

A Collaborative Evaluation of Strategies to Encourage Couples-focused Health Service Delivery in a Sample of Title X-supported Family Planning Clinics

August 2006

Prepared for:

U.S. Department of Health and Human Services
Office of Public Health and Science
Office of Population Affairs
1101 Wootton Parkway, Suite 700
Rockville, MD 20852
Phone: 240-453-2800
Fax: 240-453-2801

Task Order 2/Contract Number HHSP23320045014XI

Prepared by:

Jamie Hart, Ph.D., M.P.H.
Ebony Ross, M.A.
Sandra Silva, M.M.
Health Systems Research, Inc.
1200 18th Street, N.W., Suite 700
Washington, DC 20036
Phone: 202-828-5100
Fax: 202-728-9469

Table of Contents

Chapter I. Introduction	page 1
A. Overview	page 1
B. Scope and Purpose of the Project	page 3
Chapter II. Methodology	page 5
A. Literature Review	page 5
B. Key Informant Interviews	page 6
C. Site Visits	page 7
D. Expert Workgroup Meeting	page 9
E. Study Limitations	page 9
Chapter III. Literature Review	page 11
A. Strengths and Limitations of the Literature	page 11
B. Literature Review Key Findings.....	page 12
C. Future Directions	page 15
Chapter IV. Key Informant Interviews	page 16
A. Definitions and Perceptions of Couples-Focused Approaches	page 16
B. Goals and Desired Outcomes of Couples-Focused Approaches	page 17
C. Need and Desire for Couples-Focused Approaches	page 19
D. Challenges in Implementing Couples-Focused Approaches	page 20
E. Recommendations for Implementing Couples-Focused Approaches	page 22
F. Potential Programs for Site Visits	page 24
Chapter V. Site Visits	page 26
A. Overview of Site Characteristics.....	page 26
B. Synthesis of Current Program Activities and Challenges.....	page 27
Chapter VI. Expert Workgroup	page 36
A. Definitions and Perceptions of Couples-Focused Approaches.....	page 36
B. Goals and Desired Outcomes of Couples-Focused Approaches.....	page 37
C. Need and Desire for Couples-Focused Approaches	page 38
D. Recommendations for Implementing Couples-Focused Approaches	page 39
E. Next Steps.....	page 39
Chapter VII. Key Findings and Recommendations.....	page 41
A. Key Findings.....	page 41
B. Recommended Next Steps	page 45

Appendices

- A. Process Diagram
- B. Site Visit Location Characteristics
- C. Expert Workgroup Meeting Agenda

Chapter I: Introduction

This research study was conducted by Health Systems Research, Inc. (HSR) for the Office of Population Affairs (OPA)'s Office of Family Planning. The purpose of the study was to assess the level of use and the effectiveness of couples-focused services provided by Title X-funded programs. Working with the OPA, the HSR Project Team developed an evaluation workplan to complete the following objectives:

- Conduct a systematic review of couples-focused approaches to family planning and within various health topics, including HIV and sexually transmitted diseases (STDs), alcohol and drug abuse, and domestic violence
- Describe the range of perceptions of couples-focused approaches to family planning and reproductive health services, including the need and desired outcomes of a couples-focused approach
- Explore ways in which family planning clinics and programs successfully engage couples in services
- Identify the challenges encountered during implementation and any recommendations for programs implementing a couples-focused approach.

A. Overview

In 1970, Title X of the Public Health Service Act was enacted to provide high-quality, affordable family planning and reproductive health services to all persons who wanted and needed them, with priority given to low-income and uninsured persons. The principle of the program was, “No American woman should be denied access to family planning assistance because of her economic condition” (Dailard, 2001).

As the only Federal program dedicated solely to providing family planning and reproductive health services, Title X has ensured access to family planning services for millions of low-income or uninsured women over the past 30 years. This program provides services to approximately 5 million persons each year through a network of 4,600 clinics and is funded at \$288 million for Fiscal Year 2005 (OPA Web site, 2006). While more than half of the funds are awarded directly to States, grants are also made to family planning councils, community health centers, Planned Parenthood affiliates, and other public and private entities that provide family planning services (OPA, 2005). Clients including adolescents are provided with access to a broad range of contraceptive methods (including natural family planning) and reproductive health services such as patient education and counseling, pelvic and breast exams, STD and HIV screenings and STD treatment. These services clearly address the reproductive health care for individuals as was envisioned in the original legislation.

In recent years interest has increased for enhancing the reproductive health care offered in Title X clinics to more fully include the partners of the female clients who have traditionally used services. This reorientation and expansion of the program is the result of a confluence of factors: the increased incidence of HIV/AIDS and STDs among female clients at Title X clinics, high rates of

unintended pregnancies, especially among adolescents, and the attitudinal shifts in public health policies.

In the mid-1990s, the OPA began funding community based organizations (CBOs) throughout the United States to investigate and develop effective approaches to providing young men with family planning and reproductive health services and to more actively involve all men and communities in the promotion of contraception and pregnancy prevention strategies. Preliminary evaluation results indicate that these collaborations with CBOs and faith based organizations have been especially successful in reducing teen pregnancy rates among Title X clients in a cost effective manner (*Federal Register*, 2003).

In addition, Title X clinics have increased outreach to male partners of their female clients due to rising rates of HIV/AIDS and STDs (Brindis et al., 1998). In order to address this health challenge, some clinics report modifying their delivery of reproductive health services to include STD education, prevention, and treatment for the adolescents and young men in their communities, as well as educational components that emphasize responsible fatherhood and healthy marriage. A 2004 review of family planning research by the Urban Institute noted that outreach to and involvement with male clients was, in their words, a “relatively recent innovation” in Title X clinics. However, this particular research review commended the OPA for assuming leadership in the promotion and evaluation of couples-focused services to improve the reproductive health of women, men, and families (Sonenstein et al., 2004).

In its efforts to include both partners in reproductive health decisions, the OPA echoes international efforts that began at the 1994 International Conference on Population and Development (ICPD) in Cairo, ultimately resulting in a *Program of Action (POA)* mandating the development of innovative programs to make information, counseling, and services for reproductive health accessible to adolescents and adult men (Ndong et al., 1999). Since 1994, international efforts emphasized a more inclusive approach to reproductive health that stressed gender equality, equity, and empowerment of women and an increased emphasis on male responsibilities and participation in all aspects of family life, including marriage, child care, and reproductive health. One outgrowth of the work begun in Cairo was the development of couples-focused services by promoting the concept of men as partners in reproductive health. The *POA* identified specific action steps to support this objective:

- Increase men’s shared responsibility for family planning, prenatal care, and maternal and child health
- Promote the active involvement of men in responsible parenthood and sexual and reproductive behavior
- Improve male efforts to prevent the spread of STDs and unwanted and high-risk pregnancies (International Conference on Population and Development, *POA*, 1994).

Drawing upon both the international agenda and the experiences from other health fields that incorporate couples-focused approaches in treating conditions such as diabetes or to address mental health or substance abuse problems, Title X providers also recognize the growing need to offer services to couples. Many Title X programs have moved beyond the traditional goals of reducing the incidence of STDs and unintended pregnancies to embrace U.S. Department of Health and Human Services program objectives of preventing disease and illness, reducing behaviors and other factors that contribute to the development of chronic disease, and promoting family formation and healthy

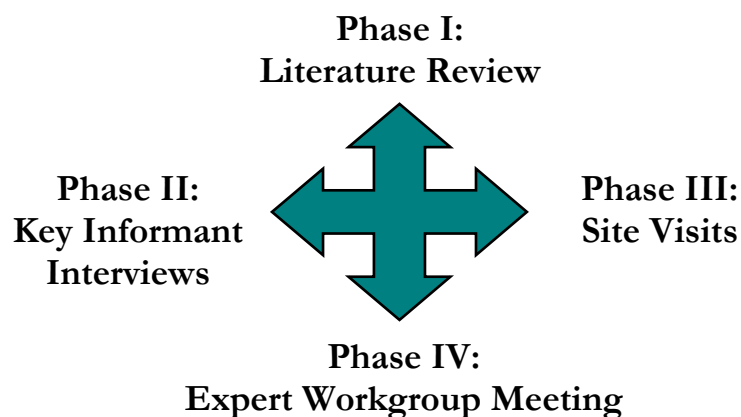
marriages. This represents a shift in the service delivery model from one that is female centered to one that includes both male and female partners. While some programs may find this shift challenging to implement, other programs have found this strategy effective in engaging men in reproductive health decisions while expanding men’s access to needed health services. Couples-focused strategies also are being used in the promotion of healthy relationships with an emphasis on the development of communication, negotiation, and conflict resolution skills.

Although there is limited research on the impact of such interventions, some findings suggest that including men in family planning decisions could result in higher rates of contraceptive use and changes in perceived vulnerability for contracting HIV/STDs, which are important in reducing the number of new STD cases. Increasing the involvement of men in women’s sexual and reproductive health will expand the scope of family planning not only by providing critically needed medical services and general counseling for men, but by helping providers and policymakers understand men’s perceptions of their roles in and feelings about sexuality, fatherhood, and related issues. Yet some argue that even more emphasis must be placed on counseling relative to the role of men in decisionmaking and on working with couples to ensure that “full communication, participation, and partnership exists between women and men.”

B. Scope and Purpose of the Project

HSR conducted this research study for the OPA with the goal of reviewing which couples-focused interventions are most effective in promoting various aspects of healthy relationships, including the prevention of HIV/STDs, enhanced contraceptive decisionmaking and use, and improved communication skills. Because little is known about the implementation of couples-focused services, this study was undertaken by the OPA to determine the content of the services being offered, how these services are perceived, what challenges programs are facing, and what recommendations would improve the provision of couples-focused services.

To address these research questions adequately, information was obtained in four phases of the data collection process (the process diagram is included in Appendix A):



The literature review conducted in Phase I involved a systematic review of available research to identify the extent to which couples-focused interventions are utilized in relation to family planning as well as other health areas, including chronic disease and substance abuse and mental health. The findings from this review were used to inform the development and conduct of subsequent phases of the study. In Phase II, both formal and informal interviews were conducted with 10 key informants who represented different levels of experience with family planning and couples-focused interventions. These individuals included administrators with Federal agencies, researchers with a focus on implementing couples-focused interventions, and Title X grantees that have worked in various clinic settings. The information gathered during these interviews was used to inform the development of the site visit protocols. Phase III involved site visits with four Title X grantees that were implementing couples-focused services and were identified as utilizing promising approaches to couples services. Phase IV included a day-long meeting with experts in the field of family planning with representatives from the Federal Government, regional Federal offices, grantees, and academic institutions. This meeting was held to gather their expert opinions on the research questions and to elicit their feedback on the presentation of the preliminary findings of this study.

The results of this study will be presented in the following six chapters. Following this introductory chapter, Chapter II will discuss in detail the methodology used in the data collection process and review the limitations of this study. Chapter III will highlight the findings that emerged from the key informant interviews. Chapter IV will summarize the site visits with grantees and identify the promising approaches being utilized in the field. Chapter V will summarize the main themes that surfaced during the expert meeting. Chapter VI will conclude the report with a presentation of the key findings and recommendations that emerged from all phases of the data collection process.

Citations

- Brindis, C., Boggess, J., Katsuranis, F., Mantell, M., McCarter, V., & Wolfe, A. (1998). A profile of the adolescent male family planning client. *Family Planning Perspectives*, 30(2), 63-66 & 88.
- Dailard, C. (2001). Challenges facing family planning clinics and Title X: Special analysis. *The Guttmacher Report on Public Policy*, 4(2), 8-11.
- Federal Register, Volume 68, No.71, Monday, April 14, 2003.
- International Conference on Population and Development. *Programme of Action* (1994). <http://www.unfpa.org/icpd/summary.htm#intro>
- Ndong, I., Becker, R. M., Haws, J. M., & Wegner, M. N. (1999). Men's reproductive health: Defining, designing and delivering services. *Family Planning Perspectives*, 25(Supplement), S53-S55.
- Office of Population Affairs, Office of Population Affairs. Office of Family Planning [Home Page]. Available: <http://opa.osophs.dhhs.gov/titlex/ofp.html>
- Sonenstein, F. L., Punja, S., & Scarcella, C. (2004) Future directions for family planning research: A framework for Title X family planning service delivery improvement research. Washington, DC: The Urban Institute.

Chapter II: Methodology

This Chapter provides an overview of the methodology used in the design and implementation of the various stages of the study and is divided into the following sections:

- Literature Review
- Key Informant Interviews
- Site Visits
- Expert Workgroup Meeting
- Study Limitations.

