Exhibit 5

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants,

Case No. 1:25-cv-12118-IT

DECLARATION OF MEGAN L. KAVANAUGH

I, Megan L. Kavanaugh, declare that if called as a witness, I would testify competently to the following:

1. I am a Principal Research Scientist at the Guttmacher Institute in New York City, New York. The Guttmacher Institute is a private, independent, nonprofit, nonpartisan entity that advances sexual and reproductive health and rights through an interrelated program of research, policy analysis, and public education. The Institute's overarching goal is to ensure quality sexual and reproductive health for all people worldwide by conducting research according to the highest standards of methodological rigor and promoting evidence-based policies. It produces a wide range of resources on topics pertaining to sexual and reproductive health and which are widely used and cited by researchers, policymakers, the media and advocates across the ideological spectrum. I have worked as a researcher at the Guttmacher Institute since 2008.
2. I am Adjunct Professor of Medicine in the Department of General Internal Medicine at the University of Pittsburgh School of Medicine in Pittsburgh, Pennsylvania. I have held this position since 2017.
3. I am affiliated faculty with the Center for Innovative Research on Gender Health Equity (CONVERGE) at the University of Pittsburgh, a center that convenes a multidisciplinary community of scholars who conduct and translate research focused on sexual and reproductive health, with particular attention to marginalized populations. I have been affiliated with CONVERGE since 2017.

4. I received a Doctor of Public Health (DrPH) degree and a Master of Public Health (MPH) degree, both in Behavioral and Community Health Sciences from the University of Pittsburgh Graduate School of Public Health.

5. A copy of my curriculum vitae is attached as Exhibit A.

6. My area of research expertise is monitoring sexual and reproductive healthcare delivery and demand in the United States, with attention to understanding inequities in access and barriers to this care. My most recent studies have tracked national- and state-level trends in contraceptive use, integrating a person-centered lens into understanding people's experiences and preferences related to contraception, and documenting barriers to sexual and reproductive health care and their consequences.

7. Of particular relevance, from 2017-2024, I served as Principal Investigator of the Reproductive Health Impact Study, a large multistate, multiyear research effort to understand the impact of federal and state policy changes on the publicly funded family planning network and on the patients served within this network.

8. I have served as a research grantee and/or consultant to a variety of federal government projects and agencies since 2010, including: grantee of the Office of Population Affairs (OPA) for Title X family planning research (2022-2025, 2014-2017, 2010-2012), consultant to the Centers for Disease Control and Prevention (CDC) regarding updating the family planning module of the Behavioral and Risk Factor Surveillance System (BRFSS) (2022), and expert panelist at the U.S. Department of Health and Human Services (DHHS)

Roundtable Series: Facilitating Reproductive Health Research post-Dobbs Decision (2023).

9. From 2004-2008, I received compensation from Planned Parenthood of Western Pennsylvania (PPWP) for employment as a part-time pregnancy options counselor.

10. I have been asked to provide my opinion on the impacts at multiple levels of Section 71113 of An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 ("Section 71113"), which I understand is intended to prohibit Planned Parenthood Federation of America ("PPFA") Member organizations from receiving federal funds through Medicaid.

11. In this declaration, I use shorthand to discuss PPFA Members' health centers, using the terms "Planned Parenthood," "Planned Parenthood health centers," and "Planned Parenthood clinics." For purposes of this declaration, unless otherwise indicated, those terms refer to the health centers owned and operated by PPFA Members, all of which include the words "Planned Parenthood" in their names.

12. In this declaration, I also use the term "publicly supported clinics" frequently. The Guttmacher Institute defines publicly supported clinics as sites that offer contraceptive services to the general public and use public funds (e.g., federal, state or local funding through programs such as Title X, Medicaid or the federally qualified health center (FQHC) program) to provide free or reduced-fee services to at least some patients. Sites must serve at least 10 contraceptive patients per year. These sites are operated by a diverse range of providers,

including public health departments, Planned Parenthood affiliates, hospitals, FQHCs and other independent organizations.

13. As further explained below, the implementation of Section 71113 of Public Law 119-21 prohibiting Planned Parenthood's ability to receive Medicaid funding, essentially removing government subsidies to support the delivery of healthcare at Planned Parenthood entities, or "defunding Planned Parenthood," will incur multiple harms across the Plaintiff States at the state, health system, and individual, including patient, levels.

14. I begin by providing an overview of why contraception is key to people leading full and healthy lives, and I then highlight how not all people have equitable access to contraception. I further explain the importance of the publicly supported sexual and reproductive health (SRH) care system in addressing inequities in access to contraception due to inability to pay, and the disproportionately large role that Medicaid plays in resourcing this system. I then situate Planned Parenthood's unique and critical role within the publicly supported SRH care system, in order to highlight the significant harms that would result from Planned Parenthood being removed from the system. I draw on evidence from two states (Iowa and Texas) to highlight case studies of what happened to these state-specific publicly supported SRH care systems when Planned Parenthood was effectively removed as an option for patients due to their carrying of Medicaid health insurance coverage.

I. Contraception is key to people living full and healthy lives

15. People use contraception for a variety of reasons, including to prevent pregnancy, to space and plan their pregnancies, to manage and treat medical conditions, and to prevent sexually transmitted infections. People also choose different contraceptive methods at different stages of their reproductive lives, and a variety of factors—like minimizing side effects, desiring a method that requires limited user oversight, and preferring to minimize provider interactions—influence which methods people prefer to use. Having access to the full range of contraceptive methods is therefore key for all people to live full, healthy lives. Beyond the immediate benefits for health and reproductive autonomy, a substantial body of evidence indicates that contraception helps people to realize social and economic life milestones—including improved economic outcomes related to educational attainment and financial security.[1]

16. Contraceptive use is ubiquitous in the United States; more than 99% of women aged 15–49 who have ever had sexual intercourse have used at least one contraceptive method during their lifetime.[2] This statistic holds across a variety of religious affiliations, urban-rural residence, education levels, and race and ethnicity.[3] About 65% of all women of reproductive age in the U.S. are currently using a contraceptive method. Among those not seeking pregnancy (i.e., women aged 15–49 who have had sexual intercourse in the

[1] ADAM SONFIELD ET AL., THE SOCIAL AND ECONOMIC BENEFITS OF WOMEN'S ABILITY TO DETERMINE WHETHER AND WHEN TO HAVE CHILDREN 7-10, 14-17 (Guttmacher Inst., 2013), https://www.guttmacher.org/sites/default/files/pdfs/pubs/social-economic-benefits.pdf.
[2] KIMBERLY DANIELS & JOYCE C. ABMA, CONTRACEPTIVE METHODS WOMEN HAVE EVER USED: UNITED STATES, 2015-2019 4 (Ctrs. for Disease Control & Prevention Nat'l Ctr. for Health Stats., 2023), https://www.cdc.gov/nchs/data/nhsr/nhsr195.pdf.
[3] *Id.* at 8.

past three months, are not pregnant or trying to conceive, and are not sterile for noncontraceptive reasons), 89% are currently using a contraceptive method.[4]

17. Women and couples rely on a wide range of contraceptive methods to achieve their reproductive goals. In 2018, 21% of female contraceptive users relied on oral contraceptive pills and 13% on condoms as their single, most effective method. The remaining 2/3 of contraceptive users relied on other methods: female or male sterilization; hormonal or copper intrauterine devices (IUDs); hormonal methods including the injectable, the ring, the patch and the implant; and behavioral methods, such as withdrawal and fertility awareness methods.[5]

18. Many people use two or more methods at once: 18% of female contraceptive users did so the last time they had sex. For example, they may use condoms to prevent STIs and an IUD for the most reliable prevention of pregnancy. Or they may use multiple methods simultaneously—for instance, condoms, withdrawal and oral contraceptives—to provide extra pregnancy protection.[6]

19. Ensuring that people have access to a range of contraceptive methods so that they can select the method or methods that best meet their own needs and life circumstances is key to ensuring that users are satisfied with their selected methods. Individuals who are satisfied with their contraceptive methods are more likely to use them consistently and correctly.

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[4] *Fact Sheet: Contraceptive Use in the United States by Method*, GUTTMACHER INST. (May 2021), https://www.guttmacher.org/fact-sheet/contraceptive-method-use-united-states.
[5] *Id.*
[6] Megan L. Kavanaugh, Emma Pliskin & Jenna Jerman, *Use of Concurrent Multiple Methods of Contraception in the United States, 2008 to 2015*, 3 CONTRACEPTION: X 1, 3 (2021), https://www.sciencedirect.com/science/article/pii/S2590151621000071?via%3Dihub.

20. For example, a study by my Guttmacher colleagues found that 30% of neutral or dissatisfied users had a temporal gap in use, compared with 12% of completely satisfied users.[7] Similarly, 35% of satisfied oral contraceptive users had skipped at least one pill in the past three months, compared with 48% of dissatisfied users.[8] In my recent research, we found that experiencing barriers to getting contraception is associated with decreased method satisfaction.[9]

II. People face a variety of barriers in accessing contraception, including cost and health insurance coverage

21. Accumulated research studies have documented that a number of factors hinder people's access to contraception, including availability of care, availability of over-the-counter options, travel distance to healthcare providers and availability of transportation, clinic hours of operation, health provider characteristics and approach, medical mistrust, and individual preferences and experiences.[10] One of the most central influences on access to care is cost and

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[7] JENNIFER J. FROST, JAQUELINE E. DARROCH & LISA REMEZ, IMPROVING CONTRACEPTIVE USE IN THE UNITED STATES 4 (Guttmacher Inst., 2008), https://www.guttmacher.org/sites/default/files/report_pdf/improvingcontraceptiveuse_0.pdf.

[8] *Id.* at 5.

[9] Megan L. Kavanaugh, Ellie Leong & Christina Geddes, *Differential Associations Between Access to Sexual and Reproductive Healthcare and Subsequent Contraceptive and Pregnancy Outcomes by Ethnicity Among Family Planning Patients in Arizona*, 12 WOMEN'S REPROD. HEALTH 199, 210-11 (2025), https://www.tandfonline.com/doi/full/10.1080/23293691.2024.2423719#d1e335.

[10] Kelsey Holt et al., *Beyond Same-day Long-acting Reversible Contraceptive Access: A Person-centered Framework for Advancing High-quality, Equitable Contraceptive Care*, 222 AM. J. OBSTETRICS & GYNECOLOGY S878, S878-S880 (2020), https://www.sciencedirect.com/science/article/pii/S0002937819327000; Rachel G. Logan et al., *"When Is Health Care Actually Going to Be Care?" The Lived Experience of Family Planning Care Among Young Black Women*, 31 QUALITATIVE HEALTH RSCH. 1169, 1169-1182 (2021), https://journals.sagepub.com/doi/10.1177/1049732321993094; Emily S. Mann, *The Power of Persuasion: Normative Accountability and Clinicians' Practices of Contraceptive Counseling*, 2 SSM – QUALITATIVE RSCH. HEALTH 1, 100049:7-8 (2022), https://www.sciencedirect.com/science/article/pii/S2667321522000117?via%3Dihub.

the role insurance plays in mediating service availability and affordability.[11] In 2024, one in five uninsured women reported having to stop using contraception because they could not afford it.[12] Research that I have led has documented that, as of 2015–2019, 23% of female contraceptive users and 39% of female nonusers of contraception living at 300% or less than the federal poverty level in the United States would prefer to use (another) contraceptive method if cost were not a consideration.[13] Cost, including affordability of methods and contraceptive-related health care, factors prominently in which methods individuals use[14] and why users may not be using their preferred method, a key predictor of continuous contraceptive use.[15]

22. Financial resources—income and health insurance coverage—also play a role in individuals' ability to realize their contraceptive preferences, with greater mismatches between preferred and used contraceptive methods among women

[11] Alicia VandeVusse et al., *Cost-related Barriers to Sexual and Reproductive Health Care: Results from a Longitudinal Qualitative Study in Arizona*, 4 SSM – QUALITATIVE RSCH. HEALTH 1, 6 (2023), https://www.sciencedirect.com/science/article/pii/S2667321523001440?via%3Dihub#bib44.
[12] Brittni Frederiksen, Karen Diep & Alina Salganicoff, *Contraceptive Experiences, Coverage, and Preferences: Findings from the 2024 KFF Women's Health Survey*, KFF (Nov. 2024), https://www.kff.org/womens-health-policy/issue-brief/contraceptive-experiences-coverage-and-preferences-findings-from-the-2024-kff-womens-health-survey/.
[13] Megan L. Kavanaugh, Emma Pliskin & Rubina Hussain, *Associations Between Unfulfilled Contraceptive Preferences Due to Cost and Low-income Patients' Access to and Experiences of Contraceptive Care in the United States, 2015–2019*, 4 CONTRACEPTION: X 1, 3-4 (2022), https://www.sciencedirect.com/science/article/pii/S2590151622000053?via%3Dihub.
[14] EMILY M. JOHNSTON, BRIGETTE COURTOT & GENEVIEVE M. KENNEY, ACCESS TO CONTRACEPTION IN 2016 AND WHAT IT MEANS TO WOMEN 5 (Urb. Inst., 2017), https://www.urban.org/sites/default/files/publication/87691/2001113-access-to-contraception-in-2016-and-what-it-means-to-women.pdf.
[15] Payal Chakraborty et al., *Use of Nonpreferred Contraceptive Methods Among Women in Ohio*, 103 CONTRACEPTION 328, 334 (2021), https://www.contraceptionjournal.org/article/S0010-7824(21)00035-4/fulltext.

with lower socioeconomic statuses than among those with higher incomes.[16] In a 2024 national study, 15% of women who were not using their preferred method of contraception indicated that the primary reason was because they could not afford it.[17] Among women at risk of unintended pregnancy in the United States, nonusers of contraception are more likely to have lower incomes and be uninsured compared to users.[18]

23. Cost barriers restrict individuals' ability to fully realize their sexual and reproductive health and well-being, forcing individuals to "prioritize affordability over health, cost avoidance over prevention and insurance acceptance over quality of care."[19] Research that I conducted with Guttmacher colleagues highlights that individuals often postpone or forgo care when experiencing cost barriers.[20] Individuals are also more likely to switch care sites to access affordable care, even when it means visiting a less-preferred health care provider or facility.[21] Importantly, my research has documented that key strategies to address cost barriers to contraception and help individuals to realize their contraceptive preferences include health insurance coverage and person-centered contraceptive counseling.[22]

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[16] Joseph E. Potter et al., *Unmet Demand for Highly Effective Postpartum Contraception in Texas*, 90 CONTRACEPTION 488, 491 (2014), https://www.sciencedirect.com/science/article/pii/S0010782414005629; Katherine He et al., *Women's Contraceptive Preference-Use Mismatch*, 26 J. WOMEN'S HEALTH 692, 698-699 (2017), https://pmc.ncbi.nlm.nih.gov/articles/PMC5512313/.
[17] Brittni Frederiksen, Karen Diep & Alina Salganicoff, *supra* note 12.
[18] Brittni Frederiksen & Katherine Ahrens, *Understanding the Extent of Contraceptive Non-use Among Women at Risk of Unintended Pregnancy*, *National Survey of Family Growth 2011–2017*, 2 CONTRACEPTION: X 1, 3 (2020), https://www.sciencedirect.com/science/article/pii/S2590151620300162?via%3Dihub.
[19] Alicia VandeVusse et al., *supra* note 11, at 6.
[20] *Id.*
[21] *Id.*
[22] Megan L. Kavanaugh, Emma Pliskin & Rubina Hussain, *supra* note 13, at 7.

