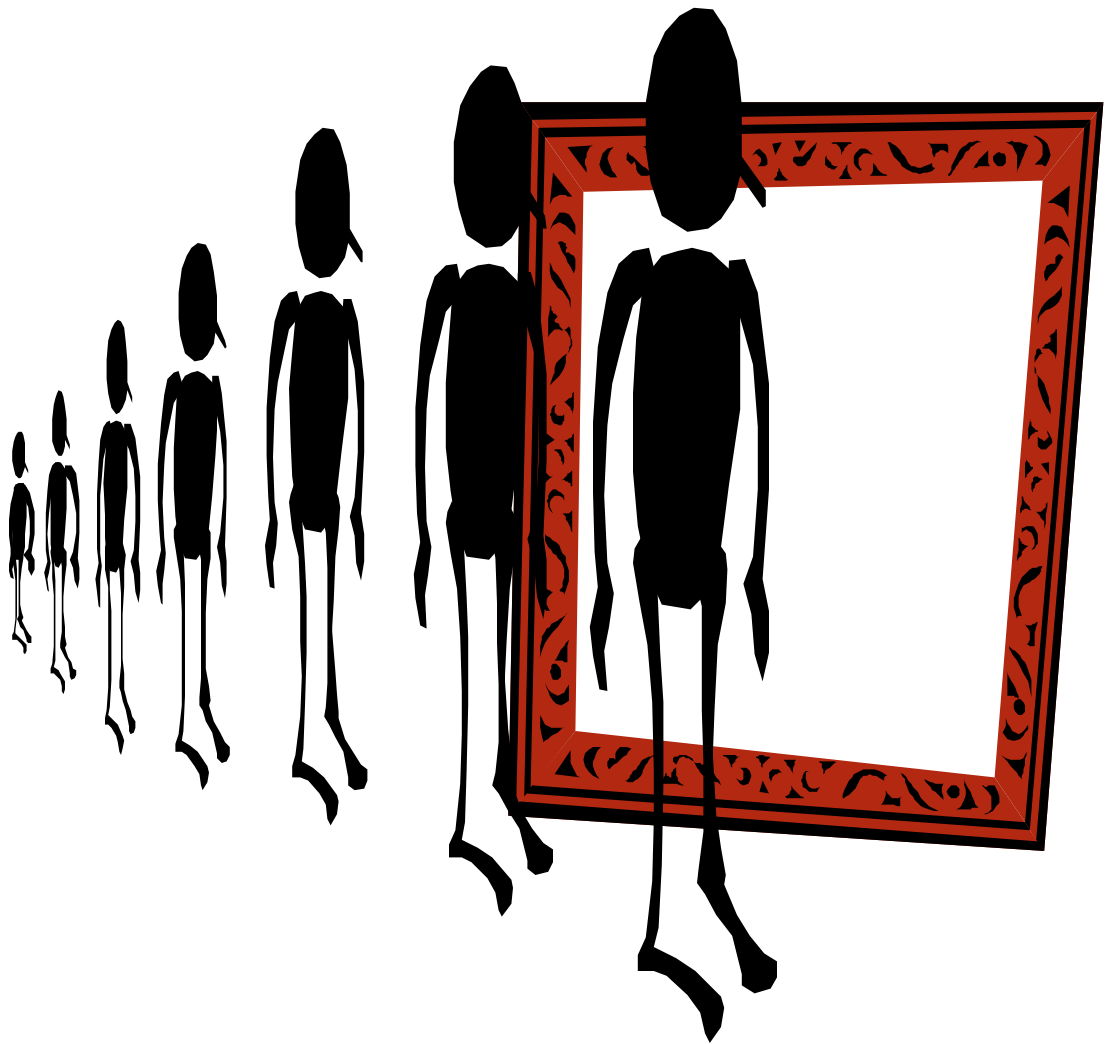


PUTTING MALES INTO THE FAMILY PLANNING PICTURE

A guide to help improve family planning services for males.

By Dan Christopulos



Putting Males Into the Family Planning Picture

TABLE OF CONTENTS

FUNDING ACKNOWLEDGEMENT.....	2
INTRODUCTION.....	3
I. REPRODUCTIVE HEALTH IN THE UNITED STATES	
A. Overview of Reproductive Health in the United States.....	4
1.The Title X National Family Planning Program.....	4
2.Males and Sexual Behavior in the United States.....	5
B. Perceptions of Title X Staff and Male Clients: Wyoming Case Study...	7
C. Current Family Planning and Males.....	9
D. Issues Affecting Involving Males In Family Planning.....	10
E. Practical Advice & Lessons of Success.....	12
II. STEPS FOR MALE INVOLVEMENT IN FAMILY PLANNING	
A. Identification of Reasons for Including Males.....	14
B. Evaluating Organizational readiness.....	15
1.Worksheet One: Is Your Organization Ready to Serve Males?.	16
2.Worksheet Two: Current Male Reproductive Health Status.....	18
3.Worksheet Three: Staff Attitude.....	19
4.Worksheet Four: Checking the Community’s Pulse.....	23
5.Worksheet Five: Mapping Existing Resources.....	26
6.Worksheet Six: Identifying Possible Target Audiences.....	29
7.Worksheet Seven: Collaborating for Success.....	32



TABLE OF CONTENTS (Continued)

8. Worksheet Eight: Prioritizing Efforts..... 35

C. Identifying Possible Resources for Sustainability..... 37

CONCLUSION..... 41

REFERENCES..... 42

This manual was funded by Family Planning Training Grants FPTPA080012-18, FPTPA080012-19 and FPTPA080012-20 through the Department of Health and Human Services.



INTRODUCTION

At the beginning of the 21st century, the United States may be compared to a multi-chromatic mosaic. It is the many distinct hues and textures that give the population of the United States its beauty and uniqueness. Contrastingly, family planning in the United States has been mostly monochromatic. Although professionals in the reproductive health and family planning fields have done an excellent job of serving women and their reproductive health needs, it is only recently that a concerted national emphasis has been placed on involving males in family planning services.

JSI Research & Training Institute (JSI) has been involved in addressing this new priority over the past several years by participating in discussions at both the national and regional levels. This manual is a result of the experiences gained through these discussions as well as the regional and national trainings on male involvement in family planning, hosted by JSI. The purpose of this manual is to guide organizations in formulating plans on how to best involve males in family planning. It is also a prescriptive effort as many of the suggestions come from the experiences of active programs. The manual is intended to provide an impetus and the necessary resources to successfully involve males in local family planning programs. Through continuous efforts to reach out to underserved males, the diverse levels of reproductive health and family planning in this country will be more accurately reflected.

JSI is indebted to countless people and agencies who have provided guidance in this endeavor. Previous research and efforts to serve males in family planning settings have pioneered the way for others to follow. This manual is dedicated to the pioneers and to family planning staff who are willing to serve males with the same zeal, commitment and expertise that they have long provided to women in this country.

Hopefully, this manual will lead organizations to creative ways of involving males in reproductive health as well as realizing the efficacy of doing so. A positive outcome of integrating males into reproductive health services would be new collaborations with those who already serve male clients and new relationships with males themselves. The ultimate goal is that, through dialogue with each other, men and women can make informed choices about reproductive health and family planning issues.

JSI would be remiss to not acknowledge a separate study that was recently published by the Center for Health Training (CHT) entitled *Blue Print for Male Involvement*. It is an excellent resource for programs that are thinking of involving males in their reproductive health activities. It is worth noting that even though the JSI and CHT studies were independent of each other, both yielded many of the same conclusions. The clarity of CHT's approach aided JSI in redesigning certain sections of this manual. JSI commends them for their efforts and recommends the *Blue Print for Male Involvement* as an additional resource.



I. REPRODUCTIVE HEALTH IN THE UNITED STATES

I A. OVERVIEW OF REPRODUCTIVE HEALTH IN THE UNITED STATES

In the United States, almost half of all pregnancies are unintended and half of these unintended pregnancies end in abortion (Henshaw, 1998). Although 93% of women use contraceptives, there are 42 million women at risk for unintended pregnancy in the United States. The small portion of those not using contraception (7%) accounts for 47% (or 3 million) of unintended pregnancies annually (Alan Guttmacher Institute [AGI], 2000). Henshaw (1998) also found that by the age of 45, the average American woman will have had 1.42 unintended pregnancies.

