Title X: Examining the Impact of Family Planning Policy in the U.S.

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Abstract

Starting in 1994, reproductive health was established as a human right. Having access physically, financially, and culturally to critical services that allow an individual to plan, space and prevent births are crucial in allowing reproductive health to be a human right. In women's reproductive health policy, Title X of the Public Health Service Act of 1970 was a turning point in recognizing that affordable and culturally competent services can assist in reducing unintended pregnancies and the adverse affects that can come with it. Forty-six years later, Title X is still the sole federal policy dedicated to family planning. From its inception, the necessity of Title X has been contested. In the past five years, Congress has proposed to *completely* cut funding for this program. This paper provides an in-depth review of the Title X Family Planning Program comprised of three parts: a legislative analysis of amendments to the law, a case study of how a Title X clinic functions in Colorado, and lastly a feminist policy analysis examining the impacts of the law. The evidence provided by these three analyses suggests that while Title X has made significant progress, more focus needs to be placed on evaluation of quality of services, vulnerable populations and the political context surrounding the policy.

Keywords: Title X, family planning, unintended pregnancy, contraception, reproductive health

Chapter 1: An Overview of Family Planning in the U.S

Adverse Effects of Unintended Pregnancies

Despite medical advances in creating more effective forms of contraception, 49% of pregnancies are still unintended in the U.S (Finer, 2011). Since 2006, this percentage has barely changed and is higher in comparison to other developed nations such as France with a 33% rate of unintended pregnancies and Scotland at 28% (Butler, 2009). Unintended pregnancy can lead to higher risks of morbidity for women due to factors such as tobacco use, alcohol consumption and delayed prenatal care. In addition, women with unintended pregnancies are at higher risk for depression, physical abuse and less economic stability. Coupled with higher risk of adverse maternal health, the child of an unintended pregnancy is at a greater risk of being born prematurely, of having a low birth weight, of not receiving the necessary nutrition for healthy growth and of being victim to abuse (2009). Women between the ages of 18-24 who are unmarried, low-income and/or members of an ethnic/racial minority are at the highest risk for unintended pregnancies; as a woman ages, the ratio of pregnancies that are unintended tends to decrease (Finer, 2011; Moshner, 2012).

Identifying a Need

Family planning is "the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births" (WHO, 2008). The Center for Disease Control has cited the advent of family planning programs as one of the ten greatest public health achievements of the 20th century (1999). Family planning can be crucial in determining the trajectory of a woman's life. The ability to have children at the desired time leads to improvements in maternal health, decreased infant and child mortality rates and improvements in social and economic condition of women (Butler, 2009).

Currently, the typical American woman wants 2 children and to achieve this, she will spend 3 decades on contraception (Frost, 2014). More specifically, a woman spends on average three years total being pregnant, post-partum, and trying to become pregnant. Three-fourths of her reproductive age, lasting from ages 13 to 44, is spent avoiding pregnancy. In 2013, 67 million women were between the ages of 13 and 44 and more than half of them, roughly 38 million, were in need of contraception. When over half a woman's reproductive life is spent avoiding pregnancy, policies that make contraceptive services more accessible and affordable become increasingly significant (Finer, 2016). Of these 38 million individuals, 20 million were in need of publicly funded services because either their income level was below the federal poverty level (FPL) or they were below 20 years of age (Frost, 2014). Of these 20 million, 77% were low-income adults and 23% were younger than 20 years of age. 9.8 million were non-Hispanic white, 3.6 million were non-Hispanic black and 4.9 million were Hispanic. From 2000 to 2013, the number of Hispanic women in need of publicly funded reproductive health services increased by 54%, the number of black women in need of these services increased by 23% and the number of white women increased by 7% (2014). From these trends, it is clear that low-income women and women from ethnic minorities will serve to be disproportionally benefitted by publicly funded reproductive health services.

Family planning programs have a significant impact on the reproductive lives of women. In 2013, publicly funded family planning services prevented 1 million unintended pregnancies that would have otherwise resulted in 501,000 unintended births and 345,000 abortions (Guttmacher, 2016). Without these sources of funding, the number of unintended pregnancies, unintended births and abortions would have been 60% higher for woman above 20 years of age, and 40% higher for teenagers.

Publicly Funded Family Planning

The advent of family planning programs serves three critical needs in American society: 1) Reduces unintended pregnancies and the adverse effects that follow, 2) Reduces the spread of sexually transmitted infections (STIs) and 3) Decreases rates of infertility (WHO, 2008). Funding for these programs was first recognized in the 1960s. The 1960s marked a time of great progress in reproductive health as the first birth control pill was approved by the Food and Drug Administration (Lam, 2011; Bailey, 2011). However, the pill was expensive, costing roughly $760 in 2010 dollars, thereby making it inaccessible to the general population (Bailey, 2011). At this time there was also an increasing international concern for the growing population. By the 1960s, the world had reached a population of 3 billion. More than this number though, the alarming fact was that it only took 25 years for the world to go from being populated by 2 billion to 3 billion people. Prior to this, it had taken 125 years to go from 1 to 2 billion (Population Bomb, 2011).

Federal intervention in family planning programs was fueled by this population growth as well as an increasing disparity between unintended pregnancy for low-income and high-income women. Low-income women are twice as likely to have an unintended pregnancy than high-income women (Vamos, 2011). An unintended pregnancy places the mother at higher risk for becoming dependent on welfare assistance, reduces her ability to complete her education and participate in the workforce (Gold, 2007). It was a general consensus in the 1960s that increasing the health of women and children and decreasing population growth would alleviate poverty. These two factors led to a multitude of changes in family planning programs. To begin with, the 1964 Economic Opportunity Act, under President Lyndon B. Johnson's War on Poverty, created the first federal family planning grants supervised by the Office of Economic Opportunity (Hoff,

2010; Butler, 2009). However, there was no specific language dedicated to family planning and the funds were controlled by states. There was a lack of standardization in requirements for eligibility, accessibility and services provided by these family planning grants (Bailey, 2011). In 1967, the Green Amendment declared family planning a national emphasis. The following three years were characterized by an increase in federal allocation for family planning totaling roughly 400 million dollars. When Nixon took office in 1969, he strongly believed in controlling the population. In his 1969 Special Message to the Congress on Problems of Population Growth, he stated, "I believe that many of our present social problems may be related to the fact that we had only fifty years in which to accommodate the second hundred million Americans" (Hoff, 2010) With population control as his main goal, Nixon significantly impacted reproductive health policy by creating Title X of the Public Health Service Act, declaring that "no American woman should be denied access to family planning assistance because of her economic condition" (Gold, 2002).

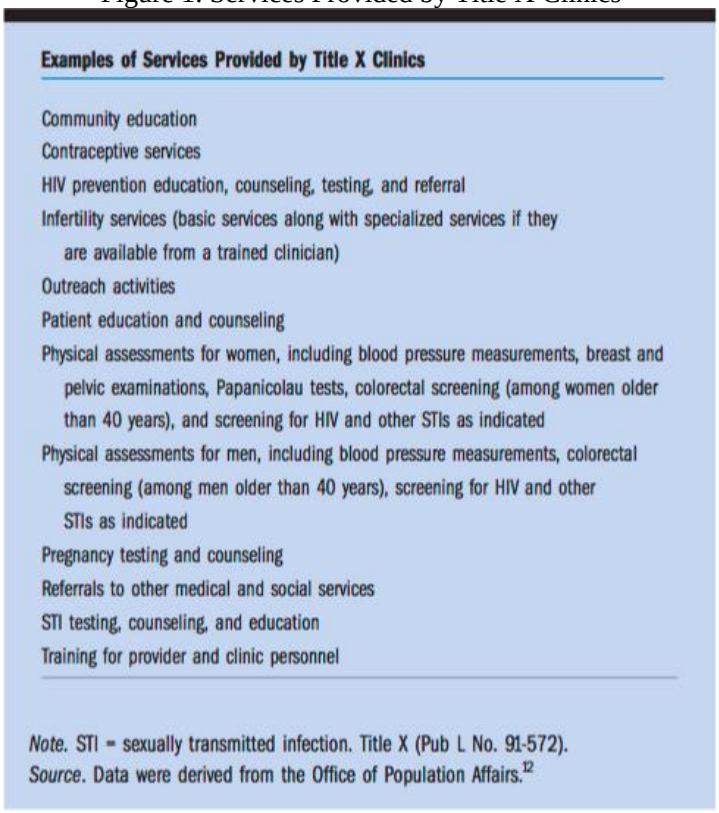
Chapter 2: Title X of the Public Health Service Act

Overview of Title X and its Impact

To this day, Title X remains the only national family planning program solely dedicated to providing voluntary and confidential services to all individuals. When Title X was enacted into law in 1970, the goal was to "assist in making comprehensive voluntary family planning services available to all persons desiring such services," with a specific focus on providing access of these services to low-income women (McFarlane, 2001). Under this law, the Office of Family Planning, housed under the Department of Health and Human Services, is in charge of granting funds to applicants. These grants are awarded on a competitive basis to both public and private entities such as state health departments, community centers, non-profits, and Planned Parenthood centers (Vamos, 2011; Butler, 2009). From its inception, abortion services were and are still not covered by these Title X grants (Butler, 2009). Spread across the nation, 10 regional offices read and accept applications from any public or nonprofit entity that has broad family planning services in a designated state (Vamos, 2011). Applicants are rewarded funds based on the number of patients served, extent to which family planning services are needed locally, relative need of applicant and their capacity to effectively use this assistance. In 1999, there were 84 clinics supported by Title X funds (Gold, 2007). Today, Title X has sustained a nationwide network of 4500 plus sites that deliver voluntary and confidential services to clients regardless of income and insurance coverage (Hasstedt, 2013). The key functions of this funding and the corresponding clinics is to have high quality services, ensure evidence-based practices, and meet the needs of patients through staff training, data collection, community based information, education and outreach (2013). In addition to subsidizing contraception, Title X clinics as stated

in Figure 1, provide preventative services for detecting STIs, physical exams, referrals, and counseling/education services (Vamos, 2011).