24. Contraceptive users covered by health insurance who do not have co-payments associated with accessing contraception are more likely to use their contraceptive method consistently, avoiding periods of being unprotected due to cost barriers.[23]

III. The publicly supported SRH care system is therefore critical to addressing cost barriers and ensuring broad access to contraceptive and related SRH care

25. To address existing barriers to contraceptive access due to inability to pay, public dollars are allocated through federal, state, and local channels to the publicly supported SRH care system. Publicly supported clinics have long been a critical source of contraceptive and other SRH care for adolescents and low-income adults in the United States, providing access for vulnerable populations and promoting SRH equity.[24] Public support for this care comes primarily through Medicaid and the national Title X family planning program, which is the only federal grant program dedicated to providing subsidized contraceptive and related SRH services, with a focus on serving individuals who are disadvantaged in their access to health care. The publicly supported SRH care system includes a range of sites that receive public funding: federally qualified health centers (FQHCs), health departments, hospital outpatient clinics, Planned Parenthood sites, Indian Health Service sites, and

[23] Cassondra Marshall et al., *The Relationship Between Prescription Copayments and Contraceptive Adherence in a New-user Cohort*, 56 MED. CARE 577 582 (2018), https://pubmed.ncbi.nlm.nih.gov/29847539/; Lydia E. Pace, Stacie B. Dusetzina & Nancy L. Keating, *Early Impact of the Affordable Care Act on Oral Contraceptive Cost Sharing, Discontinuation, and Nonadherence*, 35 HEALTH AFFS. 1616-1624 (2016), https://pubmed.ncbi.nlm.nih.gov/27605641/.

[24] Jennifer J. Frost et al., *Publicly Funded Contraceptive Services at US Clinics, 2015*, GUTTMACHER INST. (Apr. 2017), https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

other community or independent clinics. Each year, this network provides contraceptive and other SRH care to millions of patients nationwide.[25]

26. Medicaid is a health insurance program for low-income people, jointly funded by federal and state governments. As such, Medicaid reimburses health care providers for covered services. Historically, Medicaid has accounted for the largest share of public dollars that go towards the delivery of contraceptive and related care.[26] Medicaid is critical to ensuring that people of reproductive age have access to health care, including sexual and reproductive health care. In 2023, 21.4% of women aged 15-49 were enrolled in Medicaid, and that proportion went up to 52.8% for women aged 15-49 with incomes below the poverty line.[27]

27. As of 2019, 39% of U.S. women aged 15-44 relied on Medicaid and other public insurance to cover their contraceptive care, and 33% of those obtaining care at publicly supported healthcare sites used their Medicaid and other public insurance to cover their care.[28]

[25] Jennifer J. Frost et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Use, 2020*, GUTTMACHER INST. (May 2025), https://www.guttmacher.org/report/publicly-supported-FP-services-US-2020#.
[26] Kinsey Hasstedt, Adam Sonfield & Rachel Benson Gold, *Public Funding for Family Planning and Abortion Services, FY 1980–2015*, GUTTMACHER INST. (Apr. 2017), https://www.guttmacher.org/report/public-funding-family-planning-abortion-services-fy-1980-2015.
[27] Amy Friedrich-Karnik et al., *Increased Medicaid Coverage Helped Reduce the Uninsured Rate from 2019 to 2023, but Federal Policy Proposals Threaten Gains*, GUTTMACHER INST. (May 2025), https://www.guttmacher.org/2025/05/increased-medicaid-coverage-helped-reduce-uninsured-rate-2019-2023-federal-policy-proposals.
[28] Jennifer J. Frost, Jennifer Mueller & Zoe H. Pleasure, *Trends and Differentials in Receipt of Sexual and Reproductive Health Services in the United States: Services Received and Sources of Care, 2006–2019*, GUTTMACHER INST. (June 2021), https://www.guttmacher.org/report/sexual-reproductive-health-services-in-us-sources-care-2006-2019.

28. In addition to being a critical access point for SRH care, publicly supported healthcare facilities also often function as a usual source for medical care of any kind, not just SRH, indicating that these clinics often offer patients an entry point into the health care system. As of 2019, 65% of U.S. women aged 15-44 who visited a publicly funded clinic for one or more contraceptive or other related SRH care services in the prior year reported that the clinic was their usual source for medical care.[29] Non-Hispanic Black women and Hispanic women were more likely (74% and 69%, respectively) than non-Hispanic White women (59%) to report the clinic as their usual source of medical care.[30] Women with Medicaid coverage or those who were uninsured compared with privately insured women (71% and 70% vs. 53%) were more likely to report the clinic as their usual source of care.[31] Particularly for women of color and publicly insured or uninsured women, publicly supported clinics are critical to their ability to enter the health care system and get both the SRH care they need and broader medical care or referrals for such care.[32]

IV. Planned Parenthood is a crucial and widely used access point for individuals, especially those living with low incomes, to obtain high quality reproductive health care services across the United States

A. Planned Parenthood serves a substantial portion of Medicaid enrollees and publicly-supported family planning patients

[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*

29. In 2023, Planned Parenthood health centers served over two million patients, collectively delivering around 9.5 million services.[33] In 2022, 53% of Planned Parenthood patients relied on Medicaid and other government-funded health care programs to pay for their care. Planned Parenthood facilities comprise a relatively small proportion of the overall publicly supported SRH care system, but they serve an outsized number of patients who receive care from this system. In 2021, one in ten Medicaid enrollees received their family planning services at a Planned Parenthood clinic. And in some communities and for many women, Planned Parenthood is the sole source of publicly funded contraceptive care.[34]

30. In 2020, 9,388 publicly supported clinics provided subsidized family planning services nationally—5,429 (58%) were federally qualified health centers, 1,876 (20%) were health departments, 649 (7%) were hospital outpatient facilities, 600 (6%) were Planned Parenthood sites and 834 (9%) were other independent clinics.[35] Of the 4.7 million women who obtained contraceptive care from publicly supported clinics in 2020, 38% received services from federally qualified health centers, 33% from Planned Parenthood sites, 13% from health departments, 9% from hospital outpatient facilities and 7% from other independent clinics.[36]

[33] A FORCE FOR HOPE 6 (Planned Parenthood Fed'n Am., 2024), https://www.plannedparenthood.org/uploads/filer_public/ec/6d/ec6da0d6-98e5-4278-8d11-99a5cba8e615/2024-ppfa-annualreport-c3-digital.pdf.
[34] Frost, Jennifer J., and Kinsey Hasstedt. "Quantifying Planned Parenthood's critical role in meeting the need for publicly supported contraceptive care." *Health Affairs Forefront* (2015).
[35] Jennifer J. Frost et al., *supra* note 25.
[36] Jennifer J. Frost et al., *supra* note 25.

31. As highlighted in the table below, Planned Parenthood facilities serve between 5-72% of the Plaintiff States' publicly supported SRH patients; in eight of these states (California (49%), Connecticut (72%), Minnesota (66%), New Jersey (58%), Oregon (57%), Vermont (68%), Washington (59%), and Wisconsin (59%)), Planned Parenthoods service at least half of their states' overall patient counts. In seven of these Plaintiff states, at least 15% and up to 29% of female Medicaid enrollees who received SRH care did so at a Planned Parenthood clinic.[37]

Table: 2020 overall and state-level publicly supported clinic and patient numbers, highlighting share of care provided by Planned Parenthoods (PPs) across Plaintiff States[38]

	Total publicly supported clinics (2020)	Planned Parenthood clinics (2020)	**% Planned Parenthood as share of all publicly supported clinics**	Total patients served by publicly supported sites (2020)	Planned Parenthood patients served (2020)	**% Planned Parenthood patients served as share of all publicly supported patients**	% female Medicaid enrollees who went to Planned Parenthoods (2021)
All U.S states	9388	600	**6**	4740530	1585480	**33**	11
Plaintiff states							
CA	1366	121	**9**	1238800	603290	**49**	29
CO	181	18	**10**	92930	27180	**29**	12
CT	77	16	**21**	72120	52250	**72**	20
DE	55	3	**5**	14900	6220	**42**	5
DC	29	1	**3**	42920	2130	**5**	NA

[37] Brittni Frederiksen et al., *Recent Policy Proposals Could Weaken the Reproductive Health Safety Net as More People Become Uninsured*, KFF (July 28, 2025), https://www.kff.org/womens-health-policy/issue-brief/recent-policy-proposals-could-weaken-the-reproductive-health-safety-net-as-more-people-become-uninsured/.

[38] *Id.*; Jennifer J. Frost et al., *Publicly Supported Family Planning Services in the United States, 2020: Tables and Appendix Tables*, GUTTMACHER INST. (2025), https://www.guttmacher.org/sites/default/files/report_downloads/publicly-supported-fp-services-us-2020-tables-and-appendix-tables.pdf.

HI	49	2	**4**	13780	1860	**13**	1
IL	295	17	**6**	146910	29630	**20**	NA
MA	168	4	**2**	86830	12040	**14**	4
MD	117	9	**8**	69930	32860	**47**	4
ME	100	4	**4**	24730	6330	**26**	6
MI	229	16	**7**	72250	29460	**41**	4
MN	91	18	**20**	47620	31330	**66**	16
NC	240	9	**4**	102470	23240	**23**	2
NV	49	3	**6**	19360	6460	**33**	1
NJ	110	22	**20**	105640	61020	**58**	12
NM	169	4	**2**	32610	4560	**14**	5
NY	516	56	**11**	426210	109060	**26**	9
OR	156	12	**8**	66550	37800	**57**	16
PA	314	22	**7**	152570	36840	**24**	5
RI	33	1	**3**	26360	6860	**26**	4
VT	52	12	**23**	17170	11620	**68**	19
WA	239	33	**14**	134070	78860	**59**	21
WI	121	24	**20**	51,100	30,170	**59**	21

Notes: Total numbers of clinics and patients, overall and specific to Planned Parenthoods, come from: Jennifer J. Frost et al., Publicly Supported Family Planning Services in the United States, 2020: Tables and Appendix Tables, GUTTMACHER INST. (2025), https://www.guttmacher.org/sites/default/files/report_downloads/publicly-supported-fp-services-us-2020-tables-and-appendix-tables.pdf. The bolded two columns are calculated based on data from these sources. % female Medicaid enrollees who went to Planned Parenthoods come from: Brittni Frederiksen et al., Recent Policy Proposals Could Weaken the Reproductive Health Safety Net as More People Become Uninsured, KFF (July 28, 2025), https://www.kff.org/womens-health-policy/issue-brief/recent-policy-proposals-could-weaken-the-reproductive-health-safety-net-as-more-people-become-uninsured/.

B. Planned Parenthood provides high-quality and comprehensive sexual and reproductive health services

32. In addition to serving a substantial proportion of publicly supported SRH patients, Planned Parenthoods are specialized SRH care facilities that provide high-quality, evidence-based SRH care. Thus, focusing exclusively on capacity—and ultimately whether or not patient caseload can be absorbed by other provider types based on volume alone—minimizes the overall impact on

patients, who could lose access to the specialized and patient-centered contraceptive care provided by Planned Parenthood clinics. Other providers that receive public support for family planning services do so as part of a range of other services (such as primary care and mental health care, for example) and therefore offer a different value to the communities they serve than do the dedicated SRH providers at Planned Parenthood affiliates.

33. For example, one objective of Healthy People 2030, an initiative of the Department of Health and Human Services that outlines public health objectives for the United States population, is to "increase the proportion of publicly funded family planning clinics that offer the full range of reversible contraception methods onsite."[39] Planned Parenthood clinics exemplify this practice.

34. Guttmacher's 2022-2023 Family Planning Clinic Survey Trends report highlights that Planned Parenthood health centers provide the broadest range of comprehensive contraceptive options among all of the publicly supported facility types.[40] Notably, Planned Parenthood clinics offer the widest contraceptive method mix, with nearly all (99%) offering 10 or more reversible methods. Availability of a wide range of methods is an important component of patient-centered care. In addition, my Guttmacher colleagues

[39] *Increase the Proportion of Publicly Funded Clinics that Offer the Full Range of Reversible Birth Control*, U.S. DEP'T HEALTH & HUM. SERVS. (N.D.), https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning/increase-proportion-publicly-funded-clinics-offer-full-range-reversible-birth-control-fp-d01.

