Let's Hear It for the Guys: California's Male Involvement Program

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California's Male Involvement Program (MIP) is a statewide effort to involve young and adult males in teen pregnancy prevention. MIP has been successful in attracting an ethnically and culturally diverse group of young men in multiple community settings. Many of these youth are exposed to risk factors often associated with unintended teen pregnancy, including poverty and academic failure. The program also aims to support young males in a variety of ways that go beyond traditional family planning education or services, helping participants to successfully navigate a healthy passage into adulthood. Programs assist young men through mentoring, affirming cultural roots that emphasize responsibility, and providing alternatives to early fatherhood. Evaluation results document that although MIP significantly improves the knowledge of a vast number of participants concerning pregnancy risk, contraception, and sexual responsibility, it has encountered difficulty in translating knowledge into changed behavior. Nevertheless, the MIP staff understand that issues affecting male involvement in teen pregnancy prevention are complex and deeply

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rooted in cultural and societal norms—complexities that require tailoring of programs to their needs. Thus, MIP offers insights for planning and implementing an expanded set of responsive strategies at the local, state, and national levels.

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Preventing adolescents from having an unintended pregnancy has been an important federal and state goal since the early 1970s. Adolescents in the United States have a higher proportion of pregnancies that are unintended than do adults (Santelli, Lindberg, Abma, McNeely, & Resnick, 2000). Moreover, adolescents who have initiated sexual intercourse have some of the highest age-specific rates of sexually transmitted diseases, which, along with unintended pregnancy, impose enormous personal and human costs, lost social and economic opportunities, and high social welfare and healthcare costs (Flinn & Hauser, 1998; National Campaign to Prevent Teen Pregnancy, 1997). Although pregnancy clearly involves both males and females, health professionals have long struggled to define how males could and should participate in pregnancy prevention efforts.

Traditionally, efforts to improve reproductive health in the United States have typically targeted women, largely ignoring the sexual and reproductive health needs of men (Alan Guttmacher Institute, 2002; Sonenstein, 2000). In addition, standards of reproductive healthcare have been established for women, yet no similar code has been instituted for men. Recruiting men is often viewed as secondary to a clinic's primary purpose of meeting women's family planning needs, although encouraging women to bring in their male partners is seen as beneficial to female patients (Schulte & Sonenstein, 1995). Other barriers include the lack of interest among many healthcare providers in offering services to men, lack of training, and/or a concern that services for men might divert limited resources from serving women and compromise the quality and availability of care (Alan Guttmacher Institute, 2002).

The underlying reasons contributing to the reproductive health services gap between women and men are understandable (Alan Guttmacher Institute, 2002). Only women become pregnant and bear children, and safe pregnancies and the healthiest possible outcomes are essential to the well-being of women, children, and families. Apart from condoms, the clear majority of available contraceptive options are geared to females and the relative ease of impacting their fertility cycle. Furthermore, a relatively long history of political advocacy in the area of reproductive health has also been driven by women, and, as a result, diluting the limited available resources is also seen as threatening to the health and well-being of women.

Research has documented, however, that young men, in fact, do need more reproductive health information and services for a variety of reasons. First, males need to understand how to protect themselves and their partners from HIV/AIDS, other STDs, and unintended pregnancies (Schulte & Sonenstein, 1995). Second, males have sex earlier, more frequently, and with more partners than females of

comparable ages. Ten percent of males report being already sexually experienced by age 13, as compared to 4% of females (http://apps.nccd.cdc.gov/yrbss/QuestYearTable). Moreover, 14% of male ninth-graders reported that they had four or more sexual partners, as compared to 6% of females (http://apps.nccd.cdc.gov/yrbss/QuestYearTable). Third, young men report that they want more information about reproductive health issues than they currently receive. Parents of teens often do not provide their children, especially their male offspring, with the type of information they need. For example, only half of young men participating in the National Survey on Adolescent Males (NSAM) reported that they had spoken to their parents about a reproductive health topic (Lindberg, Ku, & Sonenstein, 2000). Fourth, many young men either do not know where to find or do not have access to preventive care or treatment (Lindberget et al., 2000; Schulte & Sonenstein, 1995; Sonenstein, 2000; Sonenstein, Stewart, Lindberg, Pernas, & William, 1997). In 2002, males constituted 4% of family planning clientele of clinics funded by the Title X of the Public Health Service Act (Alan Guttmacher Institute, 2003). Fifth, while contraceptive adoption often falls on the shoulders of the female partner, the more involved the young man is in the relationship, including communication regarding contraceptive use, the greater the likelihood that the couple will use contraceptives (Kirby, 2001). Cumulatively, these problems leave young men in need of much greater access to information and services that could enhance their reproductive health. By not working with men, the healthcare system misses more than half the equation as males are influential in the couple's contraceptive use, whether or not they are using condoms (Stolberg, 2002).

Research on males and sexual responsibility also indicates that, in general, males know less about sexuality, contraception, and pregnancy than females (California Office of Family Planning, 1996; Brindis, Boggess, Katsuranis, Mantell, McCarter, & Wolfe, 1998). Because they are young, many are uniformed about how to access healthcare on their own or are reluctant to do so because of embarrassment or cultural beliefs that equate seeking help with inappropriate masculine behavior. Furthermore, unlike females, who must visit a reproductive healthcare provider for most contraceptive methods, males may perceive fewer reasons to use reproductive healthcare. In addition, insurance often does not cover what men need most: information and counseling (Stolberg, 2002). Even young men who are sufficiently motivated to gain access to reproductive health services face formidable structural and cultural barriers to receiving care. Resource restrictions, predominantly female staff, negative staff attitudes, and a lack of staff training to address the unique needs of adolescent and young adult men are thought to be major barriers to including men in family planning services (Brindis et al., 1998; Schulte & Sonenstein, 1995).

Both national and international data provide numerous indications that young men are motivated to participate in reproductive healthcare behaviors and services despite the formidable obstacles they face (Armstrong, Cohall, Vaughan, Scott, Tiezzi, & McCarthy, 1999). The National Survey on Adolescent Males (NSAM) documented the dramatic increase in male teenagers' condom use between the late 1970s and the 1990s demonstrating that males can be influenced to adopt new behaviors and that programs designed to change male reproductive behavior will not necessarily fail (Sonenstein et al., 1997). Promoting the sexual and reproductive

health of young men is essential to enhancing their overall health and can lead to new inroads in promoting healthier lifestyles and reducing unplanned pregnancies and births (Sonenstein, 2000). Moreover, supporting programs that improve the overall health and well-being of young men will likely have secondary benefits, with improvements in the lives of women, their future partners, and children.

