Final Study Report

Improving Family Planning Services for Women and Their Partners: A Couple-Focused Approach

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Table of Contents

Executive Summary

"Improving Family Planning Services for Women and Their Partners: A CAPACITIES Approach" was a three-year project to study the effect of incorporating a couple-focused approach into family planning services. The purpose of the study was to determine whether incorporating a couple-focused approach and the Standard Days Method® (SDM) into family planning services is feasible and beneficial. The project was a collaboration between the Georgetown University's Institute for Reproductive Health (IRH), Planned Parenthood of San Diego and Riverside Counties (PPSDRC) in southern California, and Tri-City Health Center in Fremont, California.

The couple-focused approach is presented as a way to encourage or support couple communication and male involvement within the context of a typical family planning visit with the woman. The study intervention included SDM introduction in order to help sensitize family planning providers to the needs of the couple. The SDM, used with CycleBeads®, is a fertility awareness-based family planning method that relies on partner cooperation to avoid unprotected sex on the woman's fertile days.

This study builds on prior research that has shown that engaging the couple can improve couple communication about family planning as well as improve correct use and continuation. It also builds on worldwide research that shows that the Standard Days Method can be a useful vehicle for increasing male involvement in family planning.

The primary research questions addressed by this study are the following:

1) Does training providers to apply a couple approach, including the SDM, result in improved provider counseling practices?

2) Does incorporating a couple approach into family planning services result in:
    a. Improved satisfaction and utilization of clinic services?
    b. Increased couple communication and participation in family planning use and decision-making?
    c. Improved family planning use, satisfaction and continuation?

PPSDRC was Georgetown University's original implementing partner on the study. With PPSDRC, formative research was collected to inform the design of the intervention. Following the formative research phase, baseline data was collected, and SDM was introduced into the experimental PPSDRC clinics. However, mid-way through the study, PPSDRC withdrew, so endline data could not be collected. For this reason, the study began anew with Tri-City Health Center.

When Tri-City Health Center was identified as the new partner, the study design was modified to fit Tri-City's structure and the project's time constraints. While the elements of baseline and

endline data collection remained the same, there was no control clinic at TCHC, and the time between baseline and endline data was reduced.

Modified Study Design

Partner	Methods	Formative research	Baseline		Endline
PPSDRC	Clients and partner questionnaires	O		Begin intervention	
	In-depth interviews with managers and providers	O			
	Simulated client visits		O_1		
	Interviews with clients and partners		O_1		
	Interviews with providers		O_1		
Tri-City Health Center	Simulated client visits		O_1		O_2
	Interviews with clients and partners		O_1		O_2
	Interviews with providers		O_1		O_2
	Service statistics				

Formative research at PPSDRC

The purpose of the formative research component of the study was to help fine-tune specific details of the intervention, including the content of staff training, how a couple-focused approach could be incorporated into existing services, and educational materials. During this phase, information was collected from providers, clients and their partners in the intervention clinics of PPSDRC, in the form of in-depth interviews with providers and questionnaires for clients and their partners.

Although not formally part of the formative research phase, results from baseline data collection at PPSDRC are also described in this section as they provide additional information regarding couple-related family planning attitudes and behaviors.

Provider interviews

In general, when asked about their clients' preferences, PPSDRC staff felt that most women came into the clinic looking for information for themselves, not necessarily for their partners. Nevertheless, providers were amenable to incorporating a couple-focused approach into clinic services and felt that it would benefit some of their patients. The primary concerns of PPSDRC providers were to protect patient confidentiality and promote women's autonomy and decision making; to recognize that a couple-focused approach is not appropriate for all women; and to keep any intervention activity within the time constraints of a busy clinic. Providers also

expressed an interest in offering CycleBeads to expand choice for their clients as they were not offering any fertility awareness-based methods at that time.

Client and partner questionnaires

Results from the client and partner questionnaires suggest that providers' increased openness to and capacity for discussing birth control from a couple-focused approach could improve services and increase clients' satisfaction with their birth control methods. The information provided by the questionnaires included the following:

- **Discussion of birth control decisions:** Most male and female respondents indicated that they have discussed birth control decisions with their partner. This suggests that women do not always make birth control decisions independently.

- **Discussion of couple issues during counseling:** Many female respondents indicated that they would be interested in discussing couple-related issues during counseling such as the partner's role in birth control use, sexually transmitted infections (STIs), whether they feel safe with their partner, and sexual satisfaction or problems.

- **Men's participation in birth control**: Most of the men and women who completed the questionnaire indicated that men participate in birth control in one or more ways. These findings suggest that many men are active participants in birth control decision making and use.

- **Desire for men's involvement in birth control**: The study found that the majority of men surveyed would like to be involved in birth control decision-making and use; their interest may have been underestimated by women.

While most providers who participated in formative research in-depth interviews indicated a strong concern for women's confidentiality and autonomy, these results suggest that many women view birth control use as a couple decision, and their partner's opinion may influence their method choice and use. For this reason, raising awareness of this interest and training providers to address couple issues with women who desire partner involvement are recommended.

Client interviews

Family planning clients from participating PPSDRC clinics – specifically, pill, condom and DMPA users – were interviewed as part of the baseline data collection at PPSDRC to obtain information on client attitudes and behaviors with regard to couple issues and family planning.

Confirming the results of the questionnaires, client interviews revealed that couple communication about family planning is high. Women reported that their male partners are frequently involved in family planning decision-making and use, and joint decision making is

very important to the majority of women. However, in reality, women are the final decision makers, particularly when it comes to method choice.

Bivariate analysis was conducted to assess which client characteristics might be associated with greater male involvement. Findings suggest that women who speak Spanish at home, are not university educated, and are using condoms are more likely to report partner involvement.

These findings suggest that an approach to family planning counseling that recognizes and supports the potential involvement of the male partner would be appropriate for many women. They also provide insight into what characteristics may be associated with greater male involvement and therefore can encourage providers to tailor family planning counseling to the unique needs of each client, rather than assuming that male involvement is irrelevant to women.

Intervention components

Results from the formative research informed the intervention design. The study intervention consisted of three primary actions for clinic staff:

1) Family planning providers were advised to ask each family planning client the following two questions:

    1. "How does your partner(s) feel about birth control?"
    2. "Would your partner(s) like any information about birth control?"

    The purpose of these questions was to open the door to a discussion of couple-related issues if the woman desired it. They would enable the providers to ascertain whether or not the woman would like to involve her partner, and support her accordingly.

2) Offer SDM/CycleBeads

    Providers were taught to include the SDM/CycleBeads among the methods offered to clients. As SDM counseling requires consideration of the couple relationship, including it in the method mix could help sensitize providers to couple issues.

3) Offer new informational materials to clients

    New informational materials in English and Spanish were made available to clinic staff pertaining to the couple-focused approach and the SDM/CycleBeads. These materials were put on display in the clinic and handed out to clients.

PPSDRC's two intervention clinics began offering the SDM/CycleBeads and the couple-focused approach following a whole-site training and incorporation of CycleBeads into clinic systems and procedures. Promotional and educational materials in both English and Spanish – posters

and brochures on CycleBeads, brochures on the couple-focused approach designed specifically for this study, and birth control information for men – and CycleBeads were made available at PPSDRC intervention clinics. Community outreach was conducted by PPSDRC's *promotoras* (community health educators). Due to PPSDRC's withdrawal from the study, SDM/CycleBeads were only offered at PPSDRC's two intervention clinics for a few months in late 2006.

The intervention strategy was modified slightly for Tri-City Health Center's intervention site. Because it is a large health center, only those clinicians providing family planning counseling were trained on the intervention. However, staff members at Tri-City Health Center who had interaction with family planning clients but did not directly provide counseling services – including medical assistants, outreach staff, and administrative personnel – were oriented on the couple-focused approach and the SDM/CycleBeads. Tri-City began offering the couple-focused approach and SDM/CycleBeads immediately following the training, in July 2007.

The intervention at Tri-City included similar informational materials as PPSDRC. Outside of the Tri-City clinic, messages were incorporated into community presentations by outreach staff, and those opportunities were also used to share some of the educational materials.

Tri-City Health Center also has a teen clinic with a separate entrance that sees clients up to age 24. The teen clinic has two non-clinical counselors who were trained on the intervention. Additional educational materials designed for the study were used at the teen clinic to serve a teen audience, as described later in this report.

Findings: SDM/CycleBeads Introduction at PPSDRC Clinics

As stated previously, the study intervention was not formally tested at PPSDRC. However, in an attempt to learn from PPSDRC's brief experience of offering a couple-focused approach and SDM/CycleBeads, nine PPSDRC reproductive health counselors who had participated in the intervention were interviewed following PPSDRC's withdrawal from the study. All had been trained on the couple-focused approach and SDM/CycleBeads and had incorporated CycleBeads into their counseling practice. Since their attitudes and experiences regarding a couple-focused approach were not substantially different from what was expressed during the formative research phase, this report focuses on their experience offering SDM.

In general, counselors reported favorable opinions toward the SDM – in particular, that it is a good option for those seeking a natural method, and that it helps to empower women by teaching them about their fertility. It appeared that SDM introduction helped to improve attitudes towards natural family planning. Some counselors reported using CycleBeads themselves to either achieve pregnancy or simply to track their cycle. Key points from the post-intervention PPSDRC provider interviews included the following:

- **Adequacy and appropriateness of training**: Counselors felt that the two-hour training session provided them sufficient information to be able to offer CycleBeads. They found the training enjoyable and benefited from it because they learned how to provide not

only a new method, but a method that could meet the needs of their patients who were seeking a natural method or a non-hormonal method.

- **SDM/CycleBeads and clients' needs**: Counselors thought that CycleBeads were appropriate for some of their clients, although clients who desired a highly effective method would not be interested. They found it most worthwhile to discuss SDM/CycleBeads with new family planning clients who weren't sure what they wanted, as opposed to people who were certain they wanted a hormonal method or were satisfied users of another method. The fact that CycleBeads requires partner participation was appealing to some clients. Counselors perceived that CycleBeads were well received particularly among women who were in a monogamous relationship.

- **Raising awareness of CycleBeads availability**: Having posters and informational materials in the clinic was an effective way of letting patients know to ask about CycleBeads.

- **CycleBeads as a tool for fertility awareness**: PPSDRC counselors indicated that many clients do not have a good understanding of the menstrual cycle and, in particular, the concept of the fertile window. In addition to having CycleBeads available as a family planning option, counselors would like to use CycleBeads to help educate women about their bodies and also to help women who wish to achieve pregnancy.

This experience shows that SDM/CycleBeads is feasible to offer at Planned Parenthood clinics. It can be offered within the standard amount of time allowed for counseling and meets the needs of clients seeking a non-hormonal or partner-based method. Although the experience of these providers in offering SDM is limited to a couple of months, their experience could be useful to other programs that are considering SDM introduction.

Findings: Integration of a couple-focused approach and SDM at Tri-City Health Center

The intervention was formally tested at Tri-City Health Center. Data was collected at Tri-City Health Center's Liberty Street clinic before and after the intervention.

Research question #1

The first study question was, **Does training providers to apply a couple-focused approach, including the SDM, result in improved provider counseling practices?**

Interviews were conducted at baseline and endline at Tri-City Health Center with family planning clients within one month of their family planning visit in which clients were directly asked whether or not their provider asked them the two intervention questions; namely, whether the provider asked what her partner thinks about birth control, and whether the partner asked her if she wanted information for her partner. A smaller number of clients at

endline (39%-43%) than baseline (59%-61%) reported that the provider asked them these questions, indicating that the couple-focused approach was not implemented as planned.

The simulated client methodology was also used to gauge the effect of the intervention. Some 13 simulated clients visited the Tri-City Health Center Liberty site at baseline, and 14 visited at endline. Results of the simulated client visits revealed that there was no major change in the tendency of providers to ask about the partner or address couple issues.

One reason for the lack of change in provider behavior around couple issues could be the fact that there was no compelling reminder for the provider during each family planning visit (besides counseling aids made available to them) to ask the two key questions pertaining to partner involvement. It would have been easy for clinicians who were not in the habit of asking about the partner and who were focused on meeting the clients' immediate needs to forego asking the couple-related questions.

It is likely that staff turnover also affected the results. Two nurse practitioners who handled a large amount of the family planning clients before the intervention, typically asked about partner issues in their practice before the intervention, and were champions of Tri-City's involvement in the study left Tri-City early into the intervention. Additional detracting factors included lack of time with providers to orient and train them on the couple-focused approach.

Simulated clients and service statistics were used to assess whether the SDM was offered and accepted. Of the 14 simulated clients who visited Tri-City Health Center's Liberty site at endline, five had profiles that would have made them suitable candidates for SDM/CycleBeads. Of these five, three were actually offered the method. This means that the method was integrated into the clinic services, although not everyone who would have accepted the method was offered it.

Service statistics collected by Tri-City Health Center provide insight into SDM uptake and, therefore, whether providers offered the SDM. According to service statistics, there were 117 SDM users at Tri-City Health Center's Liberty site from July 2007 to June 2008. This information confirms that providers were offering the SDM to clients and that the SDM appealed to clients.

Endline interviews with clinicians at Tri-City Health Center asked about providers' opinions on the couple-focused approach and on offering SDM/CycleBeads. Although there was no notable change in providers' opinions on a couple-focused approach, results from the six Tri-City providers trained on SDM/CycleBeads include the following:

- All six trained providers said they found it easy to teach women how to use CycleBeads.
- All said Tri-City Health Center should continue to offer CycleBeads.
- Five of the six thought CycleBeads would be useful for involving men.

In summary, although the providers did not incorporate the couple-related questions into their practice, it appears that providers found it feasible and worthwhile to offer SDM/CycleBeads as it met the needs of some of their clients. Although providers grasped the importance of

addressing couple issues with regards to SDM use, study results do not provide evidence that SDM introduction contributed to provider's awareness of or likelihood of addressing couple issues for other methods.

Research question #2

The second research question asks **whether or not incorporating a couple-focused approach into family planning services results in improved outcomes, including satisfaction and utilization of clinic services, couple communication and participation in family planning use and decision-making, and correct use, satisfaction, and continuation with family planning methods**. The purpose of the second question is to determine what effect the couple-focused counseling approach had on family planning-associated behaviors.

Because an increase in a couple-focused counseling approach was not observed except for introduction of SDM, it is not possible to evaluate the effect of this intervention on clinic services and outcomes.

Recommendations for future studies

Given the potential positive effect of increasing couple involvement on family planning use, the high degree of couple communication around family planning that exists, and the desire among many men and women for greater male involvement in family planning decision-making and use, further research on ways to implement a couple-focused approach to counseling is warranted. Recommendations for future studies include the following:

- Implementing clinics need to be able to allow sufficient provider time for orientation meetings and training sessions. Through more "face-time" with providers, study staff can ensure that they have a firm grasp of the rationale of the couple-approach and can identify and address provider concerns.

- Greater attention should be paid to figuring out a way for providers to remember to integrate the couple-focused approach and what an appropriate trigger could be during a visit to address couple-related issues.

- Staff turnover must be anticipated, with plans firmly in place to ensure that new providers are promptly trained on the intervention.

- There should be enough time to test the fidelity of the intervention and do a refresher training if needed.

- The strategy for measuring the couple-focused approach should reflect the wide range of potential ways a provider might address couple issues during counseling.

Additional Findings: Strategies to encourage couple communication among teens

Tri-City Health Center's Liberty Street site has a teen clinic with a separate entrance and provides confidential services for teens and young adults up to age 24. At the teen clinic, clients are seen by a reproductive health counselor before the clinician. Study activities were tailored for the TCHC Teen City Clinic in order to see what counseling strategies to support partner involvement would work with teens and to explore whether new teen-focused educational materials could promote partner communication about sex and sexual health.

Intervention activities at the teen clinic included the following:

1) Asking about partner involvement in family planning

   Reproductive health counselors at the teen clinic asked the same two simple questions of clients receiving family planning services as at the main clinic:

   1. "How does your partner(s) feel about birth control?"
   2. "Would your partner(s) like any information about birth control?"

2) Offering new teen educational materials and quizzes

   Three new educational pieces were given to teens and young adults who received services at the TCHC Teen City Clinic and used in school outreach programs. Two of the pieces were designed in a quiz format similar to what might be seen in a teen magazine; the third piece was a card encouraging couple communication about sex.

3) Using CycleBeads to teach about fertility

   The counselors used CycleBeads to help clients understand when they are fertile.

As in the main study, the frequency with which providers asked the two couple-related intervention questions decreased after the intervention began. This is likely due to the fact that the clinician who saw the bulk of clients at the teen clinic before the intervention and was very supportive of a couple-focused approach left the organization.

However, even though the frequency with which providers asked the key questions decreased, it is clear that counselors addressed couple issues and participated in the intervention by giving the educational materials to teen clients. Most participants in the exit interviews reported having received the educational materials during their visit. They also indicated that the counselors asked about their partners in other ways than the two specific questions, and that they used CycleBeads to teach fertility awareness.

Through focus groups and exit interviews with teens, it became evident that most teens liked the educational materials. Most of the girls had shared them with a partner or friend, while

only some of the boys had done so. The positive response from both teens and counselors regarding these materials indicates that they were helpful for encouraging discussion of couple issues both in the client-provider interaction and among teens and their partners.

In general, it is clear that the teen clinic intervention – particularly, the availability of new educational materials – was feasible to implement and well-liked by both teen clients and counselors. This project also demonstrated that CycleBeads are a useful tool for helping teen girls understand their fertility. However, more research is needed to determine whether the use of such materials leads to healthy behaviors.

Conclusion

This study was successful in demonstrating that integrating the SDM into family planning services is feasible and represents a promising way to expand access to fertility awareness-based methods. However, it was unable to demonstrate the successful integration of a couple-focused approach into family planning services.

With regard to couple communication and male involvement in family planning, this study has shown that there is a gap between provider perceptions of women's desire for male involvement and how clients actually feel. Couple communication about family planning is very high, and the majority of women, although notably not all women, want their partners to be involved in family planning decision-making and use. Providers who take this into consideration may be better able to serve their clients.

This study resulted in development of a way to operationalize the couple-focused approach and production of a set of educational materials that may be useful to programs who wish to encourage couple communication and male involvement. While the educational materials were well-liked by providers and clients alike, the value of encouraging providers to ask a few key questions about the partner remains unclear.

Finally, this study demonstrates that there is a need to reach out to men with reproductive health information. Although this study did not obtain information from the perspective of male partners of female clients, it did collect data from men in the waiting rooms of PPSDRC clinics as well as from male teens in focus groups. Many men desire family planning and sexual health information. Focus groups with male teens revealed that while men are concerned with preventing pregnancy and avoiding sexually transmitted infections, they are reluctant to bring up the topic with their female partner. Since women are the main beneficiaries of family planning programs, they should be supported in their efforts to engage their partners and bring up sexual health topics. Ways to reach men with information and support are needed, although due to time constraints, this may fall outside the realm of a typical family planning visit.

List of Tables

List of Figures

I. Introduction

"Improving Family Planning Services for Women and Their Partners: A CAPACITIES Approach" was a three-year project to study the effect of incorporating a couple-focused approach into family planning services. The purpose of the study was to determine whether incorporating a couple-focused approach and the Standard Days Method® (SDM) into family planning services is feasible and beneficial. The project was a collaboration between the Georgetown University's Institute for Reproductive Health (IRH), Planned Parenthood of San Diego and Riverside Counties (PPSDRC) in southern California, and Tri-City Health Center in Fremont, California.