[40] Alicia VandeVusse et al., *Publicly Supported Family Planning Clinics in 2022–2023: Trends in Service Delivery Practices and Protocols*, GUTTMACHER INST. (Nov. 2024), https://www.guttmacher.org/report/publicly-supported-family-planning-clinics-2022-2023.

found that over 90% of Planned Parenthood clinics offered other important protocols for ensuring patient-centered care.[41] Using a patient-centered approach in contraceptive care and counseling is associated with higher patient satisfaction, which can lead to higher continuation of method use.[42]

35. Meeting the needs of family planning patients includes attending to how, when, and where contraception is prescribed and dispensed. The vast majority of Planned Parenthood clinics (92%) offer a supply of 12+ months of oral contraceptive pills—far more than other clinic types. (Overall, just over a third of all publicly supported clinics offer this extended supply). Dispensing 12-month supplies of contraception increases the likelihood of method continuation.[43] In the context of serving Medicaid enrollees and other communities facing barriers to care, prescription of 12 month supplies is particularly important, as the practice improves equity in SRH care; research has found that contraceptive users who discontinued use because they were unable to obtain their next supply on time were disproportionately Black and low income.[44] Planned Parenthood clinics are also more likely to dispense contraception on-site and to use Quick Start (a same day protocol), both of

[41] Jennifer Mueller et al., *Assessing the Provision of Person-Centered Contraceptive Care at Publicly Supported Clinics Providing Contraceptive Services in the United States*, 35 WOMEN'S HEALTH ISSUES 169, 172-74 (2025), https://www.sciencedirect.com/science/article/pii/S1049386725000507.
[42] Nathan Hale et al., *Contraceptive Counseling, Method Satisfaction, and Planned Method Continuation Among Women in the U.S. Southeast*, 132 CONTRACEPTION 1, 5 (2024), https://www.sciencedirect.com/science/article/pii/S0010782424000040.
[43] Diana G. Foster et al., *Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies*, 117 OBSTETRICS & GYNECOLOGY 566-572 (2011), https://pubmed.ncbi.nlm.nih.gov/21343759/.
[44] Sarah L. Day, Neena Qasba & Sarah Goff, *Twelve-month Contraception Dispensing Advances Access and Equity*, HEALTH AFFS. FOREFRONT (Apr. 2023), https://www.healthaffairs.org/content/forefront/twelve-month-contraception-dispensing-advances-access-and-equity.

which remove additional barriers for patients. Additionally, Planned Parenthood sites are most likely to offer advanced provision of emergency contraception—so that patients can keep the medication at home for future use, increasing the likelihood that users will be able to take the medication during the window when it is most effective, without additional obstacles to obtaining it.

36. Among publicly supported family planning clinics, Planned Parenthood has the highest availability of same-day IUD insertion and same-day implant insertion (available at 98% of Planned Parenthood clinics for both procedures, compared to 59% IUD and 69% implant for publicly supported clinics overall). Same-day initiation of long-acting reversible contraception (LARC), recommended by the American College of Obstetricians and Gynecology (ACOG), reduces barriers for patients, particularly related to cost and transportation associated with multiple visits;[45] these barriers can lead some patients to forgo contraception altogether.[46]

37. Data from my Guttmacher colleagues' work shows that Planned Parenthood clinics are more likely than other publicly supported family planning clinics to offer cervical cancer screenings, medication for HIV prevention, and HPV vaccination.[47] Planned Parenthood clinics are also more likely to offer

[45] ACCESS TO CONTRACEPTION: COMMITTEE OPINION NO. 615 4 (Am. Coll. Obstetricians & Gynecologists Comm. on Health Care for Underserved Women, 2015), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2015/01/access-to-contraception.pdf?rev=326fce9f62fa42b983ea4b6c39325956&hash=CFD1BD28FCB0D17A23486A587A480A19.
[46] Rebecca McColl et al., *Same-day Long-acting Reversible Contraceptive Utilization After a Statewide Contraceptive Access Initiative*, 228 AM. J. OBSTETRICS & GYNECOLOGY 451.e4-451.e5, (2023), https://www.ajog.org/article/S0002-9378(22)02582-0/fulltext.
[47] Alicia VandeVusse et al., *supra* note 40.

extended office hours, which gives patients greater flexibility in scheduling appointments around work and family responsibilities.

38. Among patients seeking SRH care at a variety of publicly supported sites, those who received more recent contraceptive care at a Planned Parenthood reported almost two times higher odds of subsequently using their preferred contraceptive method compared to those who had not received recent contraceptive care.[48]

V. Given Planned Parenthood's critical role within the broader publicly supported landscape of care and evidence of the high-quality care available across Planned Parenthoods, removing them from this system will result in harms at multiple levels

39. The provision of reproductive health care is siloed and often stigmatized from other types of health care, and providers and facilities that serve low-income people must overcome barriers and cost restrictions to provide patients with necessary care. These obstacles lead to a gap between patients' need and access to contraceptive care, despite the vast number of patients served by Planned Parenthood and other publicly supported clinics. There were 69 million US women of reproductive age (13–44) in 2020, 19 million of whom were considered to have a likely need for publicly supported contraceptive services because they either had an income below 250% of the federal poverty level or were younger than 20.[49] And yet, only an estimated 7.2 million

[48] Megan L. Kavanaugh, Ellie Leong & Christina Geddes, *supra* note 9, at 210.
[49] Jennifer J. Frost et al., *supra* note 25.

women received publicly supported contraceptive services from all sources.[50] The majority of these women—an estimated 4.7 million contraceptive patients—were served at publicly funded clinics. These 2020 data capture a picture of a system under duress, both in the aftermath of regulation changes to the Title X federally funded system in the 2019 Title X Final Rule (colloquially known as the domestic gag rule for how it restricted the program) and during the onset of the COVID-19 pandemic.[51] The gap between the numbers of people who need care and who received care demonstrates both the critical importance of publicly supported services—and that the system is already unable to meet the needs of all who need it.

40. Policies like Section 71113 of Public Law 119-21 create additional hurdles that limit who providers can see or what types of insurance they can accept and ultimately threaten to permanently close facilities. These effects ripple through the entire health care ecosystem and across communities who rely on this care.

41. By excluding Planned Parenthood clinics from receiving federal Medicaid payments, Section 71113 of Public Law 119-21 threatens Planned Parenthood clinics' ability to meet the needs of people in their communities and, in many cases, threatens their ability to remain open. They may be forced to turn away patients with Medicaid insurance and, without Medicaid as a revenue source, many may be forced to shut down. All of this creates a crisis in access to

[50] *Id.*
[51] Amy Friedrich-Karnik & Rachel Easter, *Restricting Title X Results in Cascading Harms*, GUTTMACHER INST. (Aug. 2024), https://www.guttmacher.org/2024/08/restricting-title-x-results-cascading-harms.

health care for patients and places an enormous strain on the health care systems in communities across the country.

State- and systems-level impacts

42. It is unlikely that states would be able to fill the gap of federal Medicaid funding if Section 71113 of Public Law 119-21 is allowed to stand, in part because of how payments for Medicaid family planning are structured. The Federal Medicaid Assistance Program (FMAP) determines the state/federal split for services.[52] For family planning services and supplies, federal funding covers 90% with states paying the remaining 10%—a much higher federal match than most other Medicaid services.[53] Given this FMAP allocation, this restriction on federal funding creates a particularly dire situation for Medicaid enrollees' access to family planning services.

43. Anticipated impacts of Section 71113 of Public Law 119-21 at the healthcare systems level center around the extent to which other publicly supported healthcare facilities would be able to serve Planned Parenthood patients. However, given the outsized role that Planned Parenthood plays within the publicly supported SRH care system, it is unrealistic to expect other types of clinics to serve the millions of people who rely on them for care. I base this statement on a recent analysis from my Guttmacher colleagues that estimated the extent to which other facility types within this care system would need to

[52] Medicaid's Federal Medical Assistance Percentage (FMAP) (2025), https://www.congress.gov/crs-product/R43847.

[53] Brittni Frederiksen et al., *supra* note 37.

increase their contraceptive client caseload. Based on data from 2020, they estimated the following necessary capacity increases:

- Federally qualified health center (FQHC) sites offering contraceptive care would have to increase their capacity to provide these services by 56%, or an additional one million contraceptive clients per year.
- Health department sites offering contraceptive care would have to increase their capacity to provide these services by 28%, or an additional 168,000 contraceptive clients per year.
- Hospital sites offering contraceptive care would have to increase their capacity to provide these services by 53%, or an additional 344,000 contraceptive clients per year.
- Other sites offering contraceptive care, such as those operated by independent agencies, would have to increase their capacity to provide these services by 55%, or an additional 189,000 contraceptive clients per year.

44. FQHCs are an essential part of the nation's overall health care system, and they have been identified as the most likely facility type to "pick up the slack" if Planned Parenthoods were removed as a publicly supported option for patients. However, they are not structured to take on this dramatic increase in publicly supported patients for specialized SRH care, especially in the context of documented staffing shortages, funding pressures, and challenges navigating Medicaid enrollment changes.[54] Importantly, in seven Plaintiff

[54] Celli Horstman et al., *Community Health Centers' Progress and Challenges in Meeting* (continued…)

States (CT, MN, NJ, OR, VT, WA, and WI), FQHCs and other publicly supported clinics would need to increase their caseloads by more than 100% to provide care for patients currently served by Planned Parenthood.[55] In addition, FQHCs and other publicly supported clinics in two Plaintiff States (California and Maryland) would have to increase their caseloads by 80% or more.

Provider-level impacts

45. Our research at Guttmacher has shown that when healthcare facilities are forced to grapple with the loss of a major funding source, such as losing Title X funds or Medicaid reimbursement, many are forced to adapt fee models and reimbursement plans that create more financial obstacles for patients.[56] This can increase the burden on staff, as they have to counsel patients on their new, more limited options available to pay for care. As more patients are left uninsured, staff time may be further stretched through increased demands of attempting to find alternative sources of funding. In the context of family planning providers having to navigate these funding constraints and resulting compromised ability to provide person-centered care, some providers reported increased staff burnout, morale issues, and departures.[57] As one survey

Patients' Essential Primary Care Needs, COMMONWEALTH FUND (2024), https://www.commonwealthfund.org/publications/issue-briefs/2024/aug/community-health-centers-meeting-primary-care-needs-2024-FQHC-survey.

[55] Press Release, Guttmacher Inst., Federally Qualified Health Centers Could Not Readily Replace Planned Parenthood (May 13, 2025), https://www.guttmacher.org/news-release/2025/federally-qualified-health-centers-could-not-readily-replace-planned-parenthood.

[56] Alicia VandeVusse et al., *The Impact of Policy Changes from the Perspective of Providers of Family Planning Care in the US: Results from a Qualitative Study*, 30 SEXUAL & REPROD. HEALTH MATTERS 544, 549 (2022), doi:10.1080/26410397.2022.2089322.

[57] *Id.*

respondent explained: "Staff morale is often a challenge, as we see increased patient volumes and a higher percentage of patients without any [insurance] coverage or without stable coverage. Higher rates of upset patients, increased workload and a hostile political environment can make staff feel like they are frequently under attack just for doing what they believe in."[58] The combination of all of these obstacles can result in providers making care decisions that are not centered on a patient's needs and values but on financial and other constraints.[59]

Patient-level impacts

Impacts on access to contraception

46. Impacts of restrictions on SRH care at the systems- and provider-levels ultimately trickle down to impact the very people that these systems are set up to serve, resulting in decreased access to care and reproductive autonomy. Several studies that I led under the Reproductive Health Impact Study highlight how this ripple effect can occur and portend what may follow if Section 71113 of Public Law 119-21 stands. Broadly, when we analyzed longitudinal survey data from patients seeking SRH care prior to and after the implementation of the 2019 Title X Final Rule, which resulted in all Planned Parenthoods leaving the Title X network, we found that patients who obtained care prior to the Final Rule at a Title X–funded health care center that

[58] Alicia VandeVusse et al., *Publicly Funded Clinics Providing Contraceptive Services in Four US States: The Disruptions of the "Domestic Gag Rule" and COVID-19*, GUTTMACHER INST. (July 2023), https://www.guttmacher.org/report/clinics-providing-services-in-four-us-states-disruptions-of-gag-rule-and-covid-19.
[59] Alicia VandeVusse et al., *Contraceptive Care Post-Dobbs: A Qualitative Study of Clinic Staff Perspectives*, 7 SSM – QUALITATIVE RSCH. HEALTH 1, 5-6 (2025), https://www.sciencedirect.com/science/article/pii/S2667321525000101?via%3Dihub.

subsequently left the network were less likely to have received recent contraceptive care after the rule was implemented, compared with those who had initially accessed this care at a site that either stayed in the network or was never a part of it.[60] Further, we found that patients in the first group were less likely to have been using a provider-involved method, less likely to have been using a method that carries a cost and less likely to report being satisfied with their method after the rule went into effect. These data highlight how the removal of Planned Parenthoods as a key provider within the publicly supported network has impacts for individuals who rely on this care.

47. In addition, examining what happened to publicly supported SRH patients in Iowa following the removal of Planned Parenthood as a covered provider under the state Medicaid program also helps to foreshadow some of the impacts that we can expect will result from Section 71113 of Public Law 119-21. In 2017, the Iowa legislature voted to defund Planned Parenthood and reject federal Medicaid dollars for family planning, implementing instead a state-funded program that removed funding eligibility from health care sites that provided abortion care or referrals. According to media accounts highlighting Iowa Department of Health data, there was an 86% decline in patients served within the state family planning program after the policy went into effect.[61] We surveyed patients seeking sexual and reproductive health care

[60] Megan L. Kavanaugh, Ellie Leong & Madeleine Haas, *Measuring the Relationship Between the 2019 Title X Final Rule and Patients' Sexual and Reproductive Health Care Access and Behavior in Iowa Using a Difference-in-Difference Approach*, 21 SEXUALITY RSCH. & SOC. POL'Y 598, 609 (2024), https://link.springer.com/article/10.1007/s13178-023-00876-2.
[61] Michaela Ramm, *Iowa's Family Planning Service Use Plummets 85 Percent After Switch to New Program*, THE GAZETTE (Dec. 10, 2019), https://www.thegazette.com/health-care-

(continued…)

at publicly supported family planning clinics in Iowa soon after the policy went into effect and followed them for two years. We found:[62]

- The number of patients seeking care at clinics that were affected by the policy dropped dramatically in the two years following implementation of the rule (83% of respondents sought care before the policy went into effect and 15% did so at two years).
- The number of respondents who reported not receiving any recent sexual and reproductive health care increased from 25% at the six-month follow-up to 52% at the two-year point.
- The policy resulted in many patients shifting their contraceptive method: The number who used a method that cost money decreased from 76% to 57%, while the number who used no-cost methods increased from 15% to 28%."

