

**September 2006**

# **Review of the Title X Family Planning Program Evaluation Activities and Assessment of Current Evaluation Needs**

## **Final Report**

Prepared for

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RTI project number 08490.004  
HHS contract number 233-02-0090, Task Order 4



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\*RTI International is a trade name of Research Triangle Institute.



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# 1 Introduction & Overview

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## 1.1 INTRODUCTION

The national family planning program, authorized under Title X of the Public Health Service (PHS) Act and administered by the Office of Population Affairs (OPA)/Office of Family Planning (OFP), is the only federal program devoted solely to the provision of family planning and related preventive health care (e.g., pregnancy diagnosis and counseling, breast and cervical cancer screening, sexually transmitted disease [STD] and HIV testing), education, and counseling. For many clients, Title X clinics provide the only continuing source of health care and health education. Title X funds are critical to maintaining and operating a network of more than 4,600 clinics that ensure the availability of comprehensive and high-quality family planning services to low-income and uninsured individuals in the United States.\*

The Title X family planning program operates in a milieu of changing demographics, social forces, and financing. To better respond to this changing environment, OPA requires a robust understanding of the factors that influence the dynamic relationship between the Title X program and the external environment, as well as the effect this relationship has on program performance.

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## 1.2 PROJECT OVERVIEW: GOAL, PURPOSE, AND TASKS

In October 2003, OPA contracted with RTI International (RTI) to assess the evaluation and program needs of the Title X program. This project is a collaborative effort among a number of federal stakeholders, including the OPA/OFP and the PHS regional offices, which administer and monitor the Title X family planning service delivery grants; the Office of HIV/AIDS Policy (OHAP); and the Office of Minority Health (OMH).

The goal of the 36-month task order—"Review of Title X Family Planning Program Evaluation Activities and Assessment of Current

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\* Office of Population Affairs/Office of Family Planning Web site: <http://opa.osophs.dhhs.gov/titlex/ofp.html>.

Evaluation Needs” (Contract No. 233-02-0090, Task Order 4)—is to ensure that family planning services are achieving the goals stated in statutory language through mechanisms that are most responsive to client needs and consistent with the efficient and appropriate use of taxpayer funds. The project’s objectives are to help OPA identify and understand the effects of the external environment and the program’s structural, administrative, and operational characteristics on program performance (e.g., availability, accessibility, quality, efficiency, effectiveness) and to identify evaluation and other program needs that will guide future efforts to strengthen the program and enhance performance.

The three tasks designed to achieve the goal and objectives of the project include the following:

1. identification and systematic review and synthesis of published (1992 to 2003) and unpublished (1997 to 2003) evaluations relevant to the Title X program
2. identification, review, and synthesis of family planning indicators using data sources relevant to the Title X program
3. assessment of issues affecting Title X program performance and management at the regional, state, and clinic levels through interviews and focus groups with Title X program stakeholders, including federal administrators, grantees, delegates, and family planning clients.

This report describes each task and summarizes the findings or results. We have organized the report into four sections. In Section 1 we provide background information and introduce the project and tasks. In Sections 2 through 4 we summarize each task, including the objectives, methods and their limitations, findings, and recommendations (where appropriate).

# 2 Evaluation Review & Synthesis

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## 2.1 TASK OVERVIEW

OPA supports evaluation research aimed at improving performance of the Title X program through several mechanisms, including 1% set-aside funds,<sup>\*</sup> the Service Delivery Improvement (SDI) grant program,<sup>†</sup> family planning research cooperative agreements, support for large-scale surveys related to reproductive behavior and health (e.g., the National Survey of Family Growth and the National Longitudinal Study of Adolescent Health), and support for demonstration projects aimed at addressing key program initiatives. Currently, OPA spends \$4 million to \$5 million annually on research and evaluation studies. In addition to OPA-funded research and evaluation, Title X-funded agencies and other research and academic institutions also carry out program evaluations and research with funding from other sources on issues relevant to the program and in Title X-funded settings.

Because Title X evaluation activities are wide ranging in that they are funded by a variety of sources in addition to OPA, and because the methods and findings are presented in both peer-review published and unpublished reports, OPA is interested in understanding the content, scope, and quality of relevant evaluations as a key step in determining evaluation gaps and future needs. Therefore, under this task order, RTI conducted a systematic review of published (1992 to 2003) and unpublished (1997 to 2003) evaluations relevant to the Title X program.

The review included evaluations of a range of activities relevant to the Title X program, including family planning service delivery, HIV/AIDS prevention services, non-HIV STD services, integration of HIV/AIDS and STD services into family planning services, and other topics (e.g., cost of care, client behavior, adolescent clients, male clients, limited English-proficient clients, underserved populations). A final report with

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<sup>\*</sup> Authorized under Section 241 of the PHS Act.

<sup>†</sup> Authorized under Title X, Section 1004, 42 U.S.C. 300a-2; Family Planning Services and Population Research Act of 1970, Section 6(c); Public Law 91-572; 84 Stat. 1507, as amended; Family Planning and Population Research Act of 1975, Title II, Section 202(c); Public Law 94-63; 89 Stat. 306; Appropriation Act of 1991, Public Law 101-517.

more detailed descriptions of the methods, limitations, findings, and recommendations was presented to OPA in January 2005.<sup>1</sup>

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## 2.2 METHODS

### 2.2.1 Key Questions Addressed

The evaluation review addressed two key questions:

- What is the number, scope, and quality of evaluation studies of Title X program activities conducted during the past 5 (unpublished) to 10 (published) years?
- What are the gaps or needs in evaluation of the Title X program?

These key questions guided further specification of the review and synthesis plan, including inclusion-exclusion criteria, key words for searching electronic databases (e.g., PubMed, POPLINE), and strategies for identifying and obtaining unpublished evaluations.

### 2.2.2 Identification and Selection of Evaluation Studies

**Published Evaluations.** Using the inclusion criteria and search terms, RTI identified 490 potentially relevant published studies through electronic (n = 486) and manual searches (n = 4). Based on a joint review of the abstracts, OPA and RTI excluded 73% (n = 354) of the studies identified using electronic databases because they were not relevant to the Title X program. For the remaining 132 studies, two RTI reviewers dually and independently reviewed each abstract;<sup>‡</sup> the 4 studies identified through a manual search were not subject to dual review.

Through this process, RTI identified a total of 29 published evaluations for inclusion in the review. More than one-half (56%) of excluded studies were not evaluations, 22% were not specific to the Title X program, and 22% did not focus on issues related to the program's core family planning and reproductive health objectives.

**Unpublished Evaluations.** RTI identified 112 unpublished studies through the regional program consultants (RPCs) and contacts for the 1% set-aside evaluations. Given the variation in evaluation scope,

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<sup>‡</sup> The inter-rater agreement, defined as the proportion of studies that either both reviewers excluded or both included, was 86% for citations (n = 117) identified using "Title X" as a search term, and between 73% and 75% for citations identified using the medical subject headings (MeSH) "Medicaid" (n = 11) or "community health centers" (n = 4).

quality, and standards, the reviewers found it more efficient to conduct a joint review of these studies rather than the independent dual review that was conducted for published studies.

Of the 112 unpublished studies identified, RTI reviewers selected 39 for inclusion in the review and excluded the remainder (n = 73) for the following reasons: 45% were not evaluations, 31% lacked sufficient information to complete the review, 18% were outside the review period, and 14% were not Title X-specific or relevant to the program's core objectives.

### **2.2.3 Evaluation Review and Abstraction**

Reviewers used a standard form to abstract uniform information for each study. All reviewers were trained in the use of the form. Each completed abstract was reviewed a second time to ensure completeness and accuracy.

### **2.2.4 Key Limitations of the Review**

The key limitation of the evaluation review was difficulty identifying all of the relevant published and unpublished evaluations. For published studies, the lack of a dedicated MeSH term for Title X and authors' omission of a reference to the Title X-relevant setting (e.g., Title X-funded service site) or sample (e.g., clients of a Title X-funded clinic) reduced the efficiency and effectiveness of the electronic searches. The set of unpublished evaluations is likely to be incomplete because there is no single system to track relevant Title X evaluations at the regional, grantee, or delegate levels, including those conducted and funded with OPA funding.

Despite efforts to minimize abstractor bias through training, use of standardized procedures and forms, and second review of abstracts, some degree of abstractor bias may have been introduced.

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## **2.3 KEY FINDINGS AND SUGGESTIONS**

This section presents the major findings of the evaluation review, which included 68 evaluation studies—29 published and 39 unpublished. The review findings, including needs and gaps, are summarized under three broad headings: (1) evaluation scope; (2) evaluation quality; and (3) evaluation identification.

### 2.3.1 Scope of Evaluations

**Substantive Topic.** Of the 68 evaluations (29 published and 39 unpublished) reviewed, 69% focused on supply level issues (e.g., cost of delivering services, and structural and operational factors of providing Title X-funded services) and 31% focused on demand-level issues (e.g., service utilization or characteristics of those using or needing services). Agencies were the units of analysis in most of the supply level studies, while individuals (e.g., family planning clients or women of reproductive age) were the units of analysis in the demand-level studies. The predominance of supply level studies is consistent with the purpose of evaluation, that is, to improve program effectiveness by understanding program needs, monitoring operations and performance to ensure that programs are functioning as intended, and using evaluation to develop or modify existing program strategies. To assess need, demand, utilization, and impact, however, evaluation must also focus at the individual level. A table showing the distribution of evaluations by topic and publication status is presented in **Appendix A.**

Most supply level evaluations focused on the supply of broad reproductive health care<sup>§</sup> (10 studies, 7 published), program financing or cost issues (10 studies, 7 published), and the integration of family planning, STD, and HIV services (7 studies, 1 published). Comparatively fewer examined the supply of contraceptive services only (3 studies, 1 published), STD services only (2 studies, 1 published), emergency contraception (EC) (3 studies, 2 published), or non-STD related preventive health services (2 studies, 0 published). Most published, supply level evaluations addressed the delivery of broad reproductive health services and issues of cost or financing, while just one or two addressed issues related to the supply of other services (e.g., contraceptive only, STD only, non-STD related preventive care [e.g., breast and cervical cancer prevention], and EC).

