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Perspectives on Sexual and Reproductive Health
Volume 34, Number 1, January/February 2002

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U.S. Agencies Providing Publicly Funded Contraceptive Services in 1999

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CONTEXT: Nearly one-quarter of women who obtain medical contraceptive services receive care from clinics operated by publicly funded agencies. In light of changes in government policy and funding and in the structure of health care financing, an assessment of agency policies and programs is essential for monitoring women's access to contraceptive care and services.

METHODS: In 1999, 637 of a nationally representative sample of 1,016 U.S. agencies that receive public funding to provide contraceptive services responded to a 12-page survey. Responses were analyzed according to agency type, receipt of Title X funding and main focus.

RESULTS: More than nine in 10 agencies offer the pill, the male condom and the injectable; 80% offer emergency contraceptive pills, compared with 38% in 1995. Some agencies allow clients to delay a pelvic exam when beginning use of oral contraceptives (56%), the injectable (42%) or the implant (23%). On average, agencies receive funding for contraceptive services from 4.9 sources; the proportion relying on private insurance and contributions has risen since 1995. Virtually all family planning agencies provide screening and testing for sexually transmitted diseases (STDs), and at least two-thirds offer treatment for most STDs. The vast majority of agencies offer general health care and perinatal or pediatric services; half offer general gynecologic care or infertility services. Services provided, costs and clinic policies vary according to agency type.

CONCLUSIONS: Agencies offering contraceptive services also offer a wide range of reproductive health and related services. There remain services for which provision could be increased and policies that need to be modified to facilitate clients' access to contraceptive care.

Perspectives on Sexual and Reproductive Health, 2002, 34(1):15-24

In the United States, nearly one-quarter of women who obtain contraceptive services from a medical provider receive their care from clinics run by publicly funded agencies.[1] These agencies, which include local health departments, Planned Parenthood affiliates, community centers, migrant health centers and others, are especially relied on by poor and low-income women, adolescents, blacks and Hispanics. (Of all women in these groups who obtain such care, 27-38% are served at publicly supported clinics.[2])

The funding for these agencies comes from a number of sources, such as Title X of the Public Health Service Act (the only federal program that provides categorical funding for family planning[3]) and Medicaid. With this funding, the agencies provide medical reproductive health services* and help ensure responsiveness to local differences and needs. Many of the family planning clinics provide other types of care in addition to contraceptive services, including infertility services; primary and general preventive care; health services for infants and children; and a range of mental health and counseling services.

Often, publicly funded agencies operate multiple clinic sites, some of which do not provide contraceptive services. Such agencies may choose to use specific funding sources (such as Title X) for certain clinics but not for others. Funding of contraceptive services may make up all or just a small portion of an agency's total budget. Many agencies are attempting to deal with new priorities in their contraceptive service programs, such as fully integrating services for men and meeting the contraceptive and other health needs of high-priority or marginalized groups (for example, adolescents, populations in correctional facilities, drug users and victims of domestic abuse). However, inflation-adjusted federal funding specifically for family planning services has been flat or declining for the past 20 years,[4] making it difficult for many providers to adapt to the changing needs.

To assess the current state of contraceptive services available through publicly funded agencies, The Alan Guttmacher Institute conducted a survey in 1999 of a nationally representative sample of family planning agencies. The survey data allow us to ascertain the status of several aspects of service delivery: methods and services offered, fees charged, funding sources, provision of educational programs and agency staffing. Results of a similar survey conducted in 1995 permit an examination of changes during the late 1990s.[5]

DATA AND METHODOLOGY

In the fall of 1999, we surveyed a nationally representative sample of 1,016 agencies providing publicly funded contraceptive services at one or more sites in the United States or its territories.† The sample was stratified by agency type (community or migrant health center, health department, hospital, Planned Parenthood affiliate and "other" agency‡), receipt of Title X funding (yes or no) and geographic region of the United States; agencies were randomly selected within each of the strata. Since there are more agencies of some types than of others, we varied the proportion of each agency type sampled to ensure a sufficient number to make specific estimates for each type. We sampled all Planned Parenthood affiliates, 40% of hospital agencies and other agencies, 30% of community and migrant health agencies, and 22% of health department agencies.

