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AUTHOR	Armstrong, Kay A.; And Others
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ABSTRACT

Inconsistent use of contraceptives or discontinuance of family planning services places women at risk of unintended pregnancies. Dropping out of family planning clinics also could mean interrupting gynecological care. Nonetheless, approximately 20% of adolescent family planning patients and nearly 25% of adult patients do not return for a second visit. This study examined reasons for clinic discontinuance by conducting telephone surveys of 628 women more than 2 years after their last clinic visit at one of 62 clinics. Two reasons cited most frequently by respondents were dissatisfaction with the clinic care and the inconvenience of the clinic's hours, location, or transportation. Relationships were found between reasons for discontinuation and the individual covariables of age, years of education, income, use of public assistance, and number of live births. Relationships were found between reasons for discontinuation and the clinic covariables of number of different staff seen by a patient, seeing the same medical care provider, convenience to public transportation, and number of visits by patients with incomes less than 150% of poverty level. During the period following clinic discontinuation, 39% of the women went to another place to get gynecological care or a pelvic examination and 35% went specifically to get family planning services. These findings have both programmatic and policy implications. (NB)

A Study of Women Who Drop-Out of Family Planning Clinics

Kay. A. Armstrong, MS
Roberta Herceg-Baron, MA
Gary Pickens, PhD

Family Planning Council of Southeastern Pennsylvania
260 S. Broad, Suite 1900
Philadelphia, PA 19102
215-985-2623

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Introduction

Almost five million women sought family planning services at Title X federally funded programs in the United States in 1983, the most recent year for which data are available (Torres & Forrest, 1987). While publicly funded family planning programs aid both adolescent and adult women in preventing unplanned pregnancies, the effectiveness of family planning services is largely dependent upon providing uninterrupted care to women desiring to delay or prevent a pregnancy. Inconsistent use of contraceptives or discontinuance of family planning services, places women at risk of unintended pregnancies.

Dropping out of family planning clinics also could mean interrupting gynecological care that includes testing for cervical cancer and detection and treatment of sexually transmitted diseases for women generally between the ages of 15 and 44. Low-income women are especially vulnerable. More than eight out of ten family planning patients seen in federally funded clinics have a family income below 150 percent of the federal poverty index (Torres & Forrest, 1987). Generally these women are unable to afford private health care providers.

Unfortunately, about one-fifth of adolescent family planning patients and nearly one-quarter of adult patients will not return for a second family planning visit within 18 months of their first visit. An additional 15-26% of those who do return for their second visit will not make a third visit (Herceg-Baron, Armstrong, & Pickens, 1986, Shea, Herceg-Baron & Furstenberg, 1984). Why do so many family planning patients drop out? What happens to these women?

Earlier attempts to understand more about the reasons women discontinue using family planning services and their subsequent use of contraceptives indicate that three years after their last clinic visit, about half of the women were still in need of contraceptive services. Many women in need of contraceptives left the clinics because of problems or concerns about their method (42%), others gave personal or family reasons (29%) while still others left due to dissatisfaction with factors associated with the clinic (13%) (Sear, 1973). Of the women currently in need of contraceptive services, eight to 20% used no birth control methods and an additional seven to 13% used methods considered to be only moderately effective (diaphragm, foam, condom) (Cosgrove, Penn & Chambers, 1978, Sear, 1973). At the time women were interviewed in these two follow-up surveys, two to eight percent of the women were experiencing an unplanned pregnancy. Unfortunately, neither study examined the occurrence of unplanned pregnancies during the time interval between the last clinic visit and the time of the follow-up survey.

A recent study of family planning clinic dropouts in Maryland examined both contraceptive use and pregnancy history from the time of their last clinic visit to the time of the survey averaging 23 months later. Excluding sterilization, three out of four women continued to use contraceptives 24 months later. Yet, more than one in five of the clinic drop-outs experienced a pregnancy with 66% reported as unplanned. (Chow, Rider, Su & Hou, 1987).

