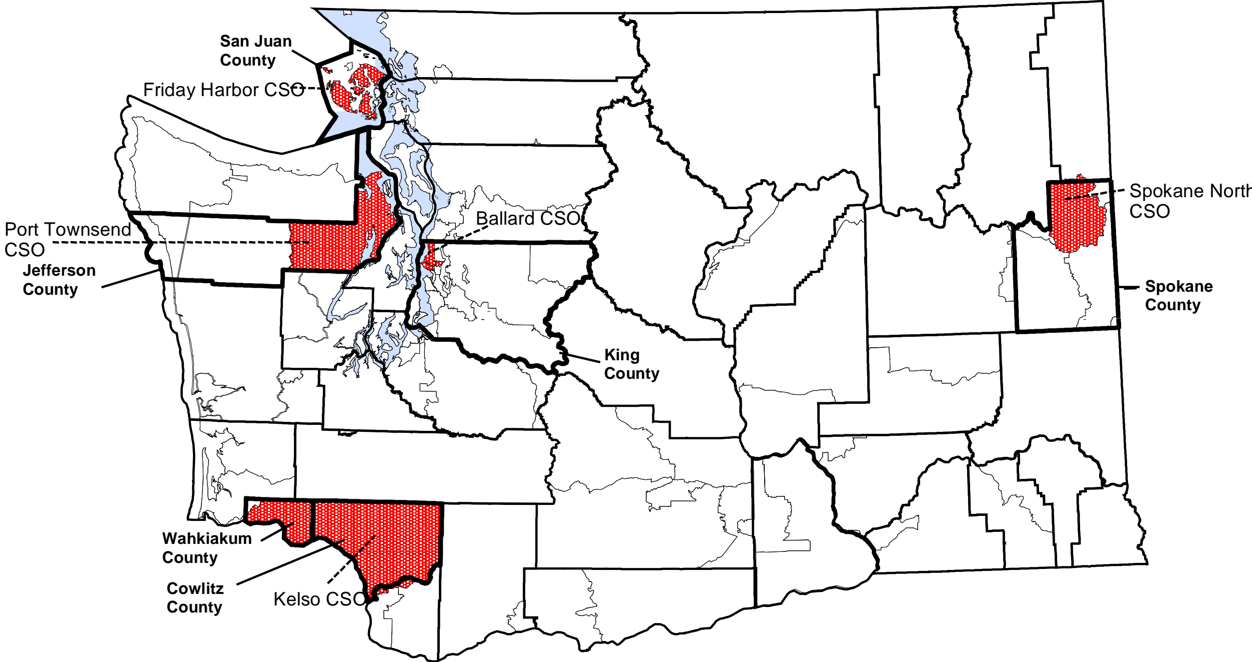
Family Planning in Washington State Community Services Offices:

Challenges and Strategies



Washington State Department of Social and Health Services
Research and Data Analysis

Family Planning in Washington State Community Services Offices:

Challenges and Strategies

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EXECUTIVE SUMMARY

Family planning is a critical component of programs designed to help welfare clients become self-sufficient and potential clients maintain self-sufficiency. Washington's Community Services Offices (CSOs) determine financial eligibility for entitlement programs and provide social services including case management. In the early 1990s, Washington started a pilot program to bring family planning services into a few CSOs. In 1994, family planning services were introduced to the remaining CSOs. Washington mandates family planning assistance and information for all Temporary Assistance to Needy Families (TANF) clients and potential clients (RCW 74.12.400 and 410).

This qualitative study presents the observations of 62 persons actively involved in CSO-based family planning services from five Washington CSOs (Ballard, Friday Harbor, Kelso, Port Townsend, and Spokane North). During in-person, semi-structured interviews, informants spoke of the challenges they faced and the strategies they used to integrate family planning into CSO activities and clients' lives, and of their vision for the future of this program. The report describes program models and strategies that may be useful for other CSOs facing similar challenges.

Key Findings

Despite the unique characteristics and program focus of the five CSOs studied, striking commonalities emerged. Overall, it is challenging to engage CSO staff members, CSO clients, and communities in dialogue about family planning. Integrating family planning services and staff into the activities of the CSOs and their communities requires that these challenges be overcome.

Critical Factors for Integrating Family Planning into CSOs

Based on the data collected in this study, the following elements are essential for integrating family planning services into CSO activities and the community:

- **Leadership from CSO administrators and supervisory staff**
- **The skills, personality, and presence of the family planning worker and contracted family planning nurse**
- **Teamwork and communication between CSO family planning staff and contracted family planning nurse and between family planning workers and CSO staff and administration**
- **Respect for clients as individuals and for their decisions and concerns**
- **Flexibility in program structure and activities**

Future Directions for CSO-Based Family Planning

While respondents from the five sites felt that family planning is becoming integrated into their CSOs and their communities, they also suggested ways to improve the program:

- **State and CSO administrators should increase the priority of family planning services with greater support and more leadership.**
- **Dedicated family planning staff in the CSO should be maintained, with clinical services provided by contracted family planning nurses available at all CSOs.**
- **Measurable objectives should be developed to help motivate CSO personnel in promoting family planning and integrating these services into CSO activities.**
- **Client outreach should be expanded to reach CSO clients or potential clients before an unintended pregnancy occurs.**

CSO-based family planning depends on the people who implement the program and the way they serve clients. Individuals responsible for the family planning programs at their CSOs exhibit extraordinary dedication to the goals of increasing client access to family planning and integrating family planning into the CSO. Clients are encouraged to make their own decisions and are given respect, whatever their circumstances. Family planning programs flourish where administrators at the CSO level, and at state and regional levels, are willing to take a stand and move forward with a family planning agenda.

Creating a supportive environment requires education and outreach programs targeting CSO staff, CSO clients, and the community. Those who are familiar with the concerns, opinions and attitudes of each community – the CSO-based family planning staff, contracted family planning nurse, CSO managers, and cooperating agency managers that work within each community – must determine which strategies are appropriate for their community. Program flexibility allows for this, as well as encouraging creative energy for new ideas and approaches.

The importance of CSO-based family planning should be more widely recognized and program efforts enlarged. Societal acceptance of family planning remains a challenge. Broader support at all levels will empower family planning personnel to increase their successful activities, such as training and teambuilding with CSO staff, community education and networking, and family planning outreach to vulnerable populations.

CONCLUSIONS

Well-integrated CSO-based family planning services are vital to assist clients in becoming self-sufficient and potential clients in maintaining self-sufficiency. While CSOs have made great strides in achieving this goal, future success depends on continuing leadership from managers and administrators and the dedicated and insightful work of family planning staff.

INTRODUCTION

Family planning is an essential component of programs designed to help welfare clients become self-sufficient and potential clients maintain self-sufficiency. Washington's Community Services Offices (CSOs) determine financial eligibility for entitlement programs, such as federal Temporary Assistance for Needy Families (TANF) and Medicaid, and provide social services, including case management. In the early 1990s, Washington started a pilot program to bring family planning services into Department of Social and Health Services (DSHS) CSOs to increase access to these services for low-income clients. In 1994 family planning services were introduced into the remaining CSOs. Washington State mandates family planning assistance and information for all TANF clients and potential clients (RCW 74.12.400 and 410). WorkFirst (Washington's public assistance-to-work program) makes explicit the goal of zero additional births for women in the WorkFirst program (*WorkFirst Implementation Handbook*, 1997).

This qualitative study describes challenges and strategies for providing family planning services at five CSOs: Ballard, Friday Harbor, Kelso, Port Townsend, and Spokane North. The report presents the observations of persons actively involved in CSO-based family planning in Washington State—those who serve the clients. During in-person, semi-structured interviews (a few interviews were by telephone), informants spoke of the challenges they faced and the strategies that they used to integrate family planning services into CSO activities and clients' lives, and of their vision for the future of this program. It is hoped that this information will enhance dialogue about family planning and furnish assistance to those CSOs that face challenges similar to the ones in this study.

To estimate the level of family planning services offered statewide, Research and Data Analysis conducted an electronic mail survey of all 65 CSOs in Washington. Survey results revealed that all CSOs offer some level of family planning services, ranging from a reliance on printed information and informal education for clients to the provision of nearly a full scope of reproductive health services (Cawthon et al., 1999).

An informal survey of other states revealed that only North Dakota and Florida reported statewide collocation of family planning services with social services (see *Appendix E*).

Medical Assistance Administration (MAA) in partnership with the Economic Services Administration (ESA) and individually contracted family planning agencies manage Washington's CSO-based family planning program. ESA allocates the total number of CSO staff hours for family planning per region based on each region's total caseload. Regional Administrators allocate staff hours per CSO. Community Services Office Administrators (CSOAs) have a limited ability to assign staff hours and duties for family planning.

The five CSOs represented in this study collaborate with three different types of contracting agencies (as shown in the table on the following page): local health districts, national affiliates (such as Planned Parenthood), and local not-for-profit agencies (such as Cowlitz Family Health). These agencies provide family planning nurses to the CSOs through contracts with MAA. The contracted family planning nurses' duties and hours are specified in their contracts.

Models of collaborations among agencies and CSOs in this study are outlined in the following table.

Models of Collaboration

CSO	Type of Contracting Agency	Name of Agency
Ballard	Local Health District	Seattle-King County Department of Public Health
Friday Harbor	National Affiliate	Mt. Baker Planned Parenthood
Kelso	Local Not-For-Profit Agency	Cowlitz Family Health Center
Port Townsend	Local Health District	Jefferson County Health Department
Spokane	National Affiliate	Planned Parenthood of the Inland Northwest

The specific direction and emphasis of CSO programs may vary. A great deal of flexibility was included in the design of the CSO-based family planning program. This allowed individual CSOs and their contracted family planning agencies to design their own family planning programs based on the needs of their communities. Kelso's program, for instance, focuses on home visits and outreach, while the Spokane North CSO has an onsite family planning clinic with full clinical exam facilities.

METHODS

SITE SELECTION

A sample of CSOs was selected to represent various models of family planning programs in Washington (see table, previous page). Other factors for consideration included population size and geographic location. Sixty-two key informants were interviewed across five CSO sites: Ballard, Friday Harbor, Kelso, Port Townsend, and Spokane North.

The CSOs in this study represent small, medium, and large CSO service areas. Sites ranged in size from the smallest, Friday Harbor, which ranked number 64 of 65 CSOs for the number of TANF cases in one month (June 1998), to Spokane North, which ranked number 4 of 65 CSOs for the number of TANF cases in the same month. Port Townsend CSO ranked 52 of 65, Ballard ranked 34 of 65, and Kelso ranked near the top, at 12 of 65 (Research and Data Analysis, 1998).

Informant Selection

Interviewers asked to speak with people directly involved with family planning. Participants included present and former CSO family planning workers, contracted family planning nurses, Social Services Supervisors, CSO Administrators (CSOAs), First Steps workers, WorkFirst coordinators, family planning agency executives and supervisors, social workers, case managers, and financial workers. Other CSO staff were interviewed at the request of the CSO if their duties included family planning services.

Key informants were contacted by letter and then by e-mail or telephone. CSOAs organized site visits or delegated their organization. A list of possible informants was sent to the CSOAs, who were asked to identify additional informants. Of 64 candidates suggested, 2 were unable to participate. For those unable to participate in person, telephone interviews were conducted. Of 62 interviews, five were conducted by phone.

Summary of Respondents by Job Description

Job Description	Interview Format		Total Interviewed
	Personal	Phone	
CSO Administrators	5	3	**8**
Contracting Agency Executives/Supervisors	6	2	**8**
CSO Financial and Social Services Supervisors	7	0	**7**
Family Planning Workers	7	0	**7**
Contracted Family Planning Nurses	6	0	**6**
CSO Social Workers	14	0	**14**
Financial Workers	3	0	**3**
Customer Services Specialists/Community Resource Program Managers	4	0	**4**
Other	5	0	**5**
TOTAL	**57**	**5**	**62**

Number of Respondents by CSO

CSO	Ballard	Friday Harbor[1]	Kelso	Port Townsend	Spokane North
# of Respondents	11	14	10	8	19

Five state administrators were also interviewed: two from MAA, two from WorkFirst, Economic Services Administration (ESA), and one from the Community Services Division (CSD) of ESA. These interviews followed the same protocol as site interviews.

DATA COLLECTION AND ANALYSIS

Interviews

Interviews were semi-structured. The interview guide was pilot tested at the Orchards CSO, and revisions were based on those responses. A copy of the interview instrument, including the statement of confidentiality, can be found in *Appendix B*. Respondents were told the intent of the report and assured of complete confidentiality. While the structure of the interview generally followed the guide, the process was flexible and respondents were given the opportunity to focus on individual priority issues. A typical interview took about an hour to complete.

The collected data consisted of audiotapes, field notes, written records, and printed information. Audiotapes were transcribed verbatim and data was systematically sorted into interview minutes. Minutes were reviewed to select appropriate highlighted information, thus the report does not cumulatively review material. Direct quotes from respondents are italicized in the report.

Card sort and written survey

Twenty-nine cards with descriptions of factors considered critical to CSO-based family planning programs were presented to interviewees. The factors were distilled from Orchards CSO pilot data. Respondents sorted these cards into three stacks: Most Critical, Critical, and Less Critical. Respondents could choose multiple factors. Of 62 informants, 56 completed the card sort, resulting in a 90% response rate. [2] (See *Appendix C*.)

A short, written survey about general attitudes towards family planning was administered to interview participants. The written survey contained nine questions with Likert scale-like responses. Of the 62 persons interviewed, 56 completed the survey resulting in a response rate of 90%. Selected results are described in *Appendix D.*

LIMITATIONS

Data for the most part reflect the views of individuals involved in family planning programs at these sites and at the state level, as well as direct observations by the research team. Such views may not be representative of *all* CSO staff and family planning personnel.

[1] Respondents from Mt. Vernon were also interviewed, as Friday Harbor is an outstation of that CSO.
[2] Telephone interviewees did not complete the card sort or written survey.

FINDINGS

Interview respondents were asked several general questions about family planning: what it is, why it is important, and for whom it is most important, on the assumption that what people think about family planning not only influences what they do but that, in every organization, the sum of everyone's views drives the social norm. Respondents spoke to the scope of social issues that surround family planning and to the challenges in opening a dialogue on the topic. A common theme that emerged was that attitudes towards family planning are part of a larger social norm that treats family planning as a *taboo* subject, hence a difficult topic to discuss with clients, with CSO staff, and within the communities served.

Answers about what family planning is ranged from varying scopes of reproductive health services to the intentional spacing of children. One informant summed the basic importance of family planning: *The self-government of one's reproductive health is absolutely key for somebody to feel that they are in control of their body and their life.*

Most respondents felt that family planning services are important for everyone, regardless of economic status: *… even your more affluent people are having unintended pregnancies, and your more educated people are having unintended pregnancies, so I really don't think it's actually narrowed only to low-income people.* A majority of respondents felt, however, that the consequences of unintended pregnancies are more far-reaching for low-income families: *I think we all need to know that we have options in our lives … but I do think it is very timely for people who are having a rough time to have a chance to talk about the issues around planning a family and whether or not a pregnancy seems like a good idea at this time.*

Most CSO respondents emphasized the crucial role of family planning, especially appropriate timing in childbearing, to achieving self-sufficiency; and that this has an impact on society as a whole: *…welfare families feel they're in a hole and they're never going to get out….* [This] *makes a big difference for how children perceive themselves and, therefore, what they do in their lives. …* [Family planning] *is crucial to survival of our society if we're going to have a good society….* [Children are] *…the next generation.*

A few respondents emphasized the importance *for women to feel they have some control and charge in their lives. I have seen such changes in individuals over the years who were able to do some planning … and to say, "this is how I want my life to go," and* [to] *do it … without … family planning—it's harder; much, much harder*. One respondent summed: *… if you master birth control, opportunities are endless.*

A vast majority of respondents felt that providing services at the CSOs was *excellent, wonderful, really good, a natural fit*; and that it dramatically increased access to services: *… providing family planning services in the CSO is absolutely providing* [services to] *a very important target group of our neighbors and friends that really need that information.*

A few respondents expressed qualified support. Reasons varied. Some respondents felt that, for some, entering the CSO itself is a barrier: *So many families, by the time they come down here, have exhausted every possible alternative and … to them it may signal failure. It may signal shame …. It's different than waiting for your tires at Les Schwab or something like that … there's a barrier for people to walk through the front door.*

The findings of this study are organized into four sections:

- **Site Descriptions: pages 7 – 28.**

  This section depicts the county and service area of each CSO through data tables and maps, and outlines characteristics of each CSO-based program.

- **Challenges and Strategies: pages 29 – 48.**

  This section examines barriers these CSOs have faced in implementing and continuing their family planning programs and how they have been overcome.

  Creative approaches to promoting family planning are also highlighted.

- **Critical Factors: pages 49 – 51.**

  This section discusses what respondents thought made their program *really work* and combines data from the card sort.

- **Future Directions: pages 53 – 59.**

  This section describes what respondents would like to see happen with CSO-based family planning in the future, including what respondents would like to see in every CSO, with a discussion of the perspectives of state administrators.

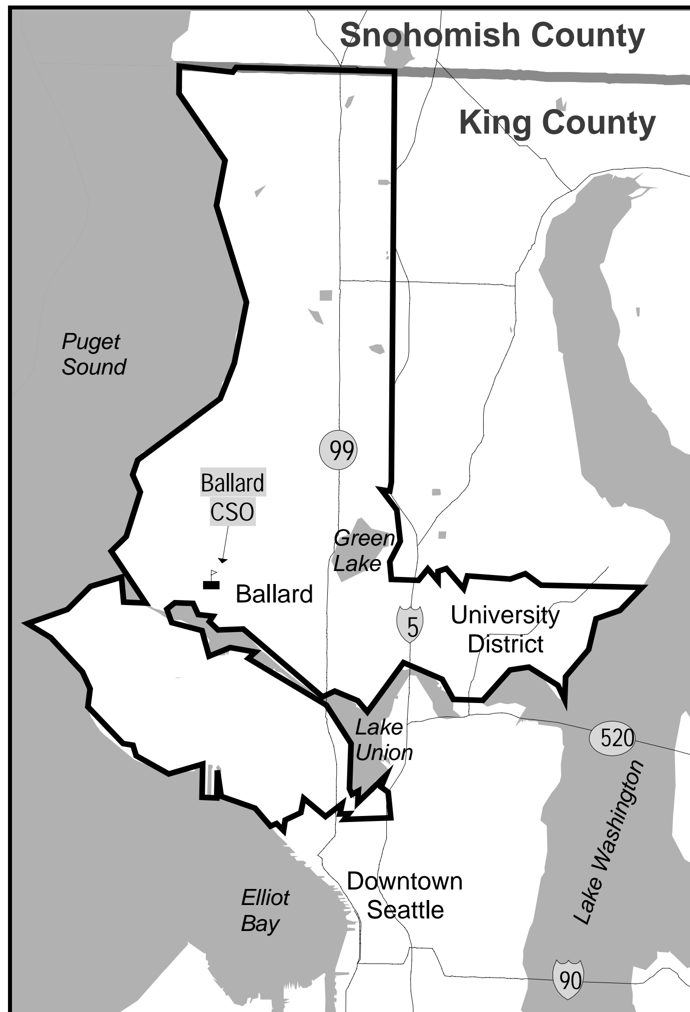
BALLARD COMMUNITY SERVICES OFFICE (CSO)

Ballard CSO serves the northwest section of King County and is one of eleven CSOs located in King County. In one month (June 1998), the Ballard CSO TANF caseload was approximately 902 cases and ranked number 34 out of 65 CSOs for number of TANF cases (Research and Data Analysis, 1998). Ballard CSO is located in Seattle, in metropolitan King County, the most populous county in Washington State. King County contains about 30% of Washington's total population.

