Increasingly, policymakers, health systems, and health insurance companies are pursuing new ways of delivering and paying for health care—all with an eye towards shifting health care systems from paying for volume to paying for value. Innovative technologies for patient and provider use, including modes of telehealth delivery, are often key components of these changes. There is enormous excitement and energy around what transformation means for improving people’s experience with the health care system, preventing illness, and improving health outcomes. Perhaps most importantly, these system changes hold great promise for addressing the health inequities people with low incomes and people of color face and putting more emphasis on the non-clinical social determinants of health.

Reforms to our health care system in the U.S. and to systems around the world are necessary to improve health care quality, equity, and affordability, and policymakers have an unprecedented and timely opportunity to ensure reproductive health care and reproductive health care providers are central to health care system transformation in its many dimensions. To be successful, though, such reforms must account for reproductive and sexual health needs and address life-threatening reproductive health inequities experienced by the hardest to reach communities in developing countries and LGBTQ+ people, women of color, and women with low incomes in the U.S. as a result of historic and ongoing racism, sexism, homophobia, and transphobia in the health care system. Current efforts at systemic reform in Medicare and Medicaid are generally lacking adequate policy foundations to address reproductive health and equity, at the cost of individual’s lives and wellbeing. Additionally, global agreements on universal health coverage must include comprehensive coverage of sexual and reproductive health services and commitments to meeting the health care needs of the communities that face the greatest barriers to care to ensure we leave no one behind.

Investment in scientific research and development with the goal of developing safe, effective, and patient-centered technologies and knowledge is needed to achieve domestic and international reproductive health, justice, and equity goals.
Invest in Health System Innovation that Promotes Sexual and Reproductive Health

CMS must continue to ensure that the quality measures used to focus and evaluate programs’ progress include basic sexual, reproductive and preventive health care measures, address the health needs of different populations, and are not used inappropriately.

Quality measurement in health care has become increasingly important under the Institute for Healthcare Improvement’s “Triple Aim” pursuit of better care, improved outcomes, and lower costs as an approach to optimizing health system performance. While the National Quality Forum (NQF) has over 600 measures dedicated to assessing patient and population health and improving the quality of health care systems, only recently have any addressed the provision of family planning services. The contraceptive care measures assess the percentage of women of reproductive age: 1) at-risk of unintended pregnancy provided with a most or moderately effective contraceptive method; 2) who have had a live birth and are provided with a most or moderately effective contraceptive method within three to sixty days of childbirth; 3) at-risk of unintended pregnancy provided with a LARC method. Having endorsed contraceptive quality measures presents significant and long-awaited opportunities to advance policy goals to improve people’s health and their access to high-quality sexual and reproductive health care.

In addition to the inclusion of the family planning quality measures in both federal and state initiatives, to truly develop innovative models that will improve outcomes it is essential to include preventative health care measures that reflect the services and care most needed by young people with low incomes and young people of color. Measures of reproductive health care quality, including contraceptive care, are especially useful to identify gaps in equitable access as well as areas for clinical quality improvement.

Because of the history and ongoing existence of reproductive coercion, particular scrutiny should be applied to measures that could have the unintended consequence of coercion in women’s reproductive health decision making. In implementing measure adoption programs, protections should be included to prevent measures from being utilized in a manner that results in coercion towards a particular intervention or outcome such as incentives for using a particular method of birth control.
• CMS should safeguard against patient coercion or steerage toward a particular method of contraception.

• CMS should require quality measure reporting be stratified by variables including race, ethnicity, sex (including sex assigned at birth, gender identity, and sexual orientation), age, disability status, primary language, and other demographic characteristics, as this facilitates identifying disparities and quality gaps, as well as intervention points and strategies.

• CMS should work to incentivize the widespread adoption and use of the contraceptive measures in the quality programs administered by Medicaid, Medicaid managed care entities, and Marketplace plans. CMS and private-sector stakeholders, also, will be strongly urged to start measuring contraceptive care in multi-payer quality improvement efforts.