This paper builds upon these studies, expanding the focus to look at reasons for clinic discontinuance, individual and clinic factors associated with women who are clinic discontinuers, use of health care providers by women still in need of family planning care and subsequent pregnancy experience. The retrospective telephone survey of 628 women offers a longitudinal view more than two years after their last visit to the clinic. This survey is part of a larger study that also examined the rates and patterns of clinic discontinuation among adolescent and adult women and the individual and clinic factors associated with these rates. (Herceg-Baron, et. al. 1986)

Background

Study Sites

The sample for the study was drawn from 62 clinics affiliated with two Title X federally funded family planning grantees. Thirty-nine of the sites are affiliated with the Family Planning Council of Southeastern Pennsylvania (FPC), the Title X grantee that coordinates the organized family planning program in the Philadelphia and surrounding urban and suburban four county area. The remaining 23 sites are associated with Maternal and Family Health Services, Inc. (MFH), the Title X grantee providing family planning services to the 15 counties in the predominantly rural area of northeastern Pennsylvania. Together the clinic sites represent a range of rural, suburban and urban centers family planning care. Among them are Planned Parenthood affiliates, hospital sites, community health centers, and public health departments.

Sample

Family planning clients who initiated services after July 1980 and had their last recorded visit before July 1983 with an interest in using contraceptives were eligible for the survey. Altogether 3586 patient records were sampled resulting in 2343 women eligible for the clinic discontinuation survey. Half of these women (1010) were traced and contacted by interviewers. The desired sample size for completed interviews was 600, approximately 400 from FPC and 200 from MFH reflecting the service population differences between the two family planning grantees; the actual number interviewed in early 1985 was 628, 445 from FPC and 183 from MFH.

The representativeness of the 628 women who participated in the survey was examined by comparing respondent and non-respondent information obtained from patient data. Women who refused to participate were more likely to be white and to be better educated at the time of their initial clinic visit. Other differences between the respondents and non-respondents were minimal.

Both individual and clinic characteristics were included in the analyses. Data on individuals included demographics, contraceptive and pregnancy histories, use of health care providers, and opinions concerning health care providers. Factors examined at the clinic level included clinic schedules, patient flow, staffing patterns, provider type, providers' profiles of its population, and contraceptive use.

At the time of the telephone interview (averaging 26 months after the last clinic visit), the mean age of the women was 24.8 years, ranging from 16 to 50 years. The two organizations differ in several demographic characteristics both in their populations of women served and in the samples of women participating in the survey. In the samples surveyed, 39% of FPC women were on Public Assistance compared to 20% from MFH. In FPC, 54% of the women were black contrasted to 3% of the MFH women. Of the 300 pregnancies occurring since the last clinic visit, almost half (49%) were unplanned with almost twice the proportion of FPC women having unplanned pregnancies than MFH women (58% vs. 30%). Because of these differences, in most of the analyses the two groups were considered separately.

Results

Reason for Discontinuing

The women's responses to the open-ended question concerning why they did not return to the clinic were grouped into nine reasons. Nineteen percent of the women (n=122) gave more than one reason while 16% (n=99) gave no specific reason. Table 1 lists the reasons by total sample and by grantee organization. Two reasons cited most frequently were dissatisfaction with the clinic care (n=134) and the inconvenience of the clinic's hours, location, or transportation (n=121). Close agreement of the reasons for discontinuing existed between the two family planning organizations with the exception that a greater percent of FPC than MFH women reported a clinic feature to be inconvenient e.g. hours, locations or transportation, and a smaller percent of FPC women than MFS perceived no need for family planning services at the time they dropped out.

Insert Table 1 About Here

Combining the reasons for discontinuing into either characteristics attributable to the clinic or to the individual, 45% of the responses were perceived problems or dissatisfaction with clinic care or clinic convenience. Personal reasons can be broken into client initiated switching or clinic referrals to other health care providers (22%), perceiving no need for continuing family planning services (13%), moving (14%) or having misperceptions about clinic fees (5%).

