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Expanding Contraception Access for Women With Opioid-Use Disorder: A Qualitative Study of Opportunities and Challenges

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Abstract

Purpose: As almost nine in ten pregnancies among women with opioid use disorder (OUD) are unintended, expanding access to contraception is an underutilized but potentially effective strategy in increasing reproductive agency and reducing the overall burden of neonatal abstinence syndrome. We aimed to identify where and how contraceptive services could be integrated into existing points-of-contact for women with OUD.

Approach: In-depth qualitative interviews.

Setting: Three diverse catchment areas in Missouri.

Participants: Women with OUD (n = 15) and professional stakeholders (n = 16) representing five types of existing OUD service points: syringe exchange programs, recovery support programs, substance use treatment programs, emergency departments, and Federally Qualified Health Centers.

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Authors' Note

E.A.H., S.F.K., K.G., R.W., and M.K.M. contributed to the conception and design of the work. E.A.H., A.D., and M.K.M. acquired data. E.A.H., A.D., S.F.K., S.S., R.P.W., and M.K.M. analyzed and interpreted data. E.A.H. drafted the work and A.D., S.F.K., K.G., S.S., R.P.W., and M.K.M. revised for important intellectual content. All authors provided final approval for the publication and agree to be accountable for all aspects of the work.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Method: Interviews were audio-recorded, transcribed, and thematically coded using Dedoose software.

Results: Six themes emerged as essential components for integrating contraceptive services into existing points-of-contact for women with OUD: (1) reach women with unmet need; (2) provide free or affordable contraception; (3) maximize service accessibility; (4) provide patient-centered care; (5) employ willing, qualified contraceptive providers; and (6) utilize peer educators. Participants affirmed the overall potential benefit of contraceptive service integration and illuminated various opportunities and challenges relevant to each type of existing service point.

Conclusion: As health promotion initiatives look to increase access to contraception among women with OUD, these six' participant-identified components offer essential guidance in selecting advantageous points-of-contact and addressing remaining gaps in services.

Keywords

qualitative research; opioid use disorder; contraception access; harm reduction; long-acting reversible contraception; neonatal abstinence syndrome; substance use; community settings; health disparities

Purpose

Opioid use disorder (OUD) quadrupled among pregnant women in the United States from 1999 to 2014.[1] Up to nine in ten pregnancies among women with OUD are unintended, a rate 2 to 3 times higher than that among the general population of reproductive-aged women.[2] Women with unintended pregnancies and OUD face multiple burdens, including the complexities of pregnancy termination decisions as well as the heightened risk of neonatal death and neonatal abstinence syndrome (NAS) among surviving infants.[3] Infants with NAS face increased risk of being born underweight and with congenital abnormalities, being placed in foster care, and developing complex medical and educational needs later in childhood.[4,5] For mothers, fetal or neonatal death or the loss of child custody can result in significant emotional trauma and risk of mental illness.[6] While evidence-based guidelines to assist women with OUD with family planning exist, they focus primarily on the postpartum period after one or more infants have been potentially exposed.[7]

Most women at risk of opioid-exposed pregnancies desire more effective contraception but face barriers.[8,9] Condoms, while readily available, have high rates of failure[10] and require partner negotiation at every use, a particular challenge for women experiencing intimate partner violence or engaging in transactional sex.[11,12] The most effective contraceptive methods require a prescription or procedure, yet women with substance use disorders (SUDs) are less likely to have regular contact with primary or reproductive health care.[13] Many women also lack information about contraceptive methods, particularly long-acting reversible contraception (LARC) such as intra-uterine devices and subdermal implants. One recent study revealed that women with OUD generally considered LARCs acceptable, but lifetime use of LARCs ranged from only 5% to 12% due to limited knowledge and access.[14]

The exponential rise of opioid use in pregnancy highlights the urgent need to move beyond postpartum family planning to increase contraception access for all reproductive-aged

