Free Pregnancy Testing Service in New York City

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THE SUCCESS AND FAILURES experienced in developing a pregnancy testing program within an established maternity and infant care-family planning project in the New York City Department of Health are described here.

The New York City Maternity, Infant Care-Family Planning Project, started in 1964, is 1 of the 53 projects federally funded under the Maternal and Child Health and Mental Retardation amendments to the Social Security Act passed by Congress in 1963. The grants to New York City for maternity and family planning services currently emanate from two sources within the Department of Health, Education, and Welfare—the Health Services Administration's (HSA) Office for Maternal and Child Health (project 507 funds) and from HSA's Office for Family Planning (project 707 funds).

Before the New York State liberalized abortion law was passed in July 1970, pregnancy testing was done in the project's centers only for maternity or prospective maternity patients, but it was seldom done. Following passage of the abortion law, the administrative staff of the project determined that free pregnancy testing would be beneficial to low-income women—many were not under medical supervision and could not pay the current rates for such laboratory tests.

Categorically, some of the benefits envisioned from such a service were *(a)* early diagnosis of pregnancy, with a referral for medically sound termination if desired by the patient, *(b)* early entry into a prenatal system, or *(c)* early entry into a family planning system, if desired.

For many low-income women, the services could provide an entrance or introduction into a comprehensive health care system. It could also provide an opportunity for infertility investigation referrals, as well as the discovery and treatment of gynecologic abnormalities.

The existing 13 Maternity, Infant Care-Family Planning Centers in 4 boroughs of New York City would provide a "built-in" springboard to launch an expanded free pregnancy testing service.

The Testing Program

The pregnancy testing service was initiated in April 1970, 3 months before the abortion law became effective, and the extent to which this "walk-in" service was used is clearly evident in the statistical records—28,154 tests performed from April 1970 through June 1973.

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At one center that is extremely popular with adolescents, however, the pregnancy test service increased so rapidly that a change in the operational pattern was necessary. It is discussed later. As with any testing program, its effectiveness is reflected in the amount of sound preplanning at both the field and headquarters staff levels.

Medical input. The type of pregnancy testing used by the Maternity, Infant Care-Family Planning Project was selected on the basis of test accuracy, length of time necessary to perform the test, and the reliability of the end point as determined by a laboratory technician. Economically feasible test material was found to fit these criteria (approximately 70 cents per test).

According to the New York City health code, only a physician may order the test. The test must be performed by a licensed laboratory technician from an approved facility, and the test result must be given to the patient by a physician or someone directly authorized by the physician. To work within the framework of the health code, which has the full implication of a law, a pregnancy testing order slip was devised which carries the signature of the project's medical director.

The tests are performed by laboratory technicians assigned by the New York City Bureau of Laboratories. The director of medical services assigned the responsibility for reporting the test results to the public health nurse, the registered nurse, or the licensed practical nurse at each center. The laboratory technicians were trained to perform the test by a supervisor assigned by the Bureau of Laboratories. However, training the nurses assigned to reporting test results to patients entailed a more complicated process.

Although counseling by nurses of the Maternity, Infant Care-Family Planning Project, was a well-established function and operating smoothly, an in-service educational program was developed to provide the counseling nurses with all the possible avenues of referral, based on the pregnancy test result. If a test is

positive, the nurse counselor asks the patient: "Do you wish to register for prenatal care in our clinic, or do you prefer to go elsewhere?" If a patient wishes to discontinue the pregnancy, a request is made to the Clearing House for Abortion Appointments for an appointment in a hospital clinic.

If a test result is negative, the nurse asks the patient about her menstrual history. If menstruation has been abnormal, the patient is referred to a gynecologic facility or to her private physician; if it has been normal, and the pregnancy test performed too early for accuracy, the test is repeated. If the patient wishes, an appointment for family planning is made at the clinic.

The nurses were instructed to report the result of the test to each patient at the clinic, rather than by telephone. This procedure protects the confidentiality of the patient and also allows the nurse to counsel the patient immediately.

