

Publicly Funded Family Planning in Arizona, 1940–2017

By

Claudia Núñez-Eddy

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Graduate Supervisory Committee:

Jane Maienschein, Chair
James Hurlbut
Erica O'Neil

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ABSTRACT

Nearly seven decades ago, the US government established grants to the states for family planning and acknowledged the importance of enabling all women to plan and space their pregnancies, regardless of personal income. Since then, publicly-funded family planning services have empowered millions of women, men, and adolescents to achieve their childbearing goals. Despite the recognized importance of subsidized family planning, services remain funded in a piecemeal fashion. Since the 1940s there have been numerous federal funding sources for family planning, including the Title V Maternal and Child Health Services Program, Office of Economic Opportunity grants, Title XX Social Services Program, Title X Family Planning Program, Medicaid, and the State Children's Health Insurance Program, alongside state and local support. Spending guidelines allow states varying degrees of flexibility regarding allocation, to best serve the local population. With nearly two billion dollars spent annually on subsidized family planning, criticism often arises surrounding effective local program spending and state politics influencing grant allocation. Political tension regarding the amount of control states should have in managing federal funding is exacerbated in the context of family planning, which has become increasingly controversial among social conservatives in the twenty-first century. This thesis examines how Arizona's political, geographic, cultural, and ethnic landscape shaped the state management of federal family planning funding since the early twentieth century. Using an extensive literature review, archival research, and oral history interviews, this thesis demonstrates the unique way Arizona state agencies and nonprofits collaborated to maximize the use of federal family planning grants, effectively reaching the most residents possible. That partnership allowed Arizona

providers to reduce geographic barriers to family planning in a rural, frontier state. The social and political history surrounding the use of federal family planning funds in Arizona demonstrates the important role states have in efficient, effective, and equitable state implementation of national resources in successfully reaching local populations. The contextualization of government funding of family planning provides insight into recent attempts to defund abortion providers like Planned Parenthood, cut the Title X Family Planning Program, and restructure Medicaid in the twenty-first century.

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Introduction

Less than a century ago, family planning was illegal, deemed obscene, and government assistance in the field of sexual and reproductive health was inconceivable. Yet as of 2017, the United States (US) spends over two billion dollars annually on reproductive health services, education, and family planning through a variety of federal-state partnerships (Gold et al. 2009). The prevailing motivations for government subsidized contraception and family planning have changed since their inception in the mid-1900s. What began as concern for the well-being of indigent infants and children in the early 1930s developed into family planning programs aimed to alleviate poverty and overpopulation in the 1960s. By the end of the twentieth century, the context of family planning expanded to include a broader array of services including health education, testing and treatment for sexually transmitted infections (STIs) and reproductive cancers, and fertility services alongside contraception, in an effort to support women and men in planning their families.

Despite the United States' seemingly substantial assistance towards reproductive health care and the development of highly effective contraceptive options in the twenty-first century, the US has one of the highest rates of unintended pregnancy and sexually transmitted diseases among wealthy, developed countries (Finer and Zolna 2016). The most common barriers to contraceptive use include the cost of contraceptives, location of family planning clinics, unfamiliarity with contraceptive methods, the absence of youth-friendly services, and an array of sociocultural deterrents towards use (Healthy People 2018). Financial barriers to access disproportionately affect women in young, low-income, and minority groups. These groups also face the highest rates of unintended

pregnancy and reproductive health issues. A 2011 study found that nearly 50% of all pregnancies in the US are unintended, a measure commonly used to evaluate the unmet need for family planning services in a population (Finer and Zolna 2016). Unintended pregnancies, or pregnancies that are either unwanted or mistimed, result in nearly \$21 billion in public costs for abortion, comprehensive prenatal, labor and delivery, post-partum, and the first year of infant care (Sonfield and Kost 2015).

Historically, government assistance toward family planning has been the principal mode to improve financial and geographic access to reproductive health care among disadvantaged groups, specifically low-income women and adolescents. Since the mid-twentieth century, federal funding for family planning has occurred through federal grants, entitlement programs, and federal-state partnerships, each providing varied sums of money, targeting different populations, and maintaining distinct rules and regulations in use. The earliest program, Title V of the Social Security Act (Maternal and Child Health Services Program), aimed to improve the well-being of mothers and children. Other funding sources originated from welfare-based programs, including the Office of Economic Opportunity grants and Title XX of the Social Security Act (Social Services Program). The only source of federal funding dedicated exclusively towards family planning comes through Title X of the Public Health Service Act (Family Planning Program). Lastly, Medicaid and the State Children's Health Insurance Program (SCHIP) provide a significant proportion of the funding for family planning in the twenty-first century. The importance of each of those individual funding sources has fluctuated over time and varies by state, as each state independently builds their family planning effort based on the unique local needs and political climate (Sollom, Gold, and Saul 1996).

While guidelines exist for spending federal funds, states can have varying degrees of flexibility regarding allocation. In general, many federal grants allow states latitude to implement programs to best meet the local population's needs (Congressional Budget Office 2013). Some grant initiatives provide only broad parameters for spending, where local recipients can determine which community issues to support, how and where to implement programs, and in what manner to use and distribute funds. While the flexibility of many of these grants may allow state and local governments to tailor programs to best suit the local population's needs, criticism often arises for two reasons. First, historically it has been difficult to measure state-level performance and hold local governments accountable for the effectiveness of program spending (Dilger and Boyd 2014). Second, critics argue that under these broad programs, the state political climate may influence the allocation of funding more than actual needs dictates (McFarlane and Meier 1998). Because of these two disparate positions, there exists political tension regarding the amount of control states should have in managing federal funding. Those tensions are exacerbated in the context of funding reproductive health care which, since the legalization of abortion, has become increasingly controversial among social conservatives in politics (Gold et al. 2009).

The contentious debate about state-level management of federal funds for family planning is evident in the increasing tensions surrounding the federal funding of Planned Parenthood. Since 2015, religious and Republican leaders have pushed to remove federal funding from Planned Parenthood because of increasing controversy about the organization independently providing abortions. In 2016, the Department of Health and Human Services (HHS) under President Barack Obama's Administration, passed a rule

that state agencies could not bar select clinics from receiving Title X Family Planning Program funds based on anything other than the ability of that clinic to provide family planning services (Calmes 2016). Ultimately, this law prevented state legislatures from passing laws that would prohibit abortion providers, like Planned Parenthood, from receiving Title X funding solely because they also provided abortion services. In April 2017, President Donald Trump approved legislation that repealed the Obama era law, and allowed states to deny funds from specific organizations (Dwyer 2017). That ultimately allowed states the freedom to remove federal funding from Planned Parenthood clinics or other abortion providers if they so choose. This provides a modern example in which state political ideology, rather than population needs or goals of the health programs, can dictate the ways in which federal funding is allocated. This also demonstrates an important shift in the cultural and legislative discussion surrounding federal funding of family planning.

Recent legislative attempts to exert more control over federal funds for family planning activity demonstrates the important role states have in efficient, effective, and equitable implementation of those funds. Though federal assistance for reproductive health services currently exists, most programs have faced substantial cutbacks in the last several decades. In 2018, under the Trump Administration and the Republican led Congress, further budget cuts to federal health programs are expected (Guarnieri 2018). The changing social, political, and economic landscape in the federal funding of family planning invites a comprehensive look at the historical arrangement of these funding sources. While many states have other sources of revenue for family planning programs, including state and county support, Arizona relies almost exclusively on federal sources

alongside patient fees and donations. Arizona historically has not provided any funding for family planning, and is one of only a handful of states similarly impacted (APHA 2001).

This thesis examines how Arizona's political, geographic, cultural, and ethnic landscape shaped the state's management of federal funding for family planning since the early twentieth century when such funding became available. Historically, Arizona's rural, frontier landscape and the large population of minority groups enabled specific forms of family planning aid to Arizona residents, including those for migrant workers and American Indians. As federal funding for family planning became available throughout the country, Arizona state agencies and nonprofits collaborated in a distinct way to maximize the resources for family planning to effectively reach the most residents possible. That partnership, established in the early 1970s, allowed Arizona providers to reduce geographic barriers to family planning in a still very rural state, and offer patients more choices in how and where they chose to seek care (Pearson 2017). By reviewing how and why this collaboration developed over time, this thesis aims to understand the ways in which federal funding for family planning can be implemented at the state level despite challenging geographic, political, cultural, and economic barriers. In addition, this thesis details the ways in which federal financing of family planning has changed, along with the challenges and opportunities those changes present. At the state level, this thesis outlines some of the trials and accomplishments in Arizona's implementation of federal funding for family planning over time. By doing so, this thesis identifies ongoing barriers and prospects for growth that lie ahead in the twenty-first century. To accomplish these objectives, this thesis analyzes the broad federal legislation and large-scale events that

influenced the national landscape towards family planning alongside Arizona specific outcomes, trends, and perspectives viewed through a more focused lens.

This thesis begins by providing a background for the roots of federally funded family planning efforts in the United States, stemming from early twentieth-century legislation aimed to improve the health and well-being of mothers, infants, and children. Chief among those programs was Title V of the Social Security Act, also known as the Maternal and Child Health Services Program (MCH). Alongside the contextual history, the first chapter discusses the illegality of contraception and the negative social morals surrounding discussions of sex to explain why birth control was not funded as part of early programs to improve the health of mothers and children.

Progressing to a focus on Arizona, the first chapter describes the setting in rural Arizona, which had one of the highest maternal and infant mortality rates in the country in the early twentieth century. As national policies were initiated to address poverty among specific minority groups, federally funded birth control moved into Arizona. In the 1930s Arizona's unique population demographics enabled the state to receive funding from the Farm Security Administration for tenant farmers and migrant workers, and the US Public Health Service for American Indians. Both initiatives discretely provided contraceptive services to eligible women. By the 1940s, the Arizona State Health Department public health nurses were using Title V MCH Program funding for family planning services.

Following significant improvements in maternal and infant mortality rates, chapter two examines the ways in which modern family planning efforts intensified in the 1960s alongside concerns of overpopulation and poverty. The first federal programs

dedicated to family planning were initiated under auspices of President Johnson's War on Poverty by the Office of Economic Opportunity (OEO) grants, made possible by the legalization of contraception in the Supreme Court case *Griswold v. Connecticut* (1965). Several organizations and counties in Arizona received OEO grants for family planning throughout the 1960s. This chapter also examines how Arizona counties developed locally-supported family planning clinics.

Chapter three outlines an array of federal programs that followed in the 1970s designed to fund family planning and reproductive health care. By that time, it was apparent that implementing family planning services within poverty-related programs did not sufficiently reach all women in need of publicly funded contraception. As such, Congress enacted the Title X Family Planning Program, the only federal initiative to exclusively fund family planning. Subsequently, local leaders founded the Arizona Family Planning Council, a nonprofit grantee of Title X in the state of Arizona. That section also discusses Title XIX of the Social Security Act, also known as Medicaid, which was amended to require participating states to cover family planning. In addition, the third chapter reviews the welfare-based program Title XX of the Social Security Act, called the Social Services Program, which could also be used for family planning.

This thesis then examines the two controversies that emerged following the passage of the Title X Family Planning Program and the legalization of abortion in the Supreme Court case *Roe v. Wade* (1973). Controversy surrounding abortion and adolescent access to contraception intensified as a direct reaction to those two events. The fourth chapter analyzes how these provocative issues manifested in Arizona, specifically

the impact on health care providers' ability to utilize federal funding for family planning services.

Chapter five explores the ways in which the controversies surrounding abortion and adolescent care continued into the 1980s and led to large-scale cutbacks for many family planning grant programs under President Ronald Reagan's Administration. While there were cuts in federal grant programs, several expansions in Medicaid eligibility led to Medicaid becoming the primary financier for family planning throughout the nation. This chapter then moves to discuss several changes that occurred in Arizona in the 1980s, allowing broad state participation in federal funding of family planning. During this time, Arizona developed its own Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), and began receiving the Title X Family Planning Program funding, greatly increasing the resources available for family planning in the state. Following this large capital influx, this thesis discusses the unique way Arizona leaders in family planning managed the largest sources of funding. Specifically outlined in this discussion are Title V, Title XX, and Title X, including how the Arizona family planning community worked to cover the large geographic region with small populations spread out across the vast, rural state.

Chapter six explores nationwide trends in the 1990s, including further budget cuts for family planning grants, a shift towards Medicaid funding for family planning, and the increasing cost of contraceptive supplies and technology. Included is a discussion of the challenges faced in Arizona, and reflected nationally, exposing the difficulty Title X family planning providers experienced in acquiring Medicaid or AHCCCS managed care contracts. In addition, this chapter provides a discussion of the ways in which health care

providers managed the increasing cost of contraceptives amid dwindling budgets.

Alongside the discussion of Medicaid expansions in the 1990s and twenty-first century, is the discussion of new grants that provide funding for family planning statewide: the Temporary Assistance to Needy Families program (TANF), the Health Center Consolidation Act, and the State Children's Health Insurance Program (SCHIP).

Finally, the discussion concludes with a view at the tension surrounding federally funded reproductive health care, and the continued fight within Arizona over the control of federal funds in the twenty-first century.

Methodology

This thesis examines how Arizona political, geographic, cultural, and ethnic landscape shaped the state management of federal funding for family planning since the early twentieth century. Moreover, it explores the ways in which Arizona implementation of federal funding for family planning has evolved since the mid-twentieth century to contextualize shifts in the state reproductive health landscape. To do that, I examined three sources of evidence. First, I conducted a broad literature review to examine patterns in family planning funding at the federal level, and the ways in which implementation of federal funding can vary by state. This broad literature review allowed me to contextualize the national story of federal family planning funding alongside the social, cultural, and political climate in which these programs developed.

After tracing the evolution of federal family planning programs, I used this as context to analyze implementation of these federal funds in Arizona. To do this, I collected oral histories from individuals who had an integral role in the administration, oversight, or implementation of federal family planning funds in Arizona. I collected these oral histories through resources from Reproductive Health Arizona, a collaborative digital project housed on the *Embryo Project Encyclopedia* website that seeks to record the history of reproductive health and medicine in Arizona and increase Arizonan's literacy of these issues. I obtained interviews from eight individuals: Jane Canby, Emily Jenkins, Jane Pearson, Judy Walruff, Charlotte Harrison, Gloria Feldt, and a joint interview with Pearl Tang and Claire Armstrong. These oral history interviews allowed me to explore the recollections, perceptions, and experiences of reproductive health

experts in Arizona involved in the management and distribution of federal family planning funds since the early twentieth century.

Table 1. Names and descriptions of interviewees.

	Active Years	Relevant Positions
Pearl Tang	1950s–1980s	OB/GYN Physician in Maricopa County Chief, Maricopa County Bureau of Maternal and Child Health
Claire Armstrong	1950s–1980s	Public Health Nurse, Maricopa County
Jane Canby	1960s–1990s	Volunteer, Planned Parenthood of Arizona Executive Director, Arizona Family Planning Council
Emily Jenkins	1970s–2000s	Executive Director, Arizona Family Planning Council
Jane Pearson	1970–2000s	Public Health Nurse, Maricopa County Assistant Director, Arizona Department of Health Services Board of Directors, Arizona Family Health Partnership
Judy Walruff	1990s– Present	Program Officer, Flinn Foundation Coordinator, Arizona Governor’s Office Board of Directors, Arizona Family Health Partnership
Charlotte Harrison	1990s–2010s	Executive Director, Arizona Family Planning Council
Gloria Feldt	1970s–2010s	President and CEO, Planned Parenthood Federation of America CEO, Planned Parenthood Arizona

Lastly, I used archival materials from Arizona newspapers and various state agencies and nonprofits involved in family planning to analyze more precise details regarding Arizona implementation of federal funds. These materials included annual reports, budgetary documents, and monthly newsletters from organizations such as the Arizona Family Planning Council and the Arizona State Health Department.

Family Planning in Maternal and Child Health Contexts

The roots of federally funded family planning stem from early twentieth-century legislation aiming to improve the health and well-being of mothers, infants, and children. Poverty, poor sanitation and hygiene, and lack of medical care resulted in high maternal and infant mortality rates throughout the US, specifically among low-income and minority groups (Melcher 2012). As a result of these poor outcomes, in 1935 Congress passed national legislation, Title V of the Social Security Act, which provided grants to states for programs that sought to improve the health and well-being of mothers and children. In the years following that legislation, birth control activists throughout the country advocated for family planning as a means to improve both the physical health of women and their children, and the economic well-being of families. As a result, those federal programs responded to include family planning as a means to promote maternal and child health. To address broader health issues resulting from poverty, Congress also approved programs for specific populations including tenant farmers, migrant workers, and American Indians.

