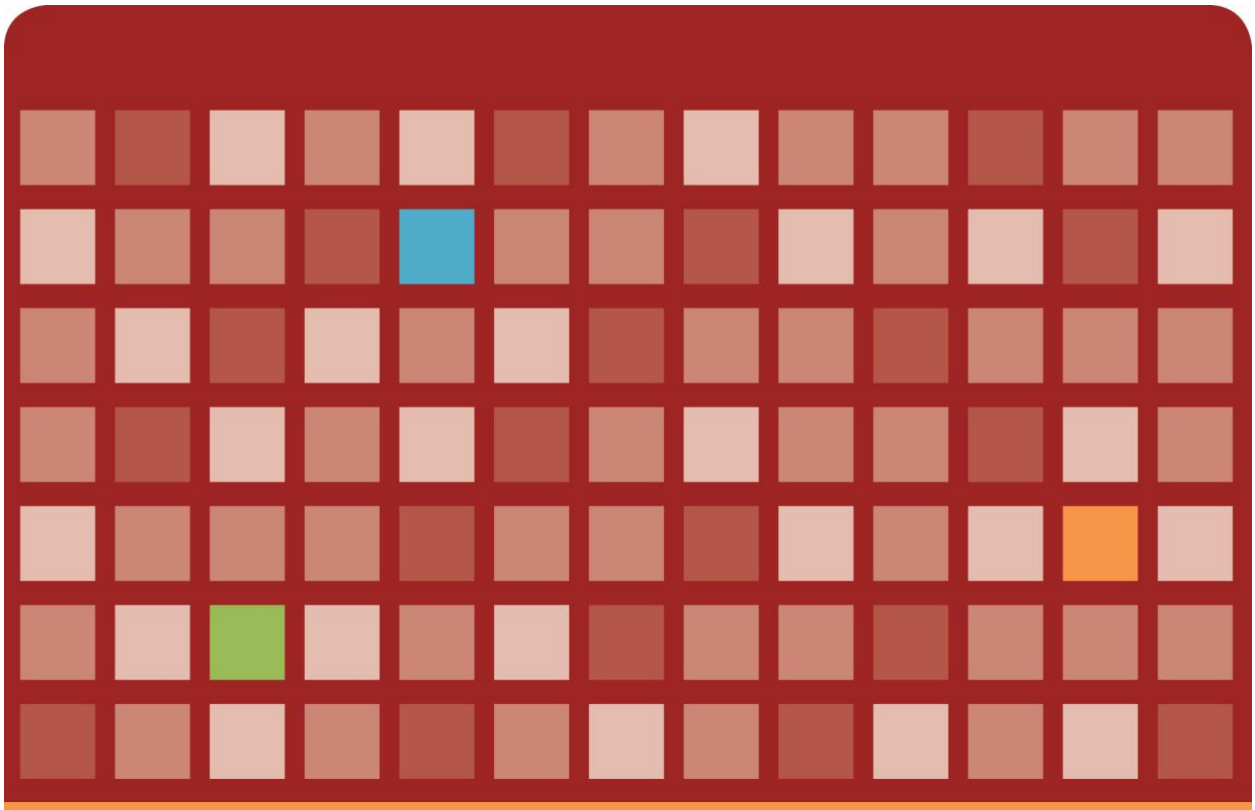

Focus on the Future

Revisiting the Family Planning Research Agenda

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Executive Summary

This report, which was commissioned by the U.S. Department of Health and Human Services' Office of Family Planning within the Office of Population Affairs (OPA), summarizes the status of recent family planning service delivery research that has been conducted to identify areas for further investigation.

The Urban Institute and Altarum Institute, two Washington, D,C., nonprofit research organizations, have conducted an extensive review of the literature that was published on this topic from 2003 to 2011. The review summarizes the findings and identifies preliminary gaps to inform this assessment. In addition, we convened a panel of 17 experts in the field to comment on the state of family planning service delivery research and to point to important areas that need further investigation.

To frame the discussion, we reviewed a previous effort to inform the family planning research agenda, which was presented in *Future Directions for Family Planning: A Framework for Title X Planning Service Delivery Improvement Research* (2004), and compared what had been identified as research gaps to strides that have been made in subsequent years. Since 2003, family planning researchers have continued to document the provision of services nationwide, identify progress in providing a wider range of contraceptive products in publicly subsidized clinics, and characterize efforts to reach vulnerable populations. Ultimately, the research agenda that OPA and other funders pursue should focus on the most efficient use of limited research dollars. With this in mind, the expert panel ranked evidence-based research on best practices for contraceptive counseling as a high priority, noting the critical role of counseling in encouraging and supporting effective contraceptive use. With the implementation of the Affordable Care Act, the expert panel ranked as its utmost priority the need to study the various kinds of family planning models, including the range of reimbursement and funding models that show the most promise in improving service delivery. In addition, the panel called for research that focuses on specific age groups, most notably 20-somethings, among whom 64 percent of pregnancies are unintended. Finally, an investment in research on the interactions between contraceptive counseling/care and chronic diseases, including obesity, diabetes, and heart disease, is needed in light of increasing rates of chronic disease in the United States, particularly among individuals of reproductive age.

What has emerged as a result of this effort to identify gaps in the literature and assign priority areas for future research endeavors is recognition of the need for focused research directions

that contribute significantly to the evidence base. This will be fueled by rigorous approaches to research and the replication of studies to confirm the results of innovative efforts that are being introduced in the field. In addition, translation of that research for the provider community as well as the general public should be OPA's top priority. Finally, continued consideration of the research landscape, increased collaborative research efforts across funding agencies, and replication of agenda-setting exercises through research projects such as this one will help the field grow in an efficient and thoughtful manner and thus improve the reproductive health of women, men, and families across the United States.

I. Overview and Purpose

This report, which was commissioned by the Office of Family Planning within the U.S. Department of Health and Human Services (HHS) Office of Population Affairs (OPA), summarizes the state of recent family planning service delivery research to identify areas for further investigation. This review focuses on the period from 2003 to 2011, building on the work of Sonenstein, Punja, and Scarcella (2004), *Future Directions for Family Planning Research: A Framework for Title X Planning Service Delivery Improvement Research*, a prior effort to summarize the family planning research and identify ongoing research priorities. While this work has been funded by OPA with the explicit goal of informing the agency's research agenda going forward, the information presented should be of broad interest to other funders, researchers, practitioners, and policymakers.

To assess progress in the field and identify research gaps and opportunities, researchers from the Urban Institute conducted a systematic literature review, assembling research on Title X and non-Title X family planning service delivery research that had been published in the peer- reviewed and gray literature. This literature review focuses broadly on a set of research questions that guided the previous agenda-setting exercise undertaken by Sonenstein et al. (2004). These broad questions include:

- How can family planning practices be strengthened?
- What strategies for reaching high-priority populations are most effective?
- How can the organization and administration of family planning clinics be improved?

In addition, Altarum Institute convened a group of technical advisors who have policy, practice, and research expertise to assess the adequacy of existing research and to help develop an informed research agenda to advance the field. (A list of advisors and their affiliations can be found in appendix C.) In preparation for the panel discussion, participants reviewed the literature synthesis, made recommendations regarding the scope and accuracy of the content, and considered gaps and opportunities in the existing body of peer-reviewed and gray literature. To build on this work, the panel was asked to generate a prioritized list of research questions it considered most critical for further developing the field.

The remainder of this report presents (1) an updated synthesis of the family planning service delivery research; (2) a discussion of how and whether research priorities emerging from prior efforts have been addressed; and (3) a presentation of the highest-priority research topics that were identified for future efforts, based on research gaps and expert input.

II. Literature Review

The Title X program, which was enacted in 1970, is designed to provide comprehensive family planning and related services for low-income individuals. The program's goal is to ensure that all adults have the resources that they need to maintain their reproductive health and the ability to independently determine whether and when to have children. Through Title X, HHS supports the provision of preventive health exams, contraceptive services, supplies, and information as well as testing and counseling to prevent and treat sexually transmitted infections (STI). While the program focuses specifically on the provision of family planning services, the impacts of Title X are far-reaching—contributing to the social, emotional, and economic well-being of individuals and families.

Urban Institute and Altarum Institute conducted a literature search to capture domestic family planning service delivery research that was published in the peer-reviewed and gray literature from 2003 and 2011. Our initial search generated more than 1,200 articles, of which slightly more than 100 articles or reports met our inclusion criteria. (A detailed description of our literature review process is included in appendix B.) To be eligible for inclusion, an article had to describe research findings from primary or secondary data, and the research had to be conducted in the United States.

We conducted this literature review as OPA and the Centers for Disease Control and Prevention (CDC) were working in partnership to revise the Title X guidelines to reflect evidence-based standards of care. As part of the revision process, CDC conducted a rigorous literature review that focused on (1) community outreach, participation, and barriers to access; (2) contraceptive counseling and education; (3) adolescent services; (4) quality assurance and quality improvement; (5) clinical services for female clients; and (6) clinical services for male clients. To promote efficiency and maximize the benefit of each contribution, we coordinated our efforts with CDC and its partners. The research questions that guided our review did not change substantially, but we designed our inclusion criteria to be broader than that specified by CDC to capture more qualitative data and implementation studies. The research that we have included in this report is complemented by the evidence base that CDC distilled for use in the guidelines revision process. A table of research gaps that CDC identified is included in section III.

HOW CAN FAMILY PLANNING PRACTICES BE STRENGTHENED?

More than half the research that we identified focuses on practice details related to family planning service delivery. This body of work encompasses research on the availability of family planning services, the scope of services offered, and trends in contraceptive access and use. To address the challenge of covering such a broad topic area, we divided the literature synthesis into three subtopics:

- Service delivery and policies;
- Contraceptives, including counseling, use, access, and knowledge; and
- Emergency contraception.

The research on emergency contraception (EC) is discussed separately from contraception in general to make the high volume of articles that we identified more manageable.

Service Delivery and Policies

This body of research focuses on the scope of family planning and contraceptive services that are available nationwide, including characterizations of typical delivery settings and discussions of the quality of services that are available. We identified nine research articles in this category, the majority of which use program data; small surveys or questionnaires; and, in a few cases, national longitudinal surveys, including the National Survey of Family Growth (NSFG).[1] Presenting a coherent synthesis of this broad research topic is challenging, but an emphasis on promoting best practices in family planning service delivery is a strong common thread. It is critical to synthesize this research, because it relates closely to the overall goal of the Title X program and OPA's mission.

As noted above, the primary objective of the Title X Family Planning Program is to ensure that all adults have access to high-quality family planning services, regardless of ability to pay. Title X, along with other publicly funded or subsidized clinics, works to create a provider network that serves as the family planning safety net for low-income men and women. One study, based on a longitudinal survey of agencies and clinics, documents the progress toward achieving the goal of providing family planning services to all who seek them. This research indicates that a growing proportion of the need for subsidized services is being met by Title X-funded clinics (up 10 percent since 1994), while clinics that were not funded through Title X experienced a 12 percent decline in clients (Frost, Frohwirth, and Purcell, 2004). Furthermore, the scope of

[1] NSFG is a national survey conducted of women in 1982, 1988, and 1995 and of adults (ages 15–44) in 2002 to provide reliable national data on marriage, divorce, contraception, fertility, infertility, and the health of women and infants in the United States.

services received has changed over the years. Between 1995 and 2002, receipt of counseling and birth control services increased across the board, as did pregnancy and STI testing (Frost, 2008). More than 75 percent of respondents said that they received services primarily from a private doctor. However, women who obtained care from publicly funded clinics were more likely to receive a broader scope of services (Frost, 2008).

Additionally, this research includes discussion of alternative models for providing family planning services, typically aimed at exploring ways to reach patients more effectively. A 2003 review of the literature identifies waiting rooms and other unconventional setting as opportunities for outreach and counseling (Kalmuss, Davidson, Cohall, Laraque, and Cassell, 2003). A peer provider model for the delivery of family planning services has been shown to improve consistent use of contraception and was particularly effective for Latina women (Brindis, Geierstanger, Wilcox, McCarter, and Hubbard, 2005). In addition, research on the incidence of negative pregnancy tests identified this event as an often-missed opportunity for providing contraceptive counseling and prescriptions (Daley, Sadler, Leventhal, Cromwell, and Reynolds, 2005). Technological opportunities to promote best practices are also identified in this literature. One research article that evaluated the effectiveness of a computer-assisted motivational intervention (CAMI) designed to reduce rapid-repeat pregnancies among low-income pregnant teens demonstrates that teens who participate in two or more of these CAMI sessions are at a significantly reduced risk for a rapid-repeat pregnancy (Barnet et al., 2009).

In Summary

The research in this category has contributed to the field by (1) quantifying the reach of publicly subsidized family planning services, (2) describing the network of family planning providers for low-income individuals in the United States, and (3) recommending alternative approaches to the provision of family planning services. Tracking of service offerings should continue to help researchers understand the landscape of family planning service delivery and advance research that evaluates the effectiveness of unique approaches to the provision of care, including the use of innovative technologies, which could inform the evolution of best practices.

Contraceptive Counseling, Access, Use, and Knowledge

The role that providers play in contraceptive counseling emerged prominently in our review. These studies considered:

- Training of family planning providers in contraceptive counseling;

- The importance of provider-client interaction;
- The efficacy of specific contraceptive counseling approaches; and
- Provider attitudes toward contraceptive counseling.

A variety of methods are used in the research studies, including interviews, focus groups, surveys, and a literature review.

The research on provider training indicates that many family planning and primary care providers are either inadequately trained or desire additional training in contraceptive counseling (Akers, Gold, Borrero, Santucci, and Schwarz, 2010; Lohr, Schwarz, Gladstein, and Nelson, 2009; Mantell, Hofner, Exner, Stein, and Atkins, 2003). Incorporating formal standardized training on contraceptive counseling into all internal medicine residency programs may go a long way toward improving counseling messages and promoting contraceptive counseling in preventive care visits (Lohr et al., 2009). This approach, however, will miss mid-level clinicians who are often more heavily relied upon to accomplish this task in public family planning settings (Landry, Wei, and Frost, 2008) and may deliver more primary care as demand for these types of providers increases with the implementation of certain aspects of the Affordable Care Act (ACA). In particular, the research suggests that physicians and other clinicians need additional training on dual protection counseling, which promotes the prevention of both unintended pregnancy and STIs (Mantell et al., 2003; Adams-Skinner et al., 2009).

Training on specific, evidence-based counseling methods could also improve family planning services. One study to evaluate the Dual Protection Counseling Checklist revealed that this structured counseling tool, which is designed for nurses, improves the quality of the nurse-client interaction and may affect contraceptive behavior (Adams-Skinner et al., 2009). A literature review by Abdel-Tawab and RamaRao (2010) suggests that the quality of the client-provider interaction could have a role in promoting continued use of contraception, although additional rigorous research would be required to confirm this finding. A study on structured approaches to contraceptive counseling indicates that systems-based strategies may improve the delivery of counseling messages and provide data for evaluating the effectiveness of different approaches (Akers et al., 2010). One strategy includes using electronic medical records that prompt primary care physicians to provide contraceptive counseling (Akers et al., 2010). Additional research findings on this topic point to the importance of the patient-provider interaction in the provision of high-quality family planning services. Evidence from a literature review, as well as a more recent qualitative study, suggest that family planning patients' level of satisfaction with their providers

influences their likelihood of returning for care and/or compliance with prescribed contraceptive methods (Becker, Koenig, Kim, Cardona, and Sonenstein, 2007; Becker et al., 2009).

Determining the effectiveness of contraceptive counseling is a challenging task. There are different outcomes to consider in addition to many varied approaches employed in both family planning and primary care settings. A literature review conducted by Moos, Bartholomew, and Lore (2003) determined that inadequate evidence exists to draw conclusions regarding the effectiveness of counseling in changing behavior, knowledge, skills, or attitudes. In the years since this review, additional studies have been published that suggest that contraceptive counseling may be effective in encouraging consistent use of contraceptives, but these conclusions are based on observational studies. Lee, Parisi, Akers, Borrero, and Schwarz (2011) report that clients who receive counseling on highly effective methods of contraception are more likely to use them. In addition, Boise et al. (2003) find that a reproductive health counseling intervention designed for women who seek pregnancy testing is associated with a 41 percent improvement in self-reported use of contraception.

Two randomized trials that examine the effects of contraceptive counseling conclude that counseling can improve contraceptive use. In one study, first-time female condom use increased among a group of women who received counseling and education, and the increase was greater among women who received additional counseling sessions (Hoffman, Exner, Leu, Ehrhardt, and Stein, 2003). Another study looks at the benefits of contraceptive counseling alone versus counseling along with the provision of contraceptives (Melnick, Rdesinski, Creach, Choi, and Harvey, 2008). Participants were randomized to one of the two groups and then asked to fill out self-administered surveys. Results from the surveys indicated that counseling plus the provision of contraceptives reduces common barriers, but the authors note the results may be biased by favorable attitudes generated by providing free contraceptives (Melnick et al., 2008). A third randomized controlled study revealed that counseling is not associated with the likelihood of using an effective contraceptive method at 3 months (Langston, Rosario, and Westhoff, 2010).

Contraceptive use may be promoted by counseling, but as the previous study by Melnick et al. (2008) indicates, availability and access remain significant barriers to use for some. Since the mid-1990s, the availability of a variety of contraceptive methods at publicly funded family planning clinics, notably Title X clinics, has improved considerably (Lindberg, Frost, Sten, and Daillard, 2006; Moskosky et al., 2011). Furthermore, efforts to facilitate access and improve

compliance have included quick-start strategies for oral contraceptives (OC)—which advocate taking the first dose on the day that the prescription is received rather than waiting until the start of a new menstrual cycle—and elimination of screening requirements, such as a pap smear or pelvic exams, as a prerequisite to receiving a prescription contraceptive (Noone, 2007). The long-term impacts of these approaches on the consistent use of OCs still remain unclear, (Kirby, 2008). Clinics are also integrating contraceptive education and provision into abortion care, facilitating access, and capitalizing on this opportunity to promote continuity of care (Kavanaugh, Jones, and Finer, 2010).

Still, the availability and use of certain contraceptive methods, such as the intrauterine device (IUD), lag behind, despite demonstrated patient interest (Schwarz, Kavanaugh, Douglas, Dubowitz, and Creinin, 2009). Some providers report both adequate knowledge of the IUD and willingness to insert it but may be inhibited by remaining concerns about its safety that stem from experiences with earlier versions of the IUD that resulted in serious injury to many users (Espey, Ogburn, Espey, and Etsitty, 2003). The use of prescription methods of contraception increased between 1995 and 2002, while the use of over-the-counter methods of contraception decreased and the use of no method at all increased (Culwell and Feinglass, 2007). OCs, particularly among young white women; and sterilization, particularly among black and Hispanic women and women over age 40, remain the top two leading methods of contraception in the United States (Mosher and Jones, 2010). Consistent use of OCs remains a challenge, however, with nearly 23 percent of women discontinuing use before starting the second pack (Kerns, Westhoff, Morroni, and Murphy, 2003). Some research suggests that a woman's choice of contraceptive method may be affected by provider input, particularly for less popular methods such as the vaginal ring, the transdermal patch, or Depo-Provera (depot medroxyprogesterone acetate) (Harper, Brown, Foster-Rosales, and Raine, 2010). Two studies that focused on the reasons for nonuse of contraceptives pointed to concerns about access and ambivalence about pregnancy (Iuliano, Speizer, Santelli, and Kendall, 2006) as well as poor communication with the woman's partner (Wilson and Koo, 2008).

In Summary

This literature suggests that contraceptive access and knowledge has improved over the past decade but that the use of highly effective methods, including IUDs, could be further improved by removing barriers, increasing knowledge, and promoting clinician comfort through training. In addition, rigorous and replicable research on the effects of contraceptive counseling is needed to understand what works and to establish an evidence base for best practices.

Emergency Contraception

Thirteen articles on EC, which has emerged as an important topic over the last decade, are included in this review, accounting for nearly 14 percent of all the research presented. Many articles track existing knowledge, use, and availability of EC, all critical topics given the politicized nature of the product and the promise that it holds for the reduction of unintended pregnancies. It is also worth noting that research that addresses common, effective methods for obtaining EC ultimately offers lessons regarding best practices from which the field can benefit.

Patients favor the advanced provision of emergency contraception, but it meets resistance from some providers who are concerned that its availability may encourage unsafe behaviors (Karasz, Kirchen, and Gold, 2004). Others express concern that patients may not use the method correctly (Whittaker, Armstrong, and Adams, 2008). A prospective, randomized study of women who received information about EC, information and access to no-cost EC, or advanced provision of EC revealed no difference in condom use across study groups, suggesting that STI risk is not affected by advanced provision of EC (Raine et al., 2005). The researchers did find, however, that women who have been given EC in advance are 50 percent more likely to use it than those who do not (Raine et al., 2005). Evidence of patient interest in EC is supported in several articles. One article surveyed women who were previously diagnosed with a common STI and asked about their family planning intentions and interest in advanced provision of EC. Of women who did not desire pregnancy, 81 percent said that they would be interested in advanced provision of EC (Golden et al., 2004).

