Provision of Contraceptive and Related Services By Publicly Funded Family Planning Clinics, 2003

CONTEXT: *In addition to contraceptive services, publicly funded family planning clinics provide low-income women with a range of reproductive diagnostic, treatment and educational services. Nationally representative information about the scope of services available from clinics is needed to formulate policy and programmatic recommendations.*

METHODS: *In 2003, more than 1,000 U.S. clinics responded to an eight-page survey on service availability and clinic policies. Differences in the proportions of clinics reporting each service or policy were examined by clinic type and receipt of Title X funding.*

RESULTS: *Nearly all clinics offer pills, injectables and condoms; 75% offer the patch; and 80% offer emergency contraception. Most clinics (73%) typically use a conventional Pap smear for initial cervical cancer screenings; 27% use liquid-based Pap tests. For follow-up, 68% of clinics use liquid-based or other advanced testing. Virtually all clinics screen at least some clients for chlamydia; Planned Parenthood and Title X–funded clinics, more than others, tend to focus screening efforts on sexually active women aged 25 and younger. Single-dose treatments are provided by 58% of clinics. Nine in 10 clinics offer HIV testing on-site, most of them to any client who requests it. Services targeted to specific populations include counseling about abstinence for minors (91%); non–reproductive health services for men (36%); and availability of staff such as translators (81%) and bilingual administrative (59%) or clinical personnel (57%) for non-English-speaking clients.*

CONCLUSIONS: *More public funding is imperative for clinics to keep up with the demands of new technologies and a diverse client base.*

Perspectives on Sexual and Reproductive Health, 2006, 38(3):139–147

By Laura Duberstein Lindberg, Jennifer J. Frost, Caroline Sten and Cynthia Dailard

Laura Duberstein Lindberg and Jennifer J. Frost are senior research associates, and at the time of this analysis, Caroline Sten was research assistant, Guttmacher Institute, New York. Cynthia Dailard is senior public policy associate, Guttmacher Institute, Washington, DC.

Publicly funded family planning clinics provide access to affordable contraceptives and related preventive health care for millions of American women each year. In 2001, 6.7 million women received contraceptive services from a publicly funded clinic.[1] Women receiving care from family planning clinics are disproportionately low-income, uninsured, young, black and Hispanic.[2]

Prior research has focused on the services provided and policies adopted by family planning agencies that receive funding through Title X of the Public Health Service Act (the only federal program that provides categorical funding for family planning); Medicaid; and a variety of other federal, state and local public health programs.[3] To date, however, no nationally representative data have been available to document the range of services provided by individual clinics. The focus on the agency level has likely masked clinic-level variation, since individual agencies typically administer multiple clinics—which may offer different services, have different policies and receive public funding from different sources. For example, agencies may administer one or more large clinics that provide a wide range of services and methods, and several smaller sites that offer more limited services but refer clients to the larger clinics for some services. Such variation is not seen in surveys of agencies, which measure service provision for all sites combined. In addition, while agencies may span wide geographic areas—including both rural and urban areas—and therefore serve a potentially diverse client population, individual clinics can adapt and target their services to meet local needs. Moreover, information about services and policies, measured at the clinic level, can be used more easily than agency-level information to identify strengths and weaknesses and to formulate policy and programmatic recommendations for expanding and targeting services where they are most needed.

In this article, we use 2003 survey data to describe some key reproductive health services and programs provided by a nationally representative sample of publicly funded family planning clinics. We not only address the availability of contraceptive methods at family planning clinics, but also describe the availability of and policies regarding a range of other reproductive health services, including cervical cancer screening, chlamydia screening and treatment options, and HIV testing practices and protocols. These services were selected for study for several reasons. First, screening and diagnosis of reproductive cancers and STDs is a critically important service provided by clinics. In addition, few details are known about how clinics make these services available to women. Moreover, although recent advances in both testing and treatment options may improve patient out-

TABLE 1. Percentage of U.S. publicly funded family planning clinics, by selected characteristics of cervical cancer screening services offered, according to type of clinic and Title X funding status, 2003

Characteristic	All (N=1,029)	Type			Title X funding	
		Health department (N=225)	Planned Parenthood (N=278)	Other (N=526)	Yes (N=647)	No (N=382)
Typical initial screening						
Conventional Pap test	73	87	83	58*,**	83	56***
Liquid-based test	27	13	17	42*,**	17	44***
Follow-up tests						
Conventional Pap test only	32	51	18*	21*	38	23***
Conventional Pap and other tests	34	30	58*	30**	36	31
Other tests only	34	19	23	48*,**	26	45***
Other tests at follow-up†						
Liquid-based	45	27	63*	54*,**	39	53***
DNA test for HPV	34	18	56*	43*,**	32	38
Combined Pap and DNA tests	13	4	27*	17*,**	12	15
Colposcopy	33	18	48*	43*	30	39***

*Significantly different from percentage for health department clinics at p<.05. **Significantly different from percentage for Planned Parenthood clinics at p<.05. ***Significantly different from percentage for Title X–supported clinics at p<.05. †Clinics could provide multiple responses.

comes, these advances also increase costs for clinics operating on limited budgets.[4] Finally, in recent years, a number of government agencies and professional organizations have issued guidelines governing when and how frequently these tests should be provided, potentially transforming the provision of reproductive health care in this country.

