EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF MARYLAND

MAYOR AND CITY COUNCIL OF BALTIMORE, *Plaintiff*, vs. ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES; and U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Defendants*.	Case No. 1:19-cv-01672 DECLARATION OF SUZANNE SANGREE

DECLARATION OF SUZANNE SANGREE, ESQ.
IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

I, Suzanne Sangree, declare that, if called upon, I would testify to the following:

1. I am a member of the Maryland State Bar, admitted to practice before this Court, employed by the Baltimore City Department of Law as Senior Public Safety Counsel and Director of Affirmative Litigation, and am counsel to Plaintiff in this action.

2. Attached hereto as Exhibit A is a true and correct copy of the Centers for Disease Control and Prevention, *HIV Infection Risk, Prevention, and Testing Behaviors Among Men Who Have Sex With Men--National HIV Behavorial Surveillance, 23 U.S. Cities, 2017*, HIV Surveillance Special Report 22 (Feb. 2019), https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html

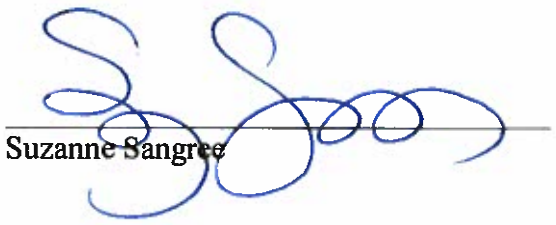
3. Attached hereto as Exhibit B is a true and correct copy of Baltimore City Health Department Press Release, *Baltimore City Awarded $5 Million SAMHSA Grant to Implement Community-based Trauma Informed Care in West Baltimore* (Sept. 15, 2016), https://health.baltimorecity.gov/news/press-releases.

4. Attached hereto as Exhibit C is a true and correct copy of HHS Trauma Informed Care Toolkit, https://www.acf.hhs.gov/trauma-toolkit#chapter-6.

5. Attached hereto as Exhibit D is a true and correct copy of Wendy Chavkin, et al., *Conscientious Objection and Refusal to Provide Reproductive Healthcare: A White Paper Examining Prevalence, Health Consequences' and Policy Responses*, 123 Int'l J. Gynecol. & Obstet. 3 at S53 (2013).

6. Attached hereto as Exhibit E is a true and correct copy of Jennifer Frost et al, *Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, Wiley Periodicals, Inc. (2014).

I declare under penalty of perjury that the foregoing is true and correct and that this Declaration was executed on June 12, 2019, in the State of Maryland.



Suzanne Sangree

Exhibit A

to Sangree Declaration

HIV SURVEILLANCE REPORT
SPECIAL REPORT
Number 22

HIV Infection Risk, Prevention, and Testing Behaviors Among Men Who Have Sex With Men

National HIV Behavioral Surveillance

23 U.S. Cities, 2017

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

This HIV Surveillance Special Report is published by the Behavioral and Clinical Surveillance Branch of the Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, Georgia.

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On the Web: https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

Confidential information, referrals, and educational material on HIV infection
CDC-INFO
1-800-232-4636 (in English, en Español)
1-888-232-6348 (TTY)
https://wwwn.cdc.gov/dcs/ContactUs/Form

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Acknowledgments
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We thank the NHBS participants and the DHAP editorial staff (Michael Friend) for their effort in making this report possible.

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Contents

Commentary

Lowering the annual number of new HIV infections is a major HIV prevention goal [1]. This goal can be achieved by implementing three important strategies for reducing HIV infections: (1) intensifying HIV prevention efforts in communities where HIV is most heavily concentrated, including gay, bisexual, and other men who have sex with men (hereafter referred to as MSM); blacks or African Americans (hereafter referred to as blacks); Hispanics or Latinos; and people who inject drugs (PWID); (2) expanding efforts to prevent HIV infection by using a combination of effective, evidence-based, scalable approaches; and (3) educating the general public about the threat of HIV infection and how to prevent it. State and local health departments, as well as federal agencies, are expected to monitor progress toward HIV prevention goals [1].

The Centers for Disease Control and Prevention (CDC) National HIV Behavioral Surveillance (NHBS) serves as a key component of a high-impact prevention approach to reducing the spread of HIV in the United States [2] by providing data for monitoring behaviors among populations at risk of acquiring or transmitting HIV infection, and identifying the populations for whom scientifically proven, cost-effective, and scalable interventions are most appropriate. NHBS also helps state and local health departments in areas with high HIV prevalence to monitor risk behaviors, HIV testing, use of prevention programs, and HIV prevalence in three populations at high risk of HIV infection: MSM, PWID, and heterosexual adults at increased risk for HIV [3, 4].

Male-to-male sexual contact continues to be the most common route of HIV transmission in the United States among adults and adolescents, accounting for approximately 70% of the HIV infections diagnosed in 2017, including those attributed to male-to-male contact and injection drug use [5]. This report summarizes findings from the fifth NHBS data collection among MSM, which was conducted in 2017. Data from previous MSM cycles of NHBS have been published elsewhere [6–9].

The report provides descriptive, unweighted data that can be used to describe HIV infection among MSM and the percentages reporting specific risk behaviors, HIV testing, and participation in prevention programs. Monitoring these outcomes is useful for assessing risk behaviors and the use of prevention efforts over time and for identifying new HIV prevention opportunities for this population.

Report Changes

CDC routinely assesses NHBS reports to ensure the content and methods best meet the information needs of the nation. The following reporting changes were made from the previous NHBS report on MSM [9]:

- Outcomes are no longer reported by HIV-positive unaware and HIV-positive aware participants; instead, all HIV-positive participants are presented in a single category.
- This report includes 23 metropolitan statistical areas (MSAs). In 2017, 23 MSAs collected NHBS data among MSM.
- Table 7 no longer includes the most recent sexual encounter with a male partner, but rather, any anal sex in the three months before interview with the most recent sex partner, if that sex partner was male.
- Table 8b is added to include MSA-specific receipt of HIV prevention.
- Diagnosis of genital warts or HPV was revised to diagnosis of genital warts (Table 9).
- Hallucinogen use (past 12 months) was removed (Table 10).
- Noninjection prescription opioid use (past 12 months) was added (Table 10).
- A visit to health care provider about HIV was changed from within 3 months after diagnosis to within a month after diagnosis (Table 12).

Some modifications to measure definitions are made routinely to more accurately or more precisely describe the outcome or characteristic of interest; measure definitions are described in the appendix of this report. Additionally, Table 11 is designed as a flexible reporting mechanism to respond to emerging issues; the outcomes presented in this table vary with each report.

TABLE ORGANIZATION

The tables in this report are ordered by content. Tables 1 and 5–11 are stratified by HIV status; that is, data are presented separately for HIV-negative participants and HIV-positive participants (HIV status was determined from the NHBS HIV test result). A small percentage of the sample (8%) could not be classified by HIV status because they had no valid NHBS HIV test result; that is, they did not consent to the HIV test, had an indeterminate result, or reported a previous HIV-positive test result but had a negative NHBS HIV test result. For data completeness, data from these participants are reported in a "No valid NHBS HIV test result" column (Table 1) or row (Tables 5–11).

HIGHLIGHTS

Demographic Characteristics, HIV Prevalence, and HIV Testing

This report describes data from 10,104 MSM who participated in NHBS in 2017, of whom 39% were aged 29 years or younger, and 35% were white, 30% black, and 26% Hispanic or Latino (Table 1). Of HIV-positive participants, 28% were aged 29 years or younger, 22% were white, 49% were black, and 22% were Hispanic or Latino. Overall, 77% of participants had more than a high school education and 81% had a household income above the federal poverty level; 83% of participants had health insurance and 86% had visited a health care provider in the 12 months before interview. A small percentage of the sample reported being homeless (8%) or incarcerated (5%) in the 12 months before interview. Among HIV-positive participants, 13% reported being homeless and 7% incarcerated in the past 12 months.

In 2017, 23% of 9,299 participants with a valid NHBS HIV test result tested positive for HIV (Table 2). HIV prevalence increased with increasing age: 14% (18–24 years), 19% (25–29 years), 24% (30–39 years), 31% (40–49 years), and 32% (50–60 years). By race and ethnicity, HIV prevalence was 39% among blacks, 30% among American Indian or Alaska Natives, 20% among Native Hawaiian or other Pacific Islanders, 19% among Hispanics or Latinos, 15% among whites, and 9% among Asians.

CDC recommends that persons at increased risk of HIV infection, including sexually active MSM, undergo HIV testing at least annually [10]. Among participants who did not report a previous HIV-positive test result or who had received their first HIV-positive test result less than 12 months before interview, 77% reported that they had been tested for HIV in the 12 months before interview, and 95% reported that they had ever been tested (Table 3). These data are consistent with continued increases in HIV testing among MSM participating in NHBS with 62% in 2008 [6], 66% in 2011 [7], 71% in 2014 [9], and 77% in 2017 reporting an HIV test in the previous 12 months.

Among participants who reported being tested for HIV during the 12 months before interview, 62% reported their most recent test was performed in a clinical setting while 31% reported being tested in a nonclinical setting such as HIV counseling and testing site, HIV street outreach program or mobile unit, syringe services program, or at home (Table 4). Testing in nonclinical settings varied by race and ethnicity: 34% of black MSM and 38% of Hispanic MSM reported their most recent HIV test was conducted in a nonclinical setting, while 25% of white MSM reported a nonclinical setting for their most recent HIV test.

Sexual Behaviors

Among MSM, condomless vaginal or anal sex with females was reported similarly by HIV-positive participants (6% vaginal, 2% anal) and HIV-negative participants (8% vaginal, 3% anal) (Table 5). Condomless anal sex with male partners was also reported similarly by HIV-positive MSM (72%) and HIV-negative MSM (72%). HIV-positive participants reported condomless anal sex with main male partners (44%) and casual male partners (49%) at a similar rate to HIV-negative participants (main: 47%; casual: 47%) (Table 6). Among MSM whose last sex partner was male, 24% of HIV-positive and 21% of HIV-negative participants reported having both insertive and receptive condomless anal sex in the three months before the interview (Table 7).

Although other prevention methods may have been used such as preexposure prophylaxis (PrEP), the reporting of condomless vaginal or anal sex with female partners and condomless anal sex with male partners (Tables 5–7) is a concern. Despite the existence of other HIV prevention options, correct and consistent condom use is one of the primary means of protection from HIV and other infections [11, 12].

The high percentages of participants who engaged in condomless sex underscore the importance of using effective, evidence-based scalable combination HIV prevention strategies among MSM at increased risk for HIV infection that include access to and use of condoms, PrEP, risk-reduction counseling, and HIV testing [2, 13].

Receipt of HIV Prevention

The receipt of free condoms and participation in HIV individual- or group-level behavioral interventions are reported in Table 8. Overall, 70% of participants reported receiving free condoms and 31% reported participating in an HIV behavioral intervention. The percentages of MSM who received condoms were similar across HIV status (74% HIV-positive; 70% HIV-negative); however, the percentage of MSM who reported participating in an HIV behavioral intervention was highest for HIV-positive participants (40%) in general, and for younger-aged HIV-positive MSM in particular (47% of 18–24 year olds; 50% of 25–29 year olds).

In 2014, CDC released clinical guidance recommending the use of PrEP for persons at increased risk of acquiring HIV, including MSM [13]. The majority of HIV-negative MSM reported previously hearing about PrEP (85%), particularly among younger age groups (18–24 years: 83%; 25–29 years: 89%). One in four HIV-negative MSM reported taking antiretroviral medicines at any point in the past 12 months to prevent HIV infection but there were notable racial/ethnic differences: whites (31%), Asians (31%), Native Hawaiian or other Pacific Islanders (25%), Hispanics or Latinos (21%), blacks (19%), and American Indian or Alaska Natives (14%).

Sexually Transmitted Infections

Sexually transmitted infections (STIs) can increase the likelihood of acquiring and transmitting HIV [14]. The percentage of MSM who reported a diagnosis of any bacterial STI (chlamydia, gonorrhea, or syphilis) during the 12 months before interview was 19% overall, and was higher among HIV-positive MSM (26%) than HIV-negative MSM (18%). Percentages of reported lifetime diagnosis of genital warts (12%) and genital herpes (10%) were also higher among HIV-positive MSM than among HIV-negative MSM (6% for both genital warts and genital herpes) (Table 9).

Since 2000, rates of reported primary and secondary syphilis have been steadily increasing, primarily attributable to increased cases among MSM; MSM who are HIV-positive account for almost half of reported primary and secondary syphilis cases with known HIV-status [15]. In the current NHBS cycle, 13% of HIV-positive MSM reported being diagnosed with syphilis during the 12 months before interview compared with 5% of HIV-negative MSM.

Drug and Alcohol Use

Drug and alcohol use, particularly binge drinking, injection drug use, and methamphetamine use, have been associated with sexual risk behavior among MSM [16]. Binge drinking prevalence was more common among HIV-negative MSM (45%) than among HIV-positive participants (32%). Use of any injection drugs was reported more often by HIV-positive MSM (5%) than by HIV-negative MSM (2%). The most common noninjection drugs reported by HIV-positive MSM were marijuana, cocaine, and methamphetamine; for HIV-negative MSM, commonly reported noninjection drugs were marijuana, cocaine, and ecstasy (Table 10). Noninjection use of prescription opioids was reported by 6% of HIV-positive and 6% of HIV-negative MSM.

Additional Outcomes

Table 11 presents data on additional outcomes related to the risk of HIV transmission and acquisition among MSM. Outcomes reported in Table 11 are of current relevance to HIV among MSM and may not be reported in future reports.

The median number of male sex partners reported in the 12 months before interview was 4 (Q1–Q3: 2–10) among HIV-positive participants and HIV-negative participants.

Giving or receiving money or drugs in exchange of sex is a recognized risk factor for HIV infection [17]. In 2017, 9% of MSM reported giving or receiving things like money or drugs in exchange for sex with a male casual partner in the 12 months before interview. The percentage of participants reporting exchange of sex with a male casual partner was higher among HIV-positive participants (15%) than HIV-negative MSM (8%).

Condomless sex with an HIV-discordant partner at last sex was commonly reported among MSM (18%). More than a quarter of HIV-positive MSM (26%)

and 16% of HIV-negative MSM reported sex without a condom during the most recent sexual encounter with a partner of different or unknown HIV status.

Receipt of HIV Care and Treatment

Achieving viral suppression through antiretroviral treatment can improve clinical outcomes and reduce the likelihood of transmitting HIV to others [18]. In 2015, a national goal for linkage-to-care changed from increasing the percentage of persons with newly diagnosed HIV linked to care within 3 months of diagnosis to increasing the percentage of linkage to care within one month of diagnosis [1]. In 2017, among self-reported HIV-positive MSM, 97% reported having ever visited a health care provider for HIV, 72% reported that they did so within one month after diagnosis, and 90% reported visiting a health care provider for HIV care in the six months before interview. Current use of antiretroviral therapy was reported by 92% of self-reported HIV-positive MSM (Table 12).

Technical Notes

NHBS conducts rotating cycles of biobehavioral surveys among MSM, PWID, and heterosexual adults at increased risk of HIV infection [3]; data are collected in annual cycles from one risk group per year so that each population is surveyed once every three years. The same general eligibility criteria are used in each cycle: age 18 years or older, current residence in a participating city, no previous participation in NHBS during the current survey cycle, ability to complete the survey in either English or Spanish, and ability to provide informed consent. In addition to these basic NHBS eligibility criteria, participation in the 2017 NHBS cycle was limited to persons who (1) were male at birth, (2) reported their gender as male, and (3) reported oral or anal sex with a male partner during their lifetime. Only participants who reported having oral or anal sex with another man in the past 12 months were counted toward the required sample size of current MSM.

A standardized questionnaire is used to collect information about behavioral risks for HIV infection, HIV testing, and use of HIV prevention services. The anonymous, in-person survey is administered by a trained interviewer using a portable computer. All participants are offered an anonymous HIV test, which is linked to the survey data though a unique survey identifier.

Activities for NHBS were approved by CDC [19, 20] and by applicable institutional review boards (IRBs) in each participating city.

Participating Cities

State and local health departments eligible to participate in NHBS are among those whose jurisdictions include an MSA or a specified division with high prevalence of HIV. In 2017, NHBS was conducted in 23 MSAs (see list at the end of the report), which represented approximately 59% of all persons living with HIV in urban areas with a population of at least 500,000 at year's end 2016 [5].

Throughout this report, MSAs and divisions are referred to by the name of the principal city.

Sampling Method

Participants in the 2017 NHBS cycle were recruited using venue-based, time-space sampling (VBS) [21]. The primary steps were identifying venues frequented by MSM, determining the best time for sampling at each venue and the number of sampling events to be conducted each month, and recruiting men at the sampling event [9].

Data Collection

Persons recruited for the interview were escorted to a private area for eligibility screening. For those who met eligibility requirements, trained interviewers obtained informed consent and conducted face-to-face interviews, which took approximately 30 minutes and consisted of questions concerning participants' demographic characteristics, HIV testing history, sexual and drug use behaviors, STI testing and diagnosis, and use of HIV prevention services and programs. As a token of appreciation for the time spent taking part in the interview, participants received $20–$30 (amount determined locally). For participants who consented to the anonymous testing for HIV, STI, or hepatitis, local testing procedures were followed, and an additional incentive was provided.

HIV testing was performed for participants who consented; blood specimens were collected for rapid testing in the field or laboratory-based testing. A nonreactive rapid test result was considered HIV-negative; a reactive rapid test result was considered HIV-positive if supported by a second rapid test or supplemental laboratory-based testing. Participants received $10–$50 for HIV testing (amount determined locally).

Each participating city's goal was to interview 500 eligible men who also reported having sex with another man in the 12 months before the interview.

Data Analysis

This surveillance report presents descriptive data; no statistical tests were performed. In addition, these data are cross-sectional; we did not attempt to infer causal relationships. Reported numbers fewer than

12, and percentages based on these numbers, should be interpreted with caution because the numbers are considered unreliable.

Data for this report are not weighted. The purpose of this report is to provide a detailed summary of surveillance data collected as part of the NHBS 2017 cycle; unweighted data provide an efficient and transparent way to do so. Further, unweighted analysis allows for detailed reporting of outcomes among small subgroups of the population of interest.

Inclusion for this report is limited to participants who (1) were eligible for and consented to the interview and (2) reported having sex with another man in the 12 months before interview.

In total, 45,098 men were approached for participation at 588 venues; 13,852 persons were screened to participate in NHBS in 2017. Of those, 3,002 persons did not meet NHBS eligibility criteria or did not provide consent and were excluded from the survey. An additional 90 interviews were excluded from this report due to incomplete survey data, survey responses of questionable validity, or data lost during electronic upload. Finally, 656 eligible persons who completed interviews but did not report having sex with a male in the 12 months before interview were excluded from this report.

The full analysis sample for this report includes 2017 NHBS cycle participants who consented to and completed the survey (n=10,104, Table 1). Additional inclusion criteria were applied for certain analyses of HIV infection and of HIV-associated behaviors; details of each analysis sample can be found in the footnotes of each table.

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Table 1. Selected characteristics of men who have sex with men—National HIV Behavioral Surveillance, 23 U.S. cities, 2017

	HIV-negative[a]		HIV-positive[b]		No valid NHBS HIV test result[c]		Total	
	No.	%	No.	%	No.	%	No.	%
Age at interview (yr)								
18–24	1,273	17.9	201	9.2	99	12.3	1,573	15.6
25–29	1,792	25.2	408	18.8	167	20.7	2,367	23.4
30–39	2,098	29.4	659	30.3	250	31.1	3,007	29.8
40–49	983	13.8	436	20.1	128	15.9	1,547	15.3
≥50	979	13.7	470	21.6	161	20.0	1,610	15.9
Race/ethnicity								
American Indian/Alaska Native	49	0.7	21	1.0	4	0.5	74	0.7
Asian	192	2.7	18	0.8	19	2.4	229	2.3
Black/African American	1,672	23.5	1,059	48.7	294	36.5	3,025	29.9
Hispanic/Latino[d]	2,002	28.1	479	22.0	137	17.0	2,618	25.9
Native Hawaiian/Other Pacific Islander	32	0.4	8	0.4	3	0.4	43	0.4
White	2,774	38.9	480	22.1	295	36.6	3,549	35.1
Multiple races	365	5.1	100	4.6	48	6.0	513	5.1
Education								
Less than high school	173	2.4	103	4.7	17	2.1	293	2.9
High school diploma or equivalent	1,307	18.3	563	25.9	131	16.3	2,001	19.8
Some college or technical degree	2,314	32.5	827	38.0	227	28.2	3,368	33.3
College degree or more	3,329	46.7	680	31.3	430	53.4	4,439	43.9
Household income[e]								
At or below the federal poverty level	1,145	16.1	602	27.7	123	15.3	1,870	18.5
Above the federal poverty level	5,926	83.2	1,558	71.7	671	83.4	8,155	80.7
Health insurance								
Yes	5,823	81.7	1,915	88.1	669	83.1	8,407	83.2
No	1,291	18.1	256	11.8	135	16.8	1,682	16.6
Visited a health care provider, past 12 months								
Yes	5,977	83.9	2,044	94.0	709	88.1	8,730	86.4
No	1,145	16.1	130	6.0	96	11.9	1,371	13.6
Homeless,[f] past 12 months								
Yes	507	7.1	273	12.6	40	5.0	820	8.1
No	6,618	92.9	1,901	87.4	765	95.0	9,284	91.9
Incarcerated,[g] past 12 months								
Yes	306	4.3	154	7.1	30	3.7	490	4.8
No	6,819	95.7	2,019	92.9	774	96.1	9,612	95.1

Table 1. Selected characteristics of men who have sex with men—National HIV Behavioral Surveillance, 23 U.S. cities, 2017 *(cont)*

	HIV-negative[a]		HIV-positive[b]		No valid NHBS HIV test result[c]		Total	
	No.	%	No.	%	No.	%	No.	%
City								
Atlanta, GA	328	4.6	164	7.5	19	2.4	511	5.1
Baltimore, MD	236	3.3	138	6.3	43	5.3	417	4.1
Boston, MA	330	4.6	25	1.1	73	9.1	428	4.2
Chicago, IL	295	4.1	98	4.5	146	18.1	539	5.3
Dallas, TX	406	5.7	97	4.5	21	2.6	524	5.2
Denver, CO	437	6.1	60	2.8	33	4.1	530	5.2
Detroit, MI	312	4.4	158	7.3	41	5.1	511	5.1
Houston, TX	371	5.2	113	5.2	21	2.6	505	5.0
Los Angeles, CA	409	5.7	109	5.0	7	0.9	525	5.2
Memphis, TN	180	2.5	93	4.3	59	7.3	332	3.3
Miami, FL	301	4.2	93	4.3	4	0.5	398	3.9
Nassau-Suffolk, NY	139	2.0	11	0.5	11	1.4	161	1.6
New Orleans, LA	272	3.8	71	3.3	42	5.2	385	3.8
New York City, NY	368	5.2	83	3.8	49	6.1	500	4.9
Newark, NJ	121	1.7	40	1.8	7	0.9	168	1.7
Philadelphia, PA	330	4.6	195	9.0	15	1.9	540	5.3
Portland, OR	321	4.5	62	2.9	40	5.0	423	4.2
San Diego, CA	423	5.9	134	6.2	14	1.7	571	5.7
San Francisco, CA	362	5.1	84	3.9	21	2.6	467	4.6
San Juan, PR	247	3.5	29	1.3	5	0.6	281	2.8
Seattle, WA	374	5.2	88	4.0	46	5.7	508	5.0
Virginia Beach, VA	232	3.3	108	5.0	39	4.8	379	3.8
Washington, DC	331	4.6	121	5.6	49	6.1	501	5.0
Total	**7,125**	**100**	**2,174**	**100**	**805**	**100**	**10,104**	**100**

Abbreviation: NHBS, National HIV Behavioral Surveillance.

Note. “Past 12 months” refers to the 12 months before interview.

[a] Participants with a valid negative NHBS HIV test result.

[b] Participants with a reactive rapid NHBS HIV test result supported by a second rapid test or supplemental laboratory-based testing.

[c] Participants who did not have a valid positive or negative NHBS HIV test result, including those who did not consent to the HIV test, had an indeterminate laboratory result, discordant rapid test results, or reported a previous HIV-positive test result but had a negative NHBS HIV test result.

[d] Hispanics/Latinos can be of any race.

[e] Poverty level is based on household income and household size.

[f] Living on the street, in a shelter, in a single-room–occupancy hotel, or in a car.

[g] Having been held in a detention center, jail, or prison for more than 24 hours.

Table 2. HIV prevalence among men who have sex with men—National HIV Behavioral Surveillance, 23 U.S. cities, 2017

	HIV-positive[a]		
	No.	%	Total No.
Age at interview (yr)			
18–24	201	13.6	1,474
25–29	408	18.5	2,200
30–39	659	23.9	2,757
40–49	436	30.7	1,419
≥50	470	32.4	1,449
Race/ethnicity			
American Indian/Alaska Native	21	30.0	70
Asian	18	8.6	210
Black/African American	1,059	38.8	2,731
Hispanic/Latino[b]	479	19.3	2,481
Native Hawaiian/Other Pacific Islander	8	20.0	40
White	480	14.8	3,254
Multiple races	100	21.5	465
City			
Atlanta, GA	164	33.3	492
Baltimore, MD	138	36.9	374
Boston, MA	25	7.0	355
Chicago, IL	98	24.9	393
Dallas, TX	97	19.3	503
Denver, CO	60	12.1	497
Detroit, MI	158	33.6	470
Houston, TX	113	23.3	484
Los Angeles, CA	109	21.0	518
Memphis, TN	93	34.1	273
Miami, FL	93	23.6	394
Nassau-Suffolk, NY	11	7.3	150
New Orleans, LA	71	20.7	343
New York City, NY	83	18.4	451
Newark, NJ	40	24.8	161
Philadelphia, PA	195	37.1	525
Portland, OR	62	16.2	383
San Diego, CA	134	24.1	557
San Francisco, CA	84	18.8	446
San Juan, PR	29	10.5	276
Seattle, WA	88	19.0	462
Virginia Beach, VA	108	31.8	340
Washington, DC	121	26.8	452
Total	**2,174**	**23.4**	**9,299**

Abbreviation: NHBS, National HIV Behavioral Surveillance (footnotes only).

Note. Data include all participants with a valid NHBS HIV test result.

[a] Participants with a reactive rapid NHBS HIV test result supported by a second rapid test or supplemental laboratory-based testing.

[b] Hispanics/Latinos can be of any race.

Table 3. HIV testing among men who have sex with men—National HIV Behavioral Surveillance, 23 U.S. cities, 2017

	Ever tested		Tested in past 12 months[a]		
	No.	%	No.	%	Total No.
Age at interview (yr)					
18–24	1,309	90.1	1,145	78.8	1,453
25–29	1,976	96.1	1,693	82.3	2,057
30–39	2,380	97.2	1,922	78.5	2,448
40–49	1,101	97.2	822	72.6	1,133
≥50	1,105	95.1	743	63.9	1,162
Race/ethnicity					
American Indian/Alaska Native	54	96.4	37	66.1	56
Asian	200	95.2	157	74.8	210
Black/African American	2,112	95.7	1,721	78.0	2,206
Hispanic/Latino[b]	2,095	94.6	1,683	76.0	2,215
Native Hawaiian/Other Pacific Islander	37	97.4	30	78.9	38
White	2,917	95.5	2,317	75.8	3,056
Multiple races	413	96.7	343	80.3	427
City					
Atlanta, GA	366	96.8	307	81.2	378
Baltimore, MD	294	95.1	224	72.5	309
Boston, MA	393	98.0	297	74.1	401
Chicago, IL	414	96.3	344	80.0	430
Dallas, TX	420	94.4	340	76.4	445
Denver, CO	438	92.8	347	73.5	472
Detroit, MI	367	88.4	260	62.7	415
Houston, TX	400	95.5	309	73.7	419
Los Angeles, CA	428	98.2	368	84.4	436
Memphis, TN	230	91.3	199	79.0	252
Miami, FL	302	92.9	241	74.2	325
Nassau-Suffolk, NY	139	93.3	101	67.8	149
New Orleans, LA	307	97.2	245	77.5	316
New York City, NY	410	96.9	342	80.9	423
Newark, NJ	127	96.2	111	84.1	132
Philadelphia, PA	382	96.2	319	80.4	397
Portland, OR	339	93.9	249	69.0	361
San Diego, CA	423	95.7	356	80.5	442
San Francisco, CA	378	99.2	323	84.8	381
San Juan, PR	241	92.7	169	65.0	260
Seattle, WA	406	97.4	331	79.4	417
Virginia Beach, VA	275	95.2	213	73.7	289
Washington, DC	392	97.0	330	81.7	404
Total	**7,871**	**95.4**	**6,325**	**76.6**	**8,253**

Note. Data include all participants who did not report a previous HIV-positive test result and participants who received their first HIV-positive test result less than 12 months before interview.

[a] "'Past 12 months" refers to the 12 months before interview.

[b] Hispanics/Latinos can be of any race.

Table 4. Setting of most recent HIV test among men who have sex with men and who were tested for HIV during the 12 months before interview—National HIV Behavioral Surveillance, 23 U.S. cities, 2017

	Clinical setting[a]		Nonclinical setting[b]		
	No.	(%)	No.	(%)	Total No.
Age at interview (yr)					
18–24	607	53.0	425	37.1	1,145
25–29	1,041	61.5	537	31.7	1,693
30–39	1,252	65.1	560	29.1	1,922
40–49	543	66.1	235	28.6	822
≥50	491	66.1	207	27.9	743
Race/ethnicity					
American Indian/Alaska Native	20	54.1	12	32.4	37
Asian	102	65.0	49	31.2	157
Black/African American	982	57.1	589	34.2	1,721
Hispanic/Latino[c]	926	55.0	644	38.3	1,683
Native Hawaiian/Other Pacific Islander	24	80.0	3	10.0	30
White	1,630	70.3	572	24.7	2,317
Multiple races	223	65.0	85	24.8	343
City					
Atlanta, GA	165	53.7	119	38.8	307
Baltimore, MD	167	74.6	36	16.1	224
Boston, MA	268	90.2	20	6.7	297
Chicago, IL	270	78.5	60	17.4	344
Dallas, TX	184	54.1	132	38.8	340
Denver, CO	251	72.3	69	19.9	347
Detroit, MI	161	61.9	80	30.8	260
Houston, TX	175	56.6	117	37.9	309
Los Angeles, CA	147	39.9	212	57.6	368
Memphis, TN	127	63.8	54	27.1	199
Miami, FL	91	37.8	137	56.8	241
Nassau-Suffolk, NY	68	67.3	23	22.8	101
New Orleans, LA	152	62.0	78	31.8	245
New York City, NY	256	74.9	71	20.8	342
Newark, NJ	36	32.4	67	60.4	111
Philadelphia, PA	121	37.9	172	53.9	319
Portland, OR	183	73.5	54	21.7	249
San Diego, CA	265	74.4	76	21.3	356
San Francisco, CA	214	66.3	98	30.3	323
San Juan, PR	43	25.4	100	59.2	169
Seattle, WA	241	72.8	74	22.4	331
Virginia Beach, VA	108	50.7	55	25.8	213
Washington, DC	241	73.0	60	18.2	330
Total	**3,934**	**62.2**	**1,964**	**31.1**	**6,325**

Abbreviation: HMO, health maintenance organization (footnotes only).

Note. Data report setting of most recent HIV test. Data exclude participants who did not report an HIV test during the 12 months before interview or who reported receiving an HIV-positive test result more than 12 months before interview. Percentages may not add to 100 because of missing data and "other" locations, which could not be classified as clinical or nonclinical settings.

[a] Clinical settings include private doctor's office (including HMO), emergency department, hospital (inpatient), public health clinic or community health center, family planning or obstetrics clinic, correctional facility, or drug treatment program.

[b] Nonclinical settings include HIV counseling and testing site, HIV street outreach program or mobile unit, needle exchange program, or home.

[c] Hispanics/Latinos can be of any race.