Figure 1: Services Provided by Title X Clinics



Examples of Services Provided by Title X Clinics

Community education
Contraceptive services
HIV prevention education, counseling, testing, and referral
Infertility services (basic services along with specialized services if they are available from a trained clinician)
Outreach activities
Patient education and counseling
Physical assessments for women, including blood pressure measurements, breast and pelvic examinations, Papanicolau tests, colorectal screening (among women older than 40 years), and screening for HIV and other STIs as indicated
Physical assessments for men, including blood pressure measurements, colorectal screening (among men older than 40 years), screening for HIV and other STIs as indicated
Pregnancy testing and counseling
Referrals to other medical and social services
STI testing, counseling, and education
Training for provider and clinic personnel

Note. STI = sexually transmitted infection. Title X (Pub L No. 91-572).
Source. Data were derived from the Office of Population Affairs.[12]

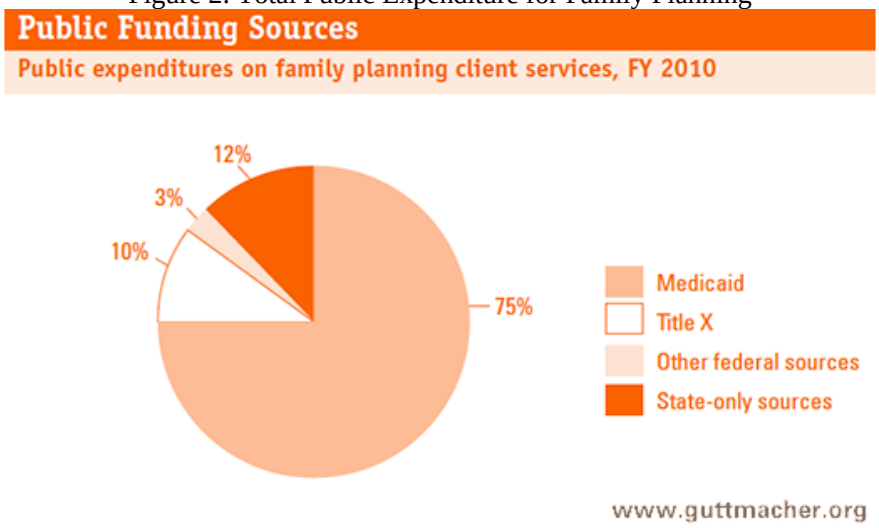
With this vast array of services, Title X clinics often serve as the first site of entry into the healthcare system for many of their patients. Services are charged on a sliding scale with individuals who fall below the federal poverty line receiving free services, while those with an income 250% of the federal poverty level paying full cost. Individuals in between 101% and 250% of the federal poverty level pay according to the sliding scale designation (OPA, 2015). In addition, a majority of teenagers are not burdened by out-of-pocket costs as their fees are based off their own income rather than their parents, further increasing their access to reproductive health services (Gold, 2002). Because Title X provides a standard on how to offer confidential and completely voluntary services including preventative treatments such as Pap tests and HIV testing as well as counseling services, these clinics are uniquely positioned to target those

women who are most likely to fall between the cracks of the healthcare system. Six in ten women that seek contraceptive care cite a Title X clinic as their usual source for medical care. Every one dollar spent on family planning programs saves the public seven dollars in funds that would have been spent on Medicaid-related costs. Without Title X clinics, the U.S would have spent $7 billion more for Medicaid through federal and state expenditures each year (Guttmacher, 2016).

Title X and Other Sources of Public Funding for Family Planning

One unique aspect of Title X-supported centers is that it allows for other public funding to be used to assist in the payment of reproductive health services. As shown in Figure 2, in fiscal year 2010, Medicaid accounts for 75% of total public family planning expenditures, state appropriations for 12% and Title X grants for 10%.

Figure 2: Total Public Expenditure for Family Planning



Despite the small Title X public expenditure for family planning, these funds play a unique role in national family planning by serving uninsured clients, assisting patients to easily obtain and use a contraceptive method that is best suited for them and by meeting the specialized needs of their patients. Unlike other publicly funded sources, Title X is not simply a financial plan but

provides standards, regulations and structure on how to provide comprehensive, accurate and confidential reproductive health care services (Gold, 2012). Title X centers also have, on average, 10 different contraceptive methods available at their clinics. Clinics funded by Title X are more likely to provide contraception on-site compared to other clinics. In addition, Title X clinics are more likely to use Quick-Start protocols allowing women to begin taking contraception immediately. Furthermore, using evidence-based research outlined by the WHO and the American College of OB-GYN, Title X-supported centers are also more likely to prescribe contraceptives without a pelvic exam and to provide emergency contraception in advance (Gold, 2012; Hasstedt, 2013). All these attributes allow Title X to circumvent common barriers to contraception that women, more specifically low-income women, face, such as long transportation and missing multiple days of work to accommodate health care visits. In addition to reducing barriers to accessing contraception, Title X centers place a strong emphasis on meeting the specialized needs of their patients by focusing on serving teens, training in different languages to treat patients with limited English proficiency and training in substance abuse, disability and homelessness to accurately treat the most vulnerable populations (Finer, 2011).

Now, forty-six years after the law was enacted, the target population of Title X has expanded and changed. The number of women living below the federal poverty level has increased significantly. A recent estimate cited 36.2 million women in need of contraceptive service, and 17.5 million of them have an income below the federal poverty level or are under the age of twenty (Butler, 2009). In 1970, when the program was established, 6.4 million individuals ages 18-44 were living below the federal poverty level. Coupled with this, the number of low-income women who are also part of a racial and/or ethnic minority has increased. In 2007, 3.2 million African American individuals and 563,000 Asians were living with an

income 101% of the federal poverty level. In addition to this increase in poverty, the number of teenagers in need of Title X services has expanded. In 2006 there were 21.4 million adolescents between the ages of 13-18 compared to 1970 where there were 20 million (Frost, 2014).

Challenges Facing Title X

When Title X was first enacted there was a large push of support as this law was seen as a necessary tool to combat the increasing population. However, as this fear dissipated, political administrations began to view family planning differently. In the 1980s, the Reagan Administration adopted major changes to the way national family planning worked. One of President Reagan's main platforms was to restructure federalism (McFarlane, 2001). He believed the federal government had too much power and that this power should be reallocated to the states. Because of Reagan's political debt to the conservative coalition, opposing public support for family planning became one of his main targets. During this administration, he consolidated fifty-seven of the grants created during President Johnson's War on Poverty into nine block grants. Title X remained intact, however funds for this program decreased by 20% from the fiscal 1981 appropriation. In addition, most grantees of Title X became state health departments because they were less likely to expand family planning services and less likely to use family planning money for more controversial health programs. In 1981 there were 222 grant recipients. The following year there were 88 grants (2001).

Reagan's administration was marked by two main amendments to national family planning. The Squeal Rule made it mandatory for Title X-supported centers to give parental notification when they provided contraception to minors (Butler, 2009). Adolescents are a target population for Title X programming, and one of the unique barriers this population faces in accessing contraception is fear of parental notification. The Squeal Rule imposed another barrier

on allowing this vulnerable population to access reproductive health care (National Family Planning, 2015). The second amendment was labeled the Gag Rule and it barred any mention of abortion in a Title X funded clinic AND any sharing of staff or space with clinics that provided abortions. Both of these rules were never fully implemented as they faced many challenges in court. In 1993, President Clinton suspended both the Gag and Squeal rule (Dailard, 2001).

The 1980s were marked by controversy surrounding family planning as many social and religious conservatives associated family planning services with promiscuity and abortion. These views have prompted funding for Title X to remain low. Title X's 1980 funding was $162 million. If the funding had increased at the same rate as inflation, it would now be funded at $942 million. However, today this program is funded at $287 million. Between 1985 and 2010, cuts to Title X totaled $13.9 million and over the last six years this funding has reduced by $31 million. With the budget consistently decreasing, Title X grantees struggle in their ability to provide competent, comprehensive and voluntary family planning services to the most vulnerable populations (NARAL).

One of the main challenges exacerbated by the decreasing budget is maintaining a diverse contraceptive choice, a standard of Title X-supported centers. Costs of contraceptive supplies, especially long acting hormonal methods have greatly increased. However, these long-acting methods are recommended by providers because they factor out human error making them more effective than oral contraceptive pills. A clinic can provide roughly three women with an annual supply of oral contraceptives for much less than the cost of providing one woman with one long-acting hormonal method, such as an injection (Dailard, 2001).

In addition, Title X attracts a diverse set of qualified providers, including nurse practitioners (NPs). Title X funds have historically supported the accreditation programs for NPs

to specialize in women's health to ensure that all clinics are appropriately staffed. This training has allowed Title X clinics to expand to more rural and underserved areas. However, this training was recently phased out, making it increasingly difficult and expensive to retain qualified providers at these centers (Hasstedt, 2013). At a time where there is an increasing number of people in need of reproductive health services, Title X funded clinics have to expand their services to ensure that they are meeting the needs of this growing population of low-income women, racial minorities, immigrants and adolescents. With the constraining financials, upgrading Title X clinic services to meet the needs of the population, however, is becoming increasingly difficult.

Coupled with financial strain, political opposition is a key obstacle faced by Title X-supported centers. Opponents of Title X believe that providing confidential services to teenagers will result in more sexually active teens and promote promiscuous behavior. Yet, research over the decades has shown that due to family planning, three-quarters of teen pregnancy rates have decreased, while only one-quarter was due to abstinence. In addition, there is a common belief that subsidizing contraception will result in more abortions. In reality, publicly funded family planning services assist in reducing the need of abortion because they allow a woman to avoid unintended pregnancy. For Title X to progress forward and meet the needs of the current population, it will need to escape the political opposition that has inhibited it for so long.

