



# Kansas Title X 2024 Needs Assessment

# Acknowledgements

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# Summary of Findings

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Title X is the only federal grant program dedicated to providing individuals with comprehensive reproductive health and related preventive health services. For more than 50 years, Title X-funded health centers have provided high-quality cost-effective reproductive health and related preventive health services to low-income, under-insured and uninsured women and men who may otherwise lack access to health care. These health centers play a critical role in ensuring access to voluntary family planning information and services for their clients regardless of their ability to pay. The Kansas Title X Program partnered with The University of Kansas Center for Public Partnerships and Research (KU-CPPR) to conduct a mixed-methods Title X Needs Assessment to understand and address the reproductive health needs of Kansans. The 2024 Kansas Title X needs assessment process helps to ensure that the state's safety net for sexual and reproductive health services continues to meet the needs of women's and men's reproductive health, particularly those of the most vulnerable. The comprehensive overview provided by the needs assessment, covering aspects such as population distribution, racial and ethnic diversity, socioeconomic determinants of health, and economic disparities, offers valuable insights into the unique challenges faced by different communities across the state. The findings of the assessment highlight the essential role Title X funded clinics play in addressing family health needs, particularly among underserved and vulnerable groups. The identification of gaps in service delivery, areas for improvement, and recommendations provided in the assessment lay the groundwork for enhancing the effectiveness and reach of Title X services in Kansas and improving reproductive health statewide. A summary of the findings and considerations follows.

## Kansas' Population

- Kansas is considered a mostly rural state, with about 3 million inhabitants.
- Over 50% of Kansans live in urban counties, while about a third live in rural or frontier areas.
- Kansas has relatively low ethnic diversity, but there are significant ethnic minority populations in certain counties.

## The Health of Kansans

- Kansas has higher mortality rates than the national average and significant rates of chronic conditions like hypertension and obesity.

- Health disparities exist among racial and ethnic groups, with Black/African Americans experiencing higher rates of chronic diseases.
- Mental health issues, substance use, and drug overdose deaths are also concerns, with disparities in access to care.

## Social Determinants of Health

- Poverty rates vary across regions, with rural areas experiencing higher rates.
- Educational attainment disparities persist, especially among minority students.
- Income inequality is significant, and communities of color face disproportionate involvement in the criminal justice system.

## Insurance Status

- Kansas is one of ten states that has not adopted Medicaid expansion.
- As of 2021, about 9% of Kansans are uninsured.
- A significant portion of uninsured individuals are concentrated in the five most populous counties in Kansas.
- There are significant disparities in uninsurance rates among different racial and ethnic groups and for those that fall under the poverty line.

## Births

- The overall Kansas birthrate is 12 births per 1,000 people.
- The overall teen birth rate is 18 per 1,000 people aged 15-19.
- The teen birth rate of Black and Hispanic teens is almost twice that of White teens.

## Infant Birth Outcomes and Mortality

- The overall infant mortality rate is 5.3 deaths per 100,000 live births.
- The percentage of births of low birthweight babies for Black mothers in Kansas is twice that of White mothers.

## Maternal Morbidly and Mortality

- The rate of severe maternal morbidity and mortality for non-Hispanic Black women in Kansas is significantly higher than for any other race and ethnicity.

## Teen Pregnancy and Unintended Pregnancy

- While overall teen pregnancy rates have been declining, significant disparities persist among different racial and ethnic groups and across geographic regions.
- Unintended pregnancy rates have been gradually declining. However, unintended pregnancy rates can vary based on factors such as age, race, socioeconomic status, and geographic location.

## Sexually Transmitted Infections and HIV

- The rates of common sexually transmitted infections such as chlamydia, gonorrhea, and syphilis have been on the rise in Kansas in recent years.
- While the overall HIV prevalence in Kansas is relatively low compared to some other states, men who have sex with men (MSM) and individuals from communities of color are disproportionately affected by HIV in Kansas.

## Title X in Kansas

- In 2022, 13,148 Kansans received family planning services through Title X, with the majority being women.
- 50% of clients were under 100% of the federal poverty level (FPL).
- About 42% of clients identified as Hispanic or Latino and over a fifth reported Limited English Proficiency.
- Over 60% of clients had no health insurance.

## Strengths and Challenges of Kansas' Title X Service Delivery System

Kansas' Title X-funded health centers provide comprehensive, standardized, high-quality, timely and accessible family planning and reproductive health care throughout the state. Among its strengths are a dedicated workforce, strong community connections, and supportive staff at the state program level. However, the Kansas Title X programs face a myriad of challenges, including financial barriers, lack of program awareness, language barriers, politically fraught interactions with local commissioners, varying perceptions of service quality, concerns with policies around confidentiality, administrative misunderstandings of Title X policy, reimbursement issues, and workforce challenges. Addressing these barriers will likely require a multi-faceted approach involving policy changes, resource allocation, education, and advocacy.

# Considerations

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In the context of the gains, strengths, and challenges for Kansas' Title X service delivery system, the following focus areas are called out for consideration and intended to guide future efforts of Kansas Department of Health and Environment (KDHE) and partners.

1. **Advocacy and Education:** Engage in advocacy efforts to raise awareness among local commissioners and policymakers about the importance of reproductive health services and the impact they have on public health. Educate them about the benefits of expanding services and the potential consequences of limiting access.
2. **Financial Support:** Advocate for increased funding for Title X programs to address the financial barriers associated with offering certain services, including Long-Acting Reversible Contraception (LARC). Explore alternative funding sources and partnerships to support the provision of these services.
3. **Community Outreach and Education:** Increase efforts to raise awareness about Title X programs and the services they offer through community engagement events, advertising, and outreach efforts. Utilize various platforms, including social media, to reach different demographics and populations.
4. **Expansion of Services:** Expand health services to include mental health and substance use disorder support and promote gender-inclusive reproductive health services.
5. **Language Access Services:** Invest in language access services, including interpreter training and translation of educational materials, to better serve individuals who do not speak English proficiently. Ensure that materials are available in multiple languages and culturally appropriate to reach diverse communities.
6. **Improving Perceptions of Quality:** Address concerns about the quality of care by investing in facility improvements, staff training, and customer service initiatives. Create a welcoming and inclusive environment that values the dignity and worth of all patients.
7. **Confidentiality Policies:** Reinforce compliance with policies that ensure confidential access to reproductive health services for adolescents and young people without parental consent, in accordance with Title X guidelines.
8. **Administrative Support and Training:** Provide administrative staff with training on Title X policies and requirements to ensure better understanding and compliance. Foster collaboration between clinical and administrative staff to optimize program operations.
9. **Reimbursement Reform:** Advocate for changes to Medicaid reimbursement policies to ensure equitable coverage of family planning services. Explore strategies to address reimbursement issues, including negotiating with insurers and leveraging funding sources.

10. **Workforce Development:** Invest in recruiting and retaining qualified healthcare providers and staff for Title X programs. Offer competitive wages, professional development opportunities, and supportive work environments to attract and retain talent.
11. **Regional Collaboration:** Explore opportunities for regional collaboration and shared services to address workforce challenges and ensure continuity of care. Establish referral networks and regional systems of care to optimize resource utilization and improve access to services.

# Introduction

## A Snapshot of Health and Health Services in Kansas

While Kansas has made strides in improving healthcare access in recent years, significant challenges remain, particularly in rural and underserved areas. Addressing these challenges requires a comprehensive approach that includes expanding insurance coverage, fostering the public health care system, increasing healthcare workforce capacity, leveraging telehealth technologies, and addressing social determinants of health to promote health equity for all Kansans.

### Population

Kansas has close to 3 million inhabitants. Kansas is primarily a rural state, with only six counties classified as urban and another 10 classified as semi-urban (KDHE, 2023a). However, urban counties are the most quickly growing, and over half of Kansas’ population live in the populous urban counties (Steiner, 2021) (see Figure 1). Still, over 1 million Kansas residents live in rural and frontier counties. These areas present unique challenges, including geographical isolation and transportation issues, which in turn contribute to disparities in access to healthcare, education, and other essential services for residents living in rural and small-town areas of Kansas (Peck & K, 2023).

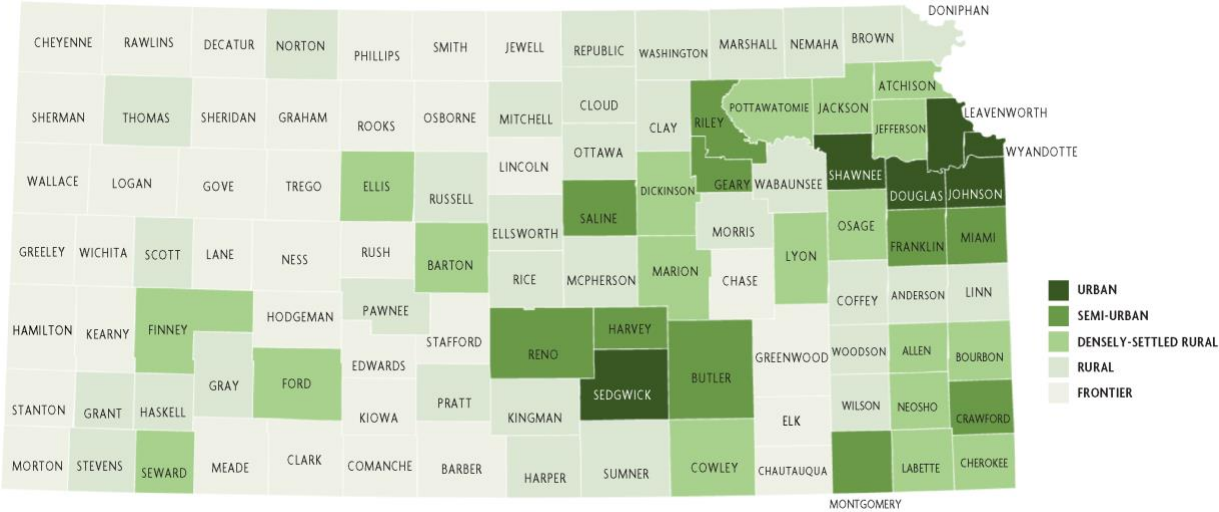


Figure 1: Kansas Population Density. Data source: Kansas Department of Health and Environment, 2023.

## Racial and Ethnic Diversity

The majority of the population in the state is classified as White, non-Hispanic, constituting 85.9% of the total population, which is higher than the national average of 75% ([US Census Bureau, 2023](#)). The state's diversity index is 45.4, which is lower than the national average diversity index of 61.1% ([US Census Bureau, 2023b](#)). This reflects that the state as a whole and most of its counties are less diverse compared to the United States overall. However, ethnic diversity varies significantly across the state. Some counties, particularly in southwest Kansas, have ethnic minority majorities. For instance, four counties in southwest Kansas (Finney, Ford, Grant, and Seward) have populations that are less than 50% white, as does Wyandotte County in the northeast (Kansas Health Institute ([KHI](#)), 2024c) (see [Figure 2](#)). The significant ethnic, mostly Hispanic, minority populations in southwest Kansas are due to the influence of the agricultural industry ([KHI, 2024c](#)). Furthermore, urban counties like Sedgwick and Wyandotte have higher diversity indexes (55.0 and 70.8 respectively), while semi-urban and rural counties also show relatively high diversity indexes (Geary County: 64.5%, Finney County: 58.7%) ([US Census Bureau, 2021](#)).

Regarding the percentage of women aged 15-44 who are non-White, Wyandotte County leads with 34.6%, followed by Geary, Riley, Montgomery, and Johnson counties. Wyandotte County also ranks highest in diversity, with a Diversity Index of 70.8, followed by Geary, Ford, Grant, and Hamilton counties. When it comes to the population density of women aged 15-44, Wyandotte County ranks highest with 215.6 women per square mile, followed by Johnson, Shawnee, Douglas, and Geary counties. For the percentage of women aged 18-49 who are uninsured, Seward County has the highest rate at 27.7%, followed by Hamilton, Haskell, Stevens, and Ford counties. For by-county details about population density, income inequality, and distribution of women of reproductive age, see [Appendix I, Table 1](#).

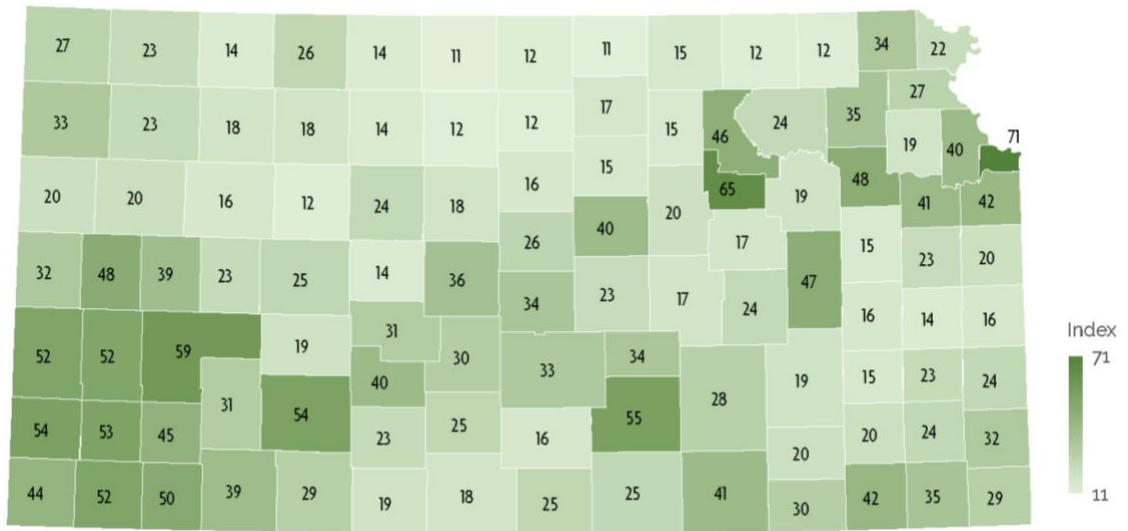


Figure 2: Kansas County Diversity Index. Counties in darker shades have higher diversity index score (>24). Data source: <https://www.census.gov/library/visualizations/interactive/racial-and-ethnic-diversity-in-the-united-states-2010-and-2020-census.html>

## Socioeconomic Determinants of Health in the State

Economic and social disparities can be linked through the social determinants of health to persistent gaps in other areas (US DHHS, 2023). Economic and social disparities can be linked through the social determinants of health to persistent gaps in other areas (US DHHS, 2023). These social conditions are shaped by the historical and institutional structures that create and sustain concentrated areas of disadvantage, particularly for communities of color. The environments where people live, including economic stability, education access and quality, health care access and quality, the built environment, and communities’ social and community context, all impact health.

## Economic Environment

Historically, agriculture has been the backbone of Kansas' economy, with the state being a national leader since the early 1900s in the production not only of wheat, but also in the production of other grains including sorghum and beef production (Kansas Historical Society, 2023). While agriculture is a vital part of the state's economy, it also exposes Kansas to fluctuations in commodity prices, weather-related risks, and market uncertainties. Droughts, floods, and other natural disasters can significantly impact farm incomes and rural communities. Kansas has experienced a slow population growth rate compared to national averages, and some regions of the state are facing population decline (Hunt & Panas, 2018). This trend presents

challenges for sustaining economic growth, as a shrinking population can lead to reduced consumer demand, labor shortages, and decreased tax revenues for public services.

In Kansas, like in some other Midwest/Plains states, many young, educated individuals leave the state in search of better job opportunities and quality of life elsewhere ([Bui, 2016](#)). This "brain drain" deprives the state of skilled workers and entrepreneurs, hindering innovation and economic development. The unemployment rate has, in recent years, been close to 3% (2.7% in January 2024) slightly below the national average but can vary widely between geographic regions and sectors ([Federal Reserve Bank of St Louis, 2024](#)). While Kansas has seen job growth in recent years, there are concerns about stagnation of wages. In 101 of 105 Kansas counties (all but the four largest counties), the average weekly wage is below the national average ([Kansas Department of Labor, 2024](#)). Kansas also has a low minimum hourly wage of \$7.25. ([Kansas Department of Labor, 2024](#)) However, minimum wage does not equate to a livable income. By one calculation, a livable wage for a family of four with two parents living in Kansas working full-time is \$23.24 per hour per working parent ([MIT, 2024](#)). A survival budget for a family with two adults, one infant, and one preschool-aged child in Kansas requires a combined hourly wage of \$27.40 ([United Way, 2023](#)).

## Poverty

Kansas ranks in the middle among U.S. states in terms of poverty rates and related socioeconomic indicators. Twelve percent of households live at or below 100% of the federal poverty level (FPL), which is less than \$30,000 annual income for a family of four, and an additional 27% of households earn above 100% FPL but still struggle to afford at least some of their basic needs ([United Way, 2023](#)). Poverty rates vary across different regions of the state, with rural areas often experiencing higher rates than urban centers. Poverty can manifest differently in rural and urban areas. While urban centers like Wichita and Kansas City may struggle with issues including homelessness and inner-city poverty, rural areas face challenges like limited job opportunities, access to healthcare, and infrastructure deficiencies.

## Educational Attainment

Educational Attainment plays a crucial role in poverty rates. Kansas has made efforts to improve its education system, but disparities in educational outcomes persist, particularly among minority and low-income students ([National Center for Education Statistics](#)). Limited access to quality education and training programs can perpetuate the cycle of poverty by restricting individuals' ability to secure higher-paying jobs and safe and stable housing. Housing affordability is a pressing issue in Kansas, particularly in urban areas where rising rents and stagnant wages make it difficult for low-income families to find suitable housing. In rural areas, affordable housing options may be limited, exacerbating poverty and homelessness.

## Economic Disparities

### Income Inequality

Income Inequality is often considered a better economic measure than metrics like average income because it provides insights into the distribution of wealth and needs at the lower end of the economic spectrum ([Beech et al., 2021](#)). Moreover, there is growing evidence that relative wealth influences health outcomes as much or more than the absolute level of wealth an individual possesses ([Beech et al., 2021](#)). Research also shows that income inequality is associated with various negative social outcomes, including poorer health outcomes, reduced life expectancy, and higher rates of crime and substance abuse ([Polacko, 2021](#)). By tracking income inequality, policymakers can better understand the underlying social determinants of health and well-being and develop targeted interventions to address them.

Income inequality in Kansas, while not as great as the U.S. as a whole, is still substantial, with the top 1% of income-earners making 18.3 times that of the bottom 99%; the average annual income of the top 1% in Kansas is \$1,034,676, compared to \$56,628 for the remaining 99% ([Economic Policy Institute, 2018](#)). The Pittsburg metropolitan area is the most unequal metro area in Kansas, and Johnson County is the most unequal county overall; in both, the top 1% make 20 times or more what the average income of the bottom 99% earn ([Economic Policy Institute, 2018](#)).

Looking at income inequality through the *Gini Index* is another standard way of illustrating economic areas of needs ([Halkos & Aslanidis, 2023](#)). The range of the coefficient is between 0 and 1, whereby 0 denotes complete equality in a population (every person receives the same income) and 1 denotes complete inequality (one person has all the wealth in the region). Based on 2018-2022 American Community Survey data, Kansas overall falls into the midrange when it comes to income equality, when compared to rest of the US ([Kansas Health Matters, 2024](#)). However, there are more than 20 counties that are in the worst 25<sup>th</sup> quartile (for Kansas, > 0.447) ([Kansas Health](#)



[Center for Educational Statistics](#)), resulting in lower graduation rates, standardized test scores, and access to advanced coursework ([WalletHub, 2023](#)). However, from 2010-2022 many of these racial and ethnic minorities did show the greatest increases in high school graduation rates ([Kansas Association of School Boards, 2023](#)). Rural schools in Kansas may struggle with challenges including limited resources, declining enrollment, and difficulty recruiting and retaining qualified teachers, contributing to disparities in educational quality and opportunities between rural and urban areas of the state ([Nguyen, 2023](#)). Finally, students with special healthcare needs face disparities in access to specialized services, accommodations, support resources, receive disproportionate high disciplinary actions and lower academic achievement outcomes for students with disabilities are common concerns in many school districts ([Nguyen, 2023](#)).

### Involvement in the Criminal Justice System

The criminal justice system can also exacerbate income disparities, particularly for communities of color. Black and Hispanic individuals are disproportionately represented in the criminal justice system, which can have long-term consequences for employment, housing, and financial stability. In Kansas, White Americans have an incarceration rate of 218 per 100,000 residents in state prisons and 226 per 100,000 in local jails. By contrast, the incarceration rate for Black Americans is sixfold higher, with 1,465 per 100,000 in state prisons and 1,278 per 100,000 in local jails, reflecting systemic disparities ([Mijis, 2021](#)).

# Kansas' Healthcare Landscape

## Access, Coverage, and Provider Shortages

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### Health Insurance Coverage

The access to healthcare services in Kansas is intricately tied to insurance coverage. While most insured Kansans rely on employer-sponsored insurance, there are also significant numbers covered by individually purchased plans, Medicare/Medicaid/CHIP, or VA Health Care. However, the lack of Medicaid expansion in Kansas, as stipulated by the Affordable Care Act (ACA), has left a considerable portion of low-income individuals without access to affordable health insurance. In addition, many rural communities have limited healthcare infrastructure, including hospitals and clinics, making it challenging for residents to access essential medical services. This lack of access not only affects residents' well-being but also contributes to economic disparities between urban and rural areas.

Most insured Kansans rely on employer-sponsored insurance (54.1%), but Kansans also are covered by individually purchased insurance plans (6.1%), Medicare/Medicaid/CHIP (20.4%), or VA Health Care (0.2%) ([KHI, 2023a](#)). While the Affordable Care Act (ACA) expanded Medicaid eligibility to low-income adults in many states, Kansas is one of 10 states that has not expanded Medicaid eligibility, leaving thousands of low-income individuals without access to affordable health insurance. In 2021 an estimated 9.2% of Kansans were uninsured (compared to 8.6% nationwide and 6.5% among states that have expanded Medicaid) ([KHI, 2023a](#)), and uninsured rates are higher among certain demographic groups, including low-income individuals and racial/ethnic minorities. For example, 20.5% of Kansans with family income below the poverty line are uninsured, compared to 3.6% of those above 400% of the federal poverty line ([KHI, 2023a](#)). Geographically, over half (53.1%) of uninsured, nonelderly adults and close to half (46.1%) of uninsured children reside in the five most populous counties (Douglas, Johnson, Sedgwick, Shawnee, and Wyandotte) ([KHI, 2023a](#)). Seward, Hamilton, Haskell, and Stevens counties have the highest proportions of uninsured women aged 18-49 in Kansas ([Appendix I, Table 1](#)).

The percentage of individuals who are uninsured is higher among Hispanic Kansans (20.4%), non-Hispanic Black Kansans (15.1%), and Kansans of other/multiple race (10.6%) than among non-Hispanic White Kansans (6.7%) ([KHI, 2023a](#)). While many uninsured non-elderly adults were employed part-time or for part of the year, more than one third (35.9%) of uninsured Kansas adults had full-time jobs all year ([KHI, 2023a](#)). The percentage of individuals who are

uninsured is higher among Hispanic Kansans (20.4%), non-Hispanic Black Kansans (15.1%), and Kansans of other/multiple race (10.6%) than among non-Hispanic White Kansans (6.7%) ([KHI, 2023a](#)).

In December of 2023, Governor Kelly announced a legislative proposal to expand Medicaid to an estimated 150,000 Kansans ([Office of the Kansas Governor, 2023](#)), and two companion bills, S.B. 355 ("[Committee on Appropriations," 2023](#)) and H.B. 2556 ("[Committee on Appropriations," 2023](#)), have been introduced to expand Medicaid coverage to childless adults with incomes at or below the federal poverty level, effective January 1, 2015, that did not pass. Of the 2.8 million Kansans, 248,308 of these are uninsured (8.6%), of which 37,192 were children from birth to 18 years of age ([KHI, 2023b](#)). The Kansas Health Institute estimates that 71,457 Kansas would have become eligible for Medicaid if the state had opted to expand coverage; another 28,902 low-income Kansans would have become eligible for Medicaid of the Children's Health Insurance Program (CHIP) but are not enrolled in the programs ([KHI, 2023b](#)).

## General Health Care Vulnerability

The Maternal Vulnerability Index (MVI) is an index designed to quantify area-level indicators of maternal vulnerability to adverse maternal health outcomes. Developed by Surgo Ventures, the MVI is based on a literature review of publications (reports, working papers, books, scientific manuscripts, and review articles) from 2000 through 2020 identifying 43 county-level indicators factors associated with US maternal mortality and morbidity. It ranks counties and states in terms of vulnerability to poor pregnancy outcomes on overall vulnerability and six themes: general healthcare, reproductive healthcare, physical health, mental health & substance abuse, socioeconomic determinants, and physical environment. The MVI assigns a score 0-100 to each county, where a higher score indicates greater vulnerability to adverse maternal outcomes.

The *general healthcare sub-score* includes accessibility, affordability, and utilization of health care including insurance coverage and the state's Medicare expansion status.

Several Southwest Kansas counties are identified as having very high *general health care* vulnerability scores, including Haskell (score =95), Morton (score =94), and Gray Counties (score =93). In addition, Gove County also receives very high general health care vulnerability scores (See [Appendix I, Table 4](#)).

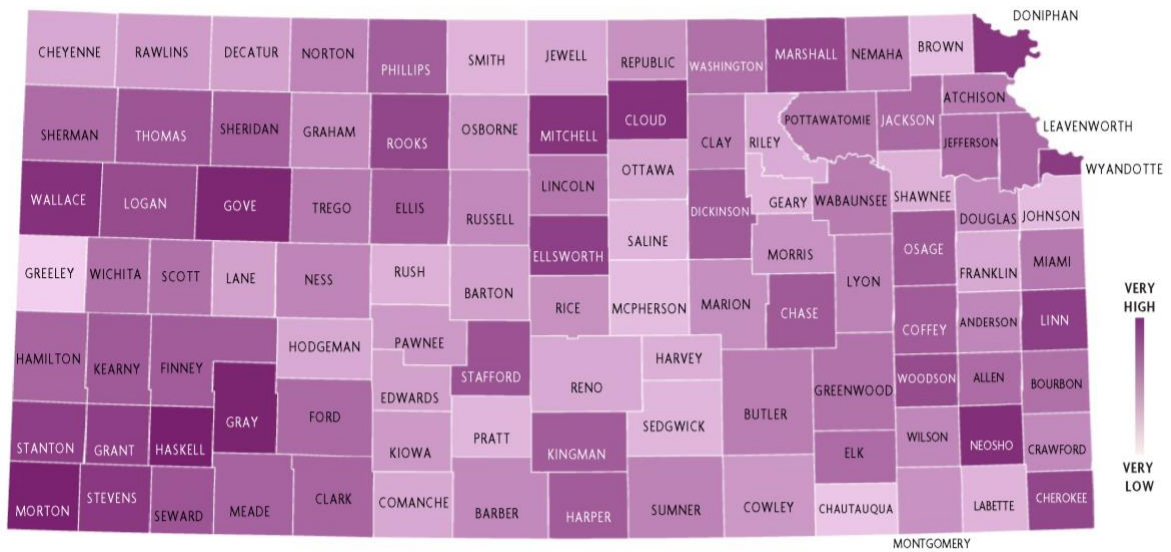


Figure 4: Maternal Vulnerability Index, General Health Care Sub-score. Data Source: Surgo Ventures. Darker color indicates higher general healthcare risk scores.

## Provider Shortages

*One third of all Kansans live in health provider shortage areas.*

The National Health Service Corps (NHSC) developed Health Professional Shortage Area (HPSA) score to determine the priority areas for assigning clinicians. The scores range from 0 to 26 where the higher the score, the greater the provider shortage. The federal Health Resources and Services Administration (HRSA) has a total of 191 Health Professional Shortage Area designations in Kansas; the population of areas designated as HPSAs is 828,259, nearly one-third of the state’s population ([Bureau of Health Workforce, 2023](#)). HRSA estimates that 132 additional practitioners are needed to remove these designations and have adequate provider coverage statewide ([Bureau of Health Workforce, 2023](#)). These shortages mean that many Kansans experience barriers to care for a variety of reasons, including geography, financial reasons, and others. Among the Kansas counties with higher HPSA scores, Crawford County leads with the highest score of 21, followed by Lyon County with a score of 20. Cowley, Reno, Sedgwick, and Wyandotte Counties all share a score of 19. To see the scores of all counties, please refer to [Appendix I, Table 1](#).

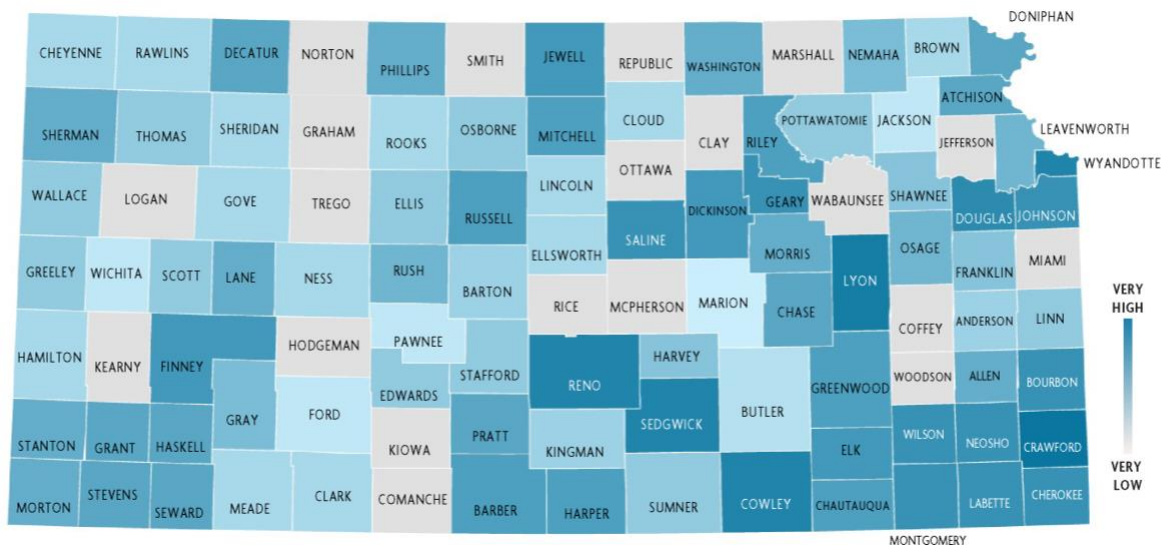


Figure 5: Health Professional Shortage Area: Primary Care, by County, 2024-Kansas. Data Source: data.hrsa.gov, January 2024.

## Geographic and Transportation Barriers

Like many states, Kansas faces disparities in healthcare access between rural and urban areas. Rural residents often have limited access to healthcare facilities and providers due to factors including geographic isolation, provider shortages, and hospital closures. This can result in longer travel times to reach medical services and delays in receiving care. Almost half of Kansans live in rural areas of the state and face growing health care shortages. 9,808 hospitals in the state have closed, and the Center for Healthcare Quality and Payment Reform estimates that over 77 of the state’s 101 rural hospitals are at risk of closure due to serious financial problems, and 26 of these facilities are at risk of immediate closure ([Center for Healthcare Quality and Payment Reform, 2023](#)). Even without the threat of hospital closures, there are existing barriers to public health and health care services, particularly in smaller, rural communities whose small populations make it difficult or impossible to offer a full range of needed specialty services. As a largely rural state, public transportation infrastructure is not available to many, and transportation is frequently cited as a barrier to health care access.

## Telehealth Utilization

Utilization of telehealth services expanded rapidly during the COVID-19 pandemic, and telehealth can improve critical access to services, particularly in rural and underserved areas of

Kansas. Telehealth allows patients to access medical care remotely through video conferencing, phone calls, and online platforms, reducing the need for in-person visits and overcoming barriers related to distance and transportation. However, telehealth utilization in Kansas still lags that of the nation as a whole. 2022 data from the Household Pulse Survey, a collaborative project of the National Center for Health Statistics, the Health Resources and Services Administration Maternal and Child Health Bureau, and the U.S. Census, found less than one in five Kansas adults (16.7% in the last reporting period) reporting recent use (during the last four weeks) of video or phone for a health care appointment, compared to 22.8% for the nation as a whole ([National Center for Health Statistics, 2022](#)).

## Health Centers

Federally Qualified Health Centers (FQHCs) and other community health centers and other community health centers play a vital role in providing primary care and preventive services to underserved populations in Kansas. These centers offer comprehensive healthcare services on a sliding fee scale, making them accessible to individuals with low incomes and those without insurance. However, there are FQHC facilities (including satellite offices) and other types of safety net clinics in less than half of Kansas counties (42 of 105), meaning that not all Kansans have local access ([Community Care Network of Kansas, 2024](#)).

Moreover, while primary care services may be locally available for many Kansans, [maternity care services](#) are not always locally available, especially to women in rural communities. In 2019-2020, it is estimated that 2,725 babies (7.9% of all births in Kansas) were born in counties characterized as maternity care deserts ([March of Dimes, 2023](#)). Almost one in ten (8.4%) of women in Kansas have no birthing hospital within a thirty-minute drive ([March of Dimes, 2023](#)) (See [Maternal and Child Health](#) section for more details).

# State Health Outcomes and Indicators

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## General Health and Chronic Disease

*The overall health status of Kansans is not optimal.*

The percentage of Kansas adults reporting fair or poor health status (14.7%) is slightly better than the national average (17.7%) (Kansas Health Matters ([KHM, 2024c](#))). However, the age-adjusted mortality rate (795.9 deaths per 100,000 population) is higher than the U.S. value of 731.9 ([KHM, 2024a](#)). Over one in three Kansas adults is diagnosed with hypertension, with a rate higher than the Healthy People 2030 target of 27.7%, and this trend over time is worsening. Almost one in five adults gets too little exercise (19.0%), and over one-third of adults are overweight (34.4%) ([KHI, 2024a](#) ([KHI, 2024b](#))). Each day there are approximately 87 deaths in Kansas, with close to half of these deaths attributed to chronic diseases including heart disease, cancer, diabetes, and stroke ([KDHE, 2023b](#)), conditions impacted by factors including inactivity, tobacco use, and diet. Unintentional injuries and suicide are also among Kansas' top 10 leading causes of death ([KDHE, 2023b](#)).

## Reproductive Age Health Status

The health status of women of reproductive age mirrors that of the general Kansas population. For example, 34.5% of women ages 18-44 years are obese which is higher than the national average (ranking 34 among all states) and is increasing ([America's Health Rankings, 2024b](#)). Over 15% of women ages 18-44 years smoke cigarettes ([America's Health Rankings, 2024c](#)), and one in five (20.8%) binge drink ([America's Health Rankings, 2024a](#)).

## Health Disparities in Chronic Diseases

*There are significant health disparities in chronic disease.*

Black/African American Kansans have significantly higher rates of hospital admissions for diabetes, heart disease, and stroke than Whites ([KHM, 2024b](#)). They also experience higher age-adjusted mortality rates for cancer, cerebrovascular disease, and diabetes, and overall age-

adjusted mortality rates ([KHM, 2024b](#)).

