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Obstacles Women Face to Receive Reproductive Health Services: A Secret Shopper Method in Mississippi

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Abstract

Background: Cost, access to trained providers, and distance to a reproductive health care facility are examples of the barriers women can face when trying to access reproductive health care. Programs and policies are in place to reduce known obstacles, but there is currently little to no research on additional barriers women face when attempting to access various reproductive services in areas where conservative political and religious views are strong (i.e., the Deep South). The goal of this project is to clarify the existing delivery systems for reproductive health and family planning services in Mississippi.

Methods: A secret shopper methodology was used to assess obstacles women face when seeking reproductive health services. An aggregated list of 332 phone numbers associated with facilities in Mississippi were randomly called by three female researchers. A total of 345 scripted telephone calls were made in which the caller's name, type of insurance, and type of service requested was randomized.

Results: One out of four calls was not answered when trying to book an appointment. Hospitals were significantly less likely to be able to book an appointment when compared to community health centers and clinics. The average wait for an appointment ranged from an average of 4 days for community clinics to almost a month with health departments. Finally, only 28% of the 32 requests for an abortion received further information about the remaining abortion clinic in Mississippi; only one individual on the phone provided alternative information to the caller about other reproductive health care options.

Conclusions: Overall, the results of this study reveal additional obstacles and barriers for women to fulfill their reproductive health needs in a timely manner. Despite recent policy changes, barriers continue to hinder legal reforms to provide full access to reproductive health care and to make services accessible where states have variable laws. Ensuring that the health systems in the most rural states are robust and capable of delivering key maternal health interventions through technically competent and respectful services needs to be a priority.

Keywords: Women; Reproductive health services; Mississippi

Introduction

Restricted access to family planning resources, including contraception and the option to terminate unwanted pregnancies, influence a majority of women and their families. In reaction to this challenge, the World Health Organization [1] published a call to action for research related to improving women's access to reproductive health services. This report emphasized the global significance of research on women's health and the importance of identifying and minimizing barriers to appropriate healthcare. However, further research is needed to fully understand what specific barriers are present to restrict full access to reproductive health services.

This study begins addressing this need by conducting a mystery shopper procedure across the state of Mississippi. Specifically, 345 calls were made to health clinics requesting reproductive health services (e.g., family planning, STI prevention/services). The types of insurance and requests made were randomized to also investigate the potential impact of these two variables on whether an appointment could be made. The resulting information can help policymakers and advocates identify where their attention, resources, and efforts should be placed to increase access to reproductive healthcare services.

Background

Title X is a federal program that was enacted in the 1970s to assist in meeting reproductive health needs by providing family planning services to low-income patients or those without insurance. While there is many centers today that still benefit from the funding from Title X, the services provided are not consistent across the country. A study by Wood et al. [2] found that, even though many federally qualified health centers receive funding to provide reproductive health services, many clinics do not provide a full-spectrum of allowable services to their patients. In addition, funding for Title X programs has increased minimally over the past decades-only enough to match inflation-and many programs barely have the funding they need to

provide requested services [3]. Women who also rely on Medicaid face difficulties in accessing appropriate information about options to meet their reproductive health needs. Dennis, Blanchard, and Cordova [4] found that information given by Medicaid offices regarding payment for alternative reproductive health services is often incorrect or inconsistent with the law, which can discourage women seeking such services.

A more recent policy has been formed to increase access to reproductive health services. The Affordable Care Act (ACA) was passed with the intention to improve healthcare coverage for all Americans by reducing barriers to accessing and promoting preventative care [5]. Access to health screening-including testing services for STIs and availability of contraception-are a part of the ACA. Plans that are included in the Health Insurance Marketplace (a component of ACA) specifically cover birth control pills, IUDs, and emergency contraception without charge to the patient.

