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Executive summary

The Society of Family Planning Research Fund (SFPRF) completed a priority setting (PS) process over June-September, 2014. With the overarching goal of identifying gaps and priority areas to guide research investments, SFPRF adapted a prominent PS methodology to shape deliberations among family planning (FP) content experts. This process created a number of outputs, including a master list of priorities for the field (and for specific topics), and recommendations for strengthening skills and approaches across the FP research community. The process provided for open dialogue and flexibility that helped create a strong consensus among FP experts on top research priorities.

A management team composed of SFPRF’s Executive Director, Grants Officer, and an external consultant adapted—with support from a feedback group—the PS methodology pioneered by the Child Health and Nutrition Research Institute (CHNRI). This process asked topic-area experts to brainstorm potential research priorities, then score those priorities using a specific set of criteria. During this criteria application step, each group ranked their priority issues from top to bottom and reviewed those weighted lists. Group leaders then met to determine the top priorities for the FP field, which are presented along with secondary priorities in Appendix A.

The process involved a flexible methodology to accommodate the compressed timeframe and the available expertise, and developed a number of feedback loops to ensure regular process reflections and modifications. Given the scant body of PS work that exists for research, this PS process required a number of innovations. As a result, this work will inform not only funding decisions for the FP field, but the field of PS itself. The innovations adopted provide sound evidence and experience applicable to other research disciplines.

Background

This document reports on the research priority setting (PS) process undertaken by the Society of Family Planning Research Fund (SFPRF). Intended to inform funders, the SFPRF board and SFP fellows, this report discusses how the PS process has developed consensus around top research priorities in the family planning (FP) field. SFPRF’s attention to priority setting was first noted in the 2011 external evaluation of its research grants program (Seltzer, 2011). Among other things, that evaluation elicited a number of comments from grantees about SFPRF’s existing research priorities. Grantees suggested that funding priorities address “big picture questions regarding provision, determinants of contraceptive choice, the state of public programs for reproductive health services, and variations across communities.” (Seltzer, 2011).

In response, SFPRF’s Board formally recommended that the organization develop a set of priorities to guide its funding decisions. To that end, SFPRF hired a consultant in
June, 2014, to lead their PS process. Following a thorough review of existing research priority setting methods (see, for instance, Campbell, 2012), SFPRF and the consultant determined that the process would best benefit from a customized version of the PS process created by the Child Health and Nutrition Research Institute (CHNRI). This method would allow for informed deliberation, application of criteria in weighting priorities, adaptation to reflect the various disciplines and perspectives of SFPRF’s core stakeholders, and accommodation of the two principal constraints of the process—a compressed time frame and reliance on email for communication.

Over July, August and early September, 2014, ten different topic-area groups brainstormed possible priorities relevant to their group, using criteria to reduce and sharpen their priority lists. The process culminated in a face-to-face meeting of group leaders on September 12, 2014. The meeting helped to finalize both a Top Priorities list, capturing the most urgent priorities for the wider FP field, and a Secondary Priorities list, derived from the work of nine of the topic-area groups (for both lists, see Appendix A). A tenth topic-area group developed specific recommendations for strengthening the FP research community (see Appendix B).

Evaluation of the SFPRF process is still ongoing. The findings (to be completed by mid-October) will be presented in a peer-reviewed paper analyzing how SFPRF achieved their results, how the SFPRF results can inform best practices for the FP field, and what the results imply for the broader body of work related to research priority setting.

**Research priority setting**

While priority setting (PS) processes have existed for decades, they have most often focused on helping health care institutions determine priority interventions to offer clients. Priority setting as a tool to determine health-related research agendas is a much more recent approach. Its primary purpose is to inform funding decisions, using scientific processes to help core stakeholders assess the issues that require new or increased funding support (Campbell, 2012). To date, the leading methodology to determine research priorities is from the Child Health and Nutrition Research Institute (CHNRI), whose work was initially supported and developed by the World Bank in 2001. Using various deliberative tools and techniques in the application of criteria—often done virtually—this methodology has successfully identified priority research issues in child health (see Rudan et al, 2008), in global mental health (see Tomlinson et al, 2009), and most recently in global reproductive health (see Ali et al, 2014).

The CHNRI methodology is most helpful in structuring brainstorming among a group of experts working in different locales, subjecting the results of that brainstorming to various criteria, and determining the relative value of all issues on a priority list (Rudan et al, 2007). For all research issues, the criteria help to assess these factors:
- **Magnitude, relevance and urgency**—Is research on the issue required within the next three to five years? (El-Jardali, 2010). Will the research issue still be a priority in five years’ time? (Alliance for Health Policy and Systems Research, 2009)

- **Applicability, deliverability, affordability, sustainability** (Rudan et al, 2007)

- **Maximum potential to reduce disease burden equitably** (Rudan et al, 2007; Baltussen and Niessen, 2006)

- **Originality**—Is the issue under-researched, or is there an existing knowledge base? (El-Jardali, 2010)

- **Research capacity and feasibility**—Do capacities exist to do the research? Is the research feasible financially, technically, socioculturally and ethically? (COHRED, 2006; Rudan et al, 2008)

- **Policy relevance** (El-Jardali, 2010); and

- **Expected impact**—Will the intended impact of the research justify its cost? (COHRED, 2006).