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women with OUD. For the vast number not connected to primary care, integrating contraceptive services into alternative points-of-contact represents a promising new harm reduction strategy. Consistent with the harm reduction paradigm, accessible contraceptive services can be designed to "meet people where they are" and offer women with substance use disorders resources to protect their health without judgment or pressure for behavior change.[15] To date, only one published intervention trial has focused on contraception access among women with OUD outside of the primary care and postpartum settings.[16] The pilot demonstrated a three-fold increase in contraceptive uptake, but faces some barriers to wider real-world implementation, including the ongoing debate surrounding the use of financial incentives for participant visits.[17,18] Related trials have integrated contraceptive services into SUD clinics for postpartum women and single-use or short-acting contraceptives (e.g., condoms, emergency contraception, and injections) into mobile syringe exchange vans.[19,20] For the high number of women with OUD or in recovery (and at high risk of relapse), new, scalable strategies are desperately needed that improve real-world contraception access while supporting personal autonomy.

We conducted qualitative formative research to identify where and how contraceptive services for women with OUD might be feasibly integrated into alternative points-of-contact. Our objectives were to (1) define core components of contraceptive services necessary to meet the needs of women with OUD and (2) identify gaps and opportunities for integrating contraceptive care into the existing landscape of health and social services that women with OUD currently access.

Methods

Setting and Participants

We conducted this study across Missouri, where years of potential life lost to opioid overdose is 20% higher than the US national average and admissions for NAS increased 350% from 2008 to 2016.[21,22] Between December 2018 and July 2019, we conducted in-depth interviews with women with current or recent OUD as well as professional stakeholders of relevent health and social service organizations (including health care providers, administrators and staff). Participants were recruited from three catchment areas: two large cities (population 500 000+) and one midsize city (population 200 000–500 000) and its surrounding rural communities.[23]

We used an iterative, purposeful sampling strategy to identify organizations serving reproductive-aged women with OUD not connected to primary or reproductive health care. We began by engaging leaders of a state-wide network of services for opioid response and continued with snowball sampling to identify related organizations in each catchment area. We recruited professional stakeholders with maximum variation sampling[24] to reach a variety of representative services, stakeholder roles, as well as geographic areas, and iterated recruitment to fill emergent gaps in the analysis.

We aimed for diverse representation of women with OUD from urban, suburban, and rural areas, with past or current OUD, with high or low engagement with service organizations, and with varying history of pregnancy and childbearing. Women ages 18 to 45 were eligible

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to participate if they reported intercourse with a male and were not currently using a LARC or prescription contraception.

Data Collection and Analysis

We conducted individual in-depth interviews lasting about 60 minutes each. Interview guides covered domains of a social-ecological model of contraceptive access and uptake based on existing literature,[25] including characteristics of services women receive for general and reproductive health care (organizational level), experiences and views of the patient–provider relationship (provider level), and personal beliefs and experiences related to opioid use and sexual health (individual level). Guides contained open-ended questions and specific probes, and interviewers were trained to use additional probes when relevant. Participants also answered structured demographic questions on drug use/reproductive health history (women), and service characteristics/clientele (professional stakeholders). At the end of the interview, participants were given a $25 gift card in recognition of their time.

Interviews were audio-recorded, transcribed, and uploaded into Dedoose software.[26] We used an iterative analysis process beginning during data collection to identify emergent themes within and across interviews.[27] After each interview, the interviewer constructed an analytic memo commenting on themes and questions for future exploration.[27] We held regular debriefing sessions to discuss emerging themes and adjust guides and recruitment to address data gaps.

