

THE ORLEANS PARISH FAMILY PLANNING DEMONSTRATION PROGRAM

A Description of the First Year

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Studies conducted in New Orleans during 1964 and 1965^{1,2} revealed a marked gradient of information concerning basic reproductive physiology, the ovulatory cycle and effective means of contraception among all social classes in the metropolitan New Orleans area. A lack of information was especially noted within the lower socioeconomic group. For example, approximately 90 per cent of the males and females in the lower socioeconomic group of the metropolitan area did not understand the relation between the period of ovulation and fertility. These studies also indicated that approximately 27 per cent of the lower socioeconomic population could be classified as either sterile or subfecund. Within the fecundable portion of the lower socioeconomic population, it was estimated that 62 per cent of the population did not use any method of contraception during their most recent year of cohabitation. Approximately 38 per cent of this population had used some form of contraception, but frequently this use was sporadic and, in most cases, consisted of highly ineffective coital-related methods. These studies did not reveal any stated evidence of basic motivational blocks to the effective use of family planning techniques, rather the respondents expressed a strong desire to control fertility.

Studies conducted on the epidemiology of infant mortality and fetal mortality in the metropolitan New Orleans area since 1964 have indicated that the lack of family planning practice in the lower socioeconomic group contributes significantly to many obstacles in the achievement of family health and stability. For example, it was estimated that one-half of the women in the lower socioeconomic group who experienced a stillbirth or infant death during 1964 had a recognizable health problem that preexisted conception, thereby increasing the probability of a stillbirth, an infant or a maternal death within this group. The study of this group of high-risk mothers revealed a similar lack of information about reproductive physiology and contraceptive methodology.³ Because of the lack of information, contraceptive practices ranging from aspirin and Coca Cola douches to diluted potash douches had been used in attempts to prevent unwanted pregnancy. Again, in this group of high-risk mothers who had recently experienced a stillbirth, or a perinatal or infant death, no marked motivational blocks could be discerned that would prevent their acceptance and usage of family planning methodology; to the contrary, this group expressed strong motivation for the use of family planning services.³

A simple illustration of the contribution of the indigent to health problems in New Orleans can be obtained as follows. It is estimated that 26 per cent of the total female population aged 15 to 44 can be classified into the lower socioeconomic portion of the total population within the Standard Metropolitan Statistical Area. In the city of New Orleans, women within the lower socioeconomic group accounted for an estimated 56 per cent of the total births, 88 per cent of the births out of wedlock, 72 per cent of the stillbirths, 80 per cent of the maternal deaths and 68 per cent of the births to women under 19 years of age. All of these events are associated with and affected by fertility practices and especially with the practice of family planning. Although these data are from New Orleans, they reflect similarities for many large cities and rural communities within the United States.

Another essential aspect of the background information was the complete lack of organized family planning services available to the

indigent of the metropolitan area. The reasons for the lack of services have been described in other documents and previous writings and will not be dealt with here.⁴ The study and experiences alluded to led to the formulation of the hypothesis that the failure of the indigent population to practice family planning was primarily caused by an inadequate understanding of basic reproductive physiology and family planning techniques. In addition, the existing inadequate system of delivery of health services for the medically indigent did not include family planning services. It was further hypothesized, on the basis of preliminary data derived from a pilot study in Lincoln Parish,⁵ that an adequately designed program would be utilized by the majority of indigent families.

PURPOSE OF THE PROGRAM

The first goal of the Orleans Parish Family Planning Demonstration Program⁶ was to develop and organize a system for the delivery of family planning information and services capable of identifying, contacting, educating and providing services for all indigent families of the metropolitan area who were desirous of them, and, through this accomplishment, to enhance the system of health services to the indigent.

The second major goal of the program was to carry out the objectives described above in such manner that the entire indigent population of the area could be identified and offered services within a two-year period from July 1, 1967 through June 30, 1969.

A third objective was to evaluate the program—measuring its impact on fertility rates among the target population and its impact on the various obstacles to family health associated with the lack of family planning. This evaluation will continue through the third year, June 30, 1970, and subsequently as necessary.

OPERATIONAL PLAN

After the decision was made in the spring of 1966 to conduct a demonstration program, the period between July 1, 1966 and Oc-

tober, 1966, was spent in formulating a plan by which such a program could be initiated. The plan has been described previously in detail and will only be outlined here.⁵⁻⁷

