Some Considerations in Developing Family Planning Services

WILLIAM A. DARITY, Ph.D.

FAMILY planning today is considered an essential element in community development and should be viewed as a positive aspect of family life. The archaic concept of birth control as a defense measure which has negative connotations is no longer applicable. The total picture of family life encompasses the economic, emotional, social, and physical aspects. Birth control or family-size limitation is only a small part of family planning, albeit an indispensable part, and should be included in planning comprehensive maternity care. Family planning should be viewed as qualitative rather than quantitative. A healthful environment should be provided for children regardless of number, and the number born should be related to the available family resources, both economic and human. Family planning, therefore, is vitally concerned with assisting families who want to limit the number of their children as well as assisting families who want to have additional children.

How do we relate family planning services to overall public health programing? Some aspects to be considered in relation to such services are attitudes toward family planning by professional workers and other personnel, correlation of sex education with family planning, the importance of interpersonal communications, the function of health education in promoting family planning in a community, and representation of the poor in planning these services.

Dr. Darity is an associate professor of public health at the University of Massachusetts, Amherst. *This article is based on a paper presented at a regional conference on family planning, sponsored by Regional Office VII, Department of Health, Education, and Welfare, Dallas, Tex., November 21–22, 1966.*

The Professional's Attitude

I wish to raise two questions not always considered in family planning. Should frequency of sexual intercourse affect the type of contraceptive recommended? How does the attitude of the professional worker in direct contact with the client affect the success of a family planning service?

The frequency of sexual intercourse may dictate the type of contraceptive recommended. Tietze (*1*), Calderone (*2*), and others have written on the acceptability of contraceptive methods; however, few writers have discussed or studied acceptance or rejection of a contraceptive as related to frequency of sexual intercourse. A study in a southern city indicated that there was a high correlation between the mean monthly frequency of sexual intercourse and the acceptance and continuous use of an oral contraceptive. Married women living with their husbands, who had a mean frequency of sexual intercourse of 10 or more times a month, were more likely to continue taking the oral contraceptive pill than were the separated, widowed, or never married woman, who had a mean frequency of sexual intercourse of 1 to 3 times a month (*3*).

This finding would indicate that in planning birth control services, the public health worker should determine the frequency of sexual intercourse before recommending a contraceptive. Coordinating the method of contraception with the frequency of sexual intercourse will aid the client in accepting the method recommended. Public health personnel need to be reoriented so they can assist in obtaining such information from the client and ascertaining its validity.

In family planning, the attitude of the professional in the public health organization toward the use of contraceptives by women who are not married or the effect of the specific type of contraceptive on the individual person can influence the success of the project. The effect of the social worker's attitude was observed in a study of five social workers in an agency with 25 professionals (*3*, *4*). It was found that the two social workers with nonambivalent feelings toward birth control, who were counseling 11 clients, had nine who continued to take contraceptives during the entire period of study and only two dropped out. Three social workers with ambivalent attitudes who were counseling 18 clients had only eight continue taking the contraceptives while 10 dropped out.

The social workers' feelings of nonambivalence or ambivalence were determined in a depth interview and by placement of their answers in a weighted test. Ambivalent workers were those who felt social pressure was needed to get results, had reservations about providing contraceptives for women who were not living with their spouses, and lacked ability to identify with general needs of clients or patients. Nonambivalent workers were those who felt patients could learn to use pills, did not have value judgments with regard to religion or marital status, and identified with patients' general problems. No firm conclusions can be drawn from these findings, however, because so few persons were studied.

Also, through discussions with professional workers it was found that many of them were ignorant of the physiological functioning of the intrauterine device; they thought it caused spontaneous abortion and therefore destroyed a life. This lack of knowledge is described in a recent World Health Organization publication (*5*):

> As yet the mechanism of action of intrauterine devices remains unknown. It was suggested very early that they stimulate the motility of the fallopian tubes, so that the ovum passes through the tube and arrives in the uterus within a day, or even less, instead of the usual 3–3½ days, after ovulation. It therefore arrives unfertilized or, if fertilized, not fully ripe for implantation in the uterine mucosa, which in turn has not had time to become ready to receive it. This theory has had some confirmation from experiments on rhesus monkeys. Other theories, believed by the group to be untenable, are that the device blocks the passage of sperm to the fallopian tube, prevents ovulation or the passage of fertilized ova from the fallopian tube to the uterine cavity, causes chronic endometritis or a chronic inflammatory reaction, or interferes with the implanted blastocyst.