We also examine service availability for select groups of clients with specialized and often growing needs. We address adolescents, a long-standing and important family planning clientele that presents unique challenges for service delivery. Relatively little is known about the programs and practices that clinics have adopted for this group of clients. Unique issues with regard to adolescent clients are the extent to which clinics promote abstinence and their policies regarding parental parental involvement in care. We also address men and non-English speakers, two groups that clinics are increasingly called upon to serve.[5]

TABLE 2. Percentage distribution of U.S. publicly funded family planning clinics, by selected characteristics of chlamydia screening and treatment services offered, according to type of clinic and Title X funding status

Characteristic	All (N=1,075)	Type			Title X funding	
		Health department (N=223)	Planned Parenthood (N=287)	Other (N=565)	Yes (N=664)	No (N=411)
Clients typically screened						
All females	42	44	22*	45**	38	47***
Sexually active females aged ≤25	43	43	59*	38**	51	31***
Certain high-risk groups only†	14	12	14	15	10	20***
None	2	0	5*	2*	1	2
Typical treatment						
Single-dose antibiotic	58	65	59	53*	61	54
3–10-day antibiotic regimen	39	34	39	43	38	41
Mix of treatments	3	1	2	4*	2	4***
Antibiotics given for partners						
Yes	32	16	45*	41*	27	39***
No	68	84	55	59	73	61
Total	100	100	100	100	100	100

*Significantly different from percentage for health department clinics at p<.05. **Significantly different from percentage for Planned Parenthood clinics at p<.05. ***Significantly different from percentage for Title X–supported clinics at p<.05. †For example, women with multiple or new partners. *Note:* Percentages may not add to 100 because of rounding.

Family planning clinics that receive Title X funds often have distinctive features that may optimize patient care yet bring financial pressures. This is because they are mandated by law to provide a full range of contraceptive methods and a broad package of preventive health services to poor and low-income clients for free or at reduced fees that are based on clients' ability to pay. We therefore focus attention on the Title X program by examining if services vary across clinics depending on their receipt of Title X funding.

METHODS

Data

Data for this analysis come from the 2003 Survey of Contraceptive Service Providers. Briefly, we surveyed a nationally representative sample of 1,001 agencies providing publicly funded contraceptive services, and 1,875 clinics within those agencies. We sampled from the 2,946 agencies and 7,423 clinics in the most up-to-date list of publicly funded family planning agencies and clinics available in May 2003. This list is maintained and updated by the Guttmacher Institute, using directories of Title X–supported clinics and clinics administered by the Planned Parenthood Federation of America, community and migrant health centers, and the Indian Health Service; we also relied on personal communication with Title X grantees, agency administrators and others to confirm clinic names, addresses, receipt of public funding and provision of contraceptive services.[6] Public funding includes (but is not limited to) federal support from Medicaid, Title X, the social services and maternal and child health block grants, and community and migrant health center funds, as well as a variety of state and local programs. The mix of public funding sources varies widely among clinics, given different local and regional patterns of public financing for health care in general and family planning specifically.

We employed a two-stage sampling design, first selecting agencies and then specific clinics within those agencies. We stratified the sample by agency type (community or migrant health center, health department, hospital, Planned Parenthood affiliate or other*), receipt of Title X funding (all clinics, some clinics or no clinics receive funding), region (Northeast, Midwest, South or West) and number of service sites (one, two, or three or more). Agencies were randomly selected within each stratum. For agencies with three or fewer clinics, we sampled all clinics. For those with more, we sampled three clinics at random.

*"Other" agencies include community-based sites that do not receive federal community health center or maternal and child health center funds, Indian Health Centers, and other women's centers or primary care clinics.

We mailed an eight-page questionnaire to the family planning director of each agency in August 2003. The questionnaire asked for basic information about the agency and each clinic, the number of contraceptive clients they serve, contraceptive and STD services, other medical and social services, education and counseling, services for special populations (e.g., teenagers and non-English speakers), services for men, staffing and funding. Most survey items were closed-ended, but in some cases, respondents were asked to provide clarifying information through open-ended questions. A reminder postcard, an additional mailing of the survey and follow-up calls were used to maximize the response rate. If agencies provided incomplete or unclear information, we followed up through August 2004 by calling, e-mailing and faxing additional information requests.

Forty-five of the sampled agencies (representing 62 sampled clinics) were ineligible for the survey, mainly because they had closed, had merged with other agencies, no longer provided contraceptive services or were located in a U.S. territory rather than a state. Of the 1,813 eligible clinics, 1,088 completed the survey, for a response rate of 60%. The response rate was 83% among Planned Parenthood affiliates, 74% among health departments, 44% among community or migrant health centers, 45% among hospitals and 67% among other clinics; it was 77% among clinics that received Title X funding and 44% among those that did not. We applied sampling weights to the responding clinics to reflect both the total universe of clinics providing services in 2003 and the distribution of clinics by the agency's type, Title X funding and region. Our having sampled only three clinics from the largest agencies may have led to underrepresentation of clinics from large agencies, but weighting the data by clinic type likely addresses this problem.