Table 5. Sexual behavior with female and male sex partners in the 12 months before interview among men who have sex with men—National HIV Behavioral Surveillance, 23 U.S. cities, 2017

	With female sex partners								With male sex partners				
	Vaginal sex		Condomless vaginal sex		Anal sex		Condomless anal sex		Anal sex		Condomless anal sex		
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	Total No.
HIV-negative[a]	885	12.4	596	8.4	353	5.0	231	3.2	6,422	90.1	5,112	71.7	7,125
Age at interview (yr)													
18–24	184	14.5	129	10.1	69	5.4	45	3.5	1,190	93.5	927	72.8	1,273
25–29	248	13.8	156	8.7	89	5.0	53	3.0	1,692	94.4	1,381	77.1	1,792
30–39	239	11.4	167	8.0	108	5.1	75	3.6	1,944	92.7	1,592	75.9	2,098
40–49	122	12.4	78	7.9	53	5.4	35	3.6	856	87.1	665	67.7	983
≥50	92	9.4	66	6.7	34	3.5	23	2.3	740	75.6	547	55.9	979
Race/ethnicity													
American Indian/Alaska Native	10	20.4	6	12.2	3	6.1	2	4.1	42	85.7	28	57.1	49
Asian	12	6.3	9	4.7	4	2.1	2	1.0	173	90.1	124	64.6	192
Black/African American	330	19.7	213	12.7	128	7.7	82	4.9	1,493	89.3	1,091	65.3	1,672
Hispanic/Latino[b]	239	11.9	153	7.6	96	4.8	61	3.0	1,853	92.6	1,472	73.5	2,002
Native Hawaiian/Other Pacific Islander	2	6.3	2	6.3	0	0.0	0	0.0	29	90.6	25	78.1	32
White	237	8.5	176	6.3	97	3.5	68	2.5	2,465	88.9	2,082	75.1	2,774
Multiple races	51	14.0	35	9.6	24	6.6	15	4.1	331	90.7	261	71.5	365
HIV-positive[c]	226	10.4	119	5.5	84	3.9	43	2.0	2,026	93.2	1,561	71.8	2,174
Age at interview (yr)													
18–24	27	13.4	14	7.0	11	5.5	6	3.0	192	95.5	149	74.1	201
25–29	48	11.8	17	4.2	12	2.9	7	1.7	400	98.0	312	76.5	408
30–39	69	10.5	40	6.1	24	3.6	12	1.8	638	96.8	506	76.8	659
40–49	41	9.4	23	5.3	19	4.4	12	2.8	404	92.7	307	70.4	436
≥50	41	8.7	25	5.3	18	3.8	6	1.3	392	83.4	287	61.1	470
Race/ethnicity													
American Indian/Alaska Native	1	4.8	0	0.0	0	0.0	0	0.0	20	95.2	17	81.0	21
Asian	0	0.0	0	0.0	0	0.0	0	0.0	18	100	14	77.8	18
Black/African American	139	13.1	74	7.0	49	4.6	27	2.5	996	94.1	710	67.0	1,059
Hispanic/Latino[b]	44	9.2	21	4.4	19	4.0	7	1.5	453	94.6	368	76.8	479
Native Hawaiian/Other Pacific Islander	1	12.5	0	0.0	1	12.5	0	0.0	8	100	6	75.0	8
White	28	5.8	16	3.3	10	2.1	7	1.5	428	89.2	369	76.9	480
Multiple races	12	12.0	7	7.0	5	5.0	2	2.0	97	97.0	74	74.0	100
No valid NHBS HIV test result[d]	75	9.3	33	4.1	27	3.4	12	1.5	695	86.3	496	61.6	805
Total	**1,186**	**11.7**	**748**	**7.4**	**464**	**4.6**	**286**	**2.8**	**9,143**	**90.5**	**7,169**	**71.0**	**10,104**

Abbreviation: NHBS, National HIV Behavioral Surveillance.

[a] Participants with a valid negative NHBS HIV test result.

[b] Hispanics/Latinos can be of any race.

[c] Participants with a reactive rapid NHBS HIV test result supported by a second rapid test or supplemental laboratory-based testing.

[d] Participants who did not have a valid positive or negative NHBS HIV test result, including those who did not consent to the HIV test, had an indeterminate laboratory result, discordant rapid test results, or reported a previous HIV-positive test result but had a negative NHBS HIV test result.

Table 6. Sexual behavior with male partners in the 12 months before interview among men who have sex with men, by partner type—National HIV Behavioral Surveillance, 23 U.S. cities, 2017

	Main male partner				Casual male partner				Main and casual male partners—sex of any type[a]		
	Anal sex		Condomless anal sex		Anal sex		Condomless anal sex				
	No.	%	No.	%	No.	%	No.	%	No.	%	Total No.
HIV-negative[b]	4,035	56.6	3,336	46.8	4,966	69.7	3,325	46.7	2,579	36.2	7,125
Age at interview (yr)											
18–24	824	64.7	662	52.0	920	72.3	555	43.6	554	43.5	1,273
25–29	1,155	64.5	970	54.1	1,338	74.7	923	51.5	801	44.7	1,792
30–39	1,246	59.4	1,051	50.1	1,504	71.7	1,052	50.1	806	38.4	2,098
40–49	465	47.3	381	38.8	652	66.3	436	44.4	261	26.6	983
≥50	345	35.2	272	27.8	552	56.4	359	36.7	157	16.0	979
Race/ethnicity											
American Indian/Alaska Native	32	65.3	22	44.9	27	55.1	14	28.6	17	34.7	49
Asian	93	48.4	74	38.5	138	71.9	90	46.9	58	30.2	192
Black/African American	935	55.9	702	42.0	1,125	67.3	660	39.5	567	33.9	1,672
Hispanic/Latino[c]	1,185	59.2	976	48.8	1,416	70.7	907	45.3	748	37.4	2,002
Native Hawaiian/Other Pacific Islander	19	59.4	18	56.3	23	71.9	18	56.3	13	40.6	32
White	1,548	55.8	1,357	48.9	1,948	70.2	1,437	51.8	1,031	37.2	2,774
Multiple races	205	56.2	170	46.6	259	71.0	177	48.5	133	36.4	365
HIV-positive[d]	1,285	59.1	965	44.4	1,570	72.2	1,068	49.1	829	38.1	2,174
Age at interview (yr)											
18–24	151	75.1	111	55.2	144	71.6	83	41.3	103	51.2	201
25–29	289	70.8	220	53.9	304	74.5	194	47.5	193	47.3	408
30–39	417	63.3	319	48.4	504	76.5	360	54.6	283	42.9	659
40–49	237	54.4	172	39.4	319	73.2	233	53.4	152	34.9	436
≥50	191	40.6	143	30.4	299	63.6	198	42.1	98	20.9	470
Race/ethnicity											
American Indian/Alaska Native	15	71.4	13	61.9	17	81.0	11	52.4	12	57.1	21
Asian	11	61.1	6	33.3	13	72.2	11	61.1	6	33.3	18
Black/African American	646	61.0	445	42.0	725	68.5	433	40.9	375	35.4	1,059
Hispanic/Latino[c]	283	59.1	224	46.8	370	77.2	270	56.4	200	41.8	479
Native Hawaiian/Other Pacific Islander	7	87.5	4	50.0	7	87.5	4	50.0	6	75.0	8
White	263	54.8	226	47.1	352	73.3	287	59.8	187	39.0	480
Multiple races	56	56.0	45	45.0	83	83.0	51	51.0	42	42.0	100
No valid NHBS HIV test result[e]	438	54.4	325	40.4	502	62.4	296	36.8	245	30.4	805
Total	**5,758**	**57.0**	**4,626**	**45.8**	**7,038**	**69.7**	**4,689**	**46.4**	**3,653**	**36.2**	**10,104**

Abbreviation: NHBS, National HIV Behavioral Surveillance.

[a] Participants who reported oral or anal sex with at least 1 male main partner and at least 1 male casual partner in the 12 months before interview.

[b] Participants with a valid negative NHBS HIV test result.

[c] Hispanics/Latinos can be of any race.

[d] Participants with a reactive rapid NHBS HIV test result supported by a second rapid test or supplemental laboratory-based testing.

[e] Participants who did not have a valid positive or negative NHBS HIV test result, including those who did not consent to the HIV test, had an indeterminate laboratory result, discordant rapid test results, or reported a previous HIV-positive test result but had a negative NHBS HIV test result.

Table 7. Anal sex with the most recent sex partner during the 3 months before interview among men whose last sex partner was male—National HIV Behavioral Surveillance, 23 U.S. cities, 2017

	Insertive[a] anal sex only				Receptive[b] anal sex only				Both insertive[a] and receptive[b] anal sex				No anal sex in the past 3 months[c,d]		
	Total[c]		Condomless[e]		Total[c]		Condomless[f]		Total[c]		Condomless[g]				
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	Total No.
HIV-negative[h]	1,913	28.1	1,257	18.5	1,177	17.3	725	10.6	1,863	27.4	1,430	21.0	1,853	27.2	6,811
Age at interview (yr)															
18–24	277	22.9	150	12.4	268	22.1	152	12.6	405	33.5	310	25.6	257	21.2	1,210
25–29	472	27.4	306	17.8	333	19.3	197	11.4	549	31.9	418	24.3	368	21.4	1,723
30–39	634	31.5	430	21.4	328	16.3	221	11.0	569	28.3	447	22.2	481	23.9	2,013
40–49	298	32.1	203	21.9	125	13.5	80	8.6	193	20.8	149	16.1	311	33.5	927
≥50	232	24.7	168	17.9	123	13.1	75	8.0	147	15.7	106	11.3	436	46.5	938
Race/ethnicity															
American Indian/Alaska Native	13	27.1	10	20.8	9	18.8	5	10.4	11	22.9	6	12.5	15	31.3	48
Asian	28	14.9	12	6.4	45	23.9	23	12.2	45	23.9	35	18.6	70	37.2	188
Black/African American	542	35.1	316	20.4	231	14.9	125	8.1	365	23.6	246	15.9	406	26.3	1,546
Hispanic/Latino[i]	523	27.0	345	17.8	331	17.1	189	9.8	626	32.4	474	24.5	453	23.4	1,934
Native Hawaiian/Other Pacific Islander	9	28.1	5	15.6	10	31.3	8	25.0	4	12.5	3	9.4	9	28.1	32
White	685	25.5	495	18.4	482	17.9	332	12.4	715	26.6	599	22.3	803	29.9	2,686
Multiple races	105	31.0	68	20.1	63	18.6	38	11.2	86	25.4	60	17.7	84	24.8	339
HIV-positive[j]	476	22.4	318	15.0	500	23.6	314	14.8	676	31.9	502	23.7	467	22.0	2,122
Age at interview (yr)															
18–24	26	13.4	17	8.8	62	32.0	34	17.5	85	43.8	62	32.0	21	10.8	194
25–29	98	24.5	68	17.0	99	24.8	63	15.8	141	35.3	94	23.5	61	15.3	400
30–39	154	23.8	106	16.4	156	24.1	104	16.1	214	33.1	162	25.1	120	18.6	646
40–49	99	23.3	70	16.5	88	20.8	53	12.5	130	30.7	107	25.2	107	25.2	424
≥50	99	21.6	57	12.4	95	20.7	60	13.1	106	23.1	77	16.8	158	34.5	458
Race/ethnicity															
American Indian/Alaska Native	5	25.0	3	15.0	5	25.0	2	10.0	8	40.0	7	35.0	2	10.0	20
Asian	1	5.6	1	5.6	8	44.4	6	33.3	6	33.3	3	16.7	3	16.7	18
Black/African American	240	23.3	150	14.6	231	22.4	119	11.6	348	33.8	238	23.1	208	20.2	1,029
Hispanic/Latino[i]	97	20.5	65	13.7	133	28.1	88	18.6	151	31.9	120	25.4	92	19.5	473
Native Hawaiian/Other Pacific Islander	2	28.6	2	28.6	2	28.6	1	14.3	1	14.3	1	14.3	2	28.6	7
White	104	22.1	79	16.8	104	22.1	86	18.3	127	27.0	109	23.2	134	28.5	470
Multiple races	23	24.0	16	16.7	16	16.7	12	12.5	35	36.5	24	25.0	22	22.9	96
No valid NHBS HIV test result[k]	188	24.1	100	12.8	117	15.0	71	9.1	230	29.5	158	20.3	243	31.2	779
Total	**2,577**	**26.5**	**1,675**	**17.2**	**1,794**	**18.5**	**1,110**	**11.4**	**2,769**	**28.5**	**2,090**	**21.5**	**2,563**	**26.4**	**9,712**

Abbreviation: NHBS, National HIV Behavioral Surveillance.

Note.Outcomes are only reported for men whose most recent sex partner was male. Men whose most recent sex partner was female (n=353) or unknown gender (n=39) were excluded. Percentages may not add to 100 because of missing data.

[a] The participant's most recent sex partner was male and the participant placed his penis in the anus of his sex partner one or more times during the 3 months before interview.

[b] The participant's most recent sex partner was male and the sex partner placed his penis in the participant's anus one or more times during the 3 months before interview.

[c] The categories—insertive anal sex, receptive anal sex, both insertive and receptive anal sex, and no anal sex—are mutually exclusive.

[d] The participant's most recent sex partner was male and the participant reported neither insertive anal sex nor receptive anal sex with the sex partner during the 3 months before interview. Includes participants who had oral sex but not anal sex with the most recent sex partner during the 3 months before interview and those who last had sex more than 3 months before interview.

[e] The participant did not use a condom during one or more of the times he had insertive anal sex with the most recent sex partner during the 3 months before interview.

[f] The participant did not use a condom during one or more of the times he had receptive anal sex with the most recent sex partner during the 3 months before interview.

[g] The participant did not use a condom during one or more of the times he had insertive anal sex or did not use a condom during one or more of the times he had receptive anal sex with the most recent sex partner during the 3 months before interview.

[h] Participants with a valid negative NHBS HIV test result.

[i] Hispanics/Latinos can be of any race.

[j] Participants with a reactive rapid NHBS HIV test result supported by a second rapid test or supplemental laboratory-based testing.

[k] Participants who did not have a valid positive or negative NHBS HIV test result, including those who did not consent to the HIV test, had an indeterminate laboratory result, discordant rapid test results, or reported a previous HIV-positive test result but had a negative NHBS HIV test result.

Table 8a. Receipt of HIV prevention in the 12 months before interview among men who have sex with men—National HIV Behavioral Surveillance, 23 U.S. cities, 2017

	Free condoms[a]		Individual- or group-level intervention[b]		PrEP awareness[c]		PrEP use[d]		
	No.	%	No.	%	No.	%	No.	%	Total No.
HIV-negative[e]	4,952	69.5	2,000	28.1	6,044	84.8	1,782	25.0	7,125
Age at interview (yr)									
18–24	924	72.6	499	39.2	1,060	83.3	274	21.5	1,273
25–29	1,307	72.9	561	31.3	1,598	89.2	502	28.0	1,792
30–39	1,430	68.2	589	28.1	1,860	88.7	637	30.4	2,098
40–49	669	68.1	191	19.4	780	79.3	233	23.7	983
≥50	622	63.5	160	16.3	746	76.2	136	13.9	979
Race/ethnicity									
American Indian/Alaska Native	35	71.4	12	24.5	44	89.8	7	14.3	49
Asian	128	66.7	57	29.7	172	89.6	60	31.3	192
Black/African American	1,183	70.8	647	38.7	1,309	78.3	315	18.8	1,672
Hispanic/Latino[f]	1,426	71.2	588	29.4	1,616	80.7	425	21.2	2,002
Native Hawaiian/Other Pacific Islander	25	78.1	9	28.1	30	93.8	8	25.0	32
White	1,878	67.7	571	20.6	2,525	91.0	856	30.9	2,774
Multiple races	254	69.6	102	27.9	313	85.8	98	26.8	365
HIV-positive[g]	1,603	73.7	858	39.5	—	—	—	—	2,174
Age at interview (yr)									
18–24	154	76.6	95	47.3	—	—	—	—	201
25–29	313	76.7	205	50.2	—	—	—	—	408
30–39	498	75.6	272	41.3	—	—	—	—	659
40–49	314	72.0	145	33.3	—	—	—	—	436
≥50	324	68.9	141	30.0	—	—	—	—	470
Race/ethnicity									
American Indian/Alaska Native	16	76.2	7	33.3	—	—	—	—	21
Asian	12	66.7	7	38.9	—	—	—	—	18
Black/African American	795	75.1	489	46.2	—	—	—	—	1,059
Hispanic/Latino[f]	367	76.6	171	35.7	—	—	—	—	479
Native Hawaiian/Other Pacific Islander	6	75.0	3	37.5	—	—	—	—	8
White	323	67.3	133	27.7	—	—	—	—	480
Multiple races	77	77.0	44	44.0	—	—	—	—	100
No valid NHBS HIV test result[h]	518	64.3	247	30.7	—	—	—	—	805
Total	**7,073**	**70.0**	**3,105**	**30.7**	**—**	**—**	**—**	**—**	**10,104**

Abbreviations: PrEP; preexposure prophylaxis; NHBS, National HIV Behavioral Surveillance.

[a] Excludes condoms received from friends, relatives, or sex partners.

[b] Individual-level intervention defined as a one-on-one conversation with an outreach worker, a counselor, or a prevention program worker about ways to prevent HIV. Group-level intervention defined as a small-group discussion that is part of an organized session about ways to prevent HIV; excludes informal discussions with friends. Conversations that were part of obtaining an HIV test were excluded.

[c] Ever heard of PrEP, an antiretroviral medicine taken for months or years by a person who is HIV-negative to reduce the risk of getting HIV.

[d] Took PrEP at any point during the 12 months before interview to reduce the risk of getting HIV.

[e] Participants with a valid negative NHBS HIV test result.

[f] Hispanics/Latinos can be of any race.

[g] Participants with a reactive rapid NHBS HIV test result supported by a second rapid test or supplemental laboratory-based testing.

[h] Participants who did not have a valid positive or negative NHBS HIV test result, including those who did not consent to the HIV test, had an indeterminate laboratory result, discordant rapid test results, or reported a previous HIV-positive test result but had a negative NHBS HIV test result.

Table 8b. Receipt of HIV prevention in the 12 months before interview among men who have sex with men—National HIV Behavioral Surveillance, 23 U.S. cities, 2017

	Free condoms[a]		Individual- or group-level intervention[b]		PrEP awareness[c]		PrEP use[d]		
	No.	%	No.	%	No.	%	No.	%	Total No.
HIV-negative[e]									
City									
Atlanta, GA	224	68.3	86	26.2	285	86.9	71	21.6	328
Baltimore, MD	133	56.4	62	26.3	168	71.2	29	12.3	236
Boston, MA	212	64.2	57	17.3	308	93.3	111	33.6	330
Chicago, IL	204	69.2	83	28.1	255	86.4	104	35.3	295
Dallas, TX	293	72.2	99	24.4	340	83.7	74	18.2	406
Denver, CO	271	62.0	91	20.8	392	89.7	103	23.6	437
Detroit, MI	224	71.8	89	28.5	179	57.4	37	11.9	312
Houston, TX	257	69.3	104	28.0	310	83.6	67	18.1	371
Los Angeles, CA	331	80.9	106	25.9	390	95.4	124	30.3	409
Memphis, TN	114	63.3	90	50.0	121	67.2	32	17.8	180
Miami, FL	188	62.5	54	17.9	209	69.4	34	11.3	301
Nassau-Suffolk, NY	93	66.9	40	28.8	108	77.7	18	12.9	139
New Orleans, LA	202	74.3	83	30.5	248	91.2	75	27.6	272
New York City, NY	269	73.1	115	31.3	331	89.9	118	32.1	368
Newark, NJ	97	80.2	78	64.5	95	78.5	20	16.5	121
Philadelphia, PA	213	64.5	120	36.4	250	75.8	68	20.6	330
Portland, OR	212	66.0	60	18.7	286	89.1	81	25.2	321
San Diego, CA	296	70.0	171	40.4	386	91.3	140	33.1	423
San Francisco, CA	244	67.4	108	29.8	352	97.2	176	48.6	362
San Juan, PR	195	78.9	55	22.3	149	60.3	9	3.6	247
Seattle, WA	290	77.5	66	17.6	355	94.9	129	34.5	374
Virginia Beach, VA	147	63.4	80	34.5	214	92.2	34	14.7	232
Washington, DC	243	73.4	103	31.1	313	94.6	128	38.7	331
HIV-positive[f]									
City									
Atlanta, GA	122	74.4	63	38.4	—	—	—	—	164
Baltimore, MD	89	64.5	48	34.8	—	—	—	—	138
Boston, MA	14	56.0	10	40.0	—	—	—	—	25
Chicago, IL	78	79.6	37	37.8	—	—	—	—	98
Dallas, TX	70	72.2	35	36.1	—	—	—	—	97
Denver, CO	44	73.3	26	43.3	—	—	—	—	60
Detroit, MI	121	76.6	68	43.0	—	—	—	—	158
Houston, TX	80	70.8	45	39.8	—	—	—	—	113
Los Angeles, CA	94	86.2	45	41.3	—	—	—	—	109
Memphis, TN	66	71.0	58	62.4	—	—	—	—	93
Miami, FL	69	74.2	20	21.5	—	—	—	—	93
Nassau-Suffolk, NY	6	54.5	0	0.0	—	—	—	—	11
New Orleans, LA	54	76.1	25	35.2	—	—	—	—	71
New York City, NY	67	80.7	41	49.4	—	—	—	—	83
Newark, NJ	32	80.0	35	87.5	—	—	—	—	40
Philadelphia, PA	135	69.2	74	37.9	—	—	—	—	195
Portland, OR	41	66.1	23	37.1	—	—	—	—	62
San Diego, CA	94	70.1	55	41.0	—	—	—	—	134
San Francisco, CA	59	70.2	20	23.8	—	—	—	—	84
San Juan, PR	23	79.3	8	27.6	—	—	—	—	29
Seattle, WA	68	77.3	24	27.3	—	—	—	—	88
Virginia Beach, VA	80	74.1	54	50.0	—	—	—	—	108
Washington, DC	97	80.2	44	36.4	—	—	—	—	121

Abbreviations: PrEP; preexposure prophylaxis; NHBS, National HIV Behavioral Surveillance.

[a] Excludes condoms received from friends, relatives, or sex partners.

[b] Individual-level intervention defined as a one-on-one conversation with an outreach worker, a counselor, or a prevention program worker about ways to prevent HIV. Group-level intervention defined as a small-group discussion that is part of an organized session about ways to prevent HIV; excludes informal discussions with friends. Conversations that were part of obtaining an HIV test were excluded.

[c] Ever heard of PrEP, an antiretroviral medicine taken for months or years by a person who is HIV-negative to reduce the risk of getting HIV.

[d] Took PrEP at any point during the 12 months before interview to reduce the risk of getting HIV.

[e] Participants with a valid negative NHBS HIV test result.

[f] Participants with a reactive rapid NHBS HIV test result supported by a second rapid test or supplemental laboratory-based testing.

Table 9. Diagnosis of sexually transmitted infections among men who have sex with men—National HIV Behavioral Surveillance, 23 U.S. cities, 2017

	Diagnosis during the 12 months before interview								Diagnosis, ever				
	Any bacterial STI[a]		Chlamydia		Gonorrhea		Syphilis		Genital warts		Genital herpes		
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	Total No.
HIV-negative[b]	1,254	17.6	633	8.9	770	10.8	347	4.9	431	6.0	405	5.7	7,125
Age at interview (yr)													
18–24	266	20.9	114	9.0	173	13.6	70	5.5	31	2.4	32	2.5	1,273
25–29	396	22.1	208	11.6	249	13.9	107	6.0	88	4.9	83	4.6	1,792
30–39	400	19.1	214	10.2	250	11.9	110	5.2	153	7.3	141	6.7	2,098
40–49	121	12.3	68	6.9	64	6.5	36	3.7	63	6.4	64	6.5	983
≥50	71	7.3	29	3.0	34	3.5	24	2.5	96	9.8	85	8.7	979
Race/ethnicity													
American Indian/Alaska Native	6	12.2	1	2.0	5	10.2	0	0.0	1	2.0	1	2.0	49
Asian	43	22.4	27	14.1	27	14.1	13	6.8	14	7.3	20	10.4	192
Black/African American	279	16.7	128	7.7	168	10.0	89	5.3	45	2.7	66	3.9	1,672
Hispanic/Latino[c]	332	16.6	159	7.9	193	9.6	109	5.4	90	4.5	92	4.6	2,002
Native Hawaiian/Other Pacific Islander	8	25.0	4	12.5	2	6.3	3	9.4	1	3.1	1	3.1	32
White	510	18.4	268	9.7	325	11.7	117	4.2	260	9.4	211	7.6	2,774
Multiple races	64	17.5	41	11.2	43	11.8	12	3.3	18	4.9	14	3.8	365
HIV-positive[d]	565	26.0	235	10.8	293	13.5	284	13.1	254	11.7	206	9.5	2,174
Age at interview (yr)													
18–24	79	39.3	39	19.4	52	25.9	34	16.9	7	3.5	8	4.0	201
25–29	107	26.2	47	11.5	55	13.5	53	13.0	27	6.6	19	4.7	408
30–39	202	30.7	81	12.3	109	16.5	105	15.9	67	10.2	50	7.6	659
40–49	107	24.5	41	9.4	52	11.9	51	11.7	63	14.4	56	12.8	436
≥50	70	14.9	27	5.7	25	5.3	41	8.7	90	19.1	73	15.5	470
Race/ethnicity													
American Indian/Alaska Native	9	42.9	5	23.8	6	28.6	5	23.8	2	9.5	2	9.5	21
Asian	6	33.3	3	16.7	2	11.1	5	27.8	3	16.7	1	5.6	18
Black/African American	222	21.0	95	9.0	112	10.6	115	10.9	59	5.6	58	5.5	1,059
Hispanic/Latino[c]	150	31.3	62	12.9	75	15.7	78	16.3	62	12.9	54	11.3	479
Native Hawaiian/Other Pacific Islander	5	62.5	0	0.0	3	37.5	2	25.0	1	12.5	0	0.0	8
White	133	27.7	53	11.0	73	15.2	61	12.7	112	23.3	81	16.9	480
Multiple races	36	36.0	16	16.0	20	20.0	17	17.0	15	15.0	10	10.0	100
No valid NHBS HIV test result[e]	112	13.9	55	6.8	73	9.1	37	4.6	61	7.6	42	5.2	805
Total	**1,931**	**19.1**	**923**	**9.1**	**1,136**	**11.2**	**668**	**6.6**	**746**	**7.4**	**653**	**6.5**	**10,104**

Abbreviations: STI, sexually transmitted infection; NHBS, National HIV Behavioral Surveillance.

[a] Any bacterial STI includes having received a diagnosis of gonorrhea, chlamydia, or syphilis in the 12 months before interview.

[b] Participants with a valid negative NHBS HIV test result.

[c] Hispanics/Latinos can be of any race.

[d] Participants with a reactive rapid NHBS HIV test result supported by a second rapid test or supplemental laboratory-based testing.

[e] Participants who did not have a valid positive or negative NHBS HIV test result, including those who did not consent to the HIV test, had an indeterminate laboratory test, discordant rapid test results, or reported a previous HIV-positive test result but had a negative NHBS HIV test result.

Table 10. Drug use in the 12 months before interview and binge drinking in the 30 days before interview among men who have sex with men—National HIV Behavioral Surveillance, 23 U.S. cities, 2017

	Used drug	
	No.	%
HIV-negative[a]		
Binge drinking (past 30 days)[b]	3,209	45.0
Any injection drugs	133	1.9
Any noninjection drugs (excludes binge drinking)	3,982	55.9
Cocaine	1,474	20.7
Crack	374	5.2
Downer[c]	486	6.8
Ecstasy	854	12.0
Heroin	77	1.1
Marijuana	3,485	48.9
Methamphetamine	421	5.9
Prescription opioids[d]	415	5.8
HIV-positive[e]		
Binge drinking (past 30 days)[b]	694	31.9
Any injection drugs	114	5.2
Any noninjection drugs (excludes binge drinking)	1,225	56.3
Cocaine	388	17.8
Crack	121	5.6
Downer[c]	124	5.7
Ecstasy	192	8.8
Heroin	24	1.1
Marijuana	1,046	48.1
Methamphetamine	267	12.3
Prescription opioids[d]	129	5.9
No valid NHBS HIV test result[f]		
Binge drinking (past 30 days)[b]	309	38.4
Any injection drugs	15	1.9
Any noninjection drugs (excludes binge drinking)	380	47.2
Cocaine	135	16.8
Crack	20	2.5
Downer[c]	43	5.3
Ecstasy	64	8.0
Heroin	2	0.2
Marijuana	344	42.7
Methamphetamine	44	5.5
Prescription opioids[d]	27	3.4

Disclaimer: The use of trade names is for identification only and does not imply endorsement by the Department of Health and Human Services or the Centers for Disease Control and Prevention.

Abbreviation: NHBS, National HIV Behavioral Surveillance.

Note. Denominator is the total number of participants in the category; HIV-negative participants: n = 7,125; HIV-positive participants: n = 2,174; participants without a valid NHBS HIV test result: n = 805. Responses are not mutually exclusive; percentages may not add to 100.

[a] Participants with a valid negative NHBS HIV test result.

[b] Defined as 5 or more drinks at one sitting during the 30 days before interview.

[c] Such as Klonopin, Valium, Ativan, or Xanax.

[d] Such as OxyContin, Vicodin, morphine, or Percocet.

[e] Participants with a reactive rapid NHBS HIV test result supported by a second rapid test or supplemental laboratory-based testing.

[f] Participants who did not have a valid positive or negative NHBS HIV test result, including those who did not consent to the HIV test, had an indeterminate laboratory result, discordant rapid test results, or reported a previous HIV-positive test result but had a negative NHBS HIV test result.

Table 11. Additional outcomes among men who have sex with men—National HIV Behavioral Surveillance, 23 U.S. cities, 2017

	Number of male sex partners	Exchange sex[a]		Condomless sex with an HIV-discordant partner at last sex[b]		
	Median (Q1–Q3)	No.	%	No.	%	Total No.
HIV-negative[c]	4 (2–10)	566	7.9	1,152	16.2	7,125
Age at interview (yr)						
18–24	4 (2–10)	122	9.6	212	16.7	1,273
25–29	5 (2–12)	131	7.3	297	16.6	1,792
30–39	5 (2–12)	149	7.1	334	15.9	2,098
40–49	4 (2–10)	79	8.0	173	17.6	983
≥50	3 (2–10)	85	8.7	136	13.9	979
Race/ethnicity						
American Indian/Alaska Native	3 (1–7)	3	6.1	11	22.4	49
Asian	4 (2–12)	9	4.7	21	10.9	192
Black/African American	3 (2–7)	194	11.6	279	16.7	1,672
Hispanic/Latino[d]	4 (2–10)	153	7.6	344	17.2	2,002
Native Hawaiian/Other Pacific Islander	5 (2.5–8.5)	3	9.4	6	18.8	32
White	5 (2–15)	159	5.7	418	15.1	2,774
Multiple races	4 (2–10)	42	11.5	69	18.9	365
HIV-positive[e]	4 (2–10)	324	14.9	555	25.5	2,174
Age at interview (yr)						
18–24	4 (2–7)	44	21.9	54	26.9	201
25–29	4 (2–10)	56	13.7	106	26.0	408
30–39	5 (2–12)	91	13.8	189	28.7	659
40–49	4.5 (2–12)	63	14.4	113	25.9	436
≥50	4 (2–10)	70	14.9	93	19.8	470
Race/ethnicity						
American Indian/Alaska Native	6 (3–12)	4	19.0	7	33.3	21
Asian	6 (3–20)	3	16.7	7	38.9	18
Black/African American	3 (2–7)	191	18.0	234	22.1	1,059
Hispanic/Latino[d]	5 (2–15)	57	11.9	138	28.8	479
Native Hawaiian/Other Pacific Islander	3.5 (2.5–5)	3	37.5	2	25.0	8
White	6 (2–20)	47	9.8	137	28.5	480
Multiple races	5 (2–12)	19	19.0	29	29.0	100
No valid NHBS HIV test result[f]	4 (2–10)	49	6.1	98	12.2	805
Total	**4 (2–10)**	**939**	**9.3**	**1,805**	**17.9**	**10,104**

Abbreviations: Q, quartile; NHBS, National HIV Behavioral Surveillance.

Note. Unless otherwise stated, outcomes are reported for the 12 months before interview.

[a] "Exchange sex" refers to giving or receiving money or drugs from a male casual partner in exchange for sex.

[b] "Condomless sex" refers to whether the participant reported engaging in vaginal or anal sex without a condom during his most recent sexual encounter. "HIV-discordant partner" refers to a sex partner of different or unknown HIV status.

[c] Participants with a valid negative NHBS HIV test result.

[d] Hispanics/Latinos can be of any race.

[e] Participants with a reactive rapid NHBS HIV test result supported by a second rapid test or supplemental laboratory-based testing.

[f] Participants who did not have a valid positive or negative NHBS HIV test result, including those who did not consent to the HIV test, had an indeterminate laboratory result, discordant rapid test results, or reported a previous HIV-positive test result but had a negative NHBS HIV test result.

Table 12. Receipt of HIV care and treatment among self-reported HIV-positive men who have sex with men—National HIV Behavioral Surveillance, 23 U.S. cities, 2017

	Visited health care provider about HIV								
	Ever		Within a month after diagnosis		During past 6 months		Currently taking antiretrovirals		
	No.	%	No.	%	No.	%	No.	%	Total No.
Age at interview (yr)									
18–24	146	94.2	118	76.1	135	87.1	137	88.4	155
25–29	349	98.0	261	73.3	321	90.2	331	93.0	356
30–39	568	96.4	423	71.8	518	87.9	527	89.5	589
40–49	406	97.4	309	74.1	383	91.8	390	93.5	417
≥50	443	97.6	301	66.3	422	93.0	434	95.6	454
Race/ethnicity									
American Indian/Alaska Native	21	100	15	71.4	18	85.7	20	95.2	21
Asian	19	95.0	12	60.0	19	95.0	18	90.0	20
Black/African American	851	96.0	608	68.6	792	89.4	802	90.5	886
Hispanic/Latino[a]	411	96.3	314	73.5	379	88.8	399	93.4	427
Native Hawaiian/ Other Pacific Islander	7	100	5	71.4	7	100	6	85.7	7
White	499	98.6	382	75.5	467	92.3	476	94.1	506
Multiple races	96	100	70	72.9	89	92.7	90	93.8	96
City									
Atlanta, GA	131	92.9	103	73.0	123	87.2	123	87.2	141
Baltimore, MD	113	99.1	79	69.3	106	93.0	104	91.2	114
Boston, MA	29	96.7	18	60.0	27	90.0	29	96.7	30
Chicago, IL	109	95.6	75	65.8	101	88.6	108	94.7	114
Dallas, TX	84	98.8	61	71.8	75	88.2	76	89.4	85
Denver, CO	60	96.8	43	69.4	56	90.3	60	96.8	62
Detroit, MI	100	94.3	72	67.9	95	89.6	97	91.5	106
Houston, TX	88	95.7	71	77.2	81	88.0	81	88.0	92
Los Angeles, CA	90	98.9	58	63.7	82	90.1	82	90.1	91
Memphis, TN	86	95.6	61	67.8	80	88.9	78	86.7	90
Miami, FL	75	97.4	62	80.5	70	90.9	71	92.2	77
Nassau-Suffolk, NY	12	100	10	83.3	11	91.7	11	91.7	12
New Orleans, LA	70	98.6	53	74.6	63	88.7	67	94.4	71
New York City, NY	82	98.8	68	81.9	81	97.6	79	95.2	83
Newark, NJ	35	89.7	27	69.2	34	87.2	33	84.6	39
Philadelphia, PA	154	97.5	108	68.4	146	92.4	145	91.8	158
Portland, OR	66	98.5	56	83.6	64	95.5	66	98.5	67
San Diego, CA	128	97.0	90	68.2	120	90.9	123	93.2	132
San Francisco, CA	87	100	67	77.0	74	85.1	83	95.4	87
San Juan, PR	18	90.0	12	60.0	17	85.0	17	85.0	20
Seattle, WA	91	98.9	65	70.7	84	91.3	89	96.7	92
Virginia Beach, VA	98	98.0	70	70.0	92	92.0	94	94.0	100
Washington, DC	106	98.1	83	76.9	97	89.8	103	95.4	108
Total	**1,912**	**97.0**	**1,412**	**71.6**	**1,779**	**90.3**	**1,819**	**92.3**	**1,971**

Abbreviation: NHBS, National HIV Behavioral Surveillance (footnotes only).