## Behavioral Health

Mental illnesses and substance use can be acute or chronic conditions. The prevalence of poor mental health rose across the nation during the COVID-19 pandemic, bringing greater national attention to the issue and its societal impact. In 2021, 14.7% of Kansans (median value) indicated their mental health was “not good” for 14 or more days in the past month ([KHM, 2024c](#), [2024d](#)). A Kaiser Family Foundation analysis of U.S. Census Household Pulse Survey data in 2023 reported that almost one in three (30.5%) of adults during the February survey period reported symptoms of anxiety and/or depressive disorder, close to the national average of 32.3% ([KFF, 2023](#); [KHM, 2024d](#)). Between 2011 and 2022, 6,051 deaths by suicide occurred in Kansas, and there was a statistically significant increase of over 50% in the suicide death rate during that timeframe ([KFF, 2023](#)). Finally, the hospital admissions rate for mental health conditions in Kansas is significantly higher for Black/African Americans (103.9 admissions per 10,000 population) than for the general population (70.6 per 10,000) ([KFF, 2023](#)).

There has also been an alarming increase in drug overdose death rates in the state in recent years. In 2022, there were 738 drug poisoning deaths in the state ([KDHE, 2024c](#)). The 2022 drug overdose death rate (25.9 overdoses per 100,000 Kansas residents) was more than double the 2018 rate of 12.4 deaths per 100,000 people ([KHM, 2024b](#)). Rates of death by drug overdose are higher for Black/African Americans (21.7 deaths per 100,000 people), Native Americans (21.7 per 100,000), and individuals of multiple race (26.9 per 100,000), when compared to the general population ([KDHE, 2024c](#)).

Alcohol and tobacco use are still issues of concern as well. The percentages of Kansas adults who binge drink (17.9% of Kansas adults) ([KDADS, 2022](#)) and who report alcohol use disorder (13.5%) ([KDHE, 2023b](#)) are both higher than the national average. Tobacco use remains the leading cause of death in Kansas, resulting in the death of 4,839 Kansans in 2022 ([KDHE, 2023b](#); [KHI, 2024a](#)). Tobacco use among adults is decreasing, but the 17.2% of Kansas adults who are current smokers is well above the Healthy People 2030 target of 6.1% ([KDHE, 2023b](#)). There are also significant disparities, with high rates of smoking use among Native Americans (35.1%), African Americans (23.4%), individuals with less than a high school education (33.7%), and those with low incomes (those with annual incomes of less \$25,000 are more than twice as likely to smoke as those with incomes \$50,000 or higher) ([KDHE, 2023a](#)). Finally, there are some concerning trends regarding smoking during pregnancy, particularly among certain demographics ([KHI, 2024a](#)). Disparities

between WIC (Women, Infants, and Children) recipients (32.5%) and non-recipients (14.0%), and between rural (23.1%) and urban residents (17.2%), highlight the need for targeted interventions and support systems ([KDADS, 2022](#)). Providing resources, education, and cessation programs tailored to these specific demographics can help reduce smoking rates and improve the health outcomes for both mothers and babies.

# Maternal and Child Health

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*Kansas faces significant challenges in maternal and child healthcare access, particularly in rural and underserved areas.*

The status of maternal health in Kansas mirrored national trends, with both strengths and areas for improvement. The state's healthcare system needs comprehensive improvements, including expanding insurance coverage, strengthening the public health system, increasing healthcare workforce capacity, utilizing telehealth technologies, and addressing social determinants of health to promote equitable access to health services, including mental health and substance use services.

## Maternal Mortality

Maternal mortality, while relatively low compared to some other states, remains a concern. Kansas' maternal mortality rate of 14.8 (from 2014-2018) is 29.8% higher than the Healthy People 2020 goal of 11.4 deaths per 100,000 live births ([KMMRC, 2020](#)), rates that can be impacted by limited access to prenatal care, maternal health complications, socioeconomic disparities, and inadequate postpartum support services ([Dagher & Linares, 2022](#)). Addressing racial disparities in maternal health outcomes is a priority in Kansas, as it is across the nation. Black and Indigenous women, as well as women from other minority communities, experience higher rates of maternal mortality and morbidity compared to white women. The rate of severe maternal morbidity (SMM) for non-Hispanic Black women in Kansas was significantly higher than for any other race and ethnicity, with a rate (100.4 SMM per 10,000 delivery hospitalizations) 87.3% higher than the rate among non-Hispanic white women (with a rate of 53.6), 72.2% higher than Asian/Pacific Islanders (rate of 58.3) and 58.3% higher than the rate among Hispanics, with a rate of 63.7 ([CDC Wonder, 2024](#); [KDHE, 2023c](#)).

## Maternal Vulnerability Index – Overall Score

The Maternal Vulnerability Index (MVI)<sup>a</sup> overall score ranks counties and states in terms of vulnerability to poor pregnancy outcomes on overall vulnerability from six themes: reproductive healthcare, physical health, mental health & substance abuse, general healthcare, socioeconomic determinants, and physical environment. The MVI assigns a score 0-100 to each county, where a higher score indicates greater vulnerability to adverse maternal outcomes. Several counties in

eastern Kansas, including Wyandotte, Linn, Montgomery, Cherokee, Bourbon, and Labette, have been identified as having high overall maternal vulnerability scores (score >60); for MVI scores for all counties, see [Table 4 in Appendix I](#).

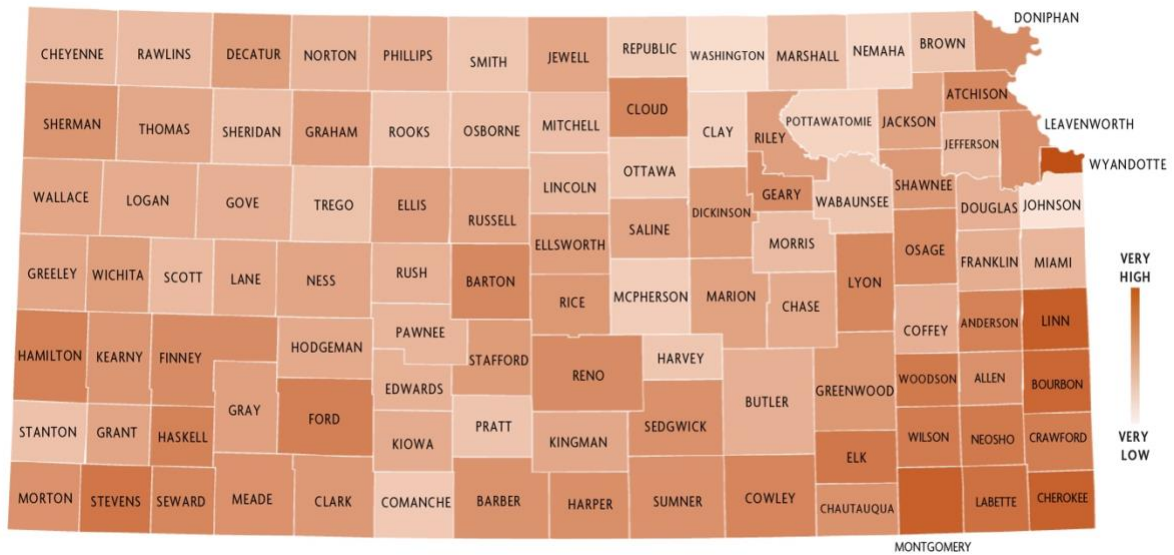


Figure 6: Kansas County MVI Overall Maternal Vulnerability Score. Note: The MVI assigns each county a relative maternal vulnerability score (where 0 = the least vulnerable and 100 = the most). Data source: Surgo Ventures. <https://mvi.surgoventures.org/>

## Births and Birth Outcomes

Kansas records about 94 live births each day, of which an average of seven are low birth weight ([CDC Wonder, 2024](#); [KDHE, 2023c](#)). Overall, the last reported (2021) infant mortality rate is 5.3 per 1,000 live births in Kansas ([Annie E Casey Foundation, 2024](#)). In Kansas, as in the rest of the nation, there are also marked racial and ethnic disparities in maternal and child health outcomes. According to CDC data, the birthrate for teen Black mothers (31 per 1,000) and Hispanics (32 per 1,000) is almost twice that of White teens (14 per 1,000) ([CDC Wonder, 2024](#)). KDHE reports that the percentage of births of low birthweight babies are twice as frequent (13.7% versus 6.4%) when comparing births to Black and White mothers in Kansas ([KDHE, 2016](#)).

## Access to Prenatal Care

Access to prenatal care is essential for ensuring healthy pregnancies and positive birth outcomes. Rates of prenatal care during the first trimester is an important indicator and predictor of positive birth outcomes. Overall, prenatal care rates are higher in Kansas than in the United States as a whole, with 88.0% self-reported first-trimester care initiation from 2017-2020 in Kansas ([KDHE,](#)

[2023d](#)), compared to a national rate of 75.6% in 2021 ([HHS, 2024](#)). However, many Kansans, particularly those from low-income or rural areas, face barriers to accessing prenatal care services, including transportation challenges, financial constraints, and shortages of healthcare providers.

Research suggests that bias (conscious or unconscious) plays a key role in these disparities in outcomes. Studies suggest that physicians express less empathy towards Black versus White patients ([Johnson et al., 2004](#)), prescribe less aggressive treatment to Black patients ([P Goddu et al., 2018](#)), and are more likely to test Black women for illicit drugs during labor and delivery regardless of their substance use history ([Jarlenski et al., 2023](#)).

# Maternal Mental Health

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Increasingly, the medical and public health community recognizes mental health's role in poor maternal health outcomes. Meta-analyses have shown associations between maternal depression and anxiety and preterm birth and low birthweight, the leading causes of perinatal mortality ([KMMRC, 2020](#)). In Kansas, mental health conditions are estimated to contribute to around one in five pregnancy-associated deaths ([KDHE, 2024b](#)). The following information sheds light on the prevalence and impact of maternal mental health issues and substance use disorders in Kansas.

## Maternal Depression and Anxiety

Almost one in five Kansas mothers report having experienced depression during pregnancy ([KDHE, 2023d](#)). Among Kansas women with a live birth in 2017-2020, 13.7% self-reported postpartum depressive symptom ([KDHE, 2023d](#)). The Needs Assessment team could not find maternal mental health indicators reported by race or ethnicity. However, other demographic descriptors indicate that postpartum depressive symptoms are more prevalent among women who were WIC recipients during pregnancy (20.5%) than those who were not (11.2%), and women who had not completed high school (16.3%) and those with a high school diploma (19.5%) have a higher prevalence than those with some college education (10.8%), highlighting the influence of social determinants of health on the health status of women ([KDHE, 2023d](#)).

## Perinatal Suicide

Among 105 pregnancy-associated deaths from 2016 to 2020 that occurred in Kansas, suicides accounted for 10.5% of cases. The most common methods of suicide were hanging/strangulation/suffocation (63.6%), followed by poisoning/overdose (27.3%), and firearm (9.1%). Five suicides occurred during pregnancy (45.5%), five occurred between 43 to 365 days postpartum (45.5%), and one occurred within 42 days postpartum (9.1%). The average age at the time of death was 26.4 years, ranging from 15 to 34 years. Most suicides were among non-Hispanic White women (54.5%), followed by non-Hispanic women of other races (27.3%), and non-Hispanic Black women (18.2%). Most victims were unmarried, including six who were never married and three who were divorced (81.8%). One was married at the time of death (9.1%), and one had an unknown marital status (9.1%). Over half of the suicides occurred among women with a high school education or less (54.5%), while three had an associate or bachelor's degree (27.3%), and two had some college education without a degree (18.2%) ([KMMRC, 2020](#)).

## Substance Use

Substance use disorders, including non-prescription opioid use, pose significant risks to maternal and child health in Kansas. Pregnant women with substance use disorders are at increased risk of adverse pregnancy outcomes, and infants exposed to drugs in utero may develop neonatal abstinence syndrome (NAS). Substance use during pregnancy and the postpartum period often goes undetected and untreated, contributing significantly to maternal mortality. Nationally from 2017 to 2020, 16.3% of pregnancy-associated deaths were linked to substance use ([Bruzelius & Martins, 2022](#)). Clinics enrolled with the Kansas Connecting Communities (KCC), a perinatal mental health and substance use support program, have shown a particularly low screening rate for perinatal substance use disorders compared to depression or anxiety. In the 2022-2023 period, the screening rate for substance use among perinatal individuals was only 34%, markedly lower than the 82% for depression and 58% for anxiety, although now rates of screening for depression, anxiety, and substance use are all over 70% among KCC enrolled providers ([Kansas Connecting Communities, 2023](#); [Kansas Connecting Communities, 2024](#)). Health providers have identified several obstacles in screening and referring perinatal patients for substance use treatment. Barriers include the time required to administer screenings, the suitability of screening tools for specific populations, a lack of familiarity with standardized screening methods, concerns about mandated reporting, and insufficient resources for referrals ([Kansas Connecting Communities, 2023](#)).

## Maternal Vulnerability Score – Mental Health and Substance Use

The MVI's maternal mental health and substance abuse sub-score includes factors related to stress, mental illness, and addiction. Several counties in southwestern and southeastern Kansas have moderate maternal mental health and substance abuse vulnerability scores. Additionally, a few counties in the southeast, including Cherokee, Linn, and Montgomery, exhibit high vulnerability scores exceeding 70 on a scale of 1 to 100, in maternal mental health and substance abuse ([Appendix I, Table 4](#)).

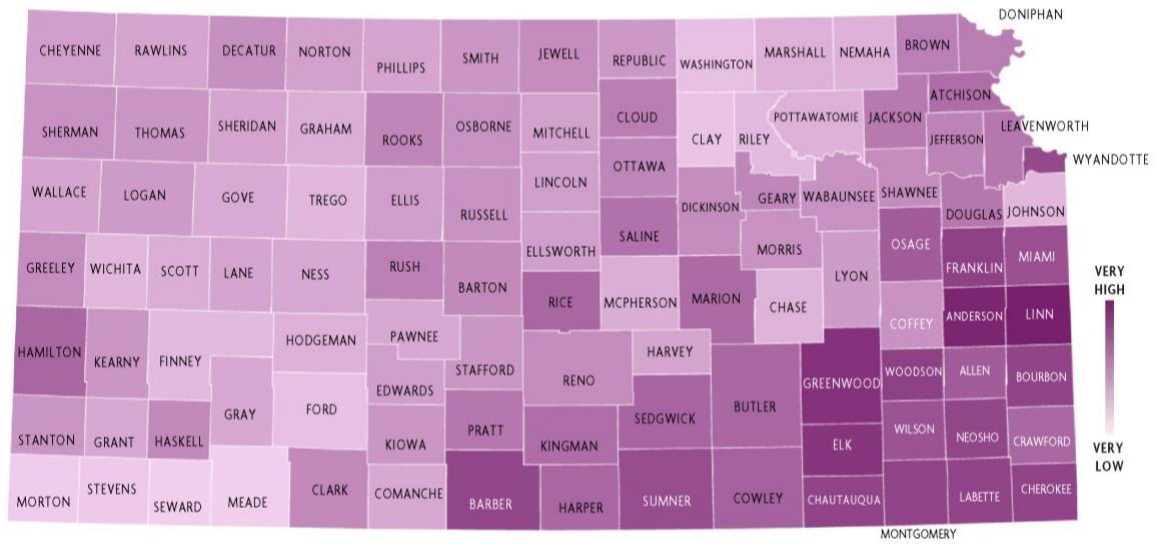


Figure 7: Kansas County MVI Mental Health and Substance Abuse Score.  
 Note. The MVI assigns each county a relative maternal vulnerability score (where 0 = the least vulnerable and 100 = the most). Data source: Surgo Ventures. <https://mvi.surgoventures.org/>

# Reproductive Health in Kansas

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The state of reproductive health in Kansas is influenced by several factors, including healthcare access, policy environment, socioeconomic disparities, and cultural attitudes towards reproductive rights and healthcare. Access to reproductive healthcare services, including contraception, prenatal care, and abortion, can vary depending on geographic location, income level, and insurance status in Kansas. While urban areas may have more healthcare providers and resources, rural areas often face challenges related to healthcare access, including shortages of providers and limited availability of reproductive health services.

## Teen Pregnancy

Kansas ranks 16th nationally in terms of teen pregnancy rates ([NCHS, 2022](#)). However, the birth rate for teen mothers (15-19 years of age) in the state is higher than the national average (18.4 births per 1,000 females) and is 42.6 births per 1,000 for teens 18 and 19 years of age in the state ([KDHE, 2022](#)). There is also a relatively high percentage of adolescents who have given birth to more than one child; the statewide percentage of live births to adolescent (<20 years) mothers with one of more living children was 15.0% between 2015 and 2019 ([KDHE, unpublished](#)). Efforts to address teen pregnancy often involve comprehensive sexual health education, which varies across school districts in Kansas due to local policies and parental consent requirements. To see teenage pregnancy rates by county, please see [Appendix I, Table 2](#).

## Comprehensive Sexual Health Education

While schools in Kansas are required to teach sex education, local school boards may establish any additional requirements for sex education curriculum. Curriculum is not required to be comprehensive, and schools are not required to include instruction on sexual orientation, gender identity, healthy relationships, or affirmative consent. In addition, Kansas currently has an “opt-in” policy for comprehensive sexual health education, requiring parental consent before students can receive sex education instructions. Consequently, sexual health education programs vary across school districts, with some schools providing evidence-based, age-appropriate education on topics including contraception, STI (Sexually Transmitted Infection) prevention, and healthy relationships, while others may offer abstinence-only education ([SIECUS](#)).

## Sexually Transmitted Infections (STI)

The rate of sexually transmitted infections (STIs, 6.1 per 1000 population), while slightly less in 2023 than in 2022, has been trending upward over time ([KHM, 2024e](#)). This rate is calculated based on reported cases of chlamydia, gonorrhea, and syphilis and likely represents just a fraction of the true burden of STIs in Kansas, given that STIs often go undiagnosed and are commonly underreported ([Niccolai et al., 2005](#)). The Needs Assessment team was also not able to find any demographically stratified data for Kansas on STIs. Many cases of STIs go undiagnosed, and untreated STIs can lead to serious long-term health consequences including infertility, especially among adolescent girls and young women ([WHO, 2019](#)). Nationally, the CDC estimates that one in five people in the U.S. population have an STI on any given day, costing the American healthcare system nearly \$16 billion in health care costs alone each year ([CDC, 2021](#)). To view STI rates by county, see [Appendix I, Table 3](#).

Kansas has comparatively low [HIV prevalence](#) compared to many other states. Kansas is ranked 32nd among U.S. states and territories for America for rates of HIV diagnoses per 100,000 population, at 5.7 per 100,000 ([AIDSVue; Statista, 2023](#)). However, it is important to note that HIV rates can fluctuate over time due to numerous factors including changes in testing practices, prevention efforts, and demographic trends. For instance, there are significant health disparities for accessing pre-exposure prophylaxis (HIV PrEP) for black and Hispanic populations in Kansas ([AIDSVue](#)).

[Chlamydia](#) is the most reported STI in Kansas, as it is in many other states. Kansas reported 474.4 cases per 100,000 population in 2021 (close to 15,000 cases for the state), ranking 27th in the United States ([AtlasPlus](#)).

[Gonorrhea](#) rates in Kansas have also been of concern, with certain regions such as Sheridan, Geary, and Seward Counties experiencing higher rates (larger than 300 cases per 100,000) than others. Kansas reported 170 gonorrhea cases per 100,000 population in 2022 (about 5,600 cases), ranking 25th in the United States ([AtlasPlus](#)).

[Syphilis](#) rates in Kansas have seen fluctuations over time, with periodic outbreaks occurring in certain communities. In 2022, Kansas reported 11.8 primary and secondary syphilis cases per 100,000 population in 2022 (or 311 cases), ranking 32nd in the United States. The [Healthy People 2030 goal](#) for reducing the rate of primary and secondary syphilis among women aged 15-44 years is 4.6 per 100,000.

## STI Testing and Treatment

Individuals in Kansas may engage in behaviors related to STI testing, including seeking regular screenings, disclosing sexual history to healthcare providers, and adhering to recommended treatment regimens for STIs. Understanding barriers to STI testing and treatment, including stigma, lack of awareness, and concerns about confidentiality, can inform efforts to expand access to STI services and reduce STI transmission rates. However, the Needs Assessment team is not aware of any available testing and treatment data for the state.

# Reproductive Health Behaviors

Reproductive health behaviors in Kansas encompass a wide range of actions and choices related to sexual activity, contraception use, pregnancy planning, and healthcare-seeking behaviors. Understanding these behaviors is essential for promoting sexual and reproductive health and addressing related issues including unintended pregnancies, sexually transmitted infection screening and treatment, and access to reproductive healthcare services.

## Contraception Use

Many Kansas women use contraceptives, with oral contraceptives (“the pill”), condoms, and female sterilization being the most common methods (Table 1). However, barriers to contraception use exist, including concerns about side effects, cost, and access to healthcare services. Three in four Kansas women aged 18-49 years (72.4%) report using contraceptives, and 75.6% of women aged 18-49 who are at risk of unintended pregnancy use contraceptives (Douglas-Hall, 2017). Of the three mostly commonly used contraceptives in Kansas, only sterilization is categorized as a Tier 1 (most effective) method, which includes both male and female sterilization, implants, and intrauterine devices (Trussell & Aiken, 2018). Injectables, vaginal rings, contraceptive patches, and hormonal pills are considered moderately effective, and many commonly used methods (male and female condoms, sponges, diaphragms, spermicides, and withdrawal) are considered less effective options (Office of Population Affairs, 2024).

Table 1: Distribution of women aged 18-49 in Kansas at risk of unintended pregnancy, by primary contraceptive method used

Source: Guttmacher Institute, State Level-Use of Contraceptives Use in the United States, 2017

Primary contraceptive method	Percent utilizing
Female sterilization	13.90%
Male sterilization	4.30%
Implant	2.60%
IUD	9.80%
Pill	19.20%
Other non-LARC hormonal	2.80%
Condom	17.50%
Withdrawal	NA
Other	4.30%
None	24.40%

Among women with a recent live birth who are sexually active, not currently pregnant, and not wanting to get pregnant, 59.2% report using a contraceptive that is most or moderately effective ([KDHE, 2023d](#)). Use of a highly or moderately effective contraceptive method is more prevalent among women who received WIC services during pregnancy (67.6%) than among women not receiving WIC (56.0%) ([KDHE, 2023d](#)) ([see Table 2](#)).

**Table 2: Distribution of women aged 18-49 at risk of unintended pregnancy, by the effectiveness of their primary contraceptive method**

*Source: Guttmacher Institute, State Level-Use of Contraceptives Use in the United States, 2017*

Effectiveness of method	Percent utilizing
Highly effective (permanent)	18.40%
Highly effective (LARC)	12.40%
Moderately effective	21.70%
Least effective	20.20%
No method	27.20%

There are a variety of reasons for not using contraceptives. [Table 3](#) provides a breakdown of reported reasons Kansas women who report not using contraceptives. It should be noted that, because of differences in definitions by various reporting entities, in [Table 4](#) sterilization is noted as a reason for not using contraception, whereas in the previous two tables sterilization (male and female) was considered a contraceptive method.

**Table 3: Reasons for Not Using Contraceptives.**

Source: Kansas Pregnancy Risk Assessment Monitoring System 2020 Surveillance Report

Self-reported reasons for not using a contraceptive method (Kansas women with recent live birth who reported not using birth control)	Percentage
Wanted to get pregnant	17.6%
Was pregnant	3.0%
Tubes tied/blocked	4.7%
Did not want to use birth control	42.4%
Worried about side effects from birth control	37.9%
Had problems paying for birth control	2.6%
Was not having sex	26.0%
Partner didn't want to use anything	11.7%
Other	22.0%

### Pregnancy Planning

Pregnancy planning and intendedness play a crucial role in reproductive health outcomes. Some pregnancies in Kansas are planned and desired, while others may be unintended or mistimed. Understanding factors contributing to unintended pregnancies, including lack of access to contraception, contraceptive failure, or ambivalence about pregnancy, can inform efforts to improve reproductive health services and support individuals in making informed decisions about pregnancy planning.

The percentage of intended pregnancies in Kansas was 62.0%, close to the national average of 62.5% ([CDC, 2023](#)). Currently, over one in four (27.8%) of all live births and nearly half of births to individuals under 20 years of age (49.3%) are *unintended* ([KDHE, 2023d](#)). The prevalence of unintended pregnancy is higher for non-Hispanic Blacks (39.8%) and Hispanics (32.4%) than for non-Hispanic Whites of 23.5% ([KDHE, 2023d](#)). Finally, *unwanted* pregnancies accounted for 6.3% of all births in Kansas in 201, slightly above the national average of 5.4% ([CDC, 2023](#)).

## Cervical Cancer Incidence Rates and Screening

The overall age-adjusted incidence rate for cervical cancer in Kansas is 7.8 per 100,000 and the rate of ovarian cancer is 9.4 cases per 100,000 women, which is slightly lower than the national average ([National Cancer Institute, 2024](#)). For cervical cancer, White women have a lower incidence rate (7.5; CI: 6.8, 8.3), compared to Black (4.7; CI: 2.8, 7.4) and Hispanic (of any race) women (10.4; CI: 7.8, 13.4). However, it is essential to consider the confidence intervals to understand the uncertainty surrounding these estimates. The wider confidence intervals for Black and Hispanic women suggest greater variability in the data, possibly due to smaller sample sizes or other factors. Similarly, for ovarian cancer, Black women have the highest incidence rate (12.2; CI: 8.9, 16.2), followed by White (9.3; CI: 8.6, 10.1) and Hispanic women (7.9; CI: 5.8, 10.6). Again, the confidence intervals provide context, indicating the precision of these estimates and the range within which the true rates are likely to fall.

In Kansas, 81.5% of women aged 21-65 years receive cervical cancer screening ([KHM, 2024d](#)), which meets the Healthy People 2030 objective ([Healthy People](#)).

## Adolescent HPV Immunization Rates

The [Healthy People 2030 goal](#) for the proportion of adolescents that get the recommended doses of the HPV vaccine is 80% ([Office of Disease Prevention and Health Promotion, n.d.](#)). Currently, only about half (41%) of Kansas teens have received the recommended doses of the HPV vaccine ([National Immunization Survey, 2018](#)).

## Breast Cancer Screening and Mortality

Breast cancer remains a significant health concern in Kansas, as it is in many other states. Efforts to improve early detection through regular screening mammograms and to provide timely and effective treatment are essential in reducing breast cancer mortality rates. Access to healthcare services, including mammography facilities and cancer treatment centers, and efforts to promote awareness about breast cancer risk factors and screening guidelines, play crucial roles in addressing breast cancer in Kansas.

As of the most recent available data, breast cancer death rates in Kansas are in line with national averages. According to the American Cancer Society's "Cancer Statistics, 2021" report ([American Cancer Society, 2021](#)), the breast cancer death rate in Kansas is approximately 20.2 per 100,000 women per year. This rate is similar to the national average. As of the most recent available data,

breast cancer screening rates in Kansas indicate that a significant portion of women aged 50 to 74 are receiving regular mammograms. According to the Centers for Disease Control and Prevention (CDC), the percentage of women aged 50-74 years in Kansas who reported having a mammogram within the past two years was approximately 72.5%.

## Health Equity Considerations

The Kansas Pregnancy Risk Assessment Monitoring System's most recent (2020) Surveillance Report ([KDHE, 2023d](#)) noted that socioeconomic disparities are observed across a wide range of indicators, including unintended pregnancy, timing of prenatal care initiation, cigarette smoking, stress experienced in the year before the birth, breastfeeding for at least 8 weeks, postpartum depressive symptoms, and indicators related to infants' sleep habits. Below, we describe the reproductive healthcare considerations of several health disparity populations.

### Race and Ethnicity

A higher percentage of non-Hispanic Black women report certain outcomes or behaviors, compared to non-Hispanic White women (e.g., gestational hypertension, pre-eclampsia, or eclampsia; unintended pregnancy; not starting prenatal care in the first trimester of pregnancy; experiencing partner-related and financial stress in the year before the birth; not breastfeeding to at least 8 weeks; and not placing the infant to sleep on his/ her back) ([KDHE, 2023d](#)) has already been noted earlier that there are significant racial differences in maternal mortality, with rates much higher among Black than White mothers. Pre-term related mortality rates among Kansas' non-Hispanic Black population of 448.9 deaths per 100,000 live births is more than twice that of the Hispanic population (172.9) and three times that of the non-Hispanic White population ([KDHE, 2023a](#)).

### Women with Special Healthcare Needs

Women with special healthcare needs may encounter unique challenges related to reproductive health, including but not limited to, barriers in accessing reproductive healthcare services due to physical accessibility issues, lack of accommodations, or inadequate provider training in addressing their specific needs ([Kalpakjian et al., 2020](#)). Consequently, women with physical and mental healthcare needs may be at higher risk of adverse maternal and infant health outcomes due to their underlying medical conditions ([Adane et al., 2021](#); [Deierlein et al., 2021](#)). Adequate prenatal care and support are crucial to mitigate these risks and promote positive outcomes. However, the Needs Assessment team was not able to locate any state-specific data on

reproductive health outcomes of women with special healthcare needs in Kansas. KDHE's included the PRAMS disability questionnaire ([CDC, 2019-2020](#)) for one year (2019). The data indicate that 6.3% of Kansas women have a physical disability ([KDHE, 2023d](#)), but there was no further healthcare receipt or outcome analysis for the population. To address these challenges and improve reproductive health outcomes for women with special healthcare needs in Kansas, it will be essential to collect data specifically focused on this health disparity population.

## LGBTQ+ Populations

All people, including those identifying as lesbian, gay, bisexual, transgender, or queer (LGBTQ+), require sexual and reproductive health care. The traditional conceptualization of sexual and reproductive health care as either "women's" or "men's" health services can be exclusionary and fail to address the diverse needs of individuals across the gender spectrum, including those who identify as non-binary, genderqueer, or transgender. It is estimated that there are close to 100,000 adolescents and adults in Kansas that consider themselves LGBTQ+ ([Dawson et al., 2021](#)). While we were not able to find Kansas-specific data, national data reveal significant health and healthcare disparities between LGBTQ+ individuals and their non- LGBTQ+ counterparts, including poorer health, more negative experiences with providers, lower preventive screening rate, lower rates of contraceptive use and reproductive healthcare utilization ([Dawson et al., 2021](#)). On the other hand, LGBTQ+ individuals exhibit higher rates of testing for STIs, and HIV compared to their non- LGBTQ+ peers. This trend aligns with recommendations for early detection, treatment, and transmission prevention. The elevated testing rates could stem from higher prevalence of STIs within the LGBTQ+ community and potentially greater awareness and understanding of the importance of testing among this demographic ([Dawson et al., 2021](#)). Recognizing and addressing the specific health needs of LGBTQ+ individuals is crucial for promoting their overall health and well-being. This includes access to comprehensive healthcare services, culturally competent care, and support for diverse family structures.

## Justice-involved Women

Reproductive healthcare for incarcerated or justice-involved women is a complex and often overlooked aspect of family healthcare. Nationally, three quarters of incarcerated women are of childbearing age (between 18 and 44 years ([Bureau of Justice Statistics, 2019](#))). In Kansas, 728 women of reproductive age were in state prisons in 2021 data, and 1,330 women of reproductive age were incarcerated statewide ([Bureau of Justice Statistics, 2019](#)). There are numerous barriers that incarcerated women may face in accessing reproductive healthcare, including limited availability of services within correctional facilities, transportation constraints for off-site medical

appointments, financial barriers, and stigma associated with seeking reproductive healthcare while incarcerated, and there is some evidence of health disparities in cervical cancer in justice-involved women ([Roberson & McGee-Avila, 2021](#)). The provision of contraception and basic reproductive health within the correctional system for incarcerated women is crucial for addressing unmet reproductive health needs. While the correctional system may serve as a key access point for reproductive healthcare, historical atrocities and instances of coercion underscore the importance of ensuring care is delivered without bias or pressure. Ultimately, delivering contraceptive care in a respectful and patient-centered manner can improve the health and well-being of incarcerated women and contribute to broader public health goals ([Routh et al., 2023](#)). The needs assessment team was unable to find any data on pregnancy or post-partum status of incarcerated women in Kansas or their maternal and child health outcomes, any governmental initiatives, or programs for this population, and is aware of only one non-profit maternal and child health intervention targeted at incarcerated women (The Topeka Doula Project) ([The Topeka Doula Project](#)). Thus, the maternal and child health of this population in the state is unclear and unaddressed.

# Access to Reproductive Health Services

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*Kansans do not all have adequate access to family planning services.*

Overall, while access to contraception in Kansas is generally available, challenges including geographic barriers, insurance coverage limitations, and healthcare provider shortages can impact individuals' ability to obtain reproductive health services. Efforts to expand access to contraception, increase awareness about contraceptive options, and address barriers to care are essential for promoting reproductive health and preventing unintended pregnancies in Kansas.

## Prescription Contraception Provider Coverage

*It is estimated that about 173,000 Kansas women in need of reproductive health services live in “contraceptive deserts.”*

The Prescription Contraception Workforce Tracker data was developed by Mullan Institute to monitor the geographical distribution, clinician specialties, and clinician density of the prescription contraception workforce. Utilizing IQVIA prescription claims data, it identifies prescribers who have issued a minimum of 10 prescriptions for contraceptive pills, patches, and/or rings. These claims encompass an estimated 92% to 94% of all retail prescription claims nationwide between 2019 and 2022. As a state, Kansas has a rate of 50.0 prescription contraceptive providers for every 10,000 females of reproductive age; this is in the next-to-best quartile among states ([Mullan Institute, 2023](#)). However, access varies across the state. It is estimated that about 173,000 Kansas women in need of reproductive health services live in “contraceptive deserts,” counties that do not have reasonable access to the full range of FDA-approved contraceptive methods ([Power to Decide, 2023](#)). While access tends to be more limited in rural compared to urban areas, the workforce providing reproductive care services is below the national median in close to one-third (N=31) of Kansas counties, including semi-urban and urban counties including Butler, Franklin, Reno, Riley, Douglas, and Leavenworth counties ([George Washington University Fitzhugh Mullan Institute for Health Workforce Equity, 2023](#)) (see [Figure 8](#) and [Appendix I, Table 5](#)).