Chapter 3: Methodology and Framework

Legislative Analysis

To understand a policy's successes and challenges it is crucial to examine its legislative history, a compilation and chronology of events and documents gathered through the legislative process (Vamos, 2011). A legislative analysis of the amendments to the law allow researchers to explore main aspects of the program that are contested. A legislative history has been compiled for Title X from 1970 to 2010 in *Approaching 4 Decades of Legislation in the National Family Planning Program* by Vamos et. al. This research continues this legislative history starting in January of 2011 and ending in December of 2015. 2011 was chosen as the starting point because it marked the first time Congress proposed to completely cut funding to Title X. The goals of this analysis are to a) outline a legislative history from 2011-2105 for Title X and b) explore the main themes of the proposed amendments to the law. In order to do this, ProQuest Congressional, an online tool to search for government documents, was used to read summaries, full texts and histories of each amendment. The key words "Title X Family Planning" were used to search for the proposed bills. In this analysis, federal House of Representative and Senate bills that proposed amendments to Title X between the 112th Congress and the 114th Congress were compiled and can be found in Appendix A. Each bill was analyzed through five in-depth steps based off of Vamos et. al's methods. The five steps include reading, coding, displaying, reducing and interpreting. Each bill was read twice and then coded based off of emerging themes. Then, sections of the bill were highlighted and displayed based off their themes, reduced down to key points. Interpretation was done throughout the process and was used to connect themes to the overall legislative history. In *Approaching 4 Decades of Legislation in the National Family Planning Program*, 293 bills were studied and seven main themes (administration, appropriation,

requirements, restrictions, related legislation, related policies, and technical amendments) emerged that were also used in this analysis. The seven themes are outlined below (Vamos, 2011).

Administration: Bills that affect the administration aspects of the program including extending/repealing the program, grant requirements, data and reporting, coordination with state.

Appropriations: Bills that deal with sums of money allocated to Title X or other related policies that affect Title X.

Requirements: Bills that propose a revision to the necessities that a Title X clinic must have to receive funding such as certain educational materials and services.

Restrictions: Bills that propose a revision that prohibits a Title X clinic from offering a service, or certain educational materials.

Related Legislation: Bills that focus on other policies that affect Title X (AIDS Outreach and Prevention Act).

Related Policies: Bills that establish national institutions and centers that respect family planning principles.

Technical Amendments: Bills that propose grammatical changes or technical changes (renaming/renumbering).

Colorado Case Study

The second part of this analysis examines Boulder Valley Women's Health Center (BVWHC), a local Title X Clinic, to understand the ways in which the goals of the policy are being implemented. The Family Planning Annual Report (FPAR) is the sole source of reporting necessary for grantees of Title X. Every year grantees including BVWHC submit their data to

FPAR to ensure that they are consistent with federal performance requirements for receiving Title X funds and to evaluate how the clinic is progressing on key reproductive health outcomes (Gold, 2002; Butler, 2009). For this analysis, data was collected only from January 01, 2013 to January 01, 2016 because 2013 is the earliest fiscal year the FPAR website still holds. Data on client profiles including income, insurance, age, gender and race were collected and compiled into tables found in Appendix C. In addition, the number of clients who received pap smears, breast referrals and STI tests from the last three years was gathered. These data sets were compared to the national FPAR of 2014 to assess BVWHC and Boulder County's performance in meeting reproductive health outcomes. These data sets were also compared to the number of females at reproductive age in Boulder County who were in need of subsidized contraception. By comparing these values, this case study analyzes how effective BVWHC is in carrying out Title X's goals of providing high quality services, preventative tests and counseling for its target population comprised of low-income women and adolescents.

Feminist Policy Analysis

The last part of this research analysis delves into a feminist policy analysis of Title X by examining the actual law, coupled with the legislative analysis and Colorado case study, in order to understand the impact of this law. Public policy can be defined as a multitude of political decisions to implement programs that reflect society's goals (C.L. Cochran & Malone, 1995). Policy analysis is a tool used to study established policies and to understand and evaluate their impact in resolving public problems (Collins, 2005; Dunn, 1981). This analysis involves identifying, examining, explaining, and understanding the content, causes and consequences of public policies (McPhail, 2003). Traditional policy analysis "identifies and calculates effects of

policies with apolitical, objective, neutral methods" (Marshal, 1997). Another common framework for analyzing reproductive health policies specifically is the Policy Circle. Through this framework the development and implementation of a program can be better understood through the 6P's outlined below (Hardee, 2004).

- The **Problems** that arise requiring policy attention
- The **People** who participate in policy and the **Places** they represent
- The **Process** of policymaking
- The **Price Tag** of the policy (the cost of policy options and how resources are allocated)
- The **Paper** produced (actual laws and policies)
- The **Programs** that result from implementing policies and their **Performance** in achieving policy goals and objectives

However, both the traditional model and the Policy Circle illustrate a framework that is gender neutral. In this research, a feminist policy analysis is utilized as Title X disproportionally affects women and children, while its legislation remains largely dominated by patriarchal views and players. A feminist perspective means critically thinking about the current paradigms in which we live and how these dominant systems affect women's needs and interests (Hawkesworth, 1994). The goal of a feminist policy analysis is to put women in where they have been left out, recognize the underlying assumptions and stereotypes of women embedded in the policy, and understand how a woman's life could be regulated through the policy. Overall, more than solely putting women back into the picture, a feminist policy analysis strives to create "a new picture that includes women and men" (McPhail, 2003). McPhail created a framework that incorporated these feminist theories to be applied to a policy. In the full questionnaire outlined in Appendix B, twelve constructs are identified. A brief summary of each construct is explained below.

Values. This first construct emphasizes that underlying a feminist policy analysis are feminist values such as eliminating false dichotomies, valuing the process and the product equally, ensuring that the reality defined is consistent with women's reality and acknowledging that the

personal is political. Feminists also value diversity, collectivity, non-hierarchal relationships and the importance of connections (McPhail, 2003).

State-Market Control. Using this factor as a tool to analyze policy allows researchers to connect how women's work and relationships could make them dependent on the state or the market. This construct also emphasizes not taking for granted the role of women in the the workforce and making sure that patriarchal males are not being replaced by patriarchal institutions, states or policies (McPhail, 2003).

Multiple Identities. This construct recognizes that women also fall into diverse racial, ethnic, class, religion, and sexual identity categories. The recognition of the intersectionality of feminism is an important player in ensuring that all women are receiving the rights they deserve. When applied to this policy, this construct allows researchers to see if white, middle-class, heterosexual women are the assumed standard for all women (McPhail, 2003).

Equality. The Declaration of Independence declared that all men are treated equally. This construct hopes to create a framework where all women can be treated equally. However, this factor also recognizes treating women the same as men does not solve the issue of institutional discrimination. Therefore, when analyzing a policy, the equality construct allows researchers to see if the policy treats people differently in order to treat them equally (McPhail, 2003).

Special Treatment/Protection. Many alternative policy approaches seek to provide women preferential treatment, an opposition to equal treatment. While, allocating specific resources to women can liberate them, it can also regulate and contain them. This double standard can often benefit males more than females. This construct simply reminds researchers to remember this double standard and analyze its successes and consequences (McPhail, 2003).

Gender Neutrality. This construct recognizes that gender neutrality is not synonymous with equality. Because we live in a society organized around gender, policies and laws have different impacts based off of gender, and therefore gender needs to be analyzed (McPhail, 2003).

Context. Recognizing the political, social and economic context of the world women live in is necessary when analyzing a policy. These contexts can be different based on location, institution and history. Understanding these different realities allows researchers to understand the impact of the policy in a more complete manner (McPhail, 2003).

Language. This factor explores how language can be used to hide the gendered nature of a policy. For example, social policy uses "elderly" and "disabled" people to describe their population, when a majority of these individuals are women (McPhail, 2003).

Equality/Rights and Care/Responsibility. This construct recognizes that the public sphere (life outside of the home that is modified by the government and institutions) and private sphere (family and home life) of a woman's life is connected. If a woman is unequally burdened with caretaking in her private sphere, making strives in the public sphere are also increasingly difficult (McPhail, 2003).

Material/Symbolic Reforms. Some policies are focused solely on making change symbolically without actual implementation. These policies can be focused on political incentives and can have little impact on the social issue (McPhail, 2003).

Role Change and Role Equity. Role equity represents policies that equalize opportunities by extending rights to women that were previously only enjoyed by men. Role change, on the other hand, allows women to move into new roles and opens new roles for both sexes. Using these labels can be an important way in determining the goal and impact of a policy (McPhail, 2003).

Power Analysis. This factor takes into consideration the interplay between power and policy and the history of powerlessness of women. This construct reminds researchers to critically think about which stakeholders have the power and how much power those who are impacted have (McPhail, 2003).

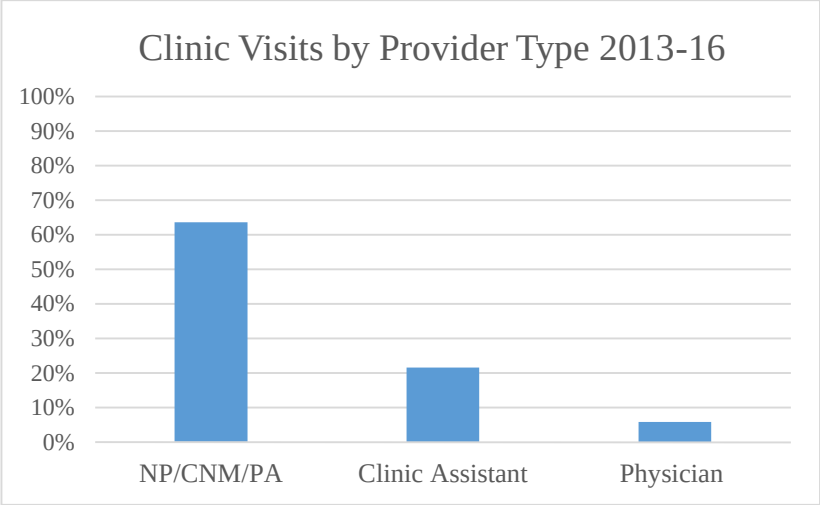
Chapter 4: Results

Analysis of Legislative Amendments to Title X

Between January of 2011 and December of 2015, fifteen proposed bills were introduced into Congress. Of theses fifteen bills, 8 were introduced into the House, 5 were introduced into the Senate, 1 passed in the Senate and 1 became a law. Three main themes emerged from the five step analysis: restrictions, requirements and appropriations. 60% of the proposed bills fall under restrictions, 20% under appropriations and the remaining 20% under requirements. Since 2011 there has been a shift in the type of bills proposed to Congress. In *Approaching 4* Decades, Vamos et. al found that from 1970 to 2010, 52% of bills were categorized as requirements, 51% as appropriations and 31% as administration. Only 17% of these proposed amendments were labeled as restrictions. 2011 marked the first time in history where there was a proposed bill to completely cut funding from Title X. In this legislative analysis, all nine bills labeled as restrictions involve abortion and propose Title X to be amended so no funds would go to entities performing abortions. Since its inception Title X funding has been prohibited from financing abortion services. However, clinics that provide abortions can still receive Title X funding, if they ensure none of these funds go towards abortion services. These nine amendments propose that no funding should go to these clinics regardless if the funding is not directed towards abortion services. Decisions about Title X have often been swayed by stakeholders' feelings regarding abortion, however more recently, as illustrated in this legislative analysis, these stakeholders have taken a more pressing and loud voice in Congress, threatening the existence of this program.