In the early twentieth-century, US women and children faced significant health challenges. In many cities, nearly thirty percent of infants died before the age of one (CDC 1999a). Infant deaths were commonly attributed to poor environmental and living conditions, factors that contributed to high rates of infectious diseases (CDC 1999a). Women faced poor health due to multiple pregnancies and complications during delivery (AMCHP 2010) In the early 1900s, approximately one in one-hundred-and-fifty women died because of a complicated pregnancy or delivery (AMCHP 2010). High rates preventable pregnancy-related complications often stemmed from poor obstetric

education and delivery practices. Approximately forty percent of maternal deaths were due to infection or sepsis following delivery or illegal abortions (CDC 1999a). In addition, multiple pregnancies with short periods between pregnancies led to infants with low birth weights, poorer nutritional health for mothers and infants, and significant financial strains on families (CDC 1999a). By the early twentieth century, birth control advocates argued that contraception could provide a means for women to preserve their health through the spacing of children.

Margaret Sanger, a nurse who first coined the term ‘birth control’ in 1915, advocated for birth spacing as a means to improve women’s health and that of their children (Sanger 1952). Working in New York City, Sanger encountered many women and men who appealed to her for methods to prevent pregnancy, citing too many children and extreme poverty as the primary motivation (Sanger 1952). Sanger argued that much of the burden placed on poor families was caused by having more children than they wanted and could support (The Margaret Sanger Papers Project n.d.). Sanger incited the movement for greater access to, and legalization of contraceptive options for women to control their fertility. Birth control advocates, like Sanger, argued that contraception could improve family stability and community health. However, the social and medical climate in which advocates worked was unreceptive toward women’s rights and largely indifferent to attempts at supporting women’s health (Melcher 2012).

Despite Sanger’s efforts to label birth control as a means to reduce poverty and improve maternal health, family planning was not seen as socially acceptable due to a traditionally conservative culture grounded in a morality that confined sex to the utility of reproductive purposes within marriage (Primrose 2012). Groups with traditional values,

often based in religion, saw birth control as promoting sexual promiscuity because it allowed partners to have sex for reasons other than reproduction (Melcher 2012). Federal and state laws prior to the mid-twentieth century reflected those moral and religious views towards reproduction.

The US Comstock Act of 1873 federally banned the use, advertisement or distribution of inappropriate or obscene materials. Under the Comstock Act and socially conservative values, contraception and sex education were classified as obscene. While the Comstock Act federally banned contraceptives, states across the country passed similar state-level obscenity laws throughout the nineteenth century in an attempt to control the morality of citizens. Without the ability to regulate their fertility, many women in the early twentieth century had more pregnancies than they wanted, resulting in high maternal and infant death rates.

In 1912, high infant and child death rates led Congress to establish the Children's Bureau, an agency responsible for research pertaining to the economic, social, health, and well-being of children in the US (Van Dyck 2010). Early reports from the Children's Bureau, led to changes in child labor laws, a national school lunch program, and improved maternal health standards (AMCHP n.d.).

The success of the Children's Bureau illuminated the role of federal policy in improving the lives of infants, children, and mothers in the US. In 1921, President Warren Harding signed into law the Maternity and Infancy Care Act, also known as the Sheppard-Towner Act, which provided grants to states for projects related to maternal and child health (AMCHP n.d.). The Act supported the establishment of state-level children's bureaus, well-baby and prenatal clinics, visiting nurse programs, and

educational programs related to nutrition and hygiene (Kotelchuck 2006). Though the appropriations were small, between five thousand and ten thousand US dollars per state, the Act marked the first time the federal government provided states grants for public health (Van Dyck 2010). However, the Act was criticized as being socialistic and many organizations, including the American Medical Association and the Public Health Service, called for its repeal (AMCHP n.d.). Ultimately, in 1927, Congress voted not to renew the Act and in 1929, the Act expired. Despite its dissolution, forty-seven states retained child health units that were created under the program (AMCHP n.d.).

The same year the Sheppard-Towner Act ended, the stock market crash of 1929 led to the Great Depression in the US. By the 1930s, the worldwide economic crisis led to high rates of poverty, unemployment, poor health, and increases in maternal and infant mortality. State and county governments struggled to address the health needs for the rising population of unemployed individuals and families (Kotch 2005). Additionally, as unemployment rates soared and the tax base decreased, state budgets were decimated leading to very little spent on maternal and child health (Kotch 2005). As a result, President Franklin D. Roosevelt sought to establish social programs to help those suffering from the economic crisis.

On 14 August 1935, Roosevelt signed into law the Social Security Act, which intended to provide aid for the elderly, unemployed, and children, through a welfare system. Embedded in the Social Security Act were two programs that would go on to be important pieces of legislation for funding family planning. The first was Title IV, also known as the Aid to Dependent Children, or Aid to Families with Dependent Children (AFDC). The program provided direct financial assistance to needy parents with

dependent children. Nearly all AFDC recipients were unemployed women caring for their children either without a husband or with an unemployed husband (Gordon and Batlan 2011). That program became the eligibility foundation for many future welfare and family planning programs established in the following decade.

The second important program in the Social Security Act was Title V, a categorical grant provided to the states for specific purposes with restrictions regarding how the funding was spent. Included in the Title V legislation was the Maternal and Child Health (MCH) Services Program, in which funding was allocated to states for maternal and child welfare. Unlike other sections of the Social Security Act, the Title V MCH program was not an entitlement program, meaning that Congress would need to appropriate funding each year (AMCHP 2010). Title V was administered by the Children's Bureau and later by the Department of Health Education and Welfare (DHEW) (Kotelchuck 2006). States were provided MCH funding based on a formula of how many children were living in poverty in a certain state in relation to the number of children living in poverty in the entire country (The Maternal and Child Health Bureau n.d.). The federal grant was provided directly to and controlled by the state government (The Maternal and Child Health Bureau n.d.). As such, Title V MCH funding typically went to the state health departments. The MCH program was flexible, allowing states to use the money for a variety of purposes including direct medical services, education, prevention activities, vaccinations, data collection, and needs assessments, so long as they directly related to maternal and child welfare (AMCHP 2010).

Title V was included in the broad sweeping poverty-related legislation, rather than enacted as specific health legislation, illustrating its aim to alleviate poverty among those

segments of the population that were dependent on public support to meet their basic needs (Kotelchuck 2006). The Social Security Act, by including Title V, thus recognized the dependence of mothers and children, rather than different diseases or health conditions, as warranting special attention (Van Dyck 2010). According to former head of the Maternal and Child Health Bureau, Peter Van Dyck, Title V demonstrated the essential interrelatedness among social and economic problems and health outcomes. As such, the Title V MCH program was required to focus on economically disadvantaged women, infants, and children. Initial Title V programs focused heavily on infants and children, emphasizing hygiene, sanitation, nutrition education, milk pasteurization, early childhood vaccination, and prenatal care to prevent low birth weight infants and reduce infant mortality. Toward the end of the 1930s, increased emphasis was placed on maternal health and preventing maternal mortality from poorly managed deliveries. Family planning and spacing of pregnancies was not included as methods for improving maternal health in the 1930s, as contraception and discussion of family planning was still illegal and socially improper. However, by the mid-1930s birth control activists who sought to improve maternal health began challenging the laws prohibiting birth control.

The Comstock Act banning birth control was first legally challenged in the 1936 case *United States v. One Package of Japanese Pessaries*. In 1933, Sanger illegally opened a birth control clinic and ordered a box of contraceptive pessaries from Japan for the clinic patients (The Margaret Sanger Papers Project 2011). Custom officials were alerted to the contents of the package and confiscated it for containing obscene materials and violating both the Tariff Act of 1930 and the Comstock Act of 1873. Sanger appealed the confiscation to the US Court of Appeals for the Second Circuit in New York City,

New York. The court ruled that physicians were excluded from laws restricting the importation or distribution of contraception or contraceptive information. The decision in *United States v. One Package of Japanese Pessaries* enabled physicians to legally provide contraceptive methods to their patients and was the first step in the process of repealing the federal Comstock Act.

Most physicians remained disinclined to discuss family planning and distribute contraceptives, despite the decision in *One Package* that legally permitted it (Aries 1987). Many physicians were uncertain about the status and enforcement of federal and state level obscenity laws and did not want to risk losing their medical licensure and ability to practice (M. Bailey 2013). Wealthy women in the early nineteenth century often had access to contraception because they could afford to select private family physicians who were willing to provide contraception. However, poor women who could not afford private physicians were left without access or education about family planning methods. Despite the legality of contraception, state and county health centers rarely offered family planning services, unwilling to entrench themselves in a potentially religious or political debate (Eliot 1966). That disparity in access to legal contraception led to the formation of organizations such as Planned Parenthood, who worked to establish free family planning clinics in areas of need. Within five years of the *One Package* decision, Planned Parenthood had expanded to more than seventy local affiliates across the country (Aries 1987). During this time, the organization was funded almost exclusively through volunteer efforts and philanthropic donations. Planned Parenthood flourished in Arizona, where Sanger partnered with wealthy local socialites who were passionate about the birth control movement.

Arizona: Farmers, American Indians, and Maternity Care

In the 1930s, Sanger moved to Arizona and was overwhelmed by the high rates of infant mortality, which she stated was an indication that women lacked family planning resources (Melcher 2012). At that time, Arizona had one of the highest maternal and infant mortality rates in the country largely due to its rural landscape, which lacked adequate transportation and trained medical professionals (Melcher 2012).

Arizona is the sixth largest state in the nation in terms of geographic size, but in 1930 had the sixth smallest population (United States Census Bureau n.d.). As such, Arizona had, and continues to have in the twenty-first century, long stretches of undeveloped land. Arizona is composed of fifteen counties, Mohave, Coconino, Navajo, Apache, Yavapai, Gila, La Paz, Maricopa, Pinal, Graham, Greenlee, Yuma, Pima, Santa Cruz, and Cochise. Though the Arizona cities of Phoenix and Tucson, in Maricopa and Pima county respectively, slowly grew into metropolitan areas, many Arizonans continued to live in rural, isolated regions throughout the state, often without electricity, running water, or proper sanitation. In addition, many towns remained detached due to lack of adequate infrastructure and transportation.

Arizona's large physical geography, with extensive distances of undeveloped land, minimal population, and poor infrastructure and transportation made getting health care, particularly emergency care, extremely difficult. In addition, as a frontier state, Arizona experienced challenges in retaining an adequate number of health care providers (AFHP 2011). As such, individuals and families living in rural Arizona were often required to travel long distances to reach a health care provider. One of the reasons

families lived in rural Arizona was to participate in the agricultural industry as migrant or tenant farm workers.

As a western territory, heavily reliant on the farming and agriculture industry, Arizona's population was comprised of many farmers and migrant workers from around the US and Mexico. Individuals who worked in the Arizona agriculture industry resided in migrant worker camps in rural areas, most living without electricity or running water. Migrant workers settling in those camps faced unsanitary living conditions, high rates of infectious diseases, and extremely poor health outcomes for women and children (Grey 1994). Those living in migrant camps with poor roads, impoverished living conditions, and lacking basic health care, faced infant mortality rates that were more than three times higher than the national average (Melcher 2012). Migrant farmworkers living in camps outside city limits experienced economic hardships and difficulty accessing health services based in the cities of Phoenix and Tucson. The Great Depression in the 1930s worsened conditions for farmers in Arizona, and in agricultural areas across the country. As such, Arizona received significant federal aid for relief and recovery throughout the decade. The federal government also sought changes to improve the health and living conditions of tenant farmers and migrant workers.

In 1935, the federal government sponsored a medical care program through the US Department of Agriculture Farm Security Administration (FSA). The goal of the FSA was to assist low-income farmers, sharecroppers, and migrant workers through resettlement programs, education on soil conservation, emergency relief funding, and small business loans (Grey 2002). The programs were largely focused in the Great Plains

and Southwest areas, both of which relied heavily on farming and experienced severe natural and economic disasters during the 1930s (Grey 2002).

The FSA comprehensive medical care program included various preventative health measures, including health education, nutrition, sanitation, immunizations, prenatal and postnatal care, and obstetric care. Local public health nurses, nutritionists, and physicians administered the program throughout the country, though nurses provided the majority of health education and care (Melcher 2012). At its height, the FSA program provided health care to more than 650,000 farmers annually (Grey 1994).

In Arizona, public health nurses of the federal health program for farmers and migrant workers began providing family planning to patients. The long distances between cities and rural areas and poor transportation infrastructure, led most Arizona women, and those living in camps to give birth at home, without medical assistance in the case of complications during delivery (Melcher 2012). Thus, home births incurred greater risks, leading to high rates of maternal and infant mortality (Melcher 2012). Rates of maternal and infant mortality were even higher in migrant worker camps, where Arizona women had extremely high rates of fertility, yet poor access to prenatal, delivery, and postnatal care (Grey 1994). Arizona FSA nurses saw contraception as a means to reduce maternal and infant death rates.

FSA nurses worked in the field, performing home visits to families living in rural camps. As such, they worked fairly autonomously and provided services as they saw fit (Grey 2002). Though the FSA program did not officially authorize the use of family planning as a preventative health care option, many FSA nurses in Arizona, and throughout the country, provided migrant workers with birth control options and family

planning information (Melcher 2012). FSA nurses in Arizona traveled throughout the rural counties providing women with information on methods of family planning, including spermicidal foam powder, sponges, and other natural methods of family planning, all of which were accessible to those living on the rural frontier. For migrants who had the means to travel, FSA nurses referred clients to the larger Planned Parenthood clinics in Phoenix and Tucson for other types of contraceptives such as diaphragms, which needed to be properly fit by a physician. Physicians and nurses operating the program viewed contraception and sex education as means to improve familial stability and the economic well-being of migrant workers (Melcher 2012). At the start of World War II, the FSA program lost popularity and funding was cut significantly as the nation redistributed funds and efforts on activities to support soldiers (Grey 1994).

During World War II, national emphasis was on wartime support efforts. Following the onset of WWII arose a new demand for health care assistance for the wives and children of deployed servicemen, who were often dislocated from their homes while their husbands fought abroad. In the early 1940s, Congress enacted the Emergency Maternity and Infant Care Program. The act distributed funds to states to provide for health care for the pregnant wives and infants of soldiers in the lowest pay grades (Kotch 2005). Though family planning was not explicitly stated as a program component, many physicians and nurses delivering care to those women provided family planning as part of preconception and postpartum maternity care. The program was phased out following the end of WWII and had afforded over a million women with maternity-related care (Kotch 2005). As more programs that delivered maternal and infant health began covertly integrating family planning into maternity and prenatal care visits, health care

organizations and legislators slowly permitted the use of federal funding for family planning.

In 1942, the US Public Health Service released a policy statement that allowed states to use Title V MCH program funding to provide family planning services (Rosoff 1973). Following this announcement, some states began using MCH Grant funding to provide family planning services discretely throughout the 1940s (Kotelchuck 2006). Several states, particularly Southwestern states with high rates of maternal and infant mortality, used Title V MCH funding to organize family planning programs through the state and county health departments (Aries 1987). However, due to limited funds granted through Title V and even smaller amounts allocated for family planning, many low-income women throughout the country still lacked access to contraceptive care.

The state of Arizona, which continued to have both high maternal and infant mortality and high birth rates in comparison to the rest of the country, began using some Title V MCH grant money through the state health department to provide family planning resources to low-income women. In 1950, Arizona's infant mortality rate was nearly fifty births per one thousand, compared to the national average of twenty-nine per thousand and had the third highest birth rate in the country (Melcher 2012). Reflecting national trends in the utilization of family planning under Title V MCH funding, family planning was initiated under the auspice of promoting maternal and infant health across the state. According to then-Planned Parenthood volunteer Jane Canby, family planning "was provided through Title V in this state and in some counties, as the county decided whether they wanted that service. It was permitted, and it was directed at maternal health.

It was very much a public health, maternal health, and child health [service]. That was the direction and orientation of it” (Canby 2016).