Relationships between the reasons for discontinuation and individual and clinic variables are noted in Table 2. Significant individual covariables ($p<.05$) included age, years of education, income, use of public assistance and number of live births; and clinic covariables included the number of different staff seen by a patient, seeing the same medical care provider, convenience to public transportation and number of visits by patients with incomes less than 150% poverty level. Other variables examined but not found to be significantly related to the reason given included race, total number of patients served in the clinic, total hours the clinic is open, waiting time and percent of direct time the clinic personnel spent with the patient.

Insert Table 2 About Here

In general, clients who did not see the same medical provider at each visit were more likely to say that they left the clinic because they were dissatisfied with t'e way the clinic functions. Women on public assistance and/or whose income levels were less than 150% poverty, those with fewer years of education and clinics whose clients see four or more staff each visit, reported leaving due to the clinics' inaccessability or inconvenience. Women who experienced a change in their financial situation, had higher incomes, more years of education, had no live births, saw fewer clinic staff persons at a given clinic visit, and were more likely to give "financial change" as the reason for discontinuing. Those women with more years of education, higher incomes, and no live births tended to discontinue due to moving. Older women were more likely to perceive no need to continue attending the family planning clinic.

Women were asked to rate their level of satisfaction with the contraceptive method they were using at the time of their last clinic visit. Thirty-five percent of the women least satisfied with their birth control method stated that they left the clinic due to discontent with the clinic care. (Not shown here).

Use of Health Care Providers

During the period following clinic discontinuation, 89% of the women went to another place to get gynecological care or a pelvic exam and 35% went specifically to get family planning services. Table 3 notes where the women went for care. Private physicians were the most frequent source of gynecological care for discontinuers (n=301) followed by hospital outpatient clinics (n=95). Differences between the two Title X federally funded family planning grantees reflect the types of providers available in the areas. Although most women did continue . obtain gynecological services, 11° f the clinic discontinuers had not gone to any health cai provider since their last clinic visit.

Insert Table 3 About Here

Table 4 summarizes the results of logistic regression models relating to visits to any health care provider for gynecological care and specifically to providers for family planning services compared with women who did not go to any provider. Women who went to any type of health care provider were more likely to be young, not on public assistance and using an effective contraceptive method (pill), and spent less time with clinic personnel. Women who used the most effective method (pill), younger women and those not originally attending a hospital clinic were more likely to go to a provider of family planning services. These variables explained 32% and 34% of the variance respectively for the total sample. Variables significantly related to subsequent health care use differed for FPC and MFH.

Insert Table 4 About Here

Similar to the results found using stepwise logistic regression models, were results from proportional hazards regression models. These regressions were run in an attempt to predict the timing of a subsequent visit to another health care provider, and specifically the timing of a subsequent visit to a family planning provider by covariates. Women who were using the pill at the time of the last clinic visit were more likely to use health care providers as well as family planning providers sooner following discontinuation. Younger women were also more likely to use family planning providers.

Lifetables (see Figures 1 and 2) illustrate the length of time by month following clinic discontinuation before women go to a health care provider or to a family planning provider. Seven months following discontinuation, about half of the women have attended a health care provider for gynecological care and by one year almost 70% of the women had. The probability of a woman going specifically to a family planning provider is lower. One year following discontinuation, only 24% had used a provider for family planning services. By two years after discontinuation, 80% had gone to a health care provider and 30% had gone to a family planning provider.

Insert Figures 1 and 2 About Here

Outcomes Subsequent to Discontinuation

During the time interval following the last family planning visit and the follow-up interview, 300 pregnancies were reported with 144 (48%) reported to be unplanned (women had wanted to be pregnant "later" or "not at all"). Of these pregnancies, 247 resulted in live births and 53 in abortions. In addition, 72 women had not yet gone to any health care provider for gynecological care since their last clinic visit. The relationship between these outcomes and the reasons for discontinuing is seen in Table 5.

