Unmet Demand for Sterilization among Latinas

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ABSTRACT

In a prospective study of Latina oral contraceptive users in El Paso, Texas, we find a large proportion of parous pill users want no more children (64%), a large majority of whom (72%) would like to be sterilized. Eight in ten of those who wanted a tubal ligation wanted the procedure at the time of their last delivery. Only one of 363 women wanting sterilization at baseline was sterilized over the course of nine months of follow up. Logistic regression results for wanting a sterilization show that parity is positively associated with wanting it while a post-secondary education is negatively associated with that outcome. In the model predicting having asked for a sterilization, we find that age is negatively associated with asking while receiving some form of government assistance and wanting to be sterilized at the last delivery are positively associated with asking for a sterilization.

INTRODUCTION

Surgical sterilization is one of the most commonly used methods of contraception worldwide (Rutenberg and Landry 1993; Bongaarts and Johansson 2002; Chandra, Martinez et al. 2005). In the US, the prevalence of sterilization increased dramatically in the last several decades (Chandra 1998). Among married women 15 to 44 years of age who were currently using a contraceptive method, approximately 4% relied on sterilization in 1965; by the 1995 cycle of the National Survey of Family Growth (NSFG), the prevalence of sterilization in this group had risen to 23.8%. Estimates from the 2002 NSFG indicate that the prevalence of female sterilization continued to increase with a sterilization rate of 27% among women currently using a method (Chandra, Martinez et al. 2005). Sterilization was more prevalent among racial/ethnic minority women. More than one-third (33.8%) of Hispanic users and 39.2% of African American users reported sterilization as their current method, compared to 23.9% of non-Hispanic white users. There is evidence, however, that since 2002 sterilization rates in the US are decreasing (Chan and Westhoff Under Review).

In developing countries, sterilization is a well-established method of contraception. In an analysis of Demographic and Health Survey (DHS) data from 26 countries, Rutenberg and Landry (1993) found that in a number of countries in Latin America (including Mexico) and South and Southeast Asia, the prevalence of sterilization was higher than that found in the US with more than 30% of current contraceptive users relying on sterilization. More recent estimates from Latin America demonstrate that female sterilization accounts for nearly 50% of the contraceptive use among married women (Bongaarts and Johansson 2002; da Costa Leite, Gupta et al. 2004). Despite the availability of other modern methods of contraception, sterilization is the most widely used method among women in Mexico, accounting for 46% of all contraceptive practice among women in a marital or conjugal union (Palma Cabrera and Palma 2007).

The widespread use of sterilization indicates that both women and providers consider it to be a safe and effective method to limit childbearing. In a widely cited review of the literature on female sterilization, Westhoff and Davis (2000) found that complications directly associated with sterilization were rare. These complications posed smaller risks than pregnancy, particularly for women with a history of medical problems. The review also showed there was little evidence to support the existence of conditions such as “post-tubal sterilization syndrome,” a term used to describe disruptions to a woman’s menstrual cycle following the procedure. Furthermore, for women who wish to limit childbearing through sterilization, the procedure may provide additional non-contraceptive benefits such as reduced risk for ovarian cancer and pelvic inflammatory disease. Although the effectiveness of sterilization overall varies by the specific method used, general failure rates for the method (measured by incidence of pregnancy) were found to be approximately 2% over a 10 year period. These failure rates, although higher than previously reported, are still markedly lower than those for other available contraceptive methods, even when used consistently and according to recommendations (Kubba, Guillebaud et al. 2000).

Surprisingly, there has been relatively little research on women’s preferences for female sterilization, or the factors that may lead to these preferences (Schoen, Astone et al. 2000). Some studies have examined the possibility that providers’ preferences rather than those of women have impacted the use of sterilization and has been raised as a possible explanation for the racial/ethnic differentials in use of this method in the US, and the high rates of sterilization found in Mexico. With respect to the US

differentials, Borrero and colleagues (2007) conducted multivariate analyses of factors associated with the use of female sterilization using NSFG. After adjusting for marital status, age, parity, income, education and type of insurance (private versus public), minority women (both Hispanics and African Americans) continued to have higher odds of sterilization. However, there were no racial/ethnic differences in the sub-sample of women with public insurance. In an analysis of the factors leading to the rise of sterilization in Mexico, Potter (1999) argued that there are important "herd effects," and that women tend to do what their friends, relatives, and neighbors do when it comes to choosing a way to limit childbearing, and doctors also tend to offer the methods that their peers are also providing. The underlying motivation in both cases is to select the proven and well-known alternative among a wide array of possibly risky options (Shedlin and Hollerbach 1981).