HISTORY OF MALE INVOLVEMENT

Actively engaging men in reproductive health is not a new idea. In the 1970s, the Federal Department of Health and Human Services funded a set of demonstration projects through Title X of the Public Health Service Act to encourage investment in men's health. These programs achieved only partial success since many agencies attempted to incorporate family planning services for males into existing female-oriented programs, often failing to account for gender-specific factors. For instance, emphasis was placed on providing condoms to young men, without first considering the underlying motivational, normative, and social factors that needed to be addressed in order to make contraceptive adoption by males (and/or support of partner's use) a social norm. Since these interventions were not designed specifically for men and were not perceived to be "male friendly" and because specific funding continued to be inadequate, young men were often marginalized from needed services (Brindis, Tye, Barenbaum, Sanchez-Flores, Judd, & Chand, 2002). As a result, these early demonstration programs were discontinued (Sonenstein, 2000). An unfortunate byproduct of this historic demonstration phase was the lack of adequate documentation of the lessons learned in serving men, lessons that could have clearly benefited the most recent attempts to support male reproductive health services. In recent years, the convergence of several public policies has once again placed the focus on the role of males in pregnancy prevention and the necessity of addressing the reproductive health needs of young men separately and/or along with their female partners (Brindis et al., 2002). These policy issues include the promotion of condom use to curb STIs and HIV/AIDS, the recognition that consistent contraceptive use by partners is a key component for preventing unintended pregnancy, more rigorous enforcement of paternity identification and child support, prosecution of statutory rape, an increase in Federal Title X family planning funded programs that provide clinical and educational services for males through their network of family planning clinics (4.7 million in FY-1999), and a national grassroots movement enhanced by federal funding to encourage male involvement and responsible fatherhood (Brindis et al., 2002; http://opa.osophs.dhhs.gov/titlex/ofp-male-grantees.html).

Given the changing social context, the funding environment, and increasing recognition of the important role that males play, it is vital to document efforts to provide an array of reproductive services to males, helping to assure that the next generation of programmatic efforts build on these lessons learned. In this article, we present a descriptive overview of an innovative approach to meet the diverse reproductive needs of males within their social and community context—California's Male Involvement Program. We present the program's philosophy, program strategies, and evaluation results.

PROGRAM HISTORY

The Male Involvement Program (MIP) was initiated in 1995 by the California Department of Health Services, Office of Family Planning (OFP). It represented the first statewide effort to mobilize adolescent and young adult males to prevent teenage pregnancy (TP) and early unintended fatherhood. From the onset, OFP pushed traditional service boundaries, going far beyond the accepted philosophy that male involvement in unintended pregnancy prevention began and ended with the provision of condoms. Rather, OFP required community agencies to develop strategies aimed at impacting the underlying community fabric that often explicitly condoned early childbearing. Agencies were encouraged to develop programs aimed at changing the essence of community social norms regarding not only contraceptive use and teenage pregnancy prevention but the essence of gender roles. Thus, OFP's Request for Application (RFA) solicited applications for community-focused prevention and health education program activities addressing the underlying problems of teen and unintended pregnancies and absentee fatherhood.[1] OFP not only sought to fund traditional clinic providers (e.g., providers who knew a great deal about providing family planning services but who may have had limited experience in serving males) but also made a deliberate attempt to broaden the applicant pool to nontraditional grantees, such as community-based programs that may have had extensive experience working with males but less of a focus on reproductive health services.

For the initial three-year funding cycle (1996-1999), OFP awarded grants to 23 community-based organizations located throughout California and operating in both urban and rural settings. For example, educational sessions were delivered in multiple settings, including alternative/continuation and mainstream schools, juvenile detention centers, and migrant work camps. A second cycle of funding supported a total of 25 agencies in 1999-2004. The Center for Reproductive Health Research and Policy at the University of California, San Francisco, conducted the formative evaluation, including qualitative and quantitative analyses of the program and its participants, as well as describing programmatic interventions over the two funding cycles.

PROGRAM OVERVIEW

The goals of MIP were three-fold: (1) to increase community and individual awareness regarding the importance of young men's roles and responsibilities in the prevention of TP; (2) to reinforce community values that support these roles; and (3) to increase knowledge, skills, and motivation of at-risk adolescent males and young adult men in order to promote their role in reducing teen pregnancies. OFP strongly encouraged MIP agencies to use a grassroots approach and adopt a holistic vision to TP prevention by utilizing a myriad of strategies that extended beyond comprehensive family life education and condom distribution. MIP agencies designed groundbreaking programming focused on the roles and responsibilities of males in preventing TP as well as assisting young men in their safe and healthy navigation into adulthood. These programs addressed the social fabric, values, and motivations that impact the knowledge, attitudes, and behaviors of young men.

OFP consultants worked individually with grantees to develop their contracts and scopes of work, facilitating program development and implementation customized to each particular site. For example, as few family life curricula existed that were male specific, program staff needed to develop specific program content that was gender specific. OFP encouraged cross-fertilization including the sharing of materials through a series of state-sponsored, regional convenings. These events served as continuing education for the grantees since they offered both the OFP and the MIP staff the opportunity to share lessons learned and gave them exposure to successful strategies that were being initially developed and tested throughout the state in local communities.

While no mandated client eligibility requirements were established, the location of programs as well as their primary target populations assured that programs sought to reach low-income, ethnically diverse young men at risk of early fatherhood. Programs served youth in a wide range of program settings, ranging from juvenile halls and alternative schools to parks and recreation areas and other nontraditional settings. As a result, staff successfully enrolled young men who often did not participate in traditional school settings. Moreover, the number of participants within each of these settings varied from one participant at a time, through one-on-one staff contacts, to hundreds reached through community health fairs, with obvious variability in intensity. The interventions also ranged in length from single educational sessions to ongoing meetings held over several months. For example, some of the interventions were up to several weeks long (once a week for a total of eight to 16 hours), such as programs that focused on youth development, while others, including program retreats, were more intense (e.g., 16 to 20 hours of intervention within two to three days).

In the following section, we describe the methodology used in this evaluation and present findings pertaining to program implementation and utilization.

METHODS

Both qualitative and quantitative methods were used to capture the development and implementation of the MIP. Qualitative data documenting MIP's interventions and educational programs were gathered through interviews with program staff, including project directors and health educators, and focus groups composed of approximately eight to 10 participants in each of the 25 MIP agencies. In the interviews, program staff discussed the profile and philosophy of their program, community norms and cultural factors that affected their policies and activities, linkages with clinical services, and the challenges they faced. In the focus groups, youth discussed such topics as their likes/dislikes about the MIP and how the program affected their lives. Questions included the following: what have you learned in MIP, how has participating in MIP helped you in your daily life, what does responsibility mean to you, and have you shared anything you learned or your experiences in MIP with your family, friends, community?[2]

In addition, the evaluation team developed a program taxonomy completed by staff to describe specific interventions and activities they were implementing. The evaluation also included data gathered from quarterly progress reports submitted to

OFP by MIP staff. These reports helped to capture process data—for example, the sites where the programs were provided, the topics covered, and the length of the program.

Information describing individual participants' demographics, sexual behavior, knowledge, attitudes regarding pregnancy and its prevention, and patterns of contraceptive behavior (e.g., use of condoms, use of contraceptives the last time they had sex) was obtained through a self-administered survey collected between July 1999 and August 2002. The survey was distributed to male participants at program entry followed by a post-survey collected at the program's conclusion. Survey results provided a baseline profile of nearly 15,000 males who completed at least one survey as part of their participation in the MIP; a matched sample of 3,094 pre- and post-surveys were also included in this analysis. While program staff attempted to gather as many matched pre- and post-tests as possible, this differential reflects the transient nature of participants, the diversity of settings in which the MIP is implemented (for example, juvenile justice settings and alternative schools, both of which had high turnover), the challenges of tracking participants by program staff, and the lack of sufficient evaluation resources to track participants.

