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PATIENT PERSPECTIVES ON SERVICE: A Case Study of the St. John's Family Planning Clinic

by


May R. Johnson, R.N., B.S.

A thesis submitted in partial fulfillment
of the requirements for the degree of
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ABSTRACT

THESIS: PATIENT PERSPECTIVES ON SERVICE: A Case Study of the St. John's Family Planning Clinic

by May R. Johnson R.N., B.S.

The primary objectives of this study are to determine patient perceptions of clinical service and needs for family planning. The need to focus on these perspectives derived from an examination of the International and National Family Planning programs. A summary of these programs is presented, and the history of the development of birth control and the family planning clinic in St. John's is discussed.

The data was collected from one hundred and forty-two women who came into the family planning clinic in St. John's seeking family planning services. Each of these patients agreed to participate in an informal interview and consented to fill out a formal questionnaire which focused on specific areas such as clinic accessibility, atmosphere of service, patient expectations of service, convenience of hours, and professional expertise of service given.

Case histories and statements given by the patient were used to illustrate types of problems encountered by them in obtaining medical services. The role of the male, discussed in the counselling section,

establishes the need for including the male in family planning but points out the fact that until very recently little thought has been given to providing a role to the male in family planning.

Lastly, the viability of the medical model as compared with the client-centered model in providing a clinical family planning approach is discussed. Traditionally, most clinics follow a medical model. Because of the importance and time spent in the counselling role, a dual-model of family planning service is proposed. This consists of a medical model for the technological aspect of family planning and a client-centered model for the counselling and patient's psychological and emotional needs.

Recommendations for changes and directions in approaching family planning policy and service in Newfoundland are suggested. Included in these is the need for Newfoundland/Labrador to establish a provincial policy to allow for long range planning in the field of family planning.

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The views expressed in this thesis are not necessarily those of Planned Parenthood Newfoundland/Labrador.

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Yet a culture survives principally, I think, by the power of its institutions to bind and loose men in the conduct of their affairs with reasons which sink so deep into the self that they become commonly and implicitly understood- with that understanding of which explicit belief and precise knowledge of externals would show outwardly like the tip of an iceberg. Spiritualizers of religion (and precisions of science) failed to take into account the degree of intimacy with which this comprehensive interior understanding was cognate with historic institutions, binding even the ignorants of a culture to a great chain of meaning.

Philip Rieff, *The Triumph of the Therapeutic* (1966).

Chapter One - Introduction

Family Planning is a term used to describe the means whereby couples are voluntarily able to determine the number and spacing of their children through prevention or postponement of conception. Terms synonomous with family planning include 'birth control', 'planned parenthood', and 'fertility control'. Family Planning information is available from a number of sources ranging from folklore and 'old wives tales' to more scientific sources such as physicians, hospitals, and clinics.

When a patient consults a professional service such as a physician or family planning clinic for birth control, he/she has already made certain decisions influenced by individual personal aspirations, social situations, environmental situations, and his/her own values. The decision of whether or not to have a child at that moment, or perhaps not at all, guides the patient into seeking professional consultation. After that he/she must be motivated enough to consistently use the method of contraception of her choice to prevent conception. In time sequence then, the visit to the physician or clinic is relatively small compared to all that the person has experienced before arriving at the decision to contracept, or that he/she will experience afterwards in carrying out that decision. Because the ability to control ones own fertility is of utmost importance in determining an individuals life patterns, it is crucial to provide guidance and help to individuals in

the most useful and acceptable way. It seems logical, then, to determine from individuals seeking contraception exactly what services they would find most helpful, and which would provide them with the ability to maintain maximum contraceptive compliance. My present job, coordinator of the clinic, provided the access to the many patients that were interviewed in the study.

Reasons for the Study

From my personal experience in the field of family planning, and my involvement with clinical practice, I observed that most of the decision making as to patient needs for family planning was carried out by people who had little to do with clinics and furthermore had never used such a service. It was apparent that patients were increasingly attending birth control clinics, but nobody ever seemed to question why they were coming, or why they chose that service over other existing services in the community.

At about the same time that I was pondering this, individuals and groups of women around me began to question medical care. Women, in general, seemed dissatisfied about taking a secondary role in the control of their own fertility.

Finally, I began to reflect upon my early clinical experience in family planning. It was apparent to me that I learned little from my nurses training about family planning and clinical organization. There seemed to be little in the literature to enlighten the picture of what a clinic was, who came to the clinic, and what patients wanted from the service when they came. I was interested in how clinics could be

established by those who had little organizational information, and few resources at their disposal.