Note. Data include all participants who reported having ever received an HIV-positive test result (which may include those who did not have a valid test result, positive or negative, or who did not consent to the HIV test). "Past 6 months" refers to the 6 months before interview.

[a] Hispanics/Latinos can be of any race.

Appendix: Measurement Notes

Sociodemographic Characteristics

- Age: Calculated from the reported date of birth; age categories were chosen for epidemiologic relevance and consistency of reporting across all 3 National HIV Behavioral Surveillance (NHBS) populations.
- Race/ethnicity: Participants reported 1 or more race categories (American Indian or Alaska Native, Asian, black or African American, Native Hawaiian or other Pacific Islander, and white). Hispanic or Latino ethnicity was asked separately; participants reporting Hispanic or Latino ethnicity were considered Hispanic or Latino, regardless of reported race. Participants reporting multiple races (but not Hispanic or Latino ethnicity) were classified as multiple races.
- Education: Highest level of education completed.
- Household income: Participants were asked about their combined monthly or yearly household income (in US$) from all sources for the calendar year before interview. Poverty was determined by using the U.S. Department of Health and Human Services poverty guidelines for 2017. These guidelines are issued yearly for the United States and are one of the indicators used for determining eligibility for many federal and state programs. The 2017 guidelines [1] were used for participants interviewed in 2017. Because the poverty guidelines are not defined for Puerto Rico, the guidelines for the 48 contiguous states and Washington, D.C., were used for this jurisdiction. Participants were asked to identify the range of their income by selecting from a list of income ranges and the number of dependents on that income. If the participant's income range and household size resulted in an ambiguous determination of poverty level, the participant's household income was assumed to be the low point of the income range.
- Health insurance: Currently having some form of health insurance.
- Homeless: Living on the street, in a shelter, in a single-room–occupancy hotel, or in a car at any time during the 12 months before interview.
- Incarcerated: Having been held in a detention center, jail, or prison for more than 24 hours during the 12 months before interview.
- City: Throughout this report, eligible metropolitan statistical areas (MSAs) and divisions are referred to by the name of the principal city. State and local health departments eligible to participate in NHBS are those in jurisdictions that included an MSA or a specified division within an MSA with high prevalence of HIV. This report presents 2017 data in 23 MSAs (see list at the end of the report), which represented approximately 59% of all persons living with HIV in urban areas with a population of at least 500,000 in 2016.

HIV Status

HIV testing was performed for participants who consented to testing; blood specimens were collected for rapid testing in the field or laboratory-based testing.

- HIV-negative: Participants with a valid negative NHBS HIV test result.
- HIV-positive: Participants with a reactive rapid NHBS HIV test result supported by a second rapid test or supplemental laboratory-based testing.
- No valid NHBS HIV test result: Participants who did not have a valid positive or negative NHBS HIV test result, including those who did not consent to the HIV test, had an indeterminate laboratory result or discordant rapid test results, or reported a previous HIV-positive test result but had a negative NHBS HIV test result.

HIV Testing

- Ever tested: Having had an HIV test during one's lifetime.
- Tested in past 12 months: Having had an HIV test during the 12 months before interview.
- Clinical setting: Participants reported the location of their most recent HIV test—private doctor's office (including health maintenance organization), emergency department, hospital (inpa-

tient), public health clinic or community health center, family planning or obstetrics clinic, correctional facility (jail or prison), or drug treatment program.

- Nonclinical setting: Participants reported the location of their most recent HIV test—HIV counseling and testing site, HIV street outreach program or mobile unit, needle exchange program, or home.
- "Other" locations could not be classified and are excluded from the clinical/nonclinical setting classification.

Sexual Behaviors

- Any sex: Includes vaginal, oral, or anal sex.
- Vaginal sex: Penis inserted into a partner's vagina.
- Oral sex: Penis inserted into a partner's mouth, or mouth on a partner's penis.
- Insertive anal sex: Participant's penis inserted into a partner's anus.
- Receptive anal sex: Partner's penis inserted into the participant's anus.
- Condomless sex: Vaginal or anal sex during which a condom either is not used or is not used throughout the sex act.
- Main partner: Person with whom the participant has sex and to whom he feels most committed (e.g., boyfriend, husband, significant other, or life partner).
- Casual partner: Person with whom the participant has sex, but to whom he does not feel committed or whom he does not know very well.
- Both insertive and receptive anal sex, condomless: participant reported both receptive and insertive anal sex with the most recent sex partner during the 3 months before interview (during the same or different sexual encounters) and reported not using a condom during one or more of those anal sex acts.

Receipt of HIV Prevention

- Free condoms: Having received free condoms during the 12 months before interview, not including those given by a friend, relative, or sex partner.
- Individual- or group-level intervention: A composite measure based on having received individual- or group-level HIV interventions. An individual-level intervention is a one-on-one conversation with an outreach worker, a counselor, or a prevention program worker about ways to prevent HIV, excluding conversations that were part of HIV testing. A group-level intervention is a small-group discussion (as part of an organized session) about ways to prevent HIV, excluding informal discussions with friends.
- PrEP awareness: Ever heard of PrEP, an antiretroviral medicine taken for months or years by a person who is HIV-negative to reduce the risk of getting HIV.
- PrEP use: Took PrEP at any point during the 12 months before interview to reduce the risk of getting HIV.

Sexually Transmitted Infections

- Chlamydia: Having received a diagnosis of chlamydia during the 12 months before interview.
- Gonorrhea: Having received a diagnosis of gonorrhea during the 12 months before interview.
- Syphilis: Having received a diagnosis of syphilis during the 12 months before interview.
- Any bacterial STI: Having received a diagnosis of chlamydia, gonorrhea, or syphilis during the 12 months before interview.
- Genital warts: Having received a diagnosis of genital warts during one's lifetime.
- Genital herpes: Having received a diagnosis of genital herpes during one's lifetime.

Substance Use

Participants were asked about their use of drugs (excluding those prescribed for them) during the 12 months before interview and their use of alcohol during the 30 days before interview. Participants were not limited in the number of substances they could report. Participants were considered to have used a substance if they reported using that substance with any frequency other than "never."

- Binge drinking: Consumed 5 or more drinks at one sitting during the 30 days before interview.

- Any injection drug: Used any injection drug (excluding those prescribed for him) during the 12 months before interview.
- Any noninjection drug: Used any noninjection drug, excluding alcohol, during the 12 months before interview.
- Cocaine: Used powder cocaine during the 12 months before interview.
- Crack: Used crack cocaine during the 12 months before interview.
- Downer: Used downers (benzodiazepines), such as Klonopin, Valium, Ativan, or Xanax, during the 12 months before interview.
- Ecstasy: Used X or ecstasy during the 12 months before interview.
- Heroin: Used heroin (smoked or snorted) during the 12 months before interview.
- Marijuana: Used marijuana during the 12 months before interview.
- Methamphetamine: Used methamphetamines, including meth, crystal meth, speed, or crank, during the 12 months before interview.
- Prescription opioids: Used pain killers, such as OxyContin, Vicodin, morphine, or Percocet, during the 12 months before interview.

Additional Outcomes

Table 11 includes outcomes that were of particular interest at the time of publication but that were not included in other tables.

- Number of male sex partners: Median number of male sex partners in the 12 months before interview; first and third quartiles (25th and 75th percentiles) are also reported.
- Exchange sex: Refers to giving or receiving money or drugs, during the 12 months before interview, in exchange for sex with a male casual partner.
- Condomless sex with an HIV-discordant partner at last sex: A composite measure based on self-reported HIV status of the participant (positive, negative, or unknown), the participant's knowledge of the HIV status of his most recent sex partner (positive, negative, or unknown), and whether the participant reported engaging in vaginal or anal sex without a condom during his most recent sexual encounter. A partner was considered to be of discordant HIV status if the participant reported that one member of the partnership was known to be HIV-positive and the other was known to be HIV-negative, or if he did not know the HIV status of at least one member of the partnership (participant or partner). The result of the NHBS HIV test (completed after the interview) was not factored into this measure.

Receipt of HIV Care

Participants who reported having received a positive HIV test result before interview were asked about their receipt of HIV care. Specifically, participants were asked the date of their first HIV-positive test result; if they had ever visited a doctor, nurse, or other health care provider for a medical evaluation or care related to their HIV infection; the date of their first visit to a health care provider for HIV care after learning they had HIV; the date of their most recent visit to a health care provider for HIV care; and whether they were currently taking any antiretroviral medicines.

- Visited health care provider about HIV, ever: Having ever visited a health care provider for HIV care.
- Visited health care provider about HIV, within 1 month after diagnosis: Having visited a health care provider for HIV care within 1 month after the date of their first HIV-positive test result.
- Visited health care provider about HIV, in the past 6 months: Having visited a health care provider for HIV care during the 6 months before date of interview.
- Currently taking antiretroviral HIV medicines: Taking antiretroviral medicines at the time of interview.

Reference

1. U.S. Department of Health and Human Services. 2017 poverty guidelines. http://aspe.hhs.gov/2017-poverty-guidelines. Published 2017. Accessed January 28, 2019.

Participating Metropolitan Statistical Areas, 2017

Principal city	Metropolitan statistical area division
Atlanta, Georgia	Atlanta–Sandy Springs–Roswell, Georgia
Baltimore, Maryland	Baltimore–Columbia–Towson, Maryland
Boston, Massachusetts	Boston–Cambridge–Newton, Massachusetts–New Hampshire (Boston Division)
Chicago, Illinois	Chicago–Naperville–Elgin, Illinois–Indiana–Wisconsin (Chicago Division)
Dallas, Texas	Dallas–Fort Worth–Arlington, Texas (Dallas Division)
Denver, Colorado	Denver–Aurora–Lakewood, Colorado
Detroit, Michigan	Detroit–Warren–Dearborn, Michigan (Detroit Division)
Houston, Texas	Houston–The Woodlands–Sugar Land, Texas
Los Angeles, California	Los Angeles–Long Beach–Anaheim, California (Los Angeles Division)
Memphis, Tennessee	Memphis, Tennessee–Mississippi–Arkansas
Miami, Florida	Miami–Fort Lauderdale–West Palm Beach, Florida (Miami Division)
Nassau–Suffolk, New York	New York–Newark–Jersey City, New York–New Jersey–Pennsylvania (Nassau Division)
New Orleans, Louisiana	New Orleans–Metairie, Louisiana
New York, New York	New York–Newark–Jersey City, New York–New Jersey–Pennsylvania (New York Division)
Newark, New Jersey	New York–Newark–Jersey City, New York–New Jersey–Pennsylvania (Newark Division)
Philadelphia, Pennsylvania	Philadelphia–Camden–Wilmington, Pennsylvania–New Jersey–Delaware–Maryland (Philadelphia Division)
Portland, Oregon	Portland–Vancouver–Hillsboro, Oregon–Washington
San Diego, California	San Diego–Carlsbad, California
San Francisco, California	San Francisco–Oakland–Hayward, California (San Francisco Division)
San Juan, Puerto Rico	San Juan–Carolina–Caguas, Puerto Rico
Seattle, Washington	Seattle–Tacoma–Bellevue, Washington (Seattle Division)
Virginia Beach, VA	Virginia Beach–Norfolk–Newport News, Virginia–North Carolina
Washington, DC	Washington, District of Columbia (DC)–Virginia–Maryland–West Virginia (Washington Division)

Addendum: National HIV Prevention Progress Indicators

Table A1 presents data for indicators used to monitor progress toward HIV prevention goals outlined in the CDC Division of HIV/AIDS Prevention (DHAP) Strategic Plan [https://www.cdc.gov/hiv/pdf/dhap/cdc-hiv-dhap-external-strategic-plan.pdf]. Similar indicators were published previously in the National HIV Prevention Progress Report, 2015 [https://www.cdc.gov/hiv/pdf/policies/progressreports/cdc-hiv-nationalprogressreport.pdf]. For consistency with National HIV Prevention Progress Reports, data reported in Table A1 are reported for men who had oral or anal sex with another man during the 12 months before interview and did not report a previous HIV-positive test result, and are stratified by the following age categories: 18–24, 25–34, 35–44, 45–54, and ≥55. Numbers and percentages may differ from those for similar outcomes included in this and other reports of NHBS data due to differences in indicator definition, analysis sample, or strata. Data for DHAP Strategic Plan indicators from NHBS will be included in future DHAP HIV Prevention Progress Reports. Published DHAP reports of NHBS data are available at https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

Table A1. High-risk sexual behavior among men who have sex with men at risk for HIV infection—National HIV Behavioral Surveillance, 2011, 2014, and 2017

	2011[a]			2014[b]			2017[c]		
	High-risk sexual behavior[d]			High-risk sexual behavior[d]			High-risk sexual behavior[d]		
	No.	%	Total No.	No.	%	Total No.	No.	%	Total No.
Age at interview (yr)									
18–24	308	13.9	2,209	259	14.5	1,787	184	13.0	1,417
25–34	332	12.3	2,710	380	12.2	3,103	374	10.8	3,463
35–44	211	13.6	1,557	209	14.4	1,448	148	9.6	1,535
45–54	144	13.5	1,069	170	14.4	1,179	143	13.2	1,084
≥55	46	9.9	464	49	9.2	533	67	10.7	628
Race/ethnicity									
American Indian/Alaska Native	11	17.5	63	3	6.1	49	9	17.0	53
Asian	14	7.0	200	16	9.5	169	11	5.3	209
Black/African American	297	14.4	2,068	310	15.2	2,034	299	14.0	2,137
Hispanic/Latino[e]	328	15.3	2,145	335	15.3	2,188	272	12.4	2,189
Native Hawaiian/Other Pacific Islander	8	15.1	53	2	4.8	42	4	11.1	36
White	344	10.8	3,177	339	10.8	3,147	266	8.7	3,041
Multiple races	35	12.3	284	57	15.2	375	52	12.5	417
Total	**1,041**	**13.0**	**8,009**	**1,067**	**13.3**	**8,050**	**916**	**11.3**	**8,127**

Abbreviations: NHBS, National HIV Behavioral Surveillance; PrEP; preexposure prophylaxis [footnotes only].

Note. Data Include men who had oral or anal sex with another man during the 12 months before interview and did not report a previous HIV-positive test result.

[a] In 2011, NHBS was conducted in 20 MSAs using venue-based, time-space sampling. Details of the 2011 sample are reported in: Centers for Disease Control and Prevention. *HIV Risk, Prevention, and Testing Behaviors—National HIV Behavioral Surveillance System: Men Who Have Sex With Men, 20 U.S. Cities, 2011*. HIV Surveillance Special Report 8. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published September 2014. Accessed January 28, 2019.

[b] In 2014, NHBS was conducted in 20 MSAs using venue-based, time-space sampling. Details of the 2014 sample are reported in: Centers for Disease Control and Prevention. *HIV Infection Risk, Prevention, and Testing Behaviors among Men Who Have Sex With Men—National HIV Behavioral Surveillance, 20 U.S. Cities, 2014*. HIV Surveillance Special Report 15. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published January 2016. Accessed January 28, 2019.

[c] In 2017, NHBS was conducted in 23 MSAs using venue-based, time-spaced sampling. Details of the 2017 sample are reported in Technical Notes.

[d] During the 12 months before interview, did not take PrEP and at the most recent sexual encounter had vaginal or anal sex without a condom with a partner who was HIV-positive or of unknown status.

[e] Hispanics/Latinos can be of any race.

Exhibit B

to Sangree Declaration

Baltimore City Health Department

The City of Baltimore is currently unable to send or receive email. If you need assistance, please call the department you wish to contact.

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Baltimore City Awarded $5 Million SAMHSA Grant to Implement Community-based Trauma Informed Care in West Baltimore

Thursday Sep 15th, 2016 Share

FOR IMMEDIATE RELEASE

Media Contacts:

Mona Rock: Office: (443) 984-2623, Cell: (410) 375-7763

BALTIMORE, MD (September 15, 2016) – The Baltimore City Health Department (BCHD) today announced that the agency has been awarded a five-year, $5 million grant by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services for the Resiliency in Communities After Stress and Trauma (ReCAST) program. The goal of ReCAST is to empower local community collaboration to assist high-risk youth and families in communities that have recently faced civil unrest through evidence-based violence prevention, community youth engagement, and trauma-informed behavioral health services.

ReCAST West Baltimore, which aims to reduce the impact of trauma and build resilience in Central West Baltimore so that young people can complete school and engage in the workforce, will serve three communities adversely impacted by the April 2015 unrest: Sandtown-Winchester, Penn North, and Upton/Druid Heights.

“Decades of poverty, neglect, racism, and widespread disparity have resulted in generations of Baltimoreans suffering from the effects trauma in communities across our city. We must recognize, treat, and prevent trauma,” said Baltimore City Health Commissioner Dr. Leana Wen. “Through this grant, we will be able to directly engage and support our most valuable resources: our communities and our residents. Together, we will provide thousands of Baltimore residents with the tools and supports necessary to break systemic cycles of trauma and create a healthy, resilient, and well city.”

Specifically, the program will implement high-quality, trauma-informed, community-based services—including youth and community organizing, mentoring programs, youth development, yoga/mindfulness activities, and healing circles—across multiple sectors in order to:

- Promote connectedness and resilience in youth;
- Increase community cohesion; and
- Link community-based organizations, youth leaders, and community residents with larger private and public institutions to create a support network and to increase access to resources.

The ReCAST West Baltimore project will be led by BCHD and a Community Board, consisting of peer-elected resident representatives, which will guide the ongoing development, implementation, and revision of a ReCAST West Baltimore Strategic Plan.

Initially, a coalition of partners, community members, and others formed through the proposal development process.

The ReCAST implementation partners include:

- Behavior Health Systems Baltimore
- Black Mental Health Alliance
- C&C Advocacy
- Communities United
- Elev8 Baltimore, a Division of Humanim
- Holistic Life Foundation
- Leaders of a Beautiful Struggle
- New Lens Youth Media
- No Boundaries Coalition
- Office of the State's Attorney
- Roberta's House
- Seeds of Promise
- University of Maryland, School of Social Work

Under the convening umbrella of BCHD, these funded partners have committed to building the capacity of smaller, community-led organizations through efforts such as, hiring from the community, sub-granting, and providing technical assistance.

Unlike the majority of awards, a portion of the grant funds remains unassigned at the time of submission. These funds will be directed by BCHD and the Community Board to meet the future needs identified in the forthcoming ReCAST West Baltimore Strategic Plan.

"We need to recognize and encourage how community-led change can become a critical tool in improving the health and lives of Baltimoreans," said Jeanette Hill, a participant in the ReCAST West Baltimore Community Coalition. "This new grant program will be an important step forward in these efforts and reflects our communities' commitment to breaking cycles of trauma in our city."

This is the latest effort from the Baltimore City to prevent and ameliorate the impact of trauma in Baltimore City. Other efforts include:

- Convening the violence prevention B'More for Youth Collaborative;
- Leading a city-wide effort to train frontline city workers on trauma-informed care;
- Addressing violence and trauma through the lens of public health;
- Recognizing that violence is a generational challenge impacted by the social determinants that shape people's lives.

These efforts are critical components of Healthy Baltimore 2020, Baltimore City's newly released strategic blueprint to promote health and well-being with one overarching vision to reduce health disparities in Baltimore by half over the decade.

###

Related Stories

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Baltimore City Health Department Announces Beginning of 2019 Code Red Extreme Heat Season

BALTIMORE, MD (May 15, 2019) Today, the Baltimore City Health Department is announcing the start of Baltimore City's Code Red Extreme Heat season. Code Red Extreme Heat is a multi-agency effort to address the impact of extreme heat on residents of Baltimore City.

Measles Case Confirmed; Possible Exposures in Baltimore Area

Baltimore, MD – On April 5, the Maryland Department of Health (MDH) confirmed a measles case in a Maryland resident.

Acting Health Commissioner, Dr. Dzirasa, Issues Statement on Maryland Senate Bill 759 to Establish Prescription Drug Affordability Board

BALTIMORE, MD (March 14, 2019) – Acting Baltimore City Health Commissioner, Dr. Letitia Dzirasa, issued the following statement regarding Maryland Senate Bill 759 that seeks to establish the Prescription Drug

Affordability Board.

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Exhibit C

to Sangree Declaration

Resource Guide to Trauma-Informed Human Services

The Administration for Children and Families, the Substance Abuse and Mental Health Services Administrations, the Administration for Community Living, the Offices of the Assistant Secretary for Health and the Assistant Secretary for Planning and Evaluation at HHS have worked together to develop this Guide to Trauma-Informed Human Services. The guide is intended to provide an introduction to the topic of trauma, a discussion of why understanding and addressing trauma is important for human services programs, and a "road map" to find relevant resources.

Experiencing deeply disturbing events or situations (i.e., trauma) can affect the way a person learns, plans, and interacts with others. This can have profound implications for how human services agencies interact with their clients. Many individuals experience few problems after enduring a traumatic event. Some will have short term symptoms lasting a few days or weeks, but will recover quickly. A few will suffer longer term changes in mood, behavior, and how they interact with others and the world around them.

This guide provides human services leaders at the local, State, Tribal, and Territorial levels with information and resources on recent advances in our understanding of trauma, toxic stress, and executive functioning. It especially highlights what these advances mean for program design and service delivery. The guide helps professionals learn about trauma-informed care and helps those currently engaged in trauma-informed work to improve their practice.

These resources provide an overview of key concepts related to trauma and a guide to resources from a range of HHS federal agencies and respected sources outside government. These materials are both a "front door" to the topic of trauma and a "road map" to relevant resources.

Concept Papers +

Guiding Questions & Answers +

Q&A: Trauma +

Q&A: Adverse Childhood Experiences +

Q&A: Post-traumatic Stress Disorder +

Q&A: Trauma-informed Services –

What do we mean by trauma-informed services and why is such an approach important?

The practice of trauma informed service is less about "what" you're doing, and more about "how" you're doing it. It requires being mindful of ways in which your interactions with clients might inadvertently make them feel unsafe, either physically or emotionally. According to **SAMHSA's concept of a trauma-informed approach (http://www.samhsa.gov/nctic/trauma-interventions)**, a program, organization, or system that is trauma-informed:

- *Realizes* the widespread impact of trauma and understands potential paths for recovery;
- *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively prevent *re-traumatization.*

The SAMHSA-funded **National Technical Assistance Center for Children's Mental Health (http://gucchdtacenter.georgetown.edu/index.html)** has put together a **series of videos (http://gucchdtacenter.georgetown.edu/TraumaInformedCare/)** by practitioners and state administrators that describe what trauma-informed means as an organizational approach, particularly in agencies that serve children and families. Being trauma-informed is described by the director of an agency as:

Taking the principles about being sensitive to someone's background and history and weaving those principles into everything you do organizationally. Not just a set-aside training program, but to really see it at the culture level, that it permeates everything you do [in an organization] from the policies and procedures to the practice and training; how you recruit, how you promote. Trauma-informed care sensitizes us.

Additional Resources:

- This **National Center on Domestic Violence, Trauma & Mental Health** guidance on **Action Steps to support emotional safety (http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Action-Steps-to-Create-Emotional-Safety-attachment-for-Increasing-Emotional-Safety-CG.pdf)** may be useful to many programs interested in strengthening and deepening an existing trauma-informed practice.

- The **National Child Traumatic Stress Network** has developed **resources (http://www.nctsn.org/resources/topics/youth-and-family-partnerships)** on building partnerships between your organization and the families and youth served. They believe such partnerships are essential in order to maximize youths' opportunities for choice and control, a key element of overcoming trauma.
- The **National Center for Families and Youth** features a **short slide show (http://ncfy.acf.hhs.gov/media-center/slideshows/5-collaborations-ensure-trauma-informed-care-youth-and-families)** on five collaborations to ensure trauma-informed services for youth and families.

My agency has decided it wants to be more trauma-informed. Where do I start?

A trauma-informed approach involves being aware of how clients who are affected by traumatic experiences may perceive and respond to your organization's practices and services. Because implementing these approaches in some cases may involve considerable change in practice, for it to be successful leadership must commit to the change and actively engage in the process. Many organizations that have undertaken trauma-informed approaches have engaged in self-study that could involve **self-assessment (http://www.nada.org.au/media/14607/tictoolkitforhomelessservicesusa.pdf)** and/or small workgroups or task forces.

Trauma-informed practices **articulated (http://gucchdtacenter.georgetown.edu/TraumaInformedCare/IssueBrief3_CreatingTraumaInformedOrgs.pdf)** by the National Technical Assistance Center for Children's Mental Health include:

- Creating safe, supportive, welcoming, and respectful environments
- Educating all staff about the impact of trauma—particularly those that provide direct care or are support staff
- Training any clinical staff in trauma-specific interventions
- Awareness by all staff about their own cultural attitudes and beliefs and education about culturally relevant approaches
- Training for all staff in avoiding re-traumatization

Additional Resources:

- **ACF** has produced **this presentation on five collaborations to ensure trauma-informed care for youth and families. (http://ncfy.acf.hhs.gov/media-center/slideshows/5-collaborations-ensure-trauma-informed-care-youth-and-families)** Some youth who have gone through traumatic experiences have a range of needs that may be best served by a group of service providers working in tandem. When each organization of the partnership comes into contact with youth, that's one more chance to assess the youth's experience with trauma and to help them heal and build resilience.

- ***Trauma-Informed Care: Perspectives and Resources* (http://gucchdtacenter.georgetown.edu/TraumaInformedCare/)**. This is a free online tool created by the National Technical Assistance Center for Children's Mental Health and partners. It includes many resources, actions, and lessons learned from entities that have become trauma-informed, and is intended to support leaders and decision makers at all levels (national, state, tribal, territorial, and local) in taking steps on their journey.

- The **National Center on Family Homelessness** has produced a ***Trauma-Informed Organizational Toolkit* (http://www.air.org/resource/trauma-informed-organizational-toolkit)**. The toolkit's *Agency Self-Assessment for Readiness for Trauma-Informed Approaches* which may provide a good starting place to gauge your agency's existing strengths for trauma-informed work, as well as identify additional training or plans you may need to get started. Although designed for agencies serving families experiencing homelessness, the agency self-assessment tool is applicable to other community organizations as well.

- The **National Clearinghouse on Families and Youth** offers a **free online course on trauma exposure in youth (https://ncfy-learn.jbsinternational.com/course/index.php?categoryid=14)**, which staff can take to

learn more about how trauma affects youth and how to interact with youth to mitigate the effects of traumatic exposures.

- The **National Center on Domestic Violence, Trauma and Mental Health** has developed a **practice tip sheet on how to manage communication problems between clients and staff caused by clients' experiences of trauma (http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/ConversationGuide_-Making-Connections_NCDVTMH_Dec2011.pdf)**. This tip sheet may be useful to share with front-line staff. Although originally developed for domestic violence services providers, the tips are applicable to work with youth who have been traumatized as a result of experiences in the home or on the street.

How do trauma-informed services differ from what I'm already doing?

SAMHSA (http://www.samhsa.gov/nctic/trauma-interventions) has developed **six principles (http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf)** that are meant to be generalized across multiple types of settings, which your organization can use to determine whether your approach is trauma-informed:

1. **Safety** - throughout an organization, the staff and people they serve feel physically and psychologically safe; the physical setting must be safe and interactions should promote a sense of safety.

2. **Trustworthiness and Transparency** - Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among clients, families and staff.

3. **Peer Support** - Other individuals who have experienced trauma can serve as key partners in recovery from trauma.

4. **Collaboration and Mutuality** - Partnering and leveling of power differences between staff and clients and among staff.

5. **Empowerment, Voice and Choice** - Individual strengths are recognized, built on, and validated and new skills are developed as needed.

6. **Cultural, Historical, and Gender Issues** - the organization incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; there is a responsiveness to gender and consideration for historical trauma.

What are the key issues in making sure my agency does not re-traumatize our clients?

Public human services agencies are charged with providing services and supports to individuals, children and families. However, for some clients who have experienced trauma, certain approaches, particularly aggressive or confrontational methods, may cause additional harm. A number of coercive practices that were once common but are no longer widely used have been of particular concern. These include **seclusion and restraints (http://www.samhsa.gov/trauma-violence/seclusion)** or other harsh disciplinary practices in the behavioral health or school system, or intimidating practices used in the criminal justice system. Where they continue to exist, these and similar policies, practices, and procedures can severely undermine efforts to achieve desired outcomes for clients in service systems.

In the past, human service agencies were not as focused on how to understand the impact of traumatic experiences on client functioning and mitigate the re-traumatizing effect of our service systems. In recent years, a range of human

service providing agencies in different sectors have focused on how to clients work through their reactions to traumatic events and reduce the chances of exacerbating existing problems through re-traumatization. The population-specific resource lists offer resources and suggestions that may be appropriate to the clients your organization or agency serves. A useful starting point is this **article providing tips for service providers on ways to avoid re-traumatizing clients (http://homelesshub.ca/resource/avoiding-retraumatization-and-fostering-recovery-among-people-experiencing-homelessness)**, prepared by a Canadian organization focusing on homelessness. Also the Department of Justice's **Office on Victims of Crime has developed a module (https://www.ovcttac.gov/taskforceguide/eguide/4-supporting-victims/41-using-a-trauma-informed-approach/)** which, while focused on trafficking issues, includes good tops on how to avoid re-traumatization.

What does my agency's physical space have to do with being trauma-informed?

The physical environment of your organization communicates your beliefs about the people you serve. It is important that your organization's physical setting be perceived as safe and welcoming and interpersonal interactions with staff and other clients promote a sense of safety. Your physical space sets the tone for your interactions with clients. For clients who have experienced trauma, reactions to perceived insecurity may be heightened and could inadvertently sabotage the ability of staff to engage families.

Additional Resources:

- A good general **resource (http://nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Tipsheet_Welcoming-Environment_NCDVTMH_Aug2011.pdf)** was created by the **National Center on Domestic Violence, Trauma, & Mental Health (http://www.nationalcenterdvtraumamh.org/)**. This tip sheet provides guidance on how to arrange a physical environment to accommodate a wide range of feelings, interactions, and behaviors. Specific tips include:
    - Communicating that a broad range of people are wanted and welcome in your programs
    - Arranging for quiet spaces or places where people can move around more
    - Reducing noise and clutter that can be unsettling
    - Areas stocked with art supplies for people who want to express themselves in other ways
- While this **resource paper (http://www.chcs.org/media/ATC_whitepaper_040616.pdf)** was designed for health care audiences, the section on creating a safe environment has straightforward suggestions for making sure both your physical space and the social and emotional environment of your agency feel non-threatening to clients with trauma histories.

Where can I learn more about evidence-based and promising interventions to address the effects of trauma?

In the past several years, there has been substantial research on interventions that address trauma in different populations. Interventions are considered evidence-based if there is empirical evidence of impacts when delivered to specific populations in particular settings, such as the clinic, home, community or school. Treatments are considered promising if research has yielded limited evidence of effectiveness. For victims of trauma to be able to access evidence-based treatments, qualified clinical staff must be adequately trained and supervised.

The **California Evidence-Based Clearinghouse for Child Welfare (CEBC)** identifies a number of interventions for addressing the consequences of trauma in **children and adolescents (http://www.cebc4cw.org/search/topic-**

areas/trauma-treatment-child-adolescent/) and in **adults (http://www.cebc4cw.org/topic/trauma-treatment-adult/)**. They define the topic area as "interventions designed to help an individual process a trauma or multiple traumas they have experienced and learn how to cope with the feelings associated with the experience (e.g., fear, posttraumatic stress, anxiety, depression, etc.)."

With respect to interventions for children and adolescents, they find 4 models that either are well supported by research (their highest category) or supported by research (next highest category), as well as many additional promising approaches. Those backed by the most research include:

- **Trauma-Focused Cognitive-Behavioral Therapy (http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/)**
- **Prolonged Exposure Therapy for Adolescents (http://www.cebc4cw.org/program/prolonged-exposure-therapy-for-adolescents/)**
- **Eye Movement Desensitization and Reprocessing (http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing/)**
- **Child-Parent Psychotherapy (http://www.cebc4cw.org/program/child-parent-psychotherapy/)**

For adults, the clearinghouse identifies six interventions considered either supported or well-supported by research and another five that are promising based on early research. The specific programs in the well-supported and supported categories are:

- **Cognitive Processing Therapy (http://www.cebc4cw.org/program/cognitive-processing-therapy-cpt/)**
- **Eye Movement Desensitization and Reprocessing (http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing-for-adults/)**
- **Narrative Exposure Therapy (http://www.cebc4cw.org/program/narrative-exposure-therapy-net/)**
- **Prolonged Exposure Therapy for PTSD for Adults (http://www.cebc4cw.org/program/prolonged-exposure-therapy-for-adults-pe-for-ptsd/)**
- **Cognitive Behavioral Therapy for Acute Stress Disorder (http://www.cebc4cw.org/program/cognitive-behavioral-therapy-for-acute-stress-disorder/)**
- **Seeking Safety (http://www.cebc4cw.org/program/seeking-safety-for-adults/)**

The **Georgetown National Technical Assistance Center for Children's Mental Health** with partners has developed a helpful series of **video interviews (http://gucchdtacenter.georgetown.edu/TraumaInformedCare/Module4.html)** with state administrators and clinicians that highlight experiences implementing and adapting evidence-based treatment modalities for children and families who have experienced trauma.

