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Family Planning Service Provision in Rural Areas: A Survey in Washington State

By Sharon A. Dobie, Lorna Gober and Roger A. Rosenblatt

Context: Women in rural areas are highly dependent on public clinics for family planning services, yet little information has been collected on rural family planning providers, especially on their funding and operation.

Methods: All 31 family planning clinic sites in rural Washington State were surveyed about their sponsorship, staffing, service provision and population coverage.

Results: Clinic sites were located in 25 of the 53 discrete rural health service areas of Washington State. While the three wealthiest areas had clinics, eight of the poorest areas had no clinics. Eight clinics were Planned Parenthood affiliates, eight were private freestanding clinics and 15 were local health department sites. Clinic sites were small (with the equivalent of 2.4 full-time staff members, on average) and offered a mean of 18 of 43 potential reproductive and women's health care services; general primary care services were rarely provided. Only one clinic offered abortions.

Conclusion: Family planning clinics in rural Washington State offer an important but limited number of services. Many rural areas have no local family planning clinic. Given these clinics' reliance on federal and state funding, decreased public support might seriously impair family planning provision in rural areas. =paragraph

For the 24% of U.S. residents who live in rural areas,¹ where access to health care is often limited by provider shortages, by the absence of local services, by lack of transportation and by economic factors, family planning clinics may be critically important in the delivery of reproductive health care to women. Publicly subsidized family planning clinics play an important role in meeting the reproductive health needs of U.S. women: One-third of all women seeking contraceptive services receive care in a family planning clinic, as do nearly two-thirds of low-income and teenage women.²

Little is known about specific patterns of family planning clinic use by rural women.³ Even if rural women have a pattern of contraceptive need similar to that of their urban counterparts, actual use in rural areas may be affected by limited availability:

Although 77% of U.S. counties are classified as nonmetropolitan, only half of the nation's 7,122 family planning clinics are in these areas. This uneven pattern of distribution is further compounded by the fact that smaller, poorer rural counties are less likely than larger, wealthier rural counties to have local family planning clinics.⁴

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Abortion is also less available in rural areas than in urban settings. Approximately two-thirds of abortion services in the United States are provided in specialized, freestanding abortion clinics, which are located mostly in urban areas. As a result, 27% of nonhospital abortion patients travel more than 50 miles for services.⁵ In addition to the centralization of services, the overall number of abortion providers has been decreasing, and the loss has been proportionally greater in rural areas. By 1992, 94% of nonmetropolitan counties nationwide had no known provider of pregnancy termination.⁶

Nationally, the reduction in the number of providers of reproductive health care places the most vulnerable women—including those who are minorities, are young, have low income or live in rural areas—at increased risk for unwanted pregnancy, morbidity from later abortions and obstetric complications.⁷ Little is known, however, about the specific impact that service reductions have had on rural women.

To broaden understanding of family planning clinic services offered in rural areas, we examined reproductive health services available through these clinics in rural Washington State.

BACKGROUND

Washington State covers 66,511 square miles and has a population of 5,429,900. The rural land area accounts for 71% of the state and is home to 20% of the population. In 1992, only about 20% of the 28 rural counties had an abortion provider, compared with approximately 82% of the 11 metropolitan counties.⁸ This represents a decrease since 1987 for rural areas of the state. Similarly, a decrease has also occurred in neighboring Idaho, where fewer than 4% of rural physicians perform abortions.⁹

Between 1980 and 1990, the local availability of obstetric care also decreased in rural areas of Washington, resulting in poorer outcomes for women and their infants.¹⁰ Compared with urban residents, women who reside in rural Washington are 20% more likely to begin prenatal care late or to receive no such care.¹¹

In our study, we explored the range of services provided by three types of family planning clinic sites available in rural Washington State: Planned Parenthood clinics, private freestanding clinics and local health department clinics. We focused on differences between the three clinic types in staffing, funding, patient volume, range of services and service area.

