Community Linkages and Outreach Services in Adolescent Contraceptive Clinic Programs

JOANNE G. GREER, PhD
MARY ANN LESNIAK, MHS

MORE THAN 1.6 MILLION TEENAGERS, 40 percent of the sexually active adolescents in the United States, are not served by the existing family planning network of public programs and private physicians (*1*). Most of these teenagers, however, live in or near areas with programs that could be expanded to accommodate them (*2a*). This expansion of adolescent family planning services could be accomplished, for example, by the addition of an outreach component or the establishment of organized referral programs (*2b*).

Recognizing this unmet need, the Family Planning Program of the Health Services Administration (HSA), Public Health Service, targeted an additional $8 million in fiscal year 1977 to reach the high-risk adolescent population (*3*). By identifying and examining the barriers to access to services experienced by specific target groups, such as adolescents and males (who often remain outside the system), the health services delivery capacity was to be strengthened; and integrated, linked systems of service provision were to be developed (*3*).

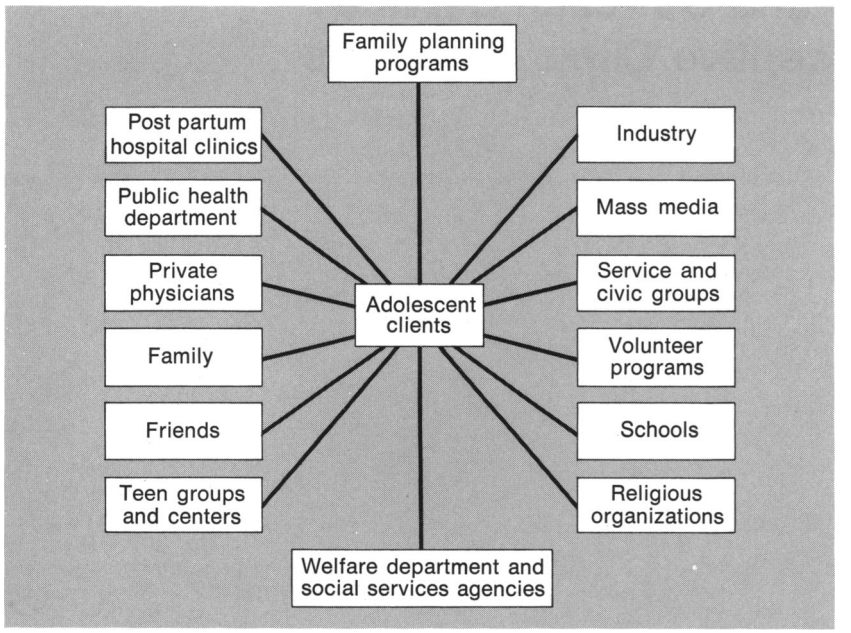
To determine whether family planning services for adolescents were being expanded, and if so, whether this expansion was accomplished by outreach methods and organized referral, in 1978 we undertook a pilot study. Exploring the current validity of commonly held assumptions about system linkages of services for adolescent family planning clients, we sought to discover whether a linked system for adolescents existed at the clinic level, how organized referral systems and outreach programs functioned, and what priority the staffs of the family planning clinics assigned to linked systems for adolescent services.

One commonly held assumption was that the establishment of organized referral programs among health providers and between the health service sectors and other human service sectors would result in an integrated and linked health system that would efficiently accommodate the contraceptive needs of the adolescents in a community. Yet according to a 1978 Government report, the referral networks for family planning then in place were informal and unsystematized at best (*4a*). Local family planning providers—often the only community agencies actively trying to prevent teenage pregnancy—reported a noticeable lack of involvement of parents, schools, churches, youth groups, and other health and social service agencies (*4b*).The linkages that would result from organized referral systems among these groups could give rise to more efficient use of manpower and resources, reduce the cost of providing services, improve the identification of problems, increase accessibility to care, and augment the comprehensiveness, continuity, and quality of that care. In recognition of these advantages, the Federal guidelines for

Dr. Greer is Acting Chief of the Special Studies Branch in the Office of Analysis, Office of Planning, Evaluation, and Legislation, Health Services Administration, Public Health Service. At the time of the study, Ms. Lesniak was a student intern from the Johns Hopkins University in the Office of Analysis.