Analysis

Data for some items are missing for some clinics because of nonresponse or concerns about data quality. The proportion of clinics missing data ranges from 1% to 6% for all measures examined here except the proportion of clients requiring language services (29% nonresponse). Clinics were included in the analysis of any measure for which data were available. We compared proportions of clinics offering services or adopting policies according to clinic type and Title X funding status, calculating standard errors and conducting tests of significance (at the p<.05 level) for pairs of proportions using the svy series of commands in Stata 8.2 to account for the stratified survey design. To best identify key variations among clinics, we condensed clinic type into three categories (health department, Planned Parenthood affiliate or other) and considered whether a specific clinic received any Title X funds.

RESULTS

Overview of Clinics

Our sample of 1,088 clinics represents the national universe of more than 7,500 U.S. publicly funded family planning clinics.[7] Among these clinics, 39% are administered by health department clinics, 12% by Planned Parenthood affiliates and 49% by other agency types. Sixty percent of all clinics receive Title X funding.

Nearly all clinics offer the most widely used reversible methods of contraception—oral contraceptives, injectables and condoms[8] (92–99%). In addition, a high proportion offer one of the newest methods on the market, the contraceptive patch (75%), and many offer the vaginal ring (40%). Clinics less commonly offer vasectomies (25%) and tubal sterilizations (30%). In addition, the vast majority of clinics (80%) distribute a dedicated emergency contraceptive product.

TABLE 3. Percentage of U.S. publicly funded family planning clinics, by selected characteristics of HIV testing services offered, according to type of clinic and Title X funding status

Characteristic	All (N=1,052)	Type			Title X funding	
		Health department (N=220)	Planned Parenthood (N=284)	Other (N=548)	Yes (N=651)	No (N=401)
Typical testing protocol						
Testing not offered; referral provided	6	4	6	8*	8	4***
Testing offered	94	96	94	92*	92	96***
On request	91	93	90	90	90	94***
On the basis of risk assessment	3	3	4	2	2	3
Type of test†						
Traditional blood stick	95	97	86*	95**	93	97***
Cheek swab	22	23	46*	16**	26	17***
Rapid-result blood test	3	2	6*	4	3	5

*Significantly different from percentage for health department clinics at p<.05. **Significantly different from percentage for Planned Parenthood clinics at p<.05. ***Significantly different from percentage for Title X–supported clinics at p<.05. †Based on clinics that provide HIV testing. Clinics could provide multiple responses.

Screening and Testing Services

Screening for cervical cancer during initial or annual family planning visits has long been the standard of care practiced by American health care providers. Increasingly, screening for one or more STDs is also part of annual family planning visits, for at least some groups of women. To examine the details of these practices, we asked clinics for specific information about the types of screening tests used, patients for whom screening is typically provided, treatment options available and protocols followed for HIV testing.

• *Cervical cancer screening.* Overall, 73% of clinics for which data were available typically conduct initial screenings for cervical cancer using a conventional Pap smear, and 27% typically use the more advanced liquid-based Pap test (Table 1). Smaller proportions of health department and Planned Parenthood clinics than of other clinic types use the liquid-based test for initial screening (13–17% vs. 42%). Similarly, a smaller proportion of clinics that receive Title X funding than of those that do not typically use the liquid-based Pap test for initial screening (17% vs. 44%). However, if a woman receives an abnormal or inconclusive reading on an initial screening for cervical cancer, only 32% of all clinics rely exclusively on conventional Pap smears for follow-up and retesting; 34% rely on a combination of conventional

TABLE 4. Percentage of U.S. publicly funded family planning clinics, by selected characteristics of services offered for teenagers, according to type of clinic and Title X funding status

Characteristic	All (N=1,062)	Type			Title X funding	
		Health department (N=224)	Planned Parenthood (N=290)	Other (N=553)	Yes (N=666)	No (N=400)
Abstinence counseling routine at initial visit						
Clients aged ≤17	91	95	85*	89*	94	87***
Clients aged 18–19	77	83	65*	75*,**	80	72***
Teenagers not yet sexually active	88	92	81*	87	91	84***
Counseling on talking with parents routine at initial visit						
Clients aged ≤17	89	94	94	83*,**	95	79***
Clients aged 18–19	65	69	49*	66**	68	60***
Teenagers not yet sexually active	79	85	75*	75*	83	72***
Educational programs						
Programs for teenagers on abstinence	45	63	38*	32*	56	29***
Programs for teenagers on talking with parents	42	58	44*	30*,**	51	30***
Programs for parents on talking with teenagers about sex	21	27	29	15*,**	26	13***
Programs for parents on talking with teenagers in general	16	15	28*	13**	17	13
Parental involvement for minors requesting contraceptives						
Not required	87	87	94*	86**	93	79***
Required for some minors	7	8	4	7**	6	9
Required for all/ most minors	6	5	2	7**	1	12***

*Significantly different from percentage for health department clinics at p<.05. **Significantly different from percentage for Planned Parenthood clinics at p<.05. ***Significantly different from percentage for Title X–supported clinics at p<.05.

Pap tests and other tests, and 34% exclusively on more advanced tests. Health department clinics are the most likely to rely exclusively on conventional Pap smears for follow-up (51% do so, compared with 18–21% of Planned Parenthood and other clinics).