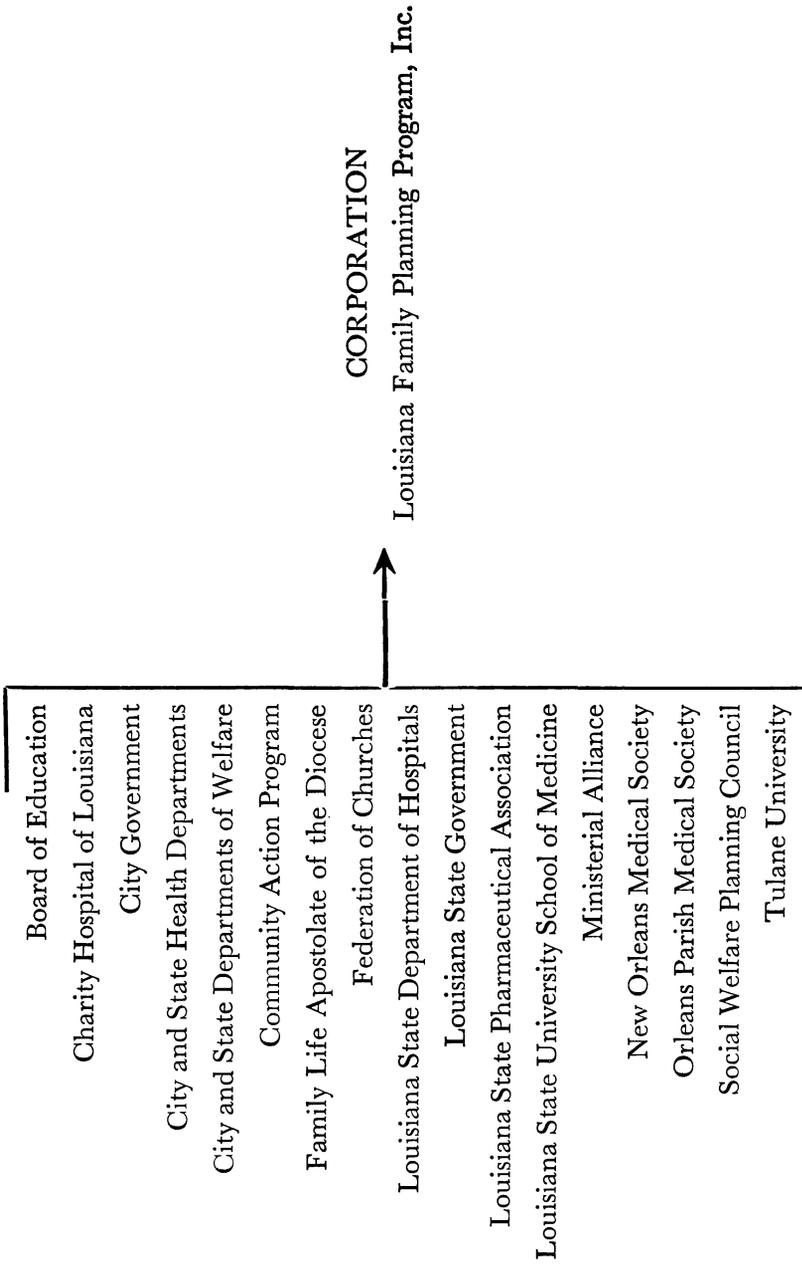
In October, 1966, the plan was initiated with the formation of a nonprofit corporation designated as the agency responsible for coordinating and implementing the service aspects of the demonstration program. This corporate mechanism was chosen, after considerable study, because the limited available funding required the use of existing resources and personnel with maximum efficiency and a degree of administrative flexibility that did not currently exist among the organizations participating in the program. Figure 1 shows the participating and cooperating agencies. From October, 1966 through April, 1967, two major types of activity were necessary. The first was to evaluate existing resources among the participating agencies and to develop the mechanisms of coordination necessary between the various agencies and the program. The second was the necessity for funding the various aspects of the program. These goals were accomplished by April, 1967, and the active preparation of facilities, recruitment and training of personnel, and other logistics began. The program was initiated officially on June 27, 1967.

DEMOGRAPHIC CHARACTERISTICS

The New Orleans Standard Metropolitan Statistical Area consists of three parishes (counties): Orleans Parish, Jefferson Parish and St. Bernard Parish. Orleans Parish can be identified as the central city of New Orleans, and Jefferson and St. Bernard Parishes form the urban ring. In 1960, the total population of the Standard Metropolitan Statistical Area was reported⁸ at 868,480 persons (69 per cent white, 31 per cent black) with 72 per cent of the total population resident in Orleans Parish. Within Orleans Parish 63 per cent of the population was classified as white.

Estimates⁹ of the total population for July 1, 1966, indicated that the Statistical Area had experienced a relative growth of 15 per cent since 1960. The 1960 census data and 1967 population

FIGURE I. PARTICIPATING AND COOPERATING AGENCIES IN THE NEW ORLEANS DEMONSTRATION PROGRAM



estimates for the three parish area are given in Table 1. Net migration estimates⁹ provided by the Bureau of the Census indicated central city area (Orleans Parish) had experienced a negative migration of approximately 28,000 persons whereas the urban area had experienced a positive net migration of approximately 58,000 persons. As of July 1, 1967, it is estimated that 66 per cent of the total population of the area was resident within Orleans Parish.

Table 1 also gives the female population data (aged 15 to 44 years) for the census period and as of July 1, 1967. The estimate for July 1, 1967, was 210,500 females aged 15 to 44 resident in the Standard Metropolitan Statistical Area. This baseline female population estimate was adjusted by information obtained from the 1965 Metropolitan New Orleans Survey¹ to estimate the total program-eligible population. The 1965 survey data yielded a 95 per cent confidence interval of 16 per cent to 23 per cent for the percentage of women who would be classified both as fertile and belonging to the lower socioeconomic class. This socioeconomic class was defined as women with family income under \$4,500, e

TABLE 1. POPULATION ESTIMATES FOR THE NEW ORLEANS STANDARD METROPOLITAN STATISTICAL AREA

<i>Date of Estimate</i>	<i>Orleans Parish</i>		<i>Jefferson and St. Bernard Parishes</i>		<i>Standard Metropolitan Statistical Area</i>	
	<i>Total Population</i>	<i>Female Population Aged 15-44</i>	<i>Total Population</i>	<i>Female Population Aged 15-44</i>	<i>Total Population</i>	<i>Female Population Aged 15-44</i>
1960 census	627,525	129,692	240,955	52,348	868,480	182,046
July 1, 1967	653,800	135,300	341,200	75,200	995,000	210,500

TABLE 2. GENERAL FERTILITY RATES, NEW ORLEANS

<i>Year</i>	<i>White</i>	<i>Black</i>	<i>Total</i>
1960	112.3	167.3	129.1
1967	78.5	138.7	95.9
Percentage decrease	30.1	17.1	25.7

The general fertility rate is defined as the ratio of all births to the number of women in the interval 15 to 44 years. It is used as births per 1,000 women of childbearing age.

cation of head of household no more than one year of high school, and occupation of head of household that falls into the service or laborer category. Applying the interval estimate for the percentage of females eligible to the baseline estimate of the total female population (aged 15 to 44) resulted in an interval estimate of 33,700 to 48,400 women eligible for the program.