Most demand-level evaluations addressed the demand for or utilization of contraceptive (8 studies, 5 published) and broad reproductive health services (8 studies, 1 published), while comparatively fewer addressed issues related to STD and HIV services integration (3 studies, 1 published), STDs (1 study, 1 published), or EC (1 study, 1 published).

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<sup>§</sup> The term "broad reproductive health" refers to contraceptive and related preventive health (STDs, infertility, breast and cervical cancer screening).



We reviewed no demand-level evaluations that addressed the cost of care or non-STD related preventive care.

There were a number of topics from the list of Title X program priorities and key issues in the 2004 consensus report "Future Directions for Family Planning Research"<sup>2</sup> that were not addressed by the evaluations we reviewed. These topics included the relationship and impact of family and school ties on adolescent sexual behavior; partnerships with community-based, faith-based, and other providers or organizations that work with vulnerable or at-risk populations; extramarital abstinence education; and HIV/AIDS risk prevention counseling based on the ABC message.\*\*

*The extent to which the lack of studies on specific demand- or supply-related topics represents a gap or need depends on whether better understanding of these topics is integral to achieving the program's long-term core objectives.*

**Evaluation Type.** Of the 68 evaluations in the review, 21 were process evaluations with (n = 8) or without (n = 13) a best practices component, 15 were output evaluations, 13 were needs assessments, 10 were outcome evaluations, and 4 were policy or cost analyses. Five evaluations were a combination of evaluation types (e.g., needs assessment and process evaluation). Of the studies reviewed, a higher proportion of policy or cost analyses (75%), output evaluations (73%), and outcome (60%) evaluations were published in peer review journals.

*In general, the evaluation methods used in these studies were appropriate for the topic and, in the case of programs or specific interventions, for the stage of development or implementation of programs or strategies within programs.*

**Underserved or Hard-to-Reach Groups.** Overall, 23 (34%) of the 68 evaluations reviewed focused on supply- or demand-related issues of underserved, hard-to-reach, or otherwise vulnerable populations, including men (n = 11), adolescents (n = 7), racial or ethnic minority groups (n = 2), persons with limited English proficiency (n = 1), and persons who had been sexually abused (n = 1). Comparatively few published or unpublished studies in the review focused on service

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\*\* The ABC counseling message is "A" (abstinence) for adolescents and unmarried individuals, "B" (being faithful) for married or individuals in committed relationships, and "C" (condom use) for individuals who engage in behavior that puts them at risk for HIV. (Source: Announcement of Anticipated Availability of Funds for Family Planning Services Grants, *Federal Register*, June 19, 2003 68(118):36804-36807.

supply- or demand-related issues among racial and ethnic minority groups, migrants, and those with limited English proficiency, while no studies addressed the needs of groups explicitly mentioned in the list of Title X program priorities or in the 2004 research framework report.<sup>2</sup> Such groups include low-literacy populations, the uninsured or underinsured, men in their late 20s and early 30s, or other populations that OPA and others have identified as populations deserving priority attention.

**Title X-Relevant Findings.** Several studies in the review were based on data from nationally representative samples of individuals (e.g., the National Survey of Family Growth (NSFG) or agencies (e.g., Alan Guttmacher Institute's (AGI's) Survey of Agencies Providing Contraceptives [ASPCS]) that included a Title X identifier.

*Inclusion of a Title X identifier in national data sets or other data collected for research purposes greatly increases analytic options, as well as the relevance of the findings to the Title X program.*

### **2.3.2 Evaluation Quality**

**Reporting Standards.** As expected, the quality of reporting in the published evaluations was substantially higher than in the unpublished studies. Published studies, and only a handful of unpublished ones, were rated well when assessed using the "Criteria for Assessing Program Evaluations of the Department of Health and Human Services' (HHS) Evaluation Review Panel" (see **Appendix B**). In general, these studies specified a satisfactory conceptual foundation for the study, clearly stated both their evaluation aims and specific research questions, used appropriate methods (design, data collection, and analysis), and were cautious and thoughtful when interpreting results and discussing findings.

Even though unpublished studies had no page-limit restrictions, they often reported too few details about the program or intervention, methods (design, data collection, data analysis), or interpretation and implications of results. In some cases, unpublished studies failed to establish a plausible connection between the results, conclusions, and recommendations. Incomplete reporting of many of the unpublished studies made the evaluation of their quality difficult and prone to judgment calls. While published studies are required to conform to strict length and content requirements imposed by journals, there are components of evaluation reporting that are expected as convention,

regardless of publication status, and that form the basis for assessing the study's quality. Unpublished reports should adhere to these reporting conventions.

*OPA may want to establish minimum reporting guidelines for OPA-funded evaluations conducted at the central, regional, and agency levels. The HHS Review Panel criteria could serve as a guide for identifying the key elements of an evaluation report.*

**Methods.** The published studies in this review were methodologically stronger and of higher quality than the unpublished studies. In terms of external validity, a majority of published studies were based on large samples, and many of those were probability samples. Therefore, these studies were generalizable to well-defined, larger populations. Published studies based on smaller samples were also generalizable to their target population because they included a majority of that population in their sample. Lower response rates, which affected several published studies, led authors to make questionable assumptions about representativeness of their samples. Finally, among the few cost studies, the failure to conduct sensitivity analysis on key assumptions when extrapolating results to a larger population was of some concern.

A larger proportion of the unpublished studies were based on smaller, non-probability samples. This restricted the generalizability of their findings to the sample. Unpublished studies were substantially more likely than published studies to use qualitative methods. As is generally true and appropriate for qualitative studies, generalizability is not an objective. For unpublished studies, the primary issue of internal validity was a failure to adequately explain the relationship between the evaluation findings and the analysts' conclusions and recommendations.

*If generalizability to a target population or other groups is an important study objective, OPA may want to ensure that technical and financial resources are sufficient to design and implement a study that meets this aim.*

### **2.3.3 Identifying Relevant Evaluations**

Problems in identifying relevant published and unpublished evaluations posed a substantial limitation of this review. First, the absence of a dedicated medical subject heading (MeSH) term for Title X greatly reduced the efficiency of searching in electronic databases of the

published health literature (e.g., PubMed). A dedicated subject heading term for Title X, like the one that exists for Medicaid, would allow indexers or study authors, depending on the database, to classify the subject as Title X-relevant.

*OPA may want to contact the National Library of Medicine to discuss the process for introducing a medical subject heading for Title X.*

Second, relevant studies conducted in Title X settings do not always indicate that the setting is a Title X-funded site or that the study population includes Title X clients. We found this to be true for one published study only because the authors mentioned the name of the agency, and we were able to use the Title X service provider directory to verify the agency's Title X funding status. This omission may be common, and currently there is no way to determine the extent to which this happens.

*Where relevant linkages exist between the study and the Title X program, OPA may want to ensure that published and unpublished studies make appropriate references to the program by building awareness among OPA staff, researchers, and Title X-funded agencies of the importance of making explicit these linkages.*

Finally, there appears to be no system for cataloging OPA-funded evaluations—conducted at the regional, state, and agency levels—that OPA does not manage centrally.

*OPA may want to consider implementing a system (e.g., ProCite database) for cataloging OPA-funded evaluations at all program levels. OPA could use this same system to track OPA-funded studies that reach publication in peer-reviewed journals.*

# 3 Data Review & Synthesis

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## 3.1 TASK OVERVIEW

The purpose of this data review was to provide OPA with a synthesis of current patterns and trends (1998–2002) in key Title X program indicators, using relevant data sources. More specifically, OPA was seeking information on program funding, revenue, and costs; service availability and utilization; contraceptive continuation rates among Title X users; characteristics of Title X users; service access and quality; staffing composition; and clinic turnover. A summary of the methods and key findings are presented below. A final report with more detailed descriptions of the methods, limitations, and findings was presented to OPA in January 2005.<sup>3</sup>

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## 3.2 METHODS

### 3.2.1 Identifying Relevant Data Sources

As specified by the contract scope of work, sources of Title X-relevant data considered for the review and synthesis included the Family Planning Annual Reports (FPAR), the NSFG, the SAPCS, AGI's Women in Need (WIN) estimates, data from the Infertility Prevention Project (IPP), the Centers for Disease Control and Prevention's (CDC's) Pregnancy Risk Assessment Monitoring System (PRAMS), region-wide Title X data systems in Regions I and X, the Behavioral Risk Factor Surveillance System (BRFSS), the Uniform Data System (UDS), and Healthy People 2010 national and state plans.

Data sources were considered for inclusion based on their relevance to the Title X program, the extent to which individual or agency responses were linked to Title X through an identifier, and the existence of publicly available reports. We based exclusion of data sources on the centrality of the data to the strategic information needs of Title X policy makers and administrators, availability and ease of access to reports, and concerns about the overall coherence of the report. Table 3-1 lists all data sources included in the synthesis, including the years for which data are available, the presence of a Title X identifier, and the level of aggregation.