Though Title V MCH funding provided subsidized family planning, Arizona residents living outside city limits of Phoenix and Tucson faced challenges in accessing those services. As such, state and county public health nurses often conducted follow-up visits at patients’ homes using the Title V MCH funding. Claire Armstrong, a public health nurse in Maricopa county, recounts,

Well in doing follow up in the field, making home visits to mothers, babies and what not, we followed up with communicable diseases, maternal and child health, family planning often times. One of the ones that stuck out in my mind was, we labeled our records as ‘Home Visits.’ This one, I labeled ‘Tree Visit.’ They were camped under a tree near an irrigation ditch and that was their water. And they’d been there for a number of months. And making a few phone calls and pushing them here and there I was able to get them into some housing (Tang and Armstrong 2016).

Pearl Tang, a physician trained in obstetrics and gynecology, began working for the Maricopa County Health Department in 1954, and recalled similar maternal and infant health disparities among low-income, rural, and minority groups. Tang recounts, “most of the infant deaths and premature babies were in areas that were outside the city in outlying areas where the low-income families have difficulty getting into the city for health care...I recall we had a clinic in Gila Bend...in an abandoned jailhouse because it had running water and a bathroom” (Tang and Armstrong 2016).

In the years that followed, Tang and her team of public health nurses were awarded Title V MCH funding to develop a mobile clinic for maternity, prenatal, postnatal, and family planning care. A physician, public health nurse, and health assistant staffed the mobile clinic and traveled to rural areas that lacked medical services (Tang and Armstrong 2016). The Title V MCH program funding enabled medical providers to serve those living in rural Arizona, improving maternal and child health outcomes and intermediate outcomes of poverty and homelessness.

Throughout the 1950s, family planning continued to be offered through state-run maternity clinics as part of postnatal follow-up care. Both Tang and Armstrong explain that family planning consultations were done discretely and in line with other maternity care programs. According to Tang, “we never set up a special program on contraceptives, so it was all part of maternity care and if they have questions on that its part of postnatal delivery. When the woman comes to see us that we might possibly discuss some of their needs” (Tang and Armstrong 2016). Public health nurses throughout Arizona maintained similar apprehensive attitudes towards discussing family planning with patients.

Armstrong recounts,

We were very careful about communication...we did not discuss anything except health care. That [family planning] provided, that this helped your health. If they had any questions about religion, we said talk to your church...we were providing a health service to these ladies. It's up to them to decide and to talk to their family, their church, and their doctor as to if they really want that...we just did it quietly and pushed the health, that [family planning] is a health service (Tang and Armstrong 2016).

In addition to family planning offered through the Title V MCH program and the FSA health care program, family planning was provided to the Arizona's Native American population through the US Public Health Service for American Indians.

Arizona has a notably large population of American Indians, twenty-one federally recognized tribes including both indigenous and relocated to tribal parcels. Arizona has the largest percentage of tribal lands in the nation, which cover over nineteen million acres and extend across the state, crossing into New Mexico, Utah, and Mexico (USDA n.d.). Because of that expanse, lack of infrastructure, and social and cultural stigmas and preferences, Native Americans throughout the country and Arizona, struggled to receive health care services. Navajo and White Mountain Apache tribes, who live on vast Arizona reservations, were separated by extended distances from the health care options in larger cities (AFHP 2011). Traditionally Native American culture highly regards the role of motherhood and were more likely to dismiss contraceptives (Melcher 2012). Therefore, this population across the country had significantly higher birth rates in comparison to other groups (Melcher 2012). In Arizona, Native Americans not only had high birth rates, but also significantly higher maternal and infant mortality rates.

Much like the FSA health program enabled Arizona migrant workers to access family planning, the Arizona Native American population gained access to contraceptives in the early 1960s as part of the US Public Health Service for American Indians, which is responsible for providing federal health services to this population (Rabeau and Reaud 1969). In 1962, the program initially provided American Indian women with birth control for strictly medical reasons. In 1964, the services expanded access to contraception for preventing pregnancy as well and by 1965, aimed to reach eighteen thousand American

Indian women of reproductive age nationwide (Rabeau and Reaud 1969). The Division of Indian Health documented results from the program and included Arizona Native American women from Tuba City, Arizona, in their comprehensive survey of family planning (Rabeau and Reaud 1969).

Though there were several programs nationally that provided some funding for family planning through maternal and child health programs, overall funding levels were low. Unique Arizona demographics allowed the state to utilize various programs that included family planning as a means to improve maternal and child health. While the Title V MCH program had contributed to family planning in several states, including Arizona, the funding levels set aside for reproductive health remained minimal (Kotelchuck 2006). Estimates show that by the mid-1960s, not more than five million had been spent on family planning through all sources since the 1940s (Rosoff 1973). While the original Title V MCH grant provided very little funding for actual family planning services, it paved the road for future federal-state partnerships in family planning funding.

Solutions to Poverty: The Beginnings of Federally Funded Family Planning

The expansion of modern family planning efforts in the US intensified in the mid-twentieth century alongside the revival of women's rights, concerns about population growth and poverty, and developments in highly effective contraceptive methods, including the birth control pill and intra-uterine device (IUD). By the 1960s, there was common consensus that multiple unplanned pregnancies directly influenced family financial status, dependence on public assistance, educational attainment, and employment (Campbell 1968). Research conducted post-WWII demonstrated that high fertility rates among low-income women were the result of unequal access to family planning, not the desire for large families (Ryder and Westoff 1971). At the same time, studies began to show that unintended pregnancies and multiple pregnancies close together led to poorer health and economic outcomes for women and their children (Brown and Eisenberg 1995). Thus, new federal programs for family planning, including grants made by the Office of Economic Opportunity and expansions in the Title V MCH program, sought to improve access among needy populations.

Women's rights activism in the 1960s re-galvanized attention on the legalization and improved access of birth control and abortion. While public health nurses and birth control advocates framed family planning in terms of public health and maternal health to gain approval at the local level, the new women's movement broadened the discussion to sexual freedom and reproductive rights. The second wave of feminism fought for gender equality in social, political, and economic spheres (Gordon 2002). Birth control, and the ability for women to control their bodies and their fertility, was simply one way for women to achieve that equality. By the mid-twentieth century, women's role in society

was changing. American women were no longer solely responsible for the household. Rather, they had greater independence, more responsibility for wage-earning, improved opportunities for higher education, and expanded legal rights (Gordon 2002). Despite the increasingly progressive role of women in US society, women's aspirations for achieving a higher education, employment, and gender equality, were hindered by the inability to control childbearing (Gordon 2002). Contraceptive options for managing and planning families were still limited and those that existed, the diaphragm and condom, were legally inaccessible and cost-prohibitive to a significant portion of the population.

In 1960, the FDA approved the first oral birth control pill, Envoid, for contraceptive use. In three years, more than two million women in the US were taking the pill (Nikolchev 2010). By 1965, approximately twenty-four percent of married women were using oral contraceptives (IOM 2009). However, despite early acceptance and support of the birth control pill, state-level obscenity laws varied in language relating to contraception, and in implications for access to the Pill (M. Bailey 2009). Although many state-level Comstock laws were outdated or no longer enforced, physicians tended to comply with state laws out of fear or uncertainty surrounding enforcement and because violating them could jeopardize their medical licenses (M. Bailey 2013).

Alongside pharmaceutical developments in birth control, there was increasing interest throughout the world on overpopulation and its relation to global poverty and food security. Thomas Malthus, a pastor and economist in nineteenth century England, formulated the cyclical relationship between population growth and poverty. Commonly referred to as the 'Malthusian Catastrophe' or 'Malthusian trap,' Malthus noted that as food production increased, the population well-being improved (Robertson 2012).

However, as food production and well-being raised, so did the number of births and total population size. He argued that while populations continued to grow exponentially, the agricultural yields did not (Robertson 2012). Therefore, the lower class would suffer poverty, famine, and disease. The cycle would continue, perpetuating a subsistence economy. Malthus argued that the way to improve living standards beyond a subsistence economy was to limit population growth through preventative measures such as late marriage and celibacy (Soloway 1978). The idea that overpopulation caused poverty was prominent in the nineteenth century, however, by the early twentieth century and the advent of stable forms of agriculture in the Western world, many were unconcerned with overpopulation.

In the decades that followed WWII, pregnancy and birth rates dramatically increased as couples were reunited. The dramatic escalation in the rate of births following the war in the US, led to the generational classification of those children born post-WWII as “Baby Boomers.” Those population growth trends were reflected worldwide and by 1960, the world population had reached three billion (Robertson 2012). The media began popularizing the domestic and international problems of unchecked population growth, renewing interest in the economic ideas of Malthus (Robertson, 2012).

In 1963, President Lyndon Johnson took office and launched what historians commonly refer to as the War on Poverty to address the nations rising social and racial inequalities (Matthews 2014). The Johnson Administration passed several pieces of legislation that attempted to reduce poverty in the US, including the Economic Opportunity Act of 1964. That Act established the Office of Economic Opportunity (OEO), which provided grants through the Community Action Program (M. Bailey

2012). The Community Action Program established community action agencies at the local level to implement programs related to improving economic opportunity and reducing poverty. Community action agencies could be nonprofits, city agencies, community-controlled groups, among others. The OEO awarded community action agencies grants for job training, adult education, small business loans, and other programs that attempted to tackle unemployment and poverty. The OEO funded these community organizations directly, bypassing state and local governments. The Act also financed the creation of neighborhood health centers, later known as Federally Qualified Community Health Centers (FQHCs) or Community Health Centers (CHC) (Kotelchuck 2006). The centers were sites of health care delivery, health education, and community development projects.

On 30 July 1965, continuing his War on Poverty, Johnson signed into law Title XIX of the Social Security Act, also known as Medicaid, which provided health care assistance to the poor through a federal-state partnership. The legislation provided states the option of receiving federal funds to provide health care to low-income children, mothers, and the disabled within their state. States were not required to participate in the program (CMS 2015). Initially, Medicaid only mandated coverage for individuals who were eligible for Aid to Families with Dependent Children (AFDC), which covered families with children under 18 in one parent households, and cash assistance recipients. Beyond that, as a federal-state partnership, the individual states established eligibility criteria for welfare recipients. There were several limitations in respect to the original Medicaid legislation. First, individual eligibility, service coverage, and budgets varied across state Medicaid programs (Kotelchuck 2006). Additionally, it only paid for acute

care services, and thus did not cover preventative services such as family planning, despite family planning having been recently legalized (Kotelchuck 2006).

In 1965, the Supreme Court found the last of the state-level obscenity laws banning contraception to be unconstitutional in the case *Griswold v. Connecticut*. Connecticut Planned Parenthood director, Estelle Griswold and physician Charles Buxton opened a birth control clinic in New Haven, Connecticut, and were subsequently charged with violating the state's obscenity law. Griswold and Buxton appealed their conviction to the US Supreme Court, which found that the Connecticut obscenity law banning the use or distribution of contraception was unconstitutional. The Court ruled that the use of contraception was a constitutionally protected private decision made between a woman and her doctor. The Court's decision in *Griswold v. Connecticut* effectively legalized contraception for married couples throughout the US. Single women were still technically forbidden from accessing contraception, though many obtained birth control by claiming they were about to be married, borrowing a wedding ring, or requesting the birth control pill to treat severe menstrual bleeding or cramps (Gordon 2002; Jenkins 2017).

Following the decision in *Griswold*, several state health departments, including the Arizona State Board of Health, released policy statements in support of family planning. On 26 November 1965, the Arizona Board of Health approved the use of public funds for birth control, stating that fostering responsible parenthood was part of its duty to preserve the health of Arizona residents (The Arizona Republic 1966). The report stated that high rates of unwanted pregnancies threatened the health of Arizona women, children, and families (The Arizona Daily Star 1965b). The statement specified that family planning should be included in medical discussions with physicians and should be

entirely voluntary (Melcher 2012). In addition, the report stated that public funds and personnel would be used to ensure family planning services were accessible (The Arizona Daily Star 1965b).

By the mid-1960s, with contraception officially legalized, advocates campaigned for the initiation of government-supported family planning programs to expand financial access to reliable, effective contraceptives (M. Bailey 2013). Despite many of the legal challenges settled, the high cost of the most effective forms of contraceptives, the birth control pill and IUD, made them unavailable to low-income individuals (M. Bailey 2013). In the 1960s, an annual supply of the birth control pill Envoid sold for roughly three weeks of full-time work at minimum wage (M. Bailey 2012). The growing demand for this new, highly effective form of contraception compelled legislators to find ways to expand contraceptive options to US women.

The first federal grants dedicated solely to family planning in the US began in the mid-1960s under the Office of Economic Opportunity established by Johnson's war on poverty. The rationale for including family planning programs under that initiative was that by subsidizing contraception, family planning programs would promote greater economic opportunities for disadvantaged women. In addition, by reducing the number of unwanted children, the program aimed to promote opportunities for children and thus achieve broader and longer term economic prosperity (M. Bailey 2012).

In 1965, the Office of Economic Opportunity began funding family planning programs through various local community action agencies nationwide (M. Bailey 2012). In 1965, the OEO funded the first family planning program, providing \$8,500 to the South Texas Planned Parenthood Clinic of Corpus Christi to provide women with oral

contraceptive pills through the establishment of an additional five clinics held in neighborhoods with high poverty rates (The Arizona Daily Star 1965a). Any local agency could apply for family planning funding. According to historian and economist Martha Bailey, the sensitivity of family planning, the small number of agencies awarded for family planning, and small amount of funding provided resulted in very few written records about the funding decisions at the OEO (M. Bailey 2012). Oral history records from OEO officials demonstrate that there were limited guidelines for appropriating the OEO funding, and disbursements were made based on the discretion of OEO officials. In addition, administrators felt there was very little time to get contracts and distribute grants, and thus there was an urgency to get the money out into the hands of the local organizations (M. Bailey 2012).

The family planning grants under the OEO supported the opening of new clinics in rural or disadvantaged areas, and the expansion of existing family planning programs (M. Bailey 2012). The funding provided education, counseling, and the provision of contraceptives and related medical services at a lower cost. Many of the first OEO grants for family planning went to Planned Parenthood clinics, which had been well established and had a track record of providing family planning care. By the mid-1960s, Planned Parenthood centers throughout the country served more than half of all the women receiving contraceptive care in the nation, while public hospitals and county and state health centers provided care to the other half (Eliot 1966). The OEO programs offered little government oversight, and the grants did not require the collection of data on patients, services, or efficiency of programs (M. Bailey 2013).

Within a few years, Congress passed several pieces of legislation that officially prioritized family planning within the various poverty-related welfare programs. By 1967, Congress amended the Economic Opportunities Act to designate family planning, and eight other issues, as a program priorities that received dedicated funding and administrative priority (Rosoff 1973). That same year, Congress approved legislation that amended the Title V MCH program and required that at least six percent of state Title V MCH program funding be spent on family planning (S. Bailey 1983). In 1967, Congress also amended Title IV-A of the Social Security Act, a part of the AFDC program known as the Social Services Program for Mothers and Children, aimed to strengthen family life for welfare recipients through social services. The amendment of Title IV-A required that all welfare agencies offer family planning services and establish programs to preventing out-of-wedlock births (Rosoff 1973). Per the regulations published in the *Federal Register*, family planning services, including contraceptive services, social services, and educational services, must be offered and provided to appropriate recipients without regard to marital status, age, or parenthood. Though initial development of these family planning programs was slow, within the next few years all states had welfare policies that allowed state welfare agency staff to refer AFDC recipients to family planning services (Fisher and Rosoff 1972).

As a result of the new legislations, states obtained more in federal funding for family planning between 1965 and 1970. From fiscal year 1967 to 1970, federal funding for family planning increased more than ten times the 1967 level (M. Bailey 2012). In the three years from 1965 to 1967, the OEO provided nearly 5.6 million dollars in grants to family planning programs (Mcfarlane and Meier 2001). Although funding increased

generously, family planning still accounted for less than 0.4 percent of the OEO's total budget (M. Bailey 2012).

Arizona: OEO grants and State and County Funding

Since its frontier days, the state of Arizona faced high rates of poverty and thus consistently received federal assistance for poverty-related issues. Arizona has nearly always had poverty rates above the national average and in 1960, nearly twenty-five percent of Arizona residents were living in poverty, almost three percent more than the national average (United States Census Bureau 2018). In addition, the more rural counties in Arizona fared even worse. More than fifty percent of the population in Navajo and Apache county, where many American Indians resided, were living in poverty. Those counties continue to have some of the highest rates of poverty in Arizona (United States Census Bureau 2018).