A key factor regarding access to emergency contraception is the drug's small window of efficacy: EC must be taken within 72–120 hours after unprotected sex to be effective, and it is more effective the earlier that it is taken. EC can legally be dispensed either with a prescription or directly from a pharmacist, although women encounter barriers to both means of obtaining it. A literature review of pharmacist-provided EC revealed that its availability is determined by each pharmacist's moral and religious beliefs and is limited by their knowledge of EC or training about the product (Farris et al., 2010). A secret shopper survey conducted in 2005–06 revealed that access directly from a pharmacist or via a health care provider is poor overall, with only 36 percent of callers being told that they could obtain EC (Sampson et al., 2009). Spanish-speaking women found it more difficult to obtain EC than other groups, and these callers were more successful when they contacted rural pharmacies than those who contacted urban pharmacies (Sampson et al., 2009). Another study of women who received EC revealed that

few women know that it is available without a prescription, and younger women experienced more delays in obtaining it than older women did (Foster, Landau, et al., 2006).

In general, recent research suggests that patient knowledge about emergency contraception could be improved. Many women are unaware of how EC works and have formed opinions about EC based on misinformation (Campbell, Busby, and Steyer, 2008). Older women are more likely than younger ones to believe that EC works after fertilization (Campbell et al., 2008), and many women believe that it is a form of abortion (Whittaker et al., 2008). Women who seek EC tend to be younger, more highly educated, and less likely married (Phipps, Matteson, Fernandez, Chiaverini, and Weitzen, 2008). They are also more likely to have received counseling on emergency contraception (Kavanaugh and Schwarz, 2008), suggesting that information provided about EC promotes its use in a timely and effective manner.

In Summary

Direct-from-pharmacist provision of emergency contraception and increased awareness of it has improved its availability (Mosher and Jones, 2010), but barriers to access still exist, particularly for young teens. Knowledge levels among consumers and pharmacists continue to lag behind. Further exploration of advanced provision as well as outreach and promotion of direct pharmacy availability could expand the expedient use of EC; there is no indication that it would increase risky behavior.

WHAT ARE EFFECTIVE STRATEGIES FOR REACHING HIGH-PRIORITY POPULATIONS?

To complement the review conducted by CDC to inform the Title X guidelines revision effort mentioned earlier, we focused our consideration of outreach and access on the following high-priority populations:

- Minority and disadvantaged populations;
- Adolescents;
- Men;
- Individuals with physical or mental risk factors; and
- Individuals with HIV.

This component of the search resulted in 35 articles being selected for inclusion, the bulk of which fall under the category of minority and disadvantaged populations (7), individuals with physical or mental risk factors (9), and adolescents (9). The topics within these categories vary

but generally consider systematic barriers to access, culturally or age-appropriate care, perceptions on quality of care, and patient satisfaction with care.

Minority and Disadvantaged Populations

The literature on minority and disadvantaged populations includes information on (1) perceived racial discrimination, (2) the role of stereotypes in the delivery of care, and (3) systematic differences in how care is offered. The concept of cultural competence emerges repeatedly in the literature and suggests that stereotypes regarding the sexual behavior and views of certain racial and ethnic minority groups persist. Three articles linked stereotyping to the inadequate provision of care (Romo, Berenson, and Segars, 2004; Sable, Havig, Schwartz, and Shaw, 2009; Thorburn and Bogart, 2005). One study challenges prevailing stereotypes regarding Hispanic culture and attitudes toward contraception, concluding that misperceptions regarding attitudes toward contraception and the role of religion in contraceptive behavior are likely to lead to the inadequate provision of services for Hispanic women (Romo et al., 2004). In a study by Thorburn and Bogart (2005), black women reported at least one of nine race-based discrimination encounters while seeking contraceptive services. Both articles recommend additional provider training to counteract these tendencies. A third article suggests that social workers who have experience working with Hispanic immigrants can be effective in providing culturally competent family planning care, particularly dual protection counseling for women who accept that their male partners are likely to be unfaithful (Sable et al., 2009).

The research also indicates that there may be differences in how minority women perceive the quality of the family planning services that they receive. By conducting a patient telephone survey, Becker andand Tsui (2008) found significant differences in perception by race and ethnicity in provider preferences and perceived quality of care. They reported that black women are more likely to report feeling pressured into using a particular contraceptive method than are Latina or white women and that Latina women are more likely to prefer a female provider (Becker and Tsui, 2008). In another study in which black women were surveyed about their contraceptive attitudes, perceived discrimination was associated with a higher likelihood of planned condom use and a lower likelihood of using OC methods (Bird and Bogart, 2003).

This literature also addresses outreach and access to family planning services for other disadvantaged groups (including low-income and incarcerated women) at high risk for unintended pregnancy and STIs. One study indicated that incarcerated women are not being offered a full range of contraceptive options (Sufrin, Creinin, andChang, 2009). The authors

found that women in prison are commonly prescribed OCs, while condoms are not widely offered, despite the population's risk for contracting STIs (Sufrin et al., 2009). These results reveal an important gap in the provision of services to a high-risk population.

Rural women face special barriers. Appalachian women, for example, who are a typically very low-income group, face significant transportation barriers, with 17 percent needing a ride to the clinic (Lukyanova and Calasanti, 2009). Although women overwhelmingly reported satisfaction with the services they received, lower rates of health care utilization may be affected by the how close-knit the community is and resulting concerns about confidentiality (Lukyanova and Calasanti, 2009).

In Summary

Although it represents a substantial proportion of the articles included in this review, the extent of available literature on contraceptive attitudes and use among minority and disadvantaged women is limited given the many high-risk groups in these categories that warrant consideration. Along with broader treatment of this topic, additional in-depth research is necessary to be able to draw reliable and generalizable conclusions about the care of minority and otherwise disadvantaged women.

Adolescents

The issue of patient confidentiality is a significant and controversial one in connection with adolescent family planning service provision. Concerns that teens will not seek contraceptive care or that parents will interfere with their efforts to do so if consent is required provide the motivation for offering confidential services to teens. Title X statutes ensure that teens can receive confidential services and that no information about their visit can be disclosed without documented consent. Other providers are not bound by this policy, however. Six out of nine articles on adolescents included in this review address the issue of confidentiality. One study finds that pediatric practices are less likely than family planning or internal medicine practices to offer confidential family planning services (Akinbami, Gandhi, and Cheng, 2003). Among publicly funded clinics, Title X- and Planned Parenthood-supported clinics are more likely to provide confidential care to adolescents (Lindberg et al., 2006). Akinbami et al. (2003) find that the existence of a written office policy on adolescent confidentiality is associated with greater agreement among the staff regarding the availability of confidential services for adolescents.

Physicians are generally willing to provide confidential services but encourage teens to involve their parents in decisions about contraception. Lawrence, Rasinski, Yoon, and Curlin (2011) found that 94 percent of ob-gyns surveyed would be willing to provide contraceptives without notifying a patient's parents, but nearly half would encourage parental involvement in the decision. A majority, 54 percent, also reported that they would counsel teen patients who are seeking contraception to practice abstinence. The authors observed that doctors who attend religious services were more likely to encourage abstinence and the involvement of parents but were no less likely to provide contraception confidentially (Lawrence et al., 2011). Harper et al. (2010) found that the physicians whom they surveyed typically integrate abstinence messages into counseling and care, with a particular emphasis on teens who are not yet sexually active.

Teen attitudes toward confidentiality are nuanced. While it is clear that they appreciate the availability of confidential services, some report that they would continue to use clinic services even if parent notification were required (Jones, Purcell, Singh, and Finer, 2005). Latino/a youths, however, indicate that they are more likely than black youths to engage in risky sex or use less effective methods of birth control if they must inform their parents of their sexual activity (Jones et al., 2005). Parental misgivings about confidential service provision are also complex, including expressed concerns regarding teen exposure to explicit material and the physical vulnerability of girls (McKee, O'Sullivan, and Weber, 2006).

Offering confidential services does not necessarily undermine teens' intentions to communicate with their parents. A review of the literature conducted in 2004 ultimately concluded that additional research is needed to fully understand the extent to which parents are involved in their children's sexual health decisions (Jones and Boonstra, 2004). A more recent study revealed that nearly 70 percent of participants who obtained confidential services informed parents of their visit to a clinic (Lerand, Ireland, and Boutelle, 2007). Title X clinics are mandated to encourage parent and child communication, and most clinics routinely counsel teens on the importance of discussing these issues with their parents (Jones, 2006).

In Summary

The impact of offering confidential services and the potential threat of eliminating them are unpredictable and depend on demographic characteristics and family relationships. Some parents support their children's efforts to seek out contraception, but not all. The offering of confidential services, along with explicit encouragement of teens to involve their parents and perhaps additional outreach to parents themselves, may be a reasonable approach to

promoting safe sexual behaviors among teens. Additional research that investigates effective ways for involving parents while maintaining open channels for teens to access confidential services will improve this body of work.

Men

Family planning research that focuses on men has emerged over the last decade or two as awareness of men's needs and family responsibilities have heightened. Nonetheless, we identified only six articles on men that fit the inclusion criteria for this review. This research focuses on reaching male clients, the services that they seek, and the scope of services that they are offered.

In general, more family planning clinics have begun reaching out to men, in some cases establishing male-specific family planning clinics (Raine, Marcell, Rocca, and Harper, 2003; Brindis, Barenbaum, Sanchez-Flores, McCarter, and Chand, 2005; Finer, Darroch, and Frost, 2003). As a result, the number of men who seek family planning services has grown steadily. Finer et al. (2003) find that the push to reach out to men is being driven by reproductive health-oriented agencies compared with agencies with a general health orientation. In addition, the research indicates that a limited scope of services is being offered to men compared with those offered to women and that systematic disparities exist. For example, low-income and minority men are underrepresented among vasectomy clients (Barone, Johnson, Luick, Teutonico, and Magnani, 2004), and most men who visit male clinics seek STI testing or treatment (Raine et al., 2003). Still, feedback from male clients indicates that they are generally satisfied with the care that they receive, and men's attitudes and knowledge regarding contraception are improving by efforts to reach out to them (Brindis, Barenbaum, et al., 2005).

In Summary

Continued tracking of the number of men reached by family planning clinics and the scope of services offered to men will help to round out an understanding of the topic. In addition, further study is needed on what services men will most benefit from, including reproductive and contraceptive counseling. Finally, more research is needed on how family planning service provision that is directed at men may affect women's reproductive lives and responsibilities and could ultimately inform women's contraceptive practices and needs.

Mental and Physical Health Risk Factors

The literature on outreach and access for individuals with physical or mental health risk factors falls into three main topics: depression, intimate partner violence, and diabetes. This research is focused on reaching out to these high-risk clients, ensuring appropriate diagnosis of these conditions, and providing specific family planning services that meet the needs of these individuals.

Depressed women and men are more likely to initiate sex at a younger age, less likely to use contraception consistently, and more likely to have sex while using drugs or alcohol (Berenson, Breitkopf, and Wu, 2003; Buzi, Weinman, and Smith, 2010). As a result, researchers recommend that men and women who seek family planning services be screened for depression and that the effect of depression on contraceptive and sexual risk-taking behavior be considered in the delivery of family planning services. The prevalence of depressed clients varies by practice setting. One study finds that clients seeking services at family planning clinics located within local health departments are likely to have high levels of depressive symptoms, perhaps because these women have particularly limited resources and should be screened and treated accordingly (Lee et al., 2005).

Individuals who are at risk of current or past intimate partner violence (IPV) are at higher risk for unintended pregnancy or STIs, particularly as a result of coercive sexual encounters. Screening tools for IPV have been tested and found to result in improved reporting (Breitbart and Colarossi, 2010). Screening for IPV, however, is a challenging task for providers, and therefore much of the research on the topic has addressed provider comfort and training on IPV screening. Breitbart and Colarossi (2010) report that the tool that they tested was well received by providers. Another study by Colarossi, Breitbart, and Betancourt (2010) finds that training on IPV and the establishment of practice policies and procedures for screening for IPV is associated with perceived usefulness of the screening, and provider reports of feeling well-trained in conducting screenings. One randomized controlled study of a program that was designed to address IPV in a family planning setting revealed that women who were subject to this intervention are more likely to end relationships that were unhealthy or felt unsafe than those who did not receive the intervention (Miller et al., 2011).

Research on diabetes included in the review focuses on the attainment and availability of accurate information. Women, especially young women, are often unaware or have limited knowledge of the implications of diabetes on their reproductive lives. Many young women with this

disease believe that their choices of birth control methods are limited (36 percent) and that birth control is less effective for women with diabetes (43 percent) (Schwarz, Sobota, and Charron-Prochownik, 2010). Additional counseling should be administered to reduce the lack of or inaccurate information many women with diabetes possess (Schwarz, Maselli, and Gonzales, 2006).

In Summary

Depression, intimate partner violence, and diabetes are key mental and physical health conditions that affect men's and women's reproductive decisions. While identification of these conditions is key to assessing risk and tailoring approaches to service provision, it is not adequate. Research on the impacts of obesity, hypertension, cardiac disease, and other chronic conditions is also warranted. In addition, research on effective methods for treating and educating women with diabetes or addressing depression and IPV within a family planning setting would be beneficial.

HIV

We identified and included only three articles that address outreach and access to family planning services for individuals with HIV. One article documents referral practices for HIV-positive patients of family planning providers in the southern United States and finds that a large majority (91 percent) of providers would not treat HIV-positive women themselves but instead refer them to another practice for family planning and other care (Felix et al., 2010). This finding suggests that most family planning providers feel inadequately prepared to treat women with HIV and that continuity of care among such patients is suffering. Tran, Hallerdin, Flowers-Maple, and Moskosky (2010) find, however, that collaboration between the Title X Family Planning Program and the Minority AIDS Initiative to integrate HIV prevention, counseling, and testing at family planning clinics improves coordination of these services and results in increased support for HIV-prevention services at family planning clinics. Lastly, a study evaluating the behaviors of HIV-positive and -negative women postpartum suggests that the rate of efforts to become pregnant or prevent pregnancy through use of contraception are similar between the two groups (Wilson et al., 2003). Although HIV-positive women are more likely to use condoms consistently, inconsistent condom use among both groups is associated with postpartum alcohol use and intentions to terminate a pregnancy (Wilson et al., 2003).

In Summary

Overall, the literature on the intersection between family planning and HIV prevention is notably limited despite the importance of the topic and the opportunity for coordination of services.

HOW CAN THE ORGANIZATION AND ADMINISTRATION OF FAMILY PLANNING CLINICS BE IMPROVED?

Only a limited amount of peer-reviewed literature on family planning service administration, organization, and funding has been conducted to date. We have included three peer-reviewed articles on this topic and six studies from the gray literature.

Over the past decade, the Centers for Medicare and Medicaid Services has extended an option for states to apply for family planning waivers, which allow them to temporarily cover family planning services for women and men who do not otherwise qualify for Medicaid. States can also apply for a state plan amendment that would further expand coverage. One study that examined the impact of Medicaid waivers on the provision of family planning services at local health departments concluded that it is worthwhile to rethink whether family planning should be delivered in this setting (Klerman, Johnson, Chang, Wright-Slaughter, and Goodman, 2007). Proponents of removing family planning from the services provided by local health departments argue that these waivers have made new sources of care available to many women. As a result, women seeking care in other settings (such as federally qualified health centers) are more likely to have access to primary care services than to local health departments (Klerman et al., 2007).

Frost, Sonfield, and Gold (2006) estimate that Medicaid eligibility expansions could prevent between 179,000 and 345,000 unintended births and from 151,000 and 291,000 abortions among new clients who will be reached as a result of Medicaid coverage expansions. In states with Medicaid expansions, Title X has served as a wraparound program, providing coverage for services that were not typically covered by Medicaid. This has resulted in the availability of more comprehensive service provision (Gold, Sonfield, Richards, and Frost, 2009). In states with income-based Medicaid expansions, the availability of publicly supported family planning funds work together to outpace family planning investments compared to states without Medicaid expansions ($141 spent per woman versus $82 spent per woman) (Gold et al., 2009).

The long-term impacts of adopting a state plan amendment, rather than instituting temporary coverage expansions, would be substantial (Sonfield, Frost, and Gold, 2011). One evaluation on the impact of a local expansion program—California's Family Planning, Access, Care, and

Treatment Program (Family PACT)—demonstrates such results. Brindis et al. (2003) show that linking eligibility determination and the delivery of services has increased enrollment substantially. In addition, the Family PACT program has averted an estimated 200,000 unintended pregnancies among adolescents (Foster, Biggs, et al., 2006).

Title X funding increases have a similar effect—resulting in fewer unintended pregnancies and abortions—as demonstrated by a study examining the effects of increases in Title X funding levels from 2000 and 2004 (Frost, Sonfield, Gold, and Ahmed, 2006). Using data from the NSFG, Frost, Finer, and Tapales (2008) estimate that, for every public dollar spent on family planning care, $4.02 is saved. Despite the proven benefits of this investment, funding lags behind the need. From 2001 to 2004, Title X spending on contraceptive supplies and diagnostic tests increased an average of 24 percent, while grant funding increased only 11 percent (Sonfield, Gold, Frost, and Alrich, 2006). The cost of an initial family planning visit during this period grew by an average of 24 percent, while reimbursement grew by only 15 percent (Sonfield et al., 2006). More recently, the recession has placed more demands on publicly funded family planning centers, resulting in capacity constraints and budget squeezes (Guttmacher, 2009).

In Summary

The cost effectiveness of coverage expansions promises to be a topic of ongoing interest as Medicaid eligibility expansion for low-income adults is implemented in 2014 through the ACA. Additional research on the effective administration and efficient organization of family planning services would contribute substantially to promoting service quality and identifying the specific impacts of funding increases.

III. Strengths, Gaps, and Priorities for Family Planning Research

REFLECTIONS: PROGRESS ACHIEVING PRIOR SET OF FAMILY PLANNING RESEARCH PRIORITIES

As noted previously, *Future Directions for Family Planning Research (2004)* was the culmination of an early effort to inform the family planning research agenda. This work resulted in a list of 16 high-priority research questions, which the panel recommended that OPA and other funders pursue. This list of questions (replicated from the 2004 report) is presented as table 1. Before presenting the recommendations for future research that have emerged as a result of the present effort, careful review of what research was funded in response to the previous set of recommendations is important to consider and will help in characterizing the field's progress.

Table 1. Future Directions: Family Planning Research Priorities (2004)

PRIORITY QUESTIONS FOR FAMILY PLANNING RESEARCH FROM FUTURE DIRECTIONS (2004)
HOW CAN FAMILY PLANNING PRACTICE BE STRENGTHENED?
What kinds of counseling and other behavior change strategies affect knowledge, attitudes, and behaviors related to reproductive health? Are these innovative approaches to helping clients choose and use contraceptives consistently?
Are there good measures of the quality of family planning services? Are they based on documented evidence? Can their use lead to improvements in family planning clinics services?
How can the Office of Population Affairs (OPA) and other organizations better disseminate research findings so that they are incorporated into practice?
What are the best practices in family planning clinics, contrasting publicly funded programs to private sector programs?
What is the effectiveness of nonclinical Title X services like information and education activities?
How are sexually transmitted diseases (STD) approached with the high percentage of women on the pill or other hormonal contraceptives?
How do programs deal with the ideal versus the reality regarding confidentiality for teenage clients?
HOW CAN HIGH PRIORITY POPULATIONS BE REACHED?
What are effective strategies for reaching low-literacy and non-English-speaking populations?
What are effective practices that clinics can use to assist adolescent and young adults in sexual decision making?
How can adolescents be better connected to their families and schools, and will these connections result in decreased sexual activity?
What information do we need about men in their early 20s and 30s who need STD and family planning services? How do we create more male clinics? How do we look for alternative sites for these clinics?
How do we monitor and use information about who is receiving services? Can programs' statistics and survey results be used more effectively?
What accounts for differences in clinic utilization rates at the sub-state, state, and regional levels?
HOW CAN THE ORGANIZATION AND ADMINISTRATION OF SERVICES BE IMPROVED?
How can STD prevention and family planning services be most effectively integrated?
What is the cost of effectiveness of delivery of Title X services in different settings? How effectively and cost-effectively can pharmacies deliver over-the-counter contraceptives compared to family planning clinics?
Have Medicaid waivers led to changes in contraceptive utilization rates and unintended pregnancies in states?

Table 2 presents a list of all OPA-funded research projects from 2005 to 2010. Comparing the two, we find that almost half the prioritized research questions have not been addressed by OPA-funded projects and of those that have, the research is often exploratory rather than rigorous enough to generate an evidence-based conclusion. It is important to note, however, that some of the research questions that were not directly funded by OPA have been addressed by non-OPA grantees, including considerations of confidentiality for teens. Nonetheless, inadequate evidence to draw reliable conclusions remains a weakness for this literature as we consider it again nearly a decade later.

Table 2. Comparison of OPA-Funded Projects and Future Directions Research Priorities

2004 Research Topic	Number of Funded OPA Studies (2005–10)	Number of Published Reports or Journal Articles*
How can family planning practice be strengthened?	10	2
How can high-priority populations be reached?	9	7
How can organization and administration of service be improved?	2	2

**This is a rough estimate, and it should be acknowledged that some grants are ongoing and may have reports in progress.*

This characterization, however, is necessarily conservative, as research typically lags behind either priority statements or funding cycles. In addition, tackling 16 priority research questions in 5 or 6 years and covering them well is a formidable challenge. Consequently, however, we see a similar set of research questions emerge today that demand additional evidence to support best practices.

