A Profile of the Adolescent Male Family Planning Client

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Context: *Family planning programs and policies increasingly focus on the male partner's roles and responsibilities in contraceptive decision-making and use. To effectively tailor services for males, policymakers and providers must refine their understanding of men's psychosocial and reproductive health needs.*

Methods: *Using self-administered questionnaires, 1,540 sexually active males aged 19 and younger who attended family planning clinics in California provided information about their sexual behavior, contraceptive use, pregnancy and parenting history, and psychosocial characteristics. Logistic regression was used to examine factors that contributed to effective contraceptive use.*

Results: *Although 73% of participants reported having used a birth control method at first intercourse, only 59% said that they or their partner had used an effective method at last intercourse, and 35% had used no method. If the client was uncomfortable with his method, the odds that he had used an effective method at last intercourse were reduced (odds ratio, 0.4). The likelihood of use at last intercourse was increased among males who agreed with their partner about their method and those who had never impregnated a partner (1.4 and 1.9, respectively).*

Conclusions: *To adequately serve young males, clinics must take into account their sexual and contraceptive histories. But screening should go beyond traditional family planning techniques to discuss how to improve communication with partners and other lifestyle issues that may interfere with consistent use.*
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Adolescent pregnancy has been a major public policy issue in the United States for nearly two decades. Only recently, however, have policymakers and researchers begun to focus on the roles and responsibilities of the male partner.[1] Among the areas receiving unprecedented attention are the role of the male partner in contraceptive decision-making and, therefore, programmatic efforts to involve men in family planning.

Much of the surge of interest in family planning services for both adolescent and adult men has been directly related to growing provider awareness of the important role played by the male partner in the consistent use of effective contraceptive methods, including condoms.[2] Without men's active engagement in and commitment to pregnancy prevention, women are often severely hampered in their efforts to prevent unintended pregnancy, even when they select "female" methods of contraception. Recognition of the importance of the male role has also been mirrored in a resurgence of government and grassroots efforts to encourage men to be responsible fathers.[3] Within an emerging men's movement, many men are clamoring to be included in the picture.

The need to reduce the incidence of sexually transmitted diseases (STDs) and HIV infection through the use of condoms has further sharpened the focus on males.[4] Approximately 12 million Americans acquire an STD every year, and of these, two-thirds are younger than 25.[5] Men and women aged 20–24 accounted for 4% of the 56,730 individuals in whom AIDS was diagnosed in 1996.[6] Yet, in the 1995 National Survey of Adolescent Males (NSAM), 56% of sexually active respondents reported having used condoms inconsistently or not at all.[7]

For the most part, males have traditionally been excluded from programs that provide family planning services.[8] Although federal Title X funds can be used to support services for male family planning clients and for STD services for the male partners of female clients,[9] limited funding precludes most agencies from offering these services. Inadequate state and federal funding also prevents providers from offering innovative services in nontraditional settings where males may be reached, as well as from engaging potential male clients through community-based outreach and education services. However, as part of a new federally funded male initiative, male high school students will work in a limited number of Title X–funded family planning clinics to increase their peers' use of these services.[10]

Apart from the extremely limited availability of services specifically designated for males, barriers that discourage males from using traditional family planning clinics include the predominantly female staffs and the female-oriented culture of most clinics. As a result, an important opportunity to educate males about STDs and pregnancy prevention, as well as other risk-taking behaviors and general health issues, is forfeited.[11]

Findings from a 1993 national survey of publicly funded family planning clinics documented that on average, only 6% of clients were male.[12] A 1993 study of 1,033 California high school students found that only 12% of male respondents had received a birth control method from a health facility, compared with 56% of female respondents.[13] According to the NSAM, only 3% of respondents aged 17–21 had obtained their most recent condom supply from a clinic or a physician.[14] This is perhaps not surprising, given that condoms, the only effective reversible male birth control method, can be readily obtained without a prescription and without a visit to a health care provider.

