FUTURE DIRECTIONS FOR FAMILY PLANNING RESEARCH:
A Framework for Title X Family Planning Service Delivery Improvement Research

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FUTURE DIRECTIONS FOR FAMILY PLANNING RESEARCH:

A Framework for Title X Family Planning Service Delivery Improvement Research

This report, commissioned by the Office of Family Planning within the Office of Population Affairs, reviews the service delivery improvement research supported by the Title X family planning program between 1985 and 2003. This research is examined in the context of other family planning research published during this period. Our purpose is to identify research opportunities that will both build from this existing knowledge base and expand the availability of information useful for improving service quality. The report relies on two primary sources of information: descriptive findings from an examination of research literature and the opinions of a group of 30 technical experts who convened twice to identify high-priority research issues facing the field and to discuss how future research could be guided and harnessed to provide better information to practitioners about best practices. The list of the technical advisors and their affiliations is available in appendix A. This report is written primarily to assist the Office of Family Planning in considering options for future investments in research. However, other funders of research on family planning services and the broader topic of health care quality may find this report useful, as will researchers and analysts in these fields. The report also summarizes the research evidence about family planning services and effective practices. This information should be useful to program directors and practitioners as they consider their own service efforts. Finally, the report calls for an enhanced effort to document, track, and evaluate how family planning services can be more effectively delivered. Furthermore, research is needed to understand how to disseminate information about effective practices to service providers in a more timely and comprehensive manner.

The focus of the Family Planning Service Delivery Improvement Research Program is fostering research that leads to the enhancement of the quality of family planning services in the United States. Indeed, improving the quality of health care in the United States is an issue about which people at all levels in this country are concerned. Recently the Institute of Medicine (IOM) issued a report on Crossing the Quality Chasm (2001) with a set of recommendations about how to develop a new, higher quality health system for the next century. We have found the vision of the IOM useful in framing this report because it acknowledges that health care quality is multidimensional and cannot be judged on a single indicator. The report advocates that all health care constituencies commit to a national shared agenda for the improvement of the health care system as a whole. This agenda calls for addressing six key dimensions of service quality:

**SAFETY** Health care should be safe and should avoid injuries to patients.

**EFFECTIVENESS** Health care should provide services based on scientific knowledge to all who could benefit from the services and should avoid providing services to those who are unlikely to benefit.

**PATIENT-CENTERED CARE** Health care should provide services that are respectful and responsive to individual patient preferences, needs, and values and ensure that patient values guide all clinical decisions.
**TIMELINESS** Health care should reduce waits and sometimes harmful delays for both those who receive and give care.

**EFFICIENCY** Health care should avoid waste, including waste of equipment, supplies, ideas, and energy.

**EQUITY** Health care should be provided that does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographic location, or socioeconomic status.

Many of the technical advisors for this project thought that linking this report about family planning research to the broader action agenda to improve health care quality would highlight the saliency of family planning services as an important component of national health promotion and disease prevention efforts. A theme that will be reiterated later in the report is the need to connect research on improving family planning service delivery to the wider research effort focused on improving health care quality in general. Several experts noted that approaches and findings from service quality research in other health care sectors might be usefully adapted to the family planning sector. Moreover, some of the research conducted about family planning might inform efforts in other sectors.

We note that the IOM report calls for an initial focus on chronic diseases as the conditions that account for the majority of health care services. To the extent that family planning services include prevention, screening, and treatment for sexually transmitted diseases, they certainly fit into this general category of chronic disease. Family planning programs also routinely provide preventive reproductive health care, including breast examinations and screening for cervical cancer. Furthermore, family planning services address conditions like pregnancy that are experienced by the majority of U.S. women and are associated with significant medical expenditures whether or not they are intended pregnancies. Thus, this effort examining family planning service quality research can contribute significantly to the overall national agenda of improving health care.

**Title X Family Planning Program: Background and History**

The Family Planning program, authorized by the Family Planning Services and Population Research Act of 1970 (Public Law 91-572) is the only federal program devoted solely to funding family planning and related preventive health care services (see appendix B). The program, known as the Title X program, supports a nationwide network of approximately 4,600 clinics and provides reproductive health services to approximately 4.9 million persons per year (Alan Guttmacher Institute [AGI] 2003). Grantees are a diverse group of public and private agencies, including state and county health departments (57 percent), private family planning organizations (19 percent), and public and private community social service agencies (18 percent). In 1999, the program helped to support 61 percent of all family planning agencies in the United States (Finer, Darroch, and Frost 2002), and in 2001 funds from Title X provided more than one quarter of the revenues of agencies receiving Title X funds (AGI 2002a).

Title X also supports activities to assist family planning clinics in responding to their clients' needs. These activities include training for clinic personnel, communication and outreach, and data collection and research to improve the delivery of family planning services. As can be noted in the title of the authorizing legislation, research was always viewed as integral to the program effort. This report reviews the data collection and research conducted by the Office of Family Planning since 1985.

The primary objective of the family planning program is to ensure that safe and effective family planning services are available to all individuals regardless of income. The program also aims to help couples space births and plan intended pregnancies, which are important elements in ensuring a positive birth outcome and a healthy start for infants. Title X services also assist individuals in avoiding sexually transmitted diseases (STDs) including HIV and concomitant complications. The mandate of the program is to provide family planning services (including medical history, laboratory tests, and contraceptive supplies and methods) on a voluntary basis to millions of individuals who, for many reasons, do not otherwise have access to these services. The program is intended to give priority to low-income individuals who may not have access to the health care system or otherwise could not afford family planning services.

While the program cannot provide full medical care, family planning projects offer related preventive health or screening services, as well as referrals to other health care providers. This is vital given the fact that family planning is often the point of entry into the health care system for many individuals. For many women, Title X clinics are an entry point to the health care system and their ongoing source for important primary care services, including breast and cervical cancer screening and STD/HIV education, counseling, and testing.

Although family planning services share some common dilemmas with the entire health care delivery system (as noted below), the family planning service system also
Family planning, like many health care services, faces continuing and emerging challenges to delivering quality care. Increasingly, the program has had to respond to new pressures that include the development and availability of new contraceptive technology and the increased cost of new methods. There was concern among some of the technical experts that the availability of high-cost technology might outstrip resources and lead to a tiered system of care in which only family planning clients with insurance might receive some of the more expensive screening tests, procedures, and methods of contraception. It was also noted that family planning programs have experienced increased pressures and demands to respond to the broader sexual health needs of patients—for example, the demands for STD testing and treatment, and the emergence of HIV.

Family planning, like the rest of the health care system, is substantially affected by the shifts in health care financing at the national and the state level. For example, the majority of family planning dollars come from Medicaid. Thus shifts in this system, like the Medicaid waiver efforts in several states or the movement to managed care, have affected the family planning providers’ ability to provide services (Gold 2003).

Finally, like the rest of the health care system, family planning faces the problem noted in the IOM report of translating knowledge into practice. This challenge is one of the key issues that this review of the research program intends to address.

Methodology
To complete this assessment, we reviewed all reports and articles supported by the Title X Service Delivery Improvement Research program since 1985. (See appendix C for an annotated list of research funded under the program). We also conducted a literature search and reviewed all articles and reports published since 1985 that report on the results of research conducted about family planning and reproductive health services in the United States. This review is available in appendix D. Just over 240 articles or reports were identified that fit the criteria that we established. The reference list is located in appendix E. The criteria used to determine that a report or article was eligible for inclusion were that it had to describe research findings from analyses of either primary or secondary data. These could include questionnaire responses, program statistics, national surveys, and meta-analyses. The research had to be conducted in the United States and oriented to service delivery issues. About one quarter of the articles and reports found to fit these criteria were supported in whole or in part by Title X funds.

In addition, the project convened a group of 30 expert technical advisors to solicit evidence-based information about the key issues and research questions facing the family planning field. This group first met at the National Institutes of Health (NIH) on May 12, 2003, to discuss and prioritize the research needs of the family planning field. In this first meeting the expert group engaged in a brainstorming and prioritization process to identify the key issues and questions facing the family planning field. The agenda for this meeting is available in appendix F.

Following this meeting, an analysis of the existing literature was prepared that was organized around the priority questions and issues generated by the expert group. These priority questions roughly fell into three types—those dealing with reaching specific populations, those dealing with the practice of family planning service delivery, and those dealing with how services should be organized, administered, and staffed.

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A second meeting of the technical experts was held on August 7, 2003, to review the results of the literature review. (The Agenda for this meeting is in appendix F.) At this meeting, the experts examined the results to ensure that most of the relevant studies had been included. As a result of this feedback, the literature review was revised to include more studies. The group also discussed gaps in the research, potential promising new directions for further research, and options specific to the Title X Service Delivery Improvement Research program. The summary below incorporates the comments of the technical advisors and presents the various options for future research that were discussed at the meeting.
### PRIORITY QUESTIONS FOR FAMILY PLANNING RESEARCH

#### How can high-priority populations be reached?
1. What are effective strategies for reaching low-literacy and non-English-speaking populations?

2. What are effective practices that clinics can use to assist adolescents and young adults in sexual decisionmaking?

3. How can adolescents be better connected to their families and schools, and will these connections result in decreased sexual activity?

4. 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?

5. How do we monitor and use information about who is receiving services? Can programs’ statistics and survey results be used more effectively?

6. What accounts for differences in clinic utilization rates at the substate, state, and regional levels?

#### How can family planning practices be strengthened?
1. What kinds of counseling and other behavior-change strategies affect knowledge, attitudes, and behaviors related to reproductive health? Are there innovative approaches to helping clients choose and use contraceptives consistently?

2. 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 clinic services?

3. How can the Office of Population Affairs (OPA) and other organizations better disseminate research findings so that they are incorporated into practice?

4. What are the best practices in family planning clinics, contrasting publicly funded programs to private sector programs?

5. What is the effectiveness of nonclinical Title X services like information and education activities?

6. How are STDs approached with the high percentage of women on the pill or other hormonal contraceptives?

7. How do programs deal with the ideal versus the reality regarding confidentiality for teenage clients?

#### How can the organization and administration of services be improved?
1. How can STD prevention and family planning services be most effectively integrated?

2. What is the cost effectiveness of delivering Title X services in different settings? How effectively and cost effectively can pharmacies deliver over-the-counter contraceptives compared to family planning clinics?

3. Have Medicaid waivers led to changes in contraceptive utilization rates and unintended pregnancies in the states?
Options for Future Family Planning Service Delivery Improvement Research

How can high-priority populations be reached?

About half of the research reviewed focused on measuring and assessing the access of individuals with varied characteristics to family planning and reproductive health services. Of the 243 reports read, 115 examined issues related to how family planning services addressed the needs of particular populations. The populations covered included low-income women—a target population for Title X services—adolescents, males, and to a lesser extent racial, ethnic, and language minorities, as well as other hard-to-reach populations like individuals with child welfare, mental health, or substance abuse issues. There were also a few studies that examined the issues related to serving clients in particular types of geographic areas, such as inner cities or rural areas.

The review of the research indicates a longstanding research tradition supported by Title X that examines the characteristics of the population served by Title X and contrasts this clientele to the population of individuals who might avail themselves of clinic services. This work monitors how well the program is reaching its target population, and attempts to assess the factors that facilitate or block access to service, such as insurance coverage. The Title X program has supported the collection of three key sources of data in this effort: The National Survey of Family Growth conducted by the National Center for Health Statistics, periodic national surveys of agencies and clinics providing subsidized family planning services, and Family Planning Annual Reports that aggregate program statistics provided by Title X grantees. The technical panel emphasized the ongoing importance of collecting data such as these to monitor the equitable access of populations to family planning services. In addition, the panel recommended periodic efforts to gather information about state policies relevant to the delivery of family planning services because of the great differences between states in terms of how they finance services and how they formulate their program regulations.

Key priority populations identified by the expert panel for future service delivery research were low-literacy and immigrant populations, adolescents, and men. While there is a substantial body of research about factors related to access to reproductive health services of the Hispanic population, there is less work that differentiates immigrants from Latin, Central American, and other countries from Latinos born in the United States. Presumably the former group will have greater language barriers. Further, the Hispanic population, although the fastest growing subgroup in the United States, is not a monolithic group; it is composed of individuals from different countries of origin, with different cultures and different levels of education. National surveys rarely include sample sizes sufficient to differentiate between these very important subgroups, and local studies of specific populations cannot be generalized to the whole. Smaller studies often do not indicate how their program participants distribute on these characteristics.

Studies of family planning service issues for other immigrant groups are extremely rare. Only one study of Southeast Asian refugees conducted in the 1980s was found. Recently the Office of Family Planning commissioned a study of language assistance services and activities available for Limited English Proficient (LEP) individuals in seven Title X clinics. This study documents practices (such as bilingual staff, translators, teleconference technology, and the like) and assesses the clients’ and workers’ opinions of their strengths and weaknesses. A descriptive study such as this provides the basis for understanding how to measure the availability of language assistance services and activities throughout the family planning network. It can also serve as a springboard for identifying particularly promising practices that might be more rigorously evaluated in terms of outcomes for clients.

Adolescents are clearly the population that have been studied the most and for the eleventh year in a row, data provided by the National Center for Health Statistics indicate that the childbearing rates among U.S. teenagers have fallen, and have fallen to a record low. Nonetheless, the U.S. teen birthrate is still one of the highest among developed countries, and there is considerable public concern about the financial and social costs of early childbearing in this country. This concern was reiterated by the panel of experts who noted that identifying successful approaches to addressing the sexual and reproductive health needs of adolescents was a high priority. Specifically the panel posed the following questions: “What effective practices can clinics use to assist adolescents and young adults in sexual decisionmaking?” and “How can adolescents be better connected to their families and schools, and will these connections result in decreased sexual activity?”

The studies reviewed indicate that many adolescents have access to health care providers but do not appear to receive counseling or services that are perceived to address their sexual and reproductive health needs. For example, although the majority of teenagers have been found to think that talking to a physician about sexual behavior
would be helpful, very few actually report such discussions. More research is needed to find out about the barriers that interfere with the delivery of needed services from the clients’ and the provider and systems’ perspectives.

There are only a few studies that have addressed the issue of parental involvement in the delivery of family planning services to teens. Small-scale studies indicate the need to develop and evaluate promising approaches that address parental and family involvement without creating barriers to services for teenagers. Recent findings from a National Longitudinal Study of Adolescent Health indicate that teenagers who report that their parents are warm, caring, and supportive are less likely to engage in sexual risk-taking as well as other types of risk behavior. These results suggest that a promising direction for improving the delivery of family planning services to teenagers might be to work with both parents and teens. Current research in this area has been quite limited with some studies focusing on the effects of obtaining parental permission and others on aspects of getting parents engaged. The small-scale studies that have been conducted indicate the need to develop and evaluate promising approaches that address parental and family involvement without creating barriers to services for teenagers.

Another high priority population identified by the expert panel was men. Program statistics for 2001 indicate that approximately 4 percent of Title X grantee clients are men, and this share represents a doubling of the percentage since 1995. The literature review uncovered 17 articles and reports that focused on research about sexual and reproductive health services for men. Six of these were supported by Title X, indicating that the Office of Population Affairs has assumed a leadership role in encouraging research in this area. More research is needed to describe and evaluate programmatic approaches to delivering sexual and reproductive health services for men. The Office of Family Planning recently initiated a request for proposals for innovative male programs. This request includes an evaluation requirement. Further new data from the most recent National Survey of Family Growth will provide information from males for the very first time. These data can be mined to understand the sexual and reproductive health needs of men better and to assess their current levels of health care utilization. The expert panel noted that the bulk of the research on male sexual and reproductive health has

focused on teenagers and young adults. More information is needed about older men.

The panel also suggested that the development and testing of approaches to serving couples might be a promising new area of research. Very little research has been done on the feasibility or effectiveness of providing contraceptive services to couples rather than to individual women or men. Since most sexual, contraceptive, and childbearing decisions are made jointly, it has been argued that involving both partners in the service intervention may be the optimal approach. Further, there is great policy interest at the federal level in enhancing the quality of relationships between romantic partners to encourage the establishment of strong and healthy marriages. The Office of Family Planning could conduct research about what the current marriage enhancement programs are doing in terms of addressing the family planning needs of their participants. The Office could also survey Title X programs to obtain a description of their efforts to serve couples and to identify innovative approaches.

In discussing the literature review results at the August meeting, the technical panel noted a few other themes that deserve special attention. In particular, they suggested the need to conduct more service-oriented research on how interpersonal violence affects clients and clients’ ability to take care of themselves and fulfill their reproductive wishes. The panel thought that more work was needed on how to serve particularly high-risk youth like those involved in the child welfare and juvenile justice populations. Finally, they urged the consideration of a life span approach to reproductive health services, and the development of more information about how to address the sexual and reproductive health needs of men and women beyond early adulthood.

How can family planning practices be strengthened?

The studies that could inform practice were few in number. As has already been shown, a good deal of evidence is collected about who is served and some evidence is collected about the services they receive. However, much less research has examined the effectiveness of family planning services in general or the effectiveness of particular approaches to delivering services. Only a small number of studies have examined effective practices, and only one
The panel suggested that measures of the quality of family planning services need to be better developed. The expert panel strongly urged that rigorous scientific studies that identify and test promising service practices should be expanded. There is a clear need for the development of evidence about what works in terms of delivering family planning services. Outcomes for these studies should focus on “behavioral outcomes.”

In addition, the panel suggested that measures of the quality of family planning services need to be better developed. And it was at this point that the group discussed the research about the quality of health care defined more broadly and the timeliness of the IOM report as a potential source of guidance. The panel also noted that there has been a good deal of research in this area conducted in other countries. The group urged the Office to encourage researchers to consult this work and to consider the transferability of some of the findings about the quality of care from this broader literature.

As noted above, there has been a lot of emphasis on the types of people that are reached by the family planning system. There is much less information about the actual services they receive, the effectiveness of those services, and how those services might be improved. Some effort might be devoted to developing better measures of the quality of services using the multidimensional criteria suggested by the IOM. If the measures are developed, some could be deployed into the statistical system that generates program statistics. The measures might also be added to some of the national surveys, like the National Survey of Family Growth or the National Health Interview Survey. If measures were developed, it might then be possible to explore how access to care and the quality of care distribute across populations and geographic areas around the country. For example, the hypothesis that there might be a two-tiered system in terms of access to new contraceptive technology and tests could be examined empirically if the data were routinely collected.

The Office might consider collecting better documentation about some of its innovative service delivery initiatives. Finally, the panel suggested that in order to ensure that information about evidence-based practice gets back to practitioners, it would be important to conduct research that obtains better data on where practitioners obtain information about practices. Therefore, the panel suggested that the Office consider supporting some research that might provide empirical grounding for a dissemination strategy when effective practices are identified.

In addition, the Office might consider collecting better documentation about some of its innovative service delivery initiatives. From time to time, the Office does support service innovations, like a recent initiative to promote the integration of family planning and HIV services. If efforts such as these were partnered with research efforts to describe and document what happens in the sites that participate, the field might benefit from this more systematic effort to identify program models or approaches that deserve to be considered for further support and evaluation.

**How can the organization and administration of services be improved?**

The bulk of the studies examining the administration and organization of services focused on financing mechanisms including insurance coverage. Only a few studies, primarily funded by Title X, examined staffing and organizational issues. Understanding financing is clearly crucial because it determines who gets access to services and the quality of services received. The types of research that have been conducted include studies of national and state expenditures on family planning services and sources of revenue and research on the influences of insurance, Medicaid, and managed care on access to services. In addition, a few studies have examined clinic costs and estimated savings achieved when clients receive services that prevent more costly conditions like unintended pregnancy and STDs. In discussing this work, the panel emphasized that it was very important to collect national and state-level data on the financing of family planning services. They noted that there is tremendous variation by state and given the importance of financing in terms of access and service quality, researchers need good data to understand the funding environments within which services are operating.

Furthermore, the panel observed that it is very important to understand the dynamics of the relationship between Title X providers, the state Medicaid and SCHIP programs, and the Community Health Centers program. While family planning services are but a small component of these bigger health programs, the impact of the funding and program
regulations from these health programs upon family planning services is substantial. Better information is needed about how clinics interact with these programs and what are the barriers and facilitators of effective service delivery through these funding sources for particular types of clients.

As noted by the IOM, how the service delivery system is organized and staffed is a crucial element of service quality. The review found a few research studies on these topics. These studies focus on scattered topics and appear to emphasize the fragmentation of the services. There appears to be an absence of an accumulating body of evidence, when one study builds from another, about how the system might be organized better.

**Additional Strategies for Enhancing the Research Infrastructure**

In addition to the suggestions of the experts about priority research gaps, the technical panel also discussed more general strategies that the Office of Family Planning, and potentially other funders, might consider to strengthen research capacity in this area. These suggestions focus on how to use the existing and future research investments of the Office in a more effective manner. These options are listed below:

1. Continue to support efforts to collect information that assesses characteristics of potential service users, monitors services delivered, and describes states’ policy environments and financing for family planning services.

2. Consider approaches that collect and make better use of existing data sources.
   - Commission studies using the National Survey of Family Growth, other secondary data sets, and available program statistics with an emphasis on analyses that address priority service issues.
   - Develop better measures of service utilization and service quality to be integrated into existing data collection systems.
   - Identify complementary or comparative data sets.

3. Encourage the intellectual expansion of the community of family planning researchers to consider the applicability of conceptual models, approaches, and findings from the fields of health care utilization, international family planning research, and other fields of inquiry that might provide new insights.
   - Market requests for proposals (RFPs) to a broader set of investigators.
   - Encourage investigators who respond to RFPs to consider broader intellectual traditions.

4. Consider approaches to improve the quality of information collected about practices in Title X clinics.
   - Systematically integrate descriptive research into program initiatives (e.g., the HIV/family planning integration initiative) so that information is available about the implementation and process content of promising practices. Note that the recent initiative on male involvement from the office does integrate research.
   - Commission a study of the practices in communities where there is low and high use of family planning services to identify promising approaches to reaching broader populations.
   - Support research that examines access to new technology across populations and geographic areas in terms of equity and cost effectiveness.

