# Sources of Referral to a Los Angeles Family Planning Center

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RECENT articles regarding population policy and control have reflected the concern that many action programs do not deal directly or effectively with the social, psychological, or economic variables that underlie the family planning behavior of the populations the programs are intended to serve. Davis has commented on the absence of understanding among policymakers as to what is involved in the acceptance of programs (*1*).

> The family planners do not ignore motivation. They are forever talking about attitudes and "needs." But they pose the issue in terms of the "acceptance" of birth control devices. At the most naive level, they assume that the lack of acceptance is a function of the contraceptive device itself. This reduces the motive problem to a technological question. The task of population control becomes simply the invention of a device that will be acceptable.

Davis illustrated this point by referring to remarks such as those of C. Chandresharan who reported failure of a family planning program using a pad saturated with sandalwood oil. "In spite of the advantages of good spermicidal activity, cheapness, and indigenous production, it failed because it was too messy in use." Davis quoted from a panel discussion on comparative acceptability of different methods of contraception (*1a*, *2*).

If it may be assumed that changes in attitudes toward family size, the values underlying motivation to have children, and the ideologies regarding childrearing as well as childbearing are involved, such changes must be given at least the same attention as changes from the use of one technique to another, identification of appropriate target groups, or other factors.

Many questions must be answered if we are to think in terms of changing ideologies. We do not yet know what participation in family planning clinics means to the clients, how clients find their way to clinics, how long they stay, or the impact of birth control on clients' views of family life. These elements must be studied immediately if effective control programs are to be developed. Some effort can be made to understand planning behavior by examining records of family planning clinics.

### Importance of Source of Referral

In almost all of the patient records kept by health agencies, private practitioners, and hospitals, one item names the agency or person who informed the client about the particular health service he now seeks. This item may have several headings, but the source of referral is usually specified. The source of referral is important for several reasons.

Although it may be a poor indicator of all the advice a client may have received, being visible only as she takes further action, the source of referral serves as an index of the effectiveness of agencies as compared with other sources of advice in educating or persuading the women who act. Consideration of these sources may further reveal that within a population

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certain persons usually follow one advising group rather than another, some persons acting more readily on their own cognizance and others responding more frequently to the advice of welfare agencies.

Much of the information and advice about family planning has been distributed in the same manner as health information and by the same personnel. Only in recent years has the base of dissemination been broadened and the topic more widely discussed. With more public discussion of worldwide population problems, printed reports of control programs in various parts of the world, and revelations of new advances in control techniques, it is no longer likely that persons in our society will get their first information about birth control in a physician's office.

Therefore, the client seeking advice from a family planning clinic presumably is not there to ask, "What is birth control?" but rather, "What is a good birth control method for me?" In an earlier report about the clinic population described in this paper, it was shown that the clients had wide experience with various contraceptive methods before they came to the family planning center (*3*).

The question of interest in this paper is: Who did the clients say sent them? A referral source is a potential nidus of attitudes toward family planning. It is a group or person to whom the client has listened.

The 1,506 women in this study registered in an urban, west-coast family planning center during 1966–67. This privately supported center is located in a low-income area in Los An-

**Table 1. Source of referrals to a Los Angeles family planning center, 1966–67, by educational level of client [1]**

| Source of referral | Grammar school | | High school | | College | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| Self | 20 | 12 | 122 | 13 | 148 | 37 |
| Bureau of public assistance, physicians, and health agencies | 72 | 42 | 387 | 41 | 91 | 23 |
| Friends and relatives | 76 | 45 | 411 | 44 | 137 | 35 |
| Mass media | 2 | 1 | 20 | 2 | 20 | 5 |
| Total | 170 | 100 | 940 | 100 | 396 | 100 |

[1] $X^2=122.7$; 6 degrees of freedom; $P=0.001$.

**Table 2. Source of referrals to a Los Angeles family planning center, 1966–67, by marital status and educational level of client**

| Marital status and source of referral | Grammar school | | High school | | College | |
|---|---|---|---|---|---|---|
| | Number | Percent of marital group | Number | Percent of marital group | Number | Percent of marital group |
| Single: [1] | | | | | | |
| Self | 2 | 9 | 23 | 13 | 38 | 30 |
| Bureau of public assistance, physicians, and health agencies | 15 | 65 | 76 | 44 | 23 | 18 |
| Friends and relatives | 6 | 26 | 73 | 42 | 63 | 49 |
| Mass media | 0 | 0 | 0 | 0 | 4 | 3 |
| Married: [2] | | | | | | |
| Self | 18 | 12 | 99 | 13 | 110 | 41 |
| Bureau of public assistance, physicians, and health agencies | 57 | 39 | 311 | 41 | 68 | 25 |
| Friends and relatives | 70 | 48 | 338 | 44 | 74 | 28 |
| Mass media | 2 | 1 | 20 | 2 | 16 | 6 |
| Total | 170 | | 940 | | 396 | |

[1] $X^2=42.2$; 6 degrees of freedom; $P=0.001$.