Next Steps: The Family Planning Research Agenda

The remainder of this discussion elaborates on the findings from the literature review, as well as the opinions of an expert panel convened to weigh in on the current status of family planning service delivery research. Input from these two sources resulted in a set of priorities that are designed to guide next steps for advancing the field of family planning service delivery. This list represents a targeted effort, characterizing research questions that were identified as being most important and promising for ensuring effective delivery of family planning services and captures an explicit demand for future efforts that are rigorous enough to generate a strong evidence base for best practice in family planning service delivery.

As noted earlier, for the present agenda-setting effort, 17 technical advisors were convened and asked to carefully consider the literature generated over the past decade and identify areas needing further investigation. During a brainstorming session, the technical advisory group generated more than 30 carefully considered research questions that were broadly organized under the following topics:

- Contraceptive counseling;
- Contraceptive use, access, and knowledge;
- General questions to consider for priority populations;
- Questions for specific populations (e.g., HIV, males, adolescent, ethnic, and cultural groups);
- Service delivery and policy; and
- Administration and organization.

Each panelist was then asked to assign a priority value to each question or overarching topic. Panelists had a total of 100 points to distribute and opportunities to explain their ranking methodology and advocate for certain methodologies to be used in conducting the research. The top six research questions, representing only those questions that generated more than 50 points, are displayed in Table 3. A complete list of the research questions and rankings is included in appendix E.

Table 3. Priorities for Family Planning Research Going Forward

Research Questions for the Coming Decade
How can family planning practice be strengthened?
1. What are effective approaches to contraceptive counseling? And what is the impact on service quality, contraception choice, etc.?
2. What are effective interventions designed to improve provider knowledge and provision of contraceptive methods, including emergency contraception?
3. How can we effectively research women who do not want to get pregnant and are: (1) not using contraception or (2) using contraception inconsistently?
How can high-priority populations be reached?
4. What are the unique characteristics of 20-somethings, and how can strategies be tailored to meet the needs of various age groups?
How can organization and administration of service delivery be improved?
5. What impact do various kinds of reimbursement and funding models have on service delivery?
6. How will health care reform affect family planning service provision? What family planning models will survive?

How Can we Strengthen Family Planning Service Delivery?

A 2009 Institute of Medicine review of Title X revealed that the program has been successful in serving the family planning needs of millions of low-income men, women, and teens for decades. Without adequate funding increases, however, Title X providers are unable to think strategically and broadly about the provision of care. Title X funding is severely constrained and has not kept pace with the increased costs associated with family planning services or demand.

The service delivery research consistently documents the scope of subsidized family planning services that are available to low-income individuals, quantifying the types and number of individuals served in Title X clinics, and characterizing the adequacy of Title X funding in support of these activities. This primarily descriptive literature enables researchers to understand the continuing and increasing demand for low-cost services. In addition, this research demonstrates that, although the availability of a wide variety of services is improving, inadequate funding for the provision of services to vulnerable populations persists.

In addition, this body of research suggests that contraceptive knowledge levels remain low and that evidence on promising strategies for reducing unintended pregnancies in the United States is weak. As a result, the panel of experts ranked highly the need for research on "effective interventions" that are designed to improve the provision and use of highly effective contraceptive methods.

Included in this research priority is an interest in promoting the effective provision of emergency contraception. Reasonable access to emergency contraception could substantially reduce the number of unintended pregnancies, births, and abortions in the United States, although years of disappointing efforts to increase the use of EC have led some to recommend shifting priorities to investment in other approaches to effective contraception.[2] Since the U.S. Food and Drug Administration approved the first EC pill Plan B in 1999 and the over-the-counter version[3] in 2006, a large body of research has been focused on issues pertaining to EC access, knowledge, and use. Research documenting common and effective methods of providing EC offers important lessons regarding best practices related to this intervention. The research on this topic indicates that women are open to using EC, but gaps in knowledge and access remain.

[2] Trussell, J., Schwarz, E. B., and Guthrie, K. 2010. Research priorities for preventing unintended pregnancy: Moving beyond emergency contraceptive pills. *Perspectives on Sexual and Reproductive Health, 42*(1), 8–9.
[3] Plan B and other EC products can be made available directly from pharmacists for women over age 17.

The expert panel also emphasized the need for research that is designed to improve understanding of effective approaches to contraceptive counseling and the impacts of these efforts. Common understanding of contraceptive counseling and standardized counseling approaches are not widespread; as a result, few studies on the topic have produced generalizable findings. In addition, rigorous research on the topic is particularly challenging given the variety of approaches that have been applied. For example, a variety of caregivers, including physicians, nurses, social workers, or other office staff, may be responsible for this task depending on the particular setting. In addition, contraceptive counseling services are rarely the primary focus of a patient's visit but are often administered under severe time pressure or other constraints.

Primary care providers have reported that contraceptive counseling is a challenging task, because many women have strong opinions about which contraceptive methods they want to use. In some cases, the availability or cost of a particular method further complicates this decision. Existing research on the topic does not point to any promising practices; in fact, some studies contradict others because of the numerous and inconsistent approaches to contraceptive counseling. Therefore, inconclusive evidence regarding the effects of contraceptive counseling indicates a clear need for further research on best practices to inform contraceptive counseling protocols. In preparation for the Title X guidelines revision, CDC's systematic review of the literature on contraceptive counseling also concludes that this area demands additional rigorous research. (See table 4: Overview of Research Gaps Identified During the Title X Guidelines Revision Process.)

In addition, contraceptive counseling has been included in HHS's approved list of clinical preventive services for women under the ACA and will therefore be a required covered service without cost sharing (http://www.hrsa.gov/womensguidelines). This heightens both the relevance and the immediacy of the need to understand which contraceptive counseling approaches work and how they affect contraceptive choice and consistent, continuous, and correct use of effective methods.

In sum, the research on family planning service delivery is broad but lacks the depth to draw reliable conclusions regarding best practices. Thoughtfully planned research that is designed to build the evidence base would result in important contributions to practice, policy, and health outcomes. The expert panel's prioritized list reflects this end goal.

Table 4. Overview of Research Gaps Identified During the Title X Guidelines Revision Process

Overview of Title X Guidelines Research Gaps
Cross-cutting Themes
• Practice-based research to facilitate application to real clinic practices. • Replication of most promising interventions. • Research on intermediate and long-term family planning outcomes. • Better understanding of fidelity in published research to facilitate assessment of the existing evidence.
Counseling and Education

• Evaluation of comprehensive contraceptive counseling models, including client-centered interventions.
  ○ Learning from clients what they want and need from a contraceptive counseling visit.
• Development and evaluation of approaches to train providers to provide effective contraceptive counseling.
• Evaluation of contraceptive decision aids and related tools.
• Research on client education techniques, including.
  ○ Tailoring information to individuals and key subgroups.
  ○ Presenting uncertainty and balancing information on risks and benefits of contraceptive methods.

Community Education and Participation and Access to Services

• Research on how new technology can strengthen service use (e.g., Internet-based and phone-based services):
  ○ For service promotion and education; and
  ○ For service provision (e.g., providing test results, making appointments).
• Research on how to increase use of services:
  ○ By certain populations: (e.g., immigrants);
  ○ In certain areas (e.g., rural/semiurban areas); and
  ○ Through certain strategies (e.g., pharmacy minute clinics, more integrated primary care settings).

Adolescent Services
• Evaluation of youth-friendly service models. • Research on how best to explain confidentiality to teens while meeting state reporting laws. • Research to encourage parental involvement in a clinic setting (without violating teen's confidentiality). • Research to incorporate a strengths-based approach to counseling adolescents.
Quality Assurance, Quality Improvement
• Identification and validation of critical performance measures.

How Can We Improve Outreach and Access to Family Planning Services for High-Priority Populations?

Access to highly effective forms of contraception and adequate culturally competent care is of particular importance for certain vulnerable populations. As noted earlier, the priority populations with unique contraceptive and family planning needs that emerged in our literature search include:

- Minority and disadvantaged individuals;
- Adolescents;

- Men;
- Individuals with physical or mental health risk factors; and
- Individuals with HIV.

The research on these groups is focused on systematic barriers to access, culturally or age-appropriate care, perceptions of quality of care, and satisfaction with care.

Recent research on minority and disadvantaged women and men suggests that progress has been made toward improving care for harder-to-reach groups and reducing the gap in disparities; however, the gaps are still of concern. In addition, there remains a need for further consideration of the family planning needs and access barriers that are specific to unique populations, including incarcerated populations and rural women—two high-risk groups that face significant barriers to accessing care, as several small research studies have indicated.

By contrast, adolescents have garnered a considerable amount of interest in the peer-reviewed and gray literature, specifically on issues related to the provision of confidential services. Despite extensive consideration, the impact of offering confidential services (and the fallout resulting from the possible impact of eliminating them) remains unclear. Additional research to investigate effective ways to involve parents, while maintaining open channels for teens to access family planning services confidentially, will improve this body of work. CDC's review of the literature on the impact of parental involvement in adolescent family planning care corroborates our conclusion that the effects of preserving confidentiality remain unclear.

As a group, 20-somethings have not received enough attention in the literature. They are considered to be in a state of extended adolescence and are a critical group with unique needs, behaviors, and risks. Women ages 20-24 are the peak group for unintended pregnancy; 64 percent of all pregnancies among women in this group are unintended. A comprehensive review commissioned by the National Campaign to Prevent Teen and Unplanned Pregnancy considered the contraceptive behaviors of young people in their 20s and made several recommendations on how to address this challenge.[4] Recommendations for this age group comprise (1) the development of targeted strategies to improve the use of contraceptives, (2) the promotion of effective methods for translating intentions into behavior, and (3) the development of evidence-based practices for contraceptive counseling. The expert panel

[4] Jaccard, J. 2009. Unlocking the contraceptive conundrum: Reducing unintended pregnancies in emergent adulthood. Washington, DC: National Campaign to Prevent Teen Pregnancy.

agreed on the need to consider the needs of various age groups separately, acknowledging that differing needs and circumstances are inextricably tied to age and development (table 3).

Although it was not ranked the among the top six research priorities, interest in the unique family planning needs and responsibilities of men was raised during panel discussion and considered extensively. Our review identified six articles that focused on strategies for reaching male clients, the services that they seek, and the scope of offerings available to them. In general, more family planning clinics have reached out to men and in some cases established settings designed to meet their specific needs. Additional study is needed, however, to determine what services men will benefit most from and how family planning services designed for them could work to inform and reinforce the needs of women. The expert panel's most prominently ranked research question specifically concerning men called for research to determine the impact of providing male reproductive health and family planning services, including the potential effects on their families. (See appendix F for a full list of research questions and their rankings).

The intersection between family planning and other health risk factors has not been adequately covered in the literature. Altarum identified several articles that provide evidence to support screening for depression during family planning visits and acknowledge the risks associated with depression and risky sexual behavior. No studies, however, tackled the important interactions between concomitant risk factors (e.g., hypertension, obesity) and family planning. This is a notable gap that the expert panel members emphasized; many acknowledged it as an important topic that warrants additional research. Specifically, panelists cited a need to understand the prevalence and effects of the patients' comorbidities and what interventions are effective in assessing and serving these complicated patients' needs. In addition, steadily increasing rates of obesity, diabetes, and related risk factors in the United States demand thoughtful care coordination and better understanding of how these chronic conditions affect family planning service delivery. The importance of this topic is paramount, as these risk factors continue to increase throughout the United States.

Overall, research on hard-to-reach family planning clients and individuals who have specialized needs is fairly broad but not very deep. Continued efforts to understand and best address the reproductive health of these populations are increasingly important, because their risk of unintended pregnancy is already high. Effective methods of engaging vulnerable populations and promoting the use of highly effective contraceptives could substantially decrease the rates

of unintended pregnancy while providing disadvantaged individuals with increased ability in controlling their reproductive health and more promise for a successful future.

How Can the Organization and Administration of Family Planning Clinics Be Improved?

As of January 2012, 28 states have received family planning waivers or State Plan Amendments, which are designed to extend Medicaid eligibility to adults who would not otherwise qualify for covered services. Evidence in the peer-reviewed and gray literature indicates that this coverage expansion has been extremely cost effective and helped many women to prevent unintended pregnancies. Title X-funded service provision has resulted in similarly effective outcomes, reducing unintended pregnancies and saving at least $4 for each public dollar spent on family planning. Title X-funding levels have not kept pace with either demand or the increasing cost of contraceptive methods, however, and diagnostic tests and are decreasing.

The cost effectiveness of coverage expansion promises to be an ongoing topic of interest as Medicaid eligibility expansion for low-income adults is implemented in 2014 as part of the ACA.

The expert panel devised two high-priority questions on this topic:

- What effect do various kinds of reimbursement and funding models have on service delivery?
- How will implementation of the ACA affect family planning service provision? What family planning models will survive?

These two questions consider different but related concerns considered likely to emerge or increase in visibility with the implementation of the ACA. Specifically, the introduction of additional complexities into an already complex administrative system (i.e., the impact of grandfathered health plans, health insurance exchanges, and Medicaid expansion) requires the reevaluation of funding models. Although providers are already encountering these issues, these schemes are expected to add to existing administrative and financing burdens. The second question considers the issue of family planning service delivery and whether, with the implementation of the ACA, family planning services may be delivered increasingly in more and different types of settings.

There is little doubt that the need for publicly subsidized family planning services (Title X or others) will continue, particularly for individuals who cycle on and off Medicaid or fall through the

gaps (including undocumented individuals or adolescents who seek confidential services). However, uncertainties remain regarding how publicly subsidized clinics will fit into the larger system as the landscape changes. Nonetheless, the cost benefits of investing in family planning services will continue to be relevant and should be repeatedly communicated especially in the current economic and social environment.

How Can Limited Research Dollars Be Used Most Efficiently?

In addition to considering the recent literature and prioritizing future research investments, the expert panel took on the task of considering how a limited amount of research funding could be used to exert the greatest impact on family planning service delivery. The panelists expressed the most concern about the need to reduce unintended pregnancies by addressing the lack of access to or inconsistent use of contraceptives. For example, evaluation of successful efforts to encourage patients to use more effective methods of contraception, particularly long-acting, reversible contraceptives, could result in a considerable reduction in unintended pregnancies.

Notably, the committee panel pointed out successful evaluation of effective methods for reducing unintended pregnancy or promoting the use of highly effective contraceptive methods among nonusers is a costly endeavor. Therefore, it is clear that, while OPA has an important role in funding this research, other funders of family planning research should also consider the priorities laid out in this report. Panelists advocated for the adoption of a considered approach to designing and funding research that is robust enough to contribute to the evidence base, with replicable results.

Conclusions

Since 2003, family planning research has continued to document the provision of services nationwide to (1) identify progress in providing a wider range of contraceptive products in publicly subsidized clinics, (2) characterize efforts to reach out to and provide services for an increasing number of men, and (3) calculate the cost savings that result from investing public funds in family planning service delivery. In addition, researchers continue to grapple with the implications of providing confidential care for teens, providing comprehensive care to populations with concomitant risk factors, and determining the efficacy of contraceptive counseling. The family planning research has not reflected the increasingly complex context within which family planning services are delivered as rates of obesity and related chronic conditions increase nationwide.

What has emerged as a result of this most recent effort to identify gaps in the literature, coupled with a thoughtful consideration of priority areas for future research, is the need for focused research that contributes to the evidence base, rigorous research approaches, and replication studies that confirm the results of innovative efforts. Many parties are implicated in these goals. OPA has responsibility for funding certain research projects that contribute to this body of knowledge; but with a small and potentially shrinking research budget, their impacts must be augmented by other funders. For example, explicit collaboration and communication between funders could result in a division of responsibilities and result in focused efforts that produce well-funded rigorous research. In addition, translation of that research should be a top priority. Continued evaluation of the state of the research such as that presented here and the previous effort that culminated in the publication of *Future Directions for Family Planning Research* provide additional critical triggers for reflection that are essential for directing and redirecting important research efforts that will affect the lives of thousands of men and women nationwide, with the end goal of improving the availability of quality family planning services for all.

APPENDIX A: Evidence Tables and Bibliography

Table 1. Family Planning Practice Details

SERVICE DELIVERY AND POLICIES

CITATION: 1. Barnet et al., 2009

PERIOD OF ANALYSIS:

2003–05

POPULATION: Pregnant, low-income African-American adolescents in Baltimore, Maryland.

AIM: Assess the effectiveness of a computer-assisted motivational intervention **(CAMI)** in preventing rapid repeat births among teens.

METHODS: Participants randomized to (1) a CAMI+ group, receiving CAMI during multiple home visits; (2) a CAMI group, receiving CAMI at a single intervention; and (3) a usual-care control group.

Follow-up interview at 24-months postpartum.

SUMMARY OF FINDINGS: **Completing two or more CAMI sessions significantly reduced the risk of repeat births in both the CAMI+ and CAMI groups.**

CITATION: 2. Becker et al., 2007

PERIOD OF ANALYSIS:

1985–2005

POPULATION: Literature from 1985 to 2005 on family planning **(FP)** service access and quality (*N* = 29).

AIM: Review the literature on the quality of FP services in the United States.

METHODS: Literature review.

SUMMARY OF FINDINGS: **Quality is associated with likelihood of returning for care.**

Satisfaction with service provision is associated with contraceptive satisfaction.

Some reported feeling pressured into using a certain contraceptive method; pressure was associated with discontinuation.

Female providers and private providers generally ranked more favorably

Contraceptive counseling is associated with improved rates of use.

CITATION: 3. Becker et al., 2009

PERIOD OF ANALYSIS:

2007

POPULATION: Black, white, and Latina women (18–35) (*N* = 40).

2 Title X FP clinics in the San Francisco Bay area.

AIM: Explore FP client experiences and values with regard to FP service quality.

METHODS: Semistructured, in-depth interviews.

SUMMARY OF FINDINGS: **Providers' interpersonal skills are particularly valued in FP settings.**

Clients appreciate open, nonjudgmental communication with providers.

Desired information about options; appreciated seeing same provider.

Few ethnic or racial differences, although Spanish-speaking clients report discomfort when translators are present.

CITATION: 4. Brindis, Geierstanger et al., 2005

PERIOD OF ANALYSIS:

1996–99

POPULATION: Adolescents.

Clients of 5 peer provider clinics.

AIM: Examine the effectiveness of a peer-provider model for FP clinics.

METHODS: Surveys.

SUMMARY OF FINDINGS: **Female clients are more likely to use contraception consistently and at last sex after peer provider clinic visit; less likely to use condoms.**

The model is particularly effective for Hispanic women; less effective for men, who are affected by clinic visits but not outreach.

CITATION: 5. Daley et al., 2005

PERIOD OF ANALYSIS:

Not listed.

POPULATION: Adolescent women (*N* = 550).

Community health agencies in New Haven, Connecticut.

AIM: Assess the incidence of negative pregnancy tests in an urban community.

METHODS: Pregnancy test results.

SUMMARY OF FINDINGS: **Negative pregnancy tests are an opportunity to counsel patients on prevention of pregnancy and sexually transmitted infections (STI).**

More than 3/4 of pregnancy tests administered to adolescents at community health agencies in Connecticut (over a 3-month period) were negative.

CITATION: 6. Frost et al., 2004

PERIOD OF ANALYSIS:

1994, 1997, 2001

POPULATION: Agencies (*N* = 2,953) and clinics (*N* = 7,683) providing subsidized FP services.

AIM: Analysis of service data for U.S. agencies and clinics providing subsidized FP services in 2001, compared with data from 1997 and 1994.

METHODS: Data requests mailed to Title X grantees, state family administrators, and individual agencies.

SUMMARY OF FINDINGS: **Title X-funded clinics met 28 percent of the national need for publicly funded FP services—up by 11 percent since 1994.**

Almost 3,000 publicly funded agencies provided contraceptive services at 7,600 clinics in 2001; a large increase of 2.3 to 2.6 clinics per agency.

6.7 million women, including 1.9 million teenagers, were served in 2001.

Hospital clinics experienced a 32 percent decline in the number of clients; Title X clients grew by 10 percent; non-Title X clinics experienced a 12 percent decline in the number of clients.

Clients served in states with FP Medicaid waivers increased by 24 percent; clients decreased by 2 percent in states without waivers (1994 versus 2001).

CITATION: 7. Frost, 2008

PERIOD OF ANALYSIS:

1995–2002

POPULATION: Women ages 15–44.

AIM: Examine patterns in the use of sexual and reproductive health care services.

METHODS: National Survey of Family Growth **(NSFG).**

SUMMARY OF FINDINGS: **Women report increased use on contraceptive services, birth control method or prescription, pregnancy testing, and sexually transmitted disease (STD) testing between 1995 and 2002; likely reflects changing use patterns and different client needs.**

Most women receive care in private settings; publicly funded clinics offer broader scope of services

CITATION: 8. **Guiahi et al., 2010**

PERIOD OF ANALYSIS:
N/A

POPULATION: Obstetrics and gynecology residents at a faith-based medical institution (*N* = 16).

AIM: Characterize a program to teach contraception, sterilization, and abortion at a Catholic institution; assess its impact on resident knowledge.

METHODS: Multiple-choice test given to participants before and after the workshop.

SUMMARY OF FINDINGS: **Residents' knowledge about contraceptive methods and practices improved significantly after the workshop.**

Knowledge improvement persisted 10 months after completion.

CITATION: 9. **Kalmuss et al., 2003**

PERIOD OF ANALYSIS:
1994–2002

POPULATION: Adolescents.

AIM: Synthesize research and program experience to inform research and practice.

METHODS: Literature review, program observations.