Tearsheet requests to Dr. Greer, Office of Analysis, Office of Planning, Evaluation, and Legislation, Rm. 14–36, Parklawn Bldg., 5600 Fishers Lane, Rockville, Md. 20857.

Model of a linked health system



family planning include provisions for coordination and referral arrangements among the various providers of health care services (*5*).

Another commonly held assumption was that an important component of a linked health care system is an organized outreach program. The Federal family planning guidelines include provisions for informational and educational programs to help the community understand the objectives of family planning and to inform the community of the availability of various services (*5*). In this area of information and education, the school system is seen as the most critical and yet most problematical link. If any such linkage, however ineffectual, exists, it is most often of the "back door" type—between a specific school and the individual family planning provider (*4c*).

A literature review, undertaken as background for our study, yielded little information about linkages among providers of adolescent family planning services. Although the literature suggests that such services are theoretically best delivered through a linked system, in practice, a major barrier to providing family planning services and information in a linked system has been the negative attitude of many members of the community, an attitude that forces the providers of these services to keep a low profile when delivering them (*4d*).

Methods

For our study, linkages were defined as the relationships, both formal and informal, among different components of the health care system and, also, between the health services sector and other human services sectors of the community (see chart). The model in the chart is a dynamic one, since the amount and type of linkages depend on the characteristics of the individual community and its needs. Linkages are demonstrated at the clinic level by an outreach program, by the coordination of a clinic's services with those of other service delivery agencies, and by a high referral rate among different components of the health care sector. Because there were no readily accessible data bases for use in tracking clients through the linkages, we did case studies of seven clinics and their surrounding communities to identify formal and informal linkages, as well as the formal and informal prohibitions against such linkages.

Since a variety of clinics provide family planning services, the seven clinics selected for study represented a range of types and were located in various regions of the United States (see table). Five were freestanding; one was affiliated with a health department and another with a hospital. Two used a State funding grant mechanism; the rest used re-

Site characteristics of the 7 clinics studied

Characteristic	*Clinic 1*	*Clinic 2*	*Clinic 3*	*Clinic 4*	*Clinic 5*	*Clinic 6*	*Clinic 7*
Location	Southeast	Midwest	Midwest	South	Northeast	Midwest	West Coast
Rural or urban..	urban	urban	urban	urban	urban	rural	rural
Type of grantee [1]	State	regional	regional	State	regional	regional	regional
Type of clinic ..	health department	hospital	freestanding	freestanding	freestanding	freestanding	freestanding
Size of clinic [2] ..	large	large	small	large	small	large	large

[1] Nature of funding grant mechanism. [2] Large if more than 2,000 teenagers served annually and small if fewer.

gional (sub-State) funding grant mechanisms. Five of the clinics were urban; two were located in rural areas. Five of the clinics were large (serving more than 2,000 teenagers annually), and two were small (serving fewer than 2,000 teenagers annually).

During field visits to the seven clinics between October 1978 and February 1979, interviews were conducted with staff members. (This field work was done by Medicus Systems Corporation of Washington, D.C., under the supervision of Robert Burke, PhD, the project director.) These interviews focused on the operations of the family planning program, the priority accorded the teenage component, and the role in and the relationship of the clinic with the community. The interview protocol contained special segments for the clinic directors, for their assistants, for the direct providers of the services, and for the health educators. The same set of questions was asked at all sites.

The topics covered during the interviews included the availability of adolescent services, the level of effort in providing adolescent services, the sources of referrals, outreach services, and the coordination of services. The availability of the expected types of adolescent family planning and contraceptive services was recorded, along with any special additional services offered, such as followup procedures and services directed to males. Whether or not the clinic management perceived a need for more services to teenagers was also noted. In assessing the level of effort in providing services, consideration was given to such factors as whether (*a*) the adolescent population had been defined, (*b*) the target population included male teenagers, (*c*) the clinic had a plan for establishing adolescent services, (*d*) figures on utilization were collected, (*e*) efforts were made to increase teenage use, (*f*) followup procedures were used, and finally, (*g*) what factors were believed to limit utilization.