However, there are additional obstacles that have formed since the passing of ACA to restrict access to reproductive services. Specifically, many states have begun passing increasingly restrictive policies regarding options to terminate a pregnancy. According to the Guttmacher Institute [6], 338 new abortion restrictions were enacted between 2010 and 2016 in the United States. Relevant to this study, the state of Mississippi has one abortion-providing clinic resulting in ninety-nine percent of counties in Mississippi not having a facility that provides abortion and ninety-one percent of women in Mississippi not living in a county with an abortion facility [7]. There is also a law requiring a minimum of two visits to the abortion clinic which is particularly challenging for women with restricted access to reliable transportation and limited time to travel, with a majority of women needing to travel more than 25 miles one way to access an abortion facility in Mississippi [7,8]. Additionally, federal funding is not to be used to provide abortion services to patients. Therefore, those who rely on institutions funded by Title X may not have access to safe and appropriate abortion services [2].

Another example is gaining access to emergency contraception (EC). As of 2013, Plan B One-Step-a form of EC-should be available in all fifty states to women over the age of 18 without a prescription [9]. According to the Guttmacher Institute, [6] there are nine states that have restricted access to emergency contraception. One state excludes EC from state funded family planning services, two states exclude EC from their contraception services, and six states-including Mississippi-allow pharmacists to refuse to dispense contraception and emergency contraception. Thus, even though options to terminate pregnancies are currently legal, the services available at clinics are highly variable due to local restrictions [2].

For those seeking services to prevent pregnancies there are additional challenges to accessing appropriate contraception regardless of type of insurance or contraception requested. Specifically, women that are categorized as having little education, young (i.e., between the ages of 18-25), and in a low socioeconomic status are more likely to reference cost as a barrier to accessing effective contraception; these women are also the most likely to have unintended pregnancies [10]. Women with systemic obstacles face the struggle of prioritizing their health and receiving appropriate reproductive health care when compared to their other needs. For example, in a study by Kennedy et al. [11] many women identified receiving appropriate care as a low priority when compared to other stressors in their lives such as providing healthy food for their family. These challenges are only escalated when women do not have access to quick-start methods of birth control or have reliable transportation [11].

Another challenge to accessing contraception is with the information/training given to health care providers serving women that face these additional obstacles. For example, women in sparsely populated areas of the country are significantly less aware of alternative options to pregnancy (e.g., emergency contraception) and are not receiving this information from their health care providers [12]. Even if a woman was to have reliable transportation and knowledge of the services she needs, there is limited information on how to find providers in rural areas where poverty is found to be higher [13]. Even though reproductive health care facilities receive federal funding to provide information about preventative services such as birth control pills and IUDs, a provider with adequate knowledge of best practices to provide these services to patients that are facing systemic challenges such as poverty may not be available [2]. There are programs, such as the Long Acting Reversible Contraception training, designed to provide hands on education at no charge for providers that typically serve women in high poverty areas [14]. However, these providers must first meet professional requirements prior to participating in such training and often have to pay to travel for an on-site training course. For small town providers-that are typically located in rural areas with women struggling with their finances-the relative few resources and costs to support such training while maintaining a small practice could be particularly challenging.

Overall, the literature identifies many barriers that women may face when trying to access reproductive health care. Cost is a barrier in accessing many different forms of healthcare for individuals who rely on publicly funded insurance such as Medicaid; access to trained providers is often limited by funding restrictions; and geographical limitations make travelling an additional burden for those who can afford to take off work and/or have personal transportation options. Even with programs like the Affordable Care Act and Title X-which aim to provide healthcare coverage to all citizens-women still face many barriers to accessing these services.

There is currently little to no research on additional barriers women face when attempting to access various reproductive services in areas where conservative political and religious views are strong (i.e., the Deep South). There is also limited information on how booking an appointment could vary by type of clinic, service being requested, and insurance. The goal of this project is to clarify the existing delivery systems for reproductive health and family planning services in Mississippi by understanding the variations in obstacles that might present themselves when including the aforementioned variables. Overall, the results of this study will increase the knowledge and understanding of our advocates and policymakers about the availability, accessibility, barriers, and utilization of these services in their relevant communities.