A. Literature Review

Building upon previous work and the needs of the OPA, this literature review seeks to:

- Explore the limitations within the research and define common terms
- Consider the impact of couples' communication and negotiation styles, relationship dynamics, gender, and culture
- Examine studies specifically utilizing couples-focused interventions within family planning and other settings
- Explore efforts to address male reproductive health within family planning settings
- Synthesize and then use the findings to guide protocol development for key informant interviews and site visits to Title X clinics.

Couples-focused interventions in Title X clinics are an emerging reproductive health strategy; therefore, it follows that the research base evaluating their effectiveness is limited. Our literature search revealed that rigorous research using an experimental design for couples-focused family planning counseling is very limited. Difficulty in measuring long-term behavioral change is costly and problematic due to the mobility of low-income families and the frequent dissolution of relationships. In addition, a number of program outcomes are self-reported and therefore difficult to verify; ethical considerations can limit the use of control groups; and as in all behavioral studies, impediments exist for the control of confounding variables. In the studies that do exist, sample sizes tend to be small and participants are typically recruited from preexisting groups, such as clinic clients or college students, rather than randomly selected. In most instances, the data collected are qualitative in nature and not compared to results of a control group.

Relevant research does exist in other areas (alcohol abuse, domestic violence, agoraphobia, heart disease, diabetes, and asthma) but focuses more on the quality of the couple's relationship and its impact on health outcomes and less on any couples-focused intervention. Taking a broader view of couples-focused interventions, research is available on providing services to men in Title X clinics. Although qualitative in nature, this research begins to uncover what men need and want from family planning clinics and identifies creative outreach strategies used in a variety of programs.

Unfortunately, there is a dearth of rigorous evaluation of these male-directed services and outreach efforts.

Despite these limitations, a comprehensive review of the literature revealed more than 80 studies that provide insight into the rationale and strategies for providing effective couples-focused services. Although significantly more research is needed on the topic, the review provides the OPA and its partners with an overview of the research in the field that exists today.

A comprehensive search was conducted of the available literature, both published and unpublished, on the use and effectiveness of couples-focused family planning and reproductive health services at Title X clinics. Relevant articles were selected based on a set of inclusion criteria, namely that articles were limited to those published within the past 10 years (1994–2004) and written in the English language. As noted in the previous section, due to the relatively new emphasis on couples-focused family planning counseling, it was necessary to include international studies and research specific to the inclusion of men in reproductive health services. In addition, a limited number of studies were identified that used couples-focused interventions for the prevention and treatment of chronic diseases. Special effort was made to identify studies related to reducing health disparities and improving the health outcomes for communities of color.

B. Key Informant Interviews

Key informant interviews were conducted with the OPA Regional Program Consultants, Title X grantees, Researchers, and Federal program representatives to identify:

- Definitions and perceptions of couples-focused approaches
- Goals and outcomes of couples-focused services
- Need and desire for couples-focused approaches
- Challenges in implementing couples-focused services
- Recommendations for implementing couples-focused services
- Potential programs for site visits.

With assistance from the OPA, 10 persons were invited to participate in the study as key informants. The interviews were conducted in an individual teleconference with each informant during the months of April and May 2005. Each interview lasted approximately an hour and was audiotaped. All key informants signed an informed consent form that reviewed the purpose of the study, ensured their confidentiality, and advised them of the audiotaping procedures for the interview.

Protocols for the key informant interviews were designed using priority areas designated during the initial OPA contractor meeting and tailored to complement the overall objectives of the study. Four major categories of questions were asked (and are described in detail in Chapter III). The categories included:

- Refine the definition of a “couples clinic”
- Design of the site visit protocol

- Evaluation of innovative and promising practices
- Identification of potential family planning clinics providing couple-focused activities for site visits.

The experiences reported by the key informants enabled the Project Team to learn more about the types and levels of programs for couples being provided by Title X programs as well as the challenges they face when integrating couples-focused activities into family planning services. Based on a wide range of experiences from the micro level (with specific clinics) to the macro level (with Title X and other clinics across the regions), the key informants discussed the availability of regional and State program support for couples services and provided valuable assistance with the identification of clinic sites to be included in the study.

C. Site Visits

As a complement to the literature review and key informant interviews, the intent of the site visits was to talk with clients and clinic staff and administrators to:

- Assess the various types of couples-focused activities currently being provided
- Understand the structural issues faced in relation to integrating couples-focused services in family planning
- Understand, from program staff members and clients, the couples-focused interventions that have occurred, their effectiveness, and their potential for replication
- Assist with identification of innovative or promising practices where couples-focused services are integrated with traditional family planning services.

1. Protocol Development

Following the key informant interviews, site visit protocols were developed to guide interviews with Clinic Directors, clinical/educational staff members, and clients. The interview and focus group tools were designed to incorporate the overall objectives of the study and were tailored to incorporate questions addressing the themes and priority areas highlighted by the key informant interview process.

Separate protocols were developed to record the various perspectives of Clinic Directors, clinical/educational staff members, and clients. The site visit protocol addressed such issues as:

- Program goals and objectives
- Program models
- Target audience
- Overall approach for evaluation
- Strategies for family involvement
- Location and recruitment strategies as they relate to couples

- Structural issues faced by Title X programs in implementing couples-focused programming
- Availability of resources to implement programs that address a spectrum of interrelated objectives related to family planning, STDs, healthy relationships, and prevention of chronic disease.

Upon completion of the site visit protocol, HSR developed the forms and related materials for data collection at the sites. These included (1) an informed consent form to be used in the introduction to all interviews and focus groups, (2) interview and focus group note taking forms, and (3) a signature form for client focus groups confirming receipt of cash incentive. The site visit protocols were interactively implemented by HSR facilitators to provide the opportunity to learn directly from the staff and clients' observations. Interviews with clinical staff members identified the types of couples-focused services being provided, the opportunities and challenges that staff members and clients face during implementation and delivery of services, the availability of support and resources, and promising approaches to couples-focused services. In addition, HSR learned directly from clinic clients' observations about the types of couples-focused services that they have received or been offered, as well as which activities have been most appropriate and effective.

2. Site Selection and Process

With assistance from the key informants and the OPA workgroup, clinic sites were selected based on the following criteria:

- The use in the clinic of couples- or family-focused interventions to provide integrated preventive health services that promote healthy relationships, reduced STD and unintended pregnancy rates, and prevention of chronic disease
- Diversity among the approaches used by the clinics in their couples- or family-focused interventions (e.g., content of services, methods of delivery)
- Geographic criteria (e.g., rural or urban settings, region of the country)
- Demographic mix of clientele (based on racial and ethnic categories and socioeconomic status)
- Availability of resources
- Willingness to participate
- Model programs/best practices in relation to the delivery of services to couples and families (based on structure, outcome, and process measures).

Using these criteria, HSR reviewed site-specific programmatic data and information available from the sites suggested by the key informants. In order to complement the programmatic data, HSR also consulted additional data sources to become familiar with the demographic data of each site. Following identification of potential sites, HSR arrayed them in a matrix classifying them according to each of these criteria and, in consultation with the OPA Project Officers, identified the seven sites that would be acceptable for a site visit based on this preliminary information. HSR made an initial contact with each of the seven approved sites to (1) confirm their conduct of couples- or family-focused interventions, (2) clarify the focus and content of these activities, and (3) inquire about their interest in participating in the study.

A letter of invitation was written and disseminated to grantees operating the invited clinics and, in some instances, Clinic Directors. Conference calls then were held with each participating clinic to discuss the site visit planning process. The Project Team completed four site visits in August 2005, November 2005, and March 2006. Semistructured, one-on-one interviews were conducted with the Clinic Director at each site. Interviews with the other clinical/educational staff members were conducted as semistructured group interviews, as many clinics integrated the functions. Since staffing varied from site to site, it was important for the Project Team to understand how clinical and educational functions were provided prior to setting up the itinerary, to understand which staff members were responsible for particular couples-focused activities.

One focus group was conducted at two of the sites, and two were conducted at one of the sites. The fourth site did not participate in the focus group portion of the study. In order to encourage participation, incentives of \$25.00 and refreshments were offered to each participant.

D. Expert Workgroup Meeting

Since so few clinics had been identified for site visits, the OPA and the HSR project team determined it would be useful to convene a workgroup of OPA grantees, OPA staff members, and external experts to:

- Consider the need for, barriers to, and challenges of providing couples-focused services within family planning programs
- Identify specific strategies and effective practices that are being used to provide couples-focused services within family planning programs
- Identify potential next steps for OPA and Title X providers in relation to couples-focused services.

Fifteen representatives convened for a one-day meeting in Washington, D.C. The literature review, key informant interview, and site visit findings were presented and followed by a discussion of definitions, need, implementation, and future directions.

E. Study Limitations

While the study yielded important and useful information, several key limitations must be considered, including study size, clinic recruitment and participation, focus group recruitment, and the use of self-report data. Although the results are not necessarily generalizable across all Title X-funded family planning programs and therefore are formative and merit further investigation, the study presents a qualitative overview of the experiences of the staff members and clients at a select group of clinics that will be useful to the OPA.

1. Study Size

The Title X Family Planning Program funds grantees in all 10 Federal regions, with approximately 4,500 clinics. Since only 10 key informant interviews and four site visits were conducted, the number of site visits conducted represents only a small sample of the larger Title X program.

2. Clinic Recruitment and Participation

The Project Team experienced some difficulty in locating clinics providing couples-focused services, and for the clinics identified, some were not interested in participating. Although key informant interviews provided a list of suggested clinics and referrals, the HSR staff found that a large percentage of the couples-focused clinics were no longer providing services and/or the couples-focused providers were no longer affiliated with referred clinics. Additionally, of the clinics that were identified and operational, two Clinic Directors never responded to numerous mail, e-mail, and telephone attempts to introduce and discuss the opportunity to participate in the study.

3. Focus Group Recruitment

Due to limited funds and the nature of the evaluation, it was suggested that the participating clinics find participants by advertising the focus groups in flyers posted in their offices and asking current clients if they would like to participate. Although this was the most effective recruitment strategy, it raised a number of challenges. First, this process limited the participants to current clients only and did not reach those who had stopped using the services because of dissatisfaction or other reasons. Second, because recruitment was undertaken by the clinics themselves, the Project Team had little control over which clients were invited to participate.

Ultimately, the client focus groups did provide extremely valuable information concerning the knowledge and beliefs about couples-focused services in family planning clinics, the types of services that Title X clinics can offer to meet clients' needs, the importance of creating a comfortable environment to provide couples-focused services, the language and cultural barriers that clients may face in accessing and receiving services, and the opinions of clients about the integration of couples-focused services in family planning. This information can prove quite useful in the design and implementation of effective, client-centered couples-focused strategies in the family planning setting.

4. Self-report Data

Interviews produced only self-report data concerning staff and client behavior. Because the Project Team could not observe office visits directly, the self-reports could not be validated. For example, if clinic staff members stated that they consistently provided STD prevention education and counseling during visits, their specific clients could not be asked to report on their interactions with the staff member. In addition, if a client reported an improved ability to utilize contraceptive methods resulting from the educational efforts of the clinic staff, their sexual partners were not typically asked to report as well.

Chapter III: Literature Review

Building upon previous work and the needs of the OPA, a comprehensive literature review of more than 80 studies providing insight into the rationale and strategies for providing effective couples-focused services was conducted by HSR at the onset of the project. The overarching objectives of the review were to:

- Provide a systematic review of couples-focused approaches to family planning and other preventive health conditions and identify those that the research has shown to be most effective in improving health outcomes. The review also explores the limitations within the research and defines common terms.
- Explore ways in which family planning clinics and programs successfully engage couples or families in services, as well as the barriers and challenges they may have encountered during the process. The review examines couples-focused outreach strategies and, since a couples-focus is an emerging practice, also studies that examine successful strategies for integrating men as reproductive health partners into Title X programs.
- Document successful strategies for delivering couples-focused services. Specific emphasis is placed on effective ways to enhance couples' communications as it relates to promoting healthy relationships, enhancing effective contraceptive decisionmaking and usage, protecting against STDs, and improving reproductive health and general preventive health behaviors.
- Synthesize and then use the findings to guide protocol development for key informant interviews and site visits to Title X clinics.

A. Strengths and Limitations of the Literature

While literature on couples-focused family planning services – both in the United States and internationally – is extremely sparse, the relevant studies that have been reviewed in the literature review contribute important information to an emerging area of reproductive health care. Most notably, there are important qualitative findings from this research that provide insight into the rationale and strategies for providing effective couples-focused services. These studies also point to consensus on a set of definitions for the terms needed to design couples-focused program interventions with a clear set of common goals. There is agreement in the literature on the following terms: reproductive health, reproductive health care (from both female and male perspectives), family planning, couples and/or partners, and couples-focused services. These definitions helped guide the primary research HSR conducted for the OPA on Title X-funded couples-focused services and can guide the design of future program interventions by the OPA and its partners.