To effectively tailor efforts to engage men in family planning, it is imperative that policymakers and providers refine their understanding of the psychosocial and reproductive health needs of adolescent and adult males. Toward that end, this article presents a profile of the adolescent males who participated in the California Office of Family Planning's Expanded Teen Counseling Program (ETCP). The program was one component of a statewide adolescent pregnancy preven-

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Table 1. Percentage of clients reporting various psychosocial problems, Expanded Teen Counseling Program, California Office of Family Planning, 1992–1994 (N=1,780)

Problem	%
Unemployment	21
Problems talking to family/friends	9
Alcohol	5
Death of family member/close friend	5
Drugs	4
Gang involvement	4
Parents' separation/divorce	3
Arrest of a relative/friend	3
Homeless/runaway	3
Serious illness	1
Physical abuse	1
Sexual abuse	1
Traded sex for money, drugs or shelter	<1
Other	3
None	54

Note: Respondents could indicate more than one category.

tion initiative that was implemented from 1991 to 1994. Its purpose was to enhance clinical family planning services by offering on-site, short-term counseling and referrals to community-based health and social service agencies.

NSAM data suggest that the use of condoms by males is associated with age and with race or ethnicity (but not with socioeconomic status).[15] Among sexually active NSAM respondents, the proportion who had used a condom at last intercourse declined steadily from 65% among 16-year-olds to 40% of those aged 19. In addition, condom use was more prevalent among black and white adolescents (47% and 46%, respectively) than among their Hispanic counterparts (29%). We were interested in determining if similar associations existed among the adolescent males who sought services through the ETCP.

Program Description

In 1991, the California Office of Family Planning funded the ETCP in 20 of the state's 58 counties. The agencies selected to conduct the program included public health departments, Planned Parenthood affiliates and community-based organizations (community health centers, hospital-based programs for teenagers and other nonprofit agencies). The 30 clinics that offered the program were located in urban, suburban and rural areas with varying degrees of racial and ethnic diversity.

The ETCP was designed to reduce the incidence of teenage pregnancy by helping sexually active adolescents become more effective and consistent contraceptive users, and by promoting responsible contraceptive decision-making. It was based on the premise that reproductive decision-making is influenced by a variety of behavioral, psychosocial, environmental and social factors. The intervention consisted of extensive community outreach efforts to engage at-risk teenagers, including presentations in community settings such as shopping malls, alternative schools and community-based agencies. Other approaches included flyers, posters and advertisements in newspapers that are popular with teenagers. Some clinics began serving males as early as the first year of the program, but males were not a priority until 1993, when the state required agencies to make an effort to recruit them into the program.

On their first visit to a participating clinic, all consenting clients completed a questionnaire that had been developed specifically for the program. A family planning counselor reviewed the completed questionnaire with each client before the appointment proceeded. Teenagers who were determined to be at high risk for pregnancy or other problems (psychosocial, behavioral or health) were referred to professional counselors located on-site. Community resource networks were also developed to facilitate referrals to other types of agencies (including those that provide medical, mental health, substance abuse, educational, parenting, sexual abuse and HIV or AIDS services; homeless shelters; and housing and employment programs).

Methodology

Our findings are based on male clients' responses to the questionnaire, a self-administered instrument comprising questions in three categories: demographic characteristics, sexual behavior and psychosocial problems. The demographic characteristics the survey asked about were the teenager's race, age and socioeconomic status. The sexual behavior questions covered the teenager's comfort with the contraceptive he and his partner used; agreement with his partner about method use; and whether he ever impregnated someone, had an STD or was tested for HIV. The psychosocial areas explored included problems in school, depression, drug use during sex, difficulties in talking with others, employment, gang-related problems, homelessness, history of forced sex and the presence of a teenage parent in the family.

We conducted a multivariate analysis to establish which, if any, independent variables were significantly associated with the likelihood that these young men had used an effective method of contraception (condom, pill, diaphragm, implant or injectable) at last intercourse.

Results

Background Characteristics

From 1992 to 1994, a total of 1,780 males made a first visit to ETCP family planning clinics and completed a questionnaire. More than one-third of these young men (37%) were Hispanic, and slightly fewer (30%) were white. Fewer than one-fifth were black (18%) or Asian (12%); 6% were members of other racial or ethnic groups. (Clients could indicate more than one racial or ethnic category.)

