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The Effect of a No-Cost Contraceptive Initiative on Method Selection by Women with Housing Insecurity

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Abstract

Objectives—To compare the sociodemographic characteristics of participants in a contraceptive initiative by housing security and determine the association between housing insecurity on contraceptive method selection before and after the removal of cost.

Study Design—This cross-sectional assessment includes 4,327 reproductive-aged participants in the *HER Salt Lake Contraceptive Initiative* who sought new contraceptive services and reported housing status at enrollment. *HER Salt Lake* prospectively explored the impact of improved contraceptive access on socioeconomic outcomes in Salt Lake County (USA). For six months (September 2015-March 2016) we collected control data, which included clinic standard-of-care cost-sharing. The intervention started March 2016, and provided no-cost contraception services and unlimited opportunities for method switching over the subsequent three years.

Results—There were 964 (22%) housing-insecure participants. Compared to those with stable housing, housing-insecure individuals more commonly identified as a sexual minority, received public assistance and lacked health insurance. Housing-insecure women preferentially selected long-acting reversible contraception during the control period (aOR 1.60; 95%CI 1.01–2.56), but method selection equalized across housing status during the intervention.

Conclusions—When cost is not a barrier, all women desire a comprehensive selection of contraceptive methods, regardless of housing security. Contraceptive clients in this vulnerable population need interventions which address access barriers to all methods to support reproductive planning.

Keywords

contraception; reproductive health; homelessness

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Introduction

Single women and women in families with children contributed to 40% of the U.S. housing-insecure population in 2017, including homeless individuals sleeping on the street and those living in temporary housing, shelters, sharing-rooms, living on couches, and other transitional living situations. [1] Housing insecurity may occur as a result of economic situations or domestic violence and/or trauma. Women experiencing homelessness and housing insecurity have a high prevalence of chronic physical, mental health, and substance use diagnoses that increase risk of adverse outcomes in the event of an unintended pregnancy, such as preterm birth. [2–5]

The most effective way to prevent unintended pregnancy is through consistent and correct contraceptive use. Unfortunately, socioeconomic and environmental disparities in contraceptive access and uptake exist, especially for the most effective but also the most costly long acting reversible contraception (LARC), including intrauterine devices (IUDs) and contraceptive implants. [6] Women with housing insecurity tend to have low contraceptive utilization, in part due to lack of insurance and variation in free clinic services, which may only offer condoms or short-acting methods. [7,8] Recent work with homeless youth identified contraceptive cost, lack of knowledge regarding how to access contraceptive information or navigate insurance, concern for stigmatization at health centers, and other logistical barriers to contraceptive use. [9] Addressing the reproductive health needs of women struggling with housing insecurity is essential, as sexual trauma and survival sex are common and an unintended pregnancy may destabilize a fragile housing situation. [7,10]

Utah is one of many U.S. states that have health insurance gaps for individuals living in or near poverty. The limited insurance coverage options available in 2014 resulted in 32% of reproductive-aged Utah women (207,350) with need for publicly-funded contraceptive services. [11] To specifically address the healthcare needs of the homeless population, the state of Utah approved a limited Medicaid expansion in 2016 (Utah House Bill 437). However, women with housing insecurity who have not yet accessed homeless services, would not be eligible.

Another safety-net for under- and un-insured women has been community contraceptive initiatives (St. Louis [12], Iowa [13], and Colorado [14]). All studied initiatives have demonstrated that removal of financial barriers increased uptake of LARC methods and reduced unintended pregnancy and abortion rates across populations. [13,15] Distinct from other community contraceptive initiatives, which focused on method selection and pregnancy, the *HER Salt Lake Contraceptive Initiative* was designed to improve family planning clinic capacity, remove out-of-pocket cost for those in need, and is prospectively exploring the long-term impact of improved contraceptive access on socioeconomic outcomes. [16] The *HER Salt Lake* cohort enables exploration of the relationship between housing insecurity and contraceptive choice, while controlling other factors associated with method selection. Thus, the objectives of this study were to (1) compare the sociodemographic characteristics in *HER Salt Lake* participants by housing security and (2) determine the association between housing insecurity on contraceptive method selection before and after the removal of cost.