The Planned Parenthood Committee of Phoenix in Phoenix, Arizona, applied for funds through the OEO to expand family planning services to residents. In Summer 1966, the Planned Parenthood Committee of Phoenix received approximately \$69,000 in OEO grants to hire eighteen new staff members and double its patient load (Buchen 1966). The Committee of Phoenix received OEO funds for several years, ending in 1968, as the OEO was phased out and replaced by the US Department of Health, Education, and Welfare (Buchen 1968).

In 1967, the Planned Parenthood Center of Tucson in Tucson, Arizona received a \$42,733 grant from the OEO to expand family planning services to outlying areas of Pima County. The grant was a compromise from the initial proposal submitted to the OEO, in which they requested, but were denied, an additional \$18,000 to purchase a

mobile unit to provide women in rural, outlying areas with family planning resources (The Arizona Daily Star 1967). Through the grant, the Planned Parenthood Center of Tucson added five additional weekly clinic sessions at their main office and established clinics in several surrounding areas of Pima County. The Planned Parenthood Center of Tucson continued to receive funding from the OEO for direct care services until 1970 when the grant ran out (The Arizona Daily Star 1970). Following 1970, the Center continued to receive a \$26,000 grant from OEO for educational outreach programs, until 1973 when OEO funds were slowly phased out (The Arizona Daily Star 1973).

Several other counties in Arizona received grants from the OEO throughout the next several years, including Santa Cruz County. In 1970, the Santa Cruz Council of the Committee for Economic Opportunity started a family planning program with funds from the OEO. The OEO provided the program with \$35,000 to hire three health aids and make family planning services available in Nogales, Arizona (Ready 1970). The initial agreement planned to fund the program for two years, with the hope that the county health department would assume responsibility for continuing the program following its development (Ready 1970).

As family planning became increasingly seen as both a health and social welfare concern, state and county health departments across the country began establishing their own state and county supported family planning clinics. In 1937, North Carolina established the first state-supported family planning program and several neighboring southern states followed suit (McFarlane and Meier 2001). These family planning programs were often centered in rural areas and incorporated into general maternity clinics, rather than in separate family planning devoted clinics, in the way many private

agencies had done (Eliot 1966). It was not until 1961 that any state outside the South established state-supported family planning programs (McFarlane and Meier 2001). By 1965, only eleven states used any state or local funding for family planning programs (Eliot 1966).

Arizona did not have any state or county funded family planning clinics until 1965 when Maricopa county became the first Arizona region to provide family planning services financed with local funds (Eliot 1966). In that first year, the county held nearly twenty-five clinic sessions a month in nine different locations across Maricopa (Eliot et al. 1968). Under the limited funding, those services were primarily provided to new mothers (Buchen 1966).

That same year in 1965, the Arizona Department of Health Services began offering consultation services to the remaining fourteen counties to assist local health departments in setting up their own family planning clinics (Eliot 1966). The following year, the Department began providing in-service training opportunities and financial assistance to help county health departments establish locally-run family planning clinics (Eliot et al. 1968). In 1966, the Arizona Department of Health Services allocated \$18,000 to assist counties in establishing county-run family planning clinics (Buchen 1966). The State Department of Public Welfare also developed a family planning program under the auspice of the Title IV-A Aid to Families with Dependent Children (AFDC) program, in which AFDC recipients could obtain contraceptive services (Buchen 1966). Under this program, the State Welfare Board approved social workers to discuss family planning services with AFDC recipients and then direct the women to either Planned Parenthood or county clinics (Buchen 1966).

In 1967, the Pima County Health Department in Arizona opened its first publicly supported family planning clinic (Sears 1967). The county family planning clinic received funding from the Arizona Department of Health Services for medical materials and supplies, but had to use county funding for staff and office space (Sears 1967). These small clinics, supported almost entirely by local funds, saw only a limited number of patients. As a newspaper article describing the new clinic states, the County Health Department family planning clinic in Pima County would start by serving only women who had previously received prenatal or pregnancy-related care through the county health department (Sears 1967).

By the end of the 1960s, in response to perceived national and international problems resulting from overpopulation and the growing demand for contraception, the US government pursued legislative action to expand reproductive health care services to all US women regardless of socioeconomic status, ethnicity, or geographic location. While federal funding for family planning had been available to some extent since the 1940s, efforts stemmed from attempts to address maternal and child health, and widespread poverty. By the start of the 1970s, it became clear that including family planning services into broader poverty-based legislation would not be sufficient to serve all women in need of subsidized family planning (M. Baily et al. 2011).

The 1970s Boom: Title X

In the 1970s the federal government initiated several new grants that provided funding throughout the country for family planning. Three pivotal federal grant programs included the Title X Family Planning Program, which was the first and only federal program dedicated exclusively to family planning; expansions in Medicaid to require coverage of family planning; and the Title XX Social Services Block Grant, which sought to reduce welfare dependency and allowed services for family planning. While the federal government was ramping up its commitment to funding family planning, Arizona did not participate in many of the new initiatives. It was not until the 1980s that Arizona entities received funding from Title X or participated in the federal Medicaid program due to state legislative decisions. Until then, wealthy Arizona women continued to see private physicians, while low-income women relied heavily on Planned Parenthood centers and county health departments for contraceptive and reproductive health care. Those clinics were funded through Title V MCH, OEO grants, private donations, and patient fees.

The existing fears amidst overpopulation and poverty that were brought on by the population boom following World War II reached an all-time high in 1968 when Paul Ehrlich, a Stanford University professor, published the book *The Population Bomb*. In a shocking restatement of Malthusian theory, Ehrlich forecasted the collapse of society resulting from unchecked population growth and Earth's inability to sustain its inhabitants. Ehrlich predicted that millions across the world would starve to death by the 1980s. He claimed that the US was consuming more than its fair share of world resources and argued the US should be a leader in controlling population growth, through tax schemes,

and expansions of sex education, abortion, sterilization, and contraceptive services. The publication was a best-seller, with more than a million copies sold in the first two years (Gottlieb 2005). The author's alarmist-tone had people worldwide concerned with growing population numbers, and its effects on poverty, family structure, and race and ethnic relations. President Richard Nixon began discussing the issue of overpopulation and its impact on large-scale issues such as the US economy and international security.

Amidst political discussions of overpopulation and increasing demand for widespread access to contraception, it became clear that small grants administered to the states for family planning were insufficient to meet the demand for subsidized contraception (Aries 1987). First, state government control of most existing grants led to variability in the accessibility, eligibility criteria, and health services provided among states and even between counties in the same region (Gold 2011). Secondly, many existing federal funds were provided to and administered through social services or welfare agencies. Those programs, while useful for addressing the issues of poverty, often lacked trained health professionals with skills for providing direct reproductive health care services and family planning information (The Alan Guttmacher Institute 2000). As a result, legislators and public health professionals advocated for a federal program to distribute family planning grants directly to the health care entities providing contraceptive care thus bypassing the state government (IOM 2009).

Continuing his predecessor's support for federal family planning programs as solutions to overpopulation and poverty, in 1969 President Richard Nixon appointed the Commission on Population Growth and the American Future, to research and report on US population trends and issues (The Alan Guttmacher Institute 2000). Investigations

stemming from this initiative showed that a lack of access to contraceptives, not a desire for more children, was responsible for higher birth rates among low-income women (Ryder and Westoff 1971). The results illustrated that lower income women were unable to plan their families and have the number of children they desired. In addition, research showed that unintended pregnancies, and pregnancies spaced closely together, led to poor health outcomes for both the woman and child, and increased poverty and welfare dependency (Brown and Eisenberg 1995; Campbell 1968). In a 1969 letter to Congress, Nixon proclaimed that American women should not be denied access to contraception simply because of their socioeconomic status. He urged Congress to establish a federal program to provide voluntary family planning options to low-income families. Congress accepted Nixon's proposal, and in 1970 passed Title X of the Public Health Service Act, the only federal program devoted exclusively to the provision of family planning services. The law received bipartisan support from legislators, passing the Senate unanimously and the House 298 to 32 (Rosoff 1973).

In December 1970, Nixon signed into law Title X of the Public Health Service Act, also known as the Family Planning Services and Population Research Act. The Title X Family Planning Program provided public or private entities across the country with categorical project grants, meaning that the federal funding was awarded through a competitive application process for a specific project purpose with restrictions on funding allocation. As a categorical grant, Title X authorized entities to fund only family planning services. The program had eight original aims: 1) to provide voluntary family planning services, 2) to coordinate research on family planning needs, 3) to improve the administrative and operational function of family planning programs, 4) to assist in the

development and growth of public and nonprofit organizations providing family planning, 5) to develop and disseminate educational information on family planning, 6) to evaluate the effectiveness of family planning programs, 7) to provide training for professionals working in family planning, and 8) to establish an Office of the Population Affairs (OPA) within the Department of Health, Education, and Welfare (DHEW), later known as the Department of Health and Human Services (HHS), to oversee all programs related to population research and family planning (IOM 2009). Title X funds are used for an array of family planning necessities including contraceptive services and counseling, preventative health services such as pelvic and breast exams, cervical cancer screenings, and STI tests and treatment, as well as pregnancy diagnosis, counseling, and education (IOM 2009). In addition to direct medical services, Title X funds are used for community and educational programming, and infrastructure costs related to service delivery (NFPRHA n.d.).

Unlike other government programs, Title X does not have specific eligibility criteria. Instead, Title X supported clinics serve all individuals and charge clients based on ability to pay. Individuals with incomes below the federal poverty level received services free of charge, while individuals with incomes above the federal poverty level are charged fees on a sliding scale (IOM 2009). Adolescents are charged fees based on their own income, not that of their parents, and thus most adolescents receive services free of charge (The Alan Guttmacher Institute 2000). Due to the more flexible eligibility criteria, Title X plays a unique role in providing subsidized services for low-income, uninsured women who may not meet the stringent requirements for other government aid programs (The Alan Guttmacher Institute 2000).

The OPA distributes the federal funds to regional offices across the country, which are then responsible to award the grants to their region through a competitive application process. The United States is divided into ten administrative regions for Title X distribution. Each administrative region office then distributes funds to one or more grantee for each of the fifty states, the District of Columbia, Puerto Rico, Virgin Islands, American Samoa, Republic of Palau, Republic of Marshall Islands, Federated States of Micronesia, and Guam (OPA 2017). Each state may have one or more grantees which then uses funds to provide family planning services throughout the state. The Title X grantees can provide services through their own clinics or can distribute the funds to delegates, or subcontracting clinics throughout the state.

In contrast to other federal grant programs like the Title V MCH program, Title X does not require a state agency to be the grantee and they do not require state legislatures to approve or match funding. Examples of Title X grantees across the nation include state health departments, hospitals, university health clinics, Planned Parenthood centers, Community Health Centers, and private nonprofits. In this way, Title X funding often bypasses state and local governments, instead funding family planning programs directly. Clinics that received Title X funding were often dedicated family planning clinics which served primarily contraceptive, family planning, or reproductive health clients (The Alan Guttmacher Institute 2000). By limiting their services to primarily family planning services, Title X funded clinics typically served more clients and offered more contraceptive options than clinics supported by other federal or state funding (The Alan Guttmacher Institute 2000). Title X funds were first appropriated at six million dollars for fiscal year 1971 (HHS 2017). Title X funding expanded drastically throughout the

decade, reaching a high of \$162 million in 1980, when accounting for inflation (HHS 2017).

Federal funds for family planning continued to expand when Congress amended the Social Security Act in 1972. The amendment to Title XIX of the Social Security Act required states participating in Medicaid to cover family planning as a program benefit (The Alan Guttmacher Institute 2000). The revision also required states to provide family planning resources to minors and unmarried individuals who requested such services and were eligible for Medicaid. By this point, family planning services were allowed through various federally sponsored welfare programs including Title V, Title IV-A, and Medicaid. However, many states either did not provide family planning services to eligible recipients under the programs, or did little to make them easily accessible (McFarlane and Meier 2001). As a result, in 1972 Congress amended both the Title IV-A Social Services for Mothers and Children program and the Medicaid program to add more incentives for states to provide eligible individuals with family planning services. The amendment increased federal reimbursement for family planning services provided under Title IV-A and Medicaid from 75% reimbursement to 90% reimbursement, meaning states would get more money when providing family planning to eligible individuals (McFarlane and Meier 2001).

Despite nearly nationwide participation in Medicaid and the requirement to cover of family planning, Medicaid accounted for very little of the total funding for subsidized family planning. Many low-income, reproductive aged women in need of family planning services were not eligible for Medicaid because they either did not have dependent children, were not eligible for cash assistance, or were above 133% of the federal poverty

level, the classification to be medically needy (Aries 1987). The amendment to Medicaid also failed to provide a uniform definition of family planning or specifically the covered services (Meier and McFarlane 1995). In addition, Medicaid did not provide funding for family planning services that were not directly health care oriented, such as community outreach or health education (Aries 1987).

In 1975, Congress passed Title XX of the Social Security Act, also called the Social Services Program, to encourage states to provide assistance so its residents could achieve economic self-sufficiency, prevent the neglect or abuse of children and adults, and reform admission for institutional care to be appropriate (Meier and McFarlane 1995). Aimed at low-income individuals, one of the only funding requirements was that at least half be spent on residents who were eligible for welfare programs like Medicaid. Title XX Social Services funds were allocated to a state agency, usually the state welfare or social service department (Meier and McFarlane 1995). As with Title V MCH funding, the Title XX Social Services grants were provided directly to and controlled by state governments. The majority of programs funded under Title XX were social services. However, family planning was one of the few direct medical services eligible through the program. Family planning was recommended to be included the state program, as the federal government reimbursed states for 75% of expenses, but reimbursed family planning expenditures at 90% (Gold and Sonfield 1999). The following year in 1976, Congress passed an amendment to Title XX allowing states to use Title XX Social Services funding to provide family planning services to individuals regardless of income (McFarlane and Meier 2001). Family planning was the only medical service to receive that status (Gold and Sonfield 1999).

Throughout the 1970s, the Title X Family Planning Program was the primary funding source for government supported family planning for low-income individuals across the country. Family planning clinics funded by Title X provided contraceptive options and health care services to women who did not qualify for other forms of government support, such as Medicaid which still had prohibitive eligibility requirements. As Title X funding increased steadily throughout the 1970s, OEO grants slowly diminished and the OEO funds were eventually transferred into the Title X Family Planning Program. In fiscal year 1974, fifteen million was transferred from the OEO budget to Title X and the OEO ceased to fund family planning projects (Rosoff 1973). As the total amount of federal money for family planning reached an estimated \$239 million in 1977 from Title X, Title V, Title XX, and Medicaid, the number of family planning clinics and women served increased drastically (Torres 1979). Clients using government supported family planning clinics more than doubled in just three years, with more than four million individuals seeking care in family planning clinics annually by 1976 (The Alan Guttmacher Institute 2000).

Arizona in the 1970s: Little Change

Despite substantial federal financial commitment to family planning programs throughout the 1970s, Arizona did not receive funding from the two largest sources, Title X or Medicaid, until more than a decade later. Following the passage of the federal-state partnership Medicaid program back in the mid-1960s, the Arizona legislature elected not to participate. By 1972, Arizona was the only state not partaking in Medicaid and not receiving federal support for the health care needs of Arizona residents (Bogert n.d.). As such, the expansion of Medicaid to require coverage of family planning did not impact

Arizona women's ability to access contraceptive care. Instead, Arizona's 1901 Territorial Revised Statutes required that counties provide services and care to the indigent populations (Bogert n.d.). Since each Arizona county provided care for its residents independently and without federal funding, eligibility criteria, services provided, and county expenditures different from county to county (McCall et al. 1985).

Emily Jenkins, an Arizona lawyer and the first director of the Arizona Family Planning Council, describes the Arizona indigent health care program as demeaning, with indigent populations having to beg for services at county hospitals or county health departments (Jenkins 2017). As a result, Jenkins states that Arizona residents:

didn't get access to any kind of care, there were large parts of the state that were really kind of uncovered in terms of reproductive health. You could get a baby delivered and that was about it. There were pharmacists that would not dispense birth control pills, so it was a climate of ignorance and lack of access and probably the only people who had access were those that had enough money to pay to go somewhere to get something (Jenkins 2017).

