BARRIERS IN THE PROVISION OF FAMILY PLANNING INFORMATION FROM SOCIAL WORKERS TO THEIR CLIENTS

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The United States has the highest unintended pregnancy rate relative to other Western countries (Division of Reproductive Health, 2002). Mothers and children of unintended births face increased risk of substantial physical and social problems (Brown & Eisenberg, 1995; Gold, 2001). The high unintended pregnancy rate in the U.S. is primarily due to the lack of consistent contraceptive use by many individuals who are at risk for unintended pregnancy (Piccinino & Mosher, 1998). Due in part to the NASW position on family planning, social workers are in a key position for providing family planning information to clients.

This study investigates the barriers that social workers face in providing family planning information to their clients through the use of a survey questionnaire. The questionnaire includes a modified version of the Bardis Religion Scale (1961), and items related to Bandura's social cognitive theory (1986) with a focus on family planning knowledge, comfort, self-efficacy, perceived social worker roles, and moral attitudes toward providing information on family planning to clients. A section for respondent characteristics was also included.

A sample of 800 respondents, with a final sample of 203 respondents, was randomly selected and surveyed from the 2007 roster of Pennsylvania licensed social workers. Findings revealed that greater religiosity, conservative political beliefs, a tendency to vote for Republicans, and a "pro-life" abortion stance were associated with reported increased barriers in

providing family planning information. Participation in family planning coursework or training, and practicing in an urban area were found to be related to lower reported barriers, regardless of religiosity. Years of experience and work function had no significant effect on providing family planning information. Moral objection ranked low as compared to other barriers. Lack of workplace incentive and issues related to lack of family planning training and knowledge were of greater importance in understanding barriers. Furthermore, many social workers lack accurate family planning information, especially related to emergency contraception. These results suggest need for family planning training within social work professional education and continuing education, as well as an urgent need to address policies that undermine social work clients' access to family planning information and services.

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1.0 PROBLEM STATEMENT

In the United States approximately 49% of pregnancies are unintended, with 54% of those ending in elective abortion. This ranks the U.S. as having the highest unintended pregnancy rate, and the second highest abortion rate, relative to other industrialized Western countries (Division of Reproductive Health, 2002). Unintended pregnancy can be devastating to individuals and to the larger society. Mothers of unintended births face increased risk of single parenthood, incomplete education, poverty, unemployment, and welfare dependency. Those who do marry are at a greater risk of separation and divorce. Compared to a mother with a planned pregnancy, a mother with an unintended pregnancy is less likely to seek prenatal care in the first trimester and more likely to obtain no prenatal care at all (Kost, Landry & Darrock, 1998). She is also more likely to expose the fetus to harmful substances such as tobacco and alcohol (Brown & Eisenberg, 1995).

Children of unintended pregnancies are at greater risk of dying in their first year, of being abused, and of not receiving sufficient resources for healthy development (Kost, Landry, Darrock & 1998a). Furthermore, these children face greater risks of living in poverty, living with a single parent, and having health and developmental problems (Gold, 2001). Estimates of overall monetary cost to U.S. taxpayers for adolescent births range between $7 billion and $15 billion per year, mainly attributed to higher public assistance costs, foregone tax revenues resulting from changes in productivity in teen parents, increased child welfare, and higher

criminal justice costs (Maynard, 1997). Unintended births to adolescents cost more than $1.3 billion in direct health expenditures each year (Trussell, Koenig & Stewart, 1997).

The high U.S. level of unintended pregnancy is primarily due to lack of contraceptive use among individuals who are at risk of unintended pregnancy. Furthermore, many people who do rely on contraceptives fail to use these methods correctly and consistently (Piccinino & Mosher, 1998). Differences in young people's age of sexual debut and level of subsequent sexual activity fail to explain why U.S. adolescent pregnancy rates continue to exceed the rates of Western European countries (Darroch, Frost, & Singh, 2001). Evidence to date suggests that Americans, especially youth, are far more likely to experience obstacles in accessing family planning methods than their peers in Western Europe (Berne & Huberman, 1999). Information such as this raises the question of whether unintended pregnancy in the U.S. could be reduced by improving education, information, and access to family planning. Although all people vulnerable to unintended births can likely benefit from improved services, consumers receiving social work services have particular access to information on family planning, as they are already in contact with a system of care, and tend to experience higher rates of unplanned pregnancy (DiClemente & Ponton, 1993; Coverdale, Turbott, Roberts, 1997).

1.1 SOCIAL WORK RELEVANCE

The profession of social work has a long history of supporting access to birth control. The American Birth Control League, a predecessor of Planned Parenthood, was accepted as a Kindred Group by the National Conference on Social Work in 1929, providing the birth control movement with a route to develop relationships with relief agencies (McCann, 1994). Thus,

contraceptive information was passed through a network supported by social workers. Furthermore, the residents of Hull House were in the forefront of supporting reproductive rights for women (Haslett, 1997). The support for family planning continues today within the field of social work. The National Association of Social Workers (NASW) issued a policy statement on family planning approved in 1975 and upheld in 1991 that states a woman's right of choice in family planning is consistent with the principles of self-determination, empowerment and dignity that form the foundation of social work (National Association of Social Workers, 2003). However, the little empirical evidence that does exist about the capacity of social workers to provide family planning information suggests that additional training of social workers in this topic would be beneficial (Ford & Hendrick, 2003).

1.2 PURPOSE OF THE STUDY

The purpose of the current study is to investigate the barriers that Pennsylvania social workers face in providing family planning information to their clients. A questionnaire was sent via the U.S. postal service to 800 randomly selected Pennsylvania licensed social workers. The first question determined if the respondent works with clients in the reproductive age group. The next portion of the questionnaire was a set of true/false items meant to test family planning knowledge. Respondents were then surveyed about their perception of possible obstacles they face in providing all relevant family planning information in their professional work environments. Attention was focused on self-assessed family planning knowledge, perceived social worker roles in providing family planning information, level of comfort and self-efficacy

in discussing family planning, and moral attitudes toward providing information on family planning to clients of all ages.

A modified version of the Religion Scale (Bardis, 1961) was also used in this study. Values and attitudes of individual social workers, and subsequent behaviors, have been shown to be significant in impacting the actions of clients. Bergin (1980) theorized that discrepancy often exists between the values of therapists and clients. Subsequent research has demonstrated that clinicians' values and attitudes not only influence the effectiveness of therapy, they also influence clients' personal values (Kelly, 1995). Furthermore, the earlier external influence of orthodox religion was identified as a potentially stronger portion of a participant's behavior than professional responsibility (Bergin, 1980). The Religion Scale (Bardis, 1961) includes many items that focus on concrete behaviors that are expected of oneself and others due to religious beliefs. This scale is intended to measure three concepts of religion: ideas about divinity, doctrines concerning relationships between divinity and humanity, and behaviors designed to satisfy God's expectations and achieve future rewards and avoid punishment. It was chosen specifically for its behavioral component. The last portion of the questionnaire included background information, such as demographics, practice environment, work experience, and political and religious beliefs.

Existing literature and concepts within the social cognitive theory (Bandura 1986) led to the development of the hypotheses of the current study. Bandura emphasized values, beliefs, and attitudes as part of a collection of cognition classes that are believed to influence behavior. Thus, religious and political attitudes and values would likely influence behavior. Observational learning, self-regulation, self-efficacy, and reciprocal determinism are also key components in social cognitive theory. Subsequently, hypotheses incorporated these concepts as well.

Utilizing knowledge of identified barriers, training could more adequately pinpoint the needs of social workers, specifically in Pennsylvania. Educational family planning programs could then be developed with the goal of reducing the barriers that hinder the ability of social workers to meet the needs of their clients. Thus, programs could enhance the likelihood that social workers will provide appropriate family planning-related information. It is hoped that properly educated social workers could help reduce the rate of unintended births within the populations with which they work.

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2.0 HISTORY OF U.S. FAMILY PLANNING SERVICES IN THE TWENTIETH CENTURY

The quest for birth control methods has an extensive and complex history as recorded in the earliest of written texts (McLaren, 1990; Robertson, 1990). The emergence of the modern state brought political influence into the realm of reproductive rights through public policy. Although policies related to family planning were present prior to 1900, the twentieth century was witness to hard-fought advancements in access to family planning that continue to shape current policy. For example, in the United States, the family planning movement had distinct driving forces. On one side were the rights of women to control their sexuality, partially driven by a concern for the health and emancipation of women. At the beginning of the twentieth century, the U.S. had the highest maternal death rate of any developed country Likewise, more women died in childbirth at this time in the U.S. than with any other cause except tuberculosis (Katz, 1996; Trattner, 1989). On the other side were various forces attempting to control the sexuality of women. Birth control rights could not be advanced until forces controlling sexuality were convinced that contraception was beneficial to their own quest.

2.1 COMSTOCK ACT

Perhaps the most tenacious judicial hurdle for the legalization of birth control in the early twentieth century was the Comstock Act. In 1873 Congress amended the U.S. Postal Code to

prohibit the distribution of obscene materials, including contraceptive information and tools. These laws carry the name of their author, Anthony Comstock, director of the New York Society for the Suppression of Vice, who believed that any matter related to contraception was obscene. Comstock was born in Connecticut, one of 10 children. Although his mother, a strict Puritan, died when he was only ten, he stated that she was the greatest influence of his life. Throughout his life, Comstock proved to be an intolerant, rigid, and merciless man and was quite unpopular. Several anecdotes exist to demonstrate his character. While a soldier during the Civil War, he preached to his fellow soldiers on issues, including those related to alcohol. Comstock melodramatically poured his soldier's ration of whisky on the ground so no one could drink it. Furthermore, his manner of dress was extremely conservative. Except for his one substitution at Christmas when he would wear a white tie, he wore only black suits with a black tie (Robertson, 1990).

As a leader against birth control, Comstock dedicated much of his adult life to zealously fighting against the emerging birth control movement, stating that the use of contraceptives made a "brothel of the home" (Robertson, 1990, p. 88). Like many others of his time, he also expressed a fear that if women had sexual control over their own bodies, they would be more likely to have extramarital affairs. Many of his techniques gained criticism for their devious and cruel nature, even from the strongest birth control opponents. He frequently operated under false pretenses to obtain information to use against men and women who were practicing family planning. For example, Comstock told a sad story of poverty and unwanted pregnancy to sixty-year old Madam Restell, a purveyor of contraception and abortion, and dignified woman of her local community. When she agreed to perform the abortion he requested, Comstock had her arrested. The thought of prison led Restell to commit suicide. Despite his despised behavior,

his campaign to control the sexuality of women significantly delayed the development of the birth control movement in the United States (Robertson, 1990).

2.2 EUGENICS MOVEMENT

During the late 1800's and early 1900's an early foe of the birth control movement emerged into general public discussion. In1883 Sir Francis Galton first employed the term "eugenics" to describe the science of racial improvement through controlled breeding. Galton, the founder of modern statistics, was inspired by the work of his distant cousin, Charles Darwin. His intent was to improve humanity by giving "the more suitable races and strains of blood a better chance of prevailing speedily over the less suitable" (McCann, 1994). Furthermore, in 1891, Francis Walker, director of the 1870 and 1880 U. S. Census, advanced the concept of "race suicide" to describe the statistical differential between immigrant and old-stock growth rates (Reed, 1996, p.27). Walker frequently connected declining birth rates to the selfishness of suffragists who were seen as abandoning their natural duty of motherhood to fight for voting rights. This belief was fought by women's rights advocates who argued that by limiting their pregnancies to their level of economic resources, women could better fulfill a role as a mother (McCann, 1994).

In 1906, The American Breeder's Association formed the first eugenics organization in the United States. Charles Davenport, a biologist who converted to Mendelianism, was elected as the secretary of its Committee on Eugenics. The following year, Indiana passed the nation's first compulsory sterilization law affecting anyone who was deemed mentally challenged or mentally ill. In 1912, Henry Goddard published the first modern eugenics genealogy, *The Kallikak Family*. By following two branches of a family, he purported to prove that "feeblemindedness"

(mentally challenged, mentally ill, or simply viewed as less intelligent) was an inherited trait. For over a decade, Goddard's writing would contribute to fear of the danger of allowing lower classes to produce the bulk of the population (McCann, 1994). The strength of this fear is partially demonstrated in the passing of an emergency Immigration Restriction Act in 1921 and the permanent Immigration Restriction Act in 1924 (Reed, 1996).

Later the birth control movement gained an ally in the study of eugenics. In 1916, William Robinson, a socialist physician, published *Birth Control or the Limitation of Offspring*, in which he details the eugenic benefits of birth control. In this era, it made sense that an alliance with eugenics was necessary for the advancement of birth control rights. In other words, allowing women to control their own reproductive rights was not viewed as justifiable. However, using techniques to reduce the birth rate of the lower class could gain favor among selected segments of society. Contraception could then be perceived to have an economic advantage while distancing it from the controversial sexuality of women. Thus, many birth control advocates fought for this alliance. It is of note to mention that although mainstream society tends to look upon eugenics unfavorably today, prior to World War II eugenics was an accepted part of larger society. Many favorite movements, such as sanitation, pure milk for infants, and prevention of venereal disease, used eugenics to advance their cause (McCann, 1994).

2.3 GENDER CONSTRUCTS OF THE EARLY TWENTIETH CENTURY

The social constructs related to gender also began to go through a transformation in the beginning of the twentieth century. The early twentieth century was a time of progressive

thinking, with positive attention placed on intellectual thought and social progress. The 1910's and 1920's saw an increase in valuing heterosexual expression, especially among the leftist intellectuals. Voluptuous figures were replaced by the image of the flapper. The flapper was a popular image of a young woman with short hair and slim hips, who played sports and danced. With male friends, she was a partner against outdated sexual roles of parents and gender exclusion. She even became sexually physical with men she may not marry. The flapper represented women's increased control over their own sexual expression as opposed to the Victorian model of radical female chastity (Reed, 1996).

The emergence of the flapper did not totally win over the general population, even within women's groups. Occurring in the early 1900's was the emergence of the infant welfare movement, led mostly by women, to fight the nation's high rates of infant mortality. In 1912, Congress created the U. S. Children's Bureau to investigate and report upon "all matters pertaining to the welfare of children and child life among all classes of our people" (Trattner, 1989, p. 218). In 1913, the Children's Bureau published its first advice pamphlet for mothers, *Prenatal Care*. Contraception was not mentioned. Not unlike other female centered organizations of the time, the Children's Bureau refused to endorse birth control on the grounds that it may undermine its own political authority that rested on feminine chastity. It was known all too well that promoting women's control of their own bodies was politically dangerous. It was not until 1938 that the Children's Bureau released a report revealing that 25-30 percent of maternal deaths occurred as a direct result of illegal abortions. This information was useful in the fight for legalized contraception (McCann, 1994).

Finally, national hysteria developed over the white slave trade, the purported practice of abducting young women into prostitution. The public at large did not want to believe that women

would chose to become prostitutes under any circumstance. In reaction to this white slave trade hysteria, Congress passed the Mann Act in 1910, which prohibited interstate transport of women for immoral purposes. The concern of white slavery increased national anxiety about female sexuality from 1907-1911. This distaste for sexual misconduct also limited the support for the birth control movement (McCann, 1994).

2.4 THE EARLY WORK OF MARGARET SANGER

Margaret Higgins Sanger (1879-1966) is generally credited with being the founder of the birth control movement in the United States. She focused on the connection between freedom and a woman's right to regulate her own body. She was quoted as saying, "No woman can call herself free who does not own and control her own body. No woman can call herself free until she can choose consciously whether she will or will not be a mother" (McCann, 1994, p.31; Sanger, 1920). She was born the sixth of eleven children, the daughter of a father who she described as a "philosopher, a rebel and an artist" (Critchlow, 1996, p.2). On the other hand, her mother was a frail woman who died at the age of forty-eight, partly weakened by her frequent pregnancies. Despite being Irish agnostics, her family settled in a largely Roman Catholic area in Corning New York (Critchlow, 1996). In 1912, Margaret Sanger began to work as a nurse for the Lillian Wald Visiting Nurses Association on the lower east side of New York City. The population of the area was mostly European immigrants, who struggled with frequent pregnancies. The display of up to a hundred women waiting in line on the streets of New York City to obtain five-dollar abortions horrified her. The death of women, particularly a close friend, Sadie Sachs,

from illegal abortions inspired Sanger to fight to legalize contraception. She abandoned her nursing career to devote her time to the birth control movement (Robertson, 1990).

Ideologically, Sanger and her husband, William Sanger, adopted a socialist orientation. However, a friend of Sanger encountered unexpected opposition to family planning from Marxists at a meeting of the Neo-Malthusian Congress. The argument presented was that any reduction in the birth rate of the working class would inevitably diminish the class's political power (Robertson, 1990). Typically, it was the lower classes that were unable to practice the same birth control techniques that were available to the upper classes (Critchlow, 1996; McLaren, 1990). Thus, Sanger chose to follow the teachings of E. A. Westermach, a Finnish anthropologist, whose followers asserted that since the beginning of recorded history, women have sought to limit the number of their children (Robertson, 1990)

In 1914, Margaret Sanger coined the phrase "birth control" to refer to contraception and published nine issues of the magazine *The Woman Rebel* to publicize contraception (McLaren, 1990). She also published *Family Limitation*, the first pamphlet to provide concrete and reliable birth control information since the passage of the Comstock Act. Arrested on charges of obscenity and incitement to murder and riot, she fled to Europe (Critchlow, 1996). Hoping to force Sanger's husband to divulge her whereabouts, Comstock entrapped William Sanger. Sanger refused to state his wife's location and was sentenced to 30 days in jail (Robertson, 1990).

Despite Sanger's absence, events in 1915 continued the advancement of birth control rights. First, the National Birth Control League (NBCL) was formed in 1915 to pursue the legalization of contraception. In particular, the league formed to seek repeal of the New York State and Federal Comstock laws. Mary Ware Dennett (who later formed the Voluntary

Parenthood League in 1919), Anita Block, Clara Stillman, and Otto Bobsein were the officials of the league (Critchlow, 1996). Second, Sanger received training in birth control while in the Netherlands. It is here that she met Johannes Rutgers, who was known throughout Holland for providing contraceptive advice and fitting pessaries (now called occlusive diaphragms). Sanger became convinced that pessaries were the best method of birth control of the time (McCann, 1994). Third, Anthony Comstock died of pneumonia (Robertson, 1990).

The level of activity increased after Sanger returned to the U.S. in February 1916, Sanger returned to face her trial for the charges stemming from her publication of *The Woman Rebel*. Charges were dismissed even though she refused to promise to abide by the Comstock law. In April, Sanger began a national speaking tour promoting birth control. In October, Sanger, Ethel Byrne (Sanger's sister), and Fannie Mindell opened the first U.S. contraceptive clinic in the Brownsville section of Brooklyn. The clinic remained open for ten days, and 488 women were fitted for pessaries and provided with supplementary spermicidal jelly. Sanger, Byrne, and Mindell were arrested for their involvement. Sanger and Byrne were convicted for dispensing contraceptive devices in the Brownsville clinic and Mindell was convicted of distributing obscene information. Each served a thirty-day prison sentence. Shortly after release, Sanger began publishing the *Birth Control Review*. It would be another five years before another birth control clinic would be opened (Robertson, 1990).

In 1918, two years after the pro-contraceptive eugenic writing *Birth Control or the Limitation of Offspring* was published, the New York Court of Appeals upheld Sanger's 1917 conviction for distributing contraception. However, Judge Crane's decision widened the physicians' exemption in the law, allowing greater freedom in contraception prescription. Dr. Johannas Rutgers from Holland had already persuaded Sanger that medical instruction was the

key to fitting and using pessaries. Unfortunately, physicians' prescription of birth control was limited to condoms as they served to contain venereal diseases. Condoms were still illegal in all cases for the use of preventing conception. Furthermore, midwives and nurses were excluded in prescribing birth control altogether. In effect, Judge Crane's decision rejected any nonmedical justification for birth control but upheld the use of contraception in cases for the "cure and prevention of disease" (McCann, 1994, p.64; People v. Sanger, 1918). In addition, he widened the application of contraception by defining disease as any change in necessary function that threatened pain or sickness. As pregnancy was defined as having almost inevitable potential for pathology in the 1910's, Judge Crane's decision could be interpreted to sanction the prescription of birth control (McCann, 1994).

