Services for Men at Publicly Funded Family Planning Agencies, 1998–1999

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CONTEXT: *Men's reproductive health needs are receiving increased attention, but most family planning clinic clients are female, and clinics have reported barriers to serving men.*

METHODS: *A 1999 survey of publicly funded agencies that administer family planning clinics asked several questions about current policies and services and the number of men served in 1998. Data on 17 services were collected, as well as the proportion of clients who were male and agencies' barriers to serving men.*

RESULTS: *The services most commonly offered to men in 1999 were condom provision and sexually transmitted disease (STD) counseling (95% of all agencies), contraceptive counseling (93%), and STD treatment (90%) and testing (89%). The proportions offering various male reproductive health services were lowest among hospital-based clinics. Eighty-seven percent of agencies served some male contraceptive or STD clients in 1998; those that did served a mean of 255 men and a median of 50. The male client caseload increased between 1995 and 1998 at 53% of agencies, and four out of five agencies were interested in serving more men in the future. The most commonly reported barriers to serving men were men's unawareness that services were available (58%) and inadequate agency funding (55%).*

CONCLUSIONS: *Although most clients of publicly funded family planning agencies are women, a nonnegligible number are men. Additional efforts are needed to determine the best way to deliver reproductive health services to men.*

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The sexual and reproductive health of men in their own right is a topic that has garnered increased attention in recent years, as has the subject of how men can contribute to women's reproductive health.[1] Several efforts have been made to define the services that men need and how best to provide them.[2] Although men's clinical care needs are not as broad as women's, men clearly need access to many of the same services, such as testing and treatment for sexually transmitted diseases (STDs) and reproductive tract disorders. Indeed, some researchers have suggested that increases in STD rates in the United States have motivated family planning clinics to expand their services to include men.[3] Moreover, it can be argued that societal responsibility for contraception falls too heavily on women and that men should play a greater role in using methods, participating in contraceptive decisions and supporting women's use.

Public family planning clinics are an important component of reproductive health care in the United States. About one-quarter of women aged 15–44 who obtain a medical contraceptive method do so from publicly funded clinics, and the proportion is higher among disadvantaged women.[4] Clinics receive public support from a variety of federal and state programs, including Medicaid (a federal-state collaborative program), Title X of the Public Health Service Act (the one federal program providing categorical funding for family planning services), and the maternal and child health and social services block grants from the federal government to the states.[5]

A 1987 pilot study of 35 family planning agencies found that although most agencies were interested in improving services for men, limited resources meant that men's services were offered only nominally.[6] A 1995 survey of 600 public agencies indicated that only 39% of agencies routinely served men.[7] Both studies found that the primary barriers to serving men were a lack of funding and the general perception that clinics are for women only. The Title X program has recently made males a priority population, however,[8] and although men represent a small proportion of all family planning clinic clients (4% at Title X–funded clinics in 2002[9]), their number and proportion have increased over time.

To better understand the provision of male reproductive health services within the network of publicly funded family planning clinics and to update information on their availability, The Alan Guttmacher Institute included a series of questions on male services in its 1999 survey of agencies that administer those clinics.

METHODS

A detailed description of the survey methodology can be found elsewhere.[10] Briefly, in 1999, we surveyed by mail a nationally representative sample of 1,016 of the approximately 3,100 U.S. publicly funded family planning agencies; 637 of 967 eligible agencies (66%) responded. (Among the ineligible agencies were those that had closed, had merged with another agency or were no longer providing contraceptive services.) The survey included questions on

TABLE 1. Percentage of family planning agencies offering various services to male clients and mean factor score, by service type, according to agency type and receipt of Title X funding, 1999