Though there were family planning clinics funded through the Title V MCH grant, Title XX social services grant, and small clinics run by the OEO and Planned Parenthood, they provided a limited number of family planning services. According to Jenkins, a significant problem was that "people didn't have anywhere to go if [family planning clinics] diagnosed something that needed follow-up or needed additional services, because there really wasn't a health care plan for indigents. So if you didn't have a county hospital...or if you didn't have something like the county health department with some additional resources, people were really in trouble" (Jenkins 2017).

Since Arizona did not participate in the federal Medicaid program, funding for family planning in Arizona was dependent on state and county budgets for county health departments to provide family planning services. In addition, many of the federal grants for family planning, including the Title V MCH program, Title XX, and the Title IV-A Aid to Families with Dependent Children, required states to match federal funds to varying degrees. In the 1970s, the Arizona state legislature allocated small amounts of funding to the state welfare agencies to match contributions from federal grants for family planning provided (Weinberg 1972; Melcher 2012).

In addition to not receiving Medicaid funds, it took Arizona organizations nearly a decade to receive a Title X Family Planning grant. The Title X Family Planning program included funding for states to establish nonprofits entities to administer the grant in instances where state agencies chose not to compete for Title X funds. That was the case in Arizona, where the state agencies elected not to apply for Title X funds. As one of the founding members of the Arizona Family Planning Council, Jane Canby recalls,

there were some states like Arizona where the State Health Department said, ‘we want the [Title X] money to come in, but we’re not going to administer the funds. It’s too political for us.’ So there were funds in the legislation to develop councils in those states. So, the [administrators] from Region 9 from San Francisco gathered all the providers of family planning [in Arizona] in a meeting...to talk about how to set up a council (Canby 2016).

Jane Pearson, Director of the Maternal and Child Health Department at the State Health Department recalls similar reasoning by the state health department,

the [Arizona] Family Planning Council was created to receive the Title X funding and that decision was made primarily as a political decision...at the time and probably over the years to this day, there was a strong feeling that that funding should be separated and put out, out into the private sector in a nonprofit so that it wasn't vulnerable to the legislature or Governor, or any political imaginations, except at the federal level of course (Pearson 2017).

Because of Arizona state agencies' unwillingness to administer Title X funds, in 1974, the Arizona Family Planning Council was established as a private nonprofit Arizona corporation with a mission to promote community education, professional training, and advocacy for family planning. In establishing the council, Jenkins traveled throughout Arizona visiting county health departments, local Planned Parenthood clinics, and querying advocates and women regarding reproductive health needs to determine how the council could support Arizona residents. Jenkins reports, "out of that 'what do you need' we really built an organization that was information, lobbying, and advocacy, and training, and then we were able to keep growing" (Jenkins 2017). The Council received its first Title X Family Planning grant in the early 1980s.

Despite initial bipartisan support for programs such as the Title X Family Planning program, political, social, and religious controversy surrounding family planning programs quickly escalated throughout the 1970s and into the 1980s. The national debates and political divisions surrounding the issues of abortion and adolescent contraception moved family planning programs back into a contentious field. These debates led to plateaus and eventual drops in federal funding and clinic growth nationwide.

New Controversies: Abortion and Adolescents in Arizona

The increases in funding for family planning and bipartisan support programs initiated during the early 1970s were short lived. Two major controversies that gained traction in the 1970s, provoked tension surrounding the federal funding of family planning programs. The first was the legalization of abortion in the Supreme Court case *Roe v. Wade* (1973). The second was an increasing debate surrounding adolescent access to confidential family planning services and comprehensive sex education in public school systems.

In 1973, the US Supreme Court ruled in *Roe v. Wade* that a Texas law banning abortion was unconstitutional. The Court found that the constitutional right to privacy, established in *Griswold v. Connecticut* (1965), extended to a woman's decision to terminate her pregnancy. The decision forced many states, including Arizona, to overturn their restrictive abortion laws and gave women new legal options to address unwanted pregnancies. Per the CDC, abortion-related deaths decreased nearly 90% following the Supreme Court decision (CDC 1999a). While the *Roe v. Wade* decision was a win for supporters of reproductive rights, the decision provoked opposition towards family planning more generally.

Despite the Title X Family Planning Program restrictions in funding abortion, soon social and religious conservatives began linking family planning providers with abortion, and arguing that family planning clinics promoted abortion. Quickly, family planning, alongside abortion, became a heated political issue, with legislators taking firm stands on both sides of the debate. According to Jane Canby, Executive Director of the Arizona Family Planning Council,

Title X was a Republican based program. George H.W. Bush was one of the sponsors but as soon as the abortion issue became prominent that changed the direction. By then, the Democrats were understanding the health implications [of legal abortion] and...so it shifted politically in terms of party politics and the right to choose became very active politically. And through the 1970s we still, we had to lobby at a national level to protect the [Title X Family Planning] program (Canby 2016).

The abortion debate continued on a national level, with several Court decisions and legislative actions that began to restrict access to legal abortions. Congress passed the Hyde Amendment in 1976, prohibiting the use of federal funds for abortions, except in cases where the mother's life was in danger. In 1977, the US Supreme Court ruled in *Beal v. Doe* that a Pennsylvania law barring the use of state funds for nontherapeutic abortions was constitutional. The decision allowed state and county health departments to refuse to cover abortions through county indigent medical programs. Following the *Beal v. Doe* decision, Arizona began restricting the number of abortions performed in public hospitals. Three years later, the Arizona legislature passed a state law, similar to the Hyde Amendment, prohibiting state funds from being used for abortions (Melcher 2012).

The second major controversy surfaced during the 1970s as the adolescent population began increasingly using federally funded family planning clinics for confidential contraceptive services (The Alan Guttmacher Institute 2000). During this decade, several federal programs including Title X, amended their program requirements to emphasize expanding services to the adolescent population (IOM 2009). Adolescents, particularly those who are uninsured or come from low-income families, may have

limited access to primary medical care and instead depend on school health centers, publicly funded clinics, and hospitals for both reproductive and general health care (IOM 2009). Social and religious conservatives, often those who also staunchly opposed abortion, argued that the availability of confidential contraceptive services to minors undermined parental decision making and promoted promiscuity and premarital sex (The Alan Guttmacher Institute 2000). Throughout the 1970s and 1980s, the US saw a steady rise in teenage pregnancy and childbearing rates (The Alan Guttmacher Institute 2016). Those trends divided the country with many viewing contraception and sex education as means for teens have the tools and information to decide how and if to engage in responsible sexual behavior (Kotch 2005). However, others argued that easy access to contraception promoted the irresponsible and increasingly early sexual behavior that led to teen pregnancy (The Alan Guttmacher Institute 2000). Flinn Foundation researcher and Governor's Office staff member, Judy Walruff, stated that while working on projects related to adolescent pregnancy in Arizona there was "at the time a burdening problem with adolescent pregnancy and parenting, and therefore, very poor birth outcomes... We started out with six school based teen pregnancy and parenting programs and then moved into a more comprehensive model after those projects that looked primarily at primary prevention. And that's access to health care, and access to contraceptives. [It was] controversial the whole way" (Walruff 2017).

In addition to contraceptive services for adolescents, sex education in the public-school system was equally contentious. Amidst the controversies family planning faced in the mid-1970s, Gloria Feldt, Director of Planned Parenthood of Central and Northern Arizona at the time, recalls

I came to Arizona where I was suddenly in the state capital and having to deal with politics, the likes of which were really much more ferocious than what I had dealt with in Texas. When I got to Arizona there was a fair amount of controversy around sex education in particular. Abortion yes, but at the time more of the controversy was around sex education, and it was, it was quite in your face and that was not something I had experienced before (Feldt 2016).

The nature of sex education varied greatly by county and school district. The information given during sex education depended largely on the political inclinations of the counties and school districts. Arizona Family Planning Council director Charlotte Harrison reports,

most schools did have abstinence [programs] in some form or another. There were a few schools particularly in Pima County, and I think Mesa, [that were] surprisingly progressive in that they allowed someone from Planned Parenthood...to come in and give a presentation if the parents opted-in. You know for a lot of services you have to opt-out, but for that you have to actually say yes I want it. But it was always you know a bunch of barriers (Harrison 2017).

Throughout the following decades, Congress approved funding for several abstinence-only education programs. Eventually, abstinence education was added as a program under Title V of the Social Security Act, though it was kept separate from the Maternal and Child Health program (AMCHP n.d.).

In 1977, the US Supreme Court ruled in *Carey v. Population Services International* that a New York state law prohibiting the sale of contraceptives to minors under sixteen was unconstitutional (The Alan Guttmacher Institute 2000). The Court

determined that the right to privacy in reproductive health decisions, established in *Griswold v. Connecticut* and *Roe v. Wade*, extended to minors and their reproductive health decisions. By 1977, approximately 1.3 million adolescents were receiving family planning services annually, making up 31% of the total client base (Torres 1979).

Throughout the 1970s, Congress passed several amendments to existing grants, allocating adolescent-specific funding and highlighting the importance of serving adolescents. In 1978, Congress amended the language of the Title X Family Planning program to place adolescent services as a program priority (The Alan Guttmacher Institute 2000). Congress also amended Title VI of the Health Services and Centers to provide additional grants to programs that provided services to pregnant adolescents. The grants were required to provide pregnancy testing, family planning services, general health services, sex education, screening for sexually transmitted diseases, prenatal care, pediatric care, and adoption services (S. Bailey 1983). By the 1980s, legislators took a step back from adolescent contraceptive services, amending the Title X legislation again in 1981, requiring health professionals to encourage teenagers seeking contraceptive services to talk to their parents about family planning. However, Congress retained that all services, including those provided to adolescents, through Title X be completely confidential and dismissed the idea of parental consent or notification for contraceptive services through the Title X program.

Strongly held views on abortion and adolescent access to contraceptive and sex education were ongoing and clouded the discussion of federally funded family planning, directly affecting those who provided contraception. Planned Parenthood, a family planning organization which also provided abortion services at many of its clinics,

became a lightning rod targeted by those who opposed abortion. In Arizona, Planned Parenthood was one of the major sources of family planning throughout the 1970s, since Arizona state agencies did not yet receive funding from Title X and Medicaid. In 1980, the Arizona legislature added a footnote to their general appropriations bill excluding all federal family planning funding to any organization that provided abortion services, counseling, or referrals (Marshall 1985). That essentially excluded Arizona Planned Parenthood affiliates from receiving Title XX Social Services funding because the organization independently provided abortions. In response, Planned Parenthood filed a lawsuit against the state in the case *Planned Parenthood of Central and Northern Arizona et al. v. State of Arizona* (1986). The Court ruled that Planned Parenthood sufficiently demonstrated that funding for abortions and Title XX funding were kept separate (Melcher 2012). Following a lengthy court case, in which the enforcement of the footnote was halted, the District Court ruled in 1984 that the footnote banning federal funding for family planning to agencies that independently provide abortions was unconstitutional (Marshall 1985).

Although this period demonstrated exponential growth and funding for family planning services nationally, by the late-1970s federal funding leveled off due to increasing political opposition for family planning for adolescents and opposition to abortion and the funding of organizations that independently provide abortions (Kotelchuck 2006).

By the start of the 1980s, alongside the election of Republican, social and religious conservative President Ronald Reagan, the debates of abortion, adolescent

confidentiality, sex education, and family planning in Arizona was spreading concurrently at the national level. Feldt, recalls

what was starting to happen was that some of the political challenges in Arizona were being mimicked in other parts of the country. You could say we were the leading edge... some of the issues that we had to deal with during that time [at the national level] was an anti-ERA campaign, there was the whole anti-choice movement was galvanized by having the *Roe v. Wade* decision. You know that's how that happens. Every victory you have sows the seeds for the next defeat and every defeat sows the seeds of the next victory (Feldt 2016).

With the many victories in federal family planning funding, access to confidential contraceptive services for adolescents, and legalization of abortion in the 1970s, the 1980s brought on cuts in funding for family planning, attempts at restrictions on abortion access, and the proliferation of funding and requirements for abstinence-only sex education. The issues of abortion, sex education in public schools, and adolescents access to confidential family planning services, continued to be argued at the national level through the twenty-first century.

1980s: Funding Cuts and Polarized Support

The controversies over abortion, sex education, and minors' access to family planning culminated in the presidential election of social and economic conservative Ronald Reagan and led to large-scale cutbacks for family planning programs. Under Reagan's campaign to reduce state regulation and federal government spending, federal funding for many health, social welfare, and family planning programs drastically decreased during the decade. While funding for family planning dropped at the federal level, changes in Arizona granted individuals greater access to family planning resources. During the 1980s, Arizona accepted the federal Medicaid program, bringing in federal reimbursement for health services for low-income individuals. In addition, the Arizona nonprofit, Arizona Family Planning Council, received its first Title X Family Planning grant in the early 1980s, enabling the organization to fund family planning clinics throughout the state and increasing women's access to contraceptive care.

While tensions surrounding abortion and sex education had been growing throughout the 1970s, the pro-life, socially conservative, religious right movement gained traction with the election of President Ronald Reagan in 1980. Reagan, the first outspoken pro-life president, made significant changes to the federal funding of family planning throughout the decade. During his presidency, none of Reagan's presidential budgets included funding for family planning (Kotch 2005). It was during this time, that opposition towards abortion began to become linked with negative attitudes towards family planning (Kotch 2005). In addition to Reagan's socially conservative policy, his plans to reduce government spending and deregulate states impacted the federal funding of family planning (McFarlane and Meier 2001).

The Reagan Administration sought to reduce the size, reach, and economic responsibility of the federal government and thus return the power and responsibility to the states (Kotch 2005). To do this, the Administration proposed to convert nearly one hundred of the categorical grants into three block grants to the states (McFarlane and Meier 2001). Unlike categorical grants, which are provided for a specific programmatic purpose, block grants have fewer restrictions and requirements, and instead enable states to use the funding in the best way for their specific population needs. However, critics argue that under block grants, a state's political inclination influences the allocation of funding more than the population's actual needs dictate (McFarlane and Meier 1998). Ultimately, Congress consolidated twenty-one health-related categorically funded programs into four block grants (Kotch 2005). These four grants gave states funding for substance abuse and mental health, preventative health, primary care, and maternal and child health (Kotch 2005).

The Omnibus Budget Reconciliation Act (OBRA) of 1981 converted the Title V Maternal and Child Health Program into a block grant. The Act combined seven categorical grants for related maternal and child health programs into the single block grant called The Maternal and Child Health Services Block Grant (The Maternal and Child Health Bureau n.d.). By converting the Title V MCH Program into a block grant, Congress sought to provide states with greater flexibility in the use and management of the funds to solve maternal and child health issues specific to that state population and needs (S. Bailey 1983). The Act also required greater financial commitment from states. Previously a one-to-one match, the OBRA 1981 required that for every three federal MCH dollars spent the states must match with four dollars (McFarlane and Meier 2001).

The Act also removed the previous requirement that states must spend 6% of the MCH funding on family planning.

The OBRA of 1981 also converted the Title XX Social Services program into a block grant, which became the Social Services Block Grant (Leighton 1993). In addition to the conversion into a block grant, the Act required states to provide one dollar for every nine dollars of federal funding received through the Social Services Block Grant (Nestor 1982).

Many conservatives praised the Act, arguing that it allowed states more flexibility and responsibility in appropriately distributing funding to best meet state needs. However, critics of the act argued that it did not require state accountability or provide adequate reporting mechanisms to ensure states were using funds effectively and efficiently (AMCHP n.d.). The issues of accountability and reporting continued throughout the 1980s, and were ultimately addressed in the OBRA 1989, when new amendments required greater state reporting on MCH Block Grant funding use (AMCHP n.d.).

The consolidation of grants in OBRA 1981 led to a 17% reduction in appropriations for MCH Block Grant funding that year (McFarlane and Meier 2001). However, despite the initial substantial decreases in MCH program funding, Congress slowly increased funding throughout the latter half of the decade and by 1986, funding for the MCH Block Grant reached a high of \$527 million (Kotch 2005). The MCH Block Grant was not as controversial in comparison to the Title X family planning program, because it was often not associated with family planning (Gold Sonfield 1999). As such,

throughout the 1980s, the MCH block grant remained an important source of funding for both maternal and child health and family planning.