By mapping the service areas for these clinics, we delineated those areas of the state that had locally available publicly funded family planning services. In addition, where abortions were not available in the community, we sought to determine how far women were traveling to receive that service. In order to predict the future availability of abortion services in these areas, we also inquired whether mifepristone (medical abortion) would be prescribed by practitioners in the clinics if it were approved for use.

METHODS

We surveyed every family planning clinic (defined as facilities whose primary focus was family planning services) in rural Washington State. We did not survey the 19 migrant and community health center sites in rural Washington or individual providers

and hospitals in these areas. While they also provide family planning services, their focus is primary care and not strictly family planning.

The Washington State Department of Health and the Department of Social and Health Services, which distribute family planning funds provided under Title X and Title XIX, identified 56 family planning clinic sites throughout the state. We defined a clinic as rural if its zip code was in any of the 53 rural health service areas (defined as the medical service catchment area served by a rural hospital).¹² Of the 56 identified facilities (Planned Parenthood, private freestanding and local health department), 31 met our definition of rural.

In June 1995, we mailed a survey, along with a self-addressed, stamped envelope and a cover letter, to the directors of these 31 clinic sites; 14 surveys were returned initially. The remaining 17 respondents were contacted by telephone in July 1995. Five completed the survey over the phone, and the remaining 12 returned the completed survey by mail. The final response rate was 100%.

The survey asked for a description of each clinic's staff by profession and by full-time equivalents (a measure of staffing hours in which one full-time equivalent is equal to one person working full-time). The exact number of hours for "full-time" was not specified, however. Respondents were also asked about funding sources. In addition, we requested that respondents check off from a list of 43 services the reproductive health services provided at their clinic, services they had discontinued, services they would like to add, barriers to adding services and the clinic's reasons for not performing abortion. Finally, we asked respondents for the distance patients in their communities traveled to obtain abortions and whether their clinic would prescribe mifepristone if it were approved for use.

A coding form and instructions were written, and the data were coded, entered and cleaned in accordance with these instructions. Data analysis was performed using SPSS software. We ran frequencies and cross-tabulations of the data. We did not use inferential tests, since all clinics were surveyed. However, we did perform chi-square tests in our comparisons between the clinic types.

We used 1995 data from the Washington State Health Personnel Resource Plan to make comparisons between the rural health service areas that had family planning services and those that did not. These data provide information about the demographic characteristics of each area.

In addition, we analyzed the state's standardized score of socioeconomic status for each area in this data set. The state's score was constructed from the percentage of persons over 65, the percentage of residents whose incomes were less than 200% of the poverty level and the percentage of women receiving inadequate prenatal care. The state then ranked the areas, with a higher standardized score indicating an area with lower socioeconomic status. For all of the health service areas in Washington State, scores ranged from 69 to 133.¹²

RESULTS

Affiliation, Staffing and Productivity

Eight of the clinics were Planned Parenthood sites, eight were private freestanding

clinics and 15 were local health department clinic sites. Most providers were nurse practitioners, physician assistants or registered nurses. While each site was under the supervision of a physician medical director, there were virtually no physicians providing clinical services at these sites (Table 1). Local health department clinic sites had the largest staffs, with 3.5 mean full-time equivalents, compared with private freestanding clinic sites (1.8 mean full-time equivalents) and Planned Parenthood clinic sites (1.2 mean full-time equivalents).

Table 1. Mean staffing in full-time equivalents at rural family planning clinics, by staff position, according to type of clinic, Washington State, June 1995 (N=31)

Position	Clinic type		
	Planned Parenthood	Private free standing	Local health dept.
Total staff	1.2	1.8	3.5
Physician	0.0*	0.0*	0.0*
Nurse practitioner and physician assistant	0.8	0.9	0.6
Registered nurse	0.0	0.4	1.2
Health educator	0.1	0.3	0.1
Counselor	0.1	0.1	0.7
Other	0.3	0.1	0.9

*Greater than zero, but rounds to zero.

In 1994, 25 of the clinics reported productivity information to the State of Washington Department of Health. They served a mean of 809 clients, with a range of 69 to 2,086. This corresponds to a mean service rate of 131 clients per 1,000 women aged 15-44.¹³

AVAILABILITY OF SERVICES

Nine of the 43 potential reproductive services were not provided by any clinic site. Therefore, when comparing the clinics, we considered the maximum number of services to be 34. The number of services provided by clinics ranged from nine to 28, with a mean of 18.