Type of service	All agencies (N=3,117)	Type of agency†					Title X funding‡	
		Community/ migrant health center (N=553)	Health department (N=1,429)	Hospital (N=468)	Planned Parenthood affiliate (N=137)	Other (N=530)	Yes (N=1,894)	No (N=1,223)
Reproductive health								
STD counseling	95	99	98	82**	100*	91*	96	93
Condom provision	95	95	99	80**	100	91	97	90**
Contraceptive counseling	93	96	95	81*	98	92	94	92
STD treatment	90	97*	91	75*	93	85	90	89
STD testing	89	98***	92	74**	88	80*	90	88
Mean factor score	*0.00*	*0.10*	*0.19*	*–0.83****	*0.27*	*–0.21**	*0.10*	*–0.18**
General health/preventive care								
Testicular cancer screening	60	87***	47	67*	64**	59	52	72***
Sports/work physicals	52	99***	29	66***	31	57***	38	74***
Case management	48	80***	41	57*	13***	43	42	59**
Primary care	46	99***	21	68***	14	49***	31	71***
Prostate cancer screening	46	89***	29	57***	31	40	34	65***
Smoking cessation programs	42	65***	35	53*	22*	35	35	53***
Mental health services	28	60***	10	47***	5	35***	16	48***
Mean factor score	*0.00*	*1.14****	*–0.42*	*0.31****	*–0.48*	*0.10****	*–0.27*	*0.49****
Specialized care								
Infertility counseling	28	38	25	35	29	24	28	29
Vasectomy	24	25	22	36	39**	17	24	24
Genetic counseling	13	7*	14	29**	1***	10**	14	12
Infertility treatment	7	10	3	24**	7	3	5	10
Phalloscopy	6	12*	2	14	1	8	5	10
Mean factor score	*0.00*	*–0.10*	*–0.04*	*0.54**	*–0.08*	*–0.10*	*–0.01*	*0.01*

*p<.05. **p<.01. ***p<.001. †Significance levels refer to difference between the specified value and the value for health departments. ‡Refers to Title X funding of contraceptive services at one or more of an agency's clinics. *Note:* Data are weighted.

contraceptive and STD services for women, educational and counseling programs, and agency management. In addition, two of the 16 questionnaire pages were devoted to questions on men. Surveys were addressed to the family planning director of each agency. In most cases, personnel who were likely to be familiar with clinical service provision—directors, agency or clinic managers, or nurse practitioners—completed the survey.

We asked agencies whether they currently offered any of 17 health services to men. These ranged from reproductive health services, such as condom provision and STD counseling, to general health services, such as case management and primary care. Factor analysis techniques were used to determine whether these services grouped together in any way and, if so, whether the groupings could be easily described. Using the loadings from the factor analysis, we calculated score variables (or indices) for each factor; these range from −1.0 to 1.0 and indicate the "strength" of an agency's service provision in that grouping (so a higher score means a greater level of service provision).

We also requested data on how many men had received contraceptive or STD services or both in 1998, and whether that number had changed since 1995. To obtain a measure of men's share of family planning agencies' caseload in 1998, we calculated the number of men as a proportion of all clients served.* We also inquired about the proportion of male clients who were partners of female clients.

Additionally, we asked whether agencies were currently interested in serving more men in the future and offered any programs on contraception, STD prevention, or sexual and reproductive responsibility that were specifically targeted to men. Finally, we asked a closed-ended question about potential barriers that agencies faced in their attempts to serve men. These possible barriers, based partly on findings in the literature,[11] included inadequate funding, a shortage of male providers, difficulty finding or recruiting male clients, men's unawareness of services, facilities' lack of male orientation and hours that were inconvenient for men.

We tabulated the number or proportion of providers offering each service or giving each response by two key variables: agency type (community or migrant health center, health department, hospital, Planned Parenthood affiliate or other) and the agency's receipt of any Title X funds.† We developed multivariate regression models to more precisely

*For men, we inquired about the number of contraceptive or STD clients (because many men receive only STD services at family planning agencies), whereas for women, we requested the number of contraceptive clients, without making reference to STD services. We then divided the number of male contraceptive and STD clients by the total number of clients (male contraceptive and STD clients plus female contraceptive clients). Although the numerator and denominator are not strictly analogous, we refer to the result as the proportion of clients who were male. To test the reasonableness of this measure, we repeated most analyses with only male contraceptive clients in the numerator (and only male contraceptive clients plus female contraceptive clients in the denominator), and the findings were similar to the ones reported.