SUMMARY OF FINDINGS: **Clinics should institute health educators in the waiting room and follow up with emails and/or phone calls to reinforce counseling messages.**

Programs should reach out to younger adolescents earlier.

Programs should take into account socioeconomic disadvantage, lack of behavioral skills, social norms, and peer pressure.

Insufficient male involvement in adolescent pregnancy prevention programs; need for research on how these services should be structured.

Learning disabilities and cognitive immaturity are possible risk-factors for sexual risk-taking; additional research is recommended.

CITATION: 10. **Shlay, Zolot, Bell, Maravi, and Urbina, 2009**

PERIOD OF ANALYSIS:
2003–06

POPULATION: Women receiving initial FP services (Denver Metro Health Clinic).

AIM: Examine the association between provision of initial FP services and unintended pregnancy.

METHODS: Medical records.

SUMMARY OF FINDINGS: **Risks for subsequent STD infection and risk for pregnancy are different and should be closely examined.**

Women treated at an STD clinic and referred for FP services—no less likely to become pregnant than the general population.

Women categorized as high risk were twice as likely to become pregnant.

CONTRACEPTIVE COUNSELING

CITATION: 11. **Abdel-Tawab and RamaRao, 2010**

PERIOD OF ANALYSIS:
N/A

POPULATION:

AIM: Review the literature on the relationship between client-provider interaction **(CPI)** and continuation of contraceptive regimens.

METHODS: Literature review.

SUMMARY OF FINDINGS: **Need rigorous research to understand role of CPI in contraceptive continuation and factors that moderate the relationship, including sociodemographic, behavioral, and contextual factors.**

Inconsistent results may be due to methodological factors, characteristics of interventions to improve CPI, or conceptual factors related to the issue of contraceptive continuation.

CITATION: 12. Adams-Skinner et al., 2009

PERIOD OF ANALYSIS:
N/A

POPULATION: Female, low-income clients in four clinics in New York City.

AIM: Evaluate the reliability and validity of the Dual Protection Counseling Checklist **(DPCC)** in FP practice settings.

METHODS: Structured assessment instrument post-nurse counseling.

SUMMARY OF FINDINGS: **The DPCC is a reliable tool for monitoring nurse-client interactions.**

Suggests that quality of the nurse-client interaction and use of a checklist to ensure adherence to the protocol affects contraceptive behavior.

CITATION: 13. Akers et al., 2010

PERIOD OF ANALYSIS:
2007

POPULATION: Primary care physicians, nurses, and pharmacists at University of Pittsburgh Medical Center (*N* = 48).

AIM: Characterize challenges to contraceptive counseling in the primary care setting.

METHODS: Focus groups.

SUMMARY OF FINDINGS: **Adequate training and use of systems-based strategies (e.g., electronic medical records) could increase appropriate primary care provision of contraceptive counseling.**

Primary care providers are not providing contraceptive counseling to their patients.

Patient preference for a particular contraceptive method is a perceived barrier to contraceptive counseling.

Knowledge, skills, and difficulty conveying health risks associated with pregnancy are common challenges.

CITATION: 14. Boise et al., 2003

PERIOD OF ANALYSIS:
2000–01

POPULATION: Women who sought a pregnancy test in a managed-care setting who did not desire pregnancy.

AIM: Pilot reproductive health counseling intervention for women obtaining pregnancy testing.

METHODS: Reproductive health risk-assessment,

Follow-up evaluation,

Interviews with medical staff about the feasibility of the intervention.

SUMMARY OF FINDINGS: **Participants report the reproductive health counseling to be useful at baseline and follow-up (94 percent and 83 percent, respectively); 41 percent of participants improved their self-reported use of contraception.**

100 percent of medical staff found the intervention important and feasible.

CITATION: 15. Borrero, Schwarz, Creinin, and Ibrahim, 2009

PERIOD OF ANALYSIS:
2002

POPULATION: Women 18–44 years.

Intercourse within 12 months.

Not seeking pregnancy.

No surgical sterilization.

AIM: Examine the role of race and ethnicity in use of FP services and the likelihood of receiving contraceptive counseling.

METHODS: NSFG

SUMMARY OF FINDINGS: **No racial or ethnic differences in the use of FP services were identified.**

Hispanics and blacks were more likely than whites to receive counseling for birth control, more likely than whites to be counseled on sterilization, and less likely to receive a method of birth control or a prescription for a method of birth control during a visit.

CITATION: 16. Choi, Wojcicki, and Valencia-Garcia, 2004

PERIOD OF ANALYSIS:

1996–97

POPULATION: Women attending a FP clinic (*N* = 62).

AIM: Explore communication styles of women attending a FP clinic, and evaluate effective negotiation strategies promoting the use of female condoms in sexual relationships.

METHODS: Baseline interview questionnaire.

Participants received a male and female condom educational training session.

Semistructured, open-ended interviews at 3 months.

SUMMARY OF FINDINGS: **Less direct approaches for negotiation appeared to be as effective in supporting use of the female condom as more direct approaches.**

Continued engagement of partners led to more frequent use of the female condom.

CITATION: 17. Hoffman et al., 2003

PERIOD OF ANALYSIS:

1991–97

POPULATION: Women at a Planned Parenthood clinic in Brooklyn, New York (*N* = 360).

AIM: Evaluate female condom use among women participating in an HIV/STD intervention designed to reduce unprotected sex.

METHODS: Baseline semistructured interviews; two follow-up interviews.

Participants randomized to
(1) 8 sessions of an HIV/STD intervention- including education about female condom use and
(2) 4 sessions of the intervention.

SUMMARY OF FINDINGS: **First-time female condom use was significantly higher in both the 8-session and 4-session intervention groups relative to controls at 1 month post-intervention.**

Repeated use was predicted by perceived ability to use, personal and partner satisfaction, dislike of male condoms, and previous diaphragm use.

CITATION: 18. Landry et al., 2008

PERIOD OF ANALYSIS:

2005

POPULATION: Private and public contraceptive care providers (*N* = 1,256).

AIM: Explore the differences in the provision of care between public and private providers of contraceptive services, what problems were perceived, and providers' views on how to improve patients' methods use.

METHODS: Mixed-mode survey (mail, internet, and fax).

SUMMARY OF FINDINGS: **Private providers almost always involved in contraceptive counseling and services, while in public settings more providers rely on mid-level clinicians and nurses for the same; majority of all providers (85 percent) highly valued counseling and education.**

Public providers reported greater proportions of their contraceptive clients to be young, minority, and disadvantaged than did private providers.

Private providers reported fewer patients having specific problems that might impact contraceptive efficacy.

Public providers were significantly more likely than private providers to offer quick-start pill initiation.

CITATION: 19. Langston et al., 2010

PERIOD OF ANALYSIS:
2008–09

POPULATION: Women (>18 years) (*N* = 222).

No desire to become pregnant right away; seeking a first trimester procedure for a spontaneous or induced abortion at a FP referral clinic.

AIM: Evaluate structured contraceptive counseling versus usual care on choice, initiation, and continuation of a very effective contraceptive after abortion.

METHODS: Phone interviews at 3 and 6 months.

Random assignment to
(1) structured, standardized, nondirective contraceptive counseling and
(2) usual care.

SUMMARY OF FINDINGS: **In the multivariate models, structured counseling is not associated with likelihood of using a very effective method at 3 months.**

54 percent of all participants chose a very effective contraceptive method.

Participants in the counseling group were no more likely to initiate the requested method immediately than those in the usual care group.

CITATION: 20. Lee et al., 2011

PERIOD OF ANALYSIS:
2008–10

POPULATION: Women ages 18–50.

AIM: Evaluate primary care provision of contraceptive counseling and contraceptive use.

METHODS: Surveys.

SUMMARY OF FINDINGS: **Counseling on highly effective reversible methods is associated with the use of those methods.**

CITATION: 21. Lohr et al., 2009

PERIOD OF ANALYSIS:
2004–05

POPULATION: Internal medicine residents in nine internal medicine training programs in Los Angeles (*N* = 152).

AIM: Investigate the provision of contraceptive counseling by internal medicine residents.

METHODS: Self-administered survey on demographic, contraceptive practice patterns, and training.

SUMMARY OF FINDINGS: **75 percent of internal medicine residents want more contraceptive training; formal education on contraceptives was reported by half of respondents.**

Few (17 percent) residents reported routinely providing contraceptive counseling to women of reproductive age.

CITATION: 22. Mantell et al., 2003

PERIOD OF ANALYSIS:
1998

POPULATION: FP service providers.

NYC Community Healthcare Network.

AIM: Explore health care provider approaches to STI and pregnancy prevention.

METHODS: Interviews.

SUMMARY OF FINDINGS: **Providers need additional training and reinforcement promoting dual protection counseling.**

Providers favor dual protection (condom + hormonal contraception), but in practice, counsel on contraception and STD prevention separately.

CITATION: 23. **Melnick et al., 2008**

PERIOD OF ANALYSIS:

Unknown

POPULATION: Women at risk for pregnancy.

Sex in the last month or plans to have sex in the next month.

No consistent used of birth control (*N* = 103).

AIM: Explore the influence of community health nurse home visits on perceived barriers to contraceptive access and contraceptive use self-efficacy.

METHODS: Self-administered surveys.

Randomized to
(1) counseling and contraception or
(2) counseling only.

SUMMARY OF FINDINGS: **The counseling and contraception group reports significant decreases in three of four barriers: time limitations, inconvenience, and cost; the counseling-only group reports a significant decrease in inconvenience.**

Differences between the two groups may be the result of more favorable attitudes after being provided with contraceptives at the time of the visit; no significant difference in reports of seeing a provider for birth control.

CITATION: 24. **Moos et al., 2003**

PERIOD OF ANALYSIS:

1985–2000

POPULATION:

AIM: Literature review on the effectiveness, benefits, and harms of reproductive counseling in a clinical setting.

METHODS: Literature review.

SUMMARY OF FINDINGS: **Studies on the effectiveness of counseling in changing knowledge, skills, and attitudes are poorly designed and difficult to compare.**

No experimental or observational literature reliably answers how effective counseling in the clinical setting is in reducing unintended pregnancy.

CITATION: 25. **Petersen, Albright, Garrett, and Curtis, 2007**

PERIOD OF ANALYSIS:

2003–04

POPULATION: Women ages 15–44 at risk for unintended pregnancy.

AIM: Evaluate the effectiveness of a counseling intervention designed to reduce the risk and occurrence of unintended pregnancy.

METHODS: Self-administered questionnaires at baseline, 2 months, 8 months, and 12 months.

Women randomized to
(1) pregnancy and STD prevention counseling at enrollment and 2 months and
(2) one session of general health counseling.

SUMMARY OF FINDINGS: **Counseling improved contraceptive use in the short term, but additional counseling services may be needed to improve long-term use and reduce risk of pregnancy and STDs.**

CITATION: 26. **Zolna, Lindberg, and Frost, 2011**

PERIOD OF ANALYSIS:

2009

POPULATION: Title X clinics (*N* = 45).

AIM: Evaluate Title X-funded family clinic interest in offering couple-focused services; factors associated with interest and capacity.

METHODS: Client surveys distributed at a nationally representative sample of Title X clinics serving 200 or more clients.

SUMMARY OF FINDINGS: **Interest in couple-oriented services to discuss "when to have a baby" were of interest (58 percent), as was "choosing and using birth control" (43 percent); financial and capacity constraints limit the feasibility of offering these services.**

CITATION: 27. Cox, Posner and Sangi-Haghpeykar, 2010

PERIOD OF ANALYSIS:

N/A

POPULATION: First-time users of either oral contraceptives **(OC)** or depot medroxyprogesterone acetate **(DMPA)** (*N* = 481).

AIM: Explore correlates (e.g., demographic and relationship characteristics, condom use) of partner involvement in contraceptive decisionmaking.

METHODS: Baseline self-administered questionnaire prior to initiation of hormonal contraception.

Follow-up survey at 3 months after initiation of hormonal contraception.

SUMMARY OF FINDINGS: **Women with high-risk partners had reduced odds of joint responsibility for contraceptive decisionmaking.**

Consistent condom use and duration of sexual activity with partner for less than 2 years were associated with increased likelihood of joint responsibility for contraceptive decisionmaking.

CITATION: 28. Culwell and Feinglass, 2007

PERIOD OF ANALYSIS:

1995–2002

POPULATION: Women ages 15–44 at risk of unintended pregnancy (*N* = 4,767 in 1995; *N* = 3,659 in 2002).

AIM: Examine changes in prescription contraception use between 1995 and 2002 by insurance status.

METHODS: NSFG.

SUMMARY OF FINDINGS: **Overall use of prescription contraceptives increased significantly from 1995 to 2002; overall use of OTC contraceptives decreased significantly (7 percent), and nonuse of contraceptives increased significantly (4.5 percent).**

Women in 1995 were 10 percent less likely to report current use of prescription contraception than women in 1992.

Uninsured women were more than 20 percent less likely to report prescription contraceptive use in both years.

CITATION: 29. Gilliam, Knight, and McCarthy, 2004

PERIOD OF ANALYSIS:

1998–99

POPULATION: African-American women age 25 or younger with unplanned pregnancies who expressed intention to use OCs postpartum (*N* = 33).

AIM: Examine the effectiveness of postpartum educational intervention aimed at increasing compliance with OCs and decreasing repeat pregnancies in the year following an unplanned pregnancy.

METHODS: Questionnaire at enrollment, immediately after intervention, 6 weeks, 6 months, and 12 months.

Participants randomized to intervention and control group.

SUMMARY OF FINDINGS: **No difference in repeat pregnancy versus the control group, one year postpartum.**

More women were not pregnant and were still using contraception at year 1 than in the control group.

CITATION: 30. Harper et al., 2010

PERIOD OF ANALYSIS:

2005–07

POPULATION: Women ages 15–24.

Unmarried, not planning to get pregnant within 12 months.

English- or Spanish-speaking.

Received Rx for hormonal contraceptive method (ring, patch, pill, or injectable) for the first time.

Seen at one of four Planned Parenthood clinic sites in low-income communities outside of San Francisco, California (*N* = 1,387).

AIM: Examine factors associated with the initiation of new hormonal methods among women at high risk of unintended pregnancy.

METHODS: Self-administered, Web-based survey.

SUMMARY OF FINDINGS: **Contraceptive knowledge is generally low.**

18.7 percent of respondents chose the vaginal ring during the clinic encounter; 28.9 percent chose the transdermal patch; 31.1 percent chose an OC; 21.3 percent chose injectable DMPA.

Ring or patch initiators were more likely to report choosing their method with their provider; more likely to be returning clients than pill initiators.

3/4 reported their provider had discussed 1–2 methods, while only 14 percent reported provider discussing all 4 methods.

Most respondents (89 percent) chose their contraceptive method, 11 percent chose with their provider, and less than 1 percent said their provider had chosen the method.

Provider trust was not associated with initiation of newer methods.

CITATION: 31. Iuliano et al., 2006

PERIOD OF ANALYSIS:

N/A

POPULATION: Women from inner-city New Orleans (93 percent African-American) (*N* = 1,372).

AIM: Understand reasons for contraceptive nonuse at first sex and subsequent unintended pregnancy.

METHODS: Computer-assisted survey on self-reported.

reasons for nonuse of contraception at 3 time points: first sex, first pregnancy, and current pregnancy for multiparous women.

SUMMARY OF FINDINGS: **Nonusers at first sex and initial unintended pregnancy report nonuse due to concern about their parents' finding out (29 percent and 31 percent, respectively) and unexpected sex (20 percent and 13 percent).**

Concerns about parents finding out are significantly more likely to be reported in women under age 18.

Nonusers of contraception at current, second, or subsequent pregnancy report nonuse due to problems accessing contraception, discontinuation of methods, and ambivalence about contraception.

CITATION: 32. Kerns et al., 2003

PERIOD OF ANALYSIS:

2000

POPULATION: First-time pill users; repeat users initiating a new segment.

FP clinic in New York, New York (*N* = 213).

AIM: Assess potential reasons behind discontinuation of the pill.

METHODS: Interviews at the conclusion of a clinic encounter and follow-up by telephone 6 weeks later.

SUMMARY OF FINDINGS: **Women whose partners were not aware they were taking the pill were significantly more likely to discontinue use, as were women who did not take the pill during the first visit, women who were happy about becoming pregnant in the next 6 months, and women intending to use the pill for 1 year or less.**

23 percent discontinued the pill before starting the second pack.

Age is negatively associated with early discontinuation.

CITATION: 33. Mosher and Jones, 2010

PERIOD OF ANALYSIS:
1982–2008

POPULATION: Women (15–44) (*N* = 7,356).

AIM: Provide national estimates of contraceptive use and method choice in the United States.

METHODS: NSFG.

SUMMARY OF FINDINGS: **OCs and female sterilization were the leading method of contraception in the United States in 2008 (17 percent).**

CITATION: 34. Omar, Fowler, and McClanahan, 2008

PERIOD OF ANALYSIS:
1999–2003

POPULATION: Patients attending the Young Parent Program at a university-based health center *(N* = 1,386).

AIM: Describe a comprehensive multidisciplinary approach to reducing repeat teen pregnancies.

METHODS: Retrospective review of teen pregnancy data.

SUMMARY OF FINDINGS: **No teen who used DMPA as a method of contraception had a repeat pregnancy.**

CITATION: 35. Schwarz et al., 2009

PERIOD OF ANALYSIS:
2008

POPULATION: Women ages 15–44 seeking either walk-in pregnancy testing or emergency contraception **(EC).**

Four FP clinics in Pittsburgh, Pennsylvania (*N* = 412).

AIM: Explore use of intrauterine devices **(IUD)** among seekers of EC and pregnancy testing.

METHODS: Survey.

SUMMARY OF FINDINGS: **Women who have more than a high school education or who have given birth one or more times are more likely to be interested in same-day IUD insertion.**

Interest in same-day insertion is associated with difficulty accessing contraception (difficulty getting an appointment or cost); 12 percent of women were interested in same-day insertion.

CITATION: 36. White and Westhoff, 2011

PERIOD OF ANALYSIS:
2007–09

POPULATION: Women attending an urban FP clinic (*N* = 700).

AIM: Examine effect of increased **oral contraceptive pill (OCP)** supply on 6-month continuation rates.

METHODS: Randomized trial—women randomized to receive 3 of 7 cycles of OCPs; women older than 18 were randomized to receive either all packs or a prescription.

SUMMARY OF FINDINGS: **A longer supply of OCPs and direct provision of packs can increase compliance among women, particularly younger women.**

CITATION: 37. Wilson and Koo, 2008

PERIOD OF ANALYSIS:
1993–2000

POPULATION: Low-income women at risk of unintended pregnancy at public FP, postpartum clinics, and maternity wards in 2 southeastern cities.

Selecting a contraceptive method they had not used in the previous 3 months.

AIM: Investigate relationship characteristics and women's contraceptive behavior.

METHODS: Longitudinal survey: face-to-face interview; and 3 follow-up interviews.

SUMMARY OF FINDINGS: Women who have a child with their partners have an increased likelihood of contraceptive nonuse and decreased likelihood of using a female method.

Women in long-term relationships have an elevated likelihood of contraceptive nonuse and lower likelihood of condom use.

Women with good communication practices with their partners have an increased likelihood of condom use.

Women who anticipate emotional support from their partner if they became pregnant are more likely to report condom use and less likely to report contraceptive nonuse.

CONTRACEPTIVE ACCESS

CITATION: 38. Goodman, Klerman, Johnson, Chang, and Marth, 2007

PERIOD OF ANALYSIS:
1999–2000

POPULATION: Adolescents in Alabama, Ohio, Oklahoma, and Washington.

AIM: Test if greater geographic access to FP facilities is associated with lower rates of unintended teenage pregnancies.

METHODS: Pregnancy Risk Assessment Monitoring, birth certificate records, and U.S. Census data.

SUMMARY OF FINDINGS: **No significant relationship between the geographic accessibility of FP facilities and the risk of unintended pregnancy was found.**

CITATION: 39. Moskosky et al., 2011

PERIOD OF ANALYSIS:
2009–10

POPULATION: Office-based physicians (*N* = 635).

Federally funded Title X clinics (*N* = 1,368).

AIM: Assess the availability of contraceptive methods to patients of office-based physicians and Title X clinics.

METHODS: Survey.

SUMMARY OF FINDINGS: A significantly higher proportion of Title X clinic providers report onsite availability of all methods of birth control except IUDs.

Office-based physicians are more likely to prescribe or recommend each contraceptive method, including OCs, the patch, DMPA, and condoms.

Referrals were uncommon.

CITATION: 40. Kavanaugh et al., 2010

PERIOD OF ANALYSIS:
2008–09

POPULATION: Administrators at large nonhospital facilities that provide abortions (*N* = 173).

AIM: Investigate the availability of contraceptive services at abortion settings.

METHODS: Semistructured interviews.

Mail questionnaires.

SUMMARY OF FINDINGS: **Nearly all abortion clinics (96 percent) incorporate contraceptive education into abortion care.**

The most common methods distributed at abortion clinics are birth control pill, vaginal ring, and DMPA; contraceptive services are typically included in cost of abortion care.

CITATION: 41. **Kirby, 2008**

PERIOD OF ANALYSIS:
1990 and beyond.

POPULATION: Women, primarily adult.

AIM: Review experimental and quasi-experimental studies that evaluated policies or programs designed to increase contraceptive use or reduce pregnancy among adult women in the United States.