Unmet Demand for Sterilization

Despite the prevalence of sterilization as a contraceptive method in the U.S. and the predominance of this method among racial/ethnic minorities, there is mounting evidence that minority and low-income women still have an unmet need for sterilization. The Borrero et al. (2007) results noted above are certainly consistent with this hypothesis. The fact that Hispanics and African Americans have higher rates of sterilization among those with private insurance, but not among those with public (or no) insurance may not be due to lack of desire for sterilization among the latter but rather to their inability to obtain the procedure.

Several studies have investigated the discrepancy between low-income and minority women's desire for sterilization during pregnancy and the fact that they did not receive a sterilization post-partum. In a study of more than 1,200 women who desired post-partum sterilization at three urban hospitals in the U.S., Davidson and colleagues (1990) found that more than 40% of these women were not sterilized within 10 months of delivery. The main reason for not obtaining a sterilization (cited by 32% of respondents) was "bureaucratic barriers" such as delivering before the consent form's 30 day waiting period had expired and unavailability of providers or operating rooms. Other commonly reported reasons included failure to meet health care professionals' "ad hoc" criteria for sterilization and fears of the procedure. Among women who did not get sterilized, nearly half (47%) expressed regret about not having the procedure. These findings have been corroborated in more recent research on unmet demand for sterilization by Zite and colleagues. In their 2006 study of women who desired sterilization during prenatal care but who did not receive it upon hospital discharge following delivery, the authors found that nearly one-third of women faced bureaucratic barriers to sterilization, such as the expiration of the Medicaid consent form (Zite, Wuellner et al. 2006). In a qualitative study of low-income minority women who did not have the desired procedure post-partum, those who were prevented from doing so due to bureaucratic barriers or provider influence expressed regret for not getting sterilized (Gilliam, Davis et al. 2008). Several women felt anxious about their ability to prevent another pregnancy, and some became pregnant less than one year following their delivery. In a 2008 study, women seeking sterilization often reported feeling that their doctors and the health care system served as barriers to having the procedure (Borrero, Reeves et al. 2008). And, in 2009, a study conducted in a Philadelphia-area hospital also demonstrated a frustrated demand for post-partum sterilization (Seibel-Seamon, Visintine et al. 2009).

Similar findings of unmet need for sterilization among women accessing public health services in Scotland and Brazil have also been reported. A recent pilot study investigating the decline of female sterilization in Scotland found that of 56 women who consulted their family doctor about sterilization, almost half were not referred to a hospital, and fewer than one in three was eventually sterilized (Chen, Glasier et al. 2008). Sterilization is the most commonly used method of contraception in Brazil – accounting for approximately 53% of contraceptive use among married women in 1996 (da Costa Leite, Gupta et al. 2004). In a prospective study of more than 1600 pregnant women, Potter and colleagues (2003) found that there was a substantial demand for post-partum sterilization among women receiving prenatal care in both public and private clinics. Follow-up interviews with women after delivery demonstrated, however, that there were significant differences between the outcomes of the two groups of women. Women with private insurance were far more likely to have obtained a sterilization post-partum than women who delivered in publically funded hospitals (69% versus 33%). Even after adjusting for type of delivery, women using public sector health services had approximately 60% lower odds of obtaining a post-partum sterilization than women in the private sector.

There are several reasons why Latina women might be especially likely to prefer female sterilization as a method. First, they are likely to begin childbearing earlier, and reach their desired family size at a younger age than are non-Hispanic Whites. Second, among women with close ties to their country of origin, there may be contagion effects resulting from the very high reliance on female sterilization found in such major sending countries such as Mexico. Additionally, some have suggested that providers may actually encourage or even pressure minority women to undergo this procedure. However, there is also accumulating evidence that a substantial proportion of women, especially those with public or no health insurance, have not been able to get a sterilization that they have asked for.

In this paper, we seek to assess the extent of unmet demand for female sterilization among current users of oral contraception in El Paso, Texas using data from a recent cohort study. We also seek to identify the factors associated with wanting sterilization among women who plan to have no more children, discriminating between those related to exposure and those related to social and economic circumstances, including their ties with Mexico. Finally, we examine the rate of sterilization among women in this prospective study during the nine month follow-up period, as well as who reported asking for sterilization but who were not sterilized.