[2] $X^2=106.4$; 6 degrees of freedom; $P=0.001$.

geles comprising white, Negro, and Mexican-American residents of varied religious backgrounds, students from a nearby university, and a transient "beatnik" and "hippy" population. The population is more diverse than that of other nearby low-income areas.

The center provides fertility and birth control services for a small fee or for no fee to those who cannot pay. The sources of referral to the clinic of these clients are shown below.

| *Source of referral* | *Number* | *Percent* |
|---|---|---|
| Self | 290 | 19 |
| Bureau of public assistance | 178 | 12 |
| Physicians | 79 | 5 |
| Health agencies | 293 | 19 |
| Friends | 524 | 35 |
| Relatives | 100 | 7 |
| Mass media | 42 | 3 |
| Total | 1,506 | 100 |

Clients' statements about sources varied in validity. When a client said that the Los Angeles Bureau of Public Assistance, the Los Angeles County Health Department, U.C.L.A. Medical Center, or a physician referred her to the clinic, she probably was being accurate. When she reported that she heard about the clinic from a friend or relative, heard about it on the radio, or read something in the newspaper, there was less confidence in her statement.

When the client said that she came in on her own advisement, we did not know the process by which she reached her decision. We only knew that she thought of herself as self-motivating at the time of registration.

One interesting observation was that more than five times as many friends as relatives were cited, and that among the 100 relatives, no husband was mentioned as the source of referral by any client. Husbands may have been concealed in the response "self" to the extent that they discussed birth control with their wives or encouraged earlier visits to physicians. However, no client said, "I came because my husband thought I should."

### Education, Ethnic Group, and Religion

Referral sources are shown in table 1 where the pattern can be seen to vary by educational level. As expected, an increase in the level of

**Table 3. Source of referrals to a Los Angeles family planning center, 1966–67, by race, surname, and educational level of client**

| Race, surname, and source of referral | Grammar school | | High school | | College | |
|---|---|---|---|---|---|---|
| | Number | Percent of racial or cultural group | Number | Percent of racial or cultural group | Number | Percent of racial or cultural group |
| White: [1] | | | | | | |
| Self | 6 | 11 | 78 | 15 | 137 | 39 |
| Bureau of public assistance, physicians, and health agencies | 26 | 46 | 203 | 38 | 77 | 22 |
| Friends and relatives | 23 | 40 | 244 | 46 | 117 | 33 |
| Mass media | 2 | 3 | 9 | 1 | 19 | 5 |
| Nonwhite: [2] | | | | | | |
| Self | 2 | 10 | 29 | 13 | 6 | 19 |
| Bureau of public assistance, physicians, and health agencies | 10 | 53 | 109 | 49 | 8 | 26 |
| Friends and relatives | 7 | 37 | 78 | 35 | 16 | 52 |
| Mass media | 0 | 0 | 7 | 3 | 1 | 3 |
| Spanish surname: [3] | | | | | | |
| Self | 12 | 13 | 15 | 8 | 5 | 33 |
| Bureau of public assistance, physicians, and health agencies | 36 | 38 | 75 | 41 | 6 | 40 |
| Friends and relatives | 46 | 49 | 89 | 49 | 4 | 27 |
| Mass media | 0 | 0 | 4 | 2 | 0 | 0 |
| Total | 170 | | 940 | | 396 | |

[1] $X^2 = 102.34$; 6 degrees of freedom; $P = 0.001$.
[2] $X^2 = 8.19$, not significant.
[3] $X^2 = 11.03$, not significant.

**Table 4. Source of referrals to a Los Angeles family planning center, 1966–67, by religious affiliation and educational level of client**

| Religious affiliation and source of referral | Grammar school | | High school | | College | |
|---|---|---|---|---|---|---|
| | Number | Percent of religious group | Number | Percent of religious group | Number | Percent of religious group |
| Protestant: [1] | | | | | | |
| Self | 7 | 12 | 68 | 13 | 49 | 30 |
| Bureau of public assistance, physicians, and health agencies | 28 | 50 | 213 | 42 | 46 | 29 |
| Friends and relatives | 19 | 34 | 222 | 44 | 57 | 35 |
| Mass media | 2 | 4 | 7 | 1 | 9 | 6 |
| Catholic: [2] | | | | | | |
| Self | 12 | 11 | 38 | 11 | 25 | 36 |
| Bureau of public assistance, physicians, and health agencies | 39 | 37 | 142 | 41 | 20 | 29 |
| Friends and relatives | 54 | 50 | 155 | 45 | 24 | 34 |
| Mass media | 0 | 0 | 9 | 3 | 1 | 1 |
| Jewish and nonaffiliated: [3] | | | | | | |
| Self | 1 | 11 | 16 | 19 | 74 | 45 |
| Bureau of public assistance, physicians, and health agencies | 5 | 56 | 32 | 37 | 25 | 15 |
| Friends and relatives | 3 | 33 | 34 | 40 | 56 | 34 |
| Mass media | 0 | 0 | 4 | 4 | 10 | 6 |
| Total | 170 | | 940 | | 396 | |

