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Family Planning Digest

Welcome to Family Planning Digest

Providing current information on family planning activities is a natural outgrowth of the program of the National Center for Family Planning Services. The service program currently funds approximately 200 family planning projects throughout the United States under the aegis of state and local health departments and appropriate private nonprofit organizations. The National Center was created two years ago as the first federal program to focus exclusively and directly on the delivery of family planning services to the millions of Americans who do not have access to them either because they cannot afford these services or the services themselves do not exist.

With the passage of the Family Planning Services and Population Research Act of 1970, the National Center was authorized to provide technical assistance, manpower training, operations research and informational and educational services, in addition to project grants. *Family Planning Digest* is being introduced as part of this comprehensive effort. The unusually rapid growth of the family planning field in the past few years has resulted in a proliferation of written materials about advances in contraceptive technology, methods of service delivery and related issues.

To date, digests of literature in the field have been essentially listings or annotated bibliographies, useful to the scholar but less so to the busy administrators, nurses, aides and other family planning workers who do not have the time or are not likely to have access to specialty journals for materials outside their own particular disciplines.

It is to deal with this problem—to meet

the special needs of the multidisciplinary family planning program workers across the United States—that *Family Planning Digest* has been launched.

Published by the National Center under contract with Planned Parenthood's Center for Family Planning Program Development, *Digest* will cull information from over 100 journals, articles from other sources, meetings, reports, speeches and documents which have material relevant to family planning service delivery.

Readers are invited to send in brief reports of innovative experiences in the field which they would like to share with their counterparts in other areas of the country. We would, in addition, genuinely welcome suggestions from readers about areas which they would like to see covered in *Digest*.

This inaugural issue introduces what we hope will bring current, practical information from the field to a wide range of people who are doing the many different kinds of jobs needed to establish and make freely available high quality family planning services.

Frank N. Beckles

Frank N. Beckles, M.D.
Director, National Center for Family Planning Services

Adolescents

Young Men Will Use Contraception

Condoms are an acceptable form of contraception for inner-city youths, most of whom will use them to protect their sex partners from unwanted pregnancy (as well as to protect themselves from VD). These

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are the conclusions of Charles Arnold, M.D. and Betty Cogswell on the basis of a 13-week study made in 1970 of a free condom distribution project through commercial channels in Raleigh, North Carolina.

On the basis of special Census Bureau tabulations, the investigators estimated that there were 3,000 males 12-24 years of age residing in the four poverty neighborhoods studied. Condoms were chosen for distribution because they are cheap and can be obtained without a medical examination. Distribution began in May 1969 at project offices, where some 1,200 condoms were distributed over the next six months by female outreach workers. (The investigators found that "there was no apparent hesitation by the young men to come in to our office, request, and receive condoms from these young women.") In January 1970, a young male outreach worker was employed to develop new sites for condom

distribution, using commercial outlets. He selected the shops and explained the program to storekeepers. By March 1970, nine distribution sites were in the program, including five barbershops, two grocery stores, a pool hall and a restaurant. The shopkeepers agreed to distribute the condoms free to young men, restricting the maximum number to 12 per person, and attempting to discourage "trivial" uses. Shopkeepers varied in their level of promotion of the program: One, for example, put up a large sign saying "Free," above an openly displayed box of condoms; one or two kept the condoms under the counter. With the program underway, a 13-week study was undertaken to test the feasibility of continuing to use these commercial sites and to evaluate the effectiveness of the program in reducing unprotected coitus.

Condom recipients were asked to complete a brief form giving their age, the number of blocks they lived from the site, the last time they used a condom, their age when they first used a condom, whether or not they used a condom the last time they had sex, whether their sex partner used contraception at the time and whether they planned to tell their friends about the free distribution program. Ninety-eight percent of the young men completed the questionnaire. Some 23,000 condoms were distributed over the 13 weeks—18,000 of them from the nine sites, 5,000 from the project office and the project worker's automobile. The study found that the median age at which respondents reported

first use of the condom was just under 14. Eighty percent of them lived within six blocks of the distribution point where they picked up their condoms indicating, according to the authors, that "wide dispersal of participating outlets would be necessary to gain maximum participation."

Recipients relied more and more on the condoms as the weeks went on, the study showed. During the first week, only 20 percent said they had used one the last time they had intercourse. This figure rose to 91 percent by the end of the 13 weeks. Continuing use of the condom appeared to be particularly critical among this group since only 16 percent of the condom recipients reported that their sex partners used any form of contraception; this proportion did not vary over the 13-week period.

More than two-thirds of the recipients said they used the condom to prevent unwanted births, indicating to the investigators that inner-city young men "contrary to many present-day stereotypes . . . are willing to assume a sizable share of responsibility for family planning." A similar proportion of the recipients said that they used the condoms for protection against VD. Only one-fifth to one-fourth cited peer pressure of other young men and women as their reason for using condoms.