• CMS should incentivize the use of measurement to hold the system accountable for equity gains and population health outcome improvements.

• CMS should develop more SRH-focused measures, including a patient-reported outcome measure and measures that reflect that health needs of LGBTQ+ people.

• CMS should develop safeguards against unfriendly use of measurement and reporting requirements to undermine providers’ capacity to offer comprehensive sexual and reproductive health care.

Policymakers must prioritize development and broad adoption of delivery system and payment models that recognize how people of reproductive age define quality, value and choice and how they access comprehensive reproductive and sexual health care, including family planning, LGBTQ+-inclusive counseling, prenatal and pregnancy care, abortion, related preventive services, and gender-affirming care, in a range of settings including self-managed care and care accessed by telehealth means.

Alternative payment and clinical care delivery models should view patients and their loved ones as valuable partners at all levels of care and focus on coordinated patient-centered care delivery that includes a commitment to care planning. Care coordination and continuity should include appropriate interface with primary and specialty care. Financial incentives should reward delivery of high-quality care that is measured by high-value quality measures, including patient-reported outcomes measures and patient experience of care measures. Care should be delivered in a range of settings according to patient preference, including with a greater emphasis on providing resources, training, and equipment for telehealth in all medical specialties and disciplines.
Alternative payment and clinical care delivery models should never intentionally or unintentionally allow for coercion towards a particular clinical intervention or outcome; instead models should acknowledge the history and continued existence of reproductive coercion, and must center the needs, perspectives and leadership of those most harmed by reproductive oppression including but not limited to people of color, Indigenous people, cis and trans women and femmes, people with low incomes, LGBTQ+ people, immigrants, and young people.

Achieving health equity should be an explicit goal of efforts to transform the health care system.

Everyone should have a fair and just opportunity to live their healthiest life possible. Therefore, achieving health equity should be an explicit goal of all efforts to transform health care and the health care system. Racism plays a direct role in health outcomes and contributes to negative social determinants of health, for instance by creating barriers to educational attainment and earning capacity. Without making equity an explicit goal, unintended consequences of systemic change can further perpetuate and worsen existing health disparities.

Women of color, specifically, face overlapping issues of systemic oppression, racism, sexism, and the legacy of coercion and exploitation within the healthcare system. To begin to account for historic and ongoing oppression, new models of care delivery should seek to be trauma-informed, culturally sensitive, designed based on the specific needs of communities with direct input and/or participation from the affected communities, and centered on empowerment and choice. Policymakers and health care providers should be committed to reducing racial and ethnic disparities for women of color, including by addressing how racism and other forms of oppression negatively affect health in our current system.

- The administration must take action to make achieving health equity an explicit goal for new models of care delivery and payment. This should include requirements to disaggregate data by race, ethnicity, sex assigned at birth, gender identity, and sexual orientation; training and assessment of delivering culturally sensitive care and combatting implicit bias by health care providers; support for workforce diversity and increased development and access to alternative models of care, such as community health workers; and specific metrics for reducing disparities within patient populations.

- New models should provide greater investment and financial support for safety net providers—particularly reproductive health providers—who are essential sources of care for many communities of color.

- The administration should support transformation efforts that are grounded in the needs of communities of color and should seek to provide care that is equitable, trauma-informed, reflects the health care needs of all women of color, and fully integrates reproductive health care.
Policymakers must ensure reproductive health providers can fully participate across innovative delivery system models; and that patients can see the provider of their choosing.

The Affordable Care Act (ACA) encourages innovative models of care coordination systems such as Accountable Care Organizations (ACOs) and other integrated models. It is critical that patients of these new care models have access to a robust choice of reproductive health providers, as they are an important source of primary care for many individuals. A lack of integration of these providers in delivery system models will mean that efforts to coordinate care for women with chronic diseases and other comorbidities will fail to address their reproductive health needs.