Within this context, teen pregnancy is especially significant. Each year in the United States, one in eight women aged 15-19 becomes pregnant, resulting in over half a million births. Two thirds of these births are unintended (Hatcher, et al., 1998) while three quarters of the pregnancies are unintended (Henshaw, 1998). Furthermore, only 25% of the men involved in the pregnancies among women under age 18 are also of the same age group; three fourths are older and nearly 40 percent are at least 20 (AGI, 1994). Although the teenage pregnancy rate in the United States has been dropping since 1990, it is still much higher than in many other industrialized countries: twice as high as in England, Wales, France and Canada; and nine times as high as in the Netherlands or Japan (AGI, 1994).

Addressing Sexually Transmitted Infections (STIs) is also a part of the national Family Planning priority. STIs affect 15.3 million Americans annually with one quarter of new cases occurring in teens 15 – 19 years old, and two thirds of cases occurring in people ages 15-24 (American Social Health Association, [ASHA]1998). STIs increase susceptibility to HIV by three to five times and at least one in three sexually active people are estimated to have contracted an STI by the age of 24 (ASHA, 1998).

I A1: THE TITLE X NATIONAL FAMILY PLANNING PROGRAM

The National Family Planning Program was created in 1970 as Title X of the Public Health Service Act (P.L.910572). The mission of Title X is to provide individuals with the information and means to exercise personal choice in determining the number and spacing of their children. Grants made under this section provide funding for comprehensive family planning and preventive reproductive health services.

The Title X program, funded at \$238.9 million for FY 2000, is administered by the Office of Family Planning within the Office of Population Affairs. Services are provided through a network of 4,600 clinics nationwide.

Family planning plays a key role in the prevention of unintended pregnancy, including adolescent pregnancy. Preventing unintended pregnancy also reduces the incidence of abortion and improves birth outcomes. Similarly, family planning information, education, and services reduce both the incidence and impact of sexually transmitted infections through screening and treatment.

Family planning clinics are often an entry point into the health care system for young and low-income persons. These services are the principal source of health care for many, particularly those who are uninsured and do not qualify for other publicly supported health programs, such as Medicaid.

Some salient facts regarding the Title X program are:

- Title X supports approximately 85 service grantees in all 50 states, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin to provide essential family planning medical and counseling services through a network of 4,600 clinics.
- Annually, 4.5 to 5 million individuals receive clinical family planning services.
- Nearly 85 percent of the population served by Title X clinics are from low income households, 30 percent are less than 20 years of age and 60 percent are less than 25 years of age.
- Services are provided on a sliding scale based on income, with persons at or below the Federal poverty level receiving services at no cost. No one is refused services because of inability to pay.
- Title X has no residential requirement for receipt of services.

In addition to contraceptive services, Title X clinics provide basic reproductive health care such as screening for breast and cervical cancer; screening for sexually transmitted diseases, including HIV; level I infertility services, as well as general health education, counseling and referrals.

I A2. MALES AND SEXUAL BEHAVIOR IN THE UNITED STATES

Before discussing the topic of serving young males in family planning and reproductive health settings, it is important to have an understanding of their sexual attitudes, beliefs, knowledge, and behaviors. Unfortunately, there are very few studies which focus on these aspects at the national level. Nevertheless, two surveys with nationally representative samples, the National Survey of Adolescent Males (NSAM) and the Youth Risk Behavior Survey (YRBS), are probably the best sources for gaining a glimpse into young male sexual attitudes, beliefs, knowledge and behaviors.

Below are some of the significant findings from the NSAM (1995) which surveyed 1,729 males ages 15-19, selected to represent young men in households across the United States. Most of these analyses were derived from the Urban Institute's *Involving Males in Preventing Teen Pregnancy: A Guide for Program Planners* (1997).

- 56% of males ages 15 – 19 have had sexual intercourse (a decrease from the 1988 NSAM where 60% reported having had sexual intercourse).



- Half of teenage males have had sexual intercourse by the age of 17.
- At age 19, 15% of males are still virgins, while 85% report having had sex.
- African American teen males initiate sex earlier than their Hispanic or White peers.
- Most adolescent males are not promiscuous. The majority (54%) of sexually active males ages 15 – 19 have one partner or less in a year. Eighty percent have two partners or less.
- 69% of young men reported that they used a condom at first intercourse compared with only 55% in the 1988 NSAM.
- 90% reported that they had used condoms this past year, but less than half reported that they used condoms every time that they had sex.
- Similarly, those reporting that they used an ineffective or no method of contraception at first sex decreased from 38% in the 1988 NSAM to 27% in the 1995 survey.
- Teenage males express strong beliefs that preventing pregnancy is a male responsibility.
- Only 5% of the males believed that “getting a girl pregnant would make you feel ‘a lot’ like a real man.” 60% said that they would “not at all” feel that way.
- Over 90% of the young males surveyed said that it is their responsibility to talk about contraception before intercourse with their partner, use contraception to protect against unwanted pregnancy, and take responsibility for any child that they fathered.
- About 75% of young men who reported that they had used illegal drugs in the past twelve months and had past criminal involvement also were sexually experienced.
- 87% of those who are two or more years behind in school for their age are sexually experienced.
- Schools and television are the two most frequent places where teen males receive information about contraceptives. Less than 50% of teen males ever receive such information from their parents.

The Youth Risk Behavior Survey (YRBS) was conducted by the Centers for Disease Control and Prevention (CDC) in 1997 as part of the *Youth Risk Behavior Surveillance System*. The *YRBS* (1997) interviewed a representative sample of over 16,000 students in grades 9 – 12 in 151 schools. Below are a few of the most significant findings regarding young males from that study.

- 9% of the males in the study reported that they initiated sex before the age of 13 (compared with 4 % of females).

- About 18% of male students who were sexually active reported that they had four or more sex partners during their lifetimes.
- 32% percent of the males who were sexually experienced reported that they were currently abstinent (i.e. abstinent during the last three months). This compares with 23% of female students who reported that they were currently abstinent.
- 62% of males who were currently sexually active reported that they or their partner used a condom during last intercourse. (Black students (64%) were significantly more likely than white students (56%) to report condom use.)
- Males (30%) were significantly more likely than females (18%) to report alcohol or drug use during last sexual intercourse.
- Male students (59%) were significantly less likely than female students (67%) to report that they talked with their parents or other family members about HIV/AIDS.

I B. PERCEPTIONS OF TITLE X STAFF AND MALE CLIENTS: WYOMING CASE STUDY

An exploratory study conducted for the Wyoming Health Council (Christopoulos, 1999) used focus groups to investigate factors that either enhanced or inhibited young males' access to Title X family planning services in the state. The study included four adolescent male focus groups and three family planning staff focus groups. A total of twenty-seven young males, ages 14-21, comprised the four male focus groups, whereas twenty family planning staff from throughout the state made up the three staff focus groups.

Two of the four young male groups included males who had accessed Title X services or had been to the clinic with their partner. The other two groups were comprised of young male students, who had not accessed Title X, from the Wyoming Boys School and a Technical Institute. The vast majority were currently, (or had been) sexually active. Below are some of the most salient themes that emerged from the four male focus groups:

- Participants defined “family planning” in very different terms than those in the reproductive health field. Two typical responses: “It’s about mom and dad and the kids – planning vacations, what to do about stuff;” “How I can help out (my) family go to school and get a job and give my family stuff.” Only one young male responded, “Two people discussing pregnancy and what to do about it.”
- A substantial minority of young males were not familiar with the term “contraception”, but all understood the term “birth control.”
- Participants wanted “friendly,” “non-judgmental,” “understanding,” “competent,” and “relaxed” staff to interact with in the clinics.
- They also felt that negative posters, brochures, and staff attitudes would keep them away from coming to the clinic for services. One young male stated that he didn’t want to see

staff that, “Look at you like a criminal. I didn’t do anything wrong.” This same participant related how he brought his girlfriend in to the clinic and met with a female staff member. He continued, “I could tell she was uptight. I’m the one who brought her (his girlfriend) down here and they don’t want me to know anything. If this is the way they do things, I won’t come back.”