We mailed a 12-page questionnaire to the family planning director of each agency, asking about the agency's services, policies, clients, staff and funding sources. Questions about structure and policies were asked with reference to the time of the survey; questions about caseloads and funding sources were asked for calendar year 1998. We did not ascertain sources of funding for or numbers of clients receiving noncontraceptive care. We asked each agency to provide information about services offered and clients served at any of its clinic sites, regardless of whether the clinic

received public funding for contraceptive service delivery. When policies differed between an agency's sites, we asked the agency to report the most common policy or the policy at its largest site.

Reminder postcards, two additional survey mailings and follow-up calls were used to improve response rates. In cases where agencies provided incomplete or unclear information, we followed up by calling and faxing additional information requests.

Of the agencies sampled, 49 were ineligible for the survey, in most cases because the agency had closed, had merged with another agency or no longer provided contraceptive services. Of the 967 eligible agencies, 637 (66%) submitted completed responses, including 86% of Planned Parenthood affiliates, 79% of health departments, 48% of community and migrant health centers, 43% of hospitals and 69% of other agencies. While 76% of agencies that received some Title X funding responded, only 51% of agencies not receiving Title X support did. Regional response rates ranged from 76% in the Midwest to 54% in the Northeast.

We weighted the responding agencies to reflect the total number of publicly funded agencies providing contraceptive services in 1997 and the distribution by type, Title X funding status and region.[6] Because our focus is on policies and programs at the agency level, most results presented in this article are weighted to represent the national universe of agencies. To provide estimates for a few key measures that are based on the universe of women utilizing agency services rather than the universe of agencies, we calculated a second set of weights by multiplying the agency weights by the number of contraceptive clients per agency.[§] Standard errors and significant differences were calculated using statistical software that accounted for the stratified sampling design.[**]

We analyzed variation in service provision according to three agency characteristics: type, focus and funding. For type, we used the same categories as we had in stratifying the samples. Agencies that reported having contraceptive service, women's health care, maternal and child health care or STD service as their primary focus were categorized as reproductive health-focused, while those that reported any other main focus were classified as not. Funding was defined by whether an agency received any Title X support.

Many of the analyses describe agencies as "offering" services; however, just because a service is offered does not guarantee that any clients receive it. In some cases, therefore, we asked specific questions about the numbers of clients who received services. We restricted most questions to female contraceptive clients to get a sense of whether women receiving contraceptive services are also receiving other kinds of services.[††] Contraceptive clients were those who received a medical exam related to method provision; clients regularly receiving a method for whom a chart was maintained; and women who chose periodic abstinence or natural family planning. Women who received only abortion services, pregnancy tests, infertility services or counseling were not included as contraceptive clients.

For the majority of questions, nonresponse ranged from 1% to 6%; however, for several questions, nonresponse was substantially larger. For example, many agencies were unable to provide the number of clients who received the injectable (23%) or

emergency contraceptive pills (15%); 13% did not provide information on media, advertising or educational programs; and 15-20% did not provide information on fees or the proportion of clients using each form of payment. Hospitals and community and migrant health centers generally had the highest levels of nonresponse; small and medium-size facilities had higher nonresponse rates than larger facilities. We excluded nonrespondents from calculations rather than imputing values.

RESULTS

Agencies and Clients

Of the 3,117 U.S. agencies providing publicly funded contraceptive services, 46% are state or local health departments (Table 1). Community and migrant health centers, hospitals and other agencies each account for 15-18% of agencies, while Planned Parenthood affiliates represent 4%. More than half of agencies (56%) have a reproductive health focus, and 61% receive Title X support for some or all of their clinics. Virtually all Planned Parenthood affiliates and two-thirds of health departments that operate family planning clinics have a reproductive health focus; only 8% of community and migrant health centers are reproductive health-focused. Eighty-two percent of Planned Parenthood affiliates and 87% of health departments receive Title X funding, compared with 26% of hospitals and 23% of community and migrant health centers that provide publicly funded contraceptive services.

