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Women's experiences after Planned Parenthood's exclusion from a family planning program in Texas*

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Abstract

Objective—We assessed the impact on depot medroxyprogesterone continuation when a large care provider was banned from a state-funded family planning program.

Study Design—We used three methods to assess the effect of the ban: (a) In a records review, we compared how many state program participants returned to two Planned Parenthood affiliates for a scheduled dose of depot medroxyprogesterone acetate (DMPA) immediately after the ban; (b) We conducted phone interviews with 224 former Planned Parenthood patients about DMPA use and access to contraception immediately after the ban; (c) We compared current contraceptive method of our interviewees to that of comparable DMPA users in the National Survey of Family Growth 2006–2010 (NSFG).

Results—(a) Fewer program clients returned for DMPA at a large urban Planned Parenthood, compared to a remotely located affiliate (14.4%, vs. 64.8%), reflecting different levels of access to alternative providers in the two cities. (b) Among program participants who went elsewhere for the injection, only 56.8% obtained it at no cost and on time. More than one in five women missed a dose because of barriers, most commonly due to difficulty finding a provider. (c) Compared to NSFG participants, our interviewees used less effective methods of contraception, even more than a year after the ban went into effect.

Conclusions—Injectable contraception use was disrupted during the rollout of the state-funded family planning program. Women living in a remote area of Texas encountered more barriers.

Implications—Requiring low-income family planning patients to switch healthcare providers has adverse consequences.

Keywords

Depo-Provera; Contraceptive agents; Family planning programs; Planned Parenthood Federation of America; Family planning policy; Texas

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1. Introduction

On January 1, 2013, Texas became the first state in the United States to enforce a ban excluding Planned Parenthood from a fee-for-service family planning program. After the ban went into effect, the state took over the entire cost of the Women's Health Program (WHP), US\$31.7 million annually [1]. Started in 2007, WHP previously was supported as a Medicaid demonstration project, with the federal government providing a nine-to-one match for state expenditures.

The ban resulted from a directive by the 2011 state legislature to exclude clinics that either provided abortion services or were affiliated with an abortion provider. In the years immediately preceding the ban, Planned Parenthood was the largest single provider in WHP — seeing approximately 40% of clients [2]. This ban generated unsuccessful legal challenges to the state's right to exclude qualified providers from the program and to operate a program with state funding when federal money was available.

WHP served women ages 18–44 with incomes at or below 185% of federal poverty level who were citizens or qualified residents. The program grew in importance following the 2011 legislative session when, in a parallel effort to defund Planned Parenthood, the state cut grant funding for family planning by 67% and created a tiered allocation system that privileged clinics providing comprehensive care over specialized family planning clinics [3].

The state argued that excluding Planned Parenthood from WHP would have no adverse impact on Texas women, because there was an ample supply of alternative providers [2]. Opponents of the exclusion argued that not all alternative providers had the training and capacity to provide family planning services, particularly for longer-acting reversible methods [4]. The Texas Health and Human Services Commission recorded a substantial decline in WHP enrollment immediately after the exclusion, and as of mid-2015, enrollment remained well below former levels [5]. But these data reveal only how many women continued to use WHP to pay for contraception.

In this paper, we focus on three additional questions related to the impact of the exclusion: How many women returned to Planned Parenthood after the ban went into effect, although this meant paying for services that they had formerly obtained at no cost? Among women who remained enrolled in WHP and chose to seek a new provider, how challenging was that process? And, finally, what was the longer-term impact of the exclusion on the contraceptive continuation of the former Planned Parenthood clients and their subsequent pregnancy rates? We address these questions for a cohort of Planned Parenthood clients who had used injectable contraception and obtained their method in either Houston or Midland, Texas.

2. Methods

We carried out a mixed-methods study with clients at one major metropolitan and one smaller Planned Parenthood affiliate. The clinics were located in Houston, the fourth most populous city in the United States, and in Midland, a West Texas city of 119,000 people, more than 330 miles from any major metropolis. We chose to focus on users of intramuscular depot medroxyprogesterone (DMPA) because this method requires a clinic

visit every 3 months. Our evaluation consisted of three linked components: (a) a records review to assess whether the proportion of WHP participants returning to the two Planned Parenthood affiliates for DMPA changed after the ban; (b) interviews with former Planned Parenthood patients to assess their experience seeking a new provider; and (c) a comparison of our interviewees with a similar cohort of DMPA users who participated in the 2006–2010 National Survey of Family Growth (NSFG).