DATA AND METHODS

Study Site: El Paso, Texas

El Paso, Texas is among the poorest communities in the country. According to the 2004 American Community Survey, El Paso's median household income of $31,764 ranked it 61st among the 70 cities with populations greater than 250,000. Educational attainment is also low with just 20% of El Paso's residents holding a bachelor's degree or higher, while 18% of El Paso residents have less than a ninth grade education. Some 37% of El Pasoans between the ages of 18 and 64 lack health insurance (while the Texas average is 25%). Compared to the 14% immigrant population throughout the state of Texas, approximately 28% of El Pasoans are foreign born, of whom 86% entered the US before 2000. The border is quite porous; four bridges link the two cities, and thousands cross frequently in both directions for commerce, family, recreation, education and services, such as health. Previous studies (Amastae and Fernandez 2006; Fernandez, Howard et al. 2007) have established that an important number of the El Paso population seeks health services in Ciudad Juárez for reasons including lower cost, convenience, family networks, cultural comfort, perceived quality of care, and a different regulatory system (Bastida, Brown et al. 2008).

Family planning services for low-income women in El Paso have historically been provided by a limited number of health care facilities, such as Thomason General Hospital Family Planning Clinic and Planned Parenthood, with funding provided by a variety of state-administered federally-funded programs, such as Medicaid Titles V, XX, and the Medicaid Women's Health Program. As a result of budget riders passed by the Texas legislature, beginning in the 2006-07 budget cycle, $25 million of these family planning funds for low-income Texans were diverted from the traditional providers to Federally Qualified Healthcare Centers (FQHC's). In El Paso, as elsewhere throughout the state, these FQHC's had little experience providing family planning services. Over time, FQHC's have established service contracts with the traditional family planning providers, but the funding for services is now divided among a greater number of health care facilities. Prior to the allocation of family planning funding to FQHC's, the Thomason Family Planning Clinic and its satellite centers averaged 3,000 patient visits per month; these sites now have approximately 1,000 patient visits per month. Moreover, in June 2009, Planned Parenthood Center of El Paso, which had experienced increasing difficulties with funding, permanently closed its doors, thereby potentially making it more difficult for many El Paso women to access family planning services.

Although Medicaid has been a main source of funding for family planning services, many women in the El Paso area, particularly those seeking services at county hospitals like Thomason Hospital, do not qualify. For these women, few resources are available to pay for family planning services. Sterilization, however, is either not an available family planning method or a reimbursable procedure under several of these programs. Pregnancy and delivery-related health care programs for women, such as Health Care Options, CHIP Perinatal, and Emergency Care, do not pay for post-partum sterilization as it is considered an elective surgery. Medicaid reimbursement for the procedure is low ($1800) relative to

the private sector cost in El Paso ($3000 to $4000), and not all Medicaid family planning programs cover sterilization. For example, tubal ligations are not reimbursable procedures under Medicaid Title V, but are under Medicaid Title XX. A participant in the Women's Health Program (Medicaid Title XX funds), however, loses access to preventative health services like Pap tests after a sterilization because she is deemed no longer in need of family planning and related services. Medicaid Title XX is the main source of funds that pays for sterilizations at Thomason Hospital, and the effect of funding cuts has reduced the number of procedures performed from 30 to 40 per month to fewer than 15 per month. Yet, patient demand for sterilization remains high. The director of Women's Health Centers at Thomason Hospital estimates that its family planning clinics could serve 100 to 200 women per month for sterilizations alone (personal communication, Carmen Diaz de León). This high demand has led to a backlog of women desiring sterilization and the establishment of a client waiting list for the procedure should funds become available.

Prospective Study of Pill Users

In the Border Contraceptive Access Study (BCAS; R01HD047816, J. E. Potter, PI), we recruited over 1000 El Paso resident oral contraceptive pill users and interviewed them four times over nine months. Half of the participants obtained their pills at family planning clinics in El Paso while the other half obtained them from pharmacies in Ciudad Juarez.