As previously mentioned, programs varied by length and intensity, which impacted when baseline and follow-up data were gathered. Nine percent of MIP participants completed the pre/post surveys within one week, 33% between one and five weeks, 19% between six and 10 weeks, and 39% completed the post survey after 10 weeks of participating in the program. These differences reflect the wide variability in program length as well as content. Human subject approval was successfully sought from UCSF, and all participants completed consent forms before participating in the focus group and survey data gathering.

ANALYSIS

All surveys were submitted to University of California, San Francisco, where they were reviewed for irregularities and/or inconsistencies. After being cleaned, the surveys were entered into an Excel database; Statistical Analysis System Version 8.2 was used to analyze survey data. Simple analytic approaches were used to calculate frequency distributions using cross-tabulations to present descriptive statistics. *T*-tests were used to test for significant differences between groups. Excel was used to analyze the qualitative information. In the following section, we present key results, combining both quantitative and qualitative data to describe the accomplishments of the MIP as well as areas that need further development.

RESULTS

MIP STRATEGIES AND CROSS-CUTTING THEMES

MIP is rooted in the philosophy that, by focusing and building on the strengths and assets of young men, their families, and communities, young men will be exposed to opportunities and a sense of future that they may not have realized was within their reach. But operationalizing such a philosophy was often found to be challenging

throughout each phase of program development. On the whole, MIP worked within an environment that denied young people's need for information regarding their sexuality and reproductive health. Despite substantial research indicating that the provision of health information does not encourage young people to engage in sexual behavior or increase the number of sexual partners (Kirby, 2001), many community members were wary of supporting male-focused, comprehensive family life education that incorporated a dual message of abstinence and contraceptive use.

Additional challenges included (1) working within a societal context that actively resisted engaging males in contraceptive decision making and promoting male responsibility, (2) family planning program staff who were concerned that a focus on males could dilute limited resources available to serve women, (3) a barrage of popular media messages that appeared to instill casual attitudes toward sex, (4) the often-held attitude in many MIP communities that young fatherhood is inevitable, and (5) a shortage of qualified community-based organizations and clinic-based male staff who could effectively work with the MIP population.

In an effort to face these myriad challenges, each MIP project followed core components: (1) community awareness of male involvement; (2) community mobilization; (3) prevention education services; (4) youth leadership development; (5) youth-adult partnerships; (6) institutionalization of male involvement programs; and (7) referral and linkages with clinical services. Although agencies were not initially required to implement all components, they were urged to utilize the framework components to fashion their programs, choose their curricula, and design their activities. Opportunities to learn from each other's experiences helped to facilitate this process. Qualitative data showed that, while not every MIP agency was able to incorporate all seven components into their programs, most were able to incorporate a number of components. The level of consistency within a specific program also varied to some extent, given the diversity in settings, age groups, and ethnicity across MIP programs. Agencies chose those components that would most effectively respond to their population and that could realistically be implemented given available resources. In the following section, we present qualitative results regarding the implementation of the program components, followed by participant survey results.

Community Awareness and Mobilization

In order to mobilize communities regarding the importance of involving young men in TP prevention and the tremendous responsibility of fatherhood, local projects implemented community media awareness campaigns. This was seen as an initial step in raising community awareness regarding the importance of male responsibility and the value of providing young men with clear messages regarding their vital role in planning not only for their own futures but also the futures of their partners by avoiding early parenting.

Messages were crafted by program staff and participants to ensure their cultural relevance and to reflect the styles of youth from diverse backgrounds. Programs worked with community organizations and local businesses to post a variety of messages on local billboards, bus benches, and public bulletin boards, including "What

you do today creates tomorrow," "Be a Man, Be Responsible," and "My blood, my son, my responsibility." MIP projects received specific funding to develop these media messages as well as social marketing strategies, including brochures (77%), T-shirts (68%), featured articles in newspapers (59%), and radio PSAs (41%). While the evaluation tracked how many agencies used social marketing strategies, it did not track how often strategies such as PSAs or newspaper ads were played or featured. However, staff and participant data documented the importance of these strategies in engaging both the young men and their families. This was especially true when a contest was held to select from among the local grantees two examples of social marketing strategies that were in turn used statewide as part of a media campaign.

PREVENTION EDUCATION SERVICES

MIP agencies recognized that in order to prevent TP, STIs, and HIV/AIDS, they had to better understand and meet their participants' greater psychosocial needs. The taxonomy (see Figure 1) showed that, while the core set of educational topics included teen pregnancy, fatherhood, contraception, abstinence, and STI prevention, other topics covered by the curricula included information that the young men needed, for example, legal issues and information on their own cultural heritage and values. The selected topics were dependent on the length of time available for the MIP curricula,

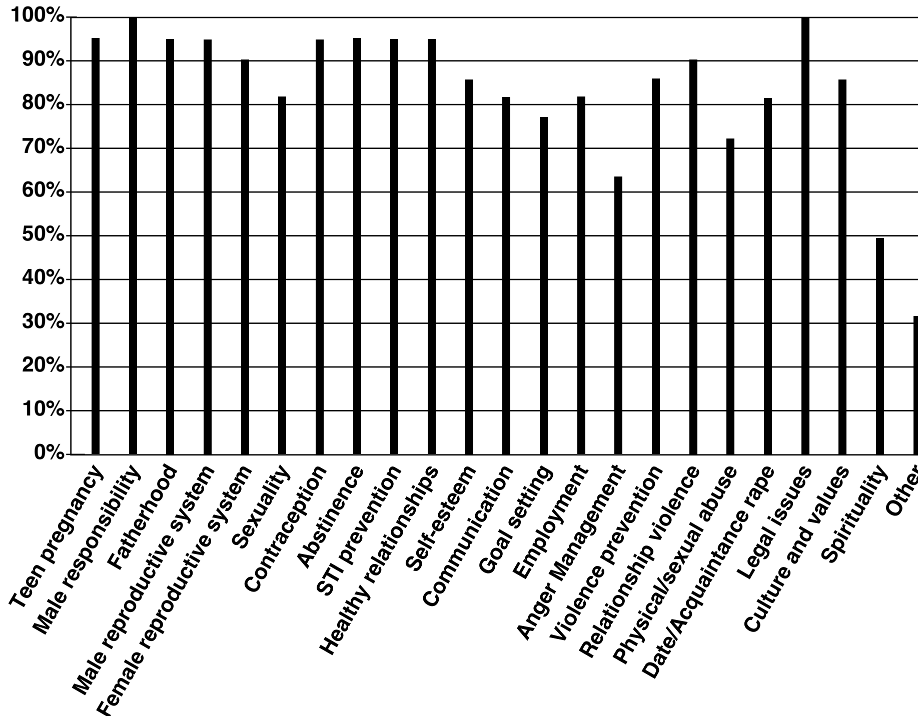

Figure 1. Topics covered by MIP projects ($N = 22$).