48. We also conducted three rounds of in-depth interviews with some of these patients over eighteen months after the policy went into effect, and these interviews illustrated how pervasive cost-, access-, and quality-related barriers impeded patients' ongoing access to their preferred contraception.[63] Cost barriers such as high fees for visits and methods as well as restrictive or inadequate insurance coverage, and access barriers such as long appointment

medicine/iowas-family-planning-service-use-plummets-85-percent-after-switch-to-new-program/.

[62] Megan L. Kavanaugh et al., *A Prospective Cohort Study of Changes in Access to Contraceptive Care and Use Two Years after Iowa Medicaid Coverage Restrictions at Abortion-providing Facilities Went into Effect*, 41 POPULATION RSCH. & POL'Y REV. 2555, 2569 (2022), https://link.springer.com/article/10.1007/s11113-022-09740-4.

[63] Lori Frohwirth et al., *Access to Preferred Contraceptive Strategies in Iowa: A Longitudinal Qualitative Study of Effects of Shifts in Policy and Healthcare Contexts*, 33 J. HEALTH CARE FOR POOR & UNDERSERVED 1494, 1496-1513(2022), https://muse.jhu.edu/pub/1/article/862431/pdf.

> wait times were most common; these barriers were often experienced simultaneously, thus compounding one another. One respondent's story of navigating her SRH care and preferred contraception in the wake of the Iowa Medicaid policy restrictions illuminates the barriers and, ultimately, disrupted access to contraception and care:[64]

J was an uninsured OCP user who initially reported getting pills at a [Planned Parenthood] without any difficulty:

I thought that even if I was charged, I knew I would be charged a lot lower, because at [the site], they try to make them a little more affordable and a little more acceptable, but when I reported my income, they told me it was free. I was like, yay!

At Wave 2, J said staff at the site told her they would soon have to stop providing free pills onsite due to changes to their funding:

I knew that things have been covered on the media about the potential for defunding for [the site] and the birth control. I never knew that it had actually officially been passed that when I called, they told me that it had been passed and that people are just no longer eligible for the free birth control at all … So, that's no longer an option for me … our funds are quite tight.

She planned to get her pills through a pharmacy or a mail-order system instead of directly from the clinic:

Since all the funds have been cut, not all but most, but definitely for birth control, it's cheaper for me to go back to a regular pharmacy. I get at least a $10 discount going through the pharmacy instead of going through [the site].

[64] *Id.* at 1509.

At her last interview, she was delaying her annual SRH visit until she was sure that she could pay for it:

I asked about the coverage and if it was changed or what had changed, and they said yeah, all of our funding got cut and birth control is like this much. I asked if the appointment itself would end up costing me money and then she said, yes it would end up costing me money, and I canceled my appointment.

She did not know exactly when she might reschedule her visit, which was required to renew her prescription.

49. Taken together, the survey and interview findings indicate that the Iowa Medicaid restrictions on Planned Parenthood diminished access to high-quality, more affordable and more comprehensive sexual and reproductive health care and resulted in some patients shifting their contraceptive use to a method that they preferred less. These impacts on individuals' decision-making power run counter to the tenets of reproductive autonomy.

50. Texas provides another case study of how removing Planned Parenthoods from the publicly supported SRH care system impacts patients. In 2012 Texas legislators cut state funding for family planning services and passed legislation to exclude abortion-affiliated providers (primarily Planned Parenthoods) from participating in the state Medicaid program.[65] As a result, about a quarter of family planning clinics in Texas were forced to close, resulting in significantly

[65] Kari White et al., *Cutting Family Planning in Texas*, 367 NEJM 1179, 1179-1180(2012), https://doi.org/10.1056/NEJMp1207920.

fewer patients served.[66] In addition, patients were also forced to pay more for contraceptive services that had been reduced in cost or free under the program.[67] A 2016 New England Journal of Medicine (NEJM) study examining additional impacts of excluding Planned Parenthoods from the Texas Medicaid program attributed significant reductions in the use of long-acting and injectable contraceptive methods and, ultimately, increases in Medicaid-covered childbirths to the Medicaid restrictions.[68]

51. Patients who rate their interpersonal interactions with their sexual and reproductive health care provider more favorably are more likely to still be using their contraceptive method after six months and to use more effective methods.[69] As noted in Section V.B., Planned Parenthood clinics offer unique benefits in terms of not only volume of patients served, but also in the quality of specialized SRH care. In addition to not having capacity to take on previous Planned Parenthood patients, evidence indicates that FQHCs don't have the same breadth and depth of quality SRH care as specialized health centers like Planned Parenthoods,[70] indicating that patients would be harmed through both reduced access to care as well as reduced access to quality care.

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[66] Kari White et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105 AM. J. PUB. HEALTH 851, 851 (2015), https://doi.org/10.2105/AJPH.2014.302515.

[67] Kristine Hopkins et al., *Women's Experiences Seeking Publicly Funded Family Planning Services in Texas*, 47 PERSPS. ON SEXUAL & REPROD. HEALTH 63, 65-66 (2015), https://doi.org/10.1363/47e2815.

[68] Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 NEJM 853, 858-59 (2016), https://www.nejm.org/doi/full/10.1056/nejmsa1511902.

[69] Christine Dehlendorf et al., *Association of the Quality of Interpersonal Care During Family Planning Counseling with Contraceptive Use*, 215 AM. J. OBSTETRICS & GYNECOLOGY 78.e1, 78.e4-78.e8 (2016), 10.1016/j.ajog.2016.01.173.

[70] Alicia VandeVusse et al., *supra* note 40 *Appendix Tables*, GUTTMACHER INST.,

(continued…)

52. Additional evidence from California helps to fill out the picture of how putting up cost barriers to people's access to contraception results in them shifting their use of methods. A survey among patients in California's publicly supported family planning network asked respondents what contraceptive methods they would use if paying out of pocket; respondents reported that their contraceptive use would shift from higher-efficacy to lower-efficacy methods. Specifically, respondents reported that the imposition of cost barriers would cause their use of lower-efficacy birth control to nearly double, from 25% to 46%, with use of medium- and high-efficacy methods decreasing.[71]

Impacts on access to broader SRH care

53. Many patients denied access to a Planned Parenthood clinic—either because they can't accept their Medicaid insurance or because the clinic is forced to shut down—would likely experience a serious gap in access to family planning services, which could result in untreated sexually transmitted infections (STIs) or cancers detected too late due to missed cancer screenings. Wellness visits at Planned Parenthood health centers typically include a regular physical exam (e.g., height, weight, and blood pressure), questions about a patient's medical history and family's medical history, vaccinations including for HPV, contraceptive counseling STD screening, cancer-related screenings such as pelvic exams, Pap tests, and breast examinations.[72] Evidence from California

https://www.guttmacher.org/sites/default/files/report_downloads/publicly-supported-family-planning-clinics-2022-2023-appendix_tables.pdf.

[71] ANTONIA BIGGS ET AL., FINDINGS FROM THE 2012 FAMILY PACT CLIENT EXIT INTERVIEWS 11 (Bixby Ctr. for Glob. Reprod. Health, 2014), https://familypact.org/wp-content/uploads/2019/10/Findings-from-the-2012-Family-PACT-Client-Exit-Interviews.pdf.

[72] *Wellness Visit*, PLANNED PARENTHOOD, https://familypact.org/wp-content/uploads/2019/10/Findings-from-the-2012-Family-PACT-Client-Exit-Interviews.pdf.

indicates that most patients getting care at publicly supported SRH facilities, approximately half of which in California are Planned Parenthoods, received key, preventive health screenings including for blood pressure, diabetes, alcohol, tobacco and drug use, and for experiences with interpersonal violence.[73]

54. Based on the most recent annual report from PPFA,[74] data on affiliate medical services provided across the network indicated the following annual services: 769,851 HIV tests, 4,330,310 STI tests, 173,397 Pap tests, and 40,247 HPV vaccinations, among other services. We at the Guttmacher Institute have developed a tool[75] to estimate the health benefits associated with the provision of publicly supported family planning. Using our "impact calculator" and the service data from PPFA's most recent annual report, the preventive services provided at Planned Parenthoods highlighted above avert, in a year, the following public health outcomes (approximated):

- 82,000 chlamydia infections
- 9,500 cases of pelvic inflammatory disease (PID)
- 820 ectopic pregnancies
- 1600 cases of infertility
- 130 HIV infections
- 200 cervical cancer cases

[73] ANTONIA BIGGS ET AL., *supra* note 71, at 9,19.
[74] A FORCE FOR HOPE, *supra* note 33, at 23.
[75] Frost, Jennifer J., et al. *Return on investment: a fuller assessment of the benefits and cost savings of the US publicly funded family planning program,* THE MILBANK QUARTERLY 92.4 696, 671 (2014), https://doi.org/10.1111/1468-0009.12080.

55. Without access to these services at Planned Parenthoods in the Plaintiff States due to Section 71113 of Public Law 119-21, we can reasonably expect that many of these public health outcomes would no longer be averted. Many of these negative health outcomes will likely be disproportionately experienced among patients from marginalized communities. For instance, the prevalence of STIs such as chlamydia, gonorrhea, and syphilis are influenced by geography and sociodemographic characteristics, with increased rates occurring among Hispanic and African American populations and individuals with lower incomes.[76]

56. Data from Iowa in the time period after the implementation of the Medicaid restrictions that excluded Planned Parenthood from the state Medicaid program (described above) help to provide an example of the broader SRH health impacts when this key provider is no longer available to patients for preventive care. According to media accounts highlighting Iowa Department of Health data from prior to after the restriction went into place, there was a spike in cases of gonorrhea, chlamydia, and syphilis in the year following the restriction. The 20,000 cases of the STIs represented an increase of more than 1,800 within a single year.[77]

57. There is no reason to believe that the effect of removing Planned Parenthood healthcare facilities from the federal Medicaid program on the Plaintiff States would be any less pronounced than the observed effects of excluding local

[76] JERUSHA BARTON ET AL., SEXUALLY TRANSMITTED DISEASE SURVEILLANCE 69-75 (Ctrs. for Disease Control & Prevention, 2016), https://stacks.cdc.gov/view/cdc/41806.
[77] Michaela Ramm, *supra* note 66.

Planned Parenthood sites from programs in specific states, such as Iowa or Texas. Instead, it is reasonable to believe that many of the negative contraceptive and SRH outcomes documented in the state-specific research studies described above—including declines in the use of preferred and provider-involved methods, access to high-quality contraceptive care, and increases in STIs and reproductive cancers—will be replicated on a national scale if Section 71113 of Public Law 119-21 stands.

VI. Conclusion

58. For the reasons outlined above, Planned Parenthood healthcare facilities provide sexual and reproductive health services that cannot be readily replaced—in neither quality nor volume—by other existing providers. The implementation of Section 71113 of Public Law 119-21 will have immediate and long-lasting detrimental effects on the health and well-being of patients and their families in the Plaintiff States, as well as for the provider networks and states more broadly.

I declare under penalty of perjury that the foregoing is true and correct. EXECUTED on September 2025.

Megan L. Kavanaugh

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Exhibit A

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EDUCATION

Doctor of Public Health, Behavioral and Community Health Sciences, June 2008
University of Pittsburgh, Graduate School of Public Health, Pittsburgh, Pennsylvania
Dissertation: *Exploring the Context and Social Determinants of Unintended Pregnancy*
Advisor: Dr. Patricia Documét

Master's Certificate in Women's Studies, December 2005
University of Pittsburgh, Department of Women's Studies, Pittsburgh, Pennsylvania

Master of Public Health, Behavioral and Community Health Sciences, April 2005
University of Pittsburgh, Graduate School of Public Health, Pittsburgh, Pennsylvania
Thesis: *Emergency Contraceptive Services in Children's Hospital Emergency Departments*
Advisor: Dr. Martha A. Terry

Bachelor of Science, Agricultural and Biological Engineering, May 2001
Cornell University, College of Engineering, Dean's List, Ithaca, New York

PROFESSIONAL EXPERIENCE

Principal Research Scientist, Guttmacher Institute, New York, New York, August 2017 – Present
Play substantive lead on Institute's core area of domestic contraception. Contribute to overseeing and broadly providing input to research projects related to contraception, including idea generation, proposal development and institutional representation. Provide managerial supervision of senior and midlevel staff as well as broad mentorship to supervisees and other staff. Management and research duties as described for Senior Research Scientist below.

Adjunct Professor of Medicine, School of Medicine, Department of General Internal Medicine and Center for Innovative Research on Gender Health Equity (CONVERGE), University of Pittsburgh, Pittsburgh, Pennsylvania, February 2018 – Present
Lecture on topics related to mixed-methods research design and reproductive health to a variety of departments within the University of Pittsburgh. Present research at department seminars. Mentor and advise graduate students on topics related to expertise. Participate in regular meetings and initiatives to promote rigorous, policy-relevant research related to women's health through CONVERGE.

Senior Research Scientist, Guttmacher Institute, New York, New York, July 2010 – July 2017
Designed and managed research projects on sexual and reproductive health issues, specifically abortion, contraceptive use and unintended pregnancy, using quantitative and qualitative methods. Led quantitative analyses of large, national-level datasets and quantitative and qualitative analyses of smaller datasets from primary data collection. Oversaw junior research staff on research project tasks such as literature reviews, development of survey instruments and interview guides, sampling strategies and data collection. Wrote summaries of research to submit for publishing in peer-reviewed academic journals and developed research proposals to submit for grant funding. Disseminated findings of research to a broad audience of stakeholders.