Table 2 gives a general indication of the fertility patterns experienced in the Statistical Area during the period 1960 to 1967. The general fertility rate dropped from the 1960 level of 129.1 to 95.9 in 1967, a relative decline of 26 per cent during this seven-year period. Ethnic-specific fertility rates indicated that the general fertility rates for the white population experienced a 30 per cent decrease and the fertility rates for the black population experienced a 17 per cent decline during the same period. Thus the area is in a period of declining fertility but an interaction appears between the period fertility declines and the ethnic-specific differentials. It is hypothesized that much of the interaction and the comparative levels of fertility performance between the white and black fertility rates are the result of the previous unavailability of family planning information and services for the indigent segment of the population. It is also hypothesized that with the provision of information, education and service, the fertility rates in the black population will "rapidly" approximate those observed in the balance of the population. To support this conjecture a recent study² has noted that the fertility among the middle-class black in New Orleans presently is lower than the corresponding fertility observed in the white population.

RESULTS OF THE FIRST YEAR

Table 3 gives the total number of contacts made, appointments kept and the total number of acceptors of family planning methods during the first year of program operation. In this period of time a total of 12,256 contacts were made by the clinic program. These 12,256 contacts yielded 9,210 first admissions to the clinic program, which subsequently led to 8,886 patients accepting a method of

TABLE 3. TOTAL PROGRAM RESPONSE AND ACCEPTANCE RATES

<i>Annual Rates</i>		<i>Rate per 100 Females Aged 15-44 Years</i>	<i>Rate per 100 Estimated Program-Eligible Females Aged 15-44 Years</i>
Total program contacts	12,256	5.8	25.3-36.4
Total first admissions	9,210	4.4	19.0-27.3
Total acceptors	8,886	4.2	18.4-26.4

family planning. The type of method accepted and demographic characteristics of the acceptors are reported in a subsequent section.

The data representing the total response of the target population to the clinic program are also presented in Table 3 relative to both estimates of the total female population aged 15 to 44 years and the defined program-eligible population aged 15 to 44 years. Approximately six per cent of the total female population aged 15 to 44 was contacted by the program and this represents a contact rate of between 25.3 and 36.4 contacts per 100 eligible females. This program contact rate, then, generated a first admission rate of between 19.0 and 27.3 first admissions per 100 eligible females. The family planning method acceptance rate is estimated to be between 18.4 and 26.4 acceptors per 100 eligible females.

CONTACT PRIORITIES AND MECHANISMS OF PATIENT CONTACT

The total response to the program can best be interpreted by understanding the priorities and mechanisms established at the start of the program for contacting the eligible patient population. As stated previously, the immediate program goals were to identify the entire eligible population of the metropolitan New Orleans area and to contact, educate and offer services to this population within a two-year period from the start of the program. In terms of achieving these goals a set of contact priorities was established and the prospective patient population divided into four target groups. These four target groups, defined below, will be referred to as (1) the postpartum group, (2) the identifiable high-risk group, (3)

the identifiable low-risk group and (4) the nonidentifiable group.

The highest contact priority was placed upon the postpartum group. This group consists of all indigent women who have experienced a reproductive event since May, 1967. As of May, 1967, every woman experiencing a reproductive event in The Charity Hospital of Louisiana at New Orleans was personally contacted by a Family Planning Program nurse on day one or two postpartum. This contact mechanism is established on a current and continuing basis.

The postpartum contact consists of an individual education session and the offer of an appointment to the program for postpartum and family planning care. In addition, the patient is given literature that she and her husband can study at home and that emphasizes the value of family planning and the importance of a postpartum medical examination.

The second type of postpartum contact is made through the cooperation of the medical societies in the metropolitan area. Indigent patients delivering in private hospitals are referred to the program if, in the judgment of the physician and the patient, that is the best manner of completing her postpartum and family planning care.

The third type of postpartum contact is made with patients delivering at home. A program or public health nurse makes a home visit upon the receipt of a birth certificate indicating a home delivery. In these cases the nurse provides generalized health information and services for the mother and child. This home contact includes the offer of an appointment to the clinic program for postpartum and family planning care.

These three types of postpartum contact thus enabled the clinic program to reach, with both information and service, a high proportion of disadvantaged patients who experienced a birth during the initial program year. The emphasis of the postpartum contact is upon highly individualized contact between the patient and nurse. The patient's privacy is protected and emphasis is placed upon the total maternal health aspects of postpartum care as well as upon family planning care. The initial contact with the patient

is considered as the beginning of an educational process that is to be continued throughout the patient's association with the clinic program. Patient dignity is the primary consideration in the scheduling of individual appointments.

The second contact priority was directed at those indigent women who were not currently pregnant, but who had a recognized reproductive event during the past three years and who possessed at least one of the following high-risk characteristics: (1) six or more children, (2) under 16 or over 40 years of age, (3) experienced a previous stillbirth or infant death, (4) experienced a premature birth at the most recent delivery, (5) last birth out of wedlock. The term *recognized reproductive event* refers to any live birth or stillbirth that can be identified through the state vital record system.

The identifiable high-risk women are contacted on an individual basis by a family planning auxiliary worker. The prospective high-risk patient is informed of the program and offered an opportunity to participate in the clinic program. If a prospective patient is interested, she is given an appointment to the program at a specified time and date. This high-risk group of women is scheduled for complete contact within the first 18 months of program operation.

The third contact priority is directed at the identifiable low-risk group of women. The low-risk group consists of those indigent women who had a recognized reproductive event during the past three years, but who had not developed any reported characteristic that, from a statistical basis, would place them in the high-risk category previously defined. The entire low-risk population is scheduled for personal contact during the second year of program operation.