In 1998, 35% of agencies had fewer than 500 female contraceptive clients; 23% had 500-999 clients, 25% had 1,000-2,999 and 17% had 3,000 or more (not shown). Planned Parenthood affiliates served substantially greater numbers of female contraceptive clients than did other types of agencies: Ninety-five percent had 3,000 or more clients in 1998. By contrast, more than half of community and migrant health centers served fewer than 500 women. Agencies receiving Title X funding and reproductive health- focused agencies also served greater numbers of contraceptive clients than did other agencies.

In 43% of agencies, at least half of clients are contraceptive clients; this is true for 95% of Planned Parenthood affiliates and 68% of other agencies, but only 9% of community and migrant health centers (Table 1). About half of agencies (48%) have only one location that offers contraceptive services; 28% have two or three, 14% have four or five, and 10% have six or more. Sixty-three percent of Planned Parenthood affiliates have four or more locations (not shown).

Contraceptive Services Offered

•*Methods.* Virtually all agencies offer the pill and the injectable, and roughly nine in 10 provide male condoms, spermicides and the diaphragm (Table 2, page 17). Eight in 10 provide emergency contraceptive pills and natural family planning instruction; about half offer the female condom, IUD or implant insertion; and one-quarter offer cervical caps, tubal ligation or vasectomy.

Since 1995, the mean number of methods offered by agencies has increased from 7.9 (not shown) to 8.5. The proportions of agencies offering several methods in 1999 also represent significant increases since 1995: emergency contraceptive pills (80% vs. 38%), the female condom (55% vs. 30%), the cervical cap (30% vs. 20%) and the

injectable (98% vs. 96%). The proportion offering the implant decreased from 59% to 47%.

Hospital agencies and Planned Parenthood affiliates are significantly more likely than any other agency type to offer the IUD and implant. In addition, Planned Parenthood affiliates are the most likely to offer emergency contraceptive pills and the diaphragm, female condom and cervical cap. As a result, Planned Parenthood affiliates and hospitals generally offer more methods (means of 10.7 and 9.7, respectively) than other types of agencies (7.9-8.4). Because Planned Parenthood affiliates serve large numbers of clients and because all of the affiliates surveyed offer emergency contraceptive pills, 93% of female contraceptive clients visit agencies that offer emergency contraceptive pills (not shown), although only 80% of agencies offer the method.

Agencies with a reproductive health focus are more likely than those without to provide spermicides, the diaphragm, emergency contraceptive pills and the IUD. Agencies that receive Title X funds are more likely than those that do not to provide the male condom, spermicides, the diaphragm, emergency contraceptive pills, natural family planning and the implant; they are less likely than others to provide female sterilization.

•*The pill.* While virtually all agencies offer the pill, agencies differ in their provision approach (Table 3). Most (74%) dispense pills on-site, but 14% give prescriptions to be filled elsewhere, and 12% provide the initial supply and a prescription for later cycles. Initially, 55% of agencies provide three cycles, while at later visits, 16-23% of agencies each provide an additional three, six, nine or 10 packs (not shown).

