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Original article

Interventions to Increase Male Attendance and Testing for Sexually Transmitted Infections at Publicly-Funded Family Planning Clinics

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A B S T R A C T

Purpose: We assessed the impact of staff, clinic, and community interventions on male and female family planning client visit volume and sexually transmitted infection testing at a multisite community-based health care agency.
Methods: Staff training, clinic environmental changes, in-reach/outreach, and efficiency assessments were implemented in two Family Health Center (San Diego, CA) family planning clinics during 2010–2012; five Family Health Center family planning programs were identified as comparison clinics. Client visit records were compared between preintervention (2007–2009) and postintervention (2010–2012) for both sets of clinics.
Results: Of 7,826 male client visits during the time before intervention, most were for clients who were aged <30 years (50%), Hispanic (64%), and uninsured (81%). From preintervention to postintervention, intervention clinics significantly increased the number of male visits (4,004 to 8,385; $\Delta = +109\%$); for comparison clinics, male visits increased modestly (3,822 to 4,500; $\Delta = +18\%$). The proportion of male clinic visits where chlamydia testing was performed increased in intervention clinics (35% to 42%; $p < .001$) but decreased in comparison clinics (37% to 33%; $p < .001$). Subgroup analyses conducted among adolescent and young adult males yielded similar findings for male client volume and chlamydia testing. The number of female visits declined nearly 40% in both comparison (21,800 to 13,202; −39%) and intervention clinics (30,830 to 19,971; −35%) between preintervention and postintervention periods.
Conclusions: Multilevel interventions designed to increase male client volume and sexually transmitted infection testing services in family planning clinics succeeded without affecting female client volume or services.
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IMPLICATIONS AND CONTRIBUTION

Family planning clinics within San Diego's Family Health Centers implemented program and community interventions that showed significant increases in the frequency of male reproductive health client visits and chlamydia testing. These effective innovations contribute to the practice literature on increasing clinical services to adolescent and young adult males.

Conflicts of Interest: The authors have no conflicts of interest to disclose.
Disclaimer: The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention or the Office of Population Affairs.

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Family planning has been named one of the 10 greatest public health achievements of the 20th century [1]. The federal Title X national family planning program, established by the Public Health Service Act of 1970 [2], is the only grant program dedicated solely to providing individuals with comprehensive family planning and related preventive reproductive health services [3]. The program has historically filled a need for reproductive health and contraceptive services for low-income and uninsured individuals and served primarily females. Over the last 40 years, males have comprised a small but increasing proportion of clients visiting federally funded family planning clinics.

In the mid-1990s reproductive health visits by male clients began to increase, as almost all publicly funded family planning clinics provided services to males, including testing and treatment for sexually transmitted infections (STIs) and reproductive health counseling [4]. In addition, for the past 15 years, the Department of Health and Human Services Office of Population Affairs, the federal agency managing Title X, has funded initiatives for improving family planning information, education, and clinical services targeting males. These programs have been successful, as the proportion of family planning visits by males more than quadrupled from 2% to 9% between 2002 and 2014 [5,6]. Often when males have accessed care, however, their reproductive health services have been neither comprehensive nor integrated into their broader health care needs [7]. Studies have sought to identify clinic-based interventions to improve male client reproductive health knowledge and increase safer sex behaviors [8,9].

Targeted STI screening of higher risk males, such as those seeking reproductive health services, enrolled in job training programs, or who are socially disadvantaged, may be an effective public health prevention strategy [10–12]. For example, many clinic-based STI testing programs addressing *Chlamydia trachomatis* have focused on adolescent and young adult women and their male sex partners [13]. In these programs, the rates of genital chlamydial infections among men are moderately high, particularly in young adult and racial minority males [14]. A broad set of interventions has been identified that show promise for improving the mix of family planning clinic users by sex and provision of STI testing [15,16].

Based on prior research, we implemented a 5-year field intervention study designed to increase the number of males seeking services at family planning clinics. Our objective was to assess the impact of staff, clinic, and community-level interventions on male and female family planning clinic volume for selected clinics that did and did not implement project interventions. We evaluated whether interventions increased visits by males to family planning clinics, increased provision of chlamydia testing services of male clients, and affected the census of female clients and receipt of chlamydia testing services by adolescent and young adult women served at those clinics.

Methods

Study design

The Department of Health and Human Services/Office of Population Affairs funded five family planning grantees in 2009 to expand male reproductive health services via staff and clinic innovation interventions within both the clinics and the surrounding community. As a project grantee, Family Health Centers (FHCs) of San Diego, CA, included 15 clinics that provided family planning, reproductive health, or STI-related services. Of these, we enrolled two family planning clinic programs as intervention sites and also identified five other FHC family planning programs with similar client populations and family planning service models to serve as comparison sites. Intervention sites were chosen in collaboration with FHC management and factored in medical director support and staff capacity to commit to training and intervention activities. Five interventions, described in the following section, were initiated beginning in 2010, at the two intervention clinics:

1) In-reach: Clinic staff members were trained on using in-reach strategies with their female clients by encouraging women to inform male partners, friends, and relatives about reproductive health services. Promotoras, middle-aged women who were well-respected community members, were used at one intervention site in a predominantly Hispanic community. These part-time volunteers approached males and couples in the clinic waiting room and at the building entrance to inform them about the availability of male reproductive health services. For males expressing interest, the promotoras arranged clinic appointments and shared contact information with the project coordinator, who proceeded to make reminder calls in advance of scheduled appointments. At the second intervention site, the clinic's outreach worker provided community outreach and clinic in-reach. For the latter, the worker approached male clients in the waiting area. If interested, the worker would suggest having a further confidential conversation about STI services in a separate room, as needed.
2) Outreach: Clinic staff made presentations to community-based organizations and local health, social service, and correctional agencies about available male reproductive health services at FHC.
3) Clinic efficiency: Patient flow analyses were implemented to help program managers identify and resolve service bottlenecks for clients transitioning between clinic stations and to reduce wait times. Intervention sites did not receive additional resources to increase staff or program hours.
4) Staff training: Staff members were provided training on the "culture of men" and providing services to male clients. The training included gender differences in communication and decision-making, influences of socialization on male sexual health, and the possible impact of male stereotyping on services. Staff reviewed clinic visit components, including determining service needs, contraceptive options, medical history, sexual health assessment, sexually transmitted disease services, preventive health services, and risk counseling. Clinical staff also received skill-based training on conducting male genital exams, including documentation of normal growth and development and other common genital findings.
5) Clinic environment: Staff assessed intervention sites' physical settings to identify possible areas for improvements, for example, incorporating male-appropriate brochures and materials in waiting rooms and medical posters in exam rooms. Clinic intake forms, policies, and protocols were updated to better reflect male clients and their health care needs.

Data sources

For primary analyses, we accessed all 20,711 de-identified male family planning client clinic visit records from the administrative client information system for the seven participating clinics in FHC's network (i.e., two interventions and five

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