Fourteen percent of the male clients were 14 years old or younger, 50% were 15–17 years old and 36% were 18–19 years old. Nine percent reported having Medicaid insurance, and 3% received Aid to Families with Dependent Children.

The questionnaire asked clients to indicate the reasons they had sought care at the clinic. The leading reasons were to obtain a birth control method (31%), an infection check (27%) or a physical examination (26%); because their partner or girlfriend wanted them to come to the clinic (22%); and for information or for someone to talk to (15%).

Responses to the questionnaire enabled clinic staff to identify some of the most salient psychosocial issues facing these adolescents. An extraordinarily high proportion of respondents reported recent episodes or symptoms of depression, such as problems sleeping, wanting to hurt themselves, feeling alone or feeling "no good" about themselves (88%). Nearly one-quarter (23%) indicated that they were having problems with school.

When asked to state the most serious problems that currently affected them, 21% of the males identified unemployment, 9% said they had problems talking to family or friends, and 5% reported a problem with alcohol use or the death of a family member or close friend (Table 1). Other concerns included drug problems, gang involvement and the separation or divorce of their parents.

Reproductive Behavior

The majority of the males who completed a questionnaire were sexually active at the time of their ETCP enrollment (86%). The findings presented here apply only to these clients. Nearly half (48%) of sexually active male clients were 14 or younger when they first had a sexual encounter; 22% were 15 years old, 17% were 16, 8% were 17 and 5% were 18 or 19.

Nearly three-quarters of the sample (73%) reported that they had used a contraceptive method the first time they had sex. Six percent had waited up to six

months before taking steps to prevent pregnancy, 4% had waited six months to a year, 5% had waited more than a year and 12% had never used a method (Table 2).

More than half of the respondents said that at their most recent intercourse, they or their partner had used an effective method of birth control: Fifty percent reported having used a condom, and 9% indicated that their partner had used the pill; about 5% said she had used the diaphragm, implant, injectable or IUD. Thirty-five percent stated that they had used no method of birth control. (Some of these young men may not have known if their partner was using a method that would be unapparent to them, such as the injectable or the pill.)

Three-quarters of the sexually active male clients said they used their method of birth control either "always" (42%) or "most of the time" (33%). However, one-quarter "hardly ever" or "never" used birth control. Eighteen percent reported that they sometimes disagreed with their partner about using a method. The majority of condom users (71%) said they were comfortable with their method.

Twenty-one percent of the young men had impregnated a partner, and 8% were parents. Thirty-six percent reported that a family member had been a teenage parent. When asked what they would want their partner to do if she became pregnant, 41% of those who gave an answer said "keep the baby," and 36% were not sure; 16% would want her to have an abortion, and 5% would want her to "do something else." About one-fifth of respondents did not answer this question.

While 17% of respondents reported having had one sex partner in the last six months, 38% had had two partners, 15% had had three and 25% had had four or more; 5% did not respond to this question. Only 9% said they had had an STD, but 18% had been tested for HIV. Slightly fewer than one-third (31%) indicated that they are always or sometimes high on alcohol or drugs during sex. Six percent reported having been forced or tricked into having sex.

After race and age of the client were controlled for by using logistic regression, three of the 20 independent variables were found to be significantly associated with the likelihood of using an effective method of birth control at last intercourse (Table 3). If the client was uncomfortable with his method, the odds that he used an effective method of birth control at last intercourse decreased (odds ratio, 0.4). Males who agreed with their partner about which method of birth control to use, or whether to use a method at all, were more likely than those who sometimes disagreed with their partner to have used an effective method (1.4). Those who had never impregnated a partner were nearly twice as likely as those who had to have used an effective method at last intercourse (1.9).