2.1. Records review

We selected an index cohort of WHP enrollees who received DMPA at a Planned Parenthood affiliate between October 1, 2012 and December 31, 2012. To determine the proportion of WHP enrollees who returned as scheduled between January 1, 2013 and April 30, 2013, we used a computerized search in Houston and we hand searched Midland paper charts. Time between doses was noted; we considered a dose late if 16 weeks or more had passed. At both affiliates, patients obtaining DMPA routinely received a reminder card to return in 12 weeks.

For a baseline comparison, at the Houston affiliate, we also obtained the number of WHP patients who received DMPA in the last quarter of 2011 and returned for a dose in the first 4 months of 2012. In Midland, since no electronic records were available due to the affiliate's closure in early 2013, for comparison, we used patients not enrolled in WHP who received DMPA in the last quarter of 2012 and returned by April 30, 2013.

2.2. Interviews with DMPA users who failed to return

To assess the difficulties that former DMPA patients at Planned Parenthood may have encountered in finding a new provider, we constructed a 5-min. questionnaire covering current method of contraception and any difficulty obtaining the method before May 2013, pregnancy occurrence in 2013 and demographic characteristics. Eligibility criteria were enrollment in WHP and use of DMPA in the last quarter of 2012, failing to return to Planned Parenthood by April 30, 2013 and speaking English or Spanish. Both affiliates provided phone numbers of former DMPA patients to an internal Planned Parenthood call center. The call center culled duplicate entries from the computer-generated list of Houston patients and telephoned former DMPA patients from both affiliates. The study had resources to make two calls to each Houston patient and four calls to each Midland patient who was relevant to the study. Women provided verbal consent for interviews, which were conducted between April 2014 and October 2014. Interviewers read scripts from a secure, Web-based application and recorded responses in the application. If a woman reported multiple birth control methods, only the most effective method was recorded. Participants received a US\$10 debit card as an incentive.

Due to small Midland numbers, extra effort was made to include these women by calling up to four times. Human subjects research approval was obtained from the Committee for the Protection of Human Subjects of the University of Texas Health Science Center at Houston and the University of Texas at Austin Office of Research Support.

2.3. Comparison with NSFG interviewees

To construct a comparison cohort with which to assess the contraceptive use of our interviewees, we used publicly available data from the NSFG, 2006–2010 Cycle [6]. In NSFG, 12,279 women completed an inperson interview that included a contraceptive calendar in which they retrospectively reported the specific method used each month during the 3 years prior to the interview. The respondents selected for this comparison were 197 women who used DMPA 18 months prior to the NSFG interview and who also reported income <186% of federal poverty level. We then classified these NSFG respondents by the type of method they were using 18 months later, at the time of the interview. We compared the resulting method mix with that found among the Houston and Midland interviewees who failed to return for DMPA and tested for statistical significance using the Pearson χ^2 statistic corrected for the NSFG survey design.

3. Results

3.1. Records review

In Houston, only 14.4% of WHP patients who obtained injectable contraception at the end of 2012 (295 of 2045) returned to Planned Parenthood for another dose by April 30, 2013, a sharp dip from 77.0% the prior year (1735 of 2252) ($p < .001$). By contrast, in Midland — where alternative providers were scarce and our interviewees reported only one provider accepting WHP in early 2013 — 64.8% of WHP patients (35 of 54) returned within the first 4 months of 2013. This proportion is similar to the proportion returning among non-WHP injectable users, 75.5% (80 of 106), in the same timeframe ($p = .16$). At both affiliates, most patients who returned did so on time — 89% in Houston and 98% in Midland.

3.2. Interviews with DMPA users who failed to return

Of the 2099 women who obtained DMPA at both Planned Parenthood affiliates, 1769 did not return to Planned Parenthood. The study started more than a year after eligible patients were last seen in clinic, and many phone numbers were outdated; 80% of eligible women (1369 of 1715 validated records) were unreachable in our limited number of attempts. Of the 20% we contacted, 65% agreed to interviews, providing a sample of 224 (Fig. 1). The mean age was 27.6 years (SD: 5.5). About two thirds (65.6%) had some college education. Half (50%) were African American, 28% Hispanic, 20% White and 5% other. The high proportion of African Americans is in keeping with the racial profile of DMPA users nationally [7–10]. Both the interviewed sample and the main source population — WHP patients in Houston who received DMPA in the last quarter of 2012 — included about twice as many African Americans as WHP overall (personal communication, Burek S, Texas Health and Human Services Commission, August 1, 2014). Only 12 women in the final sample were from Midland.