The couple-focused approach conceived by this study recognizes that many family planning services are geared towards women. Therefore, the couple-focused approach is presented as a way to encourage or support couple communication and male involvement during the counseling session with the woman. Joint counseling is an option, but it is not the cornerstone of this approach. The study intervention includes SDM introduction in order to help sensitize family planning providers to the needs of the couple. The SDM is a fertility awareness-based family planning method that relies on partner cooperation to avoid unprotected sex on the woman's fertile days. Typically used with a visual tool called CycleBeads®, the SDM specifies the woman's fertile window as days 8-19 for women with menstrual cycles between 26 and 32 days long.

The study, which began in October 2005 and concluded in September 2008, included a formative research phase to inform the intervention design and data collection phases before and after the intervention to determine the effect of the intervention on family planning services and outcomes. The purpose of this report is to describe the study process, intervention design, and key results.

As will be described in this report, significant changes to the original study protocol had to be made mid-project to adapt to external circumstances. Namely, mid-way through the study, PPSDRC, the implementing partner, withdrew from the study due as a result of an internal decision to close its research department. As a result, IRH acted quickly to identify an alternate partner with whom to conduct the study and developed a partnership with Tri-City Health Center.

The impact of this switch was profound and will be made evident in this report. However, in spite of the challenges faced, the study experiences both with PPSDRC and Tri-City Health Center provide relevant information regarding couple communication and male involvement in family planning; provider perceptions about male involvement and a couple-focused approach; how a couple-focused approach may be operationalized; and the feasibility of integrating the Standard Days Method into Title X family planning services. In addition, the study developed materials to promote couple communication and male involvement in family planning for both teens and adults that continue to be used by both PPSDRC and Tri-City Health center after the study and are available for other organizations' use.

II. Background and rationale

This study builds on prior research that has shown that engaging the couple can improve couple communication about family planning as well as improve correct use and continuation. It also builds on worldwide research that shows that the Standard Days Method can be a useful vehicle for increasing male involvement in family planning.

A. Rationale for addressing couples and couple issues

Research has shown that addressing couples – rather than women alone – increases correct use of and satisfaction with family planning methods (Becker and Robinson, 1998). In spite of the potential benefits of engaging couples, most family planning services are directed only to women.

Increasingly, the reproductive health literature calls on programs to consider the sexually active couple as an appropriate unit for addressing reproductive health issues (Becker and Robinson, 1998; Koo et al., 2005). Beckman and Harvey comment that reproductive health decisions are frequently couple rather than individual decisions, raising issues about power in intimate relationships and women's ability to negotiate with their partners (2005). Research suggests that the context of a woman's relationship is a significant factor in method use. According to one study, women whose partners share in family planning decisions are more likely to protect themselves from both pregnancy and STDs than are women who make these decisions on their own (Riehman et al., 1998). Family planning decisions and behaviors take place within the couple context, yet scant attention has been given to couple-focused approaches for family planning. This research suggests that reorienting family planning messages and services to target couples could prove efficacious.

In particular, although relatively little is known about how partners influence patterns of family planning use among the rapidly growing Latina population, existing research suggests that partner support and approval significantly influence contraceptive behavior among this population. Results of a recent study suggest that Latina women who communicate with their partners about use of family planning methods and whose partners are supportive of method use are more likely to use methods effectively (Harvey, et al., 2004). Other studies suggest that lack of partner communication about method use and partner disapproval result in early discontinuation of oral contraceptives (Erickson, 1994; Kerns et al., 2003).

In spite of the potential benefits of couple-focused services, it is neither realistic, nor probably desirable, to expect a significant reorientation of female-oriented family planning services towards couples. The potential obstacles for such an approach are daunting. First, most reproductive health services are oriented towards one sex, and the details and costs associated with a couple approach remain unclear. Also, treatment of the couple as a unit could be seen as reinforcing gender inequities, in contrast with programs that target women alone and can seek to bolster women's self-esteem and improve their status. Furthermore, mandating services to

couples would raise important concerns about how to maintain the privacy of the client-provider relationship, protect the informed choice and autonomy of each partner, and prevent partner violence. Given that research has demonstrated that improved partner involvement leads to better outcomes, if couple counseling is not widely feasible, other innovative approaches are needed to optimally involve couples.

In diverse settings, spousal communication has been consistently associated with greater – and better – family planning use. Several studies show that women who have discussed family planning with their husbands are more likely to use family planning and less likely to experience unintended pregnancy than those who have participated in a standard family planning program (Salway, 1994; Wang, et al.,1998). In a study of Latino couples, women who decided themselves or jointly with their partners to use condoms were more likely to report use, and reported more frequent use, than women who said their partners made that decision (Harvey, et al., 2002).

Empowering women to discuss sexual health issues with their partners and increasing the information that men receive through informal networks is a feasible strategy in the absence of couple counseling. Even if providers do not counsel men directly, they can recognize the couple dynamic while providing services – engaging women in conversation about their sexual relationships, their perception of their partners' attitudes toward family planning, ways to gain their partners' support for family planning use and safe reproductive health practices, etc. – rather than treating female clients as if they existed in a vacuum (Blanc, 2001).

B. Rationale for including the SDM as part of a strategy to reach couples

Introducing the SDM into family planning services is another approach to involve the couple. The SDM is an important new tool in efforts to improve the quality of family planning services by expanding choice and including men (Gribble, 2003). Results of an efficacy trial demonstrated that it is effective (first year failure rate of 4.8 with correct use), easy to use, and affordable (Arévalo et al., 2002). CycleBeads, a string of color-coded beads specially designed to identify fertile and infertile days of a woman's cycle and monitor cycle length, visually assist couples using the SDM. Programs are able to incorporate the method into their routine service delivery, utilizing existing counselors and providers.

Introduction of the SDM into family planning services helps programs adopt a couple-focused perspective in several ways. By including the SDM in its services, the program offers a method that requires communication and cooperation between partners. This not only helps programs meet the needs of couples interested in this type of family planning option, but also encourages providers to consider how well their programs are addressing couple issues in their counseling, materials, and outreach efforts. As a result, providers become more sensitive to and more comfortable with discussing couple issues which are intrinsic to using a fertility awareness-based method (and also play a role in the use of other methods) such as couple communication, negotiation about when/whether to have sex, use of alternative methods during the fertile days, partner involvement in understanding and using the method consistently and correctly, STI risk, alcohol and drug use, and partner violence.

Research has shown that including the SDM improves provider attitudes toward male involvement in family planning as well as provider skills in counseling women and men in family planning use. Studies conducted in El Salvador and India demonstrated that integrating the SDM into community-based and clinic programs had a positive effect on couple communication and joint decision-making. Further, involving men in counseling (individually or as a couple) or providing men with information through their wives and community outreach efforts improved method use and satisfaction (Lundgren, et al., 2005).

III. Methodology

This section will describe the primary research questions, study design, and methods.

A. Research questions

The primary research questions addressed by this study are the following:

1) Does training providers to apply a couple approach, including the SDM, result in improved provider counseling practices?

The purpose of the first question is to determine whether, and to what extent, the providers adopted the intervention approach to engaging the couples, including offering the SDM as part of the method mix.

2) Does incorporating a couple approach into family planning services result in:
    a. Improved satisfaction and utilization of clinic services?
    b. Increased couple communication and participation in family planning use and decision-making?
    c. Improved family planning use, satisfaction and continuation?

The purpose of the second set of questions is to determine what effect the couple-focused counseling approach had on family planning-associated behaviors.

The study was designed to test a number of hypotheses regarding provider and client behavior and utilization of clinic services, as follows:

The hypotheses associated with Question 1 posit that as a result of incorporating a couple-focused approach:

Hypothesis 1: providers will be more likely to address couple issues during family planning counseling with clients (including, but not limited to, those interested in the SDM).

Hypothesis 2: providers will view more favorably including men and couples in family planning service counseling.

The hypotheses associated with Question 2a posit that as a result of incorporating a couple-focused approach:

Hypothesis 3: the number of new family planning clients will increase at participating clinics.
Hypothesis 4: the number of couple and men consultations will increase at participating clinics.
Hypothesis 5: clients' satisfaction with services provided by the clinic will increase.
Hypothesis 6: the percentage of clients who return for a follow-up visit will increase.

The hypotheses associated with Question 2b posit that as a result of incorporating a couple-focused approach:

Hypothesis 7: couple communication regarding family planning will improve.
Hypothesis 8: men will be more involved in family planning decision-making.
Hypothesis 9: men will be more involved in family planning method use.

The hypotheses associated with Question 2c posit that as a result of incorporating a couple-focused approach:

Hypothesis 10: correct use of family planning (according to method instructions) will increase among clinic clients.
Hypothesis 11: satisfaction with family planning among clinic clients will increase.

B. Study design

This section describes the study design as it was originally intended for PPSDRC and how it was adapted when activities were shifted to Tri-City Health Center.

1) Original design for PPSDRC

The study was originally designed for PPSDRC as a quasi-experimental study with nonequivalent control group. That is, equivalence between experimental and control groups at the baseline was not assumed, although similarities between them were maximized in the selection of two intervention/experimental clinics and two control clinics. This required collecting data at the baseline and after the intervention (endline) and comparing experimental and control clinics with a focus on baseline-endline changes in the observations. Figure 1 shows the study design as it was originally conceived for PPSDRC. According to the plan, baseline and endline data were to be collected approximately one year apart. Midline data in the form of simulated client visits was to be conducted to test the fidelity of the intervention so that refresher training could be provided if needed.

Figure 1: Original study design

	Formative research	Baseline	Begin intervention	Midline	Endline
In-depth interviews with clients and partners	O				
In-depth interviews with managers and providers	O				
Simulated client visits		O_1		O_2	
Interviews with clients and partners		O_1			O_2
Interviews with providers		O_1			O_2
Service statistics					

Two control clinics and two experimental/intervention clinics were selected from among PPSDRC's network of over 14 clinics. A third clinic that was located close to one of the experimental clinics also participated in the intervention. The formative research phase and baseline phase were fully implemented at PPSDRC, and the results will be described in this report. However, shortly after intervention clinic staff were trained on the intervention, PPSDRC withdrew from the study, so the intervention was discontinued, and midline and endline data were not collected.

2) Adaptation for Tri-City Health Center

When Tri-City Health Center was identified as the new partner, the study design was modified to fit Tri-City's structure and the project's time constraints (see Figure 2). While the elements of baseline and endline data collection remained the same, necessary changes made to the study design included the following:

- A formal formative research phase was not repeated at Tri-City. Rather, the opportunity to implement the intervention at PPSDRC was considered a pilot test. The intervention strategy was adapted to Tri-City based on conversations with Tri-City's management staff and selected providers. The intervention and the way it was modified for Tri-City will be described later in this report.

- Because Tri-City did not have a network of clinics that were similar in size, the quasi-experimental nature of the study could not be sustained. Instead, the intervention was implemented at Tri-City's main clinic on Liberty Street, and data was collected before and after. The project attempted to utilize Tri-City's Mowry clinic as a control, but this was not feasible as the sample size was too small.

- The project faced time constraints as over one year had elapsed by the time PPSDRC withdrew from the study. As a result, the time between baseline and endline data collection at Tri-City was reduced to approximately six months (i.e., cut in half). This was a necessary change but meant that there would not be time to make substantive changes to intervention in response to midline data from simulated client visits.

Figure 2: Modified Study Design

Partner	Methods	Formative research	Baseline		Endline
PPSDRC	Clients and partner questionnaires	O		Begin intervention	
	In-depth interviews with managers and providers	O			
	Simulated client visits		O_1		
	Interviews with clients and partners		O_1		
	Interviews with providers		O_1		
Tri-City Health Center	Simulated client visits		O_1		O_2
	Interviews with clients and partners		O_1		O_2
	Interviews with providers		O_1		O_2
	Service statistics				

C. Data sources

The data sources are summarized here and explained in greater detail in subsequent sections.

During the formative research phase, data was collected in the form of client and partner questionnaires and in-depth interviews with PPSDRC staff members in order to inform the intervention design.

1) *Client and partner questionnaires*: Two-page questionnaires were distributed to clients in the waiting room of PPSDRC intervention clinics over a period of two months until 100 were completed. The instruments included questions about partner communication and involvement in family planning decision making and use. Clients were also given a questionnaire for men to take to their partners that contained similar questions.

2) *In-depth provider interviews*: approximately five staff members at each PPSDRC intervention clinic including both clinicians and counselors/educators were interviewed for approximately 20-30 minutes and asked about their experience counseling couples, how frequently they address couple issues and what issues are discussed, how often men come to the clinic and for what, and their knowledge and practices pertaining to the SDM and any other fertility awareness-based methods.

The following elements were collected at baseline and endline at Tri-City Health Center (and at baseline at PPSDRC) to determine the effect of the intervention:

1) *Simulated client visits*: Simulated clients are not real clients, but women who are hired by the study and trained to enact the role of a client with a particular profile. At both baseline and endline, three sets of simulated clients were sent to all study clinics: one group who would choose the pill if offered, one group who would choose DMPA if offered, and one group who would choose a non-hormonal method (condoms at baseline, SDM at endline) if offered. Following their visit, they completed a checklist to indicate the outcome of their visit, including which topics were addressed by the provider.

2) *Interviews with providers*: Semi-structured interviews with providers were conducted at all participating study clinics at baseline and endline. The interviews asked about the frequency and comfort level with which the providers addressed couple issues and offered the SDM. Endline interviews at Tri-City Health Center also included questions on the way in which intervention activities impacted the clinic and whether or not they wished to continue offering the couple-focused approach and/or the Standard Days Method. All family planning providers at participating clinics were invited to be interviewed.

3) *Interviews with clients*: Family planning clients who selected either the pill, DMPA, condoms, or the SDM (endline only) were invited to participate in the study. During their visit, after they selected their method, they were recruited either by the provider or by a trained study staff member stationed at the clinic. If the clients agreed to participate and signed a consent form, they were interviewed twice: once within one month of receiving their method, and again three months later. The initial interview asked them about their previous family planning use and communication with their partner about family planning. The follow-up interview asked about partner involvement, correct use and continuation of the method. The goal was to interview a total of 200 clients at both baseline and endline.

4) *Interviews with partners*: After their follow up interview, family planning clients who participated in the study were asked for permission to invite their partners to be interviewed. If the client granted permission to invite her partner into the study and if he agreed to an interview, he was interviewed once and asked similar questions as the woman, but from the male perspective.

In addition, monthly service statistics were collected at Tri-City Health Center over the course of the study to track SDM uptake.

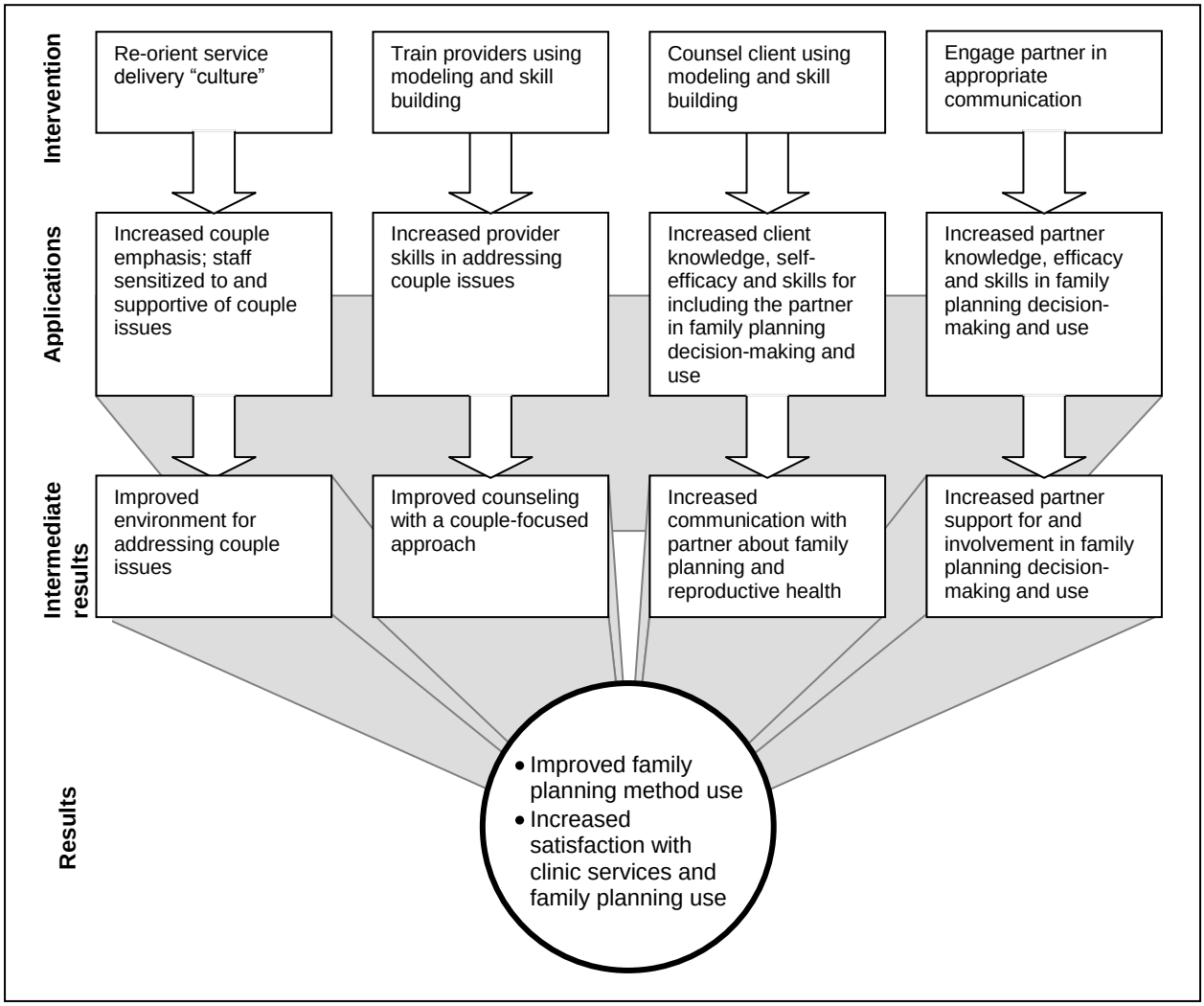
D. Conceptual framework for the intervention

The study hypotheses and the intervention are based on **social learning theory (SLT**) (e.g., Bandura, 1977, 1986, 1997), which emphasizes a three-way relationship among cognitive, behavioral and environmental influences. SLT involves both learning and behavior. It emphasizes modeling and skill development, both of which were to be included in the intervention in provider training and client counseling. According to SLT, behavior change occurs when a person observes and imitates the behavior of others, sees positive behaviors modeled and practiced, increases his/her own capability and confidence to implement new skills, gains positive attitudes about implementing new skills, and gets support from his/her environment to use the new skills.

According to the SLT concept of **reciprocal determinism**, behavior change results from an interaction between individuals and their environment. The **behavioral capability** concept suggests that knowledge and skills influence behavior, and it emphasizes the importance of modeling as a pathway to behavior change. **Self-efficacy**, or confidence in one's ability to behave in a particular way, is necessary for behavior change. Desired behaviors and skills can be acquired through **observational learning** of modeled behavior, particularly when the learner also has had an opportunity to practice behaviors and receives **reinforcement** for doing so.

Figure 3 further illustrates how SLT is applied to the relationships of the intervention to expected results of the proposed research.