•*The injectable.* Among agencies that offered the injectable in 1998, the median number of clients per agency who initiated or continued its use was 150; the mean was 445. Planned Parenthood affiliates provided the injectable to the largest number of clients per agency (a median of 1,066). Agencies with a reproductive health focus had more than twice as many injectable clients (a median of 206) as other agencies (100); the same is true for agencies that receive Title X funding compared with those that do not (206 vs. 83). On average, 81% of clients who initiated the injectable returned for a second injection, roughly the same proportion reported elsewhere.[7]

•*Emergency contraceptive pills.* Despite the widespread availability of emergency contraceptive pills in publicly funded clinics, few clients actually receive the method. Only 18% of agencies that offer emergency contraceptive pills provided it to more than 20 women in 1998; at agencies that offer emergency contraceptive pills, the median number of clients per agency obtaining the method was five. The proportion of clients who received emergency contraceptive pills ranged from 1% in all community and migrant health centers and health departments to 5% in all Planned Parenthood clinics.

Eighty-one percent of agencies that offer emergency contraceptive pills dispense it on-site; 56% do not require a complete initial contraceptive visit before a new client can receive the method. Twenty-one percent prescribe or dispense emergency contraceptives ahead of time for a woman to keep at home, while 16% prescribe it over the telephone (Table 3). Hospitals and Planned Parenthood affiliates are the most likely to prescribe emergency contraceptive pills over the telephone, and Planned

Parenthood affiliates are the most likely to dispense it in advance; health departments are the least likely to do either.

•*Scheduling and follow-up.* Across all agencies, the median time reported between a client's phone call and her contraceptive visit is one week; the mean is nine days. At 13% of agencies, women can typically get same-day appointments. Planned Parenthood affiliates reported the shortest average wait (five days); community and migrant health centers and other agencies had intermediate waits (seven days); and hospitals and health departments had the longest waits (10 days).

Fifty-eight percent of agencies remind clients who use the pill or the injectable of scheduled checkups or resupply visits, while 53% contact clients who miss an appointment (Table 3). Of all the agency types, Planned Parenthood affiliates are the least likely to take these steps (39% and 24%, respectively); agencies with a reproductive health focus are less likely than those without to follow up on missed visits (45% vs. 63%).

•*Pelvic exams.* All agencies require pelvic exams for women who receive oral contraceptives, although 56% allow a delay for some women who are initiating a method. Because large proportions of Planned Parenthood affiliates, health departments and other agencies allow women to delay a pelvic exam, 69% of women visit agencies that permit such a delay. Agencies that receive Title X funding are more likely than those that do not to allow delayed pelvic exams; agencies that permit delayed exams are more likely than those that do not to provide the pill directly (not shown).

Some agencies allow women who initiate other contraceptive methods to delay a pelvic exam: 42% for women who wish to initiate the injectable and 23% for those obtaining the implant. Fifty-five percent of female contraceptive clients visit agencies that allow an exam to be delayed for provision of the injectable; 29% go to agencies that delay an exam for the implant (not shown).

OTHER SERVICES FOR WOMEN AND CHILDREN

•Pregnancy tests. More than 99% of agencies offer pregnancy tests. When a woman makes a visit specifically for a pregnancy test and receives a negative result, most agencies provide her with counseling (96%) and written information on pregnancy prevention (85%). Only 54%, however, indicated that such women typically leave the clinic with either a contraceptive method or a prescription for one. Title X-funded agencies are more likely than others to provide most clients with a method or prescription on the spot (62% vs. 50%). Only 35% of Planned Parenthood affiliates do so, compared with 63-65% of hospitals and health departments, and 46-51% of other agencies.

•*STD services.* Screening clients for STDs (using risk criteria to identify individuals who should undergo testing) is a common component of sexual and reproductive health services: More than eight in 10 agencies screen for chlamydia, gonorrhea, syphilis and HIV either routinely or for some clients deemed to be at high risk (Table 4). While three-fourths routinely screen for chlamydia and gonorrhea, fewer than half do so for syphilis or HIV. A greater proportion of agencies screen high-risk clients for HIV, syphilis and herpes simplex virus than for other STDs. At least two-thirds of

agencies screen for urinary tract infections and human papillomavirus.