While the qualitative findings from studies of couples-focused family planning interventions provide important contributions for further research and for reproductive health care program planners, we emphasize that their findings do not support or negate the efficacy or effectiveness of any one model of a couples-focused family planning intervention. Nor do they provide enough information to compare either the effectiveness or efficacy of couples-focused approaches as compared to women-only or men-only approaches. The findings face several important limitations. First, their

sample sizes are small and thus not necessarily generalizable to larger or diverse populations. Second, the study participants have not been randomized, due to ethical rules governing the use of control groups in real world health care settings. Finally, these studies usually have not been designed to measure the impact of the many potential confounding variables on program outcomes, including the racial, ethnic, cultural, and socioeconomic characteristics of the couples or service providers.

B. Literature Review Key Findings

The following three sections draw together the key findings from existing research on family planning and other health care services. They also note the areas requiring further research and list potential program-level applications of the findings for the design and implementation of couples-focused family planning services.

1. Family Planning Decisionmaking is Impacted by Communication and Negotiation Styles, Relationship Dynamics, Gender, and Culture

Key Findings

The existing literature suggests that couples do not always agree with regard to what occurs during reproductive events, their attitudes, or their intentions about family planning. It appears that lack of communication or miscommunication serves to exacerbate these differences and affect family planning decisionmaking in couples. In particular, gender and culture have a substantial impact on negotiation and communication styles, relationship dynamics, decisionmaking, and power relations within the couple.

Given the existence of gender-based inequity in many cultures and its documentation as a barrier to reproductive health, the ICPD's *POA* and many studies on reproductive healthcare interventions designed to prevent pregnancy and STD infection suggest that recognizing the impact of gender and culture is a critical part of planning effective reproductive healthcare interventions for couples. Particularly relevant to the development of couples-focused interventions was the finding that, in some cultures, women may not be empowered, in the traditional sense, to negotiate sexual issues with men. Yet they may use forms of communication (e.g., indirect versus direct) that, though not traditionally seen as empowering, may allow them in fact to be active partners in sexual and contraceptive decisionmaking. The research suggests that integrating an understanding of gender roles and culture into reproductive healthcare programs appears to have a positive impact on outcomes, whether the interventions accommodate gender roles and cultural differences or seek to transform gender and cultural inequities.

Further Research Needs

Our review indicated a significant gap in the research literature concerning the influence of race and ethnicity (alone and in combination with gender) on couples' communication and negotiation styles or on their attitudes and intentions about family planning. Furthermore, to understand cultural differences and similarities truly, there is a clear need for more research that looks at subgroups within racial and ethnic groups (e.g., differentiating between the many subgroups that are characterized together as African-American, Asian, or Hispanic).

Program-level Implications

The consistent research findings that family planning decisionmaking is impacted by a couple's communication and negotiation styles, their relationship dynamics, and their gender roles have important implications for the design of effective family planning services. In particular, the research suggests that family planning services should focus more strongly on couple dynamics and gender roles in family planning decisionmaking and thus should:

- Be sensitive to varying gender roles in different cultures and gender differences in negotiation styles (e.g., direct versus indirect)
- Use different skill-building techniques to address communications and decisionmaking among couples effectively
- Provide support for women's efforts to initiate and negotiate condom use and facilitate couples' communications about sexual needs and desires.

2. Lessons Can Be Learned from Existing Couples-focused Interventions Within Family Planning and Other Settings

Key Findings

The majority of studies on couples-focused health care interventions echo the common themes of improving communications, negotiation, and conflict resolution to improve health behaviors and support healthy choices in the couple and in the family. The limited existing studies comparing women-only and couples-focused family planning and STD prevention interventions suggest that women-only single-session interventions, which include only educational components, are less effective at increasing instances of protected sex or increasing communication between partners than multisession interventions for women, single-session interventions for couples, or multisession interventions for couples. Recognizing the role of communications dynamics in contraceptive decisionmaking and the need for building improved communication skills between sexual partners, the research suggests that successful family planning and STD prevention interventions must combine information and educational components with skill-building exercises.

The review of studies on couples-focused physical and behavioral health care interventions also provided information useful for the development of culturally appropriate family planning interventions. In particular, they suggest that in order to be culturally appropriate, the interventions need to be conducted in a community-based setting and use face-to-face interviews as well as culturally appropriate recruitment sites, procedures, and facilitators.

Further Research Needs

Expanded research on the design of culturally appropriate couples-focused interventions is clearly needed among various racial, ethnic, and age groups. There is also a need to investigate whether community-based, culturally appropriate interventions can be a more cost-effective model for couples at various levels of relationship stability – potentially requiring new interventions.

Program-level Implications

The literature findings indicate that there may be alternative methods for effective family planning and HIV/STD prevention for women in long-term relationships, but that it may be helpful for the interventions to include the following components:

- Both information and education components
- Skill-building exercises to improve communication, negotiation, and conflict resolution
- Ongoing support – a buddy system, hotline, etc.

3. There Is a Need to Address the Challenges That Exist to Serving Males in Family Planning Clinic Settings

Key Findings

A key finding from the literature suggests that efforts by Title X clinics to include couples-focused family planning services should be complemented by services to address male reproductive health needs. The literature also indicates that if men are more knowledgeable about reproductive health issues and are able to discuss them with their partners, then they can help make better reproductive healthcare decisions for the couple. Furthermore, it appears from the research surveys of male teenagers and adults that most men indicate genuine concern about unintended fatherhood and the prevention of STDs, particularly HIV/AIDS.

However, involving men in the family planning clinic setting – either for individual counseling or as part of a couples-focused service – requires a paradigm shift for Title X services, clients, and providers from a female-oriented focus to one that incorporates men and couples. This will require changes in both perceptions and the use of resources. Clinics traditionally have trained their staff and tailored their setting, educational materials, confidentiality practices, and other services to women. For those clinics that are philosophically prepared to accommodate men and couples, there remain important practical obstacles. For example, among clinic providers, a lack of adequate resources to augment their current services was the most frequently cited barrier to providing male-oriented reproductive health care.

Future Research Needed

There is a need to understand more about what types of services men want and need from family planning clinics, how they can feel more comfortable accessing these services, and what types of outreach effectively can get them to the clinics in the first place. Although many programs currently are engaging in a variety of activities in providing male-oriented services, rigorous evaluations of services and outreach strategies have yet to occur.

Program-level Implications

Despite the documented barriers to serving men in traditional family planning clinics, program data and surveys document that during the 1990s, many family planning clinics across the U.S. – including those supported with Title X funds – expanded their scope to serve a significantly increased number of men. Services included prevention of unintended pregnancy, prevention of STDs, and comprehensive strategies for promotion of health and well-being. The lessons learned from the expansion of Title X to serve men are directly applicable as clinics consider the incorporation of couples-focused approaches to family planning. Specifically, the research suggests the inclusion of:

- Creative outreach strategies and changes to the clinic’s physical setting and staff to attract and retain male clients
- A focus on services perceived as a priority by men (e.g., access to condoms and STD testing and treatment, contraceptive counseling)
- Tailored reproductive health messages that are geared to diverse audiences, reinforce the importance of male health concerns, and suggest that responsible reproductive health behaviors by men are vital to the reproductive health of their partners, families, and communities
- Gender and cultural sensitivity self-assessment and training for providers to address attitudes, behaviors, and needed skills for male- and couples-focused services.

C. Future Directions

In closing, the existing research identifies possible barriers and opportunities in the implementation of couples-focused services at Title X family planning clinics. However, there is a dearth of evidence indicating just what comprises an effective couples-focused family planning intervention in the United States and specifically within the Title X setting. Clearly there is a need for more research addressing lessons learned and promising strategies, including how to tailor interventions to meet the needs of specific socioeconomic and cultural populations served by the Title X program.

Chapter IV: Key Informant Interviews

This chapter summarizes the findings that emerged from the key informant interviews, which were conducted with 10 key informants. The key informants were chosen with input from the OPA and selected based on their knowledge of family planning or couples-focused interventions. These individuals included Federal or Regional Program Administrators, researchers with a focus on implementing couples-focused interventions, and Title X grantees who have worked in various clinic settings. The purpose of the interviews was to identify:

- Definitions and perceptions of couples-focused approaches
- Goals outcomes of couples-focused services
- Need and desire for couples-focused approaches
- Challenges in implementing couples-focused services
- Recommendations for implementing couples-focused services
- Potential programs for site visits.

A. Definitions and Perceptions of Couples-focused Approaches

A number of questions were posed to the key informants to ascertain thoughts about couples-focused approaches to reproductive health care and family planning services. Although various opinions were raised, there were some key themes that emerged from review of the interviews.

1. Defining the Terminology

In discussing the definition of a couples-focused approach, many respondents addressed the definition of “couple” in the context of providing these services. Many felt the use of the term implied involvement in a committed and monogamous relationship. Key respondents felt that this concept was inconsistent with the experience of those clients that report involvement with multiple sexual partners or involvement in transient sexual relationships. One researcher described the concept as fluid and flexible based on the population characteristics. A client that is involved with multiple partners may feel that the term “couple” does not apply to her relationships. A few key informants noted that they prefer to use the term “sexual partner” and avoid the use of the term “couple” because “sexual partner” is considered broader and more inclusive.

Although some respondents were unclear on how to define the scope of services that would fall under a couples-focused approach, most distinguished between a couples-based from a couples-focused approach. A couples-based model was generally described as a model that targets the couple at the outset, in which all or most of the programming is directed toward the couple or dyad.

A couples-focused approach was typically described as an approach that targets the couple at the outset (e.g. a couples-based model) but also as an approach that begins with an individual female client and then expands services to include her partner. Alternatively, this model might not involve both partners directly but might address issues related to the relationship or male partner. One respondent provided an example of this approach from her work on a study of condom use. That

study targeted the intervention to one individual but tailored it based on the individual relationship barriers to condom use. The intervention focused on developing the most persuasive message for that particular partner. The couples-focused approach is considered to be broader and more consistent with the traditional family planning approach and the current service delivery model.

2. Perceptions of Couples-focused Services

Of the grantees interviewed, most indicated that they were offering couples-focused services. All stressed that the service delivery model is client centered and therefore designed to meet the needs of the client. Even though offering services to a couple is not standard protocol in Title X clinics, should a female client request that services include her male partner, this request is accommodated. One exception is in the area of natural family planning, where services are targeted at a couple and requires the cooperation of the male partner to practice this method successfully. One key informant that provides natural family planning services shared that there is a much higher participation rate for these family planning services. Almost all couples come in together for the initial visit, although she noted that this percentage drops to about one-third after the initial appointments, often due to scheduling challenges.

Most respondents felt that a couples-focused service delivery model would be most appropriate for couples in stable and monogamous relationships. The conclusion was that this approach would be less effective or more difficult to implement with a client who was not involved with a stable partner.

Some of the key informants provided examples of couples-focused approaches they have implemented. One respondent recruited men who accompanied their female partners seeking family planning or prenatal services. Men were approached in the waiting area and then invited to attend a session on men's health and given the opportunity to receive a health exam. The men provided positive feedback on the experience and some even brought their friends at a later date. Another approach that was shared is identifying men through a STD diagnosis of women. Each time a female patient was diagnosed with a STD, she was given the option of providing her partner's name and contact information. The program contacted the partner, offered him testing and treatment, and an opportunity to attend the men's group.

B. Goals and Desired Outcomes of Couples-focused Services

Key informants were asked about the goals and outcomes associated with a couples-focused approach and whether these differ from those of the traditional service delivery model that focuses on the individual client. They were also asked to comment on any potential undesired outcomes that could result from the implementation of couples-focused services.

1. Goals and Desired Outcomes

The key informants identified a number of goals and outcomes, which can be grouped into the areas of knowledge, beliefs and attitudes, behaviors and skills, and health outcomes. Respondents mentioned that these goals and outcomes are consistent with those already used in Title X programs. During this portion of the interview, some expressed concern about mandating the collection of

data in order to evaluate program outcomes and felt this was beyond the capacity of individual programs.

The table below presents a consolidated list of the goals and desired outcomes mentioned by the respondents.