Figure 3: Conceptual Framework



IV. Results from formative research and baseline data

The purpose of the formative research component of the study was to help fine-tune specific details of the intervention, including the content of staff training, how a couple-focused approach could be incorporated into existing services, and educational materials. During this phase, information was collected from providers, clients and their partners in the intervention clinics of PPSDRC, in the form of in-depth interviews with providers and questionnaires for clients and their partners.

Although not formally part of the formative research phase, results from baseline data collection at PPSDRC are also described in this section as they provide additional information regarding pre-intervention couple-related family planning attitudes and behaviors.

A. Providers and the couple-focused approach

In-depth open-ended interviews were conducted in intervention clinics with the clinic managers and one or two clinicians and reproductive health counselors to assess: 1) current practices regarding incorporating couples into family planning services: 2) their interest in and attitudes toward enhancing this approach; and 3) their suggestions for better addressing couple needs.

A total of ten interviews were conducted at the intervention clinics, representing about one-third of clinic staff. At the first clinic, a clinician, two reproductive health counselors, and the assistant manager (who is also a counselor) were interviewed. At the second clinic, the manager, assistant manager, one clinician, and three counselors were interviewed. Interviews lasted generally 20-30 minutes and were tape recorded. The interviews were then transcribed, coded, and sorted to facilitate analysis.

Results of the provider interviews provided critical information regarding counseling practices around couple issues.

Current patterns and practices

Planned Parenthood staff reported that a large portion of their patients already know what method they want before they are counseled – one counselor estimated that this is true for about half of women. Older patients generally know which method they want, while younger women are less familiar with their birth control options. The most popular method was the pill.

Women who know what method they want have usually learned about it from friends and family members. Advertisements also influence method choice, particularly with the patch. As well, many patients have heard about methods from community health educators (*promotoras*). Some patients have used the method before and are returning because they wish to use it again.

"Some just want a birth control method because their mother uses it. Some have no idea that we have the patch and the Nuva Ring and all that. They say, "My mom just told me to go for birth control pills." Some people do decide to take the pill, but others decide on the patch or the ring, or the depo. Some people don't want to worry about taking a pill every day, and they decide on the patch or the Nuva Ring."

-Counselor

Sometimes patients request that their partner accompany them to a birth control counseling session. However, PPSDRC policy specifies that partners are not allowed into the session in order to protect the woman's privacy. While staff at one of the intervention clinics professed a strict compliance with this policy, a clinician at the other clinic indicated that exceptions are made on occasion. In such cases, the woman would be counseled privately first, and then the partner would be invited in upon the woman's request.

"Do women ever request that their partner come to the counseling session with them?"

-Interviewer

"Yes. But we don't allow it because of confidentiality. Sometimes the partner wants to come in, or the mother wants to come in, but the patient doesn't want that, so we want to give her that space. We want to enable her to talk about birth control methods or STIs – it's up to them."

-Counselor

Respondents indicated that they typically do not to ask about the partner during birth control counseling. Nevertheless, partner issues do come up from time to time, usually with regard to STI risk, condom use, or because the patient asks if her partner can participate in the session. The topic of partners also arises when the patient wants to keep her birth control method hidden from her partner and in discussions about how to time intercourse to achieve pregnancy.

"Does the partner ever come up in the discussion? Not want to use a particular method?"

-Interviewer

"Yes, particularly with IUDs. The client may ask if the partner would be able to feel it, because 'he doesn't want me using any birth control but I don't want any more children. Is he going to feel the string?' Etc. So sometimes you do have women doing it without their partner knowing."

-Counselor

Likewise, providers reported that the issue of couple communication is not usually addressed in counseling sessions. When it does come up, it tends to be in relation to condom use or sexual dysfunction. Providers generally do not give patients materials to take to their partners (beyond the standard written information patients receive with their method), except for condom use or vasectomy.

"Have you ever talked to patients about their communication with their partner? Using the method?

-Interviewer

"Not really. We're usually concentrating on them [the patient]."

-Clinician

Generally, providers appeared to be in favor of the involvement of male partners in birth control decision making and use. Several were extremely positive, citing personal experience. Some providers, however, qualified their support of male involvement by saying that it should be the woman's choice, and it is only appropriate if the patient desires it.

One provider mentioned that male involvement would be good in an ideal situation, but sometimes women may be susceptible to coercion or too much influence from the male partner. Some patients have partners who don't want them on birth control, so they must hide method use from their partner.

Thoughts on why men might not be involved include a sense that men care more about avoiding pregnancy in general rather than which method to use and that some men either aren't educated enough, don't care enough, or simply would prefer to leave it up to the woman.

"Some [men] don't care to be involved. Priority is, I don't want to be pregnant. Take care of it. And other men/partners are very involved. Often we'll see the males come in for EC because they don't want their partner to be pregnant. That I guess is the main motivation. Let the female decide what she would find the most convenient for her to plan this."

-Clinician

Providers' opinions on addressing couple issues in a counseling session with just the woman were mixed. Some providers believed it would be worthwhile or useful, while others felt that it would be worthwhile only if it was what the patient wanted and was looking for, and it wasn't forced on her. As well, some providers expressed uncertainty as to how this approach would work.

"*If time and circumstances allowed, do you think your patients would like to talk more about couple issues during a counseling session?"*

-Interviewer

"It's hard because the patients don't really talk about their partner. They just want to get information for themselves…they just come for their needs, not for their partners needs."

-Counselor

"How do you think your patients would respond to a counseling approach that addresses couple issues?"

-Interviewer

"If it's wanted, I mean if this is something they were looking for, I think they would be very receptive to it."

-Clinician

"I think it's fantastic. The more involved everybody is – even with the relationship itself – it could help the relationship just because they're talking more about it. Then if something were to happen, like if they were to get pregnant, it wouldn't fall completely on her. So yes, great."

-Counselor

Interviewers asked Planned Parenthood staff what concerns they had about engaging men from a clinic-wide perspective. Overwhelmingly, the providers' primary concerns were protecting patient confidentiality and ensuring that patients were comfortable involving their partners. Providers were also concerned about whether couple issues could be addressed during the amount of time allotted for counseling, as clinics are often very busy and wait times can be long. However, respondents seemed to think that a couple-focused approach might be beneficial as long as these concerns could be addressed.

"We want to make sure that the patient is OK with the partner being involved. I know that in the Latino culture, the man is the man is the man, and sometimes if he says I don't want you to use anything, that's how it is, and I just want her to be OK with having him there. It should be her choice…it's always been engraved in our minds that it's a woman's decision."

-Manager

Providers' experience and training

All providers interviewed reported that they have experience and feel comfortable counseling men. The most common issue addressed with men is sexually transmitted infections (STIs). Some providers have experience counseling couples, while others do not. Most providers indicated that they would feel comfortable addressing couple issues during counseling.

Neither clinic offered fertility-awareness based methods. However, respondents expressed enthusiasm about offering such a method. They predicted that a fertility awareness-based method would not attract large numbers of patients but that there would be patients who use condoms or periodic abstinence who could benefit from this option.

"Do you think some of your clients might be interested in [a fertility awareness-based method]?"
-Interviewer

"Oh yes. Not a whole lot, but there are. There's women that can't be on hormonal methods and don't want an IUD. They use condoms. So, if they don't want to use condoms anymore this would be great."
-Counselor

In general, providers were interested in offering SDM/CycleBeads, especially as it would expand options and provide a means to involve the partner, and as something that could be used jointly with condoms or emergency contraception. Some providers also liked the idea of the CycleBeads as a physical tool that could help women track their cycle and know when they are fertile.

"I think it [SDM/CycleBeads] would be a nice birth control method because they have something that can tell them when they're ovulating and when their period is going to come and can keep track of it with the beads. I don't know how it's going to work…it would be a learning experience for me too."
-Counselor

Implications for intervention design

The results of the provider interviews and their implications for the intervention design are summarized in Table 1. The primary concerns of PPSDRC providers were to protect patient confidentiality and promote women's autonomy and decision making; to recognize that a couple-focused approach is not appropriate for all women; and to keep any intervention activity within the time constraints of a busy clinic.

Because so many women decide what they want prior to coming to the clinic, it is important to do outreach to let people know about the availability of a new method. It is also important to understand that younger women may not have had much experience with or knowledge about methods and take that into account when counseling.

Table 1: Summary of Recommendations from Provider Interviews

Current practice	Recommendation
Providers want to protect women's confidentiality	Intervention should safeguard women's privacy
Women's needs come first	Intervention should be sensitive to providers' concern for the rights and autonomy of the woman and should complement, not oppose, this philosophy
Some women aren't in a "couple" or a stable relationship; others are using birth control secretly	Intervention should recognize that the couple approach may not benefit all women and should reassure providers that this approach would not be imposed on women with no interest in it
The pill is the most commonly dispensed method – the patch is also gaining popularity – and providers tend to steer patients towards these popular methods	Intervention should help providers – particularly counselors – to offer all method options in order to best meet patients' needs
Many women already know what m method they want when they come to the clinic	Outreach will be necessary to ensure that women know they can ask about SDM/CycleBeads
Clinics are busy and wait times can be long	Intervention should fit within the time constraints of the clinic
Younger patients have less experience with birth control, are less familiar with their options, and may not be accustomed to communicating with their partner about birth control	Intervention should consider life cycle approach and address special needs of younger patients
Clinicians and counselors perform different functions	Intervention should offer enhanced counseling techniques for both counselors and clinicians
Respondents don't perceive a need for training on counseling but are open to learning something new	Intervention should take advantage of the SDM and CycleBeads training opportunity to discuss counseling techniques

Overall, these interviews indicated that the incorporation of a couple-focused approach and the SDM/CycleBeads into clinic services would be well received by clinic staff and would benefit at least some patients, as long as it complements rather than conflicts with Planned Parenthood's philosophy and operational structure.

B. How clients and their partners feel about a couple-focused approach

Important information for the design of the intervention was also obtained from client and partner questionnaires. The client questionnaires assessed client perceptions of their partner's involvement in family planning decision-making and use and how clinic services typically addressed couple issues. The questionnaires for male partners addressed the same questions, from the male perspective.

Front desk personnel from the two intervention clinics asked clients to fill out a brief questionnaire in English or Spanish. Women who completed a questionnaire were given a take-home questionnaire for their partners to complete along with a self-addressed stamped envelope. Partners who mailed in the completed survey received two movie passes by mail as an incentive to increase partner participation. Participation was voluntary and the target was to have completed 100 female and 100 male questionnaires (50 for each clinic, for each gender).

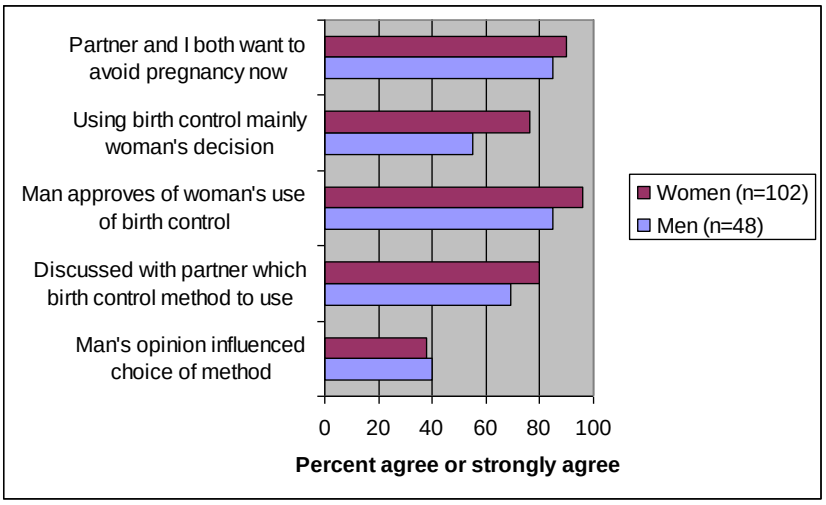
In the end, 102 questionnaires were completed by female clients and 48 by male partners. Since the collection of male questionnaires was particularly slow, clinic staff were told to distribute the questionnaires to men in the waiting room, as well as to women to take home to their partners. Some of these men may have been partners of family planning clients, however others may have been accompanying their partner for other services or there to receive services themselves. Nevertheless, it was decided that it was important to obtain some feedback from men.

Family planning communication and decision making

The results of the questionnaires indicate that couples discuss birth control decisions. Most male and female respondents reported that that they have discussed birth control with their partner and that the man supports his partner's decision to use birth control.

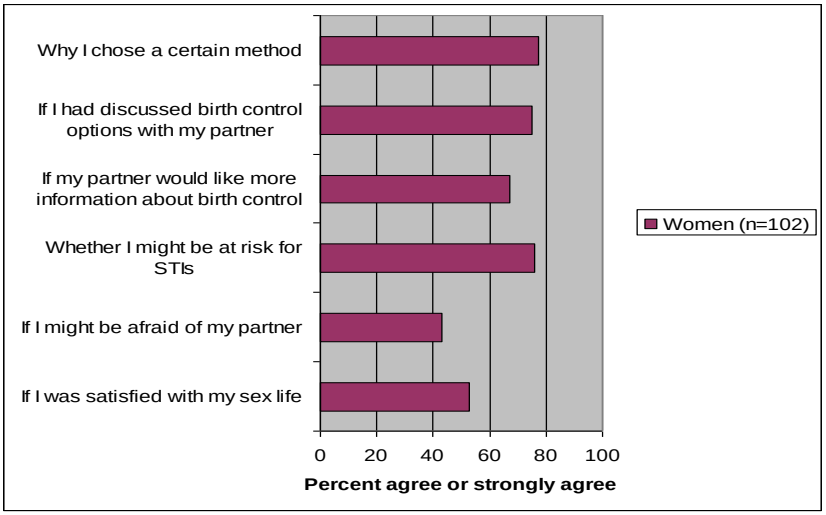
Although for many respondents (76.5% of women, 55% of men) using birth control was mainly the woman's decision, over 85% of respondents indicated that the male partner approves of this decision, as shown in Figure 4. About 40% of men and women reported that the man's opinion influenced the woman's decision to use a method. Many men and women discussed which method to use with their partner.

Figure 4: Birth control decision making



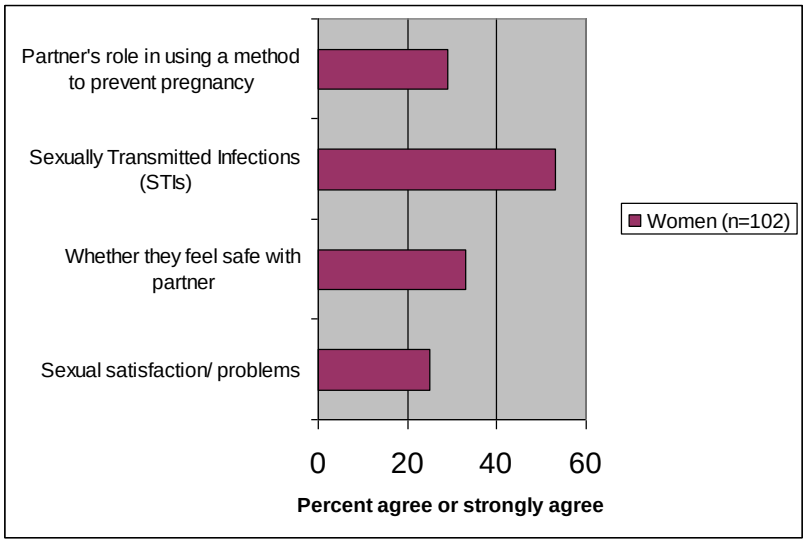
An important percentage of women who completed the questionnaire expressed an interest in discussing couple-related issues during birth control counseling, and in fact, many women reported that couple issues were addressed during their counseling session. As shown in Figure 5, many women reported having discussed whether her partner would like information about birth control, whether she might be at risk of STIs, and other partner-related issues.

Figure 5: Topics asked by provider during counseling



More than half of female respondents indicated that they would like to discuss sexually transmitted infections during counseling, as shown in Figure 6. Some women wanted to discuss her partner's role in pregnancy prevention, whether they feel safe with partner, and sexual satisfaction.

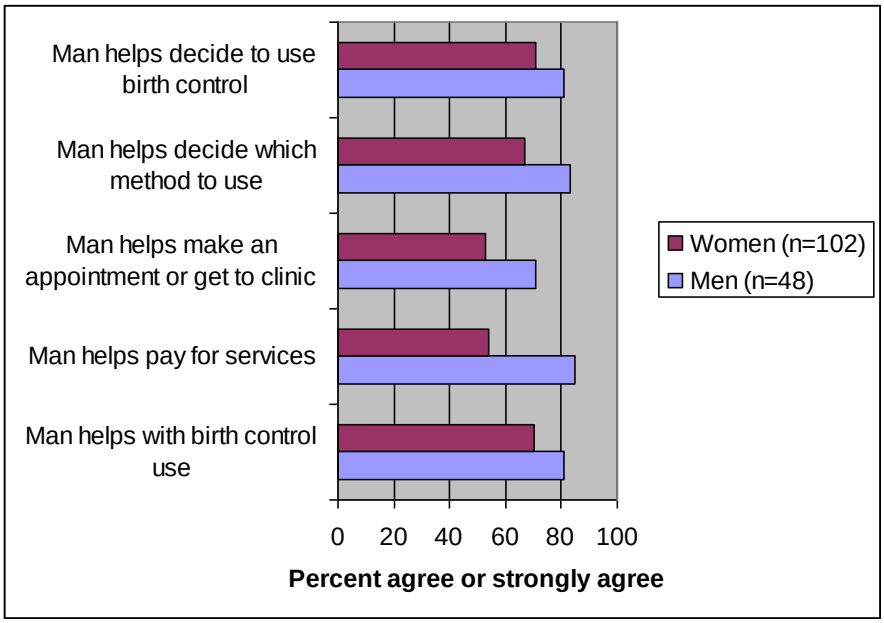
Figure 6: Topics clients would like to discuss during counseling



Men's interest and participation in birth control

Many male respondents reported being involved in birth control use, but in comparison to women, they report greater male involvement. As shown in Figure 7, from 50 to 70% of female respondents mentioned ways their partners help them use birth control, as compared to 80% of men. Some of the ways men and women reported that men are involved include deciding which method to use, making an appointment, paying for services, and helping in actual use of the method.

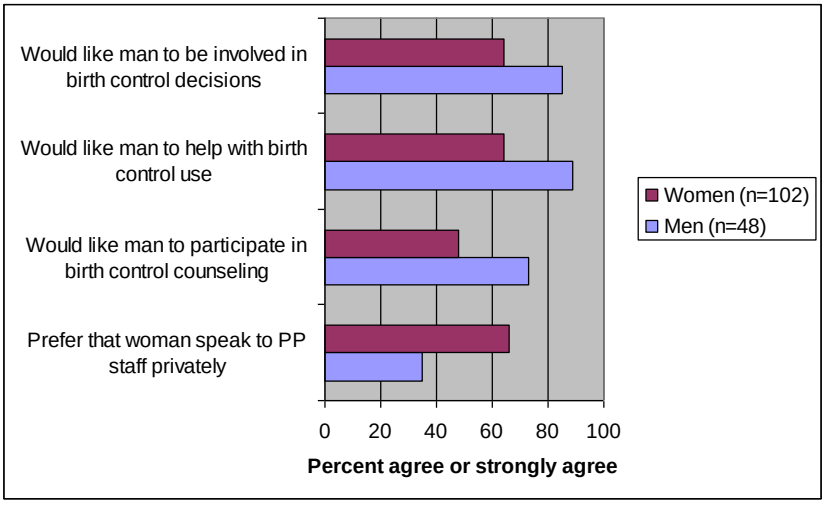
Figure 7: Perceptions of men's participation in birth control



Male respondents expressed an interest in greater involvement in birth control, and the majority of female respondents indicated that they would approve of greater male involvement. However, an important percentage of women stated that they do not want their partners more involved. For example, 85% of men reported that they would like to be involved in birth control decisions, while only 64% of women would like their partners involved.