Insert Table 5 About Here

Women who discontinued because they perceived no need for contraceptives were most likely not to continue seeing any health care provider. Those women who reported that they felt the clinic schedule or location were inconvenient or those who had moved out of the clinic area experienced more unplanned pregnancies and abortions than women discontinuing for other reasons. The influence of these unfortunate outcomes on the womens' perceived reasons for leaving the clinic at the time of the follow-up survey is unclear. Yet women voicing dissatisfaction with the clinic did not experience as many of these outcomes; they had fewer unplanned pregnancies and abortions than those women who found the clinic inconvenient or women who moved out of the area.

Discussion and Implications

Both programmatic and policy implications emerge from this study of clinic discontinuers. Clear steps are indicated that might reduce clinic discontinuation, increase uninterrupted health care, and, furthermore, might decrease unintended pregnancies.

At the programmatic level, almost half of the women state that their reason for discontinuation is clinic related. Family planning providers need to be aware of the clinic features and services causing patient dissatisfaction and inconvenience. Dissatisfaction with long waits, lack of privacy and with the way they are treated by the staff in the clinic, as well as clients' preferences to see the same medical provider and fewer numbers of staff, should be addressed. In particular, women who are poor, non-white and without a high school education are more likely to discontinue due to clinic related reasons and to experience subsequent

unplanned pregnancies. For women planning to move outside the clinic area, clinic personnel could assist them in finding another health care provider in that area.

Policy-makers and federally funded family planning providers should be aware of their clients' movements to other providers of care. According to our results, half of the women will leave family planning clinics and switch to private sources, a third will use a different federally funded family planning provider but some, 11% in this study, will not go to any health care provider for at least two or three years. Policy makers need to be aware that yearly a minimum of 11% of all clinic discontinuers are placing themselves at risk of unplanned pregnancies and/or other gynecological problems by not using health care providers consistently. Support for improving family planning clinics in terms of consultation and/or financial assistance, could help to alleviate some of the reasons associated with clinic discontinuation.

Family planning providers can obtain better medical histories by asking new clients where they last went for family planning services and getting medical record release forms signed. In contacting former family planning providers, not only will better histories of family planning use be obtained but also it will inform the previous provider of the client's continuing care and save them from time consuming searches for clients who are no longer in need of care from that site.

One additional action step, barring medical contra-indications, is to encourage the use of oral contraceptives. Women who discontinue using family planning clinics but who leave using the pill, are more likely to visit other providers for continuing family planning and gynecological services.

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Table 1: Stated Reasons why Women Have Not Returned to the Clinic*

	TOTAL		FPC		MFH	
	#	%	#	%	#	%
Dissatisfied with clinic care (waiting time, treatment by staff)[1]	134	21	97	21	37	20
Clinic inconvenient, inaccessible (hours, location, transportation)[1]	121	18	95	20	26	14
Financially able to switch to private sector (HMO, etc.)[2]	103	16	75	16	28	15
Client moved out of clinic area[2]	92	14	64	14	28	15
Perceives no need for medical care (not sexually active, sterilized)[2]	86	13	52	11	34	18
Referred to another health care provider or only temporarily used clinic[2]	42	6	30	6	12	6
Perceived financial barrier[2]	34	5	22	5	12	6
Problem with method or inadequate health care at clinic[1]	32	5	23	5	9	5
Client perceives clinic has closed or moved[1]	7	1	7	2	0	0
TOTAL	651	89%	465	100%	186	99%

*Unweighted frequencies, includes up to two reasons per respondent, 99 other or no specific reason given are not included in this table.