5. Test new practice approaches.
   - Consider developing a network of family planning clinics to serve as sentinel clinics that would test the effectiveness of promising practices.
   - Issue RFPs that request the rigorous testing of promising practices—include requirements for logic models and multidimensional measures of quality of practices and behavioral outcomes.
   - Consider issuing an RFP that commissions studies of aspects of family planning service quality in the United States that utilize learning and approaches tried internationally (e.g., what aspects of services increase success of outreach, compliance, and continuation of services, yielding better health outcomes such as the avoidance of unplanned pregnancies, STDs, and other health problems like cancers of the reproductive organs, infertility, and complications associated with contraceptive methods).

6. Commission rigorous qualitative and quantitative studies to construct and/or test theories and hypotheses about the motivations of individuals to use services and to change behavior.

7. Commission research about how effective practices can be better disseminated through networks of practitioners.
   - Conduct descriptive research about where family planning practitioners—inside and outside the Title X system—obtain information.
   - Consider involving professional organizations in the conduct of research about practices.
   - Support evaluations of dissemination interventions.
8. Support the development of infrastructure and capacity to conduct research about family planning services.
   • Support training in applied research methods.
   • Support postdoctoral fellows.
   • Support research centers focused on family planning research.

Concluding Remarks
Over the past two decades, the Office of Family Planning has supported a significant proportion of the research that has examined family planning services and their effectiveness in the United States. Given this substantial investment and the influence of the Office as measured by its presence in the field as a funder, it is prudent to take stock and to examine how to best use these research resources so that service delivery improvements occur. Many members of the technical panel applauded the Office’s efforts to review its research investments. The options developed for the Office are numerous, but they are presented in the spirit of enhancing and complementing the strong foundation of research that the Office has supported in the past. There is recognition that resource limitations constrain how much can be accomplished. However, collaborative efforts across the Department of Health and Human Services and public/private initiatives may open up opportunities to use science to improve the delivery of family planning services to men and women in this country.
APPENDIX A
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Project Grants and Contracts for Family Planning Services Sec. 1001 [300]

(a) The Secretary is authorized to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents). To the extent practicable, entities which receive grants or contracts under this subsection shall encourage family\(^1\) participation in projects assisted under this subsection.

(b) In making grants and contracts under this section the Secretary shall take into account the number of patients to be served, the extent to which family planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of such assistance. Local and regional entities shall be assured the right to apply for direct grants and contracts under this section, and the Secretary shall by regulation fully provide for and protect such right.

(c) The Secretary, at the request of a recipient of a grant under subsection (a), may reduce the amount of such grant by the fair market value of any supplies or equipment furnished the grant recipient by the Secretary. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment on which the reduction of such grant is based. Such amount shall be deemed as part of the grant and shall be deemed to have been paid to the grant recipient.

(d) For the purpose of making grants and contracts under this section, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1971; $60,000,000 for the fiscal year ending June 30, 1972; $111,500,000 for the fiscal year ending June 30, 1973; $111,500,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; $115,000,000 for fiscal year 1976; $115,000,000 for the fiscal year ending September 30, 1977; $136,400,000 for the fiscal year ending September 30, 1978; $200,000,000 for the fiscal year ending September 30, 1979; $230,000,000 for the fiscal year ending September 30, 1980; $264,500,000 for the fiscal year ending September 30, 1981; $126,510,000 for the fiscal year ending September 30, 1982; $139,200,000 for the fiscal year ending September 30, 1983; $150,030,000 for the fiscal year ending September 30, 1984; and $158,400,000 for the fiscal year ending September 30, 1985.

Formula Grants to States for Family Planning Services Sec. 1002 [300a]

(a) The Secretary is authorized to make grants, from allotments made under subsection (b), to State health authorities to assist in planning, establishing, maintaining, coordinating, and evaluating family planning services. No grant may be made to a State health authority under this section unless such authority has submitted, and had approved by the Secretary, a State plan for a coordinated and comprehensive program of family planning services.

(b) The sums appropriated to carry out the provisions of this section shall be allotted to the States by the Secretary on the basis of the population and the financial need of the respective States.

(c) For the purposes of this section, the term “State” includes the Commonwealth of Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, the Virgin Islands, the District of Columbia, and the Trust Territory of the Pacific Islands.

(d) For the purpose of making grants under this section, there are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1971; $15,000,000 for the fiscal year ending June 30, 1972; and $20,000,000 for the fiscal year ending June 30, 1973.

\(^1\)So in law. See section 931(b)(I) of Public Law 97-35 (95 Stat. 570). Probably should be “family”.
Training Grants and Contracts; Authorization of Appropriations Sec. 1003 [300a-1]

(a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to provide the training for personnel to carry out family planning service programs described in section 1001 or 1002 of this title.

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $2,000,000 for the fiscal year ending June 30, 1971; $3,000,000 for the fiscal year ending June 30, 1972; $4,000,000 for the fiscal year ending June 30, 1973; $3,000,000 each for the fiscal years ending June 30, 1974 and June 30, 1975; $4,000,000 for fiscal year ending 1976; $5,000,000 for the fiscal year ending September 30, 1977; $3,000,000 for the fiscal year ending September 30, 1978; $3,100,000 for the fiscal year ending September 30, 1979; $3,600,000 for the fiscal year ending September 30, 1980; $4,100,000 for the fiscal year ending September 30, 1981; $2,920,000 for the fiscal year ending September 30, 1982; $3,200,000 for the fiscal year ending September 30, 1983; $3,500,000 for the fiscal year ending September 30, 1984; and $3,500,000 for the fiscal year ending September 30, 1985.

Research Sec. 1004 [300a-2]
The Secretary may—
(1) conduct, and
(2) make grants to public or nonprofit private entities and enter into contracts with public or private entities and individuals for projects for research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population.

Informational and Educational Materials Sec. 1005 [300a-3]
(a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to assist in developing and making available family planning and population growth information (including educational materials) to all persons desiring such information (or materials).

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $750,000 for the fiscal year ending June 30, 1971; $1,000,000 for the fiscal year ending June 30, 1972; $1,250,000 for the fiscal year ending June 30, 1973; $909,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; $2,000,000 for fiscal year 1976; $2,500,000 for the fiscal year ending September 30, 1977; $600,000 for the fiscal year ending September 30, 1978; $700,000 for the fiscal year ending September 30, 1979; $805,000 for the fiscal year ending September 30, 1980; $926,000 for the fiscal year ending September 30, 1981; $570,000 for the fiscal year ending September 30, 1982; $600,000 for the fiscal year ending September 30, 1983; $670,000 for the fiscal year ending September 30, 1984; and $700,000 for the fiscal year ending September 30, 1985.

Regulations and Payments Sec. 1006 [300a-4]
(a) Grants and contracts made under this subchapter shall be made in accordance with such regulations as the Secretary may promulgate. The amount of any grant under any section of this title shall be determined by the Secretary; except that no grant under any such section for any program or project for a fiscal year beginning after June 30, 1975, may be made for less than 90 per centum of its costs (as determined under regulations of the Secretary) unless the grant is to be made for a program or project for which a grant was made (under the same section) for the fiscal year ending June 30, 1975, for less than 90 per centum of its costs (as so determined), in which case a grant under such section for that program or project for a fiscal year beginning after that date may be made for a percentage which shall not be less than the percentage of its costs for which the fiscal year 1975 grant was made.

(b) Grants under this title shall be payable in such installments and subject to such conditions as the Secretary may determine to be appropriate to assure that such grants will be effectively utilized for the purposes for which made.

(c) A grant may be made or contract entered into under section 1001 or 1002 for a family planning service project or program only upon assurances satisfactory to the Secretary that—
(1) priority will be given in such project or program to the furnishing of such services to persons from low-income families; and
(2) no charge will be made in such project or program for services provided to any person from a low-income family except to the extent that payment will be made by a third party (including a government agency) which is authorized or is under legal obligation to pay such charge. For purposes of this subsection, the term “low-income family” shall be defined by the Secretary in accordance with such criteria as he may prescribe so as to insure that economic status shall not be a deterrent to participation in the programs assisted under this title.
(d) (1) A grant may be made or a contract entered into under section 1001 or 1005 only upon assurances satisfactory to the Secretary that informational or educational materials developed or made available under the grant or contract will be suitable for the purposes of this title and for the population or community to which they are to be made available, taking into account the educational and cultural background of the individuals to whom such materials are addressed and the standards of such population or community with respect to such materials.

(2) In the case of any grant or contract under section 1001, such assurances shall provide for the review and approval of the suitability of such materials, prior to their distribution, by an advisory committee established by the grantee or contractor in accordance with the Secretary’s regulations. Such a committee shall include individuals broadly representative of the population or community to which the materials are to be made available.

Voluntary Participation Sec. 1007 [300a-5]
The acceptance by any individual of family planning services or family planning or population growth information (including educational materials) provided through financial assistance under this title (whether by grant or contract) shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service or assistance from, or to participation in, any other program of the entity or individual that provided such service or information.

Prohibition of Abortion Sec. 10082 [300a-6]
None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning.

2Section 1009 was repealed by section 601(a)(1)(G) of Public Law 105-362 (112 Stat. 3285).
## APPENDIX C: TITLE X SERVICE DELIVERY IMPROVEMENT RESEARCH PROJECTS

Projects Studying Access to Services

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<tr>
<th>CITATION</th>
<th>PURPOSE OF STUDY</th>
<th>RESEARCH DESIGN</th>
<th>COMMUNITY &amp; SETTING</th>
<th>SUMMARY OF FINDINGS</th>
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<tr>
<td>Jennifer Frost. Public or Private Providers? U.S. Women’s Use of Reproductive Health Services. (SDI Report—AGI). 2001.</td>
<td>The purpose of this study was to assess trends in the percentage of U.S. women obtaining family planning services from all providers and from publicly funded providers. The study sought to compare patterns of usage of reproductive health services among clients of public and private providers.</td>
<td>This study uses data from the 1995 National Survey of Family Growth (NSFG—compared to the 1982 and 1988 NSFG) in which women reported whether they had obtained a contraceptive or reproductive health service in the last year. The women who had received these services were classified by their primary source of care, and the services they received and their characteristics were analyzed.</td>
<td>The 1995 NSFG collects data from a large, nationally representative sample of U.S. women age 15–44.</td>
<td>The percentage of women of reproductive age who obtained family planning services increased slightly between 1988 and 1995, mostly among women age 30 and older. Twenty-five percent of women who received any contraceptive care visited a publicly funded family planning clinic, as did 33 percent of women who received contraceptive counseling or STD testing and treatment. Women whose primary care was a publicly funded clinic received a wider range of services than women who visited private providers.</td>
</tr>
<tr>
<td>Jennifer Frost, Nalini Ranjit, Kathleen Manzella, Jacqueline Darroch, and Suzette Audam. Family Planning Clinic Services in the United States: Patterns and Trends in the Late 1990s. (SDI Report—AGI). 2001.</td>
<td>This report assesses the type and the geographic distribution of publicly funded family planning clinics and their capacity to meet the contraceptive service needs of American women.</td>
<td>A survey was administered to 3,117 agencies and 7,206 clinics providing publicly funded family planning services in the United States in 1997. Numbers of female contraceptive clinics were collected and compared with similar data gathered in 1994. Access to services by county data were also tabulated using the presence of family planning clinics and private physicians compared to the number of women assessed as needing publicly funded care.</td>
<td>The study examines agencies and clinics providing subsidized family planning services in the U.S. and local jurisdictions.</td>
<td>Fifty-nine percent of clinics received Title X funding. Clinics provided care to 6.6 million women, approximately two of every five women estimated to need publicly funded contraceptive care. The number of providers and women served was stable between 1994 and 1997. Eighty-five percent of all U.S. counties had one or more publicly funded family planning clinic.</td>
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### CITATION
Jaqueline Darroch.  

Barbara Sugland.  

Laraine Winter.  

### PURPOSE OF STUDY
This report brings together more than five years of research and analysis of publicly funded family planning services.

The study was conducted in 1995–1999 to better understand adolescents’ motivations to prevent pregnancy and to develop a comprehensive framework of fertility motivation.

This study evaluated an experimental protocol designed to address the psychosocial needs of young clients in relation to family planning services. The intervention included giving clients basic information regarding reproductive health, contraception, and pelvic exams, as well as providing additional time for counseling and more frequent clinic contact.

### RESEARCH DESIGN
This literature review examines data from the National Survey of Family Growth (NSFG) and surveys conducted by the Alan Guttmacher Institute of publicly funded family planning clinics, the agencies that run them, and state funding agencies.

This study used a survey and focus groups to test possible explanations for racial and social class disparities in early pregnancy risk-taking among U.S. adolescents. Survey items measured the decision-making process involving pregnancy and risk-taking.

A randomized experimental design was used with 1,225 female patients, age 11–18 years from two clinic sites.

### COMMUNITY & SETTING
Publicly funded family planning clinics serve approximately 6.5 million women each year. One in four women obtain contraception at a clinic; clinics serve one in seven women of reproductive age who receive services; and one in four women of reproductive age seeking HIV tests. One in three women obtaining STD tests do so at these clinics.

African-American and European-American focus groups were conducted in Baltimore, Maryland. Mexican-American teens were recruited from Houston, Texas. Groups were stratified according to the youth’s race, ethnicity, and gender.

Planned Parenthood of Central PA-York was assigned to the experimental condition. Planned Parenthood of the Susquehanna Valley-Lancaster was assigned to the control condition.

### SUMMARY OF FINDINGS
Results show that a broad array of factors was viewed by teens as important in affecting teen behavior. Although these numerous factors influence behavior, subgroup differences were found between low-income youth, youth of color, white youth, and moderate income youth.

Results revealed significant improvements in knowledge in many patients at the experimental site, compared to baseline and the control site. However, there were no significant differences in pregnancy rates or contraceptive use measures.
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<tr>
<td>Jennifer Frost and Michele Bolzan. The Provision of Public-Sector Services By Family Planning Agencies in 1995. (SDI Report). 1997.</td>
<td>To describe the services and programs supported by public funding for family planning services. The study examines differences in the provision of services by the type of sponsoring agency and whether or not the agency is funded through the Title X program.</td>
<td>A survey collected data from a sample of 603 agencies about services, policies, and practices and the numbers and characteristics of their contraceptive clients, as well as their funding sources and billing options.</td>
<td>This is a nationally representative sample of 603 publicly funded family planning agencies. In previous studies, community and migrant health centers were included only if they received Title X funding, but in this study, all agencies receiving community or migrant health center funding that reported providing contraceptive services were included.</td>
<td>Ninety-six percent of publicly funded family planning agencies rely on federal funding. Although only 25 percent of the contraceptive clients served by these agencies are Medicaid recipients, 57 percent have incomes below the federal poverty level. Forty percent of recipients of services are black, Hispanic, or from other minority groups, and 30 percent are younger than 20. Each agency employs an average of 3 physicians who together provide about 71 hours of care per week. The pill is the only contraceptive method provided by all agencies. Almost 70 percent of agencies have at least one special program to meet the needs of teenagers.</td>
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<td>Patricia Donovan. Taking Family Planning Services to Hard-to-Reach Populations. (SDI Report, AGI). 1996.</td>
<td>This study explores the kinds of programs family planning agencies offer to hard-to-reach populations (e.g. substance abusers, incarcerated individuals, the disabled, the homeless, and non-English-speaking minorities) and the problems agencies may encounter in serving these groups.</td>
<td>Interviews with 100 administrators, program supervisors, and clinicians in family planning agencies that make special efforts to serve hard-to-reach populations provided data on the range of services offered.</td>
<td>The agencies were selected through a number of ways. Some were respondents to a 1995 survey, some were identified by state and regional health department officials, and some were suggested by fellow providers of services for hard-to-reach groups.</td>
<td>The most likely group to be targeted for services is substance abusers. Some of the programs focus on HIV prevention but others offer comprehensive services and education. Other groups targeted by programs include prison inmates, the homeless, disabled persons, non-English speakers, and a small percentage of battered women and sex workers. The response to such programs in agencies like jails or homeless shelters has been overwhelmingly positive. The key barriers to utilization of these services by the people include establishing trust and language and cultural differences.</td>
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<td>Jennifer Frost. Family Planning Clinic Services in the United States, 1994. (SDI Report, AGI). 1996.</td>
<td>The purpose of this study is to provide an updated enumeration of all subsidized family planning clinics in the United States and numbers of women and teenagers who obtained contraceptive services from the clinics in 1994. The study identifies clinics that receive funds through the federal Title X program and those that receive other public and private subsidies, such as hospital outpatient clinics, community and migrant health centers, and independent clinics.</td>
<td>A survey gathered data on about 7,122 clinics operated by 3,119 family planning agencies. Respondents were asked to provide agency or clinic updates and information on the funding status of each site, as well as the total number of female contraceptive clients served per site in 1994 and the number of female clients served who were younger than 20.</td>
<td>The study examines agencies and clinics providing subsidized family planning services in the United States and its jurisdictions. A contraceptive client was defined as a woman who made at least one visit for contraceptive services during the 12-month reporting period.</td>
<td>The number of subsidized family planning agencies increased by nearly 20 percent between 1992 and 1994. An estimated 6.6 million women received contraceptive services through the network of subsidized family planning providers, a 30 percent increase over the nearly 5 million served at family planning clinics in 1983. Nearly 30 percent of all women served were younger than 20.</td>
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<td>Stanley Henshaw, Jennifer Frost, and Jacqueline Darroch. State and County Estimates of Contraceptive Needs and Services. (AGI). 1995.</td>
<td>This study developed estimates by state and county of the number of women needing contraceptive services and supplies, according to their age and income level.</td>
<td>The calculations of women needing services are new estimates based on data from the 1995 NSFG survey and 1990 Census. Information on the availability of family planning clinics and number of women served at these clinics were collected by AGI. Data on the availability of private physicians in 1994 was compiled from the 1996 area resource file.</td>
<td>The 1995 NSFG is a representative sample of 10,808 women age 15–44. The AGI clinic data includes all clinics funded through the federal Title X program, health department clinics that provide contraceptive services, hospital outpatient clinics that are open to the general public and provide contraceptive care, all Planned Parenthood clinics, community health centers that provide contraceptive care, and independent centers that provide contraceptives funded, at least in part, through public or private subsidies.</td>
<td>Of all women in need, 16.5 million (50 percent), were considered to be in need of publicly supported services. The number of women served at publicly funded clinics was 39 percent of those in need. In 1994, 3,119 publicly supported agencies delivered the services around the United States. Health departments were the most common type of clinics used, followed by hospitals.</td>
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<td>Margaret M. Schulte and Freya L. Sonenstein. &lt;br&gt;Men at Family Planning Clinics: The New Patients? (SDI Report, AGI). 1995.</td>
<td>This study identified family planning clinics that made substantial efforts to serve men. It documents how these clinics recruit male clients, deliver services to them, and pay for services. The study sought to uncover promising models of service delivery that could be adopted by other clinics interested in expanding services to men.</td>
<td>The study consisted of a national survey, clinic questionnaire, and follow-up telephone interviews. The 600 clinics selected came from a 1993 national survey of publicly funded family planning clinics, and the final sample size was 567 clinics. Questionnaires were mailed to both clinic managers and direct care workers in the 567 clinics to collect information on a range of service delivery topics. Follow-up telephone interviews were conducted with 25 clinics, selected from the 52 clinics that reported a male client share of at least 10 percent.</td>
<td>From winter to summer 1993, 109 state administrators from the Title X, Maternal and Child Health Block Grant, Social Services Block Grant, State and Medicaid programs were interviewed by telephone.</td>
<td>Nearly 31 percent of clinic managers reported that the number of male clients increased over the last five years. Factors pushing clinics to provide reproductive health services for men include clinics’ desire to reduce incidence of STDs among female patients, the overall increase in STD rates and in public awareness of STDs, and the need to provide primary health care services to low-income men.</td>
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<td>Barbara Sugland, Kristin Moore, and Constance Blumenthal. &lt;br&gt;State Family Planning Service Delivery: Administrators’ Perspectives on Service Delivery and Options for Future Family Planning Services. (Child Trends/Urban Institute). March 1994.</td>
<td>The study reviews the evolution of services through the 1980s and looks at possible directions for the future.</td>
<td>A state survey was used to gather information about state-level family planning service delivery and administrators’ insights about future policy. Particular attention is given to Title X funded services.</td>
<td>Subjects were selected daily from males who walked into the Adolescent Clinic at Children’s National Medical Center in Washington, D.C. Patients were interviewed and then randomly assigned to one of three groups: 1) an educational intervention with monetary incentive, 2) free condom distribution, or 3) follow-up control.</td>
<td>A need for more comprehensive services for low-income women was found. Expansion was favored, meaning a combination of family planning with maternal and child health, preventive health, or STD services. Decreased funding has led to a reduction in services and staff.</td>
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<td>Lawrence J. D’Angelo. &lt;br&gt;Influencing Adolescent Male Contraceptive Behavior and Attitudes. (SDI Report). June 1992.</td>
<td>This study sought to investigate whether attitudes about condom use among males could be influenced by two interventions—increasing the availability of condoms or instilling condom users with increased knowledge of the benefits of condoms. In addition, the study sought to document differences in the knowledge and attitudes of sexually active males versus sexually inactive males.</td>
<td>Case control study design with 468 male participants between the ages of 11 and 20. Of the participants, 311 were sexually active while 157 were not active. Ninety-nine percent of participants were black.</td>
<td>Although the two intervention groups showed similar improvements, neither demonstrated a significant increase over those who did not receive any intervention. The study found that males who perceived more “benefits” from condom use were more likely to use them consistently.</td>
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### APPENDIX C Projects Studying Access to Services continued