Table 1. Goals and Outcomes Identified by Key Informants	
Knowledge	<ul style="list-style-type: none"> • Improve clients’ knowledge about contraception choices, STD and HIV prevention, and particularly men’s knowledge about contraception • Learn about other health topics and healthy lifestyle choices
Beliefs and Attitudes	<ul style="list-style-type: none"> • Change male attitudes about their responsibility toward contraception and protection against STDs • Change negative attitudes regarding the use of condoms • Change the perception of individual vulnerability and help clients realize their risk of STD/HIV • Help couples feels more positive about their relationship • Increase self-efficacy and the likelihood of engaging in protective sexual behaviors
Behaviors and Skills	<ul style="list-style-type: none"> • Improve decisionmaking skills related to family planning decisions • Increase HIV-preventive behaviors and decrease unprotected sexual behaviors (as through contraception and condom use) • Improve clients’ ability to discuss family planning goals • Enhance communication and conflict resolution skills • Build level of family and social support • Help couples transition to a phase of mutual monogamy and trust
Health Outcomes	<ul style="list-style-type: none"> • Reduce the rate of unintended pregnancies • Reduce the transmission of STDs and HIV

2. Potential Undesired Outcomes

Most key informants were concerned with the possibility of compromising the safety of a female client involved in an unhealthy or violent relationship. Many were sensitive to the issues of intimate partner violence and felt that a client could feel coerced to receive services with her male partner. There was also the possibility that receiving services with her male partner could place her at increased risk of abuse should she disclose sensitive information, such as that related to her past sexual history. Even in relationships where the staff may assess no risk of violence, the disclosure of

personal information that previously was not shared with a partner could lead to disagreement. Should these issues not be adequately addressed within an intervention, it could result in ongoing conflict or the termination of the relationship.

Many respondents were concerned that by increasing the involvement of a male partner in family planning decisions, he may have more influence over her choices, which could result in the erosion of a woman's reproductive rights. Most were concerned about impacting the potential loss of autonomy a woman might experience, again by involving her partner in the decisionmaking process. Also mentioned as potential undesired outcomes were breaches of medical privacy or creating stigma for persons accessing services without a partner.

C. Need and Desire for Couples-focused Approaches

Key informants were asked to comment on the need for couples-focused services. Need was defined broadly and could be based on health indicators, program outcomes, or barriers to effective contraceptive use. This was followed by questions about the desire on the part of Title X clinics to learn more about these types of services and the strategies for implementation.

1. Need for Couples-focused Services

Most respondents agreed that there is a need for Title X programs to offer more services to couples and increase the involvement of men in the service delivery model. The rationale is that the inclusion of men in more educational or clinical interventions could improve the effectiveness of the intervention and ultimately reduce rates of unwanted pregnancies and the transmission of STDs and HIV. Although most expressed a need for these services, one respondent noted that Title X clinics should not be the point of entry for couples-focused services.

It was noted that utilizing a couples approach provides an enhanced opportunity to address HIV and STD prevention, either by educating a couple together or by working with an individual client. Sessions with a couple or an individual client could be used to provide education on these topics and to improve and practice communication skills in order to help facilitate discussions on the topics of STD prevention and family planning. A grantee that managed a men's HIV prevention program felt that men need to hear the message that family planning is a joint responsibility. Also, in his experience, men were not well-informed on the issues. He shared that many men in the prevention program had misconceptions about contraception and provided positive feedback on the educational component they had received as part of the program.

Although several respondents mentioned that clients seeking STD or HIV services could benefit from couples-focused services, they did acknowledge that the issues surrounding STD/HIV prevention differ from those related to family planning. Because of the potential stigma, a client may be less likely to involve a partner if she is seeking treatment for an STD than if she is seeking family planning services. Some key informants believed that providing a couples session in such a situation could be beneficial, but they added that it could be difficult, particularly in a posttest counseling session. If a partner in a monogamous relationship is diagnosed with an STD, then the client may be reluctant to participate in couples-focused services.

2. Desire for Couples-focused Services

Key informants expressed that most Title X staff members would be receptive to learning more about couples-focused services and would welcome this model as another service option available to their clients. It was stressed that these services should be optional and provided within the client-focused model, which is driven by the needs of the client.

The grantees that were interviewed reported that few female clients request couples-focused services, but some research with clients did reveal interest if these services were offered. One grantee reported that focus groups with consumers revealed a tremendous interest, particularly among women, to engage their partners in these types of services. Another grantee that conducted focus groups with young men, both African-American and Latino, found a high level of interest in education related to family planning and contraception. In implementing a couples intervention, one researcher found that men were very interested in learning how to develop healthy relationships and improve as partners, although it was noted that these men were involved in more stable relationships and may be more motivated to change.

D. Challenges in Implementing Couples-focused Services

A number of questions about barriers to implementation were directed at key informants. They were asked to comment on the challenges that family planning clinics would have to address in order to implement couples-focused services.

1. Funding Limitations

The limitation of funding was considered the greatest challenge in implementing couples-focused services. Although most supported the idea of increasing services to men, it would be difficult to justify directing resources to serve men considering the high level of unmet need among women. With decreased State funding, some expressed that clinics are struggling to maintain their current scope of services and do not believe it is realistic to provide additional services with the same level of funding.

The other point that was mentioned was that the provision of couples-focused services most likely would be more time intensive and require more staff time. This also could require that the staff be available beyond regular clinic hours, if a program is trying to coordinate an appointment with a couple. Because of these factors, couples-focused services may fall outside of the normal clinical service schedule and require an adjustment to the patient flow. Some key informants were unsure of the ability of their clinics to manage this level of services. Some questions were raised about how these services would be billed.

2. Staff Limitations

Staff limitations were mentioned frequently as a challenge in implementing these services. For those key respondents with experience providing family planning services, they felt that their clinics did not have the appropriate staff configuration to provide couples-focused services. There was no agreement as to the level of clinical training that would be required of a staff member providing

couples-focused services. Some expressed that clinics usually lack the funding to have a trained clinician (Master of Social Work) on staff and instead would rely on health educators to provide couples-focused services. Some expressed that it would be necessary to hire additional clinical staff members because they felt that a nonclinical staff member may not be able to facilitate effectively a discussion with a couple on sensitive topics such as STDs and HIV or other more involved relationship issues, should they be introduced during a session. Other key informants did not feel that only a clinician could provide these services. One respondent cited literature that supports the use of peer educators to perform this type of work, if limited in scope. Some felt strongly that nonprofessional staff members, such as *promotoras*, could be trained to provide these services adequately. The consensus was that staff working with couples must have the capacity to facilitate this level of discussion or have the ability to identify situations where a trained clinician was necessary and then provide the appropriate referral.

Beyond the clinical skills that may be necessary, several key informants felt that some current Title X staff members may lack the knowledge or comfort level to address male reproductive health issues. For instance, while the staff may feel very comfortable discussing reproductive health issues with women, they may not have the knowledge to confidently discuss issues on male topics, such as vasectomies or male infertility.

3. Resistance

There were varying opinions on the degree to which resistance would be encountered. Some felt that Title X clinics have encouraged the participation of men in the last decade and are becoming more comprehensive in their view of health care. Other key informants felt that most clinics are uncomfortable and resistant to serving men and that most providers still hold the traditional approach with the goal of preventing pregnancy mainly through hormonal methods and are less concerned with protecting women from STDs.

Some felt that current Federal initiatives emphasizing abstinence and marriage are inconsistent with the expansion of services to men. One key informant with experience managing male programs felt that content about relationship development and negotiating sex would be relevant but that focusing on messages of abstinence would not be a realistic approach and would not encourage the participation of men in these programs.

4. Cultural Considerations

Some expressed the challenge that comes with providing services that are culturally appropriate for a population, which could involve hiring bilingual or bicultural staff members as well as adapting a curriculum or materials for specific population groups. Several commented on the importance of understanding cultural norms and their influence on family planning decisions and gender dynamics before a program or intervention is designed. For instance, some cultures may consider it inappropriate for men and women to discuss these topics with each other, or in a group setting. Even for populations with no language barrier, cultural considerations are still relevant.

E. Recommendations for Implementing Couples-focused Services

Key informants were asked to provide recommendations on how couples-focused services could be implemented most effectively, considering the challenges and issues previously identified in other sections of the interview. These comments were organized into the four recommendations that follow.

1. Keep Services Client Focused

It was noted that the Title X program uses a model that is client-centered with the goal of providing the best possible services to clients. Title X clinics would be most open to incorporating couples-focused services if they were another option and desired by the client.

Because of the concerns about the potential for violence, it was suggested that Title X staff members conduct a private individual assessment with each female client before providing services jointly with her partner. This gives a client the opportunity to raise any issue that she may feel uncomfortable discussing in front of her partner. It also allows staff members to assess adequately the risk of abuse or violence and make the determination if couples services are appropriate. This is especially important for a woman with limited access to services or providers, where this may be her only opportunity to seek help.

There were other clinic factors that were mentioned by respondents as important, such as a staff that is flexible and accommodating of clients' work schedules and child care needs. This was thought to be an important consideration with couples-focused services because scheduling an appointment to accommodate the work schedule of two individuals will be challenging and may require extended or weekend hours.

2. Expand Staff Capacity

All agreed that hiring appropriate staff members with the right combination of training and skills is key to the successful provision of couples-focused services. Most agreed that hiring staff that reflect the language, race, ethnicity, and age of the client population is very important. Beyond having a staff in place that is representative of the client population, they must have the necessary skills to provide the expanded services. For existing staff members, training must be provided so that they feel competent providing this level of service and have the ability to address the individual needs of clients and partners. This could require additional skills training related to cultural competency, mediation and intervention, and training on topics such as male reproductive health issues. For those respondents in support of using nonprofessional staff members to provide couples-focused services, they stressed that supervision and protocols for referrals should be in place.

3. Involve Community Members in Program Development

Most of the respondents felt that the couples-focused service delivery model should be tailored to the needs of the specific target population. To help ensure this, it was recommended that the program development process incorporate community input and participation. Several grantees mentioned using a community empowerment model as an effective way to obtain input, which can be a tremendous incentive to group participation as well. For those programs working with ethnic

and racial minority populations (e.g., Mexican immigrant population), this process was described as especially helpful. Several grantees described the use of community consultants to help a clinic director or program manager identify cultural gender norms that can be helpful in developing the educational content for an intervention or in identifying strategies for recruitment and marketing. One key informant utilized focus groups to help her determine the scope of services. A best practice that was recommended is having a Community Advisory Group in place that would meet regularly and provide continual feedback to program administrators.

A key informant shared an example of how the cultural and educational background of participants can influence the content of an intervention. As a grantee working with a Mexican immigrant population, he developed an intervention that provided participants with general health information as well as information on reproductive health. He was surprised by the level of engagement the men exhibited during the educational sessions. The male participants saw this as an educational opportunity and did not view it as a health intervention. The key informant believed that because the men had relatively little formal education, they were more receptive to general health information and willing to participate in the sessions. He also made the point that in the Mexican community, there is a well-accepted tradition of community health promotion through *promotoras*, which was consistent with the program design. Based on his experiences in reproductive health, he felt this type of program was very effective in a Mexican immigrant population but would be less appealing in a White suburban population.

Beyond helping to determine the content of services, community input was important in determining the program design. The key informants described their experiences with programs and interventions with varying design models, which included mixed-gender groups, single-gender groups, and individual couple sessions. For those programs with a focus on health education, it was suggested that a group format would be effective and allow participants to learn from one another through group discussion in a question and answer format. One grantee who conducted male health education classes felt that men would have been less willing to have open discussions on some topics, such as men's views toward marriage and monogamy, had the group been mixed gender. One program conducted a client survey in individual sessions and found that most clients preferred receiving information in individual session compared with group settings. Others felt that services should be provided just to the sexual dyad and tailored to the needs of the individual couple rather than in a group intervention. Because people have to disclose personal information in group settings, issues related to privacy and confidentiality are of concern, particularly in small and rural communities. There was no consensus about the best format for couples-focused services. There were benefits and costs associated with each format type, and the conclusion was that the program design should be determined by the program objectives and the population needs.

4. Adapt Clinic Services and Environments to Appeal to Men

The key informants believed that family planning clinics would have to make several adaptations, such as in the design of health messages and the physical environment, to appeal to men. It was suggested that current health messages be broadened beyond the topic of family planning, because this topic does not resonate with men as it does with women. Also, several mentioned that many Title X clinics would need to alter the physical environment of the clinics (e.g., wall colors, magazines and posters displayed) so that men find these environments more comfortable and welcoming.

Several commented that messages alone most likely will not be enough to appeal to men. It was suggested that incentives such as food or transportation be provided if possible. One respondent mentioned that providing a nonfinancial incentive is especially important for men, who may find financial incentives less appealing than female clients.