- There was agreement across the groups on wanting posters, brochures, and magazines that were more male-friendly.
- There was also agreement on the need to advertise more vigorously, especially targeting males and letting them know, in the words of one participant, “Family Planning is not just for women anymore.”
- Although they would prefer to have more males around, none objected to being examined by female practitioners.
- All participants felt that it was the responsibility of both partners’ to use contraception.

The three staff focus groups were conducted in three different parts of the state and included 19 female and 1 male staff member. More themes emerged in the staff focus groups, but several of them mirrored those in the young male groups. Highlighted below are a few of the most notable results from these groups.

- Staff articulated the family planning mission as extending to all people, but the internal frame of reference was “women.”
- Staff agreed with the young males on what is expected of a clinic staff member. In addition to the words “competent,” “friendly,” and “non-judgmental,” staff added words like “caring,” “warm,” and “empathic.”
- Staff felt that clinics were not currently very male friendly in terms of magazines, brochures, posters, and colors. One female participant said that there should be, “positive posters; no male bashing.”
- They felt that outreach to males should be done through female partners, male staff, and male mentors.
- There was agreement that males probably felt “out of place,” “intimidated,” “nervous,” and “uncomfortable” in the clinic.
- While all staff was very positive about males who came into the clinic with their partners, this positive response changed to negative if the male partner wanted to come into the exam room with her. Three representative quotes from female staff about the male partner were: “He is a dominant person, and I don’t like it;” “There is some type of domestic violence;” and “He wants to take control – hear what’s being said.”

Findings from the study have been communicated with family planning personnel throughout the state. Also, a twelve-minute documentary video entitled “The Challenge” was developed to target risk taking Wyoming men. The video, together with an accompanying discussion guide, address how to assess the risks involved in sexual behavior and take the necessary precautions to prevent harm. (“The Challenge” is available from the Wyoming Health Council at 1-307-742-7700 or Wyrephc@aol.com)

I C. CURRENT FAMILY PLANNING AND MALES

Since their inception in 1965, publicly funded family planning clinics have been designed to meet the needs of low-income women. By the mid 1990’s, over 4000 family planning clinics in the United States existed to provide reproductive services to poor women, not to mention the private physicians who catered to the reproductive needs of other women (Schulte & Sonenstein, 1995). Over 90% of staff in the clinics are female with professional backgrounds in female reproduction, and the primary birth control methods utilized in the clinics are designed for females. The strength of the clinics has been their ability to be sensitive to the needs of female clients. Certainly, this has been seen as good policy by a society where most effective contraceptive methods are designed for females. Additionally, women are most directly affected by the consequences of unintended pregnancies.

With such a history and infrastructure, it is no surprise that a recent Urban Institute survey of publicly funded family planning clinics found that, on average, males comprise only 6% of all family planning clinic clientele (Burt, Aron & Schack, 1994). Similarly, Ku (1993) found that in the US-federally subsidized Title X clinics, males made up only 2% of the total client population. The existing reality, both in this country and throughout the world, is that males do not access family planning clinic services in significant numbers.

In the past few years, however, the federal government has placed a renewed emphasis on increasing male access to family planning services. An earlier effort in the late 1970’s funded by the Office of Family Planning was deemed a failure by many because it did not attract a substantial number of male clients (Schulte & Sonenstein, 1995). This recent reemphasis can be attributed to several factors. First, rising sexually transmitted infection (STI) rates have forced clinics to look at expanding their services to males (Schulte & Sonenstein, 1995). The clinics are providing STI testing and treatment to the partners of affected female clients. In addition, the fear of Human Immunodeficiency Virus (HIV) and other STIs, is prompting men to become educated in condom usage as the only effective protection against HIV.

Second, the rise and expansion of managed care has been a factor related to including men in family planning services. In order to compete more effectively in a health care market with shrinking reimbursement, some family planning clinics include expanding services to males as part of their strategy to increase revenues (Schulte & Sonenstein, 1995).

Third, a recent governmental emphasis on male responsibility in welfare and child support enforcement programs has also contributed to the new impetus in male involvement in family planning. As the number of children born out of wedlock continues to increase, The Child Support Enforcement Program (established in 1975) has increasingly focused on paternity

establishment so that fathers could assume financial responsibility. Less than one-third of non-marital births have paternity established, about half of the custodial parents have child support orders in place, and only half of these orders are fully paid (U.S. House of Representatives, 1996). Legislation, at both the federal and state levels, is being drafted to strengthen child support collection. If men are to be held accountable for unintended pregnancy, some argue that they should have publicly funded family planning services available to them as well (Sonenstein & Pleck, 1995).

Finally, attitudes of men themselves are changing regarding family planning. In 1975, Pleck, Sonenstein and Swain found that only about one-third of adolescent males believed that men and women should be equally responsible for contraception. By the late 1980's, however, more than two-thirds of young men endorsed the belief that men and women share an equal responsibility for contraception (Clark, Zabin, & Hardy, 1988). By 1991, 78% of men ages 20-39 believed that men and women share equal responsibility about contraception (Grady, Tanfer, Billy & Lincoln-Hanson, 1996). Today, most men not only engage in contracepting themselves, but are also more supportive of their female partner's use of contraception.

While various reasons that support the recent emphasis on involving males in family planning can be identified, there is still little research on how to meet men's reproductive health needs. Although evidence shows that many males are motivated to use contraception, especially condoms, and that many contribute to the contraceptive decision-making of their partners, public policy has largely ignored males when family planning issues are considered (Sonenstein & Pleck, 1995).

I D. ISSUES AFFECTING MALE INVOLVEMENT IN FAMILY PLANNING

Even though there has been some success in trying to increase male utilization of family planning services, the reality remains that most males do not utilize the services. It is evident that while some positive strides have been taken, some negative influences act to inhibit male involvement.

Negative Influencing Factors

- ***Family planning clinics are female dominated.*** In a 1995 study of 25 family planning clinics reporting a male client share of at least 10%, the researchers found that the most frequently cited barrier to providing reproductive health services to men was the perception (by men) that family planning clinics are female organizations that serve only women (Shulte & Sonenstein, 1995).
- ***Men are not as familiar with the health care system as women.*** While conducting a telephone survey of clients from 25 Title X family planning clinics in 1995, Shulte and Sonenstein discovered that males are less likely to see a doctor or confide in providers about their medical problems than females. Women commonly begin seeing doctors with the onset of menstruation and seek reproductive health care when they become sexually active. Men, however, are not equally encouraged to seek preventive care.

- ***Negative attitudes toward male involvement by staff.*** Although Forrest (1987) sees negative staff attitude as one of the barriers prohibiting males from accessing family planning services, more recent studies (Burt, Aron & Shack, 1994; Sonenstein & Pleck, 1995) seemed to indicate that managers might not be as opposed to involving males in services as previously reported.
- ***Negative attitudes toward male involvement by female consumers.*** One of the strengths of family planning clinics has been their ability to create a safe and sensitive environment for their predominantly female clientele. Sonenstein, Schulte and Levine (1994) reported that, in a study of 21-40 year old women, a substantial minority (25%) preferred a facility that served only women. One-third of African-American women in the same study said that they preferred a female-only clinic. Unfortunately, there is no data for younger women available.
- ***Male attitudes toward involvement in family planning.*** One of the glaring gaps in the research is the fact that men themselves have not been asked what they seek in a provider and what types of services would entice them to participate in family planning. Even though there is evidence that many males favor using contraceptives, there is no tradition of providing such services in the family planning culture and it seems that family planning providers are unsure of how to go about it (Sonenstein & Pleck, 1995).
- ***Lack of training on men's reproductive issues.*** In a 1987 study, Forrest found that resource restrictions, predominantly female staff, negative staff attitudes and a lack of staff training seemed to be major barriers to including men in family planning services. Today, his findings still ring true. It appears that very little is known about how to deliver reproductive health services to men, and as a result, training designed specifically on how to incorporate men's reproductive issues is limited.