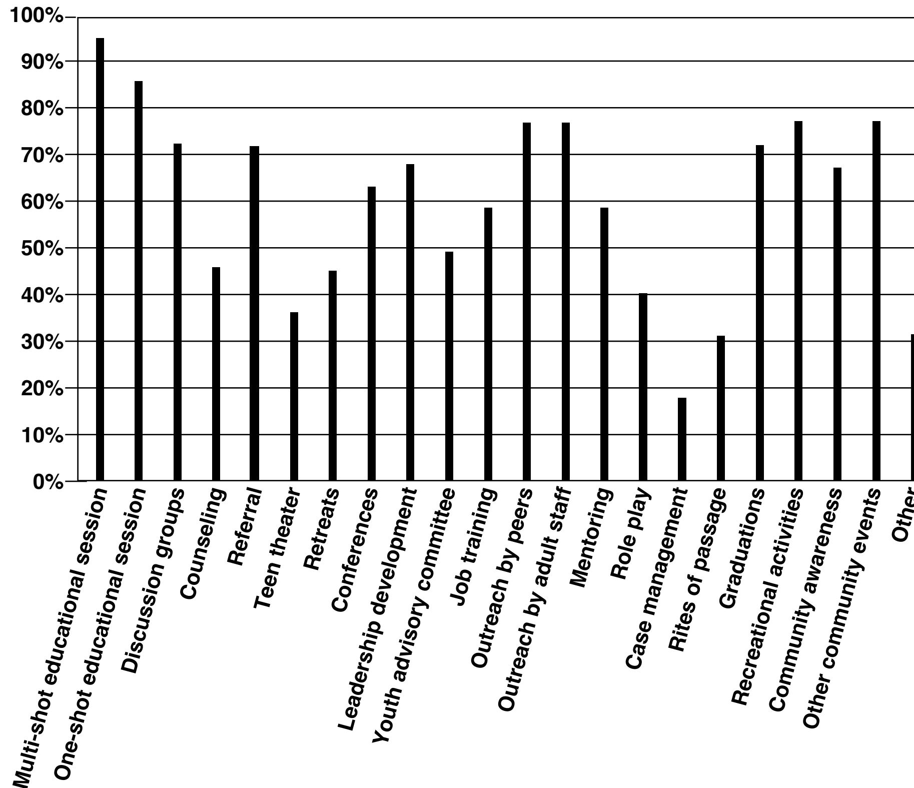

Figure 2. Interventions and strategies used by MIP projects ($N = 22$).

the setting, the developmental appropriateness of the curricula to the audience, and the interests of the school and other program staff who invited MIP educators to conduct these programs. As shown in Figure 2, MIP staffers presented their program and conducted outreach to young men in a wide variety of community settings, contributing to a high level of community visibility with a wide number of agency staff and adolescents who are often marginalized.

YOUTH LEADERSHIP PROGRAMS

MIP used a combination of educational interventions and strategies that assisted participants in developing crucial life skills they needed to navigate safely their adolescence and eventually adulthood (see Figure 3). For example, learning how to build connections to others, trust adults, and be dependable and a "man of your word and honor" were developed through opportunities offered to the participants. Peer mentoring components helped many young men to develop their leadership skills, improved their self-esteem, increased their understanding of what male responsibil-

ity means, and helped them to understand their personal value through cultural pride and their sense of spirituality. At one MIP agency, several participants were asked to serve on the program's advisory board and planning committees, thus making participants stakeholders in the success of the program's efforts. Agencies also provided sessions on job preparation, training on preparing a resume, role-playing interviews, and creating a community employment referral system.

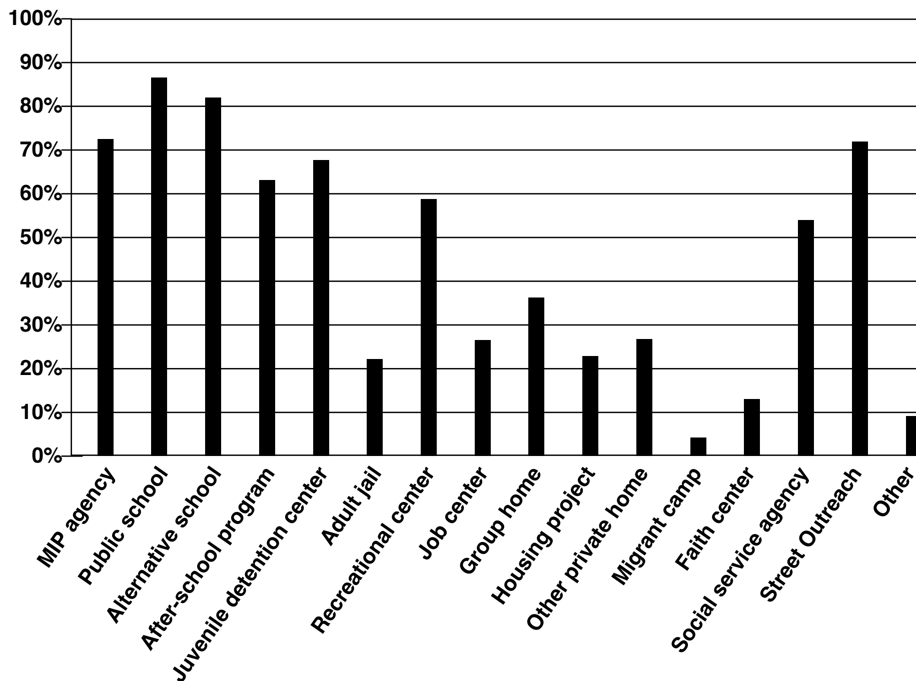

Figure 3. Settings where MIP staff conduct outreach and educational sessions (N = 22).

The largest youth development undertaking was the annual three-day Young Men's Summit, which allowed young men to meet their MIP counterparts from throughout the state. It also provided many of the young men an opportunity to further develop positive leadership skills necessary to enhance their local TP prevention efforts.[3] MIP staff believed that activities like the summit, where young men from all 25 agencies planned every detail, including the invited speakers, the workshops, and the food served, had a tremendous impact on their self-esteem and productivity. Since the summit was held on college campuses, it provided many young men with their first exposure to the possibility of pursuing this opportunity. This reinforced the message that there was a greater likelihood of being able to pursue these opportunities if they delayed early fatherhood.

YOUTH-ADULT PARTNERSHIPS

Program components, such as youth-adult partnerships, helped to assure that participants spent time with caring adults who offered positive role modeling, assistance, guidance, and friendship. At one agency, the sheriff's department provided a Saturday study hall for middle and high school students. Volunteers from the community participated in weekly meetings by tutoring and facilitating educational sessions on topics of interest to males and/or assisting young men with their school work. In the afternoon, the adults and teens teamed up to play sports. At other sites, the "elders" in the community participated in sweat lodges with the young men, which exposed young men to cultural traditions and values, including teaching respect for family. This activity helped the young men develop a far stronger sense of identity and pride as well as a new personal connection to their traditions. These partnerships also taught youth to communicate effectively with people of different ages and visualize their life potential as well as providing them with a sense of self-confidence that they have both the ability and the means to achieve their dreams.