Methods

The project used a secret shopper methodology, which has been successfully used in other studies evaluating access to health care [15-17]. An aggregated list of numbers associated with reproductive health care clinics was achieved in three phases. First, phone numbers for each health department were collected by searching online for a facility in each county of Mississippi. Secondly, a list of hospitals was gathered from the Mississippi Hospital Center's website (ms.hospitalscenter.com). A researcher would then go to the hospital's

main website and search for "reproductive health" and/or "women health." If an option was provided for a physician, this information was included in the call list. Finally, a list of practicing obstetricians and gynecologists were found by visiting the American College of Obstetricians and Gynecologists' website (www.acog.org). Any Mississippi facility that the physician worked for that was not included in the list of contact information was added. The phone numbers used were the ones found on each individual facilities' website and were categorized as a hospital (n=139), health department (n=108), community health center (n=39), or clinic (n=46); this aggregated to 332 facilities.

Three female researchers made scripted telephone calls to the reproductive health providers over a six month period. Prior to making the calls, each caller read about neuro linguistic programming to better understand their communication practices and to interpret feedback received [18]. The researchers then posed as potential patients and inquired about the next available appointment date. Each time the researcher called, the survey would randomly present the researcher's name, type of insurance, type of service requested, and the number called. This was accomplished by utilizing the software Qualtrics to guide the presentation and to provide the caller with follow up questions. Data were collected and organized as summarized in Figure 1. A total of 345 calls were done between 8:00-5:00 CST, Monday through Friday. The research was approved by the University of Southern Mississippi's Institutional Review Board and received funding from Packard Foundation via the non-profit agency, *Faith in Women*.

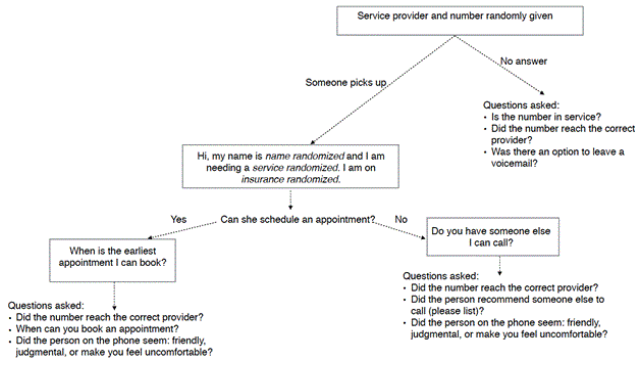

Figure 1: Model for progression of phone call.

Results

A total of 89 (26.1%) calls were not answered or not correct. Specifically, 9 (2.6%) calls were no longer in service, 20 (5.9%) did not reach the correct provider, and 62 (18.2%) were never answered. Of the 62 calls that were not answered, 12 (19.4%) provided an opportunity for the caller to leave a voicemail. Table 1 shows the number of times type of insurance and service requested were presented in the remaining 256 calls while Table 2 shows it by type of clinic.

	Family Planning Medicaid	CHIP	Tricare	No insurance	Medicaid
Birth control pills	7	10	9	11	10
Birth control injection	8	12	10	13	12
Abortion	5	5	8	9	5
IUD	9	7	8	5	11
Emergency contraception	6	10	7	8	10
STD testing	5	8	7	7	12

Table 1: Number of times the type of insurance and service requested was presented during randomized calls.

	Hospital	Health Department	Community Health Center	Clinic
Birth control pills	18	15	9	5
Birth control injection	20	14	10	11
Abortion	12	8	6	6
IUD	10	8	5	7
Emergency contraception	14	9	10	8
STD testing	16	9	8	6

Table 2: Number of times the type of clinic and service requested was presented during randomized calls.