†Overall, 46% of the agencies we surveyed were health departments, 18% community or migrant health centers, 15% hospitals, 4% Planned Parenthood affiliates and 17% "other." (These "other" agencies are predominantly independent health clinics, Indian health centers and community health centers not listed as community or migrant health centers.) Sixty percent of the agencies received some Title X funding. (Source: reference 10.)

TABLE 2. Selected measures of reproductive health services provided to men, according to agency type and receipt of Title X funding, 1998

Measure	All agencies	Type of agency†					Title X funding‡	
		Community/ migrant health center	Health department	Hospital	Planned Parenthood affiliate	Other	Yes	No
%, MEAN OR MEDIAN								
% serving any men	87	95	94	49***	98	91	91	79***
No. of male contraceptive or STD clients served§								
Mean	255	222	293	122*	625**	137	265	235
Median	50	47	45	50	248	55	50	50
% of contraceptive or STD clients who are male§,††								
Mean	14	20	14	12	4***	12	12	18**
Median	6	13	7	3	3	4	5	10
% of male contraceptive or STD clients who are partners of female clients§								
Mean	53	57	46	65*	57*	60*	52	56
Median	50	60	40	75	50	75	50	60
% DISTRIBUTION								
By type of services males received								
Contraceptive only	22	16	23	22	12***	27	23	22
STD only	45	54	44	38	57*	39	44	45
Both	33	30	32	40	31	34	33	33
By proportion of male contraceptive or STD clients who are partners of female clients								
0%	8	7	7	19**	0*	6	6	11
1–49%	36	26	46	22**	31*	30	40	29
50–99%	41	48	36	31**	59*	47	41	41
100%	15	19	11	28**	9*	17	14	19
By change in no. of male contraceptive or STD clients served since 1995								
Increased	53	58	49	46	73***	55	54	50
Stayed the same	41	39	43	47	25***	38	39	45
Decreased	6	4	7	7	2***	7	7	6
Total	100	100	100	100	100	100	100	100

*p<.05. **p<.01. ***p<.001. †Significance levels refer to difference between the specified value and the value for health departments. ‡Refers to Title X funding of contraceptive services at one or more of an agency's clinics. §Among agencies that serve any men. ††Females who are STD clients only are omitted from the denominator. *Note:* Significance tests were not performed for medians.

examine which variables were associated with two key outcomes—the types of male services provided and the proportion of clients who were male. The analyses were weighted to account for the stratified sampling strategy as well as nonresponse, and significance tests took into account the stratified nature of the sample. All analyses were performed using Stata statistical software.

RESULTS

Bivariate Analyses

• *Services offered.* The factor analysis of services offered to men suggests that the 17 services group into three factors—reproductive health, general health and preventive care, and specialized care (Table 1, page 203). Notably, even though we determined the factor groupings separately from the tabulations of services offered, the groupings correspond neatly with the proportions of providers offering each service. The five most common services offered to men in 1999 were grouped in the reproductive health factor: condom provision (95% of agencies); contraceptive counseling (93%); and STD counseling, treatment and testing (95%, 90% and 89%, respectively). Hospitals were significantly less likely* than other types of agencies to offer these services. The factor score of −0.83 for hospitals also reflects their lower probability of offering reproductive services.

Overall, 28–60% of family planning agencies offered general health and preventive services, including primary care, cancer screening, case management and mental health care. Community or migrant health centers and hospitals were more likely than all other types of agencies to offer these services. For example, 99% and 68%, respectively, offered primary care, compared with 14–49% of all other types of agencies. Planned Parenthood affiliates and health departments were the least likely to offer general health and preventive services. In addition, agencies that received title Title X funding were less likely than those that did not to offer these services.

Specialized services—infertility counseling and treatment, vasectomy, genetic counseling and phalloscopy—were the

*Subgroup comparisons reported in the text but not shown in the tables are significant at p<.05.