METHODS: Literature review.

11 studies met the specified criteria for inclusion.

SUMMARY OF FINDINGS: **Identified positive impacts associated with providing contraceptives at initial meeting; long-term impacts are unclear.**

Topics covered included pregnancy and STD counseling at clinic enrollment, providing contraceptive care in nontraditional settings, quick-start hormonal methods of contraceptive care, advanced supplies of EC, and contraceptive reminder systems.

CITATION: 42. **Lindberg et al., 2006**

PERIOD OF ANALYSIS:
1995, 1999, 2003

POPULATION: Publicly funded FP agencies.

AIM: Examine trends in the provision of contraceptive methods to women at FP agencies and measures the extent to which agencies offer newer methods.

METHODS: Survey.

SUMMARY OF FINDINGS: **Agencies offered significantly more contraceptive methods in 2003 than in 1995 (14 versus 12), but few offered all available methods.**

The proportion of agencies that dispensed or prescribed EC increased significantly from 38 percent to 79 percent;

In 2003, 47 percent agencies provided EC ahead of time (versus 21 percent in 1999), 36 percent prescribed it over the phone (versus 16 percent in 1999).

The proportion of women clients who were required to pay the full fee declined significantly from 19 percent to 14 percent; the proportion of agencies with at least one managed care contract increased from 24 percent to 59 percent.

CITATION: 43. **Noone, 2007**

PERIOD OF ANALYSIS:
N/A

POPULATION:

AIM: Review the literature on evidence-based strategies to remove barriers and maximize contraceptive success.

METHODS: Literature review.

SUMMARY OF FINDINGS: Strategies found to promote contraceptive adherence include.
consideration of preferred contraceptive method, educational counseling on how the method works and its use, side effects, and warning signs of adverse reactions.

Strategies for removing barriers to contraceptive use include “quick start” for OC; no prerequisite screenings for contraceptive Rx; expanding access to contraceptives (advanced provision and pharmacy provision of EC).

CONTRACEPTIVE KNOWLEDGE

CITATION: 44. Davis et al., 2006

PERIOD OF ANALYSIS:
1998

POPULATION: Female patients using or planning to use OCPs at a public FP clinic in Louisiana (*N* = 400).

AIM: Assess patient understanding and use of OCPs and investigate whether these are associated with literacy.

METHODS: Structured survey assessing demographic characteristics, sexual behavior, and knowledge of contraceptives and OCPs.

Rapid Estimate of Adult Literacy in Medicine assessment.

SUMMARY OF FINDINGS: **Ability to name side effects and risks of OCPs is limited, and associated with literacy levels; ability to name at least 1 common side effect is not associated with literacy.**

1/3 of respondents are able to describe how OCPs work; 16 percent incorrectly state that OCPs prevent disease; knowledge is significantly higher for respondents w/higher literacy levels; 19 percent know what to do if they missed two OCP pills in a row; 3 percent know what to do if they miss 3 in a row.

CITATION: 45. Espey et al., 2003

PERIOD OF ANALYSIS:
2000

POPULATION: Navajo Indian Health Service providers.

AIM: Explore provider IUD-related knowledge and current practice and their attitudes toward recommending and inserting the IUD.

METHODS: Survey.

SUMMARY OF FINDINGS: **Providers are aware of and had adequate knowledge of IUDs, although they were rarely inserted; remaining concerns about risks and side effects exist.**

Women who receive IUDs are generally happy.

Insurance coverage is not an issue for this population.

EMERGENCY CONTRACEPTION

CITATION: 46. Averbach, Wendt, Levine, Philip, and Klausner, 2009

PERIOD OF ANALYSIS:
2007–08

POPULATION: Women in San Francisco requesting a prescription for EC.

AIM: Describe the Plan B Online Prescription Access program.

METHODS: Records of prescriptions requested through the program.

Pharmacist records of prescriptions filled through the program.

SUMMARY OF FINDINGS: **152 electronic prescriptions were requested by 128 women within past 18 months; 51 percent of these prescriptions were filled by pharmacists.**

Median age of users was 21, and 32 percent of women were 17 or younger.

CITATION: 47. Campbell et al., 2008

PERIOD OF ANALYSIS:
2006

POPULATION: Women ages 18–50.
Family medicine clinic in the southeastern United States.

AIM: Evaluate women's beliefs regarding pregnancy and EC's mechanism of action.

METHODS: Questionnaire.

SUMMARY OF FINDINGS: **Many open to using EC but unaware of how it works.**

38 percent would use EC only before fertilization or implantation.

42 percent unsure how fetal development would impact potential use.

Younger women believed that EC works before fertilization.

Lower-income women more likely to believe that life begins at the egg and sperm joining.

CITATION: 48. Farris et al., 2010

PERIOD OF ANALYSIS:
Up to July 1, 2009

POPULATION: Pharmacists.

AIM: Review the literature regarding pharmacists' roles in preventing unintended pregnancy, laws, and policies.

METHODS: Systematic literature review.

SUMMARY OF FINDINGS: **Pharmacists play a key role in preventing unintended pregnancy through provision of EC.**

The degree to which EC is made accessible by pharmacists varies due to moral or religious positions and a lack of knowledge and training about EC.

Studies examining new practice models for pharmacists that expanded the role of pharmacists in reproductive health through collaborative practice agreements were met with pharmacist and patient satisfaction.

Recommend additional research on the topic given its potential for improving access to contraceptives for women.

CITATION: 49. Foster, Landau, et al., 2006

PERIOD OF ANALYSIS:
2004

POPULATION: Women who received EC from pharmacies in California that provide direct access to EC (some had an Rx)

AIM: Explore reasons that women seek EC and methods of access

METHODS: Questionnaire

SUMMARY OF FINDINGS: **Recommend advanced provision, education, and reduced barriers**

Most women received EC within the necessary 72 hours; younger women experienced more delays

Women with an Rx reported not knowing that EC was available directly from the pharmacist

CITATION: 50. Godfrey et al., 2010

PERIOD OF ANALYSIS:
2008–09

POPULATION: Female clients at a publicly funded STI clinic in Chicago; predominantly low-income, African- American women (*N* = 150).

AIM: Explore the contraceptive needs of women seeking care from a public STI clinic.

METHODS: Survey.

SUMMARY OF FINDINGS: **Improved awareness and provision of EC and contraception needed**

Many women surveyed are at risk for unintended pregnancy; would have benefited from immediate use of EC at time of visit.

CITATION: 51. Golden et al., 2004

PERIOD OF ANALYSIS:
2001–03

POPULATION: Women enrolled in a randomized trial of different approaches to partner notification, who had previously been diagnosed with gonorrhea or genital chlamydial infection.

AIM: Define the risk for unintended pregnancy and assess effectiveness of FP referral and interest in advanced provision of EC among women with gonorrhea or chlamydial infection.

METHODS: Telephone interview.

SUMMARY OF FINDINGS: **Among women who do not desire pregnancy, 34 percent were using no contraception (15 percent) or condoms alone (19 percent) and 81 percent desired advanced provision of EC.**

CITATION: 52. Kavanaugh and Schwarz, 2008

PERIOD OF ANALYSIS:
2002

POPULATION: Sexually active women ages 15–44.

AIM: Investigate the prevalence and predictors of emergency contraceptive use of or counseling about the method.

METHODS: NSFG.

SUMMARY OF FINDINGS: **Women who utilized EC in the last year were more likely to report having received counseling about it from a clinician; younger women and women who had previously had an abortion were more likely to report having received counseling on EC.**

CITATION: 53. Karasz et al., 2004

PERIOD OF ANALYSIS:

POPULATION: Patients and clinician.

FP clinic in New York, New York.

AIM: Explored attitudes toward emergency contraception among patients and providers.

METHODS: Semistructured interviews.

SUMMARY OF FINDINGS: **Many patients are unfamiliar with EC but expressed interest upon learning about it.**

Clinicians favor routine counseling but had reservations about advanced prescribing based on concerns that it would encourage more risky behavior or convey a message that routine forms of contraception are inadequate.

CITATION: 54. McCarthy, Telljohann, Coventry, and Price, 2005

PERIOD OF ANALYSIS:
2001

POPULATION: High school-based health centers (*N* = 250).

AIM: Assess the provision of education, referral and prescription services for EC among high school-based health centers **(SBHCs).**

METHODS: Survey.

SUMMARY OF FINDINGS: **Providing reproductive health services and pregnancy prevention were predictors of offering prescriptions for EC.**

59 percent of SBHCs offer education and referral for EC; 30 percent provided prescriptions.

CITATION: 55. Phipps et al., 2008

PERIOD OF ANALYSIS:

2003–04

POPULATION: Women ages 17–43 seeking EC at an emergency facility (*N* = 114) or seeking any FP service at a walk-in family clinic (*N* = 113).

AIM: Compare demographic characteristics and sexual risk behaviors of women who seek EC and FP services.

METHODS: Questionnaire.

SUMMARY OF FINDINGS: **Women seeking EC are significantly younger than those seeking general FP services, have higher levels of education beyond high school, and are less likely to be married.**

A larger proportion of the women in the EC group are white (61 percent); more Hispanic women sought general FP services (45 percent).

The EC group is more likely to have had unprotected sex at last intercourse and less likely to have a previous STI.

CITATION: 56. Raine et al., 2005

PERIOD OF ANALYSIS:

2001–03

POPULATION: Women ages 15–24 not desiring pregnancy, not using long-acting contraception, not having had unprotected sex within the last 3 days, and not requesting EC.

4 California clinics (*N* = 2,117).

AIM: Evaluate the effect of direct access to EC through pharmacies and advance provision on reproductive health outcomes.

METHODS: Interviews (baseline and 6 months).

Random assignment to (1) receipt of information regarding pharmacy access to no-cost EC; (2) direct, advance provision of 3 packs of EC, or (3) receipt of information about clinic access to EC (control).

SUMMARY OF FINDINGS: **Advanced provision of EC increases likelihood of use by 50 percent.**

No difference between the pharmacy access group and the control group.

The frequency of unprotected intercourse was similar for all groups.

Slightly less than half (46.7 percent) who had unprotected sex used EC.

Women in the pharmacy access and advanced provision groups did not experience a significant reduction in pregnancy rate or increase in STIs.

No significant differences in contraceptive and condom use and sexual behavior across study groups.

CITATION: 57. Sampson et al., 2009

PERIOD OF ANALYSIS:

2005–06

POPULATION: English- and Spanish-speaking mystery shoppers posing as (1) 15-year-old women who had unprotected sex the night before and (2) 18-year-olds who had unprotected sex 4 days ago.

Pharmacists and health care providers.

AIM: Investigate the role of pharmacy access to EC among Spanish- versus English-speaking females.

METHODS: Calls were recorded and coded.

SUMMARY OF FINDINGS: **Qualitative interviews with pharmacists and health care providers suggested that poor cooperation exists between pharmacists and clinics.**

36 percent of calls were successful (told that they could obtain EC).

Spanish-speaking callers were less successful than English-speaking callers (24 percent versus 48 percent).

Callers to urban pharmacies were less successful than rural (27 percent versus 44 percent).

CITATION: 58. **Whittaker et al., 2008**

PERIOD OF ANALYSIS:

2001–02

POPULATION: Sexually active women ages 15–39 at a Title X clinic in Pennsylvania.

Not pregnant; seeking to get pregnant; sterilized; or using long-acting, reversible contraceptives (*N* = 211).

Clinic staff (counselors and clinicians) (*N* = 22).

AIM: A qualitative perspective on the practice of advance provision of EC and potential barriers to it.

METHODS: Survey of clients (intake and prior to meeting with clinician).

Interview or mail survey of staff.

SUMMARY OF FINDINGS: **Barriers to advance provision included staff prejudging patients' needs and ability to use the method, time constraints, and inefficiencies in clinic procedures.**

80 percent of patients say they would use EC; 93 percent felt it would be easy to obtain; 46 percent believed it is a form of abortion.

Staff comfort level for a policy of advance provision of EC to eligible patients was found to be 10 on a 10-point scale).

Table 2. Outreach and Access for High-Priority Populations

HIV

CITATION: 1. Felix et al., 2010

PERIOD OF ANALYSIS:

2006

POPULATION: Medicaid-enrolled FP providers in two Southern states (*N* = 456).

AIM: Document referral practices and facilitation activities of family planning **(FP)** providers who see HIV-positive patients.

METHODS: Mail survey to assess provider referral practices and support activities for HIV.

Data on the availability of free or reduced-cost health care services within a 30-minute drive.

SUMMARY OF FINDINGS: **Provider perception of patient competence, resources, relationships with referral providers, and urban or rural nature of a community are associated with providers referral behaviors.**

91 percent of providers would refer an HIV-positive woman to another provider rather than provide treatment themselves or within their practice.

Providers from nonprofit clinics report more personal relationships with referral providers than private practices or health department providers.

CITATION: 2. Tran et al., 2010

PERIOD OF ANALYSIS:

2001–10

POPULATION: People with HIV.

AIM: Detail a collaborative effort between the Title X FP Program and the Minority Aids Initiative to integrate HIV prevention counseling and testing at FP clinics.

METHODS: Program report.

SUMMARY OF FINDINGS: **Clinics that received funding have increased institutional capacity for HIV-prevention services, successful implementation and integration of HIV-prevention services, and identification of HIV-positive individuals referred for care.**

CITATION: 3. Wilson et al., 2003

PERIOD OF ANALYSIS:

1996–98

POPULATION: HIV-seropositive women (*N* = 258)

HIV-seronegative women (*N* = 228).

Recruited from prenatal clinics in 4 U.S. states.

AIM: Describe pregnancy intentions and contraceptive use among sample of HIV-positive postpartum women or postpartum women at risk of HIV infection.

METHODS: In-person interviews prenatally (24–40 weeks); 6 months postpartum.

SUMMARY OF FINDINGS: **Few differences found between HIV-positive and -negative women in reproductive behaviors.**

HIV-positive women were significantly more likely to report consistent condom use.

HIV-positive women were less likely to report use of OCs.

Inconsistent condom use associated with postpartum alcohol use and intention to terminate an unintended pregnancy.

CITATION: 4. Berenson et al., 2003

PERIOD OF ANALYSIS:

1999–2000

POPULATION: Women under age 40; excluded pregnant and postpartum women (*N* = 4726).

FP clinics in Texas.

AIM: Estimate the prevalence of depressive symptoms among women of reproductive age and demographic and reproductive characteristics associated with these symptoms.

METHODS: Survey.

Included Beck Depression Inventory.

SUMMARY OF FINDINGS: **Providers should screen for depression, which may be predictive of certain risk behaviors.**

30 percent of women had mild, moderate, or severe depressive symptoms; moderate or severe depressive symptoms were associated with being Hispanic, no partner, less than high school education, and unemployment.

Depressed women had more partners, initiated sex at a younger age, and were less likely to have used birth control at first or most recent sex.

They were more likely to have been pregnant one or more times, engaged in sex while using alcohol or drugs, and not had sex.

CITATION: 5. Buzi et al., 2007

PERIOD OF ANALYSIS:

N/A

POPULATION: African-American and Hispanic males (*N* = 1294).

FP clinic clients in southwestern United States.

AIM: Examine the differences in sociodemographic, risk factors, and interest in health care topics between males reporting depression.

METHODS: Survey.

SUMMARY OF FINDINGS: **FP providers should screen males for depression.**

Depressed males had more risk factors and less consistent condom use.

More interested in information on sexually transmitted infections, relationships, depression, alcohol counseling, employment, anger control, smoking cessation, immigration issues, and general educational development.

CITATION: 6. Breitbart and Colarossi, 2010

PERIOD OF ANALYSIS:

2006–07

POPULATION: Women (15–24) (*N* = 645).

Ethnically diverse.

AIM: Describe the implementation of intimate partner violence screening in FP centers.

METHODS: Survey.

Questions added to the standard medical history.

Focus groups with providers.

SUMMARY OF FINDINGS: **Women who complete the new screening form are 2.5 times more likely to report past or current violence and 4 times more likely to report both past and current violence.**

Focus groups also indicated providers were pleased with new tool.

CITATION: 7. Charron-Prochownik et al., 2006

PERIOD OF ANALYSIS:
N/A

POPULATION: Adolescents ages 16–20 with diabetes; matched controls without diabetes.

AIM: Examine diabetic adolescents' knowledge, attitudes, intentions, and behaviors regarding reproductive issues.

METHODS: Structured telephone interviews.

SUMMARY OF FINDINGS: **Results suggest a lack of knowledge among adolescents with diabetes regarding implications for their reproductive health.**

CITATION: 8. Colarossi et al., 2010

PERIOD OF ANALYSIS:
2009

POPULATION: Health care staff from a large, urban FP organization (*N* = 75).

AIM: Compare licensed and unlicensed FP service providers who work in a setting with institutional policies and procedures for intimate partner violence screening.

METHODS: Focus groups.

Self-administered survey.

SUMMARY OF FINDINGS: **Receipt of training on partner violence is positively associated with perceived helpfulness of written and verbal screening, perceiving few barriers to screening, and feeling prepared to discuss partner violence with clients.**

CITATION: 9. Lee et al., 2005

PERIOD OF ANALYSIS:
2000

POPULATION: Women at FP clinics located in North Carolina Health Departments.

AIM: Examine the prevalence of depressive symptoms, risk factors, and use of mental health services among female FP patients.

METHODS: Survey.

SUMMARY OF FINDINGS: C**omprehensive mental health screenings are needed based on high levels of depressive symptoms at local health department FP clinics.**

CITATION: 10. Miller et al., 2011

PERIOD OF ANALYSIS:
2008–09

POPULATION: English- and Spanish-speaking females ages 16–29 at 4 FP clinics (*N* = 906).

AIM: Evaluate the efficacy of an FP clinic-based intervention to address intimate partner violence and reproductive coercion.

METHODS: Computer-assisted survey.

FP clinics randomized to 2 control and 2 intervention clinics.

SUMMARY OF FINDINGS: **Women in the intervention group are more likely to end relationships that were unhealthy or felt unsafe.**

CITATION: 11. Schwarz et al., 2006

PERIOD OF ANALYSIS:
1997–2000

POPULATION: Diabetic and nondiabetic women (14–44).

Visited U.S. ambulatory practices.

AIM: Evaluate the impact of diabetes on provision of contraceptive counseling to women in U.S. ambulatory practices.

METHODS: National Ambulatory Medical Care Survey.

SUMMARY OF FINDINGS: **Diabetic women need more contraceptive counseling and may require a dedicated visit to address FP.**

Visits by diabetic women of reproductive age are significantly less likely to include contraceptive counseling than nondiabetic women of reproductive age.

Visits by younger diabetic women (<25) are less likely to have included contraceptive counseling than visits made by older women.

CITATION: 12. **Schwarz et al., 2010**

PERIOD OF ANALYSIS:

2003–05

POPULATION: Girls (13–15) with type 1 diabetes (*N* = 89).

Recruited from 2 large university-based diabetes centers.

AIM: Assess beliefs regarding, perceived access to, and practices regarding contraception among adolescent women with type 1 diabetes.

METHODS: Questionnaire.

SUMMARY OF FINDINGS: **Young women with diabetes need more information and counseling on FP options.**

36 percent believe that women with diabetes have limited birth control choices.

43 percent believe that birth control methods are less effective for women with diabetes.

Fewer than half discussed birth control with a health care professional.

Half of sexually active respondents had had unprotected sex.

MINORITY AND DISADVANTAGED POPULATIONS

CITATION: 13. **Becker and Tsui, 2008**

PERIOD OF ANALYSIS:

1995

POPULATION: Women ages 18–34.

Black, white, and Latina.

At risk for unintended pregnancy.

Family incomes < 200 percent of the federal poverty level (*N* = 1741).

AIM: Assess the racial, ethnic, and language-based differences in women's preferences for reproductive health service delivery and in their perceptions of its quality.

METHODS: Telephone survey.

SUMMARY OF FINDINGS: **Significant differences in preferences and perceived quality of care by race and ethnicity were found.**

Latina women are more likely to prefer a female provider than white women.

Latina and black women are more likely to prefer getting reproductive services where general health care is also available.

Black women are more likely to report feeling pressured into using a particular contraceptive method.

CITATION: 14. **Bird and Bogart, 2003**

PERIOD OF ANALYSIS:

N/A

POPULATION: African-Americans ages 18–45 (*N* = 71).

AIM: Explore the relationship between birth control conspiracy beliefs and perceived discrimination and contraceptive attitudes and behavior.

METHODS: Cross-sectional telephone survey.

SUMMARY OF FINDINGS: **Stronger agreement with conspiracy beliefs about birth control is related to lower intentions to use birth control pills in the next year.**

Women who report conspiracy beliefs, and women who have high group discrimination scores, have a higher likelihood of planned condom use during their next sexual encounter; women who score highly on the perceived personal discrimination scale have lower intentions of using birth control pills in the next year.

CITATION: 15. Julliard et al., 2008

PERIOD OF ANALYSIS:

N/A

POPULATION: Hispanic women age 18 years old living in Brooklyn, New York (*N* = 28).

AIM: Explore factors, such as culture and background, that contribute to a Hispanic patients' nondisclosure of medical information during a clinical encounter.

METHODS: In-depth, semistructured, one-on-one interviews focused on the subject of disclosure of health information in clinical encounters with physicians.

