1. Parenting attitudes and feasibility
2. Abortion attitudes and feasibility
3. Adoption attitudes and feasibility
4. Reproductive autonomy and choice

Development Updates. The domains were based on a conceptual framework, developed from 44 in-depth interviews, and with content and lived experience experts. The team will continue to perform psychometric testing and cognitive interviews to refine the items.

Team. Center for Innovative Research on Gender Health Equity (CONVERGE) in the Department of General Internal Medicine at the University of Pittsburgh School of Medicine.

Defining a Measure of Sexual and Reproductive Wellbeing (SRWB)

SRWB aims to measure the degree to which people achieve the SRH lives they wish to have and their experience of achieving those outcomes. This includes achieving fulfillment in all outcomes related to SRH and experiencing fulfillment in the process to achieve those outcomes.

Rationale. A population-level person-reported outcome measure (PROM) that captures people's sexual and reproductive experiences in a comprehensive manner is vital to robustly evaluate the state of sex/sexuality and reproduction in the US. This work will help move SRH measurement to a more holistic and comprehensive framing by adding new perspective to the range of measurable outcomes. Since wellbeing literature does not touch on SRH and SRH has not considered wellbeing, this work acknowledges the need for bi-directional integration. Essential, too, is centering equity and reproductive justice framings in the measure itself and the process of measure development.

Development Updates. The team began by identifying the SRWB construct to help address the needs of and gaps in existing SRH measurement. A working group of diverse experts was then formed and convened to thoughtfully develop equity-informed principles for defining and developing a measure of SRWB and to consider a definition and measure of SRWB over a series of meetings. In conjunction with working group discussions, the team conducted a scanning process of existing measures and qualitative assessments of SRH to better understand the current measurement space and efforts to move toward more holistic and nuanced constructs. Both the scans of the existing evidence and the working group's analysis and discussion informed development of a conceptual understanding, definition, and initial measurement framework of SRWB.

Draft Definition of Sexual and Reproductive Wellbeing

SRWB is a state of complete physical, mental, and social fulfillment in all matters related to sex and reproduction, free of injustice, oppression, coercion, violence, and stigma and their consequences.

This includes having:

- **Freedom and ability to control, act on, and not act on** one's sexual and reproductive decisions, desires, goals, and identities, including having comprehensive information, services, and supports, and not being hindered or harmed
- **Holistic and high-quality care** for one's sexuality and reproduction, free of judgement and bias, and coercion, that prioritizes personal needs and desires
- **Optimal sexual and reproductive outcomes in accordance with one's needs and desires,** including:
    - Attaining one's ideal level of sexual and reproductive health
    - Having the choice of if, when, and how to become a parent, and ability to do so
    - Having a pleasurable and safe sex life

The next phase of the work, with ongoing stakeholder engagement and intensive qualitative work, will focus on creating a universally applied population-level measure reflective of diverse experiences. The team also has funding to consider how SRWB applies in diverse global contexts.

Team. Coalition to Expand Contraceptive Access (CECA), National Birth Equity Collaborative (NBEC), and The Person-Centered Reproductive Health Program (PCRHP) at the University of California, San Francisco.