In 1917, NBCL introduced the first open bill to repeal the New York State prohibition on contraception. This approach differed from the Sanger's approach. Mary Ware Dennett led the attack against the Comstock Act to have the words "for the prevention of conception" removed from obscenity charges, thereby removing birth control from obscenity classification. The NBCL disbanded after the measure failed. Dennett immediately formed the Voluntary Parenthood League, which concentrated on amending the Federal laws of obscenity in the postal code. Each year from 1921-1925, the American Birth Control League attempted the same approach as Dennett and also failed. The division between Sanger and Dennett continued. In 1920, Mary Ware Dennett resigned from the editorial board of the *Birth Control Review*, a Sanger-authored periodical, because of her perception that it had a militant tone (McCann, 1994).

Strengthened by the Nineteenth Amendment granting women the right to vote, the Sheppard-Towner Act was passed by Congress in 1921. Led largely by women, the Sheppard-Towner Act served to bring the federal government into the territory of child and maternal health

(Katz, 1996; Trattner, 1989). In November 1921, Margaret Sanger sponsored the First American Birth Control Conference in New York City. Immediately before the conference, Sanger officially announced the founding of the American Birth Control League (ABCL). Police arrested speakers at the Conference's closing event, a meeting held at Town Hall. The police maintained that they acted due to an appeal from the archbishop Patrick Hayes. Charges were later dropped. The event was rescheduled and transpired without further incident (McCann, 1994). The following year, 1922, W.E. DuBois gave his public endorsement of birth control. He identified birth control as a tool for betterment in a racist society (Dubois, W.E., 1922).

2.5 THE CLINICAL RESEARCH BUREAU

Under Sanger, the ABCL rented space for a birth control clinic in New York. The State Board of Charities, the agency responsible for licensing medical centers in New York, informed Sanger that she could not operate without a license. Furthermore, requests for a license were denied (McCann, 1994). However, medical services could be offered as long at it was under a research project in a physician's private practice and not in a clinic. In January of 1923, the Birth Control Clinical Research Bureau (CRB) opened in New York City and operated without a license. Dr. Dorothy Bocker, the original physician in charge, was later replaced by Dr. Hannah Stone (Robertson, 1990). The CRB faced difficulty with acquiring the necessary funds to provide services regardless of a woman's ability to pay. It was the alliance with eugenicists that provided the scientific legitimacy to secure stable funding from philanthropists (McCann, 1994).

For the birth control movement to gain substantial ground however, alliances needed to be formed with the medical profession. Despite CRB data confirming the effectiveness of

contraceptives in preventing pregnancy-related disease and mortality, an alliance with the medical profession proved to be a difficult task. At that time, the medical profession was composed of upper and middle class conservative and moderate male physicians (Robertson, 1990). Furthermore, the medical profession represented itself as the gatekeeper of women's virtue, stating that indiscriminately supplying birth control to women would cause harm to their sexual morality. In January of 1924, Dr. Robert Dickinson conducted a surprise inspection of the CRB and published a harsh criticism of the work of the CRB based on his belief that the CRB's data were insufficiently scientific (McCann, 1994). However, Dickinson was the person most responsible for the acceptance of birth control by the American medical profession (Robertson, 1990). In 1923, he had established the Committee on Maternal Health (CMH) to scientifically investigate contraception, sterility and abortion (McCann, 1994). Dickinson did not view contraception as morally improper despite being a devout Episcopalian. As the President of the American Gynecologic Society his initial address was titled "Sexual Counseling and Contraception." Instead of focusing on the reproductive rights of women, he focused on the use of birth control to facilitate a harmonious marriage between a husband and wife. He connected the rising divorce rate to sexual slackening due to fear of pregnancy. Thus, he believed that birth control could contribute to stabilizing family life (Robertson, 1990).

While Dickinson and Sanger did not see eye to eye, they were able to work together to advance the right to use birth control. In 1925, the ABCL and the CMH agreed to form a joint council, the Maternity Research Council (MRC). The purpose of the MRC was to secure a license for the operations of birth control clinics under the CRB. Dickinson insisted that the ABCL and the CRB be detached from one another. Sanger complied with this request for several reasons including the increased ability to obtain funds and licensure. The Bureau of

Social Hygiene immediately provided a $10,000 grant to fund the CRB. A license, however, proved to be more difficult to obtain. Dr. Hannah Stone, who was forced to resign her hospital affiliation due to her connection with the CRB, became the first director of the CRB (McCann, 1994). Later in1928, Hannah Stone published the first study of contraception effectiveness based on CRB data that indicated contraception could be used safety and effectively to reduce unwanted pregnancies (Robertson, 1990).

Without a license, the CRB was raided by police in 1929. The New York Academy of Medicine protested the raid due to the violation of patient-doctor privilege by the seizing of patient files. Dickinson and Sanger attempted to use this publicity to their advantage by securing a license. Part of this plan was proposed by Dickinson who tried to convince Sanger to give up control of the CRB to a for-profit hospital. Sanger and the board of the CRB disagreed with Dickinson's proposal. Sanger and Dickinson would continue to disagree on the course of action for the CRB in part due to Dickinson's, and the medical profession's, perception of lay organizations and women in medicine. The American Medical Association (AMA) tended to regard women physicians, who composed about six percent of their membership, as social workers more than doctors. Despite being admitted to the AMA beginning in 1915, women physicians had little influence in the organization (McCann, 1994). The CRB was not exempt from this gender bias.

2.6 THE INTERRACIAL ALLIANCE FOR CONTRACEPTION

While many historians connect the decreased birth rate in African Americans to poverty, disease and coerced birth control, many records paint another picture. Historically, much can be said

about the activism of African American women in the establishment of family planning clinics and in the defense of abortion rights. Recognizing the deliberate activities of empowered African American women within the birth control movement is crucial to understanding the development of birth control services in the U.S. (Ross, 1992).

During Dickinson's effort to control the CRB, Sanger met with the New York National Urban League and the Social Worker's Club of Harlem. During the 1920's, Harlem became the most densely populated black community in the nation. Barred from living in white sections of the city, African Americans were forced to pay high rent for deteriorating living conditions. Congestion and unsanitary conditions caused a death rate 42 % higher than any other part of the city. Furthermore, maternal and infant death rates were twice that of whites. The recognition of these problems was a catalyst for the Urban League's pursuit of a birth control clinic in Harlem. In October of 1929, the Social Worker's Club of Harlem publicly endorsed the CRB's plan to open a branch clinic in Harlem. Sanger secured the funding. In 1930 the Harlem Branch of the Clinic Research Bureau opened (McCann, 1994).

The clinic was run as a branch office of the CRB. The clinic, like the CRB, offered women gynecological exams by a physician, provided contraceptive instruction by a nurse, and dispensed pessaries. The stated fee was five dollars: three dollars for the exam and two dollars for the pessary and a six-month supply of spermicidal jelly. Services were charged on a sliding scale. Records indicate that less than ten percent of the patients seen paid the full fee and more than half of the African American patients paid no fee at all. In 1932, the fee for African Americans was dropped to one dollar. Until 1933, about half of the patients were white women from downtown (McCann, 1994).

Initially, the Advisory Council of the main clinic served the Harlem clinic. By the end of 1930, Sanger organized the Harlem Advisory Council, a separate council for the Harlem Clinic. Sanger expressed a desire to reach those women who needed help the most, as well as to maintain the "confidence and cooperation" of African American public health professions. In this effort, African American physicians, nurses and clergy were added to the staff (McCann, 1994).

The Harlem Branch faced two major difficulties. First, in a society focused on eugenics and fear of race suicide, distrust of the mostly Caucasian-managed CRB by African American women kept many African American women away. The Advisory Council suggested that the clinic's location on a side street identified by a hand-written placard saying "research" and its position within Harlem were problematic. In 1932, the Harlem Branch Clinic was moved to a more central location, the New York Urban League building, and the word "research" was replaced by "birth control." Reports of the clinic's activities focused on the similarity between African Americans' and Caucasians' need for and use of birth control. In addition, the temporary basis of birth control, as opposed to the permanent status of sterilization, was emphasized. Second, funding proved to be an insurmountable problem for the Harlem clinic. Faced with extreme funding difficulties, the New York City Committee of Mother's Health Centers took over the CRB's Harlem Branch in 1935. This division would remain until the ABCL and the CRB reunited to form the Birth Control Federation of America (BCFA) in 1939 (McCann, 1994).

An effort to introduce African Americans to the benefits of birth control was not limited to New York City or the northeast. Under New Deal health legislation, birth control proponents attempted to gain funding with little success (Sharpless, 1996). Furthermore, southern African

Americans were excluded from many of the medical and social welfare initiatives of the time. The birth control movement called for funding for an educational project to subsidize birth control clinics in southern African American communities. After several years of lobbying philanthropic resources, the BCFA obtained a grant of $20,000 from Albert Lasker in 1939 to begin the Division of Negro Service (DNS) (McCann, 1994).

Sanger attempted to use her experience with the Harlem Branch clinic in the work of the DNS. Primarily, she wanted to include African Americans in the administration and staff. However, Lasker disagreed and vetoed all educational work in favor of two demonstration projects run by Caucasians. Sanger led a campaign within the DNS to solicit funds for the educational work she proposed. Florence Rose, Sanger's former secretary, ran the educational campaign by organizing the National Negro Advisory Council (NNAC). The focus was on reducing the death rate of African Americans. The campaign steered away from expressing the right of African American women to control their own sexual expression. The bulk of the work of the NNAC focused on providing information at African-American professional conferences. In 1941, the National Council of Negro Women became the first women's organization to officially endorse the practice of contraception. In 1942, BCFA hired Mae McCarroll, a black physician, to be present at meetings of African American professional organizations. The same year, the National Medical Association endorsed the work of the DNS (McCann, 1994).

2.7 THE PURSUIT OF POLITICAL AND PROFESSIONAL ALLIANCES

In addition to the CRB, the ABCL became involved in political activity to increase the support for birth control, with little initial success. As previously mentioned, other women's groups in

the early twentieth century did not take up the advancement of the right to use birth control as it threatened to undermine their own political authority resting on female chastity of the Victorian model. A philosophical division between welfare feminists and liberal feminists was partially the reason for the split between the focus of women's organizations. While liberal feminists rallied for full participation of women in society, including the workforce, welfare feminists focused on protecting working mothers from exploitation by harsh industrial life. Welfare feminists used the alleged superior morality of women to argue that women should be entitled to stay home to raise their children by raising the wages of men. Sanger argued that with birth control, women could regulate the size of a family to the level of the male wage earner. However, supporting birth control legislation challenged women's supposed moral superiority that welfare feminists relied upon (McCann, 1994).

The controversy of birth control caused difficulty for birth control activists who were attempting to connect with women's groups. In 1921 at the organizing convention of the National Women's Party (NWP), Alice Paul prevented the issue of birth control, as well as the rights of African American women, from being introduced to the floor. Each issue was viewed as being so controversial that it would overwhelm the other issues on the agenda. In 1923, the ABCL again met with the NWP but failed to convince the party's leaders to support birth control legislation based on the controversy of the legislation (McCann, 1994).

Furthermore, it became apparent in 1924 that little had changed regarding contraception within the League of Women Voters (LWV) since its organizing convention in 1920. At the initial convention, a LWV leader, Carrie Chapman Catt, stated that birth control could lead to some good but overall would lead to "degeneracy" and "over-sexualization" (McCann, 1994, p.50). In 1924, Sangerists tried unsuccessfully to introduce birth control as a study item in the

League of Women Voter's Citizenship Committee. Instead, the Citizenship Committee decided to study a separate proposal for sterilization as a measure to reduce the births from parents who were deemed genetically inferiority. Opponents of the inclusion of birth control who sponsored the sterilization proposal argued that the topic of birth control was too controversial. They also argued that birth control did not belong among the concerns for women citizens. Furthermore, in 1924 and again in 1928 the ABCL tried unsuccessfully to introduce birth control into the LWV's Child Welfare and Social Hygiene Committees. The topic of birth control was considered a threat to the cohesion of the LWV. The National Council of Catholic Women had sworn to fight any efforts anywhere in the U.S. to repeal laws against birth control. The fear was too great that Roman Catholic members would resign if contraception legislation was supported (McCann, 1994).

The American Medical Association avoided dealing with the issue of contraception until the growth of the female hygiene business, under Sheppard-Towner, led to their forming the AMA Committee on Contraception (McLaren, 1990). In 1936, this committee issued a report incriminating all contraception and the lay organizations that sponsor it. After this condemnation, Dr. Robert Dickinson provided large amounts of data to support the use of contraception, including data to support child spacing for medical reasons. Consequently, in 1937 the AMA Committee on Contraception reversed its 1936 statement and gave limited endorsement to contraception. The report issued emphasized the physician's right to determine birth control procedures instead of the right of women to obtain contraception (McCann, 1994).

The ABCL, as well as the general right for birth control, received support from the profession of social work. The ABCL was accepted as a Kindred Group by the National Conference on Social Work in 1929. Falling short of fully endorsing the practice of birth control,

the Conference provided the birth control movement with a route to develop relationships with relief agencies (McCann, 1994). In this way, contraceptive information was passed through a network supported by social workers. Furthermore, the residents of Hull House were in the forefront of supporting reproductive rights for women. In particular, Alice Hamilton and Rachelle Yarros fought to bring birth control to Chicago. In addition, they opposed the withholding of abortion services (Haslett, 1997). The support for contraception and abortion continues today within the field of social work. The National Association of Social Workers (NASW) issued a policy statement on contraception and abortion approved in 1975 and upheld in 1991 that states a women's right to choose is consistent with the principles of self-determination, empowerment, and dignity that form the foundation of social work. In a case where the social worker is unable to participate in abortion counseling for moral reasons, "it is still his or her responsibility to provide appropriate referral services to ensure that this option is available to clients" (National Association of Social Workers, 2003).

2.8 THE COURT BATTLE AGAINST THE COMSTOCK ACT

One of the largest arenas for the eventual progress of the birth control movement was the arena of the U.S. court system. Judge Crane's 1918 decision, which widened physicians' exemption in the anti-contraceptive law, set the stage for a series of decisions between 1930 and 1936 that threatened the Comstock obscenity charges associated with contraception. Each ruling weakened the Comstock laws.

The Young's Rubber Co. vs. C.I. Lee and Co. (1930) decision offered the first reinterpretation of the obscenity associated with contraceptive information and devices. In this

case, two condom manufacturers were arguing over trademark rights. The defense argued that trademarks of unlawful businesses are not entitled to legal protection. In his decision, the judge suggested that obscenity is in the intent of the user of birth control and not in the devices themselves. Along the same line, in Davis vs. United States (1933), a medical supplier had been arrested for including contraceptive devices in his catalog. The court ruled that conviction under the Comstock Act required evidence of a defendant's intent to distribute contraception for immoral purposes (McCann, 1994).

Sanger and her supporters brought the 1936 United States vs. One Package of Japanese Pessaries case to court. The case presented itself after custom officials confiscated a package of Japanese pessaries sent to Dr. Hannah Stone. The U.S. Court of Appeals ruled that medical prescription of contraception for the purpose of saving a life or promoting well-being is not a condemned purpose of the Comstock Act. In effect, it legalized birth control because it did not require the presence of disease to prescribe contraception (Robertson, 1990). By the late 1930's the One Package ruling, along with the endorsement of the AMA, provided some legitimacy to the birth control movement's 350 clinics across the U.S. (McCann, 1994).

2.9 THE PLANNED PARENTHOOD FEDERATION OF AMERICA AND THE POPULATION CONTROL MOVEMENT

During the depression, women's increased demand for birth control and national economic constraints limiting private funding jeopardized the birth control movement's future. Due to the dilemma, the movement attempted to accommodate both the moral opposition and the fear of national depopulation expressed by allies and foes. Thus, in 1942, under much internal protest, the name of the organization changed from Birth Control Federation of America to Planned

Parenthood Federation of America (PPFA). The agenda of PPFA was to promote the use of contraception as a tool to improve family health and national well-being through the medically approved practice of child spacing. Thus, PPFA attempted to remove itself from politics in favor of being a modern public health agency (McLaren, 1990; Robertson, 1990; Sharpless, 1996). The first step toward PPFA becoming a public health agency occurred in 1942 when the U.S. Public Health Service discreetly allowed states to finance birth control clinics using funds from the 1939 Venereal Disease Control Act. By 1945, more than eight hundred birth control clinics existed nationwide (McCann, 1994)

The push for the federal government to become involved with and fund PPFA gained momentum with the population movement, especially after WWII when eugenics became associated with Nazism. The Population Council, founded in 1952, brought together scientists, demographers, social scientists, and birth-control leaders. The Rockefeller Foundation and Ford Foundation were major contributors. In the course of the next decade, the council's staff and field officers became increasingly involved in technical assistance programs for population control as well as remaining involved in the medical research side of family planning. However, American policymakers avoided involvement in family planning policy out of fear of political consequences (Critchlow, 1996; McLaren, 1990).

Late in Eisenhower's administration, General William Draper, a former member of Eisenhower's staff during WWII, recommended that population control movements be funded through the military-assistance program. The Draper committee also recommended that the federal government expand medical research related to the physiology of human reproduction. Eisenhower, however, abandoned the idea in 1959 after a statement from the National Conference of Catholic Bishops opposed "any public assistance, whether at home or abroad to

promote artificial birth control, abortion or sterilization" (Critchlow, 1996, p.10). At the same time, the United States entered the era of modern contraception. In 1960, both the birth control pill and the intrauterine device (IUD) became available. By 1965, the birth control pill had become the most popular form of birth control, followed by the condom, and contraceptive sterilization (Forrest, 1988).

Eisenhower and Draper continued their correspondence about population problems after Eisenhower left office. In 1964, Eisenhower became honorary co-chair with former president Harry S. Truman of the Planned Parenthood Federation, which was formally PPFA. Eisenhower focused his concern on out-of-wedlock births and mothers whom he believed were having children to increase their welfare benefit (Critchlow, 1996).

Democrats in office were equally as cautious about discussing the controversial issue of birth control. John F. Kennedy quietly sponsored increased research into reproduction. Then in late 1962, President Kennedy authorized Richard Gardner, Assistant Secretary of State, to issue the first broad statement of the U.S. on population policy before the United Nations. In early 1963, the Kennedy administration issued a memorandum stating the U.S. would assist family planning programs (Sharpless, 1996).

Fearing hostility from Roman Catholics and African Americans, President Lyndon Johnson moved more slowly into expanding population problems. The White House decided not to discuss contraception, especially before the Pope provided a final decision on birth control. With persistent and increasing pressure from Rockefeller and other key leaders rallied by Rockfeller, Johnson signed the pro-contraception declaration World Leader's Declaration on Population. Controversy increased when Sargent Shriver, head of the Office of Economic Opportunity (OEO), proposed policy to allow OEO to provide grants for family planning. In

1967, the regulations allowed for family planning clinics to be established through the Community Action Program. However, OEO grants excluded unmarried women or women not living with their husbands (Critchlow, 1996).

Johnson's 1967 State of the Union Address marked the beginning of the administration's focus on family planning. In the address, Johnson clearly stated a need to speak to the increase in population. In the summer of 1967, the new position of Deputy Assistant Secretary for Population and Family Planning was created. It was headed by Katherine Brownell Oettinger, former head of the Children's Bureau. At the same time, Congress aggressively pursued legislation to increase funding and activities for family planning programs. This initiative included the Social Security Amendments of 1967 proposed by George Bush (R-Tx) and Herman Schnebeli (R-Pa). This amendment required that not less than six percent of appropriated funds for Maternal and Child Health Services and for Maternal and Infant Care projects were to be available for family planning. The focus at the time was the concern that women receiving welfare benefits were having more children than the general population. This amendment allowed for the federal government and state governments to grant family planning funds to private organizations such as Planned Parenthood. This federal policy received bipartisan support. By 1969, U.S. government appropriations for family planning, including contraceptive services, had risen to $50 million (Critchlow, 1996; Sharpless, 1996).

The 1968 election of Richard M. Nixon continued the swift expansion of federal involvement in family planning. Due to a request from Nixon, Congress enacted the Family Planning Service and Population Research Act of 1970, which provided family planning services for the next five years to all who wanted but could not afford them. Furthermore, the law established an Office of Population Affairs and a National Center for Family Planning Services.

Within the next three years, $382 million was authorized by Congress for family planning services, research, personnel training, and educational activities. In addition, Congress authorized the establishment of the Commission on Population Growth and the American Future to be headed by John D. Rockefeller III (Critchlow, 1996).