Discussion

While many of the sexually active adolescent males in this study reportedly took precautions to prevent pregnancy and demonstrated their interest in family planning by attending the clinic, a large proportion were at risk of impregnating a partner or of contracting and transmitting an STD. Furthermore, the variations in contraceptive use among these young men point to the necessity of developing services for young males that can be tailored to individuals' specific needs, and to screen all male clients to determine appropriate counseling or intervention objectives.

Although depression was not significantly associated with birth control use, the high proportion of adolescents who reported having experienced depression illustrates the need to design programs that link family planning agencies to other community-based services, including counseling services. It can also be viewed as further evidence that family planning providers should receive broad training in adolescent health care that covers medical, reproductive health and psychosocial needs.

In addition, it is important that the locales where males traditionally receive care, such as health departments and community-based organizations, as well as such alternative locations as schools, workplaces and recreation sites, expand their role in addressing issues of family planning and STD prevention. Health care providers that offer medical services or health education should also provide counseling on sexuality and couple communication skills, referrals as needed, and continued access to birth control information and services. This is particularly important in light of the male partner's typically strong influence in contraceptive decision-making.[16]

A number of studies have documented that general health providers, social service agencies, schools and other institutions have—but do not take advantage of—a plethora of opportunities to provide family planning education, counseling services or referrals to both males and females.[17] To better accommodate teenage male family planning clients, policymakers and program staff should continually reexamine traditional family planning programs and pursue promising alternative service models.[18] Critical to this effort is the need to allocate additional funding for outreach and services that are targeted specifically for adolescent males. Reductions in Title X funds have compounded the problem because family planning programs have responded by directing their limited funds to services for females.[19]

Our findings suggest that, not surprisingly, males are more likely to use or promote a method they like. It is important that health care providers follow up and support both male and female clients in the use of their chosen method. When clients

Table 2. Percentage distribution of sexually active clients, by timing of first contraceptive use and by method used at last intercourse

Measure	%
Timing of first use (N=1,406)	
First intercourse	73
<6 months later	6
6–12 months later	4
>12 months later	5
Never	12
Method at last intercourse (N=1,540)	
Condom	50
Pill	9
Injectable/implant	3
Withdrawal	2
Spermicide	1
Diaphragm	<1
Sex only during safe time of month	<1
IUD	<1
Sponge	<1
None	35
Total	100

Table 3. Odds ratios (and 95% confidence intervals) showing the likelihood that clients used an effective contraceptive at last intercourse, by clients' characteristics

Characteristic	Odds ratio
Demographic	
White vs. Hispanic	1.10 (0.85–1.40)
White vs. black	1.11 (0.80–1.54)
White vs. Asian	1.07 (0.74–1.57)
Aged 18–19 vs. <14	0.97 (0.67–1.40)
Aged 18–19 vs. 15–17	0.96 (0.78–1.22)
Receives public assistance†	0.71 (0.50–1.02)
Sexual behavior	
Not comfortable with method	0.40* (0.33–0.50)
Agree with partner about method	1.39* (1.06–1.81)
Never got someone pregnant	1.89* (1.46–2.43)
Never had STD	0.85 (0.58–1.24)
Never had HIV test	0.88 (0.65–1.26)
Psychosocial	
No problems in school	1.07 (0.84–1.40)
No signs of depression	1.09 (0.79–1.52)
High during sex	0.96 (0.75–1.21)
Problems talking with others	0.88 (0.59–1.31)
Unemployed	1.09 (0.83–1.42)
Problems with gangs	1.35 (0.77–2.36)
Not homeless or runaway	0.59 (0.28–1.24)
Never forced or tricked into sex	0.78 (0.49–1.29)
No teenage parent in family	1.08 (0.86–1.36)

*p<.05. †Medicaid or Aid to Families with Dependent Children.

are not satisfied with their method, providers should help them or their partners choose another effective method they might find preferable. Given the challenges inherent in motivating many young men to adopt and consistently use condoms, it would be particularly useful to identify those factors that appear to contribute to the relatively high comfort level evident among the ETCP group of male condom users. Such information would be useful in shaping the next generation of programs aimed at engaging young men.