**Table 3-1. Sources of Abstracted Data**

Source	Year	Title X Identifier	Level		
			National	Regional	State
Family Planning Annual Report (FPAR)	1998–2002	♦	♦	♦	♦
National Survey of Family Growth (NSFG)	1995	♦	♦		
Survey of Agencies Providing Contraceptive Services (SAPCS)	1999	♦	♦		
Women in Need (WIN)	1995, 2000		♦	♦	♦
Pregnancy Risk Assessment Monitoring System (PRAMS)	1998–1999				♦
CDC STD Surveillance Reports (Chlamydia)*	1998–2002		♦	♦	♦

\* Infertility Prevention Project (IPP) data on chlamydia positivity among women tested in family planning clinics.

### 3.2.2 Data Abstraction, Presentation, and Analysis

Once the potential data sources were identified, RTI staff identified and collected publicly available reports, reviewed each report to identify Title X-relevant indicators, abstracted relevant data from these reports using table templates, and analyzed and summarized patterns and trends. For each indicator, RTI presented both tables and graphs to illustrate national and region-level patterns and trends over time (where data were available) and across regions.

For each state, RTI prepared a one-page summary table of state-level data for the 5-year period from 1998 to 2002. Each summary included the number of WIN nationally, regionally, and in the state; number of all users nationally, regionally, and in the state; users by gender; number of clinics and number of users per clinic; distribution of female users by age; distribution of all users by income; and estimates of unintended pregnancy (mistimed and unwanted) from PRAMS data, when available.

RTI identified and summarized data for the indicators defined below.

- **Program Funding:** Amount of federal appropriations to the Title X program, Title X project revenue by source, and Title X project revenue per family planning user.
- **Family Planning Need:** Number of women in need of publicly subsidized contraceptive services and supplies, defined as the number of women at risk of unintended pregnancy (ages 13 to 44, sexually active, fecund, and not currently pregnant or trying to become pregnant), who are low income (less than 250% of federal poverty level) or younger than age 20.<sup>4</sup>

- **Service Availability in Title X-Funded Sites:** Number of Title X-funded services sites; distribution of Title X-funded providers by agency type; availability of contraceptive methods; availability of family planning–related and noncontraceptive services; and availability of reproductive, general, and specialized health services for men.
- **Service Use:** Percentage and characteristics of reproductive-age women that rely on Title X-funded services for their contraceptive and related preventive health care, number of users per Title X-funded service site, demographics (age, race, and ethnicity) and income level of female and male Title X family planning users, female users by primary contraceptive method, and use of related preventive health services (e.g., Pap tests, clinical breast exams, HIV and STD tests).
- **Service Accessibility and Quality:** Access to oral contraceptives and emergency contraception, follow-up policies and procedures for oral and injectable contraceptive users, policies regarding pelvic exam deferral, presence and scope of male outreach strategies, and perceived barriers to serving male clients.
- **Family Planning Providers:** Composition of medical providers in Title X-funded clinics, as measured in full-time equivalents (FTEs); the ratio of nonphysician to physician FTEs; and the number of encounters per physician and nonphysician FTE.
- **Service Costs:** Users by source of payment and fees for contraceptive services in Title X-funded sites.
- **Medical Provider Staff Composition and Utilization:** Staffing patterns for clinical services personnel in Title X clinics, as well as the utilization of these different clinical services personnel in providing Title X-funded services.
- **Service Cost:** Amount of resources (e.g., labor, materials, lab and other services, supplies) used at the site of service delivery to produce or deliver a specific service, as well as fees charged to clients.

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### 3.3 SELECTED KEY FINDINGS

The final report for this task presents detailed findings, including graphs and tables showing trends and patterns over time and across regions. In this section, we present selected findings from the FPAR,<sup>5-9</sup> WIN,<sup>10-12</sup> and the 1999 SAPCS<sup>13-14</sup> data. The full report with data for all indicators, including key state-level indicators, was submitted to OPA in January 2005.<sup>3</sup>

### **3.3.1 Program Funding**

**Title X Project Revenue.** Between 1998 and 2002, actual total revenue increased 27% from \$708.6 million in 1998 to \$899.3 million in 2002. When adjusted for inflation, the growth in total revenue was substantially lower (8%), growing from an adjusted (1981 constant dollars [1981\$]) \$242.6 million in 1998 to \$261 million in 2002. The distribution of most sources of revenue remained relatively stable between 1998 and 2002, with the exception of a 4-percentage point increase in the percentage accounted for by Medicaid (13% in 1998 versus 17% in 2002). In 2002, state and local government sources accounted for 28% of revenue, followed by 26% from Title X grants, 17% from Medicaid, 11% from patient collections, and 18% from other sources.<sup>5-9</sup>

**Revenue per User.** Between 1998 and 2002, the adjusted (1981\$) total revenue per user decreased 5% from \$55.04 per user in 1998 to \$52.47 per user in 2002. Similarly, the adjusted total Title X revenue per user decreased 1% from \$13.62 per user in 1998 to \$13.51 per user in 2002.<sup>5-9</sup>

### **3.3.2 Women in Need of Publicly Funded Contraceptive Services and Supplies**

In 1995, almost 33.2 million women nationally needed contraceptive services and supplies, and about one-half (16.5 million) were in need of publicly supported contraceptive services and supplies. Of women in need of publicly supported contraceptive services and supplies, 30% were teens and 70% were low-income women between the ages of 20 and 44.<sup>10</sup>

In 2000, almost 34 million women nationally needed contraceptive services and supplies, and a slightly lower percentage than in 1995—48% (16.4 million women)—were in need of publicly supported contraceptive services and supplies. Teens accounted for almost 30% of women in need of publicly supported services and supplies, while low-income women between the ages of 20 and 44 comprised the remaining 70%.<sup>11</sup>

### **3.3.3 Title X Coverage of Women in Need**

Frost and colleagues<sup>12</sup> estimated that in 1994 Title X-funded clinics served 25% of all women estimated in 1995 to be in need of publicly funded family planning services. In 2001, this percentage increased to 28% of all women estimated in 2000 to be in need of publicly funded



services. Between 1994 and 2001, the percentage change in need met by Title X-funded clinics was 11% nationally, compared with only 3% among all publicly funded clinics. By state in 2001, the proportion of need met by Title X clinics ranged from 14% in Indiana to 53% in Mississippi, and in four states the proportion of need met exceeded 50%. Between 1994 and 2001, the proportion of need met by Title X clinics increased 50% or more in 5 states, increased between 20% and 49% in 12 states, and declined 10% or more in 9 states (-10% to -50%).<sup>12</sup>

### 3.3.4 Service Availability

**Number of Clinics.** The number of Title X-funded service sites increased 2% from 4,552 in 1998 to 4,645 in 2002. The average number of users per service site increased 11% from 969 in 1998 to 1,071 in 2002.<sup>5-9</sup>

### 3.3.5 Client Characteristics

**Number of Users.** Between 1998 and 2002, the number of family planning users increased 13% from more than 4.4 million to almost 5.0 million.<sup>5-9</sup>

**Income Level.** Between 1998 and 2002, there was little change in the percentage distribution of users by income level, and in 2002, 66% of users were at or below the federal poverty level and almost 90% had incomes at or below 200% of the federal poverty level.<sup>5-9</sup>

**Gender.** Between 1998 and 2002, the percentage of female users decreased from more than 97% in 1998 to slightly less than 96% in 2002, while the percentage of male users increased from less than 3% in 1998 to slightly over 4% in 2002.<sup>5-9</sup>

**Age.** During 1998 to 2002, the national age distribution of female users remained stable. In 2002, the largest percentages of female users were age 20 to 24 (31%) and 15 to 19 (27%).<sup>5-9</sup>

Between 1998 and 2002, there were small percentage-point shifts in the national age distribution of male users. In 2002, the largest percentages of male users were age 20 to 24 (30%) and 15 to 19 (29%).<sup>5-9</sup>

**Ethnicity and Race.** Between 1998 and 2002, the number of female users that were of Hispanic/Latino origin increased from 17% of all female users in 1998 to 21% in 2002. In the same period, there was

little change in the distribution of female users by race, with the exception of the percentage for whom race was unknown or not reported, which increased from 8% in 1998 to 11% in 2002. In 2002, 64% of female users were white, 21% were black, 5% were Asian/Pacific Islander, and less than 1% was Native American or Alaskan. Eleven percent of female users had an unknown or unreported race.<sup>5-9</sup>

Between 1998 and 2002, the number of male users that were of Hispanic/Latino origin increased from 18% of all male users in 1998 to 22% in 2002. During this same period, there were small percentage-point changes in the distribution of male users by race, with the biggest changes in the proportion of black and race unknown or not reported. In 2002, slightly more than half of male users were white (52%), 26% were black, 5% were Asian/Pacific Islander, and 1% were Native American or Alaskan. Sixteen percent of male users had an unknown or unreported race.<sup>5-9</sup>

### **3.3.6 Contraceptive Use**

Between 1998 and 2002, there were only small changes (1 to 2 percentage points) in the distribution of female users by primary contraceptive method. In 2002, contraceptive prevalence was highest for oral contraceptives (44%), followed by injectable contraceptives (17%) and male condoms (14%). Almost 14% of female users were not using a contraceptive method because they were pregnant (6%) or because of another reason (8%). Method use was unknown for 2% of female users.<sup>5-9</sup>

### **3.3.7 Utilization of Related Preventive Health Services**

**Pap Tests.** Between 1998 and 2002, agencies provided more than 2.9 million Pap tests each year. Between 1998 and 1999, the number of Pap tests performed per 10 female Title X users remained constant at 6.9. Between 1999 and 2002, the number of tests per 10 female users declined to 6.7, and by 2002 the number was 6.2.<sup>5-9</sup>

**STD Tests.** Between 1998 and 2002, the total number of STD tests performed increased 15% from 4.6 million in 1998 to 5.3 million in 2002. In 2002, Title X providers performed 10.5 STD tests for every 10 female users and 11.7 tests for every 10 male users.<sup>5-9</sup>