2.10 CONTEMPORARY CONROVERSY OF FAMILY PLANNING

The Rockefeller Commission report, issued in 1972, together with Roe vs. Wade (1973), and Pope Paul VI's *Humanae Vitae*, issued in 1968, prompted Nixon to make a drastic turn in family planning administration. The *Humanae Vitae* declared that contraception and abortion be prohibited due to concern over human life, despite opposition within the church (Hurst, 1989; Pope Paul VI, 1968). Rockefeller's report endorsed abortion, spurring opposition from the Catholic Conference. Nixon attempted to lure Catholic voters away from the Democratic party by disconnecting himself from the report. In addition, he defined his opponent, George McGovern, as an advocate of the three A's: acid (LSD), amnesty (for Vietnam draft dodgers) and abortion. Nixon had already pursued "Creative Federalism" which called for the turning over of federal dollars to states in the form of block grants. In effect, this policy would lump family planning services into welfare and health-care funds and would allow state governments to set eligibility requirements for birth control services. Nixon proceeded with his strategy despite opposition from a Republican research task force on population problems, headed by Representative George Bush (R-Tx). Furthermore, Nixon ordered no further increases in family planning grants, impounded remaining funds and ordered the disbanding of the Center for Family Planning Services (Critchlow, 1996).

Evidence of further problems of expanding family planning initiatives occurred in the United Nations-sponsored World Population Conference in 1974. The conference became tense when developing nations attacked Western nations for imposing population-control programs on developing nations instead of addressing the issue of redistribution of wealth. The Population Council was left in turmoil (Sharpless, 1996). An attack on the older leadership of the population movement, led by Joan Dunlop, a special assistant to Rockefeller, called for highlighting social and economic development. Her central concern was the role and status of women. She argued that if the economic status of women in developing countries could be improved then a decrease would occur in family size. In 1974, George Ziedenstein was made president of the Population Council. Under Zeidenstein, the Council shifted its focus to economic development, women's rights, and family planning (Critchlow, 1996).

In the late 1960's and early 1970's, the merger of the population control movement and environmental awareness movement expanded the base of support for family planning services. Books such as *The Population Bomb, Famine-1975, Born to Starve*, and *The Hungry Planet* illustrated impending doom due to overpopulation and diminishing resources. The Reagan-Bush era de-emphasized the problem of overpopulation. Instead, the influence of the conservative Christian lobby, combined with arguments to reduce government intervention from free-market economists, reduced support for federally funded family planning services. The focus on environmental concerns would return during the Clinton administration, partially founded on Vice President Gore's book, *Earth in the Balance*. Furthermore, the focus on the rights of women by the Clinton administration would be a motivating factor in lifting the gag-order of the Reagan-Bush era, which limited the access of information to women about possible abortion options (Lieberman, 1992; Sharpless, 1996).

The problems related to the population movement are reflective of the polarization within the debate of family planning. Within the movement, divisions had occurred over abortion rights, women's rights, economic development and population control. Within the U.S., the controversial issue of family planning and abortion has left every administration since Nixon grappling with passionate opposition. Furthermore, social workers have been at the frontline of policy and direct care of those most affected by access to family planning. Inadequate funding coupled with anti-family planning political agendas disproportionately affect the poor, young, and less educated. Family planning services have a legacy of success and concessions that continue to be dealt with today.

3.0 CURRENT FAMILY PLANNING POLICY

3.1 TITLE X

Despite attempts to dismantle Family Planning Services in the later part of the Nixon administration and throughout the Reagan, Bush I, and Bush II administrations, an important piece of policy came out of 1970 that remains the sole federal program dedicated to family planning today. The Family Planning program is authorized under Title X of the Public Health Service Act. It is administered within the Office of Population Affairs by the Office of Family Planning, although its budget is located within the Health Resources and Services Administration. The program was funded at $288 million in fiscal year 2005 and $283 million in fiscal year 2007. Susan B. Moskosky, MS, RNC, is the current director of the Office of Family Planning (Office of Population Affairs, 2005; Office of Population Affairs, 2007).

Title X bases it inception on research of the mid-1960's that showed inequitable access to contraceptives, not a preference for more children, was largely responsible for the difference between lower-income and higher-income women's number of births. Other research at this time focused on spacing of pregnancies, indicating medical reasons such as lower maternal and infant death, to support child spacing practices. Furthermore, evidence demonstrated that unintended births, particularly among adolescents, increased poverty and reliance on public

assistance while reducing women's ability to participate in the workforce and complete an education (Gold, 2001).

Title X provides the primary support for publicly funded family planning services in the United States. Medicaid, the social services block grant, the maternal and child health grant, the State Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF) and state and local funds are available to subsidize family planning services. Nonetheless, Title X remains the core of the national effort to provide family planning services (Gold, 2001)

In fiscal year 2006, 87 Title X grantees provided family planning services to approximately five million women and men through a network of more than 4,400 community-based clinics that include state and local health departments, tribal organizations, hospitals, university health centers, independent clinics, community health centers, faith-based organizations, and other public and private nonprofit agencies. In approximately 75% of U.S. counties, there is at least one clinic that receives Title X funds and provides services as required under the Title X statute (Office of Population Affairs, 2007).

Funds of the program are meant to have the flexibility to structure their programs to meet local needs. Title X service funds are allocated to the ten DHHS Regional Offices. The Regional Offices manage the competitive review process, make grant awards, and monitor program performance. The Title X program also supports three key functions aimed at assisting clinics in responding to clients needs: (1) training for family planning clinic staff through general training programs; (2) information distribution and community-based education and outreach activities; and (3) data collection and research to improve the delivery of family planning services (Office of Population Affairs, 2005).

One of the most significant contributions of Title X's provision of publicly funded family planning services is its set of standards. Full confidentiality is essential in Title X funded clinics. Furthermore, all services are completely voluntary. All clients are to receive information on a range of contraceptive methods, including the "natural method" with its high failure rate but Roman Catholic tolerance. Regardless of the source of payment of the individual, these standards apply to all women served in a Title X funded clinic. Title X funded clinics are open to all women, regardless of age, marital status, income or health insurance. The fee is based on income, with women whose income is below the federal poverty line entitled to free services and women with incomes between 100% and 250% of the poverty line paying according to a sliding scale. The following are the 2002 poverty thresholds: for a single person $8,860; for a family of two $11,940; for a family of three $15, 020; for a family of four $18,100; for a family of five $21,180; for a family of six $24, 260; and for a family of seven $27,340 (National Archives and Records Administration, 2002).

Title X funds are critical to maintaining and operating clinics which ensure the availability of family planning services to low-income and uninsured individuals in the United States. Over the last thirty years, the network of Title X family planning clinics has played a critical role in ensuring access to confidential family planning services for millions of low-income or uninsured women, a population which is disproportionately composed of racial and ethnic minorities, at no cost or at a reduced cost. Title X also provides access for many under-insured women who do not have coverage for contraceptive services, devices, or drugs. Nearly two-thirds of Title X clients have incomes below 100% of the poverty level and nearly nine in ten have incomes below 200% of the poverty level. Furthermore, while the majority of clients served in Title X funded clinics are poor, Medicaid covers only 21% of fees. Fees for minors are

based on their own income to reduce the barrier to their receiving care. Clinics that receive Title X funding serve 15% of all women in the U.S. who obtain contraceptive prescriptions of supplies or who receive a checkup for birth control each year (Gold, 2001).

Title X requires that clients visiting clinics for contraceptive care also be offered preventative health services. Title X official guidelines specify various services to be offered such as blood pressure evaluations, breast and pelvic exams, Pap smears, testing for sexually transmitted diseases, and HIV testing. A significant portion of U.S. women relay on Title X clinics for their reproductive health care. For many women, Title X serves as an entry point into the health care system, as well as a source of primary health care services. According to 1995 data, only 5% of Title X clinic clients received only contraceptive services on their visit. Almost 90% received some type of preventative gynecologic care, and more than half received services related to STDs or reproductive tract infections. Eighteen percent of U.S. women who receive STD testing and 14% who receive HIV testing do so at Title X funded clinics. Between the years of 1995 and 1998, clinics funded by Title X performed 19 million tests for STDs, including 1.4 million for HIV. Over the course of the past 2 decades, an estimated 54.4 million breast exams and 57.3 million Pap smears have been conducted which resulted in the early detection of an estimated 55,000 cases of invasive cervical cancer. For many clients, Title X clinics provide their only continuing source of health care and health education. Title X has always prohibited using program monies to pay for abortion. However, a pregnant woman must be offered information and counseling about her options including foster care, adoption, infant care, and pregnancy termination, as well as referrals to other sources upon request (Gold, 2001).

In the U.S., clinics receiving Title X funds have been at the forefront of efforts to reduce rates of unintended pregnancies. Each year, publicly subsidized family planning services help

women avoid an estimated 1.3 million unintended pregnancies. Over the last twenty years, the program has been estimated to have prevented almost 20 million pregnancies. Title X has been instrumental in reducing adolescent pregnancies by helping to prevent 5.5 million teen pregnancies during this same twenty years. It is estimated that without Title X, adolescent pregnancies would have been 20% higher (Gold, 2001).

The Title X program has also had a highly noteworthy economic impact, with the net effect of saving, rather than costing, public money in the long term. For every dollar spent by federal and state governments on family planning services, approximately three dollars are saved in Medicaid costs for pregnancy related care and newborn medical care alone (Office of Population Affairs, 2005). It is difficult to place a dollar value on the number of women's lives that have been saved or improved due to reproductive and medical care provided by clinics funded by Title X.

3.2 CHALLENGES TO TITLE X

Despite the obvious success in the allocation of funds to Title X, societal controversy driven by a very vocal minority has resulted in decreased funding for the program. While 90% of Americans state that they support subsidized family planning services, charges by some political conservatives that the program promotes adolescent sexual activity and abortion have at times had devastating effects. The relationship between increased teenage sexual activity and increased family planning continues to reduce funding despite the fact that the average family planning patient does not visit a family planning provider until 14 months after she has become sexually active. Opponents of the program have sought to either eliminate the program

completely or impose damaging restrictions. During the 1980's, the program became victim to steep funding cuts and has yet to fully recover. Taking inflation into account, the Title X's funding has declined by over two-thirds since FY 1980 (Dailard, 2001; Office of Population Affairs, 2007).

Furthermore, Title X funded clinics have faced rising costs. In a recent small-scale investigation, Title X-funded providers identified three clusters of financial pressures—the increasing cost of contraceptives, rising prices for diagnostic tests and inadequate levels of Medicaid reimbursement—that could jeopardize clinics' ability to continue to provide the high-quality, affordable services that have long been the trademark of the program. To further complicate the picture, these cost pressures are mounting at a time of spiraling federal deficits and a bleak economic outlook for states, making the long-term prospects for comprehensive solutions uncertain at best (Gold, 2002).

Without continued and increased support for Title X funded clinics and the set of standards that make Title X funded clinics unique, many American women will be faced with inadequate reproductive healthcare. With medical care costs soaring, funding for Title X has taken a backseat to funding for abstinence-only education through the Office of Adolescent Pregnancy Programs, also under the Office of Population Affairs (Office of Population Affairs, 2005). While both are intended to reduce unplanned pregnancy, Title X has demonstrated effectiveness in actually doing so. Despite lack of empirical evidence, funding continues to pour into abstinence-only education.

3.3 ABSTINENCE-ONLY EDUCATION POLICY

A policy that has significantly decreased access to family planning information is the Abstinence-Only Education Policy started under Title V, which is a descendent of the 1981 Adolescent Family Life Act (AFLA) within the U.S. Office of Population Affairs. AFLA's early programs taught abstinence as the only option for those who are unmarried and often promoted specific religious values. Consequently, the American Civil Liberties Union filed suit in 1983, charging that AFLA violated separation of church and state as defined in the U.S. Constitution. In 1985, a U.S. district justice found AFLA unconstitutional. However, on appeal in 1988, the U.S. Supreme Court reversed that decision and remanded the case to a lower court. In 1993 a settlement was reached out-of-court that stated that AFLA-funded sexuality education programs must 1) not include religious references, 2) be medically accurate, 3) respect the "principle of self-determination" regarding contraceptive referral for adolescents, and 4) not allow grantees to use church grounds for their programs or give presentations in parochial schools during school hours (Daley, 1997).

The first Congressional attempt to censor sexuality education using an abstinence-only provision occurred in 1994. An amendment was introduced to limit the content of HIV-prevention and sexuality education in school-based programs during the reauthorization of the Elementary and Secondary Education Act. The amendment failed as a statute prohibiting the federal government from prescribing state and local curriculum standards. However, proponents of abstinence-only programs discovered that they could manipulate the scope of state and local funding and health policy and did just that under Section 510. Section 510 is a provision that was attached to the welfare-reform law of 1996 that funneled $50 million per year for five years into state funding for abstinence-only education. Through Section 510 of Title V of the Social

Security Act, an expansion of the Maternal and Child Health block grant, federal funds have been available each year since 1996 to support abstinence programs, primarily school programs, which exclude all information on contraception. States that choose to accept funds from section 510 are required to match every four federal dollars with three state-raised dollars and then disperse the funds for educational activities (Daley, 1997). The law's definition of a fundable program has eight points, including the tenet that only a monogamous marital relationship is the expected standard for any human sexual activity at any age, and that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects (Section 510, Title V of the Social Security Act). In 1999, abstinence-only supporters obtained an additional 50 million federal dollars for abstinence-only-until-marriage programs. This funding is awarded directly to state and local organizations by the Maternal and Child Health Bureau through a competitive grant process instead of through block grants (Smith, 2000).

Programs that receive funds may not provide any contraceptive information, even with separate funds. Each year, funding for these programs has increased, with total spending for abstinence-only education reaching $100 million in fiscal year 2002. Proponents of increased funding have argued that more funding is necessary to achieve parity with more comprehensive approaches to unplanned pregnancy, such as Title X. However, this parity contrasts expenditures for abstinence-only education against soaring costs that pay largely for medical and technological services (Levin-Epstein, 1999).

3.4 LACK OF SUPPORT FOR ABSTINENCE-ONLY EDUCATION

A review of abstinence-only research does not support the use of abstinence-only policy to reduce unintended pregnancy. In fact, newer research has not only invalidated the effectiveness of abstinence-only education, it has demonstrated harm to young people. In his 2001 report, Call to Action to Promote Sexual Health and Responsible Sexual Behavior, U.S. Surgeon General David Satcher stated that informing adolescents about contraception does not increase sexual activity, either by hastening the onset of sexual intercourse, increasing the frequency of sexual intercourse, or increasing the numbers of sexual partners (Satcher, 2001). Instead, it has been found that those who have pledged to abstinence-only programs were one-third less likely than a comparison group to use contraception when engaging in sexual intercourse (Bearman & Brueckner, 2001). Furthermore, a 2003 study found that adolescents who discussed contraception with their partners prior to first intercourse had more than twice the odds of ever using contraception compared to those who had not. It was also found that taking a virginity pledge was related to decreased odds of using contraception at intercourse. The same study demonstrated positive results from sex education programs that actively engage teens in role playing to learn to negotiate contraceptive use (Manlove, Ryan, & Franzetta, 2003). In addition, a 2004 study found that Minnesota students reported twice the rate of sexual activity following an abstinence-only course than prior to taking a course (Pierre, 2004). Along the same lines, more comprehensive sex education models that include information on contraception have produced better results in that participants reported less frequent unprotected sex and sexual intercourse than a control group in an abstinence-only program (Levine-Epstein, 2001).

Some states are turning down abstinence-only federal grant money due to lack of evidence that it is effective. As of September 2005, all states, except California, Pennsylvania

and Maine, accepted section 510 funding (Smith, 2005). By April 2007, Ohio, Connecticut, Rhode Island, Montana, New Jersey, Massachusetts, Washington, and Wisconsin had dropped out of the program or planned to by the end of the year (Huffstutter, 2007). However, independent programs within these states, including faith-based organizations, still qualify and receive funding (Office of Population Affairs, 2007).

The overwhelming majority of American adults in numerous polls across the U.S. support comprehensive sexuality education in American schools. Ninety-three percent of Americans support teaching sexuality education to high school students while 84% support sexuality education for middle and junior high students. Approximately 87% of Americans believe that birth control should be among the topics included in education curriculums in schools. In addition, more than ten religious organizations are members of the National Coalition to Support Sexuality Education, including the American Jewish Congress, the Office of Family Ministries and Human Sexuality of the National Council of Churches of Christ, the Unitarian Universalist Association, and Catholics for a Free Choice (Kempner, 2004).

Despite the lack of support for abstinence-only policy, abstinence-only supporters continue to push for additional funding. The downward trend of the percentage of adolescents having intercourse hit a plateau in 2001. This leveling of behavior coincided with a significant increase in federal spending on abstinence-until-marriage policy. In reaction, Leslee Unruh of the National Abstinence Clearinghouse stated "We need to increase abstinence education and give more dollars to abstinence education. It is the healthiest program we have for young people" (Stein, 2007, p. A5). However, the rates of unintended pregnancy in the United States, coupled with relatively low contraceptive use, paint a different story.

4.0 JUSTIFICATION OF CURRENT STUDY

The proportion of U.S. females aged 15 to 44 years who practice contraception, including sterilization among males and females, rose from about 56 percent in 1982 to 60 percent in 1988 and to 64 percent in 1995. However, only about half of all U.S. women or their partners use any contraception at first premarital intercourse, with the proportion being lower for Blacks and Latinos (Piccinino & Mosher, 1998). Contraceptive practice in the U.S. is directly related to age, with the youngest individuals being the least likely to use a contraceptive method consistently (Glei, 1999). In addition, studies indicate that the average family planning patient does not visit a family planning provider until 14 months after becoming sexually active (Dailard, 2001). Other studies have demonstrated that suspected pregnancy was by far the leading reason given by patients visiting family planning clinics for the first time (Mosher & Horn, 1988).

More than one million teenage pregnancies occur each year in the U.S. (U.S Department of Health and Human Services, 2000). While U.S. adolescent birthrates decreased slightly between 1990 and 2000, these rates were still highest in the Western world. Furthermore, U.S. rates are in sharp contrast to the very low adolescent birthrates in European countries, despite similar or later age of sexual debut and similar proportion of sexually active adolescents (Ashford, LeCroy & Lortie, 2006; Darroch, Frost, & Singh, 2001). In fact, the U.S. adolescent pregnancy rate is three times that of Sweden. Yet, Swedish adolescents are more sexually active at an earlier age and are more exposed to sexual activities through television (Ashford, LeCroy &

Lortie, 2006). Opponents of providing birth control and related information to minors express concern that providing information will lead to an increase in sexual activity and adolescent pregnancy (Dailard, 2001). However, use of family planning is openly promoted in most Western European countries (Cromer & McCarthy, 1999). For example, Swedish students are provided with sexual education as part of a school curriculum starting at seven years of age (Ashford, LeCroy & Lortie, 2006).

The best model and data reflecting the influence of sex education comes from efforts outside of the U.S. For example, research indicates that the Netherlands has the lowest fertility rate and apparently the lowest ratio of unplanned to planned pregnancies in the world (Torres & Jones, 1998). The mean age of motherhood in the Netherlands increased to 27.6 years in 1991, which is higher than any other country (Beets, 1993). In addition, the Netherlands has the lowest abortion rate, despite the fact that government-sponsored programs provide abortion free of charge to patients (Torres & Jones, 1998).

Dutch government-sponsored information programs have played a major role in providing birth control information to the Dutch public. Established specifically to assist young people and immigrants, information and interpreter centers are funded by the government to provide information on access to birth control and health services. This extensive network of Dutch counseling bureaus provide referrals and guidance to anyone needing assistance related to sexuality and birth control matters. Open during most hours including evenings and weekends, clinics accept drop-in visits for emergency services such as the emergency contraception pill or abortion referrals (Jones, Forrest, Henshaw, Silverman, & Torres, 1989).

Dutch schools also provide information and facilitate access to family planning. A comprehensive sex education class is taught to high school biology teachers to use within Dutch

schools (Jones, Forrest, Henshaw, Silverman, & Torres, 1989). Plus, school nurses facilitate referral of students to family planning services. Not surprisingly, research indicates that adolescents in the Netherlands are more knowledgeable about contraception than adolescents in the United States. Reported barriers to family planning services by adolescents in the U.S. include the tendency of parents to meticulously monitor any medical care their children receive at school and the political sensitivity of school administrative bodies toward becoming involved with family planning services, including education, to students. (Cromer & McCarthy, 1999).