Additionally, a **research-to-practice brief (http://www.acf.hhs.gov/sites/default/files/opre/opre_nitr_brief_v07_508_2.pdf)** recently published by **ACF's Office of Planning, Research, and Evaluation (OPRE)** discusses what is known about the impact

of trauma on infants and toddlers, and the intervention strategies that could potentially protect them from the adverse consequences of traumatic experiences.

Additional Resources:

- **The Georgetown National Technical Assistance Center for Children's Mental Health** and partners published a resource entitled ***Evidence-Based Treatments Addressing Trauma***

(http://gucchdtacenter.georgetown.edu/TraumaInformedCare/IssueBrief4_EvidenceBasedTreatments.pdf) summarizing trauma-specific evidence-based and promising treatments.

What elements of this process need funding? How have other agencies funded these efforts?

The National Child Traumatic Stress Network has developed a ***Guide to Private Funding to Support Child Traumatic Stress and Other Trauma-Focused Initiatives.*** **(http://www.nctsnet.org/nctsn_assets/pdfs/Private_Funding_Guide_Final.pdf)**This resource provides practical guidance on how leaders can address state budgetary shortfalls and tight fiscal markets by getting started in pursuing private funding.

Q&A: Staff Capacity Building +

Trauma Resources for Specific Human Services Programs or Populations +

Community Spotlights +

Exhibit D

to Sangree Declaration

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CONSCIENTIOUS OBJECTION

Conscientious objection and refusal to provide reproductive healthcare: A White Paper examining prevalence, health consequences, and policy responses

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ABSTRACT

Background: Global Doctors for Choice—a transnational network of physician advocates for reproductive health and rights—began exploring the phenomenon of conscience-based refusal of reproductive healthcare as a result of increasing reports of harms worldwide. The present White Paper examines the prevalence and impact of such refusal and reviews policy efforts to balance individual conscience, autonomy in reproductive decision making, safeguards for health, and professional medical integrity.

Objectives and search strategy: The White Paper draws on medical, public health, legal, ethical, and social science literature published between 1998 and 2013 in English, French, German, Italian, Portuguese, and Spanish. Estimates of prevalence are difficult to obtain, as there is no consensus about criteria for refuser status and no standardized definition of the practice, and the studies have sampling and other methodologic limitations. The White Paper reviews these data and offers logical frameworks to represent the possible health and health system consequences of conscience-based refusal to provide abortion; assisted reproductive technologies; contraception; treatment in cases of maternal health risk and inevitable pregnancy loss; and prenatal diagnosis. It concludes by categorizing legal, regulatory, and other policy responses to the practice.

Conclusions: Empirical evidence is essential for varied political actors as they respond with policies or regulations to the competing concerns at stake. Further research and training in diverse geopolitical settings are required. With dual commitments toward their own conscience and their obligations to patients' health and rights, providers and professional medical/public health societies must lead attempts to respond to conscience-based refusal and to safeguard reproductive health, medical integrity, and women's lives.

1. Introduction

How can societies find the proper balance between women's rights to receive the reproductive healthcare they need and healthcare providers' rights to exercise their conscience? Global Doctors for Choice (GDC)—a transnational network of physician advocates for reproductive health and rights (www.globaldoctorsforchoice.org)—began exploring the phenomenon of conscience-based refusal of reproductive healthcare in response to increasing reports of harms worldwide. The present White Paper addresses the varied interests and needs at stake when clinicians claim conscientious objector status when providing certain elements of reproductive healthcare. (While GDC represents physicians, in the present White Paper we use the terms providers or clinicians to also address refusal of care by nurses, midwives, and pharmacists.) As the focus is on health, we examine data on the prevalence of refusal; lay out the potential consequences for the health of patients and the impact on other health providers and health systems; and report on legal, regulatory, and professional responses. Human rights are intertwined with health, and we draw upon human rights frameworks and decisions throughout. We also refer to bedrock bioethical principles that undergird the practice of medicine in general, such as the obligations to provide patients with accurate information, to provide care conforming to the highest possible standards, and to provide care that is urgently needed. Others have underscored the consequences of negotiating conscientious objection in healthcare in terms of secular/religious tension. Our contribution, which complements all of this previous work, is to provide the medical and public health perspectives and the evidence. We focus on the rights of the provider who conscientiously objects, together with that provider's professional obligations; the rights of the women who need healthcare and the consequences of refusal for their health; and the impact on the health system as a whole.

Conscientious objection is the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs [1]. This originated as opposition to mandatory military service but has increasingly been

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raised in a wide variety of contested contexts such as education, capital punishment, driver's license requirements, marriage licenses for same-sex couples, and medicine and healthcare. While health providers have claimed conscientious objection to a variety of medical treatments (e.g. end-of-life palliative care and stem cell treatment), the present White Paper addresses conscientious objection to providing certain components of reproductive healthcare. (The terms conscientious objection and conscience-based refusal of care are used interchangeably throughout.) Refusal to provide this care has affected a wide swath of diagnostic procedures and treatments, including abortion and postabortion care; components of assisted reproductive technologies (ART) relating to embryo manipulation or selection; contraceptive services, including emergency contraception (EC); treatment in cases of unavoidable pregnancy loss or maternal illness during pregnancy; and prenatal diagnosis (PND).

Efforts have been made to balance the rights of objecting providers and other health personnel with those of patients. International and regional human rights conventions such as the Convention on the Elimination of All Forms of Discrimination against Women [2], the International Covenant on Civil and Political Rights (ICCPR) [1], the American Convention on Human Rights [3], and the European Convention for the Protection of Human Rights and Fundamental Freedoms [4], as well as UN treaty-monitoring bodies [5,6], have recognized both the right to have access to quality, affordable, and acceptable sexual and reproductive healthcare services and/or the right to freedom of religion, conscience, and thought. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa recognizes the right to be free from discrimination based on religion and acknowledges the right to health, especially reproductive health, as a key human right [7]. These instruments negotiate these apparently competing rights by stipulating that individuals have a right to belief but that the freedom to manifest one's religion or beliefs can be limited in order to protect the rights of others.

The ICCPR, a central pillar of human rights that gives legal force to the 1948 UN Universal Declaration of Human Rights, states in Article 18(1) that [1]:

> Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

Article 18(3), however, states that [1]:

> Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

International professional associations such as the World Medical Association (WMA) [8] and FIGO [9]—as well as national medical and nursing societies and groups such as the American Congress of Obstetricians and Gynecologists (ACOG) [10]; Grupo Médico por el Derecho a Decidir/GDC Colombia [11]; and the Royal College of Nursing, Australia [12]—have similarly agreed that the provider's right to conscientiously refuse to provide certain services must be secondary to his or her first duty, which is to the patient. They specify that this right to refuse must be bounded by obligations to ensure that the patient's rights to information and services are not infringed.

Conscience-based refusal of care appears to be widespread in many parts of the world. Although rigorous studies are few, estimates range from 10% of OB/GYNs refusing to provide abortions reported in a UK study [13] to almost 70% of gynecologists who registered as conscientious objectors to abortion with the Italian Ministry of Health [14]. While the impact of the loss of providers may be immediate and most obvious in countries in which maternal death rates from pregnancy, delivery, and illegal abortion are high and represent major public health concerns, consequences at individual and systemic levels have also been reported in resource-rich settings. At the individual level, decreased access to health services brought about by conscientious objection has a disproportionate impact on those living in precarious circumstances, or at otherwise heightened risk, and aggravates inequities in health status. Indeed, too many women, men, and adolescents lack access to essential reproductive healthcare services because they live in countries with restrictive laws, scant health resources, too few providers and slots to train more, and limited infrastructure for healthcare and means to reach care (e.g. roads and transport). The inadequate number of providers is further depleted by the "brain drain" when trained personnel leave their home countries for more comfortable, technically fulfilling, and lucrative careers in wealthier lands [15]. Access to reproductive healthcare is additionally compromised when gynecologists, anesthesiologists, generalists, nurses, midwives, and pharmacists cite conscientious objection as grounds for refusing to provide specific elements of care.

The level of resources allocated by the health system greatly influences the impact caused by the loss of providers due to conscience-based refusal of care. In resource-constrained settings, where there are too few providers for population need, it is logical to assume the following chain of events: further reductions in available personnel lead to greater pressure on those remaining providers; more women present with complications due to decreased access to timely services; and complications require specialized services such as maternal/neonatal intensive care and more highly trained staff, in addition to incurring higher costs. The increased demand for specialized services and staffing burdens and diverts the human and infrastructural resources available for other priority health conditions. However, it is difficult to disentangle the impact of conscientious objection when it is one of many barriers to reproductive healthcare. It is conceptually and pragmatically complicated to sort the contribution to constrained access to reproductive care attributable to conscientious objectors from that due to limited resources, restrictive laws, or other barriers.

What are the criteria for establishing objector status and who is eligible to do so? In the military context, conscientious objector applicants must satisfy numerous procedural requirements and must provide evidence that their beliefs are sincere, deeply held, and consistent [16]. These requirements aim to parse genuine objectors from those who conflate conscientious objection with political or personal opinion. For example, the true conscientious objector to military involvement would refuse to fight in any war, whereas the latter describes someone who disagrees with a particular war but who would be willing to participate in a different, "just" war. Study findings and anecdotal reports from many countries suggest that some clinicians claim conscientious objection for reasons other than deeply held religious or ethical convictions. For example, some physicians in Brazil who described themselves as objectors were, nonetheless, willing to obtain or provide abortions for their immediate family members [17]. A Polish study described clinicians, such as those referred to as the White Coat Underground, who claim conscientious objection status in their public sector jobs but provide the same services in their fee-paying private practices [18]. Other investigations indicate that some claim objector status because they seek to avoid being associated with stigmatized services, rather than because they truly conscientiously object [19].

Moreover, some religiously affiliated healthcare *institutions* claim objector status and compel their employees to refuse to provide

legally permissible care [20,21]. The right to conscience is generally understood to belong to an individual, not to an institution, as claims of conscience are considered a way to maintain an individual's moral or religious integrity. Some disagree, however, and argue that a hospital's mission is analogous to a conscience–identity resembling that of an individual, and "warrant[s] substantial deference" [22]. Others dispute this on the grounds that healthcare institutions are licensed by states, often receive public financing, and may be the sole providers of healthcare services in communities. Wicclair and Charo both argue that, since a license bestows certain rights and privileges on an institution [22–24], "[W]hen licensees accept and enjoy these rights and privileges, they incur reciprocal obligations, including obligations to protect patients from harm, promote their health, and respect their autonomy" [22].

There are also disputes as to whether obligations and rights vary if a provider works in the public or private sector. Public sector providers are employees of the state and have obligations to serve the public for the greater good, providing the highest "standard of care," as codified in the laws and policies of the state [22]. The Institute of Medicine in the USA defines standard of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" and identifies safety, effectiveness, patient centeredness, and timeliness as key components [25]. WHO adds the concepts of equitability, accessibility, and efficiency to the list of essential components of quality of care [26]. There are legal precedents limiting the scope of conscientious objection for professionals who operate as state actors [23]. Some argue that such limitations can be extended to those who provide health services in the private sector because, as state licensure grants these professions a monopoly on a public service, the professions have a collective obligation to patients to provide non-discriminatory access to all lawful services [23,27]. However, it is more difficult to identify conscience-based refusal of care in the private sector because clinicians typically have discretion over the services they choose to offer, although the same professional obligations of providing patients with accurate information and referral pertain.

An alternative framing is provided by the concept of *conscientious commitment* to acknowledge those providers whose conscience motivates them to deliver reproductive health services and who place priority on patient care over adherence to religious doctrines or religious self-interest [28,29]. Dickens and Cook articulate that conscientious commitment "inspires healthcare providers to overcome barriers to delivery of reproductive services to protect and advance women's health" [28]. They assert that, because provision of care can be conscience based, full respect for conscience requires accommodation of both objection to participation and commitment to performance of services such that the latter group of providers also have the right to not suffer discrimination on the basis of their convictions [28]. This principle is articulated by FIGO [9]; according to the FIGO "Resolution on Conscientious Objection," "Practitioners have a right to respect for their conscientious convictions in respect both not to undertake and to undertake the delivery of lawful procedures" [30].

We begin the present White Paper with a review of the limited data regarding the prevalence of conscience-based refusal of care and objectors' motivations. Descriptive prevalence data are needed in order to assess the distribution and scope of this phenomenon and it is necessary to understand the concerns of those who refuse in order to design respectful and effective responses. We review the data; point out the methodologic, geographic, and other limitations; and specify some questions requiring further investigation. Next, we explore the consequences of conscientious objection for patients and for health systems. Ideally, we would evaluate empirical evidence on the impact of conscience-based refusal on delay in obtaining care for patients and their families, society, healthcare providers, and health systems. As such research has not been conducted, we schematically delineate the logical sequence of events if care is refused.

We then look at responses to conscience-based refusal of care by transnational bodies, governments, health sector and other employers, and professional associations. These responses include establishment of criteria for obtaining objector status, required disclosure to patients, registration of objector status, mandatory referral to willing providers, and provision of emergency care. We draw upon analyses performed by others to categorize the different models used: legislative, constitutional, case law, regulatory, employment requirements, and professional standards of care. Finally, we provide recommendations for further research and for ways in which medical and public health organizations could contribute to the development and implementation of policies to manage conscientious objection.

The present White Paper draws upon medical, public health, legal, ethical, and social science literature of the past 15 years in English, French, German, Italian, Portuguese, and Spanish available in 2013. It is intended to be a state-of-the-art compendium useful for health and other policymakers negotiating the balance of an individual provider's rights to "conscience" with the systemic obligation to provide care and it will need updating as further evidence and policy experiences accrue. It is intended to highlight the importance of the medical and public health perspectives, employ a human rights framework for provision of reproductive health services, and emphasize the use of scientific evidence in policy deliberations about competing rights and obligations.

2. Review of the evidence

2.1. Methods

We reviewed data regarding the prevalence of conscientious objection and the motivations of objectors in order to assess the distribution and scope of the phenomenon and to have an empirical basis for designing respectful and effective responses. However, estimates of prevalence are difficult to obtain; there is no consensus about criteria for objector status and, thus, no standardized definition of the practice. Moreover, it is difficult to assess whether findings in some studies reflect intention or actual behavior. The few countries that require registration provide the most solid evidence of prevalence.

A systematic review could not be performed because the data are limited in a variety of ways (which we describe), making most of them ineligible for inclusion in such a process. We searched systematically for data from quantitative, qualitative, and ethnographic studies and found that many have non-representative or small samples, low response rates, and other methodologic limitations that limit their generalizability. Indeed, the studies reviewed are not comparable methodologically or topically. The majority focus on conscience-based refusal of abortion-related care and only a few examine refusal of emergency or other contraception, PND, or other elements of care. Some examine provider attitudes and practices related to abortion in general, while others investigate these in terms of the specific circumstances for which people seek the service: for example, financial reasons, sex selection, failed contraception, rape/incest, fetal anomaly, and maternal life endangerment. Some rely on closed-ended electronic or mail surveys, while others employ in-depth interviews. Most focus on physicians; fewer study nurses, midwives, or pharmacists.

These investigations are also limited geographically because more were conducted in higher-income than lower-income countries. Because of both greater resources and more liberalized reproductive health laws and policies, many higher-income coun-

tries offer a greater range of legal services and, consequently, more opportunities for objection. Assessment of the impact of conscience-based refusal of care in resource-constrained settings presents additional challenges because high costs and lack of skilled providers may dwarf this and other factors that impede access. Acknowledging that conscientious objection to reproductive healthcare has yet to be rigorously studied, we included all studies we were able to locate within the past 15 years, and present the cross-cutting themes as topics for future systematic investigation.

2.2. Prevalence and attitudes

The sturdiest estimates of prevalence come from a limited sample of those few places that require objectors to register as such or to provide written notification. 70% of OB/GYNs and 50% of anesthesiologists have registered with the Italian Ministry of Health as objectors to abortion [31]. While Norway and Slovenia require some form of registration, neither has reported prevalence data [32–34]. Other estimates of prevalence derive from surveys with varied sampling strategies and response rates. In a random sample of OB/GYN trainees in the UK, almost one-third objected to abortion [35]. 14% of physicians of varied specialties surveyed in Hong Kong reported themselves to be objectors [36]. 17% of licensed Nevada pharmacists surveyed objected to dispensing mifepristone and 8% objected to EC [37]. A report from Austria describes many regions without providers and a report from Portugal indicates that approximately 80% of gynecologists there refuse to perform legal abortions [38–40].

Other studies have investigated opinions about abortion and intention to provide services. A convenience sample of Spanish medical and nursing students indicated that most support access to abortion and intend to provide it [41]. A survey of medical, nursing, and physician assistant students at a US university indicated that more than two-thirds support abortion yet only one-third intend to provide, with the nursing and physician assistant students evincing the strongest interest in doing so [42]. The 8 traditional healers interviewed in South Africa were opposed to abortion [43], and an ethnographic study of Senegalese OB/GYNs, midwives, and nurses reported that one-third thought the highly restrictive law there should permit abortion for rape/incest, although very few were willing to provide services (unpublished data).

Some studies indicate that a subset of providers claim to be conscientious objectors when, in fact, their objection is not absolute. Rather, it reflects opinions about patient characteristics or reasons for seeking a particular service. For example, a stratified random sample of US physicians revealed that half refuse contraception and abortion to adolescents without parental consent, although the law stipulates otherwise [44]. A survey of members of the US professional society of pediatric emergency room physicians indicated that the majority supported prescription of EC to adolescents but only a minority had done so [45]. A study of the postabortion care program in Senegal, intended to reduce morbidity and mortality due to complications from unsafe abortion, found that some providers nonetheless delayed care for women they suspected of having had an induced abortion (unpublished data).

Willingness to provide abortions varies by clinical context and reason for abortion, as demonstrated by a stratified random sample of OB/GYN members of the American Medical Association (AMA) [46]. A survey of family medicine residents in the USA assessing prevalence of moral objection to 14 legally available medical procedures revealed that 52% supported performing abortion for failed contraception [47]. Despite opposition to voluntary abortion, more than three-quarters of OB/GYNs working in public hospitals in the Buenos Aires area from 1998 to 1999 supported abortion for maternal health threat, severe fetal anomaly, and rape/incest [48]. While 10% of a random sample of consultant OB/GYNs in the UK described themselves as objectors, most of this group supported abortion for severe fetal anomaly [13].

Other inconsistencies regarding refusal of care derived from the provider's familiarity with a patient, experience of stigmatization, or opportunism. A Brazilian study reported that Brazilian gynecologists were more likely to support abortion for themselves or a family member than for patients [17]. Physicians in Poland and Brazil reported reluctance to perform legally permissible abortions because of a hostile political atmosphere rather than because of conscience-based objection. The authors also noted that conscientious objection in the public sphere allowed doctors to funnel patients to private practices for higher fees [19].

Not surprisingly, higher levels of self-described religiosity were associated with higher levels of disapproval and objection regarding the provision of certain procedures [49]. Additionally, a random sample of UK general practitioners (GPs) [50], a study of Idaho licensed nurses [51], a study of OB/GYNs in a New York hospital [52], and a cross-sectional survey of OB/GYNs and midwives in Sweden [53] found self-reported religiosity to be associated with reluctance to perform abortion. A study of Texas pharmacists found the same association regarding refusal to prescribe EC [54].

Higher acceptance of these contested service components and lower rates of objection were associated with higher levels of training and experience in a survey of medical students and physicians in Cameroon and in a qualitative study of OB/GYN clinicians in Senegal [55,56]. Similar patterns prevailed in a survey of Norwegian medical students [57] and among pharmacists and OB/GYNs in the USA [45].

Clinicians' refusal to provide elements of ART and PND also varied, at times motivated by concerns about their own lack of competence with these procedures. And, while the majority of Danish OB/GYNs and nurses (87%) in a non-random sample supported abortion and ART, 69% opposed selective reduction [49]. A random sample of OB/GYNs from the UK indicated that 18% would not agree to provide a patient with PND [13].

Several studies report institutional-level implications consequent to refusal of care. Physicians and nurse managers in hospitals in Massachusetts said that nurse objection limited the ability to schedule procedures and caused delays for patients [58]. Half of a stratified random sample of US OB/GYNs practicing primarily at religiously affiliated hospitals reported conflicts with the hospital regarding clinical practice; 5% reported these to center on treatment of ectopic pregnancy [59]. 52% of a non-random sample of regional consultant OB/GYNs in the UK said that insufficient numbers of junior doctors are being trained to provide abortions owing to opting out and conscientious objection [35]. A 2011 South African report states that more than half of facilities designated to provide abortion do not do so, partly because of conscientious objection, resulting in the persistence of widespread unsafe abortion, morbidity, and mortality [60]. A non-random sample of Polish physicians reported that institutional, rather than individual, objection was common [19]. Similar observations have been made about Slovakian hospitals [61].

A few investigations have explored clinician attitudes toward regulation of conscience-based refusal of reproductive healthcare. Two studies from the USA indicate that majorities of family medicine physicians in Wisconsin and a random sample of US physicians believe physicians should disclose objector status to patients [44,47]. A survey of UK consultants revealed that half want the authority to include abortion provision in job descriptions for OB/GYN posts, and more than one-third think objectors should be required to state their reasons [35]. Interviews with a purposive sample of Irish physicians revealed mixed opinions about the obligation of objectors to refer to other willing providers, as well as awareness that women traveled abroad for abortions and related services that were denied at home [62].

While the reviewed literature indicates widespread occurrence of conscientious objection to providing some elements of reproductive healthcare, it does not offer a rigorously obtained evidentiary basis from which to map the global landscape. Assessment of the prevalence of conscientious objection requires ascertainment of the number objecting (numerator) and the total count of the relevant population of providers comprising the denominator (e.g. the number of OB/GYNs claiming conscientious objection to providing EC and the total population of OB/GYNs). Registration of objectors, as required by the Italian Ministry of Health, provides such data. Professional societies could also systematically gather data by surveying members on their practices related to conscience-based refusal of care or by including such self-identification on standard mandatory forms. Academic institutions or other research organizations could conduct formal studies or add questions on conscience-based refusal of care to ongoing general surveys of clinicians.

Aside from prevalence, there are a host of key questions. Further research on motivations of objectors is required in order to better understand reasons other than conscience-based objection that may lead to refusal of care. As the studies reviewed indicate, these factors may include desire to avoid stigma, to avoid burdensome administrative processes, and to earn more money by providing services in private practice rather than in public facilities; knowledge gaps in professional training; and lack of access to necessary supplies or equipment. Qualitative studies would best probe these complicated motivations.

What is the impact of conscience-based refusal of care? In the next section, we outline systemic and biologically plausible sequences of events when specified care components are refused. Research is needed to see whether these hold true and have health consequences for women and practical consequences for other clinicians and the health system as a whole. Research could illuminate women's experiences when refused care—their understanding, access to safe and unsafe alternatives, emotional response, and course of action. Investigations on the clinician side could further explore the experiences of those who do provide services after others have refused to do so. Each of these questions is likely to have context-specific answers, so research should take place in varied geopolitical settings, and the contextual nature of the findings must be made clear.

Do clinicians consider conscientious objection to be problematic? What kinds of constraints on provider behavior do clinicians consider appropriate or realistic? When enacted, have such policies or regulations been implemented? Have those implemented effectively met their purported objectives? What mechanisms of regulation do women consider reasonable? Do they perceive conscience-based refusal of care as a significant barrier to reproductive health services? Could enhanced training and updated medical and nursing school curricula devoted to reproductive health address the lack of clinical skills that contributes to refusal of care? Could further education clarify which services are permitted by law, and under which circumstances, and thus reassure clinicians sufficiently such that they provide care? Empirical evidence is essential as varied political actors try to respond to these competing concerns with policies or regulations.

3. Consequences of refusal of reproductive healthcare for women and for health systems

We lay out the potential implications of conscience-based refusal of care for patients and for health systems in 5 areas of reproductive healthcare—abortion and postabortion care, ART, contraception, treatment for maternal health risk and unavoidable pregnancy loss, and PND. Because we lack empirical data to explore the impact of conscience-based refusal of care on patients and health systems, we build logical models delineating plausible consequences if a particular component of care is refused. We provide visual schemata to represent these pathways and we use data and examples of refusal from around the world to ground them.

We attempt to isolate the impact of conscientious objection for each of the 5 reproductive health components, although we recognize the difficulties of identifying the contributions attributable to other barriers to access. These include limited resources, inadequate infrastructure, failure to implement policies, sociocultural practices, and inadequate understanding of the relevant law by providers and patients alike.

We start from the premise that refusal of care leads to fewer clinicians providing specific services, thereby constraining access to these services. We posit that those who continue to provide these contested services may face stigma and/or become overburdened. We specify plausible health outcomes for patients, as well as the consequences of refusal for families, communities, health systems, and providers.

3.1. Conscience-based refusal of abortion-related services

The availability of safe and legal abortion services varies greatly by setting. Nearly all countries in the world allow legal abortion in certain cases (e.g. to save the life of the woman, in cases of rape, and in cases of severe fetal anomaly). Few countries prohibit abortion in all circumstances. While some among these allow the criminal law defense of necessity to permit life-saving abortions, Chile, El Salvador, Malta, and Nicaragua restrict even this recourse. Other countries with restrictive laws are not explicit or clear about those circumstances in which abortion is allowed [63].

In many countries, particularly in low-resource areas, access to legal services is compromised by lack of resources for health services, lack of health information, inadequate understanding of the law, and societal stigma associated with abortion [64].

There is substantial evidence that countries that provide greater access to safe, legal abortion services have negligible rates of unsafe abortion [65]. Conversely, nearly all of the world's unsafe abortions occur in restrictive legal settings. Where access to legal abortion services is restricted, women seek services under unsafe circumstances. Approximately 21.6 million of the world's annual 46 million induced abortions are unsafe, with nearly all of these (98%) occurring in resource-limited countries [65,66]. In low-income countries, more than half of abortions performed (56%) are unsafe, compared with 6% in high-income areas [66]. Nearly one-quarter (more than 5 million) of these result in serious medical complications that require hospital-based treatment [67, 68]; 47,000 women die each year because of unsafe abortion and an additional unknown number of women experience complications from unsafe abortions but do not seek care [68]. While the international health community has sought to mitigate the high rates of maternal morbidity and mortality caused by unsafe abortion through postabortion care programs [56], the implementation and effectiveness of these have been undermined by conscience-based refusal of care [24,56,69].

We posit that conscience-based refusal of care will have less of an impact at the population level in countries with available safe, legal abortion services than in those where access is restricted. Women living in settings in which legal abortion is widely available and who experience provider refusal will be more likely to find other willing providers offering safe, legal services than women in settings in which abortion is more highly restricted. We ground our model (Fig. 1) in the following examples: (1) in South Africa, widespread conscientious objection limits the numbers of willing providers and, thus, access to safe care, and the number of unsafe abortions has not decreased since the legalization of abortion in

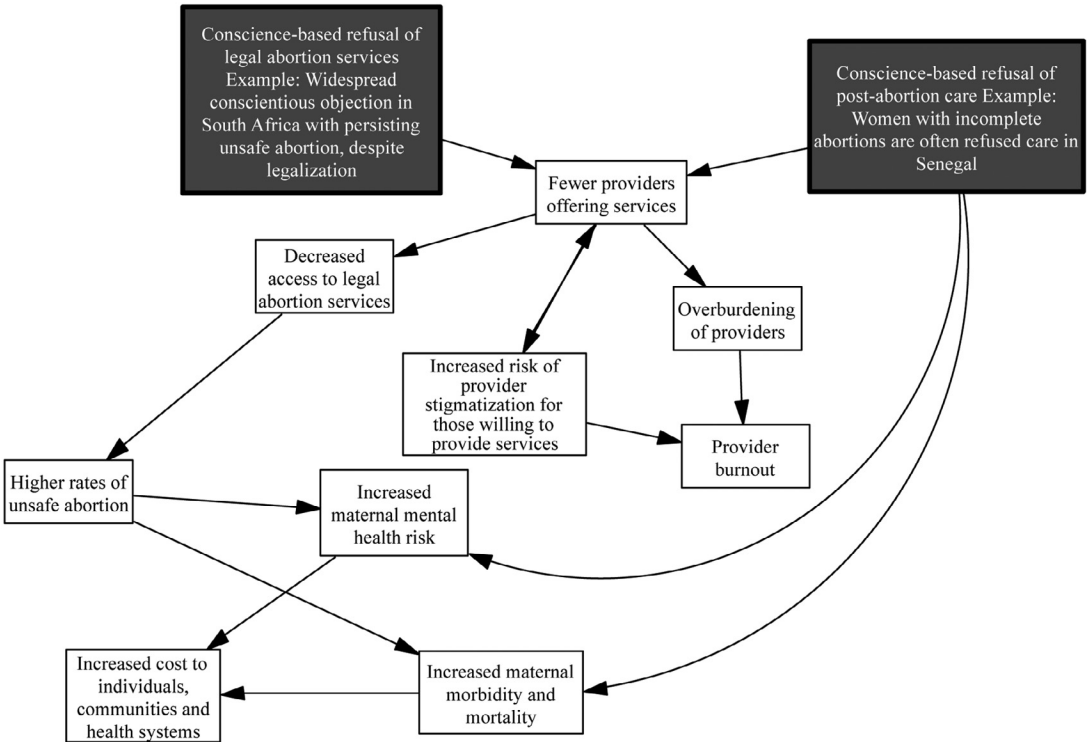

Fig. 1. Consequences of refusal of abortion-related services.

1996 [70,71]; (2) although Senegal's postabortion care program is meant to mitigate the grave consequences of unsafe abortion, conscientious objection is, nevertheless, often invoked when abortion is suspected of being induced rather than spontaneous [56] (unpublished data).

3.2. Conscience-based refusal of components of ART

Infertility is a global public health issue affecting approximately 8%–15% of couples [72,73], or 50–80 million people [74], worldwide. Although the majority of those affected reside in low-resource countries [72,73], the use of ART is much more likely in high-resource countries.

Access to specific ART varies by socioeconomic status and geographic location, between and within countries. In high-resource countries, the cost of treatment varies greatly depending on the healthcare system and the availability of government subsidy [75]. For example, in 2006, the price of a standard in vitro fertilization (IVF) cycle ranged from US $3956 in Japan to $12,513 in the USA [76]. After government subsidization in Australia, the cost of IVF averaged 6% of an individual's annual disposable income; it was 50% without subsidization in the USA [77]. In low-income countries, despite high rates of infertility, there are few resources available for ART, and costs are generally prohibitive for the majority of the population. Because these economic and infrastructural factors drive lack of access to ART in low-income countries, we posit that denial of services owing to conscience-based refusal of care is not a major contributing factor to limited access in these settings. Therefore, for the model (Fig. 2), we primarily examine the consequences of conscientious objection to components of ART in middle- to high-income countries. At times, regulations and policies regarding ART stem from empirically based concerns, grounded in medical evidence, about health outcomes for women and their offspring or health system priorities. Our focus, however, is on those instances in which some physicians practice according to moral or religious beliefs, even when these contradict best medical practices. In some Latin American countries, despite the medical evidence that maternal and fetal outcomes are markedly superior when fewer embryos are implanted, the objection to embryo selection/reduction and cryopreservation promoted by the Catholic Church has reportedly led many physicians to avoid these [78]. Anecdotal reports from Argentina describe ART physicians' avoidance of cryopreservation and embryo selection/reduction following the self-appointment of a lawyer and member of Opus Dei as legal guardian for cryopreserved embryos [78,79]. The only example that illustrates the implications of denial of preimplantation genetic diagnosis (PGD) refers to a legal ban, rather than conscience-based refusal of care. Nonetheless, we use it to describe the potential consequences when such care is denied. In 2004, Italy passed a law banning PGD, cryopreservation, and gamete donation [80]. This ban compelled a couple who were both carriers of the gene for β-thalassemia to wait to undergo amniocentesis and then to have a second-trimester abortion rather than allow the abnormality to be detected prior to implantation [80] (Fig. 2).

3.3. Conscience-based refusal of contraceptive services

The availability of the range of contraceptive methods varies by setting, as does prevalence of use [81]. In general, contraceptive use is correlated with level of income. In 2011, 61.3% of women aged 15–49 years, married or in a union, in middle–upper-income countries were using modern methods, compared with 25% in the lowest-resource countries [81,82]. Within countries, access to and use of methods also vary. For example, according to the 2003 Demographic and Health Survey of Kenya (a cross-sectional study of a nationally representative sample), women in the richest quintile were reported to have significantly higher odds for using long-term contraceptive methods (intrauterine device, sterilization, implants) than women in the poorest quintile [82].