- The administration should implement policies to support reproductive health providers in innovative delivery system models and direct resources to support their participation.
- The administration should protect patients’ choice of reproductive health provider, choice of contraceptive methods, offer a range of options, and promote informed and empowered health care decision-making between providers and patients.

Congress should require CMMI to develop more innovative, Medicaid-focused models of care and payment.

The Center for Medicare and Medicaid Innovation (CMMI) is a significant driver and funder of health care innovation. Currently, the vast majority of CMMI models are focused on the Medicare population, where new ways of delivering care, such as through accountable care organizations, have expanded and taken root. CMMI, however, has devoted less attention to the Medicaid population, which is a critical source of coverage for people of reproductive age.

- To ensure that all people are benefitting from evidence-based, patient-centered, equitable innovation, Congress should explicitly require the Center to focus on the needs of reproductive age people, including individuals who are LGBTQ+, who are more likely than the overall U.S. population to use Medicaid benefits due to systemic barriers and inequalities in the health care system.
Policymakers should incentivize leveraging new technologies to improve the quality of provider-patient interactions, to enhance telehealth and virtual health care experiences, and to expand self-directed care.

There is currently an unprecedented opportunity to encourage fresh technological approaches to expanding care, as well as novel problem-solving partnerships between academic institutions, foundations, nonprofit organizations including patient advocacy groups, companies, and government agencies. Increasingly, policymakers, health systems, and health insurance companies are pursuing new ways of delivering and paying for health care—all with an eye towards shifting our health care system from one that pays for volume to one that pays for value. Innovative technologies for patient and provider use, including modes of telehealth delivery, are often key components of these changes. There is enormous excitement and energy around what transformation means for improving people’s experience with the health care system, preventing illness, and improving health outcomes.

Perhaps most importantly, these system changes hold great promise for addressing the health inequities people with low or no incomes and people of color face and putting more emphasis on the non-clinical social determinants of health. As we promote important uses of health technology and data, we must also prohibit misuses of data for health—for example, targeting certain individuals or groups, collecting data without meaningful consent, using data to discriminate or deny services. To prevent repeating the abuses of the past we must erect guardrails to ensure that communities of color, people with low incomes, persons with disabilities, and others are not more likely to have their most sensitive data siphoned and used without their knowledge, meaningful consent and/or active participation.

• The federal government should lead the way in working across sectors to develop and implement an actionable health technologies innovation plan, to include recommendations for:
  – Novel health care delivery platforms;
  – Clinical record-keeping systems, including novel pathways toward improved patient access control, and use of their own clinical records and other health information, which would be available in multiple languages;
  – Connecting bench, clinical, and behavioral research to policy and practice;
  – Expanding quality improvement efforts that focus on patient-centered decision-making—especially for those who have limited or no access to care; and
  – Increasing access to high-quality sexual and reproductive health care by reducing technological and information barriers.
• The administration should create and Congress should support cross-sector incentives to foster innovation in:

- Health database and clinical records systems;
- Sexual and reproductive health service delivery methods to relieve workforce fatigue, including novel virtual platforms and evidence-based self-care technologies; and
- New technologies in contraception and HIV/STI prevention, such as the emerging field of multipurpose prevention methods currently in early development, particularly those under the control of the receptive partner.

• The administration and Congress should encourage development of innovative technologies and web-based platforms that work toward free and open access to sexual and reproductive health-related databases, tools, and resources. Such innovations must be introduced through programs that ensure adoption is not limited to high-resource settings but instead are available to all types of entities and communities.

Policymakers should continue to invest in the Saving Lives at Birth (SL@B) Grand Challenge program given the demonstrated effectiveness of the initiative’s partnership structure and catalytic funding model.