We developed an *a priori* coding tree based on interview content and the social-ecological constructs.[25] Four coders conducted line-by-line coding on two transcripts, referring to the preliminary coding tree and exercising the freedom to create new codes. The team synthesized revisions to the coding tree, re-coded the original transcripts, and applied codes to additional set of transcripts. This continued until the coding tree was finalized and developed into a codebook, with definitions and examples. Early transcripts were coded by two independent coders until differences were reconciled. When coding was complete, two independent reviewers examined and summarized the outputs of quotations with each code. Lastly, we categorized relevant service organizations and then synthesized organizational- and provider-level themes into a set of components for successful care integration. We then examined coded interview excerpts in a matrix of service type and component for care integration, identifying opportunities and challenges within each. We employed multiple methods to establish the trustworthiness of findings, including member checking with two focus groups of women with OUD, review of an audit trail of decision-making by the senior author, and regular team debriefings to triangulate findings.[28]

Results

Participants and Service Organizations

We interviewed 31 participants (15 women with OUD and 16 professional stakeholders; Table 1). About half of the women were aged 25 to 35 years and most had public (60%) or no insurance (33.3%). Slightly over half reported no current sexual partners (most of whom were temporarily residing in residential recovery center), and 29% were married or living

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with a current sexual partner. A majority (85.7%) of the women were trying to avoid pregnancy, yet over half (57.1%) did not use any method to prevent pregnancy at last sex. While one-third reported LARC use in their lifetime, none reported LARC at last sex. Professional stakeholders (56.3% female) represented 13 organizations across three catchment areas (Table 2).

We classified service organizations as (1) Syringe exchange programs (SEPs); (2) Recovery support programs (recovery centers with associated recovery/transitional housing services); (3) SUD and mental health treatment programs (including inpatient and outpatient facilities, some providing medication-assisted treatment); (4) Emergency departments; (5) Federally Qualified Health Centers (FQHC, primary health care for underserved populations). We note some overlap in service types (e.g., an SEP housed within an FQHC).

Systemic Barriers to Contraception

Women and professional stakeholders acknowledged a large unmet need for effective contraception among women with OUD. While women had concerns about side effects ("I've heard bad things from my friends" [age 25–34, in active use]) and effectiveness ("I've heard that people have gotten pregnant even with it [subdermal implant]" [age 18–24, in recovery]), the most salient barriers were *awareness* of contraception options and *access* to patient-centered services.

Participants explained that active drug use can be "a pretty demanding lifestyle" where mental energy is devoted to "chasing the next high" and "birth control is not something that women really think about" (age 35–44, in recovery). Even in recovery, participants prioritized other health needs over contraception and long-term reproductive health. Knowledge of methods and where to obtain them varied widely. While a few were unfamiliar with LARCs, general acceptance of these methods was high. "If someone would have offered that [subdermal implant] to me in my addiction, I would have taken it in a heartbeat" (Program director, recovery support program).

Access barriers further compromised awareness, as most women were not connected to qualified, trusted services that offered prescription, procedural, or emergency contraception. The most clientele of services surveyed lacked health insurance or other means to cover health care costs. Women also struggled with transportation and logistics of scheduling primary care appointments. Some reported stigmatization in traditional health care settings that resulted in avoiding these sites for future care.

Overall, participants felt that integrating contraceptive services into organizations serving women with OUD would help alleviate barriers of awareness and access. One provider summarized, "If people know about it [contraceptive service], and they were able to access it easily, quickly, in a familiar place, they would absolutely utilize that resource, 100%" (Program manager, FQHC).

Integrated Contraceptive Service Components

Our thematic analysis identified six essential components for successful integration of contraceptive services for women with OUD. Services need to: (1) *reach women with unmet*

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need; (2) *provide free or affordable contraception*; (3) *maximize service accessibility*; (4) *provide patient-centered care*; (5) *employ willing, qualified contraceptive providers*; and (6) *utilize peer educators*. Table 3 summarizes opportunities and challenges of realizing these components across service organization types.

Reach women with unmet need.—Maximizing reach of women at risk of unintended pregnancies was emphasized by professional stakeholders, who estimated current or recent OUD among their female clientele between 2% (emergency department) and 95% (SUD treatment center). Across sites, professional stakeholders reported the majority of women with OUD were uninsured, often poly-substance users, and not consistently using contraception.