The legal status of particular contraceptive methods also varies by setting. In Honduras, Congress passed a bill banning EC, which has not yet been enacted into law [83]. Even when contraception is legal, lack of basic resources allocated by government programs may compromise availability of particular methods. High manufacturing

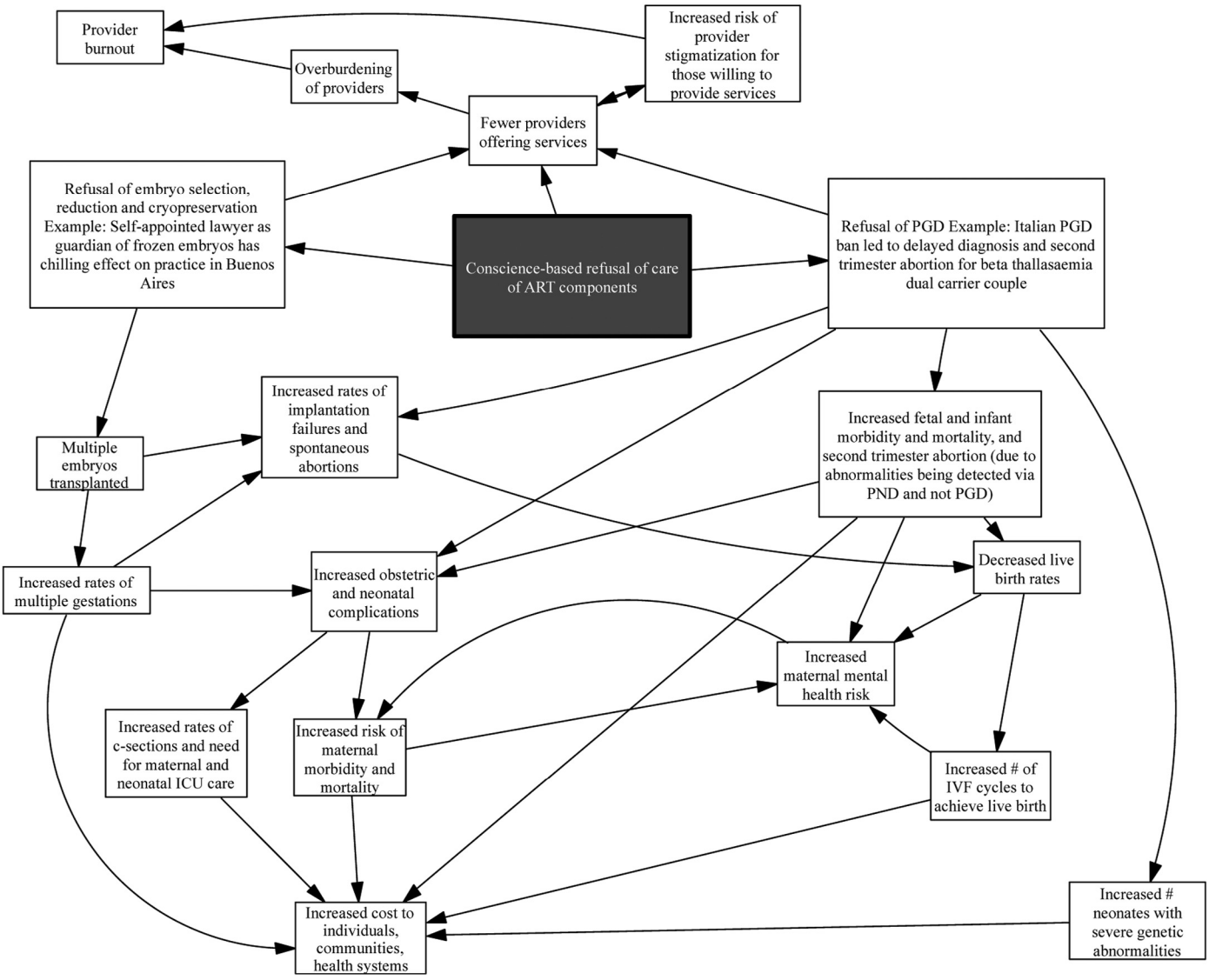

Fig. 2. Consequences of refusal of components of assisted reproductive technologies.

costs or steep prices can also undermine access [84]. In other cases, individual health providers opt not to provide contraception to all or to certain groups of women. Some providers refuse to provide specific methods such as EC or sterilization. In Poland, there is widespread refusal to provide contraceptive services (J. Mishtal, personal communication, April 2012). In Oklahoma, a rape victim was denied EC by a doctor [85], and in Germany a rape victim was denied EC by 2 Catholic hospitals in 2012 [86]. In Fig. 3, we delineate potential implications of conscience-based refusal of contraceptive services.

3.4. Conscience-based refusal of care in cases of risk to maternal health and unavoidable pregnancy loss

In some circumstances, pregnancy can exacerbate a serious maternal illness or maternal illness may require treatment hazardous to a fetus. In these cases, women require access to life-saving treatment, which may include abortion. Yet women have been denied appropriate treatment. Women seeking completion of inevitable pregnancy loss due to ectopic pregnancy or spontaneous abortion have also been denied necessary care.

It is beyond the scope of the present White Paper to define the full range of conditions that may be exacerbated by pregnancy and jeopardize the health of the pregnant woman. However, the incidence of ectopic pregnancy ranges from 1% to 16% [87–90], and 10%–20% of all clinically recognized pregnancies end in spontaneous abortion [90]. Often, refusal of care in circumstances of maternal health risk occurs in the context of highly restrictive abortion laws. We refer to 3 cases from around the world (Fig. 4) to highlight this phenomenon in our model. In Ireland in 2012, Savita Halappanavar, 31, presented at a Galway hospital with ruptured membranes early in the second trimester. She was refused completion of the inevitable spontaneous abortion, developed sepsis, and subsequently died [91]. *Z*'s daughter, a young Polish woman, was diagnosed with ulcerative colitis while she was pregnant [92]. She was repeatedly denied medical treatment; physicians stated that they would not conduct procedures or tests that might result in fetal harm or termination of the pregnancy [92]. She developed sepsis, experienced fetal demise, and died. The only example that illustrates the implications of denial of treatment for ectopic pregnancy derives from legal bans, rather than from an example of conscience-based refusal of care. In El Salvador, a total prohibition on abortion has led to physician refusal to treat ectopic pregnancy [93]; in Nicaragua, the abortion ban results in delay of treatment for ectopic pregnancies, despite law and medical guidelines mandating the contrary [94] (Fig. 4).

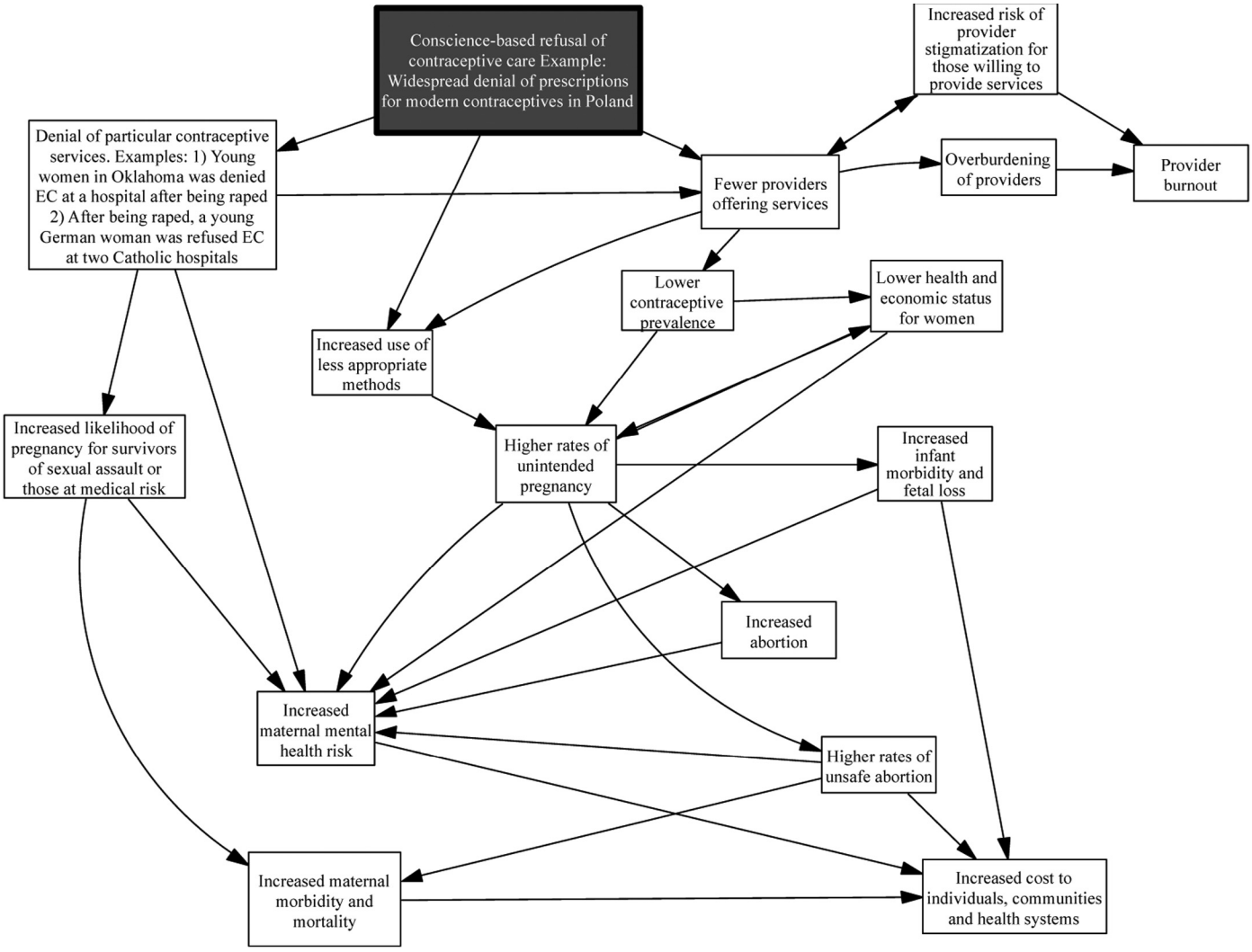

Fig. 3. Consequences of refusal of contraceptive services.

3.5. Conscience-based refusal of PND

The availability of PND varies greatly by setting—with those in middle–upper-income countries having access to testing for a variety of genetic conditions and structural anomalies, and fewer having access to a more limited series of testing in low-income countries. Access to PND provides women with information so that they can make decisions and/or preparations when severe or lethal fetal anomalies are detected. Outcomes for affected neonates vary by country resource level; PND enables physicians to plan for the level of care needed during delivery and in the neonatal period. With PND, families are also afforded the time to secure the necessary emotional and financial resources to prepare for the birth of a child with special needs [95,96]. In settings in which there are fewer resources available for PND, conscientious objection further restricts women's access to services. Figure 5 presents pathways and implications of provider conscience-based refusal to provide PND services. Because most data on access to PND are from high-resource countries, we must project what would happen in lower-income countries. We use the example of *R.R.*, a Polish woman who was repeatedly refused diagnostic tests to assess fetal status after ultrasound detection of a nuchal hygroma [97] (Fig. 5).

4. Policy responses to manage conscience-based refusal of reproductive healthcare

Here, we review various policy interventions related to conscience-based refusal of care. Initially, we look at the context established by human rights standards or human rights bodies wherein freedom of conscience is enshrined. The UN Committee on Economic, Social and Cultural Rights (CESCR); the UN Committee on the Elimination of Discrimination against Women (CEDAW); and the UN Human Rights Committee have commented on the need to balance providers' rights to conscience with women's rights to have access to legal health services [98–104]. CEDAW asserts that "it is discriminatory for a country to refuse to legally provide for the performance of certain reproductive health services for women" and that, if healthcare providers refuse to provide services on the basis of conscientious objection, "measures should be introduced to ensure that women are referred to alternative health providers" [99]. CESCR has called on Poland to take measures to ensure that women enjoy their rights to sexual and reproductive health, including by "enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection" [104].

The international medical and public health communities, including FIGO in its Ethical Guidelines on Conscientious Objection (2005) [9] and WHO in its updated Safe Abortion Guidelines (2012) [105], have agreed on principles related to the management of

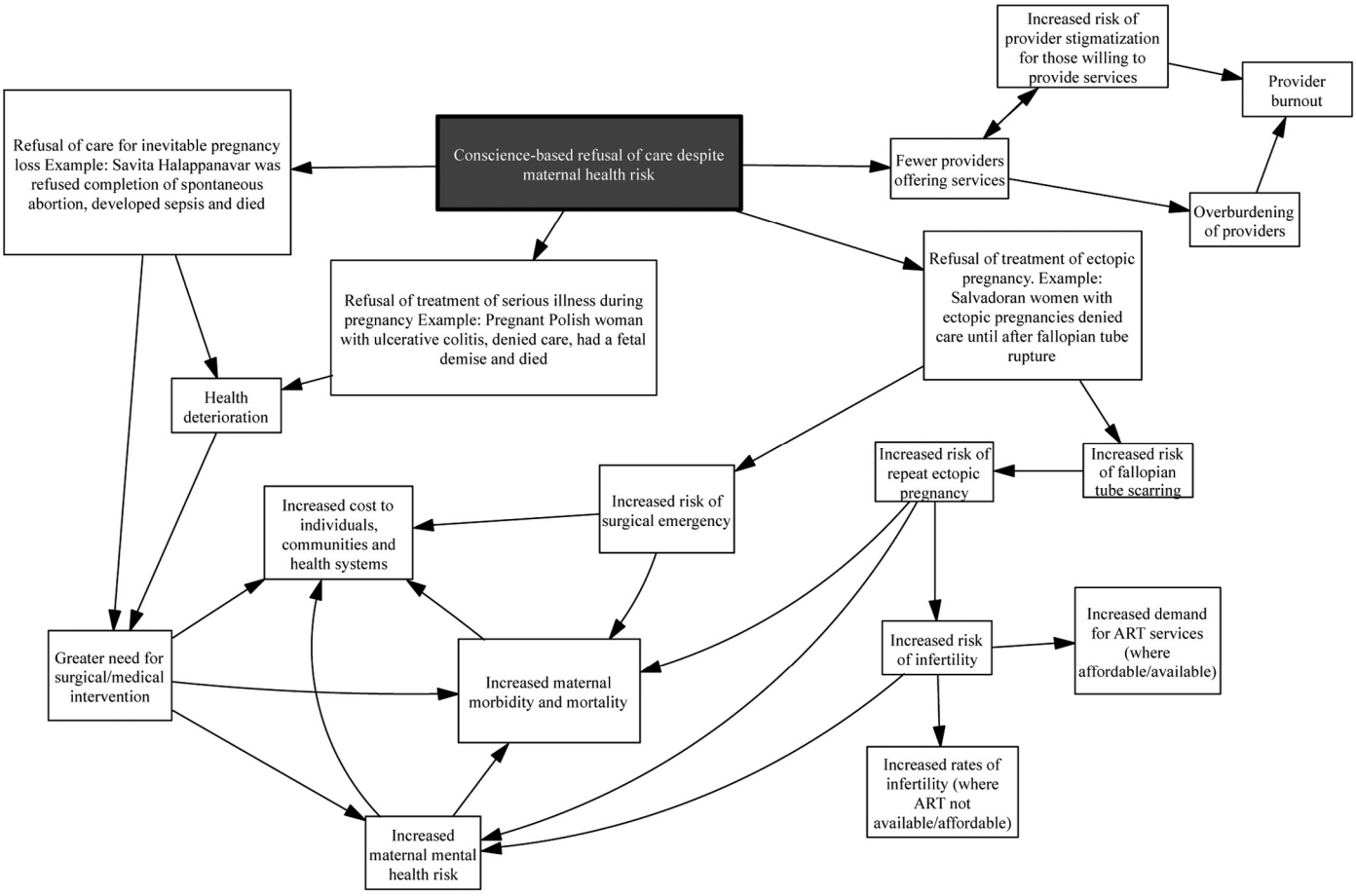

Fig. 4. Consequences of refusal of care in cases of risk to maternal health and unavoidable pregnancy loss.

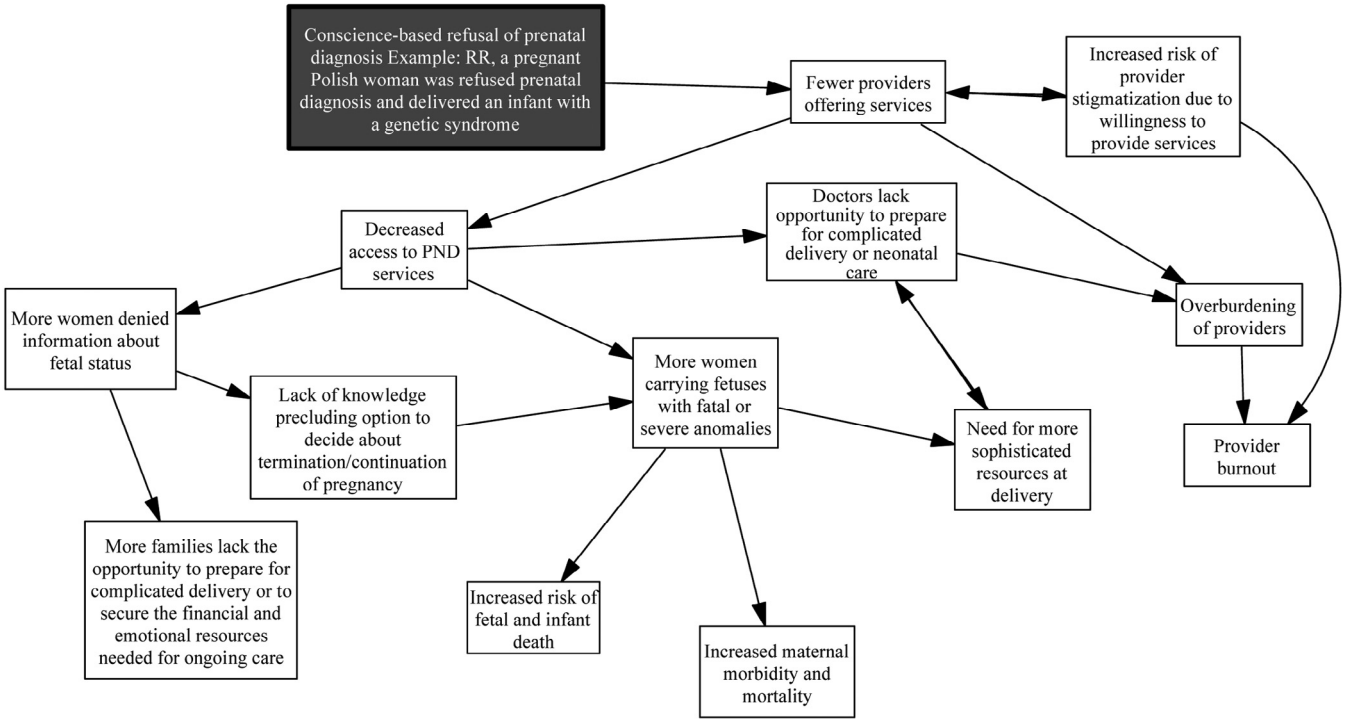

Fig. 5. Consequences of refusal of prenatal diagnosis.

conscientious objection to reproductive healthcare provision. While these are non-binding recommendations, they do assert professional standards of care. These include the following:

- Providers have a right to conscientious objection and not to suffer discrimination on the basis of their beliefs.
- The primary conscientious duty of healthcare providers is to

treat, or provide benefit and prevent harm to patients; conscientious objection is secondary to this primary duty.

Moreover, the following safeguards must be in place in order to ensure access to services without discrimination or undue delays:

- Providers have a professional duty to follow scientifically and professionally determined definitions of reproductive health services, and not to misrepresent them on the basis of personal beliefs.
- Patients have the right to be referred to practitioners who do not object for procedures medically indicated for their care.
- Healthcare providers must provide patients with timely access to medical services, including giving information about the medically indicated options of procedures for care, including those that providers object to on grounds of conscience.
- Providers must provide timely care to their patients when referral to other providers is not possible and delay would jeopardize patients' health.
- In emergency situations, providers must provide the medically indicated care, regardless of their own personal objections.

These statements support both sides of the tension: the right of patients to have access to appropriate medical care and the right of providers to object, for reasons of conscience, to providing particular forms of care. They underscore the professional obligation of healthcare providers to ensure timely access to care, through provision of accurate information, referral, and emergency care. At the transnational level, human rights consensus documents have asserted that institutions and individuals are similarly bound by their obligations to operate according to the bedrock principles that underpin the practice of medicine, such as the obligations to provide patients with accurate information, to provide care conforming to the highest possible standards, and to provide care in emergency situations.

At the country level, however, there is no agreement as to whether institutions can claim objector status. For example, Spain [106], Colombia [107], and South Africa [108] have laws stating that refusal to perform abortions is always an individual, not an institutional, decision. Conversely, Argentinian law [109,110] gives private institutions the ability to object and requires private health centers to register as conscientious objectors with local health authorities. In Uruguay, the Ethical Code does not require the institution employing a conscientious objector to provide referral services, although a newly proposed bill would require such referral [111,112]. In the USA, the question of institutional rights and obligations is hotly debated and the situation is complicated and unresolved. Currently, federal law forbids agencies receiving federal funding from discriminating against any healthcare entity that refuses to provide abortion services [113]. Yet other federal law requires institutions providing services for low-income people to maintain an adequate network of providers and to guarantee that individuals receive services without additional out-of-pocket cost [114].

International and regional human rights bodies, governments, courts, and health professional associations have developed various responses to address conscience-based refusal of care. These responses differ as to whose rights they protect: the rights of a woman to have access to legal services or the rights of a provider to object based on reasons of conscience. They might also have different emphases or targets. Some focus on ensuring an adequate number of providers for a certain service, some concentrate on ensuring that women receive timely referrals to non-objecting practitioners, and some seek to establish criteria for designation as an objector. For example, Norway established a comprehensive regulatory and oversight framework on conscientious objection to abortion, which includes ensuring the availability of providers [33,115]. In Colombia, the Constitutional Court affirmed that conscientious objection must be grounded in true religious conviction, rather than in a personal judgment of "rightness" [116].

Some of these responses are legally binding through national constitutional provisions, legislation, or case law. The European Court of Human Rights (ECHR), whose rulings are legally binding for member nations, clarified the obligation of states to organize the practice of conscience-based refusal of care to ensure that patients have access to legal services, specifically to abortion [97]. Professional associations and employers have developed other interventions, including job requirements and non-binding recommendations. In Germany, for example, a Bavarian High Administrative Court decision [117], upheld by the Federal Administrative Court [118], ruled that it was permissible for a municipality to include ability and willingness to perform abortions as a job criterion. In Norway, employers can refuse to hire objectors and employment advertisements may require performance of abortion as a condition for employment [112]. In Sweden, Bulgaria, Czech Republic, Finland, and Iceland, healthcare providers are not legally permitted to conscientiously object to providing abortion services [38]. Some require referral to non-objecting providers. For example, in the recent *P. and S. v. Poland* case, the ECHR emphasized the need for referrals to be put in writing and included in patients' medical records [119]. In Argentina [110] and France [120], legislation requires doctors who conscientiously object to refer patients to non-objecting practitioners. Similar laws exist in Victoria, Australia [121], Colombia [116,122,123], Italy [124], and Norway [115]. Professional and medical associations around the world recommend that objectors refer patients to non-objecting colleagues. ACOG in the USA [125] and El Sindicato Médico in Uruguay [126] recommend that objectors refer patients to other practitioners. The British Medical Association (BMA) specifies that practitioners cannot claim exemption from giving advice or performing preparatory steps (including referral) where the request for an abortion meets legal requirements [127]. The WMA asserts that, if a physician must refuse a certain service on the basis of conscience, s/he may do so after ensuring the continuity of medical care by a qualified colleague [128]. FIGO maintains that patients are entitled to referral to practitioners who do not object [9].

Pharmacists' associations in the USA and UK have made similar recommendations. The American Society of Health-System Pharmacists asserts that pharmacists and other pharmacy employees have the right not to participate in therapies they consider to be morally objectionable but they must make referrals in an objective manner [129]; the AMA guidelines state that patients have the right to receive an immediate referral to another dispensing pharmacy if a pharmacist invokes conscientious objection [130]. In the UK, pharmacists must also have in place the means to make a referral to another relevant professional within an appropriate time frame [131].

Some jurisdictions mandate registration of objectors or require objectors to provide advance written notice to employers or government bodies. In Spain, for example, the law requires that conscientious objection must be expressed in advance and in written form to the health institution and the government [106]. Italian law also requires healthcare personnel to declare their conscientious objection to abortion to the medical director of the hospital or nursing home in which they are employed and to the provincial medical officer no later than 1 month after date of commencement of employment [124]. Victoria, Australia [118]; Colombia [123]; Norway [115]; Madagascar [132]; and Argentina [109] have similar laws. In Norway, the administrative head of a health institution must inform the county municipality of the number of different categories of health personnel who are exempted on grounds of conscience [115]. Argentinian law [109] gives private institutions the ability to object, requiring these

institutions to register as conscientious objectors with local health authorities and to guarantee care by referring women to other centers. Argentinian law also states that an individual objector cannot provide services in a private health center that s/he objects to the provision of in the public health system [110]. Regulation in Canada requires pharmacists to ensure that employers know about their conscientious objector status and to prearrange access to an alternative source for treatment, medication, or procedure [133]. The Code of Ethics for nurses in Australia also requires disclosure to employers [134]. In Northern Ireland, a guidance document by the Department of Health, Social Services and Public Safety asserts that an objecting provider "should have in place arrangements with practice colleagues, another GP practice, or a Health Social Care Trust to whom the woman can be referred" for advice or assessment for termination of pregnancy [135].

Other measures require disclosure to patients about providers' status as objectors. For example, the law in the state of Victoria, Australia, requires objectors to inform the woman and refer her to a willing provider [121]. In Argentina, the Technical Guide for Comprehensive Legal Abortion Care 2010 [109] requires that all women be informed of the conscientious objections of medical, treating, and/or support staff at first visit. Portugal's medical ethical guidelines encourage doctors to communicate their objection to patients [136].

The right to receive information in healthcare, including reproductive health information, is enshrined in international law. For example, the ECHR determined that denial of services essential to making an informed decision regarding abortion can constitute a violation of the right to be free from inhuman and degrading treatment [97]. At the national level, laws have mandated disclosure of health information to patients. For example, according to the South African abortion law, providers, including objectors, must ensure that pregnant women are aware of their legal rights to abortion [108]. In Spain, women are entitled to receive information about their pregnancies (including prenatal testing results) from all providers, including those registered as objectors [106]. In the UK, objectors are legally required to disclose their conscientious objector status to patients, to tell them they have the right to see another doctor, and to provide them with sufficient information to enable them to exercise that right [137–139].

Professional guidelines have also addressed disclosure of health information. In Argentina, any delaying tactics, provision of false information, or reluctance to carry out treatment by health professionals and authorities of hospitals is subject to administrative, civil, and/or criminal actions [109]. FIGO asserts that the ethical responsibility of OB/GYNs to prevent harm requires them to provide patients with timely access to medical services, including giving them information about the medically indicated options for their care [9].

Some require the provision of services in cases of emergency. For example, legislation in Victoria, Australia [121]; Mexico City [140]; Slovenia [141]; and the UK [138] stipulates that physicians may not refuse to provide services in cases of emergency and when urgent termination is required. US case law determined that a private hospital with a tradition of providing emergency care was still obliged to treat anyone relying on it even after its merger with a Catholic institution. This sets the standard for continuity of access after mergers of 2 hospitals with conflicting philosophies [142]. Also, ACOG urges clinicians to provide medically indicated care in emergency situations [125]. In Argentina, technical guidelines from the Ministry of Health stipulate that institutions must provide termination of pregnancy through another provider at the institution within 5 days or immediately if the situation is urgent [109]. In the UK, medical standards also prohibit conscience-based refusal of care in cases of emergency for nurses and midwives [143].

Other measures address the required provision of services when referral to an alternative provider is not possible. In Norway, for example, a doctor is not legally allowed to refuse care unless a patient has such reasonable access [115]. FIGO recommends that "practitioners must provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardize patients' health and well being, such as by patients experiencing unwanted pregnancy" [9].

Some interventions obligate the state to ensure services. In Colombia, for example, the health system is responsible for providing an adequate number of providers, and institutions must provide services even if individuals conscientiously object [107]. The law on voluntary sterilization and vasectomies in Argentina obligates health centers to ensure the immediate availability of alternative services when a provider has objected [144]. In Spain, the government will pay for transportation to an alternative willing public health facility [106]. Italian law requires healthcare institutions to ensure that women have access to abortion; regional healthcare entities are obliged to supervise and ensure such access, which may include transferring healthcare personnel [125]. In Mexico City, the public health code was amended to reinforce the duty of healthcare facilities to make abortion accessible, including their responsibility to limit the scope of conscientious objection [140].

Some measures specify which service providers are eligible to refuse and when they are allowed to do so. In the UK, for example, auxiliary staff are not entitled to conscientiously object [145,146]. According to the BMA guidelines, refusal to participate in paperwork or administration connected with abortion procedures lies outside the terms of the conscientious objection clause [127]. In Spain, only health professionals directly involved in termination of pregnancy have the right to object, and they must provide care to the woman before and after termination of pregnancy [106]. Similarly, doctors in Italy are legally required to assist before and after an abortion procedure even if they opt out of the procedure itself [124]. Also, medical guidelines in Argentina encourage practitioners to aid before and after legal abortion procedures even if they are invoking conscientious objection to participation in the procedure itself [109]. During the Bush administration, the US Department of Health and Human Services extended regulatory "conscience protections" to any individual peripherally participating in a health service [147]. This regulation was contested vigorously and retracted almost fully in February 2011 [148,149].

In Table 1, we lay out some benefits and limitations of policy responses to conscientious objection in order to provide varied actors with a menu of possibilities. As criteria are developed for invoking refusal, it is essential to address the questions of who is eligible to object, and to the provision of which services. We have added the categories of "data" and "standardization" as parameters in the table in recognition of the scant evidence available and the resulting inability to methodically assess the scope and efficacy of interventions. Selection of the various options delineated below will be influenced by the specific sociopolitical and economic context.

5. Conclusion

Refusal to provide certain components of reproductive healthcare because of moral or religious objection is widespread and seems to be increasing globally. Because lack of access to reproductive healthcare is a recognized route toward adverse health outcomes and inequalities, exacerbation of this through further depletion of clinicians constitutes a grave global health and rights concern. The limited evidence available indicates that objection occurs least when the law, public discourse, provider custom, and clinical experience all normalize the provision of the full range of reproductive healthcare services and promote women's autonomy. While data on both the prevalence of conscience-based refusal of

Table 1
Benefits and limitations of policy interventions

Option	Health system needs	Timely access to care	Balancing rights and obligations	Developing criteria for refusers	Standardization	Data needs
Referral to willing and accessible providers	Enables system planning for service delivery	Expedites patients' access to services	Upholds patients' rights to health-related information; providers' obligations to provide information and make refusal transparent; individual conscience	Establishes obligations of those claiming objector status while acknowledging legitimacy of objection	Policies and procedures for disclosure and referral standardized throughout health system	Provides indirect data on patients' encounters with refusal
Registration of objectors/written notice to employers	Informs on prevalence of objection, enabling system planning for service delivery	Leads to more timely access to care for women who can avoid seeking care from known objectors	Acknowledges provider right to object while informing patients. Requirement of formal documentation acknowledges health system stake in such knowledge	Delineates the specific instances in which objection is permitted, and by whom; formal notification of employers makes explicit the criteria for designation as an objector	Ensures that requirements for designation as objector are standardized throughout the health system	Registries provide data on prevalence by type of provider as well as component of care refused
Required disclosure of objector status to patients	Enables women to avoid unproductive visits to objectors and delayed care, promoting smoother functioning of system	Women go directly to willing provider	Acknowledges provider right to object while upholding patients' rights to autonomy and health-related information	Defines obligations of objectors	Standardizes information provided to patients	N/A
Required information to patients about available health options	Informed patients are better able to make decisions and to locate the services that they need	Facilitates patient access to appropriate care	Upholds patients' rights to obtain health-related information; underscores providers' obligations to provide accurate information and to inform about legally available options; asserts health system's commitment to science and to patients' rights	Limits scope of objection by specifying components of care individuals obligated to provide	Standardizes information to patients about health system's range of available services	N/A
Mandated provision of services in urgent situations or when no alternative exists	Facilitates planning for provision of emergency care and for associated policies, procedures, and oversight; ensures that medical sequelae of denial or delay of care are minimized	Provides critical care in a timely fashion	Obligations of the provider to operate in the best interests of patients and to provide appropriate care take precedence over the individual clinician's right to object	Sets limits on the scope of refusal to protect patients in emergency situations	Ensures that objectors adhere to contractual obligations to provide essential and/or life-saving care	Contributes to the ability to track urgent cases and to plan service provision needs
Willingness to provide and proficiency as criteria for employment	Underscores employers' needs to ensure sufficient number of providers to meet demand for specific services	Staff competency and willingness enable ready and timely access to appropriate care	Health systems' needs to employ proficient and willing providers to respond to the health needs of the community trump provider rights to object; providers free to adhere to conscience by choosing other employment	Limits objection because only those willing and trained are eligible for employment	Standardizes such requirements in job postings throughout health system	Tracks the number of proficient and willing candidates seeking employment
Medical certification contingent upon proficiency in specific services	Improves health system-level planning for service delivery by assuring that providers are proficient in needed services	Availability of trained providers facilitates timely access to care	Establishes that objectors have the right to choose other specialties, but not to refuse essential components of a specialty; ensures patient rights to receive appropriate services from providers designated as specialists; defines and safeguards professional standards	Clarifies that specialist objectors must be trained and ready to provide care in emergency situations or when other options not available	Specialty certification guarantees mastery of a set of skills and compliance with explicit obligations	Tracks number of providers certified and, therefore, proficient, thus facilitating planning
Medical society guidelines delineating expected standards of care	Recommends that priority go to patient receipt of care and to prevention of shortages of willing and qualified providers; guidelines may lack mechanisms for implementation	Recommends policies and procedures to ensure timely access to care but may lack force	Delineates the rights and obligations of providers and the rights of patients	Suggests criteria for designation as objector and associated obligations	Asserts standards of care	N/A

care and the consequences for women's health and health system function are inadequate, they indicate that refusal is unevenly distributed; that it may have the most severe impact in those parts of the world least able to sustain further personnel shortages; and that it also affects women in more privileged circumstances.

The present White Paper has laid out the available data and outlined research questions for further management of conscience-based refusal of care. It presents logical chains of consequences when refusal compromises access to specific components of reproductive healthcare and categorizes efforts to balance the claims of objectors with the claims of both those seeking healthcare and the systems obligated to provide these services. We highlight the claims of those whose conscience compels them to provide such care, despite hardship. As our emphasis is on medicine and science, we close by considering ways for medical professional and public health societies to develop and implement policies to manage conscientious objection.

