

# Examining HIV Prevention Activities in the Title X Family Planning Program

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## Executive Summary

Family planning clinics that attempt to provide effective, client-centered HIV prevention face a complex task. Integrating an effective HIV prevention initiative into the clinic's regimen of services requires strategic planning and demands new approaches to service delivery.

In recognition of the size and scope of the integration task, the DHHS Office of Family Planning recently conducted a study so it could better understand the needs of these clinics with respect to HIV prevention and equip them with the necessary resources to implement effective client-centered programs. OFP has shown its commitment to the integration of HIV prevention in family planning through research on promising practices, regional training needs assessments, and the provision of supplemental HIV integration grants to clinics in areas disproportionately affected by HIV. This study aimed to reveal what else the clinics may need.

### Aims of the Study

The research study was conducted to help OFP identify and assess the various types of HIV prevention activities Title X programs are providing, identify gaps or weaknesses in current services, and highlight innovative strategies that address the interrelated issues that the programs and their clients face.

Now, the identified strategies and promising and innovative practices need to be shared with Title X programs and a broader audience to help programs better tailor their services to the local community, as well as help build local commitment and capacity.

### The Study Findings

Six sites were studied, using research questions developed with the assistance of key informants, in widely dispersed locations. While all site visit locations receive Title X funding, their budgets are supplemented by a variety of sources, including State funds, county funds, Medicaid, and private payments. It is important to note that one of the clinics in the study is a recipient of a supplemental HIV integration grant from OFP. Staffing also varies from site to site, with some of the smaller clinics

operating with only three or four staff members, to some of the larger clinics with more than 20 employees.

The programs vary in terms of demographics as well. Located in both urban and rural areas, the site visit locations represent geographic regions in the Southeast, Northeast, West, and Pacific. The clinics are split in terms of race and ethnicity. The two clinics with majority African American clients are located in the Southeast and Northeast, the two with majority Latino clients are located in the Northeast and Pacific, and the two with majority white clients are located in the Southeast and West. The majority of clients are under the age of 25 in all six clinics. One clinic is dedicated to teens, another runs a teen clinic on certain days of the week. Yet most clinics see women within a wide age range.

Finally, all clinics provide general family planning services that include pelvic and breast exams, pap smears, birth control methods, phlebotomy services, pregnancy tests and pre-pregnancy counseling, and referral for alternative family planning services. Five clinics offer HIV testing on site, one of which only offers testing for paying clients.

## Synthesis of Current Activities

1. Clinics demonstrate different levels of integration of HIV prevention activities and could benefit from additional resources and support.

Clinics in the study provide at least the basic level of services required under Title X guidelines, but all face a number of integration challenges. In particular, clinics face structural issues related to 1) scarce funding resources and 2) little time to incorporate HIV prevention into already hurried office visits.

Clinics reported having only limited staff available to provide additional services in HIV prevention, and said the current staff workload is too great to add new responsibilities. In most locations, staff have limited training options and opportunities; therefore, at times they lack the appropriate knowledge about HIV/AIDS to address client questions effectively.

2. Many clinic staff are not receiving current, tailored, and consistent training opportunities to enhance their ability to integrate HIV prevention activities.

Current training activities vary from site to site. Most HIV training opportunities are sponsored by State or county health departments. In one location, the health department's STD clinic staff provide HIV training informally. In several locations, particularly those with close relationships with the Title X Regional Training Centers (RTC), various staff members provide in-house training. Yet interviewees in only two of the six clinic sites were familiar with training offered by the RTCs. Some delegate clinics cite lack of collaboration and/or support concerning training when the grantee is the county or State health department. Staff at one clinic in particular felt that although the health department received funding from Title X, it did not regularly offer training in HIV prevention and did not keep the clinic informed.

Most staff find training sessions do not address their day-to-day needs, and want more training about how to work effectively with clients in client-centered counseling, risk assessment, and cultural competency and sensitivity. Many also want to know how to better address needs of HIV+ clients.

3. Clinics are providing culturally, linguistically, and demographically appropriate care, but could benefit from additional models and training.