Parents have been encouraged to be the primary sex educators for their children. However, studies indicate that most U.S. parents report feeling uncomfortable talking about sex with their adolescents (McNeely, Shew, Beuhring, Sieving, Miller & Blum, 2002). Studies also indicate that communication with parents on sexual topics typically occurs with the mother (Dilorio, Kelley, & Hockenberry-Eaton, 1999), although discussions about contraceptive choices between adolescents and their mothers often only occur after a pregnancy (Pistella & Bonati, 1998). In a nationally representative sample, over half of adolescents reported that they had never talked to their parents about contraception (Kaiser Family Foundation, 2002). Furthermore, according to a 2002 study published in the Journal of the American Medical Association, 59% of adolescents seeking contraceptive services stated that they would not obtain services if they had to inform a parent (Reddy, Fleming, & Swain, 2002)

Other studies indicate that parents are not familiar with medical information on contraception. Many parents underestimate the effectiveness of condoms for preventing pregnancy. According to a 2004 study, only 40% believed that condoms were effective for preventing pregnancy and only 52% thought that the BC pill prevents pregnancy almost all of the time. About 25% believed that most adolescents are capable of using condoms correctly and

40% believed that teens could use the BC pill correctly. Only 39% believed the birth control pill is safe. The more politically conservative a parent reported being, the less medically accurate his or her views were (Eisenberg, Bearinger, Sieving, Swain, & Resnick, 2004). When used consistently and correctly, condoms prevent pregnancy 97% of the time and the birth control pill does so 99.9% of the time (Hatcher, Trussell, Stewart, Cates, Stewart, Guest, Kowal, 1998). Furthermore, the pill is considered safe for most women (exceptions include women over 35 and heavy smokers). Among U.S. women, oral contraception is safer than childbirth (American College of Obstetricians and Gynecologists, 2002).

The alarming problem of unintended births and inadequate use of contraception has received wide national attention, such as in the goals of Healthy People 2010. Healthy People 2010 is a national set of health objectives developed by the leading Federal agencies with the most relevant scientific expertise. The Healthy People Consortium is an alliance of 350 national membership organizations and 250 agencies, including social work agencies. Individuals, groups and organizations are encouraged to integrate Healthy People 2010 into current programs, special events, publications, and meetings to build an agenda for community health improvement. The reproductive health-related objectives include, but are not limited to, the following: increase the proportion of pregnancies that are intended; increase the proportion of females and their partners at risk of unintended pregnancies who use contraception; reduce the proportion of females experiencing pregnancy despite use of a reversible contraceptive method; reduce pregnancies among adolescent females; and increase the proportion of sexually active, unmarried adolescents aged 15 to 17 years who use contraception that both effectively prevents pregnancy and provides barrier protection against disease (U.S Department of Health and Human Services, 2000).

Among other factors, knowledge of referral services has been shown to be a particularly effective tool for providing successful contraceptive services, particularly to adolescents. In one study, adolescents stated that one primary reason they did not seek contraceptive services is that they were not aware of a doctor whom they could visit (Severy & McKillop, 1990). Furthermore, studies that examine the effectiveness of family planning clinics consistently suggest that community relations, including referrals from community agencies, are important determinants of reducing the delay between a teenager's first intercourse and first clinic visit. In addition, fear around issues of confidentiality and fear based on lack of knowledge about pelvic examinations have been shown to produce a delay in seeking services (Winter & Breckenmaker, 1991).

Individuals receiving social work services have particular access to information related to family planning, as these individuals are already in a social work system. Furthermore, due to the National Association of Social Workers' (NASW) stance of the professional responsibility of social workers, social workers are in a unique position to provide family planning information. As previously stated, NASW promotes a woman's choice in family planning as consistent with the principles of self-determination, empowerment, and dignity that form the foundation of social work. NASW further adds that it is a social worker's professional responsibility to ensure that referral information on all family planning options, including abortion, is available (National Association of Social Workers, 2003).

4.1 UNPLANNED PREGNANCY WITHIN SOCIAL WORK CLIENT POPULATIONS

The populations with which social workers tend to work have been shown to be at increased risk of unintended pregnancy. For example, individuals with mental illness have been shown to be at greater risk for unintended and adolescent births than individuals in the general public (DiClemente & Ponton, 1993; Coverdale, Turbott, & Roberts, 1997; Brooks-Gunn & Paikoff, 1997). Nearly 40% of NASW members list mental health as their primary area of practice. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) social workers are the largest group of licensed mental health providers in the United States, outnumbering psychologists, psychiatrists, and psychiatric nurses combined (NASW, 2002).

Most of the research related to the sexual activity of mental health clients focuses on adolescents, specifically those receiving inpatient treatment. Compared with the general population, hospitalized teens report less frequent condom use, more frequent sexual activity, and a higher lifetime prevalence of pregnancy (DiClemente & Ponton, 1993). Inadequate sexual communication skills, impulsivity, and more involvement in prostitution are among the factors that place these youths at greater risk. Furthermore, mental health problems in general are related to unprotected sex. Research linking risky sexual behavior and specific psychiatric diagnosis has produced mixed results. Women with psychotic disorders have more unplanned pregnancies than the general population (Coverdale, Turbott, & Roberts, 1997). Depression, anxiety and low self-esteem are associated with low perceived self-efficacy (Brooks-Gunn & Paikoff, 1997; Brown, Danovsky, Lourie, DiClemente, & Ponton et al. 1997), decreased assertiveness, and minimal ability to negotiate safe sex with a partner (McFarlene, Bellisimo, & Norman, 1996). Depression and low self-esteem are also linked to low contraceptive use and

high-risk pregnancy. Furthermore, hopelessness and helplessness may reduce adolescents' motivation to make health-promoting choices (Brooks-Gunn & Paikoff, 1997)

Less is known about teens receiving outpatient psychiatric treatment. However, research that examines AIDS risk behavior among adolescents in psychiatric care indicates that troubled youth engage in higher rates of HIV risk behaviors than their same age peers who are not receiving psychiatric care. Among these behaviors, adolescents in outpatient psychiatric treatment reported high rates of sexual intercourse (54.7%), pregnancy (8.3%), and sex without a condom (42.6%). Adolescent-reported, but not parent-reported, externalizing problems were significantly related to adolescent unprotected sex (Donenber, Emerson, Bryant, Wilson, & Weber-Shifrin, 2001). Another study compared sexually active teens who use contraception all of the time (low-risk), sexually active teens who do not use contraception (high-risk), and abstainers. Factors that were associated with sexual risk-taking behavior were higher rates of contemplation of suicide and higher consumption of alcohol, as well as troubled relationships with their parents. Furthermore, 31% of the high-risk females had a history of sexual abuse, compared with 15% of the low-risk females and 5% of the abstainers. Similarly, 40% of the high-risk females reported being physically abused, compared with 12% of the low-risk group and 10% of the abstainers (Luster & Small, 1994). Other studies have demonstrated a link between exposure to abuse, violence, and family strife and increased risk of adolescent pregnancy. Specifically, women who had experienced incarceration of a family member, household substance abuse, parental domestic violence, verbal abuse, sexual abuse, divorced parents, physical abuse, or household mental illness were more likely to have become pregnant as teenagers (Hillis, 2004). In addition, students in alternative education have been shown to engage in risky sexual behavior at higher rates than do their peers in regular schools, placing

them at increased risk of unintended pregnancy (Markham, Tortolero, Escobar-Chaves, Parcel, Harrist, & Addy, 2003).

Another group of females who frequently confront unintended pregnancy are homeless women. At any given time, one-fifth of U.S. homeless women are pregnant. This rate is twice that of all U.S. women of reproductive age and substantially higher than low-income women who are not homeless (Bassuk, Browne, & Buckner, 1996; Robrecht & Anderson, 1998). Furthermore, studies related to condom use suggest that homeless and runaway youth engage in high-risk sexual behaviors at higher rates than youths in the general population (Booth, Zhang & Kwaitkowski, 1999). In a 2002 study, researchers identified several deterrents to the use of contraception in a survey of homeless women. Included at significant rates were lack of a place to store contraception, uncertainty of how to obtain or use contraception, uncertainty of what method to use, cost, fear of possible side effects, thoughts that contraception is uncomfortable or unnatural, partner dislikes use, and fear of health risks (Gelberg, Leake, Lu, Andersen, Nyamathi, Morgenstern & Browner, 2002).

Little is known about the limitations social workers face in increasing access to family planning for the individuals with whom they work. Limited information about the capacity of social workers to provide family planning information suggests that social workers are in need of training in this area (Ford & Hendrick, 2003). Furthermore, a review of the obstacles that other direct-care professionals experience underscores the need to investigate barriers that social workers may be confronting.

4.2 BARRIERS TO FAMILY PLANNING WITHIN DIRECT-CARE PROFESSIONS

Surveys of pharmacists have identified lack of knowledge, negative attitudes, low level of comfort, and lack of adequate continuing education in family planning as hindering the ability of pharmacists to meet the needs of their clients. In a 1999 Planned Parenthood New York City survey of 100 pharmacists, 97 provided incorrect information or were unable to provide any information about how emergency contraception (EC) works, and 38 did not know that it was available (Draut, 1999). In a 2004 survey of North Dakota pharmacists, only 5 % of respondents appropriately answered three basic EC questions related to safety and mechanism of action. Another 42% of respondents who worked in pharmacies that carry EC indicated that they were not comfortable with discussions of EC. Comfort level was significantly and positively correlated with greater knowledge. Comfort level did not vary with sex of pharmacist, community size, type of pharmacy, or opinion about whether EC should be available over the counter. Other barriers to providing emergency contraception included moral objection (37%), and management or administrative decisions (26%). Working at a Catholic-managed workplace was also cited as a barrier in the open-ended questions. Inadequate continuing education and lack of reproductive health information in pharmacy school curriculums were discussed as problematic (VanRiper & Hellerstedt, 2005).

Barriers identified by Pennsylvania primary care physicians in providing adequate sexual health care were lack of sufficient preparation in medical school and continuing education, time pressures, financial reimbursement difficulties, and a low level of confidence and responsibility in discussing sexual health issues. The changes that were primarily discussed in this particular study were an increased attention to reproductive health in medical education, and training that would foster physicians' confidence and sense of responsibility in matters related to reproductive

health (Ashton, Cook, Wiesenfeld, Krohn, Zambrosky, Scholle, & Switzer, 2002). Furthermore, confusion over the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has been cited as problematic for many professionals working with adolescents and family planning issues (English & Ford, 2004).

A preliminary small-scale study conducted in 2003 surveyed 19 licensed social workers practicing at a large psychiatric hospital and 53 MSW students at an urban school of social work for a total of 72 respondents. Respondents were asked to indicate if items represented barriers in their ability or the ability of their coworkers to provide full information on contraception to adolescents. Respondents reported the following to be barriers, in order of frequency, to providing family planning information to adolescent clients: it did not occur to clinicians to discuss contraception with their patients (72%); many clinicians did not believe it was their responsibility to provide contraceptive information (69%); clinicians were concerned about liability issues related to providing information on contraception (60%); clinicians were not fully aware of the community resources available to adolescents related to contraception (53%); most adolescents did not ask about birth control choices (53%); many clinicians were concerned about the safety of their adolescent patients' use of contraception (44%); many clinicians were not fully aware of current contraception options (31%); and moral opposition impacted a clinician's willingness to provide confidential contraceptive information to adolescents (21%). Open-ended questions indicated that some MSW students were not allowed to discuss contraception due to working at or having a field placement at a Catholic-affiliated workplace, while others needed clarification that abstinence is not a form of contraception (Bell, 2003).

Given inconsistent parental information, the national objectives of Healthy People 2010, the NASW code of ethics, and access to individuals who are more likely to face the devastating

consequences of unintended pregnancy, social workers need to address unintended birth risks in clients who seek their services. Little information is available about obstacles social workers experience in providing relevant care. After the barriers social workers face are investigated and better understood, more appropriate training could be developed to provide social workers with the tools for reducing unintended pregnancy. Theories that are pertinent for social work could be useful in developing valuable family planning training for social workers.

5.0 THEORETICAL FOUNDATION FOR STUDY: SOCIAL COGNITIVE THEORY

Values and attitudes of individual social workers, and subsequent behaviors, have been shown to be significant in impacting the actions of clients. Bergin (1980) theorized that discrepancy often exists between the values of therapists and clients. Subsequent research has demonstrated that clinicians' values and attitudes not only influence the effectiveness of therapy, they also influence clients' personal values (Kelly, 1995). One's personal belief or attitude toward discussing sexual issues, such as providing relevant information on family planning with a wide range of clients, would have a significant impact on the performance of that behavior. Thus, it could be expected that a social worker who has moral opposition to family planning will be less likely to discuss family planning with clients. However, other concepts are believed to impact the behaviors of individuals as well. Alfred Bandura's social cognitive theory is widely recognized for providing a framework for understanding human behavior (Pajares, 2004).

5.1 SOCIAL COGNITIVE THEORY

Alfred Bandura's research centers on the prominent role of social modeling in human motivation, learning, thought, and action. In 1977, Bandura published *Social Learning Theory,* which helped to increase interest in social learning and psychological modeling within the field of psychology. Bandura continued to explore the origins of human thought and action, resulting

in the development of social cognitive theory. Bandura's decision to rename his theoretical approach from social learning theory to social cognitive theory was due to his growing belief that the extent of his research had expanded beyond the scope of the social learning label. In addition, the social learning label had become confusing because it applied to several theories founded on dissimilar ideas. In social cognitive theory, the "social" portion of the title acknowledges the social origins of human thought and action. The "cognitive" portion recognizes the influential contribution of cognitive processes to human motivation, affect, and action. Social cognitive theory is rooted in the perspective that people are self-organizing, proactive, self-regulating, and self-regulating. Furthermore, human behavior is the product of an active interplay of personal, behavioral, and environmental influences (Pajares, 2004).

Social cognitive theory is concerned with how humans operate cognitively on their experiences and how these cognitive operations then come to influence their behavior. Individuals are believed to abstract and integrate information that is encountered in a variety of experiences. Through this abstraction and integration, they mentally represent their environments and themselves in terms of certain crucial classes of cognitions, including, but not limited to, attitudes and values. These cognitions are believed to affect the behaviors of individuals (Bandura, 1986). This study will investigate areas that may hinder social workers in providing all relevant family planning information. With this information it is hoped that future training could be developed to address these barriers. Social work clients could then benefit from having needed information.

Social cognitive theory emphasizes the role of cognition, abstraction, and integration in the concepts of observational learning, self-regulation, self-efficacy, and reciprocal determinism. Related to these concepts, research has identified educational models as possible change agents

within social cognitive theory (Bandura 1986). Thus, social cognitive theory can be useful in developing a training program to address the provision of family planning information by social workers once it is known what needs to be confronted. For this current study, social cognitive theory was utilized in developing a measure of obstacles social workers confront in providing family planning information. Items of the questionnaire reflect the concepts of moral attitudes, observational learning, self-regulation, and self-efficacy.

5.2 OBSERVATIONAL LEARNING

According to Bandura, there are four components involved in observational learning. First, observers must pay attention to the material. Second, when material has been attended to, it must be retained, with the observed behavior represented in memory. Third, symbolic representation must be converted into appropriate actions similar to the originally modeled behavior. The final process involves motivational variables. There must be sufficient incentive to motivate the actual performance of the behavior (Bandura, 1986).

According to the tenets of observational learning, family planning training for social workers would need to be tangible and interesting enough for the participating social workers to pay attention to the training material and commit it to memory. Thus, information on material that social workers would consider tangible for their profession would need to be explored. The training material would need to be easily incorporated into behavior and provide adequate incentive to motivate the participant to utilize the presented material. Bandura identified three basic models of observational learning: A live model, which involves an actual individual demonstrating or acting out a behavior; a verbal instructional model, which involves descriptions

and explanations of a behavior; and a symbolic model, which involves real or fictional characters displaying behaviors in books, films, or television programs (Bandura, 1986). Social work courses and continuing education could utilize all three of these models.

This current study's questionnaire operationalized observational learning through the use of knowledge items. Knowledge items included self-perceived knowledge and tested knowledge. Self-perceived items asked respondents how knowledgeable they believe themselves to be on issues related to family planning. Testable knowledge items asked respondents to provide answers to specific family planning information.

5.3 SELF-REGULATION

A critical challenge for any theory that involves behavior is to explain how control of behavior shifts from external sources to individual intrinsic sources. Bandura stresses this shift in his concept of self-regulation. According to Bandura, people plan a course of action, anticipate their likely consequences, and set goals and challenges for themselves to regulate their activities. They do things that give them satisfaction and refrain from actions that evoke self-devaluation. In other words, people regulate their own motivation and behavior by the consequences they produce for themselves. He explains that individuals continue to hold positions, despite changing situations, due to judgmental personal standards based on earlier external forces. Actions that measure up to these internal standards are judged positively while those that fall short are judged negatively. Additionally, individuals must choose from numerous influences in their environments. The selection of standards generally depends upon the weighing of factors such as the relevance and value of the specific activity (Bandura, 1986).

Self-regulation could function in relation to the provision of family planning when the social worker has his or her own ideas, based on external forces, about what is appropriate behavior. The social worker would then choose his or her actions accordingly. One aspect of self-regulation is setting standards and goals, in which one determines limits, boundaries, and criteria for one's behavior (Bandura, 1986). It is unclear if the vast majority of social workers are aware of their professional obligation to provide family planning information. There is also uncertainly of the extent to which social workers view family planning to be relevant to social work clients.

For the current study, self-regulation questionnaire items examined the respondents' perception of their professional role and interest in providing family planning information. In addition, respondents were questioned about their perception of the relevance of family planning information to their clients. Finally, an item asking if an incentive exists for providing family planning information in their workplace was included.

5.4 SELF-EFFICACY

Bandura also views self-efficacy as a major determinant in performing a behavior. According to Bandura, the self-efficacy belief system is the foundation of human motivation, well-being, and personal accomplishment. Individuals develop domain-specific beliefs about their own abilities that guide their behavior by determining what they try to achieve. The beliefs also impact how much effort they put into their performance in that particular domain. In other words, self-efficacy is the belief in one's capabilities to organize and implement the sources of action required to manage prospective situations. Unless people believe that they can bring about

desired outcomes by their actions they have little incentive to act or persevere. In addition, when individuals have negative self perceptions about a situation, believing they are ineffective and do not have the ability to perform well, they become preoccupied with themselves. They also become emotionally aroused. These two conditions can distract them from performing effectively (Bandura, 1986).

Discovering the areas in which social workers feel less than fully competent would be crucial in developing training. Without self-efficacy a social worker may not approach the topic of family planning, even when it is clearly needed. Increasing the perceived self-efficacy of a social worker in providing family planning information is an important factor to consider within the social cognitive theory.

The current study examined self-efficacy with questionnaire items related to perceived effectiveness of reducing unplanned pregnancy with one's own clients. Respondents were also asked about their perception of the effectiveness of the social work profession in reducing unplanned pregnancy in general. Other items examined perceived comfort and competence in discussing family planning. In addition, respondents were asked about their perception of their clients' capabilities of using family planning methods, and cultural or language barriers.

5.5 VALUES AND ATTITUDES

Self-regulation based on professional responsibility or perceived relevance of family planning to clients, and sense of self-efficacy may not be enough to neutralize personal sexual values or attitudes. For example, the earlier external influence of orthodox religion was identified as a potentially stronger portion of a participant's judgmental self-reaction than professional

responsibility (Bergin, 1980). One of the aspects unique to social work is that in order to maintain the special features of the professional role, workers must sometimes separate their own personal attitudes and behaviors from the behaviors expected in the professional role (Munson and Balgopal, 1978). Although professionally appropriate, this separation may be viewed by clients or other observers as distaste for occupying the role, which is a more common reason for people separating from their role (Ruddock, 1969).

Related specifically to family planning, Jensen and Bergin (1988) found that one of the themes of mental health values reflected in their study was that clinicians reported having definite beliefs about sexuality. Research has also indicated that sexuality is one of the main areas in which clients and clinicians commonly disagree (Khan & Cross, 1983). Thus, scale items meant to assess moral objection to providing family planning information were included in the current study.

5.6 RECIPROCAL DETERMINISM

Social cognitive theory acknowledges the interrelationship between the individual, his or her environment, and his or her behavior. In this concept of reciprocal determinism, Bandura argues that behavior, the environment, and cognition as well as other personal factors operate as interacting determinants that have a multi-directional influence on each other. Thus, expectations, self-perceptions, goals, and physical structures direct behavior, with resultant behavior then impacting the cognitions of that individual. Environmental events in the form of modeling, instruction, and social persuasions impact the individual, and the individual in turn evokes different reactions from the environment (Bandura, 1986).