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| David Fine.  
March 1992. | The purpose of this study was to investigate the impact of childhood abuse and sexual victimization on adolescent women's reproductive health, and to assess its implications on family planning service delivery. | This was a three-year study begun in 1992. It assessed sexual abuse histories, recent sexual activity, and contraceptive use among family planning clients ages 19 or younger using a clinic brief assessment (CBA). Seven Washington Delegate Agencies agreed to implement these CBAs, and a total of 452 assessments were completed. Follow up efforts resulted in 125 received responses. The study also collected qualitative data through focus groups and individual interviews. | The study involved adolescent women younger than age 19 who came into one of the 17 clinics under the seven Washington Delegate Agencies. | The study found that sexual abuse and coercion need to be systematically addressed in family planning clinics. Almost half of the sample (46 percent) responded affirmatively to one or more of six questions about forced intercourse. Both molestation and rape cases were more likely to report nonvoluntary first sexual intercourse, earlier initiation of sexual activity, and increased number of lifetime sex partners. Clients with a forced intercourse history were at greater risk of reporting a recent STD. |
| Lien Chow,  
Rider Rowland, and Su Sol.  
Family Planning Performance: Acceptance and Dropout.  
(SDI Report).  
September 1989. | This study was an analysis of the family planning programs in Maryland to identify ways to improve services. It was conducted through an analysis of computer files on family planning clients recruited during 1979 through 1982. Another major objective was to find out about contraceptive practices and to determine clients' fertility behavior after dropping out of clinics. | A sample of 1,023 clients were interviewed face-to-face or by telephone. The sampling was done through the use of computer files from which "eligible" clients were selected. Eligible clients were considered to be those admitted as new clients to Maryland County Health Department Clinics in 1980, 1981, and 1982, when they were 20–39 years of age. | The study was conducted as an analysis of services in Maryland using records from the Maryland State Health Department. | The study found that more than half of the annual acceptors were teenagers. During the interview part of the survey, 65.5 percent of the sample reported they were currently practicing contraception. Oral contraceptives were the most highly used form. |
| Ross Danielson.  
Reproductive Health Counseling for Young Men: What Does It Do?  
(SDI Report).  
August 1989. | The study introduced a reproductive health consultation as an intervention to male subjects. The consultation consisted of a one-hour medical office visit divided evenly between viewing a specifically designed slide-tape program and consultation by a nurse or other non-physician practitioner. | The 1,195 high-school-age males were members of a large HMO and completed the baseline questionnaire in the medical office. Participants were recruited by phone from the population of young men who utilized care during the recruitment period at participating medical offices. Control subjects were offered the consultation after they completed the second follow-up questionnaire. Eighty-five percent of the intervention group completed the consultation and the follow up was 82 percent. | The young men who were recruited for the study were drawn from the membership and facilities of the Portland, Oregon and Vancouver, Washington service areas of the HMO Northwest Region Kaiser Permanente. The project was first implemented in one medical office and progressively extended to seven medical offices in the first seven months of the 18-month recruitment phase. | The intervention subjects tended to practice more effective contraception and to report the use of the pill as a method of contraception. Youths who were already sexually active at baseline did not show significant intervention benefits in contraceptive practices, but showed an increased understanding of contraceptive safety and prevention of sexually transmitted diseases. Additionally, intervention subjects were more likely to report compliance with instruction in testicular self-examination. |
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<td>Burton Mindick and Constance Shapiro. <em>Rural Family Planning Services: An Interactionist View</em>. (SDI Report). February 1989.</td>
<td>This study looked at the individual differences among birth control users and contraceptive clinic clients in order to gain more insight for designing effective family planning programs.</td>
<td>For this longitudinal study, 900 subjects were divided into three groups according to their contraceptive use and service providers. Personal characteristics of contraceptive clients and potential clients were assessed. In addition, archival data were collected on family planning services in general. Participant observation at the clinics provided ethnographic data on clinic program processes.</td>
<td>The study took place in three rural counties in upstate New York. This specific population was impoverished and underserved or underserved for their contraceptive needs. The three counties were Cayuga, Cortland, and Tioga.</td>
<td>The study found an important connection between personality characteristics and experiencing side effects, personality characteristics and pregnancy, and between side effects and pregnancy. It also found a large difference between services that are needed by weakly motivated clients and those “typical” services available in the locales studied.</td>
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<td>Michael Glasser. <em>Males’ Use of Public Health Contraceptive Services</em>. (SDI Report). March 1988.</td>
<td>In recent years males have been termed the “forgotten partner.” This study provides an in-depth look at the reported behavior, experiences, and attitudes of males visiting the public health clinics for family planning needs. The study looks at two categories of males: those visiting the clinic for free condoms and those attending the clinic with a female partner for a scheduled family planning visit.</td>
<td>A survey was administered over a six-month period and entailed sampling units of time rather than subjects. A total of 378 time periods were identified, and data were collected from 113 of them. Data were collected on 207 subjects. During these selected time periods, all males visiting the family planning clinic were asked to complete a self-administered questionnaire or consent to an interview conducted by two male project members. The response rate was 76.1 percent.</td>
<td>Research was conducted at the Winnebago County Public Health Department in Rockford, Illinois. The study was based on a previous one by the state health department that indicated the reasons why males come to the clinic.</td>
<td>Those males who came with their partners seemed to have more reliance on their female counterparts for family planning methods. Males in the other group were found to be more independently active in family planning.</td>
</tr>
<tr>
<td>Judith Keith. <em>Effects of Psychosocial Factors on Teen Contraception</em>. (SDI Report). December 1988.</td>
<td>This project aimed to improve compliance by young women to their contraceptive regimens. The study used the Health Belief Model (HBM) and explored the role of cognitive processing as it interacts with the multiple factors identified in the HBM.</td>
<td>The sample was 202 unmarried, nulliparous females between the ages of 13 and 17 years of age. This included 146 black and 56 Hispanic subjects. Subjects were placed into categories based on interview responses and chart review. Background data was then collected from those subjects, and seven major categories of variables were assessed through a variety of tests and interviews.</td>
<td>Subjects were selected from the clients at the Children and Youth Project’s West Dallas Youth Clinic, where they received comprehensive health care. The clinic serves predominantly black and Hispanic adolescents from a lower socioeconomic inner-city population and is located on the area high school campus.</td>
<td>Several factors were identified as significantly relevant to sexual activity among black adolescents. These factors included the church, the family, and presence of a father, all of which were associated with not being sexually active during adolescence. Cognitive ability was also positively associated with not being sexually active.</td>
</tr>
</tbody>
</table>
CITATION | PURPOSE OF STUDY | RESEARCH DESIGN | COMMUNITY & SETTING | SUMMARY OF FINDINGS
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Susan DeLisle. Effects of the Integration Model on Family Planning Programs. (SDI Report). November 1987. | This study examined the effects of three service integration models on family planning programs. These clinic types were described and contrasted for client characteristics and service provision. | Clinic data from an ongoing computer database system monitoring service delivery for all clinics in Regions I and X were used in this study. Client visit records were used to operationalize specific dimensions of care criteria. A review was conducted of archival documents such as Title X annual proposals. | Region I was comprised of Massachusetts, Maine, Connecticut, New Hampshire, and Vermont. Region X included Washington, Oregon, Idaho, and Alaska. | The study found that clinics integrated within other health agencies are providing a lower mean proportion of nutrition counseling to new clients, and the highest mean proportion of new clients leave their first visit without a contraceptive method. Also, those family planning clinics integrated within other health agencies saw significantly higher mean proportions of older clients. |
Denise Polit, Cozette White, and Thomas Morton. Family Planning and Related Services to the Child Welfare Population. (SDI Report). March 1987. | This study examined state policies regarding adolescents in the child welfare system. The question asked is: who is responsible for the child’s sexual development and related needs? | Child welfare agency representatives were asked numerous questions about the state policy and guidelines on the dissemination of birth control information, counseling/information relating to pregnancy options, and maintenance of records on client’s sexual activity and pregnancies. Respondents were also asked to describe actual practices regarding the sexual developmental needs of their clients. | A survey of representatives of child welfare agencies in 48 states was conducted by telephone. | Of the 48 states studied, only 2 have a comprehensive policy to deal with issues of sexuality in the child welfare population. On the other hand, several states have declared a “hands off” policy and admit to having not given the issue much prior thought. Of the 48 states studied, 9 have formal policy procedures in place to address these issues. The needs of many child welfare clients are going unmet with regards to sexuality and pregnancy prevention. |
Lawrence D’Angelo. The Male Role in Adolescent Contraception. (SDI Report). 1986. | The purpose of the study was to identify the attitudes of males towards contraceptive practices, and in particular condoms. | A questionnaire was administered to 242 sexually active black adolescent males between the ages of 13 and 19. | The data were collected from clients who entered the Adolescent Medicine Clinic at Children’s National Medical Center. | Males think about contraception prior to intercourse with 66.1 percent discussing it with their partners before intercourse. Condoms were the preferred method, and reasons for liking and disliking condoms were ascertained. |
### Citation

**Lawrence Severy.**

**Jacqueline Forrest.**

**Donald Minkler.**

### Purpose of Study

This study hypothesized that women’s choice of family planning is affected by their perceptions of family planning program features and individually held values of these features. Three types of services were examined: private physicians, public health clinics, and voluntary organizations.

The purpose was to describe the population in need of infertility services and the availability of these services at private physicians’ clinics, family planning clinics, and specialized infertility centers. A focus was low-income women.

This study’s purpose was to identify family planning knowledge, attitudes, and practices of southeast Asian refugees.

### Research Design

The study was a two-wave, longitudinal (15 month lag) survey involving 665 low-income women. Of particular interest was the subset of women who switched from one form of family planning provider to another. Expectancy-value scores for all respondents were calculated and were found to accurately predict change from one service to another.

The need for the services was estimated from the National Survey of Family Growth (NSFG), Cycle III, conducted by the National Center for Health Statistics, DHHS. In 1982, 8,000 women age 15–44 were interviewed about their reproductive histories.

The study employed both quantitative and qualitative methods. The study included an analysis of 646 abstracts of medical records from refugee health clinics, analysis of records of births to southeast Asian immigrants, structured in-depth interviews with Asian immigrants, and an analysis of benefits and costs of subsidized family planning services.

### Community & Setting

Subjects were randomly selected participants representative of different age groups and ethnicities from a 12 county area. Private physician services ranked highest in the majority of the categories with public health clinics next, followed by voluntary organizations. Low-income women report one of the most critical features was a “concern for program competence.”

Data about services available were collected from several different sources, including an AGI survey in 1983 of office-based physicians, a nationally stratified sample survey of 508 hospitals, health departments, planned parenthood affiliates, other agencies which have family planning clinics, and a survey of 19 specialized infertility treatment centers.

The study was carried out in collaboration with three refugee health clinics in Alameda, Santa Clara, and San Francisco counties in California. Five of the major subgroups of refugees were Vietnamese, Cambodian, Lowland Laotian, Lao Mien, and Lao Hmong.

### Summary of Findings

Private physician services ranked highest in the majority of the categories with public health clinics next, followed by voluntary organizations. Low-income women report one of the most critical features was a “concern for program competence.”

The need for infertility services is such that 35.9 percent of women of child-bearing age have fecundity problems. Low-income women (because they are younger) tend to have less prevalence of these problems. As for availability of services, for people with adequate financial resources, infertility services are readily available. However, for low-income people, especially those without Medicaid or other insurance, these services are practically unavailable.

Seventy percent of respondents who did not want to get pregnant were using contraceptive methods. Language barriers limit knowledge of reproductive physiology.
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<th>CITATION</th>
<th>PURPOSE OF STUDY</th>
<th>RESEARCH DESIGN</th>
<th>COMMUNITY &amp; SETTING</th>
<th>SUMMARY OF FINDINGS</th>
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</table>
| Susan Zuravin.  
Child Care Adequacy and Family Planning Practices: A Study of the Fertility Patterns and Contracepting Behaviors of Low-Income, Child Abusing and Child Neglecting Mothers. (SDI Report). May 1985. | The purpose of this study was to examine the family planning use and adequacy of mothers who maltreat their children. | The design was structured as interviews with 518 single parents who received AFDC in Baltimore, Maryland, during January 1984. Of these 518 single parents, 237 were maltreating mothers who were also part of a population of 1,733 families receiving services from the Baltimore City Department of Social Services. | All parents were from the Baltimore, Maryland area. | Results indicated significant fertility pattern differences between maltreating and non-maltreating mothers, as well as between abusive and neglectful mothers. Maltreating mothers have more unplanned live births, by more partners, begin at a younger age, and have closer spacing between children. |
### CITATION | PURPOSE OF STUDY | RESEARCH DESIGN | COMMUNITY & SETTING | SUMMARY OF FINDINGS
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Laraine Winter. *Improving Condom Use for STD Prevention by Clinic Patients.* (SDI Report). December 2000. | This study explored whether the lack of social skills in discussing condom use with sexual partners is a major barrier to condom use among women. An experimental counseling protocol using social skills counseling (SSC) was compared to usual-care counseling to see if addressing interpersonal barriers affects condom use in women. | A randomized control group design was used with 1,407 female clients 12–48 years old. | Clients were recruited from four family planning clinics in Pennsylvania and Maryland. | Clients who received SSC reported using condoms marginally more in the past year than usual-care clients, but STD infection at 12-month follow-up did not differ by treatment condition. |
Betty Chewning. *Evaluation of a Computerized Contraceptive Decision Aid for Adolescent Patients.* 1999. | The purpose of the study was to evaluate the effectiveness of a computer-based contraceptive decision aid for family planning clinic visits by adolescent patients. The aid for contraceptive decisionmaking (ACD) was designed to promote effective selection and use of contraception by young women. | Five hypotheses were tested on control vs. experimental groups of family planning patients in this one-year longitudinal study. Following the intervention, the patients received their physical exam, consultation, and pills. The second interview was conducted after the exam, and the third was conducted 12 months later. | The study sample included 500 young women from two clinics in Madison and 449 women from a clinic in Chicago. Patients were required to know English, have expressed interest in receiving contraception, and be 20 years of age or younger. | Sixty-seven percent of Madison patients and 63 percent of Chicago patients said they felt better about using the pill after viewing the ACD program compared to the controls. Reasons included feeling more comfortable and knowledgeable about the use of birth control. |
Lawrence B. Finer, Jacqueline E. Darroch, and Susheela Singh. *Sexual Partnership Patterns as a Behavioral Risk Factor for Sexually Transmitted Diseases.* September/October 1999. | This study examines how many women and men are at risk of contracting an STD based on how many recent sexual partners they have had. | The 1988 and 1995 cycles of the National Survey of Family Growth (NSFG) and five rounds of the General Social Survey (GSS) conducted from 1988 to 1996 are used to examine women’s and men’s numbers of recent sexual partners. Levels of direct risk for STDs (two or more partners in the past year) and the social and demographic correlates of multiple partnership are analyzed. In addition, women’s indirect risk for STDs is estimated using their partners’ involvement with other partners in the past year. | The NSFG is a household interview that surveyed 8,450 women age 15–44 in 1988 and 10,847 women in 1995. The GSS surveyed both men and women ages 18 and older through personal household interviews; sample sizes between 1988 and 1996 ranged from 1,372 to 2,992. | About 17 million women age 15–44 (34 percent of those sexually active in the past year) were estimated at risk for STDs because of direct exposure to multiple partners (5.4 million), indirect exposure (6.3 million), or both direct and indirect exposure (5.5 million). In all, 21 percent of women were at direct risk and 23 percent were at indirect risk. In comparison, among men age 18–44, 24 percent were at direct risk for STDs. |
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</table>
| Kay Armstrong.  
Norplant, Depo Provera,  
The Pill—Influences and Outcomes. (SDI Report). September 1996. | The purpose of this study was to identify strategies to improve services related to three contraceptive methods—Norplant, Depo Provera, and the Pill. Factors assessed included: 1) contraceptive decision-making, 2) contraceptive use, 3) pregnancy, 4) contraceptive side effects, 5) sexually transmitted diseases, and 6) service provision. | A longitudinal study conducted April–December 1994. In this study, 429 women completed a self-administered survey before and immediately after seeing clinic staff. Clinicians/counselors then completed a survey about their perceptions of each patient’s contraceptive decision. Then 282 women completed the 8- and 16-month follow-up telephone interviews. | The women, age 14–34, were enrolled in five Title X family planning clinics and had indicated that they were planning to use oral contraceptives, Norplant, or male condoms. | The results indicated that staff influence was not a primary factor in method selection, but instead staff had a greater impact in teaching women how to use their chosen method. |
| Betty Chewning.  
Demonstration and Evaluation of Computerized Contraceptive Counseling Aid. (SDI Report). April 1992. | This purpose of this study was to gain more information about adolescents’ concerns, knowledge, and errors regarding oral contraceptives. To aid the staff in educating clients about these issues, a computerized contraception education program was implemented and evaluated. | Clients were interviewed at their first clinic visit after using the computerized contraceptive counseling aid and again by phone one year later. Subjects were women under the age of 20 scheduled for an initial visit for contraception at one of three family planning clinics. Participation rates were 91 percent in the two Madison sites and 94 percent in Chicago. Five hundred clients were enrolled in Madison and 451 in Chicago. | The study was conducted at the following Planned Parenthood clinics: Rosalind Clinic in Chicago, Illinois; Central Clinic in Madison, Wisconsin; and East Clinic in Madison, Wisconsin. | The findings indicate that client reaction to the computer program was positive. The majority of clients reported 1) they liked getting information about birth control from a computer, 2) they felt better about the method afterwards, 3) they got new information about the method from the program, and 4) they would recommend that their boyfriends see the computer program. |
| John R. Weeks.  
Factors Affecting the Choice of Natural Family Planning. (SDI Report). January 1989. | The principal aim of this study was to look at the availability of natural family planning (NFP) services. Natural family planning in this study was defined as basal body temperature (BBT), the Billings ovulation method, and the symptothermal method (STM). The study also looked at the extent to which barriers are imposed on the delivery of these services by providers. | Data were gathered using a questionnaire administered to clinic administrators and service providers, OB/GYN physicians in private practices, and NFP-only providers. The overall response rate was 51 percent. | This study took place in Southern California. The subjects were contacted from a list of administrators and providers given to investigators by San Diego County. Lists were also obtained from Los Angeles County and the Southern California Kaiser-Permanente Health Maintenance Organization. | The study found that private OB/GYN physicians were the least informed about NFP, and just over one-third knew about all three methods. NFP-only providers had the most knowledge, while clinic providers and administrators were in between. The single most identifiable barrier to the availability of NFP is skepticism among physicians about its use and effectiveness. |
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<tr>
<td>Henry David, Janine M. Morgall, and Niels Kr. Rasmussen. <em>Family Planning Services Delivery: Danish Experience.</em> (SDI Report). July 1988.</td>
<td>The major aim of the study was to look at Danish experiences in family planning delivery systems, family planning, and services for population subgroups. The objective was to identify key aspects of the Danish experience for application to family planning service delivery in the United States.</td>
<td>A combination of quantitative and qualitative data were used. U.S. and Danish policies were systematically compared on health care delivery systems, climate of opinion and media influences, family planning service delivery systems, contraceptive services, abortion, adolescents' needs and services, and services for other population subgroups.</td>
<td>Denmark was selected as a comparison because of its policies on reproduction and family planning.</td>
<td>Findings showed that the Danish are more successful than the U.S. in promoting effective contraception practice, conveying information to high risk groups, and reducing the incidence of unintended pregnancy and abortion.</td>
</tr>
<tr>
<td>Pearila B. Namerow, Jacqueline W. Kaye, and Norman Weatherby. <em>The Effectiveness of Contingency Planning Counseling.</em> (SDI Report). September 1987.</td>
<td>This study examined whether patients receiving a counseling intervention will have greater rates of clinic and contraceptive continuation and are less likely to have unintended pregnancies. Counseling intervention patients wrote a Pregnancy Prevention Plan to deal with contingencies that may affect birth control over time.</td>
<td>The random assignment study enrolled 914 patients—412 to contingency counseling and 502 to traditional services. Follow-ups were conducted 6 and 12 months after enrollment. Outcomes studied included clinic continuation, occurrence of unintended pregnancy, and contraceptive use.</td>
<td>Female patients at two clinics located in Presbyterian Hospital, New York City.</td>
<td>The outcome indicators of clinic and contraceptive continuation were not affected by the intervention. There was some effect on the pregnancy rate after six months for the non-Medicaid population.</td>
</tr>
<tr>
<td>Mark Tompkins. <em>The Impact of Family Planning Services in South Carolina, 1980–1984.</em> (SDI Report). June 1986.</td>
<td>This study measured the impact of family planning service delivery on teenage and adult women in South Carolina’s 46 counties over a five-year period.</td>
<td>Statewide databases provided data on vital statistics (including live births, fetal deaths, and abortions). The following factors were measured and associated with increasing numbers of pregnancies within the counties: the number of women at risk of pregnancy (teenage and adult), education levels, unemployment rate, population dispersion or concentration, and religious affiliation.</td>
<td>The 46 counties vary in their demographic characteristics (urbanization, economic character, racial make-up, and age distributions). Numbers served and services provided vary greatly from one county to another.</td>
<td>Findings show that when more patients are contacted, the greater the impact is in averting teenage pregnancies. The payoffs to delivering services more intensively and seeing patients more often, while positive, are modest compared to those realized from serving more patients. Unwanted pregnancy rates are more affected by direct services than by education and employment.</td>
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<td>Susan Gadon. Family Planning Service Delivery Improvement Project. (Cicatelli Associates). September 2002.</td>
<td>The purpose was to assess the impact of increasing costs on the delivery of family planning services over five years. Issues looked at include staff retention, cost of diagnostic techniques, cost of specific contraceptive methods, provider revenue, and cost of providing services to underserved populations.</td>
<td>Quantitative and qualitative data analyses were used to measure how increasing costs have impacted service delivery. Data collection included several sources: purchasing and service records, surveys of clinic operations, client demographic data, and interviews with veteran staff.</td>
<td>This project focused on six Title X grantees and provider agencies across the United States that met the following selection criteria: 1) large metropolitan area, 2) longevity of grantee senior management, 3) availability of service delivery cost data, 4) geographic diversity, and 5) commitment to the project.</td>
<td>In all six case studies, the clinics were attempting to maximize the number of patients served based on funds available. This was difficult due to the rising costs of salaries, benefits, and other services. In response to these cost increases, grantees were forced to absorb these increases and increase payments for services, or reduce staff. Others dealt with these rising costs by changing their program by having fewer visits per patient, or reducing their education, training, and outreach activities.</td>
</tr>
<tr>
<td>Rachel Benson Gold. Nowhere But Up: Rising Costs for Title X Clinics. (SDI Report—AGI). December 2002.</td>
<td>The purpose was to explore some of the major financial pressures weighing in on publicly funded family planning programs.</td>
<td>In a mail survey to 16 agencies (12 agencies responded), data were collected about clients, services, and costs specific to their Title-X funded projects. The survey also asked providers to identify major factors contributing to the changes in costs over time.</td>
<td>The 12 agencies (serving 200,000 contraceptive clients in 2001) were selected from the 430 Title X-funded respondents of a 1999 AGI survey of family planning agencies nationwide. The following criteria were used: had been in existence for at least 10 years, served at least 1,000 contraceptive clients annually, could provide budget and funding data since the mid-1990s, and had at least one contract with a managed care plan.</td>
<td>Three types of financial pressures that clinics reported were increasing costs of contraceptives, rising prices for diagnostic tests, and inadequate levels of Medicaid reimbursement.</td>
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### FUTURE DIRECTIONS FOR FAMILY PLANNING RESEARCH

#### CITATION

Jennifer J. Frost.  