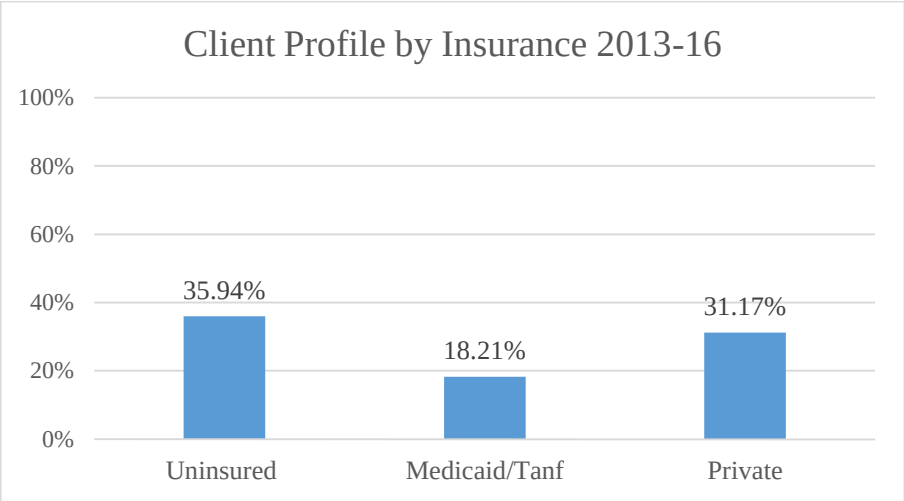
Colorado Case Study

From 2013 to 2016, Boulder Valley Women's Health Center saw 11,242 patients. Of these visits, 63.6% were seen either by a Nurse Practitioner (NP), Certified Nurse Midwife (CNM) or a Physician's Assistant (PA). This variety of clinical providers parallels the findings in the National FPAR of 2014, where 67% of clinic visits were seen by NPs, CNMS and PAs, while 18% were seen by physicians.



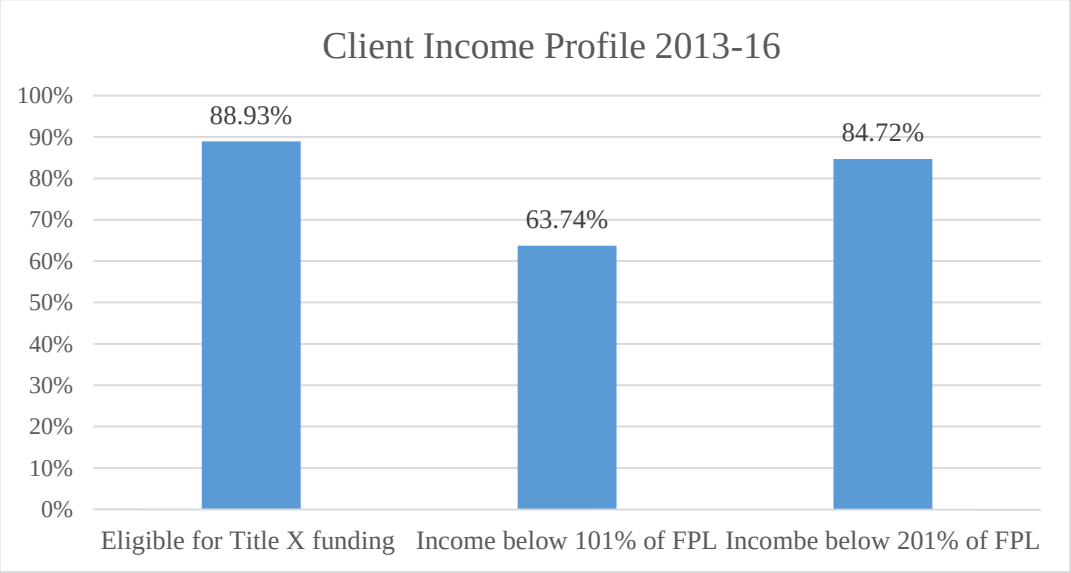
The second factor that is gathered in FPAR is patient profile by insurance. Title X clinics see three types of insurance from their patients: public, private and uninsured. Public refers to any local, state or federal government health insurance plans such as Medicaid, Medicare, and Children Health Insurance Program. Private insurance refers to health insurance coverage provided by an employer or a union. Uninsured encompasses those who do not have either public or private insurance. Over the past three years, the proportion of BVWHC patients who were uninsured has decreased by roughly 840 individuals, while those presenting with Medicaid or Temporary Assistance for Needy Families (TANF) has increased by roughly 450 individuals. While BVWHC still sees on average more uninsured patients (36%) than individuals with

private or public insurance, because of the Affordable Care Act, more of these individuals are able to become insured. While Title X funding is still necessary for subsidizing contraception, training, data collection, and educational outreach, the percentage of patients using these funds to pay for their visit has decreased by 19% over the past three years.



The third measure in FPAR is sorting patients based off of their income. Of the 11,242 patients seen at BVWHC, 9,997 qualified for Title X funding to pay for their visit either fully or on a sliding scale. 64% (7166 individuals) qualified for fully subsidized contraception because their income was 101% of federal poverty level (FPL), while 25% (2831 individuals) were eligible to pay fees through a sliding scale because their income fell between 101 – 250% of the FPL. On a national scale, Title X clinics overall saw 91% of patients with an income level below the FPL, 22% were in between 101 – 250% and 5% had an income above 250% of the FPL. Compared to the national average, BVWHC saw less people below the poverty level, but roughly the same percentage of people qualifying for the sliding scale and who were above 250% of the federal poverty level (roughly 11%). In accordance with Title X's goals, all grantees must have a patient population where 67% have an income below 101% of the FPL and 90% who have an income

below 200% of the FPL. Comparatively, BVWHC has been consistently meeting these standards for the past three years.



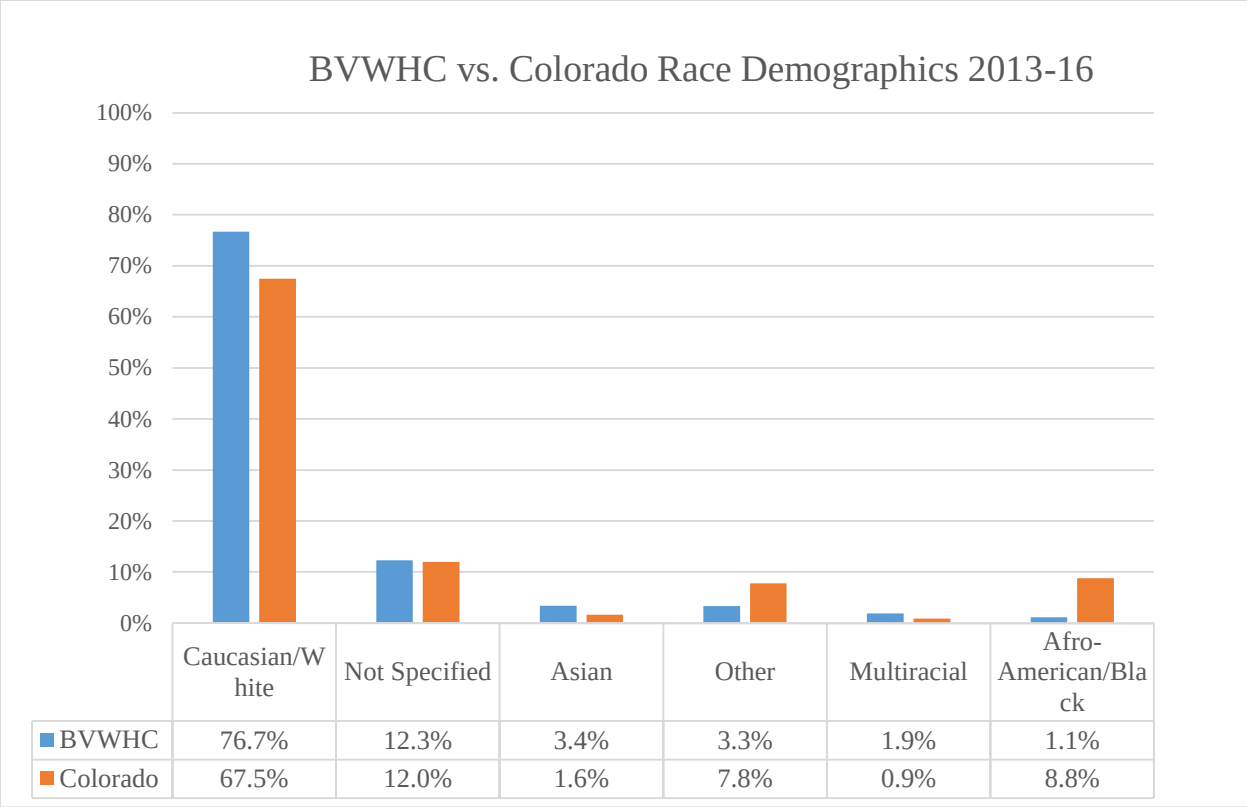
Over the past three years, the BVWHC patient demographic has been, on average, 97% female and 3% male, which is slightly higher than the national FPAR average of 91% female patients and 9% males. The largest age demographic served by this health center is individuals between the ages of 20 and 24 who made up 25% (2784 individuals) of the patients seen at BVWHC from 2013-16. 43% (4843 individuals) of patients have been between the ages of 20 and 29 ranking similarly to the national FPAR percentage of 50%. In 2013, Boulder County, Colorado had 65, 903 women who were in their childbearing age (Figure 3). Of these females, 17,030 women were below 150% of the federal poverty level and in need of subsidized contraception. In 2013, BVWHC served 3,584 women ages 15-44 and 3,015 of them were below 150% of the federal poverty level. Therefore, 17.7% of women in need of publicly funded reproductive health services in 2013 were seen by Boulder Valley Women's Health Center.