Among the tests other than conventional Pap smears typically used to follow up abnormal cervical cancer test results, liquid-based Pap testing is the most common; 45% of clinics with data use this method. Reflex testing for human papillomavirus (HPV) DNA is used by 34%, and combined Pap plus DNA is used by 13%. One in three clinics provide services on-site for clients needing colposcopic evaluation. Although 83% of Planned Parenthood clinics use conventional Pap smears for initial cervical cancer screening, only 18% rely exclusively on this method for follow-up. Planned Parenthood and other clinics are less likely than health department clinics to offer only conventional Pap tests during follow-up, and are more likely to provide colposcopy on-site. Title X–supported clinics are more likely to use conventional Pap smears, less likely to use liquid-based testing for follow-up and less likely to perform colposcopies on-site than are those receiving no Title X funds.

• *Chlamydia screening and treatment.* Chlamydia is one of the most common STDs, affecting more than 900,000 Americans each year.[9] Virtually all family planning clinics screen at least some clients for chlamydia (Table 2, page 140). Forty-two percent of clinics with relevant information typically screen all female clients for chlamydia during the initial or annual visit, and 43% screen sexually active women aged 25 and younger (a population targeted by current federal screening guidelines[10]); the rest screen only women in perceived high-risk groups, such as those with multiple or new partners (14%), or do not provide chlamydia screening at all (2%). Planned Parenthood and Title X–funded clinics are less likely than others to screen all female clients for chlamydia and are more likely to direct their screening efforts at those who are sexually active and aged 25 and younger. Whereas all health department clinics provide some chlamydia screening, 5% of Planned Parenthood clinics and 2% of others do not provide this service at all.

The conventional treatment for chlamydia is a 3–10-day antibiotic regimen, but newer treatments that are given in a single dose are considered a higher standard of care. These are generally administered under direct observation, making them a particularly good option for clients at risk for not following through on an extended regimen. The majority of clinics (58%) with data usually or always provide single-dose treatments; 39% typically rely on traditional antibiotic regimens, and the rest administer both courses of treatment, depending on client characteristics. In addition, one-third of clinics give or prescribe antibiotics for women to take home to their partners. Health department and Title X–supported clinics are the least likely to provide antibiotics to male partners without a clinic visit.

• *HIV testing.* Among clinics for which HIV testing practices were reported, more than nine in 10 offer testing on-site; the rest refer clients elsewhere, either to other clinics within the same agency or to other providers (Table 3, page 141). A smaller proportion of clinics that receive Title X funding than of those that do not provide on-site testing. Virtually all clinics that offer HIV testing (91%) provide it to any client who requests it. Only 3% provide HIV testing solely on the basis of a risk assessment; in open-ended responses, the risk factors most commonly listed were multiple partners, current or past drug use, and direct exposure to HIV or another STD. Of the 85% of clinics with data on the timing of HIV testing, 84% offer this service at the same time and place as contraceptive services; the remainder provide the two types of services separately (not shown).

Among clinics providing HIV testing, 95% use a traditional blood stick. Newer, less invasive and rapid-result methods are much less common; 22% of clinics use cheek swabs, and only 3% use rapid-result blood tests. (Some clinics use more than one type of test.) These newer tests are most common among Planned Parenthood and Title X–supported clinics.

Data about funding sources were available for 75% of clinics that provide HIV testing; of these, 48% have a dedicated HIV funding source, such as Ryan White funds, Title

X grants earmarked for the expansion of HIV services and funding from the Centers for Disease Control and Prevention (CDC). Dedicated HIV funding sources are most common among health departments (63%) and significantly less so among Planned Parenthood affiliates and other clinics (36% of each). In addition, 51% of clinics with relevant data receive some HIV funding from other public sources, including Medicaid and state and local programs. A variety of factors limit clinics' ability to offer HIV testing: lack of funding (28% of all clinics), lack of counseling staff (19%) and other reasons (9%).

Services Targeting Specific Client Groups

• *Adolescent counseling and educational programs.* During an initial contraceptive visit, most clinics provide routinely counseling about abstinence to adolescent clients (Table 4), particularly those who are 17 and younger (91% of clinics for which information was provided) and those not yet sexually active (88%). About three-quarters routinely counsel 18–19-year-olds about abstinence. Additionally, most clinics routinely counsel adolescents about the importance of discussing issues related to sex with their parents; they most frequently do so for adolescents aged 17 and younger (89%). Health department clinics are the most likely to report routine counseling on abstinence. Although Planned Parenthood affiliates are as likely as health department clinics to routinely counsel younger teenagers about the importance of parental involvement (94% of each do so), they are the least likely to report routine counseling of older teenagers on either topic. For each group of adolescents, Title X–supported clinics are significantly more likely than others to routinely counsel adolescents on either topic.

In addition to one-on-one counseling, many clinics offer educational programs on these same topics, either on-site or off-site (e.g., at schools, youth centers). Some 45% have programs for adolescents that emphasize abstinence, and a similar proportion have programs that include discussion of how to talk to parents about issues related to sexual behavior. Programs for parents on how to talk to their teenagers are less common; one in five clinics offer such programs. Title X–supported clinics are significantly more likely than those not receiving Title X funds to offer teenagers and their parents these types of programs.

The vast majority of clinics with data (87%) do not require parental notification or consent for minors requesting prescription contraceptives. Seven percent require consent or notification for some minors (usually the youngest clients), and 6% require it for most or all minors. Planned Parenthood clinics and Title X–supported clinics are significantly more likely than others to provide care to adolescents without parental involvement; more than nine in 10 do so. (Clinics receiving Title X funding are required by law to maintain patient confidentiality; we would speculate that the 7% of Title X–funded clinics that require parental involvement for at least some minors do so when they see adolescents whose visits are not covered by their Title X funding.)