The fourth group, the nonidentifiable group, consists of women who are not currently pregnant nor able to be classified into one of the groups defined above. The program depends upon referral from a large variety of agencies for contact with this group. The total number of patients involved in this nonidentifiable group is unknown, thus it is difficult to evaluate the various methods of contact. Patients from this group are referred by the Department

of Welfare, other services in the Louisiana State and Tulane University Medical Schools, private hospitals, private physicians, poverty program workers, ministers, priests and many voluntary organizations. An active health education program is being developed for the purpose of identifying, contacting and educating as many patients in this category as possible.

FAMILY PLANNING AUXILIARY WORKER SYSTEM

The potential magnitude of the patient referral systems described in the previous section clearly dictated that the manpower resources required to accomplish these tasks be concisely defined at an early stage of program operation. For example, initial program estimates of the high-risk reservoir were that 12,500 patients would be initially classified as high-risk patients. This fact, coupled with the realization that all clinic patients would receive initial and routine revisit medical examination with patient follow-up, led to the development and implementation of the Family Planning Auxiliary Worker System.

A carefully designed program¹⁰ for the recruitment, education and training of indigenous personnel was developed and fully implemented within the first six months of program operation. Initially 30 women were selected from census tracts where the majority of the patients reside. Many of the women who ultimately became auxiliaries were clinic patients, but this was not one of the selection criteria. The auxiliaries were selected from a highly intelligent group of women within the poorer segment of the population who had a relatively low level of education, but a predicted high capacity for training.

The principal functions of the auxiliary system involve contact work within the high- and low-risk segments of the population and patient follow-up in the case of missed clinic appointments. The family planning auxiliary workers also frequently carry out special functions of the overall program. For example, if a patient has a positive cervical smear suggesting cancer of the cervix, these auxiliaries will enter into what amounts to an extensive form of detective

work to follow up every patient with a suspected life-threatening lesion. At times the auxiliaries also accompany patients to special clinics when such referrals are necessary.

Within their role as follow-up workers in the case of missed clinic appointments, the family planning auxiliary workers act as intermediaries between the patient and the program. They introduce themselves to the patient, explain the reason for their appearance and ask if the patient is still interested in the program and desires another appointment. If the patient is still undecided about an appointment and requests further information, the family planning worker provides information to the patient in the areas of reproductive physiology and family planning. The family planning worker also attempts to find out if the patient has had some contact with the program that was in any way unpleasant. If this has occurred, the incidents are documented and referred to the coordinator of patient services for individual case investigation.

Because of the marked importance to the improvement of maternal and child health in the identifiable high-risk population, initial and follow-up contacts with this group have been maintained as highest priority. After the high- and low-risk populations have been contacted, it is planned to enhance the quality and intensity of a variety of activities in which family planning auxiliaries will be engaged.

ANALYSIS OF INITIAL APPOINTMENTS

The total response to the program by appointment type is given in Table 4. The first column of Table 4 describes three types of initial clinic appointments. If a patient fails to keep her first clinic appointment, (I1), she is subsequently contacted by telephone or mail. In this telephone or mail contact (I2) she is offered another appointment. If the patient fails to keep the second appointment, she receives a home visit from one of the program's family planning auxiliary workers. The auxiliary system has follow-up responsibility for every patient who accepted an initial appointment and did not keep that appointment.

TABLE 4. INITIAL APPOINTMENTS MADE AND KEPT, AND PROPORTION KEPT BY TYPE OF APPOINTMENT

<i>Type of Appointment</i>	<i>Number of Appointments Made</i>	<i>Number of Appointments Kept</i>	<i>Proportion of Appointments Kept</i>
First appointment (I1)	12,256	7,557	0.62
Second appointment made by phone or mail (I2)	4,300	1,074	0.25
Third appointment made at time of home visit (I3)	1,360	579	0.43
Total	17,916	9,210	0.51

As can be seen in Table 4, a total of 12,256 women accepted an initial appointment. A total of 7,557 or 62 per cent of the women kept their initial appointment. Of those not keeping the initial appointment, 4,300 were contacted either by phone or by mail and 1,074 kept appointments as a result of this type of contact. After the first or second contact 1,360 women failed to keep an appointment and thus received a home visit. Of the 1,360 women receiving a home visit, 579 or 43 per cent kept an appointment. Of the total 12,256 initial appointments given, 9,210 or 75 per cent were kept. This 75 per cent attendance figure is a minimal estimate because some patients were given initial appointments during the first program year, but could be kept only after July 1, 1968. Internal clinic data indicate that between 75 per cent and 85 per cent of the women will accept and eventually keep their initial appointment. To involve these 9,210 women in the program, a total of 17,916 appointments of all types were given. It can be seen from Table 4 that the total number of women who kept an initial appointment was increased from 7,557 to 9,210 or 22 per cent because of the existence of the follow-up system.

Previous experience in Lincoln Parish indicated that the yield of a second or a third contact in the event of a missed first appointment decreases with each contact and on the basis of these data the decision was made to remove from the follow-up system women

TABLE 5. FIRST ADMISSIONS BY SOURCE OF REFERRAL AND TIME PERIOD OF ADMISSION

<i>Time Period</i>	<i>Postpartum Referral</i>	<i>Source of Referral</i>			<i>Total</i>
		<i>Clinic Worker Referral</i>	<i>Self or Friend Referral</i>	<i>Other Referral</i>	
July*					
August 1967	1,440	5	195	301	1,941
September					
October					
November 1967	1,430	95	490	224	2,239
December					
January					
February 1968	1,292	483	672	251	2,698
March					
April					
May 1968	1,311	378	495	148	2,332
June					
Total	5,473	961	1,852	924	9,210
Per cent	59.4	10.4	20.1	10.0	

* The first quarter report includes 325 patients who were admitted as special patients previous to June, 1967.

who did not keep an initial appointment after they had received one home visit.⁵ The fact that between 75 per cent and 85 per cent of all women who were offered appointments to the program accepted and kept their initial appointments indicates strong motivation in this population toward participation in the Family Planning Program.