This study is an attempt to provide a guide to others of what a clinic is, and what the patients themselves perceive as important to them in the provision of service.

Clinic Model - Medical versus Patient-Centered

At the present time family planning services are set up on a medical model. The people using the services are called 'patients', and the clinic is staffed predominantly with medical personnel: nurses, physicians. Patients are in effect 'medicalized'. Is this the best type of model for a preventative type of service? Legally we need physicians in Canada to prescribe oral contraceptives, or to insert intrauterine devices. However, in the United States, Nurse Practitioners are functioning very successfully in this field, working under standing medical orders. In fact, some patients ask for them rather than for a physician for contraceptive service.[1] In some of the underdeveloped countries, non-medical personnel are being trained to prescribe pills, insert IUD's, and fit diaphragms.[2] In Thailand, government midwives were trained to dispense the oral contraceptive using a 'check list' to identify women with potential contraindications. A 400% increase in acceptors was reported in the first six months of the program.[3] Statistics have shown that there is no difference in risk factors associated with non-physicians administering contraceptive needs.[4] Why then do we in Canada need highly trained, costly physicians to do all the family

planning procedures? Is it necessary to develop a medical image to give acceptability to family planning? Certainly, physicians are involved in family planning needs with their patients whether they are comfortable with the topic or not. Indeed, the post partum patient and often the newly married, all see the physician for their health needs.[5]

Do family planning needs become low priority cases to more pressing emergencies in medical practice? Certainly, when time is at a premium, priorities will go to the more seriously ill patient than to a healthy patient who wants to control her own fertility. In these cases, does she become a "routine procedure" with little personalized care? Certainly, for someone with extensive training in difficult procedures, inserting an intrauterine device, or writing out a prescription becomes commonplace and routine. But perhaps the most serious limitation of family planning in the medical model is its idea of 'pathology', rather than prevention, and the patient dependence that appears to go along with this particular model.[6] At the present time, clinics are conceived, and usually run, on the model of providing services to sick people. But sick people are different from people who are well. They are different, not because they are sick, but because they know they have to depend upon someone else - the physician or other health personnel - for their recovery. It is because of this dependency that they are prepared to accept certain abuses and to undergo certain experiences which are difficult for a well person to undergo on a continuous basis. This dependence on a relationship discourages individual thinking and decision making.

Methodology

As was mentioned previously, a service is often established, it exists, and then it becomes a part of a bureaucracy. Most of the organization, service component, and day to day running, is set up the way the professionals perceive the need. Seldom is any thought given to what the patients themselves might want. It was decided to examine the clinic service by seeking opinions and suggestions from the people for whom the clinic was established.

There are many ways to analyze this type of problem.[7] To a large extent, the research goals of determining patient perception suggested that an ethnographic approach would be most appropriate. However, in order to provide a most complete and useful analysis of patient perceptions, it was decided to combine data collected in three different ways using different methods. If only one method of retrieving data was used, the investigator would only determine one trend. However, several methods will give more trends or aspects of empirical reality which should overlap giving a more accurate assessment of the overall picture. This is particularly useful when the experimental approach is not used. Multiple methods of observations are called triangulation. The notion of triangulation is supported by Denzin[8], who argues that triangulation is used to reduce the inherent bias of any one approach. It is well documented that in any one method used, there is a likelihood of certain bias. By using multiple methods, one can assume that the inherent bias in any particular method will be reduced

in the use of a combination of methods.

Three sources of data have been used to determine patients needs in this study; participant observation, informal interviews in a counselling situation, and structured and open-ended questionnaires.

Our sample was derived from patients coming into the clinic to use its services, supplying us with a constant but self-selected population. Because of the nature of the people we interviewed, we cannot generalize our findings to the total population of Newfoundland. Likewise, we are only able to discuss utilizers of clinic services, not utilizers of other services or the classification of 'non-utilizers'.

Non-utilizers cannot be discounted from a complete picture of family planning just because there are no records, because often these are people who receive services by 'friends', 'relatives', or 'phone consultations'. It is important to realize that the first point of contact about a problem is usually not the professional person. People usually try to cope with their personal problems by seeking help from their own interpersonal environment, particularly friends and relatives. If an individual does not receive help, which in her view is suitable, she will most likely seek help from another source. In other words, an individual's decision to seek professional help will be a function, in part, of her earlier interactions with her 'confidants' or lay helpers. Therefore, we must not assume that because they do not come to the clinic or other existing service they are not getting help

of any kind, because they are possibly getting help from their own network of friends and relatives. We particularly see this in the teenage population who are not ready to become 'patients' at this time, and have not been provided with legitimated access to contraceptive information and advice. The American experience suggests that informal, non-professional helpers are more widely consulted than are all the specialists combined (physicians, clergymen, mental health workers).[9]

The interviewers were full-time, part-time, and volunteer staff from Planned Parenthood. By profession, they were predominantly nurses, social workers, and students in professional fields. The interviews were conducted in private offices with the prior consent of the patient involved.