Considering the ambivalent feelings and lack of information that a professional may have, it becomes obvious that the success of a family planning service can be affected more by the professional's attitude than by the attitude of the client.

Some professionals believe that the oral contraceptive may prolong the menopause. This belief seemed to be more prevalent among the social workers with ambivalent feelings toward contraceptives referred to earlier. In contrast, those professional workers who felt that the use of contraceptives was a matter of personal and individual choice, that use was normal, and that marital status was irrelevant were most successful in keeping the client in the program.

Implications for Sex Education

Complete family planning is more than birth control; it includes sex education which can be a part of family life education. When planned parenthood services are being initiated is a logical, realistic time to further the parents' understanding of human physiology and reproduction and to point out how and why to explain to their children certain aspects of life.

The social worker or other professional has, at this time, the opportunity to talk intimately with the client, particularly the mother. This opportunity is particularly auspicious, because there is no need to initiate a new topic at a time when there is no opening or when there is no incentive for the patient to learn. As the types of contraceptives are discussed, women should become less inhibited about how to talk about sex and pregnancy with their children. The door

is open and the two programs can be coordinated closely and easily. However, a high degree of skill in discussing this topic by the professional—nurse, social worker, or other worker—is essential. To function effectively, health workers must clearly understand the relationship of sex education to family planning. They must be able to communicate on an equal, informal basis—using terms that are acceptable and understood by the client—must be willing to listen, and must understand the background of the client.

Interpersonal Communications

To develop future public health services in family planning, young adults and their parents and young adults and professionals in public health, social work, medicine, and education must be able to communicate. Such communication between persons in our society is the one essential that is missing. To develop or to use the type of communication needed to promote family planning, channels of communication must be established. These channels must be formed between the young adult and older adults, between parents and children, and between professional and nonprofessionals. Communication patterns need to be established to motivate people, both the subordinate and the superordinate, to exchange ideas and to learn from one another.

The lack of effective communication is a major problem in sex education and family planning today. Kirkendall (*6*) in his study of the integration of sex in interpersonal relationship, states that "most of the subjects said that their sexual conduct had never been discussed with any adult." The subjects also said that few adults, particularly their parents, teachers, and religious leaders, had any idea or even showed any concern about their sex habits and practices which, according to Kirkendall, indicated that sex is simply not discussed in our culture in any context. He continues:

> Youths and adults usually find it difficult to converse freely and objectively about sex. About the best adults can do is give youths physiological, depersonalized facts about reproduction. If the discussion relates to youthful conduct, adults can seldom be accepting or permissive. Their past experience compels them to be judgmental and forbidding.

Because of such negative experiences and lack of adequate communication, barriers are created between the professional and the recipient of health services, between young adults and their parents, and between young adults and the public health profession.

Communication is bound to be difficult between the public health professional worker and the recipient of public health services. Difficulty in communication is caused by the superordinate role that the public health professional worker plays, which is the passing of information or telling, rather than a mutual exchange of ideas. Public health personnel should be trained to communicate more effectively with the prospective recipient of public health services.

The need to establish communication between parents and children was reflected through a retrospective analysis of 213 women, among whom 84 percent were reluctant to discuss such subjects with their families as they grew up (*3*). This reluctance, this inability to discuss sex, marriage, and family life with their own families is now being reflected in the women's inability to establish a communication pattern with their children. Discussion, therefore, is needed to remove the inhibitions that interfere with the free flow of information about marriage and the family, planned parenthood, and sex education. Public health personnel must become interested in improving communication within the family.

In a current study of a random sample of women in an eastern university, a lack of communication was found between young persons and their parents, counselors, and teachers. This study is incomplete, but only 19 percent of the women gave parents as their main source of information on sex, marriage, and family living; 44 percent gave friends or peer groups; 24 percent gave books; and the remaining 13 percent gave teachers, counselors, and a combination of teachers, counselors, and peer groups. (William A. Darity and co-workers: Variations in sex knowledge and attitudes among 164 college females, unpublished paper.)

The young women did not consider adults a main source of information about sex, family life, and child rearing. In another study by Angrist among 50 college freshman women, she stated (*7*):

Discussion of birth control during both high school and college was characteristic of 85 percent of the freshmen; the remainder reported talking to no one about the subject. It was primarily with close girl friends or roommates that such exchange of information took place, but during high school, discussion with mothers and teachers occurred frequently. In college, discussion centers more in the peer group represented by increased communication with boys and girls.