The Reagan Administration also sought to convert the Title X Family Planning Program into a block grant. However, Congress rejected the proposal (Aries 1987). As a categorical grant, Title X provided funding directly to family planning programs and bypassed state government and state agencies, something the Reagan Administration strongly opposed (Aries 1987). After unsuccessfully attempting to convert Title X into a block grant, they sought other administrative measures to exert control over the funding for family planning (Aries 1987). In the early 1980s, using administrative directives, the US Public Health Service office was able to give Title X grant applications from state health departments priority consideration over other non-state agencies (IOM 2009). As a result, the Reagan Administration consolidated many of the Title X grantees in a state into one Title X grantee, namely, the state health department.

As state agencies, state health departments are bound by the legislative requirements of the state government. According to health policy historians Deborah McFarlane and Kenneth Meier, state health departments were unlikely to fund controversial health programs, unlikely to expand, and less likely to lobby for funding in comparison to independent family planning clinics (2001). For all those reasons, the Reagan Administration sought to put the Title X Family Planning program into the hands of the state agencies. The number of grantees across the country decreased dramatically because of the administrative changes: in 1981 there were 222 grantees across the country and by 1983 the number of grantees reduced to eighty-five (McFarlane and Meier 2001). The impact of these administrative directives can be seen most prominently

in Texas, which had thirty-seven grantees in 1980 and the following year the sole grantee was the Texas Department of Health (McFarlane and Meier 2001).

In addition to cutting funding from the MCH Block Grant and other health and social welfare programs, funding for the Title X Family Planning Program decreased throughout the 1980s, dropping nearly 70% during the decade (Kotch 2005). In 1982 alone, appropriations for Title X were cut by more than 20% (HHS 2017). Jane Canby, Executive Director of the Arizona Family Planning Council at the time, discusses the challenges during the Reagan Administration and his attempts to defund family planning programs. Canby states,

President Ronald Reagan arrived and put in charge under...the Health and Human Service...they put in charge...a man from California named Gary Bower, whose goal was to stop Title X. He said it out loud, we all knew it. So [the Council] spent a lot of time, I mean the state Health Departments couldn't do this lobbying, public health people can't do that... so the Councils... and the Planned Parenthood took on the role of lobbying and we worked really hard and we organized often and around the country and in Washington and we saved the [Title X] program. It never got defunded. The funds reduced a little, but it never got defunded (Canby 2016).

After the initial growth in Title X appropriations in the 1970s, funding decreased steadily throughout the 1980s under the Reagan Administration until it reached the lowest point in 1991 when \$231 million was appropriated (M. Bailey 2013). Despite the decline in funding from Title X, it remained an important source of funding due to its flexibility to be used for not only direct medical services, but also infrastructure-related clinic

operation costs (The Allan Guttmacher Institute 2000). In fiscal year 1985, the authorization of appropriations for Title X from the federal government ended, and it was never reauthorized though several attempts have been made over the years (Napliil 2017). Regardless, appropriation bills have continued funding the program (Napliil 2017).

Amidst legislative challenges to family planning by means of funding structure, the Reagan Administration also sought to inhibit abortions and adolescents access to contraceptive care. In 1982, the Reagan Administration attempted to require Title X supported clinics to notify parents prior to providing minors with contraceptives (The Allan Guttmacher Institute 2000). The rule, commonly known as the ‘sequel rule,’ was struck down in the court systems because it contradicted one of the main tenants of the Title X legislation, which was to prevent teenage pregnancies. Thus, the court found that the order undermined the original intent of Congress (The Allan Guttmacher Institute 2000). Reagan, and other social conservatives opposed to sex education and minors’ access to contraceptives, argued that both of those encourage teens to be sexually active and diminishes parental authority (The Allan Guttmacher Institute 2000). The Reagan Administration continued passing legislation attempting to regulate Title X providers and instilling religious morals into policy making.

In 1987, the Administration passed what was commonly known as the ‘gag rule,’ which prohibited any provider receiving Title X funding from discussing abortion with clients, even if a woman specifically requested that information (Meier and Mcfarlane 2001). In addition, the ‘gag rule’ required that both a physical and financial barrier exist between abortion and family planning services if a clinic provided abortions using independent funding (The Allan Guttmacher Institute 2000). The ‘gag rule’ was

challenged in court, and ultimately the Supreme Court ruled that it was constitutional in *Rust v. Sullivan* (1991). However, within two days of taking office, President Bill Clinton initiated the repeal of the rule (Meier and Mcfarlane 2001).

As federal funding for grants slowly diminished in the 1980s, Medicaid became the impetus for improving women's health (Kotelchuck 2006). When Medicaid was first established in the mid-twentieth century, the eligibility requirements were strict.

Generally, only single mothers in families eligible for the Aid for Dependent Children (AFDC) cash assistance program were eligible for Medicaid (Gold and Alrich 2008). As a result, low-income women without children were typically ineligible for Medicaid. In 1984, only 14% of childless women living in poverty were eligible for Medicaid (Gold and Alrich 2008).

Throughout the 1980s, Congress incrementally expanded Medicaid's eligibility requirements, by lowering the income eligibility in each year's budget reconciliation act (Kotelchuck 2006). By 1985, Medicaid programs were required to cover children of AFDC eligible families through the age of five, and all AFDC eligible pregnant women (Kaiser Family Foundation). By 1989, Congress severed the connection between AFDC welfare and Medicaid eligibility, requiring that all state Medicaid programs cover all pregnant women and children under the age of six, with incomes at or below 133% of the federal poverty level, regardless of their AFDC status (Kaiser Family Foundation). It also allowed states to expand eligibility for pregnancy-related services for women with incomes up to 185% of the federal poverty level, much higher than most states regular Medicaid eligibility (Sonfield and Gold 2011). States participating in Medicaid were required to cover prenatal, delivery, postpartum care and specifically postpartum family

planning care for all eligible women (Gold and Alrich 2008). Because of Medicaid eligibility expansions for pregnancy-related care, Medicaid began paying for, and continues to cover, nearly half of all births in the US (Sonfield and Gold 2011).

The expansions in Medicaid coverage for pregnancy-related care enabled states to reimburse these services through Medicaid and use MCH Block Grant funds for other unaddressed needs, including family planning for childless women (Gold 2007). That was important, because while the revisions expanded care to more pregnant women and women with children, they did not extend coverage to women prior to a first pregnancy (Gold and Alrich 2008). The Title V MCH Block Grant transitioned into a safety net source of funding, filling the gaps in family planning coverage where Medicaid and Title X fell short (Gold et al. 2009).

Despite expansions in Medicaid there were still many limitations of its use in financing family planning. Firstly, the eligibility criteria were still very strict. Ultimately, the gaps in coverage included poor childless, non-pregnant women, moderately needy women, and men (Leighton 1993). Secondly, clinics, providers, and pharmacies needed to enroll in a Medicaid managed care contract and be willing to accept Medicaid reimbursements. Many smaller dedicated family planning clinics were unable to get a Medicaid contract, while private physicians were increasingly unwilling to accept Medicaid as payment, which was often significantly lower than amounts other insurers paid (Leighton 1993).

Arizona in the 1980s: AHCCCS and Title X

In the 1980s, Arizona accepted the federal Medicaid program and received the Title X Family Planning grant, increasing the amount of federal funding available in the

state for family planning. Prior to the 1980s, Arizona legislators had refused to accept the federal Medicaid program, fearing it would require a large financial commitment from the state (Schneider 2003). However, by the 1970s, counties were unable to finance the high costs of health care for the indigent population (Schneider 2003). Thus, Arizona legislators agreed to discuss a plan for accepting the Medicaid program in the state.

As part of the federal Medicaid law, the Center for Medicare and Medicaid Services (CMS) can grant states waivers related to certain Medicaid laws, including eligibility requirements, scope of services, methods of reimbursements, among others (Arizona State Senate Research Staff 2010). Included in these waivers is Section 1115 of the Social Security Act, which provides states the option to complete a five-year demonstration project to develop their own unique managed health care system programs that may not normally be allowed under the Medicaid framework (Arizona State Senate Research Staff 2010).

On 18 November 1981, Senate Bill 1001 was signed into law creating the Arizona Health Care Cost Containment System (AHCCCS), Arizona's managed health care system for the indigent population (Bogert n.d.). Following the passage of AHCCCS, Arizona began negotiations with the CMS to receive a Section 1115 waiver for the unique Arizona Medicaid program. When the AHCCCS officially began operating in October 1982, it reimbursed for all health care services except long-term care, psychiatric care, and family planning, all of which would remain the responsibility of the counties to provide (Bogert n.d.). At the time, AHCCCS was the only Medicaid program that functioned under a 1115 waiver and excluded the funding of family planning (Arizona State Senate Research Staff 2010).

Since AHCCCS did not initially cover family planning, it remained a county specific responsibility. In 1985, county contributions to family planning accounted for approximately 15% of the total state expenditures for family planning (Marshall 1995). Following the end of the AHCCCS five-year demonstration period, the CMS required that family planning was instated as a reimbursable service because Arizona could not demonstrate cost savings for the federal government in not including the service. AHCCCS did not cover family planning until 1988 when the state legislature passed Senate Bill 1486 allowing the program to cover family planning (Marshall 1995).

The other source of family planning revenue in the state of Arizona came from the Title X Family Planning program in the early 1980s (Nestor 1982). The Arizona Family Planning Council, a nonprofit established in the mid-1970s, was the first organization to receive the Title X grant in Arizona.

With the influx of funding from the Title X Family Planning Program, Arizona leaders in family planning sought to maximize all the different sources of funding for family planning, in order cover the states large, still rural geographic area. The Title V MCH Block Grant and the Title XX Social Services Block Grant went to the state health department to fund family planning at state and county health clinics. Title X, was distributed by the nonprofit Arizona Family Planning Council to select clinics throughout the state. In addition, a limited number of county-supported family planning clinics provided services. In order to best use the array of funds, the state health department needed to work with the Arizona Family Planning Council to see where MCH Block Grant, Social Services Block Grant, and Title X funds would be used. Jane Pearson, the

Bureau Chief for the Office of Maternal and Child Health at the time, describes this collaboration,

We partnered with the Family Planning Council...to look at all the funding that was available for family planning and decide how that could best be distributed to make sure that the state at least had coverage in all parts of the state...There was a lot of pressure to be efficient with [Title X] money and so because it was a [categorical] grant funded type... So basically, the agreement was [the Council] would use the Title X funding to fund large agencies and organizations, so the larger counties and the Planned Parenthoods, both in Phoenix and Tucson... and then the State would fund all the other counties that really didn't have to be efficient (Pearson 2017).

Jane Canby, the Executive Director of the Arizona Family Planning Council at the time, confirms this collaboration, stating that initially clinics in Pinal, Pima, and Santa Cruz counties were awarded Title X funding for family planning services, as well as the Planned Parenthood clinics in Phoenix and Tucson (Canby 2016).

Pearson discusses why it was difficult and inefficient to conduct family planning in rural areas, and why using the Title V MCH Block Grant funding was a better use of federal resources,

When you're trying to put services in Graham county or Greenlee county and you're serving a very small number of women relatively...you're just not efficient. That's the bottom line... [The counties] are used to putting together services in very small increments, so they can have a clinic half a day a week, somewhere in the middle of now where if you will, and address that. And they are

locally based...they have the privilege and the responsibility for knowing their community and how services can be provided most effectively (Pearson 2017). Therefore, Title X funds were used primarily in urban, highly populated areas where there was less of an infrastructure cost associated with clinic management. In contrast, Title V MCH Block Grant funds were used largely in rural areas by public health nurses who made home visits and mobile health clinic services, delivery methods which are typically more costly. The last source of federal grant funding, Title XX Social Services Block Grant, was small comparatively, and so was used to supplement the funds from Title V and Title X. Pearson states that the Title XX funds, “were basically used to augment the Title V and Title X funds, so they tended to go to the larger counties because...the Title V funding pretty much covered the rural counties in terms of need, but the Title XX funds then augmented both the Planned Parenthoods and the County Health Departments in the large counties” (Pearson 2017). The goal of this strategic planning was to help reduce geographic barriers to seeking care in a large state with expansive rural areas.

By the end of the 1980s, the Title X Family Planning program was well established in Arizona. The partnership that had emerged between the Council and state health department set the stage for funding distributions that remained relatively the same throughout the next several decades.

Federal Medicaid, and state and local funding were the only revenue sources that increased after 1980, largely as a response to cuts from other federal sources (Sollom, Gold, and Saul 1996). As an entitlement program, free from the budgetary appropriations of congress, Medicaid expenditures could increase when grant funded family planning

programs decreased (Leighton 1993). Because of these increases, throughout the 1980s and into the 1990s, Medicaid became the prominent funding source for federally-funded family planning services. At the start of the 1980s, 50% of all federally-funded family planning services came from the Title X Family Planning Program (Leighton 1993). By the mid 1990s, that percentage had dropped to barely 20%, with Medicaid funding the bulk of direct health care services. That enabled Title X Family Planning program and Title V MCH funding to be used for educational services, infrastructure-related costs, and direct medical services for individuals who did not qualify for Medicaid (The Alan Guttmacher Institute 2000). In 1991, Medicaid expenditures for family planning was an estimated \$352 million, only about 0.4% of the total Medicaid expenditures (Leighton 1993). By the end of the 1980s, after a decade of dramatic decreases in federal expenditures for family planning, funding cuts leveled off (Sollom, Gold, and Saul 1996).

Increases in Medicaid

Following the drastic budget cuts in the 1980s, the 1990s and twenty-first century brought small but steady increases in funding for the Title V Maternal and Child Health (MCH) Block Grant and the Title X Family Planning Program. While the Title X Family Planning Program funding peaked in 2010 at \$317 million actual dollars, when taking inflation into account program allocation has decreased approximately 60% by 1980 constant dollars (Gold 2001). The Title V MCH Block Grant has seen similar trends. In contrast, Medicaid expenditures swelled and began financing the bulk of subsidized family planning services following a series of state initiated Medicaid eligibility expansions. By the twenty-first century, AHCCCS funded nearly ninety percent of all publicly subsidized family planning in Arizona (AFHP 2011). Despite increases in Medicaid spending on family planning, challenges remained for Title X family planning providers and dedicated family planning clinics in acquiring AHCCCS contracts. Alongside Medicaid expansions, Congress passed three pieces of legislation that provided small amounts of family planning funding, the Temporary Assistance to Needy Families program (TANF), the Health Center Consolidation Act, and the State Children's Health Insurance Program (SCHIP). With the skyrocketing costs associated with new, long-term, and more effective contraceptive options and dwindling budgets, many Arizona providers were forced to ration select contraceptive services (APHA 2001). With increasing gaps in health care coverage, advocates sought mandates for insurance companies to cover contraceptives.

Though Medicaid eligibility expanded considerably throughout the 1980s, the expansions focused largely on pregnant women and AFDC eligible women with children.

Very few low-income, childless, non-pregnant women were Medicaid eligible. In 1993, the Center for Medicare and Medicaid Services (CMS) instituted a family planning waiver program, also often called the Family Planning Services Extension Program, to enable states to waive traditional Medicaid eligibility requirements and extend coverage of family planning to those low-income individuals who would normally not qualify for Medicaid (IOM 2009). The waiver program allowed states to take three approaches to extending eligibility (Gold et al. 2009). The first, allowed states to continue Medicaid coverage of family planning services for women two years postpartum. The second, enabled states to cover family planning through Medicaid for individuals who withdraw from the Medicaid program for any reason. The third, extended coverage of family planning based on income (Gold et al. 2009). Most states that received waivers chose the third approach, with the majority electing to extend coverage to individuals with an income near 200% of the federal poverty level, a level much higher than typical Medicaid eligibility (Gold and Alrich 2008). This approach extended Medicaid coverage for family planning to large numbers of low-income women prior to a first pregnancy, enabling family planning providers to initiate family planning services, preconception care, and prenatal care prior to a first pregnancy (Gold and Alrich 2008).