One recommendation is to standardize a definition of the practice and to develop eligibility criteria for designation as an objector. Such designation would have accompanying obligations, such as disclosure to employers and patients, and duties to refer, to impart accurate information, and to provide urgently needed care. Importantly, professional organizational voices can uphold conformity with standards of care as the priority professional commitment of clinicians, thus eliminating refusal as an option for the care of ectopic pregnancy, inevitable spontaneous abortion, rape, and maternal illness. In sum, medical and public health professional organizations can establish a clinical standard of care for conscientious objection, to which clinicians could be held accountable by patients, medical societies, and health and legal systems.

There are additional avenues for professional organizations to explore in upholding standards. Clinical specialty boards might condition certification upon demonstration of proficiency in specific services. Clinical educators could ensure that trainees and members are educated about relevant laws and clinical protocols/procedures. Health systems may consider willingness to provide needed services and proficiency as criteria for employment. These last are noteworthy because they also move us from locating the issue at the individual level to consideration of obligations at the professional and health system levels.

These issues are neither simple nor one-sided. Conscience and integrity are critically important to individuals. Societies have the complicated task of honoring the rights of dissenters while also limiting their impact on other individuals and on communities. Although conscientious objection is only one of many barriers to reproductive healthcare, it is one that medical societies are well positioned to address because providers are at the nexus of health and rights concerns. They have the unique vantage point of caring simultaneously about their own conscience and about their obligations to patients' health and rights and to the highest standards of evidence-based care. The present White Paper has disentangled the range of implications for women's health and rights, health systems, and objecting and committed providers. Thus, it equips clinicians and their professional organizations to contribute a distinct medical voice, complementary to those of lawyers, ethicists, and others. We urge medical and public health societies to assert leadership in forging policies to balance these competing interests and to safeguard reproductive health, medical integrity, and women's lives.

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Conflict of interest

The authors have no conflicts of interest.

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Exhibit E

to Sangree Declaration

THE MILBANK QUARTERLY
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Original Investigation

Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program

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Policy Points:

- The US publicly supported family planning effort serves millions of women and men each year, and this analysis provides new estimates of its positive impact on a wide range of health outcomes and its net savings to the government.
- The public investment in family planning programs and providers not only helps women and couples avoid unintended pregnancy and abortion, but also helps many thousands avoid cervical cancer, HIV and other sexually transmitted infections, infertility, and preterm and low birth weight births.
- This investment resulted in net government savings of $13.6 billion in 2010, or $7.09 for every public dollar spent.

Context: Each year the United States' publicly supported family planning program serves millions of low-income women. Although the health impact and public-sector savings associated with this program's services extend well beyond preventing unintended pregnancy, they never have been fully quantified.

Methods: Drawing on an array of survey data and published parameters, we estimated the direct national-level and state-level health benefits that accrued from providing contraceptives, tests for the human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs), Pap tests and tests for

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human papillomavirus (HPV), and HPV vaccinations at publicly supported family planning settings in 2010. We estimated the public cost savings attributable to these services and compared those with the cost of publicly funded family planning services in 2010 to find the net public-sector savings. We adjusted our estimates of the cost savings for unplanned births to exclude some mistimed births that would remain publicly funded if they had occurred later and to include the medical costs for births through age 5 of the child.

Findings: In 2010, care provided during publicly supported family planning visits averted an estimated 2.2 million unintended pregnancies, including 287,500 closely spaced and 164,190 preterm or low birth weight (LBW) births, 99,100 cases of chlamydia, 16,240 cases of gonorrhea, 410 cases of HIV, and 13,170 cases of pelvic inflammatory disease that would have led to 1,130 ectopic pregnancies and 2,210 cases of infertility. Pap and HPV tests and HPV vaccinations prevented an estimated 3,680 cases of cervical cancer and 2,110 cervical cancer deaths; HPV vaccination also prevented 9,000 cases of abnormal sequelae and precancerous lesions. Services provided at health centers supported by the Title X national family planning program accounted for more than half of these benefits. The gross public savings attributed to these services totaled approximately $15.8 billion—$15.7 billion from preventing unplanned births, $123 million from STI/HIV testing, and $23 million from Pap and HPV testing and vaccines. Subtracting $2.2 billion in program costs from gross savings resulted in net public-sector savings of $13.6 billion.

Conclusions: Public expenditures for the US family planning program not only prevented unintended pregnancies but also reduced the incidence and impact of preterm and LBW births, STIs, infertility, and cervical cancer. This investment saved the government billions of public dollars, equivalent to an estimated taxpayer savings of $7.09 for every public dollar spent.

Keywords: family planning services, cost-benefit analysis, contraception, financing.

In the United States, half of all pregnancies are unintended, and unintended pregnancy is highly concentrated among low-income women.[1] In response to this disparity, the federal and state governments have worked for decades to expand access to family planning services for young and low-income women and men, channeling public funds for family planning services primarily through 2 programs. Title X of the Public Health Service Act, enacted by Congress in 1970, is the sole federal program devoted entirely to family planning. Medicaid is a joint federal-state public health insurance program, which provides the vast majority of public family planning dollars and covers

millions of women and men of reproductive age. Since the mid-1990s, to further increase access to family planning services for low-income women not eligible for full-benefit Medicaid, 30 states have expanded eligibility under Medicaid specifically for family planning services.[2]

Decades of research have documented the reach and impact of publicly supported family planning services in the United States. Recently, Frost and colleagues found that 8.9 million poor and low-income women received publicly supported contraceptive services in 2010.[3] Such services helped women prevent an estimated 2.2 million unintended pregnancies that year, of which 1.1 million would have resulted in an unplanned birth, 760,000 in an abortion, and 360,000 in a miscarriage. Moreover, publicly funded family planning services resulted in an estimated net public savings of $10.5 billion in 2010.

Although compelling, these findings capture only a portion of the total health impact of and savings generated by public efforts. The analysis by Frost and colleagues and similar previous analyses by Guttmacher Institute researchers[4-8] were limited to the numbers of unintended pregnancies, abortions, and unplanned births averted by clients' increased contraceptive use. They also were limited to a portion of the public savings from averting unplanned births that would have been funded by Medicaid, including only prenatal care, labor and delivery, postpartum care, and 12 months of infant care. Other studies of the benefits and cost savings from publicly funded family planning services went beyond those by Guttmacher in several ways, such as accounting for the medical costs of care for up to 5 years of a child's life, estimating public savings from averted miscarriages and abortions, and including costs for social services for infants and young children.[9-12]

A sizable body of literature indicates that the health impact and public-sector savings of publicly supported family planning services in the United States extend well beyond the impact of preventing unintended pregnancies.[13] Research indicates that by enabling women and couples to plan, delay, and space pregnancies, contraception is linked to improved maternal and child health outcomes.[13-15] Appropriate pregnancy spacing is linked to better birth outcomes, including the reduced likelihood of babies born prematurely, at a low birth weight (LBW), or small for their gestational age.[16,17]

Moreover, the package of care delivered as part of a publicly supported family planning visit extends well beyond contraception. Clients routinely receive screenings for sexually transmitted infections (STIs), such

as chlamydia, gonorrhea, syphilis, and HIV; cervical cancer prevention services, including Pap tests, and testing and vaccination for human papillomavirus (HPV); breast exams for early detection of breast cancer; and screenings for a variety of other health conditions and risks, such as diabetes, high blood pressure, and intimate partner violence. Screening services can lead to early detection, preventive behavior change, and prompt treatment. Some forms of treatment, such as for chlamydia and gonorrhea, are routinely provided on-site; others are facilitated through referrals to specialists. This broader package of preventive services has taken on heightened importance in recent years as policymakers, health care experts, providers, and insurers all have emphasized the importance of prevention, and indeed, the Affordable Care Act, which was enacted in March 2010, requires most private health plans to cover most of these preventive services without any out-of-pocket costs to enrollees. The impact on health and the cost savings of many of the individual preventive services delivered as part of a publicly supported family planning visit have been studied independently; for example, numerous studies have explored the benefits and costs of various HIV prevention strategies, including routine HIV screening.[18-22] But no study has looked at these services together in the context of what care is delivered to publicly supported family planning clients in the United States.

The analysis presented in this article expands on both Frost and colleagues' research[3] and earlier research at Guttmacher[4-8] on the benefits and cost savings of publicly funded family planning services. First, we estimated the direct health benefits and cost savings from several services delivered during a publicly funded family planning visit: testing and treatment for chlamydia and gonorrhea, HIV testing, Pap and HPV testing, and HPV vaccination. Second, we estimated the numbers of averted unplanned births that would have been preterm or LBW and that would have been closely spaced (<18 months interpregnancy interval). Third, in line with other recent cost-benefit studies,[9,10,12] we estimated the public savings from averted unplanned births to include the costs of medical care for children aged 13 to 60 months, factored in the medical costs from averted miscarriages and abortions, and readjusted to account for some averted births that were simply delayed and would not have contributed to public savings over the 5-year period. We concluded with a unified estimate of cost savings from publicly supported family planning care by combining the findings by Frost and colleagues[3] with those from this analysis.

Methods

Overall Approach

In this article, publicly supported providers refer to all health centers that offer publicly funded family planning services, such as health departments, federally qualified health centers, Planned Parenthood affiliates, and hospital outpatient clinics, as well as private doctors who provide family planning services to Medicaid recipients. We followed a similar pattern for each of the specific services covered by this analysis. First, we estimated the number of individuals who received that particular service from publicly supported providers in 2010; for some services (specifically, chlamydia, gonorrhea and HIV testing), we included male clients as well as female clients. Next we calculated how many individuals obtained a direct health benefit from that service that they would not have obtained in the absence of publicly funded care. This usually required comparing the health outcomes for individuals who received services with the anticipated health outcomes for individuals in a counterfactual situation for whom publicly funded services were not available. We assumed that the latter clients would shift to a less effective mix of methods or that some would delay obtaining noncontraceptive preventive services (the specific assumptions for each service are described later). We then calculated the cost of providing care for the medical conditions that would have ensued had family planning services not been available. We refined that calculation further by estimating how much of those savings would have been public savings.

We summed the public savings resulting from each specific service provided to obtain the total amount of public cost savings. We then compared this total with the total public cost of providing publicly funded family planning and related sexual and reproductive health services in 2010, previously estimated at $2.2 billion.[3] (Note that the cost estimates used here for the family planning program differ slightly from those in an earlier report based on different data.[23] For this report, we derived family planning program cost estimates from Title X revenue data in order to apportion the expenditures by provider categories at the state level.) These total public costs already included the costs of providing all the various services studied in this article (ie, contraceptive method provision; STI, Pap, and HPV testing; and HPV vaccination); therefore, no additional costs for noncontraceptive services were factored

into the analysis. Table 1 summarizes the specific services examined, health benefits measured, and public costs averted.

State and National Estimates. When possible, the analyses were carried out at the state level and then summed to produce national totals. We examined data at the state and national levels for all health centers that provide family planning services and for Title X–supported health centers specifically. But as in previous analyses,[3] we could look at data for Medicaid-reimbursed private doctors only at the national level.

Time Frames. The data on services provided and actual costs were for 2010. Because many benefits of the services provided extended beyond a single year, the analysis for each specific service depended on assumptions about how many years of benefits would accrue from services provided in 2010. HIV and cancer prevention services, for example, have lifetime benefits. Because those services avert diseases that would have been identified and treated years or decades later, any analysis of their benefits must use an extended time frame. By contrast, services that prevent curable STIs have more limited, episodic benefits. They avert health consequences and treatment costs that would have occurred only a few months or years later, and they do not prevent future infections. The benefits of contraceptive care in helping women and couples avert unintended pregnancies are fundamentally different from the benefits of other services in that the averted medical costs theoretically could be extended to a child's entire life. For contraceptive services, however, we used a 5-year time frame, which has become widely accepted in the literature focusing on medical costs related to unplanned births.

Expected Receipt of Services in the Absence of Publicly Funded Care. We assumed that in the absence of publicly funded family planning services, many women and men who would have made a family planning visit and obtained contraceptive and related services would have been less likely to make such visits. Some women who would have used more effective contraceptive methods would instead have used less expensive over-the-counter methods or no method; this alternative method-mix scenario was based on the behavior of similar women who did not use publicly funded services but were eligible do so. Both scenarios were calculated using the 2006-2010 National Survey of Family Growth (NSFG) and form the basis for our estimates of the numbers of unintended pregnancies prevented by publicly funded contraceptive services.[24]

Without public funding, many women would forgo family planning visits and thus also forgo the receipt of related services, such as screening

Table 1. Health Benefits Obtained and Public Costs Averted From Specific Services Received During Publicly Funded Family Planning Visits

Service	Health Benefits Obtained	Public Costs Averted
Contraceptive services	Unintended pregnancies are prevented, leading to: Fewer unplanned births and abortions; Fewer births with short interpregnancy intervals (IPIs); and Fewer preterm or LBW births.	Maternity and birth-related care to 60 months for all unwanted births and some mistimed births (mostly Medicaid). Care for miscarriages (including ectopic pregnancies) and abortions (mostly Medicaid).
Chlamydia and gonorrhea testing	Infections are identified and treated, leading to: Fewer cases of pelvic inflammatory disease (PID), epididymitis, and other sequelae (pelvic pain, ectopic pregnancy, infertility); Fewer infections and their sequelae transmitted to partners; and Fewer cases of STI-attributable HIV.	Treatment for PID and other sequelae (mostly Medicaid).
HIV testing	Clients are informed of their HIV status, thereby reducing HIV infections and sequelae in partners.	Treatment for HIV and AIDS (Medicaid, Ryan White, and others).
Pap and HPV testing	Cases of HPV and sequelae are identified, including abnormal cervical cells, precancerous lesions, and cervical cancer, thereby reducing cases that progress to cervical cancer and death.	Treatment for cervical cancer (mostly Medicaid and Medicare).
HPV vaccination	Fewer clients become infected with HPV, so fewer individuals experience its sequelae: abnormal cervical cells, precancerous lesions, cervical cancer and death, and other HPV-attributable cancers (vulvar, vaginal, anal/rectal, and oropharyngeal cancers).	Treatment for more severe sequelae of HPV infection, including cancers (mostly Medicaid and Medicare).

for STIs and cervical cancer and HPV vaccination. We assumed that all women in our comparison group who were expected to continue to use prescription methods (13%), such as oral contraceptives or long-acting reversible methods, would also obtain these related screening and vaccination services in a timely manner. We assumed, too, that 16% of the remaining 87% of women in our comparison group who, in the absence of publicly funded services, were expected to use nonprescription methods or no method, would make a visit to obtain preventive services, including these screening and vaccination services. We based this proportion on the observed behavior of similar women in the NSFG. Accordingly, we calculated the benefits and cost savings for STI and cervical cancer screening and for HPV vaccination for only the 73% of female clients who, in the absence of publicly funded services, would likely forgo both the use of prescription methods and preventive gynecological visits for these screening and vaccination services. For male clients in the absence of publicly funded services, we assumed that 100% would forgo care.

Data Sources. We used various sources of data for this analysis. Our calculations of numbers of women served were based primarily on the Guttmacher Institute's 2010 Census of Publicly Funded Clinics Providing Contraceptive Services,[3] which counted the number of women served at all US health centers that provide publicly supported family planning services, and we estimated the number of women receiving Medicaid-funded contraceptive services from private physicians. In addition, we used data from the Family Planning Annual Report (FPAR)[25] produced by the federal Office of Population Affairs, which gives additional details about specific services provided to women and men served at Title X–supported facilities. Our analyses sometimes generalized the data for these facilities to all publicly supported facilities. In some cases, we used data from the Planned Parenthood Federation of America as a proxy for the larger universe of these clients,[26] which is reasonable given that Planned Parenthood's network of 800 centers provides services to 36% of all publicly supported family planning center clients.[3] Estimates of the incidence of medical conditions were drawn from either actual data for the client universe (such as the 2010 FPAR report)[25] or the medical and epidemiological literature. Additional estimates of clients' characteristics were based on the NSFG and the American Community Survey (ACS). Appendix Table A1 summarizes the key parameters related to this analysis.

Discounting and Inflation. Data on the cost of treatment for specific diseases and conditions were adjusted for inflation to 2010 dollars, using the Consumer Price Index (All Urban Consumers) for Medical Care.[27] Separately, for the cost of treatment that would occur years in the future, we applied a 3% annual discount, in accordance with the recommendations of the US Public Health Service Panel on Cost-Effectiveness in Health and Medicine.

Rounding. The incidence of most events usually was rounded to the nearest 10 or 100, although numbers less than 100 were left unrounded. The numbers of dollars saved were usually rounded to the nearest 1,000.

Pregnancy Spacing and Preterm/LBW Births

A substantial body of research indicates that short interpregnancy intervals (IPIs)—often defined as less than 18 months between a birth and a subsequent pregnancy—are positively associated with babies being born prematurely, at LBW, or small for their gestational age.[16,17,28,29] Unintended pregnancy is strongly predictive of short IPIs, whereas contraceptive use is protective against them.[30-32]

To estimate the impact of the US family planning effort on women's ability to avoid short IPIs and poor infant health outcomes, we started with state-level numbers of the unplanned births averted by women's use of publicly supported family planning.[3] Next we analyzed data from the 2006-2010 NSFG and found that of all unplanned births to US women with incomes below 250% of the federal poverty level, 26% were conceived less than 18 months after an earlier birth.[33] We applied this 26% rate to the number of unplanned births averted in 2010 to arrive at state-level estimates of the number of short IPI births averted through publicly supported family planning services.

Using vital statistics data from the Centers for Disease Control and Prevention (CDC) for 2008, we tabulated the proportion of total births in each state that were preterm, LBW, or both.[34] We then applied these rates to the numbers of unplanned births averted in 2010 to arrive at state-level estimates of the number of preterm or LBW births averted through publicly supported family planning services.

Frost and colleagues' 2010 estimates of the costs and cost savings from publicly supported family planning services already included the costs of contraceptive services.[3] Moreover, the public-sector cost savings from

averted unplanned births that they had calculated were based on the average cost of Medicaid-funded maternity and infant care, including care for preterm and LBW births. Therefore, we factored no additional costs or savings into this analysis.

Chlamydia and Gonorrhea Testing

Screening for STIs, including chlamydia and gonorrhea, is an integral component of reproductive health services that is offered at 97% of publicly funded sites that provide family planning.[35] The costs of STIs in the United States—for both health consequences and economic burden—have been well documented,[13,36] although the impact that STI testing and treatment during publicly funded family planning visits have had on reducing those consequences has not been calculated. Chlamydia and gonorrhea are two of the most common STIs in the United States, with an estimated 2.9 million new chlamydia infections and 820,000 new gonorrhea infections each year.[37] Untreated, such infections can lead to a host of adverse health outcomes, including PID, infertility, ectopic pregnancy, and chronic pelvic pain in women and epididymitis in men.[38,39]

We estimated the direct medical benefits from testing for chlamydia and gonorrhea during family planning visits by first figuring the proportion of public clients who received positive test results for each STI during family planning visits. We applied these proportions to the numbers of women and men who would be expected to forgo family planning visits and related STI testing in the absence of publicly funded services (73% of current female clients and 100% of current male clients).

To estimate the proportion of female clients positive for each STI, we began with the reported number of female clients tested for chlamydia at a Title X–funded health center in 2010, by age (<20, 20-24, ≥ 25) and state, and the total number of gonorrhea tests performed on female clients that year by state (counting tests, even if the same woman received more than 1 test during the year).[25] We calculated the number of female clients tested for gonorrhea in each state as 96% of the number of tests conducted on the basis of the national ratio of female clients receiving chlamydia tests to total gonorrhea tests performed on female clients. We multiplied the number of women who received each test by age- and state-specific chlamydia positivity rates and state-specific gonorrhea

positivity rates reported for women attending family planning clinics[40] through the CDC's infertility prevention project to estimate the number and percentage of female Title X clients with a positive chlamydia or gonorrhea result in 2010.

These percentages were then applied to state-level data on the number of all female contraceptive clients served at publicly funded health centers in 2010 (both Title X and non–Title X) and to national-level data on the number of female Medicaid recipients who received contraceptive services from private physicians that year.[3]

For men, we followed similar steps, beginning with the reported state-level numbers of male clients tested for chlamydia during a family planning visit at a Title X–funded health center in 2010 and the numbers of gonorrhea tests performed on male clients. We multiplied the number of men receiving each test by state-specific positivity rates for chlamydia and gonorrhea reported for men aged 16 to 24 entering the national job-training program[41] to estimate the number of male Title X clients with a positive chlamydia or gonorrhea result in 2010. We determined the numbers of male clients tested in non–Title X health centers by assuming that the same ratio of males tested to female clients found at Title X centers would apply in non–Title X centers and that the same proportion of positive test results would apply in both types of centers. We did not estimate any male clients served or tested for STIs by private doctors, because we had no data on the numbers of male Medicaid recipients making family planning visits to private doctors.

We assumed that 96.5% of both female and male clients testing positive for chlamydia or gonorrhea would receive treatment.[42] Following published formulas for estimating costs averted by STI prevention programs developed by Chesson, Owusu-Edusei, and others,[43-46] we assumed that the likelihood that treated women would develop PID would be reduced from 15% to 0% of symptomatic positive cases and from 15% to 7.5% of asymptomatic positive cases. We also assumed that the likelihood that men would develop epididymitis would be reduced from 2% to 0% in all cases. Recent evidence indicates that treatment is less effective for women with asymptomatic chlamydia or gonorrhea, as their infections may already have progressed to PID before treatment.[47] We assumed that 31% of women testing positive for chlamydia or gonorrhea would be symptomatic.[39] Following Chesson and colleagues, we adjusted our estimates of the impact of chlamydia treatment to account

for possible coinfection with gonorrhea (multiplying by 0.925 for both men and women). We also adjusted our estimates of the impact of gonorrhea treatment to account for possible coinfection with chlamydia (multiplying by 0.79 for women and 0.90 for men) and for possible reinfection within 1 year (multiplying by 0.70). We used updated estimates of the lifetime direct medical cost per case of untreated PID ($3,202) and epididymitis ($313).[46,48]

In addition to the direct medical benefits of testing, we also estimated the benefits from the reduced transmission of chlamydia and gonorrhea in the population, using published formulas that assume that each infection treated (in both women and men) will result in 0.5 fewer cases in the population.[44] For this, we relied on published estimates of the average cost per STI case. The cost per case of chlamydia ($197) was calculated by averaging the cost per case for women ($364) and for men ($30)[46] and was applied to the estimated number of prevented infections. The average lifetime cost per case of gonorrhea was calculated at $217, again by averaging the cost per case for women ($354) and for men ($79).[46]

Finally, we estimated the number of HIV infections prevented by treating individuals infected with chlamydia or gonorrhea before they contracted an STI-attributable HIV infection. We used published formulas assuming that the average numbers of new HIV cases attributable to a new case of chlamydia and gonorrhea are 0.0011 and 0.0007, respectively, and that the treatment of these infections would reduce by one-fourth (multiplying by 0.25) the time frame in which an STI-attributable HIV transmission is possible; and we adjusted for any overlap in the sex-partners of those clients being treated (multiplying by 0.75).[44]

To calculate the percentage of averted costs that would have been paid from public sources (primarily Medicaid) for both chlamydia and gonorrhea treatment, we first distributed the averted costs according to the percentage of Title X clients in 2 income groups (<100% or 100% to 249% of the federal poverty level). We then used data from the 2008-2010 ACS to determine the percentage of women aged 15 to 44 enrolled in Medicaid or other public programs (eg, Medicare or Indian Health Service) for each of those 2 income groups[49] and applied those percentages to the averted costs. Nationally, an estimated one-third of the averted costs for chlamydia and gonorrhea sequelae were public.

HIV Testing

HIV testing is often provided during family planning visits and is offered at 92% of health centers that provide publicly supported family planning services.[35] It is a preventive care service for partners of individuals who learn they are HIV positive, because it leads to less risky behavior after a positive test result and reduced infectivity (via earlier entry into treatment for people living with HIV),[13] both of which significantly decrease transmission.

We started with state-level data specific to Title X–supported family planning centers[25] on the numbers of HIV tests performed on each female and male contraceptive client, and on the numbers of positive HIV tests for all those tested. Because the number of positive HIV tests each year was small, we combined data from 2010, 2011, and 2012[50,51] to calculate positivity ratios. Then we adjusted these state-level rates by sex, using data on HIV testing in health care settings from the CDC. The positivity rate for males between 2008 and 2010 (the most recent 3 years available) was 3.33 times that for females.[52,53]

Next, we applied the HIV testing rates and positivity rates to state-level estimates of female clients at publicly funded health centers in 2010 (both Title X and non–Title X) and to national-level estimates of female Medicaid recipients who received contraceptive services from private physicians that year.[3] We also applied them to state-level estimates of male health center clients, assuming that the same ratio of male to female clients found at Title X centers would apply in non–Title X centers; we did not estimate any male clients served by private doctors. We then adjusted these numbers to apply only to those women and men who would be expected to forgo contraceptive and related STI services in the absence of publicly funded care (73% of current female clients in each provider setting and 100% of male clients). We further adjusted the number of positive test results by multiplying the totals for each state by 0.63 to account for individuals who already knew they were HIV positive or did not return for their test results; the adjustment was based on an estimate from Holtgrave.[20]

To estimate the impact of the positive test results, we applied a rate of 7.8 transmissions averted per year per 100 persons newly aware of their serostatus, based on an estimate from Hall and colleagues accounting for the reduction of risky behavior and of infectivity after receiving treatment.[19] The preventive effects of learning about one's serostatus do

not last for merely 1 year, however. In their study of a publicly funded HIV testing program, Hutchinson and colleagues assumed that in the absence of that testing program, patients would receive an HIV test from another source an average of 3 years later.[22] We applied that assumption to our own estimates for testing received through publicly funded family planning by multiplying the annual number of HIV infections averted by 3.

To estimate the public-sector cost savings from averted HIV infections, we started with an estimate of the total lifetime medical costs associated with HIV. Farnham and colleagues reported a cost of $330,000 in 2011 dollars, discounted by 3% annually to the year of infection.[18] We applied that figure to the state-level numbers of HIV cases averted to arrive at the total cost to society. Finally, we applied to those state-level savings Holtgrave and colleagues' estimation that 75% of HIV treatment costs nationally are paid for with public dollars.[21]

Cervical Cancer Testing and Prevention

Although the incidence and mortality of cervical cancer have declined in recent years, more than 12,000 women were diagnosed with the disease in 2009, and about 4,000 died from the disease that year.[54] The direct annual health care costs for screening, treating, and managing abnormalities related to cervical cancer and cervical dysplasia in the United States are estimated to be as high as $4.6 billion.[55] Because family planning providers play an important role in identifying and reducing the risk of cervical cancer, in this analysis, we examined 2 related forms of care: Pap and HPV testing, and HPV vaccination.

Pap and HPV Testing. For decades, Pap tests have been used to identify abnormal cervical cells, facilitating early and effective treatment. Now it is common practice to "co-test" with an HPV test to detect for viral strains associated with cervical cancer. Our analysis determined the direct medical benefits and cost savings that accrue from cervical cancer testing of publicly supported clients. The conceptual premise for these benefits is that testing enables the early identification of HPV-attributable abnormal cells, precancer, and cervical cancer and thus the early (and less costly) treatment and prevention of more serious diagnoses and death.

To calculate these benefits, we began by determining the number of publicly supported clients receiving a Pap test. We used the proportion of unduplicated clients who received a Pap test at a Title X–supported health center in 2010[25] as a proxy for all public clients. We determined the ratio of women tested to all women served at the state level and then applied, by state, that ratio to the total number of public clients served at Title X and non-Title X health centers, who would be expected to forgo services in the absence of publicly funded care (73% of current clients). We also applied the national-level ratio to the number of female Medicaid recipients receiving family planning services from private providers.[3] Thirty-one percent of all clients were tested for cervical cancer and its precursors.

The next step was to calculate the number of cervical cancer cases and deaths averted by testing. We used data from Mandelblatt and colleagues[56] on the number of cases and deaths that would occur without testing and under various testing scenarios, including Pap testing only and both Pap and HPV testing, in which women are tested every 3 years from ages 20 to 65 and receive a maximum of 16 tests. By comparing the testing scenarios with the no-testing scenario, we were able to determine the number of cases averted in each scenario. These scenarios were chosen because of their similarity to the testing recommendations that were current at the time of this analysis.

We thus were able to produce ratios of cancer cases averted (148 cases per 100,000 women for Pap testing only and 165 for Pap and HPV testing) and deaths averted (87 per 100,000 women for Pap testing only and 94 for Pap and HPV testing) for 1 year of testing. We applied these ratios to the proportions of all publicly funded clients who would have received the Pap-only testing regimen and the co-testing regimen (59% and 41%, respectively, based on information from the 2010 Survey of Clinics Providing Contraceptive Services[35,57]) to get the number of cancer cases and deaths averted. To calculate the cost savings from these tests, we multiplied the number of cancer cases averted by the per-case cost to treat cervical cancer. Costs were calculated from Chesson and colleagues[58] ($38,800) and discounted at 3% per year to account for the average number of years between testing[59] and cervical cancer diagnosis (23),[60] which resulted in a final discounted 2010 per-case cost of $19,692.

Finally, we determined the proportion of these total cost savings attributed to the public sector by estimating the proportion of women

diagnosed with cervical cancer who were covered by public insurance, stratified by age at cancer incidence. Specifically, we used the 2008-2010 ACS to identify state-level proportions of women with Medicaid, Medicare, or Indian Health Services coverage by age group.[61] We multiplied that proportion for each age group by the national-level proportion of total cancer diagnoses for women in that age group[60] and then summed the results for each age group to yield state-level and national-level totals. Nationally, an estimated 28.9% of cervical cancer costs were public costs. Finally, for each state, we applied the result to total cost savings to arrive at public-sector cost savings.

HPV Vaccination. Vaccination against HPV has become an essential component of reproductive health care. Because HPV is responsible for almost all cases of oncogenic dysplasia of the cervix, the 2 vaccines currently on the market could significantly reduce the incidence of cervical cancer, as well as other HPV-attributable cancers of the vulva,[62] vagina, anus/rectum, and oropharynx.[63]

For this analysis, we estimated the direct medical benefits and cost savings that accrue from HPV vaccinations administered to women at publicly funded family planning visits. We began by determining the number of HPV vaccine injections administered during family planning visits at publicly funded centers. We used data from the Planned Parenthood Federation of America's annual report[26] to estimate the ratio of vaccine injections administered to all clients (0.014), and used that as a proxy for the ratio of all female clients receiving publicly supported care who would have forgone care in the absence of publicly funded services (73% of current clients). (Earlier research indicates that similar proportions of Planned Parenthood clinics, health departments, and federally qualified health centers provide the HPV vaccine.[57])

A complete vaccination sequence entails 3 injections. We converted the number of injections to the number of individuals vaccinated based on National Immunization Survey data on the proportion of women vaccinated by the number of vaccine doses received: Of clients vaccinated at a public facility, 46% received at least 3 doses, 32% received 1, and 22% received 2.[64]

Virtually all HPV vaccines distributed in the United States are quadrivalent, meaning that they are designed to prevent 4 types of HPV, including types 16 and 18, which cause 70% of cervical cancers. Because the quadrivalent vaccine has a 99% efficacy in preventing cervical precancers in women not previously exposed to HPV, we applied that

efficacy rate to women who received 3 doses.[65,66] We discounted the efficacy rate by a conservative 10% per dose missed, for an estimated 2-dose efficacy of 89%, and a 1-dose efficacy of 80%. These estimates are in line with the literature, which indicates that 2 doses might be nearly as effective as 3 and that receiving 1 or more doses is 82% effective.[67-69]

These estimated efficacy rates were based on the assumption that vaccinations are given to 12-year-old girls who have not yet become sexually active. In reality, however, some girls are vaccinated after they have become sexually active and thus already might have been exposed to HPV. Therefore, we adjusted the efficacy rates by first multiplying the percentage of vaccines administered to women of each year of age up to 26 (the oldest age for which the vaccine is recommended) by an age-specific vaccine efficacy adjustment factor published by Chesson and colleagues.[70,71] We then summed these products to get 1 adjustment proportion.

Next we obtained an estimate of the proportion of women who would have contracted HPV and experienced selected medical sequelae—abnormal Pap tests, precancerous lesions, and cervical cancer—over their lifetime had they not been vaccinated. To do so, we calculated the difference between published estimates of the number of cases that would occur in nonvaccinated women minus the number of cases in vaccinated women. For abnormal Pap tests, precancerous lesions, and cervical cancer, these differences were 50,000, 10,000, and 500 cases per 100,000 women vaccinated, respectively.[72] We applied these rates to the population of vaccinated women. Using the rate of 200 deaths per 100,000 women vaccinated, we also calculated the number of women who would have died from cervical cancer within 5 years of receiving a cancer diagnosis.[72]

We then calculated the number of other cancer cases averted by vaccination using published data[46] on the annual incidence of HPV-attributable vulvar, vaginal, anal/rectal, and oropharyngeal cancer in the United States. To get the absolute number of noncervical cancer cases averted among women receiving public services, we calculated the ratio of annual incidence of each HPV-attributable cancer to the annual incidence of cervical cancer. For vulvar cancer, this ratio was 1,560 vulvar cancer cases to 11,370 cervical cancer cases. For vaginal, anal/rectal, and oropharyngeal cancers, the ratios were 460, 2,770, and 1,450 cases to 11,370 cervical cancer cases. We then multiplied each ratio by the

absolute number of cervical cancer cases averted in women receiving public services.