Direct evidence as to whether a linked system existed was based on the information respondents gave on the clinic's sources of referrals. When there was a written or an informal policy prohibiting referrals from the school system, that fact was noted. The information sought about outreach services centered on the target of such services, the type of advertising used to promote them, and the existence of special outreach directed at males or teenage couples. The data sought about coordination of services centered on three areas: (*a*) the composition of the community board and whether it attempted to coordinate services; (*b*) the presence of any other coordinating groups; and (*c*) whether the community had other sources of similar clinic services and, if so, whether these services were shared among the various providers. The final item that was noted was the clinic personnel's perception of the community's attitudes toward their work. A brief caveat must be issued at this point. These results are based on an interview survey, and therefore in several areas, they represent the perceptions of the clinic personnel—perceptions which may or may not represent the community reality. However, as will be noted in the following sections, knowledge of these perceptions is valuable in and of itself.

Results

The results of the survey are reported under five headings, each corresponding to a subject covered during the interviews.

Adolescent services provided. The standard array of family planning services was available to adolescents at most of the seven clinics studied. All seven offered the following:

Contraception-related services:
- Provision of birth control methods and materials
- Birth control counseling

Pregnancy-related services:
- Pregnancy testing
- Prenatal referral
- (Pregnancy counseling and referral for problem pregnancies were also offered at all clinics but one.)

Miscellaneous services:
- Health examinations (Papanicolaou smear, breast examination)
- Educational sessions
- (Venereal disease counseling or treatment was also offered at all clinics but one.)

None of the clinics offered special male services, and only two provided an educational program for males. Respondents from six of the clinics believed that more teenage services were needed in their communities.

Level of effort in providing adolescent services. Six clinics had defined their adolescent target population, but only four included male teenagers in their figures. The percentage of patients who were male was negligible in all the clinics. Three clinics had a formal plan for establishing adolescent services. The staffs of six indicated that they had tried to increase teenage use, but only three had collected any utilization data to monitor their progress toward this goal. Five clinics had followup procedures for dropouts, and three had established special clinic hours exclusively for teenagers. When asked to name the factors limiting use of their clinics by teenagers, the staffs of all seven clinics noted a lack of funds. Lack of referral and lack of coordination were each mentioned by the staff at only one clinic. None of the clinic staffs expressed the belief that a lack of outreach efforts limited utilization of family

planning services. This perception of the clinic staffs is contrary to opinions expressed in the literature and merits further exploration.

Sources of referral. The smallest number of different sources of referral noted by any one clinic was 3, and the greatest number was 11. Following are the number of clinics reporting various sources of referral:

Friends	7
Other clinic patients	6
Families	6
Schools	5
Post partum hospital clinics	4
Private physicians	4
Welfare departments	4
Social service agencies	3
Church organizations or ministers	3
Social and civic groups	2
Public health departments	2
Teen centers	1

The staffs of all seven clinics stated that the most frequent sources of teenage referrals were friends and other clinic patients. This result is consistent with two earlier Government studies showing that 81 percent of all female patients at family planning clinics had been referred by their family, friends, or other clinic patients (*6*) and that the primary source of adolescent clients was word-of-mouth referral by their peers (*4e*). Although the staffs at five clinics noted that they received referrals from the school system, another clinic staff cited a written policy against school referrals, and the staffs of four clinics (three of whom had received school referrals) cited an informal community policy against such referrals.

Outreach services. All seven clinics provided outreach services, which was a larger proportion than expected, since only 64 percent of family planning providers in a 1975 survey were found to supply such services (*7*). The following is a list of the target areas for outreach that were used by the clinics in our study, along with the number of clinics reporting each use:

Institutions and organizations	6
Schools	6
Community groups	5
Teen centers	4
Hospitals	4
Door-to-door canvassing	4

The number of areas targeted for outreach by an individual clinic varied from two to five. Six clinics directed their outreach toward schools as well as toward other agencies. Although special outreach efforts directed at teenage couples were reported at five clinics, only one reported special outreach efforts directed at males.

All seven clinics used advertising as a form of outreach. Following are the types of media the clinics used to convey information about their services, along with the number of clinics reporting the use of each:

Pamphlets	6
Radio	6
Television	5
Posters	4
Newspapers	2

Five of the clinics used special advertising directed at teenagers; three of these clinics directed their advertisments toward the school system. For any one clinic, the number of types of advertising media used ranged from two to five. The most frequently used media were pamphlets and radio.