**HIV Tests.** Between 1998 and 2002, the total number of HIV tests performed increased 18% from 418,437 in 1998 to 493,622 in 2002. In

2002, Title X providers performed three HIV tests for every 10 male users and less than one HIV test for every 10 female users.<sup>5-9</sup>

### 3.3.8 Service Access and Quality

**Access to Oral Contraceptives (OCs).** Of the Title X-funded agencies surveyed in the 1999 SAPCS, 90% provide OCs on site, 6% provided only the initial supply on site and a referral for remaining cycles, and 4% provide a prescription only. Compared with agencies that received no Title X funds, a significantly higher proportion of Title X-funded agencies provide OCs on site (90% versus 49%,  $p < .001$ ), and a significantly smaller proportion provide either a prescription only (4% versus 30%,  $p < .001$ ) or the initial supply on site with a prescription for later cycles (6% versus 21%,  $p < .001$ ).<sup>13</sup>

**Access to Emergency Contraception (EC).** Of the Title X-funded agencies surveyed in the 1999 SAPCS, more than 9 of every 10 (92%) provide EC onsite, 64% do not require new clients to have a complete visit before providing EC, 19% will provide or prescribe EC before it is needed, and only 11% will prescribe EC over the phone. Compared with agencies that received no Title X funds, a significantly higher percentage of Title X-funded agencies provide EC at their clinics (92% versus 61%,  $p < .001$ ) or do not require new clients to have a complete visit before obtaining EC (64% versus 41%,  $p < .001$ ). Conversely, a significantly lower percentage of Title X-funded agencies prescribe EC over the phone compared with agencies receiving no Title X funds (11% versus 26%,  $p < .001$ ).<sup>13</sup>

#### **Followup Policies and Procedures for OCs and Injectable**

**Contraception.** Of the Title X-funded agencies surveyed in the 1999 SAPCS, 59% remind oral and injectable contraceptive clients of their next visit and 50% contact these clients if they miss an appointment. Between agencies with and without Title X funding, there are no significant differences in the percentages that practice these follow-up procedures.<sup>13</sup>

**Pelvic Exam Deferral Policies.** Among Title X-funded agencies, 65% permit deferral for OCs, 47% permit deferral for injectable contraceptives, and 22% permit deferral for contraceptive implants. Compared to agencies that received no Title X funds, a significantly higher percentage of Title X-funded agencies permit deferral of a pelvic exam for a client initiating oral (65% versus 41%,  $p < .001$ ) or injectable contraceptives (47% versus 36%,  $p < .05$ ).<sup>13</sup>

### **3.3.9 Services for Males**

**Male Outreach.** Of the Title X-funded agencies surveyed in the 1999 SAPCS, 83% want to serve more men than they are currently serving, 22% have programs targeted to men, and 24% implement activities to recruit male clients. Compared to agencies without Title X funding, significantly higher percentages of Title X-funded agencies have programs targeted to men (22% versus 12%,  $p < .01$ ) and implement activities to recruit men (24% versus 15%,  $p < .05$ ).<sup>14</sup>

**Barriers to Serving Male Clients.** Compared to agencies without Title X funding, significantly higher percentages of Title X-funded agencies cited lack of men's awareness of services (62% versus 51%,  $p < .05$ ), difficulty finding or recruiting male clients (53% versus 41%,  $p < .05$ ), a shortage of male providers (49% versus 22%,  $p < .001$ ), lack of a male orientation at the facility (37% versus 18%,  $p < .001$ ), and inconvenient hours for men (20% versus 11%,  $p < .01$ ) as barriers to serving men.<sup>14</sup>

### **3.3.10 User Payment for Services**

Among Title X-funded agencies surveyed in the 1999 SAPCS, 20% of clients relied on Medicaid for payment, 63% received care for free or a reduced fee, and 17% paid full price. Compared with clients obtaining family planning care in publicly funded agencies that received no Title X funds, a significantly lower percentage of Title X clients relied on Medicaid (20% versus 41%,  $p < .001$ ) or paid full price (17% versus 25%,  $p < .05$ ), and a higher percentage received care for free or a reduced fee (63% versus 34%,  $p < .001$ ).<sup>13</sup>

### **3.3.11 Clinic Staffing and Utilization**

Between 1998 and 2002, the total number of physician FTEs increased 31% from 395 in 1998 to 516 in 2002, while the number of encounters per physician FTE decreased 24% from 2,424 in 1998 to 1,835 in 2002. For this same period, the total number of FTE nonphysician providers increased 43% from 1,895 in 1998 to 2,706 in 2002, while the number of encounters per FTE nonphysician provider decreased 10% from 2,212 in 1998 to 1,987 in 2002. In 2002, there were 5.2 FTE nonphysician providers for every FTE physician involved in the direct delivery of Title X-funded care.<sup>5-9</sup>

### **3.3.12 Data Gaps**

We were unable to identify national-level information on rates of contraceptive continuation among Title X clients for the review period.

While a literature review on this issue was beyond the scope of this task, a limited search identified several studies<sup>15-19</sup> that used 1995 NSFG data to examine contraceptive practices. None of these studies, however, controlled for source of care (e.g., private physician, Title X clinic, non-Title X clinic, other) in their analyses.

We also were unable to identify national-level information on the cost of providing services in Title X-funded clinics. Instead of data on service costs, we present information on fees charged for a range of contraceptive services by publicly funded family planning agencies, including Title X-funded agencies. Information on service fees are based on data from the 1999 SAPCS.<sup>13</sup>

*Review of the Title X Family Planning Program Evaluation  
Activities and Assessment of Current Evaluation Needs*

# 4 Assessment of Issues Affecting Title X Program Performance

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## 4.1 TASK OVERVIEW

To address OPA's need for information about the internal (e.g., structural, administrative, operational) and external factors affecting the program's performance and management at the regional, state, and clinical levels, RTI conducted interviews and focus groups with Title X program stakeholders, including the federal staff that administer the program at the regional level (Regional Health Administrators [RHAs] and Regional Program Consultants [RPCs]), Title X service grantees and delegates in nine states, and family planning clients. RTI also collected data using self-administered questionnaires. The final report for this task was submitted to OPA in September 2006.<sup>20</sup>

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## 4.2 METHODS

### 4.2.1 Key Informant Identification/Selection

Between October 2004 and June 2005, RTI completed 48 interviews with 78 informants, including 9 RHAs, 10 RPCs, 4 other region-based federal staff, 19 staff from nine grantee agencies, and 36 staff working in clinics operated by eight delegates and one grantee.

The number of grantees selected to participate in the key informant interviews was limited to nine to adhere to Office of Management and Budget (OMB) restrictions on data collection. RTI collaborated with OPA to select the regions and participating grantees. Selection was based on factors deemed important to capturing the diversity of the national Title X program, including geographic diversity, type of agency administering and monitoring the Title X service grant (e.g., state health departments, Planned Parenthood), structure of the delegate network (i.e., health department only, private only, or public-private mix), number of family planning users served by the Title X grantee and delegates, and the availability of family planning funding

through state Medicaid waivers. The nine grantees included five health departments, three Family Planning Councils, and one Planned Parenthood. All but one grantee had a mixed delegate structure (i.e., both public and private delegates), and four grantees operated in states with a Medicaid family planning waiver.

Working with RTI and the RPC, each grantee identified a delegate agency in their network that met the selection criteria and was willing to assist with focus group planning and recruitment. RTI and OPA sought delegates that reflected the diversity of the Title X service network (e.g., diversity by agency type, rural or urban location, level of STD/HIV integration, level of STD prevalence in the area being served) and clientele (e.g., diversity by age, gender, race, ethnicity).

The nine agencies (eight delegates and one grantee) that participated in the clinic interviews and focus groups included three county health departments, three federally qualified health centers, a youth center, a Planned Parenthood affiliate, and a hospital-based program. The primary service function for almost two-thirds (67%) of participating agencies was general primary health care or public health, while family planning/reproductive health services was the primary service for one-third (33%) of participating agencies. In terms of service networks, delegates had an average of 27.3 clinics overall and slightly fewer (26.1) Title X-funded clinics.

We initially sought a sample of 27 clinics (three per delegate) that was heterogeneous with respect to STD/HIV integration, but found that among the delegates selected, there was a uniformly high degree of STD/HIV integration in their clinics; therefore, this criterion was dropped. The final sample included 22 clinics. Participating clinics served an average of 1,496 female users (median = 1,251) and 116 male users in 2003.

#### **4.2.2 Client Focus Group Recruitment**

The purpose of the focus groups was to solicit client perspectives on the availability and accessibility of Title X-funded services, experiences with clinical and nonclinical personnel, and overall satisfaction with the care they received from Title X-funded clinics. RTI worked with grantee and delegate representatives to develop a plan to recruit participants for 20 focus groups, which were homogeneous with regard to gender, race/ethnicity, and age. To minimize the burden associated with recruiting participants and hosting the focus groups, RTI provided



Section 4: Assessment of Issues Affecting Title X Program Performance

agencies with printed recruitment materials (posters, informational flyers). Furthermore, clinic staff scheduled focus groups at times that would minimize disruptions in clinic flow. Each clinic received \$100 for assisting with focus group recruitment and coordination. RTI also offered participants a cash incentive for participating in the discussion. The incentive amount, initially set at \$25, was increased to \$35 to facilitate recruitment and increase participation.

Between October 2004 and June 2005, 91 individuals participated in 15 RTI-led focus groups. Data for two female groups (n = 8 participants) were excluded from the analysis because RTI learned that the participants were clinic employees or volunteers. Table 4-1 presents the focus group breakout by gender and race/ethnicity and notes about exclusions.