#### PURPOSE OF STUDY

The purpose was to learn whether family planning agencies are seeking ways to serve and obtain reimbursement for serving the growing number of clients who are managed care enrollees.

#### RESEARCH DESIGN

A 1995 mail survey sought information from 885 agencies, a nationally representative sample of publicly funded family planning agencies. Data were collected about the agencies’ involvement with managed health care plans and related clinic services, policies, and practices. Responses were received from 603 agencies.

#### COMMUNITY & SETTING

The universe for the study consisted of 3,119 publicly funded individual agencies, which operate more than 7,000 clinic sites and serve about 7.5 million contraceptive clients annually. The study examines opportunities and obstacles facing family planning agencies in the managed care context. It identifies a range of strategies that family planning providers have developed in pursuing arrangements with managed care organizations and identifies issues that have arisen.

#### SUMMARY OF FINDINGS

The universe for the study consisted of 3,119 publicly funded individual agencies, which operate more than 7,000 clinic sites and serve about 7.5 million contraceptive clients annually.

The five states were selected because of high levels of managed care penetration in both the commercial and Medicaid sectors, geographic distribution, and a mix of differing types of family planning service providers.

The opportunities facing community-based family planning agencies that are seeking to become players in the provision of contraceptive and related services in the managed care context include a variety of clinic strengths such as a wide array of services, outreach to hard-to-reach populations, location of clinic sites, and experience with functioning as part of larger system. Successful tactics include leveraging existing relationships, working in coalitions, training staff, and developing a marketing plan.

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Rachel Benson Gold and Cory L. Richards.  

#### PURPOSE OF STUDY

The study examines opportunities and obstacles facing family planning agencies in the managed care context. It identifies a range of strategies that family planning providers have developed in pursuing arrangements with managed care organizations and identifies issues that have arisen.

#### RESEARCH DESIGN

Telephone interviews were conducted in 1996 with people working in, or closely with, a range of family planning provider agencies in five states (California, Colorado, Florida, Massachusetts, and Michigan).

#### COMMUNITY & SETTING

The five states were selected because of high levels of managed care penetration in both the commercial and Medicaid sectors, geographic distribution, and a mix of differing types of family planning service providers.

The opportunities facing community-based family planning agencies that are seeking to become players in the provision of contraceptive and related services in the managed care context include a variety of clinic strengths such as a wide array of services, outreach to hard-to-reach populations, location of clinic sites, and experience with functioning as part of larger system. Successful tactics include leveraging existing relationships, working in coalitions, training staff, and developing a marketing plan.

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### APPENDIX C Projects Studying Organization/Staffing/Administration

#### CITATION

Rachel Benson Gold and Cory L. Richards.  
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<tr>
<td>Jacqueline Forrest and Rene Samara.</td>
<td>Impact of Publicly Funded Contraceptive Services on Unintended Pregnanacies and Implications for Medicaid Expenditures. (AGI). Sept./Oct. 1996.</td>
<td>The purpose of the study was to examine the impact that publicly funded contraceptive services have on the women who use them as well as the Medicaid expenditures linked to these services. This was done by 1) estimating contraceptive use, and 2) estimating effects of services.</td>
<td>Data from Cycle 4 of the National Survey of Family Growth were used to identify the number and characteristics of women using reversible contraceptives who had recently visited a publicly funded service provider. The number of unplanned pregnancies was estimated by linking information about their contraceptive behavior to data on one-year method-specific failure rates.</td>
<td>Of the 21.2 million U.S. women who were using a reversible method of contraception in 1988, 64 percent had gone to a medical provider, 23 percent to a clinic, 1 percent to a physician reimbursed by Medicaid, and 41 percent to a physician who was paid privately. If these subsidized contraceptive services were not available, women who currently use them would have an estimated 1.3 million additional unplanned pregnancies annually. Roughly one-fourth of women using reversible contraceptives depended on a publicly funded provider. More than one-third of users were younger than 25, with low income and have never been married.</td>
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<tr>
<td>David Landry and Jacqueline Forrest.</td>
<td>Private Physicians' Provision of Contraceptive Services. (AGI). Sept/Oct. 1996.</td>
<td>Private physicians provide family planning services to the majority of American women. This study focuses on provision of family planning care by private physicians.</td>
<td>Data used in this study came from the 1990, 1991, and 1992 National Ambulatory Care Survey (NAMCS), conducted annually by the National Center for Health Statistics. The Survey provides information from a nationally representative sample of physicians about patient visits to private office practices and the services provided during those visits.</td>
<td>Physicians principally engaged in office practice are selected from master files maintained by the AMA and the American Osteopathic Association. The sample includes physicians working in HMOs, private/non-hospital-based clinics, but those employed by the federal government are excluded. An annual average of 13.5 million contraceptive visits were made to private physicians in 1990–92. The majority of patients who received contraceptive care have a reason other than family planning as the primary purpose of their visit. Women whose visit was publicly funded were less likely to have a contraceptive prescribed or obtain a Pap test than those with private insurance.</td>
</tr>
<tr>
<td>David Landry and Jacqueline Forrest.</td>
<td>Public Health Departments Providing Sexually Transmitted Disease Services. (AGI). Nov/Dec. 1996.</td>
<td>This article reports findings from the first ever national survey of public health department STD programs. The survey focused on services related to STDs other than HIV due to lack of knowledge on this topic. Health departments were examined because they are the primary providers for STD services.</td>
<td>The study consisted of a mail survey to a sample of local health departments drawn from the NACCHO. List health departments were grouped according to 1) levels of syphilis in the county and 2) according to the setting in which they provide STD services.</td>
<td>Information was obtained from 587 agencies with a final response rate of 77 percent overall (73 percent in counties with a high level of syphilis and 82 percent in counties with low levels). In 1995, 50 percent of all local health departments directly provided STD services. These are located predominantly in non-metropolitan areas. More than 50 percent of agencies reported no staff hours for STD community presentations or street outreach activities. Thirty-six percent of health department clients are younger than 20, and 15 percent are 30 or older. Sixty percent are women.</td>
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### Citation
Terry Sollom and Rachel Gold
*Public Funding for Contraceptive, Sterilization, and Abortion Services, 1994.* (AGI). July/August 1996.

### Purpose of Study
This study looks at the sources of funding for reproductive health services. The article presents the results of the AGI FY 1994 survey compared to previous survey data collected between 1980 and 1992.

### Research Design
Surveys were conducted by AGI of nonstate Title X grantees and state health, Medicaid, and social services agencies. Responses received from state health agencies in 50 states, Medicaid agencies in 46 states, and social service agencies in 48 states plus Washington, D.C.

### Community & Setting
Periodic surveys of state agencies.

### Summary of Findings
In 1994 federal and state funding for contraceptive services and supplies reached 715 million. The largest source of public funds continues to be the joint federal-state Medicaid Program. State funds are the second largest source. Between 1992 and 1994, spending under Title X rose by 37 percent, making it the third largest funding source for contraceptive services and supplies.

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<th>Author</th>
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<tr>
<td>Lori S. Franz</td>
<td><em>A Mathematical Model for Family Planning Clinic Staffing,</em> (SDI report)</td>
<td>July 1985</td>
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<tr>
<td>Steven Hayes and Mark Tompkins</td>
<td><em>Analysis of Organizational Arrangements in Family Planning Services Delivery in S.C.</em> (SDI Report)</td>
<td>March 1985</td>
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This report was a design and analysis of a multi-objective linear program for staffing family planning clinics in multiclinic regions. The optimal assignment of providers (physicians, nurses, etc.) is considered in conjunction with individual clinic operating schedules.

The mathematical programming model was tested in two family planning regions in South Carolina. Data for the model were collected via in-depth interviews with family planning and nursing supervisors as well as examinations of scheduling documents and state personnel records.

The model was tested in two family planning regions in South Carolina: the Upper Savannah and Lower Savannah Family Planning Districts.

Employees are most dissatisfied with personnel practices, including training opportunities, availability of incentives, promotions, and fairness. Workers are mostly satisfied with supervisors and coworkers. The largest amount of complaints were about inadequate resources.

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**APPENDIX C** Projects Studying Organization/Staffing/Administration continued
**APPENDIX D**


**Introduction**

The purpose of this review is to synthesize findings from current and previous service delivery improvement research supported by the Title X Family Planning Program and other funders and to identify opportunities for future research. This review was commissioned by the Office of Family Planning within the Office of Population Affairs in the Department of Health and Human Services. It was conducted to provide a picture of the state of research in the field and to provide a basis for developing research options for the Office and other funders with the assistance of 30 technical experts. These experts were convened twice as a group to identify high priority research issues and to suggest research options to the Office that would contribute to the improvement of family planning services in this country.

The Family Planning Program, authorized by the Family Planning Services and Population Research Act (Public Law 91-572), was initiated in 1970 and is the only federal program devoted solely to funding family planning and related reproductive health care services. The program provides access to contraceptive supplies and information to all who want and need them, with priority given to low-income persons. The program supports a nationwide network of approximately 4,600 clinics and provides reproductive health services to approximately 4.9 million persons per year (Office of Population Affairs 2003). Title X also supports activities that assist family planning clinics to respond to their clients’ needs. These activities include training for clinic personnel, communication and outreach, and data collection and research to improve the delivery of family planning services. This report reviews the data collection and research conducted by the Office of Family Planning since 1985.

To complete this assessment, we have reviewed all reports and articles supported by the Title X Service Delivery Improvement Research program since 1985. We have also conducted a literature search and reviewed all articles published since 1985 that report on the results of research conducted about family planning and reproductive health services in the United States. Just over 240 articles or reports were identified. To be included, a report had to describe research findings from analyses of either primary or secondary data. These could include questionnaire responses, program statistics, national surveys, or meta-analyses as well as other results from data collection activities. The research had to be conducted in the United States and oriented to service delivery issues.

In addition, the Office convened a group of 30 expert technical advisors to solicit evidence-based information about the key issues and research questions facing the family planning field. Many members of this group first met at NIH on May 12, 2003, to discuss and prioritize the research needs of the family planning field. This review responds to their assessment of research priorities. We describe the research evidence already collected about their key priority areas, identify gaps in the research, and provide the information needed to identify promising new lines of research for the Office. At a second meeting of the experts held on August 7, 2003, the results of the literature review were examined to ensure that most of the relevant studies had been included. As a result of this feedback, the literature review was revised to include more studies.

At the first meeting of the expert technical advisors, the group engaged in a brainstorming and prioritization process to identify the key issues and questions facing the family planning field. These questions have been organized into three types—those dealing with reaching specific populations, those dealing with the practice of family planning service delivery, and those dealing with how services should be organized, administered, and staffed. We have organized the review of the literature around these three categories.

The specific questions and issues raised by the group are listed below by category.

1. How can high priority populations be reached?
   a. What are effective strategies for reaching low-literacy and non-English-speaking populations?
   b. What are effective practices that clinics can use to assist adolescents and young adults in sexual decision-making?
   c. How can adolescents be better connected to their families and schools, and will these connections result in decreased sexual activity?
   d. 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?
e. How do we monitor and use information about who is receiving services? Can programs’ statistics and survey results be used more effectively?
f. What accounts for differences in utilization rates at the substate, state, and regional levels?

2. How can family planning practices be strengthened?
   a. What kinds of counseling and other behavior-change strategies affect knowledge, attitudes, and behavior related to reproductive health? Are there innovative approaches to helping clients choose and use contraceptives consistently?
   b. 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 clinic services?
   c. How can OPA and other organizations better disseminate research findings so that they are incorporated into practice?
   d. What are the best practices in family planning clinics, contrasting publicly funded programs with private sector programs?
   e. What is the effectiveness of nonclinical Title X services like information and education activities?
   f. How are STDs approached with the high percentage of women on the pill or other hormonal contraceptives?
   g. How do programs deal with the ideal versus the reality regarding confidentiality for teenage clients?

3. How can the organization and administration of services be improved?
   a. How can STD prevention and family planning services be most effectively integrated?
   b. What is the cost effectiveness of delivering Title X services in different settings? How effectively and cost effectively can pharmacies deliver over-the-counter contraceptives compared to family planning clinics?
   c. Have Medicaid waivers led to changes in contraceptive utilization rates and unintended pregnancies in the states?

The following sections of this report cover the research evidence about these questions.

How can high-priority populations be reached?
Almost half of the research reviewed focused on measuring and assessing the access of individuals with varied characteristics to family planning and reproductive health services. One hundred fifteen of the reports we read examined issues related to how the needs of particular populations are addressed by family planning services. The populations covered included low-income women—a target population for Title X services—adolescents, males, and to a lesser extent racial, ethnic, and language minorities as well as other hard-to-reach populations like individuals with child welfare, mental health, or substance abuse problems. There were also a few studies that examined the issues related to serving clients in particular types of geographic areas like inner cities or rural areas.

Characteristics of Women Served (Including Low-Income Women)
Our review found information available about:

1. The characteristics of the women who utilize family planning clinic services. Who are they? What services do they most use? What demographic groups do they represent?
2. The influences on women’s utilization of these clinic services. These studies include the effect of such diverse influences as insurance coverage and women’s opinions about what they want and what they receive.
3. The choice of provider. What influences women’s choices to go to a public versus a private provider of family planning services?

Women Who Use Family Planning Services
There are three key sources of data that are used to examine the characteristics of women who use family planning services. These sources are the National Survey of Family Growth (NSFG), a national survey of women conducted in 1982, 1988, and 1995; periodic national surveys of agencies and clinics providing subsidized family planning services by the Alan Guttmacher Institute (AGI) conducted in 1983, 1992, 1994, 1997, and 1999; and the Family Planning Annual Reports (1995–2001) prepared using program statistics from Title X grantees. Compiling data from these sources provides a picture of the characteristics of women attending family planning clinics as well as how the clientele has shifted over the years.

Almost 4.7 million women received services from Title X family planning clinics in 2001. Twenty-nine percent were under age 20, 31 percent were between 20 and 24, and 40 percent were 25 or older. The majority of the women were white (63 percent), 22 percent were black, and 20 percent were Latina.3 Almost two-thirds of the women (65 percent) came from households at or below the federal poverty level. Trend data indicate some increase in the number of female clients since 1995 (from 4.4 million), and the age distribution of women served has shifted somewhat as the share of clients in their twenties declined from 52 to 48 percent and the share in their thirties rose from 20 to 23 percent. The share of teenage clients remained the same.

3These numbers sum to more than 100 percent because race and ethnicity data are reported separately.
The race composition of the clients has also remained stable, but the share of Latinas rose from 15 to 20 percent. In addition to serving women, Title X clinics also serve men. Between 1995 and 2001 the share of clients who were male rose from 2 to 4 percent.

Over 4 million women in these family planning clinics used a contraceptive method, 88 percent of the female clientele. In 2001, 52 percent of the contraceptors used oral contraceptives, down from 62 percent in 1995. During the same period, the use of newer contraceptive methods increased. For instance, Depo-Provera increased from 12 to 20 percent. The number of IUD users rose and the number of hormonal implant users declined, but the shares represented by these methods were very small. The use of other methods remained fairly constant during the period. Program statistics about other services indicate that the numbers of Pap tests, breast exams, STD tests, and HIV tests have all risen during the period. In 2001 there were 65 Pap tests per 100 users, 61 breast exams, 105 STD tests, and 12 HIV tests. The share of HIV tests rose 41 percent compared to the previous year.

The statistics described above come from the Family Planning Annual Report. In contrast, the NSFG provides a picture of the reproductive health needs and service use of all women ages 15 through 44. In 1995 there were 60.1 million women of reproductive age in the United States, up from 57.9 million in 1988 and 54.1 million in 1982. In 1995 the NSFG found that the leading method of contraception was female sterilization, used by 10.7 million women, as compared to 7.0 in 1982 and 9.6 in 1988. The use of the pill rose from 8.4 million in 1982 to 10.7 million in 1988, and remained the same at 10.4 million in 1995. Condom use at first intercourse has risen steadily from 18 percent in 1982 to 36 percent in 1985 to 54 percent in 1995. Condom use among never-married women tripled between 1982 and 1995, from 4 percent to 14 percent. The number of women whose partner was currently using a condom at the date of the interview was 3.6 million in 1982, 5.1 million in 1988, and 7.9 million in 1995.

The Alan Guttmacher Institute (AGI) periodically surveys family planning clinics to determine the types of services they provide as well as the number of contraceptive clients they serve. The latest survey was completed in 1999. It found that 3,117 agencies offered publicly funded contraceptive services at 7,206 clinic sites. More than half of these clinics (61 percent) received Title X funding. These clinics provided contraceptive services to more than 7 million women, reaching approximately two out of every five women estimated to need publicly funded contraceptive care because of their low incomes and fertility status. Of all women needing publicly funded family planning care, 39 percent are served at publicly funded clinics and 26 percent of these are Title X-funded clinics. Health department clinics as well as Planned Parenthood clinics were the providers used most frequently. Health Departments served one in three women younger than 20. For most provider types and in the majority of regions of the country, adolescents make up roughly one-quarter to one-third of clients.

Data drawn from these three sources provide a description of the women who need and use family planning services. Program statistics are collected annually, but the National Survey of Family Growth and the National Survey of Family Planning Clinics are only collected periodically. This year, 2003, the National Survey of Family Growth completed a new round of data collection and these data will be available toward the end of next year. This new survey includes a sample of men for the very first time. The National Center for Health Statistics, which is a part of the Centers for Disease Control and Prevention, conducts the survey, and the Office of Population Affairs contributes funds to support the survey. The Office of Population Affairs has also supported the periodic surveys of family planning clinics.

Influences on Women’s Utilization of Clinics

There were a few studies conducted in the 1980s and 1990s that delved into reasons why women use family planning clinics and their views of these providers. Data sources for these studies included a survey of a national sample of women of childbearing age (Sonenstein, Schuler, and Levin 1994), a survey of low-income women in Arizona covered by the state managed care program (Kirkman and Kronenfeld 1994), a population-based sample of women of childbearing age in Los Angeles county (Mendenhall 1987), and a sample of low-income women in North Central Florida (Severy 1986; Severy and McKillop 1990). The studies by Mendenhall and Severy were funded by Title X. The lack of health insurance was identified by these studies as one of the major influences on the non-use of family planning services. For example, the survey of low-income women in Arizona covered by the state’s managed care program showed that their use of family planning services increased dramatically when the services were included in the Arizona health care cost system. There was an increase from 17 percent in 1984 to 33 percent in 1989; this increase was most striking among populations of Latino women, women ages 18 to 20, and less educated women (Kirkman and Kronenfeld 1994).

Other reasons behind the lack of family planning service use include the absence of a regular source of health
care and a perceived lack of need for service (Mendenhall 1987; Sonenstein et al. 1994). The studies in Florida by Severy (1986) and Severy and McKillop (1990) also showed that, among reasons why women chose certain providers, having a trustworthy, friendly, and understanding staff was rated as important as the competence of the staff. The most desirable features of a family planning service were found to be a well-trained, trustworthy, and friendly staff, and the presence of a doctor. These findings are corroborated by a national survey that found that, for women, how a provider interacts with their patients is a very important factor in the patients’ choice of providers (Sonenstein et al. 1994).

The Choice of Private versus Public Family Planning Provider

There were five studies that explore the use of different types of services by women. An analysis of the NSFG 1995 survey examines the factors predicting women’s use of publicly subsidized family planning clinics (Frost 2001). Public clinic users were more likely to be young, minority, unmarried, less educated, poor, and Medicaid recipients, and uninsured women were three to four times more likely to obtain clinic care. For women without insurance, subsidized clinics assume a crucial role in providing access to family planning care. Without access to subsidized clinics, three-quarters of low-income women without insurance would have out-of-pocket costs for care from a private provider, compared to only 50 percent of patients with insurance utilizing a private provider.

A study by Mendenhall (1985) looked specifically at the role private physicians play in providing family planning services to low-income women. It showed that the major predictor of the use of a physician was not poverty, but rather insurance coverage. The second reason behind private provider use was patient satisfaction. There were no real differences associated with the types of care received from different providers except that private providers provided more primary care, while clinics provided more education, that is, more information on prevention measures. Another study with similar findings by Radecki and Bernstein (1989) found that the most powerful predictor of the use of a public clinic rather than a private one was the lack of insurance coverage. Another predictor was women’s lack of a regular health care provider. In both studies, Radecki and Bernstein (1989) and Mendenhall (1985) found clinic use was highest for Hispanics, followed by white and then black women.