There's a number of clinical services that are available in King County, not that there's enough for those that don't have money … [and] *we tend to have local city and county support for these* [family planning] *services.*

Race/Ethnicity of Ballard Economic Services Administration Clients (1994)

White	70%	Hispanic	4%	Native American	3%
Black	11%	Asian/Pacific Islander	1%	Other	2%



Ballard CSO Birth Statistics, Two-Year Averages (1992-1993 & 1996-1997)*

	1992-1993		1996-1997	
	Ballard	**State**	**Ballard**	**State**
Population Estimates				
Total Population	232,581	5,178,810	231,863	5,561,810
Women Ages 15-44	63,513	1,193,892	59,533	1,234,080
Women Ages 15-24	16,959	333,636	14,570	348,925
Women Ages 25-44	46,554	860,257	44,963	885,155
Number and Rate of Births				
Number of Births				
Women Ages 15-44	2,569	78,423	2,417	77,414
Women Ages 15-24	434	28,513	328	26,875
Women Ages 25-44	2,136	49,910	2,089	50,539
Birth Rates (per 1,000)				
Women Ages 15-44	40.4	65.7	40.6	62.7
Women Ages 15-24	25.6	85.5	22.5	77.0
Women Ages 25-44	45.9	58.0	46.5	57.1
Number and Rate of Abortions				
Estimated Number of Abortions				
Women Ages 15-44	1,819	27,346	1,666	26,451
Women Ages 15-24	943	14,798	778	13,439
Women Ages 25-44	876	12,548	888	13,012
Estimated Abortion Rates (per 1,000)				
Women Ages 15-44	28.6	22.9	28.0	21.4
Women Ages 15-24	55.6	44.4	53.4	38.5
Women Ages 25-44	18.8	14.6	19.8	14.7
Percent Medicaid Births				
Women Ages 15-44	23.4%	40.1%	23.6%	42.2%
Women Ages 15-24	64.7%	66.6%	71.2%	70.3%
Women Ages 25-44	15.1%	24.9%	16.1%	27.3%
Estimated Percent of Births from Unintended Pregnancy**	35%	41%	33%	37%

*1992-1993 data represent the period immediately prior to implementation of the family planning pilot programs. 1996-1997 data are the most recent available that include all categories of information. Continued monitoring of birth and abortion rates is important to track future changes.
**Estimated statewide unintended pregnancy rates were adjusted by Medicaid status at the CSO level. The adjustment assumes women with similar Medicaid status have the same rates of unintended pregnancies in every CSO throughout the state.
For sources of data and calculation methods, please see *Appendix A* .

FAMILY PLANNING AT BALLARD COMMUNITY SERVICES OFFICE

Family planning posters, brochures, and pamphlets are immediately noticeable in the Ballard CSO lobby. Condom containers are obvious on counters, in the client restrooms, and in the waiting areas. Occasionally, videos about family planning topics play in the lobby. The high visibility of family planning in this CSO reflects the strategy expressed by one respondent: *If you put it everywhere, pretty soon it becomes normal.*

The referral process of Ballard's family planning program depends upon gaining widespread CSO staff comfort and acceptance of family planning issues. As conceived at the family planning program's inception in 1995, Ballard integrates family planning into the general services of the CSO. For instance, since all pregnant clients are referred to the First Steps worker, this person also handles family planning for these clients. Similarly, since all TANF clients see a case manager, case managers are charged with informing them about family planning services. Financial workers are instructed to mention family planning services to those clients who do not necessarily see anyone else, such as food stamps clients. At initial contact, staff explain which family planning services are available to clients and in-depth information is provided through referrals to the family planning staff. Ballard's family planning staff consists of a lead family planning worker, who is also the First Steps worker, and the nurse who is contracted from the local health jurisdiction (Seattle-King County Department of Public Health) on a half-time basis.

Ballard has an active outreach program. Once a week, two Ballard CSO staff members conduct presentations, including a family planning segment, for WorkFirst applicants at the Employment Security Department (ESD). They also conduct health seminars that include family planning, at a variety of locations. Activities inside the CSO consist of a family planning booth at health and job fairs, special teas for new parents, conversations with clients waiting for other services, lobby videos on reproductive health issues, and staff family planning training breakfasts are held. Often the family planning staff pay for costs associated with these activities out of their own pockets.

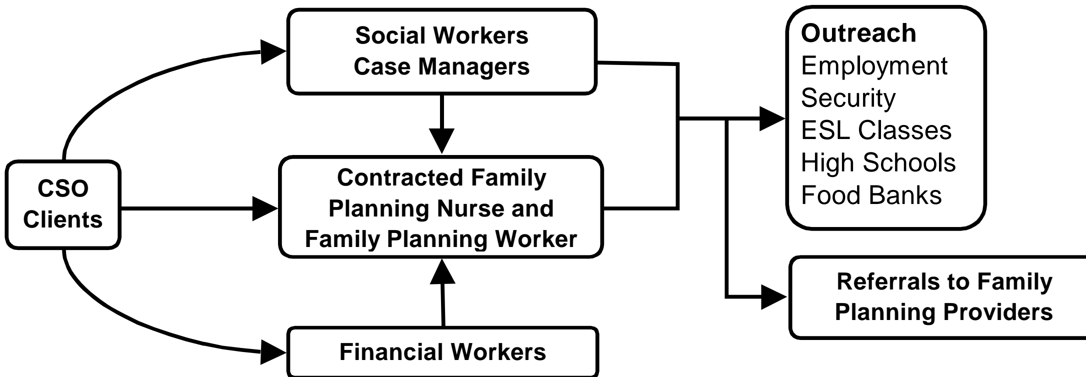
Several respondents explained that the purpose of outreach is to *maximize what's already happening to the population* by frequenting places where low-income persons gather. One respondent stressed that it is *easier to get into a group than to try to pull a group together* and that *places like food banks, some of the family centers, the Employment Security office and … ESL*[3] *classes—because many of them are taking ESL because of Work First*—offer an opportunity to contact groups who are more likely to be facing poverty. Respondents who have participated in these outreach activities mentioned that client feedback is very positive: *most of the audience is very receptive and they ask us everything … even the older gentlemen.* In order to estimate whether or not clients knew about services, one respondent conducted an informal, written survey of CSO clients: *They knew the services, so that's good because I'm seeing the trend … when I first started here nobody knew anything.*

Since Ballard is located in a resource-rich urban area, clients needing clinical medical services, such as pelvic exams or birth control prescriptions, are referred to other public and private providers. Ballard also works closely with Community Health Access Programs (CHAP), a

[3] ESL: English as a Second Language

community referral agency. Family planning services provided on site at Ballard include the following: printed information and one-to-one education (including languages other than English) on Sexually Transmitted Infections and Diseases (STIs and STDs), Human Immunodeficiency Virus (HIV), and birth control; pregnancy testing; non-prescription birth control; emergency contraception;[4] and referrals.

Ballard CSO Family Planning Program



Implementation Process

Major challenges Ballard faced during implementation focused on CSO staff and client discomfort with speaking about family planning. Because Ballard's referral structure relies on referrals from each CSO staff member with client contact, overcoming feelings of discomfort about family planning issues was paramount to the success of the program. All respondents felt that this basic issue had been met using a variety of strategies that essentially normalized the topic of family planning in the CSO.

Most respondents at Ballard felt that a majority of CSO staff were supportive of the program. Integration of family planning staff into CSO activities, however, occurred gradually. Family planning staff personally contacted each employee to emphasize the purpose and importance of the program. They also held various activities and informal discussions to help promote the program and increase acceptance. E-mails from family planning staff about new developments kept the CSO staff reminded and informed. Promotional materials, such as condom key chains, posters, T-shirts, and condom baskets, also kept focus on the program.

[4] Emergency contraception uses birth control pills taken in a high dose up to 72 hours after unprotected sex to prevent pregnancy. Special protocols enable pharmacists to prescribe Emergency Contraception Pills (ECP) directly to women in need, based on agreements between pharmacists and prescribing clinicians (Office of Population Research, 1998 and WAC 246-863-100). Further protocols enable public health nurses to dispense ECP under similar arrangements with prescribing clinicians. The state has also established a contraception hotline: 1-888-NOT-2-LATE. Callers can ask questions and learn which pharmacies in their area offer ECP.

The Washington State Project for ECP was funded by the David and Lucile Packard Foundation and was initiated by a collaboration among Program for Appropriate Technology in Health (PATH), Washington State Pharmacists Association, Washington State Board of Pharmacy, and Elgin D.D.B.

FRIDAY HARBOR COMMUNITY SERVICES OFFICE

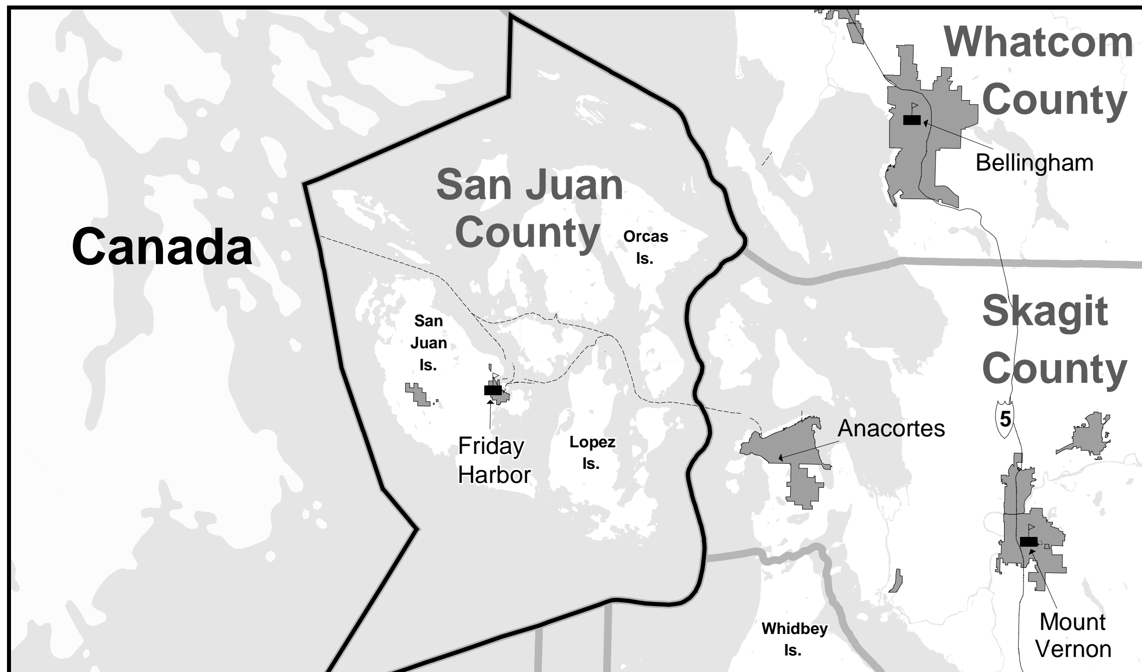
The Friday Harbor CSO serves all of San Juan County. In one month (June 1998), the Friday Harbor CSO TANF caseload was approximately 40 cases and ranked number 64 out of 65 CSOs for number of TANF cases (Research and Data Analysis, 1998). Friday Harbor is 1.5 hours by ferry from the nearest mainland point, Anacortes, Washington.

The San Juan Islands are a popular tourist destination, with the majority of local jobs in retail and services. The population of San Juan County has increased by 200% since 1970, largely due to an influx of retirees. A jarring disparity exists between the workers who rely upon wages for their income and those who receive a high level of investment income (usually retirees). Investment income constitutes an unusually high proportion (43%) of the county's total personal income (Barrier, 1995).

… demographically, this is a very interesting island. There's a lot of haves and have nots … we have a large fraction of hidden poor, and the reason for that is … there are a lot of people who want to come here. It's … beautiful, but unless you're a professional, there isn't much to do … you wait on tables. They're mostly low salaries, minimum wage, so that there are a lot of people who really need help.

Race/Ethnicity of Friday Harbor Economic Services Administration Clients (1994)

White	96%	Hispanic	2%	Native American	<1%
Black	<1%	Asian/Pacific Islander	1%	Other	1%



Friday Harbor CSO Birth Statistics, Two-Year Averages (1992-1993 & 1996-1997)*

	1992-1993		1996-1997	
	F.H.	**State**	**F.H.**	**State**
Population Estimates				
Total Population	11,020	5,178,810	11,888	5,561,810
Women Ages 15-44	2,014	1,193,892	2,049	1,234,080
Women Ages 15-24	400	333,636	491	348,925
Women Ages 25-44	1,614	860,257	1,558	885,155
Number and Rate of Births				
Number of Births				
Women Ages 15-44	107	78,423	107	77,414
Women Ages 15-24	30	28,513	18	26,875
Women Ages 25-44	77	49,910	90	50,539
Birth Rates (per 1,000)				
Women Ages 15-44	52.9	65.7	52.2	62.7
Women Ages 15-24	73.8	85.5	35.6	77.0
Women Ages 25-44	47.7	58.0	57.4	57.1
Number and Rate of Abortions				
Estimated Number of Abortions				
Women Ages 15-44	39	27,346	25	26,451
Women Ages 15-24	11	14,798	7	13,439
Women Ages 25-44	28	12,548	17	13,012
Estimated Abortion Rates (per 1,000)				
Women Ages 15-44	19.3	22.9	12.1	21.4
Women Ages 15-24	27.8	44.4	15.3	38.5
Women Ages 25-44	17.2	14.6	11.1	14.7
Percent Medicaid Births				
Women Ages 15-44	46.9%	40.1%	49.5%	42.2%
Women Ages 15-24	72.9%	66.6%	85.7%	70.3%
Women Ages 25-44	37.0%	24.9%	42.5%	27.3%
Estimated Percent of Births from Unintended Pregnancy**	42%	41%	39%	37%

*1992-1993 data represent the period immediately prior to implementation of the family planning pilot programs. 1996-1997 data are the most recent available that include all categories of information. Continued monitoring of birth and abortion rates is important to track future changes.

**Estimated statewide unintended pregnancy rates were adjusted by Medicaid status at the CSO level. The adjustment assumes women with similar Medicaid status have the same rates of unintended pregnancies in every CSO throughout the state.

For sources of data and calculation methods, please see *Appendix A* .

FAMILY PLANNING AT FRIDAY HARBOR COMMUNITY SERVICES OFFICE

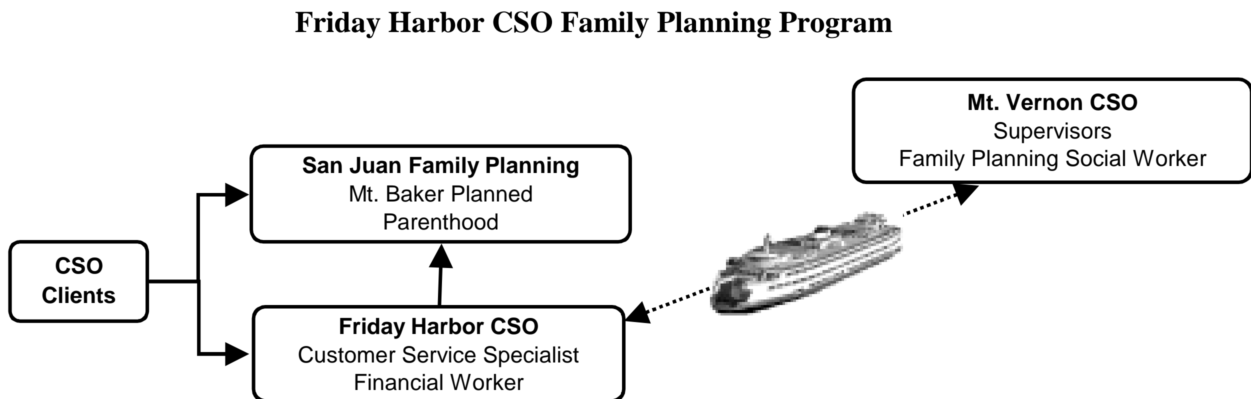
The San Juan Family Planning clinic, operated by Mt. Baker Planned Parenthood, is the heart of family planning activities in Friday Harbor. A Nurse Practitioner and bilingual (English/Spanish) receptionist staff the clinic one afternoon per week.[5] Pelvic exams, pregnancy tests, emergency birth control, and vasectomies are available, as well as testing for HIV, and testing and treatment for STIs and STDs. Pregnancy and HIV tests are also provided at the local health department, San Juan County Health and Community Services. Clients requesting tubal ligations are referred to private providers.

The CSO is inconspicuously located on a side street near the center of town. The CSO and the clinic, along with the other businesses in the building, have separate entrances. Signs are small and discreet. A connecting hallway links the CSO to the clinic. The CSO client restroom shares a wall with the clinic lab area for pass-through specimens.

Two full-time staff are stationed at the Friday Harbor CSO: a Customer Service Specialist and a Financial Services Specialist whose duties include WorkFirst orientations. A part-time social worker travels between the three main islands: San Juan, Orcas, and Lopez, resulting in one or two days per duty per island. All supervisory and clerical support staff for the Friday Harbor CSO are located at the Mt. Vernon CSO. The Mt. Vernon family planning worker is responsible for family planning activities for both San Juan and Skagit Counties. Respondents noted, however, that Island residents do not use the mainland CSO facility to meet their reproductive health needs.

The Financial Services Specialist, Customer Service Specialist, and First Steps Social Worker all refer clients to the San Juan Family Planning clinic for family planning services. The Customer Service Specialist in Friday Harbor formerly provided family planning outreach in Friday Harbor, but the job description has been redefined, excluding family planning outreach. Referrals to the family planning clinic also originate from San Juan County Health and Community Services.

Friday Harbor CSO Family Planning Program



[5] On days when San Juan Family Planning is closed, call forwarding to Mt. Baker Planned Parenthood in Bellingham allows clients to make appointments for the Friday Harbor clinic. A newly hired family planning nurse will also travel between islands to provide additional services.