After a participant signed informed consent, we administered an hour-long baseline face-to-face interview. We collected information on the participant's background, social networks, and bi-national relations; motivation for choosing their pill source; medical, birth, and contraceptive histories; pill-use knowledge and practice; and childbearing intentions. The second and third follow-up interviews took place approximately three and six months after the initial interview. During the 20 minute telephone interviews, women were asked about changes in their health and pill-use practice during the prior three months, as well as follow-up questions on contraceptive knowledge.

The final (time 4) interview was completed in person nine months after the baseline interview, and lasted about one hour. In the final interview, we asked women about previous hypertension diagnoses and current risks, postpartum contraception and barriers to contraceptive use, and included open-ended questions soliciting women's beliefs about how the pill works and its side effects. We also measured participants' height, weight and blood pressure to create objective measures of potential contraindications to OC (oral contraception) use. In addition, we asked women who wanted no more children if they wanted to end childbearing with female sterilization, whether they had ever attempted to get a sterilization in the past and, if so, what happened that they were not able to actualize their desire.

In this study, we restrict our sample to Latina women with at least one child who completed the final (time 4) interview, and who did not plan on having another child at that time. Among these women, we examine how many would like to have a sterilization in the future, how many would have liked to have been sterilized while they were in the hospital delivering their last child, and how many were actually sterilized in the approximately nine month period following the baseline interview. We use logistic regression to analyze the covariates of wanting a sterilization among women in this sample, and to analyze the covariates of having asked for a sterilization among women who wanted a sterilization but who were not yet sterilized. While we rotated a large number of covariates through these models, we report only one parsimonious specification for each model.

RESULTS

We recruited 1046 OC users from December 2006 through February 2008, 532 who obtained their pills in family planning clinics and 514 who obtained them in pharmacies in Mexico. We used multiple strategies to recruit participants including approaching women at health or family planning clinics, posting flyers, visiting local community centers, and obtaining referrals from current participants. By November 2008, we completed all time 2 (N=965), time 3 (N=936), and time 4 (N=941) follow-up interviews. Retention was very high. At time 4 a total of 105 women could not be contacted resulting in a final retention rate of 90%. The majority of participants (n=64) had moved away from the El Paso area while 3 participants had been deported, and 1 had died. The rest (n=37) declined further participation. Only 21 participants in the baseline sample did not self-identify as Latina.

Of the 861 Latina women with one or more children who started the study, 75 dropped out. A comparison of the women who completed the fourth interview and those who dropped out shows that those lost to follow-up are younger (28.7 vs. 31.3 years), more likely to have been born and educated in the US (35% vs. 22%) and less likely to have wanted no more children at baseline (43% vs. 56%). Finally, women who did not complete the final interview were less likely to have been in the sample that got their pills from pharmacies in Mexico (52% vs. 40%). There were, however, no differences in mean parity or years of schooling at baseline between the two groups.

Of the 786 parous Latina women who completed the final interview, 506 (64%) declared that they planned to have no more children at that time. A complete breakdown of these women according to their fertility intentions at baseline, and whether they were clinic or pharmacy users may be found in Appendix Table I.

Table 1 presents characteristics of the parous respondents who completed the final interview and planned to have no more children, and who therefore were potential candidates for female sterilization. The first two columns refer to this entire sub-sample (n=506), while the last two columns restrict the sample further, to parous women who want no more children and who said that they would like to get a female sterilization (n=363). Compared to all women who completed t4, the two sub-samples are skewed older and toward higher parity. The large majority of women are married or in a consensual union, and education levels are relatively low. A significant portion of the samples were both born and educated in Mexico, and have a strong preference for Spanish in their everyday lives. Only a small portion of the samples have US health insurance and over three-quarters of both samples receive at least one form of government assistance such as WIC, food stamps, or Medicaid. Finally, a sizeable percentage of these women have at least one contraindication to the pill. Regarding the outcome variables in Table 1, over seven in ten women said they wanted to get a female sterilization. Among women wanting a sterilization, a large majority wished they had gotten sterilized at the time of their last birth, but only slightly more than half had asked for a female sterilization at some point in the past. In our entire sample, only one women was actually sterilized between the baseline and final interviews.

Among the women who asked for a sterilization, the majority had requested one during or after their last pregnancy (Table 2). The primary reasons the women recounted for not getting a desired sterilization were financial barriers, doctor refusal, and bureaucratic barriers.