Charlotte Ellertson Social Science Postdoctoral Fellow in Abortion and Reproductive Health, Guttmacher Institute, New York, New York, September 2008 – June 2010

Designed, conducted and managed research projects on providers' and patients' perspectives regarding the existence and value of contraceptive services in US abortion care settings. Developed study protocol, analyzed data and began drafting a manuscript from findings exploring the links between HIV stigma and abortion stigma around motherhood issues in Zambia and Nigeria. Assisted in project development, conceptual framing and analysis of colleagues' sexual and reproductive health research. Presented and submitted findings from fellowship and dissertation research projects to professional meetings and peer-reviewed journals. Participated in leadership/advocacy activities to develop skills for translating sexual and reproductive health research into practice.

Paraprofessional Counselor, Planned Parenthood of Western Pennsylvania/Women's Health Services, Pittsburgh, Pennsylvania, April 2004 – August 2008

Counseled patients regarding sexual health issues and pregnancy options. Assessed patients' medical histories and provided education on safe sexual health behaviors. Assisted physicians and supported patients during clinical procedures.

Research Assistant III, Center for Research on Health Care, University of Pittsburgh, Pittsburgh, Pennsylvania, January 2008 – September 2008

Designed and administered a quantitative survey instrument to measure prospective pregnancy intentions and assess interest in receiving IUDs during pregnancy testing services. Managed IRB submissions and revisions, data collection and data entry efforts of research team.

Graduate Student Researcher, Behavioral and Community Health, University of Pittsburgh Graduate School of Public Health, Pittsburgh, Pennsylvania, May 2006 – September 2007

Analyzed data from an evaluation of child abuse prevention intervention program using SPSS. Facilitated focus groups of pediatric clinicians for evaluation of child abuse prevention intervention and drafted the first manuscript based on the focus group data. Supervised undergraduate students involved in literature reviews and data entry.

Sexual Health Educator, University of Pittsburgh Student Health Service, Pittsburgh, Pennsylvania, August 2004 – April 2006

Planned, implemented, and evaluated sexual health programs for university students. Coordinated planning and execution of health fairs and outreach events. Served as a resource for individual or group outreach programs related to sexual health.

Program Evaluator, The Program Center (TPC), University of Pittsburgh Graduate School of Public Health, Pittsburgh, Pennsylvania, January 2004 – September 2004

Conducted participant observations at offender work-release facility. Developed in-depth interview guide and facilitated unstructured interviews with residents regarding program orientation. Analyzed qualitative data and presented completed evaluation to program supervisors.

Research Associate, Trophogen, Inc., Rockville, Maryland, October 2001 – June 2003

Designed and developed therapeutic analogs of TSH and gonadotropins. Performed immunoassays and bioassays of analogs to determine concentrations and activity. Investigated structure-function relationships of glycoprotein hormones and their receptors.

Computer Programming Teaching Assistant, Cornell University Department of Agricultural and Biological Engineering, Ithaca, New York, August 1999 – May 2001

Taught classes of 20+ students on developing algorithms and creating computer programs in Java. Worked with other teaching assistants to develop lectures and presentations for classes. Assisted in writing, revising, and grading homework sets and course exams.

Research Assistant, Cornell University Department of Environmental Health and Safety, Ithaca, New York, August 1997 – May 1999

Developed and implemented a mercury recycling program among all labs at the university. Lab research involved recycling of mercury and other hazardous wastes. Compiled and presented recommendations for universal implementation of program.

PUBLICATIONS

Peer-reviewed publications

Olson H, Haas M, Douglas-Hall A, **Kavanaugh ML**. How health insurance instability differentially impedes access to sexual and reproductive healthcare, by race/ethnicity and nativity. *Health Services Research* (in press).

Kavanaugh ML, Desai S, Borrero S, Gomez AM, Higgins J, Holt K, Malcolm N, O'Donnell J, VandeVusse A, Wade J, Zolna M, Frost J. Call to Action: Bringing sexual and reproductive health equity into how we quantify the impact of contraceptive access. *Contraception* (in press).

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Leong E, Geddes C, Weeks F, **Kavanaugh ML**. Contraceptive care and method use by sexual and gender minority individuals: insights from a longitudinal study of sexual and reproductive health care patients in Wisconsin. *Sexual and Reproductive Health Matters*. 2025; DOI:10.1080/26410397.2025.2544432.

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Olson H and **Kavanaugh ML**. Where do female contraceptive users get contraception, and does this differ by insurance coverage? A state-level examination. *Contraception*. 2025; DOI:10.1016/j.contraception.2025.110834.

Neiman E, Bornstein M, Norris Turner A, **Kavanaugh ML**, Gallo M. Use of period- or fertility-tracking technologies pre- and post-Dobbs. *Contraception*. 2025; DOI:10.1016/j.contraception.2025.110812.

Kavanaugh ML, Leong E, Geddes C. Differential associations between access to sexual and reproductive healthcare and subsequent contraceptive and pregnancy outcomes by ethnicity among

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Kavanaugh ML, Haas M, Douglas-Hall A. Differential associations between experiences of contraceptive care and subsequent contraceptive access and preferences among family planning patients by racial identity: Evidence from Arizona, Iowa, and Wisconsin. *PLOS ONE*. 2024; DOI:10.1371/journal.pone.0312111.

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Gomez AM, Reed RD, Bennett AH, **Kavanaugh ML**. Integrating Sexual and Reproductive Health Equity into Public Health Goals and Metrics: Comparative Analysis of Healthy People 2030's Approach and a Person-Centered Approach to Contraceptive Access Using Population-Based Data. *JMIR Public Health and Surveillance*. 2024; DOI: 10.2196/58009.

Kavanaugh ML, Hussain R, Little A. Overall and method-specific contraceptive preferences among reproductive-aged contraceptive users in Arizona, Iowa, New Jersey, and Wisconsin. *Health Services Research*. 2024; DOI: 10.1111/1475-6773.14297.

Kavanaugh ML, Friedrich-Karnik A. Has the Fall of *Roe* Changed Contraceptive Access and Use? New Research from Four US States Offers Critical Insights. *Health Affairs Scholar*. 2024; DOI: 10.1093/haschl/qxae003.

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Moore AM, Keogh S, **Kavanaugh ML**, Mulambia C, Bankole A, Mutombo N. Bucking social norms: Examining anomalous fertility aspirations in the face of HIV in Lusaka, Zambia. *Social Science & Medicine*. 2014, 119:88-97.

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Kavanaugh ML, Frohwirth LF, Jerman J, Popkin R, Ethier K. Long-acting reversible contraception for adolescents and young adults: Patient and provider perspectives. *Journal of Pediatric and Adolescent Gynecology*. 2013, 26(2):86-9.

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Reports, monographs and other publications

Friedrich-Karnik A and **Kavanaugh ML.** *The right is waging a quiet war on contraception*. Op-ed in The Hill; September 4, 2025.

Rodriguez M and **Kavanaugh ML.** *Navigating Reproductive Health Post-Dobbs: What We Know About Changes in Contraception*. Blog post for Academy Health; September 3, 2025.

Kavanaugh ML, Blades N, Friedrich-Karnik A, Frost J**.** *Trump Administration's Withholding of Funds Could Impact 30% of Title X Patients*. Guttmacher Policy Analysis; April 8, 2025.

Kavanaugh ML. *Is Birth Control Under Attack?* Op-Ed for Zocalo Public Square; September 9, 2024.

Olson H, Haas M, **Kavanaugh ML**. *State-Level Contraceptive Use and Preferences: Estimates from the US 2022 Behavioral Risk Factor Surveillance System*, New York: Guttmacher Institute, 2024. DOI: 10.1363/2024.300488.

Easter R, Friedrich-Karnik A, **Kavanaugh ML**. *Any Restrictions on Reproductive Health Care Harm Reproductive Autonomy: Evidence from Four States*, New York: Guttmacher Institute, 2024.

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Douglas-Hall A, Li N, **Kavanaugh ML**. *State-Level Estimates of Contraceptive Use in the United States, 2019*, New York: Guttmacher Institute, 2020.

Douglas-Hall A, Kost K, **Kavanaugh ML**. *State-Level Estimates of Contraceptive Use in the United States, 2017*, New York: Guttmacher Institute, 2018.

Kavanaugh ML and Anderson RM, *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers*, New York: Guttmacher Institute, 2013.

Sonfield A, Hasstedt K, **Kavanaugh ML**, Anderson RM. *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, New York: Guttmacher Institute, 2013.

Manuscripts under review and in preparation

Swan LET, Seymour J, Hung A, Higgins J, **Kavanaugh ML**. Understanding Reasons for Contraceptive and LARC Non-Use: Insights from the Reproductive Health Impact Study (under review).

VandeVusse A, Muller M, Douglas-Hall A, Sackiety S, **Kavanaugh ML**. Understanding patient perspectives on the quality of family planning care: a qualitative study (under review).

Olson H, Douglas-Hall A, Haas M, **Kavanaugh ML**. Investing in Reproductive Health: Contraceptive Use and Preference Fulfillment Among Low-Income Individuals Across State Policy Contexts (under review).

Zolna M, Mitchell L, **Kavanaugh ML**. Did *Dobbs* impact access to and use of preferred contraception and related outcomes?: Quasi-experimental evidence from three states in the U.S. (under review).

Smith M, Chakraborty P, Kim T, Peluso A, Steinberg J, **Kavanaugh ML**, Gallo M. State policy context and abortion support before Dobbs: Results from the Surveys of Women (under review).

Frost J, **Kavanaugh ML**, Gomez A, Douglas-Hall A. Moving Towards a Population Level Measure of Person-Centered Contraceptive Need in the United States (under review).

Mason RE, Caioli K, Pleasants E, Turner AN, Gallo MF, **Kavanaugh ML**, Smith MH. Changes in Emergency Contraception use pre- and post-*Dobbs* across seven states (in preparation).

Pleasure ZH, Pleasants E, Danaux J, Hassan A, Scales D, Gómez AM, **Kavanaugh ML**. Society of Family Planning Research Practice Support: Key considerations for contraceptive misinformation and disinformation research (in preparation).

Pleasure ZH, Pleasants E, Danaux J, Hassan A, Scales D, **Kavanaugh ML**. A conceptual framework for understanding the comprehensive contraceptive health information ecosystem (in preparation).

GRANTS AND RESEARCH SUPPORT

Time-Sensitive Research to Assess the Effects of Reproductive Health Policy on the Health Outcomes of People with Chronic Diseases (INTREPID)
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Advisory Board Member *Funded: September 2023 – Present*
People with chronic and complex medical conditions are particularly vulnerable to adverse health consequences as a result of abortion policy. This study, Investigating Time- sensitive Reproductive Health Equity Post-Dobbs for Patients with ChronIc Disease (INTREPID), will evaluate the time-sensitive impact of evolving abortion policies on the health and well-being of patients, particularly those with chronic diseases that increase the risk of severe maternal morbidity and maternal mortality (e.g., cardiovascular disease, cancer, systemic lupus erythematosus); the clinical practice of physicians who care for people with chronic diseases; and downstream clinical outcomes at a population level. This project seeks to inform health policy that will optimize reproductive healthcare and clinical outcomes in the post-Dobbs era.

Evaluating indirect survey question methods on reproductive health behavior
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Co-investigator *Funded: September 2023 – Present*
Supports a body of research to advance understanding on the characteristics, attitudes, and behaviors of those obtaining abortions in nine U.S. states by evaluating the validity of the Item Sum Technique (IST) to estimate mean numbers of abortions per woman of given sociodemographic characteristics and state of residence. This exploratory research will enable development and application of indirect survey questions on abortion in future state and national sample surveys of fertility and reproductive health. It will provide cross-state baseline information against which to gauge changes in abortion utilization in the near-term, especially critical given the increased restrictions on abortion access at the state level.

Generating Actionable Data to Ensure High-Quality, Equitable Sexual and Reproductive Health Care *Funded: September 2022 – Present*
Office of the Assistant Secretary for Health (OASH), Office of Population Affairs (OPA)
Role: Co-Principal investigator
Supports a comprehensive package of research to generate actionable data and ensure that high-quality, equitable sexual and reproductive health services are available to all people. Activities address individual-level, provider-level and systems-level questions of health equity to advance foundational resources to assess family planning care in the US. Information generated from this research will provide new insights and answers to four key research questions: Who needs SRH care? Where, for whom, and how is care provided and received? What care do people want? and What difference does access to care make?

Advancing Innovative Measurement of Pregnancy Preferences with Longitudinal Data
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Expert Advisory Panel Member *Funded: September 2022 – Present*
This proposal addresses critical scientific and measurement gaps using longitudinal data from population-based surveys, fielded to over 12,000 women, aged 18-44, across nine US states, which include the Desire to Avoid Pregnancy (DAP) scale. The DAP reconceptualizes "intentions" as "preferences" and captures the diversity of considerations and feelings women have about a potential future pregnancy. The insights gained and development of innovative extensions of the DAP instrument will facilitate the use of rigorous, meaningful measures in future research.

Development and validation of a novel, person-centered measure of post-conception pregnancy acceptability (the Post-CAP) *Funded: February 2021 – Present*
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Consultant
Supports work to develop a new, multidimensional measure of post-conception acceptability of pregnancy (the Post-CAP) to assess the relationship between existing pregnancies and health and social outcomes.

Advancing Measurement and Understanding of Contraceptive Failure in the United States
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Co-investigator *Funded: September 2018 – Present*
Supports work to provide updated and enhanced measures of contraceptive failure by more fully incorporating theoretical perspectives on reproductive behavior. The project includes secondary analysis of qualitative interviews describing contraceptive strategies that resulted in contraceptive failures, updated estimates of method-specific contraceptive failure rates using Bayesian models to exploit richness of national-level data sources, and a national survey that draws on the findings from the first two components to identify factors contributing to changes over time in contraceptive failure rates.

Reproductive Health Impact Study *Funded: September 2017 – September 2024*
The William and Flora Hewlett Foundation
Anonymous Donor
Role: Principal investigator
Supported work to monitor the impact of policy changes affecting the publicly funded family planning safety net in the United States. The project tracked changes in reproductive health services and financing and employed longitudinal data collection (both quantitative and qualitative) to assess the impact of policy change on service providers and on the people who need the care provided by this health system in four states: Iowa, Arizona, New Jersey and Wisconsin.