We divided the services offered by rural family planning sites into three groups:

- *Core services*, defined as those provided by 90% or more of the sites;
- *Discretionary services*, defined as those provided by 11-89% of the sites; and
- *Rare services*, defined as those provided by fewer than 10% of the clinics.

Table 2 shows that core services at rural family planning clinics included nonprescription contraceptives (offered by 97% of the clinics), oral contraceptives and injectables (offered by 94%), sexually transmitted disease (STD) screening and treatment (94-100%, depending on type) and colposcopy (90%). Discretionary services included emergency contraception (77%), the cervical cap (65%) and specialized contraceptive services, such as the implant (65%) and the IUD (55%). In comparison, U.S. data indicate that only 21% of family planning agencies nationwide offered emergency contraception, 20% the cervical cap and 41% the IUD.¹⁴ In 1991, approximately 40% of family planning agencies nationwide offered the implant.¹⁵

Table 2. Number and percentage of family planning clinics in rural Washington State that provide selected reproductive health services

Service	N	%
Core		
Chlamydia screening and treatment	31	100.0
Gonorrhea screening and treatment	31	100.0
STD counseling	31	100.0
Foams, jellies, condoms	30	96.8
Minor sexually transmitted infection evaluation	30	96.8
Pap smear	30	96.8
Breast exam	29	93.5
Contraceptive counseling	29	93.5
HIV test	29	93.5
Injectable	29	93.5
Oral contraceptives	29	93.5
Colposcopy	28	90.3
Discretionary		
Cryocautery	27	87.1
Diaphragm	27	87.1
Endometrial biopsy	27	87.1
Herpes simplex virus test	27	87.1
Emergency contraception	24	77.4
Human papillomavirus test	23	74.2
Hepatitis B test/vaccination	21	67.7
Cervical cap	20	64.5
Implant	20	64.5
IUD	17	54.8
Peri/postmenopausal services	14	45.2
Hormone replacement therapy	13	41.9
Infertility services	6	19.4
Routine prenatal care	4	12.9
Rare		
Genetic counseling	3	9.7
High-risk delivery	2	6.5
Low-risk delivery	2	6.5
Maternal alpha-fetoprotein test	2	6.5
Triple screen*	2	6.5
First-trimester abortion	1	3.2
Second-trimester abortion	1	3.2
Vasectomy	1	3.2

*Consists of maternal alpha-fetoprotein, estradiol and human chorionic gonadotropin tests. Note: Amniocentesis, breast biopsies, cesarean section, chorionic villus sampling, dilation and curettage, loop electrosurgical excision procedure, tubal ligation and ultrasound (either level I or level II) were not offered by any clinics.

Rare services included pregnancy terminations. Only one clinic in the population provided this service.

The scope of services provided by the three clinic types was very similar. At half of the clinic sites, fewer than 56% of the potential services were available. All three clinic types reported that they had never provided approximately 40% of services surveyed. There were no significant differences between the services currently provided among the three types of clinic. On average, fewer than 2% of the surveyed services had been discontinued by any of the clinic sites. The highest mean number of discontinued services (1.3) was reported by the local health department clinics.

Only 10 clinic sites indicated that they were providing primary care services other than those mentioned in the survey. These clinics listed additional services such as "general primary care," "maternity support" and "immunizations." Five clinic sites indicated that they did not provide any other primary care services, while the remaining 16 left this item blank.

When asked what currently unavailable services they would like to provide, eight respondents stated that they would not like to add any services, and eight left the item blank. The remaining 15 respondents gave a wide variety of answers. The most commonly mentioned services were hormone replacement therapy, colposcopy, and perimenopausal and postmenopausal care. No respondents indicated a desire to provide abortion services at the clinic site.