TABLE 5. Percentage of U.S. publicly funded family planning clinics, by selected characteristics of services offered for men, according to type of clinic and Title X funding status

Characteristic	All (N=1,072)	Type			Title X funding	
		Health department (N=225)	Planned Parenthood (N=288)	Other (N=561)	Yes (N=668)	No (N=404)
Non–reproductive health services† offered to male contraceptive/STD clients	36	40	24*	36**	36	35
Recruitment efforts targeting partners of female clients	35	37	47*	31**	38	31***
Male providers available	24	13	10	38*,**	16	37***
Reproductive health programs/services designed for men	22	30	34	13*,**	28	14***
Advertising/recruitment efforts targeting men	18	21	29	12*,**	23	9***
Special hours when men can receive services	4	2	4	5*	4	4

*Significantly different from percentage for health department clinics at p<.05. **Significantly different from percentage for Planned Parenthood clinics at p<.05. ***Significantly different from percentage for Title X–supported clinics at p<.05. †For example, sports physicals, general health care.

• *Services for males.* Clinics that serve men must tailor a different set of services and programs than have traditionally been available for females. Most clinics have at least some male STD (74%) or contraceptive (68%) clients, but males remain a small proportion of the overall caseload for most publicly funded family planning clinics. However, the situation has been changing over the past decade; for example, the proportion of Title X–funded clinic clients who are male increased from 2% in 1995 to 5% in 2004, and three-quarters of all agencies report a desire to serve more male clients.[11] Reflecting these trends, clinics direct a variety of specialized services and activities at men (Table 5). More than one-third (36%) of those with relevant data offer non–reproductive health services, such as sports physicals or general health care, for men, and a similar proportion make efforts to recruit partners of female clients (35%). One in four clinics employ male providers on-site, and one in five offer reproductive health services or have recruiting efforts targeted specifically toward men. However, only 4% of clinics offer special clinic hours for male clients.

Clinics take different approaches in targeting services to men. Planned Parenthood and Title X–supported clinics are the most likely to focus on efforts to recruit male clients; nearly half of Planned Parenthood clinics recruit female clients' partners. Clinics administered by "other" agencies and those receiving no Title X funding are the most likely to employ male providers (37–38%), probably because such clinics are the most likely to be community health centers or other sites providing primary care and serve males for a variety of health care needs. However, such sites are the least likely to have reproductive health programs or services specifically for their male clients (13–14%).

TABLE 6. Percentage of U.S. publicly funded family planning clinics, by language services offered, according to type of clinic and Title X funding status

Characteristic	All (N=778)	Type			Title X funding	
		Health department (N=172)	Planned Parenthood (N=175)	Other (N=431)	Yes (N=298)	No (N=480)
Client forms/materials in other languages	88	86	96*	87**	86	90
Translators available	81	81	66*	83**	78	84
Administrative staff speak other languages	59	46	55	70*,**	47	75***
Medical/clinical staff speak other languages	57	40	54*	73*,**	46	74***
Other†	24	35	23	16*	31	15***

*Significantly different from percentage for health department clinics at p<.05. **Significantly different from percentage for Planned Parenthood clinics at p<.05. ***Significantly different from percentage for Title X–supported clinics at p<.05. †For example, translation services via phone or video. *Note:* Percentages are based on clinics with non-English-speaking clients.

• *Services for non-English-speaking clients.* Ninety-five percent of clinics have non-English-speaking contraceptive clients. Meeting these clients' needs is especially challenging for clinics serving diverse populations who speak multiple languages. On average, individual clinic populations include speakers of four languages other than English.

Clinics use a range of approaches to better serve their non-English-speaking clients (Table 6). Most clinics with non-English-speaking contraceptive clients provide written materials in alternate languages (88% of those with responses on this item). The majority employ translators (81%), administrative staff who speak other languages (59%) or clinical staff who speak other languages (57%). Compared with health department and Planned Parenthood clinics, other clinic types are more likely to have multilingual staff; they also are more likely than Planned Parenthood clinics to use translators. Title X–funded clinics have a smaller share of non-English-speaking clients than clinics not supported by Title X, and are significantly less likely to have staff who speak other languages; they are more likely to rely on other language services, such as translation via phone or video. The greater availability of staff who speak other languages among clinics not receiving Title X funding and clinics administered by "other" agencies also likely reflects that many of these clinics are community health centers providing federally funded primary care services to low-income, often predominantly Hispanic populations.

DISCUSSION

This study provides the first national snapshot of what publicly funded family planning clinics are doing to serve their clients. However, more research is needed to ascertain how agencies structure and organize services across their clinics. The current data suggest that to some extent, agencies concentrate costly and technical procedures in selected clinics so as to focus their resources while ensuring that services are available. For example, although 5% of Planned Parenthood clinics do not offer chlamydia testing, in analyses not presented here, we found that all Planned Parenthood agencies offer testing; presumably, when one clinic does not offer this service, it can refer clients to other sites within the agency. Similarly, whereas the availability of surgical sterilization (both male and female) is somewhat lower among individual clinics than at family planning agencies, the proportion of clinics that offer each reversible contraceptive method is nearly identical to the proportion of agencies offering each.[12] These contrasts suggest that for the most part, once an agency decides to offer a reversible method, it does so at all clinics that it operates.