USAID has pioneered innovative approaches to bring business-minded approaches to the development and roll-out of new global health technologies and accelerate progress against some of the world’s most important health issues. By investing seed capital in the most promising ideas, and leveraging funding, partnerships, and expertise to advance the next generation of global health technologies, the Agency maximizes the impact of U.S. taxpayer dollars, transforming targeted investments into cutting-edge innovations. For example, the Saving Lives at Birth (SL@B) Grand Challenge has successfully leveraged $20 million in U.S. government funding to attract more than $150 million from outside donors to fund a pipeline of 116 innovations aimed at saving the lives of mothers and newborns, with potential to save 150,000 lives by 2030. By making funding available to the brightest innovators around the world, SL@B is an important way USAID is supporting countries as they develop their own health systems. Congressional support is important to ensure such innovative and effective programs continue.
Invest in Research & Development that Promotes Sexual and Reproductive Health

Policymakers should fund and require research and data collection that identifies disparities in health care access and barriers to quality care.

In order to address health inequities in a comprehensive and integrated way, it is essential that we gain a better understanding of both the overall health status and the sexual and reproductive health status and experiences of all communities, including those for whom research data are frequently lacking, such as communities of color, LGBTQ+ people, and young people.

- By improving data collection on abortion, contraception, sexually transmitted infections, sexual orientation and gender identity, formal sex education, and social determinants of health for under-researched groups, we can meaningfully expand capacity to address sexual and reproductive health inequities. National- and state-level government surveys must collect data about the sexual and reproductive health of all communities while soliciting specific data on race, ethnicity, age, sexual orientation, sex assigned at birth, and gender identity so that data may be disaggregated for Asian and Pacific Islander American (AAPI) communities, for young people, and for LGBTQ+ people. This will help reveal important findings about groups that are frequently made invisible by research designs that obscure their identities and experiences. AAPI communities, for example, are often grouped together in studies for convenience, but this masks substantial differences in the circumstances of different ethnic groups. Additionally, in most federal and administrative surveys conducted, questions regarding sexual orientation or gender identity are not routinely asked, which leads to a lack of information about how sexual orientation and gender identity intersect with other data points in any given survey. It is important to note that, given the particular personal and political sensitivities surrounding the issue of abortion in the United States, any moves to improve state abortion surveillance must safeguard the privacy, rights, and needs of abortion patients and providers. Governmental public health reporting systems must be limited to collecting basic incidence and demographic data for legitimate public health purposes. Official governmental reporting systems that go beyond this limited scope have the effect of stigmatizing women obtaining abortions or harassing abortion providers for the purpose of promoting an anti-abortion policy agenda. Using a public health surveillance system for this purpose cannot be justified on any grounds.

- The administration must take action to produce comprehensive data that is disaggregated by sex assigned at birth, gender identity, sexual orientation, race, ethnicity, national origin, age, income, and geographic location.
  - The President must propose a budget that includes funding for research on the lives and experiences of LGBTQ+ people.
Agencies should ensure that their data collection tools use multi-step identification questions. Identification questions in surveys and research should go beyond a singular question about gender question. For instance, in most surveys and forms, one question asks about “gender” and the options are only “male” or “female.” This data collection tool should also be implemented into applications for federal health programs, such as Medicaid, so that electronic systems do not bypass reproductive health and pregnancy-related questions for transgender men and nonbinary and gender nonconforming people.

The Department of Health and Human Services must conduct research on the experiences of LGBTQ+ people seeking and/or receiving reproductive health care.

Congress must hold oversight hearings of administrative agencies conducting data collection to ensure that all LGBTQ+ people are being accounted for, and that no population is left behind.

The administration must conduct comprehensive, non-partisan research into the barriers to access that individuals and communities face, and particularly the barriers imposed by recent regulatory changes such as illegal 1115 waivers, the 2019 Title X final rule, changes to ACA provisions, expanded global gag rule, and more. These types of policies have a significant impact on people’s health and well-being, and disproportionately harm people of color, people who live in rural communities, LGBTQ+ people, Native Americans, and young people. We must have a full and clear accounting of the barriers to access and negative health outcomes that result from these policies.