Participant Observation

The first source of data is participant observation and comprises the total experience of the investigator in the field of family planning and in counselling patients. This experience was obtained over a period of five years working in the field, and provides many of the directions which have been defined in this study.

It has been vigorously argued in the literature that "participant observation gives us the most complete information about social events and can thus be used as a yardstick to suggest what kinds of data escape us when we use other methods."[10] The participant observation

method has proved to be invaluable as a modus operandi in the work of social science. Indeed, many social scientists have made this method a 'life style'. Such studies as Whytes Street Corner Society[11], Mayo's The Social Problems of an Industrialized Civilization[12], and Kimball's The Talladega Story[13], may be cited as but a few examples of sociological classics utilizing the participant observer method. In the area of anthropology this method has been effectively used to gather data in the works of Spradley[14], Malinowski[15], Radcliffe-Brown[16], and Kluckhohn[17].

The work of Becker[18] and Kluckholn[19] has illustrated the many advantages of the participant observer method. This method has been defined by Kluckholn as:

> "A conscious, systematic sharing, insofar as circumstances permit, in the life-activities, and, on occasion in the interests and affects of a group of persons".[20]

Other advantages of the participant observation method are:

1. The actions of the group or individuals are least likely to be changed or affected by the presence of a person who is accepted as a participating member of the group.
2. Opportunities for observation are increased to the participant observer because of his close contact with the field situation; and
3. Certain interactions and sentiments will come to a participant observer which would be impossible for a researcher in another role to experience.

A further list of advantages implicit in the participant observer method includes:

4. The participant observer is not basically limited by a priorisms, but can reformulate the problem as he becomes familiar with the field situation.
5. Through familiarization with the field situation the observer is able to avoid misleading or meaningless questions.
6. The impressions of a participant field worker are very often more reliable as a way of structuring observations than are the rigid structures of an index based on a questionnaire.
7. The researcher is able to 'ease' himself into field situations and choose the appropriate moment to inquire into delicate or sensitive areas. In short, the researcher is able to 'play it by ear'.
8. It is possible to impute motives more validly on the basis of the interlocking aspirations and actual behavior, supplemented by occasional 'feedback' reactions.
9. The researcher can constantly reformulate, and remodify his conceptual categories to provide more meaningful analysis of his problem under study.
10. He can select additional informants in such a way as to throw additional light on emerging hypotheses.
11. He can generally reach 'in depth' materials more easily.
12. He can absorb considerable information which seems at the time irrelevant, but later proves valuable for elaboration and clarification of specific points central to the research.

13. He can make use of selected imformants' skills and insights by giving them free rein to report the problem situation as they see it. This is particularly important for the present research.
14. He is able to move back and forth between data-gathering in the field and desk analysis..
15. Through free data gathering the researcher probably distorts less the difficult-to-quantify situations or aspects of a problem.

The participant observer concept as a research methodology can be thought of as a continuum of activity, ranging from the researchers' passive observations to a complete involvement in the lives and activities of the subject. In the case of the latter the dangers are well known.

At one end of the continuum, that of complete inactivity, the researcher is an outside observer rather than an active member of the group surveyed. The observer would not be an intimate part of the groups activities, and he would view the events more as an outsider. Such a 'detached' perspective has certain advantages. The observer has more opportunity to count and quantify interactions, sentiments and activities. However, opportunities for certain interactions and sentiments do not come to a researcher operating from this pole of the continuum. The presence of an observer who is not

part of the activities is more likely to change the actions of the group under scrutiny than is a person whose presence is accepted as a routine day-to-day activity.