The per-case costs of treating cervical dysplasia and precancerous lesions were estimated based on a study of administrative and laboratory records that are related to HPV health care costs from 2002 and that account for false positives.[73] We adjusted the costs to 2010 dollars and then discounted them 3% annually to account for the average number of years between vaccination and diagnosis of dysplasia and precancer (12 and 7, respectively). Data on median age at vaccination came from a large national network of family planning centers, and the median age at each diagnosis was calculated based on the diagnosis rate by age for each diagnosis.[74] The resulting costs were $690 per case of dysplasia and $1,863 per case of precancer.

To calculate the cost to treat cervical cancer, we started with the same 2010 estimate of $38,800[58] used in the Pap and HPV testing analysis. We discounted the cost 3% per year to account for the average number of years between vaccination and cervical cancer diagnosis (28),[60] which resulted in a figure of $16,732. Similar calculations were made to determine the cost of treating cases of other HPV-attributable cancers, discounting the time between the average age at vaccination and the median age at diagnosis for each cancer type ($6,404 per case of vulvar cancer, discounted by 44 years; $7,366 per case of vaginal cancer, discounted by 44 years; $11,263 per case of anal/rectal cancer, discounted by 40 years; and $12,889 per case of oropharyngeal cancer, discounted by 41 years).

Finally, we calculated the proportion of these averted costs that would have been public costs. For dysplasia and precancerous lesions, we assumed that the proportion borne by public funding was equal to the proportion of women who have public insurance. For cervical cancer, we used the proportion of women diagnosed with cervical cancer who were covered by public insurance, stratified by age at cancer incidence. We used a similar approach to determine the public cost of treating other HPV-attributable cancers. These estimates were calculated at the state level and then totaled to produce national estimates of 28.0% for precancerous lesions, 28.9% for cervical cancer (which is the same proportion used in the Pap and HPV testing analysis), 60.6% for vulvar cancer, 60.4% for vaginal cancer, 46.1% for anal/rectal cancer, and 48.5% for oropharyngeal cancer.

Extended Cost Savings From Averting Unplanned Births

As indicated earlier, publicly funded contraceptive services helped US women prevent an estimated 2.2 million unintended pregnancies in 2010, 1.1 million of which would have resulted in an unplanned birth.[3] The detailed methodology for estimating unintended pregnancies averted has been described elsewhere,[24] so we offer only a brief summary here. Alternative estimates of unintended pregnancies averted are given in the following sensitivity analyses. Our estimates are based on a comparison of the actual mix of contraceptive methods used by current clients of publicly funded providers with a hypothetical mix of methods that we expect these women would use in the absence of such services.

The hypothetical method-mix scenario was based on the contraceptive behavior of sexually active women who were not trying to get pregnant but who did not visit a publicly funded family planning provider in the prior 12 months or who visited a private doctor and paid for that visit themselves. These women were of similar age and income as women using publicly funded services (ie, were at risk for unintended pregnancy and either younger than 20 or aged 20 to 44 and under 250% of poverty), were eligible for publicly funded care and in need of contraceptive services to prevent an unintended pregnancy, but did not receive any publicly funded contraceptive care in the previous year (though they may have received such care at an earlier date).

For each group, we estimated the number of unintended pregnancies that would be expected over a 1-year period by combining the distribution of methods used and the failure rates of each method (using subgroup-specific data when available, broken down by age, marital status, racial and poverty status). (Our method failure rates were further adjusted to compensate for the difference between typical first-year failure rates and actual rates of failure among contraceptive users who may have used their method for longer or shorter durations. The basis for this adjustment is a comparison of the number of pregnancies expected among all current contraceptive users and the actual number of pregnancies for US contraceptive users in 2008.)

Out of 1,000 actual users of publicly funded contraceptive services 62 would have had an unintended pregnancy; in our hypothetical scenario, 350 per 1,000 would have had an unintended pregnancy. Subtracting the

former from the latter resulted in the number of unintended pregnancies (288) that are prevented per 1,000 users of publicly funded family planning care. We then applied this ratio to the numbers of contraceptive clients served by publicly funded centers in 2010 and to the data on numbers of Medicaid recipients receiving contraceptive services from private doctors to arrive at 2.2 million unintended pregnancies averted. These were classified according to births, abortions, and miscarriages based on the 2008 distribution (for adult women and teens separately) of unintended pregnancies by outcome.

The public cost savings of preventing unplanned births for 2010 were originally estimated by Frost and colleagues[3] for all unplanned births to women eligible for Medicaid-covered maternity care and included costs for prenatal care, delivery, postpartum care, and 12 months of infant care. We built on those findings by adjusting the number of unplanned births included in the cost analysis and by including the direct medical costs paid by Medicaid for care of children for months 13 to 60.

First, we reviewed the assumption that all averted births would result in public savings. Other researchers have instead assumed that at least some births would be delayed, not averted altogether, and because such births would eventually end up as costs or public costs, they should not count as current savings.[10,11,75] We felt that such an adjustment was important to incorporate into this analysis, especially because we are considering public cost savings that extend beyond 1 year. To make this adjustment accurately, however, it is necessary to differentiate 4 types of averted unplanned births: unwanted births, mistimed births that would have contributed to "extra" births (ie, those resulting in women having a higher completed parity than they would have had otherwise), mistimed "nonextra" births that would have been privately funded if they had been delayed until the woman wanted the birth, and mistimed "nonextra" births that would have continued to be publicly funded even if they had been delayed until the woman wanted the birth.

Next we describe our methodology for categorizing into the 4 groups the unplanned averted births among publicly funded family planning clients. Then we explain our estimations of the public cost savings for unplanned averted births that fall into the first 3 categories. Averted births that fall into the fourth category do not represent public savings, as their costs would still be covered by public funds.

Unwanted Births. Of the unplanned births to women most likely to be using publicly funded family planning services (ie, all teens, plus adult women under 250% of poverty), 37% are unwanted and 63% are mistimed.[33]

"Extra" Births. Using the 2006-2010 NSFG, we compared the mean parity for women aged 30 and older with at least 1 mistimed birth with that for same-aged women with no mistimed births.[33] Because this comparison assumes that both groups of women have the same overall desired parity and that some groups of women may be more likely than others to have a mistimed birth and to desire more children, we compared the overall parity for women with and without mistimed births within each racial and ethnic group and estimated separately for each group the differences in overall parity between women with and without mistimed births.

We then recalculated the average difference, weighting the results according to the racial and ethnic distribution of women served at Title X–funded health centers.[25] The difference in overall parity between women with and without mistimed births using this methodology and adjusting for race and ethnicity was 0.80 births. By comparing this excess parity with the total average number of births to women with mistimed births (2.89), we estimated that 28% of mistimed births could be considered "extra."

Mistimed Births Not Paid for With Public Funds. Using the 2006-2010 NSFG, we estimated the actual number of years in which all mistimed births had occurred too soon.[33] We made separate estimates for teen births and adult births and also weighted the results by race and ethnicity using the distribution of women served at Title X centers.[25] On average, women reported that the mistimed births they had had as a teen had occurred 4.7 years too soon and those they had had as an adult had occurred 2.4 years too soon.

To estimate how many women with an averted mistimed birth would have been eligible for Medicaid maternity care had that birth been delayed (4.7 years for teens and 2.4 years for adults), we looked at the percentage of births paid for by Medicaid according to the woman's age at birth (in 2-year increments) and to whether the birth was planned or unplanned. For teens, we looked at payment for first births, because 92% of mistimed births to teens are first births,[33] and for adults, we looked at payment for all births.

Specifically, we compared the percentage of *unplanned* first births for 2 age groups of teens (<18 and 18-19) paid for by Medicaid with the percentage of *planned* first births paid for by Medicaid for women who were 4.7 years older than those aged <18 and 18-19 and then calculated the percentage change between these 2 proportions. Partial years were interpolated between age groups, assuming the change over the interval was constant. The average for all teens, adjusting for the age distribution of teens served at Title X centers, was 33%.

We used a similar process for 8 two-year age groups of adults between ages 20 and 35, comparing the percentage of unplanned births that were paid for by Medicaid with the percentage of planned births that were paid for by Medicaid for women 2.4 years older. The age-adjusted average decline in use of Medicaid for all adult women was 44%.

By applying these adjustments to the 1.1 million unplanned averted births in 2010, we estimated that 37% (409,000) were unwanted births, all of which could have incurred public savings; 17% (193,000) were "extra" births, all of which could have incurred public savings; and 46% were "nonextra" mistimed births (on average, such births occurred to women 2.9 years too early). Of the "nonextra" mistimed births, 4 in 10 (19% of all unplanned births, or 209,000) would not have been publicly funded if they had occurred at the desired time, and all of them could have incurred public savings. The other 6 in 10 (27% of all unplanned births, or 285,000) would still have needed to be covered by public funding even if they had occurred at the desired time; therefore, none of these would have incurred public savings.

Overall, we considered 811,000 unplanned averted births as potentially contributing to public cost savings. Of these, an estimated 94% (762,000) would have been to women currently eligible for Medicaid maternity care (a proportion that varies by state).[24]

The public cost per birth for the first 12 months of maternity and infant care varied by state and was previously estimated to be $12,770 nationally, unweighted.[3] To estimate the public cost of medical care for children aged 13 to 60 months, we analyzed state-level data from the Medicaid Statistical Information System (MSIS)[76] and found that the annual amount paid by Medicaid per eligible child was about $2,300 nationally. We then applied 3 adjustments to the state-level public cost per child and summed the results across 4 years. First, we reduced the number of eligible children each year to account for changes in family income; this was based on an analysis of the ACS that estimated

the proportionate drop in Medicaid coverage among children by single years of age.[61] Using the proportion of infants covered by Medicaid as the base, 94% were covered at age 1, 91% at age 2, 88% at age 3, and 85% at age 4. Second, we discounted costs 3% annually. Finally, we made an adjustment to account for multiple births by drawing on US vital statistics data: Some 3.95 million children were born in 2011 through 3.88 million deliveries, for a ratio of 1.018 children per birth.[77] With these adjustments, we estimated the final unweighted national cost per birth for 4 years of public medical care to be $7,950. After multiplying the state-level costs per birth by the number of births averted and summing across states, we arrived at our estimates of the total medical cost savings from unplanned births averted.

Extended Cost Savings From Averting Unplanned Pregnancies Ending in Miscarriage and Abortion

Publicly funded contraceptive services also helped women avoid 360,000 miscarriages and 760,000 abortions in 2010.[3] The cost savings estimated by Frost and colleagues did not account for these averted outcomes; we made those estimates here.

For miscarriages, we first applied the estimate from Frost and colleagues of the proportion of births averted by publicly funded contraceptive services that would have been born to women currently eligible for Medicaid maternity care (94% overall, varying by state).[24] Next, because state-level estimates for the public cost per miscarriage were not available, we derived our own estimates. We did so by dividing a national estimate of the public cost of miscarriage (including ectopic pregnancies) from Monea and Thomas[10] ($1,252, after adjusting for inflation) by Frost and colleagues' estimated national average of the public cost per birth for the first 12 months of maternity and infant care ($12,770)[24] and then applying the result (9.8%) to Frost and colleagues' state-level per birth cost estimates to arrive at state-level estimates for the public cost per miscarriage. We assumed that state-level costs for miscarriage effectively varied in the same way as state-level costs did for births. We then multiplied those state-level costs per miscarriage by the number of Medicaid-funded miscarriages averted and summed across states.

The estimates for abortions were complicated because Medicaid coverage of abortion is barred by federal law (except in the rare cases of

rape, incest, or endangerment of the woman's life), but as of 2010, 17 states had policies requiring them to use state funds to pay for abortions for women enrolled in Medicaid.[23] To estimate the proportion of averted abortions in each state that would have been paid for with public funds, we divided the state-level number of publicly funded abortions in 2010 from Sonfield and Gold (181,000 nationally)[23] by the total state-level number of abortions to state residents in 2008 (1.2 million nationally),[78] which was the most recent available year. The result—the proportion of abortions that were publicly funded—was 15% nationally but varied from 0% in many states to more than 40% in several. For the several states for which data were not available, we used the average proportion among states with similar abortion-funding policies. These are conservative estimates because they include abortions for all women in the state, rather than only those for the lower-income women who used publicly supported family planning, but state-level breakdowns of abortion incidence by income were not available.

We calculated state-level estimates for the public cost per abortion from Sonfield and Gold[23] by dividing each state's public expenditures for abortion in 2010 by its reported number of publicly funded abortions that year ($376 nationally). For those several states for which data were not available, we used the average cost per abortion in states with similar abortion-funding policies. We then multiplied together the state-level estimates (number of averted abortions, proportion paid for with public funds, and public cost per abortion) and summed them across states.

Net Savings

All estimates of the gross cost savings attributable to the benefits described in each of the preceding sections were then summed together and compared with the estimated public cost to provide publicly funded contraceptive care in 2010 (previously estimated at $2.2 billion).[3]

Results

In 2010, nearly 9 million women received contraceptive services from publicly supported providers in the United States,[3] which represents more than one-third of the 25 million US women who receive contraceptive services each year.[59] Without access to subsidized family planning

visits, these women would have experienced a host of additional adverse health outcomes with far-reaching consequences for themselves and their families. In addition, these outcomes would have cost the government far more than it paid to provide the women with family planning and related preventive services. Approximately 75% of the measured health benefits and cost savings reported here are attributable to the services that women received from publicly funded health centers, and more than half are attributable to Title X–funded centers.

Tables 2 and 3 present national-level estimates for all averted outcomes and cost savings according to provider type. Our summary here focuses on estimates for the overall publicly funded family planning effort. (State-level estimates for many of these indicators are presented in supplementary Tables 1, 2, 3, and 4, available online at http://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12080/abstract).

Benefits From Contraceptive Use

Women who rely on publicly supported providers for their family planning care use a more effective mix of contraceptive methods than they would if they did not have these subsidized services. In addition, publicly funded family planning services allow women to better plan the timing and spacing of the births they do want, which leads to better health outcomes for themselves and their infants. Of the estimated 1.1 million unplanned births avoided by women receiving publicly funded contraceptive care in 2010, an estimated 287,500 would have been closely spaced, and 164,190 would have been premature, LBW, or both (Table 2).

Benefits From STI Testing

During family planning visits at publicly funded providers, women and men receive a range of other related preventive care services. Nearly half (49%) of female clients, some 4.4 million in 2010, received a chlamydia test; 49% were tested for gonorrhea; and 19% received an HIV test. STI testing also was common among the much smaller group of men who made family planning visits at publicly funded providers. Without access to publicly funded contraceptive services in 2010, an estimated 3.2 million women (73%) would have forgone chlamydia or gonorrhea testing, which would have resulted in tens of thousands of undetected and untreated STIs.

Table 2. Health Benefits From Contraceptive and Related Noncontraceptive Services Received During Family Planning Visits at Publicly Funded Providers, According to Provider Type, National Summary, 2010

Adverse Health Outcomes Averted	Publicly Funded Health Centers		Private Doctors Serving Medicaid Recipients	All Publicly Supported Providers
	All	Title X–Funded		
From contraception:				
Unintended pregnancies	1,677,200	1,181,500	552,700	2,229,900
Unplanned births	831,700	585,900	274,100	1,105,800
Abortions	572,200	403,100	188,600	760,800
Unplanned births after short interpregnancy intervals (<18 months IPI)	216,240	152,310	71,260	287,500
Unplanned preterm/low birth weight (LBW) births	122,820	87,110	41,370	164,190

Continued

Table 2. *Continued*

Adverse Health Outcomes Averted	Publicly Funded Health Centers: All	Publicly Funded Health Centers: Title X–Funded	Private Doctors Serving Medicaid Recipients	All Publicly Supported Providers
From STI testing:				
Chlamydia infections	76,680	53,450	22,420	99,100
Gonorrhea infections	12,440	8,810	3,790	16,240
HIV infections	350	250	65	410
PID cases	9,910	6,920	3,260	13,170
Ectopic pregnancies	850	590	280	1,130
Infertility cases	1,660	1,160	550	2,210
From Pap and HPV testing:				
Cervical cancer cases	2,710	1,900	890	3,600
Cervical cancer deaths	1,570	1,100	520	2,090
From HPV vaccination:				
Abnormal cervical cell cases	5,640	3,970	1,860	7,500
Precancer cases	1,130	790	370	1,500
Cervical cancer cases	61	43	20	81
Cervical cancer deaths	15	11	5	20
Other HPV-attributable cancer cases	33	24	11	44

Table 3. Cost Savings From Contraceptive and Related Noncontraceptive Services Received During Family Planning Visits at Publicly Funded Providers, According to Provider Type, National Summary, 2010

Cost Savings (in 000s of dollars)	Publicly Funded Health Centers		Private Doctors Serving Medicaid Recipients	All Publicly Supported Providers
	All	Title X–Funded		
Maternity and birth-related costs to 60 months	11,072,327	7,805,411	4,162,828	15,235,155
Miscarriage and ectopic pregnancy costs	296,630	209,195	112,755	409,385
Abortion costs	33,272	23,228	10,630	43,902
Chlamydia and gonorrhea testing	24,886	17,418	7,663	32,550
HIV testing	76,994	54,968	13,539	90,533
Pap and HPV testing	15,416	10,807	5,080	20,496
HPV vaccination	1,621	1,142	534	2,156
Total gross savings	11,521,147	8,122,170	4,313,030	15,834,177
Family planning costs	1,640,731	1,140,753	594,005	2,234,736
Total net savings	9,880,416	6,981,417	3,719,025	13,599,441

The identification and treatment of these infections prevented future infections among the partners of clients and resulted in direct health benefits for the clients tested. By reducing their transmission to partners, an estimated 99,100 chlamydia infections, 16,240 gonorrhea infections, and 410 HIV infections were prevented. And among the clients who tested positive for chlamydia or gonorrhea and were treated, an estimated 13,170 cases of PID were avoided, which would have resulted in 1,130 ectopic pregnancies and 2,210 women becoming infertile (Table 2).

Benefits From Cervical Cancer Testing and Prevention

In 2010, an estimated 59,000 young women received at least 1 dose of the HPV vaccine during family planning visits at publicly funded providers. By vaccinating women before they contracted HPV, publicly funded providers helped them avoid an estimated 7,500 cases of abnormal cervical cells, 1,500 cases of precancer, and 81 cases of cervical cancer. An estimated 20 women avoided dying of cervical cancer, and 44 women avoided contracting other HPV-attributable cancers, such as anal or vulvar cancer (Table 2).

Most women who receive family planning services from publicly funded providers are not, however, vaccinated against HPV, and vaccination does not protect against all high-risk (ie, oncogenic) strains of HPV. Periodic testing therefore remains the standard of care to detect potential cervical cancer. In 2010, an estimated 3.2 million women received cervical cancer testing during a publicly funded family planning visit. In the absence of publicly funded family planning services, an estimated 2.3 million women would have forgone or postponed cervical cancer testing that year. Through this testing, an estimated 3,600 potential cervical cancer cases were identified and treated before the cancer developed, and 2,090 cervical cancer deaths were averted (Table 2).

Cost Savings

For each of the adverse health outcomes averted, we estimated both the total direct medical costs of sequelae attributable to those outcomes and how much of those costs would have been paid for by public funds, primarily Medicaid and Medicare. Only public costs and savings are presented here. As described earlier, and following the methodology of prior studies, our estimates include only the public cost savings for

services provided to clients who, in the absence of publicly supported care, would have used a less effective mix of contraceptive methods or would have delayed obtaining other preventive care services. We did not estimate the gross benefits or savings that would have accrued if the clients had stopped using *all* contraceptive methods or had never received any of the other preventive care services.

The biggest share of averted public costs was attributed to contraceptive services, which help prevent unplanned pregnancies and their associated costs (Table 2). Without such services, an estimated additional $15.2 billion would have been spent in 2010 on Medicaid-covered maternity and infant care and on publicly funded medical care for children aged 13 to 60 months. An estimated additional $409 million would have been spent on Medicaid-covered care for miscarriages (including ectopic pregnancies), and $44 million for abortion care (almost all of which would have been spent in the 17 states that use their own funds to pay for abortions for Medicaid enrollees).

In 2010, an estimated $123 million in cost savings was attributable to STI and HIV testing during family planning visits: Specifically, without chlamydia and gonorrhea testing, an estimated additional $33 million would have been spent on treating PID or epididymitis in women and men with untreated chlamydia or gonorrhea infections or on treating clients with STI-attributable HIV infections, and without HIV testing, an estimated additional $91 million would have been spent on HIV care for clients' partners who contracted the virus because the clients did not know their serostatus. Finally, an estimated $23 million in cost savings was attributable to HPV sequelae being identified and treated earlier because of testing for cervical cancer ($20.5 million) or prevented because of vaccines ($2.2 million).

Together, publicly supported services averted an estimated total of $15.8 billion in gross public costs in 2010. Subtracting the total public cost to provide family planning and related sexual and reproductive health services that year—$2.2 billion—results in an estimated total net savings of $13.6 billion. Of the total net savings, an estimated $9.9 billion was attributable to publicly funded health centers—$7 billion to Title X–funded centers alone—and $3.7 billion was attributable to the Medicaid-funded family planning services provided by private physicians. Overall, by providing clients with the services they want and need to avoid unintended pregnancies and to protect their health against reproductive cancers and STIs, these services saved taxpayers an estimated $7.09 for every public dollar spent.

Sensitivity Analyses

All these findings rely on a wide array of parameters drawn primarily from earlier published research. Although we attempted to choose the best parameters available, in many cases we could have chosen other data and assumptions as part of a given estimate. As reported earlier, we often chose those indicators that produced conservative estimates, so to test these choices further, we performed a series of sensitivity analyses.

Cost Savings. Our estimates of net cost savings from publicly funded family planning and related services depend primarily on 4 factors: (1) the rate of unintended pregnancies averted per 1,000 contraceptive clients; (2) the adjustment for mistimed births that would not be cost saving; (3) the cost per Medicaid-funded birth (including maternity care and care through 60 months of age); and (4) the cost per family planning client. We tested changes in all 4 of these parameters. (Although the savings from STI testing and cervical cancer prevention services do not have a major impact on net cost savings, we did test changes to the key parameters used in our estimates of those benefits.)

First, we performed threshold tests to determine how high or low these variables would have to be for the net savings to equal zero. We found that for these services not to produce any net savings, the number of unintended pregnancies averted would have to drop from 288 per 1,000 contraceptive clients[3] to 31 per 1,000. Alternatively, the total cost per Medicaid-funded birth would have to drop from a weighted national average of $19,902 to $2,137, or the cost per family planning client would have to increase from a weighted national average of $251 to $1,776. None of these scenarios is remotely feasible.

We tested several other extreme scenarios. Even using the highest cost per family planning client ($512 in Alaska) and the lowest cost per birth ($5,848 for delivery and months 1 to 12 in New Hampshire, plus $3,260 for months 13 to 60 in Idaho)—a scenario that ignores the fact that all health care costs vary substantially by state—the results would still be an estimated savings of $1.66 for every dollar spent. Similarly, even if we assumed that all mistimed births would not be cost saving and therefore limited the savings to unwanted births, publicly funded family planning and related services would still save an estimated $3.71 for every dollar spent.

Finally, we tested the impact on cost savings from the use of alternative scenarios for the rate of unintended pregnancies averted

per 1,000 contraceptive clients. Researchers (Foster and colleagues) assessing California's Family PACT program have produced several of the most robust cost-benefit studies related to family planning care, drawing on a wealth of individual-level data that are not available nationally.[9,11,12,79] In our test, we used both their base scenario estimate of the rate of unintended pregnancies averted (287 per 1,000 clients, estimated using the method mix of clients before their first Family PACT visit) and their conservative alternative scenario for this rate (80 unintended pregnancies averted per 1,000 clients, estimated using the method mix reported by clients in an exit interview asking what contraceptive method they would use without this program). Since their base scenario rate is almost identical to our rate, 288, our cost savings are almost identical as well. Their alternative scenario rate is roughly one-quarter of both their and our base scenario rate and returns proportionately lower cost savings, but would still result in an estimated $2.16 saved per dollar spent. Finally, we tested the scenario used both by Foster and colleagues[11,79] and by Guttmacher in past studies,[5,6,7] which assumed that all women would use no contraceptive method in the absence of publicly funded services. In this scenario, the number of unintended pregnancies averted per 1,000 clients rose to 828, and the estimated cost savings increased to nearly $20 saved for every dollar spent.

STI Testing. For the chlamydia and gonorrhea testing analysis, we tested the impact of changes to 2 parameters that were known to vary widely. The reported incidence of both chlamydia and gonorrhea among populations tested by federally funded clinics varies widely from state to state; we tested the impact of using either the highest state incidence (10.2% in South Carolina for chlamydia and 2.8% in Wisconsin for gonorrhea) or the lowest state incidence (3.43% for chlamydia in Vermont and 0.04% for gonorrhea in Wyoming).[40,41] A recent review highlighted the difficulty of estimating how many untreated STI cases would ultimately progress to PID.[47] We tested a 50% variance around the average proportions used for both chlamydia and gonorrhea. Overall, the impact was greater when we varied the incidence of each STI based on the states' high and low incidence levels. The number of cases of chlamydia and the savings fell by 40% with the lowest state incidence and rose by 75% with the highest state incidence. The number of cases of gonorrhea and the cost savings fell by 96% using the lowest state incidence and rose by 182% using the highest state incidence.

For the HIV testing analysis, we tested 2 parameters that relied on assumptions from the literature, rather than on actual data. First, we tested the assumption from Hutchinson and colleagues that individuals would be tested, on average, 3 years later in the absence of publicly funded services.[22] Changing that parameter to 2 years would reduce the number of HIV infections averted by this testing and the resulting cost savings by one-third; increasing it to 4 years would increase both results by one-third. Second, we tested the assumption from Holtgrave and colleagues that 75% of HIV treatment costs are paid for with public dollars (which is a rough, national estimate rather than the state-specific estimates used in other parts of this analysis).[21] We replaced that parameter with the proportion of chlamydia and gonorrhea costs paid for with public dollars (data that vary by state but that exclude many avenues of public funding, such as the federal Ryan White program), which averages 33% nationally, and found that cost savings from HIV testing would total $43 million, slightly under half the base scenario.

Cervical Cancer Prevention. For the HPV vaccine analysis, we changed 2 parameters based on available data. We used the low and high ends of the confidence intervals around the vaccine efficacy adjustment factors by age (a measure of the extent to which women of different ages were exposed to HPV before being vaccinated) published by Chesson and colleagues.[71] We also changed the efficacy of 1 and 2 doses of the vaccine. For the low end, the effectiveness of 1 dose was replaced by the low end of the confidence interval of at least 1 dose from Markowitz and colleagues,[67] and the efficacy of 2 doses was the median of 1 and 3 doses. For the high end, 1 and 2 doses were considered as protective as 3 doses, as concluded by Kreimer and colleagues.[68] For the Pap and HPV testing analysis, we changed 1 parameter: the distribution of cervical cancer screening between those who received only a Pap test and those who received a Pap plus an HPV test, in which the low end was based on the proportion receiving each kind of test among Title X clients only and the high end was based on non–Title X clients only.[57] Of these 3 parameters, the only change that resulted in a substantial change in cases averted was the first, the effectiveness adjustment factor. In the low scenario, the number of cases of abnormal cells fell from 7,500 to 3,210, and the number of cases of cervical cancer fell from 81 to 35. In the high scenario, the number of cases increased to 12,160 and 130, respectively. This suggests that exposure to HPV before vaccination can have a noticeable effect on the impact of the vaccine.

Limitations

We tried to use the best available parameters from the literature to model the broader impact of publicly funded family planning services. Nonetheless, many of our assumptions, as well as our data, were deficient in one or more ways. For example, we often relied on data on services provided in Title X health center settings (which cover 53% of all women served by publicly funded providers) and then assumed that such services were delivered similarly in non–Title X settings. Although this assumption is not perfect, we felt that it was reasonable. We looked at both published[59] and unpublished[33] national data on service use by provider type and found that for our target population of women relying on publicly funded care, rates of testing were similar across settings (women served at Title X and non–Title X centers, and Medicaid clients served at private practices) for Pap, HIV, and other STI testing.

In addition, much of our analysis here began with the number of unintended pregnancies prevented by publicly funded services in 2010 estimated by Frost and colleagues.[3] The methodology used in that analysis is subject to potential bias due to unmeasured differences between the comparison group and women currently using publicly funded services, which could mean that the actual contraceptive behavior of women in the absence of publicly funded services would be more or less protective compared with our hypothetical scenario. For example, some of the small subgroup of women who have private insurance, but do not use it for contraceptive services, might do so if their access to public services were eliminated. To address this limitation, we conducted sensitivity analyses, presenting the results using alternative method-mix scenarios.

Although several steps in our analyses may have introduced some errors in our final results, they are the best available assumptions based on the literature, and when in doubt, we erred conservatively. For example, because we lacked actual data on the numbers of all publicly funded family planning clients who tested positive for chlamydia or gonorrhea, or who received treatment for their infection, we used data from other, similar provider settings for this information. We also relied on data from the literature, which are typically derived from cumulative small-scale or targeted studies, to estimate the national percentage of untreated infections that would have resulted in adverse outcomes, as well as the cost of those outcomes. Our HPV vaccine analysis used Planned Parenthood data as a proxy for the proportion of all public clients who received a vaccination, but this is likely not a perfect proxy. Finally, the literature

on the efficacy of receiving an incomplete HPV vaccination series is relatively new but is advancing rapidly. Our assumptions conservatively accounted for the newest literature.

In addition, our analysis did not account for all the health benefits for each service assessed. The HIV testing analysis did not include the health benefits (or any related costs or cost savings) accrued from the early detection of HIV for the HIV-positive individual herself; those benefits would derive from connecting HIV-positive individuals to earlier care and treatment. Nor did this analysis include the benefits from preventing vertical HIV transmission, from mother to infant.

The HPV vaccination analysis did not capture any impact that vaccines may have on noncancerous strains of HPV, although they do protect against some strains that lead to treatable medical conditions, such as genital warts. This analysis also did not account for herd immunity, although some additional benefits are likely. In addition, cervical cancer screening may lead to some unnecessary treatment of cases that would have resolved on their own. But our analysis was based on screening only every 3 years, so it is likely that this would not occur very often. In fact, some agencies even suggest a longer period between screening for some women,[80] so should the recommendations change, the cost-benefit ratio could be higher.

Similarly, our analysis of preterm and LBW births did not attempt to address the fact that by helping women avert such births, publicly supported contraceptive services avert particularly expensive births, which should reduce the average cost of a Medicaid-funded birth. Detailed state-level data on maternity and infant costs would be necessary to assess this impact on average costs and on the overall cost savings that would result.

Finally, we acknowledge that several factors might influence our findings if we updated our analysis for HPV vaccination. For example, once more older women have been vaccinated for HPV, the average age of individuals newly vaccinated will drop, effectively increasing both the efficacy of the vaccine (due to a reduction in prior exposure to HPV) and the resulting cost savings. In addition, advancements in cancer treatment mean that life expectancy may be increasing and death rates decreasing. In future years, the number of deaths averted through Pap testing, HPV testing, and HPV vaccination may decline—which would, of course, be a welcome finding.

Discussion

Helping women and couples prevent unintended pregnancy and thereby take control of their lives and futures is the primary purpose of the US family planning effort. Research has long demonstrated those successes in the form of millions of unintended pregnancies averted. Yet family planning providers, clients, and advocates have always known that the federal and state dollars spent on this effort have a long list of additional health benefits. This analysis, for the first time, provides estimates of a number of these additional benefits. These results are especially timely, as they document the impact of preventive services such as chlamydia and cervical cancer screening that are promoted under the Affordable Care Act (ACA) and are provided routinely during family planning visits.

Nationwide, the estimated 2.2 million unintended pregnancies averted each year include an estimated 287,500 that would have been closely spaced (<18 months IPI) and 164,190 that would have been preterm or LBW. The STI testing provided as part of publicly funded family planning visits prevents an estimated 99,100 cases of chlamydia, 16,240 cases of gonorrhea, 410 cases of HIV, and 13,170 cases of PID that would have led to 1,130 ectopic pregnancies and 2,210 cases of infertility in a single year. Pap tests, HPV tests, and HPV vaccinations provided at these visits prevent an estimated 3,680 cases of cervical cancer and 2,110 cervical cancer deaths annually; HPV vaccination prevents an estimated additional 9,000 cases of abnormal sequelae and precancerous lesions. The services provided at Title X–supported health centers are estimated to account for more than half of all these benefits.

The other main purpose of this analysis was to extend and refine estimates of the public savings accrued through the US family planning effort by including savings over a longer time frame and for more of the services provided and by excluding savings for some mistimed births. Earlier Guttmacher Institute estimates of cost savings from publicly funded family planning care were limited to the immediate costs associated with helping women avoid unplanned births, that is, the cost of maternity care and 12 months of infant care. Most recently, Frost and colleagues[3] found that the gross public savings from these limited benefits were estimated to be $12.7 billion in 2010, or $5.68 for every dollar spent providing contraceptive care. Here we expanded that

window to account for the medical care associated with averted births over 60 months of the child's life. At the same time, we excluded any cost savings from those mistimed births that do not contribute to higher completed parity and that would still be publicly funded, even if delayed until the woman desired the birth. Together, these changes resulted in an additional $2.5 billion in estimated public savings, for an estimated total of $15.2 billion in gross public savings due to averting unplanned births. We also factored in an estimated $453 million in public savings from averting the miscarriages and abortions that would have followed unintended pregnancies. Next, we added in public cost savings accrued from the health benefits derived from chlamydia, gonorrhea, and HIV testing; Pap and HPV testing; and HPV vaccination. Those estimated cost savings were comparatively small, roughly $146 million in 2010. Finally, we subtracted out the estimated $2.2 billion in public costs to provide family planning and related sexual and reproductive health services. All told, we estimate that the national public investment in family planning and related services saved $13.6 billion in 2010, which amounts to $7.09 saved per public dollar spent. Our sensitivity analysis found that although this ratio of cost savings could vary considerably under different scenarios, even the most extreme and unlikely scenarios would still produce substantial cost savings.