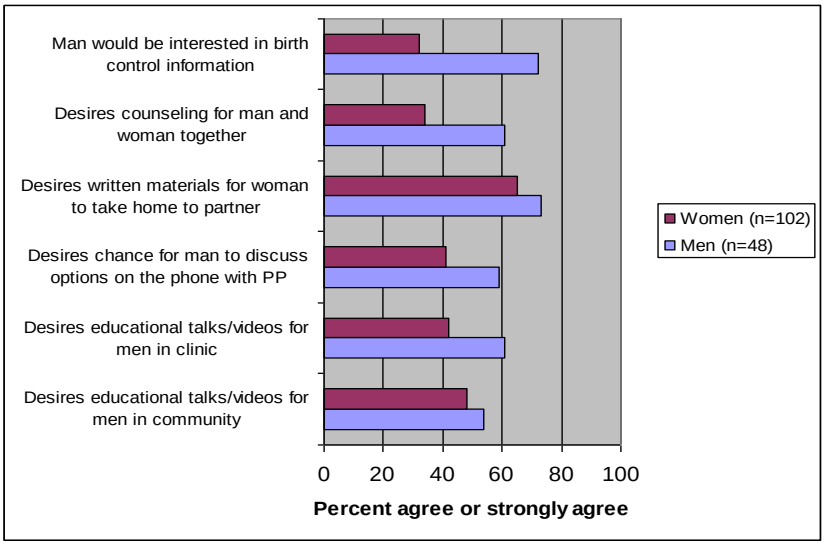
Most men (73%) stated that they would like to participate in birth control counseling, as compared to only 48% of women (Figure 8). Almost twice as many women (66%) as men (35%) indicated that they would prefer that the woman speak to Planned Parenthood staff privately.

Figure 8: Desire for men's involvement in birth control



There was a significant interest among male respondents in receiving information about birth control. This interest among men was higher than perceived by female respondents, as indicated in Figure 9. About 72% of male respondents stated that they would be interested in birth control information. However, only one-third of female respondents reported that their partners would like information. Likewise, more men than women expressed a desire for Planned Parenthood to provide birth control counseling to couples. From 50 to 70% of men would be interested in participating in counseling sessions, receiving printed information and attending talks on birth control.

Figure 9: Men's interest in birth control information



Implications for intervention design

An understanding of client preferences and practices, as well as those of their partners, can enable services to be better tailored to clients' needs. The client and partner questionnaires revealed important findings that were taken into consideration while designing a couple-focused approach.

Because the information was collected from men visiting the clinic as well as from partners of female clients, and because only women and men interested in filling out the questionnaire are represented, results may be biased towards men and women open to a couple approach. No information was collected on those who refused to complete the survey. However, even though the sample is small and not representative, the information was helpful in guiding the intervention design.

Discussion of birth control decisions: The finding that many women and men who completed the questionnaire have discussed birth control decisions with their partners and are largely in agreement suggests that women do not always make birth control decisions independently. While most providers who participated in formative research in-depth interviews indicated a strong concern for women's confidentiality and autonomy, these results suggest that many women view birth control use as a couple decision, and their partner's opinion may influence their method choice. Therefore, a greater recognition on the part of the provider of the potential involvement and influence of a woman's partner, without undermining respect for the woman's rights or autonomy, may be appropriate.

Discussion of couple issues during counseling: Because many women would be interested in discussing couple-related issues such as the partner's role in birth control use, sexually transmitted infections, whether they feel safe with their partner, and sexual satisfaction or

problems (ranging from 25–53% of women surveyed), providers who address these issues may be more successful at meeting women's needs. For this reason, raising awareness of this interest and training providers to address couple issues are recommended. For providers that are already addressing couple issues, this behavior should be supported.

Men's participation in birth control: Most of the men who completed the questionnaire indicated that they participate in birth control in one or more ways. Although they reported higher levels of participation than perceived by the women who completed the questionnaire, most women also indicated that their partners participate in birth control. These findings suggest that many men are active participants in birth control decision making and use. For this reason, it may be possible to improve services by sensitizing providers to this participation so that they may be more open to discussing male involvement with clients.

Desire for men's involvement in birth control: The finding that the majority of men questioned would like to be involved in birth control decisions and help with birth control use (85% and 89% respectively) suggests that there may be untapped potential for male involvement and support. For this reason, it may be useful for providers to ask about the partner's perspective during counseling (for example, by asking the woman how her partner feels about birth control) and, in cases where the woman would like to engage her partner, to suggest ways in which the partner could support birth control use. However, because some female respondents indicated that they do not want their partners involved in family planning decision-making or use, providers should recognize this and be prepared to support clients who do not want their partners involved.

Men's interest in birth control information: Because, according to these findings, women may underestimate men's interest in birth control information, clients may be unlikely to request information for their partners. For this reason, it could be helpful if providers took the initiative to offer clients information for their partners, or simply to ask if their partners would like any information. Among the various options mentioned in the questionnaire for providing information to men, written materials for the woman to take home to her partner was the most popular option for men and women (73% and 65% respectively). Thus, it is recommended that, for clients who want their partners involved, providers offer clients materials to take to their partners, including materials that are specifically geared towards men.

A summary of recommendations can be found in Table 2.

Table 2: Summary of Recommendations from Client and Partner Questionnaires

Finding	Intervention recommendation
Couples discuss birth control decisions.	• Create awareness among providers of potential involvement and influence of male partner on decision-making
An important percentage of women are interested in discussing couple-related issues during birth control counseling, and in fact, many women report that couple issues are addressed.	• Encourage providers to ask about couple issues during counseling • Support providers who already ask about couple issues
Many men are involved in birth control use, but in comparison to women, they overstate their participation.	• Sensitize providers to male participation for birth control • Encourage providers to suggest ways that partners could be involved in birth control use
Men express interest in greater involvement in birth control, and the majority of women would approve. However, an important percentage of women do not want their partners more involved.	• Teach providers to ask how the client's partner feels about birth control • Encourage providers to suggest ways that partners could be involved in birth control use • Encourage providers to support women's decision not to involve their partners • Continue to provide confidential services that respect women's autonomy
Men are interested in birth control information; women underestimate their interest.	• Teach providers to ask clients if their partners would like information about birth control • Provide written material for women to take home to their partners – if possible, provide material geared towards men

In summary, results from the client and partner surveys suggest that providers' increased openness to and capacity for discussing birth control from a couple-focused approach could improve services and increase clients' satisfaction with their birth control methods.

It should be noted, however, that since some women indicated that they did not want their partners to be involved, providers should only encourage men's involvement for those women who desire it and should continue their efforts to provide confidential services to women. Engagement of the male partner should be viewed as an option rather than as something that is appropriate for all women. Providers could assess a woman's interest in engaging her partner by asking how her partner feels about birth control or by asking if her partner would like information about birth control.

C. Results of client interviews at PPSDRC

This section presents results from interviews with family planning clients – specifically, pill, condom and injectable users – recruited from participating PPSDRC clinics. The interviews were administered as part of the baseline data collection for the study. Although they were not used to evaluate the effect of the intervention due to PPSDRC's withdrawal from the study, we present the results in this section due to their usefulness in planning couple-related programs, as they shed light on male involvement in family planning use and decision making.

These data provide additional information on client attitudes and behaviors with regard to couple issues and family planning that may be of interest to family planning programs and providers. Initially, providers felt that male involvement was not a priority for their clients, and might detract from their mission of empowering women. Results from baseline interviews with clients revealed another picture. These data also provide insight into what characteristics may be associated with greater male involvement.

Background of interviewees

Tables 3 and 4 indicate the demographic characteristics of the clients who participated in the study from PPSDRC and their experience with family planning methods. Most interviewees were in their young twenties, and approximately half spoke Spanish. Almost half were dating their partners exclusively but not cohabiting or married, although the majority had been with their partner for at least one year. Approximately half of the respondents had children, and the vast majority had used a family planning method in the past.

Table 3: Demographic characteristics (n=195)

Age	Mean: 24; median: 22 (Range: 18-51)
Education	41% university; 48% high school; 11% elementary or middle school
Language	51% English; 34% Spanish; 14% Both
Marital status	22% married; 27% cohabiting (unmarried); 46% dating exclusively; 5% dating multiple people
Time in union	31% <1 year; 69% 1+ years

Table 4: Family planning/reproductive health history (n=195)

Have children	48%
Ever used:	
Pill	58%
Shot	28%
Patch	20%
Condom	79%
Withdrawal	34%
Other methods	<8%
Emergency contraception	54%
Never used birth control	5%

Quality of care

In general, quality of care was high at participating PPSDRC clinics, as indicated in Table 5. However, questions about the partner were only asked about a third of the time.

Table 5: Quality of care (n=195)

Received method she wanted	94%
Had opportunity to ask questions	98.5%
Felt all questions were answered	99%
Patient chose the method	71%
Provider asked what partner thinks about using birth control	**29%**
Provider asked if she would like information to share with partner	**36%**

Male involvement

Women reported a high degree of couple communication about family planning. Some 96% of women reported that it was easy for them to talk with their partner about birth control. As shown in Table 6, most women reported talking to their partners about a range of topics including what happened during their family planning appointment and how he feels about birth control.

Table 6: Couple communication about birth control (n = 195)

She talked to her partner about…	
Going to the clinic to get birth control	91%
What happened at the clinic	95%
How he feels about birth control*	88%
Risk of HIV or other STIs**	82%
Having sex only with each other**	91%
What they would do if their method failed and she got pregnant**	81%

* = in the last year

** = ever

Women respondents reported significant male involvement in method selection and use, although women usually have the final say. As shown in Table 7, one quarter of women reported that their partners accompanied them to the clinic, and 75% reported partner assistance in method use. More than two-thirds of women stated that joint family planning decision-making was very important to them.

Table 7: Method selection and use (n = 195)

Partner came with her to clinic	25%
Partner helped her learn about methods	31%
Partner helped decide which method to use	45%
Partner helped with method use	75%
Making birth control decisions jointly with partner is very important	71%

In spite of the importance of joint decision making, only half of the women reported that the decision to use a family planning method was a joint one. Some 70% of women reported having made the decision to use a particular method herself (Table 8).

Table 8: Role of men in birth control decision making (n = 195)

Who made the decision…	**She**	**Both**	**He**	**Provider**
…to start using birth control	47%	49%	3%	1%
…to use a particular method	70%	23%	3%	4%

It is evident that couple communication is high, men are frequently involved in family planning decision-making and use, and joint decision making is very important to the majority of women. However, in reality women are the final decision makers, particularly when it comes to method choice.

Factors which may influence male involvement

Bivariate analysis suggests that women who speak Spanish at home, are not university educated and are using condoms are more likely to report partner involvement. Results are presented in the tables below. Significant associations were also found between unmarried cohabitation, time in union and partner involvement. Little to no influence was observed as a result of age of the woman or age difference between partners.

Language/acculturation: As shown in Table 9, women who usually spoke Spanish at home were more likely to report partner involvement.

Table 9: Language and partner involvement

	Spanish (n = 67)	**English, or Both English and Spanish (n = 127)**
Partner helped learn about methods**	46%	23%
Partner helped decide which method to use*	54%	30%
Consider joint decision-making very important*	84%	63%

* $p < .05$
** $p < .01$

Education: Less educated women were more likely to report partner involvement (Table 10).

Table 10: Education and partner involvement

	High school and below	**University**
Consider joint decision-making very important*	78% (n = 115)	59% (n = 79)
Partner influenced woman's decision to use their current method*	51% (n = 76)	33% (n = 52)

* $p < .05$

Method Choice: As expected, condom users were more likely to report partner involvement (Table 11).

Table 11: Method choice and partner involvement

Partner helps/helped:	Condom users (n = 69)	Hormonal method users (n = 126)
Use the method**	87%	69%
Make the decision to start using birth control*	62%	45%
Make the decision to use that method**	46%	14%

* p < .05
** p < .01

Marital Status: As shown in Table 12, cohabiting (unmarried) women were more likely to report partner involvement.

Table 12: Marital status and partner involvement

Partner helped…	Married (n = 42)	Cohabiting (n = 52)	Dating (n = 90)
Learn about birth control methods*	40%	43%	22%
Make an appointment or get to clinic**	17%	51%	35%
Pay for services**	35%	49%	18%
Make decision to start using birth control*	59%	67%	44%

* p < .05
** p < .01

Length of Relationship: The effect of length of relationship on partner involvement varied, as depicted in Table 13.

Table 13: Length of relationship and partner involvement

	<1 year (n = 58)	1-4 years (n = 72)	5+ years (n = 49)
Partner accompanied her to clinic**	40%	18%	17%
Partner helps pay for birth control services*	15%	40%	35%

* p < .05
** p < .01

Implications

According to interviews with PPSDRC staff, many PPSDRC staff felt that most women came into the clinic looking for information for themselves, not necessarily for their partners. PPSDRC staff tended to focus on protecting the women's autonomy and confidentiality when it comes to family planning. However, these results show that couple communication about family planning is high. A large percentage of women reported that their partners are involved in family planning decision making, and most women feel that it is important for men to be involved in family planning. Therefore, an approach to family planning counseling that recognizes and supports the potential involvement of the male partner would be appropriate for many women.

These data also provide insight into what characteristics may be associated with greater male involvement. These findings can encourage providers to tailor family planning counseling to the unique needs of each client, rather than assuming that male involvement is irrelevant to women.

V. Intervention Design

Results from the formative research informed the intervention design. The intervention was designed to incorporate a couple-focused approach into family planning counseling. It should be noted that a couple-focused approach refers to any of the following:

- Discussing with clients the role of their partners in birth control
- Helping women gain partner support for family planning, if they desire it
- Offering women the choice of including their partners in counseling, if allowed by the clinic
- Giving clients take-home materials for their partners
- Including Standard Days Method among method choices
- Providing appropriate referrals for men and/or couple issues
- Taking steps to ensure men feel welcome at the clinic – e.g., providing male-friendly magazines in the waiting room

It can also include addressing other issues pertinent to the couple, including STIs, partner, violence, infertility, and sexual satisfaction or problems.

A. Intervention components

A simple strategy was needed to operationalize this approach, taking into account providers' limited time for counseling and the lessons learned from the formative research. As such, the intervention consisted of three primary actions for clinic staff:

1) Family planning providers were advised to ask each family planning client the following two questions:

    1. "How does your partner(s) feel about birth control?"
    2. "Would your partner(s) like any information about birth control?"

    The purpose of these questions was to open the door to a discussion of couple-related issues if the woman desired it. It would enable the providers to ascertain whether or not the woman would like to involve her partner, and support her accordingly. In this way providers could assist women who desired greater partner involvement or information for their partner and could identify those who did not want to involve their partner.

2) Offer SDM/CycleBeads

    The SDM, used with CycleBeads, is a knowledge-based method that is feasible to offer within the time constraints of counseling in the participating study clinics. Providers were taught to include the SDM/CycleBeads among the methods offered to clients. As it is a fertility awareness-based method, it requires participation of the couple and therefore is considered a "couple" method. As SDM/CycleBeads counseling requires consideration of the couple relationship, including it in the method mix could help sensitize providers to couple issues.

3) Offer new informational materials to clients

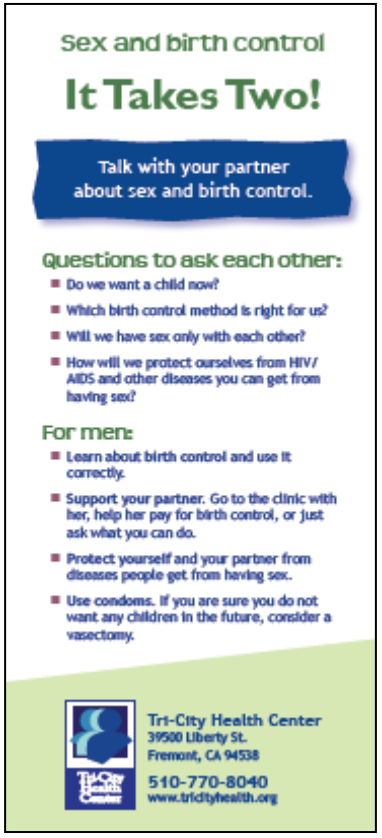
    New informational materials in English and Spanish were made available to clinic staff pertaining to the couple-focused approach and the SDM/CycleBeads. These materials were designed specifically for this study, except where noted, and included:

    - A 9"x4" card with the slogan "It Takes Two!" to encourage couple communication and male involvement in family planning. It included a list of concrete actions men can take to get more involved in family planning (Figure 10)
    - A 9"x4" card about CycleBeads (Figure 11)
    - A pamphlet with information about how to use SDM/CycleBeads
    - A fact sheet about SDM/CycleBeads designed to match the style and format of the organization's other method fact sheets
    - A booklet called "What Men Want to Know about Sex and Birth Control," which was not designed by study staff but purchased from the California Family Health Council

    These materials were put on display in the clinic and made available to clinic staff to hand out to clients.

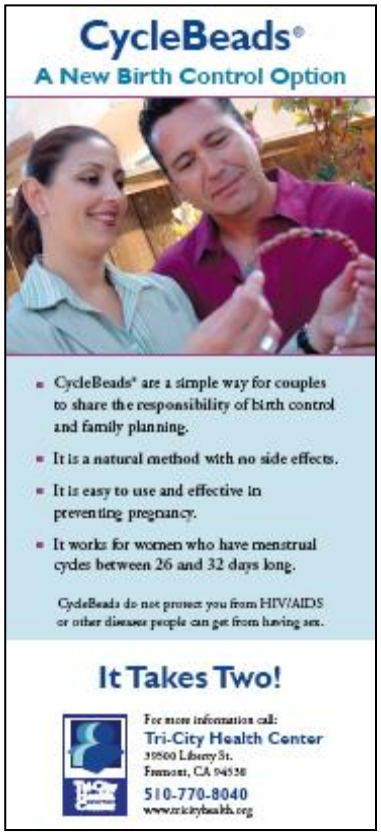
Figure 10: "It Takes Two!" Card to Promote Couple Communication and Male Involvement

Front

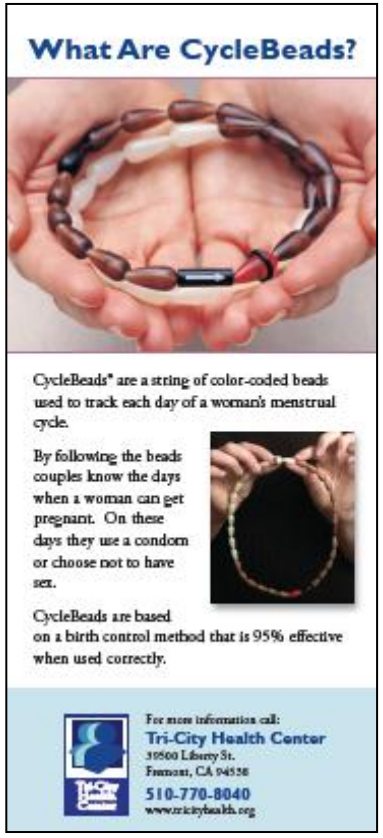


Back

Figure 11: CycleBeads Card



Front



Back

B. Intervention implementation

In keeping with social learning theory, implementation of the intervention called for the following components: 1) whole-site staff training; 2) integration of the SDM and couple-focused approach into family planning services; 3) enhanced education and client counseling; and 4) IEC activities. This four-pronged approach was designed to enable the experimental sites to offer an effective, fertility awareness-based method on-site, incorporate the couple-focused approach during other relevant client interactions, and increase partner awareness and communication about reproductive health issues important to the couple. The intervention components, rationale, and anticipated outcomes are described in Table 14.