At the opposite end of the continuum of inactivity to active participant observation the observer is privy to certain kinds of information generated from within the ranks of the group itself. Because of the observer's somewhat integrated position information, sentiments, and activities are presented freely and he is in a position to isolate those aspects of behavior which he considers important. There is an administrative dilemma on whether the 'participant observer' or 'investigator' should be from within the organization, such as is the case in the present study, or from outside the organization, as an independent researcher. There is a rather common notion that only outsiders are likely to provide objective research and will therefore present any negative findings on the program. However, Freeman presents a quite different view. He states that:

> "...the image of the researcher who remains outside the environment and evaluates what others are doing in no way squares with the reality of his engagement in these programs. It is clear that the researcher is involved in a situation in which he must lock himself into the environment, not only because he has a background that can be exploited by persons designing programs, but because otherwise he cannot accomplish his evaluation task. Unless he participates, indeed leads the dialogue and bargaining required for the identification of goals, for description of input-output variables, and for the elaboration of a rationale that specifies the relationship between input variables and goals, these tasks are likely to remain undone. Once formulated he must continue to remain within the environment, like a snarling watchdog ready to fight alterations in program and procedures that could render his evaluation efforts useless."[21]

Riley (1963) has suggested that the participant observation studies are subject to two classes of error - "control effect" and "biased - viewpoint effect".[22] To counteract "control effect" an attempt has been made to systematize the population studied. The selection of four weeks including the total population seen at the clinic in each of those weeks should minimize the risk of measuring only 'positive patients'. The "biased - viewpoint effect" indicates that the interviewer will interpret the results given to him/her and will enhance the program or problem that is being studied or choose information which will substantiate his theory. This is a criticism both of researchers who are involved in their own program as well as outside evaluators who are brought in to do an independent evaluation. It is assumed that an outside researcher will have increased objectivity and be less personally involved in the outcome of the study. However, this is not always the case because contracts and program changes are based on the positive results of the studies. The inside researcher, as with the present study, has the advantage of knowing the problems to be dealt with, and is usually perceived to be non-threatening to the staff associated with the program.

The question of whether or not any data collected by any method has objectivity is discussed in some detail by Spradley[23]. Spradley believes that the most significant distortions in any scientific study of social behavior operate during the process of data collection. He goes on to explain that no researcher can study everything, so that the

data selection itself is biased. By being aware of this, the investigator is able to control for his/her own prejudices. It is in order to counteract some of this bias, that the triangulation approach has been used in this study.

The criteria for the adequacy of qualitative data are not available in as explicit a form as are those pertaining to quantitative analysis. It does not follow, however, that the data is therefore less adequate, but only that the evaluation of its adequacy is less easily agreed upon. In dealing with the problem of inference and proof in qualitative research, Becker points to certain similarities between quantitative and qualitative analysis:

> "In assessing the evidence for such a conclusion the observer takes a clue from his statistical colleagues. Instead of arguing that a conclusion is either totally true or false, he decides if possible, how likely it is that his conclusion about the frequency or distribution of some phenomenon is an accurate quasi-statistic, just as the statistician decides, on the basis of the varying values of a correlation coefficient or a significance figure, that his conclusion is more or less likely to be accurate."[24]

Becker has also suggested that qualitative research would become more 'scientific' and less 'artistic' endeavours if the data were presented in the main body of the research. Indeed, he stressed that the reader be given '...greater access to the data and the procedures on which conclusions are based'[25].

Becker's advice accounts in large part for the format of this study. The reader is given access to much of the data. Direct patient

quotes and actual cases have been used. However, the name of the patients has been changed and incidental information has been altered in order to protect the confidentiality of the patients. Many quotations are included in order to assist the reader in his assessment of the analysis.

The approach taken in this study is ethnographic or a study of self-selected patients in one clinic and consequently the other patients that seek family planning services elsewhere are analytically irrelevant.

Informal Interviews

The informal interviews conducted in the direct service counselling sessions were unstructured and allowed for an ethnographic approach to the study. An ethnography is not merely an objective description of people and their behavior from the observer's viewpoint. It is a systematic attempt to discover the knowledge a group of people have learned and are using to organize their behavior.[26] It recognizes that complete objectivity is impossible, that personal prejudice influences data collection and that selective observation and interpretation always occur during any method of research. The goal then, is to make a description and interpretation of the patients perceptions in the least distorted manner, and to make apparent, where possible, any underlying biases.

The most important element in ethnographic field work is the 'category'. Categories are inventions of the human mind. They make

experience manageable by generalizing about similar experiences and grouping them together.[27] As Watson and Watson have noted, "All knowledge depends on categorization; that is, the classification of objects according to their similarities to and differences from other objects".[28] In contrast to popular opinion, categorization is not a discovery of the natural groupings of objects in the environment. It is, rather, an invention of ways to classify and organize experience.[29] We look for a common response to an array of objects.