SOURCES OF PATIENT REFERRAL

Table 5 presents a tabulation of first admissions by source of referral and the time period of admission. As would be expected from the establishment of the contact priorities, 59 per cent of all women who actually attended the clinic did so as a result of a postpartum referral. The secular variation observed in the number of postpartum referrals is principally a result of the seasonal variation in the number of births.

The Family Planning Auxiliary Worker System accounted for

approximately ten per cent of the referrals during the first year of program operation. This auxiliary system was not fully implemented until December, 1967, and during the first six months of program operation accounted for only 100 of the patient referrals. After full implementation of the auxiliary system, its activity produced 483 patients in the subsequent quarter. The number of patients generated as a result of the auxiliary system decreased during the fourth quarter by approximately 25 per cent. The principal reason for the decrease was that the proportion of auxiliary time required for patient follow-up increased substantially in this period and thus the amount of time available for contact with the high-risk group decreased.

Twenty per cent of the first admissions were classified as friend or self referrals. It is of interest to note that these referrals occurred without the benefit of an extensive community educational program or the use of mass media. It is anticipated that the proportion of friend or self referrals will increase and will be enhanced by the implementation of a community health education program.

Other types of referrals accounted for only ten per cent of the total number of initial patients. These patients were referred to the program by public welfare departments, poverty program agencies, voluntary organizations and private institutions. This ten per cent was of particular interest because a well-organized educational program was carried out with employees of all agencies that apparently had considerable contact with the indigent segment of the population. The number of referrals from these sources decreased during the year and this aspect of the referral system is currently under review. These data clearly indicate that had the program depended primarily upon referrals from established poverty-oriented agencies, it would have reached very few of the indigent population.

The impact of the set of referral data is in the area of program design. The initial design of any family planning program must incorporate a comprehensive mechanism for contacting, educating and giving service to the total population. The success of a pro-

gram is to a large degree dependent upon total patient contact; therefore, a program must provide dynamic and effective outreach systems.

THE PATIENT POPULATION

Ethnic Composition

Table 6 gives the ethnic composition of the group of first admissions during the initial program year. Of the total of 9,210 patients, 95.7 per cent of the patients were black and only 4.2 per cent were white.

An important factor that has become apparent is that many lower socioeconomic white patients, because of their racial prejudices, are not receiving family planning services. For example, the clinic receives frequent requests from women to be seen in either segregated clinics, or to be seen under special circumstances. Because these requests are not honored and these patients are seen in a routinely scheduled manner, it creates hostility and rejection of the program among the lower socioeconomic white population. The problem of how to reach this population and simultaneously operate a truly integrated clinic has proven to be a perplexing problem. A great deal of research needs to be conducted on this topic.

The data indicate a very strong motivation by black couples for family planning services and this appears to be the most important

TABLE 6. ETHNIC COMPOSITION OF FIRST ADMISSIONS BY SOURCE OF REFERRAL

<i>Ethnic Composition</i>	<i>Postpartum Referral</i>	<i>Source of Referral</i>			<i>Total</i>	<i>Per cent</i>
		<i>Clinic Worker Referral</i>	<i>Self-Friend Referral</i>	<i>Other Referral</i>		
Black	5,237	944	1,821	811	8,813	
Per cent	95.7	98.2	98.3	87.8		95.7
White	230	17	31	113	391	
Per cent	4.2	1.8	1.7	12.2		4.2
Other/unknown	6				6	
Total	5,473	961	1,852	924	9,210	

TABLE 7. AGE AND PARITY DISTRIBUTIONS OF FIRST ADMISSIONS BY REPORTED MARITAL STATUS*

Parity	Age						Un- known	Total	Per Cent
	Under 20	20-24	25-29	30-34	35-39	40+			
0-1									
Ever married	604	658	121	16	9	5	6	1,419	19.8
Never married	539	404	73	16	2		5	1,039	50.9
2-3									
Ever married	345	1,330	639	172	65	29	10	2,590	36.1
Never married	152	332	168	28	14		3	697	34.2
4-5									
Ever married	9	409	659	308	134	37	11	1,567	21.9
Never married	4	68	79	32	8	4	2	197	9.7
6-7									
Ever married		58	321	312	107	46	8	852	11.9
Never married		3	37	26	5	2	1	74	3.6
8+									
Ever married		4	115	256	223	132	6	736	10.3
Never married			6	13	10	3		32	1.6
Unknown									
Ever married			1					1	
Never married		1						1	
Total									
Ever married	958	2,459	1,856	1,064	538	249	41	7,165	77.9
Never married	695	808	363	115	39	9	11	2,040	22.1
Per cent									
Ever married	13.4	34.3	25.9	14.8	7.5	3.5	0.6		100
Never married	34.1	39.6	17.8	5.6	1.9	0.4	0.5		100

* This table excludes five cases where marital status was not determined.

TABLE 8. REPORTED AGE AT FIRST PREGNANCY AND YEARS OF FORMAL EDUCATION

Age at First Pregnancy	Years of Formal Education						Un- known	Total	Per- cent
	None	1-3	4-6	7-8	9-11	12+			
11-13	0	8	31	82	46	1	1	169	1.8
14-15	4	11	109	500	854	74	0	1,552	16.9
16-17	4	11	90	468	1,973	484	2	3,032	32.9
18	2	7	27	137	650	530	1	1,354	14.7
19	1	0	31	96	402	520	2	1,052	11.4
20+	4	14	51	158	572	1,134	3	1,936	21.0
Unknown or not applicable	1	0	5	14	42	51	2	115	1.3
Total	16	51	344	1,455	4,539	2,794	11	9,210	
Per cent	0.2	0.6	3.7	15.8	49.3	30.3	0.1		

factor in the high level of patient acceptance among the black indigent population. Because their motivation is so strong, no severe threat is seen to continuing participation by the indigent black couples in the program as long as the program is properly conducted from a medical standpoint, respects the privacy of the individual and respects the patient's freedom of choice.