Data derived from the youth focus groups and the taxonomy found that it did not appear to matter whether the concept of male responsibility was relayed to youth through activities, such as sports; cultural events and trainings; or mentoring. What did matter, however, was that the educators who delivered the messages experienced the same kind of world that they did. MIP messages resonated with young males because educators they related to presented the MIP message of male responsibility, sharing that they too had had to learn this message within their own community normative lens, a lens that was often at odds with the program's message of responsibility. The messages also resonated with the young men because they were being delivered in their own community settings. A number of participants commented that they felt positive about the program when they would run into the program staff in the evenings and weekends, not just during program hours.

The teens reported that their participation in the groups helped them understand their background and feel a sense of worth and a greater appreciation of relationships, especially with women and their parents. Many teens believed that participating in the groups kept them out of trouble and provided them a good education regarding sexuality. They also often shared the knowledge and information learned in MIP with their peers and parents. This was particularly significant since a sizeable portion of the parents of MIP participants do not have the knowledge and/or the ability to teach their children about sexuality and contraception, reflecting their own gaps in knowledge as they were growing up and cultural taboos. Since many youth in MIP come from economically disadvantaged and single-parent homes where they often lack a steady male role model and direction, program staff often played important roles as mentors and informal advisors long after the program ended.

During staff interviews, MIP staff expressed that their participants matured in MIP by gaining ownership of their program and by exploring their cultural background. Youth felt the information they received dispelled negative stereotypes about their environments and about themselves. MIP provided a picture that instilled ethnic pride and prosocial attitudes and behaviors, not anger.

The MIP staff also addressed a broad range of young men's concerns (e.g., economic security, academic pursuits, and safety) that influenced sexual and contraceptive decision making. Program staff addressed these concerns as well as the underlying individual motivation, social norms, and values influencing these behaviors with sufficient time and intensity.

INSTITUTIONALIZATION OF MALE INVOLVEMENT

Ensuring that male involvement became an integral component of youth programs and community institutions was a primary goal of MIP. By becoming active on school boards, city councils, and CBO advisory boards, MIP staff developed trusting relationships with other community agencies as well as playing an active role in community coalitions, such as those devoted to TP and/or violence prevention.

Institutionalization of MIP was recorded at several levels within MIP programs. For example, school credit toward graduation was earned by young men who participated in MIP health education classes, while in other communities several district attorney offices mandated that juvenile offenders attend MIP sessions to meet release requirements. In other settings, MIP staff trained other staff working within their sponsoring agencies to make services more male-friendly. By institutionalizing and mainstreaming the MIP's philosophy and activities, the program aimed to decrease the marginalizing of males in the prevention of TP; provided meaningful role models; created meaningful roles for themselves, for example, as youth leaders and volunteers; and offered alternatives to early or repeat fatherhood.

REFERRALS AND LINKAGES WITH CLINICAL SERVICES

Strengthening ties with clinical service providers and increasing awareness among males about available health services were principal objectives of the MIP. Nearly one-third of community-based, nonhealth organizations developed strategies to assist males in receiving the critical clinical services they needed. For example, staff developed formal and informal relationships with varied service providers, including psychological counseling, family planning, and STI testing and treatment, to help facilitate inter- and intra-agency referrals. Three other agencies began satellite family planning health centers either at or near local high schools to overcome transportation and other common barriers teenagers face in seeking care, particularly among young men who have fewer skills and less guidance in accessing care.

For the approximately one-fourth of sites that primarily worked with out-of-school youth and/or young adults, those who had concerns regarding confidentiality, or those who lacked access to a convenient health provider or clinic, a family planning mobile unit visited isolated sites several times a month. Five MIP sites offered an array of clinical services in migrant camps, such as HIV and TB screenings, perinatal outreach services, and immunizations. These multiple outreach strategies were important given the transient nature of the population served.

Staff in a number of programs recognized that males required more intensive support to access contraceptive services, particularly by CBOs that may not have a clinical component. Building relationships with clinical service providers was essen-

tial in ensuring needed access to reproductive health services and in educating others on the specific needs of males. MIP agencies held training for clinic staff on the differences between males and females regarding their understanding, access, and use of clinical services and contraception. In addition, MIP agencies encouraged clinic providers to be more male-friendly by painting their clinics a neutral color, hanging gender-appropriate posters, offering male-oriented magazines, and hiring male staff. At the system level, the challenges of accessing care led to an expansion of efforts to bridge community-based pregnancy prevention education programs to clinical services. As a result, the current grant cycle requires a link between CBOs and clinical family planning providers funded by the state OFP.

These MIP strategies along with the availability of state-subsidized reproductive health services for both males and females who meet income eligibility (< 200% of poverty) and a three-year, statewide media campaign (discontinued in 2003) that stressed male responsibility appear to have contributed to increases in the proportion of male clients enrolled in California's publicly funded family planning program (Family PACT). In 1999, there were approximately 82,636 males enrolled in Family PACT, constituting 8% of Family PACT clients (UCSF Center for Reproductive Health Research and Policy, 2004). In 2003, 183,560 males were using Family PACT services, constituting 12% of clients enrolled, representing a 45% increase over four years.

While these increases point to the feasibility of serving men when services are made available through a network of private and public sector providers, the relatively small proportion of the overall client enrollment speaks to the need for bridging efforts between community-based organizations and clinical delivery systems, especially those programs that have ongoing relationships with youth at risk of early parenthood. MIP's experience in successfully linking clinical and community education services is useful in helping to shape the State OFP's efforts to facilitate young men's use of reproductive health services and may, in turn, influence young men's use of other health services.

MIP AND STAFF-CLIENT SATISFACTION

Results from staff interviews and youth focus groups also document a high degree of satisfaction across the various MIP agencies. An important component was the local sponsoring agency since the "parent organization" influenced the scope of program activities and interventions adopted. For example, when the lead agency was a health department or Planned Parenthood, there was a tendency for those programs to focus on health services. In community-based organizations, the MIP programs concentrated on creating youth development models, often paying less attention to making clinical services available. Apart from sponsorship, the most effective MIP programs also seemed to be those implemented by organizations connected to other support services. These programs provided direct services, such as case management and work development, but could also provide referrals to health services.

Participants seemed to be most satisfied with agencies that provided them with a "one-stop shopping service," greatly facilitating their access and assuring some efforts to follow up on referrals, for example, for employment. While there was

great variability, all MIPs incorporated a health emphasis, focusing on young men protecting themselves against STDs and unintended pregnancy.

Staff expressed that a number of participants developed special relationships with staff members and maintained their contacts with the staff over long periods of time. As these young men's needs changed over time and they desired to be active in the community, they returned asking for employment assistance or requested to participate in a community event or program retreat. Focus group results indicated that many of the men expressed great appreciation for the program and felt that the staff had created a safe place for them in which they could develop new relationships as well as a better sense of their own culture.

SURVEY RESULTS

Background Characteristics of Participants. More than half (52%) of the 14,992 MIP participants surveyed were Latino, 19% African American, 15% White, 6% Asian, 5% representing other racial or ethnic groups, and 3% Native American. While 53% of MIP participants were 15 to 17 years of age, the program also reached younger males ages 14 years or younger (25%) and young adult males (22%) ages 18 years or older.