Reach potential appeared strongest at SUD treatment centers, recovery support programs, and SEPs. These organizations reported high unmet contraception need and serviced large catchment areas, with 5% to 45% of clients from rural areas. Syringe exchange programs served women at especially high risk for opioid-exposed pregnancies but who were already engaged in harm reduction practices. After entering recovery services, women were considered at risk due to high rates of relapse, yet because women's "heads are clearing […] they are trying to fix everything" (age 18–24, in recovery) many participants considered this time an opportune moment for women to act on broader health needs. Some women did mention frequenting emergency departments in place of primary care, yet stakeholders noted such patients may not be easy to identify or may temporarily lack the mental clarity needed to fully consider contraceptive options, especially if seeking overdose treatment.

Provide free or affordable contraception.—Women and professional stakeholders believed that providing contraception free of charge would be critical to uptake. Among organizations, free condom distribution was common but prescription and procedural contraceptives were offered on-site only at FQHCs, which also faced limitations in providing them widely and affordably. Emergency departments, SUD treatment centers, mobile units associated with FQHCs, and SEPs could all offer contraceptive referrals, but such conversations were rarely initiated. Referrals for urgent health needs and current pregnancies were more common. If contraception referrals were given, they were associated with additional barriers of cost, transportation, and wait time to get an appointment.

Cost was also a barrier for obtaining over-the-counter emergency contraception. Even as some participants emphasized early recovery as a time for sexual abstinence (only one-third of our sample reported being in a committed romantic relationship), they acknowledged the real possibility of needing emergency contraception and not being able to afford it.

> "When that partner crosses that boundary, we could ultimately be in a really bad position because Plan B is really expensive […] it's like $56 at most Walgreens. And I just don't have that. […] I just kind of had to pray for about a month"
>
> (age 24–34, in recovery).

Maximize service accessibility.—Participants explained that ensuring uptake of services is "all about convenience" (Program director, Recovery support program). Both

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women and stakeholders emphasized location convenience, short wait time, and reduced need for appointment scheduling. As one program manager explained, his center designed recovery services so that, "You don't need to bring a lot. You don't need proof of income and all those paperwork and things people just, being homeless or transient or whatever, might just not be able to get."

Access to SEPs was convenient for urban clients (no appointment required and minimal wait), yet due to concerns about possible legal ramifications, only two SEPs were operating in the state at the time of this study. Emergency departments, while plentiful, came with unique access challenges, such as long wait times. Where LARCs were available (eg, FQHCs) convenience was a noted barrier. Speaking of the difficulty linking SEP clients to other FQHC services, one provider explained, "We say, 'Well, we could probably get you in today, but it's going to be a little while.' And they're like, 'Oh. I got stuff to do.'"

To improve access to existing programs, many organizations featured well-developed outreach strategies, notably FQHC-affiliated mobile vans that serviced SUD clinics, recovery support centers, and other locations with basic urgent and primary care. Across sites, several participants mentioned mobile vans as an ideal means of reaching diverse locations. When asked the best way to reach women desiring contraception, an SEP client explained, "In our neighborhood we have a bus that comes by. It's a medical bus. […] There are a lot of youngsters and a lot of women, a service like that would be phenomenal" (age 35–44, in active use).

Provide patient-centered care.—Women emphasized the importance of patient-centeredness in the all services they access, including contraceptive care. Women defined patient-centeredness as treating them with respect, remaining non-judgmental, and providing thorough education through one-on-one counseling. Participants stressed that women with OUD may have had unique, relevant experiences to consider in contraceptive counseling, such as past abortions, children with conditions related to maternal substance use, or loss of parental custody. As one explained, "You wouldn't want the message to be like 'Oh, you don't think I can have a kid'" (age 24–34, in recovery).

When accessing care, women reported feeling stigmatized more often at hospitals or primary care as compared to organizations specializing in SUD. "I avoid going to hospitals or the doctor's office […] They always think I'm coming in for pain medication" (age 25–34, in recovery). As one recovery center manager explained, integrating new on-site health services within established, trusted organizations can be more successful than relying on outside referrals:

> "We see a lot of success bringing services to us. We've already built relationships with people. They have a huge amount of trust in us and they feel comfortable coming here, versus you maybe refer to somewhere. Even if it's nearby, even if they've been there before, the chances of getting from here through whatever hoops are necessary, even if it's a free service somewhere else, are lower than if the service would be available here."