Age, Parity, Education and Marital Status

Table 7 contrasts the age and parity distributions of first admissions according to the marital status reported by the patients. It can be observed that 2,040 or 22 per cent of the patients reported they were never married. Of those patients who were never married, 34 per cent of them were 19 years of age or younger as opposed to only 13 per cent of the married group in that age category. It is also of interest to note that 51 per cent of the never-married patients were at the zero or one parity levels. In the ever-married group 56 per cent of the patients were parity three or less, whereas in the never-married group 85 per cent of the patients were parity three or less.

Of women utilizing the program during the first year, 47 per cent were at parity three or less and of age 24 years or younger. This would indicate that programs with this design are capable of reaching families at a time when they are most in need of family planning services and that these programs could have the greatest possible effect upon the total number of children ever born per family.

Table 8 gives a cross tabulation of the age at which the first pregnancy occurred and the completed years of education for all first admission patients. Approximately 30 per cent of the patients were at least high school graduates. The majority of patients did not finish high school and the largest proportion, over 49 per cent, had received between nine and 11 years of formal education.

Approximately 66 per cent of the patients experienced their first pregnancies at age 18 years or younger. Of those whose age of first pregnancy was less than 18, only 20 per cent completed high school. A noticeable association appears in Table 8, namely, that as age

TABLE 9. REPORTED MARITAL STATUS OF FIRST ADMISSION PATIENTS

<i>Marital Status</i>	<i>Number</i>	<i>Per cent</i>
Never married	2,040	22.1
Married with husband present	4,808	52.2
Common-law marriage	366	4.0
Married but separated	1,678	18.2
Divorced	210	2.3
Widowed	103	1.1
Unknown	5	
Total	9,210	

of first pregnancy increases the number of years of formal education completed increases. It is believed that pregnancy is the major reason for high school dropout in girls. If this belief is correct, it lends strong support to the need for the provision of family life and sex education programs in the school system and to the provision of a better means of education for the teenager who does become pregnant during the high school years. Research is also needed to examine other means of preventing the initial teenage pregnancy.

Table 9 gives the reported current marital status of the 9,210 first admissions. Table 7 showed that 22 per cent of the patients reported they had never been married. However, if the reported marital status is examined in detail, Table 9 reveals that only 56 per cent of the patient population is currently married with their husbands present. This is an indicator of the magnitude of the problem of family instability that exists in the patient population.

These data have many implications—but two aspects of it have particular importance. The psychological consequences of the absence of the male family head on a child during the first six years of life when he is undergoing his early developmental phases is immeasurable. To say that giving family planning information and service to this population is going to cause further disruption of family structure appears in the face of these data to be unfounded because 44 per cent of the women were not married or living with their husbands at the time they came to the clinic. It is difficult to see how this family instability problem could deteriorate beyond its

TABLE 10. REPORTED SOURCES OF UNEARNED INCOME AND MARITAL STATUS OF FIRST ADMISSIONS

<i>Unearned Income</i>	<i>Marital Status</i>				<i>Total</i>	<i>Per cent</i>
	<i>Married Husband Present</i>	<i>Ever Married Husband Absent</i>	<i>Never Married</i>	<i>Unknown</i>		
Aid to Dependent Children (ADC)	204	706	368	1	1,279	13.9
Other welfare	219	190	58	0	467	5.1
No unearned source	4,708	1,086	1,600	3	7,397	80.3
Unknown	43	9	14	1	67	0.7
Total	5,174	1,991	2,040	5	9,210	
Per cent	56.2	21.6	22.1			
Per cent receiving ADC	3.9	35.5	18.0			

present level. On the contrary, it appears that lack of family planning services may be having a devastating impact on the ability to establish and maintain a stable family environment.

Sources of Income

Table 10 gives the reported sources of unearned income classified by the reported marital status of the patients. Table 10 shows that 14 per cent of the patients stated they were receiving Aid to Dependent Children and 80 per cent of the patients stated no unearned sources of income. Also, from Table 10, 36 per cent of the ever-married patients who are not currently living with their husbands are receiving Aid to Dependent Children, whereas only 18 per cent of the never-married patients are receiving it. The proportions of patients receiving aid in these two categories were expected to be similar. These data, if valid, would indicate that one-half of the never-married patients who were eligible for Aid to Dependent Children were not receiving this assistance.

Granted the validity of reporting sources of unearned income, it would also appear that though approximately 7,500 families in the metropolitan area are receiving Aid to Dependent Children, the family planning program has been able to involve only 17 per cent of these families.

The obverse point is also of interest. Eighty per cent of the patients stated no unearned sources of income. This later finding has motivated research¹¹ to estimate the amount of money indigent families are willing to spend for comprehensive family planning services. Such information is of particular importance for short-range planning because of the slow rate at which both governmental and private sources have provided funds to make comprehensive family planning services available to the large segment of the population in need of these services.