Most clinics serve as safety-net providers or the clients' first point of entry into the health care system, which means that clients typically come in with concerns other than HIV, such as substance abuse, domestic violence, or homelessness. All the clinics had HIV/AIDS information available in various languages (usually English and Spanish) and staff available for translation. Staff members' race and ethnicity is generally representative of the communities served.

Program staff brought up concerns about working with clients with respect to cultural, linguistic, and demographic issues. But clients generally felt providers understand cultural, linguistic, and demographic issues, even when services are provided by someone of a background different from their own. Clients under the age of 25 stressed the importance of compassion and understanding in providers; they did not want them to be like parents or teachers.

4. Clinics' assessment and evaluation of HIV prevention activities is limited and could benefit from effective and concise tools and strategies.

Many strategies for identifying cultural differences were identified, all built on a basic commitment to approach all clients with openness and caring, supporting confidentiality (especially when clients have fears related to citizen status, or being used as "guinea pigs" for research purposes). Special strategies are used with teenagers who think they are not at risk.

Assessment and evaluation activities surrounding HIV prevention are limited at most sites and generally include only one or two of the following: chart audits, client surveys and questionnaires to assess client satisfaction, tracking testing rates among clients referred for HIV testing, informal tracking of client follow-up and compliance, pre/post testing, and calculation of first and repeat teen pregnancy rates.

All staff mentioned challenges to assessment and evaluation, and felt methods used are often difficult, time-consuming, and ineffective. They also lacked confidence about the reliability of their client's responses to questions due to the level of intimate information required. Frustration was felt because clients, both those who had been tested and those who received other services, often do not return for a follow-up visit.

5. Clinics are increasingly involved in collaborative relationships and capacity-building activities, but knowledge and understanding of Title X among clinic staff is limited.

All six programs identified some type of collaboration with external service providers, most of which are informal arrangements. The clinics generally utilize a referral resource book, and typical referral services include HIV testing, HIV treatment and care, substance abuse treatment, and mental health care. Clinics use both written and verbal referrals. Interestingly, staff across the sites felt that clients referred for HIV-related services, particularly off-site HIV testing, are less likely to utilize the referral for confidentiality reasons and a lack of relationship with external staff. The clients themselves typically indicated that they feel more comfortable accessing HIV services at the clinic and would have no hesitation about initiating discussion of HIV services with clinic staff.

Despite the desire to collaborate, many staff found that they lack the appropriate time, resources, and staff to do it effectively. Staff turnover could also create problems in developing and institutionalizing collaborative relationships. Finally, although clinic directors were typically familiar with Title X guidelines, the knowledge and understanding among clinic staff was limited.

6. Key informants, clinic staff, and clinic clients can identify a variety of innovative and promising practices currently in place or that could be integrated into existing services.

Staff and clients identified many of the same innovative and promising practices, including mobile outreach, peer education, showing videos in waiting rooms, and utilizing speakers with personal experience. They did not, however, focus on the practices that the key informants considered to be innovative, including integrating HIV testing on-site, conducting research, and providing general HIV-related training for staff. The overlap appeared when all three groups discussed the overarching issues of client comfort-level and the appropriateness of services. Clients discussed holistic approaches to HIV prevention that dealt with a variety of related issues (e.g., mental health, spirituality, and self-esteem). Staff focused on making the client comfortable during clinic visits and providing client-centered care that was tailored to meet the needs of the individual. Key informants were interested in training focusing on conducting holistic assessments of clients as well as providing individualized and client-centered services. Ultimately, all three groups felt that the most successful and innovative practices focused on the client as a whole person and tailored the HIV prevention activities and counseling methods to fit the client's needs.

## Key Components of Effective Integration Strategies

Five components of effective integration strategies were identified during the key informant interviews and site visits

## 1. Resources and Support for Integrated and Client-Centered Care

Although budgets are tight, the necessary resources and support for integrated and client-centered care can be obtained in a number of ways.

First, programs can help to facilitate and ensure "buy-in" and acceptance of the integration of HIV prevention into family planning services by providing training and reinforcement for staff members and involving all levels of staff in strategic planning of the integration process.