The estimates obtained in our parsimonious logistic model of wanting a sterilization among women who wanted no more children at the final interview are shown in Table 3. Parity was, not surprisingly, an important predictor of wanting a sterilization. A post-secondary education was negatively associated with the desire for a sterilization; those educated beyond high school were significantly less likely to want a sterilization. Two additional marginally significant covariates were included in the model: using hormonal contraception at the final interview, and having at least one contraindication for using the pill. Both were positively associated with desire for a sterilization.

Table 4 shows the estimates from our model predicting having asked for a sterilization among Latina women who wanted no more children and wanted a sterilization. The first of the three covariates, age, is negatively associated with having asked for a sterilization. Women under 25 were more likely to have asked for a sterilization than women aged 25-34 and 34-45. Receiving some form of government assistance is also positively associated with having asked for a sterilization, as is wanting to have been sterilized at the time of the last delivery.

DISCUSSION

This study has shown that a surprisingly large proportion of Latina pill users in El Paso want no more children, and that the large majority of these women would like to be sterilized. Additional evidence of unmet demand for sterilization comes from the large proportion of parous pill users who would like to have been sterilized at the time of their last delivery and the fact, of the over 350 women who wanted a sterilization, only one was sterilized over the course of nine months of follow up.

Our model of predicting wanting a sterilization among women planning to have no more children is interesting both for the covariates included in the model and those that proved to have no recognizable association with this outcome. Notable among the latter were language ability and the country in which

the respondent was born and completed her last year of education. There was no indication in our data that women with the closest ties to Mexico would rather be sterilized than use the pill as a method of contraception. We can only speculate regarding the association between post-secondary education and wanting a sterilization. Perhaps women with more education in this sample are more confident regarding their ability to limit their fertility with hormonal or other non-permanent methods of contraception. Such confidence might also characterize women who have already switched from a hormonal method to some other form of contraception. The last covariate, having a contraindication to the pill, clearly reflects need for non-hormonal alternatives to limit childbearing. Moreover, it is notable that more than one in four women in this sample have such a contraindication.

There are a considerable number of women in this sample who, although they express a desire to be sterilized, have not actually asked for one. This could be due to not yet having had a chance to ask, or also a considered judgment that the chances of having the request met were extremely small, and that there was no point in asking. A final possibility is that losing one's eligibility for coverage of preventative health services after a tubal ligation under Medicaid's Women's Health Program is a disincentive to actually requesting a sterilization. The list of covariates predicting whether a woman had asked for a sterilization is again revealing as much for what is not included as well as for what is included. Neither education, parity, nor close ties to Mexico had a significant association, but age, receiving some form of government assistance and wanting to have been sterilized at the time of the last delivery were significant predictors. Again, we can only speculate as to why younger women were more likely to have asked for a sterilization. Receiving some form of government assistance could be an indicator of either economic hardship or an ability to negotiate and comply with bureaucratic procedures. Wishing that she had been sterilized at the time of the last delivery is clearly an indicator of having had the opportunity to ask, but possibly also of the strength of the woman's desire for a sterilization.

This study also provides some insight into the factors that prevent women wanting a sterilization from actually getting one in this setting. The responses to the question regarding why a woman's request for sterilization ended up in failure point to financial constraints, medical criteria for providing the procedure, and bureaucratic mishaps as all playing a role. We are aware that the financial pressures that have been brought to bear on the major providers of reproductive health services in El Paso have been extreme in the last four years, but further research is required to identify exactly what constraints impinge on the provision of sterilization to low-income women in this community. What we do know is that, at least among current and former pill users, there is substantial unmet demand for sterilization.

TABLES

Table 1. Characteristics of Parous Latinas who Wanted No More Children at the Final Interview; and of the Subset of Those who Wanted Female Sterilization at the Final Interview