Policymakers should increase funding for research and development and improve appropriate contraceptive, abortion, and multipurpose (MPT) technologies by $122 million annually for NIH and USAID.

The field of reproductive health research and development (R&D) is grossly underfunded. Greater financial and policy support are required for the discovery and development of new and improved contraceptives, abortion and multipurpose technologies. The current method mix of contraceptives remains inadequate; user acceptance is limited and discontinuation rates of current technologies remain high (25–50%) because of experienced or perceived side effects, amongst other reasons. Each year, 40 percent of pregnancies are unintended worldwide, and in the United States, nearly half (3.1 million) of pregnancies are unintended. The vast majority of unintended pregnancies in the United States occur because of incorrect or inconsistent use of contraceptives—or because they are not used at all. Moreover,


many existing methods are challenging for users and providers, especially in low resource settings in the U.S. and globally, because of cost or how these contraceptives must be administered. Innovation of new methods to better meet user needs and preferences would lead to increased contraceptive uptake, improved access, and effective use of high-quality family planning options worldwide.

Many contraceptive users could also benefit from multipurpose technologies (MPTs) that offer protection not just against pregnancy, but also from HIV, HPV, or other sexually transmitted infections. Every day, approximately 6,300 individuals worldwide acquire HIV, and more than 1 million individuals contract sexually transmitted infections (STIs) that can cause cancer, infertility, pregnancy complications, and increased HIV risk. Despite decades-long calls for more innovative and flexible contraceptive and STI prevention products that work better for people, there has been inadequate attention and resources paid to research and development in this critical space. Indeed, the overwhelming majority of new contraceptive products introduced in the past few decades have been adaptations of existing technologies, instead of technological innovations or breakthroughs. There are very few MPTs under development.

It is critical to invest in the discovery, development, and preparation for market launch of new or improved contraceptive technologies that can better serve millions of users whose contraceptive needs are not currently met by existing technologies. Among the new contraceptive technologies needed are methods that are private and user-controlled; long-acting methods that do not require skilled providers; methods that can be used on demand around the time of intercourse; non-hormonal methods for users who should not use, dislike, or are concerned about the side effects of hormonal methods; and new and better male contraceptives. New technologies also need to be developed for users who are harder to reach for socio-economic and geographic reasons.

The U.S. Government is the world’s largest family planning bilateral donor. Throughout history, USAID has been involved directly or indirectly in the R&D of almost every contraceptive method available today. In a field where few other actors have invested, the U.S. government continues to have a key role to play in correcting this problem and ensuring there are more comprehensive options available to all people, and that this investment has engendered benefits in lives saved, opportunities for women expanded, and health sector costs contained.


Successful, evidence-based programs to advance high-quality family planning and other aspects of sexual and reproductive health have suffered under an administration that disregards and mischaracterizes science while obfuscating the reasons for its actions. Appointees with histories of making inaccurate statements about contraception and abortion have assumed positions responsible for family planning programs. Important research projects funded under the Teen Pregnancy Prevention Program (TPPP) and Title X grant programs, as well as research involving fetal tissue, have been cut short with apparent political motives, while projects that have not undergone sufficient vetting for their consistency with programs’ statutory goals have received funding. Trump administration officials have attempted to eliminate the high-quality evidence standards that characterize TPPP, and have mischaracterized evidence on contraceptive effectiveness and safety in a rule rolling back the employer contraceptive mandate. Such erosion of scientific integrity is a trend across agencies under the Trump administration.  

Restoring scientific integrity is essential to ensure that federal investments translate to improvements in public health. Policies should be informed by high-quality evidence, and policy proposals should accurately represent evidence. Nominees, executive branch appointees, and other policy makers must use evidence-informed and medically accurate data and research, and must not interfere with agencies using science to carry out their missions. Funding decisions and evaluations should be consistent with programs’ statutory goals and made by those with relevant expertise, and once funding has been awarded it should not be rescinded based on new priorities that deviate from programs’ statutory goals. Agencies should be transparent about the evidence and other considerations that guide their decisions on policies and grant decisions, and about findings that affect public health. Government scientists, as well as contractors and grantees engaged in research and data collection, should be able to communicate their findings to Congress, the media, the public, and their scientific peers, free from censorship or other forms of interference by political appointees.