Another finding in several studies (Mendenhall 1987; Radecki and Bernstein 1989; Severy 1986; Severy and McKillop 1990) was the negative perceptions of public clinics held by women in comparison to private providers. However, black women were found to have a more favorable perception of public health clinics than other women (Severy 1986). Although Frost (2001) found that a wider range of services was offered by clinics than private providers, in general clinics are perceived to have less personalized, lower quality of care, while private physicians are perceived to have well-trained staff, privacy, and the constant presence of a doctor (Radecki and Bernstein 1989).

These findings were corroborated in a more recent study of women of reproductive age in the District of Columbia where a majority of women, regardless of income, relied on private doctors or health maintenance organizations for care. Clinic patients voiced frustration at not being able to have the same clinician over time (continuity of care) and the lack of time to get adequate explanations from clinicians (Sonenstein, Porter, and Livingston 1997).

In Summary

There is a longstanding research tradition supported by Title X that examines the characteristics of the population served by Title X and contrasts this clientele to the population of individuals who might avail themselves of clinic services. This work monitors how well the program is reaching its target population, and attempts to assess factors that facilitate and block access to its services. While the expert panel focused its priority setting on more specialized populations, like adolescents, individuals with language barriers, and males, the studies covered in this section answer the most basic questions about the program and provide a context for understanding explorations of specific populations.

Adolescents

For the eleventh year in a row, data provided by the National Center for Health Statistics indicate that the birth rate among U.S. teenagers has fallen, and have fallen to a new record low. Nonetheless, the U.S. teen birth rate is still one of the highest among developed countries, and there is considerable public concern about the financial and social costs of early childbearing in this country. This concern was reiterated by the panel of experts who noted that identifying successful approaches to addressing the sexual and reproductive health needs of adolescents was a high priority. Specifically the panel posed the following questions as critical research topics: “What effective practices can clinics use to assist adolescents and young adults in sexual decisionmaking?” and “How can adolescents be better connected to their families and schools, and will these connections result in decreased sexual activity?”

Our review of the literature revealed a large number of studies that address service delivery issues with regard to the adolescent population. There is an even larger literature about adolescent sexual and contraceptive behavior that we
have not included in this review. In this section of the report we categorize the research into two general topic areas. The first is research that examines adolescents’ utilization of family planning services, and the second examines what research has revealed about effective pregnancy prevention programs. However, we note that the rest of this report will cover other issues that touch upon adolescents, especially in the sections covering the Hispanic population and males.

**Adolescents’ Utilization of Family Planning Services**

A few studies have examined adolescents’ utilization of services, primarily in specific localities. For example, one study in Monroe County, New York, conducted a telephone survey of adolescents to find out about their service utilization and the sources of their care (Klein, McMulty, and Flatau 1998). This study indicated that 90 percent of the teenagers had visited a health care provider in the last year, and many youth identified school personnel as important resources for health and counseling needs. However, these teens also reported that reproductive health services as well as mental health services were the most difficult to obtain. Another small study of teenagers who had become pregnant in Rochester, New York, found that 93 percent of them had a doctor or clinic visit in the past year and 77 percent had a check up. Local studies such as these corroborate national research findings that indicate that many teenagers have access to health care providers but do not appear to receive counseling or services addressing their sexual and reproductive health needs (Porter and Ku 2000). Findings such as these indicate a need to find out more about the barriers that keep health providers who interact with adolescents from dealing with sexual and reproductive health issues. For example, one study looked at adolescent health screening measures in five different types of practice settings to assess how they conformed to the AMAS screening guidelines for adolescents (Blum et al. 1996). The study found that in none of the practice settings were the screenings up to the level recommended. Among all types, teen clinics screened more extensively than any other type of clinic.

A study by Schuster et al. (1996) used a self-administered anonymous survey in an urban California school district to assess the extent to which adolescents feel comfortable discussing sexual behavior with their physician, as well as whether they value the interaction and trust these providers to protect their confidentiality. The highest percentage of adolescents reporting any discussions about sexual behavior with their physicians was the 39 percent who reported having discussions about how to avoid getting AIDS from sexual intercourse. This percentage is in stark contrast to the share of adolescents who felt that it would be beneficial to discuss these matters with their physicians (80 to 90 percent). Barriers that may inhibit this communication include lack of access to physicians, failure of physicians to raise the subject, lack of responsiveness, and the adolescent feeling uncomfortable.

One barrier to visiting a family planning clinic for teenage girls is the pelvic exam. A poll indicated that 69 percent of adolescent females postponed a visit to the family planning clinic or doctor because of their fear of the pelvic examination. Responding to this concern, the Smart Start intervention described in a study by Armstrong and Stover (1994) was designed. This intervention allows young women who are seeking contraceptive services the option of delaying selected medical services, including the pelvic examination and blood work. By introducing this approach, the program planners believed that teens would be encouraged to obtain contraceptives at first visit and to continue using the services. On the first visit, a thorough family and medical history was taken, and teens were required to have their weight, height, and blood pressure taken and to have a urine pregnancy test. Teens who delayed the pelvic examination or blood work also had to sign a form indicating their willingness to complete the delayed services within six months of the initial clinic visit. Information about birth control was provided in the waiting room, so that during the visit a counselor could assist them in choosing the right type of birth control for their lifestyle. The third program component was follow-up counselor contacts.

The findings of the study showed that the teens who delayed the pelvic examination did return to the clinic in order to complete it. Also, these teens did not experience any serious complications or STDs when the procedure was delayed. In addition, more teens came to the clinic through word of mouth when they heard they could delay the pelvic examination. Once at the clinic, they were given anticipatory counseling and guidance to alleviate fears about the medical examination. Teens were more willing to return once they had received the counseling and had their fears alleviated; simultaneously, their trust in the providers increased through this intervention.

The success of the Smart Start intervention has now been translated into clinical practice. More than one half of family planning agencies permit clients to delay pelvic exams when first receiving the pill or an injectable (Finer, Darroch, and Frost 2002). The Food and Drug Administration approved this practice in 1993, and a demonstration study in California found that the practice...
expands low-income women’s access to hormonal contraceptives and improved their chances of obtaining other reproductive health services (Harper et al. 2001).

Another example of a new approach to delivering family planning services is implementation of the Family PACT program in California (Brindis, Llewelyn et al. 2003). The PACT program, which stands for planning, access, care, and treatment, was developed by the California state legislature to increase access to care in the state since demand for services outweighed the limited funding available. The program began implementation in 1997 and is considered unique because it is the first in the country to establish a program in which the state funds services and supplies for low-income male and female residents. The program was developed with the assistance of a number of other partners including The American Academy of Gynecology and Pediatrics and the California Academy of Family Physicians. The differences between this model of care and that previously existent in California include expansion of the provider base to include private providers, pharmacies, and laboratories. In addition, client eligibility for the program is determined at point of service using self-reported data; clients are screened for eligibility and then issued a Health Access card that allows them access to services. The PACT program operates as a fee-for-service program in contrast to the previous payment plan in which providers were reimbursed flat rates for all services.

A recent evaluation of the Family PACT program examined whether the program increased access to family planning services for adolescents in California. Several data sources were utilized to conduct this evaluation, including program data, client exit surveys, and on-site observations. The results show that the numbers of adolescent clients have increased substantially since the implementation of Family PACT. However, the number served remains at about one-third of adolescents needing services, as determined by estimates from the Alan Guttmacher Institute in 1997. One-half of all clients identified themselves as Hispanic, 32 percent as white, 9 percent as African American, and 6 percent as Asian, Filipino, or Pacific Islander. Utilization patterns among the adolescents showed that they are more likely than adults to seek services from community clinics.

There are only a few studies that have addressed the issue of parental involvement in the delivery of family planning services to teens (Jaccard 1996). Recent findings from a National Longitudinal Study of Adolescent Health indicate that teenagers who report that their parents are warm, caring, and supportive are less likely to engage in sexual risk taking as well as other types of risk behavior (Resnick et al. 1997). A recent article corroborated this finding with a higher risk population. Among urban youth attending alternative high schools, the students’ perceptions of connectedness to their families were found to be protective factors associated with lower levels of sexual experience, unprotected sex, and pregnancy (Markham et al. 2003).

Current research in this area has been quite limited with some studies focusing on the dampening effects of obtaining parental permission and others on the challenging aspects of getting parents engaged. Our review uncovered only a couple of older studies about the types of services requiring parental permission and providers’ perspectives on confidential access to care for adolescents (Fleming, O’Conner, and Sanders 1994; Swenson et al. 1991). A more recent study (Reddy, Fleming, and Swain 2002) focuses on these issues but from teenagers’ perspectives. In a study of girls attending planned-parenthood clinics in Wisconsin, 59 percent of the girls indicated that they would stop using sexual health care services and delay testing and treatment for HIV or other STDs, even though parental notification only applied to contraceptives. These findings conform to those of earlier studies by Kaplan (1989) and Zabin, Stark, and Emerson (1991). In addition, 57 percent of teens using clinics in the latter study indicated that they were unwilling to communicate with their parents about sexual issues.

The findings above from small-scale studies indicate a need for further work about how to address parental and family involvement without reducing the utilization of clinic services by teenagers.

The findings above from small-scale studies indicate a need for further work about how to address parental and family involvement without reducing the utilization of clinic services by teenagers. Indeed, an earlier study by Herceg-Baron et al. (1986) tested two types of special clinic services in nine clinics and evaluated their effectiveness. The two types of services included promoting greater involvement of the teenager’s family through special counseling sessions, and the second was to provide more frequent contact between teenager and staff through frequent telephone calls. Fifteen months after the initial visit there were no significant differences in regularity of contraceptive use and pregnancy rates between the teens who received the special services and those that did not. The study also reported great difficulties in getting teens to attend the family support sessions; when teens did attend, only 5 percent showed up with a parent.

A recent study by Sugland, Leon, and Hudson (2003) examined the state of parental engagement among adolescent reproductive health providers. This three-pronged investigation included 1) review of relevant research to understand the role of parents and families in adolescent...
sexual and reproductive health behavior, 2) identification of parental engagement programs, and 3) telephone interviews with key informants from these programs. Nineteen programs were identified across the nation and the investigators looked in-depth at four of these programs. The goals of the programs included helping parents feel comfortable talking with their children about sexuality, establishing a positive relationship with the community, and involving parents in services. The major challenges for the programs include involving males, retaining trained parents, continuity and consistency of parent participation, initial community resistance, staff knowledge about cultural and language issues, and outreach to rural families. This report demonstrates that programs involving teens and their parents have been successfully implemented but they are not widespread.

**Effective Pregnancy Prevention Programs**

Much of the service-related research regarding adolescents has focused on describing and evaluating various programmatic approaches to preventing pregnancies and/or STDs among teenagers. There have been a number of comprehensive reviews of this research (Card et al. 1996; Kirby 2001; Manlove et al. 2003). The review by Kirby is perhaps the most extensive and is certainly the longest-running review, since several updated versions have been issued over the past 15 years as evidence about programs has accumulated. To be included in the most recently issued review, program evaluations had to meet several standards that included having been completed in 1980 or later in the United States or Canada, been targeted at adolescents of middle school or high school age, employed an experimental or quasi-experimental design, had a sample size of at least 100 in the combined treatment and control group, and measured impact on sexual or contraceptive behavior, pregnancy, or childbearing. In addition to examining sex education, the study covers abstinence education programs for teens, contraceptive and family planning services, early childhood programs, youth development, and service learning interventions.

The review cites eight programs as having strong evidence of success—five are sex education programs, two are service-learning programs (i.e., community service combined with group discussions and reflection), and one is an intensive program that combines sex education, comprehensive health care, and activities such as tutoring.

In addition, the review concludes that family planning clinics probably prevent a large number of teen pregnancies—although there is remarkably little evidence to support this view. However, several studies testing what happens during a clinic visit have indicated that when clinics give clear messages about sexual and contraceptive behavior and include one-on-one consultation, clinics can increase contraceptive use among male and female teenagers, although not always for a prolonged period of time.

While substantial numbers of sexually experienced female students in schools with school-based or school-linked clinics obtain contraceptives from those clinics, and while students obtain large numbers of condoms from schools when schools provide those condoms in private locations and with few restrictions, studies measuring the impact of such programs on contraceptive use have produced mixed results. A recent study by Brindis, Klein et al. in 2003 surveyed 806 school-based centers currently operating in the country and obtained a 70 percent response rate. The results show substantial growth in school-based health centers from 1988 to 1998 from 120 to nearly 1,200 clinics.

The review concludes that the jury is still out about the effectiveness of abstinence-only programs. That is, current evidence about the success of these programs is inconclusive. This is due, in part, to the very limited number of high-quality evaluations of abstinence-only programs available, and because the few studies that have been completed do not reflect the great diversity of abstinence-only programs currently offered. Fortunately, there is currently a high-quality, federally-funded evaluation of abstinence-only programs underway, which should offer more definitive results within the next two years.

Another recent review conducted by Johnson et al. (2003) focused on 44 HIV prevention research studies available as of January, 2001, with data from 56 interventions. These interventions included about 35,000 participants between the ages of 11 and 18. This review concluded that the most successful interventions related to HIV risk behavior were those that taught teens how to communicate with their partner, negotiate how to use a condom, and dispensed condoms. Students in information-only programs that provided no help with behavior skills showed no increase in condom use.

**Clinic Studies**

In addition to the broader reviews of effective programs, we also cite a few studies that concentrate on specific interventions. One intervention that was unique was the Peer Provider Model, in which a clinic is led by teens for teens. This particular type of model was implemented in five settings in various counties of California in 1996. A three-year descriptive evaluation took place, and key outcomes were identified by the Center for Reproductive Health Research and Policy at UCSF. The key components of a peer provider model include: a teen-centered staff, peer providers who pro-
provide service during certain hours, a teen supervisor, a male client focus, a teen telephone line, and telephone follow-up. This project showed promising results on a number of outcomes. Some of the key results included an increase in male clients, increased frequency of birth control use among female clients, increased condom use among females, and improved continuity of care among both male and female clients. The program was found to be especially successful among the Latina population. A sub-study of the Latina clients at the clinics showed that the sample reporting that they “always” used birth control increased from 46 to 81 percent from the first to follow-up visit.

A study by Hughes, Furstenberg, and Teitle (1995) of an effort to increase resources devoted to teenage services tested the question of whether increasing services would increase the proportion of at-risk teens taking advantage of these services. The RESPECT project conducted in the Philadelphia area used strategies such as initiating or expanding after-hour clinic services, beginning teenage walk-in hours, as well as outreach efforts conducted through community centers and health fairs. Data were collected twice: before the project was implemented and 2.5 years later for the teens (14 to 18 years old) in the area where clinics were set-up and a control group of teens from a community in northern Pennsylvania used strategies such as showing that the sample reporting that they “always” used birth control increased from 46 to 81 percent from the first to follow-up visit.

Another study by Kissinger et al. (1997) conducted in the Orleans Parish Family Clinic in New Orleans, Louisiana, showed that teens’ use of services could be increased. This study used adolescent-specific initiatives to improve understanding of family planning services and promote contraceptive use. Orientation sessions and three-month booster visits were conducted for 737 African-American teenagers. The results were positive, showing that initiation of services was associated with attending the orientation session, while attendance at the three-month booster visit was associated with the annual visit attendance. The study concluded that specific techniques to motivate teens can improve initiation and compliance.

A Title X-funded study by Winter (1998) also tried the approach of tailoring services to teens. In this case the tailored approach was designed to address the psychosocial needs of adolescents. The experimental protocol integrated additional time for counseling, informational videotapes, and more frequent clinic contact. Two clinics were studied with a total of 1,225 female clients enrolled at both sites: the Planned Parenthood clinic of Central PA–York was the experimental site, and the Planned Parenthood of Susquehanna Valley–Lancaster was the control. As a result of the intervention, significant improvements in knowledge were found. However, rates of pregnancy or contraceptive use measures were not affected.

**In Summary**

There has been a substantial amount of research conducted to test and evaluate programs for teenagers. This work has uncovered a number of program models that appear to influence adolescents’ sexual risk taking. How programs might engage parents with the goal of reducing teens’ risky behavior is less well understood. Recent research on programs indicates that some organizations have developed approaches to engaging parents that do not reduce the participation of teenagers. However, the jury is still out about the effectiveness of these programs in influencing the teenagers’ sexual and contraceptive behavior. Further, the research about how family planning clinics could more effectively influence the risky behavior of their teenage clients is fairly limited. The evaluation and later widespread implementation of the Smart Start approach, however, suggests the promise of continue investigating how family planning clinics might better address teenage clients who make up approximately one-quarter of the program clientele.

**Males**

The literature review uncovered 17 articles and reports that focused on research about reproductive health services for men. Six of these studies were supported by Title X, indicating that the Office has assumed a leading role in encouraging research in this area. About half of the studies examine the characteristics of men using family planning services. A few studies (four) focus on describing the current services available to men, and the remaining three studies examine specific interventions.

**Characteristics of Men Using Family Planning Services**

Data from the Family Planning Annual Reports (AGI 2002a) prepared by the Alan Guttmacher Institute indicate that Title X grantees served 4.7 million individuals at clinics in 2001. Of these individuals, 199,245, or 4 percent, were male. However, this share represents a doubling of the percentage of male clients since 1995, with a 17 percent increase occurring in the past year. Among male clients, about one-third were under the age of 20. Twenty-seven
percent were 20 to 24 years old, and 15 percent were 25 to 29. Males over the age of thirty made up 24 percent of the male clientele. Half of the male clients were white, and 31 percent were black. Twenty percent of male users identify themselves as Hispanic. In terms of services used, the 211,444 STD tests utilized by male users represent about 4 percent of the total number of STD tests provided. For HIV tests, the number reported for male users is 13 percent of all tests provided, a higher ratio for male compared to female users.

Young men have been the focus of most of the research efforts. A sizable population of young men use family planning clinics to obtain condoms (Glasser 1990). This function of family planning clinics appeared early, as demonstrated by an early Title X-funded study of black adolescent males attending an Adolescent Medicine clinic in Washington, D.C. (D’Angelo 1986, 1992).

One recent study by Gilmore and colleagues (2003) in Washington State moved beyond a focus on condoms to explore sexually active men’s beliefs about three approaches to STD prevention: abstinence, mutual monogamy, and condom use. The men in the study held mixed beliefs about abstinence. While acknowledging that abstinence would allow them to get to know a woman before they became involved with her, they also believed it would be sexually frustrating and interfere with the development of a close relationship. However, men’s attitudes toward monogamy were favorable; in fact, out of the three approaches, this received the highest mean outcome belief score, suggesting that this may be a promising prevention approach. Another encouraging finding from this study is that men feel motivated to comply with their health care provider’s advice. Thus, discussion of methods of protection by health care providers should be encouraged.

Services Available for Men

Several recent reports have concluded that many men are out of touch with the preventive health care system (Sandman, Simantov, and An 2000; W.K. Kellogg Foundation 2003). Lack of attention to their sexual and reproductive health needs is but one component of the “silent crisis” in men’s health.

A 1999 survey of publicly funded family planning clinics indicated that over half reported increases in the male caseload since 1995. Virtually all the clinics surveyed said they provided some services for men. The most common services were STD counseling (95 percent), contraceptive counseling (93 percent), STD treatment (90 percent) and testing (89 percent). Around half reported providing testicular cancer screening, sports/work physicals, prostate cancer screening, and primary care. Infertility counseling was offered by 28 percent of the clinics; vasectomies were offered by 24 percent (Finer, Darroch, and Frost 2003). An earlier study of clinics serving men identified five general approaches that clinics could adopt to incorporate more males into using their services: 1) clinics providing primary care to attract the men; 2) clinics placing a heavier emphasis on male reproductive health; 3) clinics using community outreach and partners of female clients to recruit men; 4) hospital-based clinics providing comprehensive care; and 5) school-based clinics providing a range of reproductive health services (Schulte and Sonenstein 1995).

Earlier work by Forrest, Swanson, and Beckstein (1989) found that, in comparison to the educational and training materials available for female family planning clients, very little was available for males. A survey of family planning agencies in 1985 investigated possible reasons why men did not utilize services. The reasons identified included no male staff, services specifically designed for women, and negative attitudes and lack of training of the program staff.

Interventions for Men

Over the past decade there has been a significant growth in programs aimed at involving males. A survey in 1995 indicated that very few (under 25 percent) had been around for more than three years, and very little research was being conducted to document or evaluate these efforts (Sonestein, Stewart et al. 1997). Since that time, there has been very little research published that reports the results of assessment or evaluations of men’s services.

One study describes the success of an aggressive outreach campaign into the life space of adolescent males in a New York City neighborhood through use of videos, condom distribution, social services, and group education. The success of this intervention at the Young Men’s Clinic at Columbia Presbyterian in New York was attributed to the outreach effort into the community which utilized influential adults in the adolescents’ lives. This outreach lead to increased utilization of the young men’s clinic (Armstrong et al. 1999).

Other studies examined a variety of approaches including: a condom distribution/education component, a counseling/instructional video intervention, and an establishment of a men’s clinic within a young women’s clinic. The first intervention found no improvement in condom use among a group of young men who regularly received condoms (D’Angelo 1992). An experiment in a health
maintenance organization using an instructional video and counseling led to improvements in contraceptive behavior (Danielson et al. 1989). A more recent study of the New Generation Health Center (NGHC), a publicly funded affiliate clinic at University of California, San Francisco, found that coupling a first phase of outreach into the community with male peer educators and a second phase of implementing a separate males-only clinic session led to a doubling of the number of male clients served. Eighty-four percent of the males served at the clinic had come in for their first visit; they had never been to another STD or family planning clinic in the past. Eighty-seven percent of males reported having sexual intercourse within the past three months, with two-thirds of the males not using condoms at last intercourse and one-third reporting they had impregnated someone previously (Raine et al. 2000).