History of Program

The Friday Harbor family planning program started under unusual circumstances. A remote location and a lack of affordable family planning resources created barriers to persons seeking affordable family planning on San Juan Island: *It takes all day to go the mainland, all day. Plus there's the cost—the cost of the ferry for your car, and the cost of meals. If you're going to go to family planning on the mainland you have to* [go] *clear to Mt. Vernon.*

Initially, the Department of Health was approached by an island resident to provide family planning services at Friday Harbor for the San Juan Islands, but the population of San Juan County was too small to qualify for state services. A family planning needs assessment (Campbell, 1986) was conducted and presented to Mt. Baker Planned Parenthood, who also felt that the island population was too small to support a clinic. A community member, through her involvement with a local health services advisory board, learned of the needs assessment and of San Juan County's high abortion rate. Meanwhile, a movie production company approached her about filming on her property. She and her husband agreed to allow the filming to take place if the money was donated to Planned Parenthood as seed money for a clinic in Friday Harbor.

Local action coincided with the dedication of funds by the Washington State Legislature to collocate services in CSOs: *... we did it at the right time because that's when funds were first becoming available for unintended pregnancies, and we were just ripe for it.*

The proposed clinic had to overcome resistance from the local medical community. Because of the small numbers of possible clients on the Island, local physicians were concerned that a family planning clinic on the island would threaten their client base. Concerned community members contacted groups of people they knew and garnered support for a family planning clinic. Also, Mt. Baker Planned Parenthood presented the program as being non-competitive with the private practitioners. *The medical profession saw this as offering additional services and helping them not to have to do pro bono services.*

The combination of community support, seed money raised by community advocates, Planned Parenthood investment, and state appropriations for the MAA CSO family planning project made the clinic possible. Mt. Baker Planned Parenthood opened the San Juan Family Planning clinic in October 1995. The program has not yet become self-supporting. Mt. Baker Planned Parenthood organizes fundraising to alleviate deficits.

The clinic's presence has increased access to family planning services on the Island. Respondents indicated that clinic usage has increased each year since it opened. Several respondents attribute the dramatic decrease in county abortion rates to the presence of the clinic. In 1994 San Juan County experienced the third highest abortion rate (23.1/1000 women of childbearing age, 15-44) in the state but by 1997, San Juan County's abortion rate was 25th (12.1/1000) out of 39 counties (Center for Health Statistics, 1997). A respondent summed: *MAA was right. Given the opportunity, women will manage their family size. Friday Harbor demonstrates this.*

KELSO COMMUNITY SERVICES OFFICE (CSO)

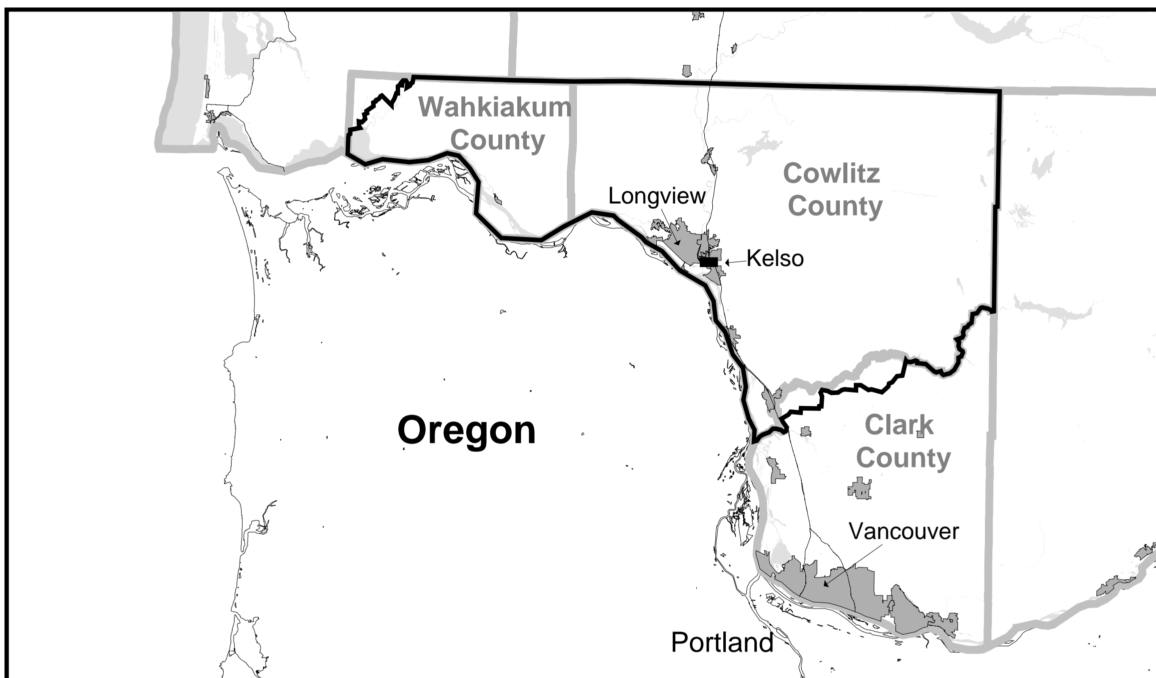
The Kelso CSO serves Cowlitz and Wahkiakum Counties. In one month (June 1998), the Kelso CSO TANF caseload was approximately 2183 cases and ranked number 12 out of 65 CSOs for number of TANF cases (Research and Data Analysis, 1998). Roughly 21% of the total population of the two counties receives some form of DSHS services. For 77.3% of Cowlitz County's population high school is the highest level of educational attainment, compared to 28.3% statewide (U.S. Census, 1990).

… it used to be that kids here could drop out of school in 8th grade, go to work at the mills making good money, and work there all their lives. In the past six or seven years, that has changed. The mills have downsized.

… now you have the historical … results of not necessarily emphasizing a lot of advanced education along with the changing job market which means you're not going to be able to get as good a job. It's not an area where people would have a lot of hope for things getting better for them.

Race/Ethnicity of Kelso Economic Services Administration Clients (1994)

White	93%	Hispanic	2%	Native American	1%
Black	1%	Asian/Pacific Islander	2%	Other	—



Kelso CSO Birth Statistics, Two-Year Averages (1992-1993 & 1996-1997)*

	1992-1993		1996-1997	
	Kelso	**State**	**Kelso**	**State**
Population Estimates				
Total Population	89,018	5,178,810	96,792	5,561,810
Women Ages 15-44	19,032	1,193,892	19,996	1,234,080
Women Ages 15-24	5,392	333,636	5,699	348,925
Women Ages 25-44	13,639	860,257	14,297	885,155
Number and Rate of Births				
Number of Births				
Women Ages 15-44	1,265	78,423	1,232	77,414
Women Ages 15-24	653	28,513	586	26,875
Women Ages 25-44	612	49,910	646	50,539
Birth Rates (per 1,000)				
Women Ages 15-44	66.4	65.7	61.6	62.7
Women Ages 15-24	121.1	85.5	102.8	77.0
Women Ages 25-44	44.8	58.0	45.1	57.1
Number and Rate of Abortions				
Estimated Number of Abortions				
Women Ages 15-44	327	27,346	268	26,451
Women Ages 15-24	195	14,798	154	13,439
Women Ages 25-44	131	12,548	114	13,012
Estimated Abortion Rates (per 1,000)				
Women Ages 15-44	17.2	22.9	13.4	21.4
Women Ages 15-24	36.2	44.4	26.9	38.5
Women Ages 25-44	9.6	14.6	8.0	14.7
Percent Medicaid Births				
Women Ages 15-44	49.7%	40.1%	50.1%	42.2%
Women Ages 15-24	67.2%	66.6%	68.1%	70.3%
Women Ages 25-44	31.2%	24.9%	33.8%	27.3%
Estimated Percent of Births from Unintended Pregnancy**	45%	41%	41%	37%

*1992-1993 data represent the period immediately prior to implementation of the family planning pilot programs. 1996-1997 data are the most recent available that include all categories of information. Continued monitoring of birth and abortion rates is important to track future changes.
**Estimated statewide unintended pregnancy rates were adjusted by Medicaid status at the CSO level. The adjustment assumes women with similar Medicaid status have the same rates of unintended pregnancies in every CSO throughout the state.
For sources of data and calculation methods, please see *Appendix A* .

FAMILY PLANNING AT KELSO COMMUNITY SERVICES OFFICE

Kelso's family planning program began in 1992 as a pilot site for the Family Planning Project. The original pilot program, funded for nine months, included a Registered Nurse, and three full-time Community Workers supervised by a Community Resource Program Manager (CRPM) dedicated to family planning. The program has been reduced over time and currently employs one full-time Community Worker for family planning. Despite turnover at all staffing levels in the CSO and the family planning agency, the program has continued to be active in integrating family planning into CSO activities.

Family planning and STI/STD information and a basket of condoms are immediately visible on a counter next to the reception desk in the CSO lobby. Opposite the reception desk is the contracted family planning nurse's office. A table with coloring books and crayons inside the nurse's office attracts children, providing the nurse with an opportunity to talk with parents who follow their children into the office. The nurse's consultation area is screened from the coloring area by a divider.

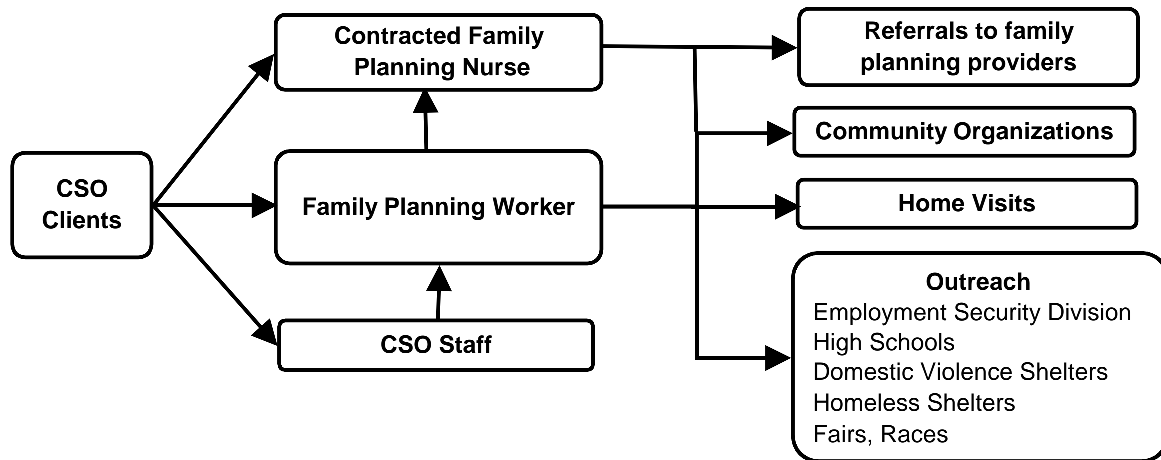
At the time of this study, Kelso's family planning program was in transition: the family planning contracted nurse would usually be a central component of the program, but the position was vacant. Since that visit, the position has been filled. The family planning nurse provides staff training, family planning information and counseling, domestic violence referrals, pregnancy and STD testing and counseling; and also supplies emergency contraception, birth control pills, and Depo Provera shots on site at the CSO, by standing order (as provided in WAC 146-863-100).

Several respondents stated that many CSO clients have transportation problems or are uncomfortable coming into the CSO. Efforts to get clients to attend family planning events at the CSO were not successful. To make family planning more convenient and comfortable for clients, the family planning worker makes home visits for about 30 clients per week. In addition, a flier in the application packet for all DSHS clients explains what family planning services Medicaid ID cards cover and includes the phone number for the family planning worker. Because CSO staff have many responsibilities, internal referrals for family planning are informal: financial workers give the family planning worker a copy of an in-house First Steps eligibility form, send her an e-mail, or leave her a note. The family planning worker follows-up with a letter to clients, informing them of her intention to visit. Informants said that HIV is a major concern in the Longview/Kelso area, so this letter emphasizes that the family planning worker will have information about preventing HIV infection.

The family planning worker teaches family planning workshops as part of WorkFirst trainings at the Employment Security Department and organizes monthly or quarterly Healthy Options[6] health fairs in the CSO lobby. The fairs include a family planning booth and general health information. Representatives from various agencies such as the Housing Authority also participate.

[6] Washington's Medicaid managed care program, administered by the Department of Social and Health Services, Medical Assistance Administration.

Kelso CSO Family Planning Program



Outreach

Kelso's program emphasizes outreach and community linkages. The family planning staff's intensive involvement with local service organizations in Longview, Kelso, and nearby communities has integrated them with other social service community members. This integration has allowed the family planning staff to pursue educational outreach efforts with greater support.

The majority of respondents mentioned the importance of hiring family planning staff with the right characteristics for the job—especially given Kelso's extensive outreach efforts. Among the qualities mentioned were an outgoing personality, ease with sexuality issues, and empathy for low-income clients.

The Kelso CSO and Cowlitz Family Health Center run a health information/family planning booth at local events, including the Cowlitz County Fair and the Cow Chip Boogie,[7] to distribute family planning literature and supplies, such as condoms and the Safer-Sex-To-Go-Kit. Non-family planning CSO staff have helped at these events for four years. Because of the extra hours required for outreach activities and a high level of involvement with community agencies, the family planning staff is allowed to structure their work hours around after-hours job demands.

The family planning staff provides sexuality education for area high schools, except for the Longview schools. The CSO staff continues to work with the Longview school board and principals in other capacities. During the summer, the family planning worker visits the Youth at Risk program teen room.[8] She teaches a class on STDs and birth control methods. The family planning worker provides educational outreach at the homeless shelter and teaches two family planning classes per month at the domestic violence shelter. She also teaches family planning at monthly safety meetings for three of the community's major employers: *... because she is out there and visible, she's received requests from large employers in the area to come*

[7] The Cow Chip Boogie is a nationally attended motorcycle race.
[8] Youth at Risk is an activities program of the Longview/Kelso schools.

and talk to their staff about it [family planning]. Respondents said that the level of interest is high—workers ask numerous questions.

A few respondents reported that, despite large community concerns about HIV, community leaders were reluctant to talk publicly about sexuality issues. These respondents felt that state-led campaigns, which might help HIV and family planning become more acceptable topics of conversation, are unavailable in the Longview/Kelso area. To address this problem, family planning staff have obtained state promotional materials and distributed them locally.

A few respondents also mentioned that a small, nearby community is fiercely independent and dislikes advice from outsiders. Access for people in remote locations has been enhanced by the CSO family planning staff identifying receptive community workers within that community: *Let them know that we're here. Find out the places that are receptive to us and make sure that they're aware of the services we provide and then that community can do their own kind of linkage with us. Because their locals and they can make inroads where we can't coming from over here.*

PORT TOWNSEND COMMUNITY SERVICES OFFICE (CSO)

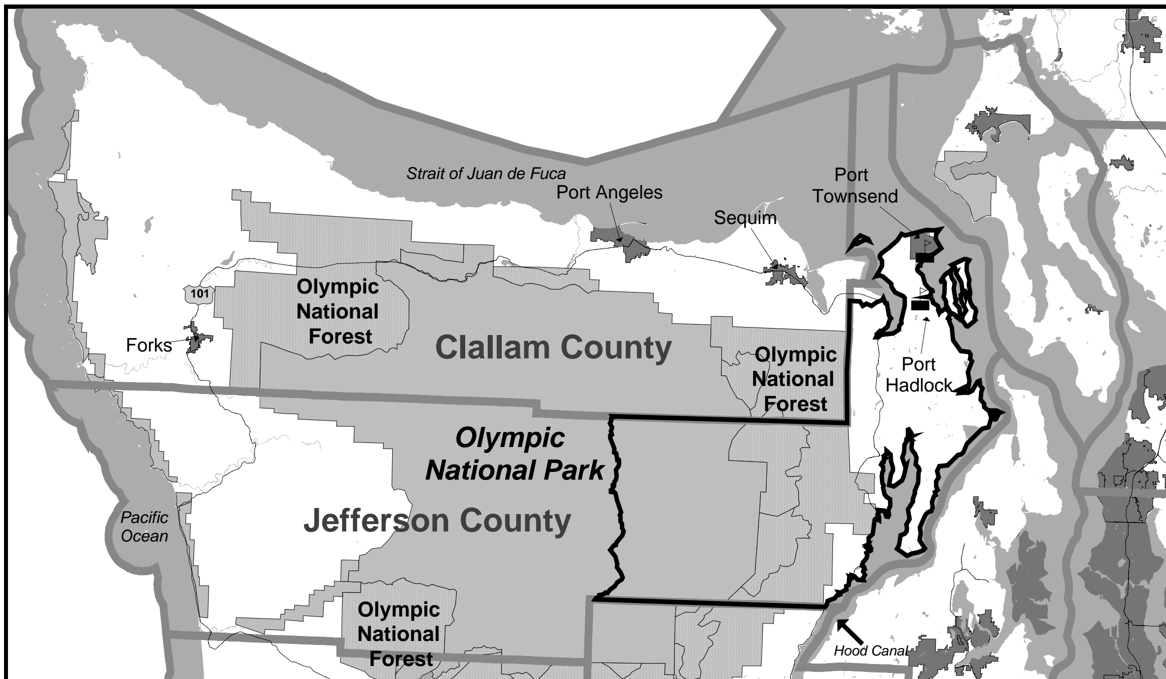
Port Townsend is one of three CSOs serving Jefferson County. The service catchment area of Port Townsend Community Services Office (CSO) is east Jefferson County, where 98% of the county's population resides. In one month (June 1998), the Port Townsend CSO TANF caseload was approximately 300 cases and ranked number 52 out of 65 CSOs for number of TANF cases (Research and Data Analysis, 1998).

Jefferson County has a small population of about 25,700 people. The Port Townsend Paper Corporation is the single largest employer in the county. Port Townsend is one of only three Victorian seaports on the National Historic Register and attracts many tourists to its historic waterfront.

It's a pretty eclectic community. ... I think people like living in this community for a variety of reasons. They're attracted by the community itself, and the size of the community, the location, just to the art—there's a lot of artistic things going on.

Race/Ethnicity of Port Townsend Economic Services Administration Clients (1994)

White	97%	Hispanic	1%	Native American	1%
Black	1%	Asian/Pacific Islander	<1%	Other	<1%



Port Townsend CSO Birth Statistics, Two-Year Averages (1992-1993 & 1996-1997)*

	1992-1993		1996-1997	
	P.T.	**State**	**P.T.**	**State**
Population Estimates				
Total Population	21,476	5,178,810	24,260	5,561,810
Women Ages 15-44	3,940	1,193,892	4,309	1,234,080
Women Ages 15-24	935	333,636	1,143	348,925
Women Ages 25-44	3,004	860,257	3,166	885,155
Number and Rate of Births				
Number of Births				
Women Ages 15-44	207	78,423	192	77,414
Women Ages 15-24	81	28,513	70	26,875
Women Ages 25-44	127	49,910	123	50,539
Birth Rates (per 1,000)				
Women Ages 15-44	52.5	65.7	44.6	62.7
Women Ages 15-24	86.1	85.5	60.8	77.0
Women Ages 25-44	42.1	58.0	38.7	57.1
Number and Rate of Abortions				
Estimated Number of Abortions				
Women Ages 15-44	47	27,346	75	26,451
Women Ages 15-24	26	14,798	32	13,439
Women Ages 25-44	21	12,548	43	13,012
Estimated Abortion Rates (per 1,000)				
Women Ages 15-44	11.8	22.9	17.3	21.4
Women Ages 15-24	27.8	44.4	27.9	38.5
Women Ages 25-44	6.8	14.6	13.5	14.7
Percent Medicaid Births				
Women Ages 15-44	57.2%	40.1%	59.4%	42.2%
Women Ages 15-24	82.6%	66.6%	82.0%	70.3%
Women Ages 25-44	41.1%	24.9%	46.5%	27.3%
Estimated Percent of Births from Unintended Pregnancy**	46%	41%	43%	37%

*1992-1993 data represent the period immediately prior to implementation of the family planning pilot programs. 1996-1997 data are the most recent available that include all categories of information. Continued monitoring of birth and abortion rates is important to track future changes.
**Estimated statewide unintended pregnancy rates were adjusted by Medicaid status at the CSO level. The adjustment assumes women with similar Medicaid status have the same rates of unintended pregnancies in every CSO throughout the state.
For sources of data and calculation methods, please see *Appendix A* .