### Priority setting methodology

SFPRF hired a consultant to design and lead the process, adapting the CHNRI methodology as needed. The consultant’s role included tasks such as managing information, providing focus prompts to stimulate dialogue, creating criteria, tallying criteria scores, and resolving regular process challenges or modifications. A management team (including the consultant and SFP Research Fund’s Executive Director and Grants Officer) was formed, which in turn created a feedback group to provide guidance to the process and resolve any process issues or modifications. The feedback group included Dr. Moazzam Ali (leader of the World Health Organization’s 2014 CHNRI-informed process to gather global reproductive health priorities); Dr. Lydia Kapiriri (a professor at McMaster University in Canada and a global expert on PS processes, including their evaluation); and the SFPRF Executive Committee.

In adapting the CHNRI methodology, the management team faced two constraints. The first was a highly compressed timeline—the process had a fixed completion date of mid-September, 2014. This timeline provided only two and a half months from start to finish, much shorter than other CHNRI processes. The second constraint was the communications channel. Email, which the SFPRF process relied on due to the timeline and geographic separation of participants, has some disadvantages in promoting open dialogue. In particular, individual email communication styles differ, and deliberative nuances can be easily lost.
A research issue describes an issue from the project level, which might be explored through multiple research questions.

A research question typically describes an issue explored by a specific intervention for a specific population over a specific timeframe, whereas a research issue is more general in its statement of a problem, theme or dynamic.

The group chose the third bullet—“What can improve the safety of 2nd trimester abortion?”—as the level of primary inquiry to pursue, with the second bullet serving as a possible illustrating example.

As the SFPRF board of directors felt that specific topic areas required detailed exploration to identify overall priority issues for the field, it decided at the outset to create ten different topic-area groups, each with two co-leaders:

- Adolescent Sexual and Reproductive Health
- Biomedical Research
- Equity in Reproductive Health Research
- Global Family Planning Research
- Health Services Research
- Innovation-driven Research
- Patient-Centered Outcomes Research
- Public/Institutional Policy Research
- Research on Stigma
- Strengthening the Research Community

**PS process design**

Figure 1 on the facing page illustrates the 13 separate steps of the PS process. An initial survey was administered to all SFP fellows, requesting that they identify potential research priorities and research gaps both for the FP field in general and for any specific topic-area group. Topic-area leaders and a number of outside experts participated as well. This step resulted in an extensive list of raw priorities designed to prompt and focus initial deliberation among the topic-area groups.

On July 28, the work of the topic-area groups began. Each group was tasked with:

- agreeing on the definition and scope of their group (see Appendix C);
- reviewing the priorities identified by SFP fellows (e.g., are the survey-identified priorities reasonable? Strong? Requiring qualification or re-organization?)
- initiating group brainstorming on gaps and priorities relevant to their group’s scope.

Some groups arrived quickly at a definitional consensus—typically, those groups with established parameters related to their mandate—while others required more time to determine their group’s exact focus. Some topic-area groups had immediate agreement on the types of research issues they should prioritize; others discussed the concept of a research issue in much greater depth. The Global group, for instance, used the following example to build consensus on their desired level of detail and area of inquiry:

- a. Is Laminaria or Dilapan better for cervical prep in 2nd trimester abortion procedures?
- b. What is the best way to prepare the cervix for 2nd trimester abortion procedures?
- c. What can improve the safety of 2nd trimester abortion?
- d. Second trimester abortion.
The management team shared this example with several other topic groups requiring some resolution or insight on the desired level of inquiry.

In early August, the topic-area groups began creating extensive lists of priorities. Some used teleconferences to review their brainstorming progress and determine their next steps. All went through a process of funneling priorities—discarding some, condensing others—and sharpening their focus in preparation for the criteria application step. Figure 2 on page 6 shows the steps groups used in moving through the PS process.

### PS criteria application

With ample time and resources (e.g., see Rudan, 2009; Kapiriri et al, 2007; Tomlinson et al, 2011; Campbell, 2010), the deliberants in a PS process may determine as a group the criteria they wish to apply in comparing all research options. A step such as this one allows the group to discuss an ideal type of research and then design criteria that, when applied, rank issues relative to that ideal.

Because of the time constraints associated with the SFPRF process, the management team wanted participants to be able to focus their time and expertise on identifying priority issues. In consultation with the feedback group, the management team therefore took on the job of determining the criteria that the groups would apply to their
lists of research issues. The criteria selections were informed by a literature review of criteria used in similar PS processes (e.g. Ali et al, 2014; Rudan et al, 2007; Campbell, 2012). Six criteria were established:

- **Answerability.** How likely is it that research objectives will be met over the next three-five years, given the current state of science and knowledge on the topic?

- **Relevance and urgency.** How likely is it that potential research on the issue will generate relevant and/or urgent knowledge?

- **Applicability and sustainability.** How likely is it that the research will generate results that are applicable and sustainable for clinical practice, community/local/state/national/ institutional policies, health interventions, and/or health programs?

- **Equity.** How likely is it that the research will generate results that will benefit vulnerable and/or underserved populations?

- **Positive effects on health outcomes.** How likely is it that the research will generate results that will lead to positive improvements in health outcomes?

- **Innovation.** How likely is it that the research will generate truly innovative knowledge?

In mid-August, groups began the criteria application step. Seven of the groups used the criteria that the management team and feedback group had identified. Two groups—the Innovation group and the Strengthening group—didn’t require the criteria application step. Due to the inherent differences related to biomedical research, the leaders of the Biomedical group selected four slightly different criteria that its members applied to their priorities:
Answerability. How likely is it that research objectives will be met over the next three-five years, given the current state of science and knowledge on the topic?

Significance and relevance. Will the research findings have high impact and applicability for the field?

Translation from basic research to clinical. Will potential research on the issue be easily or effectively translated for clinical use?

Positive effects on health outcomes. How likely is it that results from potential research will lead to positive improvements in health outcomes?