In Summary

Title X has been one of the leading funders of research on involving men in reproductive health services. More research is needed to describe and evaluate these types of services. The Office recently initiated a request for proposals for innovative male programs. This request included an evaluation requirement that will lead to better documentation of program efforts and outcomes. In addition, as the new round of data from the National Survey of Family Growth becomes available, the information obtained from the male respondents can be mined to understand better the sexual and reproductive health needs of men and to assess their current levels of health care utilization.

Further, according to Sonfield (2002), two types of men could use reproductive health services. The first are the younger men who need services relating to condom use and education, STD testing and education, and family planning counseling. Most of the research and effort has concentrated on this group of men. The second type consists of older men who need services related to medical reproductive health care, infertility, vasectomy, and cancer. More research attention needs to be paid to older men.

Ethnic Minorities

Latinas

The fastest growing population in the United States is Hispanic persons. This group is now the largest minority group in the country. By 2005, this group is estimated to make up one-quarter of the U.S. population. According to recent data from the Family Planning Annual Reports, 20 percent of the women served were Latina. Birth rates among Hispanic women are high, although there is some difficulty calculating accurate rates since the denominator in the calculation, the number of Hispanic women, requires an accurate count of the documented and undocumented population. However, the Hispanic population is heterogeneous, composed of both native and foreign-born individuals, with origins in Central and South America, Cuba, and Puerto Rico. The largest subgroup of this population are individuals with family origins in Mexico. To address the family planning needs of this diverse population, programs must deal with within-group variations in cultural norms, facility in English, and levels of education.

There has been a substantial amount of research examining the family planning needs and health care use of Hispanic women. Very often this research has focused on broader populations with subanalyses of Hispanic study participants. A smaller number of studies have focused in-depth on specific Hispanic populations. For example, a 1996 study conducted by Forrest and Frost used a telephone survey to examine the family planning attitudes and experiences of low-income women age 18 to 34 who were sexually active and at risk for unintended pregnancy. The investigators over-sampled for black and minority women, and thus ended up with a sample comprised of 1,852 individuals: 454 white, 451 black, and 947 Hispanic women. Among Hispanic women, 63 percent of pregnancies were unplanned, although it was unclear whether this pattern of high unintended pregnancy was a proxy for socioeconomic disadvantage or other barriers faced by these women. In comparison to the two other groups, Hispanic women were more likely to be currently married or have been with their partner for more than three years. In addition, Hispanic women were significantly more likely to say that they would be glad if they found out they were pregnant. Among the three groups (whites, blacks, and Hispanics), Spanish-speaking contraceptive users were most likely to be relying on long-acting methods. However, English-speaking Hispanic women were more likely to rely on condoms as their most effective method. In terms of satisfaction with their method, Hispanic women remained significantly less likely to be satisfied with their contraceptives. Differences among Spanish-speaking and English-speaking Hispanics may be attributed to the more common use of long-acting methods in Central and South America.

A study that focused on Latinas attending a reproductive health clinic in the San Francisco area examined differences between foreign-born and U.S.-born patients (Minnis and Padian 2001). The study recruited 361 females from reproductive health clinics between 1995 and 1998 who completed an interview that assessed sexual risk behaviors and history of pregnancy, abortion, and sexually transmitted infections. Foreign-born Latinas had a higher median age at first intercourse than did U.S.-born Latinas. However,
they were also at increased risk of pregnancy due to their decreased reliance on hormonal contraception or abortion. Second-generation Latinas had higher teen pregnancy rates, but foreign-born Latinas age 19 to 24 years had higher pregnancy rates at this age. Thus, although age at first intercourse is higher among the foreign born, their rate of pregnancy is higher at later ages. The majority of pregnancies occurred after migration to the United States; 86 percent of those that reported a history of pregnancy became pregnant for the first time after moving to the United States.

A key issue in the delivery of services to Hispanic women is whether higher levels of acculturation to U.S. culture puts them at higher risk of problem pregnancies. A study of Hispanic women attending a Southwestern hospital clinic for high-risk pregnancy found that although these women bring with them cultural traditions that encourage a healthy pregnancy and childbirth, they have gaps in their “health” knowledge and familiarity with effective methods of family planning. This study suggests that practitioners can use time in this country as an indicator of adherence to traditional beliefs (Jones et al. 2002).

Other studies have examined contraceptive attitudes and behavior of Hispanic women. The following study is illustrative of the impact of cultural influences. Picardo et al. (2003) asked individuals whether or not they thought oral contraceptives (OCs) decreased, did not affect, or increased the risk of twenty different symptoms or disease processes. In addition, patients were asked to identify from a list of sources what they had or had not used. Overall, the results show that women continue to be uncertain about the health benefits and risks of OCs. In addition to being unsure about the ovarian cancer risk, many also had misconceptions about the pill in regards to weight gain, fertility problems, and endometrial cancer. Hispanic women reported family and friends as their primary source of information. This is in line with previous evidence about the influence family and close-knit communities have among Hispanics in the United States.

A study conducted by Sangi-Haghpeykar, Horth, and Poindexter (2001) explored the use of condoms among sterilized and nonsterilized Hispanic women. The study is particularly important because sterilization is increasingly popular among women, and Hispanic women are at risk of contracting HIV and other STDs, often because of their partners’ behavior. The study took place at a facility that served primarily low-income women. When asked how frequently they had used condoms in the last three months, sterilized women were half as likely to have used condoms “at least 90 percent of the time” compared with users of the pill or injectable contraceptives. However, those whose partners had favorable attitudes toward the condom and those who considered themselves highly susceptible to disease had elevated odds of using condoms consistently (Sangi-Haghpeykar et al. 2001). Work such as this corroborates the need for family planning and reproductive health services in this population.

Some research has been conducted on the perspectives of Hispanic women regarding family planning clinic use. In the 1996 study (Forrest and Frost), Hispanic women's use of family planning was highest among the three major racial/ethnic groups. However, these women were less likely to report that they had a positive experience at their last visit. On the other hand, their satisfaction levels with the visit did not vary from the other groups. This may indicate that these women may have just come to expect a lower standard of care. Almost 96 percent of Spanish-speaking women preferred to be served by Spanish-speaking providers. Of these women, only 69 percent reported that at least one of their health care providers spoke Spanish to them at their last visit. Among Spanish-speaking women, the ones who assigned a low rating to their visit satisfaction cited the language barrier as the main obstacle in their care.

A recent study commissioned by the Office assessed the language assistance services and activities that were available for limited English proficient (LEP) individuals in seven Title X-funded clinics (COSMOS Corporation 2003). The study assessed the following: 1) In what way were clinics responding to the growing demand for language assistance in their communities? 2) What barriers did clinics face as they strive to provide these services? and 3) How did LEP individuals perceive the services offered? What could make them more accessible? The investigation utilized document reviews, telephone and face-to-face interviews, and focus groups. The interviews were conducted with clinic staff as well as family planning clients. The report found that the clinics in the study employed a number of techniques to try and reach the LEP population. These included employing bilingual staff, staff interpreters, language line services, contract interpreters, and having on-site translation services available to translate client education materials and forms. Clinics also attempted to provide educational videos in multiple languages, train their staff in cultural competence, and develop relationships with community-based organizations (CBOs) to augment their language capacity. Language assistance was provided at some clinics through either teleconference technology or remote

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telephone interpretation; another clinic, which served a primarily rural population, used a mobile health van staffed by bilingual individuals.

The barriers identified include: LEP client characteristics like linguistic differences, cultural differences, and low levels of health literacy; resource limitations like the costs associated with translation and interpretation services; limited availability of bilingual staff and volunteers; and staff time constraints. The focus groups with the LEP clients revealed that they felt that their confidentiality was compromised when bilingual interpreters or telephone interpreters were used. Educational materials often lack the newest information, such as new contraceptive methods, while the multilingual videos are often too technical in their language. However, despite the challenges posed by these methods, clients felt the most satisfied when bilingual staff facilitated the clinic visit. They also felt that the multilingual signs and client education material were additional resources that provided helpful information.

**Latino Youth**

Additional research has focused on the particular needs of Hispanic youth. Unlike the adult population, the majority of Hispanic youth are native born. Only 13 percent are immigrants, 39 percent are the children of immigrant parents, and 48 percent are the children of native-born parents. The rate of pregnancy among this population equals that of African Americans and is double that of the white population. The birth rate for Hispanic teenagers is 92 births per 1,000 females. In other words, 1 in 11 (15- to 19-year-olds) gave birth in 2001. Latino youth are disproportionately more likely to be poor and to experience language and cultural barriers. For the youth who have migrated here, dealing with the stresses of adjusting to U.S. society is also an issue (Driscoll et al. 2002).

Title X has funded two studies of youth that have explored ethnic differences in adolescents’ views of sex, pregnancy, and contraception. Sugland (1999) conducted 12 focus groups with 106 European, African, and Hispanic American youth between 16 and 19 years of age. The study found that sex was viewed as normative among teens and their peers. However, there was also much variability in the types of sexual relationships teens engage in—from serious/monogamous to one-time sexual relationships. The type of relationship at first sex has substantial influence on subsequent sexual relationships. In addition, the adolescents in the groups indicated that family support, stronger community, and social involvement are influential factors in contraceptive use. Across all subgroups, white, black, and Hispanic, family support and involvement were considered crucial.

Keith (1988) studied 202 females 13 to 17 years of age in a West Dallas youth clinic who were predominantly black and Hispanic. The study found that cultural influences affect sexual behavior and contraception. The Hispanic girls in the study were more likely to be accompanied by their mothers to the clinic and were less likely to reveal sexual activity, thus inhibiting their chances of receiving appropriate contraception. Among black women, the influence of the church and family as well as the presence of a father figure was indicative of not being sexually active during early and middle adolescence.

**In Summary**

The Office of Family Planning has supported research that gathers information about the reproductive health needs of the Hispanic population and about service delivery approaches for LEP populations. Work in this area is hindered by the heterogeneity of the population. To be useful, research needs to differentiate populations by nativity, country of origin, educational levels, and English proficiency. National samples rarely include sufficient sample size to differentiate by these characteristics. Smaller studies often do not indicate how their program participants distributed on these characteristics.

**Other Immigrant Populations**

Our review uncovered a single other study of the family planning needs of immigrants. In 1985, Minkler et al. conducted a study of the Southeast Asian refugee population, including Vietnamese, Cambodian, Lowland Laotian, Lao Mien, and Lao Hmong populations. This study attempted to understand the knowledge and beliefs related to the fertility behavior of these groups of refugees in order to tailor services to their needs. Researchers reviewed medical records, conducted in-depth interviews with the men and women of reproductive age and analyzed the benefits and costs of subsidized services to Southeast Asian refugees. The study was carried out with the help of three refugee health clinics in California: Alameda, Santa Clara, and San Francisco counties. Although the majority of the population knew about family planning, there were gaps in their knowledge of modern methods and their usage. There was also a significant knowledge-practice gap; 70 percent of those who did not want to get pregnant were currently using contraceptive methods, and one-third of this group were using methods not considered “highly effective.” The most difficult barriers identified were the respondents’ limited knowledge of reproductive physiology and language barriers.
Native Americans

Only one study was found related to family planning services for Native Americans. A 2003 study by Espey et al. examined the reasons why the IUD method among Navajo women has lost its popularity by identifying barriers related to provider characteristics. The study was conducted in 2000 with 107 Navajo area Indian Health Service providers who offered contraceptive services. Survey results showed that the providers had good factual knowledge about IUDs and the majority reported adequate knowledge to counsel women about the IUD and how to insert it. The key reason for not recommending the IUD was concern about side effects even though women who use IUDs report very high levels of satisfaction with their method and continued use over a one-year period. This study highlighted the disparity between the attitudes of providers and their clients and suggested further assistance to the providers to narrow the gap.

Other Hard-to-Reach Populations

The hard-to-reach population is comprised of groups that typically require intensive outreach efforts and specialized services in order to involve them in safe reproductive health practices. For this reason, these populations remain at high risk for sexually transmitted diseases and unintended pregnancies. Several researchers have investigated how to take family planning services to these specific populations.

According to Donovan (1996), a 1995 survey of 3,119 family planning agencies across the United States indicated that three-quarters of the agencies provided contraceptive services to hard-to-reach populations, such as substance abusers, incarcerated men and women, the disabled, the homeless, and non-English-speaking minorities. Interviews with approximately 100 administrators, program supervisors, and clinicians indicated that there was a general consensus that these hard-to-reach populations are desperately in need of services. In this review we examine published research reports relevant to serving three hard-to-reach populations: substance abusers, individuals with mental health needs, and individuals with child protective services issues.

Substance Abusers

Substance abusers as a population represent an especially at-risk group of individuals. Two-thirds of women with HIV become infected through intravenous drug use or intercourse with a male IV drug user (Armstrong, Kenen, and Samost 1991). However, this group of individuals is difficult to identify and contact through outreach programs, and the motivations behind these individuals’ contraceptive decisionmaking is not well understood. Only four research reports were identified as addressing this population. Two of these reports use the same data source (Armstrong et al. 1991; Kenen and Armstrong 1992). These two studies focus on the beliefs and behaviors related to family planning services and contraception among substance abusers. The remaining two reports evaluate the effectiveness and outcomes of screening on different populations: individuals coming in for detoxification, and individuals coming in for family planning services. The common conclusion of all four studies was the need to integrate family planning services and drug treatment programs.

The two analyses of the beliefs and behaviors of substance users are based on a study funded in 1988 by the CDC. This project involved integrating family planning services into drug treatment programs in Philadelphia. These two reports describe the results of focus group discussions with both men and women. The first article (Armstrong, et al. 1991) looks at results from these focus groups regarding opinions and attitudes of family planning services, while the second article (Kenen and Armstrong 1992) looks at beliefs relating to contraceptive use, especially condom use. The main findings of the two studies are that traditional family planning services need to be altered in order to serve this group. Some of their needs include 1) misconceptions of what services are and to whom they are targeted; 2) education about how to use condoms; 3) mistrust between men and women; 4) negative perceptions regarding health care providers; 5) dislike of condoms; 6) irregular use of condoms; 7) unplanned pregnancies; and 8) high level of risky sex practices (Kenen and Armstrong 1992).

The two other studies used screening approaches to identify target populations for service. The first study (Harwell et al. 1996) examined the prevalence of drug and alcohol use among an inner-city family planning population, and identified factors associated with a positive urine test. The purpose of the study was to evaluate the utility of screening family planning clients for drug and alcohol use so that counseling and treatment services could be offered. The study conducted blind drug and alcohol tests on 309 women attending an inner-city hospital clinic, and found the prevalence of drugs to be 15 percent, with marijuana and cocaine use being most prevalent. The second study (Shah et al. 1998) administered pregnancy tests to women coming into emergency detoxification in Denver. When sober, the women were surveyed about their contraceptive use and behavior. This study was motivated by the adverse fetal outcomes associated with substance abuse during pregnancy. The study found a 7 percent pregnancy rate. More than half of the women did not use contraceptives with every sexual encounter.
Populations with Disabilities

Two research articles covered the topic of mentally ill patients and reproductive health services. Both concluded that mentally ill patients, especially females, are at high risk for unwanted pregnancies, and their needs are rarely addressed by family planning clinics. A study by Coverdale, Aruffo, and Grunebaum (1992) advocated taking services from clinics into mental health centers because this option offers many advantages, including enhanced communication between caretakers and family planning providers, as well as an environment to provide classes such as parenting and substance abuse. The study found that mentally ill patients are especially in need of classes that provide basic physiological information as well as training in assertiveness. A study by Kessler et al. (1997) examined retrospectively the relationship between early onset psychiatric disorders and subsequent teenage parenthood. The data were from the National Co-morbidity Survey. Information on the disorders was gathered during face-to-face interviews. The study found that early onset psychiatric disorders were associated with teenage parenthood among both females and males. The study recommended that family planning clinics need to take this into account when designing interventions and services.

A third study conducted more recently by Cheng and Udry (2003) examined mentally disabled adolescents and their parents using the National Longitudinal Study of Adolescent Health. Results from this study show that compared to parents of average adolescents, parents of the mentally disabled hold more negative attitudes toward sex education at home, and do not talk about sex, STDs, pregnancy, or birth control with their children. In addition, the study shows that a significant proportion of mentally disabled boys are sexually active, however their knowledge in this area is highly “incorrect.” The fact that quite a significant proportion of adolescents are sexually experienced yet their parents are unaware of these activities and are unwilling to discuss them can make the teenagers particularly vulnerable to health risks, unwanted pregnancy, and sexual exploitation. It is important for providers to understand parents’ attitudes and the obstacles parents feel they face in discussing these issues with their children.

Furthermore, Cheng and Udry (2002) have conducted similar analyses of physically disabled teenagers in the National Longitudinal Study of Adolescent Health. The results show that despite the fact that these adolescents are slower in pubertal development and more socially isolated, they are as sexually experienced as their nondisabled peers. Physically disabled adolescents’ sexual development and specific needs should not be ignored, especially since these analyses also showed that adolescent girls with disabilities experienced higher rates of forced sex.

Child-Welfare Population

The Office of Family Planning has supported most of the research that has examined the family planning needs of the child welfare population, although all these studies occurred more than 10 years ago. Five studies were identified.

Two of the reports were based on a telephone survey of public child welfare agencies in 48 states (Polit, Cozette et al. 1987; Polit, White et al. 1987). The survey was carried out to assess whether the agencies addressed the family planning issues in the adolescent child welfare population. From the survey results it was clear that the majority of the agencies believed they should address family planning issues only if they find out the client is sexually active or if they are asked for information. On the other hand, several states have declared a “hands off” policy and had not given the issue much prior thought. Of the 48 states studied, 9 have formal policy procedures in place to address these issues. The study concluded that that the needs of many child welfare clients are going unmet with regards to issues of sexuality and pregnancy prevention (Polit, White et al. 1987). It is unclear what are the current practices of child welfare agencies.

In the third study, Zuravin (1985) examined the family planning behaviors of low-income maltreating mothers. To do this, the investigators interviewed 518 single parent mothers who were receiving AFDC in Baltimore during January 1984. Within this population there were 237 maltreating mothers and 281 control mothers. The results showed significant differences between the two types of mothers. Maltreaters had more unplanned live births, more total live births, more partners, began at a younger age, and had closer spacing between first and second child. The study concluded that preventing the birth of subsequent children to these mothers should be an important goal.

Two studies examined the effect of maltreatment on children’s subsequent sexual behavior. An earlier one funded by Title X was guided by the author’s earlier findings that 64 percent of pregnant and parenting adolescents in Washington State had a nonvoluntary sexual experience prior to their first pregnancy (Fine, Boyer, and Killpack 1992). In a subsequent study, the authors sought to 1) assess sexual abuse histories among family planning clients age 19 and younger in seven Washington State agencies to investigate the prevalence of nonvoluntary sexual activity among adolescents in Title X clinics, and 2) collect qualitative data through focus groups and individual interviews on adolescent sexual interactions and perceptions of sexual activity and at-risk behaviors. The study found that sexual abuse and coercion need to be systematically addressed in family planning as a factor that may affect reproductive health. Forty-six percent of the respondents answered affirmatively...
to one or more of six forced intercourse questions, and these individuals were more likely to have earlier initiation of sexual activity as well as an increased number of sex partners.

The most recent study looked at the relationship between childhood sexual abuse and HIV risk behaviors in a sample of 167 adolescents, ages 15 to 19, who are participating in an independent living preparation program (Elze et al. 2001). Multivariate analysis demonstrated a significant relationship between the severity of the abuse and the youth’s recent HIV risk behaviors. These findings support HIV prevention programs targeting sexually abused youths.

In Summary

Very few of the research studies that we reviewed dealt with particularly difficult populations like the mentally ill, substance abusers, or child welfare clients. Those studies that have been conducted focus on describing the reproductive and family planning needs of these populations. None have tested approaches to addressing their needs.

How can family planning practices be strengthened?

The second set of questions posed by the advisory group addressed how family planning services could be strengthened in terms of practice and service quality. A report prepared by the Alan Guttmacher Institute (2000b) summarizing five years of research in the family planning area identified the main roles of family planning clinics today: provide family planning care to millions of American women; provide a large and diverse clinic system that is able to reach the low-income population; provide a wide range of services by publicly subsidized family planning clinics; and provide reproductive health services to many women. As has already been shown, a good deal of evidence is collected about who is served and the services they receive. However, much less research has examined the effectiveness of family planning clinics in general or the effectiveness of particular approaches to delivering services in these clinics. By effectiveness, we mean research focused on the outcomes of the services for clients. The following section summarizes the relevant literature regarding program effectiveness.

In 1995 the Institute of Medicine (Brown and Eisenberg) published a review of what was then known about programs whose goal was to prevent unintended pregnancies. This is one of the primary objectives of the family planning program. The review found that various studies had examined cost savings of such programs and the effect of spending on fertility, pregnancy rates, and birth rates (and to a lesser degree, expenditures’ effects on other outcomes such as birth weight, infant mortality levels, and abortion rates). However, the report concluded that these programs had not been well evaluated in terms of effectiveness, especially in terms of their impact on unintended pregnancy. The committee reviewed the effectiveness of prevention programs on this outcome and found that many had not been evaluated. Of the more than 200 local programs identified, only 23 had been rigorously evaluated, and most of these were programs that targeted adolescents as described in the previous section of this report.