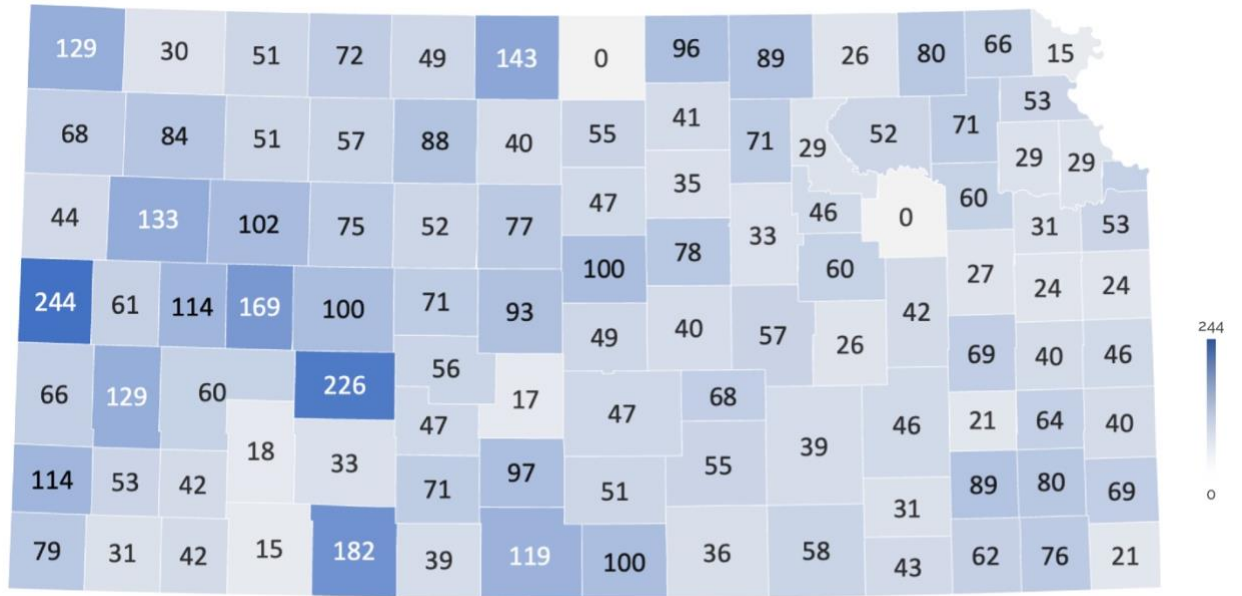


Figure 8: Prescription Contraception Workforce. Data Source: Fitzhugh Mullan Institute for Health Workforce Equity.

# Snapshot of Kansas Title X program

## Administration

The Kansas Department of Health and Environment (KDHE) is a statewide, cabinet-level agency whose mission is to protect and improve the health and environment of all Kansans. KDHE is led by a Secretary, Secretary Janet Stanek, appointed by the Governor, who serves on the Governor’s Cabinet. As the state health agency, KDHE works to promote policy and programs to ensure the health and well-being of all Kansans, including the provision of reproductive and related preventive health services through the federally funded Title X program. Delivered through a network of local health and community service agencies, Title X ensures access to high-quality, client-centered family planning care for thousands of Kansans, with a particular focus on low-income and/or uninsured individuals.

## History of Title X in Kansas

Title X was enacted as part of the Public Health Service Act in 1970, during the Nixon administration. The program aimed to address issues of unintended pregnancy, reduce infant and maternal mortality, and improve access to reproductive healthcare services, particularly for low-income individuals and families. Title X funds are allocated to support a network of clinics and healthcare providers across the state including Planned Parenthood affiliates, community health centers, and other organizations that offer a range of reproductive health services (see Figure 9).

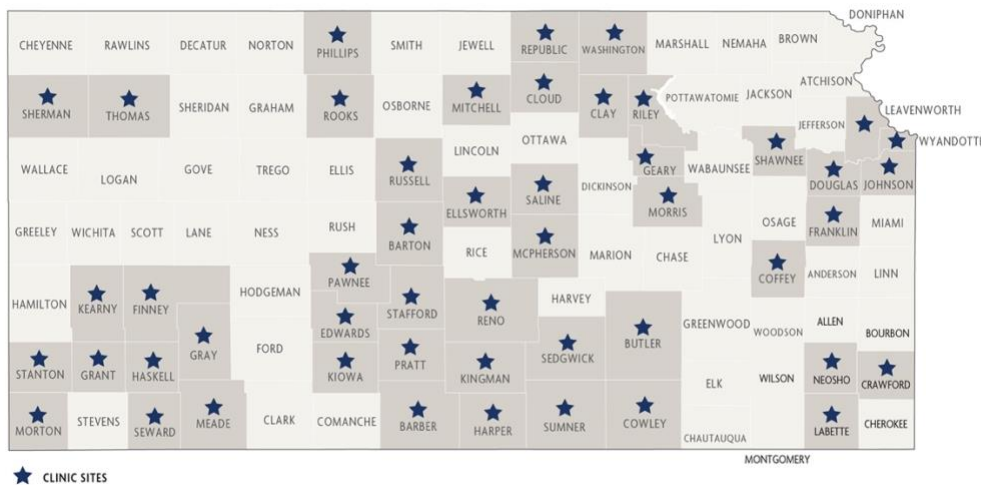


Figure 9: Title X Program Distribution. For a list of counties covered by Title X programs, see Appendix I, Table 2.

In Kansas, Title X funding has been instrumental in supporting family planning clinics and healthcare providers that serve low-income and underserved populations since 1972. These clinics offer a wide range of reproductive health services, including contraception, STI testing and treatment, cancer screenings, and reproductive health counseling. Title X funding helps to cover the costs of these services for individuals who may otherwise be unable to afford them.

## Funding and Political Challenges

Changes in federal funding policies and political dynamics have impacted the availability and accessibility of family planning and reproductive health services in the state. Although federal law prohibits clinics from using Title X money to pay for abortions, policies implemented by the Trump administration in 2019 significantly impacted Title X clinics, leading to a sharp decline in participating sites and the number of people receiving services ([Clochard, 2023](#)). These policies included barring Title X funds from being used for referrals for abortion services and prohibiting abortion providers from sharing physical space with Title X clinics, resulting in a sharp drop of participating sites, from 3,825 sites in 2019 to 3,031 the following year. With fewer clinics, and due to the COVID-19 pandemic, the number of people receiving free or low-cost family planning services through the program nationally fell from 3.1 million in 2019 to 1.5 million in 2020.

President Biden's administration overturned many of these policies in 2021, restoring access to services and counseling on abortion options. However, there are currently several federal legal challenges that raise concerns about potential barriers and uncertainties that may affect access to confidential reproductive healthcare.

- With the Supreme Court's reversal of *Roe vs Wade*, some states find themselves in violation of federal requirements for receiving federal Title X funds. The Department of Health and Human Services (HHS) requires clinics to offer pregnant women information about prenatal care and delivery, infant care, foster care, adoption, and pregnancy termination. But, after the reversal of *Roe vs. Wade*, following those rules puts medical providers in some states at odds with state laws banning abortion, with possible penalties including jail time, fines, or the loss of medical licenses if they help someone end a pregnancy. For instance, in Tennessee ([State of Tennessee v. Becerra et al, 2024](#)) and Oklahoma ([State of Oklahoma v. Becerra, 2024](#)), the Title X requirement conflicts with state laws, where abortion bans and restrictions are in place.

Consequently, Tennessee became the first abortion-banning state to lose its Title X funding in March of 2023, followed by Oklahoma in November 2023.

- The March 2024 ruling in *Deanda v. Becerra* ([Deanda v. Becerra, 2024](#)), concerning the issue of access to confidential reproductive healthcare for minors, highlights ongoing legal battles and potential barriers to such access. The ruling partially upholds a lower court decision from December 2022, which blocked federally funded family planning clinics from providing contraception to teens without proof of parental agreement. However, this contradicts HHS regulations, which affirm teenagers' right to access confidential contraception services at Title X clinics without parental consent. Title X clinics, funded by federal grants, are mandated to provide birth control to anyone seeking it, including minors, without requiring proof of parental consent. This regulation aims to ensure confidential access to reproductive healthcare services for minors. In states where minors lack the right to confidential contraception services, appeals courts have consistently upheld the regulation prohibiting Title X clinics from requiring parental consent. This legal precedent supports minors' access to confidential reproductive healthcare services under federal regulations. Since the Fifth Circuit ruling in *Deanda v. Becerra* avoided a definitive ruling on the regulation barring Title X clinics from requiring parental consent, there remains uncertainty regarding the future of birth control access for minors. Further litigation could potentially reintroduce the issue of minors' access to confidential reproductive healthcare services into the legal arena.
- Ohio and other petitioner states sought a preliminary injunction against the 2021 rule in the U.S. ([Becerra, 2023](#)). District Court for the Southern District of Ohio. The court denied the preliminary injunction request. The petitioner states appealed to the Sixth Circuit, which issued a decision on November 23, 2023. The Sixth Circuit found that the requirement for Title X providers to include abortion in options counseling was not arbitrary and capricious and should not be enjoined. However, the court determined that HHS did not act appropriately in rescinding and replacing the physical separation requirement from the 2019 rule. As a result, the court enjoined the rule only in Ohio, as that state alone demonstrated financial irreparable harm from the rule change. The true effect of the Sixth Circuit's decision on the Title X program is difficult to determine. While the court upheld certain aspects of the 2021 rule, it found issues with the removal of the physical separation requirement. The decision's applicability only to Ohio further complicates its impact. Additionally, the upcoming presidential election year will likely influence future HHS leadership and regulatory decisions regarding Title X.

## State-level Challenges

- In August 2022, Kansas voters rejected an amendment that would have declared that the Kansas Constitution does not guarantee a right to abortion, giving the state government the power to regulate and prosecute individuals involved in abortions, and stating that the government is not required to fund abortions. The timing of the referendum coincided with the Supreme Court's ruling in *Dobbs v. Jackson Women's Health Organization*, which overturned *Roe v. Wade*, thus allowing individual states to implement abortion bans. The amendment was ultimately defeated by a significant margin, with voters rejecting it by an 18-point margin. While this vote and research ([Pew Research Center, 2015](#)) shows that Kansans are generally protective of reproductive rights, Kansas has implemented various restrictions on abortion over the years, including mandatory waiting periods, parental consent requirements for minors, and restrictions on insurance coverage for abortion services ([Center for Reproductive Rights](#)). As a result, access to abortion care may be limited, particularly for individuals facing financial barriers or living in rural areas with few abortion providers. Kansas also has over 50 crisis pregnancy centers (CPCs), which the American College of Obstetrics and Gynecology (ACOG) describes as “using deception, delay tactics, and disinformation, undermine the tenets of informed consent and patient autonomy and impede access to comprehensive, ethical care” ([ACOG, 2022](#)).
- [House Bill 2789](#), introduced during the 2024 Kansas legislative session, proposed the doubling of the \$2 million “pregnancy compassion fund” that includes funding for CPS was heard by the House Committee on Health and Human Services, but was not passed out of committee.
- Governor Kelly vetoed [House Bill 2749](#), the bill that mandates abortion patients be asked invasive questions about their reasons for getting an abortion, and that those answers be registered in a state database at KDHE.
- Governor Kelly also vetoed [House Bill 2436](#) that would create the felony crime of engaging in physical, financial, or documentary coercion to compel a girl or woman to end a pregnancy despite an expressed desire to carry the fetus to term. The veto on both bills was overridden by the Kansas legislature.

While federal litigation for Tennessee and Oklahoma is still ongoing, these legal and policy challenges and developments underscore the complex and evolving landscape of reproductive healthcare access, shaped by federal policies, state laws, and ongoing legal battles at both the federal and state levels.

*Title X-funded family planning clinics play a crucial role in providing affordable reproductive healthcare services to low-income individuals and families in Kansas.*

Despite these challenges, Title X continues to play a critical role in expanding access to reproductive healthcare services for thousands of Kansans each year. By supporting a network of clinics and providers that offer comprehensive family planning services, Title X helps to improve health outcomes, reduce unintended pregnancies, and promote reproductive autonomy and choice for individuals and families across the state. The mission of the Kansas Title X Family Planning Program is *to provide individuals the information and means to exercise personal choice in determining the number and spacing of their children and provide access to additional health services that lead to the overall improvement in those individuals' health* ([Kansas Title X Program, 2022](#)). The program prioritizes service to low-income and other individuals at elevated risk for poor health outcomes. In SFY 2023 Title X services were provided through 42 grant sub-recipients who provide services in 50 counties. Fifty-five Kansas counties are not directly covered by Title X-funded programs ([KDHE, 2023e](#)). The counties served by Title X clinics are home to 491,845 women of reproductive age (15 to 44 years), which is 86.5% of the total population of women 15 to 44 living in the state. This suggests a strong geographic distribution of clinics across the state.

By providing care to millions of low-income individuals who otherwise would not have access to care, publicly funded reproductive health services have been shown to produce enormous public sector cost savings, through preventing unplanned births, STI/HIV testing, and Pap and HIV testing and vaccines. While there currently is no reliable estimate of unmet contraceptive need in Kansas, a Guttmacher Institute report, using 2016 data, estimated that public costs savings from contraceptive and related non-contraceptive services received during publicly supported family planning visits was \$42.8 million, of which approximately \$30.6 million in savings came from visits specifically at Title X clinics ([Frost et al., 2019](#)). Another Guttmacher Institute study estimated that the number of women in Kansas in need of publicly supported contraceptive supplies and services numbered over 180,000 and that 17% of this need was met by Title X-funded clinics, and 21% by all public supported providers, which includes all clinics that use public funds, including Medicaid, for at least some clients ([Frost, 2015](#)).

Contraception counseling and provision are only a few of many services provided through Title X. Kansas Title X ensures access to a full range of family planning services including contraceptive services, pregnancy testing and counseling, basic infertility services, sexually

transmitted infection services, preconception health, and related preventive health services, including screening for breast, cervical, and colon cancer.

# Results and Discussion

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## Quantitative Data

### Number of Clients Served

According to KDHE, the number of clients served has dropped in each of the last three years, from 20,461 in 2019, to 14,365 in 2020, 13,291 in 2021, and 13,148 in 2022 ([KDHE, 2023a](#)). It should be noted that certain Title X program grantees did not submit client-level data until 2020. Instead, they provided aggregate data to KDHE which may have not accurately represented an unduplicated count of clients, explaining some of the dramatic reduction in client numbers reported in 2020 compared to 2019 when a true unduplicated count could not be ensured. Subsequent quantitative data analysis for this needs assessment, which utilizes client-level data collected by the DAISEY (Data Application and Integration Solutions for the Early Years) system, does not include the aggregate data submitted prior 2021, meaning that some clinics are excluded from analysis for that year. Client level data in the DAISEY system was used in analysis for this needs assessment total 13,466 clients in 2019, 12,920 in 2020, 12,884 in 2021, 13,230 in 2022, and 11,065 in January to November 2023 ([Appendix I](#)).

### Population Served

Kansas Title X providers serve a socioeconomically disadvantaged population, most of whom are female, low income, and uninsured, according to the 2022 Family Planning report prepared by Mathematica on behalf of the Office of Population Affairs at the U.S. Department of Health and Human Services. In 2022, 13,148 Kansans (11,467 women and 1,681 men) received family planning services through Title X ([Clochard, 2023](#)). Over half (55%) of those served were under 100% of the federal poverty level (FPL), and another third (32%) were between 101% and 250% of the FPL ([Clochard, 2023](#)). The age distribution showed a concentration in the 25-35 age group, which accounted for 33% of the clients, followed by the 35-45 age group at 22%. Regarding race, the majority were White (76%), with Black or African American individuals making up 13%. The ethnicity breakdown indicated that 42% of the clients identified as Hispanic or Latino, while 58% were not Hispanic or Latino. English was the primary language for 76% of the clients, with Spanish spoken by 22%. Limited English Proficiency (LEP) was reported by 21% of the population. Education levels varied, with 47% having a high school diploma or GED, about a quarter (26%) having less than high school education, and 7% holding a bachelor's degree or

higher. Employment status showed 38% unemployed and 41% employed full-time. The marital status indicated 75% were single, and 22% were married. Over 60% clients had no health insurance, and 16% were covered under some type of public insurance, including Medicaid ([Clochard, 2023](#)) ([Appendix I, Table 8](#)).

## The Typical Kansas Title X Client

Cluster analysis is a statistical technique used to group objects that are like each other within the same cluster ([Wade, 2023](#)). This method is instrumental in identifying patterns or groupings within a dataset without prior knowledge of group definitions.

The demographic data from Kansas Title X clients reveals distinct profiles among the population served. Cluster analysis identified three main groups: Spanish-Speaking Adults, Adults, and Youth.

1. **Spanish-Speaking Adults:** This group comprises 25% of the sample and is characterized by clients older than 19 years, predominantly White and Hispanic, with a significant portion having Limited English Proficiency (LEP). Many individuals in this group have education levels below high school, with a notable portion being unemployed. However, around 40% are employed full-time ([see Figure 10](#)).
2. **Adults:** Representing 50% of the sample, this group consists mainly of White individuals, with about a fifth being Black clients. They are primarily non-Hispanic and English-speaking. This group exhibits varying levels of education, with around half employed full-time and about a third unemployed ([See Figure 11](#)).
3. **Youth:** This group constitutes 25% of all Title X clients and comprises individuals under 25 years old, mostly White, with a mix of non-Hispanic and Hispanic backgrounds. They primarily speak English and have not yet earned their high school diploma. The majority of this group are unemployed and single ([see Figure 12](#)).

The significant differences between the clusters, as indicated by the ANOVA results with F-values significant at  $p < .001$ , suggest that each cluster represents a distinct demographic profile within the Kansas Title X client population. Understanding these demographic profiles is essential for tailoring services and interventions to meet the specific needs of each group effectively. Additionally, it underscores the importance of providing language-accessible services, addressing educational disparities, and considering employment status and marital status in service delivery strategies.

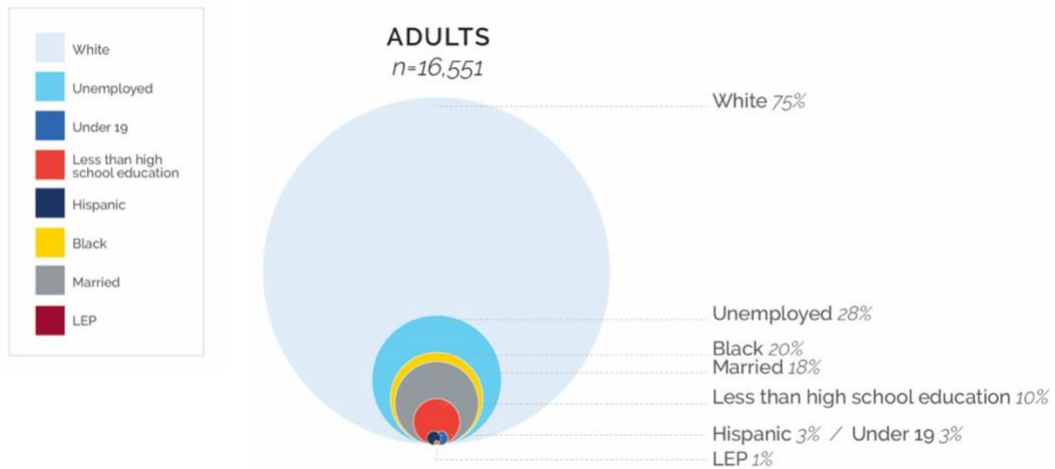


Figure 10: Group 1 of the cluster analysis, characterized by being mostly Hispanic, white, more than 50% have limited English proficiency, and about 40% are unemployed and have less than a high school degree.

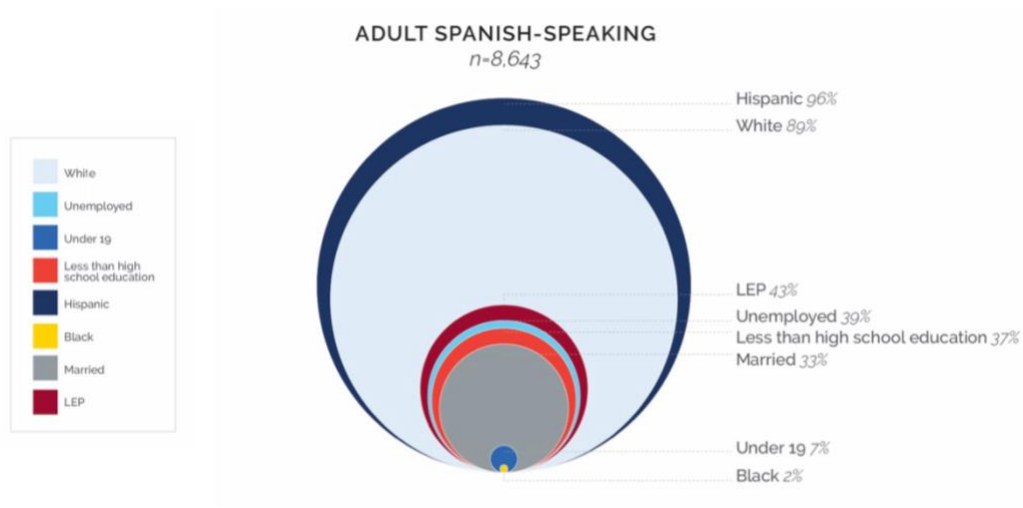


Figure 11: Group 2 of the cluster analysis, characterized by being mostly white, unemployed, under the age of 19, about a fifth of that group is Hispanic.

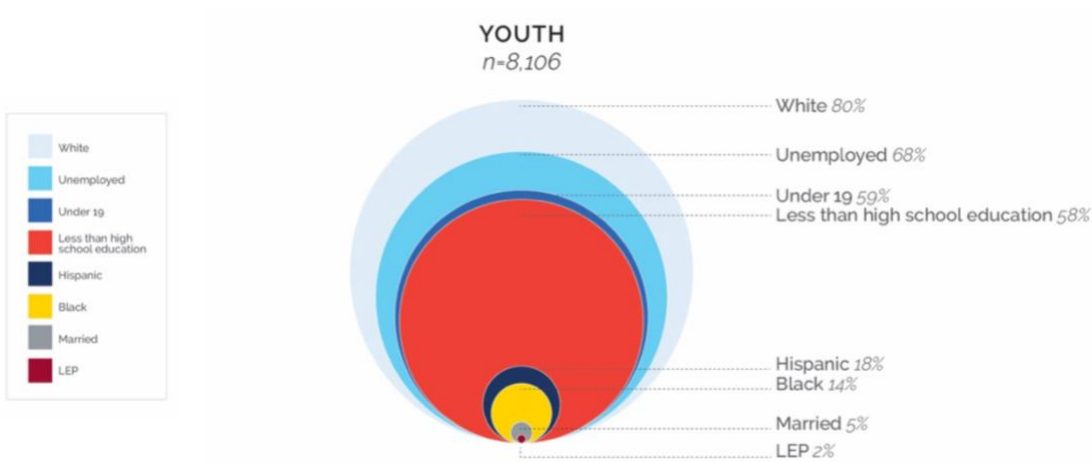


Figure 12: Group 3 of cluster analysis, characterized by being mostly white, unemployed, under 19, have not received a high school degree yet; about a fifth are Hispanic.

### Geographic distribution of client types

Sedgwick, Finney, and Wyandotte Counties served the most clients in each cluster analysis group. Sedgwick County serves the highest number of all client types, Finney and Wyandotte Counties serve a high number of Spanish-speaking adults. Wyandotte and Geary Counties are

also among the top 5 counties that serve Spanish-speaking adults and White adults. Sedgwick, Finney, Barton, Geary, and Leavenworth are the top five counties serving youth.

Table 4: Top 5 Counties Serving Clients of the Three Identified Groups Separately, 2019-2023

Top 5 Counties Serving Spanish-Speaking Adults	N	Top 5 Counties Serving White Adults	N	Top 5 Counties Serving Youth	N
Sedgwick	1,681	Sedgwick	3,002	Sedgwick	1,025
Finney	1,441	Leavenworth	1,535	Finney	802
Wyandotte	1,214	Riley	1,287	Barton	574
Seward	797	Wyandotte	934	Geary	574
Barton	438	Geary	902	Leavenworth	512

## Services Provided by Kansas Title X Program 2019-2023

### General Overview of Services Provided

This section outlines the services provided by Kansas Title X from 2019 to 2023, including client screenings, counseling, and testing for various health conditions. The data highlight the range of services provided by Kansas Title X and the evolving trends in client screenings, counseling, and testing over the five-year period. These services play a crucial role in promoting and maintaining the health and well-being of individuals served.

From 2019 to 2023, Kansas Title X served 63,096 clients (counts were de-duplicated within each year but may be duplicated across years). Screening rates for various conditions fluctuated, with some dropping in 2020 but picking up quickly afterward. There was an overall upward trend in testing and screening rates, particularly for anxiety, substance use disorders, and STIs.

Contraceptive counseling saw a significant increase in 2023, reaching 61% of clients. However, screening rates for clinical breast exams dropped from 38% in 2019 to 28% in 2023 ([Appendix I, Table 9](#)).

### Screening and Testing

**Depression** screenings were conducted for 42% of clients in 2019, with rates increasing to 52% by 2023. **Anxiety** screening was initiated in 2019 but rose to 37% by 2023, which may be a result of

increased screening efforts by the state's Title V (J. McDonald, personal communication, May 14, 2024) and KDHE's KCC programs. **Hypertension** screenings increased from 38% in 2019 to 41% in 2023, and **mental health** screenings were conducted for 32% of clients in 2019 and the rate increased to 40% in 2023. Screening rates for clinical breast exams dropped from 38% in 2019 to 28% in 2023.

Screening rates for SUD (substance use disorder), tobacco, and alcohol use increased significantly over the years, with tobacco use screening reaching 61% in 2023 from 48% in 2019, alcohol use screening increasing to 57% in 2023, and substance use screening rising from 44% in 2019 to 56% in 2023. Human trafficking and intimate partner violence screenings were conducted for 26% and 36% of clients, respectively.

Testing for sexually transmitted infections (STIs) including chlamydia, gonorrhea, and syphilis saw increasing percentages over the years. Notably, syphilis testing increased from 24% in 2019 to 37% in 2023. Chlamydia and gonorrhea tests were performed on 48% and 47% of the clients, respectively. Other STI testing was less common, at 7.3% of clients.

Pregnancy testing was administered to 34% of clients, although the data does not allow analysis for reasons for testing, which could be related to requirements related to prescribing contraception or be done as a pregnancy confirmation (I. Rivera-Newberry, March 14, 2024).

## Treatment and Counseling

STI treatment services were provided to 6.6% of the clients. Future analysis could compare clients who received STI treatment services at Title X clinics to clients who were tested at Title X clinics. This would help identify potential gaps between screening, results, and treatment.

Counseling services were provided for alcohol and tobacco use, depression, and contraceptive counseling. Counseling for alcohol use was provided to 3.5% of clients, while tobacco use counseling was provided to 4.9%. Depression counseling was provided to 3.1% of clients, and contraceptive counseling to 56% of clients, with follow-up contraceptive counseling provided to 54%.

However, a significant proportion of services are being captured in a catch-all "education" category, which does not allow for analysis of services and may result in an undercount of specific counseling services.

## Screening/Service Rates by Demographics

The following section provides information about difference in screening and service rates by various demographic factors, including gender, race, ethnicity, insurance status, employment status, limited English proficiency status, education level, and poverty level. Here is a summary of the key findings:

### Gender, Gender Identity, and Sexual Identity

While most of the Kansas Title X clients are female, the programs also served male clients (11%). The counties of Douglas, Wyandotte, Riley, Finney, and Geary served the highest numbers of male clients.

Overall, female clients are more likely to be screened for depression (female 42% vs male 36%) and mental health issues (female 33% vs male 21%), while males have higher screening rates for anxiety (male 14% vs female 9.8%). On the other hand, male clients have higher rates of screenings for alcohol (male 58% vs female 47%), tobacco (male 55% vs female 47%), substance use disorders (male 54% vs female 43%) and sexually transmitted diseases (male 35% vs female 4.2%), and higher rates of receiving STI treatment services (male 25% vs female 4.3%). Counseling services reflect similar trends, with females more likely to receive counseling for depression (female 3.3% vs male 1.4%), hypertension (female 2.4% vs male 1.4%), and general mental health (female 2.8% vs male 1.2%), while contraceptive counseling is significantly higher among females (female 7.9% vs male 1.2%) ([Appendix I, Tables 10a-10f](#)).

Kansas' Title X programs started collecting optional gender identity and sexual orientation data in 2023. However, over 70% of providers skip these questions or mark them as "unknown," making analysis difficult (see Table 8f in Appendix). Despite informal collaborations with LGBTQ+ organizations and the health departments in Riley and Neosho counties ([KDHE, 2024a](#)), there are currently no formal programmatic initiatives within Title X for this population. PrEP counseling and administration are also not currently in DAISEY, making it difficult to estimate the contribution of Title X clinics to HIV prevention. This highlights a need to improve data collection and implement targeted initiatives to better address the healthcare needs of the LGBTQ+ community.

## Race

Native Hawaiian or Other Pacific Islanders have higher rates of screenings for depression (60%), anxiety (21%), alcohol (70%), and tobacco use (69%) compared to other racial groups (See Appendix, Table 11a). This could be due to their smaller population size and their localized concentration in seven specific counties. Conversely, African American individuals demonstrate a higher probability of undergoing screenings for sexually transmitted diseases including Chlamydia and Gonorrhea (59% for both) ([See Appendix I, Tables 11a-11d](#)).

## Ethnicity

Hispanic or Latino individuals show lower screening rates for depression (38% vs. 44%), anxiety (7.4% vs. 12%), hypertension (35% vs. 42%), and mental health (30% vs. 34%). Compared to their non-Hispanic or Latino counterparts, Non-Hispanic or Latino individuals have significantly higher rates of alcohol (53% vs. 39%) and tobacco use screenings (53% vs. 40%), as well as screenings for substance use disorders (SUD) (49% vs. 37%). Counseling services for alcohol use, tobacco use, depression, hypertension, and mental health are significantly lower among Hispanic or Latino individuals. Contrarily, contraceptive counseling shows a slightly higher reception rate among Hispanic or Latino individuals (7.7% vs. 6.8%) ([See Appendix I, Tables 12a-12d](#)).

## Insurance Status

Overall, insured clients, especially those with public insurance, receive more comprehensive health screenings and counseling services compared to self-paying clients. Of the 41,217 self-paying clients, 38% were screened for depression, 7.9% for anxiety, and 46% each for alcohol and tobacco use, indicating a lower rate of screenings and tests compared to insured groups. Private insurance holders, numbering 12,241, showed higher percentages in screenings for depression (48%) and hypertension (45%), as well as a 50% rate for alcohol use. The 9,055 clients with public insurance had the highest percentages for anxiety screening (18%), mental health (41%), and substance use disorder (SUD) screening (53%). Insured individuals, particularly public insurance holders, showed higher screening rates for sexually transmitted diseases like chlamydia, gonorrhea, and syphilis. Contraceptive counseling was significantly higher among public insurance clients at 11%, compared to 6.4% for self-pay and 7.0% for private insurance clients ([See Appendix I, Tables 13a-13d](#)).

## Employment Status

Full-time employed clients have higher rates of certain health screenings, including HIV (35%) and syphilis (34%), but lower rates of receiving contraceptive follow-up services (47%), when compared to other employment groups. Counseling services, particularly for alcohol use and tobacco use, were more frequently provided to those employed part-time ([See Appendix I, Tables 14a-14d](#)).

## Limited English Proficiency Status

Individuals with limited English proficiency (LEP) have lower rates of screenings, tests, and counseling services across various health areas compared to non-LEP individuals. Significantly lower percentages of LEP individuals received screenings for depression (37% vs. 43%), anxiety (8% vs. 11%), hypertension (35% vs. 41%), alcohol (40% vs. 50%), tobacco (40% vs. 50%), and SUD (37% vs. 46%), as well as tests for Chlamydia (33% vs. 51%), Gonorrhea (33% vs. 50%), and other STIs (3.4% vs. 8.3%), indicating notable gaps in healthcare accessibility or utilization. However, LEP individuals had higher rates of pregnancy tests (40% vs. 33%) and clinical breast exams (40% vs. 31%). Counseling service provision indicates disparities, with LEP individuals less likely to receive counseling for alcohol use (0.7% vs. 4.1%), tobacco use (1.1% vs. 5.8%), and mental health issues (0.9% vs. 3.0%). Interestingly, LEP individuals utilized more contraceptive follow-up services (59% vs. 52%) and education services (70% vs. 67%), highlighting specific areas where LEP populations engage more with healthcare services ([See Appendix I, Tables 15a-15d](#)).

## Educational Attainment

Overall, individuals with only high school education were screened for depression (44%), anxiety (10%), mental health (34%), human trafficking (35%), intimate partner violence (37%) and alcohol use (50%) at lower rates, compared to those with either less education or higher education levels. Individuals with associate degree or vocational certifications were screened for tobacco (65%), SUD (60%), and hypertension (54%) at higher rates than those with other education levels. Individuals possessing a college education, but no degree, were tested for Chlamydia (57%) and Gonorrhea (56%) at higher rates than those with other education levels. These individuals also demonstrated to receive the highest rates of counseling for alcohol use (6.2%), depression (6.2%), and mental health (5.3%). The rate of pregnancy tests declined with increasing education, from 38% among those with less than 12 years of education to 22% among those with a bachelor's degree or higher ([See Appendix I, Tables 16a-16d](#)).

## Poverty

Individuals with incomes below the federal poverty limit were more frequently screened for STIs and pregnancy but had slightly lower rates on other screenings compared to those above the poverty line. For screenings, individuals above the poverty line have marginally higher percentages of depression (43%), anxiety (15%), and hypertension (40%) screenings. Notably, screenings for mental health (34%) and intimate partner violence (37%) are also slightly more prevalent in this group. Conversely, individuals under the poverty line have higher engagement in testing services, particularly for sexually transmitted diseases including Chlamydia (51%), Gonorrhea (51%), Syphilis (33%), and HIV (33%), as well as pregnancy tests (38%). In terms of counseling and other services, there is a subtle increase in the utilization of services related to tobacco use, mental health, contraceptive counseling, and human trafficking counseling among those under the poverty line ([See Appendix I, Tables 17a-17d](#)).

## Regression Analysis of Provided Services

Regression analysis is a statistical method that examines the relationship between two or more variables of interest while “controlling” for other variables that may have an effect on the outcome ([Montgomery et al., 2021](#)). The results are discussed in terms of “odds ratios,” which indicate the likelihood of a client receiving services based on various factors. An odds ratio greater than 1 indicates a higher likelihood of service receipt, while an odds ratio less than 1 suggests a lower likelihood. These findings highlight potential disparities in healthcare access and utilization based on demographic factors and insurance status, and the impact of county-level characteristics on healthcare services related to mental health screenings, contraceptive counseling, and STI testing and treatment within Kansas’ Title X clinics.

Here is a summary of the key findings from the regression analysis (for details, please see [Tables 23-25](#) in Appendix I).

### Screening for Depression, Anxiety, and Substance Use Disorder (SUD)

- There were significant fluctuations in screenings for depression and SUD after 2019, with a decrease followed by an increase in 2023.
- Male clients were less likely to be screened for depression but more likely to be screened for anxiety compared to female clients.
- Hispanic or Latino clients had a higher likelihood of being screened for depression but were less likely to be screened for anxiety and SUD compared to non-Hispanic or Latino clients.

- Age groups also played a role, with the 19-35 age group less likely to be screened for depression and anxiety than older patients.
- Clients with private insurance were more likely to be screened for depression and anxiety compared to those without insurance.
- Higher county-level STI screening rates were associated with a greater likelihood of being screened for depression, anxiety, and SUD.