Figure 3: Women in Need, Boulder County

Women in Need of Subsidized Contraception by County
Colorado, 2013

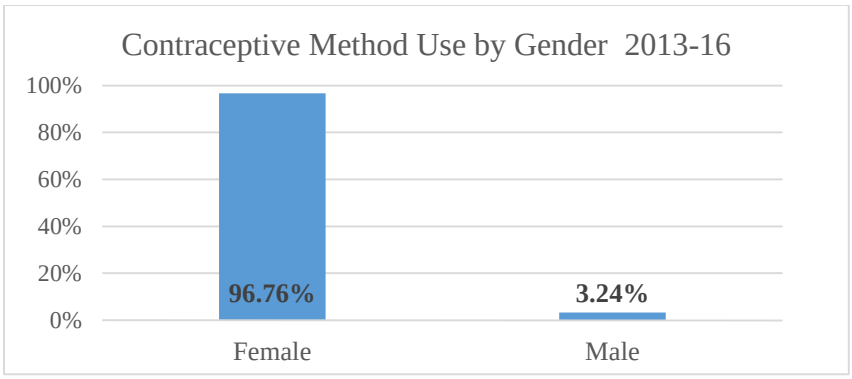
	Female Population	Women in Need of Subsidized Contraception, 2013				Women in Need as Percent of Female Population
County	Ages 15-44	15-19	20-24	25-44	Total	Ages 15-44
Adams	99,500	7,290	3,370	14,570	25,230	25%
Alamosa	3,270	290	370	720	1,380	42%
Arapahoe	124,360	9,460	4,600	16,750	30,810	25%
Archuleta	1,840	160	70	300	530	29%
Baca	550	50	40	130	220	40%
Bent	680	60	50	120	230	34%
Boulder	65,900	5,920	4,930	6,180	17,030	26%
Broomfield	12,410	970	420	600	1,990	16%
Chaffee	2,590	200	110	390	700	27%

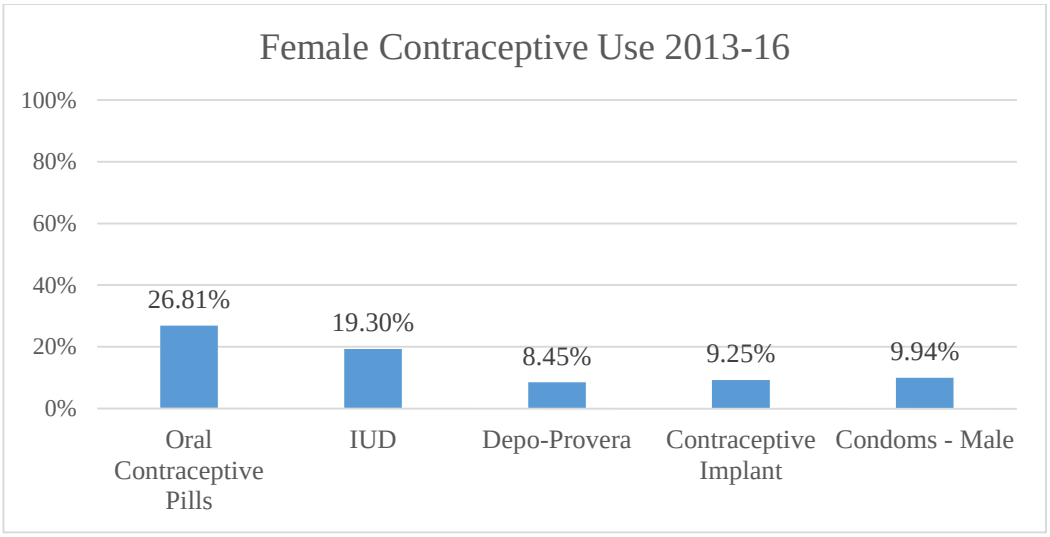
In addition to age and gender, FPAR also has data regarding the racial demographic of the patient population. As stated earlier in this paper, one of the central goals of Title X is to provide low-income women with the means to access contraception. Over the past decade this low income population has become increasingly dominated by racial minorities, immigrants and adolescents. Identifying which racial demographics are being seen by BVWHC will be beneficial in assessing if this center is targeting the most vulnerable populations. 76.7% of BVWHC's patients are Caucasian, 3.4% Asian and 1.1% African American. In contrast, the national racial demographic for Title X Clinic patients was comprised of, on average, 54% Caucasians, 21% African Americans, and 3% Asians. BVWHC patient population shows a larger quantity of Caucasian patients and barely any African Americans. However, when comparing this demographic breakdown to the state (Colorado) demographics, BVWHC's racial breakdown is quite similar, indicating that BVWHC is serving the demographic of Colorado well.



	Caucasian/White	Not Specified	Asian	Other	Multiracial	Afro-American/Black
BVWHC	76.7%	12.3%	3.4%	3.3%	1.9%	1.1%
Colorado	67.5%	12.0%	1.6%	7.8%	0.9%	8.8%

Another factor measured by FPAR is which contraceptive method is used by what age range. The most popular contraceptive method for women was oral contraceptives (27%) followed by IUDs (19%). These proportions differ greatly from the national FPAR values of 51% of female patients using oral contraceptive pills and 13% using IUDs. As stated above, BVWHC patient demographic has a higher proportion of individuals ages 20-24 who also have the highest number of contraceptive users. Again, among this age range, oral contraceptives followed by IUDs have been the most common method for females in the past three years. Males, on the other hand, have lower reported contraceptive use, reflective of only 3% of BVWHC's patient demographic consisting of males.





Lastly, FPAR measures the quantity of preventative services provided by Title X Clinics including breast exams, physical exams, and STI, HIV and Pap Tests. From 2013-16, 2094 female patients (19%) received physical exams. 419 female patients (3.85%) received breast exams, a relatively low number compared to the national FPAR value of 31% of female users receiving breast exams. In addition to breast cancer screening, Title X Clinics screen for STIs. The most common tests include gonorrhea, chlamydia, and syphilis. At BVWHC, 5829 female patients (54%) were tested for gonorrhea, exactly the same as the national FPAR value of 54%. In BVWHC, 26% of these females were 20-24 years old. 4682 female patients (43%) were tested for chlamydia and 481 (4.42%) females were tested for syphilis. 26% of chlamydia female patients were between 20 and 24 years old and 25% of syphilis patients were in between that

same age range. The national FPAR values for chlamydia and syphilis testing are 48% and 12% respectively. 645 BVWHC female patients (6%) were tested for HIV and 42% of these patients were between ages 20 and 29. The national FPAR value for female HIV testing is 25%. In addition, 1278 female patients (12%) received Pap tests over the past three years compared to the national value of 21%. 29% of the female patients at BVWHC were between the ages of 20 and 24.

	BVWHC	FPAR National Average
Physical Exams	19%	-
Breast Exams	3.85%	31%
Gonorrhea	54%	54%
Chlamydia	43%	48%
Syphilis	4.42%	12%

Overall, Boulder Valley Women's Health Center values are similar to the national average values reported in FPAR. The main concern is when looking at the population of women in need of Title X services in Boulder County, Women's Health only serves roughly 18% of this population. In addition, the FPAR data does not evaluate the quality of services. While the quantity of services is well measured through the number of patients, preventative tests received, age, gender, income, insurance, etc., little information is found on the quality of the interaction between the provider and the patient. More information is needed such as the number of patients who came back for their follow up or who were referred to another provider and went to that appointment, to more accurately evaluate the quality of services provided at Women's Health.

Feminist Policy Analysis

McPhail's constructs were used as a framework to analyze Title X as a whole by first looking at the actual law, the legislative analysis and lastly the Colorado case study. The twelve feminist factors often overlap so the following analysis incorporates them together into one overall analysis, rather than a breakdown of the policy categorized by each construct.

One of the main priorities of Title X, following decreasing the population, is to increase access of reproductive health care to low-income women. However, when looking at the Colorado case study and the policy language it is clear that low income women who are also from a racial or sexual minority, are overlooked. It is assumed that the target population is mainly white and heterosexual. In the actual policy itself there is no language that details how income level could be associated with different ethnic minorities. In addition, while the FPAR does report on the racial and ethnic demographic of populations, there is no link made between the number of patients below 101% of the FPL and their race. Instead, race and ethnicity are categorized by age and gender. While there has been research done on race and income level in relation to Title X, it is concerning that the main evaluation and reporting method, FPAR, does not connect the two traits. Sexual identity is even more overlooked. Again there is no specific language in the policy discussing trans* individuals. In FPAR, gender is reported through a binary system with only female and male as options. Without taking into consideration multiple identities and what populations comprise the overarching population of low-income women, Title X will not accurately and fully meet the needs of the most vulnerable who stand to suffer the most without proper access to contraception.

Furthermore, when looking at Title X in terms of equality, this policy is a step towards gender equality. By allowing a woman more control over her reproductive life, she is more likely to actively participate in higher education and the workforce. Women receive a form of special treatment because they are biologically the ones who deliver the baby. Therefore, a large portion of the technology produced to avoid pregnancy is for the female body. However, while it is clear that Title X has a strong emphasis on women, the language in the actual policy stays gender neutral by using "all persons." By not including this specific language, the policy overlooks how these programs and their correct implementation will disproportionally affect women than men.