Agencies that screen only high-risk clients commonly use patterns of partnership to determine who should be screened: Ninety-seven percent use multiple sexual partners as a screening criterion, and 77% consider having a new sexual partner to be a risk factor. Additionally, 64% consider young age to be a risk factor; 27%, a history of STD or self-reported exposure to STD; and 25%, being single (not shown).

Virtually all agencies test clients who meet the screening criteria for STDs and treat those who test positive. The major exception is HIV: While 85% of agencies test for HIV, only 35% provide treatment.

•*Other services.* Family planning agencies offer a broad range of noncontraceptive services (Table 5).[‡‡] Most (89%) offer some perinatal or pediatric care, including immunizations for children (78%). Half counsel clients on infertility (although few offer treatment for the condition), while four in 10 provide colposcopy, a procedure to evaluate cervical cell abnormalities.[§§] Two-thirds of hospitals, but only one-quarter of agencies overall, offer mammography services. Many agencies offer other general health care services, such as physical examinations and nutrition counseling; more than half of hospitals and community and migrant health centers offer mental health services.

Twelve percent of agencies that provide publicly funded contraceptive services offer abortion services in at least one site (although without the use of federal funds): Nine percent offer surgical abortion and 9% offer medical abortion; 6% offer both (not shown). Provision of abortion varies by agency type: Fifty-six percent of Planned Parenthood affiliates, 44% of hospitals and 8% of both community and migrant health centers and other agencies provide abortion; abortion services are unavailable at public health department sites. While at least two-thirds of agencies offer clients case management and nutrition services, only a fraction (7%) provide day care.

In general, agencies with a reproductive health focus provide fewer noncontraceptive services than other agencies. They are less likely to offer perinatal, pediatric or general health care, but more likely to provide abortion services. Similarly, Title X-funded agencies provide a somewhat more focused set of services than other agencies.

A greater proportion of agencies offered midlife women's health programs in 1999 than in 1995 (61% vs. 43%). However, agencies shifted away from perinatal and pediatric care during that time: With the exception of genetic counseling, all services in this category were offered by significantly smaller proportions of agencies in 1999 than in 1995 (not shown). The largest component of this shift occurred at health departments. Agencies also became less likely to provide infertility counseling and more likely to offer mammography and general midlife women's health services.

INFORMATION, EDUCATION AND SPECIAL SERVICES

•*Information and counseling.* Almost all agencies (97%) provide routine counseling on the importance of regular Pap tests and breast self-exams. Most provide information to all clients on STDs (91%), on all contraceptive methods (88%) and on the importance of using condoms in addition to hormonal methods (88%). Seventy-eight percent assess all clients for domestic violence or sexual abuse; 56% give all clients

information on condom negotiation skills, while an additional 26% discuss condom negotiation only with adolescent clients.

•*Media. Overall, 88% of agencies (ranging from 100% of Planned Parenthood affiliates to 84% of hospitals) use some form of media to advertise, to attract clients or to provide educational messages.*†* The most common forms used are flyers (63%), newspapers or magazines (58%), the yellow pages (44%) and radio (27%). Only 18% of agencies use the Internet for advertising or educational purposes, although 70% of Planned Parenthood affiliates do so. Planned Parenthood affiliates are the most likely to use each form of media; community and migrant health centers also commonly use advertising and educational media.

•*Educational programs.* The vast majortiy of agencies (88%) offer educational or outreach programs in a clinic setting or at external locations. Sixty-nine percent of agencies (including three-quarters of Title X-funded agencies) offer programs that emphasize abstinence or postponement of sexual activity; 58% offer programs on teenage communication and negotiation skills; and 57% offer contraceptive education in schools and youth centers. Programs teaching parenting skills to pregnant or parenting teenagers are offered by 49% of agencies; community and migrant health centers are the most likely to offer such programs (63%). Some 46% of agencies offer programs to encourage adolescent parents to delay the next birth; 43% offer programs to help parents communicate with their adolescent children and to educate or train other organizations' staff. Planned Parenthood affiliates are more likely than other agency types to offer all of these programs, except parenting classes.