Table 14: Intervention Components

	Staff training	Integration of SDM/Couple approach	IEC activities in English and Spanish	Enhanced client education and counseling
Intervention Component	• How to offer SDM • Counseling for partner involvement • Clinic-wide approaches to addressing couples • Cultural competency and the couple-focused approach	• Supplies, billing issues, reimbursement • Protocols • Service statistics • Expanded screening and referrals • Hours of service	• Fact sheet for SDM clients • Flyer for all clients with couple-focused messages • Cue card for providers with couple-focused messages • Outreach messages targeting men and couples through radio and other media	• Offering the SDM to interested clients (screening, teaching, supporting couple use, follow-up) • Incorporating a couple-focused approach as appropriate for other methods
Rationale	Increase staff awareness, skills, and competencies in offering the SDM and in incorporating the couple-focused approach during relevant client interactions	Address possible obstacles to effective, efficient services Update and revise standard procedures, as needed	Attract new family planning users Increase awareness about the SDM, RH, FP, couple communication, and the couple-focused approach among men and the community at-large	Address unmet need for a simple, non-device, non-hormonal method Increase method options for clients Provide a "couple-focused" method Involve men through enhanced counseling of their female partners
Anticipated Outcomes	• Availability of a fertility awareness-based method of family planning • Provider capability to develop and support women's efforts to include partners • Increased client skills in discussing family planning and reproductive health issues with their partners • Increased couple communication and support of partners for family planning use and decision-making • Improved use and continuation of family planning methods/services			

The pilot test of the intervention at PPSDRC and the way in which it was adapted for Tri-City Health Center are described here. Appropriate adjustments were made at both organizations to ensure that SDM and CycleBeads were incorporated into inventory and records keeping systems.

1) Summary of Intervention at PPSDRC

The intervention at PPSDRC consisted of activities to incorporate the SDM/CycleBeads and a couple-focused approach into family planning services at the intervention clinics. Whole-site training strategy was utilized during the PPSDRC pilot test to foster organization-wide support for intervention. Participants included clinicians, managers, and reproductive health counselors. At PPSDRC, reproductive health counselors handle the front desk and administrative work and also perform the bulk of the family planning counseling at the clinic.

Training sessions are listed in Table 15. In general, the responses of the participants were extremely positive, and no suggestions for improving the training were provided. At one of the clinics, three on-the-job training visits were conducted in which study staff observed counseling and provided feedback.

Table 15: PPSDRC staff training activities

Venue	Subject	Duration	# of participants
PPSDRC In-service training	Male Involvement and Latino Cultural Awareness	1.5 hrs	27
Clinic 1	How to offer SDM and CycleBeads	2 hrs	13
Clinic 1	Incorporating a couple-focused approach	1.5 hrs	12
Clinic 2	How to offer SDM and CycleBeads	2 hrs	13
Clinic 2	Incorporating a couple-focused approach	1.5 hrs	12

The intervention clinics began offering the SDM/CycleBeads and the couple-focused approach immediately after having completed all the training sessions (July-August 2006). Promotional and educational materials in both English and Spanish – specifically, posters and brochures on CycleBeads, brochures on the couple-focused approach and birth control information for men – and CycleBeads samples were made available at intervention clinics.

To help them remember key counseling points, staff were provided with counseling aids. During the PPSDRC Pilot test, standard 8.5”x11” job aids developed by IRH for SDM/CycleBeads were made available to counselors. The two key questions for the couple-focused approach were printed on laminated cards and posted in counseling rooms.

Outreach activities were planned to raise awareness of the enhanced services. At one clinic, an outreach worker held a stall at a local flea market on two occasions during the summer of 2006 at which she provided information about family planning method options including SDM/CycleBeads, distributed print material on a range of family planning methods including CycleBeads, and told interested individuals where they could get more information about family planning methods including the SDM /CycleBeads. No further outreach activities were conducted due to PPSDRC's withdrawal from the study.

At the two intervention clinics located near each other, outreach activities were conducted by community health educators called *promotoras*. The *promotoras* are a group of community-based peer outreach workers who provide health and family planning information to migrant workers and low-income Latinos. In September, 2006, study staff and consultants conducted a Spanish-language training for the *promotoras* to enable them to discuss and offer SDM/CycleBeads and the couple-focused approach in the community. Training materials, handouts, and job aids were modified for this group. Fourteen participants attended the *promotora* training. The *promotoras* were enthusiastic about the method and incorporated it into their community talks as well as into their poster-size display of available family planning methods.

PPSDRC decided to stop offering CycleBeads at the intervention clinics upon cessation of their involvement in the study in order to maintain a standard package of family planning methods across their network of clinics. However, the Standard Days Method has been included as one of the fertility awareness-based methods on PPSDRC's website (www.planned.org).

2) Adaptation for Tri-City Health Center

Although whole-site training is optimal, it was deemed not cost effective for a primary health center like Tri-City where only a handful of clinicians provided the bulk of the family planning services. Therefore, at Tri-City Health Center's intervention site (Liberty Street clinic), only clinicians providing family planning counseling were trained on the intervention. Staff members at Tri-City Health Center who had interaction with family planning clients but did not directly provide counseling services – including medical assistants, outreach staff, and administrative personnel – were oriented on the couple-focused approach and the SDM/CycleBeads to approximate a "whole-site" approach.

Table 16: Tri-City Health Center staff training and orientation activities

Type of session	Subject	Duration	# of participants
Training	How to offer SDM and CycleBeads and incorporate a couple-focused approach	2.5 hrs	7 clinicians, 2 outreach staff, 1 manager
Training	How to offer SDM and CycleBeads and incorporate a couple-focused approach	3 hrs	2 teen clinic counselors and 1 medical assistant
Training	Male involvement	1 hr	3 clinicians
Orientation	Couple-focused approach and SDM/CycleBeads	30 minutes	20 medical assistants
Orientation	Couple-focused approach and SDM/CycleBeads	30 minutes	5 front desk staff

Tri-City Health Center also has a teen clinic with a separate entrance that sees clients up to age 24. Although the teen clinic previously had a dedicated clinician, at the time the intervention began, clinicians from the main clinic served rotating shifts at the teen clinic. The teen clinic also has two non-clinical counselors who were trained on the intervention. Additional educational materials were used at the teen clinic to serve a teen audience, as described later in this report.

Although research staff requested more time to train Tri-City providers, three hours was the maximum amount of time the clinic could release its providers for training. The actual training time for clinicians was 2.5 hours because some were late to the training.

Family planning providers at Tri-City Health Center were taught to ask the two partner-related intervention questions during family planning counseling in order to open the door to discussion of couple issues for women who desired it. Although at PPSDRC, clinic policy prohibited male partners from participating in counseling sessions with women, this was allowed at Tri-City, so Tri-City providers were encouraged to offer the option of joint counseling if the client desired it. In addition, Tri-City providers were taught to offer SDM/CycleBeads as part of the method mix. They began offering the couple-focused approach and SDM/CycleBeads immediately following the training, in July 2007.

At Tri-City, providers requested a counseling aid that could fit in their pocket. At their request, a 4”x6” pocket-sized job aid was developed and distributed to family planning providers that included the two key questions as well as key SDM/CycleBeads counseling points.

The couple-focused and SDM-focused flyers and brochures were also made available at Tri-City, with minor adjustments as a result of feedback from Tri-City staff. The two-sided cards that

were developed and used at PPSDRC were improved upon by streamlining some of the messages and including real photos instead of illustrations.

In Planned Parenthood's communities, the bulk of non-Caucasian clients were Latino, whereas at Tri-City Health Center the communities were more diverse. Although there were many Latinos, there were also significant numbers of Afghans, Indians, Chinese, and clients of other ethnic and linguistic groups. Therefore, it did not make sense to Tri-City to emphasize the Latino perspective. Nevertheless, materials were made available in both English and Spanish for Tri-City Health Center. Funding was not available to translate the materials into other languages.

Additional materials made available to providers included CycleBeads samples and a poster listing all family planning methods, developed by the Center for Health Training. Many counselors had their own tools that they used for counseling – for example, posters or fact sheets developed by pharmaceutical companies that listed the range of methods available – however it was not possible for the project to revise all of these materials.

Tri-City did not post CycleBeads posters because it would have been inconsistent with their current practices, but the educational cards and brochures were displayed at the clinic. Outside of the Tri-City clinic, messages were incorporated into community presentations by outreach staff, and those opportunities were also used to share some of the educational materials. Funding and time constraints precluded radio or newspaper advertisements.

VI. Findings: SDM/CycleBeads Introduction at PPSDRC Clinics

As stated previously, the study intervention was not formally tested at PPSDRC. However, in an attempt to learn from PPSDRC's brief experience of offering SDM/CycleBeads, PPSDRC counselors from the intervention clinics were interviewed following PPSDRC's withdrawal from the study. Before turning to the results of introducing the couple-focused approach including SDM/CycleBeads at Tri-City Health Center, in this section we present data on SDM/CycleBeads introduction at PPSDRC obtained from post-intervention in-depth interviews with Planned Parenthood counselors.

There are many reasons for highlighting the experience of SDM/CycleBeads introduction at PPSDRC. As this study represents the first time in which the introduction of the Standard Days Method and CycleBeads has been studied in the United States, this data sheds light on the feasibility and acceptability of introducing SDM into the method mix in US clinics. Whereas Tri-City Heath Center is a primary health care and family-centered clinic, it is worthwhile to consider the experience of Planned Parenthood clinics that emphasize women's reproductive health and rights.

In addition, although Tri-City providers were interviewed post-intervention, those interviews were structured in order to measure a qualitative difference pre-and post-intervention. The data presented in this section, however, comes from in-depth interviews with Planned Parenthood staff who introduced SDM/CycleBeads and therefore provide more details regarding the experience of SDM/CycleBeads integration.

A. Methods for getting feedback from Planned Parenthood staff on SDM/CycleBeads integration

At the time Planned Parenthood withdrew from the study in the fall of 2006, some staff had had the opportunity to offer CycleBeads to clients, and others had not. In spite of their withdrawal from the study, Planned Parenthood permitted study staff to conduct informal, in-depth interviews with select staff who had participated in intervention training to learn from their experiences.

A small group of PPSDRC staff members were interviewed in February and March of 2007 to learn about their experiences offering the Standard Days Method and CycleBeads and offering a couple-focused approach to family planning counseling. The analysis here focuses on their experience offering CycleBeads, rather than the couple-focused approach. The reasons for this include the following:

- Their responses with regard to a couple-focused approach are difficult to interpret because there appeared to be some confusion around what exactly the couple-focused

approach consisted of – e.g., some people thought it was counseling the couple together;
- Those interviewed perceived that their counseling practices did not change much in terms of incorporating a more couple-focused approach; and
- The interviewees' statements with regard to couples and family planning were not substantially different from their responses from the formative research interviews - i.e., that the couple-focused approach was appropriate for some women but not others.

Their responses with regards to introducing the SDM/CycleBeads, however, provided new information and reflected the experience of integrating the SDM/CycleBeads into services in a U.S. setting and, in particular, through Planned Parenthood clinics.

B. Results

A total of nine in-depth interviews were conducted with PPSDRC staff from the intervention clinics; seven with counselors (two of whom also held assistant manager positions) and two with community health educators (*promotoras*). Interviews were tape recorded and transcribed to facilitate analysis. (A tenth interview was conducted but the tape was inaudible.)

No clinicians participated in the follow-up interviews due to scheduling constraints. However, the counselors were primarily responsible for family planning counseling and, in particular, offering SDM/CycleBeads. Clinicians had a peripheral role in offering SDM/CycleBeads due to the nature of the SDM as a knowledge-based, non-clinical method.

All of the counselors interviewed had been trained on SDM/CycleBeads and had incorporated CycleBeads into their counseling practice. Following the training, counselors reported that they typically mentioned CycleBeads when counseling a new family planning user, but not necessarily with someone who was already using a method or knew what they wanted. Also, counselors reported that they tended to bring up CycleBeads more with older clients (i.e., non-teenagers) who appeared to be in a stable relationship.

"We would offer it to all the patients when they would ask the different types of methods when they didn't know what they wanted to use".

– Counselor

"I kind of broke it down into categories. if they didn't want to use a hormonal method, then I talked about CycleBeads and condoms and the IUD."

– Counselor

"If they wanted to start taking the pill, I wouldn't necessarily offer them the CBs. If they said I'm just here, I don't know, I just want to talk about birth control methods, I would definitely bring up the CBs. If they were coming in just to pick up condoms I would definitely talk about CBs."

– Counselor

"If she's 15, you would definitely want her on [a hormonal method]. If they're married and they want to know about everything then you would probably introduce [CycleBeads]. It depends on the patient and what they're coming in for. A lot of them have been coming in here for a while so they just want to continue with their method."

–Counselor

Counselors stated that they would also discuss CycleBeads when clients asked about them. At one of the clinics, several CycleBeads posters were up in the waiting room and at the information desk, prompting many inquiries from clients. At the other clinics, there were CycleBeads pamphlets available in the waiting area. This prompted many clients to ask about CycleBeads.

"We had some posters in the waiting room so some patients coming into the counseling room already had the questions of, well, what is the CycleBeads?"

–Counselor

Visual aids were used in the clinic to help counselors in explaining the method. These included CycleBeads and the package insert, pamphlets, and provider cue cards. Counselors reported that they found all of these items useful but that having the actual CycleBeads sample was the most critical and useful tool for explaining the method. Having a set of CycleBeads hanging in the counseling room also helped to remind counselors to mention them to clients.

"It was good to have not just a picture of the CycleBeads, but the actual CycleBeads themselves to have in the top drawer so we could pull them out to actually show people how to move the ring around. That was the most effective tool."

–Counselor

"The best way [to explain how to use CycleBeads] in my opinion is to take out CycleBeads along with the calendar."

–Counselor

As long as CycleBeads were on hand at the clinic, counselors did not perceive many barriers for them to be able to offer the method. Counselors cited a learning curve at the beginning but with practice found CycleBeads easy to teach. Although the counselors generally expressed confidence in the method's effectiveness, one counselor cited her own skepticism about the method's effectiveness as a barrier. One the whole, the counselors interviewed did not perceive that time constraints were a barrier. There seemed to be a consensus that SDM/CycleBeads counseling would fit within the time allotted for counseling, which was about 10 minutes.

"In the beginning, [the challenge was] just myself getting used to how CycleBeads work. The first couple times, just checking myself, making sure I got the colors right…But not much else. If you have the CycleBeads right there in front of you…it's really an easy method to explain to someone and to show how it can work for someone as a birth control method."

–Counselor

"To me, I was still skeptical to tell them, "OK, these are the days that you are not going to get pregnant." You know? Because it was so new to us. But other than that, I knew how to explain it."

– Counselor

"The only thing is that we were offering it, then we stopped, then patients were coming back asking for it."

– Counselor

"With the counseling, it really doesn't take that long to show someone how to use CycleBeads, if you have the CycleBeads right there in front of you."

–Counselor

"Usually our counseling sessions take 10 minutes, and I think that is enough time. If they see a nurse, they have more time."

–Counselor

Counselors reported that many women were receptive to learning about CycleBeads because it taught them more about the menstrual cycle and is something they would have to do with their partner. One also reported that this method would be well received by the Latino community.

"The women who were condom users or weren't using any method were really receptive to using it, found it pretty easy, felt like they were doing something more for themselves than using the condom or just hoping every month that they didn't get pregnant…. I also found that in general the Latino community was much more receptive to the CycleBeads. The older generation in the Latino community was not necessarily receptive to using hormonal birth control, so something like a combination of condoms and CycleBeads, or at least just the CycleBeads, they were really receptive to that."

–Counselor

"They were very interested in the method just because they have to do it with their partner."

–Counselor

Although it was feasible to offer, counselors perceived barriers for many clients to accept CycleBeads. The most commonly cited barrier was the difficulty in convincing women that the method would actually work. Secondly, they cited the fact that many women aren't interested in non-hormonal methods. Another reason mentioned was that some women don't want to be bothered to track their cycle – either because they didn't feel like it, or because they did not have sex frequently enough to make the effort worthwhile – and just thought it would be easier to use a condom when they needed it.

"At first they worried that it wouldn't work or their partner wouldn't help them."
–Counselor

"They [clients hearing about CycleBeads] didn't sound convinced. They needed more information… A lot of girls are not informed of how and when they can get pregnant. A lot of girls think they can get pregnant at any time. They need to be convinced that that is not the case first."
– Counselor

"Young teenagers want to be on birth control [pills] because they feel they can get pregnant with CycleBeads."
– Counselor

"The people coming in for hormonal birth control, that's what they want. They've made that decision and want a 99.8% effective method that they know is going to be effective for them. People that were condom users that weren't receptive to the CycleBeads, the barriers might have been…just not wanting to deal with it, to keep track. If they're going to be sexually active they're just going to use a condom. I'd say the people that weren't in monogamous relationships really didn't have a steady sexual partner, their sexual activity was more random and sporadic, were the ones that were less receptive to using CBs because it didn't affect them on a daily basis."
– Counselor

These barriers, however, did not prevent some clients from choosing CycleBeads. Although service statistics are not available from PPSDRC, counselors from one of the clinics reported that many clients took CycleBeads home. At the other two clinics there were fewer CycleBeads users, as they introduced the method later than at the first clinic and had less time to incorporate the method before study activities ended. The clients they remembered who selected CycleBeads were either not using any family planning method or had been using condoms but were not satisfied with them. Some counselors however had minimal interaction with CycleBeads clients.

"There was one person who came in for her first visit for birth control. We set her up with CycleBeads. She needed to come back for her annual exam a couple months later. I recognized her as a CycleBeads user and I asked her how it was going. She said she was using them and felt that she was more in charge in terms of getting pregnant or not getting pregnant."

– Counselor

"[A client who accepted CycleBeads was] excited because her boyfriend did not want to use condoms and she wanted something that would help her. She told me it would guide her more than a calendar."

– Counselor

"The people I've seen in monogamous relationships who use CycleBeads, their partners are really receptive to it."

– Counselor

In general, counselors reported favorable opinions towards CycleBeads – in particular, that it is a good option for those seeking a natural method, and an empowering tool for women to learn about their fertility. Some counselors reported using CycleBeads themselves, to either achieve pregnancy or track their cycle.

"I think it's a great method for anybody that wants a natural method, if they're trying to get pregnant or not trying to get pregnant. It's just a matter of really being consistent and knowing how to use it and if you're a good candidate to use it."

–Counselor

"I think that the CycleBeads can be really empowering for women who don't know – as a birth control method and also women that don't know about their fertility cycle or their anatomy. I just think it can be a really empowering tool for women to know how their bodies work."

