INTRODUCTION

The Male Family Planning Research Project, 2009 – 2014, represented the third round of research on this topic funded through the U.S. Department of Health and Human Services (DHHS) Office of Family Planning (OFP) as part of the national Title X Family Planning Program. This third and final wave built on the lessons learned in the first two, and assessed the effectiveness of a comprehensive service delivery model aimed at increasing the number of males who access family planning (FP) and related reproductive health (RH) services in clinical settings. OFP funded five FP agencies across the United States and one research coordinating center to implement and assess this service innovation.

The service delivery model is comprised of three components: 1) restructuring the clinic environment, 2) provision of staff training and technical assistance, and 3) targeted community outreach and promotion of clinic services.
PARTNERS

Cardea, as Coordinating Center, provided training and technical assistance to study sites, and designed and conducted the research in conjunction with OFP. Research study sites were responsible for implementing the comprehensive service delivery model components and collecting and submitting all data in accordance with study protocols.

STUDY SITES

- Bexar County Hospital District, University Health System – San Antonio, TX
- Family Health Centers of San Diego, Inc. – San Diego, CA
- Family Planning Council, Inc. – Philadelphia, PA
- Planned Parenthood of Montana – Billings, MT
- Montachusett Opportunity Council, Inc. – Fitchburg, MA

Our Model Clinic was Women’s and Men’s Health Services of the Coastal Bend (formerly Planned Parenthood of South Texas), who participated in OPA’s second round of research, and developed and refined the model. Mandy Stukenberg, CEO, and Efrain Franco, Male Clinic Director, provided invaluable expertise from their “on-the-ground” perspective. Cardea and Women’s and Men’s Health Services of the Coastal Bend (WMHS) shared a long history and knowledge of Title X, including familiarity with Title X guidelines, understanding of Title X clinics’ strengths and weaknesses which could become assets and challenges for serving males. WMHS brought a peer perspective to the project, and generously shared their experiences in planning and implementing the project, as well as tools and other resources they developed, such as focus group protocols, clinic assessment instruments, and marketing and client education materials. WMHS’ documented success in growing its unduplicated male client population from under 200 annually in 2002 to over 1,400 in 2008 provided them essential credibility with the new study sites.
ASSessment

During the first year of the project, Cardea worked with study sites to assess their readiness to implement male services. The tools and activities used during this phase were subsequently compiled into *Getting Ready for Male Reproductive Health Services: An Assessment and Implementation Toolkit*.

The toolkit includes:

- essential elements for male-friendly services,
- why and how to create an assessment team,
- resources for collecting and analyzing data, and
- a variety of pilot tested tools, easy-to-use discussion guides, and worksheets to help prioritize recommended innovations in environment, staff training and community partnerships.

Finally, a range of ideas, resources and recommendations are offered regarding prioritizing and staging program improvements, sustaining program changes, and working with staff and male clients. The toolkit is available for free download at

[www.cardeaservices.org/ourwork/projects/family-planning-male-research](http://www.cardeaservices.org/ourwork/projects/family-planning-male-research)

The toolkit provides a variety of organizational development tools and processes for administrators, clinical providers, community-based organizations and health clinics.
IMPLEMENTATION

Innovations spanned the three key areas of our service delivery model: modifying the clinic environment, staff training, and targeted outreach and in-reach. Study sites were asked to pursue innovations across all three areas, but were encouraged to develop and tailor interventions to their individual organizations and client-base. Examples of interventions in each of these areas are described below.

Environment

Environmental program innovations/enhancements ranged from clinic efficiency and other systems modifications to concrete physical changes to the clinic setting. Examples of systems modifications included improving patient flow and reducing wait time, more consistent tracking of problems, and reporting safety issues, improving medical records audits, and increasing overall staff participation in such changes. Examples of physical changes included changed signage, posters, or addition of male-specific magazines and educational television programming in their waiting rooms or hallways. Others developed and strategically placed their own health education materials and program promotion brochures. Some developed and distributed small-print media such as wallet referral cards and others changed clinic schedules to offer evening, walk-in or Saturday clinics. Others updated patient forms and medical exam procedures as well as job descriptions to emphasize male inclusion and some offered new services such as HIV screening and testing where services did not exist before.