### Contraceptive Counseling for Teens

- There was an increased likelihood of teens receiving contraceptive counseling from 2020 to 2022 but a significant decrease in 2023 compared to 2019.
- White teens were more likely to receive contraceptive counseling compared to other racial groups, while Black teens had significantly lower odds.
- Teens with limited English proficiency were less likely to receive contraceptive counseling compared to their English-proficient peers.
- Teens with private insurance were more likely to receive counseling compared to those with no insurance.
- Higher county-level STI rates were associated with a decreased likelihood of counseling, while higher low birth weight percentages were associated with an increased likelihood.

### STI Testing and Treatment

- There was a significant increasing trend in testing for Chlamydia, Gonorrhea, and Syphilis from 2020 through 2023 compared to 2019.
- Males had significantly higher odds of being tested for and receiving treatment for STIs compared to females.
- Black individuals had higher odds of being tested for all three STIs compared to other racial groups.
- Older clients had lower odds of being tested for Chlamydia and Gonorrhea but higher odds of Syphilis testing.
- Individuals with limited English proficiency had lower odds of being tested for STIs and receiving treatment.
- Individuals with private insurance had lower odds of being tested for STIs and receiving treatment compared to those with no insurance.
- Higher county-level STI rates were associated with a higher likelihood of being tested for STIs and receiving treatment.

## Geospatial Unmet Needs Analysis

We used a descriptive geospatial design to identify potential gaps in services ([Grekousis, 2020](#)). For this, we layered county-level characteristic or outcome data over clinic-level service data to answer the following questions:

1. Are clinics located in “high needs” counties (those with high teen pregnancy rates, high STI rates, or high maternal or reproductive vulnerability)?
2. Are clinics in “high needs” counties meeting the need by providing high levels of contraceptive counseling or STI testing?

### Summary of Geospatial Needs Assessment Findings

The geospatial analysis found that numerous counties with high teen pregnancy rates, STI rates, and maternal and reproductive vulnerability lacked coverage from Title X clinics. Disparities were observed in contraceptive counseling and STI testing rates, particularly in counties with high need but limited access to services. Identified gaps in healthcare service provision highlight the need for targeted interventions to improve access to reproductive and maternal health services in underserved areas.

#### 1. Identifying High Needs Counties:

- Nineteen counties in Kansas have reported primary and secondary syphilis rates exceeding 5 cases per 100,000 individuals, and three of these counties lack Title X coverage.
- Several counties in western and southeastern Kansas exhibit elevated levels of overall maternal vulnerability, with some lacking Title X clinic facilities.

#### 2. Clinic Coverage and Services:

- Despite high need, certain counties lack coverage from Title X clinics, indicating potential service gaps.
- Counties with high reproductive vulnerability scores often lack Title X clinic facilities.
- Among counties with high STI rates, there are disparities in testing rates, with some counties having low testing rates despite high STI prevalence.
- Similarly, among counties with high teen pregnancy rates, there are disparities in contraceptive counseling rates.

### 3. Potential Gaps in Services:

- Counties like Hamilton, Woodson, Chautauqua, Lyon, Cherokee, and Montgomery exhibit high rates of teen pregnancy or STIs but lack Title X coverage, suggesting potential gaps in service provision.
- Counties with high reproductive vulnerability scores but lacking Title X clinics indicate further gaps in support systems for maternal health.

### Geographic Crosswalk of Areas with High Teen Pregnancy and Clinic Location

In Kansas, 48 counties have teen pregnancy rates exceeding 10 per 1,000 females aged 10 to 19, with 19 counties not covered by Title X services. In Kansas, 48 counties exhibit teen pregnancy rates surpassing 10 per 1,000 females aged 10 to 19 — a contrast to the overall county median of 9.4 and the national average of 13.5. Within this group, 19 counties, including those with notably high rates like Hamilton (25), Woodson (20), and Chautauqua (18), are not covered by the Title X services (see Figure 13, and [Appendix, Table 21](#)).

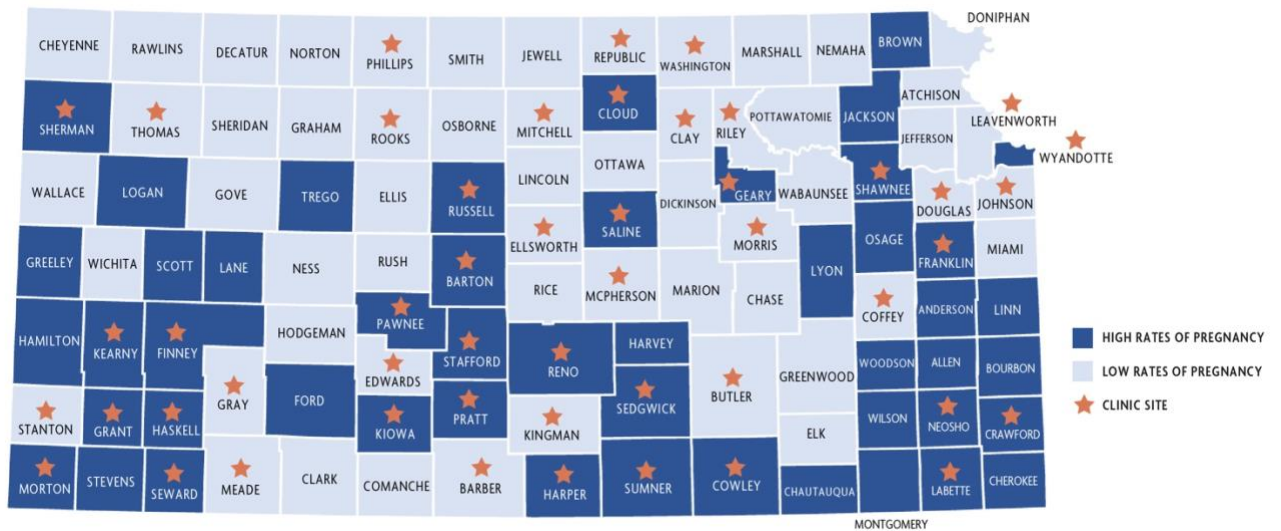


Figure 13: Teen Pregnancy Rates in Kansas Counties and Clinic Locations. Data Source: Kansas Health Matters, KDHE.

## Geographic Crosswalk of Areas with STI Rates and Clinic Location

In Kansas, 19 counties having reported primary and secondary syphilis rates are considered “high needs” by exceeding 5 cases per 100,000 individuals (Target is 4.6 per 100,000; ([Healthy People](#))). Additionally, there are 19 counties with higher overall STI rates. Among these, three counties (Lyon, Cherokee, and Montgomery) currently do not have Title X coverage, indicating a potential service gap (see Figure 14, Appendix I, Table 19).

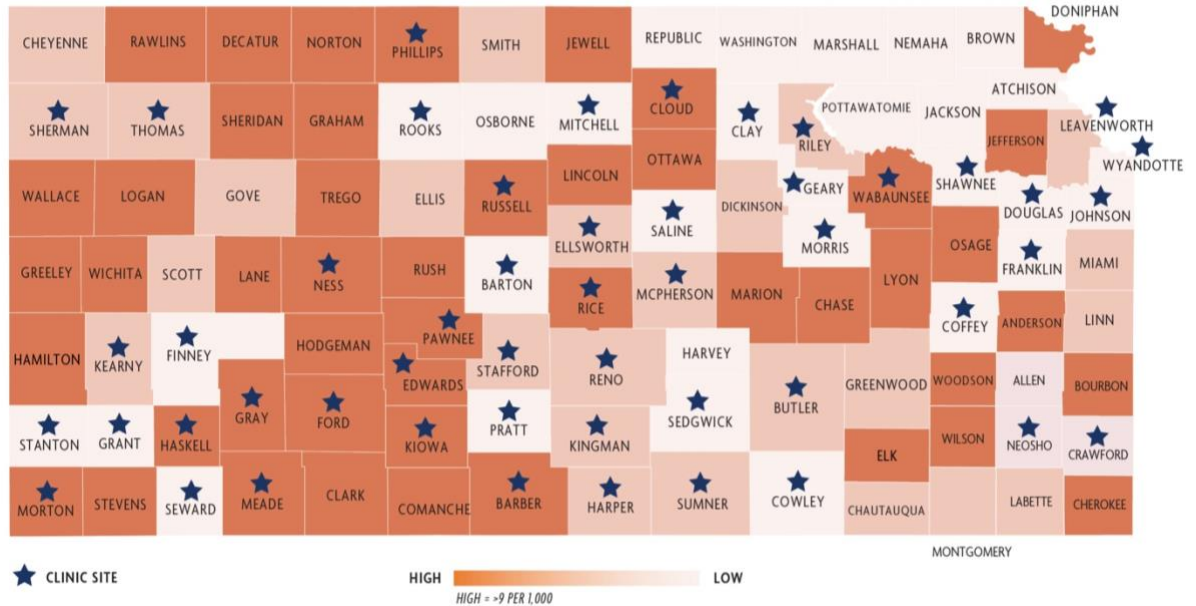


Figure 14: Areas of high STI rates and clinic locations

## Geographic Crosswalk of Areas with High Maternal Vulnerability Index and Clinic Location

The overall MVI score suggests that numerous counties in western and southeastern Kansas exhibit elevated levels of overall maternal vulnerability. Presently, several counties with high overall MVI scores lack Title X clinic facilities, including Woodson, Lincoln, and Chautauqua counties (See Figure 15).

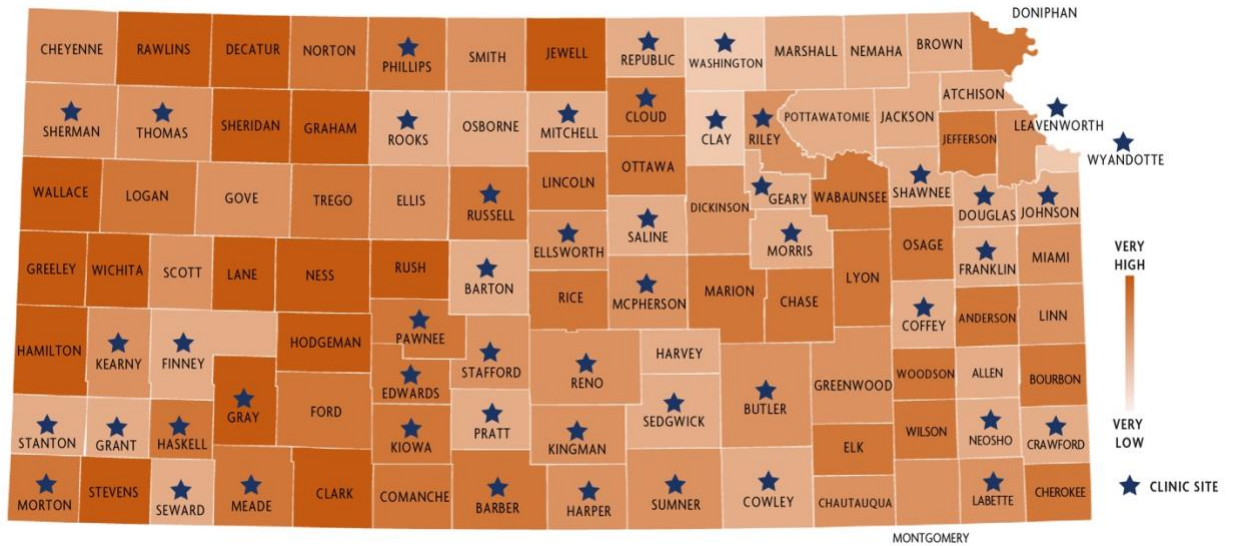


Figure 15: Overall Maternal Vulnerability Index score. Darker colors indicate higher vulnerability.

## Geographic Crosswalk of Areas with High Reproductive Vulnerability Score and Clinic Location

The reproductive vulnerability score developed by Surgo Ventures includes access to family planning and reproductive services such as abortion, and the availability of the skilled attendants. In Kansas, out of 105 counties, 47 are flagged as having high or very high reproductive health vulnerability scores. However, of these, only 16 counties are recipients of Title X program services, highlighting a potential gap in the support system for maternal health. Several counties with high or very high reproductive vulnerability scores do not have Title X clinic facilities, including Stevens, Graham, Lane, Wichita, Greeley, Hamilton, Hodgeman, Rush, and Cherokee (see [Appendix 1, Table 4](#)).

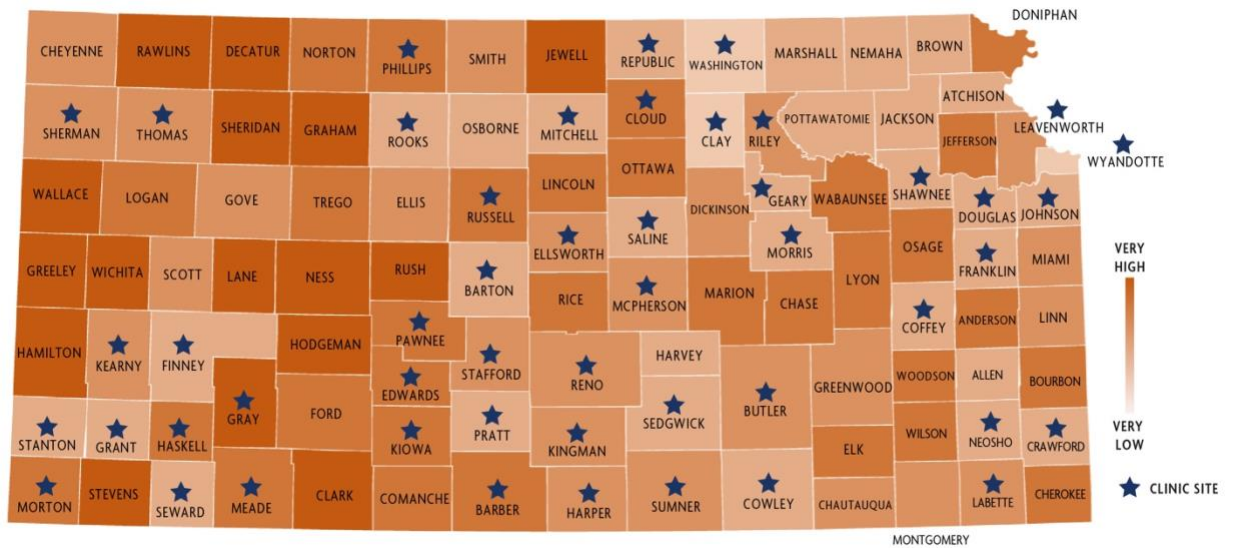


Figure 16: Reproductive Vulnerability Score. Note. The MVI assigns each county a relative maternal vulnerability score (where 0 = the least vulnerable and 100 = the most). Data source: Surgo Ventures. <https://mvi.surgoventures.org/>

## Areas with High STI Rates and Clinic Testing Rates

Among the top ten counties with high STI rates, Title X program clients have been tested for STIs at a higher rate in eight counties. However, residents residing in two counties with high STI rates, Lyon and Geary, are not being screened at high rates in the Title X clinics that serve them (see Figure 16). Notably, Lyon County is currently not covered by Title X program services (see [Figure 17](#), and [Appendix I, Table 19](#)).

These counties have **high STI levels**. HIGH or LOW STI testing levels is indicated.



Figure 17: STI Rates in Kansas Counties and Clinic STI Screening Rates. Data Source: Kansas Health Matters and DAISEY, KDHE.

## Areas with High Teen Pregnancy Rates and Clinic Contraceptive Counseling Rates

Among the top ten counties with high teen pregnancy rates, Title X program clients have received contraceptive counseling at a higher rate in eight counties. However, residents in two counties, Geary and Wyandotte, are receiving low counseling rates for contraception (see Figure 18, and [Appendix L, Table 21](#)).

These counties have **high teen pregnancy levels**. **HIGH** or **LOW** contraceptive counseling levels is indicated.



Figure 18: Teen Pregnancy Rates in Kansas Counties and Clinic Contraceptive Counseling Rates. Data Source: Kansas Health Matters and DAISEY, KDHE.

# Qualitative Data

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## Summary

We conducted a series of key informant interviews and focus groups to examine barriers and facilitators of providing Title X services in Kansas (more details in [Methodology](#) section). The discussions around barriers to providing care through Title X clinics touched upon several critical areas, including workforce challenges, interactions with county commissioners, financial constraints, reimbursement issues, administrative misunderstandings, language and cultural barriers, factors influencing patient volumes, transportation barriers, lack of program awareness, perceptions of quality, policies around confidentiality, and ideas to meet the health needs of clients.

One prominent challenge highlighted was the shortage of healthcare professionals interested in public health careers, including public health nursing. This shortage affects recruitment and retention efforts, leading to burnout among staff due to underestimated workloads and administrative responsibilities. Financial barriers, including the high cost of long-acting reversible contraception (LARC) methods and reimbursement challenges, hindered the sustainability of Title X programs. Additionally, administrative misunderstandings of Title X policy and funding allocation issues have caused confusion and inefficiencies. Interactions with county commissioners varied, with some programs facing opposition to expansion and conservative preferences influencing the types of services offered. Despite challenges, some commissioners encouraged program expansion, recognizing the importance of comprehensive reproductive health care. Language barriers posed challenges in serving non-English proficient individuals, highlighting the need for more bilingual staff, and appropriately translated materials in various languages.

The COVID-19 pandemic significantly impacted patient volumes, with concerns about decreased in-person visits and an increase in no-show appointments. Limited clinic hours and transportation barriers further hindered access to care. Efforts to address program awareness, perceptions of quality, policies around confidentiality, and meeting client health needs included integrating services, expanding contraceptive options, improving communication and outreach, and seeking state-level support.

Addressing barriers to accessing care for adolescents, including confidentiality concerns and stigma, are crucial for ensuring their access to essential reproductive health services. Integrating adolescent-friendly services and ensuring confidentiality in Title X programs can help meet the unique health needs of adolescents effectively.

## Barriers to Providing Care

### Workforce

The concerns raised regarding the workforce in Title X clinics reflect several challenges in recruitment, retention, and overall staffing.

#### 1. Financial Barriers to Recruitment

One significant challenge is the inability to offer competitive wages compared to hospitals or other healthcare facilities. Despite the importance of the work, lower wages can deter qualified individuals from pursuing opportunities in public health. Said one participant:

*“The hospitals, at least in [town], are paying a lot more than what the health department can offer for RNs to come and work, or even NPs. So, I think that’s definitely a barrier for staffing. You can entice people, and they might be interested in what you do and think what you’re doing is wonderful, but when the dollar hits the dime, they’re going to choose a job where they’re going to likely make more money.”*

#### 2. Difficulty Finding and Retaining Individuals Interested in Public Health

There is a perceived lack of interest in public health careers among healthcare professionals. Retaining staff is also a concern, with burnout being a significant issue. The workload in public health settings is often underestimated, leading to disillusionment among staff who may perceive clinic work as easy. The complexity of tasks, including administrative responsibilities, can contribute to burnout and turnover.

*“You really have to want to be a part of the community that you’re working in to want to stay in public health. I’m from [town], so it just worked well for me because public health is just where my niche is, I guess. But people think it’s super easy, but there’s still a lot of other things that go along with it that it’s not easy. I mean, it’s a lot of work...you have to want to be here.”*

One participant spoke about how recruiting public health nurses is a challenge because of lack of nursing training in public health:

*“There’s a lot of programs for public health personnel through the MPHs or MPH programs. But public health nursing classes aren’t as prominent or prevalent, and that needs to be something that the education system needs to recognize, just to train and introduce new public health nursing staff. That is another one of the items pinned on my to-do list of thinking about in the future...to bring in the future generation of*

*public health nurses as students who are graduating with a better concept of what health departments do and our role.”*

### 3. Challenges in Recruiting Medical Providers

Recruiting and retaining medical providers, including nurse practitioners or physicians, poses additional challenges. Limited availability of providers, inconsistent schedules, and difficulties in finding replacements in case of turnover further strain Title X clinics. One participant explained:

*“We contract with [university], and so we are assigned an attending, a physician. Our clinic is only on Tuesday afternoon, so we have them four or five hours a week. And then it’s staffed by residents. And so, we constantly have a revolving door of providers seeing our patients. So sometimes consistency of care can be a little bit different and different approaches depending on the attending provider, their preferences, their styles. So having a single provider who consistently saw our patients and possibly more times than just the one afternoon a week would be fantastic.”*

### 4. Potential Solutions through Collaboration

Participants discussed potential solutions including regional systems of care, where multiple health departments collaborate to share providers and resources. This approach could help address staffing shortages and ensure consistent access to care across regions. One participant noted:

*“I think building a collaboration between smaller health departments and the big health department for the services that cannot be provided by other local health department is good...We are taking clients from other counties that don’t have the LARC option. We see quite a few referred to us for that.”*

*Addressing workforce challenges in Title X clinics will require a multifaceted approach, including competitive compensation, targeted recruitment efforts, strategies to reduce burnout, and collaborative regional solutions to ensure continuity of care.*

## Finance

Financial barriers pose significant challenges for Title X programs, impacting their ability to offer certain services and sustain operations. The conversations highlighted the complexities of clinic operations under the Title X program, particularly regarding STI services and billing practices. They underscored the need for clearer guidance from state authorities and a better understanding of grant requirements to ensure consistency and compliance across clinics.

### 1. Cost of Long-Acting Reversible Contraception (LARC)

LARC methods, including Nexplanon and IUDs, are highly effective but expensive. Some programs struggle to justify the cost of providing these methods, leading to concerns about sustainability and access for clients.

*“LARC is the most expensive method, but we have seen increased interest in that, and it’s very effective. It’s the most effective of all birth control methods. So, if the aim is for unintended pregnancy, that would be preferred method. However, the cost efficiency can be hard to justify, especially Nexplanon compared to Paragard.”*

*“We implemented LARC. The Liletta is what we started out with, and our practitioner is struggling with providing those, getting those inserted and staying. So, we’ve kind of talked about going to Nexplanon, but they’re so expensive that, of course, I think that’s a barrier. And I’m sure others feel that same way, that those LARCs are all expensive.”*

### 2. Confusion about Reimbursement Guidelines and Recommendations

The focus group participants discussed changes to their clinic services prompted by suggestions from the state Title X program, particularly regarding the handling of STI services. Some clinics charged a flat rate for STI testing and did not consider it part of their family planning services, thus not submitting these visits to DAISEY (the state’s data reporting system). However, others were informed during a site visit that all STIs should be submitted through DAISEY, regardless of billing practices. This discrepancy led to confusion and prompted clinics to reevaluate their billing practices. Ultimately, some clinics shifted to a sliding scale for STI services to comply with grant requirements and ensure accurate reporting in DAISEY.

One participant mentioned that their clinic had separated STI services from family planning and started charging a flat fee for STI testing following a site visit from the Title X program. They

noted a decrease in young people seeking STI services since implementing this change. Another participant expressed uncertainty about the decision to remove STI family planning services and mentioned challenges in receiving guidance from the Kansas Department of Health and Environment (KDHE) on clinic operations.

*“Now we offer them separately, and we charge an admin fee for STI testing that’s not included in the family planning visits... We’ve definitely seen a drop in the number of people that we’ve had coming in for STI testing because they’re used to it being on a sliding fee scale, aka free. And when we tell them it’s \$35, like, ‘Oh, okay. I’m going to run to the bank,’ and we never see them again. And when we do see people, we are seeing people again when they’re coming in with symptoms, with problems. I think that we’re doing a great disservice to the community.”*

### 3. Insurance Reimbursement Challenges

Title X programs face challenges with reimbursement for services covered by health insurance. Some insurers refuse to pay for certain methods of contraception, including pills or patches, which affects the financial viability of providing these services. One participant lamented:

*“A downfall for sure is that health insurance, if they [clients] do have coverage, they [insurers] will not pay the health department for their scripts. They just they won’t pay health departments. The depo shot they will pay us for, which is interesting. But they won’t pay us for pills. They won’t pay us for patches, rings. They won’t do any of that.”*

### 4. Advocacy for Policy Changes

State Title X programs may advocate for policy changes that impact the affordability and availability of services. These changes can have varying effects on program operations and client access, depending on the context and implementation.

### 5. Staff Limitations and Resource Allocation

Limited staffing and resources can hinder the ability of Title X programs to maximize reimbursement and provide outreach and promotion. Staff may be stretched thin, leading to difficulties in completing tasks and providing services effectively.

## 6. Operational Challenges

Operational challenges, including balancing outreach events with clinic availability, can further strain resources and impact service delivery. Staff may face conflicting priorities and limited support for promotional activities.

*Addressing these financial barriers requires strategic planning, advocacy, and resource allocation to ensure the sustainability and effectiveness of Title X programs in providing essential reproductive health services to communities.*

## Reimbursement issues

The concerns raised regarding reimbursement of services, particularly in relation to Medicaid, highlight several challenges faced by Title X providers:

### 1. Requirement for Services to be Provided by Kansas Providers

Participants expressed frustration with the Medicaid requirement for services to be provided by Kansas providers, even when clients live closer to large medical centers in other states. This leads to significant travel burdens for clients and raises safety concerns, especially for families with children. There is a call for more flexibility in allowing clients to continue receiving care at their established locations, particularly when travel to another state is required.

### 2. Impact on Established Care

Participants shared personal experiences where insurance changes, including switching Medicaid managed care organizations (MCOs), required them to switch all their doctors and care to medical centers hours from their residence. This disrupts established care relationships and can be particularly challenging for individuals with special health care needs or complex medical conditions.

### 3. Insurance Reimbursement for Prescriptions

There is frustration among providers, especially health department directors, regarding insurance companies not reimbursing health departments for prescriptions. Despite offering essential services like contraceptive methods, insurance companies may refuse to pay for these services if obtained directly from the health department. This creates financial challenges for both the health department and clients, who may face additional costs if they choose to obtain prescriptions elsewhere.

### 4. Non-reimbursable services

Staff limitations or perceived limitations make it difficult to maximize reimbursement. Clinicians may be overwhelmed with administrative tasks, reducing their capacity to focus on patient care. Also, administrative staff may be reluctant to assist with outreach events or promotion, further limiting providers' availability to deliver services in clinics.

*“I come from a clinic setting of urgent care to where I was seeing 30 patients a day, and I’m now seeing 10. And I’m having trouble completing those 10 because I’m doing so many other tasks that are irrelevant to the care that I’m supposed to be giving and be focusing on...”*

*“When it comes time to doing outreach events and promotion, our administrative staff doesn’t want anything to do with helping with the promotion or doing the advertising. If it’s a health fair event, they want me, the nurse manager to be there, our social worker there, and our WIC coordinator there. But if we are there, we are not available to be in the clinic to provide services. So, it’s kind of like a catch-22 or like a Cinderella situation, I feel like, like, ‘Oh, you can go to the ball, but you have to get all of your chores finished first.’”*

*Overall, these concerns highlight the need for policy changes and improved reimbursement practices to ensure equitable access to care, minimize travel burdens on clients, and facilitate reimbursement for essential services provided by health departments, including prescriptions. Collaboration between shareholders, including Medicaid agencies and insurance companies, may be necessary to address these issues effectively.*

## Administrative Misunderstanding of Title X Policy

It is evident from the discussions that several Title X providers are facing challenges due to administrative misunderstanding of Title X policy and requirements. Here are the key concerns expressed by providers:

### 1. Lack of Understanding by Administration and Imposition of Arbitrary Rules

Providers expressed frustration with administrators who lack understanding of Title X program requirements and grant regulations. This lack of understanding hampers effective program operation and adherence to grant guidelines. One provider said:

*“On the administrative side, a lot of our people don’t understand the programs and the requirements and what we need to do....a challenge that I’ve been having is I have my administrative manager telling me that the providers are not doing everything they’re supposed to do during a visit, and they’re going to decide a checklist of all the things that need to be done based on what they have had done when they go see their provider. I’m just trying to explain to them, ‘This isn’t about what you think should happen during a visit. There are standards of practice. There are multiple different organizations that set out what needs to be included in an annual exam, what things the provider should be looking for, the questions that need to be asked.’”*

*“They’re trying to make rules, but they don’t understand the clinical aspect of it. They don’t understand the requirements of the grant programs, and they don’t want to talk to the providers to kind of get more information about it.”*

### 2. Funding Allocation Issues

Concerns were raised about the allocation of funds to cover salary expenses, with some providers feeling disconnected from how their salaries are being funded. There were discrepancies in reporting and understanding of how funds were being utilized, leading to confusion and inefficiencies. Said one participant:

*“The disconnect there is between our different reports and then the financial aspect of it; the people who are reporting the numbers or the percentage of the salaries that are spent...half of my salary’s coming from her grants, and I’m like, ‘I don’t have anything to do with your programs.’”*

### 3. Optimal Use of Staff Skills and Lack of Support Staff

Many providers mentioned being understaffed and lacking support staff, which results in them having to perform various non-clinical tasks in addition to patient care responsibilities. This limits their capacity to see patients efficiently and provide quality care. A nurse practitioner noted:

*“I don’t know if our clinic is run pretty much the same as everybody else’s...I’m the only provider, and I don’t have any support staff. So not only am I seeing the patients, I’m ordering the supplies. I’m checking the numbers and making sure-- and communicating with the person who can order stuff. And then I’m also doing the laundry, and I’m cleaning the rooms in between seeing the patients, and I’m gathering the history. I’m ordering the labs. I’m processing the labs in our lab...there’s absolutely no support staff. We’re losing an opportunity to use my skill, what it’s meant to be used for. I’m the provider. I shouldn’t be doing laundry. But getting people to understand that, they’re like, ‘Well, that’s the way it’s always been.’ Well, that doesn’t make financial sense. Let me get some revenue in here. Let’s double, triple the people that we’re seeing.”*

*Addressing these administrative misunderstandings and challenges is crucial for ensuring the efficient and effective operation of Title X programs and maximizing the quality of care provided to patients. Collaboration between administrative and clinical staff, along with a better understanding of Title X policies and requirements, is essential for overcoming these obstacles.*

## Language and Cultural Barriers

Title X providers recognize the challenges posed by language barriers when serving individuals who are not proficient in English. Here are some key points highlighted by providers:

### 1. Lack of Educational Offerings and Services

Providers acknowledge a deficiency in educational offerings and services tailored to Spanish-speaking community members. This gap can hinder effective communication and access to reproductive health services.

### 2. Limited Staff Capacity

Despite efforts to accommodate Spanish-speaking clients, limited staffing resources can lead to delays and backlogs in serving this demographic. Providers express the need for more bilingual staff to address these challenges effectively.

### 3. Importance of Interpreter Services

While language lines are utilized for translation, providers emphasize the importance of recruiting and training staff proficient in medical Spanish. This enables more detailed and accurate communication during consultations.

*“A perfect provider would be somebody who was bilingual...family planning is kind of one of those things where mom probably doesn’t want to bring her five-year-old in to translate for her, so we use our language line for it, but a provider that was bilingual would be a perfect scenario.”*

Respondents also talked about what it takes to provide good care to non-Spanish speaking immigrants and refugee populations. One participant noted that

*“it is important that “they feel safe and not judged, and you’re willing to learn and ask question. I ask them, ‘How was your life there? How is your life here? How do you say this in your language?’ I ask even though I’m using an interpreter because they’re specific and they like that. They like that you’re interested and that you really want to learn about them and your culture.”*

#### 4. Importance of culturally competent care:

The discussion shed light on the unique cultural beliefs and misconceptions surrounding birth control services among the Hispanic population served by Title X providers. Many Hispanic individuals may have concerns about birth control methods that alter menstruation patterns. For example, the Depo-Provera injection, which can result in lighter or absent periods, may be viewed negatively due to misconceptions about the health implications of not having a regular period. One provider, talking about periods, stated that:

*“A lot of them, especially in the Hispanic community, don’t like the Depo because they think that not having a period is bad. And they have been told by their family members, if they’re not having a period, it’s just sitting in there collecting and it’s going to cause cancer. And so, we do a lot of education in the Hispanic community.”*

Another shared a similar experience, noting:

*“They come in, and they’re like, ‘Hey, something’s wrong. I’m not getting a period.’ They want to have a period. For them, they say it’s something that’s cleansing them. So, we do have to educate them and explain why medically, how it’s protecting them from getting pregnant, but also how it’s okay. It’s not something that absolutely has to happen or something’s wrong with you. So, we do have to educate them, and then they’re okay with it.”*

Cultural and spiritual beliefs play a significant role in shaping attitudes towards birth control and family planning. Some individuals may hold beliefs that are inconsistent with modern contraceptive practices or prioritize cultural and religious values over medical recommendations. Providers talked about being sensitive to these beliefs and providing culturally competent care that respects clients' values while also offering appropriate education and support.

*“Others, if they’re Catholic, they don’t believe in birth control, or the church doesn’t allow them....and in the Mexican culture, I mean, it’s good. The more kids, the better. But I think now there is -- financially and your health -- you should space them out. So, as they learn that, then they’re understanding more now what’s healthier for them.”*

*When we had a nurse practitioner, we did an Afghan clinic...They were asking if it was going to be a guy doctor or a woman doctor. They would prefer a female. They don’t want males to see them undressed. We found some of them had yeast infections they didn’t know about, and one of them had a high-grade, abnormal Pap result. They just wouldn’t have found it if they wouldn’t have come to the free clinic.”*

## 5. Availability of Materials in Spanish and other Languages

Providers express a desire for educational materials to be available in Spanish and other languages to ensure accessibility for clients. However, challenges arise when materials from authoritative sources like the CDC and KDHE are only provided in English, or are not translated in a culturally appropriate way, highlighting a need for improved translation efforts.

*“Sometimes these things that we get from CDC or even KDHE, the Spanish translation is just-- it’s behind. We just don’t have it yet. And we noticed that a lot with COVID too. We were like, ‘Okay. This is great. This is a great tool in English, but we need it in Spanish.’ These people need to understand this too. It’s important for them.”*

Beyond Spanish, providers recognize the need for materials in other languages to cater to diverse communities, including communities that speak Haitian-Creole, Burmese Afghani, and Pashto. Efforts to translate materials into multiple languages are viewed as essential for effective outreach and communication.

## 6. Challenges in Funding

Despite the recognition of the importance of multilingual materials and outreach efforts, providers cite funding limitations as a barrier to implementing comprehensive language access initiatives. Lack of resources restricts the ability to produce materials and conduct outreach in various languages.

Title X providers understand the importance of addressing language barriers through improved staffing, interpreter services, and the availability of multilingual materials. However, challenges related to funding and resource allocation persist, underscoring the need for greater support in ensuring equitable access to reproductive health services for all language communities.

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## County Commissioners

Interactions between Title X programs and county commissioners vary significantly, ranging from minimal involvement to more frequent interaction, sometimes with challenges:

### 1. Range of Interaction Levels

While representatives from larger programs reported having limited interactions with county commissioners, indicating that they are allowed to operate autonomously without much oversight or interference, representatives from smaller or rural programs reported having more challenging and time-consuming interactions to be able to provide services.

### 2. Positive Relationships

Despite varying levels of interaction, some programs reported positive overall relationships with their local elected officials, with commissioners supportive of their work and receptive to their needs.