Given the need for reciprocity, the concept of reciprocal determinism is more difficult to employ in the didactic setting of training. Whereas it is hoped that clients would reinforce social workers' provisions of family planning information, classroom training sessions could not address this concept. However, research has demonstrated that individuals could be fully cognizant of the nature and consequences of a given behavior without having engaged in it (Bandura, 1986). Thus, it is believed that training that lacks client reinforcement of providing family planning information would still have value in behavior change.

For purposes of the current study, reciprocal determinism was not a factor in developing scale items related to family planning. However, reciprocal determinism is examined through an item related to the respondent's primary work setting. Primary work setting is treated as an item related to respondent's background.

Bandura's theoretical arguments have been supported by empirical research. The research has mostly been of experimental analogues of socialization situations and demonstrations of procedures for achieving change, including training to promote self-efficacy. For example, Bandura demonstrated that knowledge could exist in the absence of performance. Thus, individuals could be fully aware of the features of a given behavior without having engaged in it. Also, Bandura demonstrated that the enhancement of self-efficacy could improve cognitive skill development and intrinsic interest in behavioral pursuits (Bandura, 1986). Thus, family planning training, even within a course or continuing education situation, could increase the motivation of social workers to provide relevant family planning information and subsequently increase contraceptive use among their clients.

In the case of training in issues of sexuality, Ford and Hendrick (2003) discovered that even mental health clinicians who had received graduate or postgraduate training in such topics

were only "neutral" about whether their training adequately prepared them to work with sexual issues with clients. Exploring the areas in which social workers most report needing family planning training is important. It is hoped that utilizing the concepts of the social cognitive theory will increase the effectiveness of training in this area once training needs are explored.

5.7 HYPOTHESES

Bandura (1986) emphasized values, beliefs, and attitudes as part of a collection of cognition classes that are believed to influence behavior. Thus, religious and political attitudes and values would likely affect behavior. More specifically, religious and political opinions that are generally negative toward family planning would be expected to decrease the likelihood of providing family planning information. As previously discussed, observational learning, self-regulation, self-efficacy, and reciprocal determinism are also key components in social cognitive theory. Observational learning and self-efficacy could occur or be improved by social work coursework, training, or practice experience and are thus expected to impact the provision of family planning information by social workers. Reciprocal determinism is dependent upon work environment. Thus, differences in work environment are expected to influence family planning provision. Furthermore, self-regulation related to perceived professional responsibility in providing family planning information could shape family planning barriers. Social workers who are more aware of their professional responsibility would be more likely to provide family planning information.

5.7.1 Religious characteristics hypothesis: H_1

Bergin (1980) identified the earlier external influence of orthodox religion as a potentially stronger contributor to a participant's behavior than professional responsibility. In addition, the current religious opposition against providing family planning information is evidenced by religious-based abstinence-only policy supporters (Dailard, 2001).

H_1 Respondents who report greater religiosity will report a higher barrier level in providing family planning information.

5.7.2 Political characteristics hypotheses: H_2 - H_6

Abstinence-until-marriage policy has typically been supported by the politically conservative. In current policy debates, political groups that have supported the funding of comprehensive sex education have been more liberal or progressive. Politicians who have voted to decrease the funding of comprehensive sex education and increase the funding of abstinence programs have been more conservative, and have a history of voting against abortion rights (Dailard, 2001). Furthermore, parents who were more politically conservative demonstrated less accurate knowledge of family planning information (McNeely, Shew, Beuhring, Sieving, Miller & Blum, 2002).

> **H_2** Respondents who tend to vote for Republicans will report higher barriers in providing family planning information.
>
> **H_3** Respondents who rated themselves as more conservative will report higher barriers in providing family planning information.
>
> **H_4** Respondents who identified as "pro-choice" regarding abortion rights will report fewer barriers in providing family planning information than those who do not identify as "pro-choice" in respect to abortion rights.

H_5 Respondents who tend to vote for Republicans will have fewer correct responses on Testable Knowledge.

H_6 Respondents who rated themselves as more conservative will have fewer correct responses on Testable Knowledge.

5.7.3 Observational learning and self-efficacy hypotheses: H_7 - H_9

According to Bandura (1986), observational learning, including participating in training, is a major determinant of performing a behavior. In addition, professional experience could lead to observational learning, as well as increased self-efficacy. Self-efficacy would be especially increased if the professional position is one that includes direct work with the client.

H_7 Respondents who report participating in family planning trainings will report a lower level of barriers than respondents who have had no family planning trainings.

H_8 Respondents who have more practice experience will report a lower level of barriers than respondents who have had less practice experience.

H_9 Respondents who work directly with clients will report a lower level of barriers than social workers who do not work in direct care.

5.7.4 Reciprocal determinism hypothesis: H_{10}

From a historical perspective, family planning has been more accepted and available in areas that are urban (McCann, 1994). According to Bandura (1986), environmental events in the form of modeling, instruction, and social persuasion impact the individual, and the individual in turn evokes different reactions from the environment. Pro-family planning attitudes among clients and supervisors are likely more common in urban settings than suburban or rural settings.

H_{10} Respondents who identify their primary work setting as urban will report fewer barriers in providing family planning than those who work in suburban or rural areas.

5.7.5 Self-regulation

Self-regulation is also an important component of social cognitive theory. One aspect of self-regulation is setting standards and goals, in which one determines limits, boundaries, and criteria for one's behavior. Within a profession, these standards and goals are often delineated by outlining the responsibilities of the profession. Self-regulation will be investigated on an exploratory level. Its relative position among other barriers will be noted.

6.0 METHODOLOGY

6.1 PILOT STUDY

The survey questionnaire was pilot tested with a group of 10 Pennsylvania social workers recruited from a local psychiatric hospital, and a Pennsylvania school system. The questionnaire included a cover letter, Testable Knowledge, Family Planning Barrier Measure, the Religion Scale based on the Bardis Religion Scale (1961), and a request for background information. The purpose of the pilot test was to ensure that the wording of each item was clear to the reader, establish the general amount of time required to complete the questionnaire, and to solicit general feedback for revising the family planning and demographic items. Testable Knowledge included true/false items related to family planning. The Family Planning Barrier Measure included items reflecting concepts within social cognitive theory, as well as items replicating those reported in previous research addressing barriers that direct services health care professionals face. Participation in the pilot study was fully voluntary and participating social workers could have discontinued their participation at any time. Two minor grammatical changes were made to the questionnaire to reflect feedback from pilot testing.

6.2 PARTICIPANTS AND PROCEDURES

Using a cross sectional survey design, the final survey was administered to 800 Pennsylvania licensed social workers in February of 2007. The sample included social workers who were licensed by the Commonwealth of Pennsylvania Department of State Bureau of Professional and Occupational Affairs and were classified as licensed social workers (LSW). According to the State Bureau of Professional and Occupational Affairs, there were approximately 6,000 licensed social workers as of February 2007. Eight hundred licensed social workers were randomly selected from a mailing list purchased from the Commonwealth of Pennsylvania. Surveys were sent via the U.S. postal service to the addresses provided in the mailing list. Respondents were asked to respond by the March 31st, 2007 to the questionnaire. Of the 800 surveys sent to Pennsylvania licensed social workers, 271 (34%) usable questionnaires were received in return. Twenty-four questionnaires (3%) were returned marked undeliverable by the postal service and fourteen (2%) were not usable due to lack of item completion. Of the 271 questionnaires that were returned and useable, 203 (75%) were received from respondents who indicated that they work with clients in the age range of 13-55 years.

Each eleven-page survey was mailed with a cover letter describing the study, its purpose, the voluntary nature of participation, and confidentiality protections to each respondent. Respondents were instructed to mail their completed surveys to the primary researcher at the University of Pittsburgh, School of Social Work, in an addressed business-reply envelope provided to them. No individual identifying information was collected and thus no individual returned surveys could be connected with any individual name on the mailing list. To maximize the return rate, the initial mailing of the survey was followed by a reminder postcard sent two weeks after the initial survey mailing (Dillman, 2000). Respondents were treated in accordance

with all university policies and procedures regulating human subjects research. Approval from the Institutional Review Board of the University of Pittsburgh was received for the study (see Appendix F) under exempt status.

6.3 MEASURES

The questionnaire began with an item to identify the age range of clients with whom the respondent works. The respondents were asked to report if they do or do not work with clients who are between the ages of 13 and 55. This item was included in an attempt to determine the relevance of the family planning material to the respondent's employment position. Respondents who indicated that they do work with clients within the stated age range were asked to complete the entire questionnaire. Respondents who indicated that they did not work with clients of the age range were asked to complete the first 13 items, and then skip to sections containing the Religion Scale and background information. The first 13 items do not assume that family planning is relevant to the social worker's specific professional position. Only the 203 questionnaires that were from respondents who indicated working with clients between the ages of 13 and 55 were used for the current study.

The questionnaire included Testable Knowledge, the Family Planning Barrier Measure, the Religion Scale, and a 13- item demographic and background information section. A cover letter with a brief description of the study was presented with the questionnaire as well.

6.3.1 Testable Knowledge

The Testable Knowledge portion contained 10 true/false items. The true/false items were related specifically to family planning knowledge. The Testable Knowledge scores could range from 0 to 10, with higher scores indicating greater knowledge. Examples of items include, "The birth control pill is safe for most adolescents," and "Emergency contraception requires a physician's prescription for every woman in Pennsylvania." The Testable Knowledge portion accounted for items 1-10 of the questionnaire.

6.3.2 Family Planning Barrier Measure

The Family Planning Barrier Measure contained 27 Likert-type items with 5 levels of responses ranging from "strongly disagree" to "strongly agree" with respondents indicating the extent to which they agreed with each item. As previously discussed, the Likert-type items were designed to reflect concepts associated with social cognitive theory. Thus, items reflected perceived knowledge, moral stance, perceived roles/work relevance, and self-efficacy/comfort discussing family planning topic. The Family Planning Barrier Measure followed the Testable Knowledge portion and accounted for items 11-38.

Self-assessed knowledge items related to family planning accounted for 5 of the items (items 11 - 15) of the Family Planning Barrier Measure. An example of a self-assessed knowledge item was "I am often unsure about how confidentiality laws impact my ability to confidentially discuss family planning with my client." Moral opposition was represented in five items (items 16-20) and included "I do not discuss contraception with my clients due to my own moral values." Social worker role perceptions and relevance were represented in nine of the

items (items 21-29). An example of a role perception and relevance item is "It is my professional role to provide referrals or other information for my clients to obtain contraception." Level of comfort/self-efficacy corresponded to six items (items 30-36) and included "I believe that I can be effective in reducing unplanned pregnancy with my clients." Item 37 ("I frequently discuss family planning information with clients") related to all concepts. Following the 37 items was an open-ended request for any other barrier the respondent would like to add. Some items were reverse coded so that the higher the rating, the more the item represents a barrier. The items that are reverse coded are items 11, 12, 15, 21, 22, 23, 25, 26, 27, 28, 29, 33, 34, and 37. For the Likert portion of the scale, scores could range from 27 to 135, with higher scores indicating higher barriers.

6.3.3 Religion Scale

A scale based on The Religion Scale (Bardis, 1961) was administered following the family planning survey. The Religion Scale (Bardis, 1961) was designed for use in surveys whose goal is to measure attitudes toward religious beliefs and practices. The definition of religion used by Bardis involved three components: 1) ideas about divinity, 2) doctrines concerning relationships between divinity and humanity, and 3) behaviors to satisfy God's expectations, achieve future rewards, and avoid punishment. Since the focus of the current study was the behavior of providing family planning information, this scale was chosen specifically due to its inclusion of expected behavior. While other religion scales were concerned with concepts of abstract religious beliefs, the Bardis Religion Scale included concrete behaviors that were a better match to the intentions of this current study and the behavioral components of Bandura's social cognitive theory.

The original scale consisted of 25 items. However, for the current study an item was removed as it appeared to be highly oriented toward Christianity ("People should say Grace at all meals"). In addition, the word "church" and "chapel" were changed to "religious services" or "place of worship" on six instances, and "Scriptures" was changed to "Holy Book." Two items were added that asked the respondent to self-rate his or her level of religiosity and spirituality ("I consider myself a religious person" and "I consider myself a spiritual person"). In addition, the scale was changed from a 0 to 4 rating scale to a 1 to 5 rating scale, which corresponded to the family planning scale. Each item required a response on a continuum whose end points were represented by 1 ("strongly disagree") and 5 ("strongly agree"). Summed items scores could yield a religiosity score between 26 and 130. Higher scores indicated a greater degree of reported religiosity.

For scale development, an initial pool of 200 items was taken from religious publications or supplied by persons representing a range of religious faiths. The original 200 items were pre-tested on 500 Jews and Christians from the Midwest. The 46 items that showed discriminatory power were administered through interview to 100 additional Midwesterners. Comparison of the 10 highest and the 10 lowest-scoring individuals in this sample of 100 led to the acceptance of 25 items with discrimination power for the final scale. Reliability coefficients have been reported for a number of diverse samples. Thirty students attending a Midwestern Methodist college generated a split-half reliability coefficient of .74, and Spearman-Brown coefficient of .85. Forty agnostics gave a corrected split reliability coefficient of .73. A reliability coefficient of Jews from a large city was .84, of students at a large Midwestern university was .98, and of Greeks born in Greece was .86 (corrected to .93).

The validity of the scale was demonstrated by comparison from groups that would be expected to differ on a scale of religiosity. The mean for a sample of 30 agnostics was 11.93, which was significantly different from a sample of Greek Orthodox Church members whose mean was 68.73. Similar studies found agnostics (M= 10.81) to be significantly less religious than Catholics (M=79.11), and Methodist students studying for ministry (M= 68.83) to be more religious than Methodist non-ministerial students (M=57.97).

Items of the current study's scale included, "Every school should encourage its students to attend church," "God rewards those who live religiously," "Teachers should stress religious ideals in class," "Every person should participate in at least one church activity," "Religious people should try to spread the teachings of their holy book", and "A sound religious faith is the best thing in life." Following the adapted Bardis Religion Scale were the two general self-rating items ("I consider myself a religious person" and "I consider myself a spiritual person").

6.3.4 Respondent characteristic variables

Demographic and background variables were included after the Family Planning Barrier Measure and Religion Scale. Basic demographics of sex, age, and ethnicity, were solicited. Years of social work experience and current primary work function and practice environment, which were modeled after National Association of Social Workers (NASW) membership description categories, followed. Current practice environment included aging, child/family welfare, criminal justice, health, mental health, public assistance, school social work, university setting, and other. Responses of "medical" under "other" were included in "health" and responses of "substance abuse" were included in mental health for purposes of data analysis. Primary work function included direct practice, administration, community organizer, research

or teaching, supervision, and "other." Also included were primary work setting (urban, suburban, and rural), participation in family planning trainings (none, 1-2 trainings or classes, 3 or more trainings or classes), political party voting preference (Democrat, Republic, Independent, "Other," Rarely or never vote), political beliefs (continuum from very liberal/very progressive to very conservative), stance on abortion rights (continuum from very "pro-choice" to very "pro-life"), religious preference (Fundamentalist/evangelical protestant, other protestant, Catholic, Jewish, None, "Other"), and importance of religion in respondent's daily life (continuum from very important to very unimportant).

7.0 RESULTS

The purpose of the analyses is to investigate the relative importance of religiosity and social worker background characteristics in accounting for barriers that social workers confront in providing family planning information to their clients. Barriers to providing family planning information were further explored by examining the scores of specific items related to perceived professional responsibility, relevance of family planning to social work clients, moral attitudes toward family planning, comfort in discussing family planning information with clients, and perceived self-efficacy in providing relevant family planning information.

The Results Chapter begins with reporting the psychometric information of the Family Planning Barrier Measure, the Religion Scale, and Testable Knowledge. The items used in the Religion Scale and the 27 Likert-type items of the Family Planning Barrier Measure were examined using principal components factor analysis. The Family Planning Barrier Measure factor analysis was utilized to determine if the a priori barrier categories (perceived knowledge, social work role perceptions and relevance, level of comfort/self-efficacy, and moral attitudes) on the Family Planning Barrier Measure grouped together as predicted. The factor analysis for the Religion Scale was used to determine if the additional items ("I consider myself a religious person," and "I consider myself a spiritual person") were useful additions to the modified Bardis Religion Scale. Resulting factors and reliability tests on the Family Planning Barrier Measure and Religion Scale are reported.

The next section of the Results Chapter contains the descriptive analyses. This includes a description of the sample, and the means, skewness, kurtosis, and range of each measure. Following the descriptive analyses is the hypotheses testing section. The last portion of the chapter is devoted to exploratory analyses and will include examination of the Family Planning Barrier Measure items with the highest means, and the percentage of correctly answered items in the Testable Knowledge portion of the questionnaire.

All data were assessed for outliers and all of the major analyses were conducted after confirming that the measures had approximate normal distributions. SPSS was used for all data analysis and an alpha level of .05 was used for all statistical tests. For all analyses only the scores of the group that reported working with clients in the 13-55 age range were included. Furthermore, groups that had a small number of respondents were excluded from analysis or combined with other groups for analyses. Groups that were collapsed into other groups or are excluded are noted for the appropriate analysis.

For the Testable Knowledge portion of the questionnaire, all respondents who wrote an answer such as “don’t know” or left four or less items unanswered were included in analyses. These responses were coded as incorrect responses. All 203 respondents met this requirement and thus were included for the Testable Knowledge portion. Means on the Family Planning Barrier Measure were calculated for respondents who completed a minimum of 20 items out of the possible 27 Likert-type items. There were 197 respondents who met this requirement. Means on the Religion Scale were calculated for respondents who completed a minimum of 18 items out of the possible 26. There were 201 respondents who met this requirement.

7.1 PSYCHOMETRICS

7.1.1 Family Planning Barrier Measure

The 27 Likert-type items on the Family Planning Barrier Measure were examined by principal components factor analysis. Missing values were excluded listwise. The results of the factor analysis revealed a four factor solution with the exception of one item ("There is an incentive in my workplace to discuss family planning with clients") that did not load on the four factor solution. All other items loaded above .40 (.40 to .86) on only one factor and the Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy was adequate at .811. The Bartlett's Test of Sphericity was significant, $p < .0001$. The items on each factor were examined for their congruence with the four a priori barrier categories of self-assessed family planning knowledge, social worker role perception and relevance, level of comfort and self-efficacy, and moral attitudes. The results of the factor analysis only partially replicated the a priori expectation. Thus, the scale was utilized in its entirety. The reliability of the scale in its entirety is good (Cronbach's *a* coefficient = .84). Table 1 illustrates which items grouped together under each factor with the a priori expectation in capitalized italics following the item. Items that are reverse coded are in bold.