BARRIERS TO SERVICE PROVISION

Respondents were asked to list the barriers to adding desired services. The most common answers were cost (10 respondents) and lack of trained providers (nine respondents). Other barriers listed were facility size, the clinic's focus on pregnancy prevention, increased liability, lack of equipment and lack of time to provide the named service. Some respondents affiliated with local health department clinics wrote that a particular service fell outside the scope of services defined by the funding agency.

The survey also included a list of potential reasons why clinics did not provide abortions on site. Respondents were asked to rate each reason as either "very important," "somewhat important" or "not important." As Table 3 shows, the two reasons most commonly rated as very or somewhat important were local community opposition (71%) and lack of a trained provider (55%). The two most common reasons rated as unimportant were the moral or religious concerns of staff and the availability of the service at another local facility (45% for each).

Table 3. Percentage distribution of clinics, by importance of selected reasons for not providing abortion services, according to reason (N=30)

Reason	Important	Not important	No answer	Total
Local community opposition	71	16	13	100
Lack of trained provider	55	32	13	100
Service available within a reasonable distance	52	29	19	100
Not part of mission statement	52	39	9	100
Increased malpractice insurance costs	42	32	26	100
Not allowed by funding sources	35	35	30	100

Service already available locally	32	45	23	100
Staff moral/religious concerns	23	45	32	100

Only one clinic provided abortions on-site; the rest referred their clients elsewhere. Respondents for these clinics estimated that women seeking an abortion traveled from 20 to 200 miles each way to obtain an abortion, with an average one-way driving distance of 68 miles. Approximately 36% of clinic supervisors indicated that their clinicians would prescribe mifepristone if it were available, while 48% were uncertain.

FUNDING SOURCES

The major funding source for the rural clinics varied according to clinic type (Table 4). Planned Parenthood sites reported patient payments to be their major source (34%), while federal funding was reported as the major source for private freestanding clinics (27%). Local health department sites reported that the single largest share of their budget came from state funds (36%). The smallest category of funding reported by the three groups was private donations (3% overall, ranging from 7% at Planned Parenthood clinics to 1% among local health department facilities).

Funding source	Planned Parenthood	Private free standing	Local health dept.
Federal	18	27	13
State	29	21	36
Third-party/managed care	0	10	4
Medicaid	12	21	15
Patient payments	34	16	15
Private donations	7	2	1
Other	0	3	16
Total	100	100	100

Overall, federal funds represented an average of 27% of private freestanding clinic site budgets, 18% of Planned Parenthood clinic budgets and 13% of local health department clinics' budgets. All three types of clinic received significant portions of their budgets from state funds: approximately 21% for private freestanding clinics, 29% for Planned Parenthood clinics and 36% for local health department clinics.

SERVICE AREAS

Respondents were asked to list the towns where most of their patients resided. The information was mapped, and estimated service areas for these clinic sites were drawn. Clinics were located in 25 of the 53 rural health service areas in Washington State (Figure 1, not available on web site.). Most clinics served clients from more than one area, raising the number of rural areas served to 39.

Of the 30 poorest health service areas in the state, 25 were rural. Of the 53 rural health service areas, 25 reported primary care provider shortages, and 16 reported that more than 20% of their pregnant women residents receive inadequate prenatal care.¹⁶ Of the 25 areas with primary care provider shortages, 11 had family planning clinics.

Though the difference was not statistically significant, the areas with the highest standardized scores for socioeconomic status (and therefore the lowest socioeconomic status) were less likely to have family planning clinics: Of the 14 areas with scores greater than 116, 12 were rural, and only four had clinic sites; of the 19 areas with scores lower than 85, only two were rural, and both had clinics. Furthermore, among the 39 rural areas with scores between 86 and 115, only 18 had clinics.¹⁷

DISCUSSION

Family planning clinics are a crucial source of contraceptive services for women, especially those who are young, are minorities or have a low income.¹⁸ The availability of these services is associated with fewer unplanned pregnancies, abortions, low-birth-weight babies, births with late or no prenatal care, infant deaths and neonatal deaths.¹⁹

While each of the 31 rural family planning clinics in Washington State serves clients from more than one area, there are rural areas in the state that have no local clinic access. Furthermore, clinics are absent from both poorer areas and areas with shortages of primary care providers.