### 3. Opposition to Expansion

In some cases, attempts to expand services have been met with opposition from county commissioners. Concerns about competition with other healthcare providers or businesses, and resistance to the health department's growth, have been cited as reasons for pushback. A representative of one Title X program shared:

*"...since moving to our new building, we have tried to offer some services and gotten a lot of push back from our county commissioners. They're very concerned that we are not stepping on the toes of the hospital or the doctor's office or taxpaying businesses on main street. And they've told us like, 'Why are you trying to grow the health department bigger than it's ever been?' They've told me, 'You just need to coast.' They've told me to stay in my lane."*

### 4. Cautious Approach to Controversial Services

Title X programs often tread carefully when it comes to offering services that may be deemed controversial by commissioners or the community. This includes providing contraception and abortion-related services, with some programs avoiding direct referrals to abortion clinics to avoid backlash. As one Title X program stated, they were:

*“leery of offending commissioners or getting some kind of backlash for promoting family planning services because at one point, the commissioners were upset that we were even carrying condoms.”*

## 5. Navigating Conservative Preferences

In areas where commissioners hold conservative views, Title X programs may face restrictions on the types of services they can offer and how they can allocate funding. Some programs must navigate these preferences cautiously to avoid conflict. As one participant states:

*“Our commissioners are fairly conservative, and there are certain things that we can use the money on. There are certain teachings that we can do. There are certain lines we can’t cross. So, we have to tread carefully. They would prefer that we be a freestanding clinic, that they don’t give us any money.”*

## 6. Encouragement for Expansion

While examples were limited, there were instances where Title X programs were encouraged to expand their services by commissioners who were supportive of their work and recognized the importance of providing comprehensive reproductive health care to the community.

*Interactions between Title X programs and county commissioners reflect a complex dynamic influenced by factors including political ideology, community values, and healthcare landscape. The Title X program could provide support in navigating these relationships that balance the needs of the community with the preferences of local elected officials.*

## Factors Influencing Title X Patient/Client Volumes

Participants noted a significant slowdown in services since the onset of the pandemic. COVID-related factors include the shift to telemedicine for birth control prescriptions, reduced clinic hours, and increased use of long-acting contraception methods like LARCs.

### 1. Impact of COVID-19

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### 2. Telemedicine and Long-Acting Contraception

The convenience of telemedicine for birth control prescriptions and the popularity of long-acting contraception methods have contributed to a decline in in-person visits. Participants expressed concerns about patients opting for these methods not returning for yearly check-ups as recommended.

*“I did reach out to some that had not been in for a while. And they said, ‘Well, I get my birth control by telemed. I have a telemed doc that I get it, and I just go pick them up at the pharmacy.’”*

*“I would say our numbers have slowed down as well, because we see a lot of folks who are getting the long-term. We've been able to provide a lot of LARCs. So even though we tell them they need to come back yearly, they don't always make it back yearly.”*

### 3. No-shows and Appointment Availability

Participants expressed concern about the high rate of no-show appointments, making it challenging to utilize clinic slots effectively. Some are exploring strategies to address this issue, including follow-up with missed appointments, and extending clinic hours. One participant indicated they were

*“looking at ways to increase either the number of patients seen by availability, by somehow following up on those patients who failed their appointments or looking at hours-- looking at different ways to get people into and fill the slots that are available seems to be something that we need to get creative about.”*

#### 4. Limited Clinic Hours

The limited operating hours of Title X clinics pose a barrier to access, especially for teens and individuals with busy schedules. Some clinics are only open for a few hours a day or have a single provider available, reducing their capacity to serve clients.

*“It’s mostly because of their service hours. The clinic is still only open from 9:00 to 12:00 every day. So that’s impossible for teens.”*

This aligns with service hours data the needs assessment team analyzed. Clinics in many of the smaller, rural areas of the state have limited capacity. While many clinics, both rural and urban, offer some services (pregnancy tests, screenings for sexually transmitted infections, medication pickup, etc.) on a walk-in basis and/or during most or all regular clinic hours, for clinical services including well-woman exams, contraceptive consultation, and contraceptive insertion/removal, many smaller clinics may offer the service only one or two times each month. Very few Title X clinics, urban or rural, provide clinical services for more than a limited number of hours outside of “normal business hours” of 8 am to 5 pm. Some clinics do open at 7:30 am and some may stay open past 5 pm one or two days a week (usually to 6 pm or 7 pm), but many have no extended hours for clinic services. The extent of Title X geographic coverage in the state, limited numbers of hours for clinical services in some sites, and an overall lack of hours outside of working hours (limited evening hours; no weekend hours) all can create access barriers to those in need of service.

#### 5. Transportation Barriers

Lack of reliable transportation options further impedes access to care for clients, particularly those with multiple children or limited financial resources. Some areas are exploring initiatives like micro-transit systems or van services to address this issue.

#### 6. Loss of Birthing Services

The closure of local birthing services, particularly in rural areas, creates additional challenges for individuals seeking reproductive health care. Patients may need to travel long distances to access these services, exacerbating transportation barriers.

*These factors highlight the complex challenges in maintaining patient volumes and ensuring equitable access to Title X services, particularly in the context of*

*the COVID-19 pandemic and existing barriers to care. Addressing these challenges will require a multifaceted approach involving healthcare delivery innovation, transportation solutions, and community support initiatives.*

## Transportation

Transportation barriers can significantly impact access to healthcare services for clients, particularly in areas with limited public transportation options. Some key points from the participants' comments include:

### 1. Cost of Transportation

Even when public transportation options are available, the cost can quickly add up, especially for individuals with multiple family members needing to travel. The affordability of transportation services is crucial to ensuring access for all clients.

### 2. Logistical Challenges

In addition to cost, logistical challenges including coordinating transportation for individuals with multiple children can further complicate access to services. These challenges highlight the need for flexible and convenient transportation options tailored to the needs of clients.

### 3. Limited Local Services

In some areas, the lack of local healthcare services necessitates travel to neighboring towns or cities for specialized care. Without reliable transportation options, individuals may face significant barriers in accessing essential healthcare services.

### 4. Efforts to Improve Transportation

Participants mentioned efforts to address transportation barriers, including introducing micro transit systems or organizing transportation services for medical appointments. Collaborative initiatives between healthcare providers, local governments, and community organizations can help improve access to transportation for individuals in need.

*"We don't really have a good public transportation system. We just introduced a micro transit system, so a bus-- well, more like a van service that people can use. And it's \$2 per ride, which sounds okay, but then a lot of our clients have multiple children. And then it's logistically figuring out how to get everybody transported. And then by the time you factor in the mom who has three kids, this \$2 ride is now a \$20 round-trip ride. So that's one of our biggest problems."*

*Addressing transportation barriers requires comprehensive strategies that address both cost and logistical challenges. By working together to implement accessible and affordable transportation options, communities can help ensure that all individuals have equitable access to healthcare services.*

## Lack of Program Awareness

Lack of awareness about the range of services offered by Title X programs and health departments emerged as a significant issue. Participants shared various observations and efforts to address this challenge:

### 1. Perception of Services

Some community members associate the health department primarily with vaccinations and may not be aware of the full range of family planning services available. This limited perception can contribute to a lack of awareness among the population.

*"I think a lot of people know that we provide vaccinations here, and that's what they think of the health department as, "We're going to go get our shots." But they don't know, or they forget that we provide family planning services."*

### 2. Impact of COVID-19

The onset of the COVID-19 pandemic may have shifted public perception of health department services, leading some individuals to overlook or forget about other essential functions beyond COVID-related activities.

*"I came just after the onslaught of COVID, so I feel like people...associate us with that and have forgotten that we do so many other vital functions."*

### 3. Generational Differences

Changes in service offerings, including discontinuing prenatal care services, may affect the awareness of younger generations about the availability of family planning services. Older individuals who no longer require family planning services may also contribute to a declining awareness among the community.

### 4. Outreach Efforts

Participants highlighted ongoing efforts to improve outreach and raise awareness about the breadth of services offered by Title X programs and health departments. Strategies include community engagement events, advertising campaigns, and leveraging social media platforms like Facebook and TikTok to reach different demographics.

*“We’ve established a community engagement [day?], and right now, we’re working on a little video that we have to put on Facebook and maybe even TikTok, if it’s approved, to let folks know about the other services we provide here.”*

## 5. Engaging Schools

Despite challenges related to abstinence-only education policies in some schools, there is recognition of the importance of engaging educational institutions to increase awareness about health department services. Approaching schools with a broader perspective, including hosting open houses to showcase all available services, may help overcome barriers to engagement.

*By actively addressing the lack of awareness through targeted outreach, community engagement, and creative communication strategies, Title X programs and health departments can better serve their communities and ensure equitable access to vital reproductive health services.*

## Perceptions of Quality

Participants in focus groups and interviews have expressed concerns about the perceived quality and welcoming environment of some Title X clinics and public health departments. Here are the key points raised regarding these perceptions:

### 1. Barriers to Accessing Care

Participants highlighted barriers to accessing care, including concerns about the lack of dignity and value placed on clients or patients in some clinic environments. There were also concerns about the quality of facilities in some clinics, with participants emphasizing the importance of having clean, well-equipped environments. They stressed the need for clinics to move away from a perception of being dilapidated or low-income facilities and instead strive to resemble professional medical offices.

*“I do think some of it goes back to that culture of just having centers that aren’t dilapidated, that have the reasonable tools, that have nice waiting rooms, that have that kind of dignity and worth that folks are being treated with. I think that that’s important for patients and for practitioners alike. And so, yeah, to make it not feel like it’s a low-income clinic or a place where impoverished people go for care, but rather a medical office that exists for an important reason that serves people in the same way that a for-profit agency would serve people.”*

*“I think it’s harder for them to come here and somebody see their care here or something like that at the health department. We’re a small town, so I don’t know if that’s it, if there’s a stigma for coming to the health department.”*

*“I think that lots of folks see Title X as a clinic for either teens or people in poverty.”*

### 2. Importance of Positive Experiences

Participants emphasized the critical role of positive experiences in healthcare settings. A welcoming, clean, and kind environment can significantly impact patients' willingness to seek care and return for follow-up visits. Conversely, negative experiences, including feeling like cattle being herded through or encountering miserable staff, can deter patients from seeking care in the future.

*“I think the critical thing is the positive experiences that people have when they go to access care, right? If I*

*go and I feel like, 'Man, I'm like cattle being herded through in a very aggressive way, and everyone here is miserable,' then you don't want to go back, right? But if it's welcoming and clean and kind, then you're like, 'Oh, yeah, this was fine.' I mean, no one wants to go have their annual well exam anyway. And so, making it a more positive experience, I think, goes a long way."*

*Addressing misperceptions about quality and welcoming nature of clinic environments is essential for improving access to care and promoting positive healthcare experiences for patients. This may involve efforts to enhance facility quality, improve staff training in customer service, and prioritize patient-centered care principles to create a more welcoming and dignified atmosphere for all individuals seeking services.*

## Inconsistent Implementation of Policies around Confidentiality

Participants in discussions about Title X services expressed concerns about the lack of guaranteed access to confidential family planning services for adolescent youth without parental consent. Here are the key points raised regarding this issue:

### 1. Mandate and Funding

Several participants expressed concern that confidential family planning services in their community were not available to adolescent youth without parental consent, and questioned how certain clinics were able to operate without providing confidential services to minors, considering that confidentiality is understood to be part of the Title X mandate. They emphasized the importance of ensuring that clinics receiving Title X funding adhere to the requirement of providing confidential care to adolescents.

### 2. Impact on Access

Participants highlighted the significance of confidential access to family planning services for adolescents, stating that it is crucial for increasing access to essential healthcare measures. They emphasized that access to contraception without parental involvement is essential for the overall health and well-being of young people, particularly in preventing unintended pregnancies.

### 3. Concerns about Specific Clinics

Participants shared specific instances where Title X clinics in their communities required parental consent for adolescents to access contraception. This approach was viewed as contrary to the expectation of providing confidential care and was seen as a barrier to access for young people seeking reproductive health services.

*“I think the lack of guarantee that young people can access resources in a confidential way...my understanding is it’s part of the mandate so I don’t know how places are getting around it, but I would love to see that be a stronger mandate, that, ‘If you accept this funding, here are the strings that come with it because we know that this is what’s best for increasing access to essentially what are life-saving measures,’ because it impacts overall health and well-being when young people have pregnancy before they’re ready.”*

*Ensuring confidential access to family planning services for adolescent youth without parental consent is seen as a critical aspect of Title X services. Participants called for stronger mandates and adherence to Title X requirements to guarantee access to confidential care for all individuals, particularly adolescents, seeking reproductive health services.*

## Ideas to Meet the Health Needs of Clients

In each focus group, participants were asked to brainstorm about solutions for declining patient numbers or how care for clients could be improved. The ideas shared by participants reflect a range of strategies to enhance and expand services to meet clients' health needs, particularly in family planning and beyond. Here are some key points and suggestions highlighted by the participants:

### 1. Integration of Services

Participants discussed the importance of integrating services, including incorporating STI screening into family planning visits to ensure comprehensive care for clients. Additionally, there were suggestions to expand services beyond family planning to address other health needs, including providing prenatal care and addressing mental health and substance abuse disorders.

*“One of the things that the clinic manager and I have spoken about is to incorporate the people who are coming in for STI screening into family planning. Obviously, STI screening is a part of family planning if they’re coming for family planning, but to kind of put those people in under our Title X program and at least let them know that family planning services are available as well if they would be interested or in need of those.”*

### 2. Access to Contraceptive Options

While some participants expressed interest in offering long-acting reversible contraceptives (LARCs) like IUDs and implants, the decision often depends on provider preferences and client demand. However, there's recognition that offering a variety of contraceptive options is essential to meet diverse client needs effectively.

### 3. Expansion of Services

There was a consensus among participants about the potential for expanding services beyond family planning, including addressing mental health and substance use disorders, and increasing outreach to male clients. Creating designated spaces within healthcare facilities for mental health consultations and collaborating with addiction treatment centers are some strategies discussed to enhance access to these services.

*“I think we still need to focus on family planning services, but we could maybe expand a little bit. If they’re*

*coming in and they've got an earache or something like that, we could maybe have the time to be able to address those things as well. It'd be nice if we could do prenatal care again. I hate that we had to get away from that. But again, money, so. But it would be nice to provide that continuum of care."*

*"When we built the new health department, one of the exam rooms, it has a recliner. We call it our WIC room. But if there were a mental health provider that wanted to come out and provide services to people, they could meet their clients in there. We've got sound-deadening insulation in the walls of the exam rooms in between the patient care area and the waiting room and a door that locks so that we can control access. Because there are some people that don't want to go to the doctor's office and have to explain what they're there for, who they're there to see, or sit in the waiting room because people will [ask]: 'I hope you're doing okay. What's going on?'"*

As seen in the [quantitative analysis](#), there are some notable differences in the services provided to male clients in Title X programs. While STI testing is a primary service, there is a noted gap in comprehensive family planning services for male clients. Historically, family planning services have primarily targeted women, but recognizing the importance of addressing men's reproductive health needs is crucial for comprehensive care. Men's reproductive health encompasses a broad range of services including preconception health, infertility treatments, contraceptive options, STI care, and, in many states, Title X clinics are a vital source for providing pre-exposure prophylaxis PrEP ([Sales et al., 2021](#)). However, there are several challenges in effectively providing these services to men ([Besera, 2016](#)). One significant obstacle is the lower utilization of preventive health services by men compared to women. This could be due to various factors including societal norms, perceptions of masculinity, and healthcare-seeking behaviors. Additionally, there may be a lack of awareness among men about the importance of reproductive health services and their own reproductive health needs. As related by some providers:

*"We have men coming in for STI testing that either have been named as a contact or have symptoms. And then there are a few that just want to come in once a year and get screened."*

*"For all our men, we transfer them over from STI to our family planning program, and we do have a list of things that we go through with them and a handout we give them, talking about, "This is how you can get yourself as healthy as possible before pregnancy," because there are health effects just as much as a woman's."*

Another commented,

*I always tell the young guys, especially that come in-- well, any of them, 'Don't rely on your female partner for contraception. She might miss her pill. I mean, and not on any reason on purpose, but you need to be responsible for your body,' and all those things. So, I do go over that with the males that come in.'"*

While in some clinics, efforts are being made to bridge this gap by providing education and support beyond just testing, provider attitudes and practices also play a role in the underutilization of family planning services by men in other sites. Some healthcare providers may not routinely discuss reproductive health with male patients or may not be adequately trained to address men's specific reproductive health concerns (I. Rivera-Newberry, personal communication, April 8, 2024). As explained by one administrator:

*"We don't see men specifically in our family planning program here at the request of our provider."*

It should be noted that, for those programs that are not including STIs screening in their family planning statistics, very few males are counted as family planning clients.

It is promising that there are attempts to transfer male clients from STI services to family planning programs and provide them with relevant information and resources. However, there still seems to be room for improvement in engaging and serving male clients, and clients of the LGBTQ+ community, more comprehensively within these programs. For instance, while PrEP is covered if clinics want to carry it, this prophylactic medication is not offered consistently throughout the state (J. McDonald, personal communication, May 14, 2024). Addressing these challenges requires a multifaceted approach including education and awareness campaigns targeted towards men, training healthcare providers to effectively address men's reproductive health needs, and implementing policies that promote gender-inclusive reproductive health services.

#### 4. Communication and Outreach

Participants emphasized the importance of communication and outreach efforts to raise awareness of available services. Suggestions included national or state-level ad campaigns to promote local health department services and standardized reproductive health curricula in schools to educate youth about available resources.

*“In terms of outreach, probably [what would help] is a national campaign to just raise more awareness of services available at your local health department. That would bypass the approval of the local, because if we put out ads, we have to get approval from our Board of County Commissioners. But if it’s a national ad campaign, people are aware of that and just go, ‘Oh yeah, local health department exists. We have a local health department. I will go there for that service.’”*

*“It would be really nice if KDHE could have some commercials made, saying, ‘If you need family planning services, see your local health department,’ because some of it is that we are stifled a little bit because of our county commissioners. And if the state did it, then they could get the word out more.”*

*“I don’t know how it would be facilitated, but, hey, for KDHE, at that level, to make some short commercial kind of things. And they can do these in Spanish. They could do it in Burmese. They could do it in Haitian to kind of reach out to these people and reach a further, broader audience to say, ‘Hey, find your local health department. They have all these programs. Or if they don’t, they can help you get to what you need.’ We don’t have the funding for that.”*

## 5. State-Level Support

Participants highlighted the need for state-level support in various areas, including reproductive health education curricula and communication between health departments and the State Department of Education. Standardized curricula and improved communication channels could help ensure that youth are informed about available resources and services.

*“If the state of Kansas had a standardized reproductive health curriculum would be beneficial because, I mean, there’s a lot of kids who don’t know about the services that we offer.”*

Another suggested that KDHE could work with the State Department of Education to help improve health education, saying,

*“Maybe if there was more communication between KDHE and the Kansas Board of Education [they could] improve education. Or you can bring in people from the health department to provide your reproductive health education or provide some guidance on topics. I guess, ultimately, I would hope that Kansas would move towards having a more comprehensive reproductive health education included in the curriculum.”*

*By implementing these ideas and strategies, Title X providers, administrators, the state program, and policymakers can work together to enhance access to essential healthcare services and better meet the diverse needs of communities.*

## Supports for Title X Programs

The Early Detection Works (EDW) program emerged as a significant support system for Title X programs, particularly in facilitating access to essential women's health services. Participants in the focus groups highlighted several key aspects of the EDW program that contributed to its effectiveness in enabling the provision of quality family planning services:

### 1. Financial Support

Participants noted that the EDW program provided financial assistance for women's health services, including mammograms and Pap smears. This financial support helped alleviate the cost burden for patients, making it more feasible for them to access these critical screenings and services.

### 2. Language Accessibility

Participants highlighted the accessibility of the EDW program for Spanish-speaking patients. The program's support was instrumental in assisting Spanish-speaking patients, making it easier for them to access necessary screenings and care.

*“It pays for women’s health services...When we had a provider we would send the applications, and I feel like that would help them a lot and help them come in annually knowing that they would get that help from EDW. And there was a lot of Spanish-speaking patients that would get that, so that helped them a lot...there was a lot of Spanish-speaking patients in it.”*

*“We work closely with the Early Detection Works Program, which is through the state to help pay for mammograms, Pap smears. A lot of our Spanish population takes advantage of that program.”*

### 3. Collaboration and Coordination

There was recognition of the collaborative efforts between Title X programs and the EDW program. Working closely with EDW allowed Title X programs to streamline the application process and ensure that eligible patients received the necessary support for screenings and preventive care.

#### 4. Community Engagement

The EDW program's outreach efforts were noted as effective in reaching underserved populations, including Spanish-speaking communities. By raising awareness and providing financial assistance, the program helped more individuals access critical health services.

*Overall, the EDW program served as a valuable support system for Title X programs, offering financial assistance, language accessibility, and community outreach to enhance access to essential women's health services. Its success underscores the importance of collaboration and coordination between public health programs to address the needs of underserved populations effectively.*

## Barriers to Initiating or Maintaining Title X Programs

The barriers to initiating Title X services are multifaceted and present significant challenges to health departments. Participants highlighted the complexities involved in starting a Title X program, including paperwork, space limitations, and competing demands on resources. Additionally, stigma surrounding reproductive health services emerged as a pervasive barrier, with concerns about community perceptions and judgment hindering access to care.

### 1. Administrative Requirements

Space and Time Constraints Participants expressed frustration with the complexities involved in starting a Title X program, as well as the competing demands on their time and resources. As one administrator from a clinic not offering Title X services stated:

*“We’ve never had them [Title X services] at our office that I am aware of. It had always been we were limited by our space. There was no privacy in our old building and then also no time. We offer the WIC program. We do all infant immunizations up to adult immunizations. We do public health preparedness. It was just kind of a matter of lack of staff time, and it seemed like there was a lot of paperwork, or there were a lot of hoops to jump through that I didn’t have the time to look into or try to chip away at it.”*

*“We would be starting from scratch. We would need a provider to contract with to do the well-woman checks or standing orders. I don’t know how that would work if-- I guess I’m kind of naive on what the whole process would be to start up something like this.*

### 2. Lack of County Commission Support

Participants also reported tensions that have arisen with other county departments or with county commissioners over resource allocation fairness. Justifying the importance of the health department's services and navigating competing interests are ongoing challenges. As one administrator puts it:

*“And right now, I’m so busy putting out fires with other programs because with COVID, there was an infusion of money into public health. And so, I’ve got these big multiyear grants that I’m trying to spend the money on. And then there’s other county departments that are upset because it’s not fair that we get all this money and can’t that money be used on other things other than the health department...And it’s been a constant struggle in proving why we need the health department, why the services that we provide are important, and yeah, justifying everything.”*

### 3. Stigma and Misperceptions about Services

Stigma around reproductive health services emerged as a pervasive barrier to providing education and services. Participants noted that stigma often prevented individuals from seeking care and discussing reproductive health openly. This stigma extended to receiving services from the health department, with some participants expressing concerns about community perceptions and judgment. The reluctance to address reproductive health issues openly was compounded by challenges including resistance from school boards to implement comprehensive sex education programs.

*“There’s a lot of STIs that people aren’t getting checked for and aren’t taking the precautions for or getting treated...I know it’s always been bad, but those numbers about made me--I was like, “Oh, my goodness.” It’s scary. But people don’t want to talk about it because it’s so taboo. We don’t talk about that.” Another noted, “right now, our school board really isn’t a fan of sex ed in school, so they’re not going to let us change the program, and they’re not going to let us give brochures, and they’re not going to let us do whatever.”*

Participants also noted a rise in no-show appointments during the COVID-19 pandemic, possibly due to heightened fears and uncertainties surrounding health department visits. The pandemic also intensified tensions within communities, making discussions around reproductive health more contentious.

*“We have seen a rise in no-shows. And I don’t know if it was because of the stigma. Health departments got run through the runner during COVID, and so I don’t know if people just tried to avoid the health departments because there was already so much turmoil going on with the community and the health departments or what happened.”*

*“We’re in a really weird moment...it does seem as though folks are taking sides and there isn’t as much middle ground...When talking about social-emotional learning is triggering for folks, I just don’t even know how re-engaging in this sort of-- if I were to re-engage in this sort of discussion in communities, I do feel like school board meetings may be more wild, right?”*

Family planning programs may also deal with misconceptions regarding services they provide, particularly abortion. One participant described a situation where a client did not want to receive any services from an organization that provided abortions. The participant explained:

*“Just last week we had a patient coming in for an immunization service. It was a 19-year-old, but she brought her mom, and she was in the room where we keep our supplies to place IUDs...and so the nurse had gone in. She [client] was getting a TB test. Explained the TB test, went up to draw it up, and then they came back in, and they were really upset. The mother started asking the nurse, ‘Is this an abortion clinic? Do you perform abortions here?’ And she’s like, ‘No. That’s for an IUD.’ Because they didn’t want to get a TB test in the clinic if we were an abortion provider. And going back to educating the parents, that really hit the nail on the head. I mean, the misinformation, it makes it so much worse and so much harder for us to actually be effective at doing our job.”*

*The barriers of time, administrative requirements, lack of support, and stigma underscored the complex landscape that health departments navigate in providing Title X services. Addressing these barriers will require concerted efforts to reduce stigma, improve access to comprehensive sex education, and garner support from policymakers and community partners. It will also necessitate creative solutions to streamline administrative processes and allocate resources effectively to meet the diverse needs of communities.*

# Methodology

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The approach of the 2024 Kansas Title X Needs Assessment was designed to identify both strengths and needs of the program’s delivery system, and the family health needs of Kansans. Overall direction for Kansas’ 2024 Title X Needs Assessment was provided by the Family Planning and Reproductive Health Program Manager in the Bureau of Family Health, Children and Families Section, at KDHE, including input on the assessment process, identification of key populations for focus groups and individuals to participate in key informant interviews and group discussion, review of data, and the development of the final report and considerations. Additionally, the recommendations provided in the Quality Family Planning report, QFP([Gavin, 2016](#)), which provides recommendations for delivering quality family planning services, was used as a framework to inform the needs assessment and its findings and considerations. The Needs Assessment consisted of three primary information gathering processes: (1) review and analysis of public health surveillance data, including secondary quantitative data (e.g., Family Planning Annual Report), (2) qualitative data collected through a series of key informant interviews and group discussions with Title X service providers, and (3) analysis of patient records and services provided in DAISEY, an integrated data integration system used by KDHE. Key informants included reproductive health and maternal health disparity content experts, administrators of public health clinics offering Title X services, and administrators of public health clinics not offering Title X services. For the provider focus groups, we used a convenience sample of healthcare providers who currently practice in Kansas Title X clinics. Our sample included 23 healthcare providers from diverse training backgrounds, specialties, and demographics. Interviews and group discussions explored family planning and related preventive health service needs, including needs of vulnerable populations (Youth and Spanish-speaking); family planning systems and supports, including quality; strengths and challenges for family planning services; and opportunities for improvements and/or assets to be leveraged. Interview and focus group guides are available in Appendix I.

## Quantitative Data Collection and Analysis

### Primary Data Cleaning

The Kansas Title X program has been archiving both program and client data in the DAISEY system since 2015. The scope of this study encompasses data recorded from January 1, 2019, to November 30, 2023. Within DAISEY, the Title X program data consists of various client demographic details including birth date, gender, race, employment status, insurance, education, and income, among others, as well as details from program visits. During each visit, clinic staff document services provided to the client. DAISEY data was utilized to ascertain whether a client received a specific service within a given year. Subsequently, service rates are computed based on different characteristics or groups, including year, race, ethnicity, and by county, facilitating a granular analysis of service distribution.

### Secondary Data Collection

Secondary data sources were selected to understand general county-level reproductive health landscape and needs. Also, data on potential health disparities by geographic area and racial ethnicity were analyzed. The Assessment Team analyzed over 30 quantitative health indicators to assist with understanding health needs in Kansas counties and assessing priorities in each county, and collected quantitative secondary data from multiple sources, including KDHE, and the U.S. Census Bureau.

### Client Demographics

Following the data cleaning process, the Assessment Team analyzed the shifts in the number of unique clients served across the counties, identifying those with the most significant increases or decreases. Additionally, the team scrutinized the year-over-year percentage changes within various demographic segments, including race, gender, ethnicity, age group, education level, employment and marital status, insurance coverage, English proficiency, and poverty level. This analysis shed light on the evolving demographics of the Kansas Title X program's clients over time.

### Cluster Analysis

To uncover distinct profiles within the Kansas Title X client population, a cluster analysis was performed. Clustering is a way to classify raw data and search for hidden patterns that may exist in a data set. ([Ikotun et al., 2023](#)). The K-means algorithm, a partitioning method that segments clients into clusters based on the similarity of their characteristics, was utilized. The attributes

selected for this analysis included clients' age at enrollment, race, ethnicity, English proficiency, educational background, employment, insurance coverage, and marital status. These characteristics were standardized into z-scores to equalize the influence of each variable in the analysis.

### Service Utilization

The Assessment Team then calculated overall service rates in four categories: Screening, Testing, Treatment, Counseling, and Other Services. To assess whether service utilization varied across different client demographics, including gender, race, and ethnicity, as well as other variables like employment status, level of English proficiency, and insurance coverage, Chi-square tests were employed.

Moreover, the team employed multiple logistic regression models to investigate the influence of personal factors and county-level health indicators on the likelihood of clients receiving specific services, including screenings, testing, and treatments. This analytical approach provided a nuanced understanding of the determinants impacting service distribution and utilization within the Title X program.

### Geospatial Visualization and Gap Analysis

In addition to statistical analysis, geospatial evaluations were conducted to visually represent the prevalence of service needs and the distribution of Title X services throughout Kansas. County-level STI rates were compared with the Title X program's STI screening rates, pinpointing areas with disproportionately low screening yet high STI prevalence. Similarly, counties were marked to denote high teen pregnancy rates coupled with insufficient contraceptive counseling services, signaling regions where the need for these services is acute.

### Contextualization with County Health Outcomes

The Assessment Team enhanced the data analysis by comparing Title X service data with Kansas' health outcomes drawn from accessible public datasets. This parallel examination sought to uncover comparisons between service allocation and various health indices, including maternal health disparities, STI prevalence, and teen pregnancy. We employed data visualization techniques not only to illustrate unmet need but also to pinpoint areas with emerging service needs.