TABLE 3. Percentage of agencies, by selected measures reflecting interest in future male caseload, and strategies for and barriers to serving men, all according to agency type and receipt of Title X funding, 1999

Measure	All agencies	Type of agency†					Title X funding‡	
		Community/ migrant health center	Health department	Hospital	Planned Parenthood affiliate	Other	Yes	No
Interest in serving men in the future								
More men than now	82	90	82	63*	95	81	83	80
Same number of men as now	18	10	17	37*	5	19	17	19
Fewer men than now	<1	0	1	0*	0	0	<1	<1
Total	100	100	100	100	100	100	100	100
Strategies for reaching men								
Programs targeted to men	18	18	12	12	49***	28**	22	12**
Activities to recruit men	21	27*	15	10	48***	29**	24	15*
Barriers								
Men unaware of services	58	54	59	43	89***	60	62	51*
Inadequate funding	55	56	51	47	68**	68**	56	53
Difficulty finding/recruiting male clients	49	37**	54	42	58	49	53	41*
Shortage of male providers	39	9***	56	25***	48	30***	49	22***
Facility not male-oriented	30	5***	40	32	46	26*	37	18***
Inconvenient hours for men	17	12**	27	8***	9***	3***	20	11**
Other	4	2	5	8	4	4	5	3

*p<.05. **p<.01. ***p<.001. †Significance levels refer to difference between the specified value and the value for health departments. ‡Refers to Title X funding of contraceptive services at one or more of an agency's clinics.

services provided to men least often by family planning agencies. Of these, infertility counseling and vasectomy were the services most commonly offered (by just 28% and 24% of agencies, respectively). On average, hospitals offered just 1.3 specialized services (not shown), yet this total was significantly larger than that for every other agency type except community or migrant health centers. To the extent that these services require special equipment, techniques or training, they may be relatively difficult to offer. However, most agencies are able to refer clients to other providers for such services.

• *Men served.* Most agencies (87%) served male contraceptive or STD clients in 1998 (Table 2); among these, the mean was 255 clients and the median was 50. One-quarter of all agencies served 150 or more men (not shown). Planned Parenthood affiliates served significantly larger numbers of men than other types of agencies, primarily because they served a larger number of clients overall. Although no male contraceptive or STD clients were served in 1998 at 13% of all agencies, this was the case at one half of hospital-based family planning agencies—mostly obstetrics and gynecology clinics or women's health clinics.

Among the agencies that had any male contraceptive or STD clients, an average of 14% of family planning clients were male. (At 14% of agencies, fewer than 1% of clients were male; on the other hand, at 34% of agencies, 10% or more were male—not shown.) Despite Planned Parenthood affiliates' large numbers of male clients, a small proportion of their overall clients were male (4%); 20% of clients served at community or migrant health centers and 12–14% served at the remaining agency types were male (a nonsignificant difference). Agencies that received any Title X funding reported a smaller proportion of male clients than those that did not get Title X monies (12% vs. 18%).

Because we wanted to examine the common perception that men come to family planning clinics primarily to obtain STD services, we asked the agencies to report which reproductive health services men received. Twenty-two percent of male clients received contraceptive services only, 45% received STD services only and 33% received both. In other words, while the large majority of men received STD services (78%), more than half received contraceptive services (55%).

At agencies that served any men, an average of 53% of male clients were partners of female clients; this figure was lower at health departments (46%) than at several other types of agencies (57–65%). Every Planned Parenthood affiliate reported at least some male family planning clients who came in with a partner. Agencies where 100% of men were the partners of female clients were less likely than agencies that served men who came in independently to offer STD counseling, testing and treatment (not shown). This finding probably reflects that STD services draw in men on their own.

More than half (53%) of agencies reported that their overall number of male clients had increased since 1995, while 6% indicated that the number had decreased. Planned Parenthood affiliates were more likely than every other type of agency except community or migrant health centers to indicate that their male caseload had increased (73% vs. 46–55%).

• *Goals and obstacles.* Eighty-two percent of agencies reported being interested in serving more men in the future* (Table 3). A significantly higher proportion of Planned Parenthood affiliates than of hospital agencies were interest-

*The question read: "In the future, is your agency interested in providing contraceptive or STD services to more, the same number, or fewer men?"

ed in doing so (95% vs. 63%). In addition, an agency's interest in serving a greater number of men in the future was related to whether it already served men. Fifty-four percent of agencies currently not serving men were interested in doing so in the future, whereas 85% of agencies already serving men wanted to serve more (not shown).