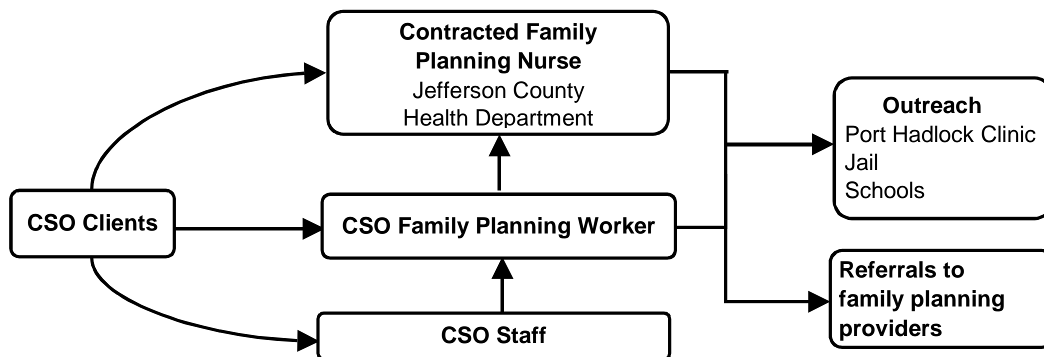
FAMILY PLANNING AT PORT TOWNSEND CSO

The proximity of the Jefferson County Health Department's (JCHD) family planning clinic to the CSO and the collaborative relationship between the CSO and JCHD staff form the basis of Port Townsend's family planning program. Port Townsend CSO shares a parking lot with the JCHD clinic and focuses on ways to compliment the JCHD family planning program. CSO family planning staff refer their clients to the contracted nurse located at JCHD as well as to other providers. In addition, they operate a number of outreach programs in collaboration with JCHD staff.

At the inception of the CSO family planning program in 1995, CSO family planning staff conducted frequent onsite family planning education seminars for CSO clients using plastic models to demonstrate contraceptive methods, but these seminars occur less frequently now due to time limitations. Social workers provide family planning information in WorkFirst orientations. Flyers explaining Medicaid services are on display in the lobby and condom containers are located in the lobby and restrooms. The family planning staff at Port Townsend CSO consists of two social workers who work total of 20 hours per week in CSO family planning.

The referral system for family planning in this small CSO (20 staff) is informal, although formal referral slips do exist. Financial workers operate as case managers and talk to the two family planning workers about clients who may need services.

Port Townsend's Family Planning Program



Outreach

Given the large scope of services provided by the JCHD clinic, the CSO and JCHD family planning staff work closely to maximize client resources without overlapping services. CSO family planning activities include outreach to the local jail and the Port Hadlock weekly satellite clinic. CSO and JCHD staff also work together on the GRADS (Graduation, Reality and Dual-Role Skills) program—a high school graduation program for parenting or pregnant teens.[9] In addition, JCHD staff conduct sexuality education in schools, and in collaboration with the CSO

[9] The GRADS program is administered through the Office of the Superintendent of Public Instruction, Secondary Education and Career Preparation, Family and Consumer Sciences Education. The program originated in the Ohio Department of Education, Division of Vocational and Adult Education.

staff, hold pizza party lunches in the high schools to distribute literature and conduct outreach for teen centers in the community.

- **The Jail Program: *Safe Mates***

Every other week, the lead family planning CSO social worker and a nurse practitioner from JCHD hold family planning seminars at the Jefferson County Jail. All birth control methods are discussed and demonstrated on plastic models; HIV and Hepatitis C tests are performed. A significant portion of the seminar is dedicated to questions and answers. Private consultation is also offered. Respondents stressed that the jail program reaches both inmates and their families who are or are likely to become CSO clients.

- **The Port Hadlock Satellite Clinic**

Family planning staff from JCHD and the CSO initially conceived the Port Hadlock satellite clinic as a teen clinic. Family planning staff felt that Port Townsend teens would feel more comfortable going to a more confidential location outside of their small community. Staff chose Port Hadlock because it is about 10 miles south of Port Townsend and is a convenient location for clients in the southern portion of the county. The clinic provides family planning education, counseling, birth control, pelvic exams, and HIV/STD/STI counseling and screening one afternoon a week.

All respondents who worked with the teen population reported success in developing a trusting relationship with the teen clientele: *... they know that they can talk to us. I also think they trust us ... because their friends did and their friends say ... "You need to go there ... This is the care I got."* As teens began to bring their older friends and relatives, the clinic expanded to include those clients from any age bracket.

Currently the clinic is located in the office of the local newspaper in a room donated by the Chamber of Commerce. The newspaper office is closed when the clinic is in operation. Respondents who staff the clinic stressed that community support was essential in establishing the clinic: *... this community really cares about our being here. And they realize the value of that location in terms of it's close to the drug store, it's ... pretty much centrally located in town. ... and if you have the community value what you're doing, then you can do some really neat things.*

In addition to high quality clinical services, a majority of respondents mentioned either the jail or teen outreach activity as highlights of the family planning program.

All of the respondents mentioned the strength of the collaborative relationship between JCHD and the CSO. One respondent summed the general feeling: *... we're really lucky .... We have a good collaborative relationship on a lot of levels ... we share interests—Maternity Support, First Steps—we are always trying to look for ways to help our clients and their lives .... I think we have common goals and also we're a small community. We know each other, we trust each other. We don't have turf wars ... I mean, part of it has to be that we have all had integrity in our dealings with each other.*

SPOKANE NORTH COMMUNITY SERVICES OFFICE

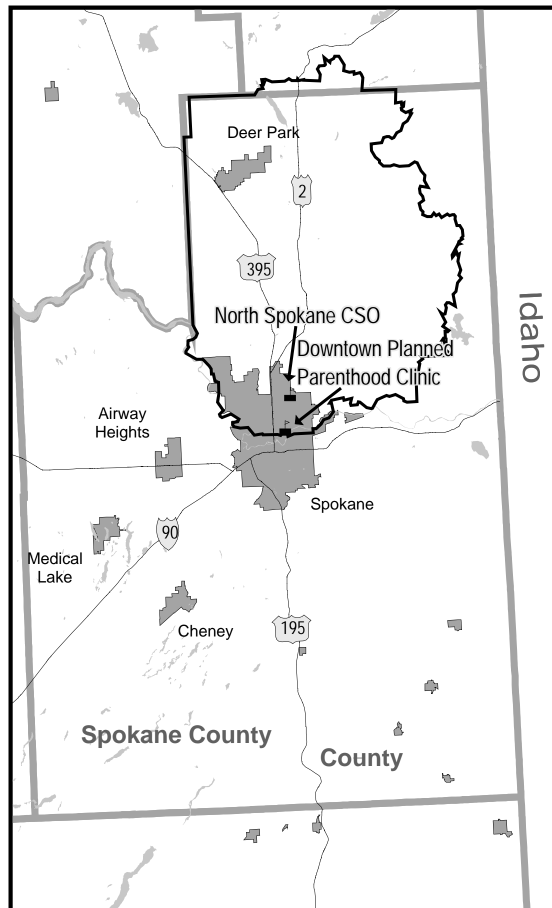
Spokane North Community Services Office (CSO) is one of three CSOs serving Spokane County and is the largest CSO participating in this study with over 100 employees. In one month (June 1998), the Spokane North CSO TANF caseload was approximately 2922 cases and ranked number 4 out of 65 CSOs for number of TANF cases (Research and Data Analysis, 1998).

Spokane County is sometimes called the capital of the inland Northwest. As the only metropolitan area in the region, it serves an important role as the retail trade and services hub for much of the region, which also includes Idaho, western Montana, southeastern British Columbia and parts of Alberta (Barrier, 1995).

Spokane doesn't accept anything new and innovative very easily. And if it is new and different, well then there's something wrong with it.

Race/Ethnicity of Spokane North Economic Services Administration Clients (1994)

White	88%	Hispanic	2%	Native American	3%
Black	2%	Asian/Pacific Islander	3%	Other	2%



Spokane North CSO Birth Statistics, Two-Year Averages (1992-1993 & 1996-1997)*

	1992-1993		1996-1997	
	Spokane N.	**State**	**Spokane N.**	**State**
Population Estimates				
Total Population	158,247	5,178,810	170,822	5,561,810
Women Ages 15-44	36,125	1,193,892	38,087	1,234,080
Women Ages 15-24	10,899	333,636	11,800	348,925
Women Ages 25-44	25,227	860,257	26,287	885,155
Number and Rate of Births				
Number of Births				
Women Ages 15-44	2,295	78,423	2,340	77,414
Women Ages 15-24	990	28,513	919	26,875
Women Ages 25-44	1,305	49,910	1,421	50,539
Birth Rates (per 1,000)				
Women Ages 15-44	63.5	65.7	61.4	62.7
Women Ages 15-24	90.8	85.5	77.9	77.0
Women Ages 25-44	51.7	58.0	54.1	57.1
Number and Rate of Abortions				
Estimated Number of Abortions				
Women Ages 15-44	715	27,346	621	26,451
Women Ages 15-24	427	14,798	359	13,439
Women Ages 25-44	289	12,548	262	13,012
Estimated Abortion Rates (per 1,000)				
Women Ages 15-44	19.8	22.9	16.3	21.4
Women Ages 15-24	39.1	44.4	30.4	38.5
Women Ages 25-44	11.4	14.6	10.0	14.7
Percent Medicaid Births				
Women Ages 15-44	48.0%	40.1%	47.6%	42.2%
Women Ages 15-24	70.1%	66.6%	73.2%	70.3%
Women Ages 25-44	31.2%	24.9%	31.0%	27.3%
Estimated Percent of Births from Unintended Pregnancy**	44%	41%	40%	37%

*1992-1993 data represent the period immediately prior to implementation of the family planning pilot programs. 1996-1997 data are the most recent available that include all categories of information. Continued monitoring of birth and abortion rates is important to track future changes.
**Estimated statewide unintended pregnancy rates were adjusted by Medicaid status at the CSO level. The adjustment assumes women with similar Medicaid status have the same rates of unintended pregnancies in every CSO throughout the state.
For sources of data and calculation methods, please see *Appendix A* .

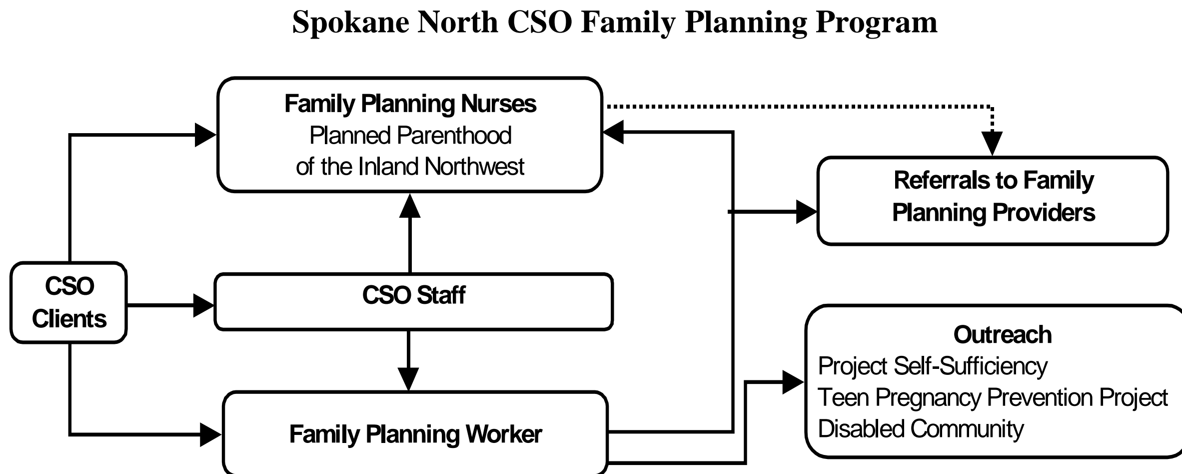
FAMILY PLANNING AT SPOKANE NORTH COMMUNITY SERVICES OFFICE

In 1994 Spokane North opened the first CSO-based family planning clinic with exam facilities in Washington State. A number of respondents expressed pride in the establishment of the program, especially given the challenges it faced during implementation.

Planned Parenthood of the Inland Northwest administers and staffs the clinic with a Nurse Practitioner three days a week and a Licensed Practical Nurse (LPN) five days a week. The clinic is small, with two exam rooms, a counseling room, and a reception/work space. A locked door separates the clinic from the CSO main lobby. All clients sign in at the CSO reception desk and wait for their names to be called.

A full-time family planning social worker facilitates the family planning component of WorkFirst orientations and provides training for CSO staff, with clinic staff serving as family planning educators. The family planning worker provides resources and outreach for non-pregnant women and teen parents through multiple community organizations and participates in the Women's Resource Council, a consortium of representatives from local service agencies. [She does*] outreach activities with health fairs, the community college classes … networking with other community resources and programs like the Teen Pregnancy Prevention Program, Health Education Program, and also got involved in bringing Family Planning information to the disabled community here.*

Spokane North CSO Family Planning Program



Posters, displayed in local tuxedo-rental dressing rooms, heighten male awareness and encourage responsibility for preventing unintended pregnancies. In the CSO, condoms in humorous seasonal folders are found by the reception desk and in other strategic locations. Posters designed by the family planning staff are on display in the CSO lobby, interview rooms, and client restrooms. These posters explain that Medicaid benefits include family planning. Referrals to the clinic from CSO staff are informal and usually by way of personal introduction. Referrals also originate from outside agencies including the downtown Planned Parenthood clinic.

Implementation Process

Without exception, respondents identified challenges to the establishment and continuance of the family planning program based on the controversy surrounding a perceived relationship between family planning and abortion. Several respondents noted that the community of Spokane was generally politically conservative: *if you know anything about Spokane, it is a conservative community even though it has a very large low-income population*.

Anti-abortion sentiment in Spokane has affected CSO staff and clients alike, fostering reluctance, fear, and overt opposition to the provision of family planning services at the CSO. Respondents noted that staff who had misgivings about family planning were reluctant to discuss family planning with clients or make referrals to the CSO family planning clinic.

Respondents reported that CSO management has stressed providing clients with information about family planning services as a job responsibility of CSO staff. Emphasizing that family planning prevents abortions and not advertising the CSO-based clinic's relationship with Planned Parenthood have been key to helping CSO staff overcome concerns about providing family planning services on site at the CSO: *... it went over fairly well.* [It] *was really kept low-key. It wasn't in-your-face ... and we made it very clear that it was family planning and didn't have anything to do with the abortion question, whatever.* Contact with the clinic staff has also helped increase staff comfort with the onsite clinic.

A generally positive relationship exists between CSO and clinic staff and referrals from the CSO staff to the clinic have increased over time. When respondents described challenges the family planning program continues to face, staff reluctance or ambivalence toward the program was the challenge most frequently mentioned. Family planning staff hope to further support and enthusiasm for the program with the recent (1999) hiring of an LPN, whose primary role is to enhance relationships with CSO staff by increasing contact between clinic staff and CSO staff and by furnishing continuous training for CSO staff.

All respondents felt that most CSO staff embraced the program and the presence of the clinic. The majority of respondents felt the success and acceptance of the program could be attributed to the high quality clinical services available and the skills, professionalism, and approachability of the family planning staff.

Respondents at Spokane North felt overall that the family planning program was a positive addition to the CSO's offerings. Responses suggest that participants believe that, in order to provide effective family planning services in a conservative community, efforts must be sensitive and appropriate for staff, clients, and the community at large.

CHALLENGES AND STRATEGIES

Throughout the development and implementation of the family planning programs described above, CSO staff and family planning nurses who contributed to this report faced an array of challenges. Most sites have experienced or continue to experience challenges in getting staff to accept and support the CSO-based family planning program. All sites have had to employ creative methods to overcome barriers to clients' receiving services, such as lack of transportation or discomfort with family planning topics. Finally, most sites have faced challenges, in various forms, to gaining acceptance in their community or cooperation from other community agencies or groups. Each site has found ways of meeting or of overcoming those challenges: strategies for providing family planning services to a broad variety of people across a range of situations. These strategies are the focus of this section.

In addition to strategies that address specific challenges (discussed below) respondents shared ideas for integrating family planning into CSO activities, for promoting family planning inside the CSO and in the community, and for making family planning services more accessible to clients. Presented in the following tables, these ideas are divided into three categories: onsite CSO activities, promotional or informational items, and extra services. While respondents reported that these ideas had worked well for them, not all ideas and strategies mentioned in this section are appropriate for every site.

ONSITE CSO ACTIVITIES

Ideas	Details	CSO[10]
Staff retreat	Administrators organized a team-building retreat for all CSO employees. This improved relationships and created a sense of ownership toward CSO programs, including family planning.	PT
Personal introductions	CSO staff are encouraged to introduce clients directly to family planning clinic staff.	S
Referral contest	Staff competition for largest number of family planning referrals—the prize: free lunch at a popular restaurant.	B
"Mom and Me" Teas	An invitation to new mothers offering treats, featured speakers on various topics of interest, and a chance to meet other new mothers: *you have to have something that's of interest to them. We don't say "We're going to tell you about family planning," because we feel that they might not want to hear it and therefore won't come.* Family planning is last in the program.	B
All-staff breakfast	Personal invitations were sent *to each staff member … saying, "You're welcome to join us for a free continental breakfast."* Staff discussed family planning concerns.	B

[10] B = Ballard, FH = Friday Harbor, K = Kelso, PT = Port Townsend, S = Spokane North

PROMOTIONAL OR INFORMATIONAL ITEMS

Ideas	Details	CSO[11]
Condom key chains	Use giveaways as incentives for clients and staff.	B,K, S
Family planning fliers	Fliers were mailed that said, *We have public health nurses that work at the DSHS office and we're available to share with you information about women's health issues, birth control, parenting…*	B
Safer-sex-on-the-beach drinks	Non-alcoholic version of popular drink—local bar now sells alcoholic version by this name, with a colorful condom (in the wrapper) floating on top. [12]	K
Safer-sex-to-go kit	To-go box containing condoms, lubricant, moist towlettes, breath mints, and family planning information	K
Poster at tuxedo shops	Male responsibility posters and family planning information in tuxedo rental dressing rooms. Posters highlight child support costs and read *"How much is this prom going to cost you?"*	S
Staff-designed posters	Attractive posters that explain eligibility requirements for family planning benefits displayed around the CSO, in the lobby, in client restrooms	S
Brown paper bags	Brown bags for clinic visitors, also available at CSO reception—include male and female condoms, lubricant, and family planning information.	S
Condom packages	Condoms are displayed in colorful packaging with seasonal slogans, produced by the family planning staff.	S
Provider newsletter	Brief newsletter with updates on services and changes	PT
Tupperware-style party	*We had* [a Loving Promises lingerie representative] *in and we invited a whole bunch of clients … we did door prizes and gave away …* [family planning] *goodies.*	K*
Gift certificates	Incentives for clients to keep family planning appointments—local businesses were solicited for donated items, such as tanning sessions.	K*
Pizza Party lunches	Held at high schools, staff use these parties as an opportunity to distribute family planning literature and do outreach for teen centers in the community.	PT

[11] B = Ballard, FH = Friday Harbor, K = Kelso, PT = Port Townsend, S = Spokane North
[12] Condoms supplied by Cowlitz Family Health Center.
*Starred ideas were part of the pilot project only; current levels of funding preclude their ongoing use.