# Appendix I: Data Tables and Graphics

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*Notes:*

- 1. P values of  $<0.05$  are considered statistically significant*
- 2. Grayed out cells should be interpreted with caution for small sample size.*
- 3. Gold cells are findings highlighted in the report*

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## Reproductive Health Landscape and Needs

(10 counties with highest rates for each measure highlighted in gold)

**Table 1: Demographics by County**

County of Residence of Client	Served by Title X-funded clinic	Region	Income Inequality (Top-to-bottom Income Ratio) <sup>1</sup>	Diversity Index <sup>2</sup>	Population Density - Women 15-44 Years of Age <sup>3</sup>	(%) of all Women 18-49 that are Uninsured <sup>4</sup>	(%) Women 15-44 Years of Age by Race - Non-White <sup>5</sup>	HPSA Primary Care <sup>6</sup>
Allen		SE	15.1	22.6	4.3	11	8.4	13
Anderson		SE	11.4	14	2.2	12.3	5.2	8
Atchison		NE	10.7	26.8	7.4	10	8.5	14
Barber	Y	SC	9.4	18.3	0.6	15.4	6.4	15
Barton	Y	SC	17.6	36.2	5	16.4	6.5	8
Bourbon		SE	9.7	24.3	3.9	13.2	8.2	17
Brown		NE	12.1	33.6	2.7	12.6	16.6	7
Butler	Y	SC	13.8	28.1	8.4	11.3	7.7	6
Chase		NE	11.2	24.1	0.5	13.8	3.2	14
Chautauqua		SE	12.5	29.5	0.7	17.3	12.8	15
Cherokee		SE	13.3	28.7	5.7	13.7	12.1	17
Cheyenne		NW	9.7	26.7	0.4	16.9	4.9	7
Clark		SW	13.5	28.6	0.3	12.5	7.6	7
Clay	Y	NC	10	14.8	19	11.4	5	NA
Cloud	Y	NC	9.3	16.6	2	10.7	7.3	7
Coffey	Y	SE	7.9	15.6	2	9.5	6.7	NA
Comanche		SC	UN	18.6	0.3	14.5	7.4	NA
Cowley	Y	SC	10	40.6	5.5	13.2	12.7	19
Crawford	Y	SE	20	31.9	13.9	13.5	10.4	21
Decatur		NW	9.9	13.7	0.4	15.5	6.3	14
Dickinson		NC	9.1	19.7	3.6	13.1	6.9	16
Doniphan		NE	9.6	22.1	3.4	12	7.7	14
Douglas	Y	NE	14.6	41	66.5	10.5	19	18
Edwards	Y	SC	10.7	40.2	0.7	20.5	9.9	9
Elk		SE	10.8	20.1	0.5	20.1	8.7	16
Ellis		NW	13.4	24	7	11.7	7.6	9
Ellsworth	Y	NC	11.6	26.2	11	11.1	4.7	7
Finney	Y	SW	11.4	58.7	5.4	23.4	11	16
Ford		SW	10.5	53.8	5.7	24.3	8.3	5
Franklin	Y	NE	8.7	22.5	7.9	11	5.8	10
Gear	Y	NE	5.4	64.5	18	9.8	30.7	17
Gove		NW	11.3	16.1	0.4	17.9	4.4	7
Graham		NW	9.4	18.3	0.4	14.9	11	NA

Grant	Y	SW	8	53.3	2.3	22.1	5.4	14
Gray	Y	SW	12.9	30.7	1.3	23.9	5.4	11
Greeley		SW	UN	32.4	0.3	16.9	3.4	9
Greenwood		SE	13.4	18.9	0.8	13.3	6.6	15
Hamilton		SW	8.3	52.2	0.5	27	7.8	7
Harper	Y	SC	19	25.3	1	18	6.8	15
Harvey		SC	9.7	33.7	11.4	13.7	7.6	10
Haskell	Y	SW	10.2	44.7	1.2	27	7.1	14
Hodgeman		SW	11.3	19.1	0.3	16.9	11.5	NA
Jackson		NE	8	35.3	3.2	14.1	15.7	5
Jefferson		NE	7.5	18.5	5.6	11.6	5.2	NA
Jewell		NC	9.8	12.3	0.4	13	4.4	16
Johnson	Y	NE	21.4	41.5	249.6	8.4	16.3	17
Kearny	Y	SW	13.1	51.9	0.8	22.2	7.9	NA
Kingman	Y	SC	9.2	16.2	1.4	11.8	5.2	8
Kiowa	Y	SC	8.6	22.6	0.6	18	8	NA
Labette	Y	SE	11.1	35.4	4.8	14.9	12.1	17
Lane		SW	9.7	22.8	0.3	13.9	8	13
Leavenworth	Y	NE	6.9	40.2	30	9.6	14.7	12
Lincoln		NC	6.8	15.9	0.6	14.3	4.2	7
Linn		SE	8.3	15.9	2.5	14.2	4.7	9
Logan		NW	9.9	20.3	0.4	11.8	4.2	NA
Lyon		NE	10.5	47	8.8	17.8	11.6	20
Marion		SC	9.1	17.1	5.7	11	6.1	4
Marshall		NE	15	12	2.1	14.6	4.9	NA
McPherson	Y	SC	13.6	22.5	1.7	10.6	4.8	NA
Meade	Y	SW	12.4	39.3	0.7	21.3	4.8	7
Miami		NE	12	20.2	10	8.4	5.5	NA
Mitchell	Y	NC	12.2	11.9	1.3	11.1	4.4	15
Montgomery		SE	11.5	42.3	8.2	17.4	17.9	17
Morris	Y	NE	7.8	17	1.2	13.5	4.7	13
Morton	Y	SW	7	43.5	0.5	19.5	12.4	13
Nemaha		NE	20.7	12.1	2.3	9.2	3.8	11
Neosho	Y	SE	13	24.4	4.7	11.7	7.7	17
Ness		SW	8.9	25.1	0.4	19.7	7.5	7
Norton		NW	12	25.6	0.8	12.2	8.1	NA
Osage		NE	6.3	15.1	3.6	12.7	4.8	12
Osborne		NC	12.1	11.8	0.6	15.1	8.1	9
Ottawa		NC	8.4	15.4	1.2	10.9	4.4	NA
Pawnee	Y	SC	11.7	31	1.2	10.4	9.7	5
Phillips	Y	NW	11.1	13.8	0.9	12.4	5.4	13
Pottawatomie		NE	12	23.7	5.3	10.3	6.9	9

Pratt	Y	SC	13	25.3	2.1	14.2	8	14
Rawlins		NW	16.4	22.8	0.3	15.7	6.7	7
Reno	Y	SC	14.9	32.7	8.3	15.5	7.4	19
Republic	Y	NC	13.1	11.2	0.9	12.8	4.6	NA
Rice		SC	11.3	34.3	2.2	12.9	6.9	NA
Riley	Y	NE	15.2	46.2	32.4	10.7	17.3	15
Rooks	Y	NW	8.7	13.9	0.9	13.4	5.9	7
Rush		SC	7.9	13.5	0.6	12.8	6.4	12
Russell	Y	NC	11.9	18.2	1.1	14.8	7.1	15
Saline	Y	NC	17.5	39.7	13.4	13.6	10.9	17
Scott		SW	12.3	38.7	1.1	17	4	9
Sedgwick	Y	SC	20.5	55	101.9	16.4	21.7	19
Seward	Y	SW	9.2	49.5	6.7	27.7	10.2	14
Shawnee	Y	NE	13.6	47.8	59.2	11.3	18.6	10
Sheridan		NW	14.7	17.9	0.4	16.1	4.1	7
Sherman	Y	NW	10.3	32.6	1	11.2	5.1	13
Smith		NC	8.4	10.8	0.5	12.9	3.7	NA
Stafford	Y	SC	10.9	30.1	0.8	17.6	6	9
Stanton	Y	SW	18.6	54.3	0.5	21	12.3	13
Stevens		SW	12.3	52.3	1.3	25.2	5.4	14
Sumner	Y	SC	8.4	24.7	3.2	12.4	7	9
Thomas	Y	NW	10.7	23.3	1.4	12.6	6	9
Trego		NW	7.1	12.3	0.4	12.1	5.8	NA
Wabaunsee		NE	6.7	18.7	1.4	9.8	6.3	NA
Wallace		NW	UN	20.4	0.3	12	4.4	9
Washington	Y	NC	12	15.2	0.9	14.2	5.3	13
Wichita		SW	UN	48	0.5	20.9	6	5
Wilson		SE	13.9	20.2	2.3	13.5	7	17
Woodson		SE	9.8	15.2	1	16	5.3	NA
Wyandotte	Y	NE	6.5	70.8	215.6	22.2	34.6	19

*Data Sources:*

<sup>1</sup> *Economic Policy Institute.*

<sup>2</sup> *US. Census Bureau Demographic and Housing Characteristics File 2020.*

<sup>3</sup> *U.S. Census Population Estimates 2019.*

<sup>4</sup> *U.S. Census Small Area Health Insurance Estimates 2019.*

<sup>5</sup> *CDC WONDER Single-Race Population Estimates 2019.*

<sup>6</sup> *Health Resources and Services Administration, 2024.*

## Table 2: MCH and Reproductive Health Outcomes by County

(10 counties with highest rates for each measure highlighted in gold)

County Residence of Client	Served by Title X-funded clinic	Low Birth Weight (%) <sup>1</sup>	Preterm Births (%) <sup>2</sup>	Infant Mortality Rate (per 1,000) <sup>3</sup>	Prenatal Care in the 1st Trimester (%) <sup>4</sup>	Teen Pregnancy Rate per 1,000 (10-19 years; 2017-2021) <sup>5</sup>
Allen		6.9	9.8	8.4	78.8	13.3
Anderson		7.6	9.6	5.8	81	12.9
Atchison		7.2	9.6	6.2	80.8	8.1
Barber	Y	7	8.5	8.2	84.3	7.9
Barton	Y	6.2	9.7		84.8	15.7
Bourbon		7.1	10	6.8	77.9	13.8
Brown		6.3	8.1	6	80.1	13.4
Butler	Y	8	10.7	6.6	85.3	7.6
Chase		7.8	10.1	6.3	85.6	6.3
Chautauqua		7.5	11.1	6.8	77.9	18.3
Cherokee		7.8	10.4	6	77.5	14.3
Cheyenne		5.5	9.2		82.2	3.1
Clark		5.9	6.9	5.3	71.9	9.6
Clay	Y	7	8.8	6.4	82	6.1
Cloud	Y	6.4	8.8	8.9	87.5	15.8
Coffey	Y	8.3	10.3	5	83.3	7.2
Comanche		7.6	8		81.6	3.4
Cowley	Y	8	10.8	6.9	83.2	15.1
Crawford	Y	7.1	10.3	5.6	76.9	13.4
Decatur		7	9.8		82.5	4.6
Dickinson		7.4	9.3	6.7	82.8	8.4
Doniphan		8.1	9.5	6.2	80.2	7.7
Douglas	Y	7.7	9.4	6	84.1	6.6
Edwards	Y	6.3	7.4	20.4	74.4	6.6
Elk		7.7	10.7	5.7	81.8	9.4

Ellis		7.6	8.8		88.8	8
Ellsworth	Y	6.3	9.5	4.7	85.3	6.4
Finney	Y	8.7	10.3	6.2	67.7	17
Ford		6	6.5	4.6	70.5	27.2
Franklin	Y	7.5	9.5	5.7	83.5	12.3
Geary	Y	6.8	8.6	5.4	81.3	32.1
Gove		5.6	10		83.5	0
Graham		10.2	10.2		83.8	6.2
Grant	Y	7.4	10.9		71.8	18.9
Gray	Y	7.5	8.7	5.6	73.7	4.7
Greeley		9	11.7		66.7	10.9
Greenwood		8.1	10.1	10.2	85.3	9.2
Hamilton		8.5	10.9		68.9	25
Harper	Y	6.1	8.8	8.5	84.5	11.9
Harvey		7.9	10.6	6.7	85.4	11.3
Haskell	Y	7.7	9.6	6.5	70.4	13.3
Hodgeman		6.2	8.7	5.5	71.5	3.3
Jackson		6.7	9.5	6.6	80.7	13.3
Jefferson		7.2	9.5	7	82.7	7.4
Jewell		6.2	9.4		87.9	8.5
Johnson	Y	6.8	9	4.4	90.3	4.9
Kearny	Y	8.8	11.1	6.7	71.6	11
Kingman	Y	8.1	10.7	7	84.8	6.5
Kiowa	Y	6.2	6.8	5.1	73.9	10.7
Labette	Y	6.5	9.8	5.8	78.3	15.9
Lane		8.3	10.8	6.1	71.5	10.5
Leavenworth	Y	7.1	9.3	7	86.8	9.3
Lincoln		7	9.7	6.6	86.4	3.2
Linn		7.1	9.5	4.7	80	15.1

Logan		6.4	10.4		81.2	13.1
Lyon		8.3	10.2	8.2	83.7	11.2
Marion		5.7	9.9	6.2	84.8	8.3
Marshall		7	9.8	6.5	86.1	7.6
McPherson	Y	6.5	8.5	6.3	82.9	6
Meade	Y	6.2	7.5	5.8	71.8	6.9
Miami		6.6	9.1	4.3	87.4	8.2
Mitchell	Y	6.6	9.2	9	88.8	7.6
Montgomery		8	10.1	5.4	78.2	15.3
Morris	Y	7.5	9.1	6.6	82.2	4.6
Morton	Y	6.4	9	7.2	69.4	24.8
Nemaha		5.8	7.8	5.1	80.8	7.1
Neosho	Y	7.2	10	6.1	78.4	14.3
Ness		6.7	10.4		83.5	7.1
Norton		10.1	9.2		80.7	8.8
Osage		7.8	10	7.1	82.2	10.2
Osborne		7.1	8.9		89.5	9.6
Ottawa		7.3	10.1	8.3	86	3.4
Pawnee	Y	6.7	10.2	5.5	83.1	19.6
Phillips	Y	8	9.1		84.6	4.4
Pottawatomie		6.4	8.6	6.5	80.8	5.4
Pratt	Y	7	9.7	10.7	82	11.3
Rawlins		5.5	9.6		81.5	4.6
Reno	Y	7.7	10.6	6.7	85	12.6
Republic	Y	6.7	9.2		85.9	4.6
Rice		6.6	9.8	4.1	83.2	9.6
Riley	Y	6.5	8.4	5.3	81.3	7.5
Rooks	Y	7.8	8.8		88.4	8.3
Rush		7.2	9.5		86.3	4.7

Russell	Y	6.7	9		86.9	11.6
Saline	Y	7.1	9.8	7	85.9	13.2
Scott		8.5	10.9	5.5	73.7	12.4
Sedgwick	Y	8.2	10.8	6.8	85.2	14.6
Seward	Y	6.2	8.3	7.4	69	22.6
Shawnee	Y	7.6	10	6.7	81.6	14.8
Sheridan		6	9.4		82	6
Sherman	Y	6.2	10.1		80.2	10.8
Smith		6.7	9.3		87.2	8
Stafford	Y	6.7	10.2	6.2	82.2	12.4
Stanton	Y	7.9	10.6	7.3	68.9	8.6
Stevens		6.5	8.3	7.5	69.1	10.7
Sumner	Y	7.7	10.8	7.1	84.2	10.2
Thomas	Y	5.2	9.1		81.6	7.4
Trego		7.8	9.2		88.2	9.9
Wabaunsee		7.4	9.1	6.8	81	7.5
Wallace		7.4	10.4		77	1.8
Washington	Y	6.9	9.2	7.4	83.4	4.7
Wichita		7.9	10.7		77.5	5.9
Wilson		8	10.2	5.5	80.5	13.6
Woodson		7.5	9.8	7.2	81.7	20.4
Wyandotte	Y	9.2	10.7	6.8	74.8	21.7

*Data Sources:*

<sup>1-2</sup> CDC WONDER Natality 2018-2021.

<sup>3</sup> CDC WONDER Cause of Death 2018-2021.

<sup>4</sup> HRSA 2017-2019 (combined).

<sup>5</sup> US Census Bureau ACS 5-year 2017-2021.

### Table 3: STI Rates by County

(10 counties with highest rates for each measure highlighted in gold)

County Residence of Client	Served by Title X	STI Rate (cases per 1,000) (2022) <sup>1</sup>	Chlamydia Rate Per 100,000 (2021) <sup>2</sup>	Gonorrhea Rate per 100,000 (2021) <sup>3</sup>	Primary and Secondary Syphilis Rate (2021) <sup>4</sup>
Allen		3.3	248.7	56.2	16
Anderson		3.6	205.7	12.9	0
Atchison		4.7	326.4	86.2	0
Barber	Y	2.2	243.3	48.7	24.3
Barton	Y	4.8	392.6	55.5	4
Bourbon		4.8	607.4	139.6	0
Brown		2.9	338.4	116.3	21.2
Butler	Y	5.1	493.5	167.9	2.9
Chase		0.8	192.5	0	0
Chautauqua		2.3	294.6	58.9	0
Cherokee		5.2	250.9	167.3	15.7
Cheyenne		1.2	189.9	0	0
Clark		1	151.7	151.7	0
Clay	Y	2.2	235.2	37.1	0
Cloud	Y	4.1	201.6	33.6	0
Coffey	Y	2.4	263.9	60	0
Comanche		4.2	179.6	0	0
Cowley	Y	5.3	414.5	202.9	5.8
Crawford	Y	7	588.1	232.7	5.1
Decatur		0.7	109.1	0	0
Dickinson		1.8	216.7	48.8	5.4
Doniphan		5	281.1	120.5	13.4
Douglas	Y	8.7	598.2	161.7	5.9
Edwards	Y	1.8	317.8	0	0
Elk		2.9	245.8	122.9	0

Ellis		4.4	493.2	128.5	3.5
Ellsworth	Y	1.4	268.3	94.7	0
Finney	Y	6.3	695.4	162.7	5.2
Ford		6.6	500.6	79	11.7
Franklin	Y	4.9	354	69.3	7.7
Geary	Y	15.1	1380.3	384	25
Gove		1.5	0	36.3	0
Graham		5	250	83.3	0
Grant	Y	3.3	300.4	81.9	0
Gray	Y	3	265.8	35.4	0
Greeley		0.8	383.4	0	0
Greenwood		1.5	235.7	33.7	16.8
Hamilton		0.8	201.3	40.3	0
Harper	Y	3.6	318.9	75	18.8
Harvey		4.8	366.7	150.8	11.8
Haskell	Y	2.8	136.3	27.3	0
Hodgeman		1.1	233.9	0	0
Jackson		4.4	362	196.1	0
Jefferson		3.7	222.7	86.9	10.9
Jewell		1.7	0	0	0
Johnson	Y	4.6	369.4	96.7	12.2
Kearny	Y	2.1	506.1	192.4	10.3
Kingman	Y	1.4	488.3	77.1	0
Kiowa	Y	1.7	230	54.1	27.1
Labette	Y	6	501.7	0	0
Lane		2.6	441.9	276.2	5
Leavenworth	Y	5	63.9	0	0
Lincoln		1.7	416.1	119.2	7.3
Linn		2.6	172.2	103.3	0

Logan		0.7	277	41	0
Lyon		7.1	110.2	36.7	0
Marion		1.5	537.5	112.5	0
Marshall		2.8	230.5	93.9	0
McPherson	Y	3	170.4	10	0
Meade	Y	3.3	378.2	136	3.3
Miami		3.7	198.9	49.7	24.9
Mitchell	Y	1.9	309.3	60.7	0
Montgomery		6.6	208.8	52.2	0
Morris	Y	2.6	462.2	266.4	19.3
Morton	Y	3.1	224	0	0
Nemaha		1.8	260	111.4	0
Neosho	Y	2.8	146.8	68.5	0
Ness		3	354.8	44.3	6.3
Norton		1.7	149.7	0	0
Osage		1.5	224.6	18.7	0
Osborne		2.3	209.3	63.4	0
Ottawa		1.6	57.2	57.2	28.6
Pawnee	Y	2.9	154.2	102.8	0
Phillips	Y	2.5	192.8	80.3	0
Pottawatomie		3.2	103.8	41.5	0
Pratt	Y	3.5	166.7	62	0
Rawlins		0.4	305	87.1	0
Reno	Y	5.3	78.5	78.5	0
Republic	Y	1.9	468.9	136.8	3.3
Rice		1.9	85.8	0	21.5
Riley	Y	9	394	74.5	0
Rooks	Y	1.7	673.1	130.2	1.4
Rush		1	165.6	0	20.7

Russell	Y	1.7	101.6	0	0
Saline	Y	5.1	193.9	119.3	0
Scott		2.6	421.2	278.4	9.3
Sedgwick	Y	9.3	272.9	19.5	0
Seward	Y	6.4	639.7	362.7	17.6
Shawnee	Y	12.3	505.8	115	0
Sheridan		1.6	816.2	389.3	4.5
Sherman	Y	3.4	242.1	40.4	0
Smith		1.1	305.3	50.9	0
Stafford	Y	1.8	83.9	0	0
Stanton	Y	0.5	148.7	0	0
Stevens		3.1	195.7	48.9	0
Sumner	Y	3.9	264.5	0	0
Thomas	Y	2.3	451.2	151.9	4.5
Trego		0.4	380.9	88.9	0
Wabaunsee		1.1	179	35.8	0
Wallace		UN	172.3	100.5	0
Washington	Y	2.5	66.3	0	0
Wichita		1.5	145.2	72.6	0
Wilson		3.9	96.1	96.1	0
Woodson		2.9	304.9	164.2	0
Wyandotte	Y	13.8	225.7	128.9	0

Data Sources:

<sup>1</sup> Kansas Health Matters 2022.

<sup>2-4</sup> CDC NCHHSTP AtlasPlus 2021.

## Table 4: Reproductive and Maternal Vulnerability Index by County

(Counties with the highest Reproductive Vulnerability Index and highest Maternal Vulnerability Index highlighted in gold)

The Maternal Vulnerability Index (MVI)<sup>a</sup> is an index designed to quantify area-level indicators of maternal vulnerability to adverse maternal health outcomes. Developed by Surgo Ventures, the MVI is based on a literature review of publications (reports, working papers, books, scientific manuscripts, and review articles) from 2000 through 2020 identifying 43 county-level indicators factors associated with US maternal mortality and morbidity. It ranks counties and states in terms of vulnerability to poor pregnancy outcomes on overall vulnerability and six themes: reproductive healthcare, physical health, mental health & substance abuse, general healthcare, socioeconomic determinants, and physical environment. The MVI assigns a score 0-100 to each county, where a higher score indicates greater vulnerability to adverse maternal outcomes.

County Residence of Client	Served by Title X	MVI (Reproductive)	MVI Category- Reproductive	MVI (Mental Health and Substance Abuse)	MVI Category (Mental Health and Substance Abuse)	MVI (Overall)	MVI Category- Overall
Allen		26	Low			46	Moderate
Anderson		68	High			54	Moderate
Atchison		33	Low			50	Moderate
Barber	Y	61	High			44	Moderate
Barton	Y	39	Low			50	Moderate
Bourbon		70	High			68	High
Brown		21	Low			17	Very Low
Butler	Y	56	Moderate			29	Low
Chase		69	High			32	Low
Chautauqua		46	Moderate			44	Moderate
Cherokee		63	High			71	High
Cheyenne		55	Moderate			25	Low
Clark		86	Very High			41	Moderate
Clay	Y	20	Very Low			11	Very Low
Cloud	Y	67	High			51	Moderate
Coffey	Y	28	Low			29	Low
Comanche		79	High			16	Very Low
Cowley	Y	32	Low			52	Moderate
Crawford	Y	39	Low			56	Moderate
Decatur		80	Very High			39	Low
Dickinson		55	Moderate			40	Moderate

Doniphan		65	High	48	Moderate
Douglas	Y	33	Low	29	Low
Edwards	Y	74	High	28	Low
Elk		77	High	59	Moderate
Ellis		58	Moderate	37	Low
Ellsworth	Y	56	Moderate	39	Low
Finney	Y	36	Low	48	Moderate
Ford	Y	70	High	55	Moderate
Franklin	Y	21	low	30	Low
Geary	Y	28	Low	48	Moderate
Gove		57	Moderate	29	Low
Graham		87	Very High	37	Low
Grant	Y	27	Low	35	Low
Gray	Y	83	Very High	37	Low
Greeley		87	Very High	34	Low
Greenwood		45	Moderate	42	Moderate
Hamilton		87	Very High	54	Moderate
Harper	Y	49	Moderate	47	Moderate
Harvey		33	Low	17	Very Low
Haskell	Y	68	High	53	Moderate
Hodgeman		86	Very High	32	Low
Jackson		21	Low	36	Low
Jefferson		62	High	25	Low
Jewell		85	Very High	34	Low
Johnson	Y	20	Low	2	Very Low
Kearny	Y	45	Moderate	43	Moderate
Kingman	Y	45	Moderate	33	Low
Kiowa	Y	73	High	31	Low
Labette	Y	40	Moderate	63	High
Lane		87	Very High	32	Low
Leavenworth	Y	45	Moderate	45	Moderate
Lincoln		71	High	25	Low
Linn		59	Moderate	73	High
Logan	Y	74	High	31	Low
Lyon		67	High	51	Moderate
Marion		68	High	36	Low
Marshall		27	Low	20	Very Low
McPherson	Y	48	Moderate	14	Very Low
Meade	Y	65	High	45	Moderate

Miami		45	Moderate	26	Low
Mitchell	Y	23	Low	21	Low
Montgomery		46	Moderate	72	High
Morris	Y	25	Low	23	Low
Morton	Y	67	High	45	Moderate
Nemaha		32	Low	8	Very Low
Neosho	Y	33	Low	58	Moderate
Ness	Y	87	Very High	35	Low
Norton		61	High	27	Low
Osage		67	High	49	Moderate
Osborne		39	Low	22	Low
Ottawa		77	High	17	Very Low
Pawnee	Y	65	High	26	Low
Phillips	Y	77	High	29	Low
Pottawatomie		23	Low	10	Very Low
Pratt	Y	27	Low	18	Very Low
Rawlins		86	Very High	23	Low
Reno	Y	56	Moderate	48	Moderate
Republic	Y	38	Low	15	Very Low
Rice	Y	66	High	42	Moderate
Riley	Y	42	Moderate	38	Low
Rooks	Y	29	Low	18	Very Low
Rush		86	Very High	28	Low
Russell	Y	60	High	35	Low
Saline	Y	37	Low	35	Low
Scott		58	Moderate	24	Low
Sedgwick	Y	35	Low	46	Moderate
Seward	Y	38	Low	51	Moderate
Shawnee	Y	39	Low	41	Moderate
Sheridan		85	Very High	22	Low
Sherman	Y	50	Moderate	43	Moderate
Smith		46	Moderate	17	Very Low
Stafford	Y	56	Moderate	40	Low
Stanton	Y	30	low	20	Low
Stevens		89	Very High	60	Moderate
Sumner	Y	57	Moderate	46	Moderate
Thomas	Y	44	Moderate	33	Low
Trego		76	High	19	Very Low
Wabaunsee	Y	71	High	17	Very Low

Wallace		86	Very High	34	Low
Washington	Y	13	Very Low	6	Very Low
Wichita		87	Very High	39	Low
Wilson		76	High	57	Moderate
Woodson		78	High	58	Moderate
Wyandotte	Y	12	Very Low	81	Very High

<sup>a</sup>Data source: Surgo Ventures Note. <https://mvi.surgoventures.org/>

## Table 5: Contraceptive Prescriber to Population Ratio by County

Counties with higher ranks (lower ratios) are highlighted in gold.

Note: Counties with a prescriber-to-population ratio lower than 39 are considered to have a lack of contraception prescribers and are highlighted in the table.

County	Served by Title X	Prescriber to pop ratio
Jewell		0
Wabaunsee		0
Doniphan		15
Meade	Y	15
Stafford	Y	17
Gray	Y	18
Woodson		21
Cherokee		21
Miami		24
Franklin	Y	24
Marshall		26
Chase		26
Osage		27
Jefferson		29
Leavenworth	Y	29
Riley	Y	29
Rawlins		29
Elk		31
Douglas	Y	31
Stevens		31
Dickinson		33
Ford		33
Ottawa		35
Sumner	Y	36
Butler	Y	39
Comanche	Y	39
McPherson	Y	39
Osborne		40
Bourbon		40
Anderson		40
Cloud	Y	41

Seward	Y	42
Lyon		42
Haskell	Y	42
Chautauqua	Y	43
Wallace		43
Geary	Y	46
Greenwood		46
Linn		46
Lincoln		47
Edwards	Y	47
Reno	Y	47
Rice		49
Phillips	Y	49
Kingman	Y	51
Decatur	Y	51
Sheridan		51
Ellis		52
Pottawatomie		52
Johnson	Y	52
Grant	Y	53
Atchison		53
Sedgwick	Y	55
Mitchell	Y	55
Pawnee	Y	56
Marion		57
Graham		57
Cowley	Y	58
Shawnee	Y	60
Finney	Y	60
Morris	Y	60
Wichita		61
Montgomery		62
Wyandotte	Y	64
Allen		64
Brown		65
Hamilton		66
Harvey		68
Sherman	Y	68
Coffey	Y	68

Crawford	Y	69
Kiowa	Y	71
Jackson		71
Clay	Y	71
Rush		71
Norton		72
Trego	Y	75
Labette	Y	76
Russell	Y	77
Saline	Y	78
Morton	Y	79
Nemaha		80
Neosho	Y	80
Thomas	Y	84
Rooks	Y	88
Wilson		89
Washington	Y	89
Barton	Y	93
Republic	Y	96
Pratt	Y	97
Ellsworth	Y	100
Harper	Y	100
Ness		100
Gove		102
Scott		114
Stanton	Y	114
Barber	Y	119
Kearny	Y	129
Cheyenne		129
Logan		132
Smith		143
Lane		169
Clark		182
Hodgeman		226
Greeley		244

*Data Source: Fitzhugh Mullan Institute for Health Workforce Equity.*

# Title X Client Description

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**Table 6: Number of Clients Served by Kansas Title X 2019-2023**

Year	Number of clients served
2019	13,466
2020	12,920
2021	12,884
2022	13,230
2023	12,326

*Note. Data source is DAISEY. 2019 and 2020 do not include data from some large grantees who submitted aggregated data to KDHE or HRSA.*

**Table 7: Change of Title X Clients by County over 2021-2023  
Timeframe**

	2021, N = 12,867	2022, N = 13,133	2023, N = 10,811	Changes 2021- 2023	% of Change 2021-2023	
Washington County HD	12	5	0	-12	-100%	
Wabaunsee County HD	11	4	0	-11	-100%	
Trego County HD	9	5	0	-9	-100%	
Pottawatomie County HD	22	0	0	-22	-100%	
Lawrence-Douglas County HD	1,079	1,180	288	-791	-73%	
Cloud County HD	85	49	32	-53	-62%	
Morris County HD	16	11	7	-9	-56%	
Edwards County HD	27	20	12	-15	-56%	
Rice County HD	33	28	15	-18	-55%	
Kearny County HD	10	10	5	-5	-50%	
Logan County HD	11	8	6	-5	-45%	
Reno County HD	532	397	302	-230	-43%	
Coffey County HD	47	40	27	-20	-43%	
Grant County HD	142	123	82	-60	-42%	
Johnson County HD	1,784	1,763	1,033	-751	-42%	
Butler County HD	116	78	70	-46	-40%	
Sherman County HD	91	85	55	-36	-40%	
Kiowa County HD	30	24	19	-11	-37%	
Sedgwick County HD	2,476	1,821	1,641	-835	-34%	
Pratt County HD	186	167	130	-56	-30%	
Morton County HD	78	71	55	-23	-29%	
Leavenworth County HD	488	500	348	-140	-29%	
Rooks County HD	51	41	37	-14	-27%	
Franklin County HD	159	153	120	-39	-25%	
Meade County HD	82	75	62	-20	-24%	
Ellsworth County HD	49	35	38	-11	-22%	
Stafford County HD	50	52	39	-11	-22%	
City-Cowley County HD	297	281	236	-61	-21%	
McPherson County HD	153	138	122	-31	-20%	
Thomas County HD	55	45	44	-11	-20%	
Kingman County HD	81	72	65	-16	-20%	
Crawford County HD	118	97	95	-23	-19%	
Clay County HD	31	29	25	-6	-19%	
Harper County HD	62	53	53	-9	-15%	
Pawnee County HD	64	66	56	-8	-13%	
Gray County HD	8	7	7	-1	-13%	
Finney County HD	1,000	854	879	-121	-12%	
Mitchell County HD	66	45	59	-7	-11%	
Neosho County HD	142	125	128	-14	-10%	
Barber County HD	33	22	30	-3	-9%	
Saline County HD	209	217	200	-9	-4%	
Russell County HD	29	27	28	-1	-3%	
Seward County HD	312	354	306	-6	-2%	
Stanton County HD	48	44	49	1	2%	
Phillips County HD	34	37	36	2	6%	
Haskell County HD	14	31	15	1	7%	
Konza CHC	807	906	891	84	10%	
Barton County HD	374	437	419	45	12%	
Sumner County HD	33	35	37	4	12%	
Riley County HD	625	876	831	206	33%	
Ness County HD	11	26	17	6	55%	
Unified Government Public Health Department	585	1,440	1,596	1011	173%	
Shawnee Co Health Agency	0	124	153	153		
Republic County HD	0	0	10	10		
Heartland Medical Clinic	0	0	1	1		
Decatur County HD	0	0	0	0		
Comanche County HD	0	0	0	0		
Chautauqua County HD	0	0	0	0		

Data source: DAISEY. Douglas County Lawrence had some data processing issues, so the count is unreliable.

## Table 8: Kansas Title X Client Demographics 2019-2023

Characteristic	2019, N = 13,466	2020, N = 12,920	2021, N = 12,884	2022, N = 13,230	2023, N = 11,065
<b>Age</b>					
<15	132 (1.0%)	119 (0.9%)	110 (0.9%)	181 (1.4%)	195 (1.8%)
15-17	505 (3.8%)	483 (3.7%)	422 (3.3%)	481 (3.6%)	487 (4.4%)
17-19	1,121 (8.3%)	967 (7.5%)	904 (7.0%)	905 (6.8%)	798 (7.2%)
19-25	3,797 (28%)	3,624 (28%)	3,435 (27%)	3,318 (25%)	2,636 (24%)
25-35	4,451 (33%)	4,327 (34%)	4,219 (33%)	4,371 (33%)	3,591 (33%)
35-45	2,567 (19%)	2,554 (20%)	2,793 (22%)	2,864 (22%)	2,390 (22%)
>45	879 (6.5%)	840 (6.5%)	995 (7.7%)	1,099 (8.3%)	938 (8.5%)
<b>Race</b>					
White	11,054 (82%)	10,528 (81%)	10,297 (80%)	10,044 (76%)	8,343 (75%)
Black or African American	1,460 (11%)	1,422 (11%)	1,573 (12%)	1,716 (13%)	1,503 (14%)
Asian	184 (1.4%)	182 (1.4%)	192 (1.5%)	226 (1.7%)	190 (1.7%)
American Indian or Alaskan Native	74 (0.5%)	78 (0.6%)	64 (0.5%)	80 (0.6%)	60 (0.5%)
Native Hawaiian or Other Pacific Islander	48 (0.4%)	51 (0.4%)	37 (0.3%)	61 (0.5%)	38 (0.3%)
Multiracial	646 (4.8%)	659 (5.1%)	721 (5.6%)	1,103 (8.3%)	931 (8.4%)
<b>Ethnicity</b>					
Hispanic or Latino	4,935 (38%)	4,680 (37%)	5,017 (40%)	5,371 (42%)	4,699 (44%)
Not Hispanic or Latino	8,095 (62%)	7,948 (63%)	7,536 (60%)	7,354 (58%)	6,011 (56%)
White Hispanic					
White-Hispanic	4,580 (42%)	4,271 (41%)	4,532 (45%)	4,623 (47%)	4,040 (49%)
White-non-Hispanic					
White-non-Hispanic	6,247 (58%)	6,118 (59%)	5,604 (55%)	5,220 (53%)	4,167 (51%)
<b>Primary Language</b>					
English	10,862 (81%)	10,450 (81%)	10,182 (79%)	10,111 (76%)	8,329 (75%)
Spanish	2,427 (18%)	2,297 (18%)	2,518 (20%)	2,848 (22%)	2,512 (23%)
Other	175 (1.3%)	170 (1.3%)	183 (1.4%)	271 (2.0%)	221 (2.0%)
LEP	2,248 (17%)	2,036 (16%)	2,252 (18%)	2,701 (21%)	2,322 (21%)

**Gender**

Female	11,993 (89%)	11,660 (90%)	11,518 (89%)	11,538 (87%)	9,652 (87%)
Male	1,471 (11%)	1,257 (9.7%)	1,365 (11%)	1,691 (13%)	1,397 (13%)

**Education**

<12 Years	3,100 (30%)	2,903 (29%)	2,533 (24%)	2,896 (26%)	2,741 (28%)
High School Diploma or GED	4,766 (46%)	4,454 (45%)	5,447 (52%)	5,236 (47%)	4,682 (48%)
Associate degree or Vocational Certification/License	903 (8.7%)	783 (7.8%)	820 (7.8%)	830 (7.5%)	787 (8.0%)
College-No Degree	1,130 (11%)	1,265 (13%)	1,194 (11%)	1,356 (12%)	994 (10%)
Bachelor's degree or higher	482 (4.6%)	575 (5.8%)	572 (5.4%)	785 (7.1%)	611 (6.2%)

**Employment Status**

Unemployed	4,531 (40%)	4,153 (39%)	4,086 (38%)	4,206 (38%)	3,540 (36%)
Part-time or occasional	2,554 (23%)	2,463 (23%)	2,431 (23%)	2,314 (21%)	2,188 (22%)
Full-time	4,188 (37%)	3,920 (37%)	4,165 (39%)	4,447 (41%)	4,184 (42%)

**Marital Status**

Single	8,838 (72%)	8,241 (72%)	8,723 (74%)	9,016 (75%)	7,780 (75%)
Married	2,953 (24%)	2,820 (24%)	2,617 (22%)	2,599 (22%)	2,323 (22%)
Separated/Divorced/Widowed	489 (4.0%)	453 (3.9%)	424 (3.6%)	382 (3.2%)	322 (3.1%)

**Insurance**

None/Self pay	9,162 (68%)	8,221 (64%)	8,024 (63%)	8,050 (62%)	6,408 (58%)
private insurance	2,746 (20%)	2,979 (23%)	2,849 (22%)	2,848 (22%)	2,385 (22%)
public insurance	1,498 (11%)	1,593 (12%)	1,827 (14%)	2,178 (17%)	2,214 (20%)
Living below Federal Poverty Line	5,168 (76%)	7,440 (72%)	8,055 (72%)	7,722 (69%)	6,379 (69%)

Data source: DAISEY

# Overall Services Provided by Kansas Title X Clinics 2019-2023

Table 9: Service Counts and Proportion of Clients Receiving Service

Service	Type	2019, N = 13,414	2020, N = 12,871	2021, N = 12,867	2022, N = 13,133	2023, N = 10,811
<b>Screening</b>	Depression	42%	36%	36%	44%	52%
	Anxiety	0%	<0.1%	<0.1%	19%	37%
	Hypertension	38%	39%	40%	40%	41%
	Mental Health	32%	27%	33%	30%	40%
	Human Trafficking	24%	23%	24%	28%	35%
	Intimate Partner Violence	36%	34%	35%	34%	40%
	Other	25%	24%	26%	25%	27%
	Alcohol	47%	44%	44%	48%	57%
	Tobacco	48%	45%	44%	45%	61%
	SUD	44%	38%	39%	45%	56%
<b>Testing</b>	Chlamydia	42%	44%	49%	50%	54%
	Gonorrhea	42%	44%	49%	50%	54%
	Syphilis	24%	22%	30%	33%	37%
	Other STI	4.3%	5.2%	6.2%	10%	11%
	Pregnancy	31%	32%	36%	36%	36%
	HIV	24%	22%	30%	33%	37%
	Pap	20%	19%	21%	21%	20%
	Clinical Breast Exam	38%	34%	33%	31%	28%
	Diabetes	14%	15%	19%	20%	24%
<b>Treatment</b>	STI Treatment	2.4%	6.9%	7.0%	8.8%	8.6%
<b>Counseling</b>	Alcohol Use	2.5%	5.1%	4.0%	3.3%	2.2%
	Tobacco Use	4.6%	6.0%	4.9%	4.7%	4.5%
	Depression	2.1%	3.4%	4.3%	2.6%	3.2%
	Hypertension	1.7%	2.4%	3.1%	2.1%	2.2%
	Mental Health	1.7%	2.9%	4.2%	1.8%	2.6%
	Achieve Pregnancy	0%	0%	0%	0%	0.7%
	Contraceptive	55%	58%	55%	53%	61%
	Human Trafficking	1.0%	1.8%	2.6%	0.6%	0.8%