Second, they can institutionalize HIV prevention by maintaining comprehensive processes, such as those for intake assessment and chart notes, to ensure that all staff are involved in the process consistently.

Third, they can creatively use resources by building relationships with agencies and organizations that provide different services and seeking joint funding opportunities with them.

## 2. Current, Tailored, and Consistent Training

Successful integration of HIV prevention activities into family planning programs requires that staff have access to and utilize current, tailored, and consistent training and information. Programs can ensure this in a number of ways.

First, programs can effectively provide accessible, current, consistent, and tailored training by increasing the range of training options for Title X staff (on-site, off-site, web-based). They should regularly assess the program's needs and coordinate and tailor the training and curriculum information accordingly. They also should develop in-house training capabilities.

Second, reinforcement can be provided from the administration in relation to incorporating new knowledge and skills when programs ask staff to report back and train each other, and solicit feedback from staff about their training needs.

Third, programs can provide cross-training opportunities for the staff, which helps them better understand the connections between such services as family planning, HIV, substance abuse, mental health, domestic violence, and homelessness. They also can build important collaborative relationships within the community and thus become better able to provide holistic, client-centered care.

## 3. Models and Training for Designing and Implementing Culturally Appropriate Services

Staff knowledge and ability to address the needs of clients can be increased effectively by providing models and training for designing and implementing culturally appropriate services. Programs can address these needs in a variety of ways.

First, staff can better understand and connect with the clients by meeting them “where they are.” Programs can foster this connection by providing translation services and producing materials in languages spoken in the community, regularly conducting needs assessments, and partnering with community-based organizations to better understand the community.

Second, programs can institutionalize practices by creating written clinic policies, addressing the demographic match between clients and staff, and providing cultural competency and sensitivity training to all staff.

#### 4. Effective and Concise Assessment and Evaluation Tools and Strategies

Programs must develop assessment and evaluation strategies that are user-friendly but also collect and evaluate the appropriate data. There are a number of ways in which programs can address these needs.

First, programs can provide models of assessment and evaluation tools and strategies that do not require too much extra time on the part of the provider. The tools should cover a number of issues in a manner that is comfortable for the client. And to avoid recreating the wheel, the strategies should have been proven to be effective.

Second, programs can institutionalize assessment and evaluation strategies and ensure that staff use them correctly and consistently. Such methods may include conducting focus groups with clients and staff, observing client sessions directly, tracking information dissemination, and tracking referral utilization and satisfaction.

#### 5. Collaborative Relationships and Capacity Building

Title X programs build capacity by enhancing existing and creating new collaborative relationships. Programs accomplish these goals in a number of ways.

First, programs should seek to collaborate with diverse partners to expand their ability to provide and connect clients with comprehensive services. These partners may include schools, faith-based organizations, community-based organizations, WIC/food and nutrition services, job-training programs, domestic violence shelters, and service systems focusing on criminal justice, mental health, substance abuse, and homelessness.

Second, programs can build capacity in the community by completing concrete action steps such as:

- Creating up-to-date referral lists through involvement in community planning groups
- Creating formal working agreements with various agencies and organizations to refer clients and share data

- Utilizing social marketing techniques to increase visibility in the community
  
- Working closely with external HIV/STD programs to provide training and referral services.

In conclusion, although the results are not generalizable across the entire Title X family planning program, this project has helped to identify some of the various types of HIV prevention activities Title X programs are currently providing and to highlight promising practices. It is clear that clinics demonstrate differing levels of integration of HIV prevention activities and could benefit from additional resources and support, particularly in relation to training in HIV prevention and in effectively utilizing models for providing culturally, linguistically, and demographically appropriate care. Programs could also benefit by identifying and sharing effective assessment and evaluation tools and strategies, as well as models for building internal capacity and forming collaborative relationships with external organizations and agencies. By sharing these promising and innovative practices among the Title X programs and a broader audience, this information will allow programs not only to better tailor their services to the local community, but also to help build local commitment and capacity.