Methods

Study Overview

HER Salt Lake enrolled a prospective cohort of new contraceptive clients between September 2015 and March 2017 from four Planned Parenthood Association of Utah (PPAU) health centers in Salt Lake County, Utah. A prior publication provides detailed information regarding recruitment and study design. [16] At baseline, three clinics subsidized contraceptive services with federal Title X funding. A fourth clinic, which provided abortion services, did not have Title X funds, but had a program that subsidized IUDs and implants through a private donor. During the control period (September 28, 2015 to March 27, 2016), women enrolled at the time of their contraceptive visit, received standard clinical care and sliding-scale costs when eligible, but most women paid for some or all of their care. The intervention period (March 28, 2016- March 25, 2017) removed all out-of-pocket cost, including insurance copays, and increased clinic capacity for same-day contraceptive services and methods. Participants could switch methods at no cost for three years. Clinical assistants, with research training, obtained informed consent from participants at study enrollment. The University of Utah Institutional Review Board approved this study.

Study Population

This analysis includes 4,327 women, ages 16–45, who presented to a PPAU clinic for a new contraceptive visit and enrolled in *HER Salt Lake* during either the control or intervention periods and reported housing status at baseline. Participants received a $20 gift card for a local supermarket for completion of a baseline enrollment survey.

Study Variables

We collected comprehensive data on contraceptive use, housing status, and other socioeconomic characteristics of the *HER Salt Lake* participants through a secure, web-based Research Electronic Data Capture (REDCap) System. [17] Variables described, including age, race, parity and others, may influence contraceptive access or are risk factors for housing insecurity. Consistent with a previous study, we defined sexual minority status as women who do not identify as exclusively heterosexual and those who engage in same-sex romantic/sexual relationships. [18] Individuals identifying as other than cisgender women were not specifically recruited, but do make up a proportion of the study population with the same access to comprehensive contraceptive methods.

We asked participants “Which of the following describes your current housing situation?” They could respond through multiple choice options (e.g. apartment, house, mobile home, shelter, etc.) or through a free-text entry, which we subsequently coded and incorporated into the final housing dataset. We also asked participants if they had difficulty paying for housing in the previous twelve months. We defined their current housing situation as “housing insecure” based upon two criteria: (1) the US Department of Housing and Urban Development definition for homelessness [1] which includes individuals who reported staying temporarily with a friend or family member, being in transitional housing, being currently in a shelter, and/or those living on the streets, and (2) those who reported difficulty

paying for housing within the past 12 months. We defined food insecurity as participants who reported receiving food stamps or reported difficulty paying for food within the past 12 months.

We stratified self-reported annual incomes as <100% Federal Poverty Level (FPL) and >100% FPL. This reflects a common state-level eligibility distinction for publicly-funded family planning services, based on household income and number of dependents. For reference, an annual income of <100% FPL was $12,140 for an individual or $25,100 for a family of four in 2018. [19] We stratified contraceptive method selection by efficacy and sought to assess predictors of uptake of LARC methods (IUDs and implants) or of less effective, short-acting methods. Researchers used this outcome in previous contraceptive initiatives and costly LARC methods limit accessibility in free clinics or homeless healthcare settings.

Statistical Methods

We limited our analyses to women who had reported their housing status in the baseline enrollment survey. We calculated proportions and used the Chi Square statistic to test relationships between categorical variables. To assess how housing insecurity impacted method selection, we conducted multivariable logistic regression models, with baseline method selection as the dependent variable (long-acting or short-acting). To identify appropriate covariates, we conducted unadjusted analyses on covariates known to influence contraception choice, including age, race/ethnicity, parity, sexual orientation, insurance status, clinic site, enrollment period, and housing security status. We included covariates in the final adjusted model if they had a *p*-value of less than 0.25 in the bivariate models. [20] We used Stata Statistical Software version 15 (StataCORP LLC, 2017; College Station, TX) for all statistical analyses.

Results

A total of 4,425 women enrolled in *HER Salt Lake Contraceptive Initiative* and 4,327 (97.6%) had an enrollment date, method selection and housing insecurity data in the baseline survey for these analyses. Table 1 represents characteristics of women stratified by housing insecurity. Women with housing insecurity accounted for 22.3% (n=964) of the total study population. Compared with secure housing participants, those reporting housing insecurity were more likely to report sexual minority status, food insecurity, receipt of public assistance and lack health insurance (p<.001 for all variables) (Table 1). Of the 964 housing-insecure women, 922 (95.6%) reported difficulty paying for housing, 25 (2.5%) described current homelessness, and 17 (1.7%) women lived in a shelter. Overlap between responses occurred, e.g., women in a shelter also reporting difficulty paying for housing. We included 23 women in the housing-insecure group who used a free-text comment to describe their housing status. Ten women reported “doubling up” or staying with friends or family as a temporary solution, such as “floating around”, “couch surfing”, or “staying with a friend due to domestic violence.” One additional woman identified a shelter in free-text comments and two reported they were in a rehabilitation facility. We coded ten additional women as

"insecure," as they reported difficulty paying for housing and listed their housing situation as a motorhome, a car, a shop, an attic, or a halfway house.