Of 224 surveyed women, 129 (57.6%) continued the contraceptive injection at a Texas clinic between January 1, 2013 and April 30, 2013. Another 40 (17.9%) did not but answered “yes” to the question, “At that time, did you want another Depo shot?” Thus, 75.4% of women either wished to continue or did continue this method, similar to the baseline percentages. Forty-five women (20.1%) did not want another dose.

Eight women could not recall whether they received a dose in early 2013, and two received doses out of state in 2013. They were excluded from analyses related to clinic access but were included in assessment of current contraception if they lived in Texas at the time of the interview. Finally, 34 women said they were not enrolled in WHP when the next injection was due; 11 of these women obtained DMPA anyway, either under other insurance or by paying out of pocket.

Of the 148 interviewees who remained enrolled in WHP when the next injection was due and also sought another injection, 80% ($n=118$) obtained the dose, but only 56.8% ($n=84$) did so at no cost and on time. By comparison, in the corresponding months of 2012 in Houston, 92% of all injectable contraception patients obtained their doses at no cost and on time.

While WHP is intended to provide contraception without cost, 9.5% of interviewees with WHP (14 of 148) reported paying because they chose a nonparticipating provider ($n=6$); bought the medicine themselves at a pharmacy because it was unavailable at the health provider's office ($n=5$); or were charged an "injection fee" or "co-pay" ($n=3$). Among all women who successfully obtained a repeat dose, regardless of WHP enrollment status ($n=129$), more than 85% ($n=110$) reported no barriers. The most common barriers, when encountered, were difficulty making an appointment ($n=14$) and affording the injection ($n=11$). In addition, more than half of women ($n=71$) were required to have a physical exam first, 17.0% ($n=22$) needed more than one visit, and 11.0% ($n=14$) said the injection was out of stock at their initial visit.

Of the 148 women with WHP, 30 missed their next dose. They gave multiple reasons for doing so, most commonly: difficulty finding a provider ($n=27$), the cost of the injection ($n=21$) and trouble getting an appointment ($n=20$).

We also asked respondents whether they became pregnant in 2013. Of the 30 women above who missed their next dose because of barriers, 7 (23.3%) became pregnant in 2013. In contrast, among 129 respondents who successfully obtained a contraceptive dose, only 10 became pregnant (7.8%) ($p=.01$).

3.3. Comparison with NSFG interviewees

Table 1 shows the distribution of our study participants by the method of contraception they were currently using at the time of the interview, which took place 16 to 24 months after the index DMPA injection. For comparison, the table shows the method used at the time of the interview by low-income women in NSFG 2006–2010 who had reported using DMPA 18 months prior to the interview. The two distributions differed ($p<0.001$), and compared to this national sample of users of injectable contraception, our study participants were more likely to be using less-effective methods: condoms, withdrawal, natural family planning and spermicides.

4. Discussion

In this study, we have documented three aspects of women's experiences accessing contraception in the wake of Texas' exclusion of Planned Parenthood from WHP on January 1, 2013. First, only a minority of DMPA users enrolled in WHP who received a dose from Planned Parenthood in the quarter preceding the exclusion returned to Planned Parenthood for an injection after the exclusion. The proportion returning to Planned Parenthood varied between the two study sites and was much greater in Midland than Houston. This finding corresponds with the greater number of alternative providers in Houston, the fourth largest city in the US. Second, the interviews with women who did not return to Planned Parenthood illuminate the challenges in finding another WHP provider. Finally, at 18 or more months after the exclusion, the former Planned Parenthood clients we interviewed used an ineffective mix of contraceptive methods in comparison with a nationally representative cohort of DMPA users.

We conclude that whether a woman returns to Planned Parenthood after exclusion may depend on how many other providers are in her vicinity. Women who live in places where Planned Parenthood is the only provider, or where other providers are difficult to reach, return to Planned Parenthood even when they must pay for services they previously received at no cost. Women who do seek another provider after the exclusion may encounter significant barriers. Our respondents reported unnecessary physical exams, multiple visits and unauthorized copayments. How much of the long-term decline in the use of highly effective methods among this cohort of DMPA users is a direct consequence of these barriers, and how much may have resulted from counseling by less experienced providers is beyond the scope of this study.