**Table 4-1. Number of Focus Groups Conducted, by Age, Gender, and Race/Ethnicity**

Age/Gender	Race/Ethnicity			Total
	Black	White	Hispanic	
<b>18–21</b>				
Female	3	1 <sup>a</sup>	1	5
Male	2	–	–	2
<b>20–24</b>				
Female	–	– <sup>b</sup>	2	2
Male	1	–	–	1
<b>20–29</b>				
Female	3 <sup>c</sup>	– <sup>b</sup>	–	3 <sup>c</sup>
Male	–	–	–	–
<b>25–29</b>				
Female	–	1	1	2
Male	–	–	–	–
<b>Groups</b>				
Female	6	2	4 <sup>d</sup>	12
Male	3	–	–	3
Total	9	2	4 <sup>d</sup>	15
<b>Participants</b>				
Female	37	8	24	69
Male	22	0	0	22
Total	59	8	24	91

- <sup>a</sup> Data for this group were excluded from the analysis because RTI learned that the participants (n = 2) were clinic volunteers.
- <sup>b</sup> RTI conducted individual interviews with the single participant that showed up for each one of the scheduled focus groups, and we included their responses in the analysis.
- <sup>c</sup> One (n = 6 participants) of the three groups in this category was excluded from the analysis because RTI learned that the participants included clinic employees.
- <sup>d</sup> Two focus groups (n = 13 participants) with Hispanic females were conducted in Spanish.

While clinic staff (and RTI) attempted to over-recruit (i.e., 12 clients per focus group) to ensure participation of 6 to 8 clients for each of the

20 planned focus groups, at some clinics recruitment was difficult because of child care issues, scheduling conflicts, lack of transportation, and low interest. The increase in the incentive amount improved participation among black clients but not among white female clients. In some cases, RTI and clinic staff expanded the age range in an effort to recruit a sufficient number of participants. Despite these efforts, success in recruiting white females was minimal.

#### **4.2.3 Data Collection Procedures and Instruments**

**Key Informant Interviews.** Each key informant interview was conducted by a team of two researchers using semistructured interview guides designed for the informant group. RTI developed the discussion guides in collaboration with OPA, including the addition of questions to collect information for the Program Assessment Rating Tool (PART) Review of the Title X program, scheduled for April 2005. The interviews were audio-taped to ensure the accuracy of interview notes. If a key informant was unavailable during the site visit, the interview was conducted by telephone. Prior to the interview, RTI sent the topic guide and other materials to key informants. The duration of the interviews varied across the informant groups: interviews lasted 1 hour for RHAs and clinic staff and 2 hours for RPCs and grantees.

**Priorities and Key Issues Score Card.** To complement the questions in the interview guides about the purpose and design of the Title X program, RTI developed a score card so key informants could rank the program's 2004 priorities and key issues in terms of each item's importance in their specific region, state, or service area. Scoring was based on a 5-point scale (1 = low importance; 5 = high importance).

**Pre-Visit Site Questionnaire.** In addition to the score card, delegate agency contacts were also asked to complete a 22-item questionnaire about the characteristics of the selected clinics, including hours of operation, service availability, family planning user profile, availability of STD testing, and protocols related to chlamydia and HIV testing.

**Focus Groups.** In the 2 to 4 weeks before the site visit, clinic staff recruited focus group participants using flyers and posters prepared by RTI. A two-member research team conducted each focus group. One member of the RTI team led the discussion, while the other took notes on a laptop computer. The RTI moderator used a semistructured discussion guide, and verbal informed consent was obtained before

starting the discussion. To ensure accuracy of the discussion notes, the discussions were also taped.

#### **4.2.4 Institutional Review Board (IRB) Procedures**

All study protocols and materials were reviewed and approved by RTI's IRB. Evidence of IRB review and approval for the study protocols was shared with participating grantee and delegate agencies. Four grantees also had their own IRBs review and approve RTI's protocols. Review at one agency was delayed and prevented focus groups from taking place in the selected clinics.

#### **4.2.5 Data Management and Analysis**

**Interview and Focus Group Data.** RTI analysts used NVivo software to code the interview and focus group notes and to generate topic-specific reports by type of key informant or client group. The codes were organized around key interview topics and questions, which were identified a priori. The coding was sufficiently flexible to account for emerging themes and issues. A senior team member reviewed the interview and focus group notes for completeness prior to coding. The notes were again reviewed for completeness and accuracy after coding.

**Pre-Visit Questionnaire and Score Card Data.** Data from the *Pre-Visit Site Questionnaire* and the *2004 Title X Priorities and Key Issues Score Card* were entered into Excel and tabulated using STATA statistical software. Additionally, RTI calculated the mean score for each priority and key issue separately and then ranked each set using the mean score. We also weighted informants' choices of the top five priorities and key issues, giving a weight of 5 to items selected as the top or first priority, a weight of 4 to items selected as the second highest priority, and so on. The weighted scores were then summed across and within informant groups to determine the top five priorities and key issues (i.e., those with the highest weighted score) overall and by group. The total weighted scores and the top five priorities and key issues are presented in **Appendix C**.

#### **4.2.6 Study Limitations**

The findings of this study are subject to both method- and study-specific limitations. First, although RTI and OPA attempted to select a diverse sample of agencies and clients to reflect the diversity of the Title X program, the sample selection was nonrandom and the sample sizes were small. As a result, the findings cannot be generalized to the

wider population from which they were drawn, such as all Title X grantees, delegates, clinics, and clients.

Second, the selection of delegates, clinics, and focus group participants may have been subject to selection bias. At each level, grantees, delegates, and clinics that participated in their selection may have consciously or unconsciously, in ways that we could not observe or measure, selected higher-performing sites or clients with more favorable views than a randomly selected sample of agencies or clients.

Third, a limitation of focus groups is that because participants are speaking in a social context, their statements may not reflect their individual views but rather the views of the prevailing group opinion (i.e., "bandwagon effect"). In addition, because not all participants responded to all questions, it can be difficult to determine how widely a given opinion was shared within the group. The focus group format also lends itself to a certain type of person that is comfortable engaging in a discourse with a group of strangers. Shy, less talkative people may be less likely to agree to participate in a focus group. Although these limitations can be minimized with skillful moderation, they are nonetheless important to bear in mind.

Fourth, the extent to which barriers to service access could be explored was limited by the fact that the focus group sample included only current Title X clients, thereby excluding past clients in the target population that are no longer using the services because they were dissatisfied with the care, had trouble accessing services, or had another reason for not using the services.

Fifth, the focus group findings are limited because we were not able to conduct all planned groups or to include the desired number of participants for some groups. In particular, the number of white women that participated in the study was extremely small because of low recruitment, and we conducted only three male focus groups, all of which were composed of non-Hispanic blacks. The extent to which white women have different perspectives than black or Hispanic women, or to which men have different perspectives than women, cannot be fully developed with these data.

Sixth, most of the discussions were held during the work day, which likely limited participation of certain types of clients, particularly those that work during the day or have child care or transportation barriers.

Finally, the topic guides went through numerous revisions in order to strike a balance between breadth and depth. In the end, the guides covered a very broad range of issues, limiting the extent to which any single issue could be explored in depth without placing an undue burden on participants' time.

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## **4.3 KEY FINDINGS: INFORMANT INTERVIEWS**

### **4.3.1 Program Purpose and Design**

**Purpose.** All key informants agreed that the purpose of the Title X program is to provide family planning services and prevent unintended pregnancies. Many respondents also mentioned delivery of related preventive health services and the priority in the provision of care to low-income, adolescent, and other underserved populations. All responses were consistent with the program's intent, as specified in the Title X statute and regulations.

**Need and Unduplicated Effort.** Key informants agreed that the Title X program addresses an important need for comprehensive family planning and related preventive health services in a manner that is not addressed by any other federal programs. Several of the program's unique features include providing priority service to low-income individuals, many of whom are uninsured and rely on Title X clinics as their only source of primary care; ensuring access to a wide range of FDA-approved contraceptive methods; ensuring confidential services to minors; providing comprehensive education and counseling; using a sliding fee scale; and using funds to support clinic infrastructure.

Limited program funding is one of the most important factors preventing the program from addressing unmet need among its target population. Other unmet needs are those that result from lack of funding to provide newer STD screening tests, newer hormonal methods and surgical sterilization procedures, on-site STD treatment, bilingual providers, and greater service availability (e.g., clinics in locations where they are needed) and accessibility (e.g., expanded clinic hours).

**Structure.** In general, there was strong agreement that the program's decentralized structure allows it to have a significant impact. Unlike more centralized programs, informants think the decentralized structure is advantageous, allowing flexibility and responsiveness to local contexts, as well as improved accountability and monitoring.

Informants recognized that RPCs play an important role in facilitating the relationship between grantees and the federal program office and in helping grantees adapt to funding and other program requirements. Grantee informants expressed appreciation for the decentralized structure, although some would prefer even greater flexibility and others pointed to inconsistencies in the interpretation of protocols and mandates across regions.

**Targeting Resources.** There is not consensus among informants that resources are targeted appropriately. Some informants stated that the funds are targeted appropriately, but that funding levels are inadequate. Other informants, however, stated that new program priorities—some of which they believe to be unrelated to Title X’s mandate—divert scarce resources away from core Title X services.

**Program Priorities and Issues.** Informants agreed that the purpose of the Title X program is to provide family planning services and prevent unintended pregnancies. Informants ranked two of the program’s top 2004 priorities—assuring access to highly effective contraception and provision of high-quality clinical family planning and related preventive health services that improve overall health—as the two most important issues in their region, state, or service area. Other program priorities and key issues that informants ranked among the five most important included the increasing cost of providing family planning services (ranked third overall); provision of family planning and related preventive health services to hard-to-reach uninsured or underinsured populations (ranked fourth overall); and assuring access to services that include STD and HIV prevention education, counseling, and testing (ranked fifth overall).