The callers were also asked to reflect on their experience by stating whether or not the person on the phone seemed friendly, judgmental, or made them feel uncomfortable. Potential responses ranged from strongly agree to strongly disagree on a 5-point Likert scale. Average responses separated by clinic, type of insurance, and service requested are presented in Table 3.

	Friendly	Judgmental	Uncomfortable
Type of service			
Birth control pills	3.91	2.39	2.43
Birth control injection	3.70	2.56	2.48
Abortion	3.48	3.23	2.94
IUD	3.76	2.60	2.60
Emergency contraception	3.79	2.45	2.55
STD testing	4.29	1.88	1.88
Type of clinic			
Hospital	3.64	2.63	2.54
Health department	3.87	2.49	2.48
Community health center	3.76	2.24	2.28
Clinic	3.94	2.44	2.38
Type of insurance			
Medicaid	3.75	2.47	2.33
CHIP	3.77	2.48	2.55
Tricare	3.88	2.55	2.51
No insurance	3.80	2.63	2.53
Medicaid waiver	3.79	2.48	2.41

Table 3: Average caller's feelings of friendliness, judgment, and feeling uncomfortable by type of service requested, clinic, and insurance type.

The callers were never able to book an appointment for an abortion. Of the 32 calls made to request an abortion, nine individuals provided the caller with further information about the remaining abortion clinic in the state; one person provided the caller information about other reproductive health options (e.g., Plan B). Since no one was able to book an appointment for this service, the 32 calls were eliminated from the remaining analysis.

Average wait times for appointments were also collected. Table 4 provides the central tendencies of the wait times by service requested and clinic/insurance type. Without accounting for the other variables, the longest wait for type of service requested was 82 days for a birth control injection. The average wait time, though, was highest for an IUD with a 29 day wait. Health departments took the longest to provide an appointment with 82 days being the maximum wait time and 30 days being the average wait time. Finally, Tricare insurance was the longest wait time with 82 days maximum and 32 days on average.

	Minimum	Maximum	Mean	
			Statistic	Std. Error
Type of service				
Birth control pills	3	81	23.63	5.93
Birth control injection	1	82	23.57	4.99
IUD	16	48	29.00	7.06
Emergency contraception	1	14	6.00	2.43
STD testing	1	19	6.09	1.64
Type of clinic				
Hospital	1	15	7.00	1.33
Health department	1	82	30.45	4.13
Community health center	1	34	8.44	3.53
Clinic	1	11	5.00	1.70
Type of insurance				
Medicaid	3	53	25.67	6.83
CHIP	1	81	18.58	4.86
Tricare	1	82	32.40	8.39
No insurance	1	36	11.60	4.07
Medicaid waiver	1	36	10.20	4.01

Table 4: Central tendencies of appointment wait times (in days).

Two direct logistic regressions were performed to assess the impact of (1) type of clinic and type of service and (2) type of insurance and type of service on the likelihood of being able to book an appointment. As shown in Table 5, the model that included the type of clinic revealed five of the independent variables made a notable contribution to whether or not an appointment could be booked. The strongest predictor of booking an appointment was if the participant called a health department, clinic, or community health center (i.e., not a hospital) when controlling for type of service requested. In addition to requesting an abortion (as noted above), the strongest predictor for not being able to book an appointment was if the request was for an IUD or emergency contraception.

	B	S.E.	Wald	p	Odds Ratio	95% CI for Odds Ratio	
						Lower	Upper
Type of clinic							
Health department	-2.12	0.40	28.55	<0.001	0.12	0.06	0.26
Community health center	-2.02	0.57	12.68	<0.001	0.13	0.04	0.40

Clinic	-1.38	0.53	6.84	0.01	0.25	0.09	0.71
Type of service							
Birth control injection	0.07	0.44	0.02	0.88	1.07	0.45	2.54
IUD	1.84	0.69	7.04	0.01	6.31	1.62	24.57
Emergency contraception	1.20	0.58	4.25	0.04	3.32	1.06	10.42
STD testing	-0.54	0.55	0.98	0.32	0.58	0.20	1.70

Table 5: Logistic regression predicting likelihood of booking an appointment with type of clinic and service requested.