–Counselor

"I used it to try to get pregnant and it works. I thought it was great. My husband was very excited. It was fun for both of us."

– Counselor

"I tried it myself, and it was okay – not for birth control, just to help me with the weeks…My sister-in-law used it to get pregnant."

– Counselor

Finally, it appeared that CycleBeads introduction helped to change some provider attitudes about natural family planning.

> *"I like [having CycleBeads] a lot better because I never trained on natural family planning. I usually say talk to the nurse practitioner."*
>
> *– Counselor*
>
> *"Now it seems easier [to offer a natural method]. Before it seemed harder because I didn't know how to use it and I wasn't sure how it worked. Now it seems doable."*
>
> *– Counselor*

While the *promotoras* did not directly offer the method, they incorporated the method into their informational talks in the community on family planning methods and provided referrals. They felt that they understood the method well and could explain how to use it.

Promotoras reported that they only referred for the method for two weeks before it was pulled from the program. Nevertheless, a summary of the responses they reported receiving from community members is as follows:

- While the method was well received among some women, there was a lot of concern in the community that one could get pregnant using the method.
- Many women were skeptical because it was a new method and none of their friends were using it.
- While some potential clients thought it would be easy to use, others said they wouldn't have the patience to use such a method. (It is unclear if they were referring to the need to avoid unprotected sex during the fertile window or to the need to move the black band each day.)
- Because of the *promotoras'* relationship with community members, one *promotora* expressed the concern that if a woman got pregnant using CycleBeads, she would accuse the *promotora* of lying to her about the efficacy of the method.
- One *promotora* mentioned that she talked to men about the method and that they liked it because they were interested to learn about when a woman is fertile.

The *promotoras* reported having referred a few women to the clinic for CycleBeads, but they do not have follow-up information about these women.

C. Discussion and implications

There are limitations to evaluating PPSDRC's experience introducing CycleBeads using these interviews. First, only a limited number of counselors were interviewed; there may have been other providers who had different experiences. No clinicians were interviewed, so the clinical perspective is missing. Second, there is no information available from clients from PPSDRC. Finally, the experience of these providers in offering CycleBeads is limited to a couple of months. Nevertheless, the feedback received from them could be useful to other programs that are considering SDM introduction.

Adequacy and appropriateness of training: Counselors felt that the two-hour training session provided them sufficient information to be able to offer CycleBeads. They found the training enjoyable and benefited from it because they learned how to provide not only a new method, but a method that could meet the needs of their patients who were seeking a natural method or a non-hormonal method.

SDM/CycleBeads and clients' needs: Counselors thought that CycleBeads were appropriate for some of their clients, although clients who desired a highly effective method would not be interested. They found it most worthwhile to discuss SDM/CycleBeads with new family planning clients who weren't sure what they wanted, as opposed to people who were certain they wanted a hormonal method or were satisfied users of another method. The fact that CycleBeads is a method requiring partner participation was appealing to some clients. Counselors perceived that CycleBeads were well received particularly among women who were in a monogamous relationship.

Raising awareness of CycleBeads availability: Having CycleBeads posters and informational materials in the clinic was an effective way of letting clients know about the availability of a new method. Clinics wishing to introduce SDM/CycleBeads may wish to consider additional means of spreading the word such as outreach workers.

CycleBeads as a tool for fertility awareness: Many clients do not have a good understanding of the menstrual cycle and, in particular, the concept of the fertile window. In addition to having CycleBeads available as a family planning option, counselors would like to use CycleBeads to help educate women about their bodies and also to help women who wish to achieve pregnancy. (However, it should be noted that while SDM/CycleBeads have been scientifically shown to help in preventing pregnancy, there have been no studies to test their effectiveness in helping to achieve pregnancy.)

This experience shows that SDM/CycleBeads is feasible to offer at Planned Parenthood clinics. It can be offered within the standard amount of time allowed for counseling and meets the needs of clients seeking a non-hormonal or partner-based method.

VII. Findings: Integration of a couple-focused approach and SDM at Tri-City Health Center

This section will address the study questions pertaining to whether incorporating a couple-focused approach into family planning counseling, including adding SDM to the method mix, is feasible and beneficial. Because endline data were only collected at Tri-City Health Center, the data in this section are from Tri-City Health Center only. As described earlier, this report includes before and after data from Tri-City's Liberty Street site (the intervention site) only.

A. Improvement in counseling practices

The first study question was, **Does training providers to apply a couple approach, including the SDM, result in improved provider counseling practices?** In other words, did providers incorporate the couple approach that they were taught as part of the intervention into their counseling, including the SDM?

1) Hypothesis 1: Provider behavior

First we examine Hypothesis 1, which states that providers will be more likely to address couple issues during family planning counseling with clients (including, but not limited to, those interested in the SDM). We use the results of the actual client interviews, simulated client reports, and service statistics to determine whether providers were more likely to offer a couple-focused approach including the SDM as a result of the intervention.

Actual client interviews

At baseline, 68 family planning clients were recruited into the study. At endline, 105 clients were entered into the study. While the project intended to recruit up to 200 clients at both baseline and endline, the project faced many recruitment challenges. Clinic staff often neglected to invite family planning clients to participate, and many clients who were invited into the study could not be reached by phone for an interview. Consequently, the sample size was smaller than anticipated.

During the initial interview within one month of their family planning visit, clients were directly asked whether or not their provider asked them the two intervention questions; namely, whether the provider asked what her partner thinks about birth control, and whether the provider asked her if she wanted birth control information for her partner. As indicated in the Table 17, a smaller number of clients at endline than baseline were asked these questions, indicating that the couple-focused approach was not implemented as planned.

Table 17: Intervention questions asked of actual clients at Tri-City Health Center

	Baseline (n=68)	Endline (n=104)
Provider asked what your partner thinks about birth control	54%	39%
Provider asked if you would like info to share with your partner	61%	43%

In fact, providers appeared to address couple issues less frequently at endline. We believe the decrease is due to the fact that two key staff members who had been responsible for providing the bulk of family planning services before the intervention and who were proactive in addressing couple issues left Tri-City at the beginning of the intervention.

Simulated client reports

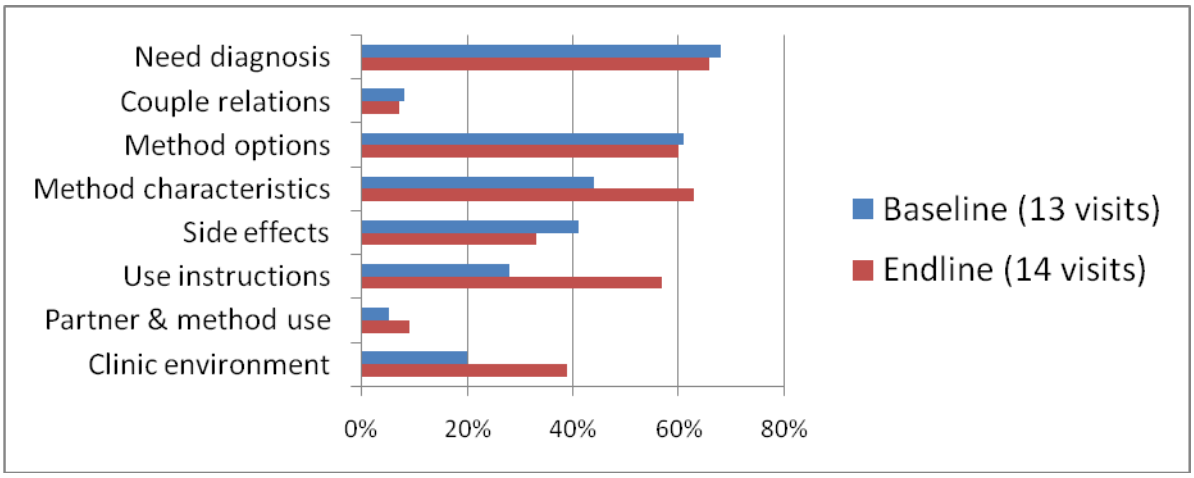
Some 13 simulated clients visited the Tri-City Health Center at baseline, and 14 visited at endline. As mentioned previously, each client was asked to play a particular role and accept a particular method, if offered. The distribution of visits from each simulated client profile is shown in Table 18.

Table 18: Simulated client visits to Tri-City Health Center at endline

	Baseline	Endline
Pill	5	4
DMPA	4	5
Condom	4	--
SDM/CycleBeads	--	5
TOTAL	**13**	**14**

After each visit, the simulated clients were asked to complete checklists to indicate what information was exchanged during the visit. For each item on the checklist, the client indicated whether the provider asked certain questions or provided specific information. The items on the checklist were divided into eight categories. Figure 12 below lists the categories and the respective score (i.e., the percentage of questions or items on the checklist that were asked or mentioned).

Figure 12: Simulated client scores at Tri-City Health Center



The two categories that pertain to the couple-focused approach are "couple relations" and "partner and method use." The "couple relations" category assesses if the simulated client was asked whether she has discussed family planning with her partner or how her partner feels about family planning. The "partner and method use" category assesses whether the provider discussed partner issues with regard to the selected method; e.g., whether the provider offered information to the partner or discussed how the partner could assist with method use. Notably, there was no major change in either of these categories from baseline to endline. These scores confirm the results from the actual client interviews – i.e., that training providers on the couple-focused approach did not increase discussion of couple issues during family planning counseling.

The increase in the "clinic environment" category reflects that more simulated clients at endline noticed materials in the clinic pertaining to SDM/CycleBeads and/or with couple-focused messages.

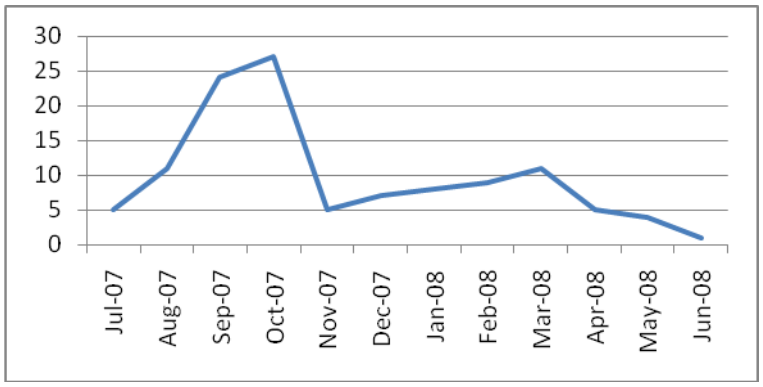
Increases in the "method characteristics" and "use instructions" categories are due to the fact that simulated clients looking for a non-hormonal method, i.e. condoms, at baseline were replaced at endline by those who would accept SDM/CycleBeads. Providers tended to give less method-specific information to condom clients than to clients of other methods, resulting in lower average scores for those two categories at baseline. This may reflect an assumption on the part of providers that clients already know about condoms and how to use them.

Of the 14 simulated clients who visited Tri-City Health Center at endline, five had profiles that would have made them suitable candidates for SDM/CycleBeads. Of these five, three were actually offered the method. This means that the method was integrated into the clinic services, although not all clients who would have accepted the method were offered it.

Service statistics

Service statistics collected by Tri-City Health Center provide insight into SDM uptake and, therefore, whether providers offered the SDM. According to service statistics, there were 117 SDM users at Tri-City Health Center's Liberty site from July 2007 to June 2008. As shown in Figure 13, the majority of CycleBeads were disbursed in the four months following the intervention training in July of 2007.

Figure 13: Number of new CycleBeads users at Tri-City Health Center, Liberty Street Clinic



This information confirms that providers were offering the SDM to clients, particularly early during the intervention phase, and that the SDM appealed to clients. The drop off in users in November 2007 likely was a result of staff turnover and the fact that some new staff were not trained on SDM counseling.

2) Hypothesis 2: Provider attitudes

The second hypothesis posits that after the intervention, providers would view more favorably including men and couples in family planning service counseling. Data that can be used to assess such a change come from the semi-structured interviews that were administered to family planning providers before the intervention and again six to eight months after the intervention began. All interviewees were female nurse practitioners and physician's assistants.

Six providers were interviewed before the intervention, and ten were interviewed at endline. Of those who were interviewed before the intervention, three were interviewed again at endline, as the three others had left the organization. Throughout the year, because of staff turnover, study staff made an effort to identify new providers and conducted intervention training for three new providers. However, there were four additional new family planning providers were never trained on the intervention. Therefore, of the ten providers who were interviewed at endline, six had been trained on the intervention and four had not (Table 19).

Table 19: Number of providers interviewed at endline

Status		Number
Trained on intervention	Interviewed at baseline	3
	Arrived after baseline	3
Untrained on intervention		4
Total		**10**

Consequently, the sample size to assess a change in attitude is limited to three providers. Among these providers, a strong change in attitude regarding a couple-focused approach to family planning counseling and male involvement in family planning was not observed. Their responses to questions such as, "How important do you think it is to help women gain partner support for birth control?" and "Do you think that addressing couple issues during counseling would help women use their method correctly?" were largely positive at baseline and remained so at endline. One provider felt that her comfort level addressing couple issues during counseling improved, although it was relatively high prior to the intervention.

Two of the three reported that they faced time constraints and issues with patient flow that prohibited the clinic's ability to make its family planning services welcoming to couples. Other providers also mentioned that couple counseling takes extra time and effort. This may be due in part to a misconception that joint counseling is required for a couple-focused approach.

> *"Patient flow is not the best. Numbers are most important at the Center."*
> *–Clinician trained on intervention*
>
> *"[We are concerned about] patient flow, quick visits. Let's get to the point – having an extra person takes extra time."*
> *– Clinician not trained on intervention*
>
> *"We don't have time for a couple approach – it takes more effort to get them in together."*
> *–Clinician trained on intervention*

It should be noted that the four untrained providers reported that they tended to address couple issues less frequently during counseling than those who had been trained and appeared to have a greater amount of skepticism toward the couple approach and male involvement than the trained group. For example, the majority of untrained providers reported asking women if their partners supported their use of a family planning method "rarely" or "never," whereas the majority of trained providers reported doing so "often" or "sometimes." Because

the untrained providers did not participate in the intervention, this information is not useful for examining the effect of the intervention. However, the fact that providers who did not participate in the intervention had less positive attitudes towards male involvement in general than those who did participate sheds light onto the possible reasons why an increase in the discussion of couple-related topics was not reported by family planning clients.

Provider attitudes: SDM and CycleBeads

Endline interviews with providers at Tri-City Health Center included some questions on SDM/CycleBeads. Responses to those questions from the six Tri-City providers trained on SDM/CycleBeads are summarized here.

- All six trained providers rated their knowledge of SDM/CycleBeads as high.
- All said they found it easy to teach women how to use CycleBeads.
- All said Tri-City Health Center should continue to offer CycleBeads.
- Five of the six thought CycleBeads would be useful for involving men.
- Five of the six thought CycleBeads are effective enough to offer as a family planning method. The sixth said it would depend on whether the woman had a stable relationship with her partner and could communicate effectively with him.
- Five of the six found the CycleBeads package insert useful for helping women learn how to use CycleBeads.
- Four of the six found the 2-fold (3-panel) brochure about CycleBeads that was designed for the study to be useful for helping women learn how to use CycleBeads.

When asked what type of women they thought CycleBeads would work best for, responses included the following:

- “Women who are a little older and who want a non-chemical way.”
- “Educated, motivated, aware of cycle.”
- “Stable relationship, women who can communicate with their partner.”
- “Women in stable unions and have partners supporting of the method.”
- “Responsible, in a stable relationship.”
- “Anyone in 26-32 day cycle. Regular cycles.”

In summary, it appears that providers found it feasible and worthwhile to offer SDM/CycleBeads as it met the needs of some of their clients. They realize that SDM is a method requiring couple communication and male involvement.

B. Effect of incorporating a couple-focused approach

The second research question asks whether or not incorporating a couple-focused approach into family planning services results in improved outcomes, including satisfaction and utilization of clinic services, couple communication and participation in family planning use and decision-making, and correct use, satisfaction, and continuation with family planning methods. The purpose of the second question is to determine what effect the couple-focused counseling approach had on family planning-associated behaviors.

Because an increase in a couple-focused counseling approach was not observed except for introduction of SDM, it is not possible to evaluate the effect of this intervention on clinic services and outcomes. The evaluation of such an effect would have been further constrained by study design problems including lack of a control clinic and small sample size of family planning clients.

Although not pertinent to the study question, it may be of interest to note that, to the extent that the intervention activities were implemented, they did not have a negative effect on quality of care (Table 19) or on couple communication (Table 20) as positive responses for both categories remained high.

Table 20: Satisfaction with services – actual clients

	Baseline (n=68)	Endline (n=104)
Care was excellent/good	93%	96%
Services met needs	94%	98%
Very satisfied	84%	83%
Had opportunity to ask questions	94%	97%
Likely to return to clinic	97%	98%

Table 21: Couple communication – actual clients

	Baseline (n=68)	Endline (n=104)
Talked to partner afterwards about family planning appointment	85%	88%
Easy to talk to partner about birth control	96%	95%
Talked to partner about how he feels about using birth control	92%	87%
Talked with partner about HIVs or other STIs	79%	82%

Therefore, data from follow-up client interviews as well as the partner interviews are not useful for addressing the study questions. Further, due to loss to follow-up due to difficulties reaching clients and their partners by phone, the sample size would have been too small to draw significant conclusions.

C. Discussion and implications

It is clear that it was feasible for Tri-City to integrate SDM into its services and that there was a demand for the method, as evidenced by the 117 SDM users over the course of a year. This study demonstrates that the SDM can be easily incorporated into clinic services with minimal training as providers offered it and clients used it. Tri-City continued to offer the SDM/CycleBeads after the study ended, although its ability to do so in the future will depend on their ability to procure CycleBeads, as the California state family planning program (FamilyPACT) currently does not include CycleBeads in its reimbursement schedule.

In spite of the success of SDM integration, the couple-focused aspect of the intervention was not implemented as expected. One of the main reasons for this could be the fact that there was nothing compelling the providers during each family planning visit (besides counseling aids made available to them) to ask the two key questions pertaining to partner involvement. Unlike the SDM, which would have been provided upon response to a client looking for a natural or non-hormonal method, it is likely that there was no similar client request to discuss couple-related issues during most family planning visits. Therefore, it would have been easy for clinicians who were not in the habit of asking about the partner and who were focused on administering clinical exams and meeting the clients' immediate needs to forego asking the couple-related questions.

Another possible explanation for the study results with regard to a couple-focused approach was staff turnover. Two nurse practitioners who handled a large amount of the family planning clients before the intervention, typically asked about partner issues in their practice before the intervention, and were champions of Tri-City's involvement in the study left Tri-City early into the intervention. At the same time, new staff were coming in – not all of whom were trained on the intervention – making it apparent that there was a different mix of clinicians who provided services for the clients at baseline when compared to endline. This is a likely explanation for the finding that clients were asked couple-related questions less frequently at endline and why the number of CycleBeads users was substantially lower during the second half of the intervention than in the first few months.

Additional factors that could have influenced the outcome of the study with regards to a couple-focused approach include the following:

- **Lack of buy-in:** Due to the shortened study time frame, there was limited time available for study staff to meet with clinic staff to orient them on the objectives of the study. This may have affected not only the providers' willingness and ability to implement the

intervention, but also to recruit clients. This also resulted in recruitment of fewer client participants than anticipated.