Although the informants’ top two priorities corresponded closely with the priorities of the Title X program, the remaining priorities varied slightly across respondent types. For example, providing services to adolescents was identified as one of the top five priorities by clinic and grantee informants, but not by federal staff. Clinic staff were the only informants that did not place the provision of services to hard-to-reach uninsured and underinsured populations in the top five, but the only ones to include the provision of STD and HIV services. The rankings overall and by group are presented in *Appendix C*.

#### **4.3.2 Program Planning**

**Planning Activities and Stakeholder Involvement.** RHAs, RPCs, and grantees are involved in a range of planning activities that differ both in substance and intensity according to their respective roles in program implementation. In general, RHAs' involvement in Title X program planning focuses on facilitating program coordination and collaboration among federal health programs, while RPCs engage in program planning activities at the central, (cross-) regional, and grantee levels. Stakeholder participation in planning occurs at all levels: the central office engages the RPCs, the RHAs engage other federal programs at the regional level, RPCs engage grantees, and grantees engage their delegates. Private nonprofit grantees and delegates also engage their boards of directors and other internal planning units, while public health agencies involve other health department units (e.g., Maternal and Child Health, Minority Health, or STD).

**Use of Targets or Performance Measures.** Almost all RPCs and grantee informants reported that planning involves discussions about targets and measures of need and performance, including service utilization measures from the FPAR (numbers of users, low-income users, and adolescent users), health outcome measures (rates of unintended pregnancy and teen pregnancy), socioeconomic status measures (poverty, uninsured rate), and other performance and quality measures initiatives (e.g., Family Planning Councils of America [FPCA] and the Region VIII Quality Improvement Project). The extent to which targets and measures are used to plan activities with delegates varies considerably across grantees.

**Suggestions for Improving Planning.** There was no consensus among informants on strategies for improving planning, but informants offered various suggestions, including strengthening delegates' capacity to collect and report measures, focusing on evaluation and "preplanning activities," holding more issue-focused planning meetings, increasing the cross-region exchange of ideas and dialogue, and developing agency planning skills.

#### **4.3.3 Program Management**

**Program Monitoring.** At each level of the Title X program, OPA regional staff and Title X-funded agencies engaged in a variety of activities to monitor program performance, quality, and compliance with program mandates, guidelines, and mandatory reporting laws.

Key procedures and tools for monitoring grantees were generally standard across regions, while those used by grantees to monitor delegates appeared to vary widely. In general, the various monitoring procedures and tools seem appropriate to ensure satisfactory grantee performance and compliance with the program's fiscal and service guidelines and mandatory reporting requirements. Each of these mechanisms provides RPCs and grantees with different types of information at numerous points in the grant cycle.

**Partnerships and Collaboration.** Additionally, OPA regional staff, grantees, and delegates engaged in a range of collaborative partnerships that both complement and supplement the Title X-funded activities. At the regional office level, these partnerships generally involved collaboration with other federal programs on issues of shared interest or relevance to Title X. In contrast, grantees and delegates coordinate with a range of federal, state, and local/community partners that vary by state and service area.

**Agency Type and Program Implementation.** Finally, informants recognized the association between type of grantee or delegate agency and implementation of Title X activities. The relative strengths and weaknesses by agency type differ across state and region, and some informants acknowledged that a "mix" of agency types enhances both management and performance.

#### **4.3.4 Program Funding**

**Funding Sources, Adequacy, and Trends.** Title X projects receive funding from a variety of sources, including Medicaid (traditional and waiver programs), state revenue, Title V and Title XX block grants, CDC, private third parties, client collections, and other sources. The composition of program revenue varies considerably across regions and states. Trends in these funding sources are mixed, with funding from Medicaid waivers representing an increasingly important source of project revenue in selected states and regions. However, not all states have waivers, and a few RPCs and grantees reported that they have done little to ease funding pressures in their regions. Given the increasing cost and growing demand for services, key informants at all levels expressed concern about reductions in the scope and quality of the services they are able to provide at current funding levels.

**Impact of and Responses to Funding Levels.** Informants agree that service availability, accessibility, and quality are negatively



affected by the program's current level of funding. The lack of adequate funding has limited the range of contraceptive options and the supply of newer hormonal methods and use of newer rapid screening technologies. In recent years, inadequate funding has led to clinic closings and/or reductions in clinic hours, which in turn have decreased the availability of services for needy clients. Other less widely noted effects of inadequate funding include limits on the range and scope of STD and HIV services, reductions in staffing or replacement of registered nurses with less qualified staff, and reductions in enabling services (e.g., transportation and language assistance). To address funding inadequacies, agencies aggressively pursue additional funding from OPA and other public and private sources. A few informants also noted such efforts as expanding service networks, actively pursuing third-party revenue and donations, and maximizing existing funding sources.

**Title X Fund Allocation.** Methods for allocating Title X funds are specific to regions and grantees. Because these methods are not uniform, grantees and delegates across regions are subject to different funding criteria, which may include historic or base funding levels, current performance (e.g., number of users), and the extent to which the program is serving target client groups (e.g., poor or low-income adolescents).

#### **4.3.5 Family Planning Services: Needs and Barriers**

**Groups in Need.** Respondents identified low-income populations, the uninsured, and teens as the groups with the greatest need for subsidized family planning services. Respondents most frequently mentioned that teens, younger teens, minorities, immigrants, those in rural areas, and the homeless are the most hard-to-reach groups. Variation across informants in terms of the "in need" and "hard-to-reach" subgroups may reflect region- and state-level differences in social and demographic characteristics of the population and health policies and laws that affect service supply and access.

**Barriers and Solutions.** The most salient barriers to family planning services mentioned were language, transportation, and limited clinic capacity. Several informants mentioned lack of political and community support for family planning services, due in part to a lack of awareness and understanding of agency activities and the wide-ranging benefits of family planning among the general public. Clinics

have implemented various strategies to reduce barriers, which include providing language assistance services, operating mobile clinics, providing bus tokens and parking validations, locating clinics on major public transportation routes, accepting payment by credit card or installment, allowing walk-in clinics, and extending operating hours (nights and weekends). Informants cited lack of funding as the major obstacle to fully addressing and eliminating these barriers. A few informants also mentioned the need for public health leaders to promote greater awareness and understanding of the benefits of family planning for women, men, children, and families.

#### **4.3.6 STD and HIV Services: Needs and Barriers**

**Groups in Need.** Respondents most frequently identified teens, young adults and, to a lesser extent, minorities as groups with the greatest need for STD and HIV services. The groups with highest and unmet need or those that were hard to reach varied across states and regions. This variation is likely a reflection of the sociodemographic characteristics of the population, health services and policies, and STD and HIV prevalence. Groups identified as being the hardest to reach overlapped substantially with those perceived as having the greatest need.

**Barriers and Solutions.** According to key informants, the main barriers to STD and HIV services were clients' embarrassment, stigma, and concern about confidentiality; clients' low perception of risk; and the high cost of providing services. Access to additional resources such as supplemental HIV funding, participation in the CDC IPP, use of rapid-testing technologies, and better coordination with off-site testing facilities were acknowledged as critically important to providing STD and HIV services. Nonetheless, informants noted that inadequate funding for these services continues to be a significant challenge.

#### **4.3.7 Integration of STD and HIV Services with Family Planning**

**Title X Integration Goal.** Generally, RHAs and RPCs reported that the goals of STD and HIV integration with family planning have been communicated well. However, some grantees and delegates commented that the goal is clear but funding is inadequate, while others stated that integrated STD services, except for HIV, have been offered in Title X-funded clinics for many years. Informants' comments indicate that integration of HIV services appears more difficult to achieve than services for non-HIV STDs.

**Barriers and Solutions.** Most of the informants noted lack of funding as the primary barrier to more complete integration through expanded service offerings, and several expressed concern about diverting limited Title X family planning funds to expand STD services. Other barriers identified include the time required to provide HIV testing services and train staff, provider resistance, difficulty maintaining adequate protocols to protect client confidentiality, inadequate staffing, limitations on the amount of new information that a client is able to absorb during a single family planning encounter, and excessive paperwork.

#### **4.3.8 Human Resource Capacity of Title X-Funded Agency**

**Staff.** Our findings highlight the staffing challenges faced by many of the Title X service providers. The most frequently cited staffing need is for nurse practitioners and bilingual providers. Barriers to recruitment or retention include noncompetitive salaries and high turnover. Informants also mentioned a shortage of staff to cover vacations, sick days, and training.

**Training Needs and Barriers.** Approximately half of clinic managers and grantees reported satisfaction with the breadth and scope of available training opportunities. Specific training needs mentioned across the informant groups include patient counseling, contraceptive and STD technology updates, HIV counseling certification, reporting and notification procedures (e.g., rape or incest), and strategies for incorporating the ABC message into STD prevention counseling. Respondents cited a lack of staff, lack of time, distance, and cost as the most significant barriers to training.

**Technical Assistance Needs and Barriers.** Like training needs, the technical assistance needs of the respondents varied considerably, but patient flow management and data collection and analysis were cited across the various groups as areas of technical need. Informants were generally satisfied with their access to technical assistance via the Regional Training Centers and other resources.

**Awareness and Use of OHAP and OMH HIV Resources.** Based on informants' responses, awareness and use of HIV technical assistance from OHAP and OMH appears to be confined to the regional offices. One-third or fewer of grantee and clinic-level informants reported that they were familiar with or used these programs.

## **4.4 KEY FINDINGS: CLIENT FOCUS GROUPS**

### **4.4.1 Views on Clinic Characteristics**

For both female and male focus group participants, the most important qualities in a clinic are its staff, efficiency, and accessibility.