- Congress must pass legislation requiring agencies that fund or conduct scientific research to develop scientific integrity policies. The Obama administration’s 2010 Scientific Integrity Directive instructed agencies to develop scientific integrity policies that ensure a culture of scientific integrity; strengthen credibility of government research; facilitate the free flow of scientific information; and establish principles for conveying scientific information to the public. By the end of the Obama administration, 28 agencies had created scientific...
integrity policies of varying strength and scope, addressing topics such as scientists’ communication with the media, scientists’ ability to review press releases describing their work, and infrastructure to oversee scientific integrity.  

- Congress must exercise oversight and investigate instances of abuses of scientific integrity, including problems with censorship, inappropriate cancelation of grants or research projects, and political interference with science-based decision-making. When concerns about scientific integrity arise, Congress should exercise its oversight role by requesting information from agency leadership, holding hearings, requesting investigations by Inspectors General or the Government Accountability Office, and/or conducting its own investigations.

- The administration must appoint and Senate should confirm nominees who exhibit views and experience consistent with agency missions and who demonstrate respect for and sufficient understanding of relevant science. President Trump has appointed individuals who have histories of promoting abstinence over comprehensive contraceptive care and advancing claims not supported by scientific evidence to roles that include responsibility for family planning programs. While these positions are not subject to Senate confirmation, the appointments indicate a willingness to select appointees whose views and experiences are inconsistent with administering a public health program that should be based on science. Members of Congress should question all administration appointees who oversee health programs, policy, or research about their commitment to scientific integrity.

- Government communications about public health topics should use medically and scientifically accurate terminology that is commonly used in the relevant field. Agencies that address family planning should use medically accurate terms regarding pregnancy and medical interventions.

Congress and the Administration should prioritize funding research for improving maternal health and pregnancy outcomes, ensuring healthy lives for all.

Between 1990 and 2015 when the global maternal mortality rate decreased by approximately 44 percent, the maternal mortality ratio for the U.S. significantly increased from an estimated 16.9 to 26.4 maternal deaths per 100,000 births and the country has now a higher ratio than those reported for most high-income countries. The majority of maternal deaths in the U.S. and around the world are

---


preventable. Among others, one key factor is the general lack of good data—and related analysis—on maternal health outcomes. Not all states have maternal mortality review boards and the data that are collected are not systematically used to guide changes that could improve prenatal care and reduce maternal mortality, morbidity, and prematurity.

Research into methods for addressing the impact of racism on maternal health disparities is also essential, and such research must involve affected communities as partners.

- **Congress and the administration should support the development and evaluation of a range of methods for eliminating racial disparities in maternal health outcomes, from efforts to eliminate bias in provider care and systems of care delivery to initiatives addressing social determinants of health.**

- **Congress and the administration should support greater investment in maternal health outcome data and greater research about the effects of most medications and therapeutics on pregnancy.** Higher quality data is needed to help individuals who are pregnant and their providers manage health problems in the safest possible manner, no matter where they live. The ability to make informed decisions about medications and pregnancy hinges on the availability of better data.