SUMMARY OF FINDINGS: **Physician-patient relationship, language, physician sex and age, time constraints, sensitive health issues, and culture and birthplace influence disclosure practices.**

CITATION: 16. Lukyanova and Calasanti, 2009

PERIOD OF ANALYSIS:

N/A

POPULATION: Women attending FP clinics in Appalachian region of Virginia.

AIM: Investigate women's perceptions concerning FP service quality.

METHODS: Client questionnaire.

Interviews with FP clinic managers and staff.

SUMMARY OF FINDINGS: **Women served in these clinics are overwhelming satisfied with the services they receive (86 percent); Appalachian women are slightly more satisfied than other women.**

Use may be affected by the closeness of the community, and concerns about confidentiality; transportation is a significant barrier to access: 17 percent needed a ride to get to the clinic and 3 percent walked.

CITATION: 17. Romo et al., 2004

PERIOD OF ANALYSIS:

N/A

POPULATION: Pregnant women: low-education, low-income, Latina (*N* = 234).

Reproductive health clinics in Texas.

AIM: Examine how acculturation, religion, and various demographic factors relate to the FP behaviors of Latina women in the United States.

METHODS: Questionnaire.

SUMMARY OF FINDINGS: **Assessing women's contraceptive needs based on cultural stereotypes is likely to result in inadequate provision of services.**

Strong ties to Latina culture associated with increased contraceptive use.

Women who were married and had fewer children were more likely to plan their current pregnancy. Women with more children were more likely to use contraception consistently.

Church and religion have no direct impact on women's contraceptive behavior or decisionmaking.

CITATION: 18. Sable et al., 2009

PERIOD OF ANALYSIS:

2003–04

POPULATION: Hispanic immigrant women.

AIM: Affect FP behaviors of recent Hispanic immigrant women.

METHODS: Focus groups.

SUMMARY OF FINDINGS: **Staff should be trained in providing culturally competent care; consider using social workers in FP settings.**

Tacit acceptance of male infidelity, emphasizing the need for dual forms of birth control (condom and hormonal); women bear the burden of the responsibility for birth control.

CITATION: 19. Sufrin et al., 2009

PERIOD OF ANALYSIS:
2006–07

POPULATION: Correctional health providers (*N* = 286).

AIM: Explore the contraception care practices for women in correctional facilities .

METHODS: Mail survey.

SUMMARY OF FINDINGS: **70 percent of correctional health providers report providing some degree of contraception counseling for women in their facilities; female providers are significantly more likely to provide contraceptive counseling than male providers.**

Only 11 percent of providers reported routine contraceptive counseling prior to release; OCs were most frequently recommended and provided; condoms were discussed frequently but not widely offered.

Discussions about birth control reported by 96 percent of providers at juvenile facilities; 82 percent at state prisons; 64 percent at city or county jails.

Majority of clinicians felt they would benefit from additional education about contraception.

CITATION: 20. Thorburn and Bogart, 2005

PERIOD OF ANALYSIS:
Not available.

POPULATION: African-American women (15–44) (*N* = 326).

AIM: Examine perceived race-based discrimination in FP services.

METHODS Telephone survey.

Random sample.

SUMMARY OF FINDINGS: **Providers should receive training to reduce stereotyping and improved provision of care to all populations.**

Most women surveyed had seen a provider for contraceptive services, many during the past year; most reported having experienced at least 1 of 9 race-based discriminatory experiences.

Perceived discrimination was not correlated with personal characteristics, but a stronger black identity was associated with perceptions of general health care discrimination.

ADOLESCENTS

CITATION: 21. Akinbami, Gandhi and Cheng, 2003

PERIOD OF ANALYSIS:
1998

POPULATION: Physician offices providing primary care within a 25-mile radius of Washington, D.C.

AIM: Assess the self-reported availability of services for medically emancipated conditions and confidential care in primary care practices.

METHODS: Telephone survey to office appointment lines.

Mail survey to physicians.

SUMMARY OF FINDINGS: **Offices with a written office policy on adolescent confidentiality are more likely to have office staff and physicians in agreement on the availability of confidential services.**

Pediatric practices are less likely than family medicine or internal medicine practices to offer services for medically emancipated conditions and confidential care in primary care practices.

CITATION: 22. **Harper et al., 2010**

PERIOD OF ANALYSIS:
2005–09

POPULATION: Clinicians serving low-income, high-risk patients.

AIM: Understand clinicians' perspectives on teenagers' counseling needs.

METHODS: In-depth interviews.

SUMMARY OF FINDINGS: **All physicians and most advanced practice clinicians report integrating abstinence into their comprehensive contraceptive counseling messages.**

Emphasize pleasure, readiness for sex, avoidance of unwanted sex, and healthy sexuality; greatest emphasis on abstinence directed to youth who are not sexually active.

CITATION: 23. **Jones et al., 2005**

PERIOD OF ANALYSIS:
2001

POPULATION: Adolescents.

AIM: Determine the extent to which parents are aware that their teenage daughters are accessing reproductive health services and how minors would react to a mandated parental involvement law.

METHODS: Surveys.

SUMMARY OF FINDINGS: **Most teens report that they would use clinics for prescription contraception even if consent is required or use OTC methods; Hispanic teens are more likely to engage in risky sex rather than inform parents of sexual activity compared with black teens.**

CITATION: 24. **Jones, 2006**

PERIOD OF ANALYSIS:
2001

POPULATION: Adolescents

AIM: Examine clinic programs and practices to promote parent-child communication for minors seeking FP services.

METHODS: Surveys.

SUMMARY OF FINDINGS: **Title X clinics are mandated to encourage this form of communication, with which they and others have complied.**

Most clinics routinely counseled adolescents on the importance of talking to their parents about sexual health issues.

Most distributed information aimed at improving this route of communication; some offered educational program.

CITATION: 25. **Jones and Boonstra, 2004**

PERIOD OF ANALYSIS:
N/A

POPULATION: Adolescents and their parents.

AIM: Synthesize research on adolescent disclosure to parents, and review state and federal laws and polices pertaining to minor adolescents' rights to access services for contraception and sexually transmitted diseases (STD).

METHODS: Review of research and state and federal law.

SUMMARY OF FINDINGS: **Additional research is necessary to understand the extent to which parents are involved in their children's sexual health decisions and how to effectively promote parental involvement.**

Many FP clinics offer activities and programs to support parents' increased involvements in adolescents' lives with pamphlets, media campaigns, open houses, and direct counseling with adolescent patients.

Formal education programs are identified as one of the most important opportunities during which parents can encourage parent-child communication about sexual health issues.

CITATION: 26. Lawrence et al., 2011

PERIOD OF ANALYSIS:

2008–09

POPULATION: U.S. ob-gyn physicians under 65 years of age.

AIM: Assess ob-gyn responses to requests for confidential contraceptive services from an adolescent.

METHODS: Mail survey.

SUMMARY OF FINDINGS: **94 percent of ob-gyns said they would provide contraceptives without notifying the patient's parents; 47 percent of ob-gyns would encourage the patient to involve a parent; 54 percent would advise abstinence until the patient is older.**

Doctors who frequently attended religious services were significantly more likely to encourage the patient to involve her parents and encourage abstinence but were just as likely to provide contraceptives without notifying their parents.

CITATION: 27. Lerand et al., 2007

PERIOD OF ANALYSIS:

N/A

POPULATION: Adolescents (*N* = 59) divided into those presenting at the clinic for confidential services and those for nonconfidential services.

AIM: Evaluate whether confidential services affect adolescents' communication with parents about their health.

METHODS: Survey.

SUMMARY OF FINDINGS: **Obtaining confidential services is not a barrier to discussion with parents about a clinic visit, reasons for coming to a clinic, or whether the patient had a serious medical condition.**

Of all participants, 69.5 percent reported having informed their parents that they were coming to the clinic.

CITATION: 28. Lindberg et al., 2006a

PERIOD OF ANALYSIS:

2003

POPULATION: Publicly funded FP clinics (*N* = 1,088).

Nationally representative sample.

AIM: Describe FP clinics service availability and clinic policies in the United States.

METHODS: Survey

SUMMARY OF FINDINGS: **Planned Parenthood and Title X-supported clinics are significantly more likely to provide care to adolescents without parental involvement.**

Most clinics offered comprehensive services including HIV testing, EC, OCs, injectable, and condoms; most also provide counseling to adolescents about abstinence, especially for those age 17 and younger (91 percent).

39 percent are administered by health departments, 12 percent by Planned Parenthood, and 49 percent by other agencies.

60 percent receive Title X funds.

The majority of clinics (87 percent) did not require parental notification or consent for minors.

CITATION: 29. McKee et al., 2006

PERIOD OF ANALYSIS:
N/A

POPULATION: Mothers and their 16- to 19-year-old daughters (ethnic minorities).

AIM: Examine perspectives of mothers and daughters on support for and barriers to risk-appropriate reproductive care.

METHODS: Focus groups.

SUMMARY OF FINDINGS: **Mothers report concerns about confidential encounters because of possible exposure to explicit material and physical vulnerability; girls' reactions were mixed, wanting their mother's help but also needing some privacy to talk frankly to the provider; mothers and daughters expressed concerns about the awkwardness of negotiating these dynamics.**

MEN

CITATION: 30. Barone et al., 2004

PERIOD OF ANALYSIS:
1998–99

POPULATION: Men receiving vasectomies (*N* = 719).

AIM: Explore the characteristics of men choosing vasectomy and why they decided to undergo the procedure.

METHODS: Nationwide, practice-based survey.

SUMMARY OF FINDINGS: **Low-income and minority men underrepresented among vasectomy clients; may be due to lack of relevant information and services.**

Men receiving vasectomies were a homogenous group—generally married or cohabiting, non-Hispanic white—and educated beyond high school; less than 1 percent paid for the procedure using public funding.

CITATION: 31. Brindi et al., 2005

PERIOD OF ANALYSIS:
1999–2002

POPULATION: Men in California's Male Involvement Program **(MIP).**

AIM: Evaluate California's MIP.

METHODS: Interviews,
Focus groups,
Surveys,
Program data.

SUMMARY OF FINDINGS: **Men were typically satisfied and comfortable with the programs.**

Attitudes and knowledge regarding contraception were affected.

Only marginal effects on behavior were observed.

CITATION: 32. Finer et al., 2003

PERIOD OF ANALYSIS:
1998–99

POPULATION: Publicly funded FP agencies (*N* = 637).

AIM: Survey publicly funded FP clinics regarding their current policies and services for men.

METHODS: Survey.

SUMMARY OF FINDINGS: **Reproductive health-oriented agencies are more likely to be interested in increasing male clientele than agencies with a general health orientation.**

Reproductive health services for men are being increasingly integrated but are still not universal; reproductive services were offered more often than general health and preventive services; specialized services were the least likely to be offered; Planned Parenthood affiliates and health departments were the least likely to offer general health and preventive services.

CITATION: 33. Kalmuss and Tatum, 2007

PERIOD OF ANALYSIS:

2002

POPULATION: Sexually active men ages 15–44.

AIM: Examine male use of sexual and reproductive health services.

METHODS: NSFG

SUMMARY OF FINDINGS: **Appropriate messages and funding should be used to promote care for men's reproductive and sexual health.**

Only 30 percent of men surveyed received comprehensive reproductive health care; black and Hispanic men are more likely to receive nontesticular sexual health care.

Few men used a condom at last sex, and few men report contraceptive counseling or HIV/STD screenings.

CITATION: 34. Raine et al., 2003

PERIOD OF ANALYSIS:

2001

POPULATION: Male clients of an FP clinic for men within a traditional FP (*N* = 110).

Existing female clients at the clinic (*N* = 51).

AIM: Implement a reproductive health clinic targeted at male adolescents and young adults that was established within a women's reproductive health clinic.

METHODS: Clinic billing data.

Questionnaires.

SUMMARY OF FINDINGS: **The number of male clients doubled 1 year after the male clinic was opened.**

Most men visited the clinic for STD testing or treatment (88 percent).

Most men (59 percent) indicated no gender preference for the provider.

75 percent of male clients heard about the clinic through word of mouth, not outreach efforts.

CITATION: 35. Young, Nguyen, Weiss-Laxer, Sigman, and Nolan, 2010

PERIOD OF ANALYSIS:

N/A

POPULATION: Health providers in Rhode Island (*N* = 224).

AIM: Assess whether health providers are addressing FP and sterilization options in the clinical setting.

METHODS: Mail survey.

SUMMARY OF FINDINGS: **Fewer than half of providers report discussing family planning, and only 20 percent reported discussing vasectomy with at least 10 percent of their male patients; providers are significantly more likely to discuss family planning and vasectomy with female patients.**

Patient objections to vasectomy included aversion to surgical procedure, desire to have more children, satisfaction with other control, concerns with masculinity, virility, or sex life, birth control is the female's responsibility, and affordability or insurance coverage.

Few providers were aware of Rhode Island's No-Cost Vasectomy Program.

Table 3. Program Administration

PROGRAM AND DETAILS	
CITATION: 1. Brindis et al., 2003	
PERIOD OF ANALYSIS: 1995–2001 **POPULATION:** California Office of Family Planning's Family Access, Care, and Treatment Program **(Family PACT).** **AIM:** Examine the effects of the Family PACT program on adolescent access to family planning **(FP)** services.	**METHODS:** Baseline data, Enrollment and claims data for the first 4 years of Family PACT, Client exit interviews, Onsite observations. **SUMMARY OF FINDINGS: The number of adolescents served by Family PACT increased substantially from the implementation of Family PACT in 1995 to 2001.** This may be attributed to the program's one-stop shop model, which links eligibility determination to delivery of services, removal of cost barriers, and expansion of the provider network.
CITATION: 2. Foster et al., 2006	
PERIOD OF ANALYSIS: 2002 **POPULATION:** Women who received contraceptives through Family PACT. **AIM:** Estimate the number of pregnancies averted through the Family PACT program in 1 year.	**METHODS:** Medical records of new clients. Program claims data. **SUMMARY OF FINDINGS: An estimated 205,000 pregnancies were averted as a result of the contraceptives provided through the Family PACT program in 2002.** Updated estimate of Foster et al. (2004), taking into account several changes recently affecting the Family PACT program: enrollment has doubled and additional contraceptive methods were added, such as emergency contraception, the contraceptive patch, and the vaginal ring.
CITATION: 3. Foster, Biggs, Ralph, Arons, and Brindis, 2008	
PERIOD OF ANALYSIS: 2003–04 **POPULATION:** Clients seeking reproductive health services at Family PACT clinics in California (*N* = 1,409).	**AIM:** Assess the reproductive intentions of low-income women and men. **METHODS:** Interviews. **SUMMARY OF FINDINGS: No significant relationship between the desired wait time until another pregnancy and the contraceptive method dispensed.** Average desired delay in childbearing was 5.4 years; most common reasons for doing so were finances and education.
CITATION: 4. Frost et al., 2008	
PERIOD OF ANALYSIS: 2002–03 **POPULATION:** Women ages 15–44	**AIM:** Provides estimates on unintended pregnancies prevented by U.S. publicly funded FP clinics. **METHODS:** National Survey of Family Growth **(NSFG).** **SUMMARY OF FINDINGS: Every $1 spent on publicly funded FP services results in $4.02 in savings.**

CITATION: 5. Frost, Sonfield, Gold, and Ahmed, 2006

PERIOD OF ANALYSIS:
2000–04

POPULATION: N/A

AIM: Examine the potential impact of four different scenarios of expanded Title X funding on the number of new clinic clients that would be served and the key outcomes that would follow.

METHODS: State-level financial and program data from Title X FP projects that have recently experienced funding increases.

SUMMARY OF FINDINGS: **Increased Title X funding would have a significant impact on averting unintended pregnancies and preventing abortions and unintended births.**

CITATION: 6. Frost, Sonfield, and Gold, 2006

PERIOD OF ANALYSIS:
N/A

POPULATION: N/A

AIM: Estimate the number of pregnancies, births, and abortions that could be averted and the resulting cost savings under 4 proposed income-based expansions to Medicaid FP services.

METHODS: State-level financial and program data for Medicaid FP costs and services.

SUMMARY OF FINDINGS: **Between 2.6 million and 5 million additional women would receive FP services under 4 different Medicaid expansion scenarios.**

From 151,000 to 291,000 abortions; 179,000–345,000 unintended births would be prevented.

The net savings would be between $1.1 billion and $1.6 billion.

CITATION: 7. Gold et al., 2009

PERIOD OF ANALYSIS:
N/A

POPULATION: N/A

AIM: Review the challenges and opportunities ahead for Title X related to financing and resources

METHODS:

SUMMARY OF FINDINGS: **Service availability and public funding for FP services is much greater in states with Medicaid waivers compared with those without**

Disparities in contraceptive use and unintended pregnancy based on income and race or ethnicity are increasing

CITATION: 8. Guttmacher, 2009

PERIOD OF ANALYSIS:
2009

POPULATION: Publicly funded FP centers.

AIM: Characterize the effect of the recession on FP centers.

METHODS: Survey of FP centers.

SUMMARY OF FINDINGS: **Recession has increased the demands on publicly funded FP centers.**

The proportion of clients served at FP centers who are economically disadvantaged is increasing.

Some centers have been able to respond to the increased demand; others have had to cut back on the services offered or deal with the consequences of increased demand, including long waiting times.

CITATION: 9. **Klerman et al., 2007**

PERIOD OF ANALYSIS:
2003

POPULATION: FP facilities.

AIM: Explore whether structural and organizational characteristics of publicly available FP facilities are associated with greater availability of services.

METHODS: Survey.

SUMMARY OF FINDINGS: **Suggest rethinking local health department (LHD) provision of FP services, noting that Medicaid waivers have made other sources of care more available.**

FQHCs are most likely to offer primary care; LHDs are least likely to provide primary care services; nearly 70 percent are open at least 35 hours per week.

CITATION: 10. **Sonfield et al., 2006**

PERIOD OF ANALYSIS:
2001–2004

POPULATION: Title X grantees (*N* = 78)

AIM: Survey grantees on Title X funds spending and Medicaid reimbursement

METHODS: Email questionnaire

SUMMARY OF FINDINGS: **Title X spending on contraceptive supplies and diagnostic tests increased by an average of 24 percent from 2001 to 2004; grants increased by an average of 11 percent**

Cost of an initial FP visit grew by an average of 24 percent, while Medicaid reimbursement for an initial visit grew by only an average of 15 percent

CITATION: 11. **Sonfield et al., 2011**

PERIOD OF ANALYSIS:
N/A

POPULATION: N/A

AIM: Examine the potential of states' new authority under the Affordable Care Act to implement an FP state plan amendment **(SPA)** to expand Medicaid eligibility for FP services to those who are otherwise ineligible.

METHODS: State-level financial/program data as well as national-level data (CPS, NSFG, and Guttmacher national estimates).

SUMMARY OF FINDINGS: **Findings show that a Medicaid FP SPA would have a substantial positive impact, including averting unintended pregnancies and reducing abortions.**

References for Table 1. Family Planning Practice Details

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APPENDIX B: Review of Family Planning Service Delivery Research from 2003 to the Present

This document details the process for conducting systematic reviews that will be used to guide the effort to update research on family planning service delivery. Previous work synthesized research on this topic from 1985 to 2003 (Sonenstein et al., 2004). To supplement, without replicating, the work being done by CDC and Manila Consulting to update the Title X guidelines, we have carved out three focus areas of research: Family Planning Practice Details, Outreach and Services for High-Priority Populations, and Program Administration.

We will follow a transparent and replicable process presented below to ensure the rigor of the review being conducted.

A. Identify key research questions for each of the three research topics identified.
B. Define search terms for each of the three research topics identified.
C. Identify databases and gray literature sources to be searched.
D. Develop retrieval and inclusion criteria.
E. Perform search of peer reviewed literature.
F. Perform search of gray literature.
G. Review abstracts or summaries when available and full reports when summaries are not available.
H. Select for inclusion.
I. Prepare evidence tables.
J. Synthesize for report.

A. Identify Research Questions and Outcomes

These questions pertain to one or more of the topic areas we have specified for the review. They will guide both the search of the literature and the selection of articles or reports for retrieval and inclusion.

Q1: How are primary care and family planning services integrated, and what are the effects on care coordination?

Q2: Are electronic medical records being used in this setting?

Q3: How can family planning practices be strengthened?

Q4: How do publicly funded practices compare with private-sector programs?

Q5: How are family planning practices integrating sexually transmitted disease prevention and family planning services? What best practices have emerged?

Q6: What is the status and outlook of family planning providers and provider training?

Q7: What outreach efforts are being used to encourage high-risk populations to use family planning services, including:

- Low-literacy and non-English-speaking populations;
- Racial and ethnic minorities;
- Obese and overweight individuals;
- Survivors of sexual abuse;
- Survivors of domestic violence; and
- HIV-positive individuals?

Q8: How effective have these outreach efforts been in increasing family planning service use among high-risk populations?

Q9: How are family planning practices accommodating high-risk populations (specified above) in their practices? What has this looked like, and how effective are providers and practices at caring for these populations?

Q10: Has providing contraceptives in various nontraditional settings proved to be cost-effective, such as over- or behind-the-counter pharmacy availability?

Q11: What has been the effect of increasing costs of providing family planning services in light of decreased funding?

Q12: What has been the effect of Medicaid family planning waivers on family planning service provision and use?