Priority scoring

Group participants applied the above criteria to each research issue on their priority list, scoring a 2 if they felt the research issue was “highly likely” to satisfy the individual criterion; a 1 if they felt the research issue was “likely” to satisfy the individual criterion; and a 0 if they felt the research issue was “unlikely” to satisfy the individual criterion. The following table shows how an individual research issue might be scored:

<table>
<thead>
<tr>
<th>1. Improving patient counseling and provider-patient communication in contraceptive and abortion care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answerability</td>
</tr>
<tr>
<td>Participant 1</td>
</tr>
<tr>
<td>Participant 2</td>
</tr>
<tr>
<td>Participant 3</td>
</tr>
<tr>
<td>AVG TOTAL</td>
</tr>
</tbody>
</table>

TOTAL SCORE = SUM OF AVERAGES/6 = 1.33

The management team then tabulated the scores for each research issue by adding the average scores per criterion and then dividing by the total number of criteria. While there are other ways of arriving at a score, the use of this method of averages provided a quick and accurate snapshot of group consensus on the relative value of any given research issue.

The criteria application step resulted in a ranked list of research issues for each topic-area group, from top (highest average score) to bottom (lowest average score). Most groups then had a teleconference to discuss their results, reviewing the ranking itself; ways to condense, combine or delete priorities; and, for some, ways to organize priorities into higher-level thematics. The groups finalized their lists in advance of SFPRF’s September 12, 2014, expert panel meeting of the PS group leaders. (See summary of the expert panel meeting on page 8.)
**Topic-area group modifications**

All groups modified the PS process to their own ends, chiefly to account for participant abilities, timing considerations, content matter, and the available communications channel. The management team allowed these modifications in an effort to balance the rigors of the methodology with the realities of a group’s ability to deliberate effectively.

In one notable modification, the Equity in Reproductive Health Research group recommended surveying the wider advocacy-oriented community for perspectives on the group’s initial list of priorities. To that end, the management team designed a survey with the group’s initial list of priorities and sent this to a few hundred researchers, activists and community leaders in the field. Results from the survey provided the group with another layer of detail informing their work and decision making. The survey also contributed directly to the group’s development of advocacy messages for reproductive health funders (see Appendix D).

**Expert panel meeting**

On September 12, 2014, most of the group leaders, along with two SFPRF Board representatives not involved in the PS process and three representatives from a foundation, met in Philadelphia. The meeting represented the culmination of the PS process. During the morning session, each group presented its list of priorities and discussed the specific challenges they had encountered and the ways in which they had responded to those challenges.

During the afternoon session, those present voted on the top three priorities from each group, from first to third. A first-place vote was worth 3 points, a second-place vote 2 points, and a third-place vote 1 point. Scores were totaled and then averaged for each research issue to identify the top three priorities per group.

These top three priorities per group were then transferred to the Top Priorities list to reflect core priorities across the entire FP field. In the immediate follow-up to the meeting, the management team refined the list by collapsing and condensing priorities and ensuring a similarity of language and level of inquiry. Most priorities are now expressed in two ways: at a higher thematic level capturing the major research gap or dynamic and as specific sub-bullets illuminating precise areas of research inquiry. The Top Priorities list and the Secondary Priorities list identified by groups are included in Appendix A.
Innovation-driven research

This particular group evolved differently from the others. SFPRF encouraged the group to think about “blue-skies” research, exploring approaches or issues in the field of FP research where time, funding and capacity would not act as constraining factors. This group did not arrive at a final list of priorities determined by applying criteria. However, it did generate a number of important ideas (as seen in Appendix A) that were strengthened at the meeting of experts.

Strengthening the FP research community

Early in the process, the feedback group decided that since SFPRF planned to identify research priorities, one specific group should focus on the complementary issue of FP researchers’ career development needs. The Strengthening group was charged with identifying approaches, techniques and ideas to advance capacities in the FP research field. The group also discussed specific ways of strengthening the research skills of individuals by providing concrete experiences for young and mid-career researchers, as well as developing necessary infrastructures for the wider FP research community. Two prompts assisted in facilitating the discussions: “If resources were not a constraint, how could we best strengthen the FP research community?” And “How can we make it worthwhile for young researchers to enter and stay in the FP field?”

Discussion details, including specific recommendations generated at the face-to-face meeting, are available in Appendix B.

PS process: Challenges

One challenge of the SFPRF PS process was to be responsive to the needs and realities of the ten different topic-area groups while remaining true to the chosen PS methodology. Achieving this balance was crucial to effective dialogue and to satisfying participant expectations and utilizing their abilities—but it created in turn two connected process challenges.

The first process challenge was the need for regular and time-intensive work by the management team and group leaders to design and implement the process modifications. These process modifications led directly to the second challenge—the difference between the various groups’ priorities in terms of their level, language and focus. With slightly different processes as a guide, each group chose to either combine their priorities into high-level themes or separate them into specific research issues. While this posed no issue for the creation of specific group lists, it posed a genuine
challenge when combining priorities into the Top Priorities list, where priorities needed to be expressed at the same level using similar language.

At the expert panel meeting, participants decided that the Top Priorities list should focus on high-level themes, with each theme illustrated through examples. It required intensive follow-up by the management team to resolve level and linguistic differences among the priorities, providing much-needed consistency.

A final challenge arose through the use of email as the dominant communications platform. For all its ubiquity and utility, email as a deliberative tool has some prominent shortcomings, principally the loss of nuance, detail and the possible bias from and overemphasis of, for instance, a particularly prolific writer’s opinion. This challenge was largely mitigated through a combination of regular phone calls, teleconferences, and the face-to-face meeting. It was clear, however, that priority setting relies on a thorough examination and exploration of themes, ideas and evidence to avoid bias and assumptions—and that routine verbal communication and fora are essential elements of this process.