1. Clinic related reason

2. Individual related reason

Table 2: Individual and Clinic Characteristics by Reason for Discontinuance*

	N	Reasons % Dissatisfied	% Inconvenience	% Financial Change	% Moved	% No Need	% Other/ No Reason
Individual							
Age							
≤ 24	361	15	17	13	16	9	30
> 24	267	16	15	12	10	17	30
Education							
< 12	114	15	22	4	11	12	36
12	287	16	17	13	9	14	31
> 12	227	15	13	16	20	10	26
Public Assistance							
Yes	197	14	27	6	9	12	32
No	393	17	11	17	15	12	28
Income							
< 150 Poverty	297	14	22	9	11	12	32
>/ 150 Poverty	331	17	11	16	13	14	29
Live Births							
None	272	16	10	19	18	11	26
</ 1	356	15	21	8	10	13	33
Clinic							
Different Staff							
< 4	594	16	16	12	13	12	31
>/ 4	34	12	21	18	18	6	25
Same Medical Prov.							
Yes	267	12	16	12	15	17	28
No	359	19	16	13	13	8	31
Convenient Public Transportation							
Yes	543	17	17	12	13	11	30
No	83	10	11	14	13	20	31

* All Variables are significant at $p<.05$ using the Chi-Square test.

Table 3: Use of Gynecological Care Providers Subsequent to Clinic Discontinuation by Council*

Provider Type	TOTAL #	TOTAL %	FPC #	FPC %	MFH #	MFH %
Private Physician	301	42	180	34	121	60
Hospital Out-patient Clinic	95	12	73	14	22	11
Another Family Planning Clinic	61	8	56	11	5	2
Planned Parenthood	53	7	44	8	9	2
HMO	34	5	31	6	3	2
Public Health Department	28	4	27	5	1	0.5
Neighborhood Health Center	26	4	24	5	2	1
Somewhere Else	52	7	38	7	14	7
Not Gone Anywhere	72	10	49	9	23	12
TOTAL	722	100%	522	99%	200	99%

* Women could list more than one gynecological care provider

TABLE 4: Variables Related to Visits to any Health Care Provider and to a Family Planning Provider Subsequent to Discontinuation using Stepwise Logistic Regression Analyses*

	Visit to any Health Care Provider			Visit to any Family Planning Provider		
	BETA			BETA		
Individual	TOTAL	FPC	MFH	TOTAL	FPC	MFH
Not on Public Assistance	+ .85					+ .56
Age	- .09	- .12		- .07	- .08	
Most Effective Method	+1.05	+1.49		+1.80	+1.49	+2.72
Least Effective Method		+1.40	-1.61			
Plan to have More Children			-1.17			
Clinic						
Hospital Clinic				- .84		
Planned Parenthood			- .09		+ .60	
% Personnel Time in Patient Contact	- .02					
R-Value	.32	.31	.40	.34	.30	.44
N	488	341	147	488	341	147

* Significant at p <.05

TABLE 5: Reasons Why Women Have Not Returned to the Clinic by Subsequent Health and Pregnancy Outcomes

	Has not Gone to Provider		Unplanned Pregnancy		Abortion	
	#	%	#	%	#	%
Dissatisfied with clinic care (waiting time, treatment by staff)	4	6	18	14	6	13
Clinic inconvenient, inaccessible (hours, location, transportation)	7	10	25	20	10	21
Financially able to switch to private sector (HMO, etc.)	1	1	14	11	4	9
Client moved out of clinic area	5	7	23	18	12	26
Perceives no need for medical care (not sexually active, sterilized)	24	33	12	10	6	13
Referred to another health care provider or only temporarily used clinic	2	3	9	7	2	4
Perceived financial barrier	7	10	5	4	3	6
Problem with method or inadequate health care at clinic	4	6	5	4	2	4
Client perceives clinic has closed	1	1	0	0	0	0
Other/no reason	17	24	15	12	2	4
N	72		126		47	

FIGURE 1

PROBABILITY OF CLINIC DISCONTINUERS NOT USING A HEALTH CARE PROVIDER BY TIME FOLLOWING DISCONTINUATION
(n=542)