Outcomes

We examined the list of short-, medium-, and long-term outcomes specified by the Centers for Disease Control and Prevention for its literature review, which is intended to inform the Title X guidelines. We determined that a more general list of outcomes would be appropriate for this literature search, because we plan to include descriptive reports and qualitative studies in our review. We expect, however, that the following outcomes are likely to be discussed in the research review. We expect that, while they are outcomes of interest, it is unlikely that we will capture research that details long-term effects such as reductions in teen or unplanned pregnancy; these long-term effects are noted in gray.

Outcomes of Interest

- **Increased intention to use contraception**
- **Increased access to services**
- **Increased use of services**
- **Increased quality, satisfaction, and/or comfort with services**
- **Increased use of contraceptives**
- **Increased consistent use of contraceptives**
- **Increased use of effective contraceptives**
- **Increased knowledge**
- **Enhanced self-efficacy**
- Decrease in unintended pregnancy
- Increase in interval between pregnancies
- Decrease in rates of abortion

B. Search Terms

Family Planning Services Review: Search Terms		
MeSH	**EBSCOhost**	**Free Text**
Family planning services	Family planning	Family planning services
Family planning programs	Family planning services	Family planning policy
Family planning p	Birth control clinics	Medicaid
Family planning program evaluation	Family planning policy	Title X
Cost-benefit analysis	Medicaid	Family planning providers
Contraception	Title X	Birth control clinics
Contraceptive methods	Family planning program evaluation	Family planning program evaluation
Safe sex	Cost-effectiveness	Cost-effectiveness
High-risk sex	Birth control	Cost-benefit analysis
HIV	Contraception	Birth control
STD	Contraceptives	Contraception
Family planning instructors	Outreach	Safe sex
Family planning training	Outreach programs	STD prevention
Family planning personnel	Communication in family planning	Care coordination
Community outreach	Community health services	Family planning outreach
Community-institutional relations Minority groups*	Community-based distribution of contraception	Community-based outreach
Mental disorders	Non-English-speaking	Health promotion
Domestic violence	Racial and ethnic minorities*	High-risk populations
Child abuse, sexual	HIV-positive persons	Racial and ethnic minorities*
Health education	Sexual abuse victims	Non-English-speaking
Health promotion	Victims of family violence	HIV-positive persons
Medicaid	Mentally ill	Sexual abuse victims
		Victims of family violence
		Domestic violence
		Mentally ill

*May choose to list individual groups (i.e., Latino, African American, Asian, American Indian, and possibly other, immigrant groups).

MeSH Search Logic

[Family planning services OR Family planning programs]
AND [Family planning policy]
AND [Medicaid]
AND [Family planning program evaluation]
AND [Cost-benefit analysis]
AND [Contraception OR contraceptive methods]
AND [Safe sex OR High-risk sex]
AND [Family planning instructors OR Family planning training OR Family planning personnel]
AND [Community outreach OR Community-institutional relations]
AND [Health education or Health promotion]
AND [HIV OR STD]
AND [Minority groups*]
AND [Mental illness]
AND [Child abuse, sexual]
AND [Domestic violence]

EBSCOhost Search Logic

[Family planning OR Family planning services OR Birth control clinics]
AND [Family planning policy]
AND [Medicaid]
AND [Title X]
AND [Family planning program evaluation]
AND [Cost-effectiveness]
AND [Birth control OR Contraception OR Contraceptives]
AND [Outreach OR Outreach programs OR Communication in family planning]
AND [Community health services]
AND [Community-based distribution of contraception]
AND [Non-English-speaking]
AND [Racial and ethnic minorities*]
AND [HIV-positive persons]
AND [Sexual abuse victims]
AND [Victims of family violence]
AND [Mentally ill]

Free Text Search Logic

[Family planning services OR Family planning OR Family planning providers OR Birth control clinics]
AND [Family planning policy]
AND [Medicaid]
AND [Title X]

AND [Family planning program evaluation]
AND [Cost-effectiveness OR Cost-benefit analysis]
AND [Birth control OR Contraception]
AND [Safe sex]
AND [STD prevention]
AND [Care coordination]
AND [Family planning outreach]
AND [Community-based outreach]
AND [Health promotion]
AND [High-risk populations]
AND [Racial and ethnic minorities*]
AND [Non-English-speaking]
AND [HIV-positive persons]
AND [Sexual abuse victims]
AND [Victims of family violence OR Domestic violence]
AND [Mentally ill]

C. Databases to be Searched

Peer-Reviewed Literature

PubMed/Medline
Academic Search Premiere
Health Policy Reference Center
Psychology and Behavioral Sciences Collection
SocINDEX
Econlit
Health Business Elite
JSTOR
URBAN 500 (a customized database)
ERIC

Gray Literature

National Family Planning and Reproductive Health Association
American College of Obstetricians and Gynecologists
Society for Adolescent Medicine
American Academy of Family Physicians
American Academy of Nurse Practitioners
Family Planning Councils
Family PACT
Society for Family Planning
Association of Reproductive Health Professionals
National Campaign to Prevent Teen and Unplanned Pregnancy
Advocates for Youth

Healthy Teen Network
Guttmacher Institute
Mathematica Policy Research
RAND
Planned Parenthood Foundation of America
Kaiser Family Foundation
Robert Wood Johnson Foundation
The Urban Institute
World Health Organization
UN Fund for Population Affairs
OPA Title X Annual Reports

Conference Proceedings

Association of Reproductive Health Professionals
National Family Planning and Reproductive Health Association
Society for Adolescent Medicine
Society for Research in Adolescents
American Public Health Association
Population Association of America

D. Retrieval and Inclusion Criteria

Articles will be assessed for pertinence to the research questions; these criteria pertain to all searches.

- Only articles published between 2003 and 2011 will be included.
- Only full-length articles will be included.
- For cases in which the same research is cited in multiple articles, only the most complete discussion will be included.
- Only U.S.-based research will be included.

APPENDIX C: Family Planning Service Research Experts

Family Planning Research Expert Panel Meeting
November 10, 2011
Washington, DC

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APPENDIX D: Family Planning Research Expert Panel Meeting Agenda

Family Planning Research Expert Panel Meeting
November 10, 2011

Altarum Institute
1200 18th Street, NW, Suite 700
Washington, DC 20036

Meeting Objectives

- Present and discuss current family planning literature
- Identify research opportunities
- Suggest research priorities for family planning in the next decade
- Identify opportunities for enhanced or new collaboration with other federal agencies and offices engaged in similar research

Thursday, November 10	
8:30 a.m.	**Continental Breakfast**
9:00 a.m.	**Welcome—Marilyn J. Keefe, MPH**
9:10 a.m.	**Introductions, Meeting Objectives, and Format—Jamie Hart, PhD, MPH** • Introductions • Review of the objectives and agenda • Discussion of meeting norms
9:30 a.m.	**Family Planning Research: Background and History—Sue Moskosky, MS, RNC** • Summarize findings from *Future Directions 2004* • Overview of research funded as a result • Synergy with Title X guideline project
9:50 a.m.	**Evidence Review Methodology Overview—Sarah Benatar, PhD**

10:00 a.m.	**Presentation and Discussion of the Evidence on:**
	• ***Family Planning Practice Details***
	• ***Outreach for High Priority Populations***
	• ***Program Administration***
	  ○ Any clarifying questions about
	  ▪ Methodology and search scope
	  ▪ Studies and their findings?
	  ○ Discussion of evidence—Panelists

11:00 a.m.	**Break**

11:15 a.m.	**Title X Guidelines Research Opportunities—Marion Carter, PhD** • Brief review of research gaps and opportunities identified by Title X guideline revision literature review and technical panels
11:40 a.m.	**Identifying Research Opportunities—Jamie Hart, PhD, MPH** • In each category, what do we not know? • What else needs to be considered?
12:30 p.m.	**Lunch**
1:00 p.m.	**Identifying Research Opportunities, cont'd—Jamie Hart, PhD, MPH**

2:30 p.m.	**Prioritizing and Disseminating of Family Planning Research**
	• Of the areas identified, which might be priority areas for future research?
	• What may be the impact of health care reform on the research agenda?
	• How should the family planning field be informed of the research agenda?
	  ○ How can the Office of Population Affairs (OPA) gather further input on the research agenda?
	  ○ How can OPA draw upon its role as a policy office to best disseminate and inform the field?
	  ○ What existing channels exist to assist with dissemination?

3:45 p.m.	**Break**
4:00 p.m.	**Implementing the Family Planning Research Agenda** • What are the intended outcomes of the research agenda? • Who are potential implementation partners (federal and otherwise)? How can they best be engaged? • What types of support may be required? • How can progress be monitored and assessed?
5:15 p.m.	**Timeline and Next Steps** • Review overall timeline and identified next steps
5:30 p.m.	**Adjourn**

APPENDIX E: Research Priorities

Office of Population Affairs Family Planning (FP) Research Expert Panel Meeting
Research Questions and Prioritization

Instructions: **You have 100 points which you can use to rank the most important questions for the field. You can distribute points in any manner that you deem appropriate.** There are also **two additional open-ended questions** listed below to indicate factors you used to rank the research questions and which research methodologies are critical to advancing the field of family planning.

A. Family Planning Practice Details	B. Outreach and Access for Priority Populations	C. Program Administration and Funding Details
• Questions addressing the availability of family planning services, the scope of services offered, and trends in contraceptive use and access	• Questions addressing minority and disadvantaged populations; adolescents; men; individuals with physical and mental risk factors; and individuals with HIV	• Research on policies impacting family planning service delivery, administration, organization and funding

A. Family Planning Practice Details		
Contraceptive Counseling		
Pts.		**Research Questions:**
91	1.	What are effective approaches to contraceptive counseling (e.g., who is conducting the counseling, how are they trained, what are preferred settings and approaches)? What are the impacts on service quality, contraception choice, and more?
17	2.	What impact does contraceptive counseling have on service quality, contraceptive choice, short- and long-term health outcomes, and more?
5	3.	How can promising programs across different populations be better replicated?
15	4.	What are the impacts and possible delivery models for couples counseling and shared responsibility?
Contraceptive Use, Access, and Knowledge		
55	5.	What are effective interventions designed to improve provider knowledge and provision of contraceptive methods, including emergency contraception (EC)?
85	6.	How can we effectively reach women who don't want to get pregnant and are (1) not using contraception, or (2) using contraception inconsistently?
25	7.	What are the most effective methods providers can use to address dual method use and choices in balancing pregnancy and sexually transmitted disease prevention?
25	8.	What are the systematic ways to encourage and test innovative contraceptive approaches?

B. Outreach and Access for Priority Populations	
General Questions to Consider for a Variety of Priority Populations	
3	1. What elements define a priority population in a given location? What variables are critical to factor in when addressing the FP needs of this population?
2	2. Where do individuals within these groups access care? Where do they want to access care?
12	3. What types of outreach models are effective with given priority populations?
7	4. How can high-quality services best be provided to individuals within these groups?
Specific Populations	
	HIV
2	5. What are the barriers to providing contraception to women who are HIV-positive, from the provider and/or the client level (e.g., community-based evaluation of service delivery problems leading to prenatal transmission)? What are the strategies to address these barriers?
	Males
23	6. How are FP services for males defined? What is the scope of practice and services for males? How they are they being provided across the country?
27	7. What do males know about and how do they view contraception, including EC?
42	8. What is the impact of providing male reproductive health and FP services on males and families?
	Adolescents
55	9. What are the unique characteristics of the 20-somethings (e.g., developmental processes, needs, motivation, impact of insurance status on where to seek services, ambivalence about getting pregnant)? How are age groups defined or differentiated? How can strategies be tailored to address the needs of various age groups?
10	10.How do young people understand confidentiality? What do they want?
	Ethnic and cultural groups
3	11.How do we highlight and build on different levels of expertise in different parts of the country (e.g., tribal communities, immigrants)?
C. Program Administration and Funding Details	
Service Delivery and Policy	
108	1. How will health care reform affect FP service provision? What FP models will survive?
13	2. What administrative and organizational practices best support effective and efficient operations among Title X clinics (e.g., electronic medical records, innovative technologies, integration of other personnel in the delivery of care)?
72	3. What is the impact of various kinds of reimbursement and funding models on service delivery?
6	4. What is the impact of changes in funding on FP service delivery?
11	5. What state variations in Medicaid policies relating to postpartum and post-abortion contraceptive services exist? How do these variations affect access, utilization,

	cost, and rates of unintended pregnancy?
49	6. What are the best strategies for disseminating and implementing practice guidelines? How can we assess whether the revised Title X guidelines are translated into actual practice at the clinical level? Are there ways to incentivize adoption?
3	7. How do we share evidence and other findings with the broad range of FP service providers and ensure fidelity to best practices?
Administration and Organization	
17	8. What is the importance and relevance of clinic location and hours to serving the target populations?
49	9. How effective is social media for addressing retention of patients, training, outreach, and more?
13	10. What core data and measures should be collected through the FP Annual Report?
19	11. What is the relationship between gaps in coverage and unintended pregnancy? What are effective methods for improving patient retention (e.g., dealing with gaps in payer services, coordination with other services)?
19	12. What are the prevalence and the effects of the complexity and comorbidities of our patients? What interventions are effective in addressing these complexities and how are they tailored?
5	13. What are effective models for partnering with other, non-FP providers (that have been developed by FP providers)? How do we document them?
2	14. What are other sources of revenue or funding, and how can they be accessed?

APPENDIX F: OPA Service Delivery Improvement Research Projects (2005–10)

OPA Funded Projects (2005–10) Categorized by Priorities Outlined in *Future Directions for Family Planning Research*

Project	Grantee	Dates
How can family planning practices be strengthened?		
1. How Well Do Family Planning Providers Link Their Low-Income Clients to Primary and/or Specialty Care?	University of Alabama-Birmingham (Janet M. Bronstein, PhD)	9/05–9/07
2. Couples and Contraceptive Practice	Family Planning Council (Paul Whittaker, PhD)	9/05–9/08
3. Impact of Pack Supply on Contraceptive Continuation	Columbia University Medical Center (Katherine J. O'Connell, MD, MPH)	9/06–9/09
4. Chlamydia and Race/Ethnicity in Title X Region X Female Clients Age 15–24 Years	Center for Health Training (David Fine, PhD)	9/06–8/07
5. Couples-Based Family Planning Services: Is There a Need?	The Guttmacher Institute (Rachel Jones, PhD)	9/07–9/10
6. Integration of Family Planning Services into an STD Clinic Setting	Denver Health and Hospital Authority, Denver Public Health Department (Judith Shlay, MD)	9/08–8/11
7. Innovative Technology-Based Outreach and Utilization of Client Home Testing to Improve Chlamydia/Gonorrhea Retesting	Public Health Foundation Enterprises, Inc. (Heidi Bauer, MD)	9/09–8/12
8. Improving Family Planning Counseling via a Computerized Tool	Research Triangle Institute (Ellen Wilson, PhD)	9/10–8/13
9. Improving Intrauterine Device Service Provision in Title X Clinics in Chicago	University of Chicago (Melissa Gilliam, MD, MPH)	9/10–8/13
10. Same Day Insertion of Intrauterine Devices or Implants for Women Seeking Emergency Contraception or Pregnancy Testing	University of Pittsburgh (Ellen Schwarz, MD)	9/10–8/13
11. Increasing Efficiency and Utilization of Family Planning Services Through Systematic Integration	Georgetown University (Rebecka Lundgren, MPH)	9/10–8/13
How can high priority populations be reached?		
1. Men's Reproductive and Sexual Health Practices, Attitudes, and Service Utilization	Columbia University Medical Center (Debra S. Kalmuss, PhD)	9/05–9/08
2. Improving Services for Latina Women and Their Partners: A CAPACITIES Approach	Georgetown University (Rebecka Lundgren, MPH)	9/05–9/08
3. CONecting with Teens About Contraceptive Use	Johns Hopkins Bloomberg School of Public Health (Kathleen M. Cardona, DrPH, MPH)	9/06–8/09
4. Disparities in Reproductive Health Care Access Among Vulnerable Populations	Research Triangle Institute (Christina Fowler, PhD, MPH)	9/06–8/08
5. Sexual and Reproductive Health Services: Reaching Latino Men in Rural Areas	Oregon State University Department of Public Health (S. Marie Harvey, PhD)	9/07–9/10
6. The Fort Peck Sexual Health Project: A Contextual Analysis of American Indian Men	Montana State University Department of Health and Human Development	9/07–9/09

	(Elizabeth Lynne Rink, PhD)	
7. Sexual and Reproductive Health Outreach for Young Women of Color: A New Approach	The Trustees of Columbia University (Debra Kalmuss, PhD)	9/08–8/11
8. Understanding and Improving Family Planning Services Through Language Assistance	The Research Foundation of SUNY, University of Albany (Dina Rekfi, MD)	9/09–8/12
9. Fort Peck Men's Sexual Health Intervention and Evaluation Study	Montana State University Department of Health and Human Development (Elizabeth Lynne Rink, PhD)	9/09–8/12
How can the organization and administration of services be improved?		
1. Medicaid Family Planning Waivers: Service Delivery, Use, and Intended Pregnancy	Emory University Rollins School of Public Health (Kathleen Adams, PhD)	9/07–9/10

Family Planning (FP) Service Delivery Improvement Research Projects, 2005–2010

How Well Do Family Planning Providers Link Their Low-Income Clients to Primary and/or Specialty Care?
Grantee Organization: University of Alabama-Birmingham
Principal Investigator: Janet M. Bronstein, PhD
Project Period: September 30, 2005–September 29, 2007

Project Description: The specific aims of this project are (1) to examine the range of referral facilitation activities provided in FP settings serving low-income women; (2) to explore the factors associated with FP clients' decisions to seek and ability to receive care for other medical conditions, including the role played by referral facilitation and discussions of the problem at the FP visits; and (3) to compare the level of concern about the ability to refer FP clients for needed primary and specialty care between clinicians who do and do not provide FP care to clients with Medicaid coverage for these services. FP providers who participate in and clients who are enrolled in Medicaid FP demonstration programs in Alabama and Arkansas are the populations under study. Data for this project will be collected through three surveys (1) a survey of FP clinicians to assess referral practices, (2) a survey of these clinicians' FP clients to examine their care-seeking behavior for general health problems and the role played by their FP providers, and (3) a survey of office physicians who are authorized Medicaid FP providers but are seeing few or no Medicaid clients.

Men's Reproductive and Sexual Health Practices, Attitudes, and Service Utilization
Grantee Organization: Columbia University Medical Center
Principal Investigator: Debra S. Kalmuss, PhD
Project Period: September 30, 2005–September 29, 2008

Project Description: The objective of the proposed study is to examine men's reproductive and sexual health (RSH) practices, attitudes, and service use to inform the development of programs for adolescent and older men. The research plan is to employ both quantitative and qualitative methods to examine men's RSH status, attitudes, and practices and how they vary across racial, ethnic, socioeconomic, age, and relationship status in order to increase the

utilization of RSH services for men. The quantitative approach would use national data from Cycle 6 of the National Survey of Family Growth supplemented by two datasets targeting high-risk groups of males ages 18–30 from northern Manhattan and the Bronx. The qualitative component, use of focus groups, is intended to obtain a more in-depth understanding of men's perceptions regarding use, such as barriers to men's use of RSH and possible strategies to increase men's use of such services. The final step in the proposed study will involve the translation of research findings into suggestions for program development and/or enhancement.

Improving Services for Latina Women and Their Partners: A CAPACITIES Approach
Grantee Organization: Georgetown University, Department of OB/GYN
Principal Investigator: Rebecka Lundgren, MPH
Project Period: September 30, 2005–September 29, 2008

Project Description: This intervention research, which will be conducted collaboratively by the Institute for Reproductive Health, Georgetown University, and Planned Parenthood of San Diego and Riverside Counties, will determine (1) whether including the Standard Days Method (SDM) as an option for clients results in an increased focus on the couple in counseling for all methods of contraception, (2) whether incorporating a couple perspective into services results in improved satisfaction with and use of services, (3) whether it increases couple communication and participation in FP use and decisionmaking, and (4) whether it results in improved used of and satisfaction with FP methods. SDM is a simple, effective fertility awareness-based method being offered in programs around the world, including a growing number in the United States. The importance of addressing couples may be particularly relevant for Latinos, given cultural considerations.

Couples and Contraceptive Practice
Grantee Organization: Family Planning Council
Principal Investigator: Paul Whittaker, PhD
Project Period: September 30, 2005–September 29, 2008

Project Description: The Family Planning Council proposes to conduct a mixed-methods investigation to study the feasibility and effectiveness of couples-focused contraceptive services, which will use an integrated complement of ethnographic and quantitative methods to attain three aims. The first is to compare the attitudes, subjective norms, and behavioral beliefs of young adult men and women regarding the involvement of intimate partners in contraception decisions and the influence of these partners on contraceptive use. The second is to identify the attitudes, subjective norms, and behavioral beliefs of Title X providers regarding the current and potential provision of couples-focused contraception services. The third is to develop and field-test the potential utility of a culturally relevant couples-focused intervention that promotes informed contraception decisions and effective contraception use.