We found no significant differences by type of administrative agency in the scope of services offered. Most of the clinics provided contraceptives that are relatively easy to offer, such as the pill, as well as basic STD services and colposcopy. Compared with family planning clinics in nonmetropolitan counties nationally, rural Washington State clinics saw more clients (809 on average, compared with 505 nationally).²⁰ They were also more likely to provide a broad range of contraceptive methods, including IUDs, postcoital contraception and the cervical cap. Very few of the clinics had discontinued a service.

Of the clinics surveyed, only one provided abortions on-site. Federal funding of most of these sites prohibits on-site pregnancy terminations. The other 30 clinic sites referred their patients elsewhere. In 1995, only 8% of rural Washington women who terminated a pregnancy obtained the abortion in rural or small urban Washington counties.²¹ Although none of the respondents in our study listed abortion as one of the services they would like to add, this does not appear to stem from moral or religious concerns of the staff: These were rated as among the least important reasons for not providing abortions.

This result was quite different from that of a study of rural physicians in Idaho. Of physicians in that study, the most important reason given for not providing abortions was moral or religious concern.²² In our study, on the other hand, the two most important reasons for not providing on-site abortions were local community opposition and lack of a trained provider.

The most commonly mentioned barrier to providing additional services was cost. The limited scope of services available in rural family planning clinics is partially explained by restrictions posed by funding and staffing. Title X family planning funding, for example, pays primarily for a prescribed core set of required services. The range of clinic activities was also limited by the clinics' small staffs: Planned Parenthood clinics had a mean of 1.2 full-time staff members, private freestanding clinics averaged only about two and local health department clinics between three and four full-time staff

members.

Federal grants are an important source of funding both for clinics in rural Washington State (where 62% of all federally funded health care sites were family planning sites) and for those in the country at large. In 1994, the federal government provided \$193 million to clinics around the country. However, in August 1995, the U.S. House of Representatives voted only narrowly (221-207) to continue federal funding to family planning clinics,²³ raising real questions about the prospect for future federal funding of family planning services.

There are also indications that financial pressures on family planning clinics are increasing. In a nationwide study of family planning clinics, public funding in real dollars was shown to have decreased, while costs for laboratory services and contraceptive supplies had increased.²⁴

Our study has several limitations. It was restricted to a description of family planning clinics, and therefore excluded other sites that may provide family planning services with or without federal funding. Similarly, characterizing the locations of the clinics only partially explores the complex question of accessibility. We also did not study the clinics' educational and outreach services; including them would have expanded the range of services provided.

Previous research, however, has not characterized the role of family planning clinics in rural areas. Our study has demonstrated that family planning clinics in rural Washington State provide an important but limited scope of services to women who live in these areas. These clinics' ability to provide services is limited by funding, clinic size, legal issues and provider availability. Yet for women in rural Washington State, these very small clinics continue to make a major contribution to health care delivery.

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Sharon A. Dobie is assistant professor with the Department of Family Medicine, University of Washington School of Medicine, Seattle, WA; Lorna Gober is resident with the Tacoma Family Practice Program, Tacoma, WA; and Roger A. Rosenblatt is professor and vice chair with the Department of Family Medicine, University of Washington School of Medicine, Seattle, WA. Funding for the project on which this article is based was provided as a Medical Student Research Training Project grant by the Department of Family Medicine, University of Washington. Additional funding was provided by the Washington, Wyoming, Alaska, Montana and Idaho Rural Health Research Center and by the Robert Wood Johnson Generalist Physician Faculty Scholars Program. The authors thank Mary-Katherine Goodwin for assistance with cartography.

*Rural hospitals are defined as nonfederal, short-stay, acute-care inpatient facilities of fewer than 50 beds, located more than 15 miles from a city of 30,000 or greater population. Fifty-three of Washington's 114 hospitals met these criteria. The catchment area for each rural hospital is the aggregate of all zip code areas whose center is closer by public road to a specific rural hospital than to any other hospital. (Source: reference 1.)