An important finding was that 35% of the young men in the sample reported that they had not used a method of birth control at the time of last intercourse. A number of reasons might explain why this proportion is so large. One is the episodic nature of sexual activity among young people, as well as inconsistencies and even ambivalence in behavior.[20] The spontaneity that so often characterizes teenagers' sexual activity works against planning for it, and thus against taking precautions. While the desire to prevent pregnancy might exist, lack of consistency militates against ensuring that adequate protection is always available.

One factor that may offset the large proportion of males who reportedly did not consistently use birth control is the unknown proportion of females who were using a method (such as the pill or injectable) without their partner's knowledge. This factor, as well as the finding that clients who disagree with their partner are less likely to use an effective method, supports the need to provide youth with added skills to improve their ability to communicate with their partners. Both males and females need assistance in learning to deal effectively with interpersonal conflict through, for example, conflict resolution and learning to negotiate differences in personal goals.

We found that agreement between partners about contraceptive use was associated with a higher level of method use. This finding is consistent with results from a study of 550 adolescents attending school- and community-based clinics, which showed that adolescent females who discussed their past and present risks with their partner were at lower risk for pregnancy and STDs than those who did not communicate with their partners. Those who did not communicate were only one-third as likely as those who did to use condoms consistently.[21] These findings suggest that family planning clinics should encourage more males to attend clinic appointments with their partners.

The substantial number of sexual partners reported by many of the adolescent males in this study should provide a major impetus for reexamining the types of contraceptive and communication counseling provided to young men. Because males frequently have multiple partners within a relatively short period of time (and are likely not to be in a steady relationship with many of them), enhanced communication skills become even more imperative. Whether or not a young man attends a clinic with his partner, there is a need to allocate contraceptive counseling time to help him learn effective communication skills, particularly regarding condom use. Male clients might also benefit from peer support programs that help them to think through the risk factors associated with multiple partners, and ways to reduce their risk.

Interestingly, males who had previously impregnated a partner were less likely to adopt an effective method following the pregnancy. From this we could infer either that the client needed more support to become a better contraceptive user or that he was not interested in preventing a pregnancy. The 1995 NSAM does not support the latter possibility, since 69% of adolescent respondents said they would be "very upset" if their partner became pregnant.[22]

Conclusion

Our findings cannot be extrapolated to the general population of adolescent males, because only a very small proportion of males attend family planning clinics, and the motivation exhibited by those who attended an ETCP clinic clearly introduces a potential bias. Although our findings do not suggest a specific model for identifying a population of clients at increased risk for pregnancy, we believe that they provide some insight into the profile of the adolescent male family planning client.

To adequately serve young male clients, clinics must take into account their sexual and contraceptive histories, as well as their psychosocial needs and their motivation to delay childbearing. Routine screening should go beyond traditional family planning techniques and discuss with teenage males how to improve communication with their partners, as well as other lifestyle issues. For example, counseling and role-playing techniques may help young men learn to convey their intention to use birth control even when they do not know their partner well, or when clear lines of communication and joint decision-making have not been established.

The importance of using condoms consistently with all sex partners should also be discussed with young male clients, especially those who are involved in more than one sexual relationship simultaneously. Furthermore, given that one in three ETCP clients reported that they are always or sometimes high on alcohol or drugs when they have sex, education and counseling should emphasize how drinking and drug use can interfere with effective, consistent contraceptive use.

Regardless of their age or ethnicity, males need focused attention to become more effective contraceptive users. Most family planning clinic staff are female, which may deter males from seeking care at these facilities. In family planning clinics' efforts to reach males, it will be important for them not only to develop special services for males, but also to hire male service providers, including counselors, clerks and outreach workers.

Some providers may hesitate to expand the focus of their programs, out of fear that engaging young men in family planning services will divert a portion of the meager funding that is currently available and thereby diminish efforts to serve female clients. Thus, in recognition of the influential role men play in contraceptive decision-making, staff training must address not only their special needs, but also the skepticism sometimes expressed by clinic providers about offering male-focused services. Furthermore, additional funding earmarked to serve males is necessary.

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