	Want No More Children at Final Interview n=506		Want Female Sterilization[1] n=363	
	n	%	n	%
Covariates				
Age in Years at Baseline Interview				
<25	54	10.7	35	9.6
25 to 34	204	40.3	149	41.1
35+	248	49.0	179	49.3
Number of Living Children at Baseline				
1	37	7.3	21	5.8
2	167	33.0	103	28.4
3	172	34.0	139	38.3
4+	130	25.7	100	27.6
Marital Status[2]				
Married/Consensual Union	386	76.3	279	76.9
Single/Previously Married	119	23.5	83	22.9
Education at Baseline				
Up to 8th grade	130	25.7	100	27.6
Some high school	172	34.0	130	35.8
Completed high school	123	24.3	86	23.7
Post high school	81	16.0	47	13.0
Country of birth, Country where completed last year of education				
Born in US, Educated in US	74	14.6	47	13.0
Born in Mexico, Educated in US	171	33.8	126	34.7
Born in Mexico or US, Educated in Mexico	261	51.6	190	52.3
Language Ability at Baseline				
Spanish only	83	16.4	61	16.8
Spanish better than English	312	61.7	227	62.5
No difference bet. Spanish & English	77	15.2	52	14.3
English better than Spanish+English Only[3]	34	6.7	23	6.3
Has US health insurance	60	11.9	39	10.7
Receives at least one form of government assistance (e.g., WIC, Medicaid, TANF, Food Stamps)	394	77.9	289	79.6
Using Hormonal Contraception at the Final Interview	451	89.1	329	90.6
Has at Least One Contraindication to the Pill	133	26.3	104	28.7
Pill Source at Baseline				
Pharmacy	291	57.5	206	56.8
Clinic	215	42.5	157	43.2
Outcome Variables				
Wants Female Sterilization	363	71.7		
If Wanted Female Sterilization, Wanted it at Last Birth			313	86.2
Asked for a Female Sterilization			186	51.2

[1]Among those who wanted no more children at the final interview. [2]1 missing from both samples. [3]Only 1 reported English only.

Table 2. Requests for Sterilization and Reasons Did Not Obtain It among Women Who Ever Asked to Get Sterilized in the Proposed Subsample

	n	%
When asked to get sterilization		
During last pregnancy	97	52.3
After last birth	55	29.7
Before last birth	29	15.4
Multiple requests	5	2.6
Reason did not get the sterilization		
Financial barriers	65	34.9
Doctor would not agree to do it	50	26.9
Did not sign consent in time or other bureaucratic barrier	32	17.2
Decided against it	9	4.8
Pregnancy-related problems	5	2.7
Husband would not agree to it	3	1.6
Some other reason	7	3.8
More than one reason	15	8.1
Total	**186**	**100.0**

Table 3. Odds ratios (95% CI) for wanting a sterilization among women who wanted no more children at their final interview

	Odds Ratio	(95% CI)
Parity		
1 live birth	1.00	
2 live births	1.18	(0.57, 2.46)
3 live births	2.94	(1.36, 6.34)
4 live births or more	2.15	(0.98, 4.74)
Education		
High school or less	1.00	
Post-secondary school	0.54	(0.32, 0.90)
Using hormonal contraception at T4[1]	1.76	(0.95, 3.26)
Contraindicated for pill use	1.52	(0.93, 2.47)

1. Hormonal method users compared to women who are pregnant, not using a method or using a non-hormonal method

Table 4. Odds ratios (95% CI) for having ever asked for a sterilization among women who reported wanting a sterilization at their final interview

	Odds Ratio	(95% CI)
Age Group, years		
Age 18 - 24	1.00	
Age 25 - 34	0.41	(0.18, 0.95)
Age 34 - 45	0.48	(0.21, 1.12)
Receives government assistance	2.09	(1.17, 3.76)
Wanted a sterilization at last pregnancy	4.34	(1.80, 10.47)

APPENDIX

Appendix Table 1. Fertility Intentions at Baseline (BL) and Final Interview (T4) for Parous Latinas

Baseline Plan		Interviewed at T4	Time 4 Plan		
Clinic	**#**	**#**		**#**	**%**
Plan More or DK	225	197			
			Plan More or DK	130	66%
			Plan No More	**58**	29%
			Missing	9	5%
Plan No More	198	181			
			Plan More or DK	19	10%
			Plan No More	**157**	87%
			Missing	5	3%
Pharmacy	**#**	**#**		**#**	**%**
Plan More or DK	168	153			
			Plan More or DK	87	57%
			Plan No More	**63**	41%
			Missing	3	2%
Plan No More	270	255			
			Plan More or DK	23	9%
			Plan No More	**228**	89%
			Missing	4	2%
Total	***861***	***786***		***786***	
			Total Plan No More at T4	**506**	64%
			Total wanting no more at both interviews	*385*	
			Total who moved from yes at BL to no at T4	*121*	*35%*
			Total who moved from no at BL to yes at T4	42	10%

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