Coodination of services. The staffs of six clinics reported that they had a community board, but only one staff reported that this board attempted to coordinate the clinic's activities with those of other service agencies. None of the community boards included any representatives of the school system. Personnel at four clinics mentioned the existence of other types of coordinating groups, but none of these groups were officially designated as such. At only one clinic did the staff indicate that its community had other sources for the type of adolescent services it provided. In other studies, negative community attitudes toward family planning services have been listed as barriers to open coordination among various agencies. However, when the clinic staffs were questioned as to the prevailing attitudes in their communities, at only one clinic did the staff perceive a negative community attitude toward its services.

Discussion

The staffs of the clinics studied indicated that in general, there was an unmet need for adolescent family planning services. The staffs at all the clinics but one indicated that more services were needed in their communities, but they expressed the belief that the fulfillment of this need would require the provision of additional funding. The staffs did not perceive the lack of a linked referral system or insufficient outreach as major problems.

The existence of a linked system of health providers was not confirmed by any respondents. Although the clinic staffs saw their clinics as the only source of adolescent family planning services in their areas, there was no coordination between these clinics and other segments of the health care community. Some of the reasons that the respondents gave for this lack was the traditionally independent operation of the service agencies, as well as the possible moral issues that might confront either individuals or the whole community in providing contraceptive services for adolescents.

No linkage between the health and nonhealth sectors of the community was found for any of the clinics. Although outreach to schools was provided, few referrals from the school system resulted, and those few that did were usually due to an informal relationship between an individual provider at the clinic and an individual school employee, in

other words, a back-door arrangement. We had hypothesized that the scarcity of school referrals might be due to State laws prohibiting official referral arrangements between a school system and a contraceptive clinic. However, a search of State laws for barriers to such linkages revealed no prohibition of such referrals. Apparently, then, what was operating to prevent them was either informal prohibitions or official indifference. Since education is financed and administered almost totally through State and local bodies, only limited initiatives can be taken at the Federal level to involve the local school system with the health care providers.

The referral network for the seven clinics was based predominately on referrals by peers—friends and other clinic patients. The linkage system for services was indeed informal and haphazard. And more important, referrals, coordination, and outreach were not perceived by the clinic personnel as problems. The limited involvement of male adolescents in the clinics' contraceptive programs was also not perceived to be a problem. In almost all the clinics, males did not use clinic services, and the clinic neither provided any special services for them, nor directed special outreach efforts at them.

In summary, several inconsistencies were noted between official Federal policy and onsite clinic priorities. Current policy emphasizes the collection of data for use in monitoring program efficiency, the expansion of services to groups outside the present delivery system, and the development of mechanisms for integrated delivery of services. But at the clinic level, the priorities may be quite different. Routine data on the utilization of adolescent family planning services were frequently not collected at the clinics studied. Little emphasis was placed on expanding services to male teenagers, who still remain outside the family planning network. Finally, because the clinic staffs did not regard the lack of a referral system and insufficient outreach as problems, these areas were given low priority. Such perceptions of personnel, which may run counter to official policy, could hamper the development of an integrated health care system.

Conclusion

Data emerging from research such as this admittedly small-scale, pilot study have implications for policy and for program planning regarding family planning services. From the standpoint of policy, if the problem of teenage pregnancy is viewed not only as a health problem but also as a social, educational, and economic problem, then the approach to its solution also must be multifaceted. That approach must involve not only the health care sector, but all sectors of the community that deal with adolescent welfare, growth, and development. If the policy, which will be put into operation by programmatic decisions, is to encourage a linked system of services, then careful thought must be given to the best way to achieve this linkage. That such a decision can be mandated by official sanction or by program funding guidelines appears unlikely. More research is needed at the community level, since that is where the existing informal linkage arrangements, the informal prohibitions against them, and the dynamics of community interaction, can best be examined.

The most appropriate way to create linkages at the local level—and the way with the greatest potential for success—is to build them from the ground up rather than base them on dictates issued from above. If local providers and planners design their own linkage mechanism, they will be more likely to be able to implement it successfully. First, however, they have to become aware of the problem and recognize the need for linkages. More research also needs to be done to determine what the most effective Federal and State strategies are for fostering commitment to such an objective at the community level. In that research, attention should be focused on the perspective and perceptions of the people providing the services for, in the long run, those providers will be the ones responsible for establishing an integrated health care system.

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