TIPS AND EXTRA SERVICES

Ideas	Details	CSO
Hospital visits	[We] *go and see them, let them know what we do, give them a packet of goodies, and information to read, because, when the baby's born, that's when most women are REALLY ready for birth control…*	K
Transit tokens	Free transit tokens are available when clients need them.	B
Free due date estimates	Women need a doctor-estimated due date to qualify for First Steps, but many women cannot afford a doctor's visit without financial aid from First Steps, so arrangements were made for free doctor-estimated due dates at a nearby hospital.	B
Color-coded filing	Clients are given a color code by their first name because last names change more often than first names. Within each color alphabetical tabs are arranged by last name.	FH
Contraceptives by mail	Mt. Baker Planned Parenthood mails contraceptives to clients in isolated rural areas.	FH
Reality education	Use "Baby Think it Over" dolls which simulate a baby's habits to educate teens about parenting infants.	B,K, S
Cuddly alternatives	Tell teens: *"Oh, puppies are really nice too, warm and cuddly."*	K

Challenges and Strategies Relating to CSO Staff, CSO Clients, and Community

This section addresses integrating family planning into CSO staff activities, delivering family planning information and services to CSO clients, and gaining community acceptance of and cooperation with the CSO-based family planning program. At the beginning of each section, a table summarizes challenges faced by most of the five CSOs and the strategies used to address them. Following the table is a more detailed discussion of the challenges and strategies.

I. CSO STAFF CHALLENGES AND STRATEGIES

Challenges	Strategies to Respond to Challenges
A. Some CSO staff were apprehensive about providing family planning information and services at the Community 4Services Offices.	**1. Education and Training** CSO leadership and family planning staff emphasized that the other CSO staff did not have to discuss individual family planning issues with clients; the goal is to let clients know that these services are available and to refer interested clients to family planning staff. Leadership provided a forum for staff to discuss family planning concerns and provided updates on family planning activities. **2. Leadership** CSO leadership emphasized the importance of family planning in helping clients become self-sufficient and stressed staff's professional responsibility. **3. Integration of program and staff into the CSO** Family planning staff approached staff individually in a non-confrontational manner, increased the presence of family planning in CSO, worked to increase partnership with CSO staff, involved CSO staff in family planning activities, and provided promotional items and incentives.
B. CSO staff do not always have time for family planning.	**1. Streamline referral process.** **2. Family planning workers give CSO staff feedback.**
C. CSO-based family planning work requires personnel with special characteristics.	**1. Have candidates demonstrate ability to discuss sensitive personal issues or willingness to learn to do so.** **2. Consider hiring clients or former clients as Community Workers.**

CHALLENGE A: SOME CSO STAFF WERE APPREHENSIVE ABOUT PROVIDING FAMILY PLANNING SERVICES AT THE CSOS.

The frustrating thing for me is … people not being able to separate themselves from the concept. You know, family planning is so personal … it's hard to get people over that mind-set, "I AM FAMILY PLANNING."… No. Family planning is a tool. Like we use shovels to dig holes … it's something that could help somebody…. This is the hardest thing … to get people to realize family planning is not about you— it's not about what you do believe, if you don't believe— … it's about a program and guidelines and rules …

Respondents spoke at length about the complexity of this challenge. The notable exception was that Friday Harbor respondents did not raise challenges and strategies relating to CSO staff, as their CSO is a branch office with a small staff (2 full-time employees) with no designated family planning worker.

Respondents from the four other sites felt that CSO staff acceptance was multifaceted: 1) some CSO staff members are opposed to family planning; 2) some CSO staff are not opposed to family planning, but are *just very uncomfortable talking about family planning*; and 3) some CSO staff members feel that the CSO is not the place for family planning services.

Ramifications of this challenge included clients not consistently receiving information about family planning services, some CSO staff not making referrals, and family planning staff sometimes feeling disenfranchised from the rest of the CSO. Respondents from four sites suggested the following strategies.

1. Education and training

> [It was very effective] *to provide training to our staff, and I'm talking about not just to social workers but to financial and to clerical staff. Everybody from the front counter all the way through the whole office structure.*
>
> [The family planning staff] *has done a lot to educate the rest of the employees about the value of family planning and the processes that we're using. Also … some of the philosophical issues around family planning get discussed so that we have a chance to deal with people's reluctance in that area in some cases.*
>
> *… we … want to reduce their discomfort level by educating them about family planning in general so that they can feel ok about referring people, even though they don't feel comfortable talking about sex.*

Respondents across sites identified the following educational approaches as the ones that they had found most useful:

- CSO-wide all-staff trainings provided a forum where the CSO staff could voice their concerns about providing family planning in the CSO, and get updated information from the family planning staff.
- Family planning staff emphasized that other CSO staff did not have to discuss individual family planning issues with clients; the goal is to let clients know that these services are available and to refer interested clients to family planning staff.

Family planning staff gave CSO staff tools to raise the issue.

We give them a dialogue, not a script that they're going to whip out and read or something. Just let them know, "Here's all you need to say."

Maybe a little checklist…That certainly reminds them to talk about this and I think tools are always a help.

Several respondents mentioned the need for a checklist of items that CSO staff should discuss with each client during the application process, including Medicaid family planning coverage. One opening line that was suggested was asking clients about whether their general health needs are being met, and explaining what family planning services the Medicaid I.D. card covers. Some respondents suggested discussing family planning while self-sufficiency and childcare are being discussed. Ballard family planning staff have created brochures that explain Medicaid family planning coverage and include free samples of birth control products that can be given to clients as a way to introduce family planning.

2. Leadership

Respondents from sites that spoke about leadership (all but Friday Harbor) stressed that the support of the CSO management was necessary to create a positive environment for family planning. Two major points surfaced:

- CSO management emphasized the importance of family planning in helping clients become self-sufficient.

  … The important thing probably is to really say, "This is our job. This is part of what we do." … It really made sense. … How do you help people become self-sufficient? … Obviously another child … is not going to help somebody move on to self-sufficiency.…

- CSO management stressed staff's professional responsibility.

  … get staff to understand why it's important to do … "[It is] *an integral part of your job because you provide eligibility for medical assistance, you provide information about programs that are available … it's not your issue … there is a law that we are providing information about what is available."*

3. Integration of family planning program and staff into the CSO

Ballard's family planning staff found it useful to build personal relationships with the CSO staff by asking about any health concerns the staff might have. Family planning workers approached training sessions by addressing the job-related health concerns of the staff first. Between this personal approach, the training sessions, and the emphasis from leadership, CSO staff gradually began to feel more comfortable about the program and its staff. Family planning workers in Port Townsend, a small CSO, focused on personal contact with all of the CSO staff. In Spokane, family planning staff conducted tours of the clinic to raise awareness of its presence. Kelso and Ballard stressed including CSO staff in family planning activities. Approaches can be summed with these points:

- Family planning staff approached staff individually in non-confrontational manner.
- Family planning staff, contracted family planning nurses, and supervisors increased the presence of family planning information and supplies in the CSO.

... you can't walk in here without ... [family planning materials] *... catching your eye.*

... we've got posters and things plastered all over the building. And condoms in baskets everywhere you look.... We fill up those baskets and we fill up the things in the bathrooms every day, sometimes twice a day, so I'm hoping they are being used.

- Family planning staff involved CSO staff in family planning activities.

  [The family planning worker] *... has incorporated other staff persons wherever possible. Having staff people volunteer to do that on their own time has really been pivotal to making them all more aware and comfortable ... after you've done it a couple of times, it's a whole different thing. And I think there's just some ownership about what's going on.*

- Family planning staff worked to increase partnership with CSO staff.

  The [family planning staff] *spent a ... lot of time in the lunchroom allowing staff to get to know* [them]. *I think when people got to know* [the family planning staff] *a little bit there was a "try" level that began to rise in the office. And that helped the situation quite a bit.*

- Family planning staff provided promotional items and incentives.

  [We] *need* [CSO staff] *and ... their referrals ... so* [we] *go into the unit meetings and take goodies, fruit or muffins or something. Food works well for this group. If* [we] *feed them* [we] *can get just about anything....*

CHALLENGE B: CSO STAFF DO NOT ALWAYS HAVE TIME FOR FAMILY PLANNING.

Several respondents stated that family planning is not always a priority for busy CSO workers—especially if it means more work: *... they're overwhelmed and unable to get stuff done.* Most sites mentioned getting referrals from other CSO staff as a challenge. Making referrals easy and rewarding were successful strategies.

1. Streamline the referral process.

Respondents in Spokane North noted that having an onsite clinic allows CSO staff to walk clients directly to the clinic, rather than refer them. The approach of Kelso's family planning staff is to streamline the referral process by accepting sticky notes, e-mails, or any other form of communication from CSO staff.

2. Family planning workers give CSO staff feedback.

Positive feedback about referrals was cited as an important motivator in Kelso and Port Townsend: *You know if a worker said "Hey, I've got somebody," they would stop and take the information or whatever they needed to do to make it easy for that worker ... that and feeding it back, letting them know that they did something, ... was the most important thing they could do. Because then there was a personal part ...*

CHALLENGE C: CSO-BASED FAMILY PLANNING WORK REQUIRES PERSONNEL WITH SPECIAL CHARACTERISTICS.

Many respondents mentioned that family planning workers must be comfortable discussing sexuality, have good rapport with clients, and be *outgoing*, *flexible*, and *creative*. They also must be knowledgeable about all family planning methods.

1. **Have family planning staff candidates demonstrate ability to discuss sensitive personal issues and willingness to learn.**

   And, not everybody can do this kind of work; not everybody can talk to people matter-of-factly. I wrote all the people who applied a letter and explained to them what the project was about. I also said that as part of the interview I wanted them to give me a demonstration and lecture on how to use condoms and why I should use condoms … it was very obvious then who could do it and who couldn't.

2. **Consider hiring clients or former clients as Community Workers.**

   Some respondents mentioned that clients or former clients can be more effective communicators: *We wanted peer-counselors, who went out and saw people and would be real comfortable … to talk about family planning. … They were also the testimonials, themselves, saying, "Hey, I've used these services, this worked for me." It was pretty non-threatening and the outreach workers grew in their own capacity because they realized that they could really be helpful.*

Summary

Most respondents stated that a majority of CSO staff were supportive of family planning efforts: *I do believe they're becoming more comfortable with it*. Respondents in leadership positions indicated that once the CSO staff understood the importance of family planning in achieving self-sufficiency, a majority considered family planning a vital addition to CSO services.

These respondents reported, however, that acceptance was gradual and took a great deal of effort on the part of the family planning staff. Reinforcement occurred through discussion of family planning at CSO staff meetings and family planning activities, such as participation in CSO health and job fairs and visits with clients in the lobby. Promotional materials such as condom key chains, family planning pencils, bookmarks, and T-shirts heightened awareness of the program in the CSO. Respondents from three sites indicated that frequent staff turnover makes it difficult to insure that CSO staff are aware of and committed to the responsibility of informing clients about family planning services. Leaders and family planning staff across sites also indicated that a few staff members still had problems with family planning. Thus the challenge of staff acceptance is an ongoing issue and similar strategies will continue to be used to make sure staff are *on the map.*

II. CLIENT CHALLENGES AND STRATEGIES

Challenges	Strategies to Respond to Challenges
A. Some CSO clients are uncomfortable discussing family planning.	**1. Staff approaches clients in terms of what services are available, rather than determining what they should do.** **2. CSO staff discuss family planning openly and in the context of overall health or other issues.** **3. Staff use culturally appropriate behaviors.**
B. Clients have many concerns other than family planning.	**Address primary concerns first, then discuss family planning.**
C. Teens are often uncomfortable with family planning issues.	**1. Family planning staff have a non-judgmental attitude.** **2. Family planning staff maintain strict confidentiality.** **3. Family planning staff are flexible in meeting teen needs.**
D. Approaching some clients about family planning can be intimidating.	**Family planning staff get the attention and trust of clients by being relaxed, showing respect, and relating family planning to their circumstances.**
E. Many clients have learning disabilities and may be missing information.	**Family planning staff present using plastic models and birth control samples.**
F. Clients often have transportation and childcare barriers.	**Some family planning workers and contracted family planning nurses make home visits.**
G. Vulnerable clients' access to birth control was restricted because of the nurse's limited prescription privileges.	**Family planning staff developed protocols with health providers to dispense emergency prescriptions and other birth control.**

CHALLENGE A: SOME CSO CLIENTS ARE UNCOMFORTABLE DISCUSSING FAMILY PLANNING.

Respondents from all sites explained that family planning is often a sensitive subject due to its personal nature. Some clients are sensitive about family planning issues for religious reasons. The two CSOs with the most diverse populations, Spokane North and Ballard, mentioned that cultural differences must also be taken into consideration. Respondents at Spokane North, with a full-service clinic, related that clients are sometimes *just embarrassed. They want to make sure that we're not going to be … announcing over the intercom, "Cindy Jones, time for your Pap smear!"* Respondents suggested the following strategies.

1. Staff approach clients in terms of what services are available, rather than determining what they should do.

Explaining what services are available is a good approach to raising the subject. Clients respond more openly when the CSO staff member does not become too personal or try *to impose … what I think they should be doing …. Most people … seemed to be pretty relieved that anybody is bringing up the topic. You know … it is okay. And talking about medical coupons first is a good entrance into that conversation … I think if you were talking about your work history and the next minute you said, "Are you having sex without protection?" that might be somewhat awkward for people.*

2. CSO staff discuss family planning openly and in the context of overall health or other issues.

Some respondents related when CSO staff are open, the client will be more receptive: As *soon as you start talking about it and you're open about it, it frees them up to talk about it. The more relaxed I am about it, the more relaxed they are about it.*

Respondents also suggested discussing general health or other topics as a *foot in the door* to discussing family planning issues. *We sometimes have to start in a very different spot than is obvious … talk about getting kids back to school, as a way to eventually get to that discussion about "Do you want more kids? What are you going to do, if you don't want more kids?"*

3. Staff use culturally appropriate behaviors.

Staff try to be aware of cultural and gender specific issues: *I try to talk to the women separately. I try to make sure I have a female interpreter. We do the best we can. We have diversity training, and we have some Ukrainian and Russian coworkers, here, and so I ask them a lot of questions about the cultural aspects of this issue.* In other cases, it may be appropriate to talk with the woman and her partner at the same time.

CHALLENGE B: CLIENTS HAVE MANY CONCERNS OTHER THAN FAMILY PLANNING.

Kelso and Port Townsend respondents raised the issue that *... family planning is not a priority 90% of the time to our clients if they don't know what they're going to feed their children that night.*

Address primary concerns first, then discuss family planning.

Respondents stressed that once emergency needs are handled the client can focus more on family planning. They added that no one is *doing this alone* and that other agencies are there to help clients: *... we do a lot of ... community resource referrals. Just whittling away at those barriers*.

CHALLENGE C: TEENS ARE OFTEN UNCOMFORTABLE WITH FAMILY PLANNING ISSUES.

... they're really kind of uncomfortable with family planning and giggle and aren't real sure what they want to do and that kind of thing ...

Port Townsend raised this issue, as working with a teen population is a large part of their program. Teens are often nervous about family planning issues for a variety of reasons: *...they're terrified of the pelvic* [exam]. *They're terrified of all the stuff that goes with it. They're terrified that it's going to cost too much money... they're not going to listen to you if they're worried about the pelvic.*

1. **Family planning staff has a non-judgmental, respectful attitude.**

   Most respondents identified trust as critical to the success of teen outreach programs and felt that a non-judgmental attitude is a key element in gaining the trust of teens: *... as adolescents* [teens are] *trying on different hats and that needs to be respected; and not to make judgments about who they are or where they are ... and not to be appalled by their different colored hair or their piercings and their tattoos.... It's kind of like ... this is where they're at and I'm just going to respect this.*

2. **Family planning staff maintains strict confidentiality.**

   Maintaining confidentiality of services provides teens with a sense of safety: *Well, I think the biggest is confidentiality. That I won't betray kids and that ... I will listen to them. I'll talk about anything.*

   Letting them know that ... everything we do is confidential ... we have ways of contacting them through their friends ... I think that's a big part of it, too, is that trust.

3. **Family planning staff are flexible in meeting teen needs.**

   Several respondents who work with the teen population mentioned that teen-aged girls are very intimidated about the initial pelvic exam. The staff has developed protocols for teens to receive an initial supply of birth control pills without an exam.

CHALLENGE D: APPROACHING SOME CLIENTS ABOUT FAMILY PLANNING CAN BE INTIMIDATING.

Port Townsend respondents who work in the jail program raised this issue: *... it's 8:00 in the morning and this lady is pulling out condoms and diaphragms and spermicide. And you just think ... these guys are just going to not listen at all or ... are going to get up and leave or be real rowdy.*

Family planning staff gets the attention and trust of clients by being relaxed, showing respect, and relating family planning to their circumstances.

Respondents stressed the need to be comfortable about family planning issues and not to be shocked by any information the clients share. They also indicated that respect is fundamental to building trust and a reciprocal relationship: *I think that showing them respect is how we get their attention.*

CSO family planning staff practice a variety of techniques to gain client focus. Using plastic reproductive models to demonstrate birth control methods grabs their attention: *I always say, "Here's Woody. Woody's wearing the condom and then this is Suzie," I call her Suzie, "and she has a female condom in."* Offering clients choices increases their interest in what they are doing, especially for those whose choices are usually limited: *We have several videos and we let them choose.*

The staff also relates family planning to the clients' circumstances: *... I held up the diaphragm one day and I looked at the people in front of me and I said, "There is a woman named Margaret Sanger,*[13] *who ... went to prison for years for this." And now they call it "The Margaret Story" and every time we go they want, "Tell us about Margaret, so and so doesn't know about Margaret."* Another respondent commented, [The story] *really makes an impact, like, somebody went to jail for family planning.*

CHALLENGE E: MANY CLIENTS HAVE LEARNING DISABILITIES AND MAY MISS INFORMATION.