Table 2 describes the contraceptive method received by participants during the enrollment visit by housing status and study period. Women with both secure and insecure housing chose a range of method types, including behavioral methods. Compared to secure housing participants, the proportion of women who selected a LARC method was higher among housing-insecure women during the control period (22.2% vs. 29.9%) but was similarly high across housing status during the no-cost intervention period (61.8% vs. 61.5%). The logistic regression models in Table 3 demonstrate a shift in demographics among those receiving IUDs and implants during the intervention period (cost removal) to include more women ages 35 years or older (aOR 1.53; 95%CI 1.11–2.11) and those with private insurance (aOR 1.67; 95%CI 1.41–1.98). Women with housing insecurity trended towards increased uptake of IUDs and implant in the control period (aOR 1.60; 95%CI 1.01–2.56) when standard clinic sliding-scale and Title X assistance were available. Housing insecurity did not significantly influence IUD or implant uptake in the no-cost intervention period (aOR 0.99; 95%CI 0.83–1.19). Clinic site was a significant predictor of method choice in both the control and intervention periods, as clients were more likely to receive LARC in the post-abortion time period at Clinic A compared to the other Title X clinics which did not provide abortion services.

Discussion

This study found 22% of women seeking contraceptive care at PPAU clinics during the *HER Salt Lake Contraceptive Initiative* reported housing insecurity. Prior to the intervention, more women with housing insecurity selected LARC methods. Removal of cost barriers resulted in increased LARC selection irrespective of housing status. While this study reports only initial method selection, the intervention removed the financial burden from the equation and allowed women to switch methods as many times as desired throughout the three years of the study. With this reassurance, the no-cost option may have become a financial equalizer in method choice across poverty and housing status.

The increased likelihood for LARC use in the control period could be explained by several factors. First, cost matters, regardless of socioeconomic status. Prior to the intervention, women with incomes <100% FPL had access to other existing contraceptive initiatives for LARC methods at the Title X clinics, while women reporting higher income still had to pay something. With removal of all cost barriers, everyone accessed LARC at the same, increased rate. Second, access to LARC methods through homeless or free clinics for uninsured women in Salt Lake City is challenging due to limited availability and lack of providers capable of placement. The higher rates in the control period may be indicative that women in need preferentially sought publicly-funded family planning clinics for LARC services, while accessing short-acting methods elsewhere. Finally, while all participating clinics used standardized, evidence-based contraceptive conversations with all clients throughout the control and intervention periods, higher LARC use in the housing-insecure population may be the result of unconscious bias directive provider counseling efforts. A heavy focus on LARC in provider counseling is perceived as coercive to women

experiencing poverty or homelessness. [21] Healthcare providers need to acknowledge their biases through the lens of a reproductive justice framework, which supports the human right to have children, not have children and parent in safe communities. [22] Removing access barriers to all methods and providing non-directive counseling to all women acknowledges their reproductive life goals are not just about their socioeconomic or housing status. [23]

It is important to highlight that FPLs provide an arbitrary limit and do not define the struggles women experience in meeting their family's basic needs. Of the *HER Salt Lake* participants experiencing housing insecurity, 38% had a designation of "higher-income" at 101–300% FPL. Additionally, housing insecurity could occur regardless of FPL, if it is the result of trauma or intimate partner violence. The *HER Salt Lake* initiative filled a gap and begins to explain why we need long-term family planning investments as part of the policy interventions to address housing security. Women experiencing homelessness or housing insecurity may seek information or referrals from a wide range of healthcare or homeless service providers. Despite this opportunity to engage women in care, a survey of healthcare providers for homeless women found lack of provider knowledge, resources and concerns for complications as barriers to comprehensive contraceptive provision in this high-risk population. [24] While housing status does not influence contraceptive method choice after removal of access barriers, real-world" barriers still exist. Access to all contraceptive methods, including training and resources for homeless service providers, could mitigate risk of an unintended pregnancy tipping housing-insecure women into homelessness. [7]

The strengths of this study include the large population and the prospective, patient-reported data on sociodemographic variables. Limitations include the lack of precision in defining housing insecurity. The use of self-reported data may under or overestimate both financial resources and housing security which could lead to misclassification. Our classification of housing insecurity extends beyond a strict definition of homelessness, yet it may be more representative of true housing struggles people, especially women, experience. This analysis does not account for future contraceptive method switching or adherence, but focuses on initial method selection of reversible methods. Additionally, this cross sectional study does not assess the effect of in contraceptive access on future housing security.