An Evidence Base for Action: Tracking the State of the Nation's Reproductive Health
Anonymous Donor *Funded: October 2014 – September 2021*
Role: Co-investigator
Supported ongoing efforts to comprehensively track the state of the nation's reproductive health, including the Guttmacher Institute's flagship research efforts documenting levels of abortion, unintended pregnancy, and teen pregnancy (nationally and for each state), as well as tracking of reproductive health laws and policies at the state level. One specific component of this work was to monitor and track contraceptive use among American women and men using biannually collected data from the National Survey of Family Growth.

Advancing Measurement and Analysis of Sensitive Behaviors in the United States
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Co-investigator *Funded: September 2016 – June 2021*
Advanced the measurement of abortion in the United States through a multi-faceted investigation of abortion underreporting in three national surveys, and through the design, testing and evaluation of a series of new approaches for improving reporting going forward.

Monitoring U.S. Family Planning Needs and Services *Funded: October 2019 – September 2020*
Anonymous Donor
Role: Co-investigator
Supported one year of work to reconceptualize and re-envision the Guttmacher research portfolio that tracks and documents contraceptive and sexual and reproductive health care in the United States. This work involved aligning the research portfolio with Guttmacher's Institutional values and identifying key evidence needed by policymakers, advocates, service providers, and litigators to develop and sustain policies and programs to protect care delivery within the publicly funded family planning health system.

Exploring Barriers to Post-Abortion Contraceptive Provision
Anonymous Donor *Funded: January 2017 – December 2017*
Role: Principal investigator
Supported work to examine and recommend strategies to overcome barriers to the provision of post-abortion contraception among abortion providers. Included under this grant was a policy analysis of provision obstacles and a qualitative study of independent abortion providers to document challenges to providing contraception within the abortion care context. Focus groups and in-depth interviews with clinic administrators were used to understand the complexities of providing post-abortion contraception.

Financial Viability and the Sustainability of Title X Centers *Funded: July 2014 – June 2017*
Office of Population Affairs, HHS
Role: Principal investigator
Supported data collection from publicly funded family planning clinics and their clients to document the gap between levels of third-party reimbursement and the cost to Title X-funded sites of delivering care, assess differences in the extent to which costs of providing care to clients were being recovered by Title X-funded systems and identify best practices in cost recovery, and identify women, or groups of women, who were seeking Title X-funded services but who were falling through gaps in the ACA's coverage expansions.

Contraceptive Use in the Health Care Reform Era *Funded: March 2015 – April 2016*
JPB Foundation
Role: Co-investigator

Supported efforts to track the impact of the Affordable Care Act (ACA) on contraceptive coverage, cost and method use, by carrying out a cross-sectional survey of women to obtain information on their source of insurance coverage, contraceptive method use and cost-sharing, and analysis of a Bayer Pharmaceuticals dataset looking at changes in what health plans were requiring women to pay out-of-pocket for IUDs.

Advancing Research on the Consequences of Unintended Childbearing
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Co-investigator *Funded: September 2011– August 2015*
Supported work to improve the health and well-being of American families by identifying and clarifying the consequences of unintended childbearing, specifically focusing on the ways in which the intention status of a birth affects women's and men's behaviors during and after pregnancy, as well as the health and well-being of infants and children. A key piece of this research was conducting qualitative interviews with men and women who characterized their most recent birth as unintended in order to understand the consequences of these births from the perspective of those who had experienced them.

Return on Investment: A Fuller Assessment of the Benefits and Cost-Savings of America's Publicly Funded Family Planning Program *Funded: March 2012 – March 2015*
JPB Foundation
Role: Co-investigator
Supported quantitative work to build on the Guttmacher Institute's existing cost-benefit research by providing a more complete accounting of the returns on investment in family planning services, with the aim of bolstering the case for publicly-funded family planning programs. New quantifiable benefits that accrue from services received during family planning visits as well as updated estimates of the cost-savings associated with unplanned birth were identified.

HIV Status and Achieving Fertility Desires *Funded: May 2008 – May 2013*
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Co-investigator
This project involved conducting in-depth quantitative and qualitative research to understand how individuals and couples in Nigeria and Zambia achieve their family size goals while avoiding or coping with HIV infection. The project provided a regional overview of the interrelationships between HIV status, fertility desires and sexual and reproductive behaviors and deepened understanding of relationships between HIV status and the actions women and men take to achieve their fertility aspirations and prevent or cope with HIV infection.

Meeting the contraceptive needs of adolescents and young adults: Program adequacy and the role of long acting reversible contraceptive methods *Funded: October 2010 – October 2012*
Office of Population Affairs, HHS
Role: Principal investigator
Supported quantitative and qualitative data collection from publicly funded family planning clinics and their clients to document contraceptive services for adolescents and young adults, the barriers to serving these populations and the need for these services. A specific focus of this project was on long-acting reversible contraceptive method services for this younger age group.

Who uses long-acting reversible contraceptive methods? *Funded: July 2010 – October 2011*
Society of Family Planning
Role: Principal Investigator
This one-year grant supported secondary data analysis of the 2006-2008 National Survey of Family Growth, which examined long-acting reversible contraceptive (LARC) method use and predictors of use.

Abortion patients' perspectives on receiving contraceptive services during abortion care
Society of Family Planning *Funded: October 2009 – October 2010*
Role: Principal Investigator
This one-year small grant supported a quantitative research study of US abortion patients' experiences with and attitudes towards receiving contraceptive services during abortion care.

Community attitudes towards motherhood and abortion for HIV-positive women
Charlotte Ellertson Social Science Postdoctoral Fellowship *Funded: March 2009 – August 2010*
Role: Principal Investigator
This two-year grant supported a project to assess community members' attitudes towards motherhood and abortion in the context of HIV in Nigeria and Zambia. The project supplemented a five-year ongoing NIH-funded research project that explores the relationship between HIV status and fertility desires among community members and clinical providers in these two countries.

Can abortion providers help women avoid subsequent unintended pregnancies and abortions?
Anonymous Donor *Funded: September 2008 – August 2010*
Role: Principal Investigator
This two-year grant supported mixed-methods research that documented contraceptive services in large, non-hospital US abortion care settings and identified barriers to the integration between contraceptive and abortion care.

Exploring the social determinants of unintended pregnancy *Funded: December 2007 – June 2008*
University of Pittsburgh Women's Studies
Student Research Fund Award
Role: Principal Investigator
This funding award supported the qualitative component of the PI's dissertation research, which encompassed in-depth interviews with low-income and African American women in Pittsburgh, PA regarding social and environmental factors that had an impact on their experiences of, and decisions about, unintended pregnancies.

Emergency contraceptive services in children's hospital emergency departments
Association of Reproductive Health Professionals
Gary Stewart Scholarship for Research *Funded: September 2006 – August 2007*
Role: Principal Investigator
This national scholarship is awarded to one public health graduate student who proposes a significant research project that addresses a pressing issue in the field of public health, especially as it may pertain to reproductive health. The award supported ongoing research regarding existing emergency contraceptive protocols and services in US children's hospital emergency departments.

Emergency contraceptive services in children's hospital emergency departments
University of Pittsburgh Women's Studies
Student Research Fund Award *Funded: December 2005 – June 2006*
Role: Principal Investigator
This funding award supported a quantitative research study of the existence and availability of emergency contraceptive services in US children's hospital emergency departments. Telephone surveys of children's hospital emergency department directors were used to collect the data.

PRESENTATIONS

Conference papers and oral presentations

Rocca C, Bullington BW, **Kavanaugh ML**, Stulberg D, Borrero S, Munoz I. Establishing evidence-based cut-points on the desire to avoid pregnancy measure. Oral presentation at the Society of Family Planning Annual Meeting, Pittsburgh, PA, October 2025 (scheduled).

Kavanaugh ML and VandeVusse A. Actionable, person-centered data to inform the landscape of contraceptive and related SRH care. Panel presentation at the National Reproductive Health Conference, virtual, August 8, 2025 (scheduled).

Olson H, Haas M, Douglas-Hall A, **Kavanaugh ML**. Investing in reproductive health: Contraceptive use and preference fulfillment among low-income individuals across state policy contexts. Oral presentation at the Population Association of America Annual Meeting, Washington, DC, April 13, 2025.

Gallo M, Johnston E, **Kavanaugh ML**, Smith M, Spencer N. Findings and the future of two state-representative surveys on reproductive health. Panel presentation at the Society of Family Planning Annual Meeting, Detroit, MI, October 2024.

VandeVusse A, Blades N, Mueller J, **Kavanaugh M**. How Policy Changes Impact Family Planning Providers and Patients: Key Findings from the Reproductive Health Impact Study. Panel presentation at the Title X National Grantee Conference, Baltimore, MD, July 12, 2023.

Kuhns T, Davis J, **Kavanaugh ML**, Gallo M. A multi-state analysis of crisis pregnancy center (CPC) attendance. Oral presentation at the Population Association of America 2023 annual meeting, New Orleans, LA, April 15, 2023.

Kavanaugh ML, Leong E, Haas M. Impact of the 2019 Title X Final Rule on patients' sexual and reproductive health care access and behavior in Iowa. Oral presentation during invited panel on Demography of Access to Contraception at the Population Association of America 2023 annual meeting. April 13, 2023.

Baker K, Beatty K, Gonzalez E, Rubin S, **Kavanaugh ML**. Conducting family planning services research with Federally Qualified Health Center (FQHC) partners. Panel presentation at the Society of Family Planning virtual annual meeting, October 10, 2020.

Khoury A, **Kavanaugh ML**, Gallo M, Boudreaux M, Hale N. Contraception use and experiences at the state level: Findings from the statewide survey of women. Panel presentation at the Society of Family Planning virtual annual meeting, October 9, 2020.

Bessett D, Bommaraju A, **Kavanaugh ML**, Hou M. Abortion Stigma: What can we learn from a comparison to miscarriage stigma? Oral presentation at the American Sociological Association 2016 annual meeting, Seattle, WA, August 20, 2016.

Kavanaugh ML, Kost K, Frohwirth L, Maddow-Zimet I. The Impact of an Unplanned Child: A Qualitative Study of the Consequences of Unintended Childbearing for Mothers and Fathers. Oral presentation at the Population Association of America 2015 annual meeting, San Diego, CA, May 1, 2015.

Bessett D, Gerdts C, Littman LL, **Kavanaugh ML,** Norris A. Does State-Level Context Matter for Individual's Knowledge about Abortion and Health? Oral presentation at the American Sociological Association 2014 annual meeting, San Francisco, CA, August 16, 2014.

Kavanaugh ML, Jerman J, Frohwirth L, Popkin R, Ethier K, Moskosky S. Provider practices and patient perspectives on LARC for young women. Oral presentation at the Office of Adolescent Health, Administration on Children, Youth and Families' and Centers for Disease Control and Prevention/Division of Reproductive Health's (OAH/ACYF/CDC) Third Annual Teenage Pregnancy Prevention Conference, National Harbor, MD, May 20, 2013.

Kavanaugh ML, Jerman J, Frohwirth L, Popkin R, Ethier K, Moskosky S. Contraceptive and LARC Services for Teens and Young Adults in Publicly Funded Facilities in the US. Oral presentation at the Population Association of America 2013 annual meeting, New Orleans, LA, April 11, 2013.

Finer LB, Jerman J, **Kavanaugh ML**. Changes in use of long-acting contraceptive methods in the U.S., 2007-2009. Oral presentation at the American Public Health Association annual meeting, San Francisco, CA, October 29, 2012.

Kavanaugh ML, Jerman J, Ethier K, Moskosky S. Meeting the contraceptive needs of adolescents and young adults: Youth-friendly and long-acting reversible contraceptive Services in U.S. family planning facilities. Oral presentation at the "Reproductive Health Disparities among Youth: Improving Services and Ensuring Access" 2012 annual meeting, Chicago, IL, May 10, 2012.

Moore AM, **Kavanaugh ML**, Keogh SC, Mulambia C, Adewole I, Oladokun A, Mutombo N, Arulogun OS, Bewupe MM, Bankole A. Achieving fertility aspirations in high HIV settings: Using anomalous case analysis in Zambia. Oral presentation at the Population Association of America 2012 annual meeting, San Francisco, CA, May 3, 2012.

Kavanaugh ML, Moore A, Akinyemi O, Adewole I, Dzekedzeke K, Awolude O, Arulogun O. Community attitudes toward childbearing and abortion among HIV-positive women in Nigeria and Zambia. Oral presentation at the Union for African Population Studies meeting, Ouagadougou, Burkina Faso, December 5, 2011.

Kavanaugh ML, Moore A, Akinyemi O, Adewole I, Dzekedzeke K, Awolude O, Arulogun O. Community attitudes toward childbearing and abortion among HIV-positive women in Nigeria and Zambia. Oral presentation at the American Public Health Association meeting, Washington, DC, October 31, 2011.

Kavanaugh ML, Lindberg L, Frost J. Factors impacting partners' involvement in contraceptive services. Oral presentation at the Population Association of America 2011 annual meeting, Washington, DC, April 1, 2011.

Jones RK, **Kavanaugh ML**. Changes in U.S. abortion rates by subgroup, 2000 and 2008. Oral presentation at the Population Association of America 2011 annual meeting, Washington, DC, April 1, 2011.

Kavanaugh ML, Arulogun O, Adewole I, Dzekedzeke K, Oladokun A. Men's abortion attitudes in the context of HIV. Oral presentation at the UCLA Bixby Center on Population and Reproductive Health meeting "Men, Masculinities and Family Planning in Africa," Los Angeles, CA, October 15, 2010.

Moore A, **Kavanaugh ML,** Arulogun O, Dzekedzeke K, Oladokun A. HIV-Positive Women's Reports of Their and their Partners' Fertility Preferences: A Case Study of Zambia. Oral presentation at the UCLA Bixby Center on Population and Reproductive Health meeting "Men, Masculinities and Family Planning in Africa," Los Angeles, CA, October 15, 2010.