The figures in the pilot study for learning disabilities in the CSOs, if I remember right, had 40%, through a conservative definition of learning disabilities, and up to 80% in a liberal definition of learning disabilities .... So our clients are not people who are going to read about family planning in a book, or ... even in a pamphlet.

Family planning staff present using plastic models and birth control samples.

Family planning staff utilize plastic pelvic models for men and women to demonstrate birth control methods and anatomy information: *It is a way that they can take the information in ... they're not going to get ... otherwise.*

[13] Margaret Sanger (1883-1966) founded the American birth control movement and later the Planned Parenthood Federation of America, as well as developed international family planning efforts. For further reading see Ellen Chesler, *Woman of Valor: Margaret Sanger and the Birth Control Movement in America* [New York: Simon & Schuster, 1992 (hardcover); Anchor/Doubleday, 1993 (paperback)].

Respondents also reported that models and samples help clients feel more comfortable with family planning issues: *... part of the thing with talking about sexuality and family planning is kind of desensitizing people to talking about it and looking at it and giving them experience ... of ... touching stuff and ... tearing packages open and squirting out spermicide. It's just fun ... this is a normal kind of thing that people need to be comfortable with .... Your sexuality should be like brushing your teeth or something, you know that it's just part of your taking care of yourself.*

These respondents stressed that one demonstration is usually not sufficient for clients to absorb the information. Presentations should be done as frequently as possible.

CHALLENGE F: CLIENTS OFTEN HAVE TRANSPORTATION AND CHILDCARE BARRIERS.

All sites mentioned lack of transportation and childcare as barriers to clients receiving family planning services.

Some family planning workers and contracted family planning nurses make home visits.

Several respondents said that home visits eliminate transportation and childcare barriers and give clients the opportunity to talk in an environment that is convenient and comfortable for them. *If you have children and you've got someone who is willing to come to your home and provide a service where it can be on your time, you don't have to wait, you don't have to travel, it's private, you know, that can be a benefit.*

CHALLENGE G: VULNERABLE CLIENTS' ACCESS TO BIRTH CONTROL WAS RESTRICTED BECAUSE OF THE NURSE'S LIMITED PRESCRIPTION PRIVILEGES.

A few participants raised the issue that vulnerable populations (such as the homeless) often have difficulty finding family planning services through other health care practitioners. Also, pharmacists do not always know that emergency contraception is covered through medical coupons. Prescribing emergency contraception and other prescription birth control such as Depo Provera on site can often reach populations that are unlikely to follow through with a referral.

Family planning staff developed protocols with health providers to dispense emergency prescriptions.

Ballard and Kelso offer emergency birth control and Kelso offers other prescription birth control via a strict protocol developed between the nurse and the prescribing authorities. The nurse collects pertinent health information and faxes this information to the prescribing authority, who then authorizes the nurse to dispense prescription medications.

Summary

Respondents who gave suggestions for interacting with clients stressed the following:

1) Clients need to be respected and staff should not be judgmental.
2) Clients need to be given information, not told what to do
3) The final decision is up to the client.

All interview respondents who dealt directly with clients felt that most clients were receptive to family planning and were getting the message that family planning is one way to control their lives: *I've been having some success lately and I've been trying to figure that out … I think it's maybe letting them know that … there can be a difference and they can make choices and they do have some freedom of choice …. It's not true that they're so poor or so battered or so dysfunctional that life always has to go on like that.*

III. COMMUNITY CHALLENGES AND STRATEGIES

Challenges	Strategies
A. Community opposed to or uncomfortable with family planning	**1. Family planning staff and contracted family planning nurse network in the community to garner support for family planning.** **2. Family planning staff perform volunteer service for a variety of community organizations.** **3. Family planning staff obtained state family planning material for local distribution.** **4. Program organizers sponsored a community education campaign emphasizing that family planning prevents abortion.**
B. Lack of support for sexuality education in schools	**1. Family planning staff targeted education efforts at community members and school boards providing demonstrations of curriculum.** **2. Family planning staff meet schools on middle ground and discuss mutual goals, highlighting what they can offer the schools.** **3. Family planning staff access teens off-campus.**
C. Some medical providers are unwilling to provide certain family planning services.	**Family planning staff advocated for client rights and arranged alternatives.**
D. Some pharmacists are unaware of Medicaid coverage of family planning supplies.	**Family planning staff visit pharmacies and explain the coverage.**
E. Local medical providers' concerns	**1. CSO and clinic management built coalitions among providers to develop shared goals and to avoid duplication of services.** **2. Clinic management stressed the clinics potential benefits to the medical community.** **3. Clinic advocates demonstrated community need and support.**
F. Maintaining confidentiality	**Family planning staff adheres to strict professional standards of confidentiality.**

CHALLENGE A: COMMUNITY WAS OPPOSED TO OR UNCOMFORTABLE WITH FAMILY PLANNING.

Many respondents discussed challenges raised by a lack of support for family planning in the community. A perceived relationship between family planning and abortion in some communities has influenced the way in which those CSOs have approached their programs. Kelso respondents felt that being out of range of statewide media campaigns contributed to community discomfort with family planning: *We're not in the Seattle media market. So, any statewide campaign to get the word out on anything doesn't come down to Southwest Washington, because we get the Oregon media.*

Family planning staff and management approached these problems using the following strategies.

1. **Family planning staff and contracted family planning nurse network in the community to garner support for family planning.**

   Family planning staff from a number of sites felt that building coalitions among service providers in their community contributed to raising the level of community support for the CSO family planning program. Family planning staff participate in consortiums and other forums for improving access to services in their communities.

   … get as many other people in the community who share that desire to have a program [in order to]*… form a group of folks that can give you some support outside your building. If you can do that, then you're halfway home.*

2. **Family planning staff perform volunteer service for a variety of community organizations.**

   Kelso respondents reported that family planning staff have volunteered to assist in whatever capacity community social service agencies needed. Their supervisor helped get them onto boards of local community health and social service organizations and started the Community Coordinating Council. Family planning staff did filing and other tasks for agencies and volunteered at the Salvation Army Christmas Center.

   Community linkages is how we have sort of sold ourselves to other community agencies so that they learned to trust us. And then, in return, we could make them a little more comfortable with family planning. So that's the approach we use here.

   Some respondents felt that providing volunteer services to other agencies has improved community attitudes toward family planning staff members, increased family planning referrals, increased access to vulnerable populations, and increased CSO clients' access to a broad range of community services.

3. **Family planning staff obtained and distributed state family planning material.**

   Some respondents distributed state AIDS and family planning advertisements locally on buses and public access television. All of the respondents who mentioned this strategy felt that presenting official, state-produced information had been helpful in moderating community attitudes.

4. **Program organizers in Spokane sponsored a community education campaign emphasizing that family planning prevents abortion.**

   [We had to] *keep making the point that family planning prevents abortions … that preventing pregnancy prevents abortions.* [It] *is very important to keep stressing that … by using birth control, you prevent abortion. So if you're anti-abortion, you want to be pro-birth control.*

CHALLENGE B: LACK OF SUPPORT FOR SEXUALITY EDUCATION IN SCHOOLS

All sites raised this issue, but the challenge was greater for some communities than others. Some respondents mused that initial community resistance to sexuality education was mostly due to a misunderstanding of what sexuality education is. A few respondents felt that community resistance to sexuality education in schools was due to a belief that it promotes promiscuity.

I was appalled at how little the schools teach kids here [about sexuality]. Meanwhile we hide the daughter in the back room because she got pregnant because she didn't know how else not to, and she's going to have sex anyway and I'm sorry folks, but it's been going on for thousands of years.

1. **Family planning staff targeted education efforts at community members and school boards providing demonstrations of curriculum.**

   Family planning staff simulated a sexuality education seminar using questions that students had actually asked. Staff purposefully retained controversial questions to demonstrate how the material could be handled in an age-appropriate way.

2. **Family planning staff meet schools on middle ground, discuss mutual goals, highlighting what they can offer the schools.**

   Respondents suggested providing schools with services they want, and not pushing ones they do not: We said we would like to help you. We realize there are a lot of expectations on the schools and maybe we can help you with some of these burdens. *This led to eventual acceptance of a broader curriculum:* At first, basically, they just wanted to talk about what I would consider sixth grade sex ed. stuff. But I accommodated them and did what they wanted me to do and they liked it. And so, I was able to slowly introduce more, until they actually let me do condom demonstrations.

3. **Family planning staff access teens off-campus.**

   … because they're off campus … we can give them what they want without stepping on anybody's toes at the schools. And during the summertime we go where they are, we go to the local beaches … they know us right when we pull up.

CHALLENGE C: SOME MEDICAL PROVIDERS ARE UNWILLING TO PROVIDE CERTAIN FAMILY PLANNING SERVICES.

Respondents reported that some pharmacists were unwilling to dispense Medicaid covered family planning devices because the client was a teenager or unmarried. Some medical doctors have refused to provide certain services, such as tubal ligations, due to their personal convictions.

Family planning staff advocated for client rights and arranged alternatives.

Respondents suggested focusing on a two-fold approach: confronting providers in a non-threatening way and obtaining factual information to give to providers: I even had facts faxed to me from Olympia that we faxed to the doctor, just to circumvent the excuses he was using.

Family planning staff also inform clients where they can obtain family planning services and supplies, such as at the health department or at independent family planning agencies.

CHALLENGE D: SOME PHARMACISTS ARE UNAWARE OF MEDICAID COVERAGE OF FAMILY PLANNING SUPPLIES.

A common issue across all sites was that some pharmacists do not know that Medicaid covers prescription and over-the-counter birth control: *When Medical Assistance Administration sends out information on our programs, especially for large chains, it goes to the corporate office or the billing office. It never filters down* [to local pharmacies]. *As a result*, *clients are sometimes denied birth control.*

Family planning staff visit pharmacies and explain the coverage.

If we hear back from a client, this pharmacist, and all … [the family planning worker] goes right out, she takes them a little flyer, reminds them ever so tactfully that this is something that is covered and it's very, very important.

Staff have a list of pharmacies that support access to birth control supplies and make sure that clients know where they can receive their family planning supplies.

CHALLENGE E: LOCAL MEDICAL PROVIDERS' CONCERNS

Some respondents mentioned resistance from local medical communities who feared that a family planning clinic would erode their client base.

1. **Program organizers built coalitions among providers to develop shared goals and avoid duplication of services.**

   [We had to] *start small and build relationships, discussing ideas of what is profitable in larger than financial terms.*

2. **The CSO-based family planning program was presented as relieving local medical providers of pro bono obligations.**

   One of the nice things that the Mt. Baker family planning folks did was to present the program as being non-competitive with the private practice services … the payment aspect of it. The

medical profession saw this as offering additional services to help them not have to do pro bono services.

3. **Clinic advocates demonstrated community need and support.**

   Community members who wanted a clinic approached other members of the community and raised support: *We had probably two pages* [of signatures] *of women and men who wanted it to happen and were in favor of it …* [we] *also talked to the board of the medical center. And so we just were aggressive.*

CHALLENGE F: MAINTAINING CONFIDENTIALITY

Site location played a major role in the way respondents discussed this issue. The most rural sites, Port Townsend and Friday Harbor, stressed that in small communities clients are concerned about having their neighbors and co-workers know that they are going to a family planning clinic. A few respondents linked this embarrassment about family planning services to the larger prevailing social norm—either in the community or in the nation. Both of these sites emphasized that teens are very concerned that the adults in their support system will know they are sexually active. This fear creates a formidable barrier for teens.

Family planning staff adhere to strict professional standards of confidentiality.

You're careful not to be led into anything. A client said, "Oh, my friend came in the other day, and you gave her XYZ." You can't acknowledge even knowing who that person is, even though they may have said a couple of things that rang a bell for you and you could identify who they were talking about.

Summary

The CSOs examined represent different models for providing family planning to CSO clients. The ways in which CSOs organize and conduct their family planning programs reflect the communities they serve. Despite their unique characteristics, the five CSOs displayed intriguing commonalties. Overall, it is challenging to engage CSO staff members, CSO clients, or communities in dialogue about family planning. General societal embarrassment about sexuality creates challenges at all levels of family planning service.

Issues relating to the community are ongoing for all CSOs and require continuous attention and effort. Feelings about community support vary from site to site. Friday Harbor has the legacy of a community-based movement to attest to its level of support. Ballard respondents reported that their community is supportive of family planning in general. Port Townsend respondents stated that their community is highly supportive of the family planning efforts of the CSO and the health department (JCHD). Kelso respondents reported an increased positive relationship with the community at large, while respondents in Spokane considered lack of visible opposition to their program to be a measure of community acceptance.

DISCUSSION

Although respondents from all sites raised challenges related to CSO staff and the broader community, it is important to note that overall, respondents believed great progress had been made in increasing community and staff support for the family planning program, largely due to the strategies discussed in this section. Levels of support in the community and CSO were also measured with a written survey following the interview. (For a complete list of survey questions, with a discussion of selected results, see *Appendix D.*)

In addition to the ideas and strategies listed above, some respondents mentioned these additional suggestions for integrating family planning into Community Services Offices:

> *Just get out there and get the family planning message out every way you can.*

- Hire competent family planning personnel who are outgoing, *creative, flexible, willing to network, talk about family planning,* and *do whatever it takes* to make the program work.
- Train and directly involve CSO staff in family planning activities.
- Get involved with the community.

  Get involved with community organizations; create a support system.

  Educate the community about the need for family planning services.

  Let community identify need for family planning and plan the program.

  Start small and let people get used to the idea.
- General or organizational advice:

  Make family planning referrals mandatory for all clients.

  Set clear goals and guidelines.

  Have a system for monitoring client follow-up.
- Conduct outreach to Medicaid clients and potential Medicaid eligible clients.

  Homeless shelters, food banks, domestic violence shelters, jails, schools, colleges, teen centers, English as a Second Language classes, fairs, parks, laundromats…
- Make sure the client has easy access to services.

  Have services at or near the CSO.

  Introduce clients to the nurse.

  Have the pill, Depo Provera, and pregnancy tests available on a walk-in basis.

... I don't think we have to keep creating the wheel ... always use other people's information.

…test the waters, experiment as much as you can, get the word out, and get as much help as possible.

… don't expect miracles overnight…. just … continually make people aware.

CRITICAL FACTORS TO CSO-BASED FAMILY PLANNING

Respondents identified factors critical to the success of family planning programs during the interviews and in the card sort (see *Appendix C)*. In interviews, all informants commented on what made the program *really work*. Following the interview, respondents read 29 cards containing factors considered important to the operation of a CSO–based family planning program. These factors were derived from pilot interviews with staff at the Orchards CSO. Respondents sorted the cards into three categories: Most Critical, Critical, and Least Critical. Respondents were allowed to identify multiple factors. Of the 62 informants, 56 completed the card sort, resulting in a 90% response rate.[14]

- **The Skills, Personality, and Presence of the Family Planning Staff**

76% of respondents in interviews and 68% by card sort identified this element as critical to the success of a CSO-based family planning program.

Respondents described their family planning workers as: *skilled*, *creative*, *high caliber*, *committed, knowledgeable*, *outgoing, able to talk about sexuality, non-judgmental, and professional*. A majority of respondents felt that the energy and enthusiasm for the program originated with the family planning staff.

- **Accessibility of Family Planning Services, Education and Information**

60% of respondents in interviews and 64% of card sort respondents identified accessibility as critical to the success of a CSO-based family planning program.

Respondents focused on a variety of access issues: service availability in collocated clinics at Port Townsend and Spokane, clinic hours at Friday Harbor and Spokane, emergency contraception in Friday Harbor, onsite birth control services for indigent populations in Ballard, outreach to a wider range of people and home visits to clients in Kelso. Respondents from four sites explained that a trusting relationship between clients and family planning staff increases the efficacy of the family planning message. Helping clients with other problems is often part of building that trust.[15]

Access to services is enhanced by education. Successful educational efforts are critical to increasing staff support for family planning programs. Education targeting clients and the community increases the overall comfort level with family planning.

[14] Respondents interviewed by telephone did not participate in the card sort.
[15] For example, helping clients obtain dental care was mentioned as an important part of gaining clients' trust and receptiveness to family planning information at 3 CSOs: Ballard, Kelso, and Spokane.

- **Teamwork and Communication Between CSO Staff**

51% of respondents in interviews and 54% of card sort respondents identified this element as critical to the success of a CSO-based family planning program.

The sometimes-controversial nature of family planning and other challenges necessitate open communication between all CSO workers, family planning workers, and contracted family planning nurses. Respondents stressed that training sessions, informal discussions with family planning staff, information updates, and resource tools, such as methods for introducing family planning topics to clients, increased referral rates and alleviated staff tensions surrounding family planning activities.

Communication and teamwork between the family planning worker and the contracted family planning nurse increase family planning staff effectiveness by allowing family planning staff to plan and coordinate activities together and by allowing them to share resources, information, and ideas.

- **Confidentiality of Services**

29% of respondents in interviews and 63% of card sort respondents identified this element as critical to the success of a CSO-based family planning program.

Respondents at all sites imparted that clients must be assured of confidentiality. Clients may feel uncomfortable seeking services if they cannot be provided discreetly. Where privacy is difficult to maintain in small communities, and at sites where communities are uneasy about family planning, respondents particularly stressed the importance of confidentiality.

Family planning staff at three CSOs mentioned that the contracted family planning nurses who work inside CSOs are not able to share client information and that sometimes this creates difficulty between family planning nurses and other CSO staff. Several respondents explained this in terms of a difference between institutional cultures. Health professionals have strict guidelines for medical confidentiality that prohibit sharing of information between colleagues without prior approval from clients, whereas sharing client information between social workers is considered the norm among CSO staff. Interestingly, analysis of the Most Critical factors card sort responses of health professionals and CSO-staff revealed that 100% of health professionals chose confidentiality as a most critical element, while only 50% of CSO staff chose this element.

- **Funding**

Well over half (63%) of card sort participants felt funding was critical to the success of a CSO-based family planning program.

Respondents who selected funding indicated that since nothing could happen without it, funding was a logical pre-requisite for any family planning activities whatsoever.

- **State and CSO Administrator Support**

35% of respondents in interviews identified leadership and 70% of card sort respondents identified Administrator support for the program as critical to the success of a CSO-based family planning program.

Some respondents from all sites indicated that if an administrator was not supportive of family planning, adequate hours might not be dedicated to family planning. In addition, line staff (receptionists and financial workers) may not be encouraged to make family planning referrals, and promotional activities, which were noted by respondents as important in raising levels of support for the program in the CSO and in the community, may not be approved.

Respondents from all sites repeatedly said that support from *the top* was critical to prioritizing the program.

Summary

Given the variety of ways these five CSOs have implemented and sustained their family planning programs, it is remarkable that the critical factors most frequently chosen were the same for all of the sites. Most noteworthy are the two factors that emerged as common top critical factors to all sites based on rankings on both card sort and interview.