This study has several limitations. The procedure we used to recruit and interview patients who failed to return to Planned Parenthood yielded a low participation rate. With only two phone calls, we were able to reach only about one fifth of the targeted patients in Houston, and with four calls we reached less than half in Midland. Due to these participation rates, findings may not be representative of the population of DMPA users impacted by the exclusion. However, we have no reason to think that the women we reached were more likely to report adverse experiences. Rather, we suspect our interviewees were advantaged because they had stable phone numbers.

Second, we focused only on users of injectable contraception, and our results cannot be extrapolated to users of other forms of contraception enrolled in WHP who previously obtained their method at Planned Parenthood. Nevertheless, DMPA was an important method of contraception among women enrolled in WHP and accounted for 39.2% of Texas' WHP contraception claims in 2013 [1].

Third, interviews took place more than a year after the policy change, so patients' recollections were less accurate — for example, 11% of interviewees (25 of 224) believed, contrary to Planned Parenthood records, that they received DMPA there at no cost after the ban. Finally, our comparator for WHP patients returning to the Midland clinic consisted of

non-WHP patients — that is, patients with private insurance, traditional Medicaid and no insurance.

Some breaks in continuity of care may be expected during any transition in a healthcare program, as seen with the Affordable Care Act and its Massachusetts precursor [11]. Our findings indicate that the exclusion of Planned Parenthood from the Texas WHP had both immediate and lasting impacts on users of injectable contraception. These results should be cautionary to states considering similar measures; they contradict the claim that Planned Parenthood could be removed from a statewide program with little or no consequence.

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References

1. Texas Health and Human Services Commission. Texas Women's Health Program: savings and performance reporting. 2015. [cited April 4, 2015; Available from: <http://www.hhsc.state.tx.us/reports/2015/tx-womens-health-program-rider-44-report.pdf>].
2. Texas Women's Health Program provider survey: patient capacity report. Austin, Texas: Texas Health and Human Services Commission; 2013. [cited April 4, 2015 ; Available from: <http://www.hhsc.state.tx.us/reports/2013/TWHP-capacity-survey-results.pdf>].
3. White K, Hopkins K, Aiken A, Stevenson A, Hubert C, Grossman D, et al. The impact of reproductive health legislation on family planning clinic services in Texas. *Am J Public Health*. 2015; 105:851–8. <http://dx.doi.org/10.2105/AJPH.2014.302515>. [PubMed: 25790404]
4. Wood S, Beeson T, Bruen B, Goldberg DG, Mead H, Shin P, et al. Scope of family planning services available in federally qualified health centers. *Contraception*. 2014; 89:85–90. <http://dx.doi.org/10.1016/j.contraception.2013.09.015>. [PubMed: 24176250]
5. Texas Health and Human Services Commission. Texas Women's Health Program enrollment statistics. 2015. [cited Nov. 29, 2015; Available from: <http://www.hhsc.state.tx.us/research/TWHPES/Womens-Health-Program-Caseload.xls>].
6. Centers for Disease Control and Prevention. National Survey of Family Growth 2006–2010. Female Respondent Data File. 2011
7. Taichman LS, Sohn W, Kolenic G, Sowers M. Depot medroxyprogesterone acetate use and periodontal health in 15- to 44-year-old U.S. females. *J Periodontol*. 2012; 83:1008–17. <http://dx.doi.org/10.1902/jop.2012.110534>. [PubMed: 22309173]
8. Dozier AM, Nelson A, Brownell EA, Howard CR, Lawrence RA. Patterns of postpartum depot medroxyprogesterone administration among low-income mothers. *J Womens Health (Larchmt)*. 2014; 23:224–30. <http://dx.doi.org/10.1089/jwh.2012.4016>. [PubMed: 24443831]
9. Dehlendorf C, Foster DG, de Bocanegra HT, Brindis C, Bradsberry M, Darney P. Race, ethnicity and differences in contraception among low-income women: methods received by Family PACT clients, California, 2001–2007. *Perspect Sex Reprod Health*. 2011; 43:181–7. [PubMed: 21884386]
10. Sangi-Haghpeykar H, Poindexter AN, Moseley DC, Bateman L, Reid ED. Characteristics of injectable contraceptive users in a low-income population in Texas. *Fam Plann Perspect*. 1995; 27:208. [PubMed: 9104608]
11. Fitzgerald T, Cohen L, Hyams T, Sullivan KM, Johnson PA. Women and health reform: How national health care can enhance coverage, affordability, and access for women (examples from