Participants value clinic staff that are friendly, professional, competent, respectful, show concern for their clients as people, and maintain client confidentiality. For adolescent participants, it is important that staff be nonjudgmental. In terms of efficiency of clinic operations, participants value prompt attention and sufficient time with service providers (i.e., they are not rushed). In terms of access, participants value a clinic that is convenient (e.g., on a bus route), is easy to locate (e.g., good signage), and has ample parking. The length of time to get an appointment, scheduling flexibility, operating hours (nights, weekends), and low- or no cost services are also important. Finally, male participants in one group stressed the value of having a program that was comprehensive and focused specifically on men. In general, participants in most focus group participants thought their clinics and the staff at the clinics had the characteristics they valued.

### **4.4.2 Views on Clinical Services Providers**

The most valued characteristics of clinical services providers, from the participants' perspective, are good rapport (friendly, welcoming, concerned with client as people) and communication (take time to find out client concerns, explain what they are doing during the exam in terms the client understands, allow client to ask questions, provide clear instructions to the client), confidentiality, and technical competence (providers know what they are doing). Additionally, Spanish-speaking participants valued communicating with their provider in Spanish rather than through an interpreter.

**Technical Competence.** Technical competence was mentioned as an important characteristic of clinical service providers, but only in a few focus groups, all of which were composed solely of black participants. Most of the participants that mentioned technical competence were satisfied with the quality of the care they received.

**Rapport.** Participants in all of the focus groups stressed the importance of rapport with their providers. Participants value providers that are friendly, respectful, patient, and show concern for them as people. Teens (ages 18–19) and young adults mentioned the importance of nonjudgmental providers. Good rapport also contributes

to good communication, particularly for Hispanic clients. In most of the focus groups, participants perceived that their providers have the characteristics that allow for good rapport. In some female focus groups, however, some participants felt that the provider did not spend enough time with them or they could not see the provider they preferred.

**Communication.** Participants want their providers to take the time to find out their concerns, to explain what they are doing during the exam, and to give clear instructions. In most of the focus groups there was a consensus that the providers do explain things clearly and give them the opportunity to ask questions, but in some focus groups, participants felt they did not have enough time with their provider.

**Confidentiality.** Confidentiality also is important to participants. In only one focus group did any participant express concern that providers would not keep client information confidential.

**Provider Gender.** Although gender was not mentioned in any of the focus groups as an important provider characteristic, when asked directly if they had a gender preference, most of the (female and male) participants expressed a preference for a female provider. Female participants generally feel a woman is better able to relate to them and to understand their issues. Most of the males and a few of the females said the provider's gender does not matter "*... as long as they treat you well.*" In a few focus groups, some female participants said that they prefer men, but no males expressed a preference for a male provider.

#### **4.4.3 Views on Other Clinic Staff**

Most of the participants' comments about other clinic staff focused on the receptionists. In general, characteristics that clients value in other staff are competence (professionalism and efficiency), rapport (friendliness and helpfulness), communication (willingness to explain things and ability to answer questions), and confidentiality.

**Competence.** Most of the focus groups stressed the notion that clinic staff should be efficient and professional. They do not want to be transferred around when they call, to have long delays getting their lab results, or experience mistakes in the scheduling of appointments. Most of the focus groups were very positive about the competence of the clinic staff.

**Rapport.** All of the focus groups emphasized the importance of receptionists being friendly and helpful. In most of the groups, there was consensus that the receptionists are friendly and very helpful in terms of scheduling appointments and making an effort to accommodate them, as well as helping them fill out paperwork in the clinic and telling them how long they will have to wait. A few focus groups were less positive, however, saying that the receptionists were sometimes rude or unhelpful. In focus groups with younger women, another key concern was whether staff are judgmental.

**Communication.** In several focus groups, participants said that they want clinic staff to take their time to explain things and to be willing to explain more than once, and when they call, they want to be able to talk to someone who can answer their questions. While for the most part there was a general agreement that staff are very helpful and will either answer questions or have someone who can answer their questions call them back, a few participants have had experiences where no one could answer their questions or no one called them back.

**Confidentiality.** Most of the focus groups stressed the importance of confidentiality. They do not want the staff to *"tell your business to other people."* In addition, participants in some focus groups commented that they do not want to have to tell the receptionist in front of other people at the clinic the reason for their visit or to have the staff yelling questions across the office. The consensus among nearly all the focus groups is that clinics do protect their privacy and confidentiality. In one focus group, however, participants were not satisfied with their clinics' confidentiality practices.

**Provider Gender.** None of the focus groups expressed a preference for the gender of other clinic staff.

#### **4.4.4 Views on Service Availability**

On the whole, participants think that the services offered by the clinics are *"pretty complete,"* although some expressed a wish for additional contraceptive options or on-site availability of STD treatment. Participants in some groups mentioned an interest in having other types of primary care (e.g., child health services) or social services connected with the clinic and *"all in one place."* Young participants that obtained services in youth-focused programs expressed concern about

where to obtain care when they were "too old" (i.e., older than 21) to go to the youth clinic.

Few participants thought it was important for the clinics to meet partner or family member needs for reproductive health care, although one group commented that it was important that partners be able to come for STD treatment, and some said that their partners would like to be more involved in their reproductive health care. Many of the female and some of the male participants thought it would be interesting to have services to help build healthy relationships, but others were less enthusiastic or thought their partners would be unwilling to attend.

There was a general agreement in most groups that clients were aware of the STD and HIV counseling and testing services offered by the clinic. Participants thought that use of flyers or posters to advertise STD and HIV services were effective in building awareness.

#### **4.4.5 Views on Service Accessibility**

Most participants thought that the services were relatively accessible. Most of the female focus groups thought the hours were relatively convenient (it should be noted, however, that because the focus groups were conducted during clinic hours, focus group participants were limited to those clients available during clinic hours). One male focus group said they would prefer weekend or early morning hours.

Participants in most focus groups agreed that the waiting time to get an appointment was generally very short (1 to 2 days), but might take longer for some services, and they agreed that clinics accommodated them when they needed to be seen immediately. One male group said that because the male clinic was held just 1 day a week, the wait to be seen could be long, although they could come on other days if they needed to. Perspectives on waiting times to see a doctor or nurse after checking in at the clinic varied widely, from very short to too long. Most participants thought the clinics were relatively accessible, although some participants noted that the clinics were not located on public transportation routes, did not have parking, or were not clearly marked.

The participants in the Spanish-speaking focus groups emphasized the importance of having a bilingual provider so that they can explain themselves clearly. They also feel it is important for the receptionist to be bilingual, because they need to be able to communicate when they

call to make an appointment or ask questions. Across the two clinics where Spanish-language focus groups were conducted, access to bilingual services varied. At one clinic, most of the staff are bilingual; in the other, the clinical service providers are bilingual but the receptionist is not. Participants in the Spanish-speaking focus groups agreed that educational and other written materials are available in Spanish.

#### **4.4.6 Clinic Environment for Client Spouses or Partners**

Most of the focus groups think it is important to be able to bring their partners. Participants in a few focus groups said that their partners want to be involved, and that they have come to the clinic and been treated well. In one focus group connected to a youth program, participants stressed that it is important for partners to come if both need to be treated for STDs.

In most of the female focus groups, participants think their partners would be comfortable coming to the clinic. However, a participant in one group said that her partner might feel uncomfortable coming to the clinic because there are so many women. Participants in a few female groups commented that their partners would not be willing to come to the clinic because men "*just don't go to the doctor period,*" and participants in one group said that they would not feel comfortable having men at the clinic and did not want them there.

In the male focus groups, some participants said that their female partners were the ones who had brought them to the clinic in the first place.

#### **4.4.7 Clinic Image and Satisfaction with Care**

With regard to overall satisfaction with care, most clinics appear to be doing a good job in meeting the needs of focus group participants. On the whole, participants are pleased with the friendliness and warmth of the clinic environment, the quality of the communication and the care, and the efficiency and accessibility of the services. While a few participants noted some areas for improvement (e.g., a broader range of contraceptive methods, more up-to-date testing technologies, shorter waiting times to see the doctor, more time with the provider), nearly all participants said that if given the choice to go anywhere for care they would choose the Title X-funded clinic. Some variability in the quality of the clinics is apparent, however. Participants from one clinic expressed much lower levels of satisfaction than clients from all of the other clinics.



# References

1. Viswanathan M, Fowler C. Review and Synthesis of Evaluations Relevant to the Title X Program: Task 2 Final Report. Research Triangle Park, NC: RTI International; 2005. Prepared for the Office of Population Affairs under Contract No. 233020090, Task Order 4.
2. Sonenstein F, Punja S, Scarcella C. Future directions for family planning research: A framework for Title X family planning service delivery improvement research. Washington, DC: The Urban Institute, 2004.
3. Fowler C, Hoover S, Appiah-Yeboah A. Synthesis of Data Relevant to the Title X Program: Task 3 Final Report. Research Triangle Park, NC: RTI International; 2005. Report prepared for the Office of Population Affairs under Contract No. 233020090, Task Order 4.
4. The Alan Guttmacher Institute (AGI). Women in Need of Contraceptive Services and Supplies, 2000: Definitions and Notes. Washington, DC: AGI; 2003.
5. The Alan Guttmacher Institute. Family Planning Annual Report (FPAR): 1998 Summary (Parts I and II). Washington, DC: AGI; 1999.
6. The Alan Guttmacher Institute. Family Planning Annual Report (FPAR): 1999 Summary (Parts I and II). Washington, DC: AGI; 2000.
7. The Alan Guttmacher Institute. Family Planning Annual Report (FPAR): 2000 Summary (Parts I and II). Washington, DC: AGI; 2001.
8. The Alan Guttmacher Institute. Family Planning Annual Report (FPAR): 2001 Summary (Parts I and II). Washington, DC: AGI; 2002.
9. The Alan Guttmacher Institute. Family Planning Annual Report (FPAR): 2002 Summary (Parts I and II). Washington, DC: AGI; 2003.
10. The Alan Guttmacher Institute (AGI). Women in Need of Contraceptive Services and Supplies, 1995 (National, Regional, and State Summary). Washington, DC: AGI; 2001.
11. The Alan Guttmacher Institute (AGI). Women in Need of Contraceptive Services and Supplies, 2000 (National, Regional, and State Summary). Washington, DC: AGI; 2003.