Training

Initial Project Orientation addressed attitudes towards males, male socialization, male behavior and communication, and decision-making patterns. Clinical Staff Training was also beneficial for most sites, and essential to increase provider comfort and confidence in conducting male exams and counseling and sexual history taking. On-going Training ensured continuous attention to the project. As one partner put it, “It’s about keeping staff motivated to not see this effort as simply a program innovation, but rather as part of what we do — our mission.”

Training addressed three areas: 1) building staff buy-in, 2) building clinical expertise, and 3) training staff on how to integrate health promotion messaging around male RH services in their work with their existing clients (described further below, under In-reach).

Risk Assessment, Education & Counseling for Men in Reproductive Health—Self-Paced Online Course

During the project, we had the luxury of providing face-to-face training for clinical providers, but knew that training for this audience is an ongoing need. Therefore, Cardea developed this self-paced online course for clinicians, medical assistants, nurses, health educators and other allied health staff to assist in gaining the knowledge and skills needed to educate and counsel men on sexual and reproductive health. The major topics of the course include understanding men’s reproductive health, communicating with male clients, and risk assessment and sexual-history taking with male clients. The 45-minute course features a
variety of interactive activities and case scenarios designed to increase effectiveness in working with male clients around sexual health issues, and is approved for continuing nursing education credits.

Targeted Outreach and In-reach

A unique component of the research model was the focus on in-reach, that is, increasing the abilities of staff and of clients themselves to promote sexual and reproductive health clinical services to men.

Staff In-reach

To promote staff in-reach, project staff learned to routinely mention to clients – male and female – the available services for males, and encouraged clients to tell their friends and family. Sites provided additional resources and support to staff to promote in-reach:

- job aids,
- FAQ sheets,
- opportunities to practice talking points, and
- patient education materials, such as male health brochures and male anatomical models.

Client In-reach

Female clients were coached and educated in waiting rooms, health education/counseling sessions, and group education sessions about the importance of male health and available services.

Male partners of clients were educated and counseled on what to do if their partner misses their pills and what they can do to help support their partner’s contraceptive method, as well as, on effective condom use.

Despite efforts to promote clinic and program services, simply talking to men and their partners was not always sufficient to improving access. Some larger grantees also instituted follow-up reminders via text and reported that their male clients appreciated this extra effort.

Outreach/Program Promotion

A variety of outreach events were hosted or conducted with formal or informal community partners and included: pub crawls, drag balls, community art projects, health fairs, events for Men’s Health Week, and larger community stakeholder/service provider conferences. Agencies distributed educational materials they developed themselves, purchased from other programs, or obtained for free (from state health departments or other public health sources). Program staff conducted formal group education on male reproductive health in diverse settings ranging from local youth detention facilities to university campuses.

Tracking outreach and in-reach efforts was key to cost effective use of resources. “It’s important and timely to know how the new client learned of your community partner. Was it through an outreach event—health fair, advertisement or other special event? Did they learn of your services through another male or female client who used your services? Or perhaps it was through a male project educator or community partner.” – Study site educator

“Many times clients will forget how they learned of an agency’s services, so adding questions on the patient intake form such as: Where did you hear about us? Was your friend male or female? Is he or she a new client or existing client?” – Study site administrator

In addition to client outreach, all of the grantees worked hard to establish, build and cement relationships with other community-based organizations. Many hours were spent serving on advisory boards, sponsoring health fairs and supporting various community events. This was worth the effort, as these partnerships led to increased referrals and heightened community awareness of the male FP/RH services offered.
Achieving Staff Buy-In
Of course, underlying the success of all of the model components is staff ownership and belief in the program. Achieving 100% staff buy-in is an ongoing process and takes time. Ongoing staff meetings were essential to address staff concerns in implementing these various changes. All project partners encouraged staff to attend or participate in national training events or conferences and as a result, many became “champions” for male sexual and reproductive health.

Providing annual and/ or routine training was essential to orienting and addressing overall staff comfort and confidence in talking to males about sexual and reproductive health. Use of a champion clinical provider helped set the tone for improved staff buy-in with the clinical staff. Most grantees found it helpful to conduct ongoing assessment regarding staff attitudes and to address staff concerns and discomfort promptly, through training, coaching and role modeling.