The second logistic regression assessed the impact of the type of insurance and type of service on the likelihood of being able to book an appointment. As shown in Table 6, the model that included the type of clinic revealed two of the independent variables made a notable contribution to whether or not an appointment could be booked. Similar to the first analysis, the strongest predictor for not being able to book an appointment was if the request was for an IUD or emergency contraception, though it was not as powerful of a predictor when compared to the previous analysis. When controlling for type of service requested, the type of insurance did not impact whether or not an appointment could be booked.

	B	S.E.	Wald	p	Odds Ratio	95% CI for Odds Ratio	
						Lower	Upper
Type of insurance							
CHIP	0.33	0.47	0.49	0.48	1.39	0.55	3.48
Tricare	0.12	0.49	0.06	0.81	1.13	0.43	3.00
No insurance	0.49	0.50	0.97	0.33	1.63	0.61	4.33
Medicaid waiver	0.35	0.46	0.58	0.45	1.42	0.57	3.53
Type of service							
Birth control injection	0.19	0.38	0.24	0.63	1.20	0.57	2.55
IUD	1.22	0.60	4.18	0.04	3.40	1.05	10.95
Emergency contraception	1.01	0.51	3.82	0.05	2.73	0.99	7.48
STD testing	-0.31	0.46	0.46	0.50	0.73	0.30	1.81

Table 6: Logistic regression predicting likelihood of booking an appointment with type of insurance and service requested.

A two-way between-groups analysis of variance was conducted to explore the impact of (1) type of clinic and service requested and (2) type of insurance and service requested on the amount of time to wait before having a reproductive health appointment. For the first model, the interaction between type of clinic and service requested was not significant, $F(9,247)=1.02$, $p=0.43$. There was a notable main effect for both type of clinic, $F(3,250)=4.51$, $p=0.008$, eta-squared=0.26, but not for the type of service requested, $F(5,248)=1.51$, $p=0.22$, eta-squared=0.13. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for waiting on an appointment when calling a hospital or clinic was notably shorter than when calling the health department. For the second model, the interaction between type of insurance and service requested was not significant, $F(14,242)=0.64$, $p=0.78$. There was a notable main effect for type of insurance, $F(5,250)=2.47$, $p=0.04$; however, the effect size was small (partial eta squared=0.04).

Discussion

The ability to prevent unwanted pregnancies and reduce sexually transmitted diseases is a legal right that a majority of individuals agree should be available to all women. However, there are both known and unknown obstacles that women face in receiving these services. In this study, one out of four women in the state of Mississippi would not have their call answered when trying to book an appointment for a reproductive health service. When controlling for type of service requested and type of insurance the potential patient was on, hospitals were significantly less likely to be able to book an appointment when compared to community health centers and clinics. This directly impacts the estimated 72% of women that book appointments with hospitals for reproductive health services [19]. However, women located in the southeast region of the United States are more likely to seek reproductive health services in community clinics [20]. The average wait for an appointment for these locations-regardless of type of service or insurance-could range from an average of 4 days for

community clinics to almost a month with health departments. Notable differences were also found with services requested where women seeking an IUD or emergency contraception were less likely to book an appointment than those wishing to be tested for STIs.

It is also important to note that only 28% of the 32 requests for an abortion received further information about the remaining abortion clinic in Mississippi; only one individual on the phone provided alternative information to the caller about other reproductive health care options. Similar results were found with women seeking emergency contraception. Although not yet implemented, this is comparable to the current attempt being made by Trump's administration to increase regulations on the Title X family planning program. Also known as the "domestic gag rule", the proposed change would not allow clinicians to refer pregnant patients to appropriate providers for abortion services, similar to what was already found with this study. However, the proposal does state that pregnant women requesting abortion services should be given information about prenatal and social services [21]. Regardless of the political landscape surrounding this topic, reproductive health centers need to at least provide resources to women seeking information about their pregnancies. The lack of any communication could result in the woman choosing an alternative route to their pregnancy that could potentially be dangerous for both the mother and child.