Conclusions and next steps

Given the scant body of work in PS for research, the SFPRF-driven process explored significant uncharted territory, with little evidence or experience to draw upon at its decision points. Ultimately, the environment created some important developments.

First, dividing the FP field into ten topic-area groups allowed for more nuanced discussion on specific issues and themes. While doing so created challenges, this type of in-depth, critical deliberation was essential for a thorough identification of priorities across the field. Dividing a specific field into focused groups has—to our knowledge—never been attempted before, and is a facet of this PS process that deserves more study and experimentation.

Second, adopting a flexible facilitation approach to modify process issues as needed (to balance creativity, expediency and methodological rigor) allowed groups to take advantage of their strengths and capitalize on the time and expertise participants could realistically offer. Effective PS processes must manage information and the experts involved in the process. SFPRF’s hands-on facilitation effectively created a deliberative atmosphere that routinely added merit to the generated knowledge through flexible but firm rules. Taking this type of hands-on approach adds to the costs—financial, time, and human resources—but is critical to ensure a balanced and effective process.

Third, the PS process created and maintained invaluable feedback loops to ensure constant monitoring of the process, the various modifications, and the final lists of priorities. The face-to-face meeting near the conclusion of the process provided a
venue for FP experts to shape the final outcomes. An evaluation will capture participant feedback, and this feedback and the resulting outcomes will contribute to the FP research field. In addition, it will make a strong contribution to the literature on PS, and to other research disciplines considering a prioritization process.

There are several next steps for the SPFRF PS process:

- Disseminate the final list of priorities to stimulate additional discussion and dialogue among SFP fellows and other stakeholders;
- Disseminate the final list and specific funding recommendations to other funders in the field;
- Design requests for proposals (RFPs) and other SFPRF funding mechanisms focused on the priority issues; and
- Write a peer-reviewed paper or papers that detail not only the outputs (e.g., the priority lists) but the process itself. Given the high level of customization and the many feedback loops, this process has much to offer the PS field and research in general.

Finally, the SFPRF board of directors and senior management team would like to sincerely thank the SFP fellows, grant reviewers, outside experts, and community advocates who volunteered their time and expertise to the process (see Appendix E). We would also like to gratefully acknowledge the foundation support that enabled the research priority-setting project.
**References**


APPENDIX A: List of research priorities

Top priorities (in no order)

1. Developing and/or validating measures that can be used to gauge and evaluate patient-centered outcomes in family planning
   - Quality-of-life measures for unintended pregnancy (UIP) and abortion
   - Patient satisfaction measures in reproductive health (e.g., measuring satisfaction with contraceptive methods, abortion experience, miscarriage management, satisfaction with reproductive health care experience)

2. Improving patient counseling and provider-patient communication in contraceptive and abortion care
   - Best practices for the provision of quality counseling in family planning (e.g., contraception, pregnancy options, abortion, and miscarriage management)
   - Influence and effectiveness of communication/counseling methods to improve reproductive health (e.g., evaluating patient preferences, patient and provider outcomes, and identifying strategies to improve interactions)
   - Measurement tools to improve the evaluation of counseling quality
   - Issues of patient-provider trust, provider bias in reproductive health recommendations (e.g., genetic testing, contraception, fertility testing) and women’s perceptions of provider recommendations

3. Characterizing women’s preferences for and acceptability and use of abortion and contraceptive methods
   - Contraceptive preferences, use and experiences (e.g., side effects, sexual function, method satisfaction), and their influence on method choice and method use
   - Preferences for medical vs. surgical abortion (including first and second trimester)
   - Management of miscarriage
   - Pain management preferences for abortion
   - Access of abortion outside the healthcare system despite legal access

4. Integrating family planning services into primary care, including system changes and provider/workforce training issues
   - Expansion of workforce/providers who are able to provide family planning services
- Strategies to improve integration of family planning into primary care (e.g., reproductive life plans, preconception care)
- Effects of integrated care on health and quality outcomes, particularly for women with chronic conditions

5. Improving clinical effectiveness, safety, and quality of abortion and contraceptive care

- Benefits/harms of routine antibiotic prophylaxis with medical abortion
- Safety of deep sedation/general anesthesia for D&E abortion
- Cervical preparation for D&E
- MVA and misoprostol to eliminate sharp curettage in low-resource settings
- Abortion in women with medical conditions
- Triage of women who can have abortions in outpatient versus hospital settings
- Effectiveness of induced abortion/early pregnancy loss with medication methods
- Postpartum versus interval placement of LARC
- Bridging emergency contraception (EC) to effective ongoing contraception (especially in pharmacies or other non-clinical settings where EC is provided)
- Weight/BMI and efficacy of emergency contraception
- Use of LARCs to delay first birth

6. Exploring how institutions and policies marginalize groups and, thus, the impact this has on reproductive health

- Intersection of reproductive health with the criminal justice system, foster care, public assistance, and child protective services, particularly as they differentially impact communities of color and poor communities
- Connections between immigration policies, family planning, and economic justice (e.g., reproductive health care needs for women in immigration detention)
- Impact of abortion and contraception restrictions on communities of color, poor, or rural communities (e.g., families’ economic hardships, education continuation)
- Conscientious objection to family planning care/coverage: prevalence; motivation; effect on individuals and health systems
7. Assessing how coercion, autonomy, and power dynamics within the medical establishment have an impact on women's reproductive health