The expansions in Medicaid eligibility throughout the 1980s and 1990 led to significant increases in program spending throughout the decades as well. However, increases in Medicaid expenditures have not been uniform across the nation. Rather, the growth in Medicaid funding has been significantly greater in those states that received a Medicaid family planning waiver (Gold et al. 2009). Ultimately, the states with Medicaid family planning waivers received overall more federal funding for family planning

because despite the waiver, revenue from other federal sources such as Title X and Title V, generally stayed the same. That translated into an increase in patients that family planning clinics served (Gold et al. 2009).

While the waiver was successful in expanding coverage to millions of women, to obtain a waiver, states needed to apply to the CMS through a process that was difficult, cumbersome, and lengthy (Gold and Alrich 2008). States spent an average of two years applying to obtain an initial CMS waiver (Gold et al. 2009). In addition, once states were granted waivers, they were only valid for an initial five years. Following the initial five-year demonstration period, states were required to renew every three years (Gold and Alrich 2008). As such, not all states applied for, or continued to renew, these Medicaid family planning expansion waivers.

Nearly two decades later, Congress acknowledged the success of the Medicaid family planning waivers by including a provision that simplifies the waiver process in the newly passed general health care reform law, Patient Protection and Affordable Care Act (ACA) of 2010. The ACA Medicaid family planning waiver provision enabled states to expand eligibility for family planning by adding an amendment to their state Medicaid plan (The Alan Guttmacher Institute 2018). If states chose this option, rather than the traditional waiver process, they would apply to CMS for a State Plan Amendment. The process to obtain approval for an SPA was much faster, and once approved becomes a permanent part of a state Medicaid program, with no need to renew (Gold et al. 2009). Throughout the 1990s and early 2000s, the number of states applying for family planning waivers steadily increased. As of January 2018, twenty-five states are approved to extend Medicaid eligibility for family planning (The Alan Guttmacher Institute 2018). Of those

twenty-five states, fifteen have a State Plan Amendment to extend eligibility for family planning services (The Alan Guttmacher Institute 2018).

As the number of US adults living in poverty reached a high at 15.1million in 1993, President Bill Clinton's Administration sought to reform the welfare program under the Aid for Families with Dependent Children (AFDC) (IOM 2009). In August 1996, President Clinton signed into law the Temporary Assistance to Needy Families Program (TANF), which repealed the AFDC federal cash entitlement program and replaced it with the TANF Block Grant. The TANF Block Grant, created under the Welfare Reform Law of 1996, provided states funding to convert their state welfare programs from the cash assistance programs of AFDC into work-related opportunity programs under TANF (Kotch 2005). Like the Title XX Social Service Block Grant, TANF funding could be used towards family planning. Another important facet of the TANF legislation was that by repealing the AFDC, it severed the eligibility link between welfare assistance and Medicaid (CMS 2015). Previously, Medicaid eligibility had been primarily dependent on status under the AFDC, now it was based on income in relation to the federal poverty level (Kaiser Family Foundation n.d.).

To fund and offset the initial costs of implementing the new TANF Block Grant, the Title XX Social Services Block Grant was cut by 15% (Gold and Sonfield 1999). Congress intended for the budget cuts to the Social Service Block Grant program to be temporary and planned to restore funding for the block grant with the projected long-term savings from TANF (Gold and Sonfield 1999). However, in 1999 the Social Services Block Grant was even cut further, and ultimately never reinstated to its original funding levels (Gold and Sonfield 1999). The drastic budget cuts to the Title XX Social Services

Block Grant in the mid-1990s forced many states to reconsider how they distributed funding, and as such most clinics that received any Title X funding no longer received Social Services funding (IOM 2009). In some states, the revenue lost from the Title XX Social Services Block Grant was replaced by TANF funding because like Social Services funding, TANF could be used to cover family planning programs for welfare recipients. By 1997, only fifteen states reported using Title XX Social Service Block Grants for family planning (Gold and Sonfield 1999). Though small amounts of the Title XX Social Services Block Grant funding are used towards family planning in the twenty-first century, it represented less than 1% of total Social Services program expenditures (Lynch 2016).

In 1996, Congress passed a second small source of federal funding for family planning through the Health Center Consolidation Act, Section 330 of the Public Health Service Act. The Act converted the Neighborhood Health Centers, initiated under President Johnson's War on Poverty in the 1960s, into Federally Qualified Health Centers (FQHC) and Community Health Centers (CHC). FQHCs and CHCs are private, nonprofit, community-based health care facilities located in low-income, high-need, underserved areas (IOM 2009). The Act also funded these Centers to provide comprehensive and preventative health services, along with employment opportunities, and community and economic development (Kotch 2005). The FQHCs were intended to be independent of state and local governments, instead be run by a board of community members. As such, the funding bypassed local government and went directly to the local community running the FQHCs (Kotch 2005). By law, all FQHCs and CHCs are required to offer a range of reproductive health services including, prenatal care, breast cancer and

cervical cancer screenings, and voluntary family planning (IOM 2009). Some FQHCs and CHCs receive Title X Family Planning funding in addition to their funding from the Health Care Consolidation Act (IOM 2009).

In 1997, in an attempt to address the rising number of uninsured children in the US, Congress passed Title XXI of the Social Security Act, also known as the State Children's Health Insurance Program (SCHIP). By 1997, nearly one in seven children in the US was uninsured, totaling nearly 11 million children without access to health care (CMS 2015). The program, administered under the CMS, provided states with matching funds to administer a health insurance program for uninsured children in low-income families whose incomes are too high to qualify for Medicaid (Humble 2010). The program allowed states to either create a separate child health insurance program, expand their states current Medicaid eligibility to cover this group of children, or develop a combination approach (Kotch 2005). SCHIP was authorized for ten years, and reauthorized most recently in 2015 (Arizona State Senate Research Staff 2010). In just five years, the number of uninsured children reduced by two million, down to 9.2 million in 2002 (Kotch 2005). Just like Medicaid, the SCHIP program funds family planning for enrolled adolescents. All fifty states have a State Children's Health Insurance Program, including Arizona. In Arizona, the SCHIP program is called KidsCare and is administered by AHCCCS (Humble 2010). The Arizona KidsCare program covers family planning services for adolescents up to the age of 19.

After more than a decade of funding cuts to family planning grant programs in the 1980s, the 1990s brought steady funding growth. The previous trends of Medicaid expansions and grant investments, as well as growth in state and local funding of family

planning, continued to increase past previous 1980 levels. However, despite growth in expenditures for the Title X Family Planning Program, it was insufficient to reinstate Title X as the primary funding source for family planning as it was in the 1970s (Sollom, Gold, and Saul 1996). The expansions in Medicaid that occurred throughout the 1980s and into the 1990s resulted in in parallel expenditures for family planning throughout the 1980s before leveling off in the mid-1990s (Sollom, Gold, and Saul 1996). Medicaid's role as the primary funder for family planning was largely due to the state-led expansions under the family planning waiver program that occurred in the 1990s. As Medicaid began supporting the majority of family planning, smaller grants like Title V MCH Block Grant transitioned from providing direct patient care to providing infrastructure and education related costs that Medicaid did not cover (Gold and Sonfield 1999).

Arizona: Medicaid Expansions, Challenges, and Rising Costs

In 1994, the Arizona state legislature passed a bill allowing AHCCCS to obtain a CMS family planning extension waiver to extend eligibility for Medicaid family planning (Marshall 1995). The AHCCCS family planning waiver extended Medicaid family planning coverage to women who were previously eligible for Medicaid due to a pregnancy and who subsequently lost eligibility after they gave birth. The waiver extended family planning care to those women for two years postpartum (APHA 2001). The waiver became effective in 1995 (Marshall 1995). Arizona renewed the family planning waiver several times, most recently in October 2011. The waiver was set to expire in September 2016, however, an April 2013 amendment to CMS did not include the family planning extension waiver, effectively discontinuing the family planning extension. Since then, Arizona has not extended Medicaid eligibility for family planning.

Despite the expansions in Medicaid coverage of family planning, there were still many barriers to care under Medicaid. Firstly, and importantly in Arizona, many immigrants were ineligible for Medicaid. Recent legal immigrants were barred from Medicaid coverage for the first five years of legal residency (Gold et al. 2009). Undocumented immigrants were ineligible for any coverage under Medicaid (Gold et al. 2009). In the US, nearly twelve million undocumented immigrants were living in the US in 2008 (IOM 2009). A large portion of those undocumented migrants resided in Arizona (IOM 2009). Given that any child born in the US is a US citizen, it is important for all women, including the undocumented, to receive access to reproductive health services including family planning, HIV and STI treatment, prenatal care, and postnatal care to ensure healthy birth outcomes for their infants. That is where the Title X Family Planning Program can fill the critical gaps Medicaid leaves. While Medicaid is clearly important in providing family planning care for many of the lowest-income women, Title X brings different and critical strengths to the family planning funding arena. Specifically, Title X funds can be used to provide free family planning care to anyone who is under the federal poverty level, regardless of immigration or residency status (Hasstedt 2014).

Secondly, though Medicaid has taken the role as the primary funding source for family planning, since the 1980s it remained a minor source of revenue for Title X funded projects, providing less than an estimated 10% of their total funding in 1991 (Leighton 1993). Of the estimated \$269 million spent by Medicaid on family planning, only approximately 14% of that funding went towards Title X family planning providers (Leighton 1993). Providers and clinics still had to obtain a Medicaid managed care contract to obtain reimbursement for treating Medicaid eligible women. In 1995, only one

in five family planning agencies or dedicated clinics nationally had a contract with Medicaid (Kotch 2005).

Those challenges were visible in Arizona, where Title X family planning clinics, FQHCs, and CHCs struggled to obtain Medicaid AHCCCS contracts. As Charlotte Harrison, the Executive Director of the Arizona Family Planning Council in the 1990s recalls,

The [Department of Health and Human Services] started to push that everybody should be capable of taking AHCCCS monies. And some of the smaller counties were a little bit behind on that score, they didn't have a computer system, they used pencil and pens. And the health plans were not exactly jumping on the idea of contracting with family planning clinics... [In addition, AHCCCS administrators] wanted to contract [providers] for the whole package of health services and of course the family planning clinics had a more limited scope, so that was a big barrier in contracting with AHCCCS health plans... our [Title X] agencies had such a hard time getting contracts with the AHCCCS health plans so we weren't able to serve a whole lot [through Medicaid]. Still, there were some agencies that were more successful than others: the two Planned Parenthoods [in Phoenix and Tucson] were quite sophisticated at getting both [AHCCCS] contracts as well as regular insurance. The county [clinics] were not so [successful], I mean they were not able really (Harrison 2017).

Harrison explains that there were big issues with dedicated family planning clinics not being able to contract with AHCCCS, "And so it became a problem that as money tightened up that you had AHCCCS eligible clients who for some reason or other didn't

want to go to their primary doctor in their small community and wanted to go to the anonymity of a Planned Parenthood, or County Health Department, that that was sort of money lost to the system because the county couldn't bill for it" (Harrison 2017).

She explained that because many of these Title X clinics or small county family planning clinics could not contract with AHCCCS, when they treated women eligible for AHCCCS, they could not bill Medicaid since they did not have a contract. Instead, they had to use Title X or Title V grant money for those services, funding that could have been used elsewhere. The expense inherent in the push toward transitioning to electronic medical records systems and other online client services necessary to fully function in the health care area, prevented many smaller low-budget family planning clinics from contracting with Medicaid and other large health insurance companies (Gold et al. 2009).

Family planning clinics with limited budgets also struggled to respond to the rising costs of contraceptive methods, new medical technology, and diagnostic techniques (The Alan Guttmacher Institute 2000). When Title X was enacted the contraceptive options available, the birth control pill, the male condom, the IUD, and sterilization, were the primary methods of family planning and were relatively cost effective (Institute of Medicine 2009). Throughout the 1990s and early 2000s, the FDA approved several more contraceptive options. These new contraceptive options allowed women more flexibility, convenience, and freedom in their family planning methods as well as improved reliability and efficacy. These new methods included improved oral contraceptives and IUDs, the contraceptive injection, the contraceptive patch, the contraceptive ring, and the contraceptive implant (Institute of Medicine 2009). However, these new, more effective, and long-term contraceptives are more expensive for clinics to provide. In comparison, a

clinic could provide three women with an annual supply of oral contraceptives for less than the cost of providing one woman with the injectable for one year (The Alan Guttmacher Institute 2000). Therefore, it was difficult for clinics to maintain full contraceptive choices for their clients.

The high cost of many of these contraceptive options along with chronic underfunding of the public health infrastructure led to the rationing of most expensive family planning options. A 2003 study found that more than half of family planning clinics were not providing certain contraceptive methods because of the high cost (Gold et al. 2009). Some clinics were forced to create wait lists for the most popular and expensive contraceptive methods (The Alan Guttmacher Institute 2000). A report published by the Arizona Public Health Association confirms this, stating that in some counties, the choice must be made to respond to the demand for family planning services until funding runs out and then no longer offer services for the remainder of the year, or to limit the number of women and types of contraceptive options who can be served each month in order to offer services for the full year (APHA 2001). In Arizona, most Title V MCH Block Grant funded county-run family planning clinics did not offer the full range of FDA approved methods of contraception due to budgetary constraints (APHA 2001). According to Harrison,

[there are] barriers related to the longer-term methods because of the expense. At the time [Title X clinics] charged sixteen to seventeen hundred dollars for a tubal, I think the going rate was twenty-five hundred, if it's not covered by your insurance, and that's clearly a big barrier for people. IUDs are expensive, they used to be five hundred [dollars]. And even our providers were hesitant because it

was so expensive, particularly because a fair amount of people came back after a couple months and said I want to take this thing out. But you know they clearly are more effective and would make a big difference if they were more available (Harrison 2017).

At the same time, contraceptives are not the only service those family planning centers provided. Family planning centers also provide exams to detect breast cancer, cervical cancer, and STIs, all fundamental to ensuring the health of women and preventing infertility later in life. As such, more than six in ten women utilize family planning centers as their regular source of medical care and as the entry point into the health care system (Gold et al. 2009). Those numbers also tend to be higher for some groups of women, including those who are low-income, uninsured, minority groups, and immigrants.

In Arizona, by the 1990s the Title X program was established and stabilized owing to the work of the Arizona Family Planning Council leaders in the early 1980s when it received the first Arizona Title X grant. The 1990s and 2000s became a period of growth for the organization, which sought to place clinics in each of the Arizona fifteen counties. According to Charlotte Harrison, director of the Arizona Family Planning Council in the 1990s,

Well I would say that by the time I came around, the program in itself was rather stabilized, although living in Arizona basic things like family planning were still controversial in many areas. So, it was also unknown to a lot of people that those services were available. So, I spent a lot of time just trying to make the services better known, particularly among low-income people, including undocumented

who had very few other resources. During [the 1990s] I would say we expanded the program quite a bit, to more sites, to more subcontractors. I think at the peak we had eleven subcontractors and thirty or forty sites, and we served about forty thousand people (Harrison 2017).

The clinics that the Arizona Family Planning Council funded with Title X money depended heavily on the county's political inclinations. Harrison recalls that when contracting with clinics to receive Title X funding, counties that embraced family planning often received Title X funding directly to county-run clinics. In those counties in which the county health department was more unwilling to provide comprehensive family planning, the Council provided Title X funding to nearby Planned Parenthood clinics. Harrison reports,

Counties that were more progressive in terms of embracing the services, Pima County clearly, Coconino County, Yavapai came around, and actually Pinal too. Mohave was more of a challenge. Globe, Greenlee, Graham they didn't have anything to do with it, so we had a Planned Parenthood clinic in Globe and that was like the only thing for miles. That has since closed. We had at one point, contracted with all the clinics pretty much of Planned Parenthood in Maricopa County and Yavapai and Yuma (Harrison 2017)

Throughout the late 1990s, the Arizona Family Planning Council awarded Title X funding to five agencies, one community health center, two county health departments, and two Planned Parenthood affiliates. Those five agencies used Title X funding to run clinics in seven of fifteen Arizona counties (AFPC 1997).

The early twenty-first century was a period of large growth for the Arizona Family Planning Council. By 2001, The Council saw a slight increase in Title X funding, and could award Title X funding to an additional three agencies. The eight agencies awarded funding ran thirty-two clinics in eight Arizona counties (AFPC 2001). The Council was also able to use funding to provide reproductive health services to high-risk women and adolescents involved in the criminal justice system throughout Maricopa and Pima county (AFPC 2001). By 2003, the Council awarded Title X funding to agencies in nine Arizona counties (AFPC 2003).