Positive Influencing Factors

Despite the many factors that act to inhibit men's involvement in family planning services, some factors do exist which positively influence men to access family planning services.

- ***Health care providers can change behavior through counseling and education.*** In a study providing health consultations to 15-18 year old male patients, Danielson, Marcy, Plunkett, Wiest & Greenlick (1990) found that those who were already sexually active used contraception more frequently; and those who were not sexually active at the time of the intervention delayed their initiation of intercourse. Explicit patient education on sexual activity may have a restraining rather than an encouraging effect on men's sexual activity. Such findings are significant in winning public support for similar programs and changing the attitudes of those who claim that men are not amenable to contraception messages.
- ***Changing attitudes of men's perceptions regarding contraceptive responsibility.*** As stated above, another significant factor in incorporating males into family planning is the

fact that attitudes involving male participation in contraceptive decision making has shifted during the past 25 years. According to the 1991 National Survey of Men, over three-fourths (78%) of those surveyed, believed that men and women share equal responsibility for decisions about contraception (Grady, Tanfer, Billy, & Lincoln-Hanson 1996).

- ***Increase in HIV and STIs.*** Although its overall effect on healthcare is negative, increased rates of HIV and STIs in this country have served as a stimulus for males to seek family planning services (Sonenstein & Pleck, 1996). The Male Services Study conducted by Schultie and Sonenstein (1995) found that every clinic in the study stated that a decisive factor in serving males in their clinics was the increased occurrence of STIs among their female clients.
- ***Movement toward primary care provision.*** In the Male Services Study cited above, another influencing factor for family planning clinics to serve males is the decision of family planning clinics to become primary care providers. In order to accomplish this, services must necessarily be offered to males.
- ***Community outreach.*** Both within and outside the United States, community outreach is a critical influencing factor in prompting males to seek family planning services. Outreach ranges from very limited to extensive programs of cultural and recreational events (Schott, 1981; Sanders & Rosen, 1987; Shultie & Sonenstein, 1995; AVSC International, 1997).
- ***Financial incentives.*** There are presently financial incentives that will spur agencies to seek male clients. Title X funding has been set aside for male involvement programs (Sonenstein & Pleck, 1995) with 30 demonstration projects currently being supported.

I E. PRACTICAL ADVICE AND LESSONS OF SUCCESS

In reviewing the literature on the topic and discussing the issues with clinicians, administrators and young males themselves, common points of advice emerge on how to best involve males in family planning. Paramount is the advice given in *Involving Males in Preventing Teen Pregnancy: A Guide for Program Planners* (Sonenstein et al., 1997), published by the Urban Institute. Below are some of these key directives.

- Listen to male clients' needs
- Be knowledgeable about the needs of the community
- Collaborate with other agencies who already serve males
- Make an organizational commitment to male involvement
- Conduct targeted outreach to males, particularly in their own environment

- Hire and/or develop staff that are motivated and committed to serve males
- Offer a broad spectrum of services
- Approach the subject of pregnancy prevention with males in playful, entertaining, and non-threatening ways
- Choose lengthier rather than more brief contact with program participants
- Be sensitive to location, cost and format of services
- Create male sensitive environments
- Utilize males as staff, volunteers, members of advisory councils and boards
- Avoid negative stereotypes about males
- Remember that satisfied participants and collaborators are the best source of publicity
- Be prepared to be resourceful in maintaining your program's funding.

II B. EVALUATING YOUR ORGANIZATIONAL READINESS

Once an agreement has been reached on why male involvement in family planning and reproductive health is necessary and beneficial, it is possible to begin assessing various aspects of your organization's readiness to serve males.

The first step in the evaluative process is to review your mission. Your organization's mission represents the foundation of its program and outlines its philosophy and scope of service. It is also what guides the expansion of services.

Review of Your Organization's Mission

Articulate the mission of your organization: (Rewrite the organization's "Mission Statement," if available.)

Once you have articulated your organization's mission above, review it against a recommended Mission Checklist below.

Mission Checklist

- Does it reflect your philosophy and values as staff and managers?
- Is it gender neutral or gender specific?
- Does it clearly state that you serve males?
- Is it realistic and meaningful to staff and managers?

If there are revisions that need to be made to your organization's mission to bring it in line with an expanded ability and desire to serve males, then the changes should be documented and clearly communicated to all staff.

On the following pages are a series of worksheets that deal with evaluating your organization's ability to serve males. They have been adapted, and draw significantly, from The Urban Institute publication *Young Men's Sexual and Reproductive Health, Toward a National Strategy: Getting Started* (Sonenstein, ed., 2000).

II B1: WORKSHEET ONE: Are You Ready to Serve Males?

The next step in the evaluative process is to review your organization’s competence to serve males. Below are a series of questions that will help ascertain readiness to serve males. *The worksheet can be completed individually and then used as part of a larger discussion with your management and/or staff team.*

Have you ever served men? Yes No

If no, please write below any reasons why males have not been served?

If you were a young man and walked into one of your family planning clinics, what types of feelings do you think the environment might elicit in you?

Is your environment male-friendly? Yes No

What things, in your mind, make it either male-friendly or not male-friendly?

Do you employ male staff or have male volunteers? Yes No

If no, can you think of reasons that might inhibit you doing so in the future?

Do you have male members on your advisory boards/committees? Yes No



Do you provide training to your staff on how to serve males? Yes No

Has your staff ever received information on male reproductive health? Yes No

Do you have linkages with other organizations that serve males? Yes No

If yes, inventory them and the types of services they provide:

Organization Name	Types of services provided to males

Can you refer male clients to ancillary services like job training and sports? Yes No

Does any staff member object to, or have concerns with, serving males? Yes No

If yes, how have these objections or concerns been addressed?

Once you have completed the worksheet discuss and record any changes that your organization needs to make in order to become more ready to serve males.

Successful programs with males:

- **Reject stereotypical views of males and believe that males can be positively involved in their reproductive health choices;**
- **Involve males on staff and as volunteers who are comfortable working with women and relate well to male clients;**
- **Commit to improving communication between men and women;**
- **Allow males to play leadership roles in traditionally female organizations;**
- **Facilitate training and open discussion for female and male staff members together in a safe environment.**

II B2: WORKSHEET TWO: Your Organization's Current Male Reproductive Health

If you are to serve males' reproductive health needs, it is important that you inventory the reproductive health services that you currently provide to males. **Please check all the services that you are currently providing for males.**

- Counseling for family planning
 - Testing, education, counseling and treatment for STIs/HIV
 - General primary healthcare
 - Male exams
 - Sports physicals
 - Infertility testing
 - Vasectomies
 - Ability/availability of lab to process male lab work
 - Education, counseling and/or outreach targeting males
 - Referrals for support services i.e. housing, employment counseling, etc.
 - Referrals for mental health and substance abuse
 - Support or educational groups for males
 - Advertise services for males
 - Marketing materials that reflect a commitment to serving males
 - Clinics have male-oriented magazines, artwork, colors or gender-neutral items
 - Avenues for males to provide feedback on services provided
 - Other services provided to males _____
-

Family planning clinics have expertise in addressing sexual and reproductive health issues, but may not have the experience doing so for males. The above services are some of the most commonly provided for males. While all are necessary, some might be accessed through referrals rather than being directly provided by your organization.

As a group, discuss the services that are currently being provided as well as not being provided to males. For those that are not being provided, brainstorm how your organization might provide or make referrals for such services.

II B3: WORKSHEET THREE: Staff Attitude

One of the common themes that has emerged in the research done on male involvement in family planning settings is staff attitude. A hallmark of family planning in this country is the respect and dignity that female clients have been afforded by family planning staff. Family planning clientele consistently give high marks to clinic staff for the personal attention and friendly service they enjoy. This is due, in large part, to the positive regard that the clinic staff has for its clients. Worksheet Three explores what kind of regard we might have for male clients and the type of situations that arise when serving males in the family planning setting.

Personal Inventory Relating to Males

Have each staff complete the worksheet alone first. Then have a general discussion about the feelings elicited in staff by the different types of individuals presented, and the challenges presented in staff responses.