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Participants reported some faith-based organizations may not be amendable to offering full contraception access, but the few that agreed to our interview were receptive. “Although we’re a Christian organization, I am not opposed to people taking preventive measures when they’re not prepared to have a child” (Director, Recovery support program).

Participants also emphasized privacy and confidentiality. Integrated contraceptive services would need private spaces for counseling and potential LARC insertion – a challenge noted in the emergency department. Heightened confidentiality concerns specific to this population were also noted, including worries that information about their substance use could reach law enforcement or child protective services. One service director thought while subdermal implants might be a popular option for women at her residential recovery center, providers need to ensure patients that “It’s not a tracking device. That nobody’s going to take my information and […] go to the cops.”

Employ qualified, willing, available providers.—Comprehensive contraceptive services also require providers who have the necessary qualifications, skills, comfort level, and willingness to provide counseling, prescribe medications, and perform procedures. Sites such as recovery centers and SEPs often did not employ prescribing providers and according to participants, lay providersrarely initiated contraception discussions or referrals. Some prescribing physicians, like one SUD treatment program psychiatrist, expressed willingness to prescribe contraception, but did not feel qualified or equipped to do so without additional training.

> “IUDs are so far outside of my scope of care because it would be a procedure […] But I would definitely want some at least basic refresher and training on oral contraceptives if that’s what we were going to do.”

Others, particularly emergency department providers, felt that it would be overly challenging to fit contraceptive counseling into their already constrained workflow.

Some SUD/mental health treatment programs, particularly in rural areas, utilized telehealth services to connect clients to medical practitioners. Considering contraception integration, however, participants noted limitations in time, skills, and types of contraception that could be prescribed via telehealth.

Utilize peer educators.—Participants endorsed peer educators as an essential component of contraceptive service integration. Peer providers were already active in different roles across organization types, like aiding with SUD clinic intake, working as patient advocates within FQHCs, and conducting outreach for SEPs. Peer coaches at one SUD treatment program conducted home visits, engaged social networks of clients who had previously overdosed, and navigated patients through the recovery process. One emergency department also used peers to link overdose patients to treatment. While not a standard pillar of these models, a few participants did report peer-educator referrals to reproductive health services.

Participants felt that peer educators or other lay providers with close client relationships could increase both awareness and patient-centeredness of new contraceptive services. Regarding awareness, identifying well-connected opinion leaders could disseminate

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information about services to otherwise hard-to-reach communities. “When I was actively using, we really did try to give each other information […] whenever someone gets access to information, they pass it on” (age 24–25, in recovery). According to participants, peer educators are key to patient-centeredness as they “make seeing a doctor less intimidating” (Nurse, SUD treatment program) and can serve as “someone to explain their life experience, because they’ve been through it. Someone that they can go to that they know is kind of on their level and understands” (Program manager, recovery support program).

Discussion

Aligning with expert perspective,[18] our participants believed that contraceptive service integration could improve outcomes for women with OUD by giving them better control over their reproductive health. Through our qualitative analysis, we defined six essential components to facilitate contraceptive access for women with OUD outside of traditional sites: (1) *reach women with unmet need*; (2) *provide free or affordable contraception*; (3) *maximize service accessibility*; (4) *provide patient-centered care*; (5) *employ willing, qualified contraceptive providers*; and (6) *utilize peer educators*. We also assessed opportunities and gaps for care integration within five categories of existing health and social service organizations, highlighting the need for strategic selection of alternative care settings and addressing gaps in services.