College and university environments contain relatively few opportunities for the young people to communicate with adults because of concentration of students in dormitories and inaccessibility of faculty and counselors. If students discuss sex and birth control before going to college, however, there is a possibility that talking with adult counselors will be acceptable to college students.

Finally, there is need for communication between public health professionals and all young adults, from those from the lowest income groups to young, middle-class persons. Many public health professionals may not find it easy to discuss family planning and sex. The attitude of the professional, however, will be reflected in the ability to communicate regardless of personal status. The married woman professional is more effective in conducting discussions and holding conferences with clients or patients than the single man or woman professional (*3*). The effectiveness of the married man as a professional counselor in family planning should be studied.

Although the discussion of interpersonal relationship is limited in this paper, its importance to the success of family planning cannot be minimized.

Implications for Health Education

Often health education is thought of as transmission of information from one person to another. Health education, however, not only reflects the transmission of information, but it is also reflected in a change in the behavior of the client. The fact that persons can repeat information does not mean that they understand it. This fact was shown in a study of women at an oral contraceptive clinic. There was no significant difference in the ability to repeat instructions on how to take oral contraceptive pills between women who were actively participating in clinic services and those who had stopped taking the medication (*8*). Women who had ceased taking oral contraceptives had done so for at least 3 months and some had stopped as long as 1 year or more before being questioned (see table).

Mean scores of clinical subjects in recall of instructions on how to take oral contraceptives

Usage	Number	Mean weighted score	Standard deviation
Taking pills	62	1.94	0.849
Stopped taking pills	41	1.71	.950

NOTE: Observed statistical t (Student's t test) = 1.29; not significant.

The objective of health education is to help people be healthy by their own action and efforts (*9*). Methodologically, health education can be viewed as the translation of knowledge about health into desirable health actions and also as the total of one's experiences which influences actions and behavior (*10*). Therefore, when working with community groups in family planning, it is important to understand the client's experiences with kinds of birth control measures, and it is equally important to understand the way information is transmitted. This information, coupled with an understanding of the various cultural practices and social and religious ideas and concepts about health, is important to the professional in a family planning service. Persons who have strong religious concepts may be less apt to use contraceptives than people who are more liberal in their religious beliefs regardless of sect. The worker should understand this social phenomenon, as it probably is not restricted to any particular religious sect.

Health education for family planning must have the sanction and support of the community. The information must be translated into language that people understand, and it is essential to put health education in its proper context. The consumer rather than the provider of services should supply the impetus to promote health education about family planning. Thus community action is a necessary part of family

planning, and all facets of community action must be used in education. Direct contact and intercommunity and neighborhood acceptance are necessary, because media gimmicks are impersonal. Educators must use personal contact and not rely on newspapers, radio, and other media as the sole means of achieving the educational goal. Intelligent decisions can be made by the self-sufficient recipient only when intrinsic and extrinsic motivational methods are consistent with the intrinsic and extrinsic motives of individual persons and groups concerned.

Implications for Poverty Program

Family planning in the poverty program also must be considered in terms of the consumer. There is a general feeling among the poor in many countries of the world, and in our own country as well, that the purpose of family planning is to eliminate the poor from society. The poor must understand that family planning is broader than birth control. The relationship between family size and quality of education in meeting the general needs of the young should be emphasized so that these families will understand that the primary objective of family planning is quality development of the family.

Community leaders among the poor in the poverty-stricken areas need to be oriented to a broad concept of family planning, and their support should be solicited. The one-to-one relationship, client to professional, will never promote the objectives of comprehensive community family planning. Community-action groups must initiate family planning services, but in the final analysis, the community must ask for such help. This will occur only if community needs are recognized by the participants themselves.

Health personnel and those associated with public family planning clinics find that the majority of their clients come from low-income, often poverty-stricken groups. The participation of the poor is going to rely heavily on their understanding of the objectives of family planning and on their having their own representatives take part in planning. The implication of "maximum feasible participation" of the Economic Opportunity Act of 1964 is relevant to successful family planning services (*11*). To gain the respect and confidence of the poor, therefore, personnel in health, welfare, and related fields will do well to help support true representation of the poor at the consumer, planning, and policymaking levels of community-action organizations.