Ideally, the expansion of health messages and changes in the physical settings would happen concurrently with the expansion of medical services available to men in Title X clinics. Several mentioned that in order to attract couples, clinics needed to make medical services available to both men and women. Currently, this is not the case, as men make up a very small percentage of Title X clients. One key informant who implemented a HIV prevention program was very successful in appealing to men and attributed the high male participation rates to the fact that he offered them access to comprehensive primary health care services. Having access to these services was an incentive to participation because many of the low-income men in his program had limited options for health care.

F. Potential Programs for Site Visits

The key informants were also asked to identify programs that are implementing couples-focused services and should be considered in the site visit selection process. Several programs were mentioned and represented different areas of focus, including traditional and natural family planning and male HIV intervention projects.

Respondents were also asked to list criteria that should be used as a guide when selecting site visits. Key informants provided a number of considerations:

- Consider sites that represent different stages of integrating services to men and couples. For instance, include grantees who have a long history of providing couples-focused services or services to men and some grantees who are still struggling to implement such services
- Consider sites that are using different methods to integrate couples-focused services. For instance, visit a site that offers individual sessions as well as a site that conducts group sessions as a primary intervention
- Consider sites that reflect different resource levels and funding sources
- Consider sites that serve diverse ethnic and racial populations
- Consider sites that provide geographic representation.

The key informant interviews were very useful in informing the next phase of the data collection process, the site visits. The information provided by the key informants was used in the process of selecting the site visit locations and in the development of the protocols used during the site visit interviews and focus groups with Title X clients. The site visit findings will be discussed in the following chapter.

A summary of the key findings from the key informant interviews is found below in Table 2.

Table 2. Key Findings from Key Informant Interviews

- There is no accepted, single definition of couples-focused services.
- The use of the term “couple” may not resonate with the target population.
- Couples-based services may not be appropriate for all clients served by Title X clinics and may be most effective with those in stable and monogamous relationships.
- Title X clinics are already providing services that may be considered couples- focused services.
- Goals and outcomes for couples- focused services are consistent with other Title X-funded programs.
- Increasing the involvement of men in family planning decisions could have the undesired outcomes of increased risk of violence or erosion of women’s reproductive rights.
- There appears to be a need for Title X programs to offer more services to men and couples.
- Couples services should be client centered and optional to clients.
- Interventions should be designed with the input of community members and target population groups.
- Staff capacity needs to be considered before implementing couples- focused services, which may require additional training or the hiring of staff members.
- Title X programs must implement adaptations in the health messages and physical clinic environments to appeal to men.

Chapter V: Site Visits

As a complement to the literature review and key informant interviews, the intent of the site visits was to talk with clients and clinic staff and administrators to:

- Assess the various types of couples-focused activities currently being provided
- Understand the structural issues faced in relation to integrating couples-focused services in family planning
- Understand, from program staff members and clients, the couples-focused interventions that have occurred, their effectiveness, and their potential for replication
- Assist with identification of innovative or promising practices where couples-focused services are integrated with traditional family planning services.

Four sites were identified with innovative and promising practices for incorporating preventive health measures into Title X family planning programs and for delivering these more comprehensive services to couples and/or families. The following chapter provides a review of the common themes discussed by the clinic staff and clients during the site visits and provides an overview of site characteristics and a synthesis of current activities and challenges.

A. Overview of Site Characteristics

What follows is a synthesis of the findings across the sites in the major topics of the research questions. (Appendix B includes a more detailed grid that summarizes specific site visit location characteristics by site.) As indicated in Table 3, the site visit locations represent geographic areas in the Southeast, Northeast, and West. While all receive Title X funding, their budgets are supplemented by a variety of sources, including State funds, County funds, Medicaid, and private payments.

Table 3. Overview of Site Characteristics			
Location	Funding		Staffing
<ul style="list-style-type: none"> • 2 Southwestern U.S. • 1 Western U.S. • 1 Northeastern U.S. 	<ul style="list-style-type: none"> • Title X • Medicaid • Private pay 	<ul style="list-style-type: none"> • Foundation • State funds • County funds 	<ul style="list-style-type: none"> • Physicians (3 sites) • Counselors (4 sites) • Health educators (3 sites)
Demographics		Services	
<ul style="list-style-type: none"> • Majority <25 years old (1 site) • 16–25 years old (3 sites) • Range from <150% Federal poverty level to middle class • Majority African American (1 site) • Majority Latino (3 sites) • Heterosexual couples (2 sites) 		<ul style="list-style-type: none"> • General family planning (3 sites) • Substance abuse (1 site) • STD screening (4 sites) • HIV counseling and testing (4 sites) • Services for men (2 sites) • Comprehensive health services (3 sites) • Research (1 site) 	

Staffing varies from site to site, with some of the smaller clinics operating with only one staff member and some of the larger clinics operating with more than 20 employees. Three of the sites have physicians on staff, while the fourth serves as a research site that provides education, STD and HIV testing, and referrals for medical appointments. Three of the clinics have trained HIV counselors and health educators.

Demographically, the majority of clients are under the age of 25 in two of the clinics, and over the age of 25 in two clinics. Two clinics have male-focused services targeted to 18- to 25-year-olds and encourage the male clients to bring in their partners. Yet most clinics see women within a wide age range. Within the program offering more comprehensive care, many of the female clients are somewhat older and in some cases bring their children to the clinic for various programs. The majority of clients receiving services at all of the clinics live at 100 to 150 percent below the Federal poverty level. The clinics are split in terms of race and ethnicity. The one clinic with majority African-American clients is located in the Northeast, and the three clinics that serve a majority of Latino clients are located in the Southeast and West.

One clinic specifically targets HIV-negative couples who have substance abuse issues. Most clinics provide general family planning services that include pelvic and breast exams, Pap smears, birth control methods, phlebotomy services, pregnancy tests, pre-pregnancy counseling, and referral for alternative family planning services. Three clinics offer HIV counseling and testing and prevention education on site. Most of the sites offer comprehensive care in terms of general medicine and other services.

B. Synthesis of Current Program Activities and Challenges – Site Visit Key Findings

The Project Team analyzed the summary reports developed at the conclusion of each site visit and synthesized the findings to analyze activities that Title X programs are implementing, examine the ability of couples-focused services to reinforce and sustain preventative health messages and behaviors, and offer some practical insights concerning the integration of “couples clinics” in traditional family planning activities. The synthesis of the results of the site visits is presented under the following key findings:

1. Clinics demonstrate different levels of integration of couples-focused activities and could benefit from additional resources and support
2. Clinics are providing culturally, linguistically, and demographically appropriate care but could benefit from additional models and training
3. Clinics’ assessment and evaluation of couples-focused activities is limited and could benefit from effective and concise tools and strategies
4. Clinics have established valuable collaborative relationships and capacity-building activities with CBOs, faith-based organizations, and educational communities to enhance their outreach, recruitment, and retention efforts.

1. Clinics demonstrate different levels of integration of couples-focused activities and could benefit from additional resources and support

Structure of Activities

All four of the sites demonstrate different levels of integration of couples-focused services. In one location, couples-focused services are provided in a group setting. The couples are required to register for and commit to participate in a 6-week curriculum-focused facilitated group process. A male/female team cofacilitates the group, covering content areas such as HIV prevention and testing, STD screening, contraceptives, sexual health, family planning, communication with partners, and general health.

Two locations provide couples-focused services on one specific day of the week only. Utilizing a sequential process, the couple is separated upon arrival and screened, medically examined, and provided with educational counseling individually. After each of the individuals completes their individual screening, the participants meet as a couple with a health educator to discuss family planning options, contraceptive concerns, and relationship issues that may need to be addressed. The fourth location is research oriented and conducts extensive outreach to recruit couples who meet stringent eligibility requirements. Couples are required to complete an extensive intake screening with a health educator to assess their eligibility to participate in the couples-focused project. Upon acceptance to the program, couples are provided with weekly sessions with trained facilitators to discuss a range of issues, including STD screening, HIV testing and prevention, contraceptive options, and general health. Couples participate for a 6-week period and receive a cash incentive each week for participation.

Staff and Client Goals and Outcomes for Couples-focused Services

Staff members at each program said that the initial goal of the couples-focused services was to get men more involved in reproductive health with their partners and to increase male participation in their own general health care. Additional goals included:

- Strengthen relationships and families
- Increase knowledge of reproductive health
- Improve communication and negotiation skills
- Decrease at-risk behaviors for STDs and HIV
- Enhance motivation
- Reduce anxiety and stigma.

Staff members from all locations reported positive outcomes, stating that men who participated in the couples-focused services began to take a more active role in contraceptive options, increase communication with their partner, and seek medical care on a more consistent basis. Two locations reported that the majority of the male partners who participated in the couples-focused services never had been to a medical provider before and that their initial screening for the couples clinic was the first medical exam that they had received. These programs have noted an increase in the number of men who come in for an annual checkup since the inception of the couples clinic.

Female clients from three locations reported that they were learning helpful skills for STD prevention and contraception before participating in couples-focused services, but that it was difficult to introduce new contraceptive options when they took the information home to their male partner. Focus group clients reported that they participated in the couples-focused services to:

- Enhance communication
- Learn about HIV prevention
- Learn about natural family planning (only discussed in one focus group)
- Learn about STD assessment
- Learn about contraceptive options.

Focus group clients reported increased communication and involvement of male partners in contraceptive and reproductive health options as a result of their participation in the couples clinic. The focus group clients reported that having a professional (health educator or clinician) provide information about contraceptive options, STD prevention, and family planning was taken more seriously than when the female partner brought information home secondhand. Additionally, staff members at one location reported that couples seemed more willing to be more open with a facilitator who was perceived as an expert to help them, because they provided a supportive environment that enabled the couples to feel safe disclosing personal information like STDs and to learn effective communication and negotiation strategies together.

Clinic Activities

Each location reported that educational materials on STDs, HIV testing and prevention, family planning, general health, and contraceptive options are offered to every client during initial intake and screening regardless of eligibility or continued participation in the program. In addition, clients from one location said that there are educational materials available in the waiting areas and that the brochures help provide information to questions that they may be uncomfortable asking during the first few visits. The materials reportedly provided a starting point for sensitive conversations about contraceptives and STDs.

Staff members from two locations shared that it is important to meet the clients where they are by tailoring curriculum and teaching techniques in an innovative manner to make the couple feel comfortable and engaged. Staff members from these locations reported the use of storytelling, role playing, and small group discussions as effective strategies to discuss and share sensitive information in a session with couples. In addition, clients from one location expressed their appreciation for the creativity of facilitators and health educators, and reported that the role plays and storytelling helped them to try new things at home.

Assistance with disclosure of STDs or HIV is provided by staff members at most locations. Each reported that some clients sought couples services specifically for that type of assistance and support. Staff members reported that some of their clients had a need to break their silence by sharing with their partner and felt that their couples clinic was a safe place for discussion. For example, some clients were aware of their HIV status before getting tested with their partner but were uncomfortable with disclosing their HIV status to their partner on their own.

Challenges

Although most of the clinics in the study are providing the basic level of services required under the Title X guidelines, they all face a number of challenges when attempting to integrate couples-focused services. In particular, clinics are dealing with structural issues related to scarce funding resources (which barely cover traditional family planning activities) and limited time frames to incorporate couples-focused services into already-hurried office visits. Two locations reported that couples-focused services could be offered only once a week on specific days. The limited time frame often can be challenging for clients to attend. The staff would like to offer more flexibility for service provision to couples but, with limited staff members and resources, are unable to address this particular challenge. Additionally, clients at one location reported that the 6-week time frame for couples in a group process can be limiting, because the couples are just beginning to really open up to the group, share experiences, and apply new strategies and techniques by the third or fourth week, which limits the opportunity for the couples to continue to explore new ideas.

Staffing for couples clinics is also a challenge. One location examines each person individually and then sees the couple together; this process is very time intensive and takes a lot of staff members and staff time. It is also challenging to coordinate couples' schedules. Quite often, couples must skip a couple of sessions because at least one of them is not available. One site tries to be as flexible as possible with timing to accommodate client schedules and ensure that they are paired up with the same provider each time they come in for services to provide a safe and comfortable environment. Lastly, two locations reported a challenge with taking regular clinics and turning them into more of a couples-friendly environment with limited and decreasing funding. According to these staff members, Title X clinics have not been traditionally male friendly and were viewed negatively: "Men were always viewed as the one who got her pregnant or gave her the STD, or he is abusive." The Title X clinic staff was traditionally trained to meet the needs of the women, and it has taken a large training effort to readjust the mindset of the staff to provide male-friendly services; however, staff members feel that much more training on male service provision is needed. The staff members at two locations are concerned about spreading the limited resources so thin that men are served instead of women, and the clinics are sometimes the only source of services for the women that they serve. Many staff members report that they already feel overwhelmed, are serving only one-third of the women who need services, and are now expected to expand services to men. Some staff members felt that additional training on male services is needed before couples-focused services are expanded. Reportedly, there are a lot of family planning clinic administrators generally who are stretched so thin that when asked to provide services to men and couples, they just throw up their hands and say, "I'd be glad to do it, but don't expect me to turn women away." There is a sense of frustration, because "over the years it's changed from family planning, to addressing STDs, to HIV testing and prevention, to male services, and now couples with the same amount of money or less. It is a challenge."