- **Lack of time for training:** The time available for training providers at Tri-City was very limited. At Planned Parenthood, 1.5 hours were allocated to the couple-focused approach and an additional two hours were dedicated to the SDM. At Tri-City, both of these topics were combined into a single 2.5-hour training session. The need to spend the bulk of the available time ensuring proper counseling skills with regard to the SDM left for little time to explore the couple-focused approach during the training.

- **Confusion about a "couple-focused approach":** The lack of time for training contributed to confusion regarding what a couple-focused approach consisted of. Although the intervention focused on asking the woman key questions about her partner, with joint counseling as an option if the woman requested it, providers appeared to confuse this and equate a "couple-focused approach" to joint counseling.

Finally, measurement of the couple-focused approach could have been an issue. Whereas the SDM is easily measured with service statistics, this study measured whether or not providers incorporated a couple-focused approach by asking clients whether providers asked them one of the two key partner-related questions. It is possible that providers discussed partner issues with clients without specifically asking either of the two key questions. However, judging by the results of the simulated client visits, this appears to be unlikely. Nevertheless, the challenge of measuring a couple-focused approach should be recognized.

Considerations for future research

Given the potential positive effect of increasing partner involvement in family planning use, the high degree of couple communication around family planning that exists, and the desire among many men and women for greater male involvement in family planning decision-making and use, further research on ways to implement a couple-focused approach to counseling is warranted. Largely as a result of the need to switch study partners in the middle of the study, the study had shortcomings that might have affected the outcome. Recommendations for future studies include the following:

- Implementing clinics need to be able to allow sufficient provider time for orientation meetings and training sessions. Through more "face-time" with providers, study staff can ensure that they have a firm grasp of the rationale of the couple-approach, and what the approach itself entails (for example, that it does not require joint counseling). Having more time would enable study staff to ensure that provider concerns are identified and addressed.

- Consideration should be given to determining an effective way for providers to remember to integrate the couple-focused approach and what an appropriate trigger could be during a visit to address couple-related issues.

- Staff turnover must be anticipated, with plans firmly in place to ensure that new providers are promptly trained on the intervention. The approach cannot rely only on the support of a few key providers.

- An opportunity to test the fidelity of the intervention and to do a refresher training if needed is essential.

- The strategy for measuring the couple-focused approach should reflect the wide range of potential ways a provider might address couple issues during counseling.

In summary, this study showed that the SDM was easily integrated into clinic services and accepted by clients. Although providers grasped the importance of addressing couple issues with regard to SDM use, study results do not provide evidence that SDM introduction contributed to provider's awareness of or likelihood of addressing couple issues.

VIII. Additional findings: Strategies to encourage couple communication among teens

Tri-City Health Center has a teen clinic with a separate entrance and provides confidential services for teens and young adults up to age 24. Study activities were tailored for the TCHC teen clinic in order to develop approaches to incorporating a couple-focused approach work for teens and explore whether new teen-focused educational materials could promote partner communication about sex and sexual health.

The approaches were designed to help teens learn about sexual health and engage in conversation with their partners about healthy sexual behaviors including the use of family planning and protection from sexually transmitted infections. The new educational materials were developed to reinforce key messages for teen sexual health and to serve as a springboard for clients to communicate with their partners about these topics.

A. Intervention Activities at the Teen Clinic

At the teen clinic, all clients are seen first by a counselor who provides them with information about available methods. Following that, the teen will see a clinician as needed. The counselors are specific to the teen clinic, whereas the clinicians often rotated in from the main clinic. The teen clinic intervention was led by reproductive health counselors and consisted of the following:

1) Asking about Partner Involvement in Family Planning

   During the intervention phase of this project, reproductive health counselors at the teen clinic asked the same two simple questions of clients receiving family planning services as at the main clinic. These questions were:

   -"How does your partner(s) feel about birth control?"
   -"Would your partner(s) like any information about birth control?"

   Based on the client's response to these two questions, the counselor would then address issues relevant to the couple and also discuss the new educational materials, as appropriate.

2) Offering New Teen Educational Materials & Quizzes

   Three new educational pieces were designed for use with teens and young adults who received services at the TCHC Teen City Clinic as well as for outreach and for classroom presentations to teens in school. The purpose of the new educational materials was to:

1) educate teens and young adults about sexual and reproductive health; and 2) encourage girls and their partners to talk about sex, family planning, STI protection and ways to maintain good sexual and reproductive health.

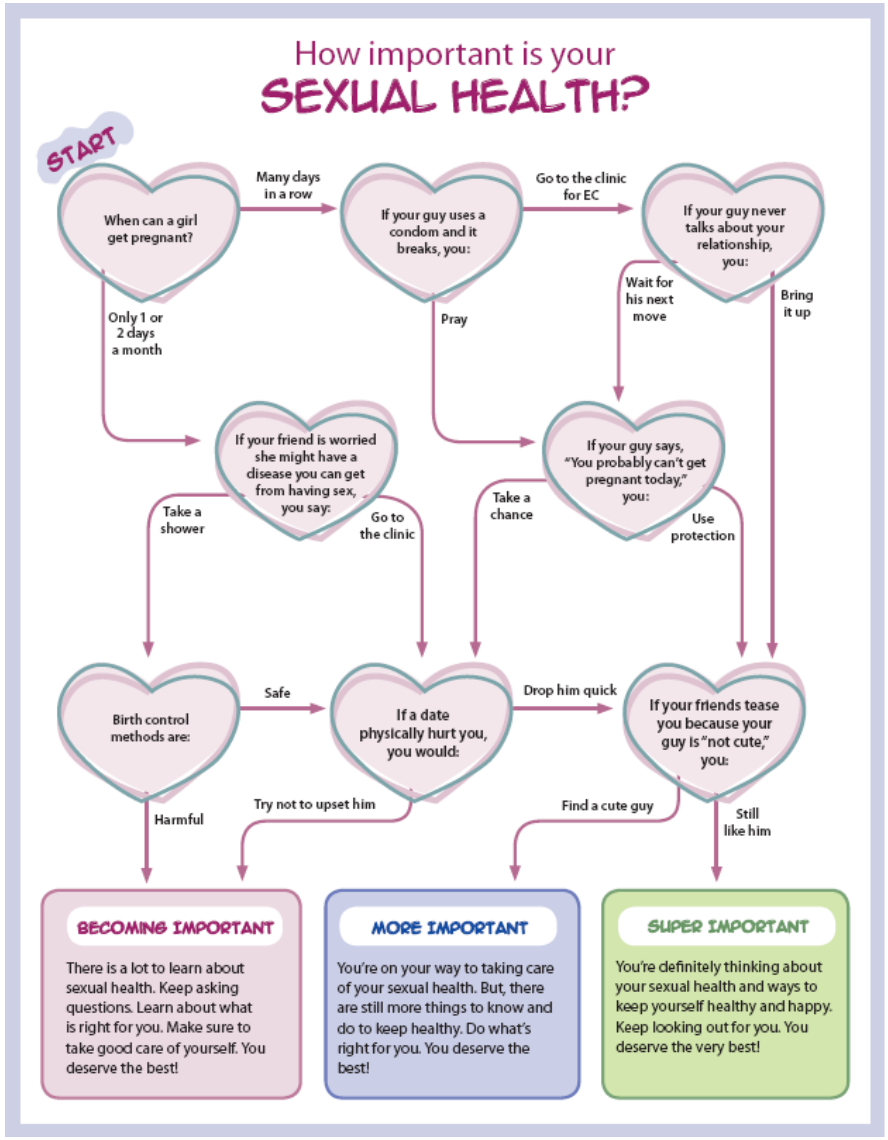
These materials were carefully designed, pre-tested and revised with input from teens, counselors, clinicians, and research and program staff to ensure that their language, tone, and format would appeal to a diverse teen audience. Two of the educational materials were fashioned after popular teen magazine quizzes; the third piece of material was modeled after a educational card that had initially been developed and tested for an adult audience at Planned Parenthood in San Diego and Riverside Counties (PPSDRC). Contact information for clinic services was included on all the materials. These new educational materials include:

- How Important Is Your Sexual Health?(Figure 14)— This is a self-assessment quiz on fertility awareness and sexual health designed just for girls, printed on 8 ½" by 11" paper. On one side, questions about sexual health are arranged in a creative flow diagram format, with one question leading to another depending upon how she answers each question. At the bottom there are messages to support girls in learning about sexual health. On the other side, there are tips to reinforce practices for good sexual and reproductive health. This quiz was given to female clients to fill out in the waiting room. Clients would then show their responses to the counselor, allowing the counselor to explain any incorrect responses.

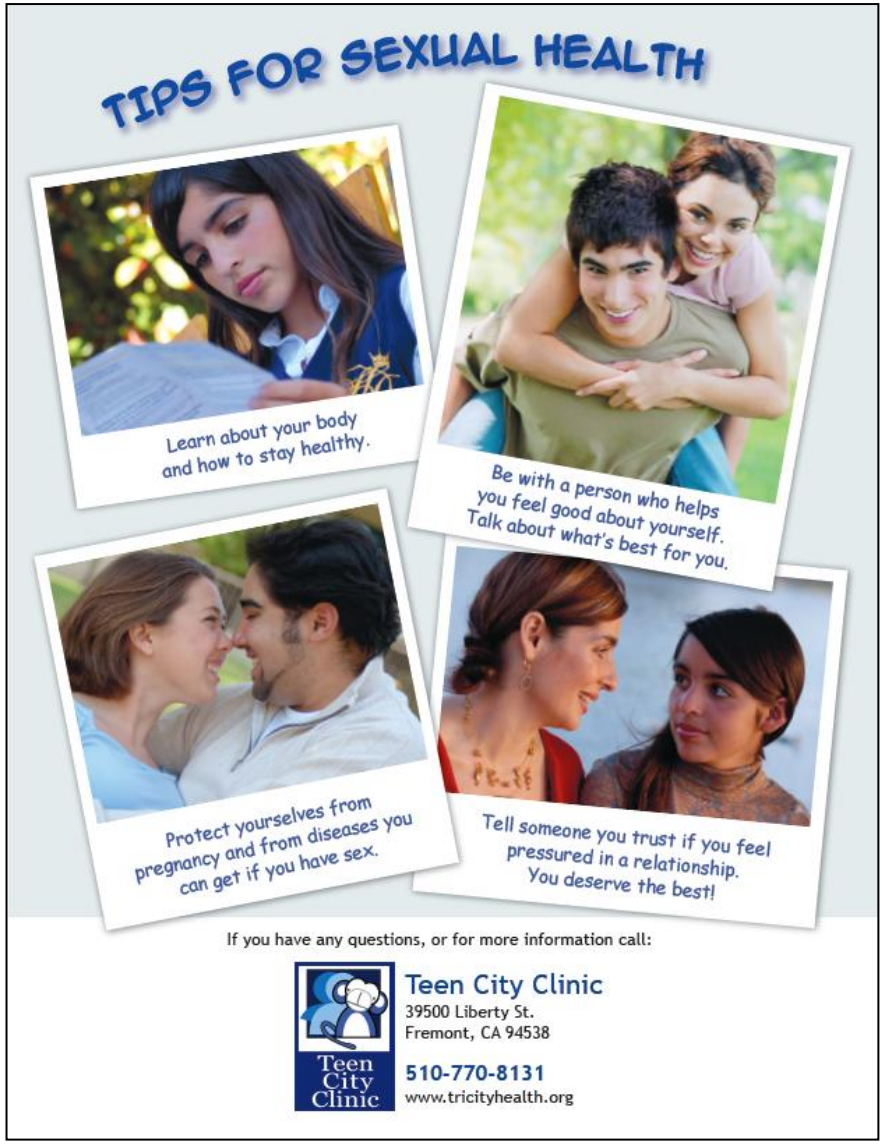
- She Says/He Says (Figure 15)— This is an interactive quiz designed for partners, printed on 8 ½ by 11" paper. On the left of the page are questions for the girl to complete, and on the right side are questions for the guy to complete. There is a perforated line down the middle so the girl can complete her section and tear off the guy's section for her partner to complete. This quiz includes questions for her to answer based on her own perception and a place to write what she thinks her partner will answer. Then, the guy and the girl compare their responses and add up points to see how well they know and understand one another, especially in the area of reproductive health choices. This quiz was given to clients to take home.

- Do You and Your Partner TALK about SEX? (Figure 16) — This is a 4" by 9", two-sided educational card for teens with messages that encourage partner communication. This piece was designed to be a springboard for partner communication about sex, family planning, and protection against sexually transmitted infections (STIs). It includes questions partners can discuss with one another and lists ways a guy can be involved and support the sexual and reproductive health of the couple. This card was displayed in the clinic and given to clients to take home.

Figure 14: How Important is Your Sexual Health?

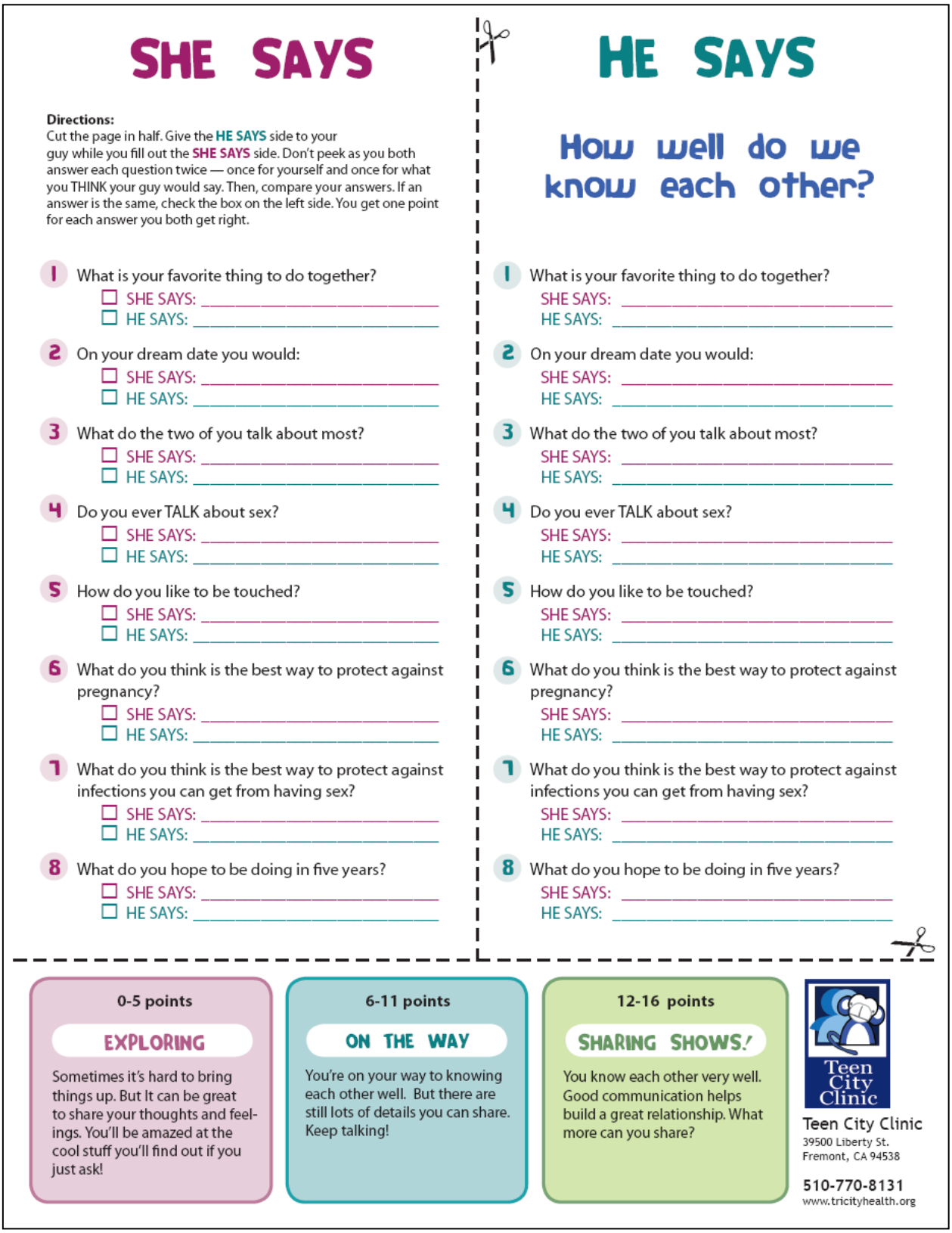


Front



Back

Figure 15: She Says/He Says



SHE SAYS

Directions:
Cut the page in half. Give the **HE SAYS** side to your guy while you fill out the **SHE SAYS** side. Don't peek as you both answer each question twice — once for yourself and once for what you THINK your guy would say. Then, compare your answers. If an answer is the same, check the box on the left side. You get one point for each answer you both get right.

1. What is your favorite thing to do together?
   - ☐ SHE SAYS: _____
   - ☐ HE SAYS: _____
2. On your dream date you would:
   - ☐ SHE SAYS: _____
   - ☐ HE SAYS: _____
3. What do the two of you talk about most?
   - ☐ SHE SAYS: _____
   - ☐ HE SAYS: _____
4. Do you ever TALK about sex?
   - ☐ SHE SAYS: _____
   - ☐ HE SAYS: _____
5. How do you like to be touched?
   - ☐ SHE SAYS: _____
   - ☐ HE SAYS: _____
6. What do you think is the best way to protect against pregnancy?
   - ☐ SHE SAYS: _____
   - ☐ HE SAYS: _____
7. What do you think is the best way to protect against infections you can get from having sex?
   - ☐ SHE SAYS: _____
   - ☐ HE SAYS: _____
8. What do you hope to be doing in five years?
   - ☐ SHE SAYS: _____
   - ☐ HE SAYS: _____

HE SAYS

How well do we know each other?

1. What is your favorite thing to do together?
   - SHE SAYS: _____
   - HE SAYS: _____
2. On your dream date you would:
   - SHE SAYS: _____
   - HE SAYS: _____
3. What do the two of you talk about most?
   - SHE SAYS: _____
   - HE SAYS: _____
4. Do you ever TALK about sex?
   - SHE SAYS: _____
   - HE SAYS: _____
5. How do you like to be touched?
   - SHE SAYS: _____
   - HE SAYS: _____
6. What do you think is the best way to protect against pregnancy?
   - SHE SAYS: _____
   - HE SAYS: _____
7. What do you think is the best way to protect against infections you can get from having sex?
   - SHE SAYS: _____
   - HE SAYS: _____
8. What do you hope to be doing in five years?
   - SHE SAYS: _____
   - HE SAYS: _____

0-5 points

EXPLORING

Sometimes it's hard to bring things up. But It can be great to share your thoughts and feelings. You'll be amazed at the cool stuff you'll find out if you just ask!

6-11 points

ON THE WAY

You're on your way to knowing each other well. But there are still lots of details you can share. Keep talking!

12-16 points

SHARING SHOWS!

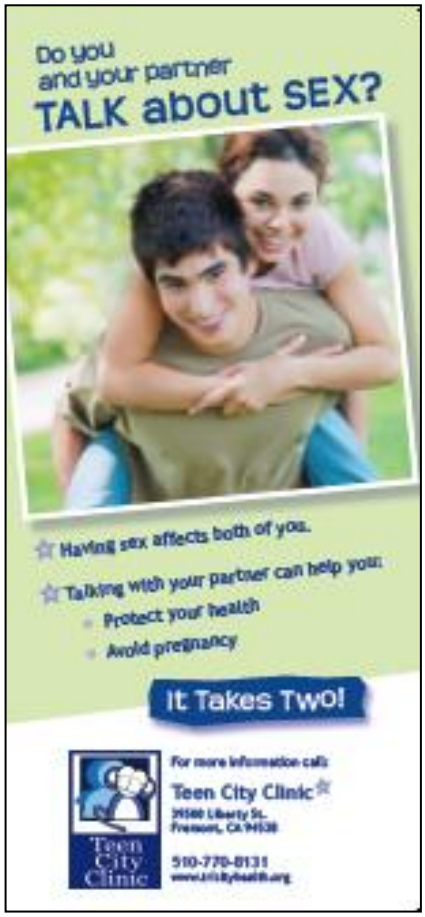
You know each other very well. Good communication helps build a great relationship. What more can you share?