In dealing with the various case histories the author has tried to classify or make typifications of the various patients who come into the clinic seeking services. The approach taken is that outlined by Alfred Schutz (1899-1959). The focus of Schutz's analysis is intersubjectivity - how we understand each other and how we come to have similar perceptions and conceptions of the world. Out of his analysis emerge the foundations of a sociology of everyday knowledge.[30] Schutz argues that we experience the external world of things, people, and events as typifications. Typifications are classifications and categorizations.[31] Schutz appreciates as others have done, that we have to classify and group in order to organize reality, and that most of these typifications are socially learned and handed down to us. One consequence of Schutz's view of knowledge is that typifications are an inherent feature of everyday knowledge.[32] Typologizing is simply a tool to aid in systematic understanding.[33]

As Schutz points out, data cannot be left at the level of summarizing what people say but the researcher must make some attempt at constructing a rational model of human behavior in a systematic way.[34] From an examination of the data, a construction of patient types based on their perceptions and behavior have been formulated in the following study. As always, it should be noted that this is not the comprehensive overall model of all patient perceptions and behavior, but in the absence of any definition of patient behaviors this will allow for a beginning typology that might provide stimulus to further development and analysis of patient needs.

The informal interviews were open-ended and unlimited in time allowing a relaxed setting for the patients to express their feelings as openly and honestly as possible.

Questionnaire

The third source of data was a questionnaire devised and given to a total population of patients who came into the agency during four selected weeks. These weeks were selected to represent a sample of weeks in any given month. We chose one of the weeks to represent six weeks after a holiday, and one of the weeks to follow six weeks after a university semester break. In choosing these two weeks it was expected, on the basis of past experience, that a higher proportion of patients might be coming in for pregnancy tests at this time. The other two

weeks are meant to represent an "ordinary week" in the year. Each patient that came into the office was given the questionnaire. If it was the patient's first visit, the questionnaire was administered at the end of the service requested. This gave us a sample of first impressions of service at the clinic. If it was a repeat patient (three or more visits), the questionnaire could be filled out while awaiting service or immediately afterwards. The reason for omitting all second visits was that it was assumed that there would be little difference between the end of the first visit and beginning of the second visit in terms of knowledge about the clinic. By the third visit the patient would be assumed to have assessed the clinic more accurately and be more knowledgeable about the facilities and programs offered.

During the four weeks of interviewing patients, 161 individuals were given the questionnaire. Of these, nineteen refused. The main reason for refusal was lack of time to fill out the questionnaire. Ten of these refusals came on their luncheon breaks and had to wait to be seen. They found that they could not afford any extra time. Three were illiterate and did not understand what the questionnaire was about. One felt uncomfortable giving any information. She wanted her visit to be very confidential and in spite of the reassurance of confidentiality she did not want to fill in the questions. Five other patients handed in blank questionnaires. It was decided at the outset that the questionnaire and interview was to be completed at the office, thus if a patient

did not have time to complete her questionnaire in situ it was not included. This was to ensure that the patient herself filled out the questionnaire and that it did not get 'lost' or 'forgotten' after leaving the clinic. A total of 142 questionnaires were completed and interviews were conducted with these same people. It should be noted in the analysis of questions, that not all persons answered all questions.

The questionnaire was pretested on a random selection of clinic patients prior to its final draft. This proved to be invaluable, because although the questions themselves appeared to be acceptable, the language did not prove to be. Patients had a great deal of trouble understanding the meaning of some words. For example, when asking "How personal do you think each of the following places are?", the meaning we were trying to convey was: "How much do each of the places care for you and how you feel?" However, in Newfoundland, "personal" means "nosy", and had we left this question unchanged the patient would not have understood the intended meaning of the question. Another problem was in the use of longer words. Words such as "knowledgeable" and "confidential" were often difficult for the patients to understand. Many of the patients had little education and when confronted with words they did not understand, they would just stop answering the questions. Research instruments then must be phrased in the language of those studied, otherwise we run the risk of committing the fallacy of objectivism.[35] Therefore, the questionnaire was changed to make it more acceptable to the patients. (see Appendix A).

Because of the difficulty in language discovered by pre-testing the questionnaire, several important considerations should be noted. When conducting informal interviews, or in the counselling process, the interviewer should be constantly aware of being understood and of understanding the meaning of what is being said. This is especially important if there are large educational differences between the counsellor and patient. The second implication is related to educational materials. Most pamphlets and audio-visual aids are made by professionals, well-versed in the subject matter they are preparing for the educational tools. It is often difficult for them to determine if the language they are using is being understood. A discussion of the importance of understanding linguistic tools will be expanded in Chapter Six.