Table 1. Items Within Each Family Planning Barrier Measure Factor

Item and a priori expectation	F1	F2	F3	F4
I frequently occurs to me to discuss family planning with my clients to reduce unintended pregnancy *ROLE/RELEVENCE*	.753			
I frequently discuss family planning information with my clients *ALL CONCEPTS*	.723			

Table 1 (continued)

Item and a priori expectation	F1	F2	F3	F4
Family planning information is relevant to the well-being of my clients *ROLE/RELEVENCE*	.707			
I am interested in providing contraception information to my clients *ROLE/RELEVENCE*	.634			
I am interested in learning more about how to effectively discuss family planning with my clients *ROLE/RELEVENCE*	.542			
I believe that I can be effective in reducing unplanned pregnancy with my clients *COMFORT/FELF-EFFICACY*	.489			
It is my professional role to provide referrals or other information for my clients to obtain contraception *ROLE/RELEVENCE*	.441			
Unplanned pregnancy is a problem among social work clients in Pennsylvania *ROLE/RELEVENCE*	.440			
Moral opposition impacts my willingness to provide abortion information and referrals *MORAL*		.862		
A social worker's religious values supersede her or his expected professional role *MORAL*		.811		
It is my professional responsibility to provide appropriate referral services to ensure that abortion is available to all clients who are considering this option *ROLE/RELEVENCE*		.723		
Sometimes my professional ethics conflict with my religious values *MORAL*		.664		
I do not discuss contraception with my clients due to my own moral values *MORAL*		.580		
I am often unsure about how confidentiality laws impact my ability to confidentially discuss family planning with my client *KNOWLEDGE*			.650	
I do not feel competent discussing family planning with my clients *COMFORT/SELF-EFFICACY*			.597	
I was provided with adequate material in social work courses to comfortably discuss family planning with clients *COMFORT/SELF-EFFICACY*			.532	
I am very knowledgeable about current family planning options *KNOWLEDGE*			.531	
I am very aware of all community resources available to my clients for contraception *KNOWLEDGE*			.520	
Continuing education in social work does not adequately address the provision of family planning information to clients *KNOWLEDGE*			.504	
The social work profession is not effective in reducing unplanned pregnancy with clients *COMFORT/SELF-EFFICACY*			.448	
I am very knowledgeable about the NASW position on providing family planning information to clients *KNOWLEDGE*			.403	

Table 1 (continued)

Item and a priori expectation	F1	F2	F3	F4
I do not have enough time to discuss family planning with my clients given my work priorties *ROLE/RELEVENCE*			.397	
Many of my clients are not capable of utilizing condoms and birth control pills correctly *COMFORT/SELF-EFFICACY*				-.702
I avoid discussing contraception and abortion with my clients due to liability concerns *COMFORT/SELF-EFFICACY*				-.675
I experience cultural or language barriers in discussing family planning with my clients *COMFORT/SELF-EFFICACY*				-.553
In the course of my work as a social worker I have been discouraged from discussing family planning with clients due to the moral objection of my employer(s) *MORAL*				-.503

7.1.2 Religion Scale

The 26 items of the Religion Scale were entered into a principal components factor analysis. Missing values were excluded listwise. The factor analysis of the religion scale demonstrated a two factor solution with one item not loading above .40 on either factor ("We should always love our enemies"). The KMO sampling adequacy was .96, with all items loading above .40 (.53 to .90) on only one factor and the Bartlett's Test of Sphericity was significant. The reliability of the final 25 items was high (Cronbach's *a* coefficient = .96).

Factor one included twenty items that indicate an inclination toward dogma and creed, especially related to religious behaviors. Of note, factor one included the item "I consider myself a religious person." The five items on factor two focused more on spirituality, as opposed to religious expectations, and included the item "I consider myself a spiritual person." Table 2 displays which items grouped together under each factor in their order of loading.

Table 2. Items Within Each Religion Scale Factor

Item	F1	F2
Every person should participate in at least one religious activity	.900	
Every school should encourage its students to attend religious services	.882	
Teachers should stress religious ideals in class	.877	
Every school should have religious services for its students	.856	
People should attend a place of worship once a week if possible	.807	
People attending religious services regularly develop a sound philosophy of life	.805	
Every person should give 10 percent of his/her income to his/her place of worship	.793	
Religious people should try to spread the teachings of their Holy Book	.784	
People should defend their religion above all things	.760	
People should read their Holy Book at least once a day	.749	
Young people should attend religious education classes, such as Sunday School, regularly	.746	
A religious wedding ceremony is better than a civil one	.736	
People should pray at least once a day	.715	
Children should be brought up religiously	.712	
God rewards those who live religiously	.697	
What is moral today will always be moral	.677	
When a person is planning to be married, one should consult one's minister, priest or rabbi	.659	
A sound religious faith is the best thing in life	.636	
Delinquency is less common among young people attending religious services regularly	.538	
I consider myself a religious person	.527	
I consider myself a spiritual person		.795
All people are God's children		.675
There is life after death		.649
Belief in God makes life more meaningful		.601
Prayer can solve many problems		.531

7.1.3 Testable Knowledge

The internal reliability of the Testable Knowledge portion of the questionnaire was low (Cronbach's *a* coefficient = .31). Correct knowledge on one item does not necessarily reflect in correct knowledge on another item. For analyses involving Testable Knowledge, a sum score for each respondent will be used.

7.2 DESCRIPTIVE ANALYSES

7.2.1 Description of primary study variables

This section reports descriptive analyses of the main study variables including the mean, standard deviation, skewness, kurtosis, minimum scores and maximum scores. All scales were relatively normally distributed. The Family Planning Barrier Measure (FPBM) and Religion Scale (RS) were analyzed in regards to their means, while the Knowledge Scale (KS) was analyzed as a sum score. The mean on the Family Planning Barrier Measure was just over the mid-point of the potential score of 2.5 (M = 2.55). The Religion Scale score was slightly high with a mean approaching 3.0 (M = 2.97), indicating slightly high religiosity. The mean of Testable Knowledge was slightly over five (5.44), indicating a mean of correctly answering a little more than half of the items correctly. Table 3 displays the descriptive statistics of the Family Planning Barrier Measure, Religion Scale, and Testable Knowledge.

Table 3. Means, standard deviations, skewness/kurtosis, minimum and maximum scores

Variable	Mean	SD	Skewness/ Kurtosis	Minimum	Maximum
FPBM	2.55	.46	-.075/-.015	1.41	3.74
RS	2.97	.75	-.127/-.257	1.12	4.69
TK	5.44	1.50	.106/-.401	2.0	9.0

7.2.2 Description of the sample

Of the 271 questionnaires that were returned and useable, 203 (75%) were received from respondents who indicated that they work with clients in the age range of 13-55 years. This sample of 203 was predominantly female (87%), and Caucasian (89%) followed by African American (6%). All other ethnicities were 2.5% or less. Respondents were mostly in the 30-39 age range (33%), followed by 50-59 years (24%), 40-49 years (21%), over 60 years (11%), and less than 30 (10%).

Most respondents were experienced social workers with only 35 respondents (17%) indicating five or less years of practice experience. Respondents overwhelmingly worked in direct practice (73%). In addition, most respondents included themselves in health (23%) and mental health (34%). Few respondents reported working in a rural area (17%) and most (68%) indicated having no classes or training related to family planning. Table 4 displays social work practice characteristics.

Table 4. Social work practice characteristics

Years of social work experience	***Percentage***	***Number***
Under 2	2%	4
2-5 years	15%	31
6-10 years	22%	44
11-15 years	22%	44

Table 4. (continued)

Years of social work experience	***Percentage***	***Number***
16-20 years	13%	27
Over 20 years	26%	53
Primary work function categories		
Direct practice	73%	148
Administration	11%	28
Community organizing	2%	3
Research or teaching	2%	3
Supervision	8%	17
Other	4%	9
Current practice environment categories		
Aging	3%	5
Child/family welfare	18%	36
Criminal justice	2%	3
Health	23%	46
Mental health	34%	68
Public assistance	2%	3
School social work	9%	19
University setting	3%	5
Other	8%	16
Primary work setting categories		
Urban	37%	76
Suburban	44%	89
Rural	17%	34
Family planning training categories		
None	68%	137
1-2 trainings or classes	23%	47
3 or more trainings or classes	9 %	18

Respondents in the current study overwhelmingly identified their voting tendency as voting for Democrats (70%). In addition, many identified as "highly liberal" (28%), "slightly liberal" (27%), or "moderate" (28%) regarding political beliefs. Only nine respondents (4%) identified as "highly conservative." The majority of respondents also identified themselves as "highly pro-choice." Table 5 displays political characteristics.

Table 5. Political characteristics

Voting tendency categories	***Percentages***	***Number***
Democrat	70%	142
Republican	15%	31
Independent	8%	17
Other	4%	8
Rarely or never vote	2%	4
Political beliefs categories		
Highly liberal/highly progressive	28%	57
Slightly liberal/slightly progressive	27%	55
Moderate	28%	57
Slightly conservative	12%	25
Highly conservative	4%	9
Abortion rights categories		
Highly "pro-choice"	57%	116
Slightly "pro-choice"	12%	25
Neutral/undecided	5%	11
Slightly "pro-life"	6%	13
Highly "pro-life"	18%	37

Religious characteristics were also reported by the respondents. Most respondents identified with a Christian denomination, such as Catholic (29%), non-fundamentalist/ evangelical Protestant (23%), and fundamentalist/evangelical Protestant (11%). Christian denominations were also present in the "other" category. Those who identified themselves in the "other" religious preference category included non-denominational Christians (3%), Unitarian Universalists (2%), Spiritual (2%), and unspecified Baptists (2%). Buddhists, United Church of Christ members, Charismatics, Quakers, Mormons, Wiccans, Pagans and unspecified Lutherans, Methodists, and Episcopals were all less than 1%. Table 6 displays the religious characteristics reported by the respondents.

Table 6. Religious characteristics

Religious preference categories	***Percentages***	***Number***
Fundamentalist/evangelical Protestant	11%	23
Other Protestant	23%	47
Catholic	29%	59
Jewish	6%	12
None	16%	32
Other	14%	29
Importance of religion categories		
Very important	44%	87
Slightly important	26%	51
Neutral	15%	30
Slightly unimportant	8%	16
Highly unimportant	8%	16

7.3 HYPOTHESIS TESTING

The hypothesis testing section is organized with each hypothesis followed by the relevant statistical test. If groups within a category were collapsed or excluded, an explanation is provided. For many hypotheses, secondary analyses followed the hypotheses to account for the effect of another study variable or to explore a corresponding relationship.

> **H_1** Respondents who report greater religiosity will report a higher barrier level in providing family planning information.

To determine religiosity, scores on the Religion Scale were used, as well as respondent reports on the importance of religion in daily life. First, given that both the Religion Scale and Family Planning Barrier Measure had relatively normal distributions, a Pearson correlation was performed to determine if significant correlations exist between the Family Planning Barrier Measure and Religion Scale. As expected, a Pearson correlation, r (195) = .277, p<.0001, demonstrated a significant positive correlation between the two scales.

As discussed earlier, 44% of respondents indicated that religion is very important in their daily lives. Two other "importance of religion" groups each contained less than 20 respondents. In an effort to balance the cells and increase the robustness of the analysis, respondents who indicated that religion is slightly important, neutral, slightly unimportant, and very unimportant were collapsed into one group. The Family Planning Barrier Measure scores of this group (M = 2.44) were compared using a *t* test against the scores of respondents who indicated that religion is very important in their daily life (M = 2.69). A *t* test was chosen since the means of two groups are to be compared. As expected, a significant difference was found between the two groups, t (192) = 3.75, $p < .0001$, such that respondents who indicated a very high importance of religion in their daily lives reported higher family planning barriers.

Secondary analysis

An analysis was performed to confirm the assumed relationship between Religion Scale scores and importance of religion in daily life. Not surprisingly, a *t* test demonstrated that Religion Scale scores of respondents who indicated that religion is highly important in their daily lives (M = 3.42) is significantly higher than for the group that did not rate religion has highly important (M = 2.54), $t (198) = 9.33$, $p < .0001$.

> **H_2** Respondents who tend to vote for Republicans will report higher barriers in providing family planning information

Given that the groups that were not Republican or Democrat each contained 4 to 17 respondents, respondents who reported that they tend to vote independent, rarely or never vote, and vote "other" were collapsed into one group (N = 29). This group's mean on the Family Planning Barrier Measure was then compared to the mean of respondents who indicated that they tend to vote for Democrats, and respondents who reported that they tend to vote for Republicans. Since there were three groups, a one-way ANOVA was used. A one-way ANOVA indicated a

significant difference, F (2, 193) = 7.566, p = .001, for the Family Planning Barrier Measure on voting tendency. Utilizing a Tukey HSD test, it was found that Democrats (M = 2.51) had significantly lower scores than Republicans (M = 2.84), p = .003. Also, a significant difference was found between the collapsed group (M = 2.44) and Republican group, such that the collapsed group had significantly lower scores than the Republican group, p = .009.

Secondary analysis

To consider the relationship between religion and voting tendency a one-way ANOVA was performed. The analysis indicated that there is a significant difference in Religion Scale scores regarding voting tendency, F (2, 199) = 29.95, p < .0001. A Tukey HSD test demonstrated lower Religion Scale scores for respondents who tend to vote for Democrats (M = 2.77) than for respondents who tend to vote for Republicans (M = 3.47), p < .0001. A Tukey HSD test also demonstrated a significantly lower scores for respondents in the collapsed group (M = 3.09) than the Republican group, p = .002.

> **H_3** Respondents who rated themselves as more conservative will report higher barriers in providing family planning information

The highly liberal, slightly liberal, and moderate group each had between 55 and 57 respondents in each category. However, the highly conservative group only had 9 respondents, and the slightly conservative group had 25. Thus, respondents who reported being slightly conservative and highly conservative were collapsed into one group to increase the robustness of the analysis, and to be able to include all respondents. This group was then compared with respondents who reported being moderate, slightly liberal and highly liberal on the Family Planning Barrier Measure. A significant difference was found, F (2,197) = 18.29, p <.0001. A post-hoc Tukey test demonstrated a significant difference between the highly liberal group (M =

2.37) and the moderate group (M = 2.68), $p = .02$, as well as with the collapsed conservative group (M = 2.82), $p < .0001$. The slightly liberal group (M = 2.45) was also significantly different than the moderate group and conservative group, $p = .002$. Thus, the highly liberal group and slightly liberal group demonstrated fewer barriers than the moderate and conservative groups.

> **H_4** Respondents who identified as "pro-choice" regarding abortion rights will report fewer barriers in providing family planning information than those who do not identify as "pro-choice" in respect to abortion rights.

For purposes of this study, it is conceptually appropriate to collapse the groups into "pro-life" and "pro-choice" groups, thus eliminating the neutral/undecided group. To compare "pro-choice" respondents to "pro-life" respondents, respondents who indicated that they are highly and slightly "pro-choice" were collapsed into one group, and respondents who indicated that they are highly and slightly "pro-life" were collapsed into another group. Since there were two groups, a *t* test was performed to compare the differences in means between the two collapsed groups. As expected, a significant difference was found between the two groups. The "pro-choice" group (M = 2.44) demonstrated a lower Family Planning Barrier Measure score than the "pro-life" group (M = 2.89), $t(184) = -6.41$, $p < .0001$.

Secondary analysis

A *t* test also demonstrated a significant difference in Religion Scale scores between the "pro-choice" group (M = 2.72) and the "pro-life" group (M = 3.60), $t(120) = -8.29$, $p < .0001$, such that the "pro-life" group indicated greater religiosity. An analysis was performed to explore the relationship between Testable Knowledge and abortion rights stance. A *t* test related to Testable Knowledge resulted in a significant difference, such that the "pro-choice" group (M =

5.66) had significantly greater knowledge than the "pro-life" group (M = 4.94), t (189) = 2.96, p = .003.

> **H_5** Respondents who tend to vote for Republicans will have fewer correct knowledge items on Testable Knowledge.

Using the collapsed groups of Republican, Democrat, and "other" with a one-way ANOVA, a significant difference was found with voting tendency on Testable Knowledge, F(2, 199) = 6.41, p = .002. Through the use of a post hoc Tukey HSD test, it was discovered that Democrats (M = 5.65) have significantly more family planning knowledge than Republicans (M = 4.61), p = .001. No significant differences were found with the other group (M = 5.34).

> **H_6** Respondents who rated themselves as more conservative will have fewer correct items on Testable Knowledge.

As before, respondents who reported being slightly conservative and highly conservative were collapsed into one group to increase the robustness of the analysis, and to be able to include all respondents. The resulting political knowledge groups of highly liberal, slightly liberal, moderate, and conservative were compared with a one-way ANOVA related to Testable Knowledge. The test demonstrated significant results, F (3, 199) = 4.64. The conservative group (M = 4.79) had significantly lower true/false scores than the highly liberal group (M = 5.74) and the slightly liberal group (M = 5.80), p = .004, indicating that the conservative group has less family planning knowledge. No other significant differences were found.

> **H_7** Respondents who report participating in family planning trainings will report a lower level of barriers than respondents who have had no family planning trainings.

A decision was made to collapse the two groups that reported participating in trainings for conceptual and statistical reasoning. First, the group that had three or more trainings only had 18 respondents. In addition, the hypothesis is more concerned with the presence of training,

versus the quantity of training. Thus, conceptually and to increase the robustness of the test, the two groups that represented respondents who had family planning trainings, "one or two trainings or classes," and "three or more trainings or classes," were collapsed into a new group. The new group represented social workers who reported having engaged in family planning training or coursework. This group's mean on the Family Planning Barrier Measure was compared utilizing a *t* test against the mean of the group of social workers who indicated having no family planning trainings. A significant difference was discovered, $t\ (194) = 5.59$, $p < .0001$, between the two groups. As expected, the group that indicated having had at least one training had lower Family Planning Barrier Measure scores (M = 2.30) than the group with no training (M = 2.67), indicating fewer family planning barriers in the group that had training.

Secondary analyses

Of note, no differences were found between the two training groups related to the Religion Scale, $t\ (198) = -.243$, $p = .81$. Surprisingly, there was no significant difference found for Testable Knowledge between the group that had training (M = 5.65) and the group that had none (M = 5.34), $p = .18$.

> **H_8** Respondents who have more practice experience will report a lower level of barriers than respondents who have had less practice experience.

Since one-way ANOVA tests are more robust when groups are more similar in size, and since one of the groups only had four respondents, a decision was made to collapse the original six "years of social work experience" categories into three "years of social work experience" categories. The resulting categories are "five years and under," "six years to fifteen years," and "16 years and over." Since there were three categories, a one-way ANOVA was used to analyze the difference in means between the experience categories in relation to the Family Planning

Barrier Measure. No significant difference was found between the means, F (2, 194) = .76, p = .471.

Secondary analyses

Analyses were performed to explore differences between experience categories related to the Religion Scale and Testable Knowledge. A one-way ANOVA did not find any significant difference between the groups regarding Religion Scale scores, F (2, 198) = 2.01, p = .14. In addition, no significant differences were found between experience categories on Testable Knowledge, F (2, 200) = .874, p = .419.

> **H_9** Respondents who work directly with clients will report a lower level of barriers than social workers who do not work in direct care.

Since the intention is to compare direct practice social workers against non-direct care social workers, the original six categories of "primary work function" were collapsed into two categories. Furthermore, four of the six categories had less than 18 respondents, with two of the groups only having 3 respondents each. Thus, the two resulting groups are direct practice and non-direct practice. Given that there were two groups, a t test was performed to compare the means of Family Planning Barrier Measure scores between direct practice social workers and all other social workers. No significant difference was found, t (195) = .618, p = .537.

Secondary analyses

Direct practice social workers were also compared with non-direct practice social workers on the Religion Scale and Testable Knowledge. No significant difference was found using a t test for Religion Scale scores between the groups, t (199) = -.3.98, p = .691. Furthermore, no significant difference was found between the groups regarding Testable Knowledge, t (201) = .355, p = .723.

> **H_{10}** Respondents who identify their primary work setting as urban will report fewer barriers in providing family planning than those who work in suburban or rural areas.

From a conceptual standpoint, it is preferable to collapse the respondents in the suburban and rural categories into a new category. Although this meant that difference in group sizes became slightly greater, a Levene's test for equality of variances for the two resulting groups was not significant (p = .885). The urban group (N = 72) was compared against a group that consisted of collapsing the suburban and rural groups into one larger group (N = 121). Since there were two group means to compare, a t test was utilized to compare the means on the Family Planning Barrier Measure, resulting in a significant difference, t (191) = -2.80, p = .006. The urban group had a lower Family Planning Barrier Measure score, (M = 2.43) than the non-urban group, (M = 2.62), indicating that the urban group reported fewer family planning barriers.

Secondary analyses

Secondary analyses were performed to explore any differences between work setting categories regarding Family Planning Barrier Scale scores that may be a result of religion or family planning training. Of note, there was no significant difference between the groups regarding their Religion Scale scores, t (195) = - 1.07, p = .285. Furthermore, a cross-tabulation utilizing a Pearson Chi-Square, Phi, and Cramer's V indicated that there was a no significant difference found between the number of trainings and the practice environment groups, $\chi 2$ = 1.151, df =1, p = .284. A cross-tabulation was chosen since there was a comparison of the nominal category of practice environment with number of trainings, which is a category that had few ordered categories.

7.4 EXPLORATORY ANALYSES

7.4.1 Family Planning Barrier Measure: comparison of means

Self-regulation is an important component of social cognitive theory. One aspect of self-regulation is setting standards and goals, in which one determines limits, boundaries, and criteria for one's behavior. Within a profession, these standards and goals are often delineated by outlining the responsibilities of the profession. In a study of Pennsylvania physicians, an increased attention to training that would foster physicians' sense of responsibility in matters related to reproductive health was cited as necessary to increase the provision of family planning (Ashton, Cook, Wiesenfeld, Krohn, Zambrosky, Scholle, & Switzer, 2002). In addition, a small scale survey of social workers in southwestern Pennsylvania also found that many social workers reported that social workers do not believe that it is their responsibility to provide contraceptive information (Bell, 2003).