Similar studies affirm the significance of these six components as best practices. For example, integration of short-acting contraception into an SEP mobile unit for sex workers in Baltimore helped maximize *accessibility* and *patient-centeredness*.[20] Though effective in increasing access (65% of visits involved contraception provision), they did not offer *free/affordable* LARCs nor *qualified providers* to insert them. After 12 months, only 7% of those who initiated injectable contraception were still returning for their three-month dose.[29] A more recent Hawaiian program piloted contraception injections at an SEP but reported only one client who initiated injections. Authors attributed this low uptake to lack of privacy for contraceptive discussions and insufficient integration of trusted staff with the new services, highlighting the critical role of *patient-centered* service design.[30] Previous research also highlights *peer educators* as an effective strategy in helping women with OUD initiate treatment or navigate prenatal care,[31,32] and in linking SUD patients in emergency departments to harm reduction and recovery treatment.[33,34]

Our study adds to this collective knowledge, being the first to synthesize what patients and providers believe to be a comprehensive set of components needed for successful contraceptive care integration. Furthermore, interventions based on perspectives of the women themselves would be an opportune contrast to previous, sometimes controversial programs rooted in behavioral economic theory. Historically, some programs have offered financial incentives to women with SUD to discourage unintended pregnancies[35] and have been criticized as coercive. Our participants never mentioned the need to be paid to use contraceptive services but instead stressed their desire for access to care that meets their needs and allows them to choose how and when they want to prevent pregnancy. Supporting full reproductive autonomy for women also means offering complete information on all contraceptive options, including short- and long-term, to meet various needs and

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preferences. Based on our findings, we believe that patient-centered contraception care integrated into accessible, trusted environments has the potential to address an unmet need for women with OUD in a manner that also supports reproductive autonomy. Evaluating such programs could provide empirical evidence to demonstrate that women can make reproductive choices that best serve them when barriers are removed, challenging persistent biases that they need to be incentivized or restricted in their contraceptive choices.

Effectively integrating services that incorporate all six components would require selecting sites with high potential and ensuring service gaps are addressed with new programs or new linkages with existing, complementary programs. SUD-specific programs that offer reach, accessibility, and patient-centeredness may be natural partners for FQHCs or other medical organizations that can provide the training, personnel, and/or supplies specific to contraception. Peer educators active at SUD-specific sites may receive training on contraceptive education and disseminate information within their broader social networks.[36] Mobile clinics, as suggested by participants and successfully used with SEPs in the United States[37] and LARC provision in the global South,[38] are one means of making this partnership feasible. Once partners are established, resources need to be redirected to support remaining gaps in contraceptive care integration, such as developing peer educators or supporting the extension of clinical operations. On a larger scale, such provisions would be the most effective if integrated with the broader response to the opioid epidemic, which provides considerable services for pregnant and postpartum women,[39] but few, if any, to support reproductive agency prior to pregnancy.

Our study has some limitations. The service landscape of our catchment areas may not completely mirror other locales facing a similar need, thus opportunities and challenges for service integration may vary with context. Furthermore, while the components we identify are sourced from a purposefully selected sample of women and professional stakeholders, they have not been empirically tested. We also recognize that many women with OUD are not connected to any service and may have different perspectives than those we interviewed.

Giving women with OUD or early in stages of recovery more power over their reproductive choices represents would have multiple health benefits for this underserved population. As public health initiatives look to integrate contraceptive services into alternative care settings, the six components we identified may be used as a guide in selecting advantageous sites and addressing remaining gaps in services.

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So What?

What is already known on this topic?

Opioid use among pregnant women has quadrupled in the past decade, and almost nine in ten of pregnancies among women with OUD are unintended. Women with OUD have a high unmet need for effective contraception but face a number of barriers in accessing it through primary care. Experts insist that offering highly effective contraception outside of primary care is a promising strategy to increase access, but research has yet to identify where and how these services could be integrated into alternative points-of-contract to best meet the needs of women with OUD.

What does this article add?