How many of the 3,000 youths estimated as the area's target population were reached over the 13 weeks? Drs. Arnold and Cogswell used two methods of estimation: One is based on condoms distributed per recipient, the other on estimated proportion of sex acts protected by a condom. The "condom-use" method produces an estimate of 25 percent of the target reached, the "protected-coitus" method, 50 percent. Either way, the authors consider this an "impressive proportion" reached over a 13-week period, although 62 percent of recipients had used a condom previously. Its use appeared to increase and become more regular as the program got under way.

The commercial outlets worked well. By contributing their time and facilities, the shopkeepers helped keep costs down. The principal costs were the young distributor's salary and expenses, his supervision, and the cost of the condoms (which came to about five cents apiece). In addition, the shopkeepers' familiarity with their neighborhoods and the young people who lived there made the program both more acceptable and more efficient.

Sources

C. B. Arnold, M.D. and B. E. Cogswell, "A Condom Distribution Program for Adolescents: The Findings of a Feasibility Study," *American Journal of Public Health*, 61:739, 1971.

"Condoms Are Free: But Is It a Clinic?" *Medical World News*, Vol. 2, No. 45, 1970, p. 28.

Contraceptive Practice

Poor Women Good Pill Users, Study Finds

Is it true, as has often been hypothesized, that low-income women use contraceptives in general and the pill in particular less effectively and consistently than their middle-income sisters? A five-year study by a team of public health specialists of 2,000 oral contraceptive patients who attended the Buffalo Planned Parenthood Center casts considerable doubt on the hypothesis. Based on the federal poverty guidelines, some 54 percent of the women were classified in the 'low-income' group; the New York State Medicaid eligibility levels determined that 36 percent were in the 'low-middle' group; 10 percent were classified as 'middle-income'. If a woman ceased oral contraception for any reason during the study period she was counted as a closed case. If she began again, she was considered an active case from the time she reentered the study.

The average age at which the women began to use the pill was 24.9 years, with middle-income women beginning at 24.1 years and low-income women at 24.9 years. The low-middle-income women began latest, at 25.1 years. A more striking difference, however, was the number of children the women had when they began to use the pill. Low-income women had an average of 3.1 living children compared to 2.1 for low-middle-income women and only 0.8 for middle-income women. "The difference in parity," the report notes, "when related to the average age of the women in the three income groups, indicates that women from the low-income group began child-bearing earlier in life and that the interval between children was relatively short."

The continuation rate for the 2,000 women after one year's use was 82 per 100, with women in the low-income group outdistancing the more affluent groups from the first year of the study. Thus, after one year, 83.2 percent of the low-income women, compared to 81.3 percent of low-middle-income and 79 percent of middle-income women, were still on the pill. After two years, the percentages were 69.8, 65.2 and 63.5 respectively. The pattern remained the same after three years of use, with the low-income women remaining more persistent in their use of the pill: In the low-income group 58.0 percent compared with 50.6 percent of low-middle- and 46.2 percent of middle-income women were still on the pills. "The difference between low- and middle-income women in the rate of continuation after three years of observation was 12 per 100," the report notes. Five-year continuation rates could be de-

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Buffalo study shows poor women as persistent contraceptors as their more affluent sisters.

terminated only for the low- and low-middle-income groups because of the limited numbers of middle-income women in the study; the low-income women continued to lead in persistence of use with 48.2 compared with 45 per 100 continuing after four years and 40.5 compared with 37.9 per 100 after five years.

Unintended pregnancies varied only slightly by income group. Thus, after one year the cumulative rate was 1.4 per 100 low-income women, compared with 1.0 for low-middle- and 1.6 for middle-income women. The cumulative termination rate because of unintended pregnancy after three years was 2.2 per 100 for both low- and low-middle-income women and 2.3 per 100 for middle-income women.

Although the rate of termination of oral contraception for medical reasons was not too dissimilar for the three income groups (4.7, 4.3 and 4.4, respectively, after one year, 9.5, 9.1 and 6.7 after two years, and 12.7, 12.3 and 9.0 after three years, according to the study), there was a substantial difference by economic level in the proportion of women who, after terminating oral contraception for medical reasons, did not return to Planned Parenthood. Forty-four percent of the low-income women, 42 percent of the low-middle-income and 29 percent of the middle-income women did not return.

The investigators conclude:

- Low-income women who chose to use oral contraceptives used them as effectively as middle-income women.
- The higher continuation rate of low-income women results largely from their greater parity at the onset of contraception.
- The larger proportion of low-income women compared to middle-income women who terminated oral contraception for medical reasons for an indefinite period suggests that the "continuation rate for low-income women would be even higher

with better knowledge about contraceptives."

- The finding that low-income women begin childbearing when they are younger indicates that "contraceptive information for teen-agers would be of great benefit."
- The greater parity and relatively few closures for planned pregnancies in the study suggest that these "low-income women use oral contraceptives to prevent the birth of additional children rather than to space their children."
- Since parity rather than income is a deciding factor in continued use of oral contraceptives, women seeking contraceptive counseling after completing their families can be expected to use contraceptives for an extended period of time. If a woman's reason for using oral contraceptives is termination of childbearing and she has many years of fertility before her, she might be advised of the availability of other means of prevention—IUDs, voluntary sterilization and, where available, long-term injectables, and medicated silastic implants—all of which provide long-term contraception more effectively and more economically.