Kavanaugh ML, Jones RK, Finer LB. How Commonly Do U.S. Abortion Clinics Offer Contraceptive Services? Oral presentation at the National Abortion Federation 2010 annual meeting, Philadelphia, PA, April 26, 2010.

Kavanaugh ML, Gold MA. Emergency Contraception Services for Adolescents: a National Survey of Children's Hospital Emergency Department Directors. Oral presentation at the Association of Reproductive Health Professionals and Society of Family Planning 2007 annual meeting, Minneapolis, MN, September 27, 2007.

Kavanaugh ML, Schwarz EB. Counseling About and Use of Emergency Contraception in the United States: Results from the National Survey of Family Growth. Oral presentation at the Society of General Internal Medicine annual meeting, Toronto, ON, Canada, April 26, 2007.

Invited lectures

Kavanaugh ML. Actionable, person-centered data to inform the landscape of contraceptive and related SRH care in the United States: Recent updates to key SRH metrics that undergird federally funded family planning care. Presentation at the SPHERE Prato Meeting 2025: Grand challenges in the international landscape for women's sexual and reproductive health, Prato, Italy, July 2, 2025.

Kavanaugh ML. Contraception in the United States: Use, access, and recent shifts in this landscape. Mitch Creinin annual Family Planning Lectureship at UPMC Magee-Womens Hospital, Pittsburgh, PA, March 11, 2025.

Kavanaugh ML. Sexual and reproductive healthcare in the post-*Dobbs* context: Current landscape and threats. Presentation at the White House Convening on Contraceptive Access on the 59th Anniversary of *Griswold v. Connecticut*, Washington, DC, June 7, 2024.

Kavanaugh ML. Rethinking how we measure the "impact" of receiving sexual and reproductive healthcare: Ongoing updating of Guttmacher research portfolio documenting the landscape of publicly funded family planning in the United States. Presentation at the Psychosocial Workshop, Columbus, OH, April 16, 2024.

Kavanaugh ML. Reproductive Health Impact Study: How Public Policies Impact Family Planning Providers and Patients. Presentation at the U.S. Department of Health and Human Services (DHHS) Roundtable Series: Facilitating Reproductive Health Research post-Dobbs Decision, Washington, DC, November 6, 2023.

Kavanaugh ML. Generating actionable data to ensure high-quality, equitable sexual and reproductive health care: Updated surveillance of the publicly funded family planning program in the United States. Presentation at the Psychosocial Workshop, New Orleans, LA, April 12, 2023.

Kavanaugh ML. Reproductive Health Impact Study: What policy change in Wisconsin means for Wisconsinites' sexual and health. Presentation at the Wisconsin Department of Health Services, virtual, March 9, 2023.

Kavanaugh ML. Sexual and Reproductive Health Care Access and Service Delivery in Wisconsin: Latest Landscape and Projected Shifts. Presentation at the UW CORE Research Exchange, virtual, January 20, 2023.

Kavanaugh ML. Contraception in the United States: Use, access, and recent shifts in this landscape. Presentation to the American Public Health Association Contraception Task Force, virtual, September 21, 2022.

Kavanaugh ML. Where do reproductive-aged women want to get contraception? Presentation at the Psychosocial Workshop, Atlanta, GA (hybrid/virtual), April 5, 2022.

Kavanaugh ML. Reproductive Health Impact Study: What policy change in Wisconsin means for Wisconsinites' sexual and health. Presentation at the UW CORE Research Exchange, virtual, October 22, 2021.

Kavanaugh ML. Telehealth delivery of SRH care: What is the landscape and how has it shifted with COVID-19? Presentation at the Funders Convening for Contraceptive Access, virtual, October 16, 2020.

Kavanaugh ML. IUD Use in the United States: Trends and Characteristics. Presentation at the Sixth International Symposium on Intrauterine Devices and Systems for Women's Health, virtual, September 30, 2020.

Kavanaugh ML. Contraception in the United States: Use, access, and how COVID-19 has shifted this landscape. Presentation at the Contemporary Topics in OB-GYN Allegheny Health Network Virtual Conference, virtual, September 26, 2020.

Kavanaugh ML. Contraceptive access in the United States: Demand, source of care, and method use. Presentation at the CECA Technical Expert Panel meeting on Funding Strategies to Expand Contraceptive Access, Washington, DC, February 11, 2020.

Kavanaugh ML. Reproductive Health Impact Study: Update on state-level research in Iowa and Arizona. Presentation at the Psychosocial Workshop, Austin, TX, April 10, 2019.

Kavanaugh ML. Contraceptive Use and Unintended pregnancy in the United States: Measurement, Missteps and More Room for Improvement. Presentation at the University of Pittsburgh Health Services Research Seminar Series, Pittsburgh PA, March 7, 2019.

Kavanaugh ML. Family planning in the United States: What's at stake in the next four years? Presentation on the Society of Family Planning panel at the American Congress of Obstetricians and Gynecologists annual meeting, Sane Diego, CA, May 6, 2017.

Kavanaugh ML. Use of multiple methods in the United States. Presentation at the Psychosocial Workshop, Chicago, IL, April 25, 2017.

Kavanaugh ML. Contraceptive Use and Unintended pregnancy in the United States: Measurement, Missteps and More Room for Improvement. Presentation at the University of Cincinnati Department of Sociology Colloquium Lecture Series, Cincinnati, OH, September 30, 2016.

Kavanaugh ML. Trends in Unintended Pregnancy and LARC Use. Presentation at the Bridging the Divide: LARC Roundtable, Washington, DC, May 10, 2016.

Kavanaugh ML. Men's reactions to pregnancy intention terminology. Presentation at the Psychosocial Workshop, Washington, DC, March 29, 2016.

Kavanaugh ML. Women seeking information about abortion services run into the "abortion black hole": Findings from qualitative interviews with abortion patients. Presentation at the Psychosocial Workshop, Washington, DC, March 29, 2016.

Kavanaugh ML. Survey Methodology: the Whys and How tos. Presentation at the Junior Fellows Professional Development Workshop at the North American Forum on Family Planning annual meeting, Chicago, IL, November 13, 2015.

Kavanaugh ML. Unintended pregnancy and contraceptive use among adolescents and prevalence of sexual activity by age. Presentation at the Adolescents and Over-the-Counter Access to Oral Contraceptives Expert Meeting, Washington, DC, October 22, 2015.

Kavanaugh ML. Financial Viability and Sustainability of Title X Centers, 2014–2017. Presentation at the Office of Population Affairs Title X Grantee Meeting, Washington, DC, August 19, 2015.

Kavanaugh ML. Qualitative explorations of the consequences of unintended pregnancy and men's pregnancy intentions. Part of panel: Findings from a 5-year R01, "Advancing Research on the Consequences of Unintended Childbearing." Presentation at the Psychosocial Workshop, San Diego, CA, April 29, 2015.

Kavanaugh ML, Kost K, Frohwirth L, Maddow-Zimet I. Qualitative explorations of men's pregnancy intentions. Presentation at the Psychosocial Workshop, Boston, MA, April 30, 2014.

Kavanaugh ML, Bessett D, Littman LL, Norris A. Knowledge about abortion compared to knowledge about contraception, pregnancy and birth. Presentation at the Psychosocial Workshop, New Orleans, LA, April 9, 2013.

Kavanaugh ML. Contraceptive Use: What do we know? What do we not know? What do we do about it? Presentation at the RNDMU Region IV Title X workshop, Chapel Hill, NC, September 18, 2012.

Kavanaugh ML. Youth-Friendly Contraceptive Services, including Long-Acting Reversible Contraception Services, for Teens and Young Adults in the US. Webinar presentation to Planned Parenthood affiliates, organized by PPFA, June 15, 2012.

Kavanaugh ML. Long-acting reversible contraceptive (LARC) services for teens and young adults in US publicly funded family planning clinics. Presentation at the Psychosocial Workshop, San Francisco, CA, May 2, 2012.

Kavanaugh ML. LARC Services for Teens and Young Adults in Publicly Funded Clinics. Webinar presentation to Office of Population Affairs (OPA) Title X grantees, organized by OPA, February 22, 2012.

Kavanaugh ML. Utilization of Long-Acting Reversible Contraception (LARC) among Adolescents. Webinar presentation to CDC pregnancy prevention grantees, organized by Cicatelli Associates, Inc., November 10, 2011.

Kavanaugh ML, Williams SL, Schwarz EB. Emergency contraception use and counseling after changes in United States prescription status. Presentation at the EC Jamboree, New York, NY, October 4, 2011.

Kavanaugh ML. LARC Methods and Younger Patients: Research on Barriers and Opportunities for Title X. Presentation at the 2011 National Title X Grantee Meeting, Miami, FL, August 4, 2011.

Kavanaugh ML, Carlin LE, Jones RK. Patients' attitudes and experiences related to receiving contraception during abortion care. Presentation at the Psychosocial Workshop, Washington, DC, March 29, 2011.

Kavanaugh ML, Moore A, Akinyemi O, Arulogun O, Awolude O, Adewole I, Dzekedzeke K. Women's stigmatizing attitudes towards motherhood and abortion for HIV-positive pregnant women in Zambia and Nigeria. Presentation at the Psychosocial Workshop, Washington, DC, March 29, 2011.

Kavanaugh ML. Providing Contraception to Patients in the Abortion Care Setting: a Qualitative Exploration of Practices and Barriers. Presentation to the medical faculty, fellows, and residents in the Columbia University Division of Family Planning and Preventive Services, New York, NY, April 7, 2009.

Kavanaugh ML, Hershey N. Emergency Contraception Meets Historic Misconceptions. Presentation at the University of Pittsburgh Honor's College Friday Lecture Series, Pittsburgh, PA, February 2, 2007.

Gold MA, **Kavanaugh ML**. Emergency Contraception and Emergency Departments. Presentation to the medical faculty, fellows, and residents in the emergency department of the Children's Hospital of Pittsburgh, Pittsburgh, PA, June 28, 2006.

Kavanaugh ML. Emergency Misconceptions: Ongoing Research on Emergency Contraceptive Services in Children's Hospital Emergency Departments. Presentation to the University of Pittsburgh Women's Studies Seminar Series, Pittsburgh, PA, February 22, 2006.

Posters

Zolna M, Chiu D, Osias P, **Kavanaugh ML**. Updated national-level contraceptive use and preference estimates in the U.S. Poster presentation at the Society of Family Planning Annual Meeting, Pittsburgh, PA, October 2025 (scheduled).

Olson H and **Kavanaugh ML**. Contraceptive preferences and use at the state level: Findings from the 2022 Behavioral Risk Factor Surveillance System. Poster presentation at the Population Association of America annual meeting, Columbus, OH, April 19, 2024.

Neiman E, Bornstein M, Norris Turner A, **Kavanaugh ML,** Gallo M. Use of period tracking apps pre- and post-Dobbs. Poster presentation at the Midwest Nursing Research Society annual meeting, Minneapolis, MN, March 1, 2024.

Kavanaugh ML, Frost J. Reproductive Health Impact Study. Poster presentation at the Title X Grantee annual conference, virtual, July 14, 2021.

Douglas-Hall A, Finn S, **Kavanaugh ML**. Health insurance coverage and contraceptive use at the state level: Findings from the 2017 Behavioral Risk Factor Surveillance System. Poster presentation at the Population Association of America 2020 annual meeting, Washington, DC, April 22, 2020.

Kavanaugh ML, Jerman J. Use of concurrent multiple methods of contraception in the United States. Poster presentation at the North American Forum on Family Planning 2017 annual meeting, Atlanta, GA, October 15, 2017.

Kavanaugh ML, Jerman J, Finer L. Who uses long-acting reversible contraceptive methods in the United States, which methods do they use, and who stops using them? Poster presentation at the North American Forum on Family Planning 2015 annual meeting, Chicago, IL, November 17, 2015.

Norris A, Bessett D, Esber A, Littman L, **Kavanaugh ML.** Do the know-it-alls actually know? Comparing perceived and assessed knowledge of sexual and reproductive health among US adults. Poster presentation at the North American Forum on Family Planning 2015 annual meeting, Chicago, IL, November 17, 2015.

Littman L, Esber A, **Kavanaugh ML,** Bessett D, Norris A. Does the source matter? The association between individuals' trusted information source and reproductive health knowledge. Poster presentation at the North American Forum on Family Planning 2014 annual meeting, Miami, FL, October 12, 2014.

Bessett D, Norris A, Littman L, **Kavanaugh ML**. Knowledge about Abortion in 'Red,' 'Blue,' and 'Purple' States: Examining the relationship between state-level political contexts and individual knowledge about abortion. Poster presentation at the North American Forum on Family Planning 2013 annual meeting, Seattle, WA, October 7, 2013.

Kavanaugh ML, Bessett D, Littman L, Norris A. Knowledge about abortion compared to knowledge about contraception, pregnancy and birth. Poster presentation at the National Abortion Federation 2013 annual meeting, New York City, NY, April 29, 2013.

Kavanaugh ML, Frohwirth L, Jerman J, Popkin R, Ethier K, Moskosky S. Long-acting reversible contraception for adolescents and young adults: Service availability, provider attitudes and patient perspectives. Poster presentation at the Society for Adolescent Health and Medicine 2013 annual meeting, Atlanta, GA, March 15, 2013.

Kavanaugh ML, Jerman J, Ethier K, Moskosky S. Long-acting Reversible Contraceptive Services for Teens and Young Adults in Publicly Funded Facilities in the United States. Poster presentation at the North American Forum on Family Planning 2012 annual meeting, San Francisco, CA, October 28, 2012.

Kavanaugh ML, Moore A, Akinyemi O, Adewole I, Dzekedzeke K, Awolude O, Arulogun O. Community attitudes toward childbearing and abortion among HIV-positive women in Nigeria and Zambia. Poster presentation at the XIX International AIDS Conference, Washington, DC, July 23, 2012.