Our study adds a framework for integrating contraception services into alternative points-of-contact for women with OUD. Through interviews with women and a variety of service providers, we identified six core components to guide programs aiming to provide contraceptive care to women with OUD outside of traditional clinical settings. Our study also points out opportunities and gaps for integrating contraception services within SEPs, recovery support programs, substance use and mental health treatment, emergency departments, and Federally Qualified Health Centers.

What are the implications for health promotion practice or research?

Health promotion initiatives looking to integrate contraceptive services into alternative care settings may use the six components we identified as a guide in selecting advantageous sites and addressing remaining gaps in services. They are (1) reach women with unmet need; (2) provide free or affordable contraception; (3) maximize service accessibility; (4) provide patient-centered care; (5) employ willing, qualified contraceptive providers; and (6) utilize peer educators. Some of these components reflect existing best practices for similar initiatives, but our framework is the first that is tailored by and for women with OUD. Future research should look to pilot and evaluate programs designed with these components.

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Table 1.

Participant Characteristics, Women With Opioid Use Disorder.[a]

Characteristic	Frequency (%)
Age category	
18–24	2 (13.3)
24–34	7 (46.7)
35–44	6 (40.0)
Race	
White or Caucasian	13 (86.7)
Black or African American	2 (13.3)
Ethnicity	
Hispanic	4 (28.6)
Educational attainment	
Some high school	5 (35.7)
High school degree or equivalent	2 (14.3)
Some college or post-high-school training	5 (35.7)
Undergraduate degree	2 (14.3)
Health insurance	
Public	9 (60)
Uninsured	5 (33.3)
Military/Veteran	1 (6.7)
Opioid use status	
In active use	5 (33.3)
In recovery	10 (66.7)
Residence	
Rural	2 (13.3)
Suburban	7 (46.7)
Urban	6 (40)
Relationship status	
Married or domestic partnership	4 (28.6)
In a committed relationship	1 (7.1)
Single	10 (66.7)
Current number of sexual partners	
None	8 (57.1)
One	5 (35.7)
More than one	1 (7.1)
Missing/declined	1 (7.1)
Current pregnancy intention	
Trying to avoid pregnancy	13 (86.7)
Would not mind getting pregnant	2 (13.3)
Contraception use at last sex	
None	8 (57.1)

Characteristic	Frequency (%)
Withdrawal	1 (7.1)
Condom	3 (21.4)
Birth control pill	1 (7.1)
Injection	1 (7.1)
Sterilization	1 (7.1)
Condom at last sex	
Yes	2 (14.3)
No	12(85.7)

[a] n = 15.

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Table 2.

Participant Characteristics, Professional Stakeholders.[a]

Characteristic	Frequency (%)
Age category	
18–24	1 (6.3)
24–34	4 (25.0)
35–44	6 (37.5)
45–54	3 (18.8)
55+	1 (6.3)
Gender	
Male	7 (43.8)
Female	9 (56.3)
Role	
Medical provider	6 (37.5)
Mental health/social work professional	3 (18.8)
Organizational leader/coordinator	7 (43.8)
Organization type[b]	
Syringe exchange program	3 (18.8)
Recovery support program	5 (31.3)
SUD and mental health treatment program	7 (43.8)
Emergency department	2 (12.5)
FQHC	4 (25.0)
Percent clientele from rural areas	
10% or less	5 (31.3)
11–25%	5 (31.3)
26–50%	6 (37.5)
Percent clientele from suburban areas	
10% or less	3 (18.8)
11–25%	4 (25.0)
26–50%	6 (37.5)
51 % or more	2 (12.5)
Percent clientele from urban areas	
10% or less	4 (25.0)
11–25%	1 (6.3)
26–50%	5 (31.3)
51 % or more	6 (37.5)

Abbreviation: FQHC, Federally Qualified Health Centers; SUD, substance use disorder.

[a]n = 16.

[b]Not mutually exclusive.

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Table 3.

Potential for Contraceptive Care Integration in Existing Health and Social Services.