Publicly funded family planning clinics offer women a wide choice of contraceptive methods. Many successfully bring women new and highly effective methods, such as the patch and vaginal ring. Further monitoring is needed to see whether use of the patch (and of other new long-lasting and more expensive methods, such as the one- and three-month injectables) replaces pill use over time, as this would have significant cost implications for clinics (since pills are much less expensive).[13] Together, the broad choice of methods and the availability of long-lasting and highly effective methods should enable women to better select the method that they can use most successfully, thereby helping them to better control their fertility and to avoid unintended pregnancies.

Screening for cervical cancer is an essential reproductive health service provided by family planning clinics. Our findings indicate that clinics rely heavily on conventional Pap tests, even for follow-up testing. This stands in stark contrast to the private sector, where the liquid-based Pap test has rapidly become the standard of care[14] since its approval by the Food and Drug Administration (FDA) in 1996. The liquid-based test may have some marginal benefit in terms of increased sensitivity for detecting precancerous cervical lesions.[15] Yet its cost is triple that of conventional Pap tests, according to reports from family planning providers.[16] More recently, a DNA test that can identify the strains of HPV associated with cervical cancer received FDA approval as a primary screening tool for women older than 30, and as a secondary screen for younger women following a regular Pap test or a liquid-based test. Title X–supported clinics, which in 2004 provided a reported 2.8 million Pap tests,[17] appear to be the least able to afford and therefore offer these new technologies to their clientele.

Additionally, in 2002 and 2003, the American Cancer Society, the American College of Obstetricians and Gynecologists and the U.S. Preventive Services Task Force all updated their cervical cytology screening guidelines in response to new scientific evidence concerning cervical cancer screening and detection.[18] The guidelines address when to begin and discontinue screening, appropriate screening intervals and the new screening technologies. In particular, they emphasize that while women need to receive regular gynecologic care, some women may be able to increase the interval between screenings. This could achieve cost savings for family planning and other reproductive health

care providers by reducing the number of women who need both primary and follow-up testing, and minimizing the potential for overtreatment, given new understanding of the course of the disease. Some anecdotal evidence suggests that private physicians have been reluctant to abandon the notion of annual Pap tests for all patients and adopt the longer screening intervals.[19] Whether and to what extent publicly funded family planning providers, who may be more cost-conscious than their private-sector counterparts, are following the testing intervals and other protocols recommended in these guidelines is unknown and may be worth future study.

Each year, family planning clinics serve one in three women of reproductive age who obtain STD testing or treatment.[20] Because of the high prevalence rate in young women, and because chlamydia is usually asymptomatic in women but can lead to pelvic inflammatory disease and infertility if left untreated, the CDC and the U.S. Preventive Services Task Force recommend annual chlamydia screening of women in their teens and early 20s.[21] Our study shows that almost all clinics are meeting these recommendations, although the fact that 16% of clinics still do not follow this protocol is cause for concern.

Family planning providers have reported that the price of chlamydia tests increased by 50% between 1998 and 2001,[22] predating the federal government's calls for increased screening. These costs likely will remain a barrier to universal compliance with the federal guidelines. The federal Infertility Prevention Program (IPP), which was established in 1993 to foster collaborations between STD prevention programs and family planning providers to promote innovative approaches to STD-related infertility prevention, could reduce these cost concerns for clinics that are fortunate enough to receive IPP funds.[23] Not all clinics do so, however, and federal funding for the program has remained low, preventing it from serving all those in need.

The population that relies most heavily on family planning clinics closely matches the demographic profile of women most at risk for HIV: young, low-income and minority. It is auspicious, therefore, that HIV testing appears to be at least fairly well integrated into the provision of public family planning services. More than nine in 10 family planning clinics, regardless of agency type or receipt of Title X funding, offer at least some HIV testing on-site. Nonetheless, a substantial proportion of clinics are limited in their ability to offer HIV testing; reported limitations are likely to present major challenges to implementing recommendations proposed by the CDC in 2006 for routine voluntary HIV screening of all patients aged 13–64 in all health care settings.[24] The CDC has also recommended that providers adopt new models, relying on new technologies, to diagnose HIV infections outside traditional medical settings.[25] Our research indicates that in 2003, only a small minority of family planning clinics had adopted these technologies, although the tests were quite new to the market at that time. Future research should examine the uptake of new technologies and assess whether and to what extent they transform the delivery of HIV services in a family planning setting.

Our survey also sheds light upon the likely experience of adolescents seeking contraceptive services at publicly funded family planning clinics. The widespread practice of maintaining confidentiality is critical to teenagers' willingness to seek care, as suggested by research findings indicating that a significant proportion of sexually active teenagers would forgo services if their parents were notified when they made a clinic visit.[26] It also comports with recent position statements by the Society of Adolescent Medicine, the American Academy of Pediatrics, and other medical and public health organizations addressing the needs of youth.[27]

Moreover, these findings make clear that, particularly during an initial contraceptive visit, family planning providers almost universally place a premium on counseling young teenagers to delay sexual activity and encouraging young people to talk to their parents about important decisions regarding sexual behavior and contraceptive use. Differences between clinics that receive Title X funds and those that do not can be explained by the current program guidelines for Title X funding recipients: Services must remain confidential, yet family planning providers are required to discuss abstinence, along with contraception and safer-sex practices, with all adolescents and encourage family participation in minors' decision to seek family planning services.[28]