Source

J. G. Feldman, S. Ogra, J. Lippe, M.D. and H. Sultz. "Patterns and Purposes of Oral Contraceptive Use by Economic Status," *American Journal of Public Health*, 61:1089, 1971.

Physician Attitudes

MDs Assume Poor Can't Remember To Take Pill

Two recent surveys of physicians' preferences, practices and perceptions with regard to family planning indicate that although they overwhelmingly favor the provision of family planning services in both public programs and in their private practices, they lack confidence in the ability of poor people to use a method such as oral contraception effectively, and large numbers of the physicians favor punitive action—compulsory sterilization or withholding of support—in cases where welfare mothers have several illegitimate children. These attitudes hold whether the physicians live in the South or the North. One study, carried out by investigators from the School of Public Health and the Carolina Population Center at the University of North Carolina, surveyed 132 physicians, all of whom practiced in a southeastern urban community of 200,000. The other, made by Planned Parenthood's Research Department, queried 234 physicians in Detroit, Grand Rapids, rural West Virginia and Memphis.

Eighty percent (105) of the physicians in the first study responded to a three-page questionnaire that had been endorsed by the county medical society.

The physicians were asked to differentiate between contraceptive methods preferred for private and public patients. Seventy-three percent of the responding doctors indicated the pill as their first choice for private patients, 15 percent the IUD and only six percent chose sterilization. For public patients the preferences were reversed: Fifty-eight percent picked the IUD as their first choice, 24 percent thought the poor could be trusted to take the pill and 14 percent suggested sterilization as their first choice for public patients. According to the investigators, many of the physicians indicated in handwritten comments on the questionnaires that they thought "public patients were not sufficiently 'reliable', 'intelligent' or 'motivated' to take oral contraceptives dependably [and that] the IUD may be preferred to pills for a person with a limited education, who may not even be able to count, let alone sustain motivation over a long time."

The gap between the physicians' perceptions and the reality concerning "public" patients is highlighted by the investigators' finding that, in actuality, the "public" family planning patients in the county had completed an average of 10 years of schooling; most chose the pill and participated in the health department clinic at a high rate. Thus, ". . . it would seem that their motivation is higher than the physicians expected." (See 'Contraceptive Practice,' p. 2.)

In the case of welfare mothers who had borne three illegitimate children, 97 percent of the physicians favored sterilization, 89 percent favored contraception and 28 percent favored abortion. In each case the physicians preferred voluntary to compulsory measures, but the differences—particularly for contraception and sterilization—were very small. Six out of 10 favored withholding public assistance for additional children and a total of 77 percent favored either compulsory sterilization or withholding support, or both. The obstetrician-gynecologists were the most punitive of the doctors surveyed, 94 percent favoring compulsory sterilization or withholding of welfare support for unwed mothers with three children. Eighty percent of the surveyed physicians born in the South favored the punitive course, compared to 47 percent of those born in other regions.

In the Planned Parenthood study, 44 percent of a total sample of the 234 physicians practicing in Detroit, Grand Rapids, rural West Virginia and Memphis believed that women with low education, low income and/or low intelligence would be unreliable

pill users. In the first two cities, 13 percent and 48 percent, respectively, held this view compared with 56 percent and 62 percent in the latter localities. It should be noted that the only major difference in attitude was among Detroit's physicians. Virtually all the physicians practiced in low-income areas.

When the physicians from these four areas were asked about proper handling of the welfare mother who has just had her third illegitimate child, a total of 96 percent felt that birth control services should be made available to her, 85 percent said she should be told about sterilization, 48 percent would suggest she have abortions in any future pregnancies, 33 percent felt that public assistance should be withheld for any future out-of-wedlock children and 30 percent said she should be taken off welfare if she did not agree to contraceptive sterilization. A regional breakdown showed that about one-third of the physicians in Grand Rapids and Memphis favored the last two steps, while in rural West Virginia 63 percent favored withholding welfare for future out-of-wedlock children and 52 percent favored dropping the woman from the welfare rolls if she did not agree to sterilization. In Detroit, one-third of the physicians favored the first and one-fifth the second.

While 85 percent of the physicians said they would favor prescription of contraception for unmarried women, only about half favored provision of birth control to those who had not borne a child previously.

Sources

A. R. Measham, M.D., R. A. Hatcher, M.D. and C. B. Arnold, M.D., "Physicians and Contraception: A Study of Perceptions and Practices in an Urban Southeastern U.S. Community," *Southern Medical Journal*, 64:499, 1971.