Summary

Success in family planning services lies in a cooperative, comprehensive, and positive approach to community needs. Such an approach encompasses planning with families for their economic, social, emotional, and physical security. Family size is important to families who want additional children as well as those who want to limit the number of their children. The initiators of a family planning service should consider these points: How the attitude of the public health worker can affect the success of the program and the importance of sex education becoming an integral part of family life education. Also, there should be a pattern of interpersonal communication between the public health worker and the client, between parents and children, and between youths and adults. The impetus for health education in family planning should come from the community, and low-income, poverty-stricken persons should participate in the planning and initiating of family planning programs.

REFERENCES

(*1*) Tietze, C.: Use and effectiveness of contraceptive methods in the United States. *In* Manual of contraceptive practice, edited by M. S. Calderone. The William & Wilkins Company, Baltimore, 1964, pp. 126–137.

(*2*) Calderone, M. S.: An inventory of contraceptive methods adapted to public health practice. Amer J Public Health 52: 1712–1719, October 1962.

(*3*) Darity, W. A.: Contraceptive education: The relative cultural and social factors related to oral contraceptives. Ph.D. thesis. University of North Carolina, Chapel Hill, 1963.

(*4*) Darity, W. A.: Continuing and discontinuing users of oral contraception in a public health clinic. *In* Advances in planned parenthood, edited by A. J. Sobrero and S. Lewit. Schenkman Publishing Company, Boston, 1965, pp. 51–60.

(*5*) World Health Organization: Intra-uterine devices. WHO Chron 20: 375–377, October 1966.

(6) Kirkendall, L. A.: Premarital intercourse and interpersonal relations. The Julian Press, New York, 1961.

(7) Angrist, S. S.: Communication about birth control: An explanatory study of freshman girls. Information and attitudes. J Marriage and the Family 28: 248–286, August 1966.

(8) Darity, W. A.: Health education in a family planning program. Health Educators at Work 16: 51–58, University of North Carolina, Chapel Hill, June 1965.

(9) WHO Expert Committee on Health Education of the Public: First report. Techn Rep Ser 89, Geneva, 1954.

(10) Turner, C. E.: Community health educator's compendium of knowledge. H. Studer S.A., Geneva, 1964.

(11) Economic Opportunity Act of 1964: Public Law 88–452, 88th Cong., 2d sess., Aug. 20, 1964.

Education Notes

Today's Hospital Problems: An Interdisciplinary Approach. The Mound Park Hospital Foundation and the University of Florida are offering a postgraduate conference on today's hospital problems. This leadership course for chiefs of staff, hospital administrators, governing personnel (or trustees), and paramedical personnel selected by hospital administration and division chiefs will be held at Tides Hotel and Beach Club, Redington Beach, October 26–28, 1967.

The program is acceptable for 18 accredited hours by the American Academy of General Practice. The faculty will be composed of selected guest lecturers and staff from the University of Florida and the foundation.

The fee is $75. More information is available from the Mound Park Hospital Foundation, Inc., 701 Sixth Street South, St. Petersburg, Fla. 33701.

Rodent-Borne Disease and Control. A course in rodent-borne diseases and control will be offered by the Training Program of the National Communicable Disease Center, Public Health Service, October 23–November 3, 1967. Subject matter will be directed to sanitarians, physicians, engineers, and members of other health-oriented disciplines.

Time will be divided equally between diseases associated with and control of commensal and wild rodents and lagomorphs. Field trips will enable trainees to use procedures learned in the classroom and laboratory.

Tuition and training manuals are free.

Information and application forms are available from the Training Office, AAEP, National Communicable Disease Center, Atlanta, Ga. 30333.

Residential Training Institute for Specialists in Aging. The University of Michigan and the Wayne State University Institute of Gerontology will conduct a 4-month residential institute to provide training in retirement housing management, multiservice centers, or milieu programing. Dates for the institute, which will be held in Ann Arbor, are September 4–December 12, 1967.

The training programs are directed especially to persons in midcareer entering the field of aging and to those already employed in services to the aging but lacking formal training in the knowledge and skills needed in their specific occupations.

Applicants must meet requirements for enrollment as special students in the graduate or undergraduate schools of either university. Upon satisfactory completion of a training program, students will be awarded a professional certificate. Qualified students may also earn college credits.

Persons accepted for any one of the programs may apply for financial assistance to cover all or part of their tuition, living, and travel expenses. In addition, a limited number of traineeships are available.

For more information write to Wilma Donahue, Director, Institute of Gerontology, 1510 Rackham Building, Ann Arbor, Mich. 48104.