RESULTS

Results from the research component of the Male FP Project were generally consistent with our initial expectations: FP/RH clinics did increase the number of male clients when they implemented agency and program innovations. All five agencies showed increases in the number of male clients during the project period. Our results suggest that the level of expansion of male RH services did not negatively affect female FP client counts or experiences. Where we were able to document male and female client volumes and visit activity, we did not find any fall off in female patient census for sites that were increasing their male patient load.

![Annual Male Visit Total](chart.png)

*based on agencies that provided comparison data

Beyond assessing changes in male patient volume, our project evaluated changes in the likelihood that these male clients would receive reproductive health services including contraception and pregnancy prevention counseling and various STI-related services. Our project results did generally show an increase in STI testing at sites implementing project innovations. Experimental sites showed significant increases in Chlamydia (CT) and HIV testing relative to comparison sites.
Although not all grantees could provide STI test results, the three agencies that did provided further support for increasing male RH services at FP clinics. CT positivities were significant across rural Montana, urban California and Texas clinic sites. Consistent with STI trends in other FP populations, gonorrhea positivity was very low, except for our Texas grantee in San Antonio which showed a high burden of infection. Since clinic databases we accessed did not capture clinical indicators, STI history or other risk factors, we were not able to assess possible predictors of these STI or whether there might be selective screening criteria that could yield efficient and effective approaches to STI testing in this population. Those issues were well beyond the scope of our efforts to increase male census and services. But, the simple level of CT positivity and its association with young age does support increasing access to RH services, certainly among adolescent and young adult sexually active men.

CONCLUSIONS AND RECOMMENDATIONS

Project Leadership

Two key elements for success were strong visionary leadership who believed in the goals of the project, and effective management systems that supported staff. Leadership ensured that

- the project stayed in the forefront despite competing priorities and challenges such as budget cuts and clinic closures,
- on-site clinical male RH champions had ongoing support from administrative leadership,
- staff understood the need that exists in the community,
- medical providers had opportunities to become comfortable with and knowledgeable about male sexual/reproductive health,
- outreach workers possessed the requisite presentation and communication skills to establish and maintain meaningful community partnerships,
- all clinic staff had access to training and other opportunities to buy-in to the new program and the importance of male reproductive health, and
- a comprehensive service delivery approach was implemented.
Planning and Assessment

Effective planning and preparation were crucial to successful implementation, and involved the following.

- Top management must show support for the assessment, changes recommended, and for the team by guaranteeing the assessment team has sufficient time to meet and work together.
- Use of logic models and work plans help define and operationalize planned changes. Allow sufficient time to develop, refine, and present planned changes to staff.
- Implementing broad based clinic change is best led by an interdisciplinary team made up of representatives from all levels of staff.
- Team members must foster an overall positive attitude about planned changes and the benefit it will bring to patients and staff.
- The tools and processes used to conduct the assessments must be user-friendly, and staff must be assured that all input is confidential and will not affect employment.
- Consider the service capacity of your organization before you implement enhanced reproductive health services for males.
- Plan a coordinated rollout of services; eg., ensure that staff are trained and ready to see male clients before undertaking any marketing efforts.

Implementation

Organizational change takes a great deal of time, as well as constant attention and nurturing. Some tips from our sites:

- Set annual benchmarks for increasing male client volume, and celebrate milestones. Staff are more vested when they have targets to meet, and they receive feedback about how well they’re doing.
- Provide ongoing staff training.
- Focus on targeted outreach and positive health promotion.
- Monitor in-reach and outreach efforts to determine impact on client volume.
- Provision of services needs to be carried out in a culturally appropriate manner.
- Reproductive health issues are best incorporated into a holistic approach for male health and can be delivered through non-traditional venues such as work sites, schools, sports and recreational centers.
- Programs that have been most effective at reaching and retaining males are well integrated in a network of health and social service providers.
- Targeted community outreach and education program activities need to be linked to quality clinical services.
- Reproductive health services often act as the primary entry point into the healthcare system for males who otherwise would not seek health care.

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To access the toolkit and the online training, please visit www.cardeaservices.org/ourwork/projects/family-planning-male-research