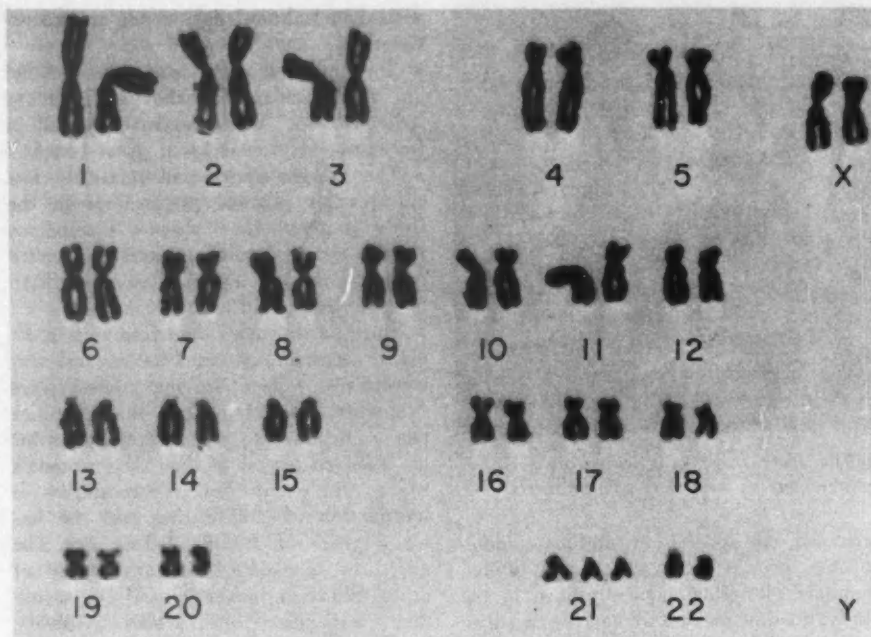
M. Silver, "Survey of Private Physicians—Summary of Initial Findings," paper presented at ninety-ninth annual meeting, American Public Health Association, Minneapolis, Minn., Oct. 11, 1971.

Genetic Counseling

A Practical Family Planning Service?

New developments in techniques of fetal diagnosis offer hope to couples fearful that they may bear children with congenital abnormalities. Recent reports from numerous investigators reveal, however, that application of the new techniques is limited, uncertain, expensive, and the degree of risk involved to mother and fetus is not yet known.

The development over the past five years of transabdominal amniocentesis and amniotic fluid cell culture in the second tri-



Extra chromosome 21 in karyotype (arrangement of chromosome pairs) above indicates mongolism. This and similar chromosomal anomalies can be detected prenatally.

mester of pregnancy to detect a variety of genetic defects in the fetus has been widely heralded as inaugurating a new era in fetal investigation and genetic counseling. Some have even suggested that genetic counseling be added routinely to family planning programs, presumably backed up by the new techniques of intrauterine diagnosis and 'management' of the affected fetus.

Diagnostic procedures on the unborn fetus began some 15 years ago in the area of Rh isoimmunization (an antibody reaction in the mother damaging to the fetus which may occur when an Rh-negative mother is pregnant with an Rh-positive fetus). Some amniotic fluid is withdrawn by amniocentesis (insertion of a needle into the uterine cavity and withdrawal of amniotic fluid by syringe) in the third trimester of pregnancy and analyzed in an attempt to identify the disorder and salvage the affected fetus. Over the past five years amniotic fluid cells have been cultured successfully early in the second trimester of pregnancy, and chromosomal and enzymatic studies on the cultivated cells have become feasible, thus making it possible to detect in the unborn fetus certain genetic or chromosomal abnormalities.

The limitations of this procedure, however, are not adequately recognized by the general public (as well as by some family planning professionals). For example, the kinds of congenital disorders that can be detected most easily prenatally are chromosomal aberrations, the most common of which is mongolism; the procedure is also useful for sex determination in X-linked

recessive disorders (such as hemophilia and Duchenne muscular dystrophy), in which case a female carrier will transmit the disease to one-half of her male offspring. While few such disorders can be diagnosed precisely in the fetus, sex may be determined through prenatal investigation with considerable accuracy, and male fetuses aborted. This means, however, that one-half of the fetuses aborted will be normal, and continued transmission of the disorder through female carriers will not be prevented. Errors in diagnosis are also likely if the pregnant woman is carrying fraternal twins of different sex, or if the fluid sample has been unwittingly contaminated with maternal cells.

Most complicated and expensive is the detection of inborn errors of metabolism through enzyme analysis of fetal cells taken from the amniotic fluid and cultured in the test tube. Successful detection is now limited to some disorders which affect tissues throughout the fetal body. Many other common congenital defects, however, are not amenable to intrauterine evaluation. These include congenital malformations of all types, or the effects of intrauterine viral infections (like rubella) or the effects of radiation or drugs. Neither is there any way at present to make an intrauterine diagnosis of any dominantly inherited disease (like Huntington's chorea), or of the most common nonsex-linked recessive disorders: sickle cell anemia, which affects one in 400 of U.S. blacks, or cystic fibrosis, which affects one in 2,000 of U.S. whites.