Limitations and Strengths of the Survey Method

There are certain limitations to using the formal questionnaire method over some of the other methods one could have used. Newfoundlanders have been the subjects of a vast amount of research done in the past, especially in the areas of Northern Newfoundland and Labrador. Many sociologists and anthropologists have gone into these areas, gathered the information they needed for their surveys or dissertations, and then left. Consequently, these people often feel exploited and suspicious of what researchers are doing, and how they are going to benefit from the studies done. Most of the research done has been anthropological in nature consisting of informal interviews or discussions.

Because of the different methodological format used by former researchers, questionnaires are 'foreign' and many people experience difficulty completing them. On the other hand, because of unfamiliarity with this type of research, people filling out the questionnaire read every word, whereas, people who are used to filling out questionnaires often do not read them carefully. Therefore, one would expect a much more accurate result from the questions asked, or at least a more considered one.

It is a fair assumption to make that social relationships are based on some expectation of reciprocity or exchange in the relationship. This is all part of social interaction. For example, we expect that there is a fair degree of embarrassment in talking about contraception and sexual behavior, especially among teenagers. Therefore, if they come to the clinic for service, it seems fair to assume that the embarrassment they might experience will be offset by the treatment or care they will receive. This is the conceptual structure that is determined by social exchange theory.[36] It is this conceptual structure that serves as a guide to the questions asked in the formal questionnaire.

Chapter Outline

In the second chapter a brief historical overview will illustrate that family planning practices are not new and that man has been attempting to control fertility patterns for centuries. A look at

the International and Canadian types of programs will follow concluding with current family planning policies in Canada.

The culture and geography of Newfoundland will be briefly discussed in Chapter Three. Issues will include the events leading up to the establishment of the clinic and the opposing factors of its beginning. The administrative structure of the clinic and its usefulness in the community will be considered.

Chapter Four discusses the patient who uses the clinical services. A description of services offered will follow with some demographic data. Case histories are all accurate, but identifying information has been changed or altered to protect the patient.

The clinic and its role will be detailed in Chapter Five. Reasons why patients attend the clinic will be examined and the data, both from the questionnaires and the interviews will be interpreted. Wherever possible qualitative data will be presented verbatim to enable the reader to understand the patients in more depth.

The counselling process and its priority in the clinic will be the content of Chapter Six. Counselling involves both men and women, and the role of the male will be considered in some detail. In this chapter ten categories, or typifications of patients, are presented.

Finally, several key issues will be expounded. The dual-role of the clinic, medical versus client-centered, will provide a framework for

thought about clinical structure. Concluding remarks will include several recommendations which this study has shown to be relevant for the field of family planning.

Footnotes and References: Chapter One

1. Allan G. Rosenfield, "Family Planning: An Expanded Role for Paramedical Personnel". American Journal Obstetrics and Gynecology, August 1, 1971. Volume 110, Number 7. pp. 1030-1039. See also: Training Non-Physicians in Family Planning Services, Population Reports, Series J, Number 6, September 1975.

2. Population Reports supra, pp. J89-J90.

3. "Community Distributions Around the World", People, Volume 2, Number 4, 1975. International Planned Parenthood Federation. See also: Allan Rosenfield, "Medical Supervision for Contraception: Too Little or Too Much?" International Journal Gynecology Obstetrics 1977. 15: pp. 105-110.

4. Allan G. Rosenfield, (1971) op. cit. pp. 1035-1038. See also: Allan Rosenfield (1977) op. cit.

5. The experience of major hospitals across the country suggests that attendance at post partum clinics more than doubles when family planning is offered. Metropolitan and Harlem Hospitals in New York, Grady Hospital in Atlanta and Lincoln Parish Hospital in Louisiana are among many reporting such results.

6. For further discussion on the medical model see: Vern L. Bullough, 'Sex and the Medical Model', The Journal of Sex Research, Volume 11, Number 4, pp. 291-303. November 1975.; Marilynn E. Katatsky, The Health Belief Model as a Conceptual Framework for Explaining Contraceptive Compliance, Health Education Monographs, Volume 5, Number 3, Fall 1977. pp, 232-243.

7. Donald T. Campbell and Julian Stanley, "Experimental and Quasi-Experimental Designs for Research", Chicago: Rand McNally and Co., 1963.

8. N. Denzin, The Research Act (A Theoretical Introduction to Sociological Methods), Chicago: Aldine Publishing Co. p.26.

9. John E. Moyer and Noel Timms, The Client Speaks, Routledge and Kegan Paul Ltd., London 1970. p. 37. See also: Gerald Gurin, Joseph Veroff, and Sheila Feld, Americans View Their Mental Health, New York Basic Books 1960.