Risk Status

Table 11 depicts the medical risk status of patients at first admission. It can be seen that 58 per cent of the initial patients could be

TABLE II. RISK STATUS OF FIRST ADMISSION PATIENTS

<i>Status</i>	<i>Number</i>	<i>Per cent</i>
Total not at high risk	3,854	41.8
Total at high risk	5,345	58.0
Risk status unknown	11	0.2
Total	9,210	100.0

TABLE 12. FAMILY PLANNING METHOD SELECTED COMPARED WITH THE PREVIOUS METHOD USED MOST FREQUENTLY

<i>Previous Method</i>	<i>Family Planning Method Selected</i>									<i>Un-known</i>	<i>Total</i>	<i>Per cent</i>
	<i>None</i>	<i>Pill</i>	<i>Foam</i>	<i>Con-dom</i>	<i>Rhythm</i>	<i>Dia-phragm</i>	<i>With-drawal</i>	<i>IUD</i>				
None	152	2,356	553	9	22	14	0	615	9	3,730	40.5	
Pill	63	1,462	216	1	1	11	0	472	8	2,234	24.3	
Jelly, cream or foam	33	850	181	0	1	22	0	361	4	1,452	15.8	
Condom	18	362	76	5	5	4	1	144	1	616	6.7	
Suppositories	4	65	22	0	0	0	0	33	0	124	1.3	
Rhythm	2	24	5	0	2	1	0	18	0	52	0.6	
Diaphragm	2	20	6	0	0	6	0	10	0	44	0.5	
Withdrawal	0	27	5	0	0	0	0	1	0	33	0.4	
IUD	2	4	2	0	0	0	0	10	2	20	0.2	
Other-unknown	22	553	141	0	1	9	0	177	2	905	9.8	
Total	298	5,723	1,207	15	32	67	1	1,841	26	9,210		
Per cent	3.2	62.1	13.1	0.2	0.3	0.7		20.0	0.3		100	

classified as medical high-risk patients. The definition of medical high risk incorporates information obtained from the physical examination of the patient. Thus, in addition to the high-risk characteristics defined previously the medical high-risk classification includes intercurrent medical conditions such as toxemia of previous pregnancy, diabetes and so forth.

It is apparent that if the total number of pregnancies is reduced in patients who are at risk of experiencing an undesirable reproductive event a decrease can be expected in the total number of untoward events such as maternal deaths, infant deaths and stillbirths. An important point to be made is that this reduction cannot be accomplished by selectively treating patients who have been identified as being at high risk, and especially not by the selective treatment of patients who have already experienced a previous perinatal death.¹² The entire population must be given service so that the total number of high-risk patients in the future can be markedly reduced. For this reason great emphasis must be placed on family planning in the overall design of family health programs.

Contraceptive Adoption

Table 12 gives a summary of family planning methods selected according to the previous method used most frequently in the past. The data indicate that 96 per cent of the 9,210 first admissions selected some method of family planning as a result of their clinic experience.

Table 12 also provides a comparison of methods used previously with methods adopted as a result of the patient's clinic experience. The extreme right-hand column of Table 12 gives the percentage of patients using a specified method in the past and the last row of the table gives the percentage of patients using a specified method after their initial program visit. It is seen that 41 per cent of the patient population reported no previous method of family planning. This can be compared to three per cent of the same patient population using no family planning method after completion of their initial program visit.

Several important transitions in method adoption can be ob-

served in Table 12. First, 24 per cent of the patients reported the pill as the method previously used most frequently; 62 per cent of the patients adopting the pill at their initial clinic visit. Only 0.2 per cent of the patients reported the IUD as their previous method, and 20 per cent of the patients adopted the IUD as a result of their clinic experience. It is also of interest that 16 per cent reported jelly, cream or foam as their previous method and 13 per cent selected foam as a method after participation in the program. The major response of the population was toward the adoption of effective family planning methods and the abandonment of methods considered to be relatively ineffective. This is best exemplified by observing that in the past only 25 per cent of the patients were using an effective method (pill or IUD) as contrasted to 82 per cent of the patient population adopting an effective method after participation in the program.

The philosophy used in patient education was to inform the patients about the advantages and disadvantages of all the various methods and then to allow them in individual nursing conferences to select the family planning method best suited to their individual needs. Table 12 depicts the results that can be expected when patients are educated in this manner. It is interesting to note that one of the negative results of the program has been the lack of acceptance of the rhythm method of family planning. Although particular emphasis has been placed on educating patients about the rhythm method, only 0.3 per cent of all patients participating in the program elected to use this method. The rhythm clinic has been one of the most expensive phases of the program when measured by patient utilization related to the required physician and nurse time. However, the rhythm clinic is judged to be essential to program development and will be maintained.

The implications of the high level of pill acceptance within the patient population are unclear at this time. The majority of the patients are adopting the pill because they believe it offers the surest form of protection from unwanted pregnancies. However, preliminary evidence indicates that the pregnancy rate of pill users will be higher than the pregnancy rate of IUD adopters.

ANALYSIS OF REVISIT APPOINTMENTS

The patient management schedule consists of an initial medical examination followed by a revisit medical examination approximately six to eight weeks after the initial examination. Revisit medical examinations are scheduled each year thereafter, unless medical problems dictate more frequent examination. The other class of revisit examinations consists of patient visits to the clinic for pill or foam supply renewals. Pill patients renew their supplies on a quarterly basis following the first revisit medical examination.

Table 13 gives the total number of revisit appointments given and the proportion kept according to the type of revisit appointment. This table represents both medical and supply revisits. If a patient misses a scheduled revisit appointment at any phase of her management a patient follow-up system is initiated. It can be observed in Table 13 that 67 per cent of the patients kept their original revisit appointment. Of those patients contacted by the R2 mechanism, 41 per cent kept their revisit appointment. Table 13 indicates that the total number of revisits kept was increased 18 per cent, from 14,040 to 17,175, because of the existence of the follow-up system. This yield of additional appointments kept appears to justify the expense and administrative effort expended to generate the observed number of appointments kept.