There are presently only a handful of

centers in the United States adequately prepared to carry out amniocentesis and the culture of fluid cells; each such center tends to 'specialize' in particular tests because of the interests of one or another investigator. (A listing of such centers is available from the National Foundation-March of Dimes in White Plains, N.Y.). The procedures involved in such investigations are extremely time-consuming and expensive, and thus cannot yet be made routinely available, even to those considered at high risk of bearing a defective infant. Despite the findings of some investigators that the immediate risks from second-trimester amniocentesis to mother and fetus may be no greater than the less than one percent risk found with third-trimester amniocentesis, overall experience with and information about this procedure is still limited. Potential risks to the fetus, as Dr. Harold M. Nitowsky of the Albert Einstein College of Medicine in New York City and others have pointed out, include amnionitis, placental perforation or detachment, fetal-maternal hemorrhage leading to fetal anemia or possible maternal Rh-isoimmunization, direct fetal injury and premature onset of labor and spontaneous abortion; potential maternal complications include bladder or intestinal perforation, hemorrhage and infection. And, as Dr. Orlando J. Miller of the Columbia University College of Physicians and Surgeons and Dr. Michael M. Kaback of Johns Hopkins have indicated, no one knows what long-term hazards the procedure may hold for the 'unaffected' fetus who goes on to delivery after an intrauterine study. Since the procedure is new, long-term follow-up of such children is still nonexistent. If, as Miller postulates, the removal of amniotic fluid in the sixteenth week of gestation, a critical period of central nervous system development, were to cause some mental retardation, "studies performed to date could not have picked this up."

Ironically, as Dr. Bassam Y. Barakat and his associates at Johns Hopkins explain, chromosomal anomalies, such as mongolism, are the most amenable to prenatal detection, but occur so sporadically that universal screening would be necessary to identify all of them, since only women over 40 (and the very few with known transmissible chromosomal anomalies) are identifiable as high-risk for this type of disorder. Most investigators agree that the likelihood of mongolism in subsequent offspring of mothers who have already borne a mongoloid child is not much greater than for the general population. Yet this is the group that is most likely to seek out intrauterine diagnosis to assure themselves that they will not have another affected infant.

Dr. Albert B. Gerbie and his colleagues

at Northwestern University Medical School performed 256 transabdominal early second-trimester amniocenteses on 231 patients during 238 pregnancies "in which there was a considerable risk that the child would be affected with a serious genetic disorder." Among this group the investigators detected affected fetuses in 32 patients, of whom 30 were aborted. Two who refused abortion were delivered of mongoloid infants. The other 86 percent of fetuses in the 238 pregnancies were normal. A similar result was obtained by Barakat and others in a smaller study of amniocenteses on 30 patients at the Johns Hopkins Birth Defects Prevention Center (three fetuses affected of the 30). As Dr. Richard Stander of Cincinnati, Ohio commented on the Gerbie findings of 86 percent normal fetuses, "Cytogenetic and biochemical analysis of human amniotic fluid would be of little value if the risks to the maternal organism or fetus, secondary to amniocentesis, were prohibitively high." Finally, it must be realized that there is currently no way of 'managing' an affected fetus except by abortion, and in all cases these will be late abortions which have the highest risk of complications. If this is not made clear, the patient may be put through complicated, expensive, risky tests when she would not be willing to accept an abortion. Indeed, in all but 15 states it is not legal to perform an abortion to prevent the birth of a defective child. In some states which do permit such terminations, abortions are not permitted after 14-20 weeks of gestation. Since it is generally agreed that early amniocentesis optimally should be performed at the sixteenth week of gestation, and since the average time for getting the results of chromosomal analysis is 14 days and for biochemical analysis 30 days, and since repeated amniocentesis is sometimes necessary, legal barriers may frustrate both physician and patient if a positive—but legally late—result is found. Gerbie describes attempts to obtain earlier results; but this clearly remains a problem.

Much is known about the relative risks couples face of bearing children with inherited disorders. These have been well described recently in articles by Dr. F. Clarke Fraser of McGill University and by Dr. Hymie Gordon of the Mayo Clinic. It is commonly agreed that for the general population the likelihood of bearing a child with a major heritable disorder (including those, like Huntington's chorea, which manifest themselves later in life) is about five percent. Providing that a very accurate and extensive family pedigree is available, a trained genetic counselor can tell prospective parents something of the odds for or against their bearing a child with a major genetic defect. The most easily identified of

the inherited pathologies are the so-called autosomal dominant inherited disorders, like 'lobster claw' deformity of the hands, multiple polyposis of the colon and many other conditions. If one parent is affected and one is normal, then each of the couple's children has a 50:50 chance of inheriting the condition (although such disorders sometimes appear to skip a generation when transmitted through a carrier who appears clinically normal). Autosomal recessive disorders are the most common of the inherited defects. They include sickle cell anemia, cystic fibrosis, cretinism, Tay-Sachs and a host of other disorders. In these cases both parents appear clinically normal, but carry a recessive mutant gene: Each of their children has a one in four chance of inheriting the disorder. Sex-linked recessive inheritance is considerably less common, but includes such feared illnesses as the hemophilias and the Duchenne muscular dystrophies. Here the mutant gene is located on the X chromosome, and each male child of a female carrier has a 50:50 chance of receiving this dismal inheritance. Many disorders are caused by the appearance of a new mutant gene, and are therefore unpredictable by the genetic counselor. Others, like cleft lip and palate, schizophrenia, epilepsy and diabetes are produced by a combination of genetic and environmental factors still poorly understood.