10. William J. Filstead (ed.), Qualitative Methodology, Chicago: Markham Publishing Co., 1970. p. 150.

11. W.F. Whyte, Street Corner Society, Chicago, University of Chicago Press, 1955.

12. E. Mayo, The Social Problems of an Industrial Civilization, Boston, Harvard Business School, 1945.

13. S.T. Kimball and M. Pearsall, The Talladega Story: A Study of Community Process, University of Alabama Press, 1954.

14. James P. Spradley, You Owe Yourself a Drunk: An Ethnography of Urban Nomads, Boston: Little, Brown., 1970.

15. B. Malinowski, Crime and Custom in Savage Society, International Library for Psychology, Philosophy, and Scientific Method, London 1926.

16. A.R. Radcliffe-Brown, Structure and Function in Primitive Society, N.Y. The Free Press, 1952.

17. F. Kluckhohn, 'Participant Observer Techniques in Small Communities', American Journal of Sociology, Vol. 46, November 1940: p. 331.

18. H. Becker, 'Problems of inference and proof in participant observation', American Sociological Review. Vol. 23, December 1958: pp. 652-660.

19. Kluckhohn, op. cit. p.331.

20. Ibid.

21. Howard E. Freeman, 'Conceptual Approaches to Assessing Impacts of Large-Scale Intervention Programs', 1964 Social Statistics Proceedings, American Statistical Association, pp. 193-194. See also: Paul F. Lazarsfeld, William Sewell, and Harold Wilensky, (ed.), The Uses of Sociology, Basic Books, Inc. New York, 1967. p. 514.

22. Eugene J. Webb, Donald T. Campbell, Richard D. Schwartz, and Lee Sechrest, Unobtrusive Measures: Nonreactive Research in the Social Sciences, Rand McNally Publishing Co. 1966. p.114.

23. James P. Spradley and David W. McCurdy, The Cultural Experience: Ethnography in Complex Society. Science Research Associates, 1972. p. 6.

24. Becker, op. cit. p. 656.

25. Ibid. p. 660.

26. Henry L. Lennard and Arnold Bernstein, Patterns in Human Interaction, Jossey-Bass Inc. Publishers, 1970. p.51.

27. James P. Spradley et al, op. cit. p. 60.

28. Ibid. p. 60.

29. Ibid. p. 61.

30. Stephen Mennell, Sociological Theory: Uses and Unities, Nelson and Sons Ltd., Great Britain, 1974. p. 46.

31. Ibid. p. 47.

32. Ibid.

33. John Lofland, Analyzing Social Settings, Wadsworth Publishing Company, California 1971. p. 23.

34. Alfred Schutz, 'Commonsense and Scientific Interpretation of Human Action', Philosophy and Phenomenological Research, Vol. XIV, Number 1, (Sept. 1953). pp. 3-47.

35. N. Denzin, op. cit. p. 102.

36. For further discussion on Social Exchange Theory see: Harry C. Bredemeir, 'Contemporary Sociology', A Journal of Reviews, Volume 6, Number 6, November 1977, pp. 646-649. See also: George Caspar Homans, Sentiments and Activities, The Free Press of Glencoe, New York, N.Y. 1962.; Richard L. Simpson, Theories of Social Exchange, General Learning Press, New York, N.Y. 1972; Joseph Bensman and Arthur Vidich, 'Social Theory in Field Research', Sociology on Trial, ed. Maurice Stein and Arthur Vidich, Prentice Hall, Ind. New Jersey, 1960.; J.K. Chadwick-Jones, Social Exchange Theory: Its Structure and Influence in Social Psychology, Academic Press, New York, 1975.; Peter P. Ekeh, Social Exchange Theory: The Two Traditions, Cambridge, Mass., Harvard University Press, 1974.; Anthony Heath, Rational Choice and Social Exchange, Cambridge University Press, New York, 1976.

Chapter Two - Historical and Contemporary Perspectives on Fertility Control: An Overview

Historical Perspectives on Fertility Control

Although the emphasis today in family planning centres is on voluntary choice and individual decision making, the notion of family planning, or of limiting or spacing children has been in existence since the beginning of humanity. Many methods of birth control are described in the Egyptian Petri Papyrus, written about 1850 B.C. and the Ebers Papyrus, dated about 1550 B.C.[1] Many of the earlier methods have now been shown, in our scientific technology, to have had sperm killing properties, or to stimulate foreign body reactions much as the modern intrauterine device. For example, a vaginal barrier was made by combining lint with powder ground from the tips of the acadia shrub. The acadia was thought to contain mildly acidic gum capable of killing sperm.[2]