	Service type				
Service components	**Syringe exchange programs**	**Recovery support programs**	**Substance use and mental health treatment programs**	**Emergency departments**	**Federally Qualified Health Centers**
Reach target population	*Opportunities:* Reaches women in active use with high unmet need for contraception; *Challenges:* Transient population from larger catchment area may present challenges to follow-up for contraceptive care	*Opportunities:* Serves women with recent SUD with high unmet need for contraception who have already taken an active step in improving their health; *Challenges:* May not be serving harder-to-reach populations; Clients in recovery may not be at immediate risk for opioid-exposed pregnancy (but the relapse rate is high)		*Opportunities:* Reaches women who are not well connected to primary care services and may have risk factors for opioid-exposed pregnancy; *Challenges:* Target population may not want to spend additional time in the department or may not be in a state to consider contraceptives	*Opportunities:* Reaches population with no other health insurance or primary care; *Challenges:* Unmet need for contraception may be lower among patients already connected to services
Provide free or affordable contraception	*Opportunities:* Some may offer free condoms to clients; *Challenges:* May not have any infrastructure for contraception prescription/insertion procedures		*Opportunities:* May have prescription capabilities for contraception; *Challenges:* Contraception not part of typical patient care		*Opportunities:* Wide range of contraception available; *Challenges:* Some methods, particularly LARC, can still be cost-prohibitive to clients
Maximize accessibility	*Opportunities:* May have well-developed outreach services; *Challenges:* Access barriers due to few established centers, limited to one urban location in our catchment area	*Opportunities:* Existing in-house health/social services extremely accessible services to residential clients; *Challenges:* Access requires intake, admission and retention in long-term programs	*Opportunities:* Large number of sites to access, particularly in urban areas, some with multiple locations; *Challenges:* Requires in-take, depending on organization, may be time-consuming or costly for patients	*Opportunities:* May be available in more rural areas; Open anytime *Challenges:* May have long waiting times	*Opportunities:* May have well-developed outreach services (such as mobile clinics); *Challenges:* Accessing existing sexual and reproductive health services may require scheduling and securing transportation
Provide patient-centered care	*Opportunities:* Well-developed, trusted relationship with hard-to-reach population of active users; *Challenges:* May require additional space or considerations to ensure privacy for contraceptive services	*Opportunities:* Specialize in SUD, extended relationships with patients, perceived as less stigmatizing of OUD; *Challenges:* Some faith-based organizations may have policies or practices around promoting contraception		*Challenges* Some women with OUD report feeling stigmatized by ED providers; Less privacy for contraceptive counseling and care	*Opportunities:* Wide range of services and experience with diverse populations; *Challenges:* Competing patient needs means contraception counseling may not always be prioritized
Employ qualified, willing, available providers	*Challenges:* Few, if any, qualified clinicians available to prescribe contraception		*Opportunities:* May already employ health professionals able to potentially able prescribe contraception; *Challenges:* Limitations in time, skill, willingness and/or space for existing providers to take on these services		*Opportunities:* Clinicians have basic training in counseling and prescribing contraception; *Challenges:* Clinicians typically have many other duties/care priorities, may have gaps in contraceptive care skills
Utilize peer educators	*Opportunities:* Formal and informal peer outreach leaders help connect women with OUD to service; *Challenges:* Peers may not have	*Opportunities:* May employ peer specialists; Informally, peer leaders further along in their recovery provide support to other women;	*Opportunities:* Some peer education, patient navigation or outreach models targeting SUD reduction have been successfully integrated in these settings; *Challenges:* Peers may not have adequate knowledge about contraception or may have biases or misconceptions		

	Service type				
Service components	**Syringe exchange programs**	**Recovery support programs**	**Substance use and mental health treatment programs**	**Emergency departments**	**Federally Qualified Health Centers**
	adequate knowledge about contraception, may have biases or misconceptions	*Challenges:* Peers may not have adequate knowledge about contraception, may have biases or misconceptions			

Abbreviations: ED, emergency department; LARC, long-acting reversible contraception; OUD, opioid use disorder; SUD, substance use disorder.

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