While contraceptive community initiatives lack sustainability, data from *HER Salt Lake* and others can inform individual patient counseling, system-level interventions, and policies that set out to support high-risk populations. Publicly-funded family planning services need to consistently cover all contraceptive options to support reproductive planning. Collaboration with state and national policy makers to drive home the overlapping needs of homeless initiatives and family planning services is a key preventive strategy to improve the health and lives of women experiencing poverty and 286 housing insecurity.

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Implications

Unintended pregnancy during housing insecurity may result in homelessness. This study found housing-insecure women desire access to all contraceptive methods, not just long acting reversible contraception. Integration of comprehensive family planning initiatives into efforts to address homelessness is essential to support this vulnerable population in their reproductive planning.

Table 1

Sociodemographic characteristics of HER Salt Lake participants at enrollment, by housing security status (*N* = 4,327).

Variable	Housing Insecure[1] (*n* = 964)	Housing Secure (*n* = 3,363)	p-value
Age			0.052
18–24	554 (57.5%)	2,071 (61.6%)	
25–29	241 (25%)	746 (22.2%)	
30–34	96 (10%)	342 (10.2%)	
35+	73 (7.5%)	204 (6%)	
Race			0.732
Non-White	157 (20.6%)	531 (20.2%)	
White	606 (79.4%)	2,094 (79.8%)	
Ethnicity			0.214
Hispanic or Latino	233 (27.8%)	831 (28.4%)	
Non-Hispanic or Latino	606 (72.2%)	2,094 (71.6%)	
Sexual minority[2]			<0.001
Yes	327 (33.9%)	876 (26.1%)	
No	637 (66.1%)	2,487 (73.9%)	
Has children in household			0.001
Yes	401 (41.6%)	1,368 (40.7%)	
No	563 (58.4%)	1,995 (59.3%)	
Food insecurity[3]			<0.001
Yes	657 (68.1%)	417 (12.4%)	
No	305 (31.6%)	2,935 (87.3%)	
Prefer not to answer	2 (0.2%)	10 (0.3%)	
Federal poverty level[4]			<0.001
<100%	594 (61.6%)	1,621 (48.2%)	
101–300%	370 (38.4%)	1,742 (51.8%)	
On any public assistance[5]			<0.001
Yes	200 (20.7%)	308 (9.2%)	
No	764 (79.3%)	3,055 (90.8%)	
Health insurance status[6]			<0.001
None	567 (59.4%)	1,455 (43.8%)	
Private	64 (6.7%)	129 (3.9%)	
Public	280 (29.3%)	1,555 (46.8%)	
Other	44 (4.6%)	183 (5.5%)	
Study Period[7]			0.731
Control	157 (16.3%)	525 (15.6%)	
Intervention	804 (83.7%)	2,831 (84.4%)	

[1]Housing insecurity was defined as individuals who reported being currently homeless/in a shelter, in temporary or transitional housing, staying temporarily with a friend or family member, and/or reported difficulty paying for housing within the past 12 months.

[2]Sexual minorities include individuals identifying as “mostly heterosexual,” “bisexual,” “mostly or exclusively gay/lesbian” or “other”.

[3]Food insecurity was defined as individuals who reported receiving food stamps, and/or reported difficulty paying for food within the past 12 months.

[4]The 2018 Federal Poverty Level was set at $12,140/year for individuals; the definition varies based on household size.

[5]Public assistance includes: food stamps, WIC, unemployment, or Temporary Aid to Needy Families.

[6]Private insurance includes insurance received through an employer, student insurance, or parental insurance plans; Public insurance includes Medicaid, Disability or Medicare, and military or VA benefits; Other insurance status includes individuals who did not know their insurance status and those who preferred not to answer.

[7]Control period refers to the 6-month control period where women received standard of care at all clinics; Intervention period refers to a year-long period where clinics improved stocking & provider coverage and women could receive all methods at no cost. Ten individuals did not complete a timestamped enrollment date and thus, these numbers do not match the total enrolled.

Table 2

Contraceptive method selection by housing status in the *HER Salt Lake Contraceptive Initiative* ($N = 4.317$[1]).