Moore A, **Kavanaugh ML,** Arulogun O, Dzekedzeke K, Oladokun A. HIV-Positive Women's Reports of Their and their Partners' Fertility Preferences: A Case Study of Zambia. Poster presentation at the XIX International AIDS Conference, Washington, DC, July 23, 2012.

Kavanaugh ML, Jerman J, Hubacher D, Kost K, Finer LB. Characteristics of Women in the United States Who Use Long-Acting Reversible Contraceptive Methods. Poster presentation at the Population Association of America 2012 annual meeting, San Francisco, CA, May 3, 2012.

Jerman J and **Kavanaugh ML**. Women's characteristics associated with pill discontinuation due to dissatisfaction, by reason. Poster presentation at the American Public Health Association meeting, Washington, DC, October 31, 2011.

Kavanaugh ML, Jerman J, Hubacher D, Kost K, Finer LB**.** Who uses long-acting reversible contraceptive methods in the United States? Poster presentation at the North American Forum on Family Planning 2011 annual meeting, Washington, DC, October 23, 2011.

Williams SL, **Kavanaugh ML**, Parisi SM, Borrero S, Schwarz EB. Contraceptive use among obese women: results from the 2006-2008 National Survey of Family Growth. Poster presentation at the North American Forum on Family Planning 2011 annual meeting, Washington, DC, October 23, 2011.

Kavanaugh ML, Carlin E, Frohwirth L, Jones RK. Patients' attitudes and experiences related to receiving contraception during abortion care. Poster presentation at the National Abortion Federation 2011 annual meeting, Chicago, IL, April 11, 2011.

Zolna M, **Kavanaugh ML**, Lindberg L. Couples-based family planning services: Is there a need? Poster presentation at the American Public Health Association annual meeting, Denver, CO, November 8, 2010.

Kavanaugh ML, Terry MA, Documet PD. Life Stability and Unintended Pregnancy: How Social Context Shapes Women's Fertility Experiences. Poster presentation at the American Public Health Association annual meeting, Philadelphia, PA, November 9, 2009.

Kavanaugh ML, Jones RK, Finer LB. Providing Contraception to Patients in the Abortion Care Setting: Practices and Barriers. Poster presentation at the Association of Reproductive Health Professionals and Society of Family Planning 2009 annual meeting, Los Angeles, CA, October 2, 2009.

Kavanaugh ML, Jones RK, Finer LB. Providing Contraception to Patients in the Abortion Care Setting: a Qualitative Exploration of Practices and Barriers. Poster presentation at the National Abortion Federation 2009 annual meeting, Portland, OR, April 29, 2009.

Kavanaugh ML, Schwarz EB. Prospective Assessment of Pregnancy Intentions Using a Single vs. Multi-item Measure. Poster presentation at the Association of Reproductive Health Professionals and Society of Family Planning 2008 annual meeting, Washington, DC, September 19, 2008.

Schwarz EB, **Kavanaugh ML**, Horowitz T. While You're Here, Can I Interest You in an IUD? Interest in intrauterine contraception among women seeking pregnancy testing. Poster presentation at the Association of Reproductive Health Professionals and Society of Family Planning 2008 annual meeting, Washington, DC, September 19, 2008.

Kavanaugh ML, Schwarz EB. Counseling About and Use of Emergency Contraception in the United States: Results from the National Survey of Family Growth. Poster presentation at the American Public Health Association annual meeting, Washington, DC, November 5, 2007.

Kavanaugh ML, Schwarz EB. Counseling About and Use of Emergency Contraception in the United States: Results from the National Survey of Family Growth. Poster presentation at the University of Pittsburgh Graduate School of Public Health Dean's Day, Pittsburgh, PA, March 16, 2007.

Terry MA, **Kavanaugh ML**, Beem P, Finch K, Goodman R. Improving African American Access to Epilepsy Resources. Poster presentation at the Pennsylvania Public Health Association, Pittsburgh, PA, October 24-26 2005.

PROFESSIONAL AFFILIATIONS

Fellow, Society of Family Planning, January 2013 – Present

- Secretary, Board of Directors, October 2019 – February 2024
  - Executive Committee, October 2019 – February 2024
  - Diversity, Equity and Inclusion (DEI) Committee Co-Chair, January 2019 – February 2024
  - Strategic Planning (VISION) Working Group Co-Chair, February 2021 – December 2022
  - Merger Working Group, May 2020 – March 2021
  - Governance Committee Chair, January 2018 – January 2021
  - Community Norms Working Group Chair, January 2019 – March 2020
  - At-large member, Board of Directors, November 2016 – October 2019
- SFP Traveling to abortion care, post-Dobbs RFP, Grant Review Committee, February 2024
- Member, Challenges in Future Abortion Research Learning Community, June – December 2022
- Research Abstract Selection Committee DEI Representative, 2022 Annual Meeting
- SFP Annual Awards Selection Committee Co-Chair, Spring 2022
- Research Abstract Selection Committee DEI Representative, 2021 Annual Meeting,
- SFP Annual Awards Selection Committee Co-Chair, Spring 2021
- Oral Abstract Judge Chair, 2020 Annual Meeting, October 2020
- Medication Abortion RFP#2 Grant Review Committee, August 2020
- Population Health Track Chair, 2019 Annual Meeting Session Working Group, May 2019
- Medication Abortion RFP#1 Grant Review Committee, August 2018
- Scientific Abstract Committee, May 2017
- Interdisciplinary Innovation (I2) Grant Review Committee, June 2016
- Trainee/Student Grant Review Committee, June 2014

Junior Fellow, Society of Family Planning, May 2007 – January 2013

- Junior Fellows Committee, March 2009 – January 2013
- Trainee/Student Grant Review Committee, June 2011

Member, Global Health Council, October 2008 – Present

Member, Population Association of America, September 2008 – Present

- Session organizer and chair, Contraceptive Use in Developed Countries, PAA annual meeting, April 2019
- Discussant, Patterns and Determinants of Contraceptive Use, PAA annual meeting, March 31, 2016
- Session organizer and chair, Contraceptive use, PAA annual meeting, May 2014
- Discussant, Determinants, Associations and Consequences of Abortion, PAA annual meeting, April 16, 2010

Member, American Public Health Association, August 2007 – Present

- Moderator, Panel on Abortion and Stigma, APHA annual meeting, November 8, 2010
- Co-chair, Abortion Task Force, Population, Reproductive and Sexual Health Section, November 2009

Member, Delta Omega Public Health Honor Society, April 2005 – Present

Member, Association of Reproductive Health Professionals, May 2006 – May 2018

Associate Faculty Member, Faculty 1000, March 2010 – January 2014

MEDIA (select interviews)

CNN. *Over-the-counter birth control pills have been available in the US for over a year. Here's who's using them.* August 18, 2025.

NBC News. *The morning-after pill is coming to a convenience store near you*. May 28, 2025.

Stateline. *More women are seeking sterilizations post-Dobbs, experts say.* October 2, 2024.

STAT. *Federal officials and physician groups express outrage over revelations of recent coercive sterilizations*. June 6, 2024.

Healthline. *After Dobbs, Study Finds Sharp Increase in Permanent Sterilizations in Young People*. April 12, 2024.

CNN. *Online orders begin for first over-the-counter birth control pill in the US*. March 18, 2024.

Des Moines Register. *Iowa women less likely to access birth control since Roe v. Wade overturned.* March 18, 2024.

Today, Explained (podcast). *Lip gloss, gum, and the Pill*. March 14, 2024.

Wisconsin Public Radio. *The economics of dogs, Over-the-counter birth control availability, Political age and gender gaps.* March 7, 2024.

Everyday Health. *Birth Control in America: A Brief History of Contraception*. October 18, 2023.

Thomson Reuters. *U.S. women struggle to find contraception as restrictions mount*. June 22, 2023.

The CUT. *The Great Morning-After-Pill Rebrand*. March 26, 2023.

Stateline. *New Research Shows State Restrictions Reduce Contraception Use*. September 22, 2022.

Montana Public Radio. *Abortion providers see greater interest in sterilization procedures*. July 22, 2022.

Bloomberg News. *Why Over-the-Counter Birth Control Has Taken So Long in the US*. July 13, 2022.

Tampa Bay Times. *Amid abortion battle, they chose permanent birth control. Here's why*. July 12, 2022.

San Francisco Chronicle. *The repeal of abortion rights sparked an online run on contraception. Bay area telehealth companies are trying to keep up*. July 5, 2022.

New York Post. *Making the cut: Younger men seek vasectomies in the wake of Roe v. Wade ruling*. July 1, 2022.

KFF Health News. *Post-'Roe,' People Are Seeking Permanent Sterilizations, and Some Are Being Turned Away*. June 25, 2022.

Medscape (podcast). *How Is US Policy Affecting Abortion, Pregnancy Rates?* September 6, 2018.

Smithsonian Magazine. *From Medical Pariah to Feminist Icon: The Story of the IUD*. June 15, 2017.

HuffPost. *Long-Term Birth Control Use Soars For American Women*. November 10, 2015.

NPR. *More Women Opt For IUD, Contraceptive Implant For Birth Control*. November 9, 2015.

Time. *More Women Are Getting the IUD and Implant for Birth Control*. October 8, 2015.

WBUR. *Coming To A Clinic Near You: The $50 IUD With A Fascinating Backstory*. October 2, 2015.

HONORS AND AWARDS

Power Player of the Month, Power to Decide, June 2024
Distinguished Alumni Award for Early Career Excellence, University of Pittsburgh Graduate School of Public Health, May 2015
Outstanding Student Award, Department of Behavioral and Community Health Sciences, April 2009
Wyeth New Leaders Fellowship, Association of Reproductive Health Professionals, September 2008
Delta Omega Poster Award, National Office, American Public Health Association, November 2007
Wyeth New Leaders Scholarship, Association of Reproductive Health Professionals, September 2007
Delta Omega Poster Award, Omicron chapter, University of Pittsburgh, March 2007
Dean's Day Doctoral Poster Prize, Graduate School of Public Health, March 2007
Gary Stewart Scholarship for Research, Association of Reproductive Health Professionals, September 2006
Jonas Salk Health Sciences Fellowship, Jewish Healthcare Foundation, September 2005-April 2006
Women's Studies Master's Paper Prize, University of Pittsburgh, June 2005
Delta Omega Public Health Honor Society, University of Pittsburgh, Inducted April 2005
Public Health Service Traineeship Scholarship, University of Pittsburgh, 2003-2004

SERVICE

Technical Expert Panel Member, Reproductive Health Experiences and Access (RHEA) Survey, December 2023 - Present
Steering Committee Member, Post-Roe Contraceptive Access Strategy, CECA, September 2023 - Present
Member, Power to Decide Research Advisory Group, March 2023 – Present
Trustee and Governance Committee member, St. Edmunds Academy Board of Trustees, Pittsburgh, PA, September 2022 – Present
Member, National Contraceptive Quality Measures Workgroup co-convened by PPFA and CECA, January 2022 – Present
Reviewer, *Adolescence Post-Dobbs: A Policy-Driven Research Agenda for Minor Adolescents and Abortion*, Youth Reproductive Equity, January 2024
Reviewer, Contraceptive agency metric development, Innovations for Choice and Autonomy (ICAN) project, July 2023
Expert stakeholder, Testimony provided during Open Public Hearing for FDA consideration of OPill OTC status, May 2023
Member, Setting a Post-Roe Contraceptive Access Strategy Summit convened by CECA, Fall 2022
Member, Contraceptive Access Metrics Working Group convened by CECA, March – August 2022
Member, Technical Expert Panel on Funding Strategies to Expand Contraceptive Access, CECA, January 2020 – August 2021
Research Advisory Board Member, Seeding New Ground pilot project of State Innovation Exchange (SiX), October 2019 – October 2020
Member, Guttmacher Institute Racial Equity Advisory Group, January 2018 – January 2021
Member, University of Pittsburgh Graduate School of Public Health Alumni Awards Committee, December 2015 – January 2020
Member, Power to Decide Reproductive Well-Being Shared Measurement Working Group, January 2019 – August 2020
Liaison, Planned Parenthood Federation of America's (PPFA's) National Medical Committee, January 2011 – February 2020
Alumni presenter, BCHS Alumni Stories Panel, Graduate School of Public Health, January 2018
Member, Guttmacher Institute Research Division Culture Team, September 2016 – March 2019
Member, IUD Data and Monitoring Work Group, IUD Task Force for New York City, January 2013 – September 2017
Participant, Training and Access Working Group (TAWG), March 2009 and October 2009

Stakeholder, ACLU Minors' Rights Project for Minor Victims of Sexual Assault, Pittsburgh, Pennsylvania, April 2007 – August 2008

Volunteer Alumni Interviewer, Cornell Alumni Admissions Ambassador Network, Pittsburgh, Pennsylvania, September 2004 – August 2008

Ad hoc reviewer

- Demography, January 2020 – Present
- International Journal of Health Policy and Management, September 2015 – Present
- Journal of Health Care for the Poor and Underserved, May 2013 – Present
- BMC Women's Health, April 2013 – Present
- Contraception, March 2013 – Present
- Human Reproduction, November 2012 – Present
- Social Problems, October 2012 – Present
- Journal of Immigrant and Minority Health, May 2012 – Present
- Journal of Women's Health, December 2011 – Present
- Women's Health Issues, December 2011 – Present
- Perspectives on Sexual and Reproductive Health, July 2011 – Present
- Social Science Research, June 2011 – Present
- Journal of General Internal Medicine, May 2011 – Present
- Journal of Adolescent Health, August 2010 – Present
- Pediatrics, June 2010 – Present
- Journal of Urban Health, August 2009 – Present
- Qualitative Health Research, August 2009 – Present
- American Journal of Public Health, February 2008 – Present

INTERNATIONAL FIELD RESEARCH

Concepts of Healing: Local Methods vs. Western Medicine, Cornell/Nepal Study Abroad Program, Kirtipur, Nepal, January 2000 – May 2000

Performed preliminary and background research on faith healers' rituals and health posts. Interviewed and observed traditional community healers and modern doctors. Collected data and wrote thesis on interactions between modern and traditional healing.