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12. Frost JJ, Frohwirth L, Purcell A. The availability and use of publicly funded family planning clinics: U.S. trends, 1994-2001. *Perspect Sex Reprod Health* 2004;36(5):206-215.
13. Finer LB, Darroch JE, Frost JJ. U.S. agencies providing publicly funded contraceptive services in 1999. *Perspect Sex Reprod Health* 2002;34(1):15-24.
14. Finer LB, Darroch JE, Frost JJ. Services for men at publicly funded family planning agencies, 1998-1999. *Perspect Sex Reprod Health* 2003;35(5):202-7.
15. Grady WR, Billy JOG, Klepinger DH. Contraceptive Method Switching in the United States. *Perspect Sex Reprod Health* 2002;34(3):135-145.
16. Ranjit N, Bankole A, Darroch JE, Singh S. Contraceptive failure in the first two years of use: Differences across socioeconomic subgroups. *Fam Plann Perspect* 2001;33(1):19-27.
17. Gleit DA. Measuring contraceptive use patterns among teenage and adult women. *Fam Plann Perspect* 1999;31(2):73-80.
18. Trussell J, Vaughan B. Contraceptive failure, method-related discontinuation and resumption of use: Results from the 1995 National Survey of Family Growth. *Fam Plann Perspect* 1999;31(2):64-72, 93.
19. Fu H, Darroch JE, Haas T, Ranjit N. Contraceptive failure rates: New estimates from the 1995 National Survey of Family Growth. 1999;31(2):56-63.
20. Fowler C, Rojas Smith, L, Wilson, E, Hoover, S. Key Informant Interview and Client Focus Group Findings: Task 4/5 Final Report. Research Triangle Park, NC: RTI International; 2006. Prepared for the Office of Population Affairs under Contract No. 233020090, Task Order 4.

# Appendix A: Substantive Topic of Evaluations Included in the Review

Substantive Topic	Published		Unpublished		Total	
	No.	%	No.	%	No.	%
<b>Reproductive Health Care Utilization and Demand Characteristics</b>	<b>9</b>	<b>31%</b>	<b>12</b>	<b>31%</b>	<b>21</b>	<b>31%</b>
Contraceptive care	5	17%	3	8%	8	12%
STD care (including HIV/AIDS)	1	3%	—	—	1	1%
Integration of contraceptive and STD (including HIV/AIDS) care	1	3%	2	5%	3	4%
Emergency contraception	1	3%	—	—	1	1%
Related preventive health care (non-STD)	—	—	—	—	—	—
Broad reproductive health care	1	3%	7	18%	8	12%
Cost of care	—	—	—	—	—	—
<b>Financing, Costs, Organizational Structure, and Operations</b>	<b>20</b>	<b>69%</b>	<b>27</b>	<b>69%</b>	<b>47</b>	<b>69%</b>
Program financing and costs	7	24%	3	8%	10	15%
Organizational structure and operations related to	12	41%	24	62%	36	53%
Contraceptive care	1	3%	2	5%	3	4%
STD care (including HIV/AIDS)	1	3%	1	3%	2	3%
Integration of contraceptive and STD (including HIV/AIDS) care	1	3%	6	15%	7	10%
Emergency contraception	2	7%	1	3%	3	4%
Related preventive health care (non-STD)	—	—	2	5%	2	3%
Broad reproductive health care	7	24%	3	8%	10	15%
Client access and clinic flow	—	—	2	5%	2	3%
Social marketing	—	—	4	10%	4	6%
CHCs and integration of Title X-funded care	—	—	1	3%	1	1%
Compliance related to care	—	—	2	5%	2	3%
Compliance unrelated to reproductive health care	1	3%	—	—	1	1%
<b>Total</b>	<b>29</b>	<b>100%</b>	<b>39</b>	<b>100%</b>	<b>68</b>	<b>100%</b>

Note: **CHCs**=Community Health Centers

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# Appendix B: Criteria for Assessing Program Evaluations of the Department of Health and Human Services' Evaluation Review Panel

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## **B.1 OVERALL SIGNIFICANCE**

- The study addresses a significant issue of policy relevance.
  - Evaluation findings are likely to be useful.
- 

## **B.2 CONCEPTUAL CRITERIA**

### **B.2.1 Conceptual Foundations**

- A literature review is included.
- The project is shown to be logically based on previous findings; the report uses either theory, or models, or both.
- The program assumptions are stated.
- The evaluation draws from any previous evaluation.
- The report is linked with a program and describes the program.
- The report presents multiple perspectives.
- Multiple relevant stakeholders are consulted and involved.
- The timing is appropriate because the program is ready for evaluation.

### **B.2.2 Questions for Evaluation**

- The aims of the evaluation are clear, well specified, and testable.
- The questions are feasible, significant, linked to the program, appropriate for the resources and audience, and derive logically from the conceptual foundations.
- The questions show ingenuity and creativity.

### **B.2.3 Findings and Interpretation**

- The conclusions are justified by the analyses.
- The summary does not go beyond what the data will support.
- The appropriate qualifiers are stated.
- The conclusions fit the entire analysis.
- Equivocal findings are handled appropriately.
- The initial questions are answered.
- The interpretation ties in with the conceptual foundation.
- The report notes that the findings are either consistent with or deviate from the relevant literature.
- The presentation is understandable.
- The results have practical significance.
- The extent of program implication is assessed.

### **B.2.4 Recommendations**

- The recommendations follow from findings; are worth carrying out; and are affordable, timely, feasible, useful, and appropriate.
- The recommendations are shown to be relevant to the questions asked.
- The breadth of specificity of the recommendations is addressed.
- Any recommendations for either future evaluations, or improvements, or both are clearly presented.

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## **B.3 METHODS**

### **B.3.1 Evaluation Design**

- Design considerations include overall appropriateness, soundness, feasibility, funding and time constraints, generalizability, applicability for cultural diversity, assessment of the extent of program delivery, validity, feasibility for data collection, reliability of selected measurements, use of multiple measures of key concepts, and appropriateness of the sample.
- Variables are clearly specified and fit with the questions and concepts.
- The design permits measurement of the extent of program implementation and answering of the evaluation questions.

### **B.3.2 Data Collection**

- Data are collected using appropriate units of measurement for analysis, controls for participant selection and assignment bias, and proper handling of missing data and attrition.
- Data collection is characterized by use of an appropriate comparison group of control; adequate sample size, response rate, and information about the sample; a data collection plan; data collection that is faithful to the plan; attention to and cooperation with the relevant community; project confidentiality; and consistency.
- The quality of the data (including the quality of any extant data sets used in the study) and the efficiency of sampling are addressed.
- The data collection is appropriate to evaluation questions.

### **B.3.3 Data Analysis**

- The data analysis addresses the handling of attrition, the matching of the analysis to the design, the use of appropriate statistical controls, the use of methodology and levels of measurement appropriate to the type of data, and estimation of effect size.
- The analysis shows sensitivity to cultural categories.
- The analysis makes appropriate generalizability of inferences.
- The chosen analysis type is simple and efficient.

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## **B.4 CROSS-CUTTING FACTORS**

The following are cross-cutting factors that are likely to be important at all stages of a report: clarity, presentation, operation at a state-of-the-art level, appropriateness, understandability, innovation, generalizability, efficiency of approach, logical relationships, and discussion of the report's limitations. The report should also address ethical issues, possible perceptual bias, cultural diversity, and any gaps in study execution.

Source: *Performance Improvement 1999: Evaluation Activities of the U.S. Department of Health and Human Service*. Accessed 12/13/04 from <http://aspe.os.dhhs.gov/progsys/99eval/appendixb.htm>.

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# Appendix C: Top Five Most Important Priorities and Key Issues Overall and by Informant Group

2004 Priority or Key Issue	Weighted Score	Ranking by Informant			
		All	Clinic	Grantee	Federal
Assuring access to a broad range of high-quality clinical family planning and related preventive health services that include <b>provision of highly effective contraceptive methods</b> ( <i>Program Priority 2, item a</i> )	149	1	1	1	1
Assuring continued high-quality clinical family planning and related preventive health services that will improve the overall health of individuals ( <i>Program Priority 1</i> )	135	2	2	3	1
The increasing cost of providing family planning services ( <i>Key Issue 1</i> )	65	3	4	2	3
Promoting individual and community health by emphasizing clinical family planning and related preventive health services for <b>hard-to-reach uninsured or underinsured populations</b> ( <i>Program Priority 5, item a</i> )	56	4	—	4	3
Assuring access to a broad range of high-quality clinical family planning and related preventive health services that include <b>STD and HIV prevention education, counseling, and testing</b> ( <i>Program Priority 2, item c</i> )	49	5	3	—	—
Assuring access to a broad range of high-quality clinical family planning and related preventive health services that include <b>breast and cervical cancer screening and prevention</b> ( <i>Program Priority 2, item b</i> )	42	—	—	—	5
Promoting individual and community health by emphasizing clinical family planning and related preventive health services <b>for hard-to-reach adolescents</b> ( <i>Program Priority 5, item d</i> )	42	—	4	5	—