Historically, family planning providers served men only as the partners of female clients, most notably to prevent the transmission of STDs. During the 1990s, there were efforts to change this, and the majority of clinics now offer a broader range of services to men. However, the pace of change seems to have stalled, and since 1999,[29] there has been little improvement in the extent to which clinics have programs targeted to men or activities to recruit male clients. An expanding body of research documents that men, throughout their lives, have important sexual and reproductive health needs, creating a call to reproductive health providers and others to define the set of medical, educational and counseling services that men require and to determine how and in what settings these services should be delivered.[30] Our findings that clinics run by different types of agencies are adopting different strategies to serve and reach men, and that only a minority of clinics adopt each of the strategies we identified, suggests that this is an evolving area of practice for family planning providers. It also suggests that the development of "best practice" standards for meeting the sexual and reproductive health needs of men would aid the field and potentially improve the sexual and reproductive health of men and their partners.

Family planning clinics are undertaking significant efforts to meet the needs of their non-English-speaking clients. However, given the numerous languages spoken by clients, it is likely that some clients are not being optimally served. In a small-scale investigation of family planning agencies

To some extent, agencies concentrate costly and technical procedures in selected clinics so as to focus their resources.

conducted in 2002, the cost associated with meeting the need for language assistance and related services was identified as one of agencies' most pressing concerns.[31] The substantial challenges associated with adequately meeting the needs of non-English-speaking clients, and the cost pressures involved with doing so, are likely only to intensify for family planning providers as the U.S. population continues to diversify in the coming decades.

The data also show that as new technologies and new service demands alter the potential standard of care, Title X–supported clinics are increasingly challenged to keep up. Compared with clinics not receiving Title X funding, they are less likely to use liquid-based tests for cervical cancer screening at either initial testing or follow-up, less likely to offer chlamydia testing to all clients and less likely to offer HIV testing on-site—probably because of cost. These results are supported by data from a pilot study showing that between 2001 and 2004, Title X grantees' average expenditures on diagnostic tests more than doubled, while their Title X grant awards increased by only 10%.[32] Thus, although Title X–funded clinics are apparently spending considerably more on diagnostic services now than they did in the past, they are still unable to adopt the most advanced technologies for all clients screened or tested because public funding cannot keep pace with improved technology.

Title X–funded clinics are doing more than others to provide counseling and education programs to teenagers and their parents. And new and expanded funding mechanisms are being promoted to help them better meet the challenges of providing up-to-date and comprehensive services to their clients. For example, in 2004, the federal Office of Population Affairs announced that it would award supplemental grants designed to help Title X projects,[33] which already provide more than half a million HIV tests annually,[34] to initiate or expand on-site HIV counseling, testing and referral services.

Although benefiting from the new, clinic-level sample design, the data and analyses presented here face some important limitations. Because we employed a mail survey, we were constrained in the number and depth of questions that could be included. In addition, respondents had difficulty answering some questions, although our extensive phone follow-up helped to minimize missing data. Finally, our results are based on national averages and may not reflect the situation in particular local areas. Nevertheless, our study illustrates the range of services and policies common among family planning clinics today. In particular, it demonstrates that these services extend beyond contraceptive care as clinics respond to changing health and client demands.

REFERENCES

1. Frost JJ, Frohwirth L and Purcell A, The availability and use of publicly funded family planning clinics: U.S. trends, 1994–2001, *Perspectives on Sexual and Reproductive Health*, 2004, 36(5):206–215.

2. Frost JJ, Public or private providers? U.S. women's use of reproductive health services, *Family Planning Perspectives*, 2001, 33(1):4–12.

3. Lindberg LD et al., U.S. agencies providing publicly funded contraceptive services: 1995–2003, *Perspectives on Sexual and Reproductive Health*, 2006, 38(1):37–45; Finer LB, Darroch JE and Frost JJ, U.S. agencies providing publicly funded family planning services in 1999, *Perspectives on Sexual and Reproductive Health*, 2002, 34(1):15–24; and Frost JJ and Bolzan M, The provision of public-sector services by family planning agencies in 1995, *Family Planning Perspectives*, 1997, 29(1):6–14.

4. Gold RB, Nowhere but up: rising costs for Title X clinics, *Guttmacher Report on Public Policy*, 2002, 5(5):6–9; and Sonfield A et al., *Cost Pressures on Title X Family Planning Grantees, FY 2001–2004*, Guttmacher Institute, 2006, <www.guttmacher.org/pubs/2006/08/01/CPTX.pdf>, accessed Aug. 1, 2006.

5. Sonenstein FL, Punja SM and Scarcella CA, *Future Directions for Family Planning Research: A Framework for Title X Family Planning Service Delivery Improvement Research*, Washington, DC: The Urban Institute, 2004.

6. Frost JJ, Frohwirth L and Purcell A, 2004, op. cit. (see reference 1).

7. Ibid.

8. Chandra A et al., Fertility, family planning, and reproductive health of U.S. women: data from the 2002 National Survey of Family Growth, National Center for Health Statistics, *Vital and Health Statistics*, 2005, Series 23, No. 25, Table 62.