In addition to low perceived professional role, other obstacles have been uncovered in providing family planning information. Confusion over the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has been cited as problematic for many professionals working with adolescents and family planning issues (English & Ford, 2004). Related to the profession of pharmacy, inadequate continuing education and lack of reproductive health information in pharmacy school curriculums was discussed as problematic (VanRiper & Hellerstedt, 2005). Thus, exploration of these and other issues were indicated in the current study.

To determine the items that represented the greatest barriers in the current study, the means of each item on the Family Planning Barrier Measure were examined. Higher means

indicated higher barriers. Lack of perceived professional responsibility did not rank among the top barriers, despite the high rank of lack of knowledge of the NASW position on providing family planning information to clients. Uncertainty of confidentiality laws ranked relatively high on the list and had a mean over the midpoint (M = 2.78). Items related to lack of family planning material in social work courses and continuing education were near the top of the list of barriers. Lack of incentive in the work place, and lack of knowledge of the NASW code of ethics related to family planning were also top barriers. Moral objection to contraception is at the bottom of the list and has a mean of only 1.49. Table 7 lists the items in order of means, highest to lowest. Items that are reverse scored are in bold.

Table 7. Means for Family Planning Barrier Measure items

Item	Mean
1. **There is an incentive in my workplace to discuss family planning with clients**	3.82
2. Continuing education in social work does not adequately address the provision of family planning information to clients	3.80
3. **I was provided with adequate material in social work courses to comfortable discuss family planning with clients**	3.65
4. **I am very knowledgeable about the NASW position on providing family planning information to clients**	3.26
5. **I frequently discuss family planning information with my clients**	3.19
6. **I am very aware of all community resources available to my clients for contraception**	3.99
7. **I am very knowledgeable about current family planning options**	2.97
8. **It frequently occurs to me to discuss family planning with my clients to reduce unintended pregnancy**	2.86
9. I am often unsure about how confidentiality laws impact my ability to confidentially discuss family planning with my client	2.78
10. The social work profession is not effective in reducing unplanned pregnancy with clients	2.58
11. **I believe that I can be effective in reducing unplanned pregnancy with my clients**	2.54
12. Many of my clients are not capable of utilizing condoms and birth control pills correctly	2.53
13. I do not feel competent discussing family planning with my clients	2.44
14. I do not have enough time to discuss family planning with my clients given my work priorties	2.41

Table 7. (continued)

Item	Mean
15. Sometimes my professional ethics conflict with my religious values	2.35
16. **It is my professional responsibility to provide appropriate referral services to ensure that abortion is available to all clients who are considering this option**	2.35
17. **I am interested in providing contraception information to my clients**	2.31
18. **I am interested in learning more about how to effectively discuss family planning with my clients**	2.27
19. I experience cultural or language barriers in discussing family planning with my clients	2.14
20. **It is my professional role to provide referrals or other information for my clients to obtain contraception**	2.13
21. Moral opposition impacts my willingness to provide abortion information and referrals	2.10
22. I avoid discussing contraception and abortion with my clients due to liability concerns	2.09
23. **Family planning information is relevant to the well-being of my clients**	2.02
24. In the course of my work as a social worker I have been discouraged from discussing family planning with clients due to the moral objection of my employer(s)	1.96
25. **Unplanned pregnancy is a problem among social work clients in Pennsylvania**	1.85
26. A social worker's religious values supersede her or his expected professional role	1.83
27. **I do not discuss contraception with my clients due to my own moral values**	1.49

7.4.2 Testable Knowledge items

Surveys of other direct-care professionals have suggested possible barriers that social workers may confront related to lack of knowledge. For example, surveys of pharmacists have identified lack of knowledge as contributing to the decreased ability of pharmacists to meet the needs of their clients, especially when providing information and access to emergency contraception (Draut, 1999; VanRiper & Hellerstedt, 2005). To determine which Testable Knowledge items represented the greatest concern, items were examined for percentage of correct responses.

Items related to emergency contraception received the least correct answers with 16% to 30% of all respondents answering correctly. Another item that was answered correctly by only 24% of respondents was "abstinence is not a form of contraception." In addition, the item

"Females under the age of 18 require parental consent to obtain prescription birth control pills in PA" was answered correctly by only 36% of the respondents. All of the other items received greater than 60% correct responses. In addition, 26% of respondents agreed, and another 6% strongly agreed, with the item "I am very knowledgeable about current family planning options." Similarly, in response to the item "Continuing education in social work does not adequately address the provision of family planning information to clients," 21% of respondents strongly agreed and 43% agreed. Table 8 provides the percentage of respondents answering Testable Knowledge items correctly. The correct answer is provided after each item in the table.

Table 8. Percentage of respondents answering Testable Knowledge items correctly

Item	Percent	Number
When used properly, condoms prevent against pregnancy less than half of the time. FALSE	88%	179
The birth control pill is safe for most healthy adolescents. TRUE	86%	174
When used correctly, the birth control pill prevents pregnancy almost all of the time. TRUE	92%	187
Abstinence is not a form of contraception. TRUE	24%	49
Emergency contraception (known to many as the "morning-after pill" or Plan B) can be used up to 120 hours after intercourse to prevent a pregnancy. TRUE	30%	61
Emergency contraception and RU486 (known to many as the "abortion pill") do not have any similarities in how they medically function. TRUE	21%	43
Taking emergency contraception will not cause birth defects, or any damage to a fetus, even if a pregnancy has already occurred. TRUE	28%	56
Emergency contraception requires a physician's prescription for every woman in Pennsylvania. FALSE	16%	32
Pregnancy is medically defined as implantation of a fertilized egg. TRUE	84%	171
Females under the age of 18 require parental consent to obtain prescription birth control pills in PA. FALSE	64%	130

In sum, the analyses presented feature the comparative value of background characteristics and religiosity in explaining barriers that social workers tackle in providing family

planning information within their professional practice. There was a significant positive relationship between religiosity and family planning barriers. Furthermore, conservative political beliefs, a tendency to vote for Republicans, and a "pro-life" abortion stance were associated with increased barriers in providing family planning information. Participation in family planning coursework or training, and practicing in an urban area were found to be related to lower barriers in providing family planning information. However, years of experience and work function produced no significant results. While religion was a consideration, it was not the only factor in understanding the behavior of providing family planning information. Moral objection ranked low compared to other barriers. Workplace incentive and issues related to knowledge were of greater importance in understanding barriers. Furthermore, there are large gaps in family planning knowledge, specifically related to emergency contraception.

8.0 DISCUSSION

The theoretical framework of this study was based on the social cognitive theory (Bandura, 1986). This model allowed for the study to focus on the behavior of providing family planning information. The a priori expectation of specific Family Planning Barrier Measure subscales was not fully confirmed. However, the present study's results are largely congruent with the social cognitive theory. When taken together, the findings related to the hypotheses tests and exploratory analyses emphasize the benefit of family planning trainings for social workers. This section will begin by discussing the results of hypothesis testing, followed by the results of the exploratory analyses. Limitations of the study and implications for social work will follow.

8.1 HYPOTHESIS TESTING

8.1.1 Religious and political characteristics

Bandura (1986) posited that a combination of elements, including one's personal attitude, will influence the performance of the behavior in question. Religious beliefs coupled with political beliefs were clearly involved in hindering the provision of family planning within a specific segment of the respondents. Respondents who scored higher on the Religion Scale and higher on importance of religion in daily life reported more barriers. Similarly, more conservative political

attitudes, including voting tendency, abortion stance, and political beliefs, were positively correlated with higher barrier scores. This is not surprising given the positive relationship between greater religiosity and greater conservative political attitude scores. In addition, the current study supports the findings of a 2002 study that found that parents who were more politically conservative demonstrated less accurate knowledge of family planning information (McNeely, Shew, Beuhring, Sieving, Miller & Blum, 2002). In the current study, social work respondents who self-rated as more conservative, had a tendency to vote for Republicans, and identified as "pro-life" answered fewer items correctly on Testable Knowledge.

Examination of each of the Family Planning Barrier Measure item scores and their relationship with political beliefs, found that eight of the twelve differing items were not moral items. There was a positive correlation between Family Planning Barrier Items and political beliefs for eleven items, such that higher barrier scores were correlated with higher ratings of conservatism. In addition to the four moral items, items that reflect knowledge of family planning options, knowledge of professional responsibility, perceived role/relevance, and liability concerns were included. One item, "Continuing education in social work does not adequately address the provision of family planning information to clients," was negatively correlated with political beliefs. Moral items did not completely account for the significant relationship found between the Family Planning Barrier Measure and political beliefs.

Similarly, Family Planning Barrier Measure item scores that were different related to voting tendency and abortion stance included items in addition to moral items. Twelve items differed between the "pro-choice" and "pro-life" groups, four of which were moral items. The differing items were identical to the items that were different regarding political beliefs, except for one. The item related to continuing education was replaced with knowledge about the

NASW position on providing family planning information. The "pro-choice" group had a significantly lower mean, thus a lower barrier score reflecting greater knowledge of the NASW family planning position. There were four non-moral items that were different related to voting tendency. Three of those items were related to perceived role and were also different related to abortion stance and political beliefs. In this case, respondents who tend to vote for Republicans were less aware of the role social workers play in the provision of family planning information. The additional item was related to uncertainty of confidentiality laws. Respondents who tended to vote for Republicans had significantly higher barrier scores than other respondents, thus more uncertainty of confidentiality laws related to family planning.

Although religiosity and political beliefs were found to contribute to higher scores on the Family Planning Barrier Measure and lower Testable Knowledge scores, these particular beliefs do not appear to be an overarching consideration for the majority of respondents in this current study. Republicans (14%), those who identified as highly conservative (4%), and respondents who indicated being slightly or highly "pro-life" (23%), were in the minority. For these respondents, personal beliefs appear to be a stronger determinant of behavior than professional role. Bergin (1980) identified the earlier external influence of orthodox religion as a potentially stronger portion of a participant's judgmental self-reaction than professional responsibility. This appeared to be the case for some respondents. For example, a healthcare respondent wrote "According to my faith, contraception and abortion are morally objectionable. This moral position supersedes my professional responsibility." Another respondent wrote "I know that NASW is pro-abortion but I don't agree with abortion." It could be argued that personal attitudes toward family planning, and sexual issues in general, are developed by early adulthood, thus preceding the socialization of professional responsibility.

8.1.2 Observational learning, reciprocal determinism, and self-efficacy

According to Bandura (1986), observational learning is a major determinant of performing a behavior. One example of observational learning is participating in training. The current study's findings provide evidence to support the importance of training and coursework in reducing family planning barriers. Respondents who indicated having received no prior training or coursework in family planning had higher scores on the Family Planning Barrier Measure. These scores were significantly different despite no significant difference on Religion Scale scores.

In examining significant differences related to participation in trainings, nineteen of the possible 27 items were significantly different on the Family Planning Barrier Measure. Of note, only one of the five moral items was significantly different, "I do not discuss contraception with my clients due to my own moral values." Respondents who reported having had training had significantly lower scores on this item. The other differing items reflected lack of knowledge of current family planning options, community resources, and the NASW position on providing family planning information, confusion about confidentiality, liability, and professional roles, adequacy of family planning course material and continuing education, and competency and effectiveness in providing family planning information. Only one Religion Scale item was found to be different between the training groups, "We should always love our enemies." Respondents who had no training had lower mean scores, thus less agreement, on this item. Once again, the importance of training is highlighted. It appears that trainings can reduce family planning barriers, regardless of religiosity.

Bandura (1986) also emphasized reciprocal determinism in social cognitive theory. Reciprocal determinism based on the background characteristic of primary work setting

demonstrated significant differences in Family Planning Barrier Measure scores. Respondents who work in an urban setting reported fewer barriers than their rural and suburban counterparts, despite statistically similar Religion Scale scores. Primary work setting did not have a significant relationship with presence of family planning training. Thus the relationship between work setting and the Family Planning Barrier Measure does not appear to be explained by family planning trainings. A total of five items related to uncertainty of confidentiality laws, moral view, interest in providing family planning, professional role perception, and one's feeling of competency, were significantly different on the Family Planning Measure. Urban respondents reported significantly lower barriers on these items than non-urban respondents. Only one item, "We should always love our enemies," was significantly different on the Religion Scale related to practice environment. The urban respondents agreed with this item to a greater degree than the non-urban respondents.

Surprisingly, family planning training or coursework did not have a significant relationship with family planning knowledge, as illustrated by Testable Knowledge scores. It is quite possible that coursework or a training related to family planning did not include the specific family planning information that is on Testable Knowledge. In addition, some of the items are reflective of recent policy changes and advancements in family planning, especially those related to emergency contraception. A social worker may have participated in training or coursework prior to the changes.

The current study did not support the concept of self-efficacy, as tested in the study, in reducing family planning barriers. In the current study, it had been hypothesized that respondents with more practice experience and those who work in direct practice would have more self-efficacy, and thus lower Family Planning Barrier scores. Family Planning Barrier scores were

not significantly different for the more experienced or for direct practitioners. However, self-efficacy based on experience and professional position may take into consideration assumptions that are not valid. For example, it assumes that the respondent has positive beliefs about his or her ability to provide family planning based on having done so. One possible explanation for the findings is that social workers are not provided with incentive or adequate resources that would lead to attempting to provide family planning information. Thus, self-efficacy would be unaffected. For example, a direct practice mental health worker wrote "I work for a Catholic hospital that forbids any discussion of birth control or abortion—only abstinence—this is in opposition to my own moral ethics and those of social work as a profession in general." Yet another wrote "My clients tend to be middle-age and married who have these issues resolved. It is very rare that family planning is a remote presenting issue." Thus, comparing years of experience and professional position would not be a sufficient approach to assess self-efficacy.

8.2 EXPLORATORY ANALYSES

8.2.1 Family Planning Barrier Measure: comparison of means

As discussed earlier, religiosity and political beliefs appear to play a role in determining Family Planning Barrier Measures with some of the respondents. However, an examination of the mean scores of each item indicated greater barriers. All moral items were in the bottom half of the list. The first moral item that appears in the list, "Sometimes my professional ethics conflict with my religious values," ranks at fifteenth place. In addition, the last item in the list, "I do not

discuss contraception with my clients due to my own moral values," is a moral item. It only has a mean of 1.49.

More pressing barriers are related to lack of family planning material in social work courses and continuing education. Lack of incentive in the work place, and lack of knowledge of the NASW code of ethics related to family planning were also top barriers. Lack of knowledge of family planning options and community resources are also top barriers. In developing or revising family planning training it is important to consider those areas that appear to be presenting the most barriers.

8.2.2 Testable Knowledge

Examination of the percentage of correct scores on the Testable Knowledge items indicates that social workers could greatly improve their knowledge of emergency contraception (EC). The lack of emergency contraception knowledge, especially in being able to obtain EC was extremely low. Only 16% of respondents knew that a prescription is not required for women in who seek EC. At the current time, EC is sold without a prescription to women 18 years of age and older in the United States. A valid form of identification is currently needed to purchase EC from behind the counter. Females under the age of 18 still require a prescription to purchase EC in the state of Pennsylvania. In addition, most respondents believed that EC and RU486 have similar properties on how they medically function. However, the mechanism of action is not at all similar. Emergency contraception contains the same medication, although at much higher doses, than birth control pills. It stops a pregnancy from occurring. Furthermore, it does not cause any damage to an already implanted embryo or fetus if pregnancy has already occurred. Only 28% of respondents were aware of that information. In contrast, RU486 can be used in the first nine

weeks of pregnancy to dislodge an embryo. Furthermore, research shows that EC can be successfully used for up to 120 hours after unprotected intercourse (Raising Her Voice, 2007). Only 30% of respondents were aware of this information.

Many respondents were also unaware of confidentiality laws related to minors. Thirty-six percent of respondents believed that female minors require parental consent for birth control pills. However, females under the age of 18 do not require parental consent to obtain prescription birth control pills in Pennsylvania under the Minors' Consent Act (Rosado, Chernoff, Field, & Shah, 2006). Also regarding birth control pills, the majority of respondents were aware that the birth control pill is safe for most adolescents (American College of Obstetricians and Gynecologists, 2002). Furthermore, the vast majority of respondents, 92%, were aware that the birth control pill prevents pregnancy almost all of the time (Hatcher, Trussell, Stewart, Cates, Stewart, Guest & Kowal, 1998). Perhaps surprisingly, 12% of respondents (24 respondents), believed that condoms prevent against pregnancy less than half of the time when used properly. However, when used consistently and correctly, condoms prevent pregnancy 97% of the time (Hatcher, Trussell, Stewart, Cates, Stewart, Guest & Kowal, 1998).

8.3 LIMITATIONS OF THE STUDY

This study has several limitations. Perhaps the most evident is the difficulty of conducting a larger scale study while trying to identify a population of respondents for whom this study is most relevant. In confronting this problem, several alternatives were explored. First, use of the NASW membership list was investigated. However, not all social workers belong to NASW, and NASW includes social workers from all aspects of the social work field. Other variables,

such as particular state policies, would further complicate the results of the study and reduce the ability to generalize the results.

Another sampling consideration was to go through agency directors to distribute surveys. The benefit of this approach is that it would reduce the possibility of surveys going to social workers who may have no family planning job relevance. However, it could potentially exclude social workers who work within settings that are hostile toward family planning. Furthermore, agencies could differ in their ability and desire to facilitate the process of distributing the surveys in a timely manner. This approach would potentially exclude information that could be valuable in understanding the needs of social workers. Thus, a decision was made to focus on one state and include all licensed social workers.

The first question asking if the respondent works with clients in the 13 to 55 age range was meant to reduce the number of irrelevant respondents in certain analyses. However, it clearly did not eliminate all irrelevant respondents. An oncology respondent wrote "I work with cancer patients in a radiation center/chemotherapy. Physicians and nurses have already discussed those (family planning) issues long before I see them." Another wrote "Many questions are not applicable to my work. I work mostly with middle-age veterans." Another respondent who is a healthcare educator wrote "I am not working in a capacity where pregnancy or contraception comes up." Still another respondent wrote "Many of these questions needed a not applicable depending upon what clientele a social worker is working with. For example, working with the terminally ill rarely includes family planning issues." Changing the question to asking if family planning is relevant to them specifically is problematic as well, since some social workers who assume that family planning is not relevant may actually be incorrect in this

assumption. Any application of the current study's results would have to take the limitation of sampling into consideration.

Secondly, another issue with any voluntary survey is that people who are more interested in the subject will be more likely to respond. Some returned surveys indicated a particular passion, either for or against family planning. One respondent wrote "NASW is pro-abortion and has little respect for colleagues who are opposed to abortion. Furthermore, because NASW supports abortion on demand it does little to reduce the frequency of abortion in America...our profession says it respects the rights of others yet has little tolerance for those of us who are more moderate in our social views." Another respondent returned the survey but wrote a refusal to participate in the study due to strong moral objections to family planning. Also, people who have less time would be less likely to complete the survey.

Thirdly, another limitation is the weakness of the measures of religiosity and family planning barriers. After reviewing over a hundred measures related to religion, political beliefs, fascism, and societal behavior control, the Bardis Religion Scale was chosen for its focus on behavior and its fit with the purpose of the study and social cognitive theory (Bandura, 1986). While the Bardis Religion Scale (1961) does have this fit it certainly could be argued that other measures may have been a better choice. Furthermore, the Family Planning Barrier Measure was developed specifically for this study and lacks previously established reliability and validity.

Fourth, this study focuses on the importance of family planning training. However, very little is known about the actual quality or focus of the trainings or coursework in which many respondents participated. Future research that compares the outcome of different educational programs could be far more effective in developing appropriate family planning training.

Furthermore, tailoring trainings to the needs of the population with whom the social worker practices would be of great importance.