Massachusetts). *Womens Health Issues*. 2014; 24:e5–10. <http://dx.doi.org/10.1016/j.whi.2013.11.006>. [PubMed: 24439947]

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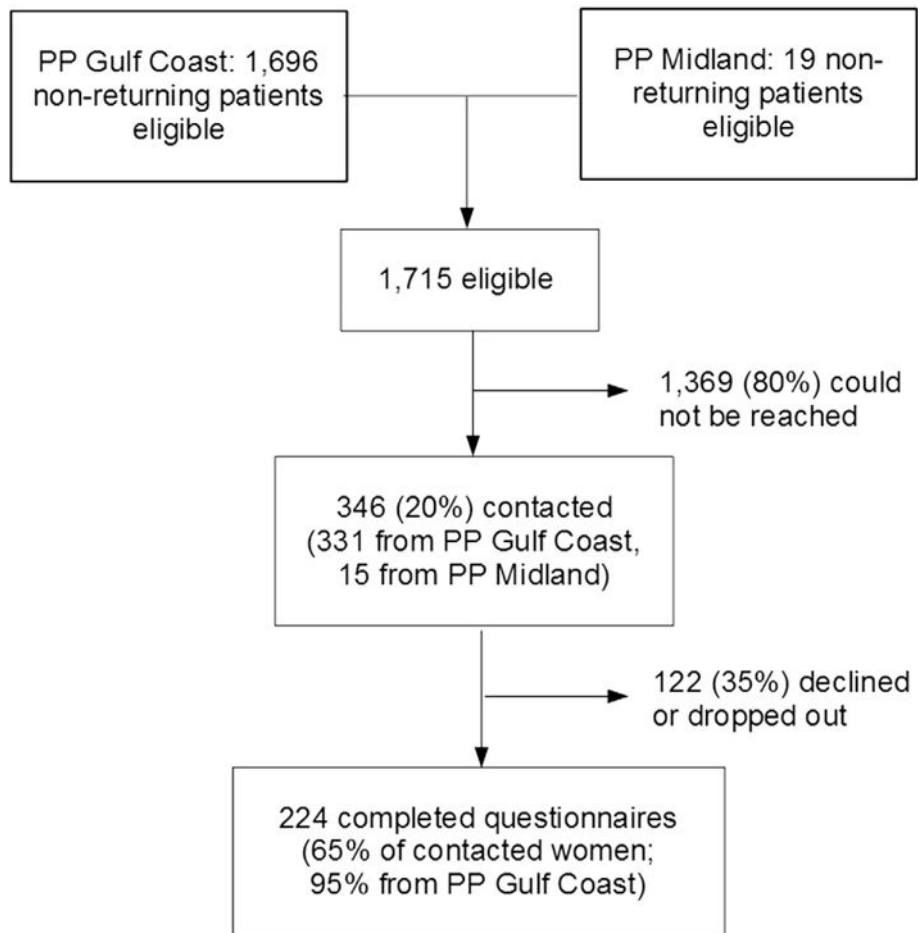


Fig. 1. Flow of eligible interview participants. Women were eligible if they received a DMPA dose between Oct. 1, 2012 and Dec. 31, 2012; did not return by April 30, 2013; and spoke English or Spanish.

Table 1

Current contraception among study interviewees 16 months–24 months after DMPA dose, compared to participants in the NSFG 18 months after dose

	Study interviewees (n=216) ^a %	NSFG interviewees (n=177) ^b %
Depo medroxyprogesterone	32.9	51.0
Long-acting and permanent methods (implant, intrauterine device, sterilization)	10.2	16.6
Other hormonals	9.7	3.6
Less-effective methods (condoms, withdrawal, natural family planning, spermicide)	35.2	10.1
Pregnant/Postpartum	3.2	7.5
No method	8.8	11.2

^aExcludes five women who had moved out of state by 2014 and three with incomplete responses.

^bExcludes women above 185% of Federal Poverty Level and those not sexually active in the last 3 months, seeking pregnancy or infertile; weighted data.

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