Effectiveness of Family Planning Programs

Our review of the literature uncovered evaluations of two state-level family planning programs completed in South Carolina and Maryland more than 10 years ago. Tompkins (1986) examined family planning service delivery in 46 counties of South Carolina over a five-year period using data from statewide databases. The evaluation found an association between family planning services and the successful abstinence of teenage pregnancy. Chow, Rider, and I-Hsiung (1989) studied the performance of the family planning program in Maryland by analyzing computer files of family planning acceptors recruited between 1979 and 1982 and interviews with 1,023 acceptors recruited between 1980 and 1982. More than half of the annual acceptors were teenagers, suggesting that the family planning program in Maryland had been reasonably successful in recruiting teenagers to practice contraception. Furthermore, the study found that family planning clinics in Maryland had performed relatively well in regard to retaining the clients (Chow et al. 1989).

A study by Armstrong, Herceg-Baron, and Pickens (1986) examined clinic discontinuation. The sample for the study was drawn from 62 clinics in Pennsylvania affiliated with two Title X federally funded family planning grantees. After tracing and contacting clients, 628 women were interviewed. Almost half of the responses to the question about reasons for discontinuing services cited perceived problems with clinic care, functioning, and accessibility. Responses included dissatisfaction with waiting time, lack of privacy, treatment by staff, continuity of care provided by the staff, clinic schedule, and/or an inconvenient or inaccessible location. Women were also dissatisfied with the adequacy of the health care or their birth control method. The study found a strong association between satisfaction with service and experience with birth control method. Eighty-nine percent of the women who discontinued services, however, went on to use another health care provider for gynecological care. Another part of the Armstrong et al. (1986) study compared the discontinuation of services for adolescents and adults. This part of the study examined family planning visit histories of
Effectiveness of Counseling Approaches in Clinics

A few studies have assessed the effectiveness of different approaches to providing counseling in family planning clinics. Most of these studies have been funded by Title X. In a study by Armstrong (1986), three counseling strategies were assessed. An approach combining risk assessment with a subsequent anticipatory counseling session tailored to the specific needs and life circumstances of the client was found to be the most effective. The outcomes assessed in this study were 1) clinic continuation, 2) contraceptive method compliance, and 3) unintended pregnancies. Two studies (Chewning et al. 1999; Paperny and Hedberg 1999) found that computer-based counseling interventions coupled with staff/counselor follow-up were effective, especially among adolescents. The Chewning studies (1992, 1999) found that the computerized contraceptive decision aid resulted in increased short-term knowledge and confidence in oral contraceptive efficacy. The experimental group also had higher knowledge after one year and a lower rate of unintended pregnancies. Another study (Namerow, Williams, and Weatherby 1987) found that contingency counseling was more effective among the non-Medicaid population than the Medicaid population. This study hypothesized that non-Medicaid clients were not impoverished and therefore they were more able to apply the skills taught in counseling to their everyday lives. Although the study found that contingency counseling did not have an overall effect on the pregnancy rate, there were effects on intermediate behavior such as 1) correctness of contraceptive use (remembering to take pills), and 2) continuing with a plan developed by a counselor for accurate contraceptive use. Winter (2000) had similar results, finding that a social skills counseling protocol was more effective in promoting condom use than usual care counseling. Overall, the counseling interventions did have a positive effect on the outcomes measured, although in some cases the effect was modest.

The counseling services/interventions described above were made available to clients in family planning clinics. A study by Paperny and Hedberg (1999) found that the adolescents were more receptive in nontraditional sites (after-school clinics, malls, etc.). Perhaps because they felt more comfortable in these settings, teenagers were more receptive to discussing health behaviors with counselors. In terms of the reactions of clients, both studies of computer-based approaches found that clients had positive reactions to counseling strategies (Chewning 1992; Chewning et al. 1999; Paperny and Hedberg 1999). Adolescents indicated that they felt more comfortable viewing information and answering questions about their sexual behavior in front of a computer. Clients also indicated that the extra time spent on the counseling was worth their time and increased their confidence to use contraception compliantly.

Clients’ Choices and Use of Contraception

There is a large body of literature on contraceptive behavior. This review focuses on studies of factors affecting method choice and use of family planning clients. Two studies examined emergency contraception, one examined condom use after a woman’s first visit to a family planning clinic, six focused on oral contraceptives, and two examined providers’ perspectives on natural family planning. One study examined providers’ perspectives on dual protection. Several studies examined the influence of client and provider interactions on method choice and use. One of these, examining clients’ method choice, was the only study in this section funded by Title X (Armstrong 1996).

The studies of emergency contraception indicated that providers face a number of issues in making this method available. A survey of reproductive health providers, family practitioners, and emergency room physicians conducted a decade ago found a lack of awareness of emergency contraception by providers and consumers. For example, the physicians sampled prescribed hormonal emergency contraception only 3.4 times on average in the last 12 months (Grossman and Grossman 1994). Another study utilized mail questionnaires to assess provider attitudes in Michigan (Brown and Boulton 1999). The providers indicated a number of barriers, including the logistics of dispensing the method, legal and political aspects of dispensation, and the lack of service guidelines. The providers’ attitudes towards emergency contraception as a method were on the whole positive, however they indicated a need for more information, improved guidelines on dispensing it, and clarity about the legal issues.

A study of the correctness of condom use among first-time family planning clients found that only 1 percent of the women surveyed indicated that they used condoms correctly (Oakley and Bogue 1995). The women who had more effective condom use had higher knowledge about birth control in general, had received a nursing intervention, or had more communication with their partner. Two studies of oral contraceptive use found high levels of misconception about side effects (Picardo et al. 2003) and found that pill-related side effects were the most frequently cited barrier to birth control use. Patients of the comprehensive clinics, however, reported fewer problems with pill-related side effects than those attending neighborhood clinics (Meyers and Rhodes 1995).
Four studies were completed between 1991 and 1998 that studied oral contraceptive continuation among women (Oakley 1994; Oakley et al. 1997; Oakley, Sereika, and Bogue 1991; Peterson et al. 1998). The 1991 study by Oakley et al. was based on data that came from a larger study that was conducted at the Oakland County Health Division (OCHD) in Michigan. The participants included in the study were those making an initial visit to any of the three OCHD clinics. Data were collected during an initial interview, then 6–12 months after, and then again from a small subset of women, two weeks after the 6–12 month contact. Among the women who chose to use the pill as their contraceptive method of choice during their clinic visit, 92 percent reported using it during the follow-up period. In general, however, the patterns of contraceptive use among the women during the follow-up period were risky. One in seven women switched their method, and/or switched to no method, two or more times. One-fourth of the women practiced risky behaviors, including missing pills and no use of a back-up method.

A later study by Oakley et al. (1997) conducted a three-month prospective study of 103 women initiating oral contraceptive use. This study employed an innovative electronic device that recorded each time a pill was removed from the pack instead of relying on self-reports. One-half of the women had no missed pill episodes. However, changes in pill packaging were recommended for the other half of women who did miss their pills. Another recommendation was shortening the hormone-free period to four to five days.

Using a different approach to the issue of consistent contraceptive pill use, Peterson et al. (1998) examined the predictors of inconsistent use in a nationally representative sample of U.S. women age 15 through 44 from the NSFG 1995 survey. Predictors for inconsistent pill use were found to be 1) characteristics of the service system, (e.g., dispensing only one pill pack at a time), 2) language barriers (e.g., Hispanic women had the highest level of inconsistent use, perhaps exacerbated by their inability to understand the importance of a strict schedule), 3) economical/financial predictors (e.g., financial constraints may inhibit getting pill packs on time, as well as buying more than one method such as condoms and pills), 4) strength of motivation to avoid pregnancy, and 5) partner support.

A couple of studies examined natural family planning. These studies found that about one-third of clinic administrators and 30 percent of private practitioners indicated that they offered the method. Among the providers, the private OB/GYN physicians were the least informed about the method than any category of respondent. The research found that the single most identifiable barrier to the availability of the method was the skepticism of physicians about its use and effectiveness (Arevalo 1997; Weeks 1989).

Several studies focused on the influence of interactions between client and provider on method choice and use. The first of these, conducted by Nathanson and Becker (1985), examined several aspects of this interaction: the control exercised by patients as compared to practitioners, the scope of the interaction, the level of trust placed by the client in the provider, and the degree to which the relationship is characterized by warmth or emotional expression. Clients making their first contraceptive visit to a Maryland county health department family planning clinic were the subjects for this study. Each of the four interactions mentioned above were assessed in the questionnaires. The findings showed that the teenage contraceptive clients show higher contraceptive use when the staff-client model is characterized by an imbalance of control between client and provider, a broad definition of what may be discussed, and high client trust in the practitioner.

Another study (Harvey, Beckman, and Murray 1989) indicated that the type of contraceptive information patients received from their practitioner influenced the contraceptive decision they chose to make. This study, based on telephone interviews with 1,057 women, found that half of providers recommended the use of specific methods, while a quarter discouraged a particular method. The majority of women stated that they adopted the method recommended by the health care professional. In addition to these findings, the women gave reasons about why the patient/provider relationship was satisfying or unsatisfying. The top three characteristics of interaction identified as positive were the friendliness of the provider and the level of comfort provided, knowledge and competency, and the provider “talked to me as a person.”

A study examining strategies to improve services related to Norplant, Depo Provera, and the Pill (Armstrong 1996) is the only Title X-funded study in this group. It assessed factors affecting contraceptive decisionmaking, contraceptive use behaviors, pregnancy, contraceptive side effects, sexually transmitted diseases, and service provision. The sample consisted of 429 women age 14 to 34 who were enrolled in one of five Title X family planning clinics in Southeast Pennsylvania. They had all previously indicated they were planning to use oral contraceptives, Norplant, or male condoms. The women completed a self-administered survey before and immediately after seeing clinic staff, and clinicians/counselors also completed a survey about their perception of each patient’s contraceptive decision. The analyses indicated that staff influence was not a primary factor in method selection, but instead staff had a greater impact in teaching women how to use their chosen method.
In Summary
The literature review uncovered very few studies that focused on testing approaches to improving how family planning services are delivered. There is some evidence that tailoring counseling approaches can lead to improved contraceptive behavior of clients. The Smart Start study described in an earlier section is, however, a unique example of a research study whose findings resulted in a change in practice (Armstrong and Stover 1994).

How can the organization and administration of services be improved?
The third set of questions posed by the expert panel addressed how services could be better organized and administered. The majority of the studies in the literature in this area focus on the how subsidized family planning services are financed. Research about other issues like staffing and organizational arrangements is relatively infrequent. In this area, funding issues have dominated the research agenda. This review covers this literature and also addresses the more limited research that has been conducted about staffing and administrative issues and the integration of STD and family planning services.

Family Planning Financing
While federal funding levels for family planning services have remained steady through the late 1990s and early 2000s, overall federal spending on family planning (adjusted for inflation) has decreased. The Medicaid program is the major source of family planning funding. Given the current deficit situation in many states, many are considering Medicaid cuts to balance state budgets. It is estimated that if the Medicaid cuts are instituted, nearly one million low-income recipients will lose health insurance coverage (Ku et al. 2003). Concerned about the uncertainty of the level of federal and state funding, many of the panel members at the family planning meeting highlighted funding cuts, clinic costs, and the ability of clinics to continue providing services as important research areas to examine. A review of the family planning literature in the finance area found that the research focused mainly on five areas: insurance coverage, expenditures and finance mechanisms, cost-benefit, clinic costs and payments, and clinic performance.

There were 15 research articles about insurance coverage; five of these focused on access to family planning services. Eight studies examined the changes in family planning expenditures, specifically the extent of federal, state, and local funding for family planning services such as contraceptive, sterilization, abortion, and related reproductive health services. Four studies examined the cost-benefits of public expenditures on family planning services. Five studies assessed clinic costs and payments. Seven research articles focused on clinic performance.

Insurance Coverage, Medicaid, and Managed Care Organizations (MCOs)
This section focuses on research about the influence of insurance on access to family planning services, coverage of family planning services in different types of plans, and the role of the Children's Health Insurance Program (CHIP) in the provision of family planning services. The studies provide a picture of the issues in the field about insurance coverage, Medicaid, and managed care as they affect family planning. However, policies in this area are fast-moving, so many of these studies are outdated. The panel members identified a number of research opportunities related to Medicaid that have not yet been examined: What has been the impact of Medicaid waivers in the states that use them to expand services on contraceptive utilization and unintended pregnancies? What is the impact of Medicaid Managed Care on family planning services? What types of agreements exist between managed care organizations and family planning clinics, and what is their cost effectiveness? Finally, what is the effect of Medicaid reimbursement to pharmacies on the over-the-counter use of contraceptives for at-risk populations?

Three relatively old reports based on national survey data report that individuals without health insurance are less likely to receive preventive services. There is no reason to think that this pattern has shifted over time. A study using the 1991 Florida Behavioral Risk Factor Survey found that those without insurance coverage were less likely to report having a check up or receiving a mammogram or pap smear in the last year; they were more likely to report needing to see a doctor but being unable to because of cost (Hopkins 1993). Analyses of the National Health Interview Survey found that the use of preventive health care is negatively related to out-of-pocket costs and positively associated with having some type of insurance coverage (Makuc, Freid, and Parsons 1994). Analyses of the 1987 National Medical Expenditure Survey (NMES) found that disadvantaged women are less likely to receive preventive care, although women spend much more on out-of-pocket health expenditures than men because of the use of reproductive services. The combination of the out-of-pocket cost and lack of insurance coverage probably discourages poor women from seeking needed services (Dooley 1994).

Even individuals with some type of insurance may have difficulty obtaining needed family planning services because the coverage does not include some components of this care. For example, a recent study in Washington State of health insurance carriers found that many individuals
with private sector insurance do not have comprehensive coverage for reproductive and sexual health services (Kurth et al. 2001). Similarly, two other studies found that coverage of family planning services varies greatly between traditional indemnity plans and various managed care organizations. There are three main types of managed care organizations: Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point-of-Service Networks (POSs). Each type of organization also varies in its coverage of family planning services. Gold and Richards (1996) found that managed care provides considerably more comprehensive coverage of the range of reproductive health services than do traditional indemnity plans. Furthermore, PPOs and POSs provide less extensive coverage of family planning services than do HMOs. The study also found that most HMO plans cover maternity care, induced abortion, and sterilization. However, coverage is less consistent regarding routine gynecological care and reversible contraception, and many do not cover oral contraception.

The study found that access to out-of-plan family planning services was limited because of poor relationships between family planning clinics and contracting managed care plans. As coverage of women by managed care grows, interest in evaluating their coverage of reproductive health services as well as prenatal care and screening for cancer and sexually transmitted diseases grows. A survey of 236 managed care plans was conducted to examine coverage of these services. The research results showed much variation in the types of services provided between different types of managed care. Although most provide comprehensive reproductive benefits, around one-fourth (23 percent) had contracts with family planning agencies such as Planned Parenthood for the more specific services. In addition, the majority allowed women enrollees to either choose an OBGYN as their personal physician or self-refer to one. The only services under managed care that lack coverage are vasectomies and tubal ligations (Bernstein, Dial, and Smith 1995). Although this survey provided information on the percentage of specific types of providers that provide selected reproductive health services, we do not know about the receipt of these services by practitioner type.

Even when an individual has insurance coverage, she may not know about the coverage of family planning services. An early study of this issue (Gold, Darroch, and Frost 1998) examined surveys of managed care organizations, family planning agencies, and women of reproductive age in five states with relatively mature managed-care environ-

ments (Colorado, Massachusetts, Michigan, California, and Florida). The study found that while 85 percent of the HMOs cover all of the six major contraceptive measures, only half of the plans informed enrollees about measures that were covered. One in four women surveyed were unsure if their plan covered oral contraceptives. Finally, one in four commercial plans had brought community-based family planning providers into their networks.

Many managed care organizations limit coverage of out-of-plan family planning services. Family planning agencies could provide services to these organizations. A 1995 mail-in survey of publicly funded family planning agencies by Frost (1998) found that over half of the publicly funded family planning agencies have served known enrollees of managed care organizations. The study concluded that family planning agencies need to seek out relationships with these organizations based on the services that they can best supply. A study by Gonen (1998) had similar results. The study found that some managed care organizations provide better coverage of contraceptive options as well as better confidentiality protections, but not enough is being done to partner with existing family planning providers and to educate providers about the need to provide family planning counseling.

A study by Aved and Michaels (1998) examined access to out-of-plan family planning services for Medicaid beneficiaries enrolled in managed care plans in California. The study found that access to out-of-plan family planning services was limited because of poor relationships between family planning clinics and contracting managed care plans. Problems cited included failure of the managed care plan to reimburse out-of-network family planning agencies, lack of coordination around the care of clients, and failure of the family planning agencies to identify managed care options through financial screening.

The California Department of Health and Human Services’s Office of Family Planning developed a program called Family PACT that provides family planning services to all California residents who are at risk of pregnancy or causing pregnancy. The program offers services to those who are at or below 200 percent of the federal poverty level (FPL) and have no other source of coverage for family planning services. Brindis and Darney (2000) evaluated the Family PACT program through surveys of providers and clients, reviews of medical charts, and analysis of provider and client enrollment data and billing data. The evaluation found that Family PACT substantially expanded access to family planning services for California’s low-income women and men. Furthermore, Family PACT reduced the number of unintended pregnancies among low-income women in California in a cost-effective way.
There was one Title X-funded research article about insurance issues. The article examined the managed care experiences of family planning providers. Gold and Richards (1998) conducted telephone interviews with family planning provider agencies in Colorado, Massachusetts, Michigan, California, and Florida and found that community-based family planning providers have four distinct strengths: ability to provide cost-effective, comprehensive contraceptive services; expertise in reaching out to and serving difficult-to-reach populations; locations of clinic sites; and functioning as part of a larger system. The study concluded that there are five roadblocks to working with managed care organizations: the requirement that family planning agencies write prescriptions instead of dispensing contraception; limitations about the services that family planning clinics may provide, either under contract or on an out-of-plan basis; the credentialing that is part of the managed care process; difficulty in obtaining payment from Medicaid; and differing medical protocols. Finally, the study identified three ways to ease the path between family planning providers and managed care organizations: the leveraging of existing relationships (such as working in coalitions); staff training on the transition to managed care; and a marketing plan directed at managed care organizations.

Most of the insurance literature focused on access to and coverage of family planning services for reproductive-age women; however, a few studies focused on adolescents. Lafferty and colleagues (2002) measured the sexual health services provided to 1,112 Medicaid managed-care enrollees age 14 to 18 through administrative data, chart reviews, and data on Medicaid visits for three HMOs (nonprofit, for-profit, and alliance of nonprofit clinics). The study found that HMOs provided primary care to 54 percent of Medicaid enrollees and preventive care to 20 percent. Girls were more likely than boys to have their sexual history recorded or to be given condom counseling. Furthermore, only 27 percent of sexually active girls were tested for chlamydia, with significantly lower rates for testing among those who spoke English as a second language. The study concluded that substantial room for improvement exists in sexual health service delivery to adolescent Medicaid managed-care enrollees.

Two other studies examined the role of SCHIP in providing family planning services to adolescents. One study, by Gold and Sonfield (2001), conducted a mail survey of CHIP administrators in all states and the District of Columbia concerning reproductive health services provided under their state’s SCHIP effort for adolescents age 13 to 18. The survey found that, overall, states provided relatively comprehensive coverage of reproductive health services, with all 58 SCHIP programs covering routine gynecologic care, screening for sexually transmitted diseases, and pregnancy testing. Fifty-four of the CHIP programs covered the full range of the most commonly used prescription contraceptive methods. Furthermore, many of the programs provided extensive information to adolescents regarding the coverage of reproductive health services, but only 18 guaranteed confidentiality and 26 provided access to family planning services of out-of-network providers. Although many programs reported outreach programs in school systems and community-based organizations, the study concluded that such efforts did not successfully target uninsured adolescents for enrollment.

Brindis et al. (1999) developed recommendations for SCHIP plans to meet the needs of adolescents based on a state survey of Title V directors, adolescent health coordinators, and CHIP coordinators. Recommendations included establishing confidentiality procedures, assuring that community providers are considered essential, and developing or strengthening linkages between the CHIP program and other state and local health agencies (e.g., family planning).

Many expert panel members identified the provision of services to adolescents as an area of interest. Further examination of the CHIP program and its coverage of family planning services for adolescents is needed. Currently, discussions are underway to expand CHIP coverage to pregnant women, 19- and 20-year-olds, and parents of eligible children. Research studying the impact of such an expansion on the provision of family planning services to that population would be illuminating.

Expenditures

Over the past two decades the Alan Guttmacher Institute has tracked public expenditures on family planning through periodic surveys of state health, social services, and Medicaid agencies. Each of the surveys has had high response rates from the state agencies. Methodological improvements over time require care be taken in comparing data from survey to survey. This research has shown that overall spending on family planning (accounting for inflation) has decreased since 1980, and Medicaid has replaced Title X as the primary source of family planning funding (Daley and Gold 1993; Gold and Daley 1991; Gold and Guardado 1988; Sollom, Gold, and Saul 1996). Despite the decline in Title X funding, the number of clients receiving services from Title X projects increased from 3.8 million in 1981 to 4.5 million in 1991 (Ku 1993). Medicaid spending on family planning services increased 41 percent between 1984 and 1991, and the number of recipients of family planning services increased by 31 percent (Ku 1993). The increase in recipients and spending by
Medicaid is not due to specific family planning initiatives, but rather because of an expansion of eligibility and an increase in the number of poor people eligible for Medicaid (Ku 1993).

Two studies look at the impact of policies on family planning spending. One study by McFarlane and Meier (1993) examined the impact of the Reagan administration’s federal spending policies on the Title X Family Planning program. The authors found a substantial decrease in spending for the program, a reduction in the number of patients served, and increased variation among the states in the provision of services to low-income women. The other study by McFarlane (1985) examined the impact of block grants on states’ responsiveness to public health. The author developed a measure that compared state family planning expenditures per woman in need of subsidized family planning services. The study found that that there was tremendous variation in the use of funds within the states, and that block grants do not enhance states’ responsiveness to local needs.