•*Special populations.* One-third (34%) of agencies tailor contraceptive service programs to at least one special population, most commonly, non-English speakers (22%). Agencies also offer specific services for individuals who are in correctional facilities (12%), are homeless (11%), abuse substances (10%), have experienced domestic abuse (9%) or have disabilities (7%). Title X-funded agencies and reproductive health-focused agencies are roughly twice as likely as others to provide contraceptive services in correctional facilities.

AGENCY FUNDING

Agencies depend on various sources of funding to support their contraceptive services (Table 6). In 1998, agencies relied on an average of 4.9 sources of funding to provide contraceptive services; Planned Parenthood affiliates utilized the most sources, on average (6.1). Title X-funded agencies and agencies with a reproductive health focus utilized more sources than others.

Eighty-five percent of agencies collect fees from contraceptive clients, 82% receive Medicaid funds, 61% get Title X support and 58% obtain reimbursement from private insurance plans. Smaller but still substantial proportions of agencies receive support from other federal grant programs—the maternal and child health block grant (37%), the social services block grant (18%), the State Children's Health Insurance Program (17%), and community and migrant health center funding (14%).

Certain types of funding are utilized primarily by specific agency types. For example, community and migrant health centers (largely by definition) are the primary recipients of community and migrant health center funding. Planned Parenthood

affiliates and health departments are the most likely to receive local funding; Planned Parenthood affiliates and other agencies are the most likely to receive support from private contributions.

From 1995 to 1999, the proportion of agencies that received Medicaid funding declined significantly (from 88% to 82%). On the other hand, a greater proportion of agencies in 1999 than in 1995 received funding through the social services block grant (18% vs. 13%), insurance (58% vs. 40%) and contributions (32% vs. 20%).

In many cases, funding is received and services are provided in the context of managed care. Overall, 54% of agencies have a contract with at least one public (i.e., Medicaid) or private managed care plan to provide contraceptive, STD or abortion services—a significantly higher proportion than the 24% reporting similar contracts in 1995.[8] Fifty-one percent of agencies have a contract with a Medicaid managed care plan, while 31% have at least one contract with a private plan.

A diversity of funding streams allows many agencies to provide services to lower-income clients at reduced or no cost. (Indeed, Title X-funded agencies are mandated to do so.) Ninety-five percent of agencies reduce or eliminate charges to clients who are unable to pay the required fee; 66% typically waive fees for adolescents. Most agencies also make other efforts to make services financially accessible: Ninety-three percent allow clients to pay in installments, and 58% waive charges for Medicaid-eligible clients who have not yet established Medicaid eligibility. However, 7% encourage clients who are unable to pay to go elsewhere for services; this proportion is only 2% for health departments but 15-16% for hospitals and Planned Parenthood affiliates.

On average, 25% of female contraceptive clients are covered by Medicaid; 57% are not covered by Medicaid but pay a reduced fee or no fee because they are poor or low-income; and 19% pay the full fee (Table 7). Hospitals and community and migrant health centers typically have the largest proportions of clients covered by Medicaid (47% and 40%, respectively); hospitals and Planned Parenthood affiliates have the largest proportions who pay full fee (20-28%). Reproductive health-focused (22%) and Title X-funded agencies (20%) tend to have smaller proportions of Medicaid clients than other agencies; Title X-funded agencies also have lower proportions of clients paying full fee than agencies with no Title X support (17% vs. 25%).

To assess how much agencies charge patients of different income levels, we asked them to indicate their fees for two hypothetical clients—one at 75% of the federal poverty level*‡ (low-income) and one at 275% of poverty (above the level qualifying for Title X support). Most agencies would not charge the low-income client for an initial visit (66%), for a three-month pill supply (74%) or for provision of the injectable (66%) or the implant (76%). Among agencies that charge low-income clients, hospitals have the highest fees (Table 8).