9. Centers for Disease Control and Prevention (CDC), *Sexually Transmitted Disease Surveillance, 2003,* Atlanta: CDC, 2004, Table 10.

10. CDC, New CDC treatment guidelines critical to preventing health consequences of sexually transmitted diseases: rescreening for chlamydia helps protect young women from infertility, news release, May 9, 2002, <http://www.cdc.gov/od/oc/media/pressrel/fs020509.htm>, accessed Sept. 6, 2005.

11. The Alan Guttmacher Institute (AGI), Family planning annual report: 2004 summary, 2005, <www.agi-usa.org/pubs/FPAR2004.pdf>, accessed Sept. 6, 2005.

12. Lindberg LD et al., 2006, op. cit. (see reference 3)

13. Siegel M and Speth S, California Family Health Council, Los Angeles, personal communication, Sept. 7, 2005.

14. Stoler MH, Cervical cancer screening in the HPV era: what is the standard of care? paper prepared for the annual meeting of the American Society for Clinical Pathology, Seattle, Oct. 8–11, 2005, <http:www.medscape.com/viewarticle/518860>, accessed June 8, 2006.

15. American College of Obstetricians and Gynecologists (ACOG), Cervical cytology screening, *ACOG Practice Bulletin,* 2003, No. 45, pp. 417–427.

16. Gold RB, 2002, op. cit. (see reference 4).

17. Frost JJ, Frohwirth L and Purcell A, 2004, op. cit. (see reference 1).

18. Saslow D et al., American Cancer Society guideline for the early detection of cervical neoplasia and cancer, *CA: A Cancer Journal for Clinicians*, 2002, 52(6):342–362; ACOG, 2003, op. cit. (see reference 15); and U.S. Preventive Services Task Force, Screening for cervical cancer: recommendations and rationale, Rockville, MD: Agency for Healthcare Research and Quality, 2003, <www.ahcpr.gov/clinic/uspstf/uspscerv.htm>, accessed Aug. 13, 2003.

19. Villarosa L, Pap-wars: whose calendar to believe? *New York Times*, June 6, 2004, p. 6.

20. Frost JJ, 2001, op. cit. (see reference 2).

21. U.S. Preventive Services Task Force, Screening for chlamydial infection: recommendations and rationale, *American Journal of Preventive Medicine*, 2001, 20(3S):90–94; and CDC, 2002, op. cit. (see reference 10).

22. Gold RB, 2002, op. cit. (see reference 4).

23. CDC, Preventing infertility in women, *Program in Brief,* 2005, <www.cdc.gov/programs/infect12.htm>, accessed Apr. 18, 2006.

24. CDC, Revised recommendations for HIV testing of adults, adolescents and pregnant women in health care settings, 2006, <http://www.hwadvocacy. com/update/newCDCrecommendations.pdf>, accessed July 7, 2006.

25. CDC, Advancing HIV prevention: new strategies for a changing epidemic—United States, 2003, *Morbidity and Mortality Weekly Report*, 2003,

52(15):329–332.

26. Jones RK et al., Adolescents' reports of parental knowledge of adolescents' use of sexual health services and their reactions to mandated parental notification for prescription contraception, *Journal of the American Medical Association*, 2005, 293(3):340–348.

27. Ford C, English A and Sigman G, Confidential health care for adolescents: position paper of the Society for Adolescent Medicine, *Journal of Adolescent Health*, 2004, 35(2):160–167; American Medical Association, *Confidential Care for Minors,* 2002, <www.ama-assn.org/ama/pub/category/8355.html>, accessed July 12, 2004; ACOG, *Health Care for Adolescents*, Washington, DC: ACOG, 2003; and Jenkins R, testimony on behalf of the American Academy of Pediatrics before the U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, July 11, 2002.

28. U.S. Department of Health and Human Services, *Program Guidelines for Project Grants for Family Planning Services,* Washington, DC: U.S. Government Printing Office, 2001.

29. Finer LB, Darroch JE and Frost JJ, 2002, op. cit. (see reference 3).

30. AGI, *In Their Own Right: Addressing the Sexual and Reproductive Health Needs of American Men*, New York: AGI, 2002; and Lindberg LD and Sonenstein FL, Why males, why now: the rationale for addressing the reproductive health of young men, in: Sonenstein FL, ed., *Young Men's Sexual and Reproductive Health: Toward a National Agenda*, Washington, DC: The Urban Institute, 2000, pp. 51–84.

31. Gold RB, 2002, op. cit. (see reference 4).

32. Sonfield A et al., 2006, op. cit. (see reference 4).

33. U.S. Department of Health and Human Services, Announcement of availability of supplemental grant awards for integration of HIV/AIDS prevention services in Title X family planning projects in areas with demonstrated high risk for HIV/AIDS, Rockville, MD: Office of Population Affairs, 2004.

34. AGI, 2005, op. cit. (see reference 11).

Acknowledgments

The authors thank Lori Frohwirth, Alison Purcell, Claire Evans and Michelle Bolton for fielding the survey and providing research assistance; Larry Finer for providing technical assistance; and Susheela Singh for reviewing several drafts of the article. The research on which this article is based was supported by grant FPR000072 from the Office of Population Affairs, U.S. Department of Health and Human Services. The conclusions and opinions expressed here are those of the authors and not necessarily those of the funder.

Author contact: *LLindberg@guttmacher.org*