There was a question regarding the feasibility of performing a gynecologic examination at the time of the test. It was decided not to do this on a walk-in, pregnancy test patient because of *(a)* lack of examining and dressing rooms for additional medical examinations in the centers which were being used to their maximum in providing services to the registered maternity and family planning patients, *(b)* accuracy of the pregnancy testing mechanism was approximately 95 percent, and *(c)* in an early pregnancy—less than 7 weeks—even a gynecologic examination would not necessarily be accurate. Thus, the agency to which the patient is referred would perform a gynecologic examination.

As time progressed, problems encountered with pregnancy testing became apparent. Approximately 50 percent of the patients in some centers had to have the test repeated. Investigation as to the cause of repeat testing uncovered these possible sources of error *(a)* the test was performed too early for accuracy, *(b)* the menstrual pattern of the patient was irregular, *(c)* the patient "guessed" the date of her last menstrual period, *(d)* the urine specimen was taken at a time when it may have been too diluted to show a positve reaction, or *(e)* patients were frequently taking a low-dosage oral contraceptive which could cause scanty menstruation or amenorrhea.

To correct these possible causes for repeat pregnancy testing, an effort was made by the clerical staff to help the patients determine their menstrual patterns and the correct dates of last menses. The patients were instructed to bring in a urine specimen taken the first time they urinated in the morning so that it would be concentrated. Patients on low-dosage contraceptives with negative test results were instructed to report the amenorrhea to their physicians or the facilities which prescribed the oral contraceptives.

Clearing House for Abortion Appointments. The clearinghouse concept was developed and initiated on June 1, 1970, the date of the new abortion law. Inherent in this concept was the assumption that a mechanism would be needed to equalize the caseload for pregnancy termination between the various municipal and voluntary hospitals caring for general services patients. This mechanism was created by the Maternity, Infant Care-Family Planning Project to expedite care of prospective patients for pregnancy termination and to equalize the caseload of these patients between participating hospitals. It would also function as a service to only those low-income residents of New York City who usually seek medical services from municipal, voluntary hospitals or health department clinics. This service would be identified as the Central Clearing House for Abortion Appointments. Since the service was initiated, three telephone operators, one a supervisor, have dealt successfully with more than 27,000 calls.

It was determined that part-time nurses, laboratory technicians, and clerks would be required for the clearinghouse. Emphasis would be placed on the patient's attitude regarding this new service, and staff would be cautioned that in no way—by work, expression, or action—were they to indicate any moral judgment for or against abortion. The New York State law states that an abortion decision is to be made solely between the patient and her physician.

Realistically, how does one evaluate one's personal feelings, attitudes, and philosophy toward abortion? How do you keep on top of the raised eyebrows, the inflection of the voice, or the apparent lack of sensitivity toward these patients? How fast can a total staff absorb the legal ramifications of a liberalized abortion law, or become knowledgeable about the cultural, racial, moral, and religious opposition toward abortion? These questions needed careful consideration and were handled through in-service education, individual staff conferences, and in some instances, the transfer of staff to other functions.

Facilities. Adequate space is a luxury the project does not have in most of the centers. Basically, additional equipment, such as larger refrigerators, desks, and file cabinets was needed—all requiring precious floor space. Envision the addition of more patients in crowded areas, plus long lines of women waiting to use the toilets. Try to explain to your supply and equipment officer the fantastic rise in orders for such mundane items as soap, toilet tissue, paper towels, urine containers, to say nothing of pregnancy testing kits.

Our supply officer, fortunately, had effectively established an inventory control system and is most understanding when there are hysterical calls from the centers to meet seasonal demands for emergency deliveries of pregnancy test kits. A monthly supply of pregnancy test kits, 100 boxes of 50 tests per box, is maintained in our central supply. The project has only one station wagon for all deliveries, and these crisis needs can raise havoc with any well-regulated logistics of a delivery service.