Promising Practices

Supporting clients' right to confidentiality and gaining their trust were seen as extremely important by both staff members and clients. Having a safe place to share and discuss sensitive information with their partner and caring and knowledgeable staff members was equally important to clients. All staff and clients stressed the importance of confidentiality within the group process (where applicable) and within the clinic, as well as between each member of the couple. All of the clients reported that they felt safe with couples-focused services because confidentiality was stressed and they had faith that their information would be secure. It is important to note, however, that due to

the sensitive nature of couples-focused services, those clients may perceive a confidentiality breach without cause. For example, at one location, a couple had completed their individual STD screening and completed the exit interview. The next day, the female returned to the clinic yelling at the staff that her confidentiality had been breached because her male partner broke up with her and she was convinced that a staff member had shared her medical results with him without her knowledge.

Family planning clinics traditionally have catered to women, and it is important to include men and make them comfortable with receiving medical care and couples-focused services at family planning clinics by developing an environment and materials that are inclusive of their interests. One location purchased a big-screen TV and shows football videos during the male clinic hours and couples clinic hours to make men feel more comfortable. The site also has made sure to paint the waiting room in more neutral tones that are not gender specific and has worked hard to include brochures and literature with pictures of men as well as women. Another site has developed official invitations for male participation in couples-focused services, for females to deliver to their male partners, because the males indicated that some official communication motivated them more than simple word of mouth.

Program staff members from two locations referenced the importance of being flexible and assisting clients' access to care. Since most clients work and have children, couples-focused services are offered during evening hours, and one location also provides child care during service hours. The clients for that site reported that the location of the clinic is accessible by public transportation and that they appreciate the assistance with transportation and child care when participating in couples-focused services.

Referrals have a large impact on the clinics' ability to recruit and retain couples. Quite often the couples served by these sites have social service and specialty care needs that are equally important to the clients and their ability to make healthy choices. Although the clinics do not provide all of the services that are often requested (food assistance, child care, transportation, housing, mental health, substance abuse), each site noted the importance of establishing linkages in the community and providing referrals to resources that can assist their clients meet additional needs.

2. Clinics are providing culturally, linguistically, and demographically appropriate care but could benefit from additional models and training

Cultural, linguistic, and demographic issues, as they apply to care provision, were discussed at each site, with several general themes appearing:

- Most clinics serve as safety-net providers or the clients' first point of entry into the health care system, which means that clients typically come in with concerns other than reproductive health (e.g., substance abuse, domestic violence, homelessness)
- All clinics have educational information available in various languages (usually English and Spanish) and staff members available for translation
- The composition of nonclinical staff members at all clinics is generally representative of the community served.

Challenges

However, one location reported concerns about recruiting African American clients. The site is located in a rural community, and the African American community traditionally has not felt comfortable seeking services with providers outside of their community. In an effort to reach out to the African American community, the clinic has worked hard to establish linkages within the faith-based organizations and social service organizations. These linkages and partnerships have assisted them in building rapport with African American community leaders and have enhanced their recruitment efforts of African American patients.

Two locations referenced their initial concern about interacting with clients effectively when their cultural background is different from that of the client. Although program staff members are culturally representative of the clients served, there is no assurance that clients will be matched with a case manager or health educator of choice. Staff members from all locations reported that clients respond favorably to providers regardless of cultural background as long as the provider is warm, caring, knowledgeable, respectful, and responsive to the needs of the client.

Three locations reported concerns about the difficulty in reaching clients who identify as gay, lesbian, bisexual, or transgendered. While two sites offer services for gay, lesbian, and bisexual clients, each referenced the need for additional training in providing services to these populations. The staff reported that they were comfortable with providing health education but felt limited in what they could offer in regard to relationship issues. One site currently limits participation in couples-focused services to heterosexual couples only because of the limited training of its staff and hopes to expand services to the gay, lesbian, bisexual, and transgendered community in the future.

In an effort to make couples-focused services inclusive of heterosexual, gay, lesbian, and bisexual relationships, one site changed the name of its program to the Friends Clinic. Unfortunately, the community responded negatively to the name change, feeling that change indicated that the clinic was targeting primarily gay, lesbian, and bisexual couples. As a result, a reduced number of heterosexual couples participated. The clinic changed the name back to Couples Clinic, and the number of heterosexual couples increased. The staff from this site reported frustration, because they would like to include the gay and bisexual couples but did not want to lose the heterosexual couples as a result. The staff requested assistance with designing outreach efforts to both heterosexual and gay couples, in an unobjectionable and inclusive manner.

Promising Practices

Program staff members from two locations shared that it is important for them to complete individual assessments (history, questions, current living situation) before implementing behavior change strategies. In particular, they work to develop strategies that meet their clients' specific needs and do not use "cookie-cutter" approaches for every client. Additionally, staff members reported that they constantly tailor services to various ethnic and racial groups in their communities. For example, in the Latino culture, storytelling is important, and stories are used by staff members to teach information in a nonthreatening and entertaining way, normalize communication patterns among couples, and challenge stereotypes or gender norms that may make it difficult for one partner to express sexual discomfort or negotiate contraceptive with a partner. For their African American clients, one location provides couples-focused services on site at faith-based organizations in their community to reduce mistrust and fear.

Another strategy employed by the majority of clinics is to hire staff members of cultural and demographic backgrounds similar to those of clients. Although the background of the clinician is not typically representative of the community the clinic serves, many hire front-desk staff members, outreach workers, and other clinic staff members whose backgrounds reflect those of residents of the surrounding community in an attempt to make the clients comfortable. In one location, a former client was hired as a health educator and worked with his peers to provide counseling and educational services. The peer employee has been well-received by clients and is highly sought because of his ability to understand and relate to their issues and challenges.

3. Clinics' assessment and evaluation of couples-focused activities is limited and could benefit from effective and concise tools and strategies

Assessment and evaluation activities surrounding couples-focused services are limited at most sites and generally include only one or two of the following:

- Assessment and evaluation activities surrounding services are limited at most sites
- Tracking testing rates among clients who have been referred for HIV testing.

Staff members from all locations referenced a number of challenges related to assessment and evaluation. They felt that methods are often difficult, time consuming, and ineffective. They were also unable to be sure if their clients' responses to questions were honest due to the very sensitive or personal nature of the questions. Finally, they also reported that they were unable to provide followup services and were unable to measure the impact of couples counseling upon completion of the sessions. Staff members report challenges in evaluating behavior change, due to relying mostly on self-report, and acknowledged a need for more effective tools and strategies to evaluate program outcomes.

Although limited, a number of clinics reported some use of assessment and evaluation strategies. Most programs conduct client satisfaction surveys periodically. One site reviews goal sheets for each client and reviews materials with clients when they come in for each session. Outcomes are measured weekly by submitting the number of missing appointments. Clients complete a written survey of the couples session after the seventh session, and a quality assurance protocol is used to randomly review 20 percent of audiotaped sessions. The review of the sessions is used to evaluate how the services are affecting the outcome and if the program is meeting established goals.

Staff members talk primarily about behavior change and the effectiveness of couples-focused strategies informally. Two sites measure clients' behavior change, such as adherence to service provision, and the increased number of males seeking medical care, as their program outcomes. Directors and staff members report that it is difficult to measure the impact of couples-focused services truly and that they would benefit from effective models that have been developed and applied to this unique application of services.

4. Clinics have established valuable collaborative relationships and capacity-building activities with CBOs, faith-based organizations, and educational communities to enhance their outreach, recruitment, and retention efforts

Directors and program staff members at all locations referenced the importance of having strong linkages and collaborative relationships with CBOs, faith-based organizations, and school systems. However, two locations had challenges establishing partnerships with some of the African American and Latino faith-based organizations in their communities, because those faith-based organizations did not want to be affiliated with clinics that supported or provided referrals for abortions. The clinics continued to move forward with their outreach efforts to those faith-based organizations that were willing to learn about all of the services offered, because in some service areas, the faith-based organizations were the only way to reach out to some of the hardest clients to serve, such as African American and Latino clients. Eventually, some of the faith-based organizations began to partner and collaborate with these clinics after realizing that their community could benefit from the couples-focused and medical services offered.

Staff members consider community linkages and partnerships to have an impact on their ability to recruit and retain couples, because the partnerships provide important resources such as food, housing, and transportation that assist clients in meeting their basic and medical needs. Additionally, linkages and community partnerships provide connections with hard-to-reach communities of color with which clinics historically may not have a connection. For example, one location has 140 partners in the community ranging from elementary schools through colleges, technical schools, drug treatment centers, and juvenile justice centers; these partnerships have increased the number of clients of color and have established their commitment within the community to provide culturally appropriate services. Another location has a partnership with a Latino-based radio station and collaborates to inform and recruit clients into services.

Table 4 highlights many of the innovative approaches to couples-focused services identified by staff and clients during the site visits.

**Table 4. Staff- and Client-identified
Innovative Approaches to Couples-focused Services**

Staff-identified	Client-identified
Philosophical Approaches	
<ul style="list-style-type: none"> • Providing information as more than a “one-shot” deal • Making the client comfortable (providing client-centered care) • Empowering women with safe-sex negotiation skills • Holistic approaches to couples services • Culturally appropriate themes (e.g., storytelling is important in the Latino community) 	<ul style="list-style-type: none"> • Extending the time frame for the couples group sessions
Community-level Approaches	
<ul style="list-style-type: none"> • Peer educators • School-based outreach • Faith-based outreach • Working with CBOs that are already established in certain communities • Targeting “hot spots” (e.g., car shows) 	<ul style="list-style-type: none"> • Peer educators • Health fairs
Clinic-level Approaches	
<ul style="list-style-type: none"> • Making waiting room and educational materials comfortable and appropriate for men and women • Stressing that confidentiality will be maintained • Flexibility of hours • Referrals • Linkages in the community • Cultural competence 	<ul style="list-style-type: none"> • Offering more hours for couples-focused services • Flexibility of hours • Knowledgeable and caring staff members
Group-level Approaches	
<ul style="list-style-type: none"> • Games and activities where couples can work together • Confidentiality – stressing the importance of keeping information shared in a group within the group 	<ul style="list-style-type: none"> • Peer learning, the ability to share experiences and learn from each other • Confidentiality – knowing that information will not be shared outside of the group • Knowledgeable and caring staff members
Multimedia/Social Marketing	
<ul style="list-style-type: none"> • Developing and using visually graphic materials • Using local media to share information about couples-focused services • Including male and female images for couples-focused services 	<ul style="list-style-type: none"> • Using radio and music personalities to provide HIV prevention message

Chapter VI: Expert Workgroup Meeting

As a followup to the key informant interviews and site visits, the OPA and the HSR Project Team were also interested in gathering a group of experts in an informal, one-day workgroup meeting to continue the dialogue on couples-focused activities in Title X programs. (Appendix C includes the Expert Workgroup Meeting Agenda.) Fifteen individuals representing OPA grantees, OPA staff members, and external experts met in May 2006 to:

- Consider the need for, barriers to, and challenges of providing couples-focused services within family planning programs
- Identify specific strategies and effective practices that are being used to provide couples-focused services within family planning programs
- Identify potential next steps for OPA and Title X providers in relation to couples-focused services.

A. Definitions and Perceptions of Couples-focused Approaches

The Expert Workgroup engaged in a collective discussion about the definitions and perceptions of couples-focused activities and expressed similar ideas as the individual conversations with key informants. In particular, they felt that couples-focused activities must be both client centered and individualized to the couple. Yet unlike the key informants, Workgroup participants began with a discussion of what couples-focused services did not include. All participants agreed that there were clear distinctions between education and counseling because of different intervention objectives and skills sets required by staff members. While many key informants viewed couples-focused services as a broad continuum, several participants also made a distinction between partner services (medical services) and couples services (relationships).