Neither the health benefits nor the cost savings estimated in this analysis represent the complete impact of the US family planning effort. For example, our estimates of the cost savings from preventing unintended pregnancies exclude the additional lifetime costs of preterm and LBW births, and they do not account for any unintended pregnancies averted by the contraceptive services provided to male clients. In addition, no benefits have been measured from counseling and education regarding the importance of preconception care and early access to prenatal care, or how to avoid STIs through the use of condoms and safe-sex practices. Nor did our analysis encompass additional common services, such as breast exams and screenings for high blood pressure and intimate partner violence. Similarly, this analysis did not include any estimates for the noncontraceptive health benefits and risks of contraceptive method use, or any related costs or cost savings.

Finally, our analysis did not extend beyond medical benefits. It did not estimate any of the numerous social and economic benefits to women and families that come from the ability to time and space their childbearing, such as greater opportunities to complete an education and participate

fully in the workforce.[81] It did not measure any nonmedical public costs associated with unintended pregnancy, such as food stamps or welfare payments. And it did not include any estimates of indirect cost savings—for example, the cost to society of lost productivity in the workplace or lost tax revenue to government coffers.

These estimates are based only on services provided by publicly funded family planning providers in 2010, well before the implementation of most elements of the ACA. But the importance of providing essential preventive services and of being able to quantify their impact remains relevant, and these results can still be used to demonstrate that impact overall, as well as to illustrate variation among states. As more individuals gain insurance coverage under the ACA, particularly under the law's expansion of Medicaid, the numbers served by publicly funded health centers and by private doctors under Medicaid can be expected to increase as well. And a growing proportion of the costs averted by preventive services can be expected to be paid for by Medicaid and other public dollars. Future work will be needed to monitor the impact of those changes.

In sum, our estimates provide new evidence of the national-level and state-level value of public programs that support family planning and related preventive services. These programs and providers not only help women and couples avoid unintended pregnancy but also make valuable contributions to reducing the incidence and impact of cervical cancer, STIs, infertility, and preterm and LBW births. And by supporting these vital preventive care services, the government also ends up saving many billions of public dollars.

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Supplementary Material

Additional supporting information may be found in the online version of this article at http://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12080/abstract.

Appendix Table 1
Appendix Table 2
Appendix Table 3
Appendix Table 4

Appendix

Table A1. Summary of Medical Cost Estimates and Additional Selected Parameter Values

Parameter	National-Level Value		State-Level	Source
	Females	Males		
Direct medical costs (in 2010 $US), discounted to year of service				
Pregnancy and birth				
Average public cost per birth for:				
prenatal care, delivery, infant care to month 12	12,770	—	√	24
care of the child, months 13-60	7,950	—	√	76
Average public cost per miscarriage	1,252	—	√	[a]11, 24
Average public cost per abortion	376	—	√	[a]23
Sexually transmitted infections				
Average cost per case:				
PID	3,202	—		46
epididymitis	—	313		46
chlamydia	364	30		46
gonorrhea	354	79		46
HIV	330,000	330,000		18
Cancers				
Average cost per case averted from testing:				
cervical cancer	19,692	—		[a]46, 58

Continued

Table A1. *Continued*

Parameter	National-Level Value		State-Level	Source
	Females	Males		
Average cost per case averted by vaccines:				
cervical dysplasia	690	—		[a]73
precancer	1,863	—		[a]73
cervical cancer	16,732	—		[a]46, 58
vulvar cancer	6,404	—		[a]46, 58
vaginal cancer	7,366	—		[a]46, 58
anal/rectal cancer	11,263	—		[a]46, 58
oropharyngeal cancer	12,889	—		[a]46, 58
Medical costs paid for with public funds				
Proportion of costs that are public:				
births and miscarriages	0.94	—	√	[a]24
abortions	0.15	—	√	[a]23, 78
chlamydia and gonorrhea	0.33	0.33	√	61
HIV	0.75	0.75		21
precancer	0.28	—	√	61
cervical cancer	0.29	—	√	61
vulvar cancer	0.61	—	√	61
vaginal cancer	0.60	—	√	61

Continued

Table A1. *Continued*

Parameter	National-Level Value		State-Level	Source
	Females	Males		
anal/rectal cancer	0.46	—	√	61
oropharyngeal cancer	0.49	—	√	61
Other parameters				
Unintended pregnancy and contraceptive use				
Proportion of unplanned births to women <250% federal poverty level conceived <18 months postpartum	0.26	—		33
Proportion of births that are LBW or preterm	0.15	—	√	34
Chlamydia, gonorrhea and their sequelae				
Proportion of clients tested for:				
chlamydia	0.50	0.58	√	25
gonorrhea	0.49	0.58	√	25
Proportion of tested clients who are positive:				
chlamydia	0.06	0.05	√	[a]40
gonorrhea	0.01	0.01	√	[a]41
Proportion of positive clients who are treated:				
chlamydia and gonorrhea	0.97	0.97		42

Continued

Table A1. *Continued*

Parameter	National-Level Value		State-Level	Source
	Females	Males		
Proportion of treated clients who were symptomatic: chlamydia and gonorrhea	0.31	0.31		82
Adjustment to account for women who would be tested without public funding	0.73	—		33
Absolute reduction in probability of sequelae due to treatment:				
chlamydia and gonorrhea, symptomatic cases	0.15	0.02		46
chlamydia and gonorrhea, asymptomatic cases	0.08	0.02		46
Adjustment to chlamydia costs averted to account for gonorrhea coinfection	0.93	0.93		44
Adjustment to gonorrhea costs averted to account for chlamydia coinfection	0.79	0.90		44

Continued

Table A1. *Continued*

Parameter	National-Level Value		State-Level	Source
	Females	Males		
Adjustment to account for reinfection: chlamydia and gonorrhea	0.70	0.70		44
Number of cases of STI averted in population per STI case treated	0.50	0.50		44
Probability of a new case of HIV attributable to chlamydia	0.0011	0.0011		44
Probability of a new case of HIV attributable to gonorrhea	0.0007	0.0007		44
Adjustment for time frame for STI-attributable HIV infections	0.25	0.25		44
Adjustment for partner overlap (heterosexuals)	0.75	0.75		44
Proportion of women with PID who:				
experience pelvic pain	0.19	—		48
experience ectopic pregnancy	0.09	—		48
become infertile	0.17	—		48

Continued

Table A1. *Continued*

Parameter	National-Level Value		State-Level	Source
	Females	Males		
HIV				
Ratio of HIV tests performed per family planning clients served	0.22	0.51	√	[a]25, 50, 51
Proportion of tested clients who are positive:				
HIV (overall)	0.0014	0.0014	√	[a]25, 50, 51
HIV (sex-specific)	0.0010	0.0035	√	[a]52, 53
Adjustment to account for women who would be tested without public funding	0.73	—		33
Adjustment to account for HIV infections previously known	0.63	0.63		20
HIV transmissions averted per 100 persons newly aware of their infection	7.80	7.80		19
Years of transmissions averted from testing	3.00	3.00		22

Continued

Table A1. *Continued*

Parameter	National-Level Value		State-Level	Source
	Females	Males		
Pap and HPV testing				
Proportion of female clients tested	0.36	—	√	[a]25, 33
Adjustment to account for women who would be tested without public funding	0.73	—		33
Number of cervical cancer cases averted per 100,000 women tested:				
Pap-only testing regimen	148	—		[a]56
Pap plus HPV testing regimen	165	—		[a]56
Number of cervical cancer deaths averted per 100,000 women tested:				
Pap-only testing regimen	87	—		[a]56
Pap plus HPV testing regimen	94	—		[a]56
Proportion of women tested using Pap-only testing regimen	0.59	—		[a]57

Continued

Table A1. *Continued*

Parameter	National-Level Value		State-Level	Source
	Females	Males		
HPV vaccines				
Ratio of HPV injections provided to female clients served	0.014	—		[a]3, 26
Adjustment to account for women who would be tested without public funding	0.73	—		33
Proportion of female clients vaccinated receiving:				
3 doses	0.46	—		64
2 doses	0.22	—		64
1 dose	0.32	—		64
Effectiveness of regimen:				
3-dose regimen	0.99	—		66
2-dose regimen	0.89	—		[a]66-68
1-dose regimen	0.80	—		[a]66-68
Adjustment factor to account for exposure to HPV prior to vaccination	0.38	—		[a]71

Continued

Table A1. *Continued*

Parameter	National-Level Value		State-Level	Source
	Females	Males		
Cases averted per 100,000 women vaccinated:				
abnormal cervical cell cases	50,000	—		72
precancer cases	10,000	—		72
cervical cancer cases	500	—		72
cervical cancer deaths	200	—		72
Ratio of other HPV-attributable cancers averted per cervical cancer case averted:				
vulvar cancers	0.14	—		46
vaginal cancers	0.04	—		46
anal/rectal cancers	0.24	—		46
oropharyngeal cancers	0.13	—		46

[a]National- and/or state-level values are calculated from figures in the reference(s) listed.

EXHIBIT 2

Anti-Vaccination Complaints Filed After November 2016 Election

Count	Date of Complaint	OCR Complaint ID	Bates No. of Complaint	Bates No. of Related Documents
1.	4/12/2017	18-289810	542217	542219 542221
2.	7/2/2017	17-277069	546049	546088
3.	7/14/2017	17-276010	546040	546048
4.	11/20/2017	18-290543	542223	
5.	12/5/2017	18-289617	546091	546099 546100 546102
6.	1/15/2018	18-293929	542533	542532 542534
7.	1/18/2018	18-293612	542396	542404
8.	1/18/2018	18-293621	545439	
9.	1/19/2018	18-293651	542405	542413
10.	1/19/2018	18-293713	542431	542439
11.	1/19/2018	18-293763	542440	542448
12.	1/20/2018	18-293790	542458	542466
13.	1/20/2018	18-293820	542467	542475
14.	1/21/2018	18-293834	542476	542484
15.	1/21/2018	18-293839	542485	542493
16.	1/21/2018	18-293847	542494	542502
17.	1/21/2018	18-293857	542503	542511
18.	1/21/2018	18-293863	542513	542521
19.	1/22/2018	18-293925	542522	542530
20.	1/22/2018	18-293935	542535	542543
21.	1/22/2018	18-293954	542544	542552
22.	1/22/2018	18-293966	542553	542561
23.	1/22/2018	18-293974	542562	542570
24.	1/22/2018	18-293976	542571	542579
25.	1/22/2018	18-293989	542580	542588
26.	1/23/2018	18-294002	542589	542597
27.	1/23/2018	18-294017	542598	542606
28.	1/23/2018	18-294057	542616	542624 542626
29.	1/23/2018	18-294065	542649	542657
30.	1/24/2018	18-294138	542667	542675
31.	1/24/2018	18-294142	545416	545424
32.	1/24/2018	18-294145	542685	542693

33.	1/24/2018	18-294148	542694	542702
34.	1/24/2018	18-294154	542703	542711
35.	1/24/2018	18-294191	542712	542720
36.	1/24/2018	18-294197	542721	542729
37.	1/24/2018	18-294203	542730	542738
38.	1/24/2018	18-294211	542739	542747
39.	1/24/2018	18-294212	542748	542756
40.	1/24/2018	18-294216	542757	542765
41.	1/24/2018	18-294228	542766	542774
42.	1/24/2018	18-294250	542775	542783
43.	1/24/2018	18-294257	542784	542792
44.	1/24/2018	18-294264	542793	542801
45.	1/25/2018	18-294268	542802	542810
46.	1/25/2018	18-294274	542811	542819
47.	1/25/2018	18-294275	542820	542828
48.	1/25/2018	18-294276	542829	542837
49.	1/25/2018	18-294299	542838	542846
50.	1/25/2018	18-294305	542847	542855
51.	1/25/2018	18-294328	542856	542864
52.	1/25/2018	18-294329	542865	542873
53.	1/25/2018	18-294331	542874	542882
54.	1/25/2018	18-294335	542884	542892
55.	1/25/2018	18-294350	542893	542901
56.	1/25/2018	18-294372	542902	542910 542911 542913 542915
57.	1/25/2018	18-294378	542917	
58.	1/25/2018	18-294390	542925	542933
59.	1/25/2018	18-294399	542934	542942
60.	1/25/2018	18-294401	542943	542951
61.	1/25/2018	18-294403	542952	542960
62.	1/25/2018	18-294406	542961	542969
63.	1/25/2018	18-294408	542970	542978
64.	1/25/2018	18-294419	542979	542987
65.	1/25/2018	18-294420	542988	542996
66.	1/25/2018	18-294423	542997	543005
67.	1/25/2018	18-294433	543006	543014
68.	1/25/2018	18-294434	543016	543024
69.	1/25/2018	18-294436	543025	543033
70.	1/25/2018	18-294437	543035	543043

71.	1/25/2018	18-294441	543044	543052
72.	1/25/2018	18-294446	543054	543062
73.	1/25/2018	18-294447	543063	543071
74.	1/25/2018	18-294449	543072	543080
75.	1/25/2018	18-294457	543091	543099
76.	1/26/2018	18-294460	543100	543108
77.	1/26/2018	18-294461	543110	543118
78.	1/26/2018	18-294462	543119	543127
79.	1/26/2018	18-294463	543129	543137
80.	1/26/2018	18-294465	543139	543147
81.	1/26/2018	18-294466	543148	543156 543157 543158
82.	1/26/2018	18-294469	543159	543167
83.	1/26/2018	18-294470	543168	543176
84.	1/26/2018	18-294474	543177	543185
85.	1/26/2018	18-294477	543186	543194
86.	1/26/2018	18-294509	543195	543203
87.	1/26/2018	18-294515	543204	543212
88.	1/26/2018	18-294516	543213	543221
89.	1/26/2018	18-294518	543222	543230
90.	1/26/2018	18-294528	543231	543239
91.	1/26/2018	18-294529	543240	543248
92.	1/26/2018	18-294531	543250	543258
93.	1/26/2018	18-294540	543259	543267
94.	1/26/2018	18-294567	543268	543276
95.	1/26/2018	18-294570	543277	543285
96.	1/26/2018	18-294574	543286	543294 543295 543296 543298 543301 543306 543314 543315 543317
97.	1/26/2018	18-294587	543323	543331
98.	1/26/2018	18-294596	543332	543340
99.	1/26/2018	18-294600	543342	543350
100.	1/27/2018	18-294608	543351	543359
101.	1/27/2018	18-294609	543361	543369

102.	1/27/2018	18-294610	543370	543378
103.	1/27/2018	18-294611	543379	543387
104.	1/27/2018	18-294612	543388	543396
105.	1/28/2018	18-294630	543397	543405
106.	1/28/2018	18-294633	543406	543414
107.	1/28/2018	18-294634	543415	543423 543424
108.	1/28/2018	18-294658	543427	543435 543436
109.	1/28/2018	18-294668	543438	543446
110.	1/28/2018	18-294674	543447	543455
111.	1/28/2018	18-294675	543456	543464
112.	1/28/2018	18-294676	543465	543473
113.	1/29/2018	18-294701	543474	543482
114.	1/29/2018	18-294704	543483	543491
115.	1/29/2018	18-294713	543492	543500
116.	1/29/2018	18-294782	543501	543509
117.	1/30/2018	18-294795	543510	543518
118.	1/30/2018	18-294881	549933	545396
119.	1/30/2018	18-294884	545397	545405
120.	1/30/2018	18-294917	543529	543537
121.	1/30/2018	18-294931	543538	543546
122.	1/30/2018	18-294933	543547	543555
123.	1/30/2018	18-294935	543556	543564
124.	1/30/2018	18-294936	543565	543573
125.	1/30/2018	18-294939	543574	543582
126.	1/30/2018	18-295802	543690	
127.	1/31/2018	18-294947	543583	543591
128.	1/31/2018	18-295021	545387	545395
129.	1/31/2018	18-295084	543592	543600
130.	1/31/2018	18-295094	543601	543609
131.	2/1/2018	18-295101	543610	543618
132.	2/1/2018	18-295181	545378	545386
133.	2/1/2018	18-295207	545369	545377
134.	2/2/2018	18-295220	543619	543627
135.	2/2/2018	18-295221	543628	543636
136.	2/2/2018	18-295351	545351	545359
137.	2/2/2018	18-295352	545360	545368
138.	2/3/2018	18-295386	545333	545341
139.	2/3/2018	18-295387	545342	545350
140.	2/3/2018	18-295389	543637	543645

141.	2/6/2018	18-295402	543646	543654
142.	2/6/2018	18-295643	543681	543689
143.	2/6/2018	18-295804	545330	
144.	2/7/2018	18-295820	543692	543700
145.	2/8/2018	18-295619	543672	543680
146.	2/8/2018	18-295840	543702	543710
147.	2/10/2018	18-296124	545312	545320
148.	2/10/2018	18-296126	543711	543719
149.	2/10/2018	18-296136	545321	545329
150.	2/12/2018	18-295438	543656	543655 543664
151.	2/12/2018	18-296347	543731	543739
152.	2/12/2018	18-297802	544053	
153.	2/14/2018	18-296546	543749	543757
154.	2/14/2018	18-296571	545451	545459
155.	2/15/2018	18-296627	543758	543766
156.	2/15/2018	18-296632	543767	543775
157.	2/15/2018	18-296633	543776	543784
158.	2/15/2018	18-296636	543785	543793
159.	2/15/2018	18-296637	543794	543802
160.	2/15/2018	18-296638	543803	543811
161.	2/15/2018	18-296644	543812	543820
162.	2/15/2018	18-296646	545532	545540
163.	2/15/2018	18-296673	543821	543829 543831
164.	2/15/2018	18-296674	543832	543840 543842
165.	2/15/2018	18-296691	543843	543851
166.	2/16/2018	18-296709	545245	545253 545291 549932
167.	2/16/2018	18-296724	543852	543860
168.	2/16/2018	18-296728	543861	543869
169.	2/16/2018	18-296731	543870	543878
170.	2/16/2018	18-296735	543883	543891
171.	2/16/2018	18-296754	543892	549905
172.	2/16/2018	18-296761	545523	545531
173.	2/16/2018	18-296773	543900	543908
174.	2/16/2018	18-296835	543927	543935
175.	2/16/2018	18-296836	545218	545226 545227

				545235
176.	2/18/2018	18-296887	549906	543936 543937
177.	2/20/2018	18-297136	543938	543946
178.	2/21/2018	18-297161	543947	543955
179.	2/21/2018	18-297213	543961	543969
180.	2/21/2018	18-297287	545514	545522
181.	2/23/2018	18-297429	543970	543978
182.	2/23/2018	18-297463	543979	543987
183.	2/24/2018	18-297580	543989	543988 543997
184.	2/24/2018	18-297582	543998	544006 544007
185.	2/25/2018	18-297593	544008	544016
186.	2/25/2018	18-297605	544017	544025
187.	2/25/2018	18-297714	544026	544034
188.	2/25/2018	18-298020	544158	
189.	2/26/2018	18-297764	545505	545513
190.	2/27/2018	18-297798	544044	544052
191.	2/27/2018	18-297945	545496	545504
192.	2/27/2018	18-297946	545487	545495
193.	2/28/2018	18-297979	544149	544157
194.	3/2/2018	18-298297	545478	545486
195.	3/4/2018	18-298344	544161	544169
196.	3/5/2018	18-298379	544179	544187
197.	3/6/2018	18-298639	544208	544216
198.	3/8/2018	18-298850	544226	544234
199.	3/9/2018	18-298957	545425	545433 545437 545438
200.	3/11/2018	18-299109	544244	544252
201.	3/11/2018	18-299118	544253	544261
202.	3/11/2018	18-299141	544262	544270
203.	3/15/2018	18-299571	544271	544279
204.	3/15/2018	18-299658	545442	545450
205.	3/20/2018	18-300085	544280	544288
206.	3/21/2018	18-300254	544291	544299
207.	3/22/2018	18-300275	544300	544308
208.	3/22/2018	18-300279	544309	544317
209.	3/22/2018	18-300324	544318	544326
210.	3/23/2018	18-300386	545460	545468

211.	3/23/2018	18-300388	544327	544335
212.	3/23/2018	18-300491	544336	544344
213.	3/25/2018	18-300537	544345	544353
214.	3/25/2018	18-300568	544354	544362
215.	3/26/2018	18-300622	544363	544371
216.	3/26/2018	18-300653	544372	544380
217.	3/26/2018	18-300657	544381	544389
218.	3/26/2018	18-300699	544390	544398
219.	3/31/2018	18-301226	544408	544416 544417
220.	4/3/2018	18-301461	544424	544432 544433 544434
221.	4/3/2018	18-301532	544447	544455
222.	4/5/2018	18-301788	544456	544464
223.	4/6/2018	18-302417	544474	
224.	4/12/2018	18-302437	544500	544508
225.	5/14/2018	18-310061	544651	
226.	6/15/2018	18-308974	544624	544632 548439 549914 549922
227.	6/15/2018	18-308995	544642	544650
228.	7/6/2018	18-310972	544669	
229.	7/6/2018	18-314425	544682	
230.	7/20/2018	18-321033	545200	545208
231.	8/30/2018	18-315669	544692	544700 544701 544704
232.	9/1/2018	18-315794	544710	544718
233.	9/5/2018	18-315969	544719	544727
234.	9/6/2018	18-326152	545209	545217
235.	9/13/2018	18-316890	544763	544771
236.	9/15/2018	18-317042	544932	544940 544944
237.	9/18/2018	18-320798	545601	545169
238.	9/19/2018	18-317417	544985	544993
239.	9/23/2018	18-317797	544994	545002
240.	9/23/2018	18-317809	545003	545011 545012
				545187

241.	9/24/2018	18-230812	545179	545188
242.	9/24/2018	18-317903	545015	545023
243.	9/24/2018	18-317927	545024	545032
244.	9/24/2018	18-320805	545170	545178
245.	9/25/2018	18-318010	545033	545041
246.	9/25/2018	18-318021	545046	545042 545043 545044 545045
247.	9/25/2018	18-318030	545054	545062
248.	9/25/2018	18-318035	545063	545071
249.	9/25/2018	18-318049	545072	545080
250.	9/25/2018	18-318078	545081	545089
251.	9/25/2018	18-318086	545091	545090 545099
252.	9/25/2018	18-318093	545106	545114
253.	9/25/2018	18-318131	545115	545123
254.	9/25/2018	18-318134	545124	545132
255.	9/25/2018	18-318139	545133	545141
256.	9/25/2018	18-318176	545142	545150
257.	9/26/2018	18-318268	545151	545159
258.	9/26/2018	18-318343	545160	545168
259.	9/26/2018	18-318349	549924	545571
260.	9/26/2018	18-320830	545191	545199
261.	9/29/2018	18-318669	545583	545591
262.	9/29/2018	18-318678	545592	545600
263.	undated	18-294141	542676	542684
264.	undated	18-296263	543720	549904
265.	undated	18-304544	544509	544510 544512 544513 544514 544515
266.	undated	18-318462	545563	545572 545580 545582

EXHIBIT 3

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME
[redacted]	[redacted]
H[redacted]ELL PHONE (Please include area code)	W[redacted]PHONE (Please include area code)
S[redacted]	
	CITY [redacted]
ST[redacted]	E-MAIL ADDRESS (If availa[redacted]
[redacted] [redacted]	[redacted]

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☒ Race / Color / National Origin ☐ Age ☒ Religion / Conscience ☐ Sex

☐ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION

NIH

STREET ADDRESS	CITY
NCCIH, 9000 Rockville Pike, Bethesda, Maryland 20892	Bethesda

STATE	ZIP	PHONE (Please include area code)
Maryland	20892	

When do you believe that the discrimination occurred?

LIST DATE(S)

09/21/2017

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

I made a cure for cancer last year,

I had a website an app, twitter, and facebook page.

I submitted a health claim petition that was denied w/o review

This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE	DATE *(mm/dd/yyyy)*
[redacted]	01/23/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of poss ble discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☐ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☒ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☐ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including he time for reviewing instruc ions, gathering the data needed and entering and reviewing the information on he completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

HHS-699 (7/09) (BACK)

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 01/23/2018

**Please sign and date* [redacted] *ed to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted]

Telephone Number: [redacted]

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

EXHIBIT 4

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME
[redacted]	[redacted]
H / CELL PHONE (Please include area code)	W NE (Please include area code)
[redacted]	
S	CITY
[redacted]	[redacted]
ST [redacted]	ZIP [redacted]
E-MAIL ADDRESS (If availa [redacted]	

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race / Color / National Origin ☐ Age ☒ Religion / Conscience ☐ Sex

☐ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION

[redacted]

STREET ADDRESS	CITY
[redacted]	[redacted]
STATE [redacted]	ZIP [redacted]
PHONE (Please include area code) ([redacted]	

When do you believe that the discrimination occurred?

LIST DATE(S)

05/26/2017

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

My son was born At Northside Hospital in Atlanta Georgia on [redacted].

I refused the New Born Screening Test (also known as PKU) on religious grounds.

I was questioned by pediatrician [redacted] as to the specific reason for refusing the procedure. I clearly explained that the procedure is against my religious beliefs, and

This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE	DATE *(mm/dd/yyyy)*
[redacted]	01/25/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☒ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

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U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement

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HHS-699 (7/09) (BACK)

COMPLAINANT CONSENT FORM

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Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

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In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 01/25/2018

**Please sign and date sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted]

Telephone Number: ([redacted]

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

EXHIBIT 5

FAX Transmission from Library Document Station 5131

To:	**OCR**	From:	[redacted]
Fax:	[redacted]	Pages:	**2 + Coversheet**
Date:	**2/13/2018**	eMail:	[redacted]**@YAHOO.COM**

Comments: **REQUEST FOR INVESTIGATION AND RECORDS**

Form Approved: OMB No. 0945-0002
Expiration Date: 04/30/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

Civil Rights Discrimination Complaint

[redacted]

YOUR FIRST NAME [redacted] | YOUR LAST NAME [redacted]

HOME PHONE (Please include area code) [redacted] | WORK PHONE (Please include area code)

STREET ADDRESS [redacted] | CITY Aurora

STATE CO | ZIP 80044 | E-MAIL ADDRESS (If available) [redacted] @yahoo.com

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME | LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☑ Race / Color / National Origin ☑ Age ☐ Religion / Conscience ☑ Sex
☐ Disability ☐ Other (specify): Biomedical / Telemedicine

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON / AGENCY / ORGANIZATION State of Colorado - Dept of Personnel & Admin (CDPHE CDOT)

STREET ADDRESS [redacted] | CITY Denver

STATE CO | ZIP 80202 | PHONE (Please include area code) [redacted]

When do you believe that the occurred?

LIST DATE(S) 10/2008 – 2/2018

Describe briefly what happened. How and why do you believe you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed) Identity Theft w/i St employment and false BH overreaching (ED/psych) led to health care fraud, medicare/medicaid fraud and terminal injuries due to Biomedical abuses, Mega HIPAA violations

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email [redacted] | DATE 2/13/18

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: www.hhs.gov/ocr/civilrights/complaints/index.html. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

HHS-700 (10/17) (FRONT)

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for OCR to communicate with you about this complaint? (*Check all that apply*)

☐ Braille ☑ Large Print ☐ Cassette tape ☑ Computer diskette ☑ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME [redacted]	LAST NA [redacted]
HOME PHONE (*Please include area code*) [redacted]	WORK PHONE (*Please include area code*) [redacted]
STREET ADDRESS [redacted]	CITY Fountain
STATE CO	ZIP 80817
E-MAIL ADDRESS (if available) [redacted]@yahoo.com	

Have you filed your complaint anywhere else? If so, please provide the following. (*Attach additional pages as needed*)

PERSON / AGENCY / ORGANIZATION / COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public; please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (*select one*)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE (*select one or more*)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☒ Black or African American ☐ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other than English):

How did you learn about the Office for Civil Rights?

☑ HHS Website /Internet Search ☐ Family / Friend /Associate ☑ Religious /Community Org ☑ Lawyer /Legal Org ☐ Phone Directory ☐ Employer

☑ Fed /State/Local Gov ☑ Healthcare Provider /Health Plan ☐ Conference /OCR Brochure ☐ Other(*specify*):

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail this complaint form to this address.**

HHS-700 (10/17) (BACK)

02/13/2018 1:50 PM FAX 2026193818 OFFICE FOR CIVIL RIGHTS P.0001

****
*** Receive Results ***
****

Receive job successful.

Job No.	5236
Address	
Name	
Start Time	02/13 01:47 PM
Call Length	03'27
Sheets	3
Result	OK

EXHIBIT 6

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME
[redacted]	[redacted]
H[redacted] / CELL PHONE (Please include area code)	W[redacted] ONE (Please include area code)
S[redacted]	
ST[redacted]	CITY: Pocono Lake
STATE: Pennsylvania / ZIP: 18347	E-MAIL ADDRESS (If available): [redacted]

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☒ Race / Color / National Origin ☒ Age ☒ Religion / Conscience ☐ Sex
☐ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION: Humana

STREET ADDRESS	CITY	STATE	ZIP	PHONE (Please include area code)
Humana Florida, p.O. Box 371400	Pittsburgh	Pennsylvania	15250	

When do you believe that the discrimination occurred?

LIST DATE(S): 01/01/2017

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

I signed up for Florida Humana in January 2017 I was not told that I had to take prescription coverage.

I do not use prescriptions. I have never paid more than $8 per month for any prescriptions.

I am 80 years old and did not understand. I do not want prescription coverage now or any other time.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE	DATE *(mm/dd/yyyy)*
[redacted]	02/27/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

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☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

Medicare

DATE(S) FILED	CASE NUMBER(S) (If known)
01/19/2018	[redacted]

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☐ Not Hispanic or Latino

RACE (select one or more)

☒ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☐ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

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HHS-699 (7/09) (BACK)

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 02/27/2018

**Please sign and date* [redacted] *ed to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted] Pocono Lake, Pennsylvania,

Telephone Number: [redacted]

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(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
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(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
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Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

EXHIBIT 7

On or about July 2017 the above named posted medical records and social security information regarding my person on social media (Facebook) under [redacted]

Clear violation of my hippa rights and ss rights

EXHIBIT 8

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME
[redacted]	[redacted]
H[redacted]LL PHONE (Please include area code)	W[redacted]NE (Please include area code)
S[redacted]	CITY [redacted]
ST[redacted] ZIP [redacted]	E-MAIL ADDRESS (If availa[redacted]

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race / Color / National Origin ☐ Age ☒ Religion / Conscience ☐ Sex

☐ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION

Ecumenical Ministries of Oregon

STREET ADDRESS	CITY	
245 SW Bancroft Street Suite B	Portland	
STATE	ZIP	PHONE (Please include area code)
Oregon	97239	(503) 221-1054 x204

When do you believe that the discrimination occurred?

LIST DATE(S)

09/12/2018

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

I was suspended from EMO HIV Day Center because I contacted their board of directors. They say I am being suspended for refusing to meet with them about my two grievances. I told them that I prefer handle everything related to my grievances, in writing. Also there is no written policy stating that I am obligated to meet with them to discuss my grievance. EMO HIV Day Center is a Ryan White funded agency.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE	DATE *(mm/dd/yyyy)*
[redacted]	09/13/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☒ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

HHS-699 (7/09) (BACK)

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 09/13/2018

**Please sign and date if submitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted]

Telephone Number: [redacted] (H)

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

EXHIBIT 9

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME
[redacted]	[redacted]
H[redacted]LL PHONE (Please include area code)	W[redacted]E (Please include area code)
S[redacted]	CITY [redacted]
ST[redacted] ZIP [redacted]	E-MAIL ADDRESS (If availa[redacted]

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race / Color / National Origin ☐ Age ☒ Religion / Conscience ☐ Sex

☐ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION

Department of Health and Human Services

STREET ADDRESS	CITY	
200 Independence Avenue, S.W.	Washington	
STATE	ZIP	PHONE (Please include area code)
District Of Columbia	20201	(877) 696-6775

When do you believe that the discrimination occurred?

LIST DATE(S)

01/19/2018

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

I just was made aware of the following -

A new federal unit that is being created under the ruse of freedom of conscience will jeopardize health care. The Conscience and Religious Freedom Division in the Office for Civil Rights at the Department of Health and Human Services will help and encourage health care providers who refuse "to perform, accommodate, or assist with certain health care services on religious or moral grounds."

This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE	DATE *(mm/dd/yyyy)*
[redacted]	01/19/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of poss ble discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☐ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☒ Other (specify): FFRF

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including he time for reviewing instruc ions, gathering the data needed and entering and reviewing the information on he completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

HHS-699 (7/09) (BACK)

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

☐ **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

☒ **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 01/19/2018

**Please sign and date mitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted]

Telephone Number: [redacted]

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

EXHIBIT 10

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME
[redacted]	[redacted]
H CELL PHONE (Please include area code)	W HONE (Please include area code)
([redacted]	
ST	CITY
[redacted]	[redacted]
S	E-MAIL ADDRESS (If availa
[redacted] [redacted]	[redacted]

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race / Color / National Origin ☐ Age ☒ Religion / Conscience ☐ Sex

☐ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION

United States Government

STREET ADDRESS	CITY
1600 Pennsylvania Ave	Washington

STATE	ZIP	PHONE (Please include area code)
District Of Columbia	20003-3228	

When do you believe that the discrimination occurred?

LIST DATE(S)

01/20/2017

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

The Current Administration has allowed religious Zealots to run health information agencies to the point that important information about the importance of Women's Health (including Reproductive Choice), Vaccination importance and the ability to refuse treatment to as well as the lack of important information about the need for scientific, evidence based treatments is felt to be not recognized.

This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE	DATE *(mm/dd/yyyy)*
[redacted]	01/20/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of poss ble discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☒ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including he time for reviewing instruc ions, gathering the data needed and entering and reviewing the information on he completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 01/20/2018

**Please sign and date* [redacted] *ed to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted]

Telephone Number: [redacted]

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
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