[1] $X^2=34.19$; 6 degrees of freedom; $P=0.001$.
[2] $X^2=20.93$; 6 degrees of freedom; $P=0.001$.
[3] $X^2=37.27$; 6 degrees of freedom; $P=0.001$.

education was accompanied by an increased reliance on self. The college-educated clients said they came to the clinic of their own volition. There was little difference, however, in the referral sources of women with grammar school or high school educations. Further analyses of the data revealed that at each educational level other factors were operative. Sources mentioned by married and single women at each educational level are shown in table 2.

In table 2 it may be seen that the married women's responses were similar to those presented in table 1, but that the unmarried came to the clinic by different routes. The married women with grade school or high school educations had heard about the clinic mainly from friends and relatives, next from agencies and physicians, and least often were self-referring. More of the married college women were self-referring, less often mentioning friends, relatives, agencies, or physicians. This pattern was quite different from that of the unmarried women.

The small number of unmarried clients at the grammar school level precluded a conclusion, but at the college level the unmarried clients mentioned friends and relatives as referral sources more often than "self." Unmarried women at all educational levels cited agencies and physicians much less than other groups. Perhaps there is fear of public disapproval or a belief that agencies cannot help them.

Actually, it is possible that agencies did make referrals that were not mentioned by these clients. A study of the referral notations in the records of the appropriate agencies would be necessary before any conclusion might be reached.

In considering the frequencies of various sources of referral by different racial groups (table 3), the patterning which is most similar to that of table 1 is that of the white respondents. As educational level increased, the clients became more self-determinant. This was not the case, however, with either the Negro clients or those with a Spanish surname. (Spanish surname is used with with no intention to denote a racial group. The term is used only in a cultural sense.)

Among Negro respondents the persistent indication of groups other than self as refer-

ents was revealing, if not conclusive, because of the small number of women in both the grammar school and college categories. Among clients with a Spanish surname, there was little shift from the grammar school to the high school level. Although markedly higher among the culturally Spanish women, the frequencies among college level women were too small for any firm conclusions and the differences were not statistically significant.

Table 4 shows the distribution of referrals by religious affiliation and educational level. The changes in referral sources are again most apparent among all of the college-educated women, the most striking difference occurring among women of Jewish and nonaffiliated backgrounds.

## Conclusion

The tables mainly indicate that, at least in this clinical setting, agencies and physicians are less important sources of referral than are self, friends, or relatives. Apparently, informal and personal advice influences client action more frequently than the advice of more formally authoritative persons.

There is no large body of research literature on the subject of referral which might be used to confirm or contradict our observations. The subject of referral is rarely explored in health research generally, and seemingly not at all in family planning research. If referrals are indeed being made, but clients are not following through, it is as important to know as the fact that referrals are not made.

The minimal indication of physician as a source of referral also raises some questions. Perhaps physicians feel that family planning advice is the proper task of private practice, and there is no need to refer patients seeking help to clinics. The activity of private physicians is valuable, but if we consider the scope of needed family planning services, private practice can only be regarded as making a minimal contribution to the large requirement of society. As yet, the American Medical Association has specified or carried out no programs to teach or provide family planning services for those who need or want them.

If we continue thinking along the lines suggested by Davis, we would conclude that it would be difficult to change family planning practices by arming the formal agencies with birth control devices and literature. What changes are to occur will more likely originate in the conversations of friends and relatives, perhaps in small group settings or in neighborhoods. If there are to be large programs, maybe an implication of these findings is that they should be conducted in small-scale settings so that natural leaders, the experienced and wise in all neighborhoods, can implement these programs with the help of agencies, rather than leaving the subject to agencies themselves.

## REFERENCES


(*1*) Davis, K.: Population policy: Will current programs succeed? Science 158: 730–739, Nov. 10, 1967; (*a*) p. 733.

(*2*) Research and family planning, edited by C. V. Kiser. Princeton University Press, Princeton, N.J., 1962, p. 376.

(*3*) Morris, M., and Weinstock, E.: The differential effects of education on family planning. Family Coordinator. In press.