Five percent of agencies would not charge a client at 275% of poverty for an initial visit or the injectable, 8% would not charge for the implant and 12% would not charge for a three-month pill supply (not shown). Among agencies that would charge this client, Planned Parenthood affiliates have among the highest fees for the pill and the injectable, while community and migrant health centers charge less than other agency types for the implant; Title X-funded agencies charge substantially less for the implant

($425) than those with no Title X funding ($734).

AGENCY STAFFING

Nurse clinicians or physician's assistants perform the majority (73%) of initial contraceptive exams at agencies providing contraceptive services, while physicians, residents or interns perform the rest. Ninety-five percent of exams performed at Planned Parenthood affiliates and 80% at Title X-funded agencies are performed by nurses or physician's assistants; however, at hospital-based agencies, 55% of exams are performed by doctors.

More than half of agencies indicate that recruitment and retention of staff has been "somewhat" or "very much" of a problem (38% and 14%, respectively). To retain staff, most agencies provide training or career development programs; 65% reported that all of their contraceptive services staff participated in such programs in 1998. However, 30% of community and migrant health centers provide training programs to less than half of their staff.

DISCUSSION

Family planning agencies clearly do more than just provide contraceptives and related care. The breadth of services they offer provides opportunities for integrated care, even though components may be funded by different sources. (This broad approach is not new, but was equally evident in 1995.)

Nevertheless, while family planning remains one of the main services provided even by organizations with a broad range of services, there are areas where contraceptive service provision could be expanded. Although 80% of agencies offer emergency contraceptive pills, use remains quite low. Considering that provision varies widely across agency types with similar client populations, and that the method does not require special medical training, there is still much room for expansion.

In addition, only about half of agencies provide the female condom, even though it is an alternative barrier method for women whose partners cannot or will not use male condoms. The IUD and the implant are offered by only about half of agencies; although these methods require specially trained staff, they are highly effective and require less user intervention than the pill or the condom.

While a low level of provision of these methods may reflect low demand, it may also reflect that women are not aware of them. In December of 2000, the Food and Drug Administration approved a new hormone-releasing IUD, which could lead to renewed interest, increased training opportunities and greater demand for the method. In any case, agencies should be encouraged not only to offer these methods but to increase clients' familiarity with them as well.

Compared with other types of agencies, Planned Parenthood affiliates provide more extensive services, see more clients, offer more methods, have shorter wait times, have more flexible provision policies and are more likely to provide outreach and educational programs. On the other hand, they are relatively unlikely to provide contraceptive supplies following a negative pregnancy test result or to follow up with their clients. This may be because of the large numbers of clients they serve. Finally, Planned Parenthood affiliates are more likely than other agency types (except

hospitals) to encourage clients who are unable to pay to go elsewhere. This may be because only one in five Planned Parenthood clients receives Medicaid, and thus, these sites are heavily dependent on patient fees. That affiliates are likely to be located in metropolitan areas with other providers to whom clients can be referred may also be a factor.

As might be expected, hospital-based agencies are able to offer a broader range of methods requiring medical personnel, more specialized services (such as mammography and mental health care) and more services provided by physicians than other agencies. However, hospitals tend to perform less outreach, utilize media less and have longer wait times, and their services are often less accessible to those who cannot pay and more expensive for those who can.

Health departments that provide contraceptive services have a substantial reproductive health focus, are likely to receive Title X funds, are less likely to turn away indigent clients and tend to have more flexible method policies. On the other hand, they are less likely to provide emergency contraceptive pills, and their clients may have to wait longer for services. Community and migrant health centers have less of a focus on reproductive health, have fewer contraceptive clients and provide fewer methods, although they provide a broader range of services and programs. Community and migrant health centers have a greater reliance on Medicaid and are less likely to receive Title X funding.