- **The skills, personality, and presence of the family planning staff**
- **Accessibility of family planning services and information**

Although general commonalities exist among factors that respondents believed were most critical to family planning programs, the individual needs and resources within a particular community were no less important: *... the social milieu really has to dictate how you do business. And you're not going to do it in Bellevue like you do it in Kelso.*

FUTURE DIRECTIONS

Interview questions provided an opportunity to discuss issues important to the future of CSO-based family planning. Points raised provide a framework of elements which respondents felt would enhance and expand the CSO-based family planning program. Respondents addressed what they would like to see in their own CSO as well as what they would like to see on a statewide level.

The following points highlight some concerns raised by respondents from the five sites.

- **Family planning services should receive greater priority on the state and CSO levels**

  1. Emphasis on the program needs to come from the top echelon of the State.
  2. CSO leadership needs to prioritize the family planning program.
  3. Too many demands are placed on CSO staff.

- **Broader populations should be included in target groups**

  Three sites primarily focused on outreach activity to the teen population with the thought that reaching young people *before* they become sexually active is essential to reducing unintended pregnancies, lowering future welfare rolls, and increasing teen health and opportunities.[16] One site also targeted jail inmates, explaining that many of the inmates' families are on or will be on public assistance. Respondents from another site felt that targeting populations likely to face poverty, such as refugees and grant recipients would be beneficial. One common desire links outreach efforts across sites:

  ➢ **Reach CSO clients and potential CSO clients *before* an unplanned pregnancy occurs.**

- **Family planning contracted nurses and family planning program workers at the CSO level should be expanded**

  Respondents across sites mentioned they would like to see more family planning staff in order to increase services. A number of respondents mentioned they would like increased hours for the contracted family planning nurse at the CSO.

- **Development of process and outcome measures**

  Respondents raising this concern believed that standardized methods for measuring the effectiveness of programs would heighten family planning priority, assure client awareness of and, therefore, access to services, and would aid in program expansion.

[16] It should be noted that teen families are not the majority of welfare recipients. Respondents felt that the family planning message reaches people more effectively before the initiation of sexual activity than after.

WHAT RESPONDENTS WOULD LIKE TO SEE IN EVERY CSO

Respondents were given the opportunity to voice what they would like to see in every CSO. The following table is a selection of responses from all sites.

Selected from goals mentioned at all five sites:

- **Expansion of Family Planning Services at the CSO**

  Additional family planning staff
  More hours for the family planning nurse
  Dedicated family planning staff worker at every CSO
  Dispensing birth control at every CSO
  Prescription birth control at every CSO
  A clinic in every CSO
  CSO money dedicated to family planning
  More education for clients
  Office space, computer, and e-mail for family planning nurses
  Family planning nurse should see every client who enters the CSO

Selected from goals mentioned at more than one site:

- **Increased outreach**

  Target males
  Target non-pregnant CSO clients and potential CSO clients
  More general outreach
  More visibility in schools and community

- **More process and outcome measures**
- **CSO staff and administrator support for family planning**

Selected from goals mentioned at one site:

- **Day care provided for clients**
- **State booklet explaining Medicaid benefits**
- **Condoms everywhere**
- **Increase HIV education**

ISSUES RAISED BY STATE ADMINISTRATORS

Researchers conducted in-person interviews with those directly involved with CSO-based family planning at the state level. Participants included the Family Planning Program Manager and the Family Services Section Manager from the Medical Assistance Administration; the Director of the WorkFirst Program; the family planning liaisons at WorkFirst and the Community Services Division (CSD) of the Economic Services Administration (ESA). Administrators expressed concerns that they had about the program, many of which were similar to those raised from the field, and discussed pending projects to address some of these concerns.

The role of the CSO staff in family planning

Several state family planning administrators mentioned the importance of CSO staff feeling comfortable with family planning services. While trainings help, CSO staff turnover rate can be quite high and building coalitions can be tough in a landscape of ever-changing personnel. Respondents stated that CSO staff often feel as if they are being required to do something far beyond what their job description should entail: *people's value systems get in the way because they don't see it* [family planning] *as objective information … and even though it's a good idea, it's not working as well as it could because … people are tied to it emotionally through their value systems.*

Several administrators stressed that line staff should not be expected to be *medical experts* or to counsel clients about sexual health, *they're not credentialed to do that*. The goal of the program is to provide an environment that is supportive of family planning, with CSO line workers mentioning that services are available and referring interested clients to the family planning staff. The purpose of the program in the CSO context should be more clearly stated: *what we're asking of CSOs in general is to make the offer or to say little things that would be supportive but not to think that they're medical experts, or that … we want them to get intimately involved in the details of people's sexual lives.*

Challenges with interagency organization

Several administrators stated that the organizational complexity of the system often creates challenges to effective delivery of what the field staff need. Some administrators, however, were not optimistic about changing the family planning framework on the macro level, and suggested that all involved parties should try to maximize their operations within the framework. Several family planning liaison assignments have recently been added to the job responsibilities of CSD and WorkFirst personnel.

One administrator indicated that the people in the agency actually shape it and that all employees need to take a little responsibility for that: *… we all work for the same agency … my primary focus is that all of our jobs are to get the client the maximum benefit that they are legally entitled to … and to help the client understand how family planning services fit in.*

Leadership

State administrators also mentioned that family planning often deserves more attention than it currently receives: *it's on the burner but the heat's not turned up enough.* While administrators acknowledged that executive management needs to *preach the gospel on this,* they also emphasized that leadership is a multifaceted phenomenon and that the responsibility for focusing on family planning has to be bolstered at the middle and ground levels as well: *... efforts to create the very best access system within each CSO absolutely must have the support of the Economic Services Administration, Regional Administrators, CSO Administrators, supervisors ... it's not a reasonable expectation that line staff are going to do all this work in a climate that's not supportive ....* One respondent stressed that individuals themselves have a responsibility to the services that are provided and that *every* CSO worker must accept this responsibility as an individual: *... one on one. I think you can move the world that way.*

CURRENT PROJECTS

In raising these issues, state administrators also explained some steps towards addressing them.

Economic Services Administration

A family planning liaison assignment has been created recently in the Community Services Division (CSD). The liaison assignment includes keeping CSO staff and supervisors informed about family planning goals and services: *... you've got social service folks and ... financial service folks and you really have to be sure that both parties get the same information.*

The WorkFirst Division has also created a family planning liaison assignment to facilitate policy development between MAA, WorkFirst, and CSOs. The primary responsibility of the person who has this assignment (among others) is to create an automated tracking system that will record referrals of WorkFirst clients to the family planning staff: *...right now we don't have a tracking system, so we have no way of knowing if that's really happening.* With such a tracking system in place, referral rates could provide a measurable process outcome for the program: *... we want a 100% referral rate for WorkFirst to Family Planning so that's one of our outcomes*.

Eventually the follow-up on referrals would be tracked: *The Family Planning worker would make an appointment or do some kind of follow-up ... which would also be tracked ... the client showed up for the meeting and they're on birth control, the client showed up and they declined services, whatever.*

The second goal involves *incorporating family planning into the actual WorkFirst message* in order to *get family planning and Work First interlinked so that people kind of connect them together*. WorkFirst and MAA have jointly developed two new posters linking a family planning message with the WorkFirst message:

> *Now that you're working ... is your birth control?*
>
> *It's your future. It's their future. Take charge of your life. Be healthy, use birth control*
>
> .

Medical Assistance Administration

Since the early 1990s, MAA has been involved in a variety of efforts and partnerships to make family planning more readily available to low-income women. A number of events have fueled these efforts. In 1989, access to medical care for low-income pregnant women in Washington was expanded with the implementation of the First Steps program. In the early 1990's, Washington State began participation in the Centers for Disease Control (CDC) survey known as PRAMS (Pregnancy Risk Assessment Management System). The 1995 release of an Institute of Medicine report and Washington State data on unintended pregnancies[17] gave statistical support for the need to increase access to and use of birth control methods (Brown and Eisenberg, 1995; Cawthon, 1995).

Also in the mid-1990s, Welfare Reform on state and national levels created lifetime limits for public assistance benefits. Additional pregnancies to low-income women, however, make attainment of self-sufficiency difficult.

For Washington State public assistance recipients, women with more than two children are likely to remain on public assistance longer. Women with an infant are 23% less likely to be employed and women with a toddler are 30% less likely to be employed than women without infants or toddlers. The most common reason reported by female recipients for enrolling in public assistance was pregnancy or a young child. While only 8% of Washington's welfare recipients are teen parents, 52% are women who gave birth under 20 years of age (Lidman, 1995). Of those women who gave birth in adolescence, over 50% have been victims of sexual abuse (Boyer and Fine, 1992).

In Washington State approximately **55% of all pregnancies are unintended at the time of conception**. The majority (57%) of unintended pregnancies occur to women in their 20s. Although the numbers of pregnancies are lowest for teenagers, over 70% of all pregnancies to women under age 25 are unintended at the time of conception. **Approximately 69% of all births to women on Cash Assistance were unintended at the time of conception** (Schrager, 1997). Currently, over 40% of the yearly births in the state are funded through MAA. The estimated average cost of MAA funded maternity care for births from unintended pregnancies from 1993-1996 in Washington State was $90,226,622 (Beyer, 1998).

DOH and DSHS are working together to impact these statistics and share a common objective of reducing unintended pregnancies in Washington State. The goal is to reduce unintended pregnancies by 3% per year over the next six years. One way MAA and DOH hope to reach this goal is through a quality improvement effort focused on family planning access. The First Steps Maternity Support Services and Maternity Case Management providers are being asked to work with pregnant women to increase knowledge of birth control methods and to ensure that each woman has a birth control method in place by six weeks post-delivery. These providers are also working to create referral systems back to the CSO staff for clients who need additional services and follow-up.

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[17] Unintended pregnancies are those pregnancies that women report they did not want (unwanted) and those they report occurred earlier than they wanted (mistimed). For an in-depth discussion of the problem and scope of unintended pregnancy, see: S. S. Brown and L. Eisenberg (Eds.), *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* (1995). Washington DC: National Academy Press.

MAA is also working to create a consistent family planning message that becomes integrated into the functions of the CSOs. Part of that goal is to talk with CSO non-family planning staff about *how to engage a client* so that staff will *feel more comfortable in doing the "pre" cognition work so that when somebody is ready to go to a practitioner, they go feeling supported in that effort*. Respondents stressed the importance of non-family planning staff mentioning the availability of family planning services to clients as often as possible. MAA holds yearly skill-building trainings for CSO family planning staff around the state.

Respondents at MAA mentioned a planned workshop for CSO contracted family planning agency staff: *... family planning agencies really want to talk about how do they maximize their doing business in the CSO, but also how does that impact them at home. And how does it impact their agencies, and ... how you work back and forth. We're asking them to go out of their comfort zone, go into an environment that in some cases is actually hostile to their being there, and then to somehow provide good services to clients.*

MAA is working with WorkFirst to design a marketing campaign based on a program title that will help reinforce the family planning message. Currently, the phrase *Take Charge* is under consideration. Respondents explained that designating a program with a simple phrase like First Steps or WorkFirst helps to familiarize CSO staff, clients, and Washington citizens with certain programs and concepts. Such a marketing strategy would help to institutionalize the program.

Working with current public assistance recipients is not sufficient to lower the numbers of women who will need assistance due to unintended pregnancies. To reach more people before they require assistance, Washington has applied for a federal Health Care Financing Administration waiver to provide family planning services to both men and women at or below 200% federal poverty level. At the time of publication, the waiver request was under consideration at the federal level.

DISCUSSION

The similarities between the issues raised by CSO level respondents and state administrators are striking. Respondents indicated a need to normalize family planning by encouraging staff to take home promotional materials for their own information, by having candid discussions with clients about the feasibility of taking control of their lives, or by talking to clients in their own homes. All sites embraced the goal of making family planning, in concept and practice, acceptable for staff, clients, and community. Given the scope of this challenge, it is heartening to see changes occurring at the CSO and state level that address this issue.

Discomfort with sexuality and family planning by staff, clients, and community creates barriers to the provision of family planning services. This issue speaks to a much broader problem than what can be encompassed by CSO efforts alone: society at large is uncomfortable discussing family planning. Advocates of family planning are faced with daunting hurdles to changing social norms, ranging from philosophical impediments to institutional barriers such as the lack of family planning coverage in major insurance plans.[18]

Some respondents talked about the importance of *normalizing* family planning in the CSOs. Normalizing family planning was described as [making] *it an everyday occurrence, where people run into it, talk about it; make it be mundane…. That's the goal to focus on, is how can I normalize it?* In addition to strategies employed on the CSO level, many respondents stated a need to normalize family planning in our society, in general. As long as there are taboos about discussing sexuality, there will be unintended pregnancies with their serious consequences for parents and children.

[18] A recent study by the Washington State Office of the Insurance Commissioner found that only half (50%) of insurance plans cover some form of family planning services and that only one in three (30%) cover the five approved reversible methods of contraception: IUD, diaphragm, Norplant, Depo Provera and oral contraceptives. Only two plans cover over-the-counter contraceptives such as condoms and spermicides. As a result, four in five women do not receive coverage for contraception. Washington State Office of the Insurance Commissioner. *Reproductive Health Benefits Survey*. Olympia, 1998.

CONCLUSION

Family planning services are a critical component of programs designed to help welfare clients become self-sufficient and to enable potential clients to maintain self-sufficiency. Ballard, Friday Harbor, Kelso, Port Townsend, and Spokane North represent five different models for providing those services. Despite the unique characteristics and program focus of each CSO studied, striking commonalities emerged. Overall, it is challenging to engage CSO staff members, CSO clients, and communities in dialogue about family planning. Integrating family planning services and staff into the activities of the CSOs and their communities requires that these challenges be overcome.

Critical Factors

Analysis of various data sources including interview material, written survey results, card sort results, and personal observation reveals that certain key elements are critical to integrating family planning services into CSO activities and the community:

- **The skills, personality, and presence of the family planning worker and contracted family planning nurse**

  Effective CSO family planning staff and contract family planning nurses are outgoing and comfortable with discussing and demonstrating family planning information to a wide range of people with various backgrounds, belief systems, and learning needs. Family planning personnel must be able to network with other providers and organizations in the community as well as with CSO staff and administrators to make family planning accessible to CSO clients and potential CSO clients. Family planning workers and CSO staff, to communicate effectively with clients about family planning, often have to step outside a narrow interpretation of their job descriptions and help clients with other concerns. This concern for clients as individuals helps establish a relationship of trust, a crucial prerequisite to good communication. This same principle holds true for establishing a good relationship with CSO staff. Family planning staff taking time to address staff concerns and spending time in CSO common areas, such as the lunchroom, builds trust toward family planning staff and contracted family planning nurses. This foundation of mutual trust and respect provides a sturdy basis for effective family planning education for CSO staff.

- **Leadership from administrators and supervisory staff**

  CSO administrators and supervisory staff play a key role in promoting family planning in the CSOs. Their unequivocal support of family planning sets the tone for the CSO. Administrators can facilitate the introduction of family planning personnel into other community organizations, by helping them make connections, and by allowing family planning staff to structure work hours around special demands upon their time. Administrators can facilitate the introduction and support of family planning staff into the CSO culture by holding regular staff trainings that include family planning personnel. They must stress the importance of CSO staff responsibility to provide family planning information and referrals to all CSO clients. Administrators can guarantee a place for family planning in the CSO by preserving employee hours dedicated for family planning.

- **Teamwork and communication between CSO family planning staff and contracted family planning nurse and between family planning workers and CSO staff and administration**

  CSO family planning workers and contracted family planning nurses need time to meet and talk. This can be an opportunity to share what is working, to coordinate efforts, and to brainstorm options for coping with challenges as they appear. Open channels of communication between family planning staff and the rest of the CSO are critical to the successful integration of family planning into CSO activities. Many respondents mentioned the importance of providing the contracted family planning nurses with the basic equipment of CSO staff, namely a computer with a state e-mail account, a CSO mailbox, and office space within the CSO, so that CSO staff and contracted family planning nurses can easily stay in contact. Regular staff trainings, including all-staff trainings and unit trainings, should include family planning staff, and be a forum for open communication providing non-family planning staff a chance to discuss their concerns about family planning services at the CSO.

- **Respect for clients as individuals and for their decisions and concerns**

  CSO clients and staff may have diverse experiences and very different worldviews. As discussed above, clients often have learning disabilities; they may have different cultural backgrounds and different belief systems. The ability to listen to all clients and accord them respect, whatever their background and current situation, is essential to providing family planning services in the CSOs. Respondents frequently cited the importance of addressing clients' most pressing concerns before approaching the subject of family planning. In addition, respondents noted that it is essential to understand that clients need access to family planning information and services so that they can make their own informed decisions about their lives.

- **Flexibility in program structure and activities**

  Although the ways that CSOs provide family planning services demonstrate numerous similarities, each program needs flexibility to operate within the unique environment of its community. A standardized approach would not be practical when so many different factors are at work: community size and location, immigration patterns that determine which cultures are represented in each community, the availability of other reproductive health services, community and staff attitudes toward family planning, economic and other factors that may affect CSO staff turnover, and the community media milieu. The need for flexibility was taken into account in the program design. While respondents felt that clear family planning goals and integration of family planning into other CSO programs, such as WorkFirst, are essential and should be directed from higher echelons of administration, serving a specific community requires the development of an individual approach at the CSO level. While not explicitly stated by respondents, the different strengths of individual family planning workers and contracted family planning nurses may also have some effect on the shape of their family planning programs.

At the core of these elements lies the concept that CSO-based family planning depends on the people who implement the program and the way they serve clients. Individuals responsible for family planning at the sites visited for this report exhibit extraordinary dedication to the goals of increasing client access to family planning and integrating family planning services into the CSO. Clients are encouraged to make their own decisions and are given respect, whatever their individual circumstances. Finally, family planning programs flourish where administrators, at the CSO level and at state and regional levels, are willing to take a stand and move forward with a family planning agenda.

Creating a supportive environment in the CSO requires education and outreach programs for CSO staff, CSO clients, and the community. Appropriate strategies for an individual community need to be determined by the people who are familiar with the concerns, opinions, likes, dislikes, and attitudes of that community – the CSO-based family planning staff, contracted family planning nurse, CSO managers, and contracted family planning agency that work within each community. In addition to allowing CSOs to solve problems in a manner appropriate to their individual communities, flexibility encourages creative energy for generating new ideas.

Next Steps for CSO-Based Family Planning

While respondents from the five sites in this study felt that these elements have effectively integrated family planning into their CSOs and their communities, they also suggested ways that the program could be improved:

- **State and CSO administrators should increase the priority of family planning services with greater support and more leadership.**
- **Dedicated family planning staff in the CSO should be preserved with clinical services provided by contracted family planning nurses available at all CSOs.**
- **Measurable objectives would help to motivate CSO personnel in promoting family planning and integrating it into CSO activities.**
- **Broader outreach is needed to reach CSO clients or potential clients before an unintended pregnancy occurs.**

The central theme of these elements suggests that the importance of CSO-based family planning needs to be widely recognized and program efforts enlarged. Societal acceptance of family planning remains an issue. Family planning workers are faced with the need to overcome a general reluctance on the part of clients, CSO staff, school boards, and community leaders to discuss anything concerning human sexuality. Broader support at all levels, including regional and state level administrators, would empower family planning personnel to increase their successful activities, such as training and teambuilding activities with CSO staff, community education and networking, and family planning outreach to vulnerable populations. These activities are essential, not only to providing family planning information and services to today's CSO clients, but also to helping make the topic of family planning acceptable in our society.