Overall, 18% of agencies offered programs that targeted men specifically,* and 21% had activities to recruit more men.† In general, these proportions were significantly higher at Planned Parenthood affiliates (48–49%) than at other types of agencies (10–29%). In addition, agencies receiving Title X funding were more likely than non–Title X funded agencies to target or recruit men.

Agencies reported that they faced a number of barriers to providing contraceptive and STD services to men. The most common one, reported by 58% of agencies, was their perception that men were unaware of the availability of such services; 55% cited inadequate funding and 49% reported difficulty finding or recruiting male clients. Planned Parenthood affiliates and health departments reported the largest number of barriers overall (not shown). Planned Parenthood affiliates were the most likely to report men's unawareness of the availability of services, while health departments were the most likely to report shortages of male providers; community or migrant health centers were the least likely to report the latter. Title X providers were much more likely than providers that received no Title X funds to mention a shortage of male staff members and the belief that their facilities were not male-oriented.

Agencies' barriers to providing male services appear to be directly related to the types of services they offer. In general, reproductive health–oriented agencies (e.g., Planned Parenthood affiliates and health departments) were more likely than other types of agencies to report barriers to serving men and to indicate interest in serving more men in the future (not shown). Facilities with a general health orientation (e.g., hospitals) had fewer such barriers and less interest in increasing their number of male clients.

Reporting any barrier to male services (except inconvenient hours) was associated with having a smaller proportion of clients who were male. In addition, agencies that reported having hours that were inconvenient for men and non–male-oriented facilities were less likely than others to report having initiated activities to recruit men, and they were more likely to offer male services but have no male clients.

Multivariate Analyses

• *Services offered.* We used multivariate analysis to examine which agency characteristics best predicted the types of male services offered (data not shown). The dependent variables were the scores for the three types of services defined by the factor analysis. The independent variables were agency type, receipt of Title X funding, the proportion of reproductive health clients who were male, whether the agency aimed to serve more men in the future and whether the agency was making any efforts to recruit men.

Title X funding status did not achieve significance in any of the regression models. However, agency type was a significant predictor of the reproductive health factor score: Planned Parenthood affiliates and health departments scored significantly higher than hospitals and other agencies on this factor. In addition, agencies that indicated a desire to serve more men in the future scored significantly higher in this area than agencies that did not intend to serve more men. The proportion of clients who were male and efforts to recruit male clients had no significant independent association with the reproductive health factor score.

For the general health and preventive care factor, community or migrant health centers and hospitals scored significantly higher than health departments and Planned Parenthood affiliates. In addition, the proportion of clients who were male was independently and positively associated with the general health factor score; however, receipt of Title X funds, intending to serve more men in the future and undertaking recruitment efforts were not significantly associated with provision of male services in the general health category.

Finally, agencies that undertook activities to recruit men scored higher on the specialized care factor than those that did not report these activities. No other agency characteristic was significantly associated with the specialized care factor.

• *Men served.* We performed multivariate analyses to determine which variables were associated with the proportion of an agency's contraceptive or STD clients who were male. The independent variables in these regressions were agency type, receipt of Title X funding, the factor scores for the three service groupings and an agency's total number of barriers to providing male services. Once these controls for agency characteristics were introduced, health departments had a significantly larger proportion of male clients than Planned Parenthood affiliates, hospitals and other agencies (a finding that differed slightly from the results in Table 2). However, Title X agencies had a significantly smaller proportion of male clients, even in the multivariate context. Further, scoring higher on the general health and preventive care factor was independently and positively associated with the proportion of male clients, but the association with reproductive health and specialized care services was not significant. In addition, the more barriers to male service provision an agency faced, the lower the proportion of clients who were male.

DISCUSSION

Sexual and reproductive health services for men have increasingly been integrated into a family planning service system that initially developed with a sole focus on women. By the late 1990s, 87% of agencies providing publicly fund-

*The question read: "Does your agency offer any programs related to contraception, STD prevention or sexual/reproductive responsibility that are targeted specifically at men?"

†The question read: "Does your agency have any activities to encourage or recruit more men to become clients?"

ed family planning services in the United States served at least some male contraceptive or STD clients.* Further, in 1999, one in five agencies had programs or activities directed specifically toward attracting or serving men.