TABLE 13. REVISIT APPOINTMENTS MADE, KEPT, AND PROPORTION KEPT BY TYPE OF APPOINTMENT, ORLEANS PARISH CLINIC SYSTEM

<i>Type of Appointment</i>	<i>Number of Appointments Made</i>	<i>Number of Appointments Kept</i>	<i>Proportion of Appointments Kept</i>
First appointment (R1)	20,886	14,040	0.67
Second appointment made by phone or mail (R2)	5,539	2,285	0.41
Third appointment made at time of home visit (R3)	1,580	850	0.54
Total	28,005	17,175	0.61

Of the 20,886 revisit appointments given during the first year, 17,175 were kept, an average of 82 per cent. It is important to note that the 17,175 revisit appointments kept represent the total revisit appointments accumulated by the acceptors of the program during the first year.

A crude measure of the program's ability to maintain contact with the patient population can be obtained by comparing the total number of first admissions to the reported number of clinic closures for the first year of program operation. A clinic closure is defined as any patient who keeps an initial appointment and subsequently terminates contact with the program by failing to comply with the revisit schedule. This category includes patients who, after their first visit, were lost to follow-up as well as those who returned to the clinic to terminate their use of contraceptive method and did not elect to further utilize the clinic services.

During the first year of operation 9,210 first admissions and 1,253 reported closures were recorded. Thus, the closure rate is 13.6 closures per 100 first admissions. In other words, out of every 100 first admissions, 14 patients elected not to continue as clinic patients.

It is recognized that the clinic closure rate is not a substitute for measures of extended contraceptive use effectiveness in the patient population. However, such measures can only be properly obtained by specialized follow-up studies. Such a specialized sample survey of the first admission population is presently under design and will be executed early in 1969. The intent of this survey will be to evaluate the total contraceptive experience of the first admission population and their ability to avoid unwanted pregnancies.

SATELLITE FACILITY UTILIZATION

The total clinic system is composed of a central clinic and three satellite clinics located in the metropolitan area. The central clinic is located at the transportation hub of the city and is within walking distance of both medical schools and Charity Hospital. One of the satellite clinics is located in the Desire housing

TABLE 14. FIRST ADMISSIONS OF THE ORLEANS PARISH CLINIC SYSTEM DURING THE FIRST YEAR OF OPERATION

<i>Month of Admission</i>	<i>Central</i>	<i>Desire</i>	<i>Clinic Algiers-Fischer</i>	<i>Sara Mayo</i>	<i>Total</i>
July, 1967	810*				810*
August	537				537
September	594				594
October	598	13			611
November	753	45	6	14	818
December	717	37	29	27	810
January, 1968	862	60	34	40	996
February	723	50	16	32	821
March	785	51	27	18	881
April	755	36	24	29	844
May	764	34	20	25	843
June	599	22	23	1	645
Total	8,497	348	179	186	9,210

* The first admission report includes 325 patients who were admitted as special patients prior to July, 1967.

area and the other satellites are located in neighborhoods that have been designated as target areas by the Model Cities and Poverty Programs.

By referring to Table 14 one can observe relations between the level of patient utilization of the clinic system and the times at which the satellite clinics became operational. Consistently patients have seemed to prefer to use the services of the central clinic rather than services of one of the satellites. It had been assumed that the converse would be the case inasmuch as the services available in the satellites are similar to those of the central clinic and the satellites are located in the areas where the majority of the patients reside.

On the basis of a preliminary appraisal the following factors appear explanatory of the levels of patient utilization observed in the central clinic.

1. The medically indigent have a tradition of utilizing the medical services established in the area of the central city.
2. The major means of public transportation from the areas where the patients reside lead into this central area.

3. Because the central clinic is open on a day-night and Saturday basis, a patient can easily schedule a clinic visit in coordination with other routine activities conducted in the central city area.
4. Patients seem to prefer to keep their use of the clinic services a matter private from the usual flow of neighborhood communication.

Patient utilization patterns at this time suggest that patients prefer to utilize the central facility. Perhaps with present limited funds further consideration should be given to this question prior to the establishment of extensive and expensive comprehensive health care facilities in a few select neighborhoods within a metropolitan area. The neighborhood facility offering comprehensive services would seem to be a desirable goal. However, it appears that needed basic maternal health service could be made available to an entire city's population for the cost of the establishment of one neighborhood comprehensive health center providing services to between ten and twenty thousand persons.

EXPECTED CONTACT AND FIRST ADMISSION RESULTS FOR THE SECOND YEAR

On the basis of the contact and first admission rates achieved during the first year of program operation, the expected second year contact and first admission rates are given in Table 15. It is

TABLE 15. RESULTS ACHIEVED DURING THE FIRST YEAR AND PROJECTED RESULTS OF SECOND YEAR OF PROGRAM OPERATION

	<i>1966-1967 Estimates</i>		<i>1968-1969 Cumulative (Projected)</i>	
	Maximum	Minimum	Maximum	Minimum
Contact rates	36.4/100	25.3/100	88/100	62/100
First admission rates	Maximum	Minimum	Maximum	Minimum
	27.3/100	19.0/100	66/100	46/100

projected that by the end of the two-year period, the program will have contacted approximately 62 to 88 per cent of the defined eligible population. As a result of this contact rate the cumulative first admission rate should be between 46 and 66 first admissions per 100 eligible females. Thus, the two-year program goals will have been essentially accomplished during the prescribed period.

CONCLUSION

The experience of the first year of the Orleans Parish Demonstration Program indicates that the indigent want family planning services and will utilize these services if they are made available in an acceptable manner. The acceptance rates observed demonstrate that the problem is primarily one of the design and provision of adequate family planning and maternal health service to the indigent, not one of persuading the indigent to accept such services. The program described in this paper represents a program model that incorporates methodology of sufficient generality and flexibility that it could be successfully adapted to other populations.

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