Sexual Experience. At baseline, 60% of all participants were sexually experienced; African American (69%) and White (68%) males were nearly equally sexually experienced, more than reported by Latinos (56%). Furthermore, 23% of MIP participants 14 years old or younger, 67% of males ages 15-17 years, and 87% of males ages 18 or older were sexually experienced. Approximately one quarter (26%) had impregnated a partner whereas 17% were already fathers upon entering the MIP program.

Of the data available from the matched pre-and post-survey ($n = 3{,}094$), approximately 50% of participants were not sexually active at baseline. At post-test, almost all of this group (88%) did not engage in sex. Among the 12% of participants who initiated sexual activity during this time, 82% reported that they used contraceptives and condoms as compared to the proportion of contraceptive use among those who entered the program already sexually active (68%, $p < .01$). Similarly, among the group that became sexually active, 72% reported using condoms versus 61% who reported condom use at program entry ($p < .01$). Average age at sexual debut for the new initiators was 13.9 versus 13.4 among those who had entered the program already sexually active. While the program may have been a contributing factor to a five-month delay in sexual debut, the data are insufficient to justify the conclusion. Rather, these patterns of early onset of sexual debut point to the high-risk nature of these young men and the need for health education, teen-friendly, confidential contraceptive services and other supportive relationships to reinforce safer sex practices.

Reproductive Knowledge. The multiple-choice questionnaire also measured participants' knowledge regarding pregnancy, including if they knew where to obtain birth control, the risk of pregnancy at first sex, the risk of pregnancy using withdrawal, and awareness of California's statutory rape law. For example, participants were asked, "Can a young man make a woman pregnant the first few times he has sex?" or "Is it against the law in California for an adult man to have sex with a 16-year old

female?” While the majority (83%) of participants at baseline reported that they knew where to obtain birth control, the proportion increased significantly to 91% at program exit ($p < .0001$).

Similarly, significantly fewer (80%) respondents at pre-test were aware of the risk of pregnancy at first sex than at post-test (91%, $p < .0001$). Participants were less aware of the risk of pregnancy using withdrawal: 55% at baseline compared to 78% at post-test ($p < .0001$). At baseline, the majority of respondents (85%) were

Table 1
Changes in MIP Participants’ Knowledge and Attitudes by Ethnicity

	Latino ($N = 1{,}578$)	African-American ($N = 522$)	White ($N = 513$)
Risk of pregnancy			
at first sex	77%	82%	88%
Pre-test	90%	93%	94%
Post-test	($p < .001$)	($p < .001$)	($p < .001$)
Risk of pregnancy			
using withdrawal	51%	59%	68%
Pre-test	74%	81%	88%
Post-test	($p < .001$)	($p < .001$)	($p < .001$)
Awareness of			
California’s			
statutory rape law	84%	86%	90%
Pre-test	92%	91%	92%
Post-test	($p < .001$)	($p < .05$)	
Know where to			
find birth control	81%	85%	90%
Pre-test	89%	92%	94%
Post-test	($p < .001$)	($p < .001$)	($p < .005$)
Gain respect if			
partner becomes			
pregnant	57%	52%	27%
Pre-test	42%	47%	24%
Post-test	($p < .005$)	($p < .03$)	
Happy if partner			
becomes pregnant	32%	36%	18%
Pre-test	30%	30%	21%
Post-test		($p < .05$)	

Table 2
Changes in MIP Participants' Knowledge and Attitudes by Exposure to Program

	< 1 week ($N = 333$)	1-5 weeks ($N = 1,147$)	6-10 weeks ($N = 677$)	> 10 weeks ($N = 1,382$)
Risk of pregnancy at first sex				
Pre-test	82%	80%	77%	80%
Post-test	93%	90%	91%	92%
	($p < .0001$)	($p < .0001$)	($p < .0001$)	($p < .0001$)
Risk of pregnancy				
using withdrawal	51%	54%	54%	59%
Pre-test	82%	81%	81%	77%
Post-test	($p < .0001$)	($p < .0001$)	($p < .0001$)	($p < .0001$)
Awareness of California's statutory rape law				
Pre-test	84%	82%	83%	86%
Post-test	87%	91%	93%	92%
		($p < .0001$)	($p < .0001$)	($p < .0001$)
Know where to find birth control				
Pre-test	82%	81%	83%	86%
Post-test	90%	90%	91%	92%
	($p < .0001$)	($p < .0001$)	($p < .0001$)	($p < .0001$)
Gain respect if partner becomes pregnant				
Pre-test	38%	50%	51%	54%
Post-test	35%	42%	46%	49%
		($p < .0001$)		
Happy if partner becomes pregnant				
Pre-test	23%	29%	28%	34%
Post-test	22%	21%	30%	34%
		($p < .0001$)		
Do not want partner to be pregnant				
Pre-test	86%	83%	83%	83%
Post-test	81%	81%	84%	81%
Used contraception at last sex				
Pre-test	81%	65%	67%	68%
Post-test	80%	69%	68%	67%
Used condoms at last sex				
Pre-test	76%	58%	70%	60%
Post-test	73%	62%	61%	60%

aware of California's statutory rape law and that if they had sex with a minor (age 17 or younger) they could be prosecuted. Significantly more youth understood the meaning and intent of the law following the program (90%, $p < .0001$).

Although knowledge varied by participants' ethnic/racial groups at pre-test, all groups experienced significant improvements at the post-test (see Table 1).[4] Moreover, regardless of the length and intensity of the program, all participants reported significant changes in knowledge (see Table 2).

Reproductive Attitudes and Behavior. Respondents expressed mixed feelings about what a new pregnancy would symbolize if it occurred at this time. At program entry, half of the respondents (50%) felt that they would gain greater respect from friends if they got their partner pregnant, decreasing to 45% at program exit ($p < .0001$). In contrast, 30% reported they would be happy if their partner were to become pregnant, decreasing to 28% at post-test ($p < .0001$).

When analyzing the data by racial/ethnic groups, only African Americans showed a significant change (between 36% and 30%, $p < .05$) regarding their level of happiness if their partner were to become pregnant. Length of intervention was not shown to have an impact on participants' attitudes regarding a partner's pregnancy, with the exception of those who participated for one to five weeks ($p < .0001$) (see Table 2).

Improvements in attitudes regarding responsibility and communication regarding contraception were also documented. Eighty-one percent of respondents at pre-test felt that contraception is a shared responsibility, increasing to 86% at post-test ($p < .0001$). Similarly, at baseline, 73% reported that it was always or mostly easy to discuss sex and contraception, increasing to 77% at post-test ($p < .0005$).

Contraceptive Use. Contraceptive and condom use at last sex marginally increased from 68% at pre-test to 69% at post-test for contraceptives and from 60% to 61% for condoms. Among all racial/ethnic groups, however, African Americans were the only group that significantly improved their own or their partner's use of contraception or condoms the last time they had sex with an increase from 72% at pre-test to 79% at post-test for contraceptives and from 65% to 72% for condoms ($p < .01$). For Whites, contraceptive use decreased from 70% at pre-test to 68% at post-test, although reported condom use increased from 57% to 59% (not significant). Contraceptive use by Latino respondents or their partners slightly decreased from 66% to 65% while condom use remained the same at 59% from pre- to post-test. Length of time in the program did not impact contraception and condom use (see Table 2).