- Balance between advocacy for safe, effective methods of birth control and coercion (e.g., perception of LARC among communities of color, immigrant communities, and other vulnerable populations)
- Sterilization barriers versus coercive sterilization
- Impact of social justice on working to end reproductive-related discrimination

8. Broadening reproductive health research models to include a reproductive justice framework.

- Evaluating reproductive health research through a reproductive justice lens and involving advocates and communities of color in research agenda setting and implementation
- Research on the prevalence, causes of, and strategies to reduce disparities in reproductive health

9. Developing/assessing new opportunities, novel settings, and new ways of delivering FP services (i.e., contraception and abortion) to adolescents

- Novel settings to reach adolescents (e.g., non-clinic or school-based, could include online, mail, and consider new approaches to information sharing)

10. Identifying the factors that influence adolescent and adult males' access to, provision of, and acceptance of their role in FP (their own contraceptive use, pregnancy and abortion decision making, female contraceptive decision making)

- Baseline data on males and contraception, abortion, abortion decision making
- Methodological issues for dyadic research (males and females)

11. Investigating how adolescents’ social and interpersonal relationships positively or negatively affect their family planning decision making and behavior (including abortion and contraception)

- Novel approaches (e.g., methods of data collection, social networks, dyadic analyses) to expand the knowledge base and inform intervention development or tailoring
12. Investigating task-shifting concepts and strategies that support the de-medicalization of abortion and contraceptive care

- Novel contraceptive methods which respond to concerns over provider-controlled methods (i.e., self-removable IUD) to shift power from health care providers to women
- Safe, effective, and accessible abortions for women seeking services outside the healthcare setting
- Safety and risk of self-administered misoprostol versus mifepristone + misoprostol when used outside the healthcare setting
- Access to medical abortion, especially in resource-poor and legally restricted settings
- Women’s ability to assess their own eligibility for medical abortion

13. Investigating abortion access and advocacy, especially in highly restricted environments/regions

- Harm-reduction strategies through collaborations with ministries of health, private sector, etc.
- Barriers to decreasing restrictions in abortion-restricted environments and possible strategies to navigate these restrictions
- Impact of restrictive laws, policies and regulations on access to and use of family planning services, including restrictions on off-label use of medications
- Barriers to care in newly decriminalized environments
- Recruitment and retention of abortion providers

14. Describing and measuring stigma experiences, impact, and outcomes

- Relationship between intersecting stigmas and reproductive outcomes
- Consequences of abortion stigma(s)
- Gaps in existing abortion stigma measurement tools, including determining which tools work best in diverse settings
- Impact of abortion stigma on social, psychological, economic, and health outcomes (e.g., educational achievement, delay of marriage for adolescents, maternal morbidity and mortality)
- Differences in abortion stigma experiences across geographical and institutional settings
- Relationship between abortion stigma and health care related policy
- Impact of abortion stigma on public discourse, attitudes, and media representations
15. Developing and evaluating interventions to reduce and manage reproductive health stigmas

- Strategies to manage, cope and/or reduce abortion stigma
- Abortion care training, health worker training, media campaigns and their impact on abortion provision stigma

16. Assessing the impact of government policies, including the ACA, on access to care and subsequent outcomes

- Best practices for conducting research on new restrictions (timeliness, community collaboration, best methods for rapid response)
- Barriers to contraceptive access due to insurance policies (i.e., patients needing to order their own methods, inability to bill Medicaid for post-placental IUDs, barriers to provision of refills, etc.)
- Impact of federal, state, and local sex education policies

17. Assessing the impact of non-governmental institutional policies on training and providing family planning services

- Institutional policies on training family planning providers
- Hospital and health systems mergers involving faith-based providers
- Religious exemptions to family planning care and coverage

18. Assessing the impact of insurance practices on access to and use of family planning services

- Restrictions on services and reimbursement (e.g., adequacy of reimbursement, bundling of services postpartum, etc.)
- Medical management policies (e.g., 12-month supplies, prior authorization, etc.)
- Scope and adequacy of provider networks (e.g., are abortion providers in network?)

19. Investigating biomedical aspects of abortion and contraception

- Novel approaches to post-fertilization mechanisms (including methods that act on the endometrium)
- Mechanisms and management of non-contraceptive benefits and side effect for males and females
- Novel hormonal and non-hormonal contraceptive methods for males and females
20. Measuring unintended pregnancy and its impact on health, economic, and policy outcomes

- Optimal measurement and conceptualization of unintended pregnancy (e.g., one or more dimensions, feelings vs. stated intentions, ambivalence)
- Disparities in unintended pregnancy across racial/ethnic groups (e.g., factors underlying differences, insights to help with prevention)
- Impact of unintended pregnancy rates on maternal and child health outcomes (e.g., methodological issues, potential pathways/mechanisms)
- Relationship of unintended pregnancy to contraceptive desires and use (e.g., difficulty implementing contraceptive plans, male partner contribution and coercion, influence of sexuality/sexual pleasure)

Secondary priorities (in no order)

Adolescent sexual and reproductive health research

1. Identifying barriers, facilitators, and effective interventions for delivering LARC to adolescents and determining ways LARC might be over- or underutilized

2. Providing high-quality, patient-centered reproductive health care for adolescents, including distinct populations (e.g., people of color, sexual minorities)

3. Assessing effective strategies for improving adolescent-specific family planning outcomes (e.g., delaying first birth)

4. Utilizing technology to improve family planning services and research approaches for adolescents

5. Improving postpartum and post-abortion contraceptive services for adolescents

6. Identifying factors that influence trends (e.g., community-level, state-level, country-level) in adolescent sexual and reproductive health outcomes (e.g., pregnancy, birth, abortion)