While it is necessary to have more recognition that this law affects more women than men, on the other hand, male involvement is also overlooked. There is a double standard here that liberates and restrains women. While a woman gains more control of her life by accessing family planning services, there is no pressure put on males to engage in this discourse with their partners, so the responsibility is carried by women mainly. This lack of male participation is reflected in BVWHC's predominately female patient population 97%, while males only comprise a small 3% of this population.

Another factor to consider, specifically when analyzing the legislative analysis, is the context of this policy. Nine out of fifteen amendments in the legislative analysis were associated with restricting rules about abortion and Title X. Abortion is a women's health issue, but at the same time it is a dominant discourse in politics. There is a stigma surrounding getting an abortion as well as receiving family planning services. Dependent on where an individual was brought up or lives or their own beliefs, they may not access Title X services because of this stigma and political context.

Overall, this policy is material reform as it has taken specific steps in terms of implementation and has seen impressive results. The goal of the policy is inherently role equity, but when looking at the legislative analysis and the challenges Title X faces, it is clear that the views of different stakeholders in power affect progress toward role equity. The political administration and Congress serve as one stakeholder who have an extreme amount of power in how much money Title X is appropriated. Their backgrounds, beliefs and opinions on family planning directly affect if a low-income woman is able to access contraception. The second stakeholder group is the Title X grantees. While these centers have power in implementing comprehensive family planning services, much of this is organized on a federal level based off of the money allocated for Title X. The third stakeholder who also holds the least amount of power is the vulnerable population. These power dynamics are illustrated by the differences between the legislative analysis and the Colorado case study. When looking at the amendments made to Title X in the past five years, it is clear that Congress wants less funding to this program and that abortion is a main factor contributing to the negativity surrounding this program. When looking at the case study, it is clear that BVWHC is seeing a great amount of patients and keeping up with the national FPAR standards. However, BVWHC is only seeing 18% of Boulder County's population of women in need of subsidized contraception. Clearly only a small percentage of the populations needs are being met, potentially because of a lack of communication and coordination between the vulnerable population, the Title X-supported centers and the government.

Chapter 5: Discussion and Conclusion

Synthesis of Research Findings

Key Finding #1: Title X has made significant progress and is at the center of America's national family planning programs.
Title X has a nationwide network of 4,500+ sites that deliver voluntary and confidential services to clients regardless of income and insurance coverage. Every year, Title X allows women to avoid 973,000 unplanned pregnancies. As a result, 433,000 unplanned births and 406,000 abortions did not occur. Although there are other sources of public funding for family planning, Title X is the only one that serves the uninsured and creates a standard and structure by which centers can provide comprehensive, voluntary and confidential reproductive health services.

Key Finding #2: The landscape of Title X is changing.
There has been a dramatic increase in the number of low-income women in the U.S over the past decade. More of these women are also from a racial and ethnic minority. The number of teenagers in need of contraception and immigrants has increased as well. While there has been an expansion of contraceptive methods and services available, Title X-supported centers are strained by the decrease in funds. Over the past six years, the budget for Title X has been slashed by $31 million.

Key Finding #3: Abortion is one of the main contributors of political clout to Title X and one of the main reasons funding has decreased.
In the past five years, fifteen proposed bills outlining amendments have been introduced into Congress. Nine of these bills deal with prohibiting clinics that perform abortions from receiving Title X funds. Opinions about abortion have negatively impacted funding allocation for Title X.

Key Finding #4: Boulder Valley Women's Health Center is meeting the requirements and standards to be a Title X Clinic.
The FPAR data gathered for Women's Health is, on average, pretty similar to the national FPAR standards of 2014. Women's Health is meeting the requirements of being a Title X clinic.

Key Finding #5: A large portion of Boulder County's population in need of contraception is not accessing these services from Women's Health.
Only 18% of Boulder County's population of women in need of contraception are being seen at Women's Health, one of two Title X clinics in this county. 82% of this vulnerable population, a priority for Title X, is not being reached.

Key Finding #6: The evaluation of the quality of Title X services is lacking.
FPAR measures data regarding quantity – the number of preventative tests, number of patients, their age, race, gender, income, insurance status and contraceptive method. However, data regarding the quality of services such as the interaction between the provider and the patient and the number of individuals who come back is not gathered for Title X.

Key Finding #7: Title X needs to be reframed as a reproductive health policy that specifically affects women.

Title X was created essentially to combat the ticking population bomb. While research has cited the rate of unintended pregnancies and the amount of low-income women having them as one of the supporting reasons Title X was enacted, this law was initially pushed on the agenda to curb the population. From a feminist perspective, it is important to reframe this law as a program necessary for the reproductive health rights of all individuals. Because women are disproportionally affected by the impacts of Title X, it is necessary to recognize how women (including women of color and trans* individuals) are affected by this law.

Conclusion

Overall, Title X of the Public Health Service Act has made great strides in providing low-income women access to family planning services. Despite these successes, Title X has faced large cuts in funding since the 1980s. With an expanding vulnerable population in need of family planning services and an expanding field of contraceptive methods, Title X-supported centers are strained to meet the needs of their population. While the quantity of services is measured well, the quality of services needs to be evaluated more. One of the key obstacles in funding this program remains the political clout surrounding abortion. Because Title X serves more females than males, the affect of policy language and implementation on these women needs to be recognized. More emphasis needs to be placed on the multiple identities found within the low-income women population and better coordination between the three stakeholders of this policy will allow for further progress.

Appendices

Appendix A: Legislative Analysis of Amendments to Title X

Name of Bill	Theme	Date	Sponsor	Passed?
112 H.R. 217 Title X Abortion Provider Prohibition Act	Restrictions	1/7/11	Mike Pence (R-IN)	Introduced in the House
112 S. 96 Title X Family Planning Act	Restrictions	1/25/11	David Vitter (R-LA)	Introduced in the Senate
112 Bill Profile H.R. 1 Full Year Continuing Appropriations Act, 2011	Appropriations	2/11/11	Harold Rogers (R-KY)	Passed in the Senate, as amended
112 H.R 1473 Dept. of Defense & Full Year Continuing Appropriations Act, 2011	Appropriations	4/11/11	Harold Rogers (R-KY)	Became law 4/15/11 (P.L 112-10)
112 S. 814 Title X Transparency and Verification Act	Requirements	4/13/11	Joe Manchin III (D-WV)	Introduced in the Senate
112 H.R. 5650 Protecting Women's Access to Health Care Act	Restrictions	5/9/12	Bob Dold (R-IL)	Introduced in the House
113 H.R. 61 Title X Abortion Provider Prohibition Act	Restrictions	1/3/13	Marsha Blackburn (R-TN)	Introduced in the House
113 H.R 217 Title X Abortion Provider Prohibition Act	Restrictions	1/4/13	Diane Black (R-TN)	Introduced in the House
113 S. 135 Title X Abortion Provider Prohibition Act	Restrictions	1/24/13	David Vitter (R-LA)	Introduced in the Senate
113 H.R 3539 Adoption Promotion Act of 2013	Requirements	11/19/13	Billy Long (R-MO)	Introduced in the House
114 S. 51 Title X Abortion Provider Prohibition Act	Restrictions	1/7/15	David Vitter (R-LA)	Introduced in the Senate
114 H.R 217 Title X Abortion Provider Prohibition Act	Restrictions	1/8/15	Diane Black (R-TN)	Introduced in the House
114 H.R. 311 Adoption Promotion Act of 2015	Requirements	1/13/15	Billy Long (R-MO)	Introduced in the House
114 S. 1725 Dept. of State, Foreign Operations & Related Programs Appropriation	Appropriations	7/9/15	Lindsey O. Graham (R-SC)	Introduced in the Senate
114 H.R. 3443 Women's Health Accountability Act	Restrictions	9/8/15	Renee L. Ellmers (R-NC)	Introduced in the House

Name of Bill	Content
112 H.R. 217 Title X Abortion Provider Prohibition Act	Restricts Public Health Service Act from providing family planning assistance to entities that perform abortions (excluding extreme cases such as rape, danger of death – hospitals are excluded)
112 S. 96 Title X Family Planning Act	Same as Bill 112 H.R. 217
112 Bill Profile H.R. 1 Full Year Continuing Appropriations Act, 2011	“Eliminates appropriations for voluntary family planning projects. Decreases appropriations available for family planning and reproductive health."
112 H.R 1473 Dept of Defense & Full Year Continuing Appropriations Act, 2011	“Decreases appropriations for voluntary family planning projects."
112 S. 814 Title X Transparency and Verification Act	"Requires Secretary of Health and Human Services to disclose on the Department of Health and Human Services (HHS) website the results of audits of entities that receive funds for activities under Title X"
112 H.R. 5650 Protecting Women's Access to Health Care Act	Restricts Public Health Service Act from prohibiting any recipient based on the fact that they provide abortions or refer for abortions or provides training for abortion providers
113 H.R. 61 Title X Abortion Provider Prohibition Act	same as Bill 112 H.R. 217
113 H.R 217 Title X Abortion Provider Prohibition Act	same as Bill 112 H.R. 217
113 S. 135 Title X Abortion Provider Prohibition Act	same as Bill 113 H.R 217
113 H.R 3539 Adoption Promotion Act of 2013	Requires counseling to include adoption information provided by licensed social workers or counselors. Requires research on reproductive health to include # of pregnancy tests administered to clients and the evaluation of the pregnancy options counseling
114 S. 51 Title X Abortion Provider Prohibition Act	same as Bill 113 H.R 217
114 H.R 217 Title X Abortion Provider Prohibition Act	same as Bill 113 H.R 217
114 H.R. 311 Adoption Promotion Act of 2015	same as Bill 113 H.R. 3539
114 S. 1725 Dept of State, Foreign Operations & Related Programs Appropriation	"Permits specified funds to be used for family planning and reproductive health."
114 H.R. 3443 Women's Health Accountability Act	"This bill prohibits federal family planning funding from being made available to Planned Parenthood Federation of America, Inc., and its affiliates, subsidiaries, successors, and clinics until Congress reviews the report described below."