Described below are different levels of responses one might have toward a male:

- **Greet:** I feel I can greet this person warmly and welcome him sincerely.
- **Accept:** I feel I can honestly accept this person as he is and be comfortable enough to listen to his problems.
- **Help:** I feel I would genuinely try to help this person in a non-paternalistic way.
- **Background:** I feel I have the background, knowledge, and/or experience to be able to help this person.
- **Advocate:** I feel that I could honestly be an advocate for this person.
- **Challenge:** I feel that I would have difficulty working with this person.

Below is a list of individuals. Read down the list and check (honestly) the attitude that might apply to you in relating to this person. **Please be honest, the responses are confidential.** Mark all that apply.

Individual	Greet	Accept	Help	Background	Advocate	Challenge
Teen male						
Teen male with body piercing						
Teen male who impregnated a girl						
Teen male who has come to clinic with several different partners						
Sexually active male with AIDS						
Teen male who has transmitted STIs to several partners						
Teen male who is gay						
Abusive male						
Older man who has fathered child with teen girl						

Values Clarification

The following situations are based on actual experiences in clinics where males have been seen and/or served. They are intended to help you think about and discuss your beliefs and values regarding working with young males and serving them in your family planning clinic.

The situations are ideal for discussion in small groups of 5 – 7 staff. Have each group assign a recorder who will record the group’s discussion and report back to the large group. Make sure that the group identifies the different issues that emerge from the vignettes and their responses to them. Facilitation of the full group discussion might be most fruitful if conducted by an outside facilitator.

Situation I

A young male sheepishly walks into the clinic. The receptionist is on the telephone so the male takes a seat in the waiting room. After fumbling through *Seventeen* and *Ladies Home Journal* for a couple of minutes he puts the magazines down. The receptionist remains busy on the telephone and the other female clients in the waiting room openly stare at him. Finally he gets up and starts to walk out. The receptionist looks up just as he is exiting.

Situation II

A young male comes into the clinic with his girlfriend. They both come to the reception desk and the receptionist checks the young woman in for her appointment. She also gives her some paperwork to complete before she will be called and asks her to take a seat. The male partner, within hearing of the receptionist stammers to his girlfriend, “Ah, I guess I’ll wait for you in the car.” He then exits and the girl takes a seat in the waiting room.

Situation III

A teenage girl comes into the clinic with her mother at the same time as a young male and his female partner. Both young women check in and then are seated with their mother and partner respectively. When the first young woman is called, her mother accompanies her to the exam room. When the next girl is called, her male partner gets up to accompany her to the exam room. Before entering the hallway, the nurse intercepts the couple and says to the boyfriend, “Oh, I am sorry, you will have to wait out here.”

Situation IV

Over the last few days two girls have tested positive for Chlamydia. When inquiring about their partners for notification, one boy’s name has come up as the partner for both of the girls. As the Nurse Practitioner is making a phone call in the front reception area, she recognizes one of the girls who tested positive for Chlamydia approaching the front desk with a young male. The NP overhears the girl say that she has brought her boyfriend “John Doe” to be tested and she

recognizes his name as the one who has been identified. The receptionist tells the couple to be seated and that she will call them when there is an opening. The NP motions the receptionist into the back hallway from the desk and says, “You can just go tell little Missy and Mr. Doe that they can just haul his little promiscuous butt over to the County STD clinic, we don’t need his business, he’s given us enough already!”

Situation V

Your Nurse Practitioner has been with you for the last two years even though you are a small town clinic. Until now the longest any mid-level has stayed is six months. She is passionate about women’s health and is enjoying small town life after having spent 10 years in the Title X clinic in a big Eastern city. She left there because she resented, “people trying to tell us how to do our job! We know how to serve women and do it better than anyone else!” She is a little upset because your clinic has received special initiative money to serve males, which she laments, “just takes service dollars away from the girls who need us.” On the other hand, she feels, “it is probably good to make males be responsible finally.” One day in the clinic, she comes to the lobby to escort a young girl back for an exam. She notices another couple seated in the lobby; the male is probably 20 or 21, while the girl appears to be 16 or 17. The NP is visibly upset and tells the girl to go on back to the exam room. She then motions to the receptionist and nodding toward the young male and young girl says, “You make sure I see that young girl, maybe I can talk some sense into her. And I would really prefer that that ‘perp’ not sit in my waiting room.”

II B4: WORKSHEET FOUR: Checking the Community's Pulse

One of the most often overlooked aspects of gearing up to provide new services, or to undertake new initiatives, is an assessment of the readiness and receptivity of the community that is to be served. Too often initiatives have been enacted without the input and guidance of the impacted community. The process should have as its starting point a method to obtain the input and suggestions of the community residents and stakeholders. This may be difficult for an individual organization to accomplish by itself. It is often helpful to convene a planning group of representatives from the community to become involved in the process. This will help the organizations gauge the level of interest, support and commitment in the community for the initiative. It also lends itself to discovering what agencies, in the community, have experience serving young men.

At this juncture, it is equally important to get the perspectives of young men themselves. This can be accomplished in a couple of ways. One way is to make sure that young males are part of the planning group. Another way is to conduct focus groups with young males. Richard Krueger's book, *Focus Groups: A Practical Guide for Applied Research* (1994), available from Sage publications (www.sagepub.com), is one of the best on focus group qualitative research.

Because conducting a needs assessment can be a very complex, time consuming and ultimately a costly process, most organizations do not have the resources of time, personnel and money to do it in a broad-based way. Using simple designs and asking the right questions, however, can produce very useful data. Below, adapted from Brindis and Davis (1998), are some of the most important questions to ask when trying to answer the question; "Is the community ready to serve young males' reproductive health needs?"

- In general, how do community residents feel about family planning and reproductive health issues?
- How does the community feel about its teenagers?
- What kinds of programs currently exist for the community's young people?
- What is the magnitude of incidences of STIs, HIV/AIDS, or unintended pregnancy in the community?
- In general, how are young males viewed in the community?
- How are males viewed in relation to STIs, HIV/AIDS, or unintended pregnancy issues in the community?
- With what agencies do young males generally interact?
- Is there a sensitivity in the community around young men's health?

- Is there a sensitivity around how young men's health status affects their health? Could this sensitivity be raised in the community?
- Is there a nucleus of people concerned about the issues of young men's health and specifically reproductive health?
- Are there any existing programs that could be expanded or built upon to target young men's reproductive health?
- What are the potential community resources that could be leveraged to address young men's reproductive health issues?
- What are the potential barriers to advancing a young man's reproductive health agenda?
- Are there enough communal resources to further a young man's reproductive health agenda?

If the answers to the above questions indicate both a need and a willingness to address young men's reproductive health issues, then a more thorough assessment of needs and assets should be undertaken. There are many resources that could be useful in helping you conduct a community needs assessment. Among the most useful are:

Adolescent Pregnancy Prevention: A Guidebook for Communities by Clair Brindis (1991). It is available through the Health Promotion Research Center at Stanford University, 1000 Welch Road, Palo Alto, CA 94304-1885 or Telephone 415-723-0003.

Conducting Needs Assessments: A Multi-disciplinary Approach by Fernando Soriano (1995) as well as *Planning and Conducting Needs Assessments: A Practical Guide* by Glead Ruth Witkin and James W. Altschuld (1995). Both of these are part of Sage Publications' *SAGE Human Services Guides* series and can be ordered through their web site: <http://www.sagepub.com>.

Regardless of the resource used, some important points (adapted from Brindis 1991) for success include:

- Define the parameters of the community
- Engage the community members and demonstrate how the information will assist the community
- Protect the participants and be sensitive to negative ways that information might be used
- Use skilled individuals to conduct the assessment and have the design reviewed by an Institutional Review Board (IRB) if possible
- Use a variety of collection strategies

- Examine other information already gathered and establish baselines
- Extend the assessment beyond just family planning and sexuality education
- Be committed to acting upon the needs identified using the strengths and assets already available in the community
- Devote enough time and money to the effort to conduct a thorough assessment.