7. Identifying the factors that influence uptake, continuation, and discontinuation of contraception among adolescents (particularly postpartum, post-abortion, and parenting adolescents)
8. Investigating understudied factors (e.g., knowledge, access, cost) that influence abortion (e.g., choice, procedure preferences, timing, service location) among adolescents

9. Identifying the counseling methods most effective for adolescents to improve family planning, contraception, and pregnancy outcomes

10. Assessing the safety, efficacy, side effects and non-contraceptive benefit profile of hormonal contraception in specific adolescent populations

11. Investigating the pharmacokinetic and physiologic effects of contraceptives on specific adolescent populations

12. Identifying the factors that influence the interrelationship between STI and pregnancy prevention behaviors among adolescents and how this body of knowledge can inform integrated services, interventions, and research approaches

**Biomedical research**

1. Developing approaches that extend/enhance the effectiveness of existing methods of contraception and abortion

2. Investigating contraception related to breastfeeding women

3. Addressing research gaps identified in the United States Medical Eligibility Criteria (US MEC)

**Equity in reproductive health research**

1. Investigating the reproductive health needs of underrepresented communities
   - Disparities, access, and experiences of contraception, abortion, prenatal care, and ART on historically underrepresented communities (i.e., Asian American, broken out further by ethnicity; Pacific Islander; LGBT; Native American; people living with disabilities; rural)

2. Developing strategic alliances to further equity in reproductive health
   - Connections between environmental justice and the impact on women’s fertility, ability to raise families in a safe environment
   - Strategies to ally FP advocacy and clinical practice with other related reproductive justice efforts
Global family planning research

1. Improving access to contraceptive services
   - Integration of contraceptive services with postpartum care, particularly immediate postpartum provision of IUDs and implants
   - Impact of current LARC-focused efforts (safety, acceptability, effectiveness) to ensure women have choices
   - Sterilization—demand, barriers to access, service delivery models in resource-poor settings
   - Integration of FP services in emergency settings

2. Improving access to later abortion, especially in resource-poor settings
   - Use of mifepristone in second trimester induction in legally restricted settings for legal indications
   - Relative safety, effectiveness, acceptability and cost-effectiveness of surgical vs. induction services in restricted and permissive environments
   - Public health impact of increased access to high-quality later abortion services

Health services research

1. Defining and developing metrics for quality assessment in contraception and abortion care
   - Interpersonal and technical quality of contraceptive counseling
   - Interpersonal and technical quality of abortion care
   - Performance targets (e.g., contraceptive protection index)
   - Performance measures and targets in family planning to improve the quality of care across different health systems
   - Capturing abortion data in health information systems
   - Delays in access to desired services
   - Effects of incentives for quality services (e.g., meaningful use of Electronic Medical Records EMR, pay for performance)
Innovation-driven research

1. Identifying and assessing innovative mechanisms for the provision of contraception
   - Over-the-counter (OTC) access to hormonal methods (measure change in uptake and continuation)
   - Community-based distribution of contraception in the United States

2. Identifying and assessing innovative mechanisms in the provision of abortion care
   - Access to mifepristone/misoprostol OTC and at non-medical sites

3. Evaluating the effectiveness of innovative abortion methods
   - Use of plant-based abortifacients (such as rue or pennyroyal)
   - Use of copper IUD insertion for abortion at <35 days

4. Determining innovations in abortion training
   - Simulators to increase skills in later abortion care

Patient-centered outcomes research (PCOR)

1. Identifying strategies for creating meaningful stakeholder/patient engagement in family planning research

2. Identifying strategies to improve women’s experience with FP procedures (e.g., for pain management with IUD insertion, medication and surgical abortion)

3. Evaluating the effectiveness of family planning interventions (e.g., counseling strategies, contraceptive methods)

Public/institutional policy research

1. Investigating how family planning issues are framed or communicated and how this influences public opinion

2. Assessing the impact of availability of services on access to and use of care
   - Scope of practice policies
   - Geographic parity of abortion providers and services available
   - Effective referral and transportation networks
   - Waiting times, other aspects of the provision of services
3. Assessing the impact of minors’ consent/confidentiality policies on access/use of care

4. Assessing the impact of policies on use of contraception and abortion among the underserved and ways to improve access

5. Translating research into practice
   - Translation of research findings into policies
   - Communication with policymakers to inform a research agenda
   - Dissemination of best practices and implementation science

6. Increasing male access to use of and involvement in family planning
   - Access to and use of vasectomy
   - Access to and use of condoms
   - Male involvement in care and decision making
This document reflects discussions regarding specific ways of strengthening research skills, providing concrete experiences for young and mid-career researchers, and building necessary infrastructures for the wider FP research community. Two focus prompts helped to hone our discussions: “If resources were not a constraint, how could we best strengthen the FP research community?” And, “How can we make it worthwhile for young researchers to enter and stay in the FP field?”

Email and phone conversation on this topic ran in parallel to the deliberations of other topic-area groups participating in SFPRF’s priority setting process over July-September, 2014. At SFPRF’s face-to-face meeting of experts on September 12, 2014, group leaders discussed and added to the major points from this dialogue. Specific recommendations are detailed below.

The group agreed on the importance of considering a macro perspective (i.e., the needs of the field as a whole, or of the institutions that lead the field) and a micro perspective (i.e., the needs of individual researchers), and of considering the differences between social science, clinical, and biomedical researchers.