	Counseling General	38%	0%	0%	0%	0%
	Teen Contraceptive Counseling	57%	63%	64%	60%	49%
<b>Other Service</b>	Contraceptive Follow Up	55%	58%	55%	52%	47%
	Help Insurance	16%	15%	18%	18%	14%
	Education	63%	67%	74%	70%	65%

Data source: DAISEY

# Tables 10a-f: Services Provided by Gender, Gender Identity, and Sexual Orientation

**Table 10a: Screening Services Provided by Gender**

	Female, N = 55,940	Male, N = 7,135	*p-value
Depression	23,699 (42%)	2,565 (36%)	<0.001
Anxiety	5,496 (9.8%)	992 (14%)	<0.001
Mental Health	18,704 (33%)	1,517 (21%)	<0.001
Human Trafficking	15,196 (27%)	1,514 (21%)	<0.001
Intimate Partner Violence	20,787 (37%)	1,664 (23%)	<0.001
Alcohol	26,091 (47%)	4,116 (58%)	<0.001
Tobacco	26,404 (47%)	3,899 (55%)	<0.001
SUD	24,186 (43%)	3,804 (53%)	<0.001
Hypertension	22,240 (40%)	2,650 (37%)	<0.001
Other	15,130 (27%)	870 (12%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

**Table 10b: Testing Services Provided by Gender**

	Female, N = 55,940	Male, N = 7,135	*p-value
Chlamydia	25,117 (45%)	4,916 (69%)	<0.001
Gonorrhea	24,956 (45%)	4,922 (69%)	<0.001
Syphilis	14,399 (26%)	3,923 (55%)	<0.001
HIV	14,272 (26%)	3,943 (55%)	<0.001
Diabetes	10,405 (19%)	1,090 (15%)	<0.001
Other STI	3,367 (6.0%)	1,254 (18%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

**Table 10c: Counseling Services Provided by Gender**

	Female, N = 55,940	Male, N = 7,135	*p-value
Alcohol Use	1,954 (3.5%)	227 (3.2%)	0.2
Tobacco Use	2,874 (5.1%)	247 (3.5%)	<0.001
Depression	1,866 (3.3%)	97 (1.4%)	<0.001
Hypertension	1,343 (2.4%)	101 (1.4%)	<0.001
Mental Health	1,573 (2.8%)	86 (1.2%)	<0.001
Achieve Pregnancy	78 (0.1%)	3 (<0.1%)	0.031
Contraceptive	4,426 (7.9%)	89 (1.2%)	<0.001
Human Trafficking	839 (1.5%)	23 (0.3%)	<0.001
Counseling General	4,594 (8.2%)	489 (6.9%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

**Table 10d: Other Services Provided by Gender**

	Female, N = 55,940	Male, N = 7,135	p-value
Contraceptive Follow Up	33,291 (60%)	456 (6.4%)	<0.001
STI Treatment	2,368 (4.2%)	1,811 (25%)	<0.001
Help Insurance	969 (1.7%)	63 (0.9%)	<0.001
Education	37,862 (68%)	4,889 (69%)	0.2

Note. \* chi-square test of independence; Data source: DAISEY

**Table 10e: Top 10 Counties Serving Male Clients**

County of Residence	N
Douglas	940
Wyandotte	699
Riley	604
Finney	489
Geary	468
Leavenworth	425
Reno	366
Sedgwick	348
Barton	273
Cowley	137

Date Source: DAISEY

**Table 10f: Number and Percentage of Clients Reporting Gender Identity and Sexual Orientation**

	Year 2023, N = 11,065	%
<b>Gender Identity</b>		
Male	631	5.7%
Female	2,139	19.3%
Female-to-Male (FTM)/Transgender Male/Trans Male	3	<0.1%
Male-to-female (MTF)/Transgender Female/Trans Woman	2	<0.1%
Other	1	<0.1%
Identifies as neither exclusively male nor female	8	0.1%
Choose not to disclose	31	0.3%
Unknown	153	1.4%
Missing	8,097	73.2%
<b>Sexual Orientation</b>		
Bisexual	142	1.3%
Lesbian, gay, or homosexual	49	0.4%
Straight or heterosexual	1,799	16.3%
Other, Something else	14	0.1%
Unknown	426	3.8%
Asked, but unknown	27	0.2%
Missing	8,608	77.8%

# Tables 11a-d: Services Provided by Race

## Table 11a: Screening Services Provided by Race

	White, N = 49,851	Black or African American, N = 7,644	Asian, N = 967	American Indian or Alaskan Native, N = 354	Native Hawaiian or Other Pacific Islander, N = 235	Multiracial, N = 4,045	*p-value*
Depression	20,650 (41%)	3,209 (42%)	448 (46%)	142 (40%)	140 (60%)	1,679 (42%)	<0.001
Anxiety	4,976 (10.0%)	730 (9.5%)	116 (12%)	46 (13%)	50 (21%)	572 (14%)	<0.001
Mental Health	15,928 (32%)	2,545 (33%)	328 (34%)	105 (30%)	124 (53%)	1,193 (29%)	<0.001
Human Trafficking	12,919 (26%)	2,212 (29%)	272 (28%)	99 (28%)	119 (51%)	1,092 (27%)	<0.001
Intimate Partner Violence	17,750 (36%)	2,708 (35%)	399 (41%)	124 (35%)	135 (57%)	1,336 (33%)	<0.001
Alcohol	23,278 (47%)	4,228 (55%)	434 (45%)	179 (51%)	164 (70%)	1,931 (48%)	<0.001
Tobacco	23,420 (47%)	4,160 (54%)	435 (45%)	175 (49%)	163 (69%)	1,959 (48%)	<0.001
SUD	21,487 (43%)	3,967 (52%)	413 (43%)	165 (47%)	153 (65%)	1,812 (45%)	<0.001
Hypertension	19,422 (39%)	3,106 (41%)	378 (39%)	134 (38%)	126 (54%)	1,728 (43%)	<0.001
Other	12,174 (24%)	2,148 (28%)	243 (25%)	81 (23%)	58 (25%)	1,305 (32%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY; 1 The notably higher screening rates among Native Hawaiian or Other Pacific Islander clients could be attributed to their presence in seven specific counties/clinics. These counties are Douglas (11), Geary (56), Johnson (17), Leavenworth (10), Riley (20), Sedgwick (32), Wichita (11).

## Table 11b: Testing Services Provided by Race

	White, N = 49,851	Black or African American, N = 7,644	Asian, N = 967	American Indian or Alaskan Native, N = 354	Native Hawaiian or Other Pacific Islander, N = 235	Multiracial, N = 4,045	*p-value
Chlamydia	23,029 (46%)	4,536 (59%)	392 (41%)	182 (51%)	81 (34%)	1,824 (45%)	<0.001
Gonorrhea	22,887 (46%)	4,533 (59%)	377 (39%)	183 (52%)	83 (35%)	1,826 (45%)	<0.001
Syphilis	13,658 (27%)	3,191 (42%)	262 (27%)	111 (31%)	51 (22%)	1,055 (26%)	<0.001
HIV	13,527 (27%)	3,220 (42%)	271 (28%)	114 (32%)	51 (22%)	1,038 (26%)	<0.001
Pap	10,429 (21%)	1,303 (17%)	232 (24%)	62 (18%)	53 (23%)	722 (18%)	<0.001
Clinical Breast Exam	17,638 (35%)	1,768 (23%)	338 (35%)	81 (23%)	59 (25%)	990 (24%)	<0.001
Diabetes	8,978 (18%)	1,520 (20%)	166 (17%)	46 (13%)	47 (20%)	739 (18%)	<0.001
Pregnancy	17,067 (34%)	2,259 (30%)	388 (40%)	112 (32%)	80 (34%)	1,540 (38%)	<0.001
Other STI	3,102 (6.2%)	997 (13%)	76 (7.9%)	40 (11%)	18 (7.7%)	391 (9.7%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

### Table 11c: Counseling Services Provided by Race

	White, N = 49,851	Black or African American, N = 7,644	Asian, N = 967	American Indian or Alaskan Native, N = 354	Native Hawaiian or Other Pacific Islander, N = 235	Multiracial, N = 4,045	*p-value
Alcohol Use	1,814 (3.6%)	204 (2.7%)	19 (2.0%)	20 (5.6%)	6 (2.6%)	119 (2.9%)	<0.001
Tobacco Use	2,636 (5.3%)	289 (3.8%)	18 (1.9%)	25 (7.1%)	8 (3.4%)	146 (3.6%)	<0.001
Depression	1,700 (3.4%)	136 (1.8%)	17 (1.8%)	16 (4.5%)	2 (0.9%)	92 (2.3%)	<0.001
Hypertension	1,233 (2.5%)	135 (1.8%)	14 (1.4%)	7 (2.0%)	3 (1.3%)	52 (1.3%)	<0.001
Mental Health	1,460 (2.9%)	107 (1.4%)	14 (1.4%)	15 (4.2%)	1 (0.4%)	63 (1.6%)	<0.001
Achieve Pregnancy	65 (0.1%)	6 (<0.1%)	0 (0%)	1 (0.3%)	0 (0%)	9 (0.2%)	0.2
Contraceptive	3,630 (7.3%)	439 (5.7%)	71 (7.3%)	21 (5.9%)	17 (7.2%)	344 (8.5%)	<0.001
Human Trafficking	784 (1.6%)	42 (0.5%)	6 (0.6%)	9 (2.5%)	1 (0.4%)	20 (0.5%)	-
Counseling General	4,324 (8.7%)	523 (6.8%)	76 (7.9%)	20 (5.6%)	12 (5.1%)	130 (3.2%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

### Table 11d: Other Services Provided by Race

	White, N = 49,851	Black or African American, N = 7,644	Asian, N = 967	American Indian or Alaskan Native, N = 354	Native Hawaiian or Other Pacific Islander, N = 235	Multiracial, N = 4,045	*p-value
Contraceptive Follow Up	28,367 (57%)	2,792 (37%)	522 (54%)	140 (40%)	82 (35%)	1,854 (46%)	<0.001
STI Treatment	2,789 (5.6%)	985 (13%)	28 (2.9%)	36 (10%)	16 (6.8%)	327 (8.1%)	<0.001
Help Insurance	853 (1.7%)	69 (0.9%)	12 (1.2%)	1 (0.3%)	4 (1.7%)	93 (2.3%)	-
Education	34,247 (69%)	4,751 (62%)	657 (68%)	229 (65%)	159 (68%)	2,719 (67%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

# Tables 12a-d: Services Provided by Ethnicity

**Table 12a: Screening Services Provided by Ethnicity**

	Hispanic or Latino, N = 24,491	Not Hispanic or Latino, N = 36,693	*p-value
Depression	9,333 (38%)	16,079 (44%)	<0.001
Anxiety	1,809 (7.4%)	4,392 (12%)	<0.001
Mental Health	7,396 (30%)	12,334 (34%)	<0.001
Human Trafficking	5,897 (24%)	10,338 (28%)	<0.001
Intimate Partner Violence	8,706 (36%)	13,162 (36%)	0.4
Alcohol	9,667 (39%)	19,490 (53%)	<0.001
Tobacco	9,680 (40%)	19,555 (53%)	<0.001
SUD	9,017 (37%)	18,013 (49%)	<0.001
Hypertension	8,572 (35%)	15,475 (42%)	<0.001
Other	6,851 (28%)	8,733 (24%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

**Table 12b: Testing Service Provided by Ethnicity**

	Hispanic or Latino, N = 24,491	Not Hispanic or Latino, N = 36,693	*p-value
Chlamydia	10,599 (43%)	18,558 (51%)	<0.001
Gonorrhea	10,576 (43%)	18,429 (50%)	<0.001
Syphilis	7,251 (30%)	10,536 (29%)	0.017
HIV	7,215 (29%)	10,470 (29%)	0.013
Pap	5,677 (23%)	6,857 (19%)	<0.001
Clinical Breast Exam	9,366 (38%)	11,176 (30%)	<0.001
Diabetes	4,212 (17%)	7,058 (19%)	<0.001
Pregnancy	9,981 (41%)	10,942 (30%)	<0.001
Other STI	964 (3.9%)	3,404 (9.3%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

### Table 12c: Counseling Services Provided by Ethnicity

	Hispanic or Latino, N = 24,491	Not Hispanic or Latino, N = 36,693	*p-value
Alcohol Use	348 (1.4%)	1,764 (4.8%)	<0.001
Tobacco Use	468 (1.9%)	2,562 (7.0%)	<0.001
Depression	413 (1.7%)	1,495 (4.1%)	<0.001
Hypertension	385 (1.6%)	1,028 (2.8%)	<0.001
Mental Health	312 (1.3%)	1,305 (3.6%)	<0.001
Achieve Pregnancy	31 (0.1%)	46 (0.1%)	>0.9
Contraceptive	1,876 (7.7%)	2,500 (6.8%)	<0.001
Human Trafficking	185 (0.8%)	661 (1.8%)	<0.001
Counseling General	1,923 (7.9%)	3,113 (8.5%)	0.005

Note. \* chi-square test of independence; Data source: DAISEY

### Table 12d: Other Services Provided by Ethnicity

	Hispanic or Latino, N = 24,491	Not Hispanic or Latino, N = 36,693	*p-value
Contraceptive Follow Up	14,419 (59%)	18,603 (51%)	<0.001
STI Treatment	965 (3.9%)	2,968 (8.1%)	<0.001
Help Insurance	381 (1.6%)	611 (1.7%)	0.3
Education	17,123 (70%)	24,530 (67%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

# Tables 13a-d: Services Provided by Insurance Status

**Table 13a: Screening Services Provided by Insurance Status**

	None/Self pay, N = 41,217	private insurance, N = 12,241	public insurance, N = 9,055	*p-value
Depression	15,638 (38%)	5,870 (48%)	4,595 (51%)	<0.001
Anxiety	3,249 (7.9%)	1,580 (13%)	1,631 (18%)	<0.001
Mental Health	12,234 (30%)	4,158 (34%)	3,720 (41%)	<0.001
Human Trafficking	9,876 (24%)	3,443 (28%)	3,281 (36%)	<0.001
Intimate Partner Violence	13,479 (33%)	4,809 (39%)	4,041 (45%)	<0.001
Alcohol	18,801 (46%)	6,134 (50%)	5,049 (56%)	<0.001
Tobacco	18,973 (46%)	6,057 (49%)	5,058 (56%)	<0.001
SUD	17,405 (42%)	5,632 (46%)	4,765 (53%)	<0.001
Hypertension	15,078 (37%)	5,461 (45%)	4,184 (46%)	<0.001
Other	10,884 (26%)	2,764 (23%)	2,229 (25%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

**Table 13b: Testing Services Provided by Insurance Status**

	None/Self pay, N = 41,217	private insurance, N = 12,241	public insurance, N = 9,055	*p-value
Chlamydia	19,562 (47%)	5,695 (47%)	4,557 (50%)	<0.001
Gonorrhea	19,501 (47%)	5,634 (46%)	4,517 (50%)	<0.001
Syphilis	12,640 (31%)	3,041 (25%)	2,517 (28%)	<0.001
HIV	12,547 (30%)	3,024 (25%)	2,518 (28%)	<0.001
Pap	9,090 (22%)	2,381 (19%)	1,249 (14%)	<0.001
Clinical Breast Exam	14,342 (35%)	4,125 (34%)	2,284 (25%)	<0.001
Diabetes	7,048 (17%)	2,424 (20%)	1,972 (22%)	<0.001
Pregnancy	13,891 (34%)	3,740 (31%)	3,619 (40%)	<0.001
Other STI	2,818 (6.8%)	931 (7.6%)	835 (9.2%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

### Table 13c: Counseling Services Provided by Insurance Status

	None/Self pay, N = 41,217	private insurance, N = 12,241	public insurance, N = 9,055	*p-value
Alcohol Use	1,283 (3.1%)	517 (4.2%)	362 (4.0%)	<0.001
Tobacco Use	1,917 (4.7%)	662 (5.4%)	520 (5.7%)	<0.001
Depression	1,102 (2.7%)	464 (3.8%)	383 (4.2%)	<0.001
Hypertension	865 (2.1%)	360 (2.9%)	213 (2.4%)	<0.001
Mental Health	945 (2.3%)	385 (3.1%)	318 (3.5%)	<0.001
Achieve Pregnancy	47 (0.1%)	22 (0.2%)	11 (0.1%)	0.2
Contraceptive	2,625 (6.4%)	862 (7.0%)	1,021 (11%)	<0.001
Human Trafficking	494 (1.2%)	194 (1.6%)	170 (1.9%)	<0.001
Counseling General	3,447 (8.4%)	1,024 (8.4%)	593 (6.5%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

### Table 13d: Other Services Provided by Insurance Status

	None/Self pay, N = 41,217	private insurance, N = 12,241	public insurance, N = 9,055	*p-value
Contraceptive Follow Up	22,373 (54%)	6,599 (54%)	4,564 (50%)	<0.001
STI Treatment	2,811 (6.8%)	728 (5.9%)	596 (6.6%)	0.003
Help Insurance	657 (1.6%)	195 (1.6%)	170 (1.9%)	0.14
Education	26,655 (65%)	8,855 (72%)	6,839 (76%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

# Tables 14a-d: Services Provided by Employment Status

**Table 14a: Screening Services Provided by Employment Status**

	Unemployed, N = 19,332	Part-time or occasional, N = 10,604	Full-time, N = 16,836	*p-value
Depression	9,236 (48%)	5,307 (50%)	8,211 (49%)	<0.001
Anxiety	2,576 (13%)	1,350 (13%)	2,183 (13%)	0.3
Mental Health	7,145 (37%)	4,103 (39%)	6,346 (38%)	0.012
Human Trafficking	6,023 (31%)	3,389 (32%)	5,389 (32%)	0.2
Intimate Partner Violence	7,839 (41%)	4,440 (42%)	6,902 (41%)	0.084
Alcohol	10,512 (54%)	6,014 (57%)	9,696 (58%)	<0.001
Tobacco	10,602 (55%)	5,989 (56%)	9,589 (57%)	<0.001
SUD	9,853 (51%)	5,545 (52%)	8,923 (53%)	<0.001
Hypertension	8,947 (46%)	5,063 (48%)	7,891 (47%)	0.052
Other	4,884 (25%)	2,494 (24%)	3,845 (23%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

**Table 14b: Testing Services Provided by Employment Status**

	Unemployed, N = 19,332	Part-time or occasional, N = 10,604	Full-time, N = 16,836	*p-value
Chlamydia	9,852 (51%)	5,663 (53%)	8,641 (51%)	<0.001
Gonorrhea	9,778 (51%)	5,624 (53%)	8,577 (51%)	<0.001
Syphilis	5,544 (29%)	3,070 (29%)	5,791 (34%)	<0.001
HIV	5,497 (28%)	3,041 (29%)	5,818 (35%)	<0.001
Pap	3,257 (17%)	2,176 (21%)	3,901 (23%)	<0.001
Clinical Breast Exam	5,946 (31%)	3,676 (35%)	5,912 (35%)	<0.001
Diabetes	4,132 (21%)	2,551 (24%)	3,953 (23%)	<0.001
Pregnancy	6,952 (36%)	3,464 (33%)	4,864 (29%)	<0.001
Other STI	1,664 (8.6%)	920 (8.7%)	1,657 (9.8%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

### Table 14c: Counseling Services Provided by Employment Status

	Unemployed, N = 19,332	Part-time or occasional, N = 10,604	Full-time, N = 16,836	*p-value
Alcohol Use	783 (4.1%)	575 (5.4%)	690 (4.1%)	<0.001
Tobacco Use	1,109 (5.7%)	706 (6.7%)	1,014 (6.0%)	0.006
Depression	778 (4.0%)	475 (4.5%)	585 (3.5%)	<0.001
Hypertension	522 (2.7%)	287 (2.7%)	502 (3.0%)	0.2
Mental Health	689 (3.6%)	411 (3.9%)	469 (2.8%)	<0.001
Achieve Pregnancy	25 (0.1%)	11 (0.1%)	36 (0.2%)	0.040
Contraceptive	1,725 (8.9%)	877 (8.3%)	1,202 (7.1%)	<0.001
Human Trafficking	374 (1.9%)	211 (2.0%)	239 (1.4%)	<0.001
Counseling General	1,665 (8.6%)	894 (8.4%)	1,308 (7.8%)	0.012

Note. \* chi-square test of independence; Data source: DAISEY

### Table 14d: Other Services Provided by Employment Status

	Unemployed, N = 19,332	Part-time or occasional, N = 10,604	Full-time, N = 16,836	*p-value
Contraceptive Follow Up	10,259 (53%)	6,074 (57%)	7,992 (47%)	<0.001
STI Treatment	1,517 (7.8%)	829 (7.8%)	1,440 (8.6%)	0.024
Help Insurance	386 (2.0%)	210 (2.0%)	280 (1.7%)	0.042
Education	13,220 (68%)	7,135 (67%)	11,172 (66%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

# Tables 15a-d: Services Provided by English Proficiency

**Table 15a: Screening Services Provided by English Proficiency**

	Non-LEP, N = 50,893	Limited English Proficiency (LEP), N = 11,474	*p-value
Depression	21,824 (43%)	4,213 (37%)	<0.001
Anxiety	5,529 (11%)	919 (8.0%)	<0.001
Mental Health	16,364 (32%)	3,636 (32%)	0.3
Human Trafficking	13,571 (27%)	2,945 (26%)	0.028
Intimate Partner Violence	18,232 (36%)	3,997 (35%)	0.046
Alcohol	25,385 (50%)	4,549 (40%)	<0.001
Tobacco	25,417 (50%)	4,588 (40%)	<0.001
SUD	23,477 (46%)	4,260 (37%)	<0.001
Hypertension	20,652 (41%)	3,992 (35%)	<0.001
Other	12,223 (24%)	3,624 (32%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

**Table 15b: Testing Services Provided by English Proficiency**

	Non-LEP, N = 50,893	Limited English Proficiency (LEP), N = 11,474	*p-value
Chlamydia	25,785 (51%)	3,835 (33%)	<0.001
Gonorrhea	25,635 (50%)	3,833 (33%)	<0.001
Syphilis	14,964 (29%)	3,088 (27%)	<0.001
HIV	14,906 (29%)	3,065 (27%)	<0.001
Pap	9,741 (19%)	2,874 (25%)	<0.001
Clinical Breast Exam	16,003 (31%)	4,598 (40%)	<0.001
Diabetes	9,110 (18%)	2,271 (20%)	<0.001
Pregnancy	16,561 (33%)	4,615 (40%)	<0.001
Other STI	4,204 (8.3%)	391 (3.4%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

### Table 15c: Counseling Services Provided by English Proficiency

	Non-LEP, N = 50,893	Limited English Proficiency (LEP), N = 11,474	*p-value
Alcohol Use	2,082 (4.1%)	76 (0.7%)	<0.001
Tobacco Use	2,966 (5.8%)	123 (1.1%)	<0.001
Depression	1,816 (3.6%)	128 (1.1%)	<0.001
Hypertension	1,233 (2.4%)	193 (1.7%)	<0.001
Mental Health	1,537 (3.0%)	102 (0.9%)	<0.001
Achieve Pregnancy	65 (0.1%)	15 (0.1%)	>0.9
Contraceptive	3,514 (6.9%)	876 (7.6%)	0.006
Human Trafficking	786 (1.5%)	63 (0.5%)	<0.001
Counseling General	4,205 (8.3%)	797 (6.9%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

### Table 15d: Other Services Provided by English Proficiency

	Non-LEP, N = 50,893	Limited English Proficiency (LEP), N = 11,474	p-value
Contraceptive Follow Up	26,558 (52%)	6,795 (59%)	<0.001
STI Treatment	3,918 (7.7%)	236 (2.1%)	<0.001
Help Insurance	846 (1.7%)	176 (1.5%)	0.3
Education	34,292 (67%)	8,042 (70%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

# Tables 16a-d: Services Provided by Education Level

## Table 16a: Screening Services Provided by Education Level

	<12 Years, N = 14,014	High School Diploma or GED, N = 19,803	Associate's degree or Vocational Certification/Licen se, N = 3,312	College-No Degree, N = 5,258	Bachelor's degree or higher, N = 2,454	*p-value
Depression	6,982 (50%)	8,628 (44%)	1,838 (55%)	2,720 (52%)	1,358 (55%)	<0.001
Anxiety	2,111 (15%)	2,007 (10%)	539 (16%)	791 (15%)	470 (19%)	<0.001
Mental Health	5,798 (41%)	6,744 (34%)	1,547 (47%)	2,210 (42%)	1,039 (42%)	<0.001
Human Trafficking	4,848 (35%)	5,490 (28%)	1,332 (40%)	1,956 (37%)	932 (38%)	<0.001
Intimate Partner Violence	6,108 (44%)	7,378 (37%)	1,565 (47%)	2,305 (44%)	1,091 (44%)	<0.001
Alcohol	7,694 (55%)	9,835 (50%)	2,151 (65%)	3,184 (61%)	1,587 (65%)	<0.001
Tobacco	7,688 (55%)	9,855 (50%)	2,138 (65%)	3,117 (59%)	1,536 (63%)	<0.001
SUD	7,226 (52%)	9,114 (46%)	1,980 (60%)	2,951 (56%)	1,486 (61%)	<0.001
Hypertension	6,652 (47%)	8,108 (41%)	1,794 (54%)	2,593 (49%)	1,279 (52%)	<0.001
Other	3,680 (26%)	4,646 (23%)	1,042 (31%)	1,314 (25%)	617 (25%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

## Table 16b: Testing Services Provided by Education Level

	<12 Years, N = 14,014	High School Diploma or GED, N = 19,803	Associate's degree or Vocational Certification/License, N = 3,312	College- No Degree, N = 5,258	Bachelor's degree or higher, N = 2,454	*p-value
Chlamydia	6,791 (48%)	10,394 (52%)	1,676 (51%)	2,981 (57%)	1,246 (51%)	<0.001
Gonorrhea	6,742 (48%)	10,319 (52%)	1,665 (50%)	2,953 (56%)	1,237 (50%)	<0.001
Syphilis	4,006 (29%)	6,261 (32%)	967 (29%)	1,689 (32%)	836 (34%)	<0.001
HIV	3,958 (28%)	6,270 (32%)	977 (29%)	1,660 (32%)	838 (34%)	<0.001
Pap	2,190 (16%)	4,430 (22%)	883 (27%)	1,083 (21%)	564 (23%)	<0.001
Clinical Breast Exam	4,753 (34%)	6,736 (34%)	1,237 (37%)	1,650 (31%)	744 (30%)	<0.001
Diabetes	3,530 (25%)	3,978 (20%)	903 (27%)	1,448 (28%)	676 (28%)	<0.001
Pregnancy	5,295 (38%)	6,995 (35%)	972 (29%)	1,400 (27%)	545 (22%)	<0.001
Other STI	866 (6.2%)	1,672 (8.4%)	336 (10%)	645 (12%)	309 (13%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

### Table 16c: Counseling Services Provided by Education Level

	<12 Years, N = 14,014	High School Diploma or GED, N = 19,803	Associate's degree or Vocational Certification/License, N = 3,312	College-No Degree, N = 5,258	Bachelor's degree or higher, N = 2,454	*p-value
Alcohol Use	500 (3.6%)	743 (3.8%)	164 (5.0%)	326 (6.2%)	135 (5.5%)	<0.001
Tobacco Use	714 (5.1%)	1,207 (6.1%)	225 (6.8%)	340 (6.5%)	107 (4.4%)	<0.001
Depression	546 (3.9%)	666 (3.4%)	138 (4.2%)	326 (6.2%)	87 (3.5%)	<0.001
Hypertension	371 (2.6%)	521 (2.6%)	104 (3.1%)	175 (3.3%)	49 (2.0%)	0.004
Mental Health	477 (3.4%)	610 (3.1%)	105 (3.2%)	280 (5.3%)	69 (2.8%)	<0.001
Achieve Pregnancy	17 (0.1%)	25 (0.1%)	10 (0.3%)	6 (0.1%)	9 (0.4%)	0.011
Contraceptive	1,468 (10%)	1,516 (7.7%)	242 (7.3%)	334 (6.4%)	188 (7.7%)	<0.001
Human Trafficking	291 (2.1%)	306 (1.5%)	45 (1.4%)	152 (2.9%)	32 (1.3%)	<0.001
Counseling General	1,297 (9.3%)	1,678 (8.5%)	323 (9.8%)	403 (7.7%)	139 (5.7%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

### Table 16d: Other Services Provided by Education Level

	<12 Years, N = 14,014	High School Diploma or GED, N = 19,803	Associate's Degree or Vocational Certification/License, N = 3,312	College-No Degree, N = 5,258	Bachelor's Degree or higher, N = 2,454	*p-value
Contraceptive Follow Up	8,414 (60%)	9,967 (50%)	1,580 (48%)	2,382 (45%)	1,013 (41%)	<0.001
STI Treatment	790 (5.6%)	1,694 (8.6%)	234 (7.1%)	511 (9.7%)	177 (7.2%)	<0.001
Help Insurance	266 (1.9%)	359 (1.8%)	59 (1.8%)	96 (1.8%)	32 (1.3%)	0.4
Education	10,395 (74%)	13,596 (69%)	2,283 (69%)	3,892 (74%)	1,610 (66%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

# Tables 17a-d: Services Provided by Poverty Level

**Table 17a: Screening Service Provided by Poverty Level**

	Above Federal Poverty Line, N = 10,329	Under Federal Poverty Line, N = 24,618	*p-value
Depression	4,477 (43%)	10,041 (41%)	<0.001
Anxiety	1,565 (15%)	2,824 (11%)	<0.001
Mental Health	3,525 (34%)	8,010 (33%)	0.004
Human Trafficking	3,141 (30%)	6,851 (28%)	<0.001
Intimate Partner Violence	3,864 (37%)	8,574 (35%)	<0.001
Alcohol	4,945 (48%)	11,750 (48%)	0.8
Tobacco	4,843 (47%)	11,754 (48%)	0.14
SUD	4,608 (45%)	11,048 (45%)	0.6
Hypertension	4,170 (40%)	9,410 (38%)	<0.001
Other	2,636 (26%)	6,336 (26%)	0.7

Note. \* chi-square test of independence; Data source: DAISEY

**Table 17b: Testing Service Provided by Poverty Level**

	Above Federal Poverty Line, N = 10,329	Under Federal Poverty Line, N = 24,618	*p-value
Chlamydia	5,045 (49%)	12,598 (51%)	<0.001
Gonorrhea	5,017 (49%)	12,523 (51%)	<0.001
Syphilis	3,030 (29%)	8,073 (33%)	<0.001
HIV	3,035 (29%)	8,008 (33%)	<0.001
Pap	1,850 (18%)	4,820 (20%)	<0.001
Clinical Breast Exam	2,761 (27%)	6,997 (28%)	0.001
Diabetes	2,349 (23%)	4,710 (19%)	<0.001
Pregnancy	3,562 (34%)	9,289 (38%)	<0.001
Other STI	778 (7.5%)	2,261 (9.2%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

### Table 17c: Counseling Service Provided by Poverty Level

	Above Federal Poverty Line, N = 10,329	Under Federal Poverty Line, N = 24,618	*p-value
Alcohol Use	378 (3.7%)	934 (3.8%)	0.5
Tobacco Use	451 (4.4%)	1,276 (5.2%)	0.001
Depression	334 (3.2%)	859 (3.5%)	0.2
Hypertension	200 (1.9%)	520 (2.1%)	0.3
Mental Health	276 (2.7%)	779 (3.2%)	0.014
Achieve Pregnancy	32 (0.3%)	34 (0.1%)	<0.001
Contraceptive	775 (7.5%)	2,098 (8.5%)	0.002
Human Trafficking	134 (1.3%)	414 (1.7%)	0.008
Counseling General	65 (0.6%)	252 (1.0%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

### Table 17d: Other Services Provided by Poverty Level

	Above Federal Poverty Line, N = 10,329	Under Federal Poverty Line, N = 24,618	*p-value
Contraceptive Follow Up	4,396 (43%)	11,529 (47%)	<0.001
STI Treatment	834 (8.1%)	2,039 (8.3%)	0.5
Help Insurance	137 (1.3%)	422 (1.7%)	0.008
Education	7,904 (77%)	17,464 (71%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

# Tables 18a-d: Services Provided by Client Cluster Groups

**Table 18a: Screening Services Provided by Cluster Groups**

	Group 1 - Spanish Speaking Adults, N = 11,149	Group 2 - White Adults, N = 18,399	Group 3 - Youth, N = 10,536	*p-value
Depression	5,546 (50%)	9,053 (49%)	5,406 (51%)	0.002
Anxiety	1,156 (10%)	2,509 (14%)	1,797 (17%)	<0.001
Mental Health	4,645 (42%)	7,390 (40%)	4,317 (41%)	0.036
Human Trafficking	3,739 (34%)	6,243 (34%)	3,625 (34%)	0.4
Intimate Partner Violence	5,176 (46%)	7,508 (41%)	4,636 (44%)	<0.001
Alcohol	5,894 (53%)	10,842 (59%)	5,865 (56%)	<0.001
Tobacco	5,844 (52%)	10,778 (59%)	5,846 (55%)	<0.001
SUD	5,484 (49%)	10,046 (55%)	5,515 (52%)	<0.001
Hypertension	5,268 (47%)	8,696 (47%)	4,993 (47%)	>0.9
Other	3,061 (27%)	4,649 (25%)	2,265 (21%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

**Table 18b: Testing Services Provided by Cluster Groups**

	Group 1 - Spanish Speaking Adults, N = 11,149	Group 2 - White Adults, N = 18,399	Group 3 - Youth, N = 10,536	*p-value
Chlamydia	5,442 (49%)	9,939 (54%)	5,639 (54%)	<0.001
Gonorrhea	5,410 (49%)	9,858 (54%)	5,592 (53%)	<0.001
Syphilis	3,965 (36%)	5,820 (32%)	2,624 (25%)	<0.001
HIV	3,994 (36%)	5,835 (32%)	2,580 (24%)	<0.001
Pap	3,018 (27%)	4,324 (24%)	962 (9.1%)	<0.001
Clinical Breast Exam	4,929 (44%)	6,235 (34%)	2,696 (26%)	<0.001
Diabetes	2,937 (26%)	4,650 (25%)	2,443 (23%)	<0.001
Pregnancy	4,424 (40%)	4,971 (27%)	4,280 (41%)	<0.001
Other STI	636 (5.7%)	2,045 (11%)	768 (7.3%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