Appendix B: McPhail Feminist Policy Analysis Framework

A. Values

1. Do feminist values undergird the policy? Which feminism, which values?
2. Are value conflicts involved in the problem representations either between different feminist perspectives or between feminist and mainstream values?

B. State-Market Control

1. Are women's unpaid labor and work of caring considered and valued or taken for granted?
2. Does the policy contain elements of social control of women?
3. Does the policy replace the patriarchal male with the patriarchal state?
4. How does the policy mediate gender relationships between the state, market, and family? For instance, does the policy increase women's dependence upon the state or men?

C. Multiple Identities

1. How does gender in this policy interact with race/ethnicity, sexual identity, class, religion, national origin, disability or other identity categories?
2. Are white, middle-class, heterosexual women the assumed standard for all women?
3. Does the policy address the multiple identities of women? The multiple oppressions a single woman may face?

D. Equality

1. Does the policy achieve gender equality? Are there equality of results or disparate impacts?
2. Does the policy treat people differently in order to treat them equally well? Does the policy consider gender differences in order to create more equality?
3. If the positions of women and men were reversed, would this pol- icy be acceptable to men?

E. Special Treatment/Protection

1. Does any special treatment of women cause unintended or restrictive consequences?
2. Is there an implicit or explicit double standard?
3. Does being labeled different and special cause a backlash that can be used to constrain rather than to liberate women?

F. Gender Neutrality

1. Does presumed gender neutrality hide the reality of the gendered nature of the problem or solution?

G. Context

1. Are women clearly visible in the policy? Does the policy take into account the historical, legal, social, cultural, and political contexts of women's lives and lived experiences both now and in the past?

2. Is the policy defined as a traditional "women's issue," i.e., "pink policy?" How is a policy that is not traditionally defined as a "women's issue" still a "women's issue?"
3. Is the male experience used as a standard? Are results extrapolated from male experience and then applied to women?
4. Have the programs, policies, methodologies, assumptions, and theories been examined for male bias?
5. Is women's biology treated as normal rather than as an exception to a male-defined norm?

H. Language

1. Does the language infer male dominance or female invisibility? 2. Are gendered expectations and language encoded in the policy?

I. Equality/Rights and Care/Responsibility

1. Is there a balance of rights and responsibilities for women and men in this policy?
2. Does the policy sustain the pattern of men being viewed as public actors and women as private actors, or does the policy challenge this dichotomization?
3. Does the policy bring men, corporations, and the government into caring and responsible roles? Is responsibility pushed uphill and redistributed?
4. Does the policy pit the needs of women against the needs of their fetus or children?
5. Are women penalized for either their roles as wives, mothers or caregivers or their refusal to adopt these roles?

J. Material/Symbolic Reforms

1. Is the policy merely symbolic or does it come with teeth? Are there provisions for funding, enforcement, and evaluation?
2. Are interest groups involved in overseeing the policy implementation?
3. Is litigation possible to refine and expand the law's interpretation?
4. What is the strength of authority of the agency administering the policy?
5. Is there room to transform a symbolic reform into a material re-form? How?

K. Role Change and Role Equity

1. Is the goal of the policy role equity or role change?
2. Does the type of change proposed affect the chance of successful passage?

L. Power Analysis

1. Are women involved in making, shaping, and implementation of the policy? In which ways were they involved? How were they included or excluded? Were the representatives of women selected by women?
2. Does the policy work to empower women?
3. Who has the power to define the problem? What are competing representations?

4. How does this policy affect the balance of power? Are there winners and losers? Is a win-win solution a possibility?

M. Other

1. Is the social construction of the problem recognized? What are alternate representations of the problem?
2. Does this policy constitute back lash for previous women's policy gains?
3. How does feminist scholarship inform the issue?
4. What women's organizations were involved in the policy formulation and implementation? Was there consensus or disagreement?
5. Where are the policy silences? What are the problems for women that are denied the status of problem by others? What policy is *not* being proposed, discussed, and implemented?
6. How does the policy compare to similar policies transnationally? Are there alternative models that we can both learn from and borrow from?
7. Does the policy blame, stigmatize, regulate, or punish women?

Appendix C: Boulder Valley Women's Health Center FPAR Data

# of Clinic Visits by Provider Type 2013-14		
Visit Qualifies for Title X Funding	Provider Type	# of Visits
✓	Physician	413
✓	Other	97
✓	Counselor	37
✓	NP/CNM/PA	4385
✓	RN	277
✓	Clinic Assistant	2725
	Total Number of Qualifying Visits	7934
✗	Physician	46
✗	Other	34
✗	Counselor	1
✗	Np/CNM/PA	140
✗	RN	0
✗	Clinic Assistant	115
	Total Number of Non-Qualifying Visits	336
	Total # of Visits	8270
	% of Qualifying Visits	96%

# of Clinic Visits by Provider Type 2014-15		
Visit Qualifies for Title X Funding	Provider Type	# of Visits
✓	Physician	541
✓	Other	3
✓	Counselor	20
✓	NP/CNM/PA	4711
✓	RN	198
✓	Clinic Assistant	1403
	Total Number of Qualifying Visits	6876
✗	Physician	37
✗	Other	5
✗	Counselor	0
✗	Np/CNM/PA	208
✗	RN	2
✗	Clinic Assistant	113
	Total Number of Non-Qualifying Visits	365
	Total # of Visits	7241
	% of Qualifying Visits	95%

# of Clinic Visits by Provider Type 2015-16		
Visit Qualifies for Title X Funding	Provider Type	# of Visits
✓	Physician	323
✓	Other	15
✓	Counselor	20
✓	NP/CNM/PA	5002
✓	RN	162
✓	Clinic Assistant	652
	Total Number of Qualifying Visits	6174
✗	Physician	35
✗	Other	8
✗	Counselor	0
✗	Np/CNM/PA	238
✗	RN	1
✗	Clinic Assistant	194
	Total Number of Non-Qualifying Visits	476
	Total # of Visits	6650
	% of Qualifying Visits	93%

Client Profile by Insurance 2013-14		
Insurance	Insurance Sub Category	# of Clients
Private	Unknown	1152
	Sub Total	1152
Public	Champus	1
	CHP+	5
	Medicaid/Tanf	406
	Medicare	10
	Unknown	18
	Sub Total	440
Uninsured	Unknown	1853
	Sub Total	1853
Unknown	Unknown	455
	Sub Total	455
	Grand Total	3900
% of people using Title X funds to pay for visits		47.51%

Client Profile by Insurance 2014-15		
Insurance	Insurance Sub Category	# of Clients
Private	Unknown	1146
	Sub Total	1146
Public	Champus	0
	CHP+	6
	Medicaid/Tanf	780
	Medicare	10
	Unknown	25
	Sub Total	821
Uninsured	Unknown	1173
	Sub Total	1173
Unknown	Unknown	586
	Sub Total	586
	Grand Total	3726
% of people using Title X funds to pay for visits		31.48%

Client Profile by Insurance 2015-16		
Insurance	Insurance Sub Category	# of Clients
Private	Unknown	1206
	Sub Total	1206
Public	Champus	0
	CHP+	5
	Medicaid/Tanf	861
	Medicare	9
	Unknown	20
	Sub Total	895
Uninsured	Unknown	1014
	Sub Total	1014
Unknown	Unknown	501
	Sub Total	501
	Grand Total	3616
% of people using Title X funds to pay for visits		28.04%

Client Profile by Income 2013-14										
Income	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
< 101%	19	532	513	597	343	244	149	89	66	2552
101-150%	1	15	69	185	134	71	38	36	33	582
151 - 200%	0	9	25	73	72	49	17	12	15	272
201 - 250%	0	3	9	47	48	25	14	13	5	164
> 250%	2	14	25	66	85	60	30	25	23	330
Totals	22	573	641	968	682	449	248	175	142	3900

Client Profile by Income 2014-15										
Income	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
< 101%	21	529	449	533	310	224	119	71	86	2342
101-150%	0	18	66	172	128	61	33	18	27	523
151 - 200%	0	9	34	88	66	39	16	7	15	274
201 - 250%	0	2	14	50	46	20	14	5	7	158
> 250%	1	3	27	69	139	85	37	28	40	429
Totals	22	561	590	912	689	429	219	129	175	3726

Client Profile by Income 2015-16										
Income	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
< 101%	32	457	441	560	323	192	129	65	73	2272
101-150%	0	11	45	138	103	74	36	22	24	453
151 - 200%	0	3	14	80	68	47	21	14	7	254
201 - 250%	0	2	5	46	57	16	11	5	9	151
> 250%	0	2	14	80	191	103	37	28	31	486
Totals	32	475	519	904	742	432	234	134	144	3616

Client Profile by Age and Gender 2013-14										
	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	20	549	607	940	667	424	237	160	130	3734
Male	2	24	34	28	15	25	11	15	12	166
Totals	22	573	641	968	682	449	248	175	142	3900

Client Profile by Age and Gender 2014-15										
	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	21	542	568	897	670	417	211	123	164	3613
Male	1	19	22	15	19	12	8	6	11	113
Totals	22	561	590	912	689	429	219	129	175	3726

Client Profile by Age and Gender 2015-16										
	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	32	466	504	891	722	416	230	131	139	3531
Male	0	9	15	13	20	16	4	3	5	85
Totals	32	475	519	904	742	432	234	134	144	3616

Agency Race Comparison with State Totals 2013-16						
	Boulder Valley Women's Health Center					
Race Demographic Data	Males Total	% of Agency	Females Total	% of Agency	Combined Total	% of Agency
Afro-American/Black	4	1.2%	99	1.2%	103	1.1%
American Indian/Alaskan	3	0.9%	51	0.9%	54	0.6%
Asian	6	1.8%	299	1.8%	305	3.4%
Caucasian/White	268	78.8%	6650	78.8%	6918	76.7%
Multiracial	6	1.8%	165	1.8%	171	1.9%
Not Specified	46	13.5%	1066	13.5%	1112	12.3%
Other	5	1.5%	297	1.5%	302	3.3%
$	0	0.0%	18	0.0%	18	0.2%
Unknown	2	0.6%	33	0.6%	35	0.4%
Totals	340	100%	8678	100%	9018	100%

