29. Polgar, op. cit.
32. Colliver, op. cit.
35. Polgar, op. cit.

Dr. Siegel is Professor and Chairman, Mr. Thomas and Mr. Tuthill are Research Associates, Dr. Coulter is Professor of Biostatistics, and Dr. Chipman is Professor of Maternal and Child Health, Department of Maternal and Child Health, University of North Carolina School of Public Health, Chapel Hill, N. C. 27514.

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THE USE OF CLIENT CHARACTERISTICS AS PREDICTORS OF UTILIZATION OF FAMILY PLANNING SERVICE

Samuel M. Wishik, M.D., F.A.P.H.A.

The differential motivations of service acceptors and nonacceptors have long been of interest to public health workers. It is appropriate that imaginative efforts are now being made to answer such questions in the family planning field, as evidenced by the articles by Siegel, et al., and by McCalister and Thiessen (in the present issue of this Journal, pp. 1372 and 1382).

With respect to family planning service, several discrete but interrelated
questions exist and are sometimes confused with one another. These ask:
What are the characteristics that differentiate:

(1) women who attend family planning clinics from those who do not?
(2) women who practice contraception from those who do not?
(3) women who choose one or another contraceptive method?
(4) women who discontinue the practice of contraception from those who continue?

At times, it may be necessary to combine questions—for example, when studying the continuation of women who use different contraceptive methods. First, it is important to keep them sharply discrete as an aid in defining the most appropriate denominators. It is so easy and seems so logical to exclude from the sample certain groups for one or another reason, but thereby to distort the statistical inferences and comparisons that are made. For example, Dr. Siegel and his co-workers had good reason to exclude former clinic clients in a study of clinic attendance. Dr. McCalister made his observations from a sample that was apparently selected for another specific purpose. The women were those who had suffered a fetal or infant loss or resembled such women, a loss that had occurred a specific number of years prior to the time of the study. With such selections, it is somewhat difficult to be sure just what the findings cover.

To be comprehensive, the design should be somewhat like that shown in Table 1. To answer question number one on clinic attendance, the characteristics of groups B plus C would be compared with those of groups D plus E. To answer question number two on practice of contraception, the characteristics of group A would be compared with those of all the other groups combined. To answer question number four on continuation, the characteristics of groups B plus D would be compared with those of groups C plus E.

Such comparative information obtained after the fact would be very helpful for program improvement and modification. With care, the same information could also be used as predictors of future behavior of different groups of women. After women are characterized by brief interview, selective types of education and interpretation could be given to them. This does not imply that the reasons why some women accept service automatically determine the content of motivation efforts with others. Rather, the conclusion is drawn that the others are different and call for a different approach.

Family planning studies, no less than other types of investigations, rarely permit a simple either-or, all-or-none dichotomy. Therefore, the pattern of

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Table 2 is called for. The logical comparison would be between the characteristics of group F and those of group H. A not uncommon error is to subclassify the nonacceptors but to use the full group of acceptors in comparison. Nonacceptance by women for whom contraception is unnecessary or not strongly indicated (group J) is considered reasonable, whereas acceptance by the same types of women (group G) is credited as an accomplishment.

Much importance can be attached to the study of acceptors of family planning since the family planning services are frequently superimposed on preexisting MCH services. Among the previous clients, some will and some will not accept the new service that is offered. Opportunity, therefore, exists for having at hand information about both groups.

Since manpower shortage is a major barrier to expansion of family planning programs, each additional routine follow-up contact multiplies that burden. Information about the differential characteristics of continuers and discontinuers of contraception could be used as predictors for selective follow-up where it is most needed and where the extra effort is most likely to pay off. For example, selective intervention could be made according to the degree of a woman’s uncertainty about the clinic, the idea of contraception or the particular contraceptive method prescribed for her. There is need, however, for philosophical thought and discussion on the very concept of follow-up. Should more intensive and more aggressive contact be tried or should corrective program modifications follow evaluative findings of deficiencies and needs? At what point should the responsibility be vested with the public to decide how much they want service and how often they want to be reminded about it?

Trying to answer the question about who will continue and who will discontinue contraception seems even more like crystal gazing when we recognize the necessity of putting time elements into the question. After all, every client will stop attending a family planning clinic some day. When does she become a discontinuer? A service might set a minimum one-year continuation goal or a desirable two- or three-year goal as in Table 3. Comparison now would be between the characteristics of group L and those of group M.

It is also necessary to look at the

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<td><strong>High level of need</strong></td>
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<td><strong>Continuing</strong></td>
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<th>Discontinuers</th>
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early part of the time span. There is special significance to the cases of women who never return after a first visit or who otherwise do not attend even a reasonably minimum time. For this, Table 4 would apply. Comparison would be between the characteristics of group P and those of group Q.

The full meaning of differentials depends on the stage of a program's development and of the community attitudes toward the program. It is certainly important to know whether the distribution of contraceptive practitioners to nonpractitioners in the community is 10 to 90, 50 to 50 or 80 to 20. If the pattern moves progressively in the latter direction, women who practice contraception would change from being pioneers to becoming conformists. Similarly the characteristics of dropouts from contraceptive practice would be different if the prevailing pattern in a service were very few dropouts, a moderate number of dropouts or a high percentage of all clients discontinuing. In the last instance, there would be stronger reasons for making program changes than for being concerned about the differential characteristics of the women.

The lack of many positive findings in the two papers referred to is of course disappointing, as it is to the authors themselves. There is a lot that we need to learn in this field. I am reminded of a study made in the early 1950s in Pittsburgh in which we were trying to find out why women sought antepartum care earlier in pregnancy. The only differential that had statistical significance was the number of years of general schooling. We were amazed that women who had had a previous unfavorable outcome of pregnancy did not seek earlier health supervision with the next pregnancy. In those pre-family planning times we had naive notions about the absence of women's ambivalence concerning the outcomes of their pregnancy.

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