II B5: WORKSHEET FIVE: Mapping Existing Resources

One important step in the process of assessing the needs and assets of the community is to develop an inventory of existing programs and activities. These can be placed into a matrix of needed services. The matrix can be used to identify untapped resources and potential collaborators, as well as gaps in service provision.

In the report *Young Men's Sexual and Reproductive Health: Toward a National Strategy Getting Started* (2000), the Urban Institute lists five goals for male sexual and reproductive health:

- Promote sexual health and development.
- Promote healthy intimate relationships.
- Prevent and control STDs, including HIV.
- Prevent unintended pregnancy.
- Promote responsible fatherhood.

In order to fulfill these goals, they also identified five service strategies. On the following page is a matrix that shows examples of the service strategies addressing each of the five goals.

Sexual and Reproductive Health Content

	Goal I	Goal II	Goal III	Goal IV	Goal V
	Promote Sexual Health & Development	Promote Healthy Intimate Relationships	Prevent & Control STDs and HIV	Prevent Unintended Pregnancy	Promote Responsible Fatherhood
Information	Anatomy, puberty, social development, hygiene, STDs	Stages in relationships, readiness for sexual involvement, forms of expression, coercion	STD symptoms & transmission Diagnosis of STDs, disease prevalence, where to get condoms, consequences of STDs	Contraception (incl.) abstinence, reproductive bio-logy, where to obtain contraceptives, costs of unintended pregnancy, alternative forms of sexual expression	Respect of parents, prenatal health and childbirth, child development, child health and well-child care, paternity establishment, child support and visitation
Skills	Resist peer pressure, communication, risk assessment	Communication & listening, partner selection, negotiating safe sex	Negotiating sexual activity & limit setting, condom usage, recognizing STD symptoms	Negotiating sexual activity & limit setting, use of contraceptives, intimacy without intercourse	Parenting skills, life skills, opportunities for self sufficiency, communication
Positive Self Concept	Self-esteem, self-respect, sexual identity, gender roles, potential	Self-esteem, self-respect, sexual identity, gender roles	Self-esteem/ respect, aware-ness of vulnerability	Self esteem/ respect, confidence in future, control	Self esteem/ respect, nurturance, sense of control over one's life and decisions
Values & Motivation	Respect for others, spirituality, healthy lifestyle,	Healthy relation-ships, role expectations, fidelity	Health as priority, concern for partner's health	Men's/women's roles in contraception, pregnancy	Values re: parenting & fatherhood, "being a man"
Clinical Services	Physical exam, screening, primary health care services, access to services	Physical exam, screening and treatment for sexual abuse, dysfunction, counseling	Physical exam, STD/HIV testing, treatment, counseling, follow-up	Physical exam, counseling, contraceptive services with partner, referral for health services	Physical exam, fertility assessment, child health and well-child care, support groups for young fathers, referrals for services

With these possible examples of how the five strategies can be fleshed out in fulfillment of the five goals, one can “map” which agencies indeed provide these types of services. *In the blank matrix below, insert the names of agencies, in your community, that provide these types of information, skills, positive self-concept, values & motivation, and clinical services in fulfillment of the five goals of male sexual & reproductive health.*

Sexual and Reproductive Health Content

Goals	Goal I Promote Sexual Health & Development	Goal II Promote Healthy Intimate Relationships	Goal III Prevent & Control STDs and HIV	Goal IV Prevent Unintended Pregnancy	Goal V Promote Responsible Fatherhood
Information					
Skills					
Positive Self Concept					
Values & Motivation					
Clinical Services					

II B6: WORKSHEET SIX: Identifying Possible Target Audiences

Once you have a sense of the male sexual and reproductive health needs in the community by mapping the existing resources, it is important to begin focusing your organization's efforts. Health education, prevention, and promotion initiatives are most successful when targeting specific audiences. Identifying client(s) will shape and guide decisions about:

- the messages to relay
- the natural settings where outreach can occur most successfully
- the community partnerships and collaboratives that are most desirable
- the types of initiatives to undertake
- sources of funding

Many organizations in the family planning community have started their service to males as a natural extension of serving their current clients. Female family planning clients are often encouraged to bring in their partner, especially with STI prevention and testing. However, if an organization is going to really commit to serving males, it is wise to be even more strategic in targeting a certain segment of males. In reviewing the community's assets and needs, a gap might become visible that your organization could help fill. There might be a niche that would fit in nicely with your organization's mission, capabilities, partnerships, and future goals. Similarly, your organization might have interest and expertise with a certain target population that could be utilized.

Although there are a myriad of ways to target young men, a few suggestions are offered below to start the process of targeting diverse audiences:

- **Age** – If you were to target adolescents, most theorists divide that up into early (12 – 14 years old), middle (15 – 17 years old), and late (18 – 19 years old). Another group that is often overlooked is young adult males ages 20 – 24. Still older adult males could be targeted for things like prostate cancer screening and issues of sexual dysfunction and impotence. Depending on the age group chosen, certain initiatives and approaches are most appropriate.
- **Racial/Ethnic Community** – Another way to target young males would be by racial or ethnic group. Even within those categories there exist special target audiences. In many of our larger communities there exist pockets of racial and ethnic communities that have specific and unique needs. Your clinics might be strategically positioned to attend to these needs.

- **Sexual Behavior** – You also could target young males based on their sexual behavior. You might design a program that endeavors to delay sexual activity, or you might target sexually active teen males with the goal of getting them to consistently contracept. Similarly, you might target gay sexually active males with a program to consistently use condoms and be screened for STIs.

Other programs have targeted males based on:

- Parenting status (young father)
- Living arrangement (homeless, incarcerated, living with parents)
- Marital status (single, married, divorced)
- Other.....(substance abuse, sexual orientation, school status, etc.)

In the space below, identify your current client population served and write in what possible target audiences are most natural extensions, or desirable to reach, for your organization.

Current Population Served	Target Audiences
<i>Age</i>	<i>Age</i>
<i>Racial/Ethnic Community</i>	<i>Racial/Ethnic Community</i>
<i>Sexual Behavior</i>	<i>Sexual Behavior</i>
<i>Parenting Status</i>	<i>Parenting Status</i>
<i>Living Arrangement</i>	<i>Living Arrangement</i>
<i>Marital Status</i>	<i>Marital Status</i>
<i>Other</i>	<i>Other</i>



II B7: WORKSHEET SEVEN: Collaborating for Success

Collaboration is a key in trying to provide a broad range of services and activities to young men. Especially in the field of male sexual and reproductive health, where efforts have been scattered and isolated, many organizations are integral to complete sexual and reproductive health services. Therefore, the desire to reach new and underserved populations (in this case, young men) should propel us to collaborate across organizations.

Himmelman (1996) has identified four types of organizational interaction:

- **Networking** – Exchange of information for mutual benefit
- **Coordination** – Exchange of information and altering of activities for mutual benefit and achievement of a common goal
- **Cooperation** – Exchange of information, altering of activities, and sharing resources for mutual benefit and achievement of a common goal
- **Collaboration** – Exchange of information, altering of activities, sharing of resources, and enhancement of each other’s capacity for mutual benefit and achievement of a common goal by sharing risks, responsibilities and rewards.

Many have used the word “collaboration” to describe and encompass all of Himmelman’s elements. In fact, it may be wise to think about collaboration as a continuum. On one end, “networking” would be the least formal and involved, while on the other, “collaboration” would be the most intensive, formal and involved. No matter how collaboration is theorized, its ultimate goal should be to provide a range of services to meet the sexual and reproductive health needs of young males. Collaboration is not an end in itself, (although many benefits are byproducts of the process), but should be client-focused and driven. Below is a list of possible collaborative partner types:

- Consumers
- Community-based organizations (CBO'S)
- HIV/AIDS services
- Private Providers
- MCH programs
- Medicaid/Medicare
- Mental Health Agencies
- Public health care providers
- Substance abuse agencies
- Behavioral care providers
- Social services
- Child care professionals
- Faith based communities

- Welfare/food stamp/TANF agencies
- WIC Program
- Youth Programs/centers
- Schools
- Community foundations
- Community policy-makers/leaders
- Media Organizations
- Tribal Organizations
- Business Sectors
- Male Focussed-groups
- Public housing communities
- Recreational/sports groups
- Community/ Migrant/Homeless Health Centers

Below is a list of collaborative activities that may occur with the various entities:

- Exchanging Information
- Training (for staff or clients)
- Outreach
- Care Coordination
- Co-location of Services
- Data Collection
- Client Tracking
- Consumer Involvement
- Co-Marketing Efforts
- Coalition/Task Force/Committee
- Community/Public Education
- Staff Sharing
- Curriculum/Educational Materials Development
- Transportation
- Resource Sharing

In the matrix below, identify your current and potential partners and activities that you currently or could partner on.