Workgroup members also discussed recruitment and retention issues and stressed that it was important to recognize that couples-focused services might not be just for sexual partners in established relationships, particularly when trying to reach vulnerable populations. Several participants mentioned that use of the term “couples” may be perceived as heterosexist and would need to be introduced in many communities that serve gay, lesbian, bisexual, and transgendered clients with extra sensitivity.

The majority of the Workgroup members felt that couples-focused approaches offered a number of advantages over traditional individually focused family planning services, because they:

- Engage male partners
- Go beyond basic education to address and facilitate communication and issues around sexuality and contraception within the relationship

- Are capable of addressing broader objectives more effectively (e.g., intended pregnancies, decreased STDs, improved health, improved communication, healthier relationships, saved lives)
- Can save time and resources on education counseling that normally would happen separately for two clients.

Despite the advantages, the Workgroup identified a number of challenges to consider when implementing couples-focused services. In particular, Workgroup members expressed the need to address relationship dynamics – including the need to consider gender and cultural norms, the potential need for interpreters, privacy issues, reporting issues related to age, underlying issues, and immediacy of concerns. They also felt there was a critical need for staff training and support, both because current staff members might not have the required skills to work with couples and because a couples-focused approach means that not everything will “fit into a box” – but staff members need to be prepared for a wide variety of issues that may come up. Finally, several members pointed to the lack of research related to developmental issues and to gender, suggesting that what is known to work for women and girls does not translate to boys or couples necessarily.

B. Goals and Outcomes of Couples-focused Approaches

Workgroup participants were asked about the goals and outcomes associated with a couples-focused approach and whether these differ from those of the traditional service delivery model that focuses on the individual client. They were also asked to comment on any potential undesired outcomes that could result from the implementation of couples-focused services. As discussed below, many of their responses were similar to those expressed by the key informants and site visit interviewees. However, the workgroup format allowed for a somewhat broader discussion of goals and outcomes at the provider and program levels.

1. Goals and Desired Outcomes

Like the key informants and site visit interviewees, Workgroup participants mentioned issues such as improved communication, health, and healthy relationships; reduced unintended pregnancies, STDs, and HIV; increased contraceptive effectiveness and use; and increased access to services for men (both from the Title X program and through referrals). They also mentioned the potential enhancement of couples’ sexual lives and improved partner equity and empowerment.

Workgroup participants focused furthermore on the community level, suggesting that couples-focused services can lead to improved health of communities and to the perception of outsiders of the clinic as family- or partner-focused. They also explored desired goals at the program-level such as expanded skill levels of providers, the ability to support other programs by generating knowledge and potential income, and the ability to leverage additional funding sources to cover services.

2. Potential Undesired Outcomes

The Workgroup expressed similar ideas to the key informants and site visit interviewees about undesired outcomes, including decreased safety for women clients, potential discord or violence within couples, and concerns about confidentiality and the comfort level of partners to speak openly with one another and the provider if they are seen together. Several members wondered if the services might be stigmatizing to people who are not in “couples” or if an emphasis on monogamous relationships might mean that clients will not speak as openly.

Again looking beyond client-level issues, Workgroup participants discussed the potential impact at the provider and program levels. Potential staff discomfort or uncertainty could limit a program’s ability to provide high-quality services, and philosophical disagreements on the issue of serving couples and/or male clients may create discord within the facility. Finally, they considered the potential difficulties documenting and maintaining records, being reimbursed for costs, and “siphoning” already scarce resources.

C. Need and Desire for Couples-focused Approaches

Most Workgroup participants agreed that there was a need for couples-focused approaches because of gender inequality (since men control condom use) and the lack of communication evident between many female clients and their partners. Stressing that needed services do not exist in the communities, participants pointed out that many Title X programs receive phone calls from men asking for services, from parents on where to bring kids, and from school nurses looking for places for young boys. In addition, Title X program staff often ask for additional training on vasectomies and exploring circumcision as a potential means of HIV prevention.

The assessment of need was also a part of the Workgroup discussion. Participants stressed the need to understand better what strategies are effective with boys and men and for Title X programs to better understand the communities in which they operate. Brainstorming about how best to get at these issues, Workgroup participants suggested that the OPA look closely at, and disseminate, the findings of the male projects; share promising practices from clinics that are assessing need (e.g., by adding questions to client satisfaction surveys); and potentially use the Service Delivery Improvement Grants to build the capacity of programs to conduct needs assessments and use the findings to guide program and policy development and evaluation.

In addition to need, Workgroup participants also perceived a desire for couples-focused approaches, suggesting that they are probably implemented more often than we might suspect, because practitioners understand that it is “good public health.” It was the group’s consensus that although people are somewhat suspicious of couples-focused services, they are always interested in knowing what others are doing. Several participants knew of clinics that saw the need, had some commitment from the administrators, and were interested in implementing couples-focused services when they had appropriate staffing and could individualize the services to fit the culture and resources of their agency and community.

D. Recommendations for Implementing Couples-focused Approaches

As discussed in the above section on definitions and perceptions of couples-focused services, the Workgroup members identified similar issues related to funding, staffing, resistance, and cultural considerations. They also agreed with the key informants' recommendations regarding keeping services client focused (e.g., by focusing on communication within relationships as defined by the client), involving community members in program development (and in turn bolstering the referral network), and adapting clinic services and environments to appeal to men (e.g., by utilizing a social networking approach like that of the Young Men's Clinic in New York).

The Workgroup discussion focused more on expanding staff capacity through a number of key strategies, including:

- Conducting a needs assessment of the clinic, the staff, and the community to see what capacity currently exists and what additional training and resources might be needed
- Providing the staff with tools to identify a clear definition of a successful encounter and identified goals/objectives (e.g., a client-level needs assessment tool and a clinic visit protocol)
- Utilizing HIV prevention integration in family planning services to focus couples efforts (e.g., building upon the mindset of HIV prevention counseling as directed counseling).

E. Next Steps

As outlined in Table 5, the Workgroup concluded with a discussion of future directions and next steps for both Title X programs and the OPA.

Table 5. Workgroup Recommended Next Steps

Define the continuum of services/programs and determine the feasibility of/interest in moving forward by:

- Assessing grantees to determine what they already are doing to address couples and healthy relationships (e.g., could provide grantees with guidance regarding questions and broad language to gather information from providers)
- Conducting an environmental scan at Federal, regional, and program level.

Gain stakeholder buy-in by:

- Framing the overarching goal as positive reproductive health outcomes
- Framing couples-focused services as part of a continuum with other Title X program activities/objectives
- Highlighting promising practices and successes to date in terms of what people already are doing and what clinics can integrate easily
- Reassuring grantees that support for integrating and providing couples-focused services exists (e.g., referral linkages and collaborative relationships)
- Continuing to discuss the topic in other venues (e.g., grantee meeting, shared report from the contract).

Enhance the continuum of services by:

- Providing examples of how to design and implement effective services (across the continuum)
- Providing resources for training
- Providing opportunities to apply for innovative projects with regional discretionary funds
- Thinking creatively about other funding options and collaborative partners (e.g., OPA male projects, Robert Wood Johnson projects, faith-based organizations, HIV-related programs).

Chapter VII: Key Findings and Recommendations

Through the conduct of a literature review, key informant interviews, site visits, and an expert workgroup meeting, the HSR Project Team has been able to assist the OPA in determining the content of the couples-focused services being offered, how these services are perceived, what challenges programs are facing, and what recommendations would improve the provision of couples-focused services. The following chapter outlines the key findings of the study gained from all data collection activities and concludes with some recommendations.

A. Key Findings

1. The Definition and Implementation of Couples-focused Interventions Within Family Planning and Other Settings Is Not Uniform

The majority of studies on couples-focused health care interventions echo the common themes of improving communications, negotiation, and conflict resolution to improve health behaviors and support healthy choices in the couple and in the family. The clinic staff and clients concurred with these intended objectives. However, it is more difficult to define the scope of services that would fall under a couples-focused approach. Most key informants and Workgroup members distinguished between a couples-based approach (one that targets the couple at the outset, in which all or most of the programming is directed toward the couple or dyad) and a couples-focused approach (one that typically begins with an individual female client and may or may not expand services to include her partner but definitely addresses issues related to the relationship or male partner). In general, the couples-focused approach is considered to be more consistent with the traditional family planning approach and the current service delivery model.

Although the evidence is limited, the small number of existing studies comparing women-only and couples-focused family planning and STD prevention interventions suggest that women-only single-session interventions, which include only educational components, are less effective at increasing instances of protected sex or increasing communication between partners than multisession interventions for women, single-session interventions for couples, or multisession interventions for couples. Recognizing the role of communications dynamics in contraceptive decisionmaking and the need for building improved communication skills between sexual partners, the research suggests that successful family planning and STD prevention interventions must combine information and educational components with skill-building exercises.

It is also important to note that the term “couple” may imply involvement in a committed and monogamous relationship, which may be inconsistent with the experience of those clients that report involvement with multiple sexual partners or involvement in transient sexual relationships. Our experience in the focus groups ranged from couples who had been together for 3 to 25 years who were attending couples-based or group sessions on natural family planning, to those who had been together 1 month to 3 years and were utilizing

individualized clinic services on “couples clinic day” to receive primarily STD testing or treatment. Recognizing this variation speaks to the importance of involving the client in defining their relationships and to tailoring the interventions to meet their specific needs.

2. There Is a Need to Address the Challenges That Exist to Serving Males in Family Planning Clinic Settings and Building Staff Capacity to Provide Couples-focused Services

The literature suggests, and the clinic staff members and clients with whom we spoke tended to agree, that efforts by Title X clinics to include couples-focused family planning services should be complemented by services to address male reproductive health needs. If men are more knowledgeable about reproductive health issues and are able to discuss them with their partners, then they can help make better reproductive health decisions for the couple. Furthermore, it appears from the research surveys of male teenagers and adults – and from the requests that Title X programs are receiving from adults, parents, and schools – that most men indicate genuine concern about unintended fatherhood and the prevention of STDs, particularly HIV/AIDS.

Challenges

However, involving men in the family planning clinic setting – either for individual counseling or as part of a couples-focused service – requires a paradigm shift for Title X services, clients, and providers from a female-oriented focus to one that incorporates men and couples. This will require changes in both perceptions and the use of resources. Barriers include:

- Perceptions that couples- or male-focused activities utilize or “siphon” scarce resources from already underfunded female-focused services
- The potential undesired outcomes of increased risk of violence or erosion of women’s reproductive rights
- Staff members who may not be appropriately trained or comfortable in providing the necessary services and addressing issues that may arise
- Resistance on the part of the staff or clients to providing or accessing couples-focused services
- Cultural or linguistic barriers to providing or accessing care.

Strategies

However, many of the lessons learned from the expansion of Title X to serve men are directly applicable as clinics consider the incorporation of couples-focused approaches to family planning. In addition, all four of the sites visited demonstrate different levels of integration of couples-focused services, ranging from individualized screening and assessment, with joint consultation if requested, to participation in a 6-week curriculum-focused facilitated group process. The following client-level strategies are recommended:

- Conducting creative outreach strategies and changes to the clinic’s physical setting and staff to attract and retain male clients
- Focusing on services perceived as a priority by men (e.g., access to condoms and STD testing and treatment, contraceptive counseling)
- Tailoring reproductive health messages that are geared to diverse audiences, reinforce the importance of male health concerns, and suggest that responsible reproductive health behaviors by men are vital to the reproductive health of their partners, families, and communities
- Tailoring curriculum and teaching techniques to build the skills of the clients to communicate and negotiate with their partners (e.g., role plays and storytelling)

The literature, interviewees, and Workgroup members also recommended a number of provider- and program-level strategies, including:

- Conducting a needs assessment of the clinic, the staff, and the community to see what capacity currently exists and what additional training and resources might be needed
- Providing training and support so that staff members feel competent providing the services and have the ability to address the individual needs of clients and partners (e.g., skills training related to cultural competency, mediation, and intervention; training on topics such as male reproductive issues and confidentiality)
- Providing gender and cultural sensitivity self-assessment and training for providers to address attitudes, behaviors, and needed skills for male- and couples-focused services
- Providing the staff with tools to identify a clear definition of a successful encounter and identified goals/objectives and to assess the encounter consistently and appropriately (e.g., a client-level needs assessment tool and a clinic visit protocol)
- Utilizing HIV prevention integration in family planning services to focus couples efforts (e.g., building upon the mindset of HIV prevention counseling as directed counseling)
- Building on (existing and new) collaborative relationships and capacity-building activities with CBOs, faith-based organizations, and educational communities to enhance their planning, outreach, recruitment, and retention efforts.