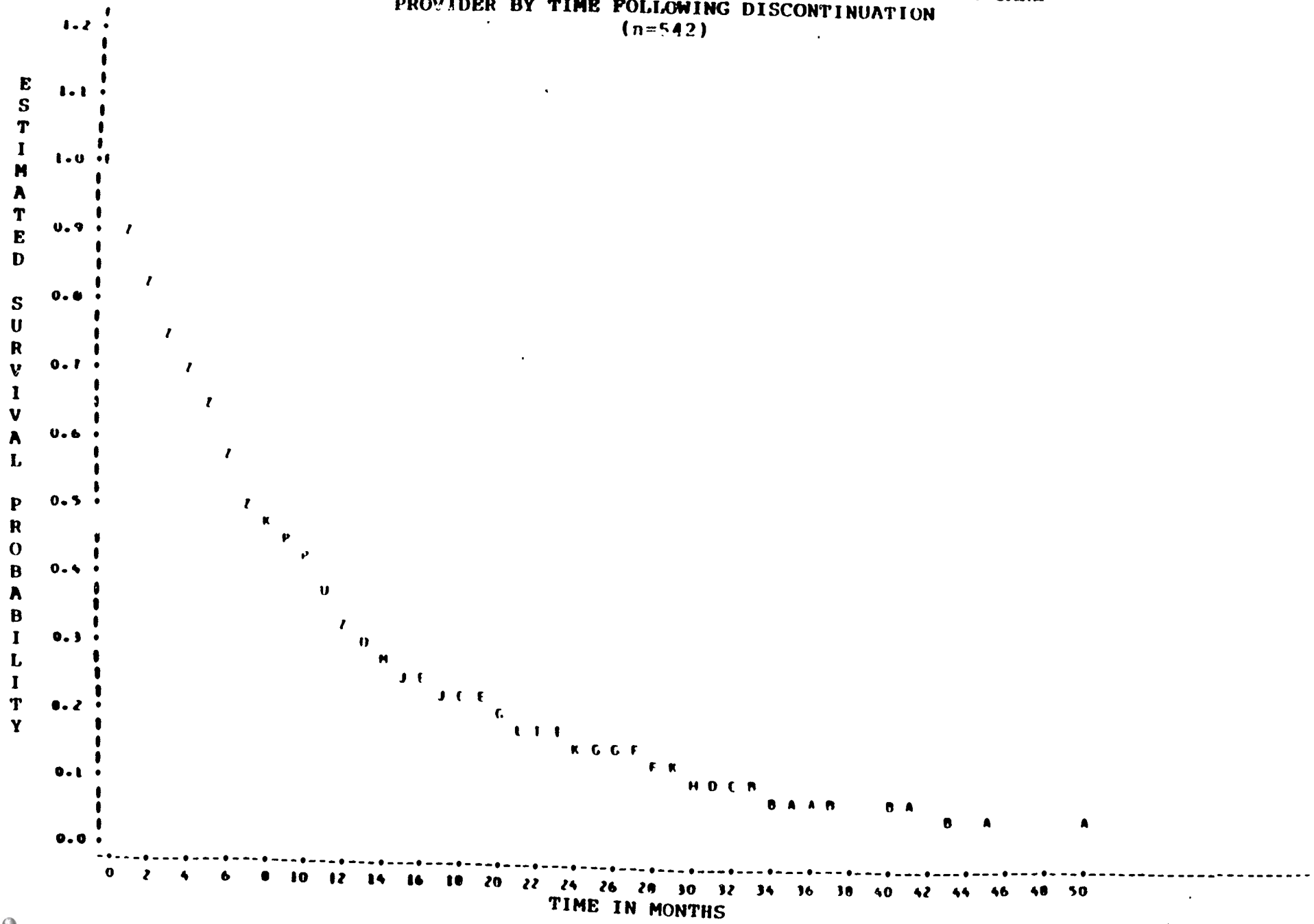

FIGURE 2

PROBABILITY OF CLINIC DISCONTINUERS NOT USING A FAMILY PLANNING CARE PROVIDER BY TIME FOLLOWING DISCONTINUATION
(n=568)