DISCUSSION

The MIP program has clearly made inroads in developing culturally responsive, developmentally appropriate, and well-accepted programs serving young men. MIP was successful in reaching young men traditionally not served by teenage pregnancy prevention programs, including youth who were 18 years and older or very young (< 14 years) men. They also reached young men through a variety of nontraditional settings, including juvenile halls, recreational centers, and migrant camps. MIP staff

used a variety of innovative strategies, including community awareness and mobilization, linkages to referrals and clinical services to reach youth who require reproductive health education and clinical services.

There is a clear need for programs such as MIP, wherein 60% of all participants had already had sex before they entered the program (13.4 as the average age of sexual initiation), but only about two-thirds reporting using contraceptives (68%) and/or condom use (61%). Furthermore, about a quarter had impregnated a partner, and 17% were fathers.

While knowledge and attitudinal changes were documented, the MIP program was not as successful in demonstrating major behavioral change in contraceptive use, one of the program's most important outcomes. Behavioral change clearly represents an important challenge to community-based programs. While MIP staff establish strong adult-child connections, which in themselves have been shown to be protective against adolescent risk-taking behavior (Bearinger & Resnick, 2003), it is also important to acknowledge the level of risk among program participants and the challenge of achieving long-term behavioral change. It may be important to adopt a "Stages of Change" (Prochaska, DiClemente, & Norcross, 1992) theoretical framework in future programs, wherein the stage of each individual participant will help shape the type of approach the program adopts in assuring that he moves toward positive adoption of safer sex practices. For example, strengthening the relationships between staff and participants may be a crucial step before participants can move through the stages of change framework. Incorporating as part of the program survey questionnaire items that build on the stages framework may help the group leaders better tailor the strategies they adopt, including creating an important bridge to clinical services.

The MIP program appeared to be most effective with youth who were not sexually active at program entry. Young men who entered the program before their sexual initiation tended to wait to initiate having sex. The majority of the "sexually inactive" group remained abstinent (88%). Among the 12% who initiated having sex, they were significantly more likely to use birth control (82% versus 68%, $p < .01$) among those who were sexually active at program entry) and condoms (72% versus 61% among young men who entered the program already sexually active, $p < .01$). Clearly, this is one area that needs further study.

Whether information was delivered in a school, a clinic, and/or the community, MIP participants and staff appeared to be very comfortable discussing condoms and other forms of contraception. The most effective programs were those that incorporated a formal curriculum but adapted the sessions to meet their own participants' needs. While the curriculum provided a structure and ensured that certain themes were covered, modifications allowed educators to be flexible so that their participants' needs were addressed.

The State of California funder as well as program staff recognized that, in order to be effective in changing human behavior, more comprehensive, culturally specific approaches were needed. The MIP evaluation documented that the program was effective in changing attitudes toward pregnancy and contraceptive use, increased the sensitivity of young men for the need for mutuality and responsibility in contra-

ceptive use, and increased their level of knowledge about pregnancy risk, statutory rape, and contraceptives. However, the MIP was not shown to be effective in changing contraceptive and condom use among the majority of participants, with the exception of African American participants. While 72% of African-Americans at post-test reported using condoms at their most recent intercourse, only 59% of Whites and Latinos reflected this pattern. For the African American and Latino participants, their behavioral changes appear to be linked to their attitudes toward early childbearing, with these young men noting that having a baby at this time would not be a positive factor in their lives and that they would not necessarily gain respect if they had a baby. African American and Latino men showed a significant decrease in their perceptions that they would gain respect if their partners became pregnant, decreasing from 52% to 47% among African American males ($p < .03$) and decreasing from 57% to 42% among Latino men ($p < .005$). Among white males, there was only a slight decrease from 27% to 24% (not significant).

A number of reasons may explain these findings, including cultural perceptions regarding parenting, condom efficacy, and the availability of and proximity to reproductive health services. Although the majority of respondents reported that they knew where to obtain birth control, it did not necessarily mean they had psychological and/or practical access in spite of the MIP efforts. Focus group findings illuminated perceived barriers. Young men explained that, although they knew where they could receive birth control, they often lacked transportation, were intimidated by the store clerks who appeared to disapprove of them buying condoms, did not feel comfortable going into clinics because they were not "male friendly," or were afraid that an adult they knew would see them obtaining services. These findings were especially prevalent among young men who attended programs that were not sponsored by a health agency or if the health agency had not made adequate provisions for on-site referrals.

These findings also point to the importance of "tailoring" strategies and providing reinforcing messages to different groups of participants. For example, the large proportion of Latinos participating in the program may require tailoring that reflects the experiences of immigrants versus other Latinos whose families have lived in this country for several generations. Patterns in sexual and contraceptive behavior have been shown to change through the acculturation process, with the more acculturated Latinos initiating sexual relations earlier but using contraceptives more frequently (Driscoll, Biggs, Brindis, & Yankah, 2001). Comparing results by ethnicity as well as level of sexual experience at program entrance helps program planners to create more customized strategies and activities in order to better serve these populations.

From the vantage point of systems change, agencies successfully formed partnerships and developed trusting relationships with other youth-serving providers and community members. Although measuring the program's impact on the community as a whole was difficult, MIP's initial efforts showed that, in spite of obstacles, many community stakeholders, such as school staff and/or CBO staff, embraced the message of male responsibility. For example, at its inception, the vast majority of MIP agencies were allowed to work only in alternative or continuation schools. MIP staff reported that the conventional wisdom during that time was that students in mainstream schools did not need and would not benefit from MIP services. With

persistence, MIP staff were able to gain entrance into mainstream schools and made significant changes in school policy, including asking MIP educators to assist in designing a health class curriculum; providing office space, janitorial service, and bus transportation for MIP activities; and paying teachers to help tutor MIP participants after school hours. In addition, MIP staff were regularly sought as authorities concerning teen pregnancy and male responsibility and as presenters at local and state conferences.

Another challenge to impacting behavioral change was noted by MIP staff across the state. Over the years, as MIPs became more visible and attracted attention locally, statewide, and nationally, greater demand for their services contributed to their reliance on one-time events as a means for accommodating multiple agency invitations. An ironic result of their success and the attention that the MIP drew resulted in staff diluting their efforts across a far greater number of programs. This resulted in more "one-time" presentations that MIP staff noted as likely contributing to limited opportunities for enough programmatic intensity to warrant behavioral change. The staff felt that, although one-time presentations were effective recruiting tools, they were less effective in terms of imparting information or contributing to behavioral change. Overall, MIPs are aware of this resource demand conflict and the impact it has had on service quality and staff. One strategy to balance this situation is to stretch limited resources by collaborating with other youth-serving providers in their communities, providing staff training on MIP-related topics so that they are able to devote themselves to offering longer programs.