It soon became apparent we had underestimated the popularity of this service and had to backtrack and initiate ground rules. The centers would have to schedule days and time for pregnancy testing; accommodating "walk-ins" was not always feasible and many had to return at another time. We had to inform patients to call before coming to the centers and that the service was restricted to New York City residents.

In one health department center, the majority of patients seeking abortion service were under 20 years of age. We had not prepared adequately for this age group

and as quickly as we could, other space and personnel were found and the pregnancy testing service was removed from the clinic setting. A 5-day-a-week schedule, 12 to 4 pm, was initiated. After sufficient time passed for proper evaluation this schedule may be used in other centers.

Preplanning. The following factors were overlooked initially and should have been considered in preplanning:

- The rapid increase in the number of "walk-in" patients following intitiation of a free pregnancy testing service
- The influx of nonresident "walk-in" patients
- The number of patients, referred from fee agencies, private physicians, or laboratories, who could not pay for a pregnancy test
- The tremendous pressure on clinic laboratory staff and facilities resulting in overcrowding of the normal clinic setting, with attendant confusion because of limited space causing delays for patients who came for scheduled service
- Insufficient time for in-depth counseling by nurses
- The number of repeat pregnancy tests done each month, especially among the adolescents who used a variety of names. We were unaware of the ingenuity youngsters use in calculating their last menstrual date to coincide with the criteria for performance of a pregnancy test as established by the director of medical services.
- The appalling lack of knowledge in the adolescent community about the risk of becoming pregnant.

Discussion and Conclusions

In light of 3 years' experience with a free pregnancy testing service which has proved lightly successful, we recommend that persons who are planning such a service have medical direction for establishing and adhering to State and local health codes. The operational component must include the following:

- Adequate facilities for an additional caseload and its rapid expansion
- Qualified personnel from the appropriate disciplines
- Maintenance of a sufficient stockpile of all necessary supplies and equipment and a delivery system for emergency runs if there are multiple clinics
- Community acceptance and support of a free pregnancy testing service
- A comprehensive knowledge of community resources to develop a definite referral system for abortions, prenatal care or family planning, infertility, and gynecology
- Flexibility in operating procedures
- The location of pregnancy testing service within an area most accessible to the greatest number of the population.
- Financial resources to initiate and sustain the service.

In 12 of the 13 Maternity, Infant Care-Family Planning Clinics that perform free pregnancy testing (an average of 4 to 115 tests per month), the existing staff has been able to handle the additional workload. In the center with the heaviest demand for testing, additional staff was added.

Positive results are emanating from the free pregnancy testing program. In a study by Daily and Nicholas *(1)* it was concluded that a free pregnancy testing service was a factor in increasing the percentage of new prenatal patients registering in the first trimester; it led to increased patient activity in family planning; and it helped women desirous of terminating their pregnancies to do so at an earlier stage. This service also provided to low-income women entry into a total medical care program. In many cases it led to referrals for infertility investigation as medically indicated and to the discovery of and referral for treatment of gynecologic abnormalities.

In retrospect, our evaluation reveals that regardless of considerable preplanning, implementation was not always effective. The uniqueness of the service presented innumerable unexpected problems. Protocol frequently had to be revised and now can be used as guidelines.

Since its beginning in 1970, the operation has become more streamlined. It now provides improved patient service, greater efficiency, and lower operating costs. We feel that the effort has been worthwhile, and that the recipients of such a service will be most grateful to the provider of such a service.

Reference

1. Daily, E. F., and Nicholas, N.: A free pregnancy testing service. Fam Plann Perspect 5: 1–6, winter 1973.

HRA CONFERENCE SUPPORTS INTERNATIONAL WOMEN'S YEAR

The United Nations has designated 1975 as International Women's Year. In support of the objectives of the year, the Health Resources Administration is sponsoring an International Conference on Women in Health, to be held June 18-20 in Washington, D.C. The Conference will bring together experts from those nations where women play a major role in the health professions as well as from countries where research has been conducted on the relationship of various societal factors to the status of women in health.