8.4 IMPLICATIONS FOR SOCIAL WORK

Social workers in direct care practice are often the only members of an interdisciplinary team who operate from an ecological perspective. It is the responsibility of the social worker to look beyond the apparent psychological or medical state of the client to evaluate needs that may prevent or reduce future challenges in the environment. Mothers of unintended births face increased risk of single parenthood, incomplete education, poverty, unemployment, and welfare dependency and are more likely to expose their fetus to harmful substances such as tobacco and alcohol (Brown & Eisenberg, 1995; Kost, Landry & Darrock, 1998). Children of unintended pregnancies are at greater risk of dying in their first year, of being abused, of not receiving sufficient resources for healthy development and face increased risks of living in poverty, and having health and developmental problems (Gold, 2001; Kost, Landry, Darrock & 1998a). This is an area that could be greatly affected by prevention. Furthermore, social workers are supported by the NASW code of ethics in providing family planning. The problem of unintended births and inadequate use of contraception has received wide national attention in the goals of Healthy People 2010 and the Healthy People Consortium, of which social work agencies are a component. Thus, it makes sense that social workers would be a part of the national effort of reducing unintended pregnancy, especially within their client populations.

This study demonstrated that participation in training can make a considerable difference in understanding confidentiality and liability policies, increasing awareness of professional role

related to family planning, and increasing, comfort, competency, and perceived effectiveness in reducing unintended pregnancy. Thus, training should provide understandable and accessible information related to confidentiality and liability, the NASW position on reproductive choice, and basic family planning information. According to the tenets of observational learning, family planning training for social workers would need to be tangible and interesting enough for the participating social workers to pay attention to the training material and commit it to memory. The training material would need to be easily incorporated into behavior and provide adequate incentive to motivate the participant to utilize the presented material. Related training materials could be provided as a source of reference for the participant to use in his or her practice. These training materials could include referral lists for family planning professionals and other community resources, for example. Research that demonstrates the importance of referrals, the goals of Healthy People 2010, and the high rates of unintended pregnancy within the social work client population could be highlighted. Investigation into the family planning needs and interests of specific social workers is crucial in developing training materials that incorporate the concept of observational learning.

Family planning information could be taken to the next level through the use of protocols on how to provide accurate family planning information. In accordance with the concept of self-regulation (Bandura, 1986), setting limits, boundaries, and criteria for one's behavior could be based on the responsibilities of the profession. Furthermore, lack of workplace incentive was found to have the highest mean score on the Family Planning Barrier Measure. Supervisors could emphasize the NASW stance of provision of family planning information, if needed, to help guide social workers in their professional obligation. In this way, the provision of family planning becomes a relevant professional activity that could then be part of one's internal

standard of behavior. For example, one public assistance respondent wrote "In my agency, all family planning is referred to a contracted agency." A homeless services respondent wrote "I am in a supervisory role and I encourage my staff to discuss and refer clients to health care providers for family planning and information."

One primary area that should be emphasized on an agency level is the importance of family planning referrals. Among other factors, knowledge of referral services has been shown to be particularly effective in ensuring successful contraceptive services, particularly to adolescents. In one study, adolescents stated that one principal reason they did not obtain contraceptive services is that they were not aware of a clinician whom they could visit (Severy & McKillop, 1990). Furthermore, studies that examine the success of family planning clinics consistently suggest that community relations, including referrals from community agencies, are important factors in reducing the delay between a teenager's first intercourse and first clinic visit (Winter & Breckenmaker, 1991). Social workers would need to know how to provide an appropriate referral.

In referring for family planning, social workers should be aware of their and their client's confidentially privileges. For example, females under the age of 18 do not require parental consent to obtain prescription birth control pills in Pennsylvania. Only 64% of social workers in this study knew this basic information. According to a 2002 study, 59% of adolescents seeking contraceptive services stated that they would not obtain services if they had to inform a parent (Reddy, Fleming, & Swain, 2002). In addition, studies indicate that the average family planning patient does not visit a family planning provider until 14 months after becoming sexually active or pregnant (Dailard, 2001). One substance abuse clinician wrote "I do address the subject with female and male clients, particularly if one, female, finds themselves pregnant. They may

initiate the discussion of options and I support them in whatever their decision is." Discussing family planning as soon as possible, and certainly prior to a pregnancy, is preferable. Family planning could even be discussed shortly after unprotected intercourse. For example, emergency contraception can be used successfully for up to 120 hours after intercourse. Furthermore, emergency contraception does not require a physician's prescription for woman over 18 years of age in Pennsylvania. Being aware of basic laws can make the difference between obtaining contraception in a timely manner or waiting until a pregnancy has already occurred.

Incorporating family planning in agency training followed by emphasis on family planning within team meetings could greatly reduce the occurrence of unintended pregnancy. Furthermore, helping social workers with any sense of ineffectiveness can be an important piece of team meetings as well. One respondent wrote "Trying to prevent pregnancies with foster children and young women was almost impossible, no matter how much I prepared them." Another social worker reported feeling alone and wrote, "I am currently working with patients seeking termination of pregnancy at a large area hospital. I discuss contraception/ abortion/ adoption every day but no one where I work will help me when needed." Making sure that social workers feel supported in their effort to reduce unintended births is crucial in preparing an environment that is effective.

Clearly, continuing educational programs that are meaningful regarding family planning must be offered. One respondent wrote "I attend many workshops/conferences as my agency is very supportive of ongoing learning, but I cannot say that I have ever even seen a training on contraception info and how to provide it to clients." Another respondent wrote "Frankly, I feel that there is a huge void—that is absence of preparation to deal with almost any area of sexuality with our clients." Furthermore, given that family planning laws and options are continuing to

change, it is important to continually offer updated trainings. One respondent wrote "I have worked as a pregnancy options counselor...but that was 15 plus years ago and my knowledge is not as current as it could be." The field of social work must recommit to reducing unplanned pregnancy and have this commitment partially reflected in social work continuing education.

Social work education should be an important part of the equation in emphasizing the importance of family planning training. Schools of social work should vocalize and improve their support of family planning within coursework and in field placement. Unfortunately, this does not always seem to be the case. One respondent wrote "No education on this subject in grad school. I should have at least some continuing education on this subject but wouldn't know where to find it." Human Behavior in the Social Environment (HBSE) is one course that could incorporate family planning information. Sexuality over the life span is a component of HBSE. Field placements could also be part of the social work education and family planning equation that create more competent social workers. A health care respondent wrote "I did an internship at Planned Parenthood but was asked to change by my field instructor because there was not social work supervision available—it was in the education department. I enjoyed it, learned a lot but there was no social worker." Another respondent wrote "My second practicum was with a family practice that provided the physicians for the MA prenatal clinic. I learned about birth control, etc. in that practicum and have no problem discussing the issue." Social work is in a position to take a lead and work with other organizations to assure that students are given the tools they need to reduce unintended pregnancy.

There are important implications for policy as well. Title X has been hurt under the current presidential administration. Similarly, extremists of the religious right have been successful in their attempts to interfere with the provision of family planning, specifically with

cuts in funding. The battles that were won in favor of family planning after the Nixon administration and the Reagan/Bush I administration can be won again, if professions such as social work take up the cause. One respondent wrote "There is no doubt that 20 years ago social workers in certain agencies were counseled not to discuss contraceptives, abortion, adoption, etc. with their clients, but this has changed since social work through their own professional empowerment view their families etc. as the client, not the agency. I thank all the social workers before me who risked it!"

Policies that focus on self-determination and public health and take the discussion away from the religious right could also be effective in reducing the unintended pregnancy rate. A respondent wrote "Social workers, especially in direct care, have limitless options to discuss contraception. It is a medical discussion, not a religious discussion. If abortion was a covered insurance benefit there would be better overall healthcare for women. There are great opportunities for impacting a woman's life pre and post abortion." Encouraging social workers to challenge the existing anti-family planning policies would be beneficial to individuals and society at large. A child welfare worker wrote "In child welfare, prevention is de-emphasized due to short-sighted politicians/DPW, so we do abuse investigations mostly. Plugging holes after the fact floods society with ill-equipped/informed parents." Instead of plugging holes, social workers should be active in supporting policies that uphold Title X to ensure that family planning is available to all who may need or request it.

8.5 CONCLUSION

Much like other countries, the United States has a history of struggling to find a place for family planning needs in governmental policies and direct care while facing opposition and controversy. Unlike many other Western countries however, the policies of the U.S. continue to be entangled in a religious battle that has interfered with providing adequate family planning services. Thus, it is not surprising that the U.S. has the highest unintended pregnancy rate out of all the Western countries.

Using the social learning theory (Bandura, 1986) as a framework, this current study investigated challenges that social workers face in providing family planning information. While religion was a consideration for some, it was not the central factor in understanding the behavior of providing family planning information. Workplace incentive and issues related to knowledge were of far greater value in understanding barriers. Perhaps the most important finding in this study is the importance of family planning trainings in accounting for family planning barriers. Despite similarities in religiosity, the presence of family planning training was connected to decreased Family Planning Barrier Scores.

The profession of social work has a tradition of supporting family planning as consistent with the principles of self-determination, empowerment, and dignity that form the foundation of social work. However, little has been known about the present-day application of this support within the care of social work client populations. Furthermore, social workers should be active in challenging the attacks on providing reproductive information and care. It is hoped that a greater understanding of existing weaknesses in the provision of family planning information from social workers to their clients and in legislative policy will help inform future social work courses and continuing education programs.

APPENDIX A

COVERLETTER

Dear Social Work Colleague,

Little is known about the involvement of social workers in the provision of family planning information to clients, and how this may differ by setting, client population, or social worker beliefs and attitudes. As a practicing professional social worker, I am interested in finding out more about social worker's involvement in this area as there may be information vital to increasing the understanding of social workers within their professional roles. For that reason, I am asking licensed social workers to complete a brief survey.

You have been randomly chosen from a select sample representing Pennsylvania social workers. Thus, your participation is critical to the success of this study. It would be greatly appreciated if you would kindly take approximately 5 - 10 minutes out of your already busy schedule to complete the enclosed questionnaire and return it in the postage-paid, self-addressed envelope by March 31st, 2007.

The questionnaire asks about (1) your reaction to statements related to providing family planning information as a social worker to your clients, (2) your reaction to statements comprising a standardized religion scale, and (3) some general demographic questions. This is an entirely anonymous survey and your participation is completely voluntary. There are no foreseeable risks associated with this project

I look forward to receiving your completed questionnaire. If you have any questions, or would like to receive a copy of the survey results, please contact me via email at melissambell.lsw@gmail.com. I also thank you in advance for your assistance in helping to improve the understanding of social workers within their professional roles. Your participation is greatly appreciated.

Sincerely,
Melissa M. Bell, MSW, LSW Ph.D. Candidate
2117 Cathedral of Learning School of Social Work
University of Pittsburgh
Pittsburgh, PA 15260

P.S. Please enjoy the enclosed 2007 wallet calendar as a token of our appreciation.

APPENDIX B

FAMILY PLANNING BARRIER MEASURE

Your current clients:

1. Do you currently work with any clients between 13 and 55 years of age?

____a. **No,** I do not work with any clients between 13 and 55 years of age.

____b. **Yes**, I do work with clients between 13 and 55 years of age.

If no: If you **do not** work with clients between 13 and 55 years of age, **please respond to only questions #1 - #12 in this section of the questionnaire**, then skip to sections II and III, **and complete the Religion Scale and Background Information**.

If yes: If you **do** work with clients between 13 and 55 years of age, **please complete the entire questionnaire.**

For each of the 9 items below, please circle "True" or "False" to show what you believe to be correct.

1. When used properly, condoms prevent against pregnancy less than half of the time .....True False

2. The birth control pill is safe for most healthy adolescents ..... True False

3. When used correctly, the birth control pill prevents pregnancy almost all of the time ..... True False

4. Abstinence is not a form of contraception ..…..... True False

5. Emergency contraception (known to many as the "morning-after pill" or Plan B) can be used up to 120 hours after intercourse to prevent a pregnancy.....True False

6. Emergency contraception and RU486 (known to many as the "abortion pill") do not have any similarities in how they medically function ..... True False
7. Taking emergency contraception will not cause birth defects, or any damage to a fetus, even if a pregnancy has already occurred ..... True False

8. Emergency contraception requires a physician's prescription for every woman in Pennsylvania .....True False

9. Pregnancy is medically defined as implantation of a fertilized egg ..... True False

10. Females under 18 years of age need parental consent obtain birth control pills.....True False

For the following items of this section, use this scale to indicate your degree of agreement or disagreement with each statement. Circle either DS, D, N, A, or SA for each item.

SD	D	N	A	SA
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

11. I am very knowledgeable about current family planning options ..... SD D N A SA

12. I am very knowledgeable about the NASW position on providing family planning information to clients ..... SD D N A SA

13. Continuing education in social work does not adequately address the provision of family planning information to clients ……..... SD D N A SA

14. I am often unsure about how confidentiality laws impact my ability to confidentially discuss family planning with my client..... SD D N A SA

15. I am very aware of all community resources available to my clients for contraception ..... SD D N A SA

16. Sometimes my professional ethics conflict with my religious values ..... SD D N A SA

17. In the course of my work as a social worker I have been discouraged from discussing family planning with clients due to the moral objection of my employer(s)..... SD D N A SA

18. Moral opposition impacts my willingness to provide abortion information and referrals .....SD D N A SA

19. I do not discuss contraception with my clients due to my own moral values. SD D N A SA

20. A social worker's religious values supersede her or his expected professional role.....SD D N A SA

21. Unplanned pregnancy is a problem among social work clients in Pennsylvania .....SD D N A SA

22. It is my professional role to provide referrals or other information for my clients to obtain contraception..... SD D N A SA

23. It is my professional responsibility to provide appropriate referral services to ensure that abortion is available to all clients who are considering this option .....SD D N A SA

24. I do not have enough time to discuss family planning with my clients given my work priorities.....SD D N A SA

25. It frequently occurs to me to discuss family planning with my clients to reduce unintended pregnancy..... SD D N A SA

26. Family planning information is relevant to the well-being of my clients ..... SD D N A SA

27. I am interested in providing contraception information to my clients……..... SD D N A SA

28. I am interested in learning more about how to effectively discuss family planning with my clients .....…. SD D N A SA

29. There is an incentive in my workplace to discuss family planning with clients ..... SD D N A SA

30. I avoid discussing contraception and abortion with my clients due to liability concerns ..... SD D N A SA

31. Many of my clients are not capable of utilizing condoms and birth control pills correctly ..... SD D N A SA

32. I experience cultural or language barriers in discussing family planning with my clients..... SD D N A SA

33. I believe that I can be effective in reducing unplanned pregnancy with my clients .....SD D N A SA

34. I was provided with adequate material in social work courses to comfortably discuss family planning with clients..... SD D N A SA

35. I do not feel competent discussing family planning with my clients ..... SD D N A SA

36. The social work profession is not effective in reducing unplanned pregnancy with clients .....SD D N A SA

37. I frequently discuss family planning information with my clients ..... SD D N A SA

38. Please provide any other reactions you may have about the provision of contraceptive information by social workers (Please use other additional paper if necessary):

APPENDIX C

RELIGION SCALE

Below is a list of statements concerning religion. Please read each statement very carefully and respond to all of them on the basis of your own beliefs. Do this by reading each statement and then circling only one of the following: SD, D, N, A, or SA. Please refer to the chart below:

SD	D	N	A	SA
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

1. A sound religious faith is the best thing in life .....SD D N A SA

2. Every school should encourage its students to attend religious services.....SD D N A SA

3. People should defend their religion above all things .....SD D N A SA

4. People should attend a place of worship once a week if possible .....SD D N A SA

5. Belief in God makes life more meaningful ..... SD D N A SA

6. Every person should give 10 percent of his/her income to his/her place of worship .....SD D N A SA

7. All people are God's children ..... SD D N A SA

8. People attending religious services regularly develop a sound philosophy of life ..... SD D N A SA

9. We should always love our enemies .....SD D N A SA

10. God rewards those who live religiously .....SD D N A SA

11. Prayer can solve many problems ..... SD D N A SA

12. Every school should have religious services for its students ..... SD D N A SA

13. There is life after death .....SD D N A SA

14. People should read their holy book at least once a day..... SD D N A SA

15. Teachers should stress religious ideals in class.....SD D N A SA

16. Young people should attend religious education classes, such as Sunday School, regularly.....SD D N A SA

17. People should pray at least once a day ..... SD D N A SA

18. A religious wedding ceremony is better than a civil one ..... SD D N A SA

19. Religious people should try to spread the teachings of their Holy Book ..... SD D N A SA

20. When a person is planning to be married, one should consult one's minister, priest or rabbi.....SD D N A SA

21. Delinquency is less common among young people attending religious services regularly..... SD D N A SA

22. What is moral today will always be moral ..... SD D N A SA

23. Children should be brought up religiously ..... SD D N A SA

24. Every person should participate in at least one religious activity ..... SD D N A SA

25. I consider myself a religious person .....SD D N A SA

26. I consider myself a spiritual person ..... SD D N A SA

APPENDIX D

BACKGROUND INFORMATION

Please circle ONE item that most closely describes your personal information

1. Sex
    1) Female
    2) Male

2. Age in years as of your last birthday
    1) Less than 30 years
    2) 30-39 years
    3) 40-49 years
    4) 50-59 years
    5) 60 years or over

3. Ethnicity
    1) African American
    2) American Indian
    3) Asian/Pacific Islander
    4) Caucasian
    5) Latino
    6) Biracial or other

4. Years of social work experience
    1) Under 2 years
    2) 2-5 years
    3) 6-10 years
    4) 11-15 years
    5) 16-20 years
    6) Over 20 years

5. Your primary work function
    1) Direct practice
    2) Administration
    3) Community organizer
    4) Research or teaching
    5) Supervision
    6) Other (please specify) _____

6. Your current practice environment
    1) Aging
    2) Child/family welfare
    3) Criminal justice
    4) Health
    5) Mental health
    6) Public assistance
    7) School social work
    8) University setting
    9) Other (please specify) _____

7. Your primary work setting
    1) Urban
    2) Suburban
    3) Rural

8. Training you have received in family planning
   If training received, please state how provided
   (i.e. continuing education, coursework, agency)
    1) None
    2) 1-2 trainings or classes_____
    3) 3 or more trainings or classes _____

9. With which party do you tend to vote
    1) Democrat
    2) Republican
    3) Independent
    4) Other (please specify) _____
    5) Rarely or never vote

10. Which best describes your political beliefs
    1) highly liberal/highly progressive
    2) slightly liberal/slightly progressive
    3) moderate
    4) slightly conservative
    5) highly conservative

11. Which best describes your stance on abortion rights in the United States

1) highly “pro-choice”
2) slightly “pro-choice”
3) neutral/undecided
4) slightly “pro-life”
5) highly “pro-life”

12. Your religious preference

1) Fundamentalist/evangelical protestant
2) Other protestant
3) Catholic
4) Jewish
5) None
6) Other (please specify) _____

13. Importance of religion in your daily life

1) Very important
2) Slightly important
3) Neutral
4) Slightly unimportant
5) Very unimportant

APPENDIX E

REMINDER POSTCARD

A few weeks ago a questionnaire seeking your response to social workers providing family planning information to clients was mailed to you. Your name and contact information were randomly selected from a list of social workers licensed in the state of Pennsylvania.

If you have already completed and returned the questionnaire, please accept our sincere thanks. If not, please do so today. We are especially grateful for your help because it is only by asking people like you to share your thoughts that we can understand how to improve training for practicing social workers.

If you did not receive a questionnaire, or if it was misplaced, please email me at melissambell.lsw@gmail.com and we will get another one in the mail to you immediately.

Melissa M. Bell, MSW, LSW
Ph.D. Candidate
University of Pittsburgh
School of Social Work

APPENDIX F

INSTITUTIONAL REVIEW BOARD APPROVAL

University of Pittsburgh
Institutional Review Board

Exempt and Expedited Reviews
University of Pittsburgh FWA: 00006790
University of Pittsburgh Medical Center: FWA 00006735
Children's Hospital of Pittsburgh: FWA 00000600

3500 Fifth Avenue
Suite 100
Pittsburgh, PA 15213
Phone: 412.383.1480
Fax: 412.383.1508

TO: Melissa Bell, MSW, LSW
FROM: Christopher M. Ryan, Ph.D., Vice Chair
DATE: July 6, 2006

PROTOCOL: Barriers in the Provision of Family Planning Information from Social Workers to Their Clients

IRB Number: 0511149

The Institutional Review Board reviewed the recent modifications to your exempt protocol and finds them acceptable for administrative review. These changes, noted in your submission of June 13, 2006, are approved. Based on the information provided in the IRB protocol, this project still meets all the necessary criteria for an exemption.
• Please advise the IRB when your project has been completed so that it may be officially terminated in the IRB database.
• This research study may be audited by the University of Pittsburgh Research Conduct and Compliance Office.

Original Approval Date: December 2, 2005
Modification Approval Date: July 6, 2006
CR: dj

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