Several limitations are worth noting. The secret shopping method was feasible for understanding the processes in the state of Mississippi. However, this does limit the diversity of the data collected and further work would need to be done to generalize the information gained to all reproductive health centers in the United States. Also, data was purposefully collected at a time likely to maximize appointment availability (i.e., not during lunch hours and not near closing/opening times). This did not reflect the experiences of women with schedules that only allow personal time during lunch hours and before/after normal work hours. Finally, all contact information was gathered online. Although effort was made to ensure that phone numbers were correct by visiting the organization's websites, mistakes could have been made influencing the number of facilities that did not answer the calls. However, the difficulties the researchers found in finding contact information is likely similar to potential barriers women in the community face.

Additional research should expand these findings to different communities. Areas where women are more likely to book an appointment in a shorter period of time could help justify funding for further resources in other communities. A physical visit from women and their reflections of the challenges faced in booking an appointment would also bring clarity to obstacles that may or may not be present. For example, a clinician may be more receptive to a woman that has already travelled to the reproductive health clinic. Differences in the presentation of the potential patient might also impact the results (e.g., age, ethnicity, type of clothing being worn, etc.). Political changes on the state and federal level should also be considered when trying to understand the ability of individuals at the clinics to answer questions and redirect services. A longitudinal study to investigate changes-such as the potential passing of the aforementioned "gag rule" policy-would help bring clarity to the dissemination and application of policy changes.

Conclusion

It is clear from the results in this study that there are obstacles and barriers to women satisfying their reproductive health needs in a timely manner. It is important that women are able to choose their preferred method of contraception and be tested/treated for STIs in a reasonable amount of time. Healthcare providers have the potential to offer a variety of methods onsite to help reduce access barriers such as providing more information about reproductive healthcare options, training of assistants answering phone calls to provide additional/accurate information and referrals, and acknowledging systemic challenges that might be present with one's patient. In addition to organizational changes, policies at the local, state, and federal level also impact access to reproductive health information and services as well as broader life choices and the communities in which women live. At every level, these policies may act as barriers or facilitators to increase reproductive health rights.

Today, policies surrounding the maternal health field are at a pivotal point; safe and effective interventions for a majority of reproductive health challenges have now been developed, evaluated and determined to be effective, but providing these services remains challenging. Ensuring that the health systems in the most rural states are robust and capable of delivering key maternal health interventions through effective contraception and technically competent and respectful services continue to be a priority. Recent transformations in the health care delivery system associated with the Affordable Care Act have presented health care providers with new opportunities to meet the reproductive health care needs of historically underserved populations and communities [5]. A first step in meeting these needs is to conduct an assessment of the current capacity of providers to deliver health care services to the underserved and the subsequent identification of opportunities for improving the accessibility and quality of service provision. Despite recent policy changes, barriers continue to hinder legal reforms to provide full access to reproductive health care and to make services accessible where states have variable laws. Legal provisions governing access to safe healthcare, availability and quality of official reproductive health services, training in appropriate attitudes of health staff and approach to clients in reducing stigma about sexual health continues to pose major barriers. Together, these barriers and challenges deprive women from easily accessing reproductive health services potentially exposing them to unwanted births and STIs.

Declarations

Ethics approval and consent to participate: All procedures were approved by the University of Southern Mississippi's Institutional Review Board.

Consent for publication: Not applicable

Availability of data and material: The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests: The authors declare that they have no competing interests.

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Authors' contributions: CK developed the study process, analyzed and reported the data collected. AP originated the idea for the study and gained access to funding. AW helped collect the data. KW

provided feedback on method and final paper. All authors read and approved the final manuscript.

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