Statewide Information						
Race Demographic Data	Males Total	% of Agency	Females Total	% of Agency	Combined Total	% of Agency
Afro-American/Black	3771	17.8%	6957	6.9%	10728	8.8%
American Indian/Alaskan	300	1.4%	915	0.9%	1215	1.0%
Asian	236	1.1%	1747	1.7%	1983	1.6%
Caucasian/White	11820	55.7%	70081	70.0%	81901	67.5%
Multiracial	175	0.8%	943	0.9%	1118	0.9%
Not Specified	3917	18.5%	10642	10.6%	14559	12.0%
Other	943	4.4%	8543	8.5%	9486	7.8%
Pacific Islander	55	0.3%	191	0.2%	246	0.2%
Unknown	9	0.0%	122	0.1%	131	0.1%
Totals	21226	100%	100141	100%	121367	100%

Contraceptive Method by Age and Gender 2013-14											
		< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	Abstinence	1	10	9	12	21	14	8	9	21	105
	Condoms - Female	0	1	0	0	1	0	0	0	0	2
	Condoms - Male	4	95	98	136	94	72	48	30	21	598
	Contraceptive Implant	2	48	56	74	34	27	5	2	2	250
	Contraceptive Patch	2	8	9	7	6	9	7	0	0	48
	Contraceptive Ring	0	17	37	59	49	15	4	1	1	183
	Depo-Provera	5	98	87	81	32	36	31	11	5	386
	Diaphragm/Cervical Cap	0	0	0	2	2	3	1	1	4	13
	Emergency Contraceptive Pill	0	11	6	7	2	2	1	0	0	29
	Female Sterilization	0	0	0	1	4	11	14	13	8	51
	Fertility Awareness Method	0	0	0	4	3	0	3	2	0	12
	IUD	0	41	72	169	152	99	54	37	22	646
	None at this time	2	21	12	27	23	22	12	14	12	145
	None - Desires Pregnancy	0	0	0	10	6	14	6	2	0	38
	None - Pregnant	0	8	10	25	22	8	5	1	0	79
	Oral Contraceptive Pills	4	190	211	314	198	75	28	19	20	1059
	Partner with Vasectomy	0	0	0	1	2	6	4	11	10	34
	Spermicide used Alone	0	0	0	2	0	0	0	1	0	3
	Sponge	0	0	0	0	1	0	1	0	0	2
	Withdrawal/Other Method	0	1	0	9	15	11	5	6	4	51
	Female Totals	20	549	607	940	667	424	237	160	130	3734
Male	Abstinence	1	2	2	0	0	0	0	0	1	6
	Condoms - Male	0	21	25	24	9	19	7	8	8	121
	Fertility Awareness Method (FAM)	0	0	0	0	0	1	0	0	0	1
	None at this time	1	1	4	1	1	2	0	0	1	11
	Rely on female method	0	0	3	3	2	0	2	1	0	11
	Vasectomy	0	0	0	0	3	3	2	5	2	15
	Withdrawal/Other Method	0	0	0	0	0	0	0	1	0	1
	Male Totals	2	24	34	28	15	25	11	15	12	166
	Grand Totals	22	573	641	968	682	449	248	175	142	3900

Contraceptive Method by Age and Gender 2014-15											
		< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	Abstinence	4	13	8	16	28	12	12	13	24	130
	Condoms - Female	0	0	0	1	0	0	0	0	0	1
	Condoms - Male	1	99	89	122	109	81	33	20	37	591
	Contraceptive Implant	1	73	67	80	44	34	7	7	5	318
	Contraceptive Patch	0	7	9	6	4	4	6	1	2	39
	Contraceptive Ring	0	10	16	40	26	18	8	2	0	120
	Depo-Provera	6	68	83	65	23	22	13	2	8	290
	Diaphragm/Cervical Cap	0	0	0	0	0	1	0	0	1	2
	Emergency Contraceptive Pill	0	21	17	6	4	3	2	0	1	54
	Female Sterilization	0	0	0	1	6	7	9	5	12	40
	Fertility Awareness Method	0	0	0	3	2	9	1	1	1	17
	IUD	3	41	71	201	167	97	58	25	23	686
	None at this time	2	18	12	29	28	33	13	11	18	164
	None - Desires Pregnancy	0	0	0	13	11	10	8	3	0	45
	None - Pregnant	0	6	4	9	14	3	1	1	0	38
	Oral Contraceptive Pills	4	183	188	284	185	62	28	18	15	967
	Partner with Vasectomy	0	0	0	0	3	7	3	8	11	32
	Spermicide used Alone	0	0	0	1	0	1	0	1	0	3
	Withdrawal/Other Method	0	3	4	20	16	13	9	5	6	76
	Female Totals	21	542	568	897	670	417	211	123	164	3613
Male	Abstinence	0	0	1	0	0	0	0	0	0	1
	Condoms - Male	1	15	18	7	11	8	6	3	7	76
	Fertility Awareness Method (FAM)	0	1	0	1	0	0	0	0	0	2
	None at this time	0	3	0	4	0	2	1	1	0	11
	Rely on female method	0	0	2	2	4	1	0	0	0	9
	Vasectomy	0	0	0	0	4	0	1	2	2	9
	Withdrawal/Other Method	0	0	1	1	0	1	0	0	2	5
	Male Totals	1	19	22	15	19	12	8	6	11	113
	Grand Totals	22	561	590	912	689	429	219	129	175	3726

Contraceptive Method by Age and Gender 2015-16											
		< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	Abstinence	2	8	10	24	17	14	10	17	18	120
	Condoms - Female	0	0	0	0	2	0	0	0	0	2
	Condoms - Male	1	52	52	112	117	64	39	26	20	483
	Contraceptive Implant	14	120	93	110	42	31	19	5	4	438
	Contraceptive Patch	0	2	0	1	0	1	3	1	0	8
	Contraceptive Ring	0	3	9	39	22	19	5	2	1	100
	Depo-Provera	6	50	56	53	24	26	18	4	6	243
	Diaphragm/Cervical Cap	0	0	0	2	4	3	3	0	2	14
	Emergency Contraceptive Pill	0	14	11	5	7	0	2	0	1	40
	Female Sterilization	0	0	0	0	3	4	4	4	7	22
	Fertility Awareness Method	0	0	0	2	6	9	4	4	3	28
	IUD	1	57	86	196	218	105	54	27	23	767
	None at this time	1	13	6	25	42	23	12	8	22	152
	None - Desires Pregnancy	0	0	1	10	17	19	12	3	0	62
	None - Pregnant	0	5	5	9	12	9	5	1	0	46
	Oral Contraceptive Pills	7	140	172	288	159	69	31	12	12	890
	Partner with Vasectomy	0	0	0	0	3	6	2	8	17	36
	Vasectomy	0	0	0	0	0	0	0	1	0	1
	Withdrawal/Other Method	0	2	3	15	27	14	7	9	2	79
	Female Totals	32	466	504	891	722	416	230	132	138	3531
Male	Condoms - Male	0	8	11	10	15	7	4	2	2	59
	Fertility Awareness Method (FAM)	0	0	0	0	1	0	0	0	0	1
	No method - partner pregnant/seeking pregnancy	0	0	0	0	1	1	0	0	0	2
	None at this time - other reason	0	0	3	2	1	1	0	0	0	7
	Rely on female method	0	1	1	1	0	2	0	0	1	6
	Vasectomy	0	0	0	0	2	5	0	1	1	9
	Withdrawal/Other Method	0	0	0	0	0	0	0	0	1	1
	Male Totals	0	9	15	13	20	16	4	3	5	85
	Grand Totals	32	475	519	904	742	432	234	135	143	3616

Breast Exam w/out Physical Clients by Age 2013-16										
	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	0	4	31	81	67	43	22	11	15	274
Percentage	0%	1%	11%	30%	24%	16%	8%	4%	5%	

Breast Referral Clients by Age 2013-16										
	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	0	3	2	7	18	13	14	36	52	145
Percentage	0%	2%	1%	5%	12%	9%	10%	25%	36%	

Physical Exam Clients by Age 2013-16										
	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	11	103	149	632	437	297	170	135	160	2094
Percentage	1%	5%	7%	30%	21%	14%	8%	6%	8%	

Gonorrhea Tests by Client Age 2013-16										
	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	41	978	1051	1511	987	608	331	185	137	5829
Percentage	1%	17%	18%	26%	17%	10%	6%	3%	2%	
Male	1	28	53	47	34	27	9	5	7	211
Percentage	0%	13%	25%	22%	16%	13%	4%	2%	3%	
										6040

Chlamydia Tests by Client Age 2013-16										
	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	28	659	770	1227	851	553	299	169	126	4682
Percentage	1%	14%	16%	26%	18%	12%	6%	4%	3%	
Male	1	28	46	42	27	24	7	5	7	187
Percentage	1%	15%	25%	22%	14%	13%	4%	3%	4%	
										4869

Syphilis Tests by Client Age 2013-16										
	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	2	18	56	119	108	84	44	26	24	481
Percentage	0%	4%	12%	25%	22%	17%	9%	5%	5%	
Male	1	3	16	14	17	13	3	2	6	75
Percentage	1%	4%	21%	19%	23%	17%	4%	3%	8%	
										556

HIV Tests by Client Age 2013-16										
	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	1	25	68	167	133	105	72	36	38	645
Percentage	0%	4%	11%	26%	21%	16%	11%	6%	6%	
Male	1	2	10	13	13	15	2	2	4	62
Percentage	2%	3%	16%	21%	21%	24%	3%	3%	6%	
										707

Pap Tests by Client Age 2013-16										
	< 15 yrs. old	15-17 yrs. old	18-19 yrs. old	20-24 yrs. old	25-29 yrs. old	30-34 yrs. old	35-39 yrs. old	40-44 yrs. old	> 44 yrs. old	Totals
Female	0	2	2	371	331	226	146	97	103	1278
Percentage	0%	0%	0%	29%	26%	18%	11%	8%	8%	

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