A diversity of funding sources is the norm for most agencies. More than 50% receive funding for their contraceptive services from a combination of federal, state, local and private sources. The most common sources of funds for contraceptive services are Medicaid, Title X, client fees and private insurance. The annual Title X appropriations (measured in real dollars) have been flat or declining since 1982.[9] Medicaid has replaced Title X as the largest source of agency funding, but the proportion of agencies relying at least partially on private insurance has increased. While managing multiple funding streams can be challenging, it also protects agencies from a severe reduction in funding that can occur if they depend on a single source.

More than half of agencies permit clients to delay pelvic exams when first receiving the pill or the injectable; fewer will delay an exam for the implant. The Food and Drug Administration approved this practice in 1993,[10] and new Title X regulations permit it if appropriate counseling is provided.[11] Many women's health advocates argue that the delay improves access for women (particularly adolescents) who may be intimidated by the exam.[12] Indeed, in several other industrialized countries, adolescents are allowed to delay an exam until a second or later visit.[13] In California, a demonstration project that provided pills to women without a pelvic exam reached women who were less likely to have a regular source of health care than women who attended a traditional clinic. Thus, having a less-restrictive pelvic exam policy may be one way to increase access to the pill and to reproductive health services in general.[14] In this context, our findings suggest that agencies not permitting a delayed exam should reevaluate the advantages and disadvantages of the requirement.

Publicly funded family planning agencies serve more than seven million contraceptive clients per year.[15] While the diversity of services may suggest that providers tailor services to their clients' needs, it also means that services may not be consistent from

one provider or area to another. It is also important to note that a client's contraceptive needs change over her reproductive lifetime, and an agency that can fulfill those needs at one point may not be able to do so later. Providers should be aware of this, as well as of their own limitations. Providers, particularly those that offer a narrow range of services, should assess the need to expand their services to better meet their clients' needs, as well as consider establishing or strengthening linkages with other organizations to ensure that women have access to the full range of reproductive health care services.

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Acknowledgments

The authors thank Suzette Audam, Juel Brathwaite, Karen D'Angelo, Lori Gerstein, Lucy Gordon, Ayana Mangum, Kathleen Manzella, Kate Nammacher, Maria Elena Ramos and Ednesha Saulsbury for survey fielding and research assistance, and Susheela Singh for reviewing several drafts of the article. The research on which this article is based was supported by grants FPR000057 and FPR000072 from the Office of Population Affairs of the U.S. Department of Health and Human Services. The conclusions and opinions expressed here are those of the authors and not necessarily those of the funder.

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*Such services include contraceptive exams; method provision; and gynecologic, pregnancy-related and sexually transmitted disease (STD) care.

†We sampled from the 3,135 agencies in the most up-to-date universe available in September 1999. Subsequent updating of our clinic database resulted in an agency universe of 3,117 at the time of final data analysis. (Source: reference 6.)

‡"Other" agencies are predominantly independent health clinics, Indian health centers and community health centers not listed as community or migrant health centers. (Source: Bureau of Primary Health Care, U.S. Department of Health and Human Services (DHHS), *Primary Care Programs Directory: 1998,* Bethesda, MD: DHHS, Health Resources and Services Administration, 1997.)

§Eighty-five agencies did not report a total number of clients. In these cases, we imputed the number of clients by using information from AGI's 1997 census of family planning clinics. (Source: reference 6.)

**Analyses were performed using the *svy* series of commands in Stata 6.0.

† †We also collected information on services to men, although men account for only a very small proportion of public agencies' contraceptive clients.

‡ ‡While most questions asked about services offered to clients who also received contraceptive care, the question on "other services" asked about services offered to clients in general.

§§While we did not specifically ask agencies whether they provide Pap tests, we assume that virtually all do so, since 99% offer hormonal methods, and a pelvic exam, which typically includes a Pap test, is required for provision of these methods.

* †Thirty-three percent of hospitals did not respond to this question.

* ‡In 1999, the federal poverty level was $13,880 for a family of three and $16,700 for a family of four. (Source: *Federal Register*, 1999, 64(52):13428-13430.)

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