Infrastructure. What research infrastructures exist in universities and research departments? How might these be improved? What are best practices for improving or creating an outstanding research infrastructure? What grant mechanisms can support building or studying infrastructures and how can they be improved? Some considerations:

- Universities/NGOs/clinics have different infrastructures, some of which may not support research. A review is needed of existing infrastructure in order to better identify, discuss, and build upon best practices.

- Infrastructure could refer to people, hardware, or systems. In the SFPRF process, the focus was primarily on people—a core of staff to get projects done (e.g., do you have access to a biostatistician or epidemiologist when needed?)

- Space/equipment, especially for seeing research participants—is there an ultrasound, is the site accessible? etc.

- Once funded, infrastructure requires ongoing maintenance.

- A community engagement perspective is an essential, yet often unspoken, aspect of successful research infrastructures.
**Multi-center studies.** Participation in multi-center studies can offer critically important learning experiences for researchers, particularly those in the early to mid-career stages. We should advocate with possible funders for more multi-site opportunities. How else might we strengthen opportunities for individuals to participate in multi-center studies?

- SFPRF should consider launching and supporting an abortion clinical trials network.
- SFPRF to release an RFP for site participation and collect information on what kinds of infrastructure exists to facilitate participation in multi-center studies. As funding opportunities arise for more multi-site studies, we’ll then be better prepared.
- We need to take advantage of funds and infrastructure already invested in Fellowship in Family Planning sites.
- SFPRF should support multi-center studies because of our experience with, for instance, the cervical prep study.
- SFPRF has an opportunity to advance collaborations across disciplines and career stages, principally by involving junior and senior researchers in collaborative work.
- SFPRF is interested in creating a network of various types of researchers and facilities. Non-clinical sites and/or involving social scientists in clinical sites are examples of possible variations.

**Social science fellowships.** Strong support emerged for developing a new type of social science fellowship that could be offered through SFPRF.

- This fellowship could be broad enough to include identifying and developing a pool of people at the undergraduate level to funnel into the field. The academic setting is where students and trainees are.

- What social science mechanisms already exist? The National Science Foundation (NSF), for instance, has mechanisms for social scientists. There may well be an opportunity to fund a formal post-doc program for social scientists.

**Career development awards.** How can we promote and support a continuum of career-development awards throughout the typical research career? Suggestions include offering more junior investigator career development awards each year, as well as funding them for two years at a time as opposed to the current one-year grants. In addition, more resident/trainee awards at $10,000 each are specifically recommended.

- With career development awards, we may wish to balance support for proven, experienced researchers, while at the same time providing learning opportunities for promising young researchers without demonstrated experience.

- SFPRF would like to use the career development grants to build a stronger sense of collaboration across the wider FP community.
**Experiential needs.** What other experiences, such as participation in multi-center studies, do researchers require to deepen their skills? The group agreed that experiential learning should take priority over didactic training opportunities.

**Didactic needs.** What specific types of didactic training needs do FP researchers have? What methodological or thematic needs exist (e.g., incorporating gender, policy influence into study design)?

- What are the funding requirements needed to develop some of these trainings?
- Improving multi-level modeling approaches in research design
- Include efforts that are tailored to the FP field but available to a wider community
- Many people are already teaching some relevant didactic courses—thus there’s little need to design courses from scratch but perhaps we need to develop a directory where courses can be accessed? (e.g., Gynuity/Ibis/Guttmacher)
- Improving the basic statistical proficiency of researchers

**Expanding the community.** Many academic physicians who don’t identify as FP may be interested in linking their research to what we do. We should reach out to non-abortion providers and researchers. We can potentially do so by attending other conferences (e.g., ASA, APHA, the American Anthropological Association) and making delegates aware of what FP mechanisms, processes, evidence, funding, and research opportunities exist.

- Are there SFP membership requirements that limit the community? To be eligible for grants, researchers must be SFP fellows, and the dues of membership may be onerous especially if an individual is not part of the FP field (and thus has little incentive to be a dues-paying member). Could there be a set-aside pot of grant funds available for non-members? Could an initial grant cover dues for the first year? Since eligibility to apply for grants is a key benefit of membership, there’s no desire to eliminate that benefit. One type of grant that could be available for non-fellows is a career-transition grant.

**Person-in-residence.** Could SPPRF provide funds for an FP expert to visit an institution for a set period of time to provide specific FP-expertise to a program or project?

Lastly, the group agreed that strong advocacy is required to encourage funders to increase their support for the FP research community (especially support for young and mid-career researchers).
This document details the working definitions that topic-area groups created in order to achieve consensus on the scope of their group and to focus the group’s deliberations.

1. Adolescent sexual and reproductive health research

This group agreed that research on adolescent sexual and reproductive health requires specific attention to the following:

- Education and environments that allows development of a positive and respectful approach to sexuality and relationships. This includes the development of one’s own sexual values, responsibility for one’s own sexual behavior, the capacity for pleasure, respect for others, etc.
- Preventing adolescent mothers and their babies from dying in pregnancy;
- Preventing unintended pregnancies and other sexual and reproductive health risks;
- Access to information including comprehensive sex education;
- Access to a full range of sexual and reproductive health services, including condoms, other means of contraception as appropriate, and other interventions for the prevention, treatment and care of sexually transmitted infections, including HIV; and
- Safe and supportive environments free from exploitation and abuse.3

2. Biomedical research

Biomedical research includes basic, pre-clinical and early clinical projects that seek to advance the state of knowledge in medicine. This can include research that uses either animal models or human specimens in the lab to test hypotheses about novel contraceptive mechanisms, side effects, or health benefits. This would also include collecting human data from PK/PD studies in Phase1-2 clinical trials. This is in contrast to phase 3/4 studies, implementation science, and social science.