Intrauterine diagnosis, clearly, is a promising new frontier; but we are still a long way from taking the gamble out of genetic counseling.

Sources

B. Y. Barakat, M.D., R. H. Heller, M.D. and H. W. Jones, Jr., M.D., "Fetal Quality Control in Pregnancies with High Risk for Genetic Disorders," *Fertility and Sterility*, 22:409, 1971.

F. C. Fraser, "Genetic Counseling," *Hospital Practice*, 6:49, 1971.

A. B. Gerbie, M.D., H. L. Nadler, M.D. and M. V. Gerbie, M.D., "Amniocentesis in Genetic Counseling," *American Journal of Obstetrics and Gynecology*, 109:765, 1971.

H. Gordon, M.D., "Genetic Counseling, Considerations for Talking to Parents and Prospective Parents," *Journal of the American Medical Association*, 217:1215, 1971.

M. Kaback, M.D., "Discussion of Symposium Papers," O. J. Miller, M.D., "Discussion of Symposium Papers," and H. L. Nadler, M.D., "Indications for Amniocentesis in the Early Prenatal Detection of Genetic Disorders," in "Symposium on Intrauterine Diagnosis," *Birth Defects: Original Article Series*, Vol. 8, No. 5, April 1971, National Foundation-March of Dimes, White Plains, New York.

H. M. Nitowsky, M.D., "Prenatal Diagnosis of Genetic Abnormality," *American Journal of Nursing*, 71:1551, 1971.

Sterilization

Young Californians Opt For Permanent Method

Almost one-fourth of all white couples in a suburban community of 400,000 near San Francisco have undergone contraceptive sterilization operations, a recently published Kaiser Foundation study reported.

More than two-thirds of a sample of wives surveyed in this community were protected through their husbands' vasectomy operation; the remainder had had their tubes tied. Including remedial sterilizations (i.e., hysterectomies), 31 percent of the couples were sterilized.

The prevalence of purely contraceptive operations in the suburban town of Walnut Creek, according to this study conducted in 1968, was considerably higher than that reported for the nation as a whole, and even for the West, in the 1965 National Fertility Study (NFS). Thus, the NFS reported eight percent of white U.S. couples and 16 percent of white western couples in this age group (wives aged 20-54) with contraceptive sterilizations. The difference was particularly marked for vasectomized men. Sixteen percent of the Walnut Creek men were found to be sterilized, compared to 10 percent reported for the West by the NFS. Tubal ligations were only slightly more prevalent for the Walnut Creek population than reported in the NFS for the West: 6.9 percent compared to 6.0 percent. The prevalence of remedial sterilizing surgery in Walnut Creek is somewhat below the average for the West (and for the nation as a whole): about 12 percent, against 13 percent.

Subscribers 'Typical'

The California study was made of subscribers to the Kaiser Foundation Health Plan (a prepaid medical program) who lived in Walnut Creek. About one-fourth of the area's population is covered by the Plan, and these subscribers are estimated by the investigator to be typical of their fellow suburbanites in the area. The data were collected in a mail survey on contraceptive methods carried on by the Foundation as part of a longitudinal study of the medical effects of oral contraceptives. Ninety-two percent of the women surveyed responded. The population surveyed is above the national average in education and income—although half are blue collar workers and 12 percent are professionals or executives. Forty-three percent of the wives work full- or part-time. Whites and blacks, married and unmarried women, were sampled; but only data from the

3,071 white married couples in the sample were reported in this paper. Since the sample was overweighted with younger women, the overall totals were weighted to the age distribution in Walnut Creek.

The higher than average level of tubal ligations is largely accounted for by the sharp increase in incidence among younger women who have been operated on since 1965, when age and parity restrictions were removed from hospital policy. The higher than average prevalence of vasectomies among the men, however, cannot be related to any change in policies—or to any unusual policies in the Kaiser Plan—since the Kaiser facilities had not performed male sterilizations prior to the time the data were collected.

The data suggested to the investigator that "the unusually high prevalence of these operations in this population, particularly in the oldest age groups, suggests that male sterilization may have gained acceptance first on the Pacific Coast and then spread to other parts of the West."

Source

N. Phillips, "The Prevalence of Surgical Sterilization in a Suburban Population," *Demography*, 8:261, 1971.

Communications

How to Tell People About Family Planning

There have been at least several hundred 'studies' of communication in family planning, many of them exhortations or subjective impressions, many others relevant to only one country or district or to solution of a very narrow problem. Not surprisingly, there is little agreement on the importance of communication to family planning, the role it should be assigned or even what its components may be.