… where I would like to see the program going is, someday if I can go into a presentation and take a handful of condoms with me and pass them out to these people at this presentation, and get no shock value out of it. That is the day that we've made an impact on the population because it will be everyday and ordinary. And that's what family planning needs to be: an everyday ordinary activity, like buckling your seatbelt or putting your bike helmet on.

Well-integrated family planning services are critical in assisting clients in attaining self-sufficiency and potential clients in maintaining self-sufficiency. While CSOs have made great strides in achieving this goal, future success depends on continuing leadership from managers and administrators and the dedicated and insightful work of family planning staff. CSOs need not reinvent methodologies for accomplishing this, when the experience of other CSO staff and contracting family planning agency staff is available. This report describes program models and strategies that may be useful for developing and sustaining CSO-based family planning programs. The program has momentum: it is hoped that this report will help foster its continued growth and sustainability.

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APPENDIX A

SOURCES AND METHODS FOR CSO BIRTH STATISTICS AND RACE TABLE

Racial/Ethnic Breakdown of Economic Services Clients

Data (1994) were provided by the Data Analysis Section, Research and Data Analysis Department of Social and Health Services, Washington State.

Birth Statistics

Population estimates per CSO service area were prepared by Washington State Department of Social and Health Services, Research and Data Analysis, Data Analysis Section and are based on estimates by Claritas, Inc. and the Washington State Office of Financial Management Forecasting Division.

The **number of births** per CSO-designated area were identified using geocodes (zip codes and census block group identifiers) from the birth certificate files, available through the Washington Department of Health, Center for Health Statistics, which were then linked to the First Steps Database.

The **birth rate** is the number of women giving birth per age group for every 1,000 women in the same age group. Numerator: Total women giving birth per defined age group by CSO-designated area. Denominator: Estimated population of women per defined age group by CSO-designated area.

Medicaid women are defined as Medicaid cases if they had either Medicaid-paid maternity care or at least three months of capitated payments in the six months prior to delivery. Status was provided by First Steps Database.

Abortion rates: County abortion rates are applied at the CSO level. CSOs are assigned the county in which they are located. County abortion rates are weighted by age groups and applied to the CSO level. Total abortions for the age group 15-44 are produced by summing the 15-24 and 25-44 age groups. The sum is divided by the population estimate for women 15-44 and multiplied by 1,000 to get the abortion rate for the 15-44 age group. *Washington State Pregnancy and Induced Abortion Statistics* (Center for Health Statistics, 1997) reported that the abortions for 1993-1995 had been underreported and adjusted county abortion rates upward based on an overall estimate.

Unintended pregnancy: An estimate of the statewide rate of unintended pregnancy was applied to CSO level data and adjusted by Medicaid status. The adjustment assumes that women with similar Medicaid status (Non-Medicaid, Medicaid Only, and Grant Recipients) have the same rates of unintended pregnancies in every CSO throughout the state. The statewide unintended pregnancy rate is from the Washington Pregnancy Risk Assessment Monitoring System (PRAMS), Department of Health, Maternal-Child Health Program.

APPENDIX B

INTERVIEW INSTRUMENT

I am going to ask you questions about your family planning program here at (CSO). After the interview, you will be asked to do two more activities. The first is a card sort; and the second will be a short, written survey about the family planning services here.

Before I begin, I would like you to read this brief description of the research project and protocol. (Give interviewee a copy of the Interview Protocol now.)

1) Do you understand that your name will not be connected to your answers in the written report? 2) Do you agree to participate in this study? 3) Do you consent to have this discussion recorded?

A. I would like to ask you a few questions about family planning in general:

1. What does family planning mean to you?
2. Why do you think family planning services are important?
3. In your opinion, are family planning services more or less important for people who are receiving State medical assistance than they are for those not receiving assistance? (Why or why not?)
4. What do you think about providing family planning services at the Community Services Offices?

B. The next questions are about your role in the family planning program at (CSO):

1. In what way does your work involve family planning services?
2. How long have you been doing this work here?
3. What is most interesting about your family planning work?
4. What part of your family planning work is the most challenging? (What would help you meet this challenge?)

C. These questions are about how family planning services are provided at (CSO):

1. Please describe the activities of your CSO-based family planning program.
2. What do you think are some of the best things about your family planning program?
3. Do you have contact with other family planning organizations?
4. Since you have been at (CSO), what developments have there been in the family planning program?
5. Do you feel there are any barriers to the success of your family planning program?
6. Do you feel that there is support within this CSO for family planning services? (What helps support CSO family planning services?)
7. What is the prevailing attitude within the (town name) community toward family planning?

D. The next questions are about general client needs and services (I will not ask for any confidential client information):

1. How would you describe the family planning atmosphere for clients at (CSO)?
2. How do you let clients know about family planning services?
   (At CSO? In community? At family planning agencies?)
3. In your opinion, what are some good strategies for effectively communicating with clients about family planning?
4. Are there any barriers to clients' receiving family planning services at (CSO)?
5. What kind of impact do you think this family planning program has on your clients?

E. I have a few more general questions to ask you, before asking you to do the activities that I mentioned at the beginning of this interview.

1. How would you define a good family planning program?
2. What, in your opinion, makes the family planning program at (CSO) work?
3. Is there anything about your CSO family planning program that makes you especially proud?
4. If someone were starting a new CSO-based family planning program, what advice would you give her/him?
5. Would you say that your family planning program is institutionalized here?
   (Why or what needs to happen to make it more institutionalized?)
6. What, if anything, would you like to see happen in every CSO?
7. What would you like to see happen with CSO-based family planning at (CSO) in the future?
8. Is there anything else you would like to say about the family planning services at (CSO)?

This is the end of the interview. I have two more things to ask of you before we are finished. The first is a card sort; the second will be a short, written survey.

Follow-up Letter

(Give follow-up contact letter to the interviewee)

APPENDIX C

CARD SORT

Card Sort

I have some cards that represent factors that might be important to a successful CSO Family Planning program. I would like you to sort these cards into three categories:

Factors which are **Most Critical** to the success of CSO Family Planning programs
Factors which are **Critical** to the success of CSO Family Planning programs
Factors which are **Less Critical** to the success of CSO Family Planning programs

---

1. Personality, skills and efforts of the family planning worker
2. A family planning nurse on Site at CSO
3. CSO staff time devoted to family planning
4. Teamwork and communication between CSO staff
5. Family planning education for clients; methods/devices available and proper use
6. Funding for CSO-based family planning program
7. CSO workers feeling they are making a difference
8. Continuity of CSO family planning staff
9. Education and training of CSO staff and providers about CSO family planning services
10. Client willingness to use family planning services provided
11. CSO Family planning staff awareness of community resources
12. Clients know what to expect of family planning services at CSO
13. Broad range of family planning services available at CSO
14. Client follow up by CSO family planning staff
15. Evaluation of CSO-Based family planning program
16. Client-determined CSO family planning program goals
17. Onsite child care at CSO
18. Confidentiality of CSO-Based family planning services
19. Active CSO family planning outreach
20. Clear CSO family planning program goals
21. Availability of family planning services during most hours of CSO operation
22. CSO Family planning program flexibility
23. Administrator support for CSO-Based family planning program
24. CSO staff support for CSO-Based family planning program
25. TANF Case Manager Support for CSO-Based family planning program
26. Good reputation of the family planning program among clients
27. Visibility of CSO family planning program in the community
28. Easy Client access to CSO-Based family planning services
29. Ability to Prescribe and Provide Examinations on Site at CSO

APPENDIX D

WRITTEN SURVEY

A short written survey about general attitudes towards family planning was administered to interview participants. The written survey contained nine questions with Likert scale-like responses.

This is the last part of the interview. For each question, please check the box that best expresses your opinion about your CSO and community. If you have any questions, please feel free to ask the interviewer.

How would you rate community support for family planning?
❑ very supportive ❑ somewhat supportive ❑ a little supportive ❑ not supportive

How would you rate support within your own CSO for the family planning services provided here?
❑ very supportive ❑ somewhat supportive ❑ a little supportive ❑ not supportive

How would you rate the level of cooperation between family planning agencies in your community?
❑ very cooperative ❑ somewhat cooperative ❑ a little cooperative ❑ not cooperative

How would you rate the accessibility of family planning services for clients at your CSO?
❑ very accessible ❑ generally accessible ❑ not very accessible ❑ not accessible

How would you rate the use of family planning services by clients at your CSO?
❑ fully utilized ❑ adequately utilized ❑ inadequately utilized ❑ not utilized

How would you rate the scope of family planning services provided at your CSO?
❑ full scope ❑ large scope ❑ medium scope ❑ small scope

How much of a problem is unintended pregnancy for State medical assistance clients?
❑ a major problem ❑ a moderate problem ❑ a minor problem ❑ not a problem

How much of a problem is unintended pregnancy for those not receiving State medical assistance?
❑ a major problem ❑ a moderate problem ❑ a minor problem ❑ not a problem

How confident are you that the family planning program at your CSO will continue?
❑ very confident ❑ somewhat confident ❑ not very confident ❑ not confident

Additional Comments:

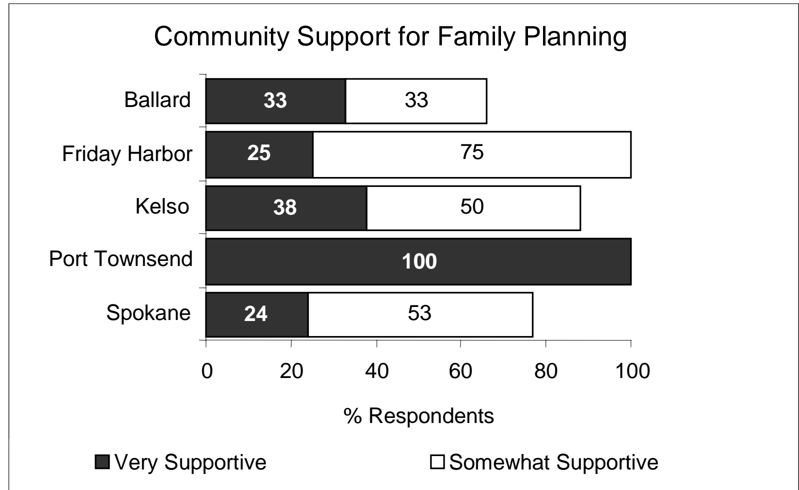
SELECTED RESULTS

Community Support

39% of respondents felt their community was Very supportive and an additional 46% of respondents felt that their community was Somewhat supportive of family planning.

Survey results generally correlate with interview responses.

Port Townsend responses support interview remarks that community advocacy established and sustains the family planning program. Kelso respondents indicated that, while the majority of the community members do not support family planning, a general acceptance of CSO family planning has been achieved by working with other community groups.

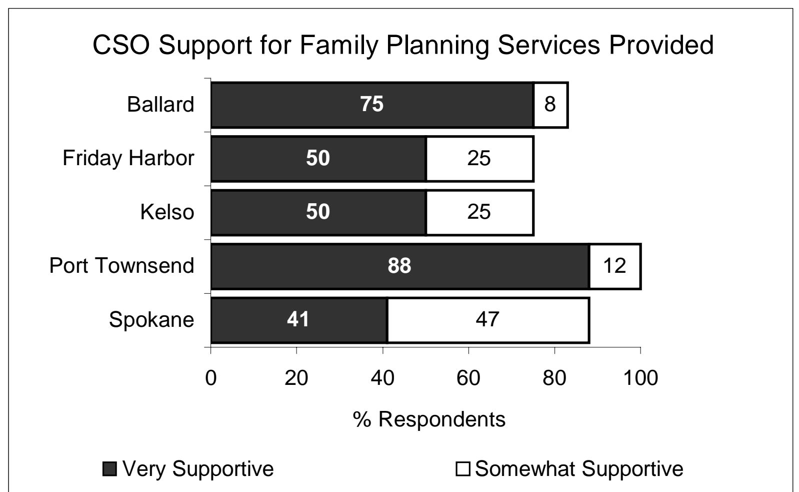


CSO Support

A majority (59%) of respondents felt their CSO was Very Supportive and an additional 27% of respondents felt that their CSO was Somewhat supportive of family planning services provided on site.

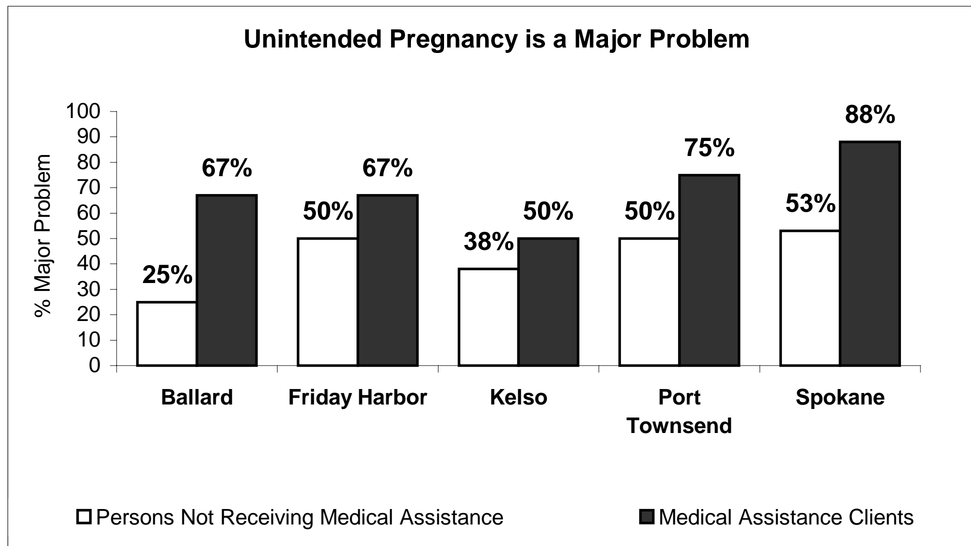
Written survey responses are similar to interview comments regarding CSO support for family planning.

All survey respondents in Port Townsend thought their CSO was Very Supportive or Somewhat Supportive of the family planning program. Respondents in both Kelso and Spokane North indicated that high levels of staff turnover, and the resulting difficulty in maintaining consistent levels of staff training, contribute to lower levels of support for family planning at those CSOs.



Unintended Pregnancy

While nearly half of respondents across sites (45%) felt that unintended pregnancy was a major problem for people not receiving Medical Assistance, nearly three-quarters (73%) of respondents felt that unintended pregnancy was a major problem for those receiving Medical Assistance.



The larger number of respondents who felt that unintended pregnancy is a major problem for those receiving Medical Assistance illustrates that, similar to responses expressed in interviews, a majority of respondents felt that the impact of unintended pregnancy is greater upon those with limited income.

APPENDIX E

INFORMAL SURVEY OF STATES

An informal e-mail survey asked 49 states whether they collocated family planning with other social services. Family planning program managers and information officers in social or health services departments from 46 states responded, by e-mail (27), by telephone (15), and by mail (4), for a response rate of 94%. Some states also shared ideas for family planning programs. Due to time constraints, researchers were unable to follow up with a request to all states for this information, and so apologize for not providing a complete list here. The following table, therefore, while far from being complete, highlights a few ideas.

Family Planning Ideas From Other States

Ideas	Details	State
Training Curriculum[19]	Teaches eligibility workers to discuss the effects of unintended pregnancy on clients' lives and the importance of family planning	AK
Resource Directory	Directory of all Medicaid providers for each community	AK
Mentoring	Matches adults one-on-one with teens to emphasize waiting to become sexually active	CA
Male Involvement	Program to increase male responsibility and knowledge to decrease unintended pregnancy.	CA OR
School-Based Health	Education, counseling, preventative/intervention services for high-risk teens	FL
Wallet Cards	Include family planning information and phone numbers	HI
Computer Field	Include field for family planning services need	IA
School Clinics	Proposed use of tobacco settlement to augment current funding	ME
Free Services	Free family planning at college and teen community health centers	MS
Medical Mall	Old mall refurbished to include health and clinical services with a theater, bills center, and teen family planning clinic open till 8 p.m.	MS
Two-Year Extension	The uninsured receive family planning services for two years.	DE MO
Targeted Mailings	Mailings about family planning services to Medicaid clients	NH
Staff Trainings	District office trainings for enrollment counselors	NH
Outreach by Clients	Some TANF clients are trained to do family planning outreach.	OK
Extended Coverage	Full-year of prescription birth control is provided at case closure.	SD

[19] *Talking to a Client About Family Planning* is available from the State of Alaska Department of Social and Health Services. This curriculum is also used by Hawaii and Montana.

Collocation of Family Planning with Social Services in the Fifty States

Heavily bordered areas represent states with statewide collocation plans similar to Washington's.

State	# of women 15-44*	Information/Referrals	Services	Eligibility	Statewide
Alabama	278,510	✔			✔
Alaska	32,480	✔			✔
Arizona	285,720				
Arkansas	156,590			✔	✔
California	2,205,920			✔	✔
Colorado	224,100				
Delaware	39,080				
Florida	804,780	✔	✔		✔
Hawaii	59,210	✔			✔
Idaho	69,750				
Illinois	701,090			✔	✔
Indiana	363,650				
Iowa	166,630	✔			✔
Kansas	563,000	✔		✔	
Kentucky	247,150				
Louisiana	314,000				
Maine	83,550				
Maryland	257,430	✔			✔
Massachusetts	356,320		✔		
Michigan	599,680				
Minnesota	255,870	✔	✔		
Mississippi	193,330		✔		
Missouri	338,630			✔	✔
Montana	52,620	✔			✔
Nebraska	100,150				
Nevada	89,620	✔			✔
New Hampshire	64,870	✔			✔
New Jersey	413,420				
New Mexico	126,230				
New York	1,199,410	✔			✔
North Carolina	455,980				
North Dakota	40,300	✔	✔		✔
Oklahoma	209,450	✔			✔
Oregon	187,040	✔		✔	✔
Pennsylvania	747,280				
Rhode Island	63,350	✔			✔
South Carolina	246,980	✔	✔		
South Dakota	47,260	✔			✔
Tennessee	336,410				
Texas	1,290,080				
Utah	127,900	✔			✔
Vermont	39,960				
Virginia	1,580,000		✔		
West Virginia	116,190	✔			
Washington	315,200	✔	✔		✔
Wisconsin	296,390		✔		
Wyoming	27,180				

*The number of women in need of family planning services (Alan Guttmacher Institute, 1998)

STATE SURVEY RESPONDENTS

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[20] Florida *W.A.G.E.S. Statewide Implementation Plan, 1996.*

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