3. Equity in reproductive health research

Equity in reproductive health means treating people fairly and without bias, and seeking to minimize remediable differences among groups of people—whether those groups are defined socially, economically, geographically, by race or ethnicity, by gender or sexual identity, or by incarceration or citizenship status. It also means valuing the rights of all

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people to have children, to not have children, and to parent their children in safe and healthy environments—and pursuing these rights both in terms of societal resources and individual autonomy.

Research on equity in reproductive health should be oriented towards this vision of eliminating inequalities, should be attuned to how institutions and ideologies can facilitate and restrict equitable access to people’s reproductive life goals, and should strive for methodologies that incorporate the communities to which research questions are directed.

4. Global family planning research

Global family planning research includes abortion and contraception studies that are generalizable to issues in developing areas and resource-poor regions. While “global” signifies research that might apply in any context, the particular focus of this group was on priority issues faced by low- and middle-income countries.

5. Health services research

Health services research strives to understand the process, structure, and outcomes of health care; seeks to improve access to high-quality, safe, and efficient care; and aims to develop methodologies for evaluating and measuring care-delivery processes and outcomes. As a multidisciplinary field, FP researchers draw on social and clinical sciences to study health services in the context of people’s varied lives, relationships, institutional settings, and communities.

6. Innovation-driven research

Innovation-driven research focuses on “blue-skies” research designed to explore approaches or issues in the field of FP research where time, funding and capacity would not act as constraining factors.

7. Patient-centered outcomes research (PCOR)

Patient-Centered Outcomes Research (PCOR) helps people and their caregivers communicate and make informed healthcare decisions, allowing their voices to be heard in assessing the value of healthcare options. This research answers patient-centered questions, such as:

- “Given my personal characteristics, conditions, and preferences, what should I expect will happen to me?”
■ “What are my options, and what are the potential benefits and harms of those options?”

■ “What can I do to improve the outcomes that are most important to me?”

■ “How can clinicians and the care-delivery systems they work in help me make the best decisions about my health and health care?”

To answer these questions, PCOR:

■ “Assesses the benefits and harms of preventive, diagnostic, therapeutic, palliative, or health delivery system interventions to inform decision making, highlighting comparisons and outcomes that matter to people;

■ “Is inclusive of an individual’s preferences, autonomy, and needs, focusing on outcomes that people notice and care about such as survival, function, symptoms, and health-related quality of life;

■ “Incorporates a wide variety of settings and diversity of participants to address individual differences and barriers to implementation and dissemination; and

■ “Investigates (or may investigate) optimizing outcomes while addressing burden to individuals; availability of services, technology, and personnel; and other stakeholder perspectives

8. Public/institutional policy research

Public/institutional policy research evaluates the impact of public or institutional policies (that either already exist or that reflect a potential change) on health, health care, social, and economic outcomes. This includes:

■ Impact of policies on contraception

■ Impact of policies on abortion

■ Impact of best practices for clinic care

9. Research on stigma

This group defined “stigma” as the way in which people (and places) become negatively marked by a particular attribute. In the eyes of stigmatizers, this single attribute can come to entirely define the stigmatized individual. As such, stigma is an interpersonal process that often results in psychological distress, social isolation, and discrimination.

Importantly, stigma is experienced and produced across different sites or levels—at the individual level (including internalized stigma); the community level (e.g., neighborhoods, families); within institutions (e.g., schools, hospitals, clinics); across
systems and structures (e.g., embedded in regulations and legal frameworks); and in discourse (political rhetoric, advertising, media). It generates and regenerates within these sites and levels as vicious cycles that repeat and deepen.

10. **Strengthening the FP research community**

This group defined itself as one examining ways to strengthen research skills, provide concrete experiences for young and mid-career researchers, and generate ideas on building necessary infrastructures for the wider FP research community. Based on this scope, two focus prompts guided the group’s discussion: “If resources were not a constraint, how could we best strengthen the FP research community?” And “How can we make it worthwhile for young researchers to enter and stay in the FP field?”
Messages from community advocates’ survey for reproductive health funders:

- Fund grassroots reproductive justice organizations to develop or co-develop their own research agenda, such as community-based participatory research programs that empower the communities being researched, are community-informed, and have input from wider constituencies.

- Any research findings should point toward action that can be taken that has implications for real-world contexts.

- More research is needed on environmental toxins and reproductive health/fertility, especially affecting women of color; on the intersections of reproductive justice and civic engagement; on why and how women of color vote; and on how that relates to reproductive justice issues.

- Equity-oriented reproductive health research needs to be seen holistically as an important component for the overall health of individuals, communities, and the nation. Communities of color, such as Asian American Native Hawaiian Pacific Islanders (AANHPI) communities, are consistently being left out. For many communities, researchers often aggregate groups—e.g., all AANHPI groups—which can display low health disparities and lead to the assumption that the racial group as a whole does not need health services. As we know, that is not the case for many ethnic groups—disparities are very significant, and sometimes a matter of life and death. Data on this is still scarce, however. We have to continue the qualitative and quantitative research—especially community-based participatory research—needed to identify data-driven approaches at all levels of our society.

Other suggestions for interventions/methodologies:

- Integrating LGBTQ issues into all of the above research issues

- Connecting reproductive justice with the fight for a universal health care system

- Making culturally competent services available and accessible, in as many languages as are represented in the population

- Pursuing reproductive health research for significantly large populations for various ethnic groups

- Documenting the long histories of women of color organizing for sexual and reproductive autonomy
APPENDIX E: Meeting attendees and group participants

Expert Panel Meeting Attendees
Philadelphia, PA—September 12, 2014

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