While one-session programs were seen as ineffective, programs that were between one and five weeks in length appeared to be more effective in terms of knowledge and attitude change as compared to even longer programs (six weeks or longer). This suggests that dosage had more effect than length. In this case, relatively shorter programs may have provided more intense intervention messages within a window of learning as opposed to longer, although possibly more diluted, interventions or programs that might have been too repetitive in content, thus effectively "turning off" participants. Far greater knowledge is needed regarding the formula of length of program, content, and impact on outcomes for different profiles of participants (e.g., different racial/ethnic groups, age, and whether or not they enter the program already sexually experienced), especially since the goal of behavioral change was elusive, no matter the length of the program. Further research is also needed to determine what is necessary to build linkages between clinical care and prevention educational services and to assess what supplementary supports are essential to successfully enroll young men in clinical settings.

LIMITATIONS AND FUTURE EVALUATION DIRECTIONS

It is important to acknowledge the limitations of this formative evaluation reflecting the different phases of the demonstration project, the evolving nature of the MIP program, and the challenges and expense associated with longitudinally following participants. First, the great variability in program setting, number of participants, length of intervention, and scope of work in each individual program introduces a

level of variability that makes it difficult to make strong evaluation conclusions. Some of the challenges to the evaluation reflect the complexity of the settings in which the program is being offered. For example, attempting to collect data in juvenile hall and migrant camps results in an inherent selection bias, given the level of turnover and its impact on being able to collect matched pre-post data.

Given that some settings are more "stable" from the vantage point of its participants, there is also a risk that results based upon the more "stable" participants will give a biased view on efforts to reach these young men successfully. For example, the profiles of nonmatched versus matched respondents showed that the non-matched group tended to be at higher risk of early childbearing; had higher rates of sexual experience (60% representing pre-test data only versus 50% among those for which there were matched pre- and post-tests); and differed in their attitudes, such as their feelings about gaining respect by becoming a father (54% for nonmatched versus 50% for matched) or feeling happy about their partner becoming pregnant (36% versus 30%, respectively). It is interesting that contraceptive and condom use did not vary as much when comparing matched and unmatched samples (67% vs. 68% reported using contraceptives at entry; 56% versus 60% reported using condoms at baseline).

As a result of these limitations, the vast majority of pre- and post-test matches were collected in mainstream schools, where the possibility of a stable respondent base was greater. Consequently, these results may be useful for future program planning in such settings but are likely not generalizable to all MIP participants. In spite of the potential bias, the risk profile of many of the participants, even in more stable environments such as schools, justifies the importance of developing culturally specific and developmentally appropriate interventions tailored to serving young men in multiple settings.

A major evaluation challenge was effective follow-up. Overall, an important lesson learned through this evaluation is that, if programs are to be effectively evaluated, resources will need to be devoted to follow up with the participants, most likely including staff and client incentives to follow up more intensively as well as staff training regarding the intent of this follow-up effort. For example, MIP staff shared that in many instances the young men, even those in the most challenging settings, had successfully finished the program or would stop by to participate at various times but were not available to complete the formal post-test because of either work or family demands.

Another aspect of the evaluation that would need to improve is adequately measuring the intervention being tested. Although the taxonomy developed for this evaluation helped to delineate the topics covered as well as the types of settings in which the program was delivered, far greater specificity is needed to better understand how these content topics were covered and whether each component was sufficiently implemented would also be necessary. For example, while the majority of programs reported covering the topic of contraceptives, it would be helpful to ascertain how the subject was introduced, what teaching approaches were used (didactic versus role play), what skills participants used, and the overall staff message provided to the young men.

In addition, more in-depth data collection of the specific length of hours by program content and client exposure is needed as well as assessing program impacts

and their sustainability. This would include ascertaining both intensity and length of program for different kinds of youth and the dosage of distinct types of program interventions. For example, does exposing young men to positive role models as well as providing life skills, counseling, viable alternatives, and TP information and medical services increase the likelihood of sustaining young men's motivation for behavioral and attitudinal change? These MIP components appear to be especially promising as they have been shown to be effective characteristics of comprehensive sex education programs (Kirby, 2001).

A next step in program evaluation would require that programs evolve from providing informal sessions to interventions that incorporate more formal curricula elements that are consistently provided to large numbers of participants. This is especially important since the current evaluation cannot control for the great variance in MIP implementation by each program. This is requisite so that there is sufficient stability in the interventions being evaluated. An additional, important element would be to assure that there are sufficient numbers of participants representative of all racial, ethnic, and age groups enrolled in the evaluation. A challenge to adopting a more formal program should be noted, however, given our initial findings that programs with formal curricula found that they needed to incorporate some degree of modification. Thus, requiring a minimum number of formal curricula along with some built-in program flexibility may be requisite before attempting to implement a more rigorous quasi-experimental evaluation design.

Thus, while the initial evaluation has some inherent limitations, these descriptive findings do provide important insights for understanding what is necessary to incorporate in the next generation of program development. For example, the ambivalence experienced by the young men regarding becoming fathers requires that we consider what approaches are necessary to help young men safely navigate this period and delay childbearing. In other words, what incentives can programs incorporate that will give young men another venue for their desired status and respect? What additional program components are needed to assure that behavioral as well as knowledge and attitudinal changes are made? For example, the changes achieved among African American young men, in contrast to Latino or White males, needs further study to understand what aspects of the program and its message as well as other community contextual factors influenced their behavioral change.

CONCLUSION

Increasing men's participation in reproductive health involves more than program activities conventionally associated with men, such as preventing and treating STIs or promoting condom use. MIP staff understood that issues affecting male involvement in teen pregnancy prevention are complex and deeply rooted in cultural and societal norms and traditions. Consequently, they took into consideration the full spectrum of males' psychosocial and environmental context and went beyond the confines of the traditional health education classroom or clinic settings. MIP programs recognized that young men needed to more fully understand the responsibilities of manhood and of being a father and assisted young men through mentoring, affirming cultural roots that emphasize responsibility, and providing them with

viable alternatives to early fatherhood. MIP staff also recognized that tailored strategies were needed to better respond to different profiles of age, race/ethnicity, and risk among participants.

Since its inception, MIP projects were able to design and implement innovative, comprehensive, and community-based approaches that more fully engage and mobilize young men to prevent teen pregnancy. Moreover, statewide efforts to expand clinical family planning services, thus providing clinical services to larger numbers of sexually active males, led to unique opportunities to further enhance the role males play in preventing teen pregnancies as well as encouraging better links between TP community educational programs with the clinical services many participants need. It is hoped that strengthening these innovative efforts will help spark interest in and gain greater support for male involvement in communities, towns, cities, and states throughout the country.

Notes

1. Specific RFA requirements and goals may be found in the "Office of Family Planning Teen Pregnancy Prevention Programs Request for Application 1996." For more information, please contact Mari Taylan-Arcoleo, Office of Family Planning, 1615 Capitol Avenue, Suite 73.430, Sacramento, CA 95814.
2. For a complete copy of the interview and focus group guides, please contact Michelle Barenbaum.
3. For more detailed information regarding the Young Men's Summit, please contact Michelle Barenbaum.
4. Asian and other/mixed ethnicities were not included in Table 1.

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