3. Providers Are Addressing Communication and Negotiation Styles, Relationship Dynamics, Gender, and Culture in the Provision of Couples-focused Services but Would Benefit from Additional Training and Support

The existing literature suggests, and our interviewees confirmed, that couples do not agree always with regard to what occurs during reproductive events, their attitudes, or their intentions about family planning. It appears that lack of communication or

miscommunication serves to exacerbate these differences and affect family planning decisionmaking in couples. In particular, gender and culture have a substantial impact on negotiation and communication styles, relationship dynamics, decisionmaking, and power relations within the couple. The research suggests that integrating an understanding of gender roles and culture into reproductive health programs appears to have a positive impact on outcomes, whether the interventions accommodate gender roles and cultural differences or seek to transform gender and cultural inequities.

Challenges

The four sites visited are all identifying and addressing gender, cultural, linguistic, and demographic issues. However, challenges do exist:

- Most Title X clinics serve as safety net providers or the clients' first point of entry into the health care system. Therefore, clients typically come in with concerns other than reproductive health (e.g., substance abuse, domestic violence, homelessness), which in turn may require great assessment skills and knowledge of community-based resources on the part of the provider
- Some clinics experience difficulty recruiting and retaining clients of color if they have not traditionally provided services within the specific communities because of lack of knowledge, fear, or mistrust
- Some staff reported that they were comfortable with providing health education but felt limited in what they could offer with regard to relationship issues when working with gay, lesbian, bisexual, or transgendered clients.

Strategies

The clinics visited are addressing gender, cultural, linguistic, and demographic issues in a variety of ways, including the following:

- All clinics have educational information available in various languages (usually English and Spanish) and staff members available for translation
- The composition of nonclinical staff members at all clinics is generally representative of the community served, and although the clinical staff is often not reflective of the community served, staff members from all locations reported that clients respond favorably to providers regardless of cultural background as long as the provider is warm, caring, knowledgeable, respectful, and responsive to the needs of the client
- Most staff members complete an individual assessment for each client, which allows them to tailor the behavioral change strategies to the client's individual needs better than by using a "cookie-cutter" approach
- In several clinics, stories are used by staff members to teach information in a nonthreatening and entertaining way, normalize communication patterns among couples, and challenge stereotypes or gender norms that may make it difficult for one partner to express sexual discomfort or negotiate contraception with the other
- One location provides couples-focused services on site at faith-based organizations in the community to reduce mistrust and fear.

Yet the clinic staff could benefit even more from training and support in implementing couples-focused approaches that truly integrate issues of gender, culture, and language. In particular, the research suggests that family planning services should focus more strongly on couple dynamics and gender roles in family planning decisionmaking and thus should:

- Be sensitive to varying gender roles in different cultures and gender differences in negotiation styles (e.g., direct versus indirect)
- Use different skill-building techniques to address communications and decisionmaking among couples effectively
- Provide support for women's efforts to initiate and negotiate condom use and facilitate couples' communications about sexual needs and desires
- Be conducted in a community-based setting and use face-to-face interviews as well as culturally appropriate recruitment sites, procedures, and facilitators.

B. Recommended Next Steps

This study was a first look into the challenges, opportunities, and promising practices related to providing couples-focused services within Title X clinics. The recommendations of the Workgroup address many of the key issues expressed in the literature, as well as those of the key informants and clinic staff members and clients, and are therefore reiterated here along with specific recommendations of the HSR Project Team.

1. Define the continuum of services/programs and determine feasibility/interest in moving forward by:

- Assessing grantees to determine what they already are doing to address couples and healthy relationships
- Conducting an environmental scan at the Federal, regional, and program levels.

→ *HSR Recommendations:* This small assessment has only begun to highlight the issues related to providing couples-focused services. A low-cost followup study would be to provide grantees with guidance regarding questions and broad language to include in their existing assessment of provider activities and needs. A larger-scale followup activity could be to create an Internet or mail survey to administer to a much larger sample of Title X programs. The scan also should include separate interviews or surveys with the Federal and regional OPA staff members to determine how these activities coincide with other priorities and if there is a commitment to move forward.

2. Gain stakeholder buy-in by:

- Framing the overarching goal as positive reproductive health outcomes
- Framing couples-focused services as part of a continuum with other Title X program activities/objectives
- Highlighting promising practices and successes to date in terms of what people already are doing and what clinics can integrate easily
- Reassuring grantees that support for integrating and providing couples-focused services exists (e.g., referral linkages, collaborative relationships)
- Continuing to discuss the topic in other venues (e.g., grantee meeting, shared report from the contract).

→ *HSR Recommendations:* It may be helpful for the OPA to distribute this report but also to create a one- to two-page brief about the key issues and strategies for distribution among grantees. In order to highlight promising practices further, the initial findings in this report could be developed into four case studies, or additional site visits could be completed utilizing the same tools. The Project Team will present the findings during the grantee meeting in September 2006, and it may be helpful to collect the names of individuals attending this session to gauge experience and interest in the issue.

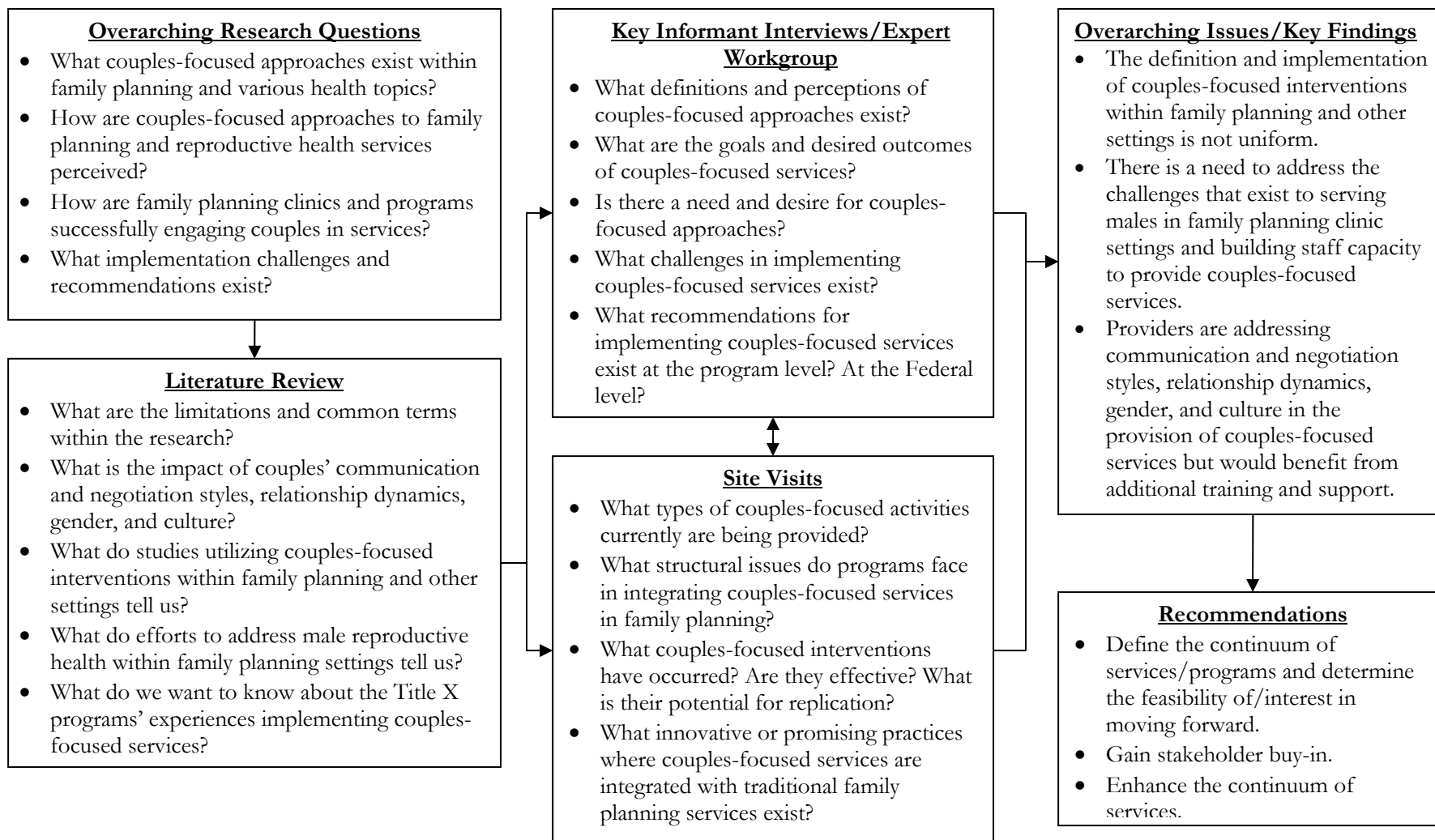
3. Enhance the continuum of services by:

- Providing examples of how to design and implement effective services across the continuum
- Providing resources for training
- Providing opportunities to apply for innovative projects with regional discretionary funds
- Thinking creatively about other funding options and collaborative partners (e.g., OPA male projects, Robert Wood Johnson projects, faith-based organizations, HIV-related programs).

→ *HSR Recommendations:* It may be helpful to work with the existing prevention training centers at the OPA, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration to develop a curriculum jointly and explore resources for expanding research and implementation of couples-focused strategies.

Appendix A: Process Diagram

Process Diagram: Couples-focused Service Delivery in a Sample of Title X-supported Clinics



Appendix B: Site Visit Location Characteristics

Site Visit Location Characteristics				
	Location	Funding	Demographics	Services
#1	Southeast	Title X Medicaid Self-pay Faith-based	>16 years old Poor/low SES Male Female Latino White	Family planning Birth control methods Community outreach Sex education
#2	Southeast	Title X	>16 years old <150% FPL Male Female Latino African American	General family planning* STD screening HIV counseling and testing Testicle exams for men Colposcopy
#3	West	Title X	>16 years old <100% FPL Male Female Latino	General family planning STD screening/counseling
#4	Northeast	Foundation	<25 years old <150% FPL Female Male African-American Latino	STD screening HIV counseling and testing

*General family planning includes pelvic exams, breast exams, pap smears, birth control methods, blood tests/screening, pregnancy tests/pre-pregnancy counseling, and referrals for family planning services (e.g., prenatal care, adoption, abortion).

Appendix C: Expert Workgroup Meeting Agenda

U.S. Department of Health and Human Services
Office of Public Health and Science
Office of Population Affairs

**ASSESSMENT OF STRATEGIES TO ENCOURAGE COUPLES-
BASED HEALTH SERVICE DELIVERY WITHIN TITLE X-
SUPPORTED FAMILY PLANNING CLINICS**

✦
CHICAGO, ILLINOIS
MAY 25, 2006

Workgroup Agenda

Meeting Objectives:

- Consider the need for, barriers to, and challenges of providing couples-based services within family planning programs.
- Identify specific strategies and effective practices that are being used to provide couples-based services within family planning programs.
- Identify potential next steps for OPA and Title X providers in relation to couples-based services.

8:00–8:30 *Registration*

8:30–9:00 **Welcome, Introductions, and Overview of Agenda**
Jamie Hart, Ph.D., M.P.H., Health Systems Research, Inc., Facilitator

9:00–9:15 **Background and Context**
Sue Moskosky, Director, Office of Family Planning

9:15–10:15 **Framing the Issues**

- Key Findings from the Literature Review, Key Informant Interviews, and Site Visits
 - Health Systems Research, Inc.: Jamie Hart, Ebony Ross, and Sandra Silva

- 10:15–10:30 *BREAK*
- 10:30–12:00 **Discussion I: Definitions and Need**
- What perceptions and definitions of couples-based approaches to family planning services exist?
 - What are the desired outcomes/benefits of couples-based approach at the client and clinician levels?
 - Is there a need and desire for couples-based services?
- 12:00–1:00 *LUNCH ON YOUR OWN*
- 1:00–2:30 **Discussion II: Implementation**
- How might couples-based approaches to providing family planning and reproductive health care services implemented in Title X programs?
 - What resources would be required to develop and implement couples-based services?
 - How can programs gauge the effectiveness of couples-based interventions?
 - What challenges might providers and programs face when implementing couples-based services?
- 2:30–2:45 *BREAK*
- 2:45–4:00 **Discussion III: Future Directions**
- Where are the gaps between what is needed and what exists?
 - Where are there opportunities for collaboration?
 - What suggestions might this group offer to OPA regarding the future direction of couples-based interventions?
- 4:00–4:15 **Identification of Next Steps**
Sue Moskosky
- 4:15–4:30 **Wrap-up and Adjournment**
Jamie Hart