Community Partners	Collaboration Continuum														
<i>In the spaces below write in the names of current & potential collaborators and place a ✓ in the box of current/possible collaborative tasks</i>	Information Exchange	Training	Outreach	Community Education	Care Coordination	Client Tracking	Co-Location	Consumer Involvement	Co-Marketing	Transportation	Curr. Materials development	Staff Sharing	Resource Sharing	Data Collection	Coalition/Task Force

Copy the chart if you have additional collaborators.



II B8: WORKSHEET EIGHT: Prioritizing Efforts

Reproductive health and family planning is replete with opportunities for males to become involved. The initiative that is best for the male clients, your community, and your organization is contingent upon an analysis of the information in the worksheets. Male needs, community needs, collaborative possibilities, staff expertise, organizational priorities, and funding opportunities must all be interwoven to accomplish male involvement in family planning.

In the charts below are some of the most common services provided to males in the family planning field. Check all those that are of interest to your organization. After that, go back through the charts and assess if your staff currently has that expertise or could acquire it. Go back through a third time and assess if your community and those being served really need the service. Finally, revisit the charts two more times and assess if there are collaborative partnership opportunities and funding available for the services that interest your organization. (Please do not hesitate to include other services to the charts as well).

Clinical Services					
Type of service	Staff Experience	Community need	Client need	Possible Collaborators	Possible Funding Sources
School/sports/ Annual exams					
Counseling					
HIV/STI Counseling & Testing					
Hepatitis B testing					
Sexual dysfunction					
Infertility testing					
Vasectomies & other birth control					

Community Outreach & Education					
Type of service	Staff Experience	Community need	Client need	Possible Collaborators	Possible Funding Sources
Individual outreach					
Group outreach					
Sexuality classes					
Discussion/support groups					
Life planning/ skills classes					
Mentoring & peer education groups					
Fatherhood groups					

In reviewing the charts, some services might be easily identifiable as most viable. If there is more than one, engage in a prioritization process to determine which initiative(s) should be pursued first. It might be wise to start small and then undertake additional initiatives as your success builds. Having identified the initiatives, the final step is to develop a work plan. The work plan should contain at minimum: target audience (including geographic area); resources needed; goals, objectives, tasks (with timeline for completion); evaluation plan; collaborative partners; staff responsibilities; and funding sources.

II C: IDENTIFYING POSSIBLE RESOURCES FOR SUSTAINABILITY

Although there are many programs that could be possible avenues of support for providing male sexual and reproductive health services, there is no one federal program with a mandate or mission to serve males. People who sustain efforts to serve males have looked to several different sources for support. The services that are offered in comprehensive male sexual and reproductive health initiatives usually fall into the category of clinical or educational and counseling services.

Clinical services are provided by doctors, mid-level providers, nurses, and other medical personnel in health care settings and typically include:

- Screening and treatment of STIs
- HIV/AIDS testing and counseling
- Other physical exams

Educational and counseling services can be provided by more diverse staff in more diverse settings. Community-based organizations, schools, teen clinics, faith-based programs, etc. are venues for these services that typically include:

- Mentoring programs
- Group education
- Group and individual counseling
- Media campaigns

These can also be linked to other services such as:

- Employment placement and training
- Housing referrals
- Violence reduction
- Substance abuse prevention

Some grants specifically fund clinical services while others specifically fund educational and counseling services. Clinical services can usually be paid through insurance programs while non-clinical services (education and counseling) are not considered “reimbursable” and are usually covered through grants.

Federal Insurance Programs - The two major federal insurance programs that family planning clinics are involved with are *Medicaid* and the *State Children’s Health Insurance Program* (SCHIP). Medicaid is the largest source of public funds for reproductive health services in the country. Medicaid recipients are usually women and children since men are less likely to be eligible for program benefits. Males under the age of 19 may qualify for benefits if they are children in welfare families, “poverty-related” children, or have disabilities. Young adult males may qualify if they have children in welfare families, or if they have disabilities. Because Medicaid is an entitlement program, there are no caps on the number of people served or the costs of services provided to them as long as they meet the eligibility requirements and the services are part of the benefit package. Because it is a state-managed program there are significant differences from state to state, the best course of action is to check with the local state

Medicaid administrators to understand how this money could be accessed to cover clinical costs for males in your state.

Congress established *SCHIP* in 1997 as Title XXI of the Social Security Act. Its goal is to expand health insurance coverage for uninsured children up to age 18 whose families have incomes at or below 200% of the federal poverty level. The programs are usually integrated with Medicaid programs and operate similarly. They are primarily insurance programs that generally would cover a broad range of medical services including STI and HIV testing and treatment, as well as various forms of counseling and case management. The law does not mandate that family planning services be covered under SCHIP, but most states are doing so. Since states have flexibility in how they set up and administer their plans, consult with state administrators to inquire about how this insurance program might help cover adolescent male services.

Federal Grant Programs – Grant programs offer more flexibility in how funds may be used, but are not entitlement programs. *Title X* of the Public Health Services Act is the federal family planning program. As described in some detail in the introduction, male involvement has become a priority of the Office of Family Planning and Title X has recently funded a number of demonstration projects to support male involvement. The funded projects are based in a variety of settings and are testing a number of approaches for outreach and service to young men. Title X is administered by the Department of Health and Human Services through the Office of Population Affairs.

Another small grant program is the *Adolescent Family Life Program* (Title XX of the Public Health Services Act) which is also administered through DHHS' Office of Population Affairs out of the Office of Adolescent Pregnancy Programs (OAPP). The legislation was passed with the aim to increase positive outcomes for pregnant and parenting adolescents and their families. OAPP administers two types of programs: those that provide care to pregnant and parenting teens (including males), and those that promote abstinence-based prevention programs. Although the last few years have seen a concentration on abstinence-based prevention programs, in 2000, more money was given for new care grantees. Grants in this program may be approved for up to five years.

The Centers for Disease Control and Prevention (CDC) has a variety of grant programs to help control and prevent communicable diseases such as HIV and other STIs. These programs have a strong interest in promoting responsible sexual behavior among males. The CDC funds a myriad of organizations including state and local health departments; national and regional minority organizations; national business, labor, and faith partnerships; and community-based organizations. In 1999 alone, the CDC spent approximately \$120 million on STI-related activities. Currently these funds are only available as continuation grants, but in the future new grantees may be sought from among organizations that provide STI screening and treatment or awareness. The CDC maintains a searchable database of public and private sources of funding for HIV/STI prevention efforts at <http://www.cdcnpin.org/db/public/fundmain.htm>.

The Health Resources and Services Administration (HRSA) of the Department of Health and Human Services distributes *Maternal and Child Health (MCH) Block Grants (Title V)* to state health departments for the purpose of improving maternal and child health. Although local and

state health departments are typical recipients, other providers may receive funding. In principle, young male reproductive health services could also be covered, but this is dependent on the plans authorized by each state health department. Similar to Title X, these funds could be used for both clinical and educational services.

Another HRSA-funded entity are *Community Health Centers* (Section 330 Public Health Services Act). Their goal is provide a broad range of primary care services to people living in medically underserved areas. Funding for Community Health Centers has increased dramatically the past couple of years and they may be ideal partners for entities that want to provide preventive health services to young men. Community Health Centers are not-for-profit clinics that are required to have a community-based board of directors.