Wilbur Schramm, Director of Stanford University's Institute for Communication, has read through much of the scattered literature on the subject and made his own observations in the field; he reports on both the research and practices in several countries, and draws his own conclusions about what family planning communications actually is and should be doing.

Schramm posits three action components essential to any fully developed family planning program: clinical services, personal contacts and public information. 'Communication', he says, includes the second and third of these components. The audiences to whom "the family planning message" is primarily addressed shifts in the course of development of a program. Thus, he points out, in the early stages of pro-



WANTED
...every baby should be

Personal Appeals: Healthy mothers, happy children most effective to boost birth control use.

moting the program, "the main audience is usually the leadership—leaders who have it in their power to make national policy or contribute to a voluntary effort." Typically, they may best be reached through personal talks, letters and reports on how overpopulation can retard economic progress, drain needed resources, etc. At the point when funds are available actually to offer clinical services, the chief audiences may be medical and paramedical personnel, reached through training courses, seminars and information handouts.

When resources are available to begin active patient recruitment, the whole population of potential consumers becomes the audience. This is the time to use all the resources of public communication: "field workers, print, broadcast, film, posters, special campaigns. . . ." This is also the time, Schramm stresses, when "feedback" channels from the field to the program administration must be set up "so that strategies and tactics may be selected or modified in the perspective of experience and research."

Reaching Special Groups

Finally, when the proportion of users has begun to plateau, it is necessary to reach "special groups" such as program drop-outs, or persons who indicated interest in contraception to outreach workers but never showed up for their clinic appointments. These may include the men, previously neglected in attempts to reach the female "target" population, or teen-agers who are just beginning sexual activity. This is the stage when introduction of family planning information into school cur-

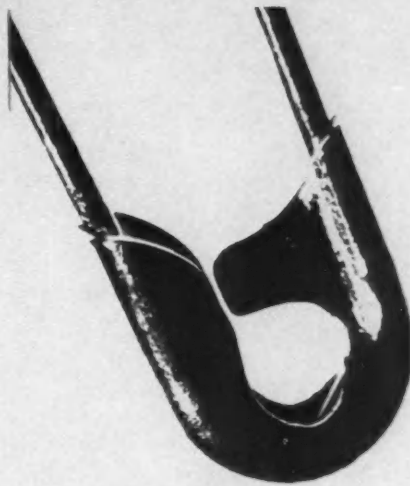
ricula becomes an important concern. It is this "postplateau period," Schramm says, which "offers the greatest challenge to family planning information campaigns and strategies."

Schramm holds that, aside from their "cultural trappings," most family planning programs reach out to their potential users in much the same way: They describe *what* the service is; then *why* it is needed (here, personal rather than collective appeals are universally found most effective: healthy mothers, happy children and family prosperity rather than the effects of population increase on the environment); *how* the services work (description of various methods, their various advantages and disadvantages, etc.); *where* and *when* the services are available and, finally, *who* is behind the program (people need reassurance they are not alone).

Research Findings

Despite the vagueness, contradictions and cultural specificity of the hundreds of studies he has read, Schramm finds a number of "generalizations that seem to be emerging from the growing body of research and related experience":

- Each of the three essential program components—clinic services, personal contacts and public information—must be strong to produce a strong program. Adequate clinic services are the sine qua non of a successful program, but will not by themselves carry a program very far. Most programs "begin with clinics, and then find it necessary to use field workers and public information in order to bring in more than a tiny fraction of the eligible women to the clinics."
- Successful programs all over the world have been built around their outreach workers. "The single most useful motivating device to bring acceptors to the clinics," Schramm observes, "is a well-trained, competent and dedicated staff of field workers."
- Public information "can create a climate of knowledge and attitudes that will make it easier for the field and clinical staff to recruit acceptors." However, the evidence is not so clear that mass media, by themselves, are powerful tools in motivating people to use family planning.
- Good news—and bad—travels fast. Strengths or weaknesses in clinic services, sympathetic or rude treatment by program workers, tasteless or false information dispersed through various media will be communicated with remarkable speed through word-of-mouth. Thus, what started as a highly successful IUD program in Singapore died quickly when highly exaggerated news of perforations and excessive bleeding



"How Long Would You Like to Wait Between Babies?"

People need to know exactly where to go and how to get family planning service.

sped through the community grapevine. On the other hand, when a family planning clinic was opened in Chulalongkorn Hospital, the most prestigious hospital in Thailand, more than 12,000 women came to it—some from distant provinces—despite almost no publicity in the media. Dr. Schramm suggests that "the most successful way of countering unfavorable rumors and reducing the number of dropouts appears to be (a) full disclosure of facts from the beginning, (b) continuing information to doctors, nurses and field workers, (c) follow-up and reassurance."

- A combination of public channels to carry the family planning message is more effective than any one alone, and a combination of public with personal channels is the most effective means of all.
- Patient recruitment campaigns concentrated in discrete time periods (Family Planning Month, Week, etc.) are effective variations on a continuous program.
- Direct mailings—to new mothers and newlyweds—have been highly successful in some programs as an inexpensive supplement to personal outreach contacts. Dr. Schramm points out that direct mail appeals have proven effective even among families unable to read; they find it "so unusual and exciting to receive a letter that the recipients make sure they find someone to read it to them."