### Table 18c: Counseling Services Provided by Cluster Groups

	Group 1 - Spanish Speaking Adults, N = 11,149	Group 2 - White Adults, N = 18,399	Group 3 - Youth, N = 10,536	p-value
Alcohol Use	202 (1.8%)	1,017 (5.5%)	519 (4.9%)	<0.001
Tobacco Use	290 (2.6%)	1,442 (7.8%)	704 (6.7%)	<0.001
Depression	253 (2.3%)	869 (4.7%)	527 (5.0%)	<0.001
Hypertension	235 (2.1%)	638 (3.5%)	280 (2.7%)	<0.001
Mental Health	203 (1.8%)	777 (4.2%)	468 (4.4%)	<0.001
Achieve Pregnancy	23 (0.2%)	32 (0.2%)	7 (<0.1%)	0.022
Contraceptive	1,066 (9.6%)	1,133 (6.2%)	1,233 (12%)	<0.001
Human Trafficking	128 (1.1%)	390 (2.1%)	268 (2.5%)	<0.001
Counseling General	1,009 (9.1%)	1,744 (9.5%)	910 (8.6%)	0.053

Note. \* chi-square test of independence; Data source: DAISEY

### Table 18d: Other Services Provided by Cluster Groups

	Group 1 - Spanish Speaking Adults, N = 11,149	Group 2 - White Adults, N = 18,399	Group 3 - Youth, N = 10,536	p-value
Contraceptive Follow Up	6,433 (58%)	8,518 (46%)	6,347 (60%)	<0.001
STI Treatment	641 (5.7%)	1,680 (9.1%)	711 (6.7%)	<0.001
Help Insurance	236 (2.1%)	315 (1.7%)	192 (1.8%)	0.042
Education	7,555 (68%)	12,779 (69%)	8,036 (76%)	<0.001

Note. \* chi-square test of independence; Data source: DAISEY

# Clinic Location and Performance by Need

(Counties with the highest STI risk at highlighted in blue)

**Table 19: High STI-rate Counties and STI Screening Rates**

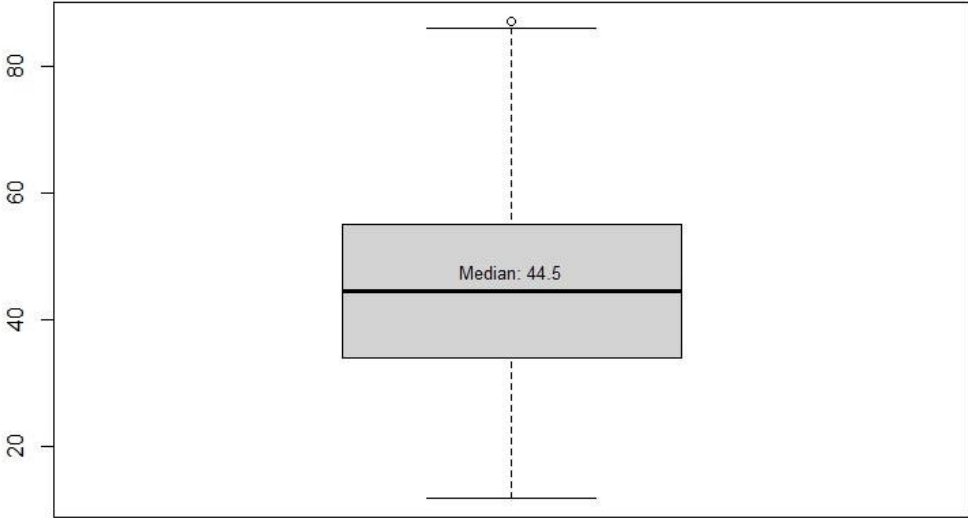
County Residence of Client	Is Served by Title X Clinic	STI Rate (cases per 1,000) <sup>1</sup>	STI Risk <sup>2</sup>	STI Screening in Title X Clinics for Clients from that County <sup>3</sup>	STI Screening Rates Category <sup>4</sup>
Geary	Yes	15.1	High	37	Low
Wyandotte	Yes	13.8	High	74	High
Shawnee	Yes	12.3	High	48	High
Sedgwick	Yes	9.3	High	56	High
Riley	Yes	9	High	65	High
Douglas	Yes	8.7	High	59	High
Lyon		7.1	High	37	Low
Crawford	Yes	7	High	46	High
Ford		6.6	High	61	High
Montgomery		6.6	High	47	High
Seward	Yes	6.4	High	55	High
Finney	Yes	6.3	High	50	High
Labette		6	High	44	Low
Cowley	Yes	5.3	High	49	High
Reno	Yes	5.3	High	70	High
Cherokee		5.2	High	33	Low
Butler	Yes	5.1	High	30	Low
Saline	Yes	5.1	High	43	Low
Leavenworth	Yes	5	Low	68	High
Doniphan		5	Low	NA	NA
Graham		5	Low	29	Low
Franklin	Yes	4.9	Low	51	High
Barton	Yes	4.8	Low	53	High
Harvey		4.8	Low	58	High
Bourbon		4.8	Low	50	High
Atchison		4.7	Low	59	High
Johnson	Yes	4.6	Low	25	Low
Ellis		4.4	Low	55	High
Jackson		4.4	Low	76	High
Comanche		4.2	Low	33	Low

Cloud	Yes	4.1	Low	44	Low
Sumner	Yes	3.9	Low	43	Low
Wilson		3.9	Low	66	High
Jefferson		3.7	Low	50	High
Miami		3.7	Low	41	Low
Harper	Yes	3.6	Low	39	Low
Anderson		3.6	Low	39	Low
Pratt	Yes	3.5	Low	55	High
Sherman	Yes	3.4	Low	61	High
Grant	Yes	3.3	Low	33	Low
Meade	Yes	3.3	Low	41	Low
Allen		3.3	Low	55	High
Pottawatomie		3.2	Low	43	Low
Morton	Yes	3.1	Low	38	Low
Stevens		3.1	Low	37	Low
Gray	Yes	3	Low	22	Low
McPherson	Yes	3	Low	36	Low
Ness		3	Low	27	Low
Pawnee	Yes	2.9	Low	48	High
Elk		2.9	Low	50	High
Woodson		2.9	Low	18	Low
Brown		2.9	Low	75	High
Haskell	Yes	2.8	Low	29	Low
Neosho	Yes	2.8	Low	54	High
Marshall		2.8	Low	39	Low
Morris	Yes	2.6	Low	30	Low
Lane		2.6	Low	87	High
Linn		2.6	Low	60	High
Scott		2.6	Low	53	High
Phillips	Yes	2.5	Low	41	Low
Washington		2.5	Low	46	High
Coffey	Yes	2.4	Low	20	Low
Thomas	Yes	2.3	Low	37	Low
Osborne		2.3	Low	12	Low
Chautauqua		2.3	Low	49	High
Barber	Yes	2.2	Low	54	High
Clay	Yes	2.2	Low	37	Low
Kearny	Yes	2.1	Low	43	Low
Mitchell	Yes	1.9	Low	15	Low
Rice		1.9	Low	52	High
Republic		1.9	Low	32	Low
Edwards	Yes	1.8	Low	52	High

Stafford	Yes	1.8	Low	51	High
Nemaha		1.8	Low	60	High
Dickinson		1.8	Low	35	Low
Kiowa	Yes	1.7	Low	40	Low
Rooks	Yes	1.7	Low	39	Low
Russell	Yes	1.7	Low	46	High
Jewell		1.7	Low	17	Low
Lincoln		1.7	Low	22	Low
Norton		1.7	Low	80	High
Ottawa		1.6	Low	38	Low
Sheridan		1.6	Low	46	High
Gove		1.5	Low	30	Low
Greenwood		1.5	Low	24	Low
Marion		1.5	Low	22	Low
Osage		1.5	Low	60	High
Wichita		1.5	Low	50	High
Ellsworth	Yes	1.4	Low	20	Low
Kingman	Yes	1.4	Low	52	High
Cheyenne		1.2	Low	56	High
Wabaunsee	Yes	1.1	Low	54	High
Hodgeman		1.1	Low	75	High
Smith		1.1	Low	19	Low
Rush		1	Low	43	Low
Clark		1	Low	73	High
Greeley		0.8	Low	86	High
Hamilton		0.8	Low	33	Low
Chase		0.8	Low	45	High
Logan		0.7	Low	37	Low
Decatur		0.7	Low	19	Low
Stanton	Yes	0.5	Low	17	Low
Rawlins		0.4	Low	35	Low
Trego		0.4	Low	22	Low
Wallace		NA	NA	58	High

Data source: <sup>1</sup> Kansas Health Matters 2022; <sup>2</sup> The [WHO](#) classifies a rate of 5% as an STI prevalence that is under control for a given population; <sup>3</sup> DAISEY; <sup>4</sup> The median of county level rates was used the cutoff – rates at or above the median were classified as “High”, and those below as “Low” (see Figure 1)

Figure 1: Threshold Determination: Title X STI Screening Rates Boxplot



Chosen cut-off: 44.5

Data source: DAISEY

## Table 20: Syphilis Testing Rates in Title X clinics for Ages 24 or Younger by County Residence

(Counties with the highest syphilis rates highlighted in gold)

Targeted syphilis testing rate for this age group per KDHE= >60%

County Residence of Client	Served by Title X Clinic	Primary and Secondary Syphilis Rate per 100,000 people (2021) <sup>1</sup>	Syphilis Testing Rates in Title X Clinics of Clients from that County <sup>2</sup>
Wichita		0	75
Wyandotte	Y	27.5	64
Jackson		0	62
Rawlins		0	50
Kingman	Y	0	48
Logan		0	46
Seward	Y	0	46
Gove	Y	25	45
Chautauqua		0	42
Rush		0	42
Cowley	Y	5.8	41
Barton	Y	4	40
Greeley	Y	0	40
Atchison		0	38
Elk	Y	0	38
Leavenworth		0	38
Jefferson		0	36
Sheridan		0	35
Douglas		13.4	34
Trego		0	34
Brown		21.2	33
Ottawa		28.6	33
Pratt	Y	0	33
Thomas	Y	0	33
Barber	Y	24.3	32
Sedgwick	Y	17.6	32
Sumner	Y	4.5	32
Stafford	Y	0	30
Saline	Y	9.3	28
Decatur		0	27
Ford		5.2	27
Lane	Y	5	27
Marshall		0	26

Scott		0	26
Stevens		0	26
Finney	Y	0	25
Graham		0	25
Kearny	Y	12.2	25
Nemaha	Y	0	25
Reno	Y	3.3	25
Riley	Y	1.4	25
Haskell		11.8	23
Greenwood		0	21
Comanche		0	20
Dickinson		5.4	20
Kiowa	Y	27.1	20
Wallace		0	20
Washington	Y	0	20
Harvey	Y	18.8	19
Geary	Y	7.7	18
Harper		0	18
Cheyenne		0	17
Lyon	Y	0	17
Ellis		0	16
Johnson		0	16
Lincoln	Y	7.3	16
Pottawatomie		0	16
Republic	Y	21.5	16
Shawnee	Y	4.5	16
Butler	Y	2.9	15
Ellsworth		3.5	15
Allen		1.6	14
Edwards	Y	5.9	14
Grant		0	13
Gray	Y	0	13
Bourbon		0	12
McPherson		0	12
Morris		19.3	12
Ness		6.3	12
Osage		0	12
Chase		0	11
Coffey	Y	0	11
Morton	Y	0	11
Smith		0	11
Clay	Y	0	10

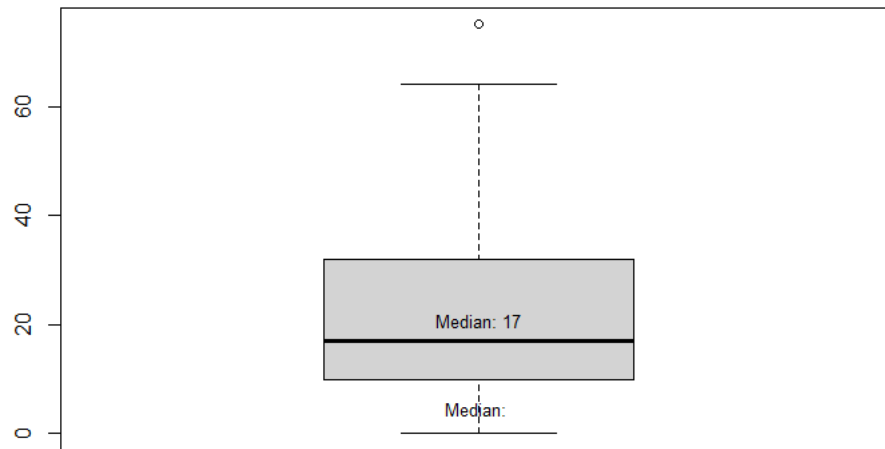
Crawford	Y	5.1	10
Meade	Y	3.3	10
Pawnee	Y	0	10
Rice		0	10
Miami	Y	24.9	8
Wabaunsee		0	8
Anderson		0	5
Marion		0	5
Franklin	Y	11.7	4
Hamilton		16.8	4
Neosho		0	4
Cloud	Y	0	3
Phillips	Y	0	3
Stanton	Y	0	3
Cherokee		15.7	2
Russell	Y	0	2
Sherman	Y	0	2
Rooks	Y	20.7	1
Clark		0	0
Hodgeman	Y	0	0
Jewell		10.9	0
Labette	Y	0	0
Linn		0	0
Mitchell		0	0
Montgomery	Y	0	0
Norton	Y	0	0
Osborne		0	0
Wilson		0	0
Woodson		0	0

*Date Source:*

<sup>1</sup> CDC NCHHSTP AtlasPlus 2021.

<sup>2</sup> DAISEY

Figure 2: Threshold Determination: Title X Syphilis Testing Rates for Ages 24 or Younger Boxplot



Chosen cut-off: 17

Data source: DAISEY

## Table 21: Teen Pregnancy Rates, Title X Clinics Coverage, and Conceptive Counseling Rates

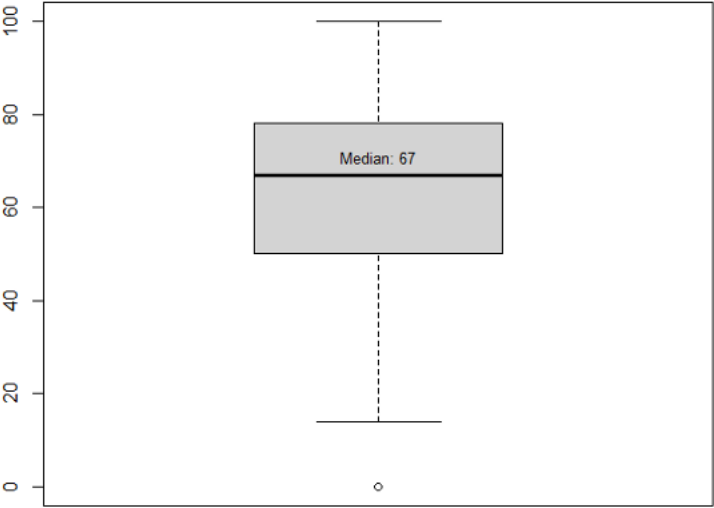
County	Residence of Client	Served by Title X Clinic	2021 Teen Pregnancy Rate (10-19 years old) <sup>1</sup>	Teen Pregnancy Risk <sup>2</sup>	Contraceptive Counseling Rate in Title X Clinic for Clients from that County (%) <sup>3</sup>	Contraceptive Counseling Category <sup>4</sup>
Hamilton			42.2	High	53	High
Woodson			27.9	High	67	High
Ford			25.5	High	59	High
Geary		Yes	23.1	High	18	Low
Pawnee		Yes	22.8	High	77	High
Stafford		Yes	20.4	High	67	High
Seward		Yes	19.8	High	73	High
Elk			18.9	High	19	Low
Anderson			18.8	High	70	Low
Grant		Yes	18.7	High	76	High
Wyandotte		Yes	18.5	High	48	Low
Jewell			18.2	High	85	High
Finney		Yes	17.3	High	54	High
Montgomery			16.8	High	35	Low
Cherokee			16.4	High	42	Low
Cloud		Yes	16.4	High	74	High
Labette		Yes	16.4	High	37	Low
Jackson			16.3	High	42	Low
Cowley		Yes	15.8	High	28	Low
Haskell		Yes	15.5	High	43	Low
Kiowa		Yes	15.4	High	70	High
Crawford		Yes	14.8	High	30	Low
Shawnee		Yes	13.4	High	58	Low
Kearny		Yes	13.2	High	44	Low
Sedgwick		Yes	13.2	High	65	High
Chase			13.1	High	64	High
Scott			12.9	High	32	Low
Neosho		Yes	12.5	High	66	High
Linn			12.4	High	60	NA
Edwards		Yes	12.3	High	70	High
Reno		Yes	12.2	High	25	Low
Allen			11.9	High	62	High
Logan			11.9	High	86	High
Sheridan			11.5	High	89	High
Barton		Yes	11.4	High	53	Low

Norton		11.2	High	0	NA
McPherson	Yes	11.1	High	82	High
Chautauqua		11	High	74	High
Marshall		10.9	High	65	Low
Pratt	Yes	10.9	High	62	High
Morton	Yes	10.8	High	78	High
Sumner	Yes	10.6	High	36	Low
Ellsworth	Yes	10.5	High	74	High
Lane		10.3	High	60	High
Dickinson		9.9	High	39	Low
Harvey		9.6	High	65	High
Bourbon		9.4	High	21	High
Greeley		9.3	High	29	NA
Rice		9.3	High	55	Low
Saline	Yes	9.3	High	74	High
Lyon		9.1	High	89	High
Doniphan		9	Low	NA	NA
Franklin	Yes	9	Low	83	High
Comanche		8.7	Low	61	Low
Greenwood		8.6	Low	86	High
Hodgeman		8.5	Low	50	High
Kingman	Yes	8.5	Low	70	High
Leavenworth	Yes	8.5	Low	29	Low
Atchison		8.4	Low	44	Low
Nemaha		8.3	Low	60	High
Meade	Yes	8.2	Low	57	High
Clay	Yes	7.8	Low	60	High
Decatur		7.8	Low	70	High
Osage		7.8	Low	43	Low
Rawlins		7.4	Low	80	High
Wabaunsee		7.4	Low	71	High
Republic	Yes	7.1	Low	60	Low
Trego		7.1	Low	74	High
Riley	Yes	6.9	Low	53	Low
Marion		6.6	Low	77	High
Ness		6.1	Low	49	Low
Ellis		5.6	Low	55	Low
Stanton	Yes	5.6	Low	62	High
Ottawa		5.5	Low	73	High
Butler	Yes	5.4	Low	77	High
Lincoln		5.4	Low	63	High
Mitchell	Yes	5.3	Low	90	High

Douglas	Yes	5.1	Low	41	Low
Jefferson		5.1	Low	55	Low
Russell	Yes	5.1	Low	76	High
Osborne		4.8	Low	46	Low
Johnson	Yes	4.6	Low	44	Low
Barber	Yes	4	Low	56	High
Pottawatomie		3.9	Low	74	High
Phillips	Yes	3.5	Low	62	High
Wilson		3.5	Low	51	High
Thomas	Yes	3.4	Low	76	High
Washington	Yes	3.3	Low	58	Low
Rooks	Yes	3.2	Low	87	High
Brown		3.1	Low	75	High
Miami		2.9	Low	44	Low
Harper	Yes	2.8	Low	47	Low
Sherman	Yes	2.5	Low	88	High
Coffey	Yes	2	Low	85	High
Stevens		2	Low	62	High
Cheyenne		0	Low	83	High
Clark		0	Low	69	High
Gove		0	Low	78	High
Graham		0	Low	76	High
Gray	Yes	0	Low	63	High
Morris	Yes	0	Low	56	High
Rush		0	Low	57	Low
Smith		0	Low	51	Low
Wallace		0	Low	88	High
Wichita		0	Low	27	Low

Data Source: <sup>1</sup> KDHE; <sup>3</sup> DAISEY, <sup>2,4</sup> The median of county level rates was used the cutoff - rates at or above the median were classified as "High", and those below as "Low" (see Figure 3)

Figure 3: Threshold Determination: Title X Teen Contraceptive Counseling Rates Boxplot



Chosen cut-off: 67

Data source: DAISEY

**Table 22: Logistic Regression Analysis of Individual and County Level Predictors of Receiving Depression, Anxiety, and SUD Screening**

	Screening for Depression		Screening for Anxiety		Screening for SUD	
	OR	95% CI	OR	95% CI	OR	95% CI
<b>YEAR</b>						
<b>2019</b>						
<b>2020</b>	0.63***	0.59, 0.67			0.65***	0.61, 0.69
<b>2021</b>	0.68***	0.64, 0.72			0.73***	0.69, 0.78
<b>2022</b>	0.98	0.93, 1.04			0.91**	0.86, 0.97
<b>2023</b>	1.44***	1.36, 1.53			1.64***	1.54, 1.74
<b>Client Gender</b>						
<b>Female</b>						
<b>Male</b>	0.46***	0.43, 0.49	1.35***	1.23, 1.47	1.05	0.99, 1.11
<b>White</b>	0.93	0.87, 1.01	0.62***	0.56, 0.69	1.01	0.94, 1.09
<b>Black</b>	0.99	0.90, 1.08	0.58***	0.51, 0.67	1.08	0.98, 1.18
<b>Ethnicity</b>						
<b>Not Hispanic or Latino</b>						
<b>Hispanic or Latino</b>	1.08***	1.03, 1.13	0.85***	0.79, 0.91	0.78***	0.75, 0.82
<b>Age Group</b>						
<b>Under 19</b>						
<b>19-35</b>	0.93*	0.89, 0.98	0.80***	0.74, 0.87	0.93***	0.88, 0.98
<b>35+</b>	1.05	0.99, 1.12	0.74***	0.67, 0.81	1.04	0.98, 1.11
<b>LEP</b>						
<b>No</b>						
<b>Yes</b>	1.13***	1.07, 1.20	1.29***	1.17, 1.42	1.09***	1.03, 1.16
<b>Insurance</b>						
<b>None/Self pay</b>						
<b>private insurance</b>	1.22***	1.16, 1.28	1.15***	1.07, 1.23	0.97	0.92, 1.02
<b>public insurance</b>	1.08*	1.02, 1.14	1.43***	1.32, 1.55	1.05	0.99, 1.12
<b>Gini Index of Income Inequality</b>	0.00***	0.00, 0.00	572***	221, 1.483	0.09***	0.04, 0.19
<b>STI Rate (per 1,000)</b>	1.44***	1.42, 1.45	1.16***	1.15, 1.17	1.49***	1.47, 1.51
<b>Population Density - Women 15-44 Years of Age</b>	0.99***	0.99, 0.99	0.98***	0.98, 0.98	0.99***	0.99, 0.99
<b>Low Birth Weight (%)</b>	0.54***	0.53, 0.56	0.35***	0.33, 0.36	0.39***	0.38, 0.41
<b>MVI (Reproductive)</b>	1.02***	1.02, 1.03	1.00*	1.00, 1.01	1.02***	1.02, 1.02
<b>Pseudo R square</b>	.196		.228		.201	
<b>N=</b>	59,442		59,442		59,442	

\*p < .05. \*\*p < .01. \*\*\*p < .001.

**Table 23: Logistic Regression Analysis of Individual and County Level Predictors of Teen Clients Receiving Contraceptive Counseling**

	Receiving Contraceptive Counseling for Teens	
	OR	95% CI
<b>Year</b>		
<b>2019</b>		
<b>2020</b>	1.32***	1.17, 1.50
<b>2021</b>	1.41***	1.24, 1.60
<b>2022</b>	1.34***	1.18, 1.52
<b>2023</b>	0.86*	0.75, 0.98
<b>White</b>	1.20*	1.03, 1.40
<b>Black</b>	0.76**	0.62, 0.92
<b>Ethnicity</b>		
<b>Not Hispanic or Latino</b>		
<b>Hispanic or Latino</b>	1.05	0.95, 1.15
<b>LEP</b>		
<b>No</b>		
<b>Yes</b>	0.71***	0.59, 0.84
<b>Insurance</b>		
<b>None/Self pay</b>		
<b>private insurance</b>	1.24***	1.11, 1.39
<b>public insurance</b>	1.09	0.99, 1.20
<b>Gini Index of Income Inequality</b>	1.54	0.27, 8.63
<b>STI Rate (cases per 1,000)</b>	0.88***	0.87, 0.90
<b>Population Density - Women 15-44 Years of Age</b>	1.00	1.00, 1.00
<b>Low Birth Weight (%)</b>	1.17***	1.11, 1.23
<b>MVI (Reproductive)</b>	1.00	1.00, 1.00
<b>Teen Pregnancy Rate (10-19 years)</b>	1.01	1.00, 1.02
<b>Pseudo R square</b>	.050	
<b>N=</b>	10,234	

\*p < .05. \*\*p < .01. \*\*\*p < .001.

**Table 24: Logistic Regression Analysis of Individual and County Level Predictors of Receiving Pregnancy Test**

	Receiving Pregnancy Test	
	OR	95% CI
<b>Year</b>		
<b>2019</b>		
<b>2020</b>	1.06*	1.00, 1.12
<b>2021</b>	1.22***	1.15, 1.28
<b>2022</b>	1.19***	1.13, 1.26
<b>2023</b>	1.14***	1.08, 1.21
<b>White</b>	0.87***	0.81, 0.92
<b>Black</b>	0.83***	0.77, 0.91
<b>Age Group</b>		
<b>Under 19</b>		
<b>19-35</b>	0.79***	0.75, 0.83
<b>35+</b>	0.42***	0.40, 0.45
<b>Ethnicity</b>		
<b>Not Hispanic or Latino</b>		
<b>Hispanic or Latino</b>	1.46***	1.40, 1.53
<b>LEP</b>		
<b>No</b>		
<b>Yes</b>	1.21***	1.15, 1.28
<b>Insurance</b>		
<b>None/Self pay</b>		
<b>private insurance</b>	0.97	0.93, 1.02
<b>public insurance</b>	1.38***	1.31, 1.46
<b>Gini Index of Income Inequality</b>	0.03***	0.01, 0.06
<b>STI Rate (cases per 1,000)</b>	0.96***	0.95, 0.96
<b>Population Density - Women 15-44 Years of Age</b>	1.00***	1.00, 1.00
<b>Low Birth Weight (%)</b>	1.33***	1.30, 1.36
<b>MVI (Reproductive)</b>	1.00*	1.00, 1.00
<b>Teen Pregnancy Rate (10-19 years)</b>	0.99*	0.99, 1.00
<b>Pseudo R square</b>	.042	
<b>N=</b>	59,451	

\*p < .05. \*\*p < .01. \*\*\*p < .001.

**Table 25: Logistic Regression Analysis of Individual and County Level Predictors of Receiving Testing for Chlamydia, Gonorrhea, and Syphilis, and Receiving STI Treatment**

	Chlamydia Testing		Gonorrhea Testing		Syphilis Testing		STI Treatment	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
<b>Year</b>								
<b>2019</b>								
<b>2020</b>	1.11***	1.05, 1.17	1.11***	1.05, 1.17	0.87***	0.82, 0.93	3.42***	2.97, 3.95
<b>2021</b>	1.34***	1.27, 1.41	1.33***	1.26, 1.40	1.28***	1.21, 1.36	3.53***	3.07, 4.07
<b>2022</b>	1.39***	1.32, 1.47	1.38***	1.31, 1.46	1.40***	1.32, 1.49	4.50***	3.92, 5.18
<b>2023</b>	1.67***	1.58, 1.77	1.67***	1.58, 1.77	1.64***	1.55, 1.74	4.61***	4.00, 5.33
<b>Client Gender</b>								
<b>Female</b>								
<b>Male</b>	2.27***	2.14, 2.40	2.32***	2.19, 2.46	3.26***	3.08, 3.45	6.16***	5.71, 6.65
<b>White</b>	1.04	0.98, 1.11	1.04	0.97, 1.11	1.18***	1.10, 1.27	0.77***	0.68, 0.88
<b>Black</b>	1.43***	1.32, 1.55	1.45***	1.33, 1.57	1.62***	1.48, 1.76	1.13	0.98, 1.32
<b>Ethnicity</b>								
<b>Not Hispanic or Latino</b>								
<b>Hispanic or Latino</b>	1.09***	1.04, 1.14	1.09***	1.05, 1.14	1.14***	1.09, 1.20	0.76***	0.69, 0.83
<b>Age Group</b>								
<b>Under 19</b>								
<b>19-35</b>	0.83***	0.79, 0.87	0.83***	0.79, 0.87			1.20***	1.08, 1.33
<b>35+</b>	0.55***	0.52, 0.58	0.55***	0.52, 0.58			0.83**	0.74, 0.95
<b>Age Group</b>								
<b>Under 24</b>								
<b>24 +</b>					1.11***	1.06, 1.15		
<b>LEP</b>								
<b>No</b>								
<b>Yes</b>	0.61***	0.58, 0.65	0.62***	0.58, 0.65	0.83***	0.79, 0.88	0.45***	0.39, 0.53
<b>Insurance</b>								
<b>None/Self pay</b>								
<b>private insurance</b>	0.86***	0.82, 0.90	0.85***	0.81, 0.89	0.77***	0.73, 0.81	0.64***	0.58, 0.70
<b>public insurance</b>	0.94*	0.89, 0.99	0.94*	0.89, 0.99	0.92	0.87, 0.97	0.84**	0.76, 0.94
<b>Gini Index of Income Inequality</b>	2.724***	1.410, 5.269	2.507***	1.297, 4.851	0.20***	0.09, 0.42	6.17**	1.62, 23.5
<b>STI Rate (cases per 1,000)</b>	1.03***	1.02, 1.03	1.02***	1.02, 1.03	1.05***	1.04, 1.06	0.99	0.98, 1.00

<b>Population Density - Women 15-44 Years of Age</b>	1.00***	1.00, 1.00	1.00***	1.00, 1.00	1.00	1.00, 1.00	0.99***	0.99, 1.0
<b>Low Birth Weight (%)</b>	1.30***	1.27, 1.33	1.31***	1.28, 1.34	1.19***	1.16, 1.22	1.11***	1.06, 1.17
<b>MVI (Reproductive)</b>	1.00***	1.00, 1.01	1.00***	1.00, 1.01	1.00***	0.99, 1.00	0.98***	0.98, 0.98
<b>Pseudo R square</b>	.062		.062		.067		.151	
<b>N=</b>	59,442		59,442		59,442		59,442	

\* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .

# Appendix II: Needs Assessment Instruments

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## KDHE Title X Needs Assessment Key Informant Interview and Focus Group guide – administrators

### Introduction

The Center for Public Partnerships and Research at the University of Kansas is partnering with the Kansas Department of Health & Environment (KDHE) to conduct a needs assessment for Title X services in Kansas. We are interested in hearing about your experiences about making the choice to offer Title X services and barriers to and facilitators of providing these services.

Your responses are confidential, and you are free to skip any questions you don't want to answer. Recordings from this session will be transcribed and personal information removed. Results of our data collection will be synthesized and reported in a way that will not enable you to be identified.

### Background

1. Tell me about your role and where you work.
2. How did you come to be in that role?

### Choosing to offer Title X services

3. Do you currently offer Title X services at your clinic?

*If yes,*

What made you decide to offer Title X services at your clinic?

What services did you decide to include? Why?

*If no,*

What made you decide to not offer (discontinue) Title X services at your clinic?

- a. What would have to happen for you to stop/start/expand services?

## Policies

4. Which current laws and policies have to be strengthened, challenged, amended, or removed to encourage clinic administrators like yourself to offer Title X services?

## How to talk about Title X in the state

5. What do you think would be an effective way for the Title X program to speak to clinic administrators to gain their support?

## [This section: For administrators offering Title X services]

### Policy Impact

6. As you may know, the 2019 Title X policy changes had a significant effect on the provision of services. The 2019 rule was overruled by the Biden-Harris' rule in November 2021. Are you familiar with the rules and the changes that happened as a result?

*If yes, proceed. If no, skip to 7.*

How did the 2019 changes impact your clinic? Do you think your clinic has recovered from the 2019 rule?

### COVID-19 Impact

7. In your opinion, how did the COVID-19 pandemic affect the provision of Title X services?  
*Prompts: What population was affected the most? Do you think the program has recovered from the services changes during COVID-19? What has been the easiest or hardest to regain?*

### Key Populations

8. In your opinion, which populations have to be addressed specifically? What are the main Title X program issues they face and how can this issue be addressed?

### Future's Thinking

9. If there were no financial or other barriers, what changes would you make to the Kansas Title X program?

Thanks so much for spending your time with me today and sharing all your ideas and experiences. This wraps up our discussion. Do you have any questions or anything extra you would like to share?

We appreciate your time and input. It has been extremely valuable.

# KDHE Title X Needs Assessment Key Informant Interview and Focus Group guide – direct care providers

## Intro

The Center for Public Partnerships and Research at the University of Kansas is partnering with the Kansas Department of Health & Environment (KDHE) to conduct a needs assessment for Title X services in Kansas. We are interested in hearing about your experiences implementing Title X services and barriers to and facilitators of providing these services.

Your responses are confidential, and you are free to skip any questions you don't want to answer. Recordings from this session will be transcribed and personal information removed. Results of our data collection will be synthesized and reported in a way that will not enable you to be identified.

## Background

1. Tell me about your role and where you work.
2. How did you come to be [that role]? (what are your motivations)
  - a. For clinicians - What sort of Title X services do you offer/perform?

## Current State of KS Title X program/Barriers and Facilitators

3. In your opinion, what is the current state of the Kansas Title X program?

*For individuals with experience working at a Title X clinic:*

What is it like working at a clinic that provides Title X services?

- b. As you may know, the 2019 Title X policy changes had a significant effect on the provision of services. The 2019 rule was overruled by the Biden-Harris' rule in November 2021. Are you familiar with the rules and the changes that happened as a result?

*If yes, proceed*

*If no, skip to 3c.*

How did the 2019 changes impact the Title X program implementation? Do you think the program has recovered from the 2019 rule?

- c. In your opinion, how did the COVID-19 pandemic affect the provision of Title X services?
- d. What could clinics or KDHE do to recruit and retain its workforce?

### Key Populations

- 4. In your opinion, which populations have to be addressed specifically? What are the main Title X program issues they face and how can this issue be addressed?

### Policies

- 5. Which current laws and policies have to be strengthened, challenged, amended, or removed to ensure that the Title X program can be implemented in the best way?

### Emerging Issues

- 6. Which issues do we need to flag as emerging issues which Title X services need to be focused on or begin to consider?

### How to talk about Title X in the state

- 7. What do you think would be an effective way for clinicians/administrators/anybody to speak to the public about the Title X program to gain support?

### Future's Thinking

- 8. If there were no financial or other barriers, what changes would you make to the Kansas Title X program?

Thanks so much for spending your time with me today and sharing all your ideas and experiences. This wraps up our discussion. Do you have any questions or anything extra you would like to share

We appreciate your time and input. It has been extremely valuable.

# Appendix III: References

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