One of the newest programs at the federal level is the *Temporary Assistance to Needy Families (TANF)* which replaced the Aid to Families with Dependent Children (AFDC). It is a block grant to states. One of TANF's main goals is the reduction of unintended pregnancy. States have used TANF funds for family planning as well as reproductive health medical and educational services. Because states have dropped their caseload of people on the program, many states have surpluses that need to be spent. The states therefore interpret the statute broadly to fund a variety of family-planning related services. This program might have tremendous potential, especially for projects concerned with low-income males.

If you are interested in seeking federal funding you can go to the specific government agency web site or access the *Federal Register* through GPO access at:

<http://www.access.gpo.gov>

The NonProfit Gateway offers links to federal agencies and clearinghouses, including the *Federal Register*, through its site at:

<http://www.nonprofit.gov>

Foundations – Every year millions of dollars in this country go unused from foundations that have been set up to support particular types of initiatives. Listed below are some of the larger foundations that have funded male involvement initiatives and other family planning and reproductive health-related programs:

- *The California Wellness Foundation* <http://www.tcwf.org>
- *Geraldine R. Dodge Foundation* <http://www.grdodge.org>
- *Ford Foundation* <http://www.fordfound.org>
- *The Henry J. Kaiser Foundation* <http://www.kff.org>
- *The John D. and Katherine T. MacArthur Foundation* <http://www.macfdn.org>
- *The David and Lucille Packard Foundation* <http://www.packfound.org>
- *The Robert Wood Johnson Foundation* <http://www.rwjf.org>

If you are interested in seeking funding from private foundations and corporate giving programs, the resources below should be useful:

- The *Chronicle of Philanthropy* is a biweekly newspaper for not-for-profit professionals that lists grant funding opportunities. While there is a subscription fee for the paper, grants that are due within one month are listed on the paper's web site at: <http://www.philanthropy.com>
- The Council on Foundations is a nonprofit membership association of grantmaking foundations and corporations. Their web site will link you to other grantmaker web sites and information about foundations and corporate giving programs. Their site address is: <http://www.cof.org>
- The Foundation Center provides information on community and private foundations, corporate grantmaking, and grantmaking public charities. It also sends out a free email publication called *Philanthropy News Digest* as well as an e-mail delivered RFP Bulletin. The Center web site is: <http://www.fdncenter.org>.

CONCLUSION

How do we involve males in family planning? The answer to this question is as diverse as the number of agencies who provide family planning and reproductive health services. Complete family planning, where males are fully integrated, is achieved at the local level, where each agency will have a particular way of converging several factors. Integrated family planning is driven by the needs of the community, and the males in the community, as well as the communal and organizational assets, expertise, and resources.

While the intent of this document is partially make a case for the need to involve males, the real emphasis is on what needs to happen once organizations have made the commitment to do so. Your organization's commitment will go through a process leading it to many decisions, including which initiative(s) to pursue in fulfillment of that commitment. Research, brainstorming, discussions, questioning and listening have moved your organization to a point of embarkment. Your organization is either ready to start the journey of serving males, or to continue on that journey in new ways. In either case, congratulations are due.

- ◆ ***Congratulations!*** – for making such a commitment.
- ◆ ***Congratulations!*** – for listening to your prospective clients.
- ◆ ***Congratulations!*** – for being open to new ways.
- ◆ ***Congratulations!*** – for being open to new clients.
- ◆ ***Congratulations!*** – for being honest in your personal and corporate introspection.
- ◆ ***Congratulations!*** – for giving this process the time and attention it demands.
- ◆ ***Congratulations!*** – for committing to give males the same nurture, expertise, professionalism, dedication, service, and care that you have shown females throughout the decades!

We hope that this manual has been a good guide and preparation as your organization embarks on this endeavor. The contents of this manual are not static, but rather dynamic and should be used throughout the process. The road ahead is not well traveled and there will be unexpected turns and roadblocks. The questions raised and answered in this manual might be worth revisiting at various points in the future. Your experiences, successes and challenges, will help pave the way for others to follow. Please share them so that the dialogue about male involvement in family planning may be enriched.

Not only are you pioneers, but also artists. Many thanks for opening avenues to involve males into family planning.

JSI Research & Training Institute Family Planning Training Staff



REFERENCES

- Alan Guttmacher Institute (1994). Sex and America's teenagers. New York: Author.
- Alan Guttmacher Institute (1994). Teenage reproductive health in the United States. New York: Author.
- Alan Guttmacher Institute (2000). Fulfilling the promise: Public policy and U.S. family planning clinics. New York: Author.
- American Social Health Association (1998). STDs in America: How many and at what cost.
- AVSC International (1997). Men as partners initiative: Summary report of literature review and case studies. New York: Author.
- Brindis, C.D. (1991). Adolescent pregnancy prevention: A guidebook for communities. Palo Alto, CA: Health Promotion Research Center, Stanford Center for Research in Disease Prevention.
- Brindis, C.D. & Davis, L. (1998). Communities responding to the challenges of adolescent pregnancy prevention, Vol. 1, Mobilizing for action. Washington D.C.: Advocates for Youth, 32-33, 41-43, and 54-56.
- Burt, M.A., Aron, L.Y. and Schack, L. (1994). Family planning clinics: Current status and recent changes in services, clients, staffing, and income sources. Washington, D.C.: The Urban Institute.
- Christopoulos, D.G. (1999). Adolescent male involvement in family planning services. Non-thesis paper for the Master of Social Work, University of Wyoming. Laramie, WY.
- Clark, S.D., Jr., Zabin, L.S., & Hardy, J.B. (1988). Sex, contraception and parenthood: Experience and attitudes among urban black young men. Family Planning Perspectives, 16, 77-82.
- Danielson, R., Marcy, S., Plunkett, A., Wiest, W., & Greenlick, M. (1990). Reproductive health counseling for young men: What does it do? Family Planning Perspectives, 22, 115-121.
- Forrest, K.A. (1987). Family planning clinics share blame for men's failure to use services. Mens Reproductive Health, 1, (3).
- Grady, W.R., Tanfer, K., Billy, J.O.G., & Lincoln-Hanson, J. (1996). Men's perceptions of their roles and responsibilities regarding sex, contraception and childrearing. Family Planning Perspectives, 28, 221-226.
- Hatcher, R. et al. (1998). Contraceptive Technology.
- Henshaw, S. (1998). Unintended pregnancy in the United States. Family Planning Perspectives, 30.
- Himmelman, H.T. (1996). On the theory and practice of transformational collaboration: From social service to social justice. In Creating collaborative advantage, edited by C. Huxham. London: Sage Publications.
- Krueger, R. (1994). Focus groups: A practical guide for research (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Ku, L. (1994). Publicly supported family planning in the United States. Financing of family planning services. Washington, D.C.: The Urban Institute.
- Pleck, J.H., Sonenstein, F.L., & Swain, S.O. (1975). Adolescent male's sexual behavior and contraceptive use: Implications for male responsibility. Journal of Adolescent Research, 3, 275-284.

Sanders, J., & Rosen, J. (1987). Teenage fathers: Working with the neglected partner in adolescent childbearing. Family Planning Perspectives, 19, 107-110.

Schott, S. (1981). PP: Involves men. Planned Parenthood Review. Spring.

Schulte, M.M., & Sonenstein, F.L. (1995). Men at family planning clinics: The new patients? Family Planning Perspectives, 27, 212-225.

Sonenstein, F.L., editor (2000). Young men's sexual and reproductive health: Toward a national strategy getting started. Washington, D.C.: The Urban Institute.

Sonenstein, F.L., & Pleck, J.H. (1995). The male role in family planning: What do we know? Commissioned paper for the Committee on Unintended Pregnancy, Institute of Medicine. Washington, D.C.: The Urban Institute.

Sonenstein, F.L., Schulte, M.M., & Levine, G. (1994). Women's perspectives on reproductive health services. Report commissioned by the Henry J. Kaiser Family Foundation to the Urban Institute and Child Trends, Inc.

Sonenstein, F.L., Stewart, K., Duberstein, L., Lindberg, Pernas, M., & Williams, S. (1997). Involving Males in Preventing Teen Pregnancy: A Guide for Program Planners. Washington, D.C.: The Urban Institute.

U.S. House of Representatives (1996). 1996 Green book: Background material on programs within the committee on ways and means. Washington, D.C. Government Printing Office.