Unanswered Questions

Schramm poses, finally, some of the questions which research has failed to answer in the communication of family planning. One problem, he says, is how to reduce the gap between those who seem to favor

WHERE CAN YOU GET BIRTH CONTROL HELP?

You can get birth control help from your family doctor or from:

Wake County Health Department
3010 New Bern Avenue
Box 949
Raleigh, N.C. (Phone 833-1655)

Please write or phone for appointment

HOW MUCH DO BIRTH CONTROL SERVICES COST?

At the Wake County Health Department eligible women get birth control services and supplies free of charge.

family planning and those who actually come to use it. Developing more, and more convenient, services is part of the solution. The role of communication here needs intensive study. A related challenge is how to reduce often high rates of clinic—and contraceptive—dropout. Reaching young couples before they begin their families is another challenge. They might be reached through the schools, but what kind of material should be included in curricula? The value systems of the school administrators and the youngsters are often different enough to raise major problems. On reaching out to serve the poor and less literate, Schramm points to evidence that these groups have a high rate of acceptance of contraception—the problem is how to reach them. With the spread of transistor radios all over the world, Schramm suggests that radio may be the most promising public channel to this end. Mass media can never do by themselves what outreach workers can do through individual contacts. However, "most programs will reach a point where the returns from further increasing field staffs . . . will no longer be financially justifiable." The question is, when?

These and many other questions challenge program workers to make better use of research. "Unfortunately," Schramm concludes, "many family planning campaigns are 'flying blind', when even the simplest research, such as pretesting, could throw a great deal of light on their programs."

Source

W. Schramm, "Communication in Family Planning," *Reports on Population/Family Planning*, No. 7, The Population Council, New York, April 1971.

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Rural Programs

They Want Good Birth Control, Can't Get It

Three out of five white, fertile, sexually active women living in a rural county in northeastern Georgia, and working in a garment factory there, are interested in receiving birth control services, a recent survey has found. (Some 85,000 women aged 15-49 work in the state's garment industry. Of these, an estimated 17,000 may be in need of contraceptive services, according to the investigators.) This is contrary to a general impression among health workers that these mountain women have beliefs and attitudes that would deter them from using family planning services and practicing contraception. At the time of the survey only 34 Rabun County women were actively enrolled in the county health department's family planning program, even though 425 women estimated to be in need of publicly provided family planning services lived in the county. Only a handful of the women employed in the garment factory had used the health department's program.

According to the survey, about one-third of the 350 garment workers of childbearing age were not at risk of pregnancy (18 percent were surgically sterile, and 13 percent had never married and stated that they had not been pregnant and had never used contraception). Roughly half of those who were at risk of pregnancy were using contraception of some kind and, of these, 47 percent were protected by medical methods; the remainder used less effective drug-store methods, or withdrawal. Only six of the women currently using contraception named the county health department as their source of services; two-fifths used private physicians and the rest purchased traditional methods at drugstores.

Of the 66 women not using birth control who wanted family planning help, 65 percent preferred the care of private physicians and only 29 percent said that the health department would be their first choice as the place to go for family planning services. Overall, of the 171 women who were using, or were interested in using, contraception, 37 said they would be willing to consider the county health department, even though some of these preferred private physicians. Since 60 percent of the women who were at risk of pregnancy and not using contraception expressed an interest in family planning services, it is worth examining some of the reasons this apparent desire for family planning was not being met.

The investigators stated that several important changes are needed if effective

contraception is to be provided for these Rabun County garment workers. Many of the women have combined family incomes somewhat higher than the levels the health department uses to determine eligibility for family planning services. Advisable changes in health department policy might include a waiver or liberalization of these eligibility requirements. Most of these working women would need care at times of day which would permit them to remain employed, specifically on weekends and in the evenings when the health department clinic is presently closed.

Neither family planning nor preventive health programs were given high priority by the three physicians in private practice in Rabun County. Only one devoted any time at all to the county health department's family planning clinic, and his services were limited to one afternoon a month for six months of the year. This same medical manpower problem is faced by rural communities in many areas of the country.

The Rabun County analysis suggests that the barriers to use of effective contraceptives by rural working women are not necessarily in the attitudes of the women themselves but in the accessibility and quality of current family planning services.



Appalachian women found to want family planning, but lack effective access to services.

Source

S. H. Moore, M.D., C. W. Tyler, Jr., M.D., and R. W. Rochat, M.D., "Family Planning Among White Garment Workers in Rural Appalachia: Evaluation By Use of a Sample Survey," presented at the ninth annual meeting, American Association of Planned Parenthood Physicians, Kansas City, Mo., April 5-6, 1971.

Credits:

p. 3: Bernard Cole; p. 4: National Foundation—March of Dimes; p. 6: Planned Parenthood—World Population; p. 7: Wake County Health Department; p. 8: Ken Heyman.