Teen City Clinic

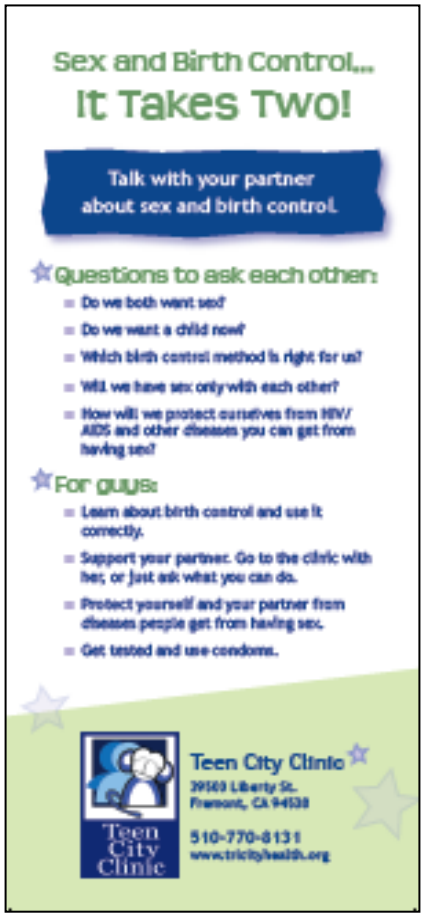
Teen City Clinic
39500 Liberty St.
Fremont, CA 94538

510-770-8131
www.tricityhealth.org

Figure 16: Do You and Your Partner TALK about Sex?



Front



Back

In addition to these new educational materials, teen clinic staff also distributed a pamphlet for men called What Men Want to Know about Sex and Birth Control which was developed by the California Family Health Council (CFHC) in 2003. This colorful pamphlet was designed and written for men, with images and messages specifically relevant to a male audience.

3) Using CycleBeads to teach about fertility

The first question on the "How Important Is Your Sexual Health?" quiz pertains to how many days during a month a woman can get pregnant. If the teen answered this question incorrectly, the counselor could use CycleBeads to help her understand when during her menstrual cycle she is fertile.

B. Methods

Information about couple communication, counseling practices, male involvement and the effectiveness of the new educational materials was obtained through:

1) Focus groups with teens: Focus groups with teens from a local high school were conducted to gain insight into communication about sex among teens in the Tri-City area and the appropriateness of the new materials.

2) In-depth interviews with teens: In-depth exit interviews and follow up calls with teen clients during the intervention phase were administered to gain insight into whether teens felt a couple approach was appropriate and whether they utilized (or planned to utilize) the new materials with their partners. These interviews were conducted by study staff in a private space in the clinic. All interviews were recorded on a digital recorder and carefully reviewed to document key messages, sort responses, and facilitate analysis. At the end of each interview, respondents were asked if they would consent to a follow-up phone call to find out whether they had shared the new educational materials with their partners and how useful these materials were in fostering conversation about the couple's sexual and reproductive health.

3) Structured interviews with teens: As part of the data collection for the main study, clients of the teen clinic were invited to be interviewed before and after the intervention.

4) Semi-structured interviews with staff: The two teen counselors were interviewed after the intervention. The instrument was adapted from that used to interview clinicians at baseline and endline.

C. Results

The results of the assessment of the teen intervention components are described here.

A. Focus groups with teens from a local high school

Fifty-six students participated in four, gender-specific focus groups at a continuation school in the Tri-City area. Two groups were conducted for males and two for females. The focus groups were facilitated by outreach staff from the clinic. The teens were provided the materials in advance so that they would have a chance to discuss them with their friends and partners, if applicable.

When asked about partner communication, many of the teens said it was important to talk about sex with a partner. In particular, most girls said that it was important to talk about sex in order to find out about previous partners, if they have been tested for STIs and how often, or to

"at least let him know you're on [birth control]." When asked how they bring up the topic of sex and sexual health, girls said you just have to *"bring it up"* and *"ask him simple questions."*

However, fear of rejection and discomfort with talking about sex were described as barriers to open communication among teen couples, particularly among males. While the boys expressed concern about getting an STI, they also talked about issues or barriers to bringing up the topic of sex, birth control, and STI protection. A few guys said, *"You'll scare them off."* Male focus group participants also described concern about being perceived as *"weak"* or *"she'll take it wrong"* if they bring up the subject of sex and STI protection.

In general the girls talked a lot about the educational materials and described them as *"helpful, interesting, and informing." "I really liked them*." Some preferred the She Says/He Says quiz, and one said, *"It was fun."* Quite a few had completed the quiz with their partners, and a few showed the quiz to a parent. Others preferred the green card— Do You and Your Partner TALK about Sex?, as they found it more accessible and useful. Some felt you had to *"really know"* the guy to ask him to do the She Says/He Says quiz. Many of the girls also liked the quiz How Important Is Your Sexual Health?

Although most of the girls reported liking the materials, about half the guys thought the materials were good, whereas the other half said they did not like them. *"The questions were dumb." "You might have to answer the questions wrong in front of your girlfriend." "Who needs this?"* Although most boys said they would not be the one to initiate discussion of the materials, one boy reported having shared the She Says/He Says quiz with his girlfriend and reported a favorable experience. None of the other guys in either of the male focus groups admitted sharing this quiz or the card with a partner. However, when asked what they liked and didn't like about this quiz, one guy said, *"It's cool…"* and others agreed.

> ***One Guy's Response: She Says/He Says Quiz***
>
> *"At first I thought it was kind of dumb. Why all these questions? But once we did it, we saw we knew each other…. We answered it identical, like we grew up together*."

The teens made recommendations to improve the materials to make them more appealing to both female and male teens. Such recommendations included the following:

- Utilize more ethnic/racially diverse models in the photographs
- Add more questions to the quizzes
- Use brighter colors
- Improve the She Says/He Says quiz by making the "She Says" side more girly and the "He Says" side more appealing to boys

B. In-depth exit interviews with teen clients

A total of 12 exit interviews were conducted with young adults receiving family planning services at TCHC Teen Clinic. Of the 12 participants, 11 were female, and 10 reported that they were currently in a relationship. Nine of the 12 clients agreed to the follow-up phone calls, and efforts were made to contact them within three days of the exit interview. Six clients were eventually reached by phone, and they shared their experiences regarding sharing the new materials and discussing them with their partners following the clinic visit.

Respondents were asked whether the teen counselor inquired about how their partner felt about birth control, and whether they were offered birth control information to share with their partners. Most respondents (10) said *"Yes,"* the counselor asked about their partner's thoughts about birth control. Sometimes the counselor used different words to inquire about partner involvement, including "Does your partner encourage birth control?" "Do you have a good relationship?" "Are you happy with him?" and "Is there something you want to talk about?" Most respondents were also asked if their partners would like information on birth control methods.

How Important Is Your Sexual Health? Quiz

All respondents (except the male respondent, as this quiz was designed only for females) received the quiz How Important Is Your Sexual Health? from the teen counselor. One person saw the quizzes on display and picked it up on her own. All female clients had completed the quiz and answered the questions following the arrows to determine how much they knew about their sexual health. Respondents described the quiz favorably.

> *"I've never seen anything like it before. It's fun."*
> *-Female client, age 19*
>
> *"It's really cute. I think it's really helpful, especially for teenagers."*
> *-Female client, age 20*
>
> *"It was easy for me. It's common sense."*
> *-Female client, age 20*

The first question on this quiz asked, "When can a girl get pregnant?" Only two respondents reported getting this question wrong. Those who missed this question received additional information about the menstrual cycle and fertility awareness, using CycleBeads as an educational tool. The use of CycleBeads as a visual aid to learn about the fertile time of the cycle was described as very helpful by both clients and counselors.

"The first question was tricky. [You can get pregnant] many days in a row. [Using CycleBeads as a) visual aid was helpful to understand."

-Female client, age 18

"When you can get pregnant….[We get] confusing messages about this…I thought it was many days in a row…but, other materials say other things."

-Female client, age 20

"I got the first questions [when likely to get pregnant] wrong…I liked the visual [aspect of CycleBeads], so that was really good."

-Female client, age 21

"Most girls don't know you can get pregnant many days in a row."

-Female client, age 16

<u>She Says/He Says</u> Quiz

All clients who were interviewed had received the <u>She Says/He Says</u> quiz from the teen counselor. Seventy-five percent of these clients said they intended to complete the quiz with their partners.

"Yeah, I would fill it out."

-Male client, age 20

"He'll do it. We like to play games."

-Female client, age 16

"We're gonna do it. I think ours will come out perfect."

-Female client, age 19

"A guy probably wouldn't want to do it. … [But he] would do it if forced to by the girl."

-Female client, age 19

A few respondents did not have "an identified partner" to complete the quiz with; and two clients said they would not complete the quiz with their respective partner for fear of offending him or scaring him off.

"No…I probably wouldn't do it. Our relationship is kinda new. This would freak him out….If we'd known each other for awhile….It's more for high school students."

-Female client, age 21

"If you want to get in a fight right now…Maybe….I'd complete it with a friend, not (with) my partner. I'd be scared of his answers."

-Female client, age 16

When asked whether the She Says/He Says quiz would be helpful for talking about sex, most said, *"Yes."* They felt it would show how well they knew each other, be a fun way to bring up topics that can be hard to bring up, and help start the conversation. *"If you weren't already comfortable it might help. It's straightforward discussion time."* Many of the clients interviewed had already talked with their partners about the key issues on the quiz.

Do You and Your Partner TALK about Sex? educational card

All of the clients interviewed had received the educational card Do You and Your Partner TALK about Sex? from a teen counselor. Some clients indicated that they preferred this over the She Says/He Says quiz, especially if the couple did not know each other well. One person wasn't clear about the purpose of the educational card. In general respondents found this card to be informative, positive, and useful.

"This card is better [than the She Says/He Says quiz] if you don't know the guy for awhile."

-Female client, age 21

"The questions are 'topic starters.' The most important questions are about birth control and being monogamous."

–Female client, age 16

"Encourages talking, being open about it. The picture makes you want to read it, I guess."

–Male client, age 20

"Questions are good. Do we want a child now? It makes you think. You don't want to bring a child in this world if you're not ready."

–Female client, age 19

Some respondents said they would share the card while others would read the information and suggested questions by themselves, and then use the card as a guide for discussing the topics in

their own words. Many indicated that they had already discussed the key points on the card with their partners. However, they noted that some of their peers would find this to be *"an eye opener."*

What Men Want to Know about Sex and Birth Control pamphlet from CFHC

Half of the respondents had received the male-directed pamphlet What Men Want to Know about Sex and Birth Control to share with their partners. A few declined the information because they didn't think their partner would be interested or because they did not have a partner at the time. A few were not offered this pamphlet.

Client perceptions about the illustrated, male-directed birth control pamphlet developed by California Family Health Council (CFHC) include:

> *"An overview…has the pluses and minuses of each method, things to look out for. I'm open to it."*
>
> *-Male client, age 20*
>
> *"I like it. I think he will like it. He would be interested in what I am using."*
>
> *-Female client, age 20*
>
> *"Guys joke about it, they are curious. Probably he would read it."*
>
> *-Female client, age 18*

When the 12 respondents were asked which of the new educational materials they preferred, five chose the She Says/He Says quiz; four chose the How Important is Your Sexual Health quiz; and three said the educational card, Do You and Your Partner TALK about SEX? Those who liked the She Says/He Says quiz best thought it was a *"fun activity," "something to do and enjoy instead of just talking,"* and it helped them to get to know one another. Those who preferred the educational card liked that it was short, had minimal writing, and included a picture of a happy/healthy couple. They also liked that it was suited for those who were no longer teens, as well as those in a new relationship or one in which there was less comfort regarding partner communication about sex. The sexual health quiz stood out for some as fun. Those who preferred the sexual health quiz said it provided *"good information and good advice."* Some also really liked the CFHC birth control method pamphlet designed for men.

Follow-up Phone calls

Six respondents were reached by phone following the initial interview. All six shared positive feedback regarding the teen/young adult educational materials, especially the She Says/He Says quiz. Five of the six respondents who were reached by phone said they had shared the materials with their boyfriends. Of these five, four had either started or completed the He Says/She Says quiz. The sixth respondent hadn't shared the materials yet but said she planned to.

> *"We did pretty good; knew what the other was thinking. He liked it too. Add more questions."*
> *"We did it; was the same. It was fun."*
> *"Yes, we're using them.*
> *"I showed it to him. He liked the She Says/He Says one, didn't look at the others."*
>
> *-Female clients*

C. Structured interviews with teen clients

Family planning clients from the teen clinic who were at least 18 years of age were included in the main study. The total number of teen clinic participants interviewed was 49 before the intervention and 80 after the intervention.

As in the adult clinic, according to these interviews, the providers appeared to be less likely after the intervention than before the intervention to ask the two key couple-related questions asked of them as part of the intervention (Table 21).

Table 22: Key intervention questions asked of actual clients at Tri-City teen clinic

	Baseline (n=49)	Endline (n=80)
Provider asked what your partner thinks about birth control	59%	39%
Provider asked if you would like info to share with your partner	68%	43%

The structured interviews with teen clients show that the intervention did not affect quality of services. Couple communication and decision making was also high before the intervention and remained so afterwards, as shown in Table 23.

Table 23: Quality of services, couple communication and joint decision making

Client Response	Baseline (n=49)	Endline (n=80)
Quality of services		
Care received was good or excellent	96%	96%
Very satisfied with quality of services	86%	85%
Couple communication and decision making		
Talked to partner afterwards about visit to clinic	90%	90%
Easy to talk with partner about birth control	96%	96%
Important to make decisions about birth control together with partner	100%	98%

D. Interviews with teen family planning counselors

The two family planning counselors at the teen clinic were interviewed to understand their perspectives on the relevance and feasibility of this approach. No clinician was interviewed specifically regarding the teen intervention because they rotate in from the main clinic. The teen counselors found the approach useful with many of their clients but not all of them.

> *"I would encourage talking to the partner, but sometimes [women] prefer to handle it themselves, which is fine."*
>
> *–Counselor*

Counselors would like to continue to offer the materials and discuss them with clients. They liked to have a variety of materials in order to meet the needs of different patients. The biggest obstacle from their perspective to addressing couple issues and involving the male partners in counseling sessions is time constraints. On the topic of fertility awareness, the two counselors reported that clients' responses to one of the quiz questions indicated to them that many clients didn't know how many days a woman can get pregnant. Counselors found CycleBeads easy to teach and useful as a tool for teaching fertility awareness.

> *"Materials are important to have because you never know how useful it would be to a patient."*
>
> *–Counselor*

E. Discussion and Implications

As in the main study, the frequency with which providers asked the two couple-related intervention questions decreased after the intervention began. This is likely due to the fact that the clinician who saw the bulk of clients at the teen clinic before the intervention and was very supportive of a couple-focused approach left the organization shortly after the intervention began, at which time clinicians at the teen clinic began to rotate in from the main clinic.

However, even though the frequency with which providers asked the key questions decreased, it is clear that counselors addressed couple issues and participated in the intervention by giving the educational materials to teen clients. Most participants in the exit interviews reported having received the educational materials during their visit. They also indicated that the counselors asked about their partners in other ways than the two specific questions, and that they used CycleBeads to teach fertility awareness.

These factors indicate that it may not have been realistic to expect counselors or providers to ask set questions in the context of a counseling visit because it was more natural to bring up couple issues in a way that fits into the conversation or to use the materials as a springboard for discussion. Therefore, determining whether or not the providers asked the two key questions may not be an accurate reflection of how often they addressed couple issues during counseling.

The focus groups and exit interviews revealed that it is important to both girls and boys to discuss issues such as birth control use and STI prevention with their partners. Girls are typically the ones to bring up the topic of sex and sexual health. Men want to know key information, particularly about STIs, but they are more reluctant to bring up such the topics. This suggests that a strategy that is focused on supporting and helping women be prepared to address these topics in her relationship, including through the use of informational materials, is appropriate. However, it also suggests that there is a greater need to reach out to males in order to help them understand how to talk about sex and address the perception among males that bringing up such topics will make them seem "weak."

The importance of having different types of materials became apparent. Those who were more secure in their relationship tended to prefer the "She Says/He Says" quiz, whereas those who just wanted tips on how to open the door to such communication preferred the "Do You and Your Partner TALK about Sex?" card. Males and females were drawn to different materials. The positive response from both teens and counselors regarding these materials indicates that they were helpful for encouraging discussion of couple issues both in the client-provider interaction and among teens and their partners.

In general, it is clear that the teen clinic intervention intervention – particularly, the availability of new educational materials – was feasible to implement and well-liked by both teen clients and counselors. This project also demonstrated that CycleBeads are a useful tool for helping teen girls understand their fertility. However, more research is needed to determine whether the use of such materials leads to healthy behaviors.

IX. Conclusion

This study was successful in demonstrating that integrating the SDM into family planning services is feasible and represents a promising way to expand access to fertility awareness-based methods. However, it was unable to demonstrate the successful integration of a couple-focused approach into family planning services. Consequently, the feasibility and potential benefit of such a couple-focused approach as conceived by this study was not determined. However, this experience provides lessons for future research projects that will address this topic.

With regard to couple communication and male involvement in family planning, this study has shown that there is a gap between provider perceptions of women's desire for male involvement and how clients actually feel. Couple communication about family planning is very high, and the majority of women, although notably not all women, want their partners to be involved in family planning decision-making and use. Providers who take this into consideration may be better able to serve their clients.

This study resulted in development of a way to operationalize the couple-focused approach and the production of a set of educational materials that may be useful to programs who wish to encourage couple communication and male involvement. While the educational materials were well-liked by providers and clients alike, the value of encouraging providers to ask a few key questions about the partner remains unclear. Although most providers see the value in partner involvement, many providers assume that a couple-focused approach calls for joint counseling and/or will take more time and effort than is available. However, it is possible to address couple issues with just the woman, and providers who feel they do not have time to address these issues have the option of providing couple-focused educational materials developed by this project for the woman to take home.

This study was successful in demonstrating that integrating the SDM into family planning services is feasible and represents a promising way to expand access to fertility awareness-based methods. However, it remains unclear whether offering such a "couple" method into programs will result in greater discussion of couple issues for other methods.

Finally, this study demonstrates that there is a need to reach out to men with reproductive health information. Questionnaires from men in the waiting rooms of PPSDRC clinics as well as focus groups with male teens reveal that many men desire family planning and sexual health information. Also, focus groups in particular reveal that while men are concerned with preventing pregnancy and avoiding sexually transmitted infections, they are reluctant to bring up the topic with their female partner. Since women are the main beneficiaries of family planning programs, they should be supported in their efforts to engage their partners and bring up sexual health topics. Ways to reach men with information and support are needed, although due to time constraints, this may fall outside the realm of a typical family planning visit.

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