A brief look through history shows us the flexibility of responses to the needs of the various times. The nomadic hunter-gatherer peoples were not only concerned with maintaining a food supply, but had to be concerned with the fertility of their women in such mobile bands. Because of their largely nomadic or semi-nomadic ways it was important that a woman not be burdened with too many small children at one time. Therefore, they required some method of controlling their spacing of children. Methods used by primitive people to prevent conception were

many and varied, and reveal the intensity of the human effort to regulate reproduction. Methods included abstinence, prolonged nursing of infants, coitus interruptus, the use of potions, intra-vaginal plugs, rituals, witchcraft, condom-like pouches, herbs, extracts, and cultural superstitions, showing the knowledge the people had of the relationship between pregnancy and intercourse. As we know from today's modern technology a lot of these methods were either totally ineffective, they interfered with the sexual act itself, or were harmful to the woman.[3]

The hunter-gatherer people also attempted to control the fertility of their animals while crossing the deserts. There is evidence to suggest that the first intrauterine device was a stone which was inserted into a camel to control pregnancy while the animal was on a voyage.[4]

A widely used method of family planning by the hunter-gatherer was that of infanticide.[5] Birdsell states that systematic infanticide has been a necessary procedure for spacing children from man's beginning to the development of advanced agriculture.[6] Infanticide permitted selective breeding - an ability to select only the healthiest of offspring and the desired sex which was needed for the workload.

Much of the infanticide practised in the present century is not practised for food or population control as much as it is the result

of superstition, and for the prevention of bad luck. As recently as the present century, the Bondei of West Africa strangled infants at birth if any of the numerous portents and omens which they watched for were unfavorable, or if the infant's upper teeth came in first.[7] In Madagascar all children born on certain unlucky days were killed to prevent them from bringing bad luck to the parents.[8] In more recent times, the Rendille, a tribe of camel herders in the Kenya highland, killed boys born on Wednesday or after the eldest brother had been circumcised.[9] In Newfoundland, a "concealed pregnancy" that is then 'dumped' can be a source of infanticide. An example of this recently was a 15 year-old girl who 'concealed' her pregnancy from the family, delivered the baby naturally, and then hid the baby in the garbage.

Traditional forms of infanticide in Samoa, the Society Islands, and various other groups scattered throughout Melanesia, were substituted in later years for abortion practice. Devereux concluded that contact with the white man was responsible for this change in practice. His explanation of the change in practice was for the more effective concealment of a practice that they conceived might not be acceptable.[10] According to Devereux the decision to abort or not to abort was made either by the woman herself or by a person capable of imposing his will upon her, or by society as a whole. In some cases the reasons for abortion seem to be related to the welfare of the family or health of the mother, in others to preserving the structure of society or maintaining population stability. Some societies had rules which specified

instances when abortion was justified. Some cultures permitted the women to abort at different ends of the reproductive continuum. That is to say, all pregnancies of women under 18 years or over 35 years of age. Others aborted all first pregnancies thinking that the subsequent pregnancies would be easier, or all pregnancies before the age of 35 to enable maturity in the mother.[11]

It is hard for us to comprehend all the methods of abortion that were used and in some cultures are still being used, which ranged from jumping on the mother's abdomen until blood spurted out, to ingestion of vomiting inducing substances. It is possible that these ancient techniques used to induce abortion are the historical roots of many of the fears and misconceptions regarding the pregnant state which now exists in contemporary society.

After 8000 B.C. in and around Turkey, Iraq, and Iran, an agricultural way of life began to replace the hunting-gathering mode of existence. This was a time of great population growth due to the need for manpower to assist in a food producing economy. Because of the increased food supply, nutrition was improved, mortality rates were lower, and people lived longer - at least to the end of their reproductive lives.[12] Women were encouraged to wean their babies earlier in order to return as soon as possible to the fields to work. Therefore, the 'natural' form of birth control that had been used in previous years was reduced considerably. Also the people at this time lived more stable sedentary

lives. Children were economic assets as laborers in the fields.[13]

In this period human fertility became an object of solemn worship. Fertility cults flourished and magical rites to promote procreation were very much a part of religious life. This was a period when jewellery symbolizing fertility luck (amulets, cowrie shells, lapis lazuli carved in the shape of a bull) flourished. All jewellery symbolized potential fertility or masculine potency.

Although political strategies were employed by the religions of this period to ensure population increase, balancing checks such as war, famine and disease, maintained an equilibrium in the population at that time. The preoccupation with fertility