Method received at baseline	Control Period[2]		Intervention Period[2]		Total
	Housing insecure[3] (*n* = 157)	Housing secure (*n* = 525)	Housing insecure[3] (*n* = 804)	Housing secure (*n* = 2,831)	
Implant	8 (5.1%)	28 (5.3%)	179 (22.2%)	608 (21.4%)	823 (19.1%)
Copper IUD	14 (8.9%)	36 (6.8%)	97 (12.0%)	382 (13.5%)	529 (12.2%)
Hormonal IUD	25 (15.9%)	53 (10.1%)	220 (27.3%)	764 (26.9%)	1,062 (24.6%)
Injectable	38 (24.2%)	128 (24.3%)	92 (11.4%)	290 (10.2%)	548 (12.7%)
Oral contraceptive	51 (32.4%)	207 (39.3%)	164 (20.4%)	639 (22.5%)	1,062 (24.6%)
Patch/ring	14 (8.9%)	44 (8.4%)	45 (5.8%)	127 (4.5%)	232 (5.4%)
Condoms (male or female)	5 (3.2%)	17 (3.2%)	1 (0.01%)	7 (0.02%)	30 (0.07%)
Other[4]	1 (0.6%)	7 (1.3%)	5 (0.06%)	12 (0.04%)	25 (0.05%)
Nothing	1 (0.6%)	5 (0.9%)	1 (0.01%)	8 (0.02%)	15 (0.03%)
Total	157	525	804	2,831	4,317[4]

IUD = Intrauterine Device.

[1] We excluded ten individuals from the study population of 4,427, as they did not have complete dates of enrollment to confirm the study period.

[2] Control period refers to the 6-month control period where women received clinical standard of care; Intervention period refers to a year-long period where clinics improved stocking & provider coverage and women could receive all methods at no cost.

[3] Housing insecurity was defined as individuals who reported being currently homeless/in a shelter, in temporary or transitional housing, staying temporarily with a friend or family member, and/or reported difficulty paying for housing within the past 12 months.

[4] Other includes spermicides, diaphragms, fertility-awareness methods, withdrawal, and emergency contraception.

Table 3

Predictors of long-acting method selection among women in the *HER Salt Lake Contraceptive Initiative*, by study period ($N = 4.317$[1]).

Variable	Control period[2] (OR, 95% CI)	Intervention period[2] (OR, 95% CI)
Poverty		
<100% FPL	Ref	Ref
101–300% FPL	0.95 (0.61, 1.46)	1.12 (0.96, 1.31)
Age in years		
18–24	Ref	Ref
25–29	**1.64 (1.02, 2.67)**	1.16 (0.96, 1.39)
30–34	1.05 (0.53, 2.10)	1.06 (0.82, 1.37)
35+	1.24 (0.49, 3.17)	**1.53 (1.11, 2.11)**
Hispanic ethnicity		
No	Ref	Ref
Yes	1.01 (0.62, 1.62)	0.97 (0.81, 1.15)
Has children		
No	Ref	Ref
Yes	1.24 (0.79, 1.94)	**1.20 (1.02, 1.41)**
Sexual minority		
No	Ref	Ref
Yes	1.12 (0.69, 1.82)	**1.19 (1.01, 1.41)**
Insurance		
None	Ref	Ref
Public	1.60 (0.62, 4.09)	1.19 (0.82, 1.74)
Private	1.55 (0.98, 2.44)	**1.67 (1.41, 1.98)**
Other	0.51 (0.14, 1.81)	0.95 (0.69, 1.33)
Housing insecure		
No	Ref	Ref
Yes	**1.60 (1.01, 2.56)**	0.99 (0.83, 1.19)
Prefer not to answer	1.27 (0.24, 6.21)	1.48 (0.76, 2.90)
Clinic site[3]		
Clinic A	Ref	Ref
Clinic B	**0.15 (0.08, 0.29)**	**0.37 (0.28, 0.49)**
Clinic C	**0.25 (0.14, 0.44)**	**0.35 (0.27, 0.46)**
Clinic D	**0.11 (0.05, 0.25)**	**0.34 (0.26, 0.46)**

FPL: Federal Poverty Level; OR: odds ratio; CI: confidence interval.

[1] We excluded ten individuals from the study population of 4,427, as they did not have complete dates of enrollment to confirm the study period.

[2] Control period refers to the 6-month control period where women received standard clinical care; Intervention periods to a year-long period where clinics improved stocking & provider coverage and women could receive all methods.

[3] Clinic A, which provides abortion services, does not receive Title X funding, but provides long-acting methods post-abortion through a private, donor-subsidized program. The other clinics do not provide abortion services and receive Title X grant support.