CONnecting with Teens About Contraceptive Use
Grantee Organization: Johns Hopkins Bloomberg School of Public Health
Principal Investigator: Kathleen M. Cardona, DrPH, MPH
Project Period: September 1, 2006–August, 31, 2009

Project Description: The objective of this study is to develop and evaluate a clinic-based intervention intended to increase contraceptive use and consistency of use and reduce 1-year pregnancy rates among adolescents. Specifically, the plan is to design an easily replicable, technology-based, and adolescent-friendly means of continuing contact to enhance contraceptive protection while encouraging parental involvement. This will involve all female clients under age 20 who present to the youth center in Baltimore City over an 18-month period. Individualized methods counseling sessions will be provided to clients, who will be contacted at regular intervals beginning 2 weeks post-enrollment and then at least monthly to discuss issues related to method use and appointment reminders. One technological innovation is clients' use of text messaging, email, or phone as a means of clinic contact. A second innovation is the use of a new Web-based database to be designed for this project, which will permit contacts to be scheduled, initiated, and recorded and which will enable the clinic to provide regular, longitudinal follow-up. Clients will also be encouraged to identify a parent or key adult to participate to learn about contraceptive options and how to communicate with the teen to reinforce appropriate use of contraception.

Chlamydia and Race/Ethnicity in Title X Region X Female Clients Age 15–24 years
Grantee Organization: Center for Health Training
Principal Investigator: David Fine, PhD
Project Period: September 1, 2006–August 31, 2007

Project Description: The research goal for this project is to explore, assess, and begin to address possible racial or ethnic disparities in chlamydia screening, prevalence, and prevention services in Title X FP clinics using existing data sets. Specific aims are to (1) assess racial and ethnic disparities in chlamydia screening coverage among Title X Region X FP clinic female clients ages 15–24, from 2004 to 2005; (2) assess racial and ethnic disparities in chlamydia positivity among Region X FP clinic female clients ages 15-24 from 1997–2005; and (3) assess an enhanced array of behavioral, demographic and socioeconomic status measures in relation to race or ethnicity and chlamydia positivity in a sample of FP clinic female clients ages 15–24. Data sources to be used for specific aims #1 and #2 include (1) a 2-year (2004–2005) dataset from the Region X Title X FP client information system that captures patient characteristics and service provision for all Title X encounters and (2) data from the Infertility Prevention Project for the assessment of racial and ethnic disparities in Chlamydia positivity. Data for specific aim 3 will come from recruiting female FP clients (375 CT+/375 CT-) ages 15–24 from clinics where racial or ethnic disparities were found based on results from specific aim #2.

Disparities in Reproductive Health Care Access Among Vulnerable Populations
Grantee Organization: Research Triangle Institute
Principal Investigator: Christina Fowler, PhD, MPH
Project Period: September 1, 2006–August 31, 2008

Project Description: This study proposes a comprehensive and systematic examination of disparities in reproductive health service access across multiple vulnerable populations. The objective of this project is to examine whether disparities in access to FP and other reproductive health services exist for vulnerable groups of women and men, specifically non-Hispanic black and Hispanic, relative to non-Hispanic white; poor (less than 100 percent of the federal poverty

level [FPL]) and near-poor or low-income (100 percent–199 percent FPL), relative to non-poor (more than 200 percent FPL); teens (ages 15–19) and young adults (ages 20–24), relative to older adults (ages 25–44); and residents of nonmetropolitan counties and metropolitan suburban counties, relative to residents of metropolitan urban counties. Data from the 1995 (women) and 2002 (women and men) National Survey of Family Growth will be used to analyze whether group differences exist in service utilization, quality, and contraceptive use and to assess the role of Title X clinics in reducing differences. The Institute of Medicine's 1993 Model of Access to Personal Health Care Services, adapted to reproductive health care, will guide the study.

Impact of Pack Supply on Contraceptive Continuation
Grantee Organization: Columbia University Medical Center
Principal Investigator: Katherine J. O'Connell, MD, MPH
Project Period: September 30, 2006–September 29, 2009

Project Description: The objective of this project is to determine whether providing an enhanced, 7-month supply of oral contraception (OC) versus the standard 3-month supply of OC results in less contraceptive discontinuation. It is believed that an extended initial supply of contraception requires fewer visits to obtain refills and may remove a common obstacle to method continuation. The proposed strategy is a randomized trial to compare two approaches to the initial supply of hormonal contraception in women age 29 and under who receive FP care at a publicly funded clinic (n = 750). The approaches are (1) a standard 3-month supply of OC and (2) an enhanced 7-month supply of OC. Interviews will be conducted at a 6-month follow-up to determine OC continuation rates and adverse events. The researchers believe that the approach of extending the initial supply of contraception has the potential to improve rates of OC—particularly among adolescents, who are at the highest risk of early discontinuation—and, by removing an obstacle to method continuation, would ultimately help to reduce the rate of unintended pregnancy.

Medicaid Family Planning Waivers: Service Delivery, Use, and Intended Pregnancy
Grantee Organization: Emory University Rollins School of Public Health
Principal Investigator: Kathleen Adams, PhD
Project Period: September 30, 2007–September 29, 2010

Project Description: Six states will serve as study sites for examining the effects of changes in the organization and delivery of FP services through Medicaid section 1115 waivers on three key outcomes: access to services, use of contraceptive or preventive services, and unintended pregnancy. In each state, the aim will be to test whether the state's waiver reduced barriers and increased use of services and thereby reduced unintended pregnancy. Overall, variation in the impact of waivers across states and across different subgroups, such as married women, teens, and minority women, will be analyzed. Both quantitative analyses (Pregnancy Risk Assessment Monitoring System and Behavioral Risk Factor Surveillance System datasets available from the Centers for Disease Control and Prevention) and qualitative research (informant interviews and focus groups) will be carried out. A synthesis of states' concerns, approaches, successes or failures, and client perceptions of the waivers will be generated. A key goal of the analyses is to elucidate the pathways whereby sexually active women who do not desire to become pregnant

are or are not served under the delivery systems each state has in place under its waiver. The six states are Arkansas, Illinois, New York, California, Washington, and Wisconsin; the project will provide a case study for each of these states.

Sexual and Reproductive Health Services: Reaching Latino Men in Rural Areas
Grantee Organization: Oregon State University Department of Public Health
Principal Investigator: S. Marie Harvey, DrPh
Project Period: September 30, 2007–September 29, 2010

Project Description: The objective of this research project is to increase understanding of the sexual and reproductive health needs of heterosexual Latino men who live in rural areas. In this two-part study, the focus is on Latino men in the new settlement areas of rural Oregon. Study 1 will consist of in-depth interviews of a convenience sample of 80 men to assess their attitudes and behavior pertaining to sexual activity and contraception, and their perceptions of their needs and of the barriers to accessing services and to determine how their attitudes and behaviors vary by age, type of sexual partner, and acculturation. Study 2 will include in-depth interviews with administrators and practitioners from publicly funded FP agencies who serve Latinos in rural areas. The specific aims of study 2 are to (1) explore experiences providing FP and HIV and sexually transmitted infection (STI) prevention services to Latino males, (2) identify barriers and facilitators to serving male Latinos, (3) explore advantages and disadvantages of integrating men into sexual and reproductive health services for FP agencies and for male clients, (4) identify preferred context for providing sexual and reproductive health services to men (e.g., couples, male only, traditional family setting or other contexts), and (5) explore how agencies can build their capacity to improve sexual and reproductive health services for Latino males.

Couples-Based Family Planning Services: Is There a Need?
Grantee Organization: The Guttmacher Institute
Principal Investigator: Rachel Jones, PhD
Project Period: September 30, 2007–September 29, 2010

Project Description: The project aims to improve contraceptive use and reduce unintended pregnancy among Title X FP clients by providing information on a new and mostly untested programmatic strategy of fostering joint decisionmaking around FP through couples-oriented services. Three interrelated activities are proposed:

- Provide a national overview of the extent to which Title X female and male clients, ages 18–44, as well as the clients' partners, express a desire for programs that are oriented to couples and are designed to improve joint decisionmaking on contraceptives and method selection.
- Explore the issue from the point of view of providers to determine what strategies clinics have so far adopted in terms of couples-oriented counseling or services, as well as perceived need for and barriers to implementing such programs.
- Disseminate findings to relevant audiences to inform public discussion about the potential for contraceptive counseling and services targeting couples in order to foster or promote joint decisionmaking on contraceptive use.

The sampling approach is based on 80 randomly drawn clinics from a universe of U.S. clinics. Individual clients will receive and complete surveys at the clinic site and be provided survey forms to take to partners; the sample size of clients is expected to be 2,500 women and 125 men. Clients' openness to a couples approach will be analyzed by relationship type (married, cohabiting, neither married nor cohabiting) and by racial and ethnic groupings. Staff at sampled clinics will complete a provider survey on couples-oriented services as well.

The Fort Peck Sexual Health Project: A Contextual Analysis of American Indian Men
Grantee Organization: Montana State University Department of Health and Human Development
Principal Investigator: Elizabeth Lynne Rink, PhD
Project Period: September 30, 2007–September 29, 2009

Project Description: The study will elucidate the individual, social and environmental factors that most greatly influence American Indian men's sexual and reproductive health. Individual characteristics to be examined include (1) knowledge of contraceptive methods and STIs; (2) perceptions of pregnancy; and (3) perceived risk of STIs, perceptions of abstinence, monogamy, and contraceptive use. Social dynamics to be examined are (1) relationships with family, (2) relationships with peers, (3) culture, (4) religion, and (5) relationships with sexual partners. The relevant environmental factors will include (1) characteristics of FP services and (2) access to and use of FP services. The target population for this project is American Indian men ages 18–24 living on the Fort Peck Indian Reservation in northeastern Montana. The research plan includes a Community Based Participatory Research (CBPR) approach and qualitative research methods. CBPR will entail engaging the Fort Peck Indian Reservation as full and equal partners in the research project, by establishing an 8- to 10-member community advisory board to provide oversight and coordinate the project. Qualitative research methods will include (1) 12–15 key informant interviews with health care professionals and (2) 112 in-depth interviews with American Indian men. Research results will be used to design effective, culturally sensitive FP intervention strategies for American Indian men.

Integration of Family Planning Services into an STD Clinic Setting
Grantee Organization: Denver Health and Hospital Authority, Denver Public Health Department
Principal Investigator: Judith Shlay, MD
Project Period: September 1, 2008–August 31, 2011

Project Description: The objective of this proposed study is to investigate how providing integrated family planning with sexually transmitted disease (STD) clinical services in an STD clinic affects (1) quality of care, (2) cost of services, (3) staff duties, (4) clinic flow, (5) clients' family planning needs, (6) satisfaction with services, and (7) incidence rates of STDs and pregnancies.

Specific aims follow:

- Assess the feasibility and replicability of the clinical processes used by clinicians to provide FP services in a STD clinic setting.

- Assess and compare the costs associated with providing FP and STD services in separate clinical settings and through separate programs versus the cost associated with providing both clinical services through an integrated program.
- Establish computerized procedures that will be used to identify clients eligible for FP services in the STD clinic.
- Assess the need or desire for and acceptance of FP services among all clients seen for STD clinical services identified as eligible for FP services.
- Evaluate the effectiveness of implementing a reminder system incorporated into the electronic medical record that notifies staff of a person's eligibility to receive FP services.
- Using surveillance data from STD clinic databases, compare rates of STDs and unintended pregnancies among clients seen in the clinic who did or did not receive FP services over the course of project and pre-and post-implementation of the computerized reminder system.

Sexual and Reproductive Health Outreach for Young Women of Color: A New Approach
Grantee Organization: The Trustees of Columbia University
Principal Investigator: Debra Kalmuss
Project Period: September 1, 2008–August 31, 2011

Project Description: The aim of this study is to (1) develop creative and feasible ways to embed sexual and reproductive health (SRH) referrals as well as promotional information and messages into workforce development (WFD) programs, (2) train staff of WFD programs how to comfortably ask men about their use of and/or need for SRH care and refer men to care, (3) train staff at Title X clinics how to make their facility and services more gender sensitive to the needs of men based on the results of a site-specific male friendliness needs assessment, and (4) implement and evaluate the efficacy and sustainability of the capacity-building outreach model in promoting men's SRH utilization.

The proposed research will occur with two WFD programs that serve low-income Hispanic and African-American males seeking new job training, and two Title X clinics.

Increasing Family Planning Utilization Among Hispanic Teen and Young Adult Women
Grantee Organization: Child Trends
Principal Investigator: Jennifer Manlove
Project Period: September 1, 2008–August 31, 2011

Project Description: The specific aims for the proposed project are to help reduce high rates of teenage and unintended pregnancy among Hispanics in the United States by employing quantitative, qualitative, and applied research methods to better assess who is and is not accessing family planning services and why. Project work will involve three stages:

- Stage 1: Analyses of national data using data from several cycles of the National Survey of Family Growth. This project will analyze family, individual, and community factors (including the presence of family planning providers in the community) associated with the utilization of family planning services among Hispanic teens and young adult women.

- Stage 2: Qualitative analyses. Focus groups will also be conducted with female teens and young adults in three cities with high concentrations of Hispanics—New York, San Antonio, and Los Angeles—to gather group insights about why women do or do not access services and how to best draw Hispanic populations into family planning clinics and programs. The project will also include three focus groups with clinics and service providers that receive Title X funding to discuss the challenges of and strategies for reaching Hispanic clients.
- Stage 3: Capacity assessments and implementation guidelines. Project staff will work with a clinic or provider in each of the target cities to assess the capacity of these programs to use the findings generated by this study, improve translation of the findings, and construct implementation guidelines for the broader family planning practitioner community. A key aim of the project will be to translate the research findings to make them accessible to the practitioner community.

Innovative Technology-Based Outreach and Utilization of Client Home Testing to Improve Chlamydia/Gonorrhea Retesting
Grantee Organization: Public Health Foundation Enterprises, Inc.
Principal Investigator: Heidi Bauer, MD
Project Period: September 1, 2009–August 31, 2012

Project Description: This study will compare the effectiveness of two levels of multifaceted chlamydia/gonorrhea (CT/GC) retesting interventions in improving CT/GC retesting among female FP clinic clients 1–6 months after treatment. The first intervention is a clinic-level intervention and involves enhancements to clinic retesting protocols and systems. Clinic enhancements will include chart flags, improved retesting counseling/education messages and client educational materials, and improved protocols for express visits for STD testing. The second intervention is a client-level intervention that will build on the clinic-level intervention by offering clients new retesting and reminder options, including home-based self-collected vaginal swab testing and an automated retesting reminder message sent via postcard, text message, and/or email message. The interventions will be implemented in six FP clinics in California with women ages 16 and older. The overall study objectives are to reduce women's adverse health outcomes associated with repeat CT/GC infections and improve overall reproductive health by identifying effective, easy-to-implement strategies to increase CT/GC retesting in FP settings.

Understanding and Improving Family Planning Services Through Language Assistance
Grantee Organization: The Research Foundation of SUNY, University of Albany
Principal Investigator: Dina Refki, MD
Project Period: September 1, 2009–August 31, 2012

Project Description: The purpose of this study is to address challenges associated with providing language assistance for limited-English-proficient (LEP) patients in FP clinics. The researchers will conduct a statewide survey with Title X FP clinic administrators in New York to understand (1) the current services available to LEP patients in family planning clinics, (2) current methods of identifying and responding to language access needs, (3) factors that may support or impede language assistance for clients, and (4) factors related to organizational urgency and capacity to be part of a research study to address language assistance. The

researchers will then conduct an intervention study with six Title X clinics to determine whether assistance in developing an organizational plan for language assistance services and a mini-grant to support implementation of specific language assistance services will improve the quantity and quality of language assistance services provided in the clinic. Results of this study will help to improve the planning and delivery of FP services for LEP populations.

Fort Peck Men's Sexual Health Intervention and Evaluation Study
Grantee Organization: Montana State University
Principal Investigator: Elizabeth Rink, PhD
Project Period: September 1, 2009–August 31, 2012

Project Description: The purpose of this study is to use a community-based participatory research approach to design, implement, and evaluate a culturally relevant intervention to reduce unplanned pregnancies and sexually-transmitted infections among heterosexual American Indian males, ages 18–24, living in a rural frontier setting. Participants will be recruited from the Fort Peck Indian Reservation in northeastern Montana and will be randomly assigned to either a control group or an experimental group. The control group will receive an educational intervention that will include information on HIV, STI, and pregnancy prevention strategies. The experimental group will receive a longer educational intervention that will include information on HIV, STI, and pregnancy prevention strategies, as well as information on psychosocial and emotional factors that facilitate or impede the use of prevention strategies; communication strategies to discuss methods to prevent HIV, STIs, and unintended pregnancy; and skill-building activities to improve self-efficacy to use prevention strategies. The intervention sessions will be implemented by local male outreach workers who are trained in HIV, STI, and pregnancy-related topics and have knowledge and sensitivity to traditional and nontraditional cultural practices. Results will be used to inform future interventions for American Indian men to increase their use of preventive strategies and family planning services.

Improving Family Planning Counseling via a Computerized Tool
Grantee Organization: Research Triangle Institute
Principal Investigator: Ellen Wilson, PhD
Project Period: September 1, 2010–August 31, 2013

Project Description: The objective of this project is to develop and test an interactive, multimedia, Web-based Family Planning Counseling Aid (FPCA). The FPCA is designed to be a low-cost tool that will improve clinic efficiency by enhancing the quality of FP services without increasing the providers' counseling workload. This decision aid is expected to help identify contraceptive methods best suited to the client and learn more about them.

Specific aims are to (1) develop the FPCA, (2) assess the feasibility of integrating the FPCA into FP clinics' workflow and the usability of the tool by both clients and providers, and (3) assess the impact of the FPCA on the quality and content of counseling.

Study sites will be two FP clinics: a county health department and a Planned Parenthood clinic. To develop the FPCA, existing counseling and decision-support tools will be reviewed and input will be sought from an expert panel. To ensure that the FPCA meets the needs of both patients

and clinicians, pretests will be conducted, focus groups will be conducted with clients, and interviews will be conducted with clinicians.

It is believed that the FPCA will help patients to be better informed, engage more in the counseling process, and make more realistic contraceptive choices, and will help clinicians tailor their counseling to be more patient centered. The expectation is that the improved counseling will help increase women's satisfaction with their contraceptive methods and the effectiveness of their contraceptive use.

Improving Intrauterine Device Service Provision in Title X clinics in Chicago
Grantee Organization: University of Chicago
Principal Investigator: Melissa Gilliam, MD, MPH
Project Period: September 1, 2010–August 31, 2013

Project Description: The proposed study will focus on decreasing the rate of unintended pregnancy among young women (ages 15–25) by improving the delivery of intrauterine device (IUD) services in the Title X FP setting. This research will use a mixed-methods (qualitative and quantitative) approach—Failure Modes Effects and Criticality Analysis (FMECA)—to understand and improve IUD service delivery. FMECA is one of several safety and risk assessment techniques commonly used in industries outside health care settings (e.g., nuclear energy, aviation) and represents the first application of safety and risk assessment in the field of family planning. In the FMECA, the clinicians and staff who provide clinical care delineate each step in the processes and systems involved in the delivery of care. The detailed description of the steps in the systems and processes of care are then graphically translated into a process "map." For the analysis, each step on the "map" is further qualified to assess the systems or parts of a system that perform in an undesirable or unintended way (failures), the ways in which the systems fail (modes), and consequences of a failure mode (effects). A composite score reflecting the frequency, consequence of an error, and any safeguards mitigating the failure (criticality) can be assigned to each step. This technique predicts how and where systems and processes have vulnerabilities or safety risks that can impair women's ability to obtain desired IUDs.

Same Day Devices or Implants for Women Seeking Emergency Contraception or Pregnancy Testing
Grantee Organization: University of Pittsburgh
Principal Investigator: Eleanor, Schwarz, MD
Project Period: September 1, 2010–August 31, 2013

Project Description: This study will evaluate the effect of structured counseling about highly effective reversible contraceptives and the offer of same-day placement of an IUD or contraceptive implant on knowledge, attitudes, and use of highly effective reversible contraception three months after women seek emergency contraception (EC) or pregnancy testing from a Title X clinic. The study investigators will also assess rates of testing and treatment for pelvic inflammatory disease in the 3 months following a visit to a Title X clinic operating under one of the three distinct service delivery protocols, with particular attention to those women who opt for same-day IUD insertion. Data will be collected at the time of each participant's initial visit to the study clinic and by telephone interview 3 months after the visit. Additional relevant data will be abstracted from the study clinic's medical records. The projected

sample will consist of 1,200 subjects between the ages of 15 and 45. This study will provide clinicians and policymakers with important information regarding the feasibility, acceptability, safety, and effectiveness of offering structured counseling and same-day access to IUDs and contraceptive implants for women seeking EC or pregnancy testing from Title X clinics.

Increasing Efficiency and Utilization of Family Planning Services Through Systematic Integration

Grantee Organization: Georgetown University
Principal Investigator: Rebecka Lundgren, MPH
Project Period: September 1, 2010–August 31, 2013

Project Description: Systematic screening is an evidence-based practice that has been successfully tested in developing countries; it typically consists of designing and using an algorithm of 5–10 questions that a provider asks a client. Depending on the answer, the provider offers the service to meet the client's identified service needs or asks another question to identify the need for a different service. This study will explore whether systematic screening is a feasible and effective strategy in achieving the following aims: (1) increase the use of FP and STI services among women and men by integrating FP counseling with diabetes care and other services and (2) increase clinic efficiency by increasing the number of services provided in a single visit. This study is a collaborative effort between Golden Valley Health Centers (GVHC) and Georgetown University's Institute for Reproductive Health. Formative research will be conducted to determine the best approach for integrating Systematic Screening into GVHC services. This study will contribute to existing knowledge regarding strategies to increase the use of FP services among vulnerable populations in the United States, particularly in Title X programs.