Unfortunately, the gains made early in the twenty-first century were not entirely long-lasting. By 2011, only seven of fifteen Arizona counties had Title X funded clinics (AFPC 2011). In 2012, Apache, La Paz, Gila, Greenlee, Graham, Cochise, and Santa Cruz counties did not have Title X funded clinics, and were also some of the most rural and underserved areas of the state. In 2014, the Arizona Family Planning Council, then renamed the Arizona Family Health Partnership, received an additional Title X grant to specifically serve the Navajo Nation in Arizona. That year, using a \$450,000 grant the Council contracted with Canyonlands Community Healthcare to provide family planning services in the predominantly Navajo communities of Page and Chilchibeto (AFHP 2015).

As of 2018, there are three Title X grants active in Arizona, administered by two agencies. The Arizona Family Health Partnership, previously known as the Arizona Family Planning Council, manages two grants: the standard Arizona Family Health Partnership Title X grant and a Title X grant specific for the Navajo population. Both of those Title X Family Planning grants added up to approximately \$5.3 million in 2017

(OPA 2017; HHS 2018) The Gila River Health Care Corporation Family Planning Program also manages a \$250,000 Title X Family Planning grant specifically for the Gila River community (HHS 2018).

In 2015, the Title X Family Planning grants served women in Gila, Graham, Greenlee, Coconino, Maricopa, Pima, Pinal, and Yavapai counties. Those counties consistently without Title X funded clinics are Santa Cruz, Cochise, and La Paz (The Alan Guttmacher Institute n.d.). However, those without Title X funded clinics are not necessarily completely without family planning services. In Arizona, those counties typically have FQHCs, CHCs, or county health department clinics that provide subsidized family planning services. In Arizona, Cochise county for example, has five FQHCs and five county health department clinics that provide publicly funded family planning services to its residents (The Alan Guttmacher Institute n.d.). In these cases, services are usually only available through AHCCCS and the Title V MCH grant, putting restrictions on who is eligible for family planning services. Those restrictions are based on Medicaid eligibility for AHCCCS and funding levels for the Title V MCH grant (AFHP 2011). As of a 2011 Arizona Family Health Partnership report, eleven counties received Title V MCH funding, with four counties receiving both Title V funding and Title X funding (AFHP 2011). Some counties also provide small amounts of county funding for county health department family planning clinics. However, the state of Arizona provides no funding for family planning and is one of only seven states to not provide any funding for family planning (APHA 2001).

Several changes throughout the early twenty-first century placed additional strain on agencies providing publicly funded family planning care. From 1990 to 2012, the

population in Arizona more than doubled, marking the second largest percentage gain in population throughout the nation (United States Census Bureau n.d.). The influx of individuals into Maricopa county, which accounts for sixty percent of Arizona's total population, led to an increase in the number of women in need of subsidized family planning. In Maricopa county, approximately three-thousand women per one-hundred square miles are in need of subsidized family planning (AFHP 2011; The Alan Guttmacher Institute n.d.). In addition, since the early twenty-first century, poverty rates in Arizona have steadily risen, ranked within the top ten states of population in poverty (AFHP 2011). In fact, since the 1960s, Arizona has consistently had poverty rates above the US national average (United States Census Bureau 2018). Arizona's Apache and Navajo counties consistently have the highest rates of poverty, which at one point had more than fifty percent of its population living in poverty (United States Census Bureau 2018).

Rising health care costs alongside increasing disparities in health insurance coverage in the early twenty-first century intensified the unmet need for subsidized family planning (IOM 2009). The economic recession in the early twenty-first century caused many Arizona residents to lose employer sponsored health insurance (AFHP 2011). That led to an increase in the number of Arizonans seeking enrollment in public insurance programs such as AHCCCS (AFHP 2011). By 2010, approximately 17% of Arizona residents were enrolled in AHCCCS, compared to 16% nationally enrolled in Medicaid (AFHP 2011). In 2011, 17% of Arizonan's were uninsured, also above the national average (AFHP 2011). Because of increases in AHCCCS enrollment, by 2010,

90% of publicly-funded family planning services in Arizona were funded through Medicaid (AFHP 2011).

However, even for those who had private or employer sponsored insurance, family planning services may not have been a covered benefit (IOM 2009). A 2003 study found that 7% of insurance plans did not include an annual well-woman exam and 13% did not cover any major types of contraceptives (IOM 2009). As such by the mid-1990s, the Arizona Planned Parenthood affiliates, the Arizona Family Planning Council, and reproductive health advocacy organizations nationwide began researching and advocating for insurance coverage of contraceptives. In 1998, Congress passed an amendment to the Federal Employees Health Benefit Program requiring that it covers comprehensive contraception. The Act passed contraceptive coverage for all federal employees. Gloria Feldt, Director of Planned Parenthood Federation of America, describes how the organization worked to advocate for a nationwide insurance mandate for contraceptive coverage leading eventually to Congress passing contraceptive coverage for federal employees, “they passed contraceptive coverage for federal employees and that is the biggest insurance plan in the country, so as that plan goes so goes pretty much every other one and so now it’s just routine. We also passed contraceptive coverage in about 26 states at that time...we won some civil rights lawsuits on gender discrimination, if men’s health was covered and birth control was not” (Feldt 2016). In 2000, the Equal Employment Opportunity Commission ruled that insurance companies who did not cover contraceptives but covered other prescription drugs were in violation of the Civil Rights Act of 1964. That ruling essentially required all new health insurance plans to cover contraceptives as they would cover any other prescription drug.

Arizona was one of those states that passed laws requiring insurers to cover contraceptives. In Arizona, Harrison describes the work the Arizona Family Planning Council did to pass a contraceptive coverage mandate in Arizona,

We did a survey of insurance companies in Arizona and it was quite involved...we wanted to know do you cover contraceptives, and if not, why. And if you do, what are the limitations and are there extra charges, do people have to pay more for that coverage...there were a lot of insurance companies that did not cover it at all and a lot of them that covered them with a lot of restrictions...So we worked with some legislators to introduce legislation [in Arizona] to mandate insurance companies to cover contraceptives on the same par that they cover Viagra for instance...We did it two years, it failed. The third year, we were more successful...it passed both houses...We did lose a big piece, we lost the individual coverage, but all the others for group coverage [were passed] (Harrison 2017).

In 2002, the Arizona legislature passed HB 2234, becoming the nineteenth state to require all health insurance plans that cover prescription medications to also cover all FDA-approved prescription methods of contraception. Those pieces of legislation added a large new source of funding into family planning by enabling insured women to access affordable contraceptive options and allowing more of the federally funded family planning programs to assist those women who were either uninsured or underinsured. In 2012, under the ACA, employer sponsored health insurance plans were required to cover at least one type of each FDA approved contraceptive option. However, the 2014 Supreme Case *Burwell vs. Hobby Lobby* (2014) found that the provision was

unconstitutional and that nonprofit companies could opt-out of covering contraceptives if they had religious objections (Freese 2017).

Over the last several decades, Medicaid has transitioned to be the largest funder of subsidized family planning, as state-driven initiatives extend Medicaid eligibility for family planning. As such, the Title X Family Planning Program, the Title V MCH Block Grant, and other smaller grants are often used as a safety-net, to fund infrastructure-related costs, community education, and special programs. The Title X program also continues to serve those individuals who are ineligible under Medicaid, namely immigrants, adolescents, and moderately needy, low-income women. The shift towards Medicaid funding of family planning has illustrated the complimentary nature the Title X Family Planning Program and the Title V MCH Block Grant have for filling critical gaps in Medicaid coverage.

However, not all see the fundamental value in the Title X Family Planning Program as a method of supporting subsidized family planning. Since 2010, conservative leaders in Congress have continued to call for the defunding of the Title X program and as a result, there has been a steady decrease in appropriations. In 2011, Republicans in the House of Representatives voted for the first time to completely eliminate the Title X program (Kreitzer and Smith 2016). Since then, each of the labor appropriation bills introduced by the House have proposed eliminating the Title X program (NFPRHA n.d.). However, the Senate has continually refused to support these bills and the program remains in operation.

CONCLUSION

The Centers for Disease Control and Prevention (CDC) has listed family planning among the top ten greatest public health achievements of the twentieth century (CDC 1999c). A woman's ability to plan, space, and time pregnancy has resulted in significant improvements in not only the health of women and infants, but also in the social and economic well-being of families (IOM 2009). Nearly seven decades ago, the US government initiated small scale grants to the states for family planning and thus, acknowledged the important benefits of enabling all women to plan and space pregnancies, regardless of personal income. The federal government, recognizing the specific barriers low-income women face in accessing care, authorized programs that established elevated standards for service delivery and cultivated the development of dedicated family planning centers across the country. Since then, publicly-funded family planning services have enabled millions of women, men, and adolescents to realize their childbearing goals. In 2015, federal funding for family planning provides free or subsidized contraception and reproductive preventative health services to approximately 8.6 million clients each year through a variety of federal-state partnerships and grants (Frost et al. 2017). That same year in Arizona, more than sixty-eight thousand individuals were served at federally-funded family planning clinics (The Alan Guttmacher Institute 2016).

Despite the recognized importance of publicly funded family planning for low-income individuals, family planning is funded in a piecemeal fashion at both the federal and state levels (Leighton 1993). There are numerous sources of funding for subsidized family planning including Medicaid, the Title X Family Planning program, the Title V

MCH Block Grant, the Title XX Social Services Block Grant, state and local government funding, private insurance, client self-payment, and private donations. Each of those sources come with different funding levels, eligibility requirements, and service coverage.

Access to subsidized family planning increased in Arizona in the early twentieth century as the federal government provided funds for specific needy populations, such as migrant farmers and American Indians. Since then, the coordination of AHCCCS, Title X, Title V MCH, and Title XX has continued to provide Arizona women with subsidized family planning. The partnership that emerged in the early 1970s between reproductive health advocates, who established the Arizona Family Planning Council, and leaders in the Arizona State Health Department enabled the development of a coordinated effort to manage those various sources of federal family planning funding. As Medicaid began underwriting the bulk of subsidized family planning services, leaders at the Arizona Family Planning Council and the Arizona State Health Department found ways to weave AHCCCS and Title X together to maximize their use. That partnership enabled the successful provision of subsidized family planning, despite Arizona's rural, frontier-like environment.

The changing political, social, and cultural landscape in the US has directly impacted the ability to provide comprehensive subsidized family planning care to needy populations (IOM 2009). Since the twentieth century, the US has seen vast transformations in the social and cultural values regarding sexual activity, technological advancements in contraceptives, and an increasing diversity of individuals needing subsidized family planning. All these changes have led to a rise in the desire of services,

cost of care, need for benefits, and complexity of delivering services in a culturally appropriate manner. The contentious debates that have emerged nationwide as part of these changing social and cultural norms have led to political polarization around topics related to reproductive health and have entrenched themselves into the family planning discussion.

The controversies surrounding abortion and adolescents' access to sex education and contraception have continued well into the twenty-first century. Those controversies, along with political, ideological, and economic concerns regarding the amount of government support to the states led to the overall decline of many of those funding sources since the 1980s (Leighton 1993). If trends to erode public funding for family planning continue, many family planning agencies are likely to be impacted. While large entities like Planned Parenthood, with significant non-governmental revenue, would likely be able to sustain some clinics nationwide, smaller, community-centered clinics whose sole source of income is federal grants would likely disappear (Feldt 2016). The reality of diminishing federal funding for family planning remains even more problematic in Arizona, where there is no state support and little county funding for family planning.

The issues of abortion, sex education, and adolescents' access to contraception have also led to increased efforts to control the federal funding of family planning at the state level, especially by religious and conservative political leaders seeking to limit women's and adolescents' access to the full spectrum of reproductive health care. Those controversies have been played out at the federal level, where the Trump Administration passed orders allowing the states to make politically determined legislation surrounding

the federal funding of women's health, and enabling conservative dominated states to make policies limiting reproductive choice.

The Trump Administration and conservative policymakers have also explored several approaches to restructure Medicaid, a program which they see as an unaffordable financial burden on the federal government (Sonfield 2017). As an entitlement program, federal spending on Medicaid automatically increases as enrollment and health care costs expand. Medicaid works by reimbursing a percentage of what states spend on health care for Medicaid enrollees, and they reimburse the same percentage regardless of how much states spend. Conservatives are proposing to convert the Medicaid program into a block grant, where the federal government would contribute a fixed amount each year, regardless of increases in enrollment or health care costs (Rudowitz 2017). Conservatives have also proposed a second option, to instead cap federal spending per individual enrollee (Rudowitz 2017). That approach would adjust for increases in enrollments, such as during a recession, but would not adjust if other health care costs increase (Rudowitz 2017). Either approach would shift health care costs for needy individuals from the federal government to state governments, and ultimately to patients themselves (Sonfield 2017). Researchers believe that ultimately either option would cover few individuals, provide less comprehensive coverage, and be less responsive to changes in the economy, health care costs, and health care needs (Sonfield 2017).

The Trump Administration and Republican dominated Congress also seek to repeal the Affordable Care Act, which would repeal the requirement of state level Medicaid eligibility expansion and effectively cut millions of dollars from the Medicaid program (Sonfield 2017). The proposals would likely cut millions of low-income people

who rely on Medicaid as their source of health care coverage from receiving any form of health care, including sexual and reproductive health care (Sonfield 2017).

The dispute about state management of federal funding has also been evident at the state level, where Arizona legislators have enacted legislation aiming to gain more control over federal family planning funds. In May 2017, the Arizona legislature passed A.R.S. 35-156.05 which requires the Arizona Department of Health Services to apply to become the Title X Family Planning Program grantee in Arizona. Any government or nonprofit agencies is able to apply to receive the Title X grant. However, Arizona state agencies have never chosen to apply (AFHP 2017). Thus, the Arizona Family Planning Council was established in the mid-1970s to receive the Title X grant and has continued to be awarded the grant since then. The law requires that the Arizona Department of Health Services apply for the grant. The provision also requires that if the health department is selected as the Title X grantee, it must distribute Title X funds first to state run health care facilities. If the Arizona Department of Health Services was selected to receive the Title X grant for Arizona, the health department, as a state agency, would be obligated to adhere to state restrictions on which organizations are eligible to receive funding from a state agency. These state restrictions, part of A.R.S. 35-195.05 which was passed in 2012, restrict any organizations that also provide abortions from receiving funding. As such, Planned Parenthood affiliates in Arizona, which operate many of Title X-funded clinics in the state, would be barred from receiving Title X funding. Thus, Arizona legislators' goal in passing this law, is to remove Title X Family Planning funding from Planned Parenthood and other abortion providers.

Per an evaluation of the Title X program, most grantees that emerged in the early days of the grant have continued to receive funding (IOM 2009). The report also noted that in the past, new grantees are typically only selected when a new area of need emerges or the grantee is absorbed by another (IOM 2009). Reproductive health leaders in the state are confident that the Arizona Family Health Partnership will retain the Title X Family Planning Program grant for several reasons. First, the state has no relevant expertise in administering the Title X grant. Secondly, in passing the law, Arizona legislators did not make it clear who in the state health department would be responsible for applying for the Title X grant, or for administering the funds. In addition, as of December 2017, the state is presently in a hiring freeze, restricting the department from hiring new personnel to administer the grant (Farzan 2017).

The recent trends in Arizona are mimicking the federal trends that occurred in the 1980s, when the Reagan Administration enacted administrative orders to move away from the nonprofit management of Title X to put the funding on state agencies. By placing federal funding exclusively in the control of state agencies, state agencies are less likely to expand and fund controversial services. Clearly there is hostility towards control of funds and management of federal funds. It becomes imperative then to question how the implementation and management of these funds truly affects the reproductive health landscape in a state and state residents' ability to access comprehensive care.

The recent attempts to defund abortion providers like Planned Parenthood, cut the Title X program, and restructure Medicaid suggest the political polarization and controversy surrounding reproductive rights and family planning legislation will only increase. By reviewing the origins of government effort to improve access to family

planning for disadvantaged individuals and describing the ways in which one state coordinated that funding, it becomes evident the ways in which such funding can be coordinated to improve the well-being of women and families. In addition, by exploring the federal and state challenges to the publicly funded family planning system, including political, geographic, social, and financial challenges, we can see different innovative approaches to resolve those issues.

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