An additional study by McFarlane and Meier (1998) compared three different funding mechanisms and the impact, if any, they have on family planning programs. The funding sources examined included Type A, or Title XIX Medicaid grants; Type B, Titles V and XX, or block grants; and Type C, Title X, or categorical grants. The impact on programs was measured through the use of annual state data on unintended pregnancies while controlling for other influential variables. The hypothesis posed by the researchers was that Title X is the most effective family planning funding mechanism. This assertion was supported by the research results. The findings show that Title X funds contributed to the largest declines in birth rates, abortion rates, and infant mortality rates. The second hypothesis that a Type A or Medicaid grant is more effective than block grants showed mixed results.

McFarlane and Meier (2001) continue to examine the impact of public policy on fertility control. The authors state that because states differ in how they utilize and distribute their various sources of funding, the concept of statutory coherence facilitates the measurement of their effectiveness. The authors hypothesize that “effective implementation is a function of a policy’s structure or its statutory coherence.” They conclude that Title X funds show the most statutory coherence, meaning that per a measure of women at risk, these funds show the least state variation.

In this work the impact of policies was measured using a pooled times series design of all states from 1982–1988. Using the dependent variables of teen birth, premature birth, low birth weight, etc., the independent variables were the policies that fund family planning services for low-income women. The analysis determined a link between these policies and public health benefits. Family planning funding is associated with a variety of outcomes including fewer babies with low birth weight, fewer births to mothers with late or no prenatal care, and a reduction in neonatal and infant mortality.

More recent research is needed about current expenditures on family planning and how to best maximize various public funding streams. The most current report available about family planning expenditures is “Family Planning Funding through Four Federal-State Programs, FY 1997” (Gold and Sonfield 1999). More current information is needed, especially given the shifts that have occurred in federal and state funding sources.

Cost-avoidance

There were six research articles addressing the cost-avoidance of family planning services. Using data from the 1988 National Survey of Family Growth (NSFG), Forrest and Samara (1996) found that publicly funded contraceptive users helped prevent approximately 1.3 million pregnancies per year. The estimate was calculated by identifying publicly supported contraceptive users from the NSFG and projecting possible contraceptive method scenarios in the absence of public funding. In each scenario, the authors calculated the probability of an unwanted pregnancy and used national information on the outcome of unintended pregnancies to estimate the number of births, abortions, or miscarriages that would occur. In the absence of publicly funded family planning, the study estimated that abortions would increase by 40 percent, teen births would increase by 58 percent, out-of-wedlock births would increase by 25 percent, and more women would have been made eligible for Medicaid (because of pregnancy). Medicaid spending alone would increase to $1.2 billion compared to the $412 million currently spent on family planning services. The authors estimate that every dollar spent on family planning services saves an estimated three dollars in Medicaid costs. An earlier study by Forrest and Singh (1990) using similar methods estimated that for every dollar spent on family planning services an average of $4.40 is saved in economic costs such as medical care, welfare and supplementary nutritional programs, or publicly funded abortions associated with unintended pregnancies.

A study examining cost-benefits of family planning in Iowa also found that the benefits of family planning services outweigh the costs of those services. Levey, Nyman, and Haugaard (1988) analyzed publicly funded family planning services to provide estimates of these services in averting unplanned and unwanted births to women who voluntarily
use them. The study found that the benefits of family planning in Iowa outweigh the costs except for women over 29 in the short term. The benefit of family planning services was highest for teenagers who would become eligible for public assistance programs upon the birth of a child.

Another study in Maryland (Mellor 1997) looked specifically at the benefits of family planning services subsidized by Medicaid in terms of lowering the fertility of women supported by public assistance. Data were collected from a sample of women on public assistance or Medicaid that had given birth to or received services in Maryland over a time period of several years. Results of the multivariate modeling showed a positive correlation between publicly funded contraceptive services and reductions in the births of women on welfare. Among women accepting contraceptives from a Medicaid provider, there was an estimated subsequent 7 percentage point decrease in the probability of giving birth. In addition, a benefit/cost ratio was calculated. It was estimated that each averted birth saved $9,810. The expenditures for contraceptives were assumed to be one-quarter of the total family planning expenditures or $2.11 million. Therefore the benefit/cost ratio was calculated at 4.26/2.11 million.

Planned Parenthood of New York City (PPNYC) conducted a cost analysis of preventive reproductive care in managed care organizations (Lewis and Hahn 1997). While many analyses find significant savings over the long term, these analyses also found short-term direct savings both to managed care organizations and purchasers. PPNYC estimated that if provision of preventive services for all the sexually active female enrollees of managed care were made, for every 1,000 members who receive contraception, $1.2 million in net costs for pregnancy-related care would be averted. For every 1,000 members who use condoms, the managed care organization would save $149,000 dollars in curative care for STDs.

Another study, cited earlier, by McFarlane and Meier (1998) sought to compare the three different funding mechanisms (Medicaid, Block Grants, and Title X) and the impact they have on family planning programs and outcomes. The findings show that Title X funds contribute to the largest declines in birthrates, abortions rates, and infant mortality rates. For every measure of maternal and child health or unintended fertility that was examined in the study, a dollar of Title X funds went further than a dollar from other federal authorizations or state appropriations.

Clinic Costs

Four articles studied various aspects of clinic costs, including overall cost issues, costs of medication, cost-saving programs, and factors contributing to changes in costs. The most recent research on this topic (described below) was funded by Title X.

Gold (2002) explored some of the major financial pressures weighing on publicly funded family planning programs. In a mail survey to 16 agencies (12 agencies responded), data were collected about clients, services, and costs specific to their Title X-funded projects. The survey also asked providers to identify major factors contributing to the changes in costs over time. The 12 agencies (serving 200,000 contraceptive clients in 2001) were selected from the 430 Title X-funded respondents of a 1999 AGI survey of family planning agencies nationwide. The following criteria were used to select the agencies: they had been in existence for at least 10 years, served at least 1,000 contraceptive clients annually, could provide budget and funding data since the mid-1990s, and had at least one contract with a managed care plan. The final sample of 12 agencies represented all regions of the country and different types of providers—health departments, Planned Parenthood affiliates, and other, independent agencies. The study found three types of financial pressures that clinics reported experiencing: increasing costs of contraceptives, rising prices for diagnostic tests, and inadequate levels of Medicaid reimbursement.

In an earlier study by Donovan (1991), based on interviews with 50 administrators and directors of family planning agencies, similar issues arose. This study found that the proportion of patients coming to family planning agencies in need of screening or treatment for sexually transmitted diseases had increased dramatically. Furthermore, the increasing costs of Pap tests and contraceptives were a problem for the clinics. Title X funding had decreased. As a result, clinics were charging higher fees and had longer waiting lists for appointments.

Earlier research indicates that some settings might have more problems with costs of medication than others. Morehead, Lobach, and Lee (1987) compared the costs of medications for nine different conditions in three different types of provider settings. They conclude that medication costs differ between settings. Reasons for higher costs include use of more expensive antibiotics and dispensing of medications on a shortsighted basis.

Description of the Publicly Funded Family Planning System

Seven articles and reports provide descriptions of the publicly funded family planning system. They examine provision of family planning services and differences between agency settings, clients served, and funding sources. These studies rely on a series of periodic surveys of publicly funded family planning agencies in the United States.
Finer, Darroch, and Frost (2002) report the findings from a 1999 survey of a nationally representative sample of 1,016 U.S. agencies (637 responded) receiving public funding for contraceptive services. The survey measured methods and services offered, fees charged, funding sources, provision of educational programs, and agency staffing. The sample was stratified by agency type (community or migrant health center, health department, hospital, Planned Parenthood affiliate, or “other” agency), receipt of Title X funding, and geographic region of the United States. The study found that agencies offering contraceptive services also offer a wide range of reproductive health and related services. More than 9 in 10 agencies offer the Pill, the male condom, and injectable contraceptives. Eighty percent offer emergency contraceptives, an increase of 38 percent since 1995. The study also found that agencies receive funding from an average of 4.9 sources, and the proportion relying on private insurance has risen since 1995. Almost all agencies offer STD testing, and two-thirds offer STD treatment. Services provided, costs, and clinic policies vary by agency type.

An earlier national survey of publicly funded clinics in 1997 found that the number of providers and women served had been stable between 1994 and 1997 (Frost et al. 2001). The study found that 59 percent of clinics received Title X funding. Clinics at that time provided care to 6.6 million women, approximately two of every five women estimated to need publicly funded contraceptive care. Furthermore, 85 percent of all U.S. counties had one or more publicly funded family planning clinic. Clinics were sometimes the only source of care available to women in rural counties. The lack of growth in clinic numbers suggests that limited funding and rising costs had hindered the further expansion and outreach of the clinic network to new geographic areas and hard-to-reach populations.

In a 1995 national survey of clinics, Frost and Bolzan (1997) studied the services and programs supported by public funding for family planning services. The study looked at differences in the provision of services by the type of sponsoring agency and whether or not the agency was funded through the Title X program. The study found that almost all (96 percent) of publicly funded family planning agencies rely on federal funding. Although only 25 percent of the contraceptive clients served by these agencies were Medicaid recipients, 57 percent had incomes below the federal poverty level. Each agency employed an average of three physicians who together provided about 71 hours of care per week. At that time the Pill was the only contraceptive method provided by all agencies.

Earlier surveys examined differences in the services delivered by different types of family planning programs. Henshaw and Torres (1994) examined clinic performance by agency setting. They found that Planned Parenthood served more clients per site than health departments at that time. Furthermore, Planned Parenthood and hospitals offered the highest mean number of contraceptive services. While many got funding from Medicaid, very little from that source was used for contraceptive services. Further analyses showed that two-thirds of women obtained services from Title X family planning clinics. In addition, health department sites were the most likely to receive Title X funding. Clinics receiving Title X funding served an average of 25 percent more contraceptive clients. In 1994, health department clinics and Planned Parenthood sites served the largest proportion of clients that year (Frost 1996).

**Staffing and Organizational Administration**

Very few studies have addressed the variation in staffing patterns among family planning clinics and how that variation affects service provision. A 1987 study by Winter and Goldy examined data from 36 family planning clinics to explore whether staffing patterns were associated with differences in clinic efficiency, cost effectiveness, and client satisfaction. The clinics, funded by the Family Planning Council of Central Pennsylvania, provided data from clinic evaluations, medical and performance evaluations, surveys of clinic directors, and client satisfaction questionnaires. Using computerized patient flow analysis, the study found that sparsely staffed clinics, with each employee performing multiple tasks, appear to function more efficiently without sacrificing client satisfaction.

Another study, funded by Title X, examined the optimal staffing assignments of family planning service providers (physicians, nurse practitioners, etc.) between clinics in a given region. Franz (1985) developed a mathematical model for staffing family planning clinics in regions with multiple clinics. The model incorporated parameters such as distance between clinics, personnel availability, personnel time, demand for services, and the mix of personnel required to perform clinic functions. The study used data from two family planning regions in South Carolina to test the model. Data sources included in-depth interviews with family planning and nursing supervisors, as well as examinations of scheduling documents and state personnel records. A comparison of the results of the model with the manual schedules was done. The authors found that scheduling decisions could be represented by mathematical programming, and that the model could be easily applied to multiple settings. The mathematical model favored keeping the staff-to-patient ratio lower than manual schedulers.

Oakley et al. (1990) used data from 844 public health nurses to examine the role of nurses in the provision of family planning services. The study found that public
health nurses were likely to practice in settings that incorporate family planning services and were knowledgeable about specific family planning methods.

Landry and Forrest (1996a) examined the role that private physicians play in the provision of family planning services in a study funded by Title X. Private physicians provide family planning services to the majority of American women. Data used in this study came from the 1990, 1991, and 1992 National Ambulatory Medical Care Surveys (NAMCS), conducted annually by the National Center for Health Statistics. The surveys provide information from a nationally representative sample of physicians about patient visits to private office practices and the services provided during those visits. According to NAMCS results, an annual average of 13.5 million contraceptive visits were made to private physicians from 1990 to 1992. The majority of patients who received contraceptive care went to the physician for care with reasons other than family planning as the primary purpose of their visit. Women whose visit was publicly funded were less likely to have a contraceptive prescribed or obtain a Pap test than those with private insurance.

Very little research has examined family planning employee job satisfaction. A Title X-funded study by Hayes and Tompkins (1985) assessed employee job satisfaction, employee attitudes, client booking procedures, pill dispensing practices, and employee perceptions of service quality and efficiency. A family planning staff questionnaire was completed by 504 staff members of the South Carolina Department of Health and Environmental Control. The study found that employees were most dissatisfied with personnel practices, including training opportunities, availability of incentives, promotions, and fairness. Conversely, workers were mostly satisfied with supervisors and coworkers. The most complaints were about inadequate resources. Among these were the need for improved facilities, larger staff, and the recurring shortages of pill supplies.

Professional satisfaction of clinic staff may be related to client outcomes. A 1985 study by Weisman and Nathanson found that satisfaction among employees was related to client satisfaction and also indirectly to client compliance. The study examined the relationship between the aggregate job satisfaction level of nursing staff in 77 family planning clinics and two client outcomes: satisfaction level of teenage clients as well as the rate of client compliance with contraceptive-related prescriptions. Data for the study was obtained through a longitudinal study of the staff and clients at all the county health departments in 21 of the 23 counties in Maryland. Worker job satisfaction was found to be the most influential factor related to client satisfaction in multivariate models.

A study in New York (Klein et al. 2003) tested whether the quality of adolescent preventive care could be improved by developing a multipronged educational intervention for service providers. Activities in this intervention included education sessions for primary care physicians and the use of charts in which confidentiality policies and the use of screener or trigger questionnaires during visits were encouraged. The assessment compared 2000 and 2001 chart reviews for rates of tobacco use, substance abuse, and HIV prevention screening and counseling. A total of 285 clinicians attended continuing education sessions, and 96 offices received visits. Improvements were seen in both the commercial and Medicaid populations of patients in terms of the rates of screening and counseling which took place during patient visits. This study suggests that adolescent preventive services can be improved through provision of these types of training activities for clinicians.

Integration of Family Planning and STD Services
Research about the integration of family planning and STD services has been limited, but this topic is given very high priority by the technical experts’ group. A study by Landry and Forrest (1996b), funded by Title X, examined the provision of STD services within public health departments. The survey focused on services related to STDs other than HIV. In 1995, 50 percent of all local health departments directly provided STD services; these agencies received about 2 million client visits each year. Clients were predominately individuals with incomes of less than 250 percent of the federal poverty level (83 percent), women (60 percent), and non-Hispanic whites or blacks (55 percent and 35 percent, respectively). For the most part, STD services were available at health departments only during weekday working hours. Almost all (94 to 99 percent) of clinics providing STD services ascertained health history and provided education and counseling regarding risk factors. However, care could be made more accessible and more appropriate for those who need it. A substantial minority of patients were unable to obtain services the same day they first sought them, and delays might cause increased risk for partner infection. Little effort was devoted by these programs to primary STD prevention; rather, the majority of efforts were focused on direct patient care and secondary prevention through treatment and partner notification.

A more recent study by Mantell et al. (2003) examines providers’ perspectives and approaches to STD risk assessment, contraceptive counseling, and dual protection. Interviews with 22 healthcare providers in New York City
indicated that providers perceived STD risk assessment and counseling as an integral part of their role as health care providers. The majority of providers believed that risk assessment should be conducted universally, and that each time a client came into the clinic, talking about STDs, safe sex, and risk assessments was imperative. Approximately half the providers felt that equal weight should be given to clients’ pregnancy and STD-related needs. Providers encouraged their clients to use dual protection because they felt that the male condom, or female condom, was not adequate protection alone. The study found that more training was needed in order to reduce providers’ negative perceptions of the female condom, as well as to reinforce the need for counseling tailored to women’s specific life circumstances.

The Office of Population Affairs recently commissioned a study of HIV prevention activities in the Title X Family Planning Program. The study looked in depth at six clinics. The study found that although clinic staff were generally able to identify a variety of innovative and promising practices, HIV prevention activities are unevenly distributed among the clinics, clinic staff need more tailored and consistent training opportunities, and clinics would benefit from assessment and evaluation of their efforts (Health Systems Research, Inc. 2003).

In Summary
The bulk of the studies examining the administration and organization of services focused on financing mechanisms including insurance coverage. Only a few studies, primarily funded by Title X, examined staffing and organizational issues. Understanding financing is clearly crucial because it determines who gets access to services and the quality of services received. The types of research that have been conducted include studies of national and state expenditures on family planning services and sources of revenue and research on the influences of insurance, Medicaid, and managed care on access to services. In addition, a few studies have examined clinic costs and estimated savings achieved when clients receive services that prevent more costly conditions like unintended pregnancy and STDs. In discussing this work, the panel emphasized that it was very important to collect current national and state-level data on the financing of family planning services.

Furthermore, the panel observed that it is very important to understand the dynamics of the relationship between Title X providers, the State Medicaid and SCHIP programs, and the Community Health Centers program. While family planning services are but a small component of these bigger health programs, the impact of the funding and program regulations from these health programs upon family planning services is substantial. Better information is needed about how clinics interact with these programs and what are the barriers and facilitators of effective service delivery through these funding sources for particular types of clients.

How the service delivery system is organized and staffed is a crucial element of service quality. The review found a few research studies on these topics. These studies focus on scattered topics and appear to reflect the existing fragmentation of the services.

Furthermore, the challenges posed by integrating STD prevention and family planning also reflect existing service fragmentation. Research about how to integrate successfully these two types of sexual and reproductive health services is very limited. The panel of experts thought that work in this area is a very high priority.


Klein, J. 1992. “Comprehensive Adolescent Health Services in the United States, 1990.” The Cecil G. Sheps Center for Health Services Research, the Center for Early Adolescence, and the Center for Health Promotion and Disease Prevention, University of North Carolina at Chapel Hill.


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PURPOSE STATEMENT FOR THE MEETING: The goals of this meeting are (1) to identify key issues and questions facing family planning services for which research is needed, (2) to prioritize these issues and questions in terms of how critical they are for service delivery improvement, (3) to assess the level of resources (time and money) needed to address the questions, and (4) to discuss the types of research questions and issues that the Office of Family Planning might fund.

8:30–9:00 Continental breakfast.

9:00–9:30 Welcome, introductions and review of the project and goals of the meeting.
Alma L. Golden, M.D., F.A.A.P, Deputy Assistant Secretary for Population Affairs.
Susan Moskosky, Director of Office of Family Planning

9:30–10:00 Kick-off for discussion of key issues and questions; introduction of the research topics already sent in by meeting participants.
Cofacilitators: Evelyn Kappeler and Freya Sonenstein

11:15–12:00 Further discussion and sorting of the nominated research issues and questions in terms of how well they are directly linked to improving family planning service delivery.
Cofacilitators: Susan Moskosky and Marvin Eisen

12:00–12:15 Explanation of the prioritization process and distribution of stickers.

1:00–1:15 Prioritizing the importance of issues and questions for family planning service delivery. (Invited experts will be given stickers to indicate their top and near top priorities.)

1:15–2:15 Discussion of the results of the prioritization process. How difficult is it to conduct research on these questions?
Cofacilitators: Alma Golden and Matthew Stagner
2:15–2:50 Brief presentation (less than eight minutes) of how different federal agencies might fund research in the priority areas. Christine Bachrach (NICHD); John Santelli (CDC); Denise Dougherty (AHRQ); and Evelyn Kappeler (OPA)

Afternoon Break (10 minutes)

3:00–4:00 Discussion of which research questions and topics can be best addressed by OPA and the Service Delivery Improvement Research Program. Are there opportunities for partnerships with other agencies? Cofacilitators: Susan Moskosky and Freya Sonenstein

4:00–4:45 Round the table: each invited experts’ two-minute summary of take-home points.

4:45–5:00 Next steps: assessing the literature against the priorities, drafting a preliminary report, and meeting again. Thank you: Alma L. Golden

Family Planning Service Delivery Improvement Research
2nd Expert Panel Meeting
August 7, 2003
Wyndham City Center: New Hampshire 1-2 Lower Level

PURPOSES OF THE MEETING:
To review the research that has been conducted since 1985 in relationship to the research questions selected by the panel.
To refine and deepen the recommendations about research opportunities that could lead to improvements in service delivery.
To provide suggestions about strategies for partnering and building off existing programmatic and research efforts to maximize the amount of knowledge obtained and disseminated.

8:00–9:00 Continental breakfast

9:00–9:15 Greetings and review of the purposes of the meeting
Dr. Alma Golden
Ms. Susan Moskosky

9:15–9:30 Brief presentation about the organization of the meeting
Ms. Evelyn Kappeler and Dr. Freya Sonenstein

Questions to be answered in each discussion session
• Is the research review missing any major studies?
• What are the major gaps in the research?
• Are there specific research questions and opportunities (collaborations) to acquire needed information?
• Are there opportunities that are particularly appropriate for Title X research projects?
9:30–10:30 Presentation about the Review of the Literature and Synthesis of Title X-Sponsored Research—Dr. Freya Sonenstein

10:45–11:00 Break

11:00–12:30 Discussion Session 1.
Research about reaching and serving high priority populations
Facilitators: Ms. Evelyn Kappeler and Dr. Freya Sonenstein
• Low-literacy/non-English speaking
• Adolescents
• Males
• Other hard to reach populations

12:30–1:30 Lunch

1:30–2:30 Discussion Session 2.
Research about how practitioners can best deliver family planning services.
Facilitators: Dr. Alma Golden and Dr. Matthew Stagner.

2:30–2:45 Break

2:45–3:45 Discussion Session 3.
Research about how to finance, organize, and administer family planning services.
Facilitators: Ms. Susan Moskosky and Dr. Marvin Eisen

3:45–4:45 Discussion Session 4.
Are there other opportunities to leverage existing research and programmatic efforts to gain needed information? What can be done to improve translation and dissemination of research information into family planning practice?
Facilitators: Ms. Evelyn Kappeler and Dr. Freya Sonenstein

4:45–5:30 Closing Session.
Round the table to gain last thoughts, and discussion of next steps.