Male services are not yet universal, however. Not all agencies serve men, and at some, the only men who come in for services are the partners of female clients. In addition, the numbers of male clients are very small, and several barriers to serving men—funding constraints, men's unawareness of services and perceptions that clinics are the domain of women—still exist. These themes are not new; indeed, they are similar to those reported by other researchers.[12]

The findings from the current survey suggest broader questions about men and sexual and reproductive health care: How can men best be served within the existing family planning clinic system? What, if any, larger implications does an expanded focus on men have for services for women? What is the best balance between efforts that focus on integrating men into the general family planning system and efforts to better integrate sexual and reproductive health care into existing male medical and social services?

Answers to these questions may depend in part on what services are seen as relevant to men—and women—now and in the future. Men's sexual and reproductive health services include clinical care as well as information and educational services, but providers still do not agree on what the best mix of these should be. Family planning clinics traditionally have provided women with information, education and counseling regarding contraception and related aspects of their reproductive health, but these services have been organized around a medical model of care. In fact, such services have usually been ancillary to women's primary goal of obtaining a clinical contraceptive method.

Currently, reversible methods of contraception used by men do not require a medical visit, and attracting men to clinics continues to be a challenge. STD services appear to fill some of the same role for men as prescription methods do for women—i.e., serving as an entry to a provider, where men then have the opportunity to receive other important sexual and reproductive health screening, care and information. Research is needed to determine which approaches to delivering family planning services are logistically and financially most effective for specific subgroups of men. Family planning and community programs that provide sexual and reproductive health services to men can be useful testing grounds for innovative and effective service models.

The attention to broader aspects of sexual and reproductive health occasioned by integrating men into existing family planning services may ultimately improve services for all by raising issues relevant to women that have not been fully addressed. Even now, for example, many women who do not need ongoing clinical contraceptive services, such as women using long-acting methods or relying on their partner's method use, still need basic sexual and reproductive health information and services, and information and care regarding STDs. Learning new ways to provide these services, and to convey their importance and availability to both men and women, can be an important side benefit of reaching out to men. The lessons learned will also be useful if and when prescription contraceptive methods for men become available, and when providers with expertise in serving men are needed.

At the same time, of course, men can also reap benefits from having reproductive health information and care more fully integrated into their general care. This integration may include not just medical services but social and community services. Over time, men's and women's sexual and reproductive health care may come to be seen not as competing for resources, but as complementary components of an increasingly integrated service system.

*This proportion far exceeds the 39% found in 1995 (source: reference 7). However, the earlier survey asked only whether agencies routinely served men, so the data are not directly comparable.

REFERENCES

1. The Alan Guttmacher Institute (AGI), *In Their Own Right: Addressing the Sexual and Reproductive Health Needs of American Men,* New York: AGI, 2002.

2. Ibid.; and Sonenstein FL, *Young Men's Sexual and Reproductive Health: Toward a National Strategy–Framework and Recommendations,* Washington, DC: Urban Institute, 2000.

3. Schulte MM and Sonenstein FL, Men at family planning clinics: the new patients? *Family Planning Perspectives,* 1995, 27(5):212–216 & 225.

4. AGI, *Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics,* New York: AGI, 1999.

5. Gold RB and Sonfield A, Reproductive health services for adolescents under the State Children's Health Insurance Program, *Family Planning Perspectives,* 2001, 33(2):81–87.

6. Swanson JM and Forrest K, Men's reproductive health services in family planning settings: a pilot survey, *American Journal of Public Health,* 1987, 77(11):1462–1463.

7. 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.

8. Office of Population Affairs, *Male Involvement Projects: Prevention Services,* Washington, DC: U.S. Government Printing Office, 2000.

9. AGI, Family planning annual report, 2002, New York: AGI, 2003.

10. Finer LB, Darroch JE and Frost JJ, U.S. agencies providing publicly funded contraceptive services in 1999, *Perspectives on Sexual and Reproductive Health,* 2002, 34(1):15–24.

11. Sonenstein FL, 2000, op. cit. (see reference 2).

12. Schulte MM and Sonenstein FL, 1995, op. cit. (see reference 3).

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