Moreover, Health care providers must be fully equipped with the information necessary to properly communicate about environmental risk factors to patients. While providers tend to discuss regularly with pregnant patients the risks of consuming alcohol, drug abuse and smoking, environmental hazards such as pesticides, certain cosmetic products, mercury in fish, and air pollution often go unmentioned and undetected. Almost nine out of ten OB/GYN’s surveyed in the Bixby’s Center study admitted to not being equipped with the adequate knowledge necessary to fully inform patients about the relationships between environmental exposures and pregnancy outcomes.85

- **Congress must fund additional research into the risks of substances suspected to harm fetal development or pregnant people’s health, and the Centers for Disease Control and Prevention and the Environmental Protection Agency should report back to Congress on the findings including making them publicly available.**

- **The administration should develop a resource tool, which should be regularly updated, for providers and health care professionals providing guidance on best practices when communicating environmental risk factors to all patients, including pregnant women and women of reproductive age.**

The Department of Health and Human Services must develop a robust research and outreach initiative on U.S. maternal mortality in the form of an interagency task force.

In order to address the high rates of mortality and morbidity related to pregnancy in the U.S., the President should develop a robust research and outreach initiative at HHS, in the form of an interagency task force comprising representatives from the National Institutes of Health, Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and other relevant agencies. This task force should be responsible for collecting data, enhancing coordination and communication among relevant federal agencies, and determining and exploring the causes for persistent high rates of maternal mortality, particularly as experienced by Black and Native American individuals, and charged with presenting public health solutions. The task force should also ensure that all federal health quality measures and payer incentives are tied to robust data collection and draw on relevant research to help address inequities uncovered through the interagency task force. Additionally, the task force must have a formal mechanism for meaningful involvement and input by affected communities.

Policymakers should require increased transparency of USAID investments in global health technologies and annual report on health-related research.

The Global Health Innovation Act requires USAID to report annually for five years on the development and use of global health innovations in the programs, projects, and activities of the Agency, as well as a description of collaboration and coordination with other Federal departments and agencies, including the Centers for Disease Control and Prevention, in support of global health product development. Continued reporting is important for transparency and oversight and for ensuring that USAID’s work in global health research and development aligns with and fully supports the agency’s global health goals. The report required by the Global Health Innovation Act should include
information about the Agency’s collaboration and coordination with Federal departments and agencies including the Department of Defense, the National Institutes of Health, the Food and Drug Administration, and the Office of the Global AIDS Coordinator, in addition to the Centers for Disease Control and Prevention, to fully capture how critical gaps in product development for global health are being filled.

Policymakers should fund investment fellowships and grants to support PhD post-doctoral individuals and early career investigators to increase the capacity of reproductive health scientists and the productivity of their labs. Trainees should be paired with institutions, either civil society or university, to facilitate mentorship and collaboration.

There is significant need to invest in a new generation of reproductive health scientists. The lack of reliable sources of support for contraceptive R&D—and even more so for abortion research—stifles the careers of biomedical and biotechnology scientists who wish to pursue work in the relevant sciences. Without sufficient funding or incentives by pharmaceutical companies or donors, the cadre of trained investigators in this field has dwindled as career trajectories are limited. Significant developments are unlikely to occur if top scientists do not enter the field and funding is not available to them to move the science forward with discovery and translational research.

- This next generation of scientists will play significant roles in developing new reproductive health technologies while continuing to develop skill sets needed to succeed as researchers.
- NIH grants will be critical in expanding the pool of next generation reproductive health researchers by providing the funding necessary for mentorship and career development.
The President must propose increased funding for reproductive health technology research and development.

- At least double the National Institutes of Health (NIH) and United States Agency for International Development (USAID) funding available for the research and development of contraceptives that are more effective, affordable, and easier to deliver— as well as for the research and development of multipurpose prevention technologies (MPTs), which are products that simultaneously protect against unintended pregnancy, HIV, or other STIs. This increase should include the following:
  - An additional $80 million to the National Institute of Child Health and Human Development to accelerate the research and development of contraceptives and MPTs;
  - An additional $12 million to the National Institute of Allergy and Infectious Diseases for the expansion of the research and development of MPTs;
  - An additional $30 million to USAID’s Office of Population and Reproductive Health to accelerate the research and development of contraceptives and MPTs; and
  - Continuing $45 million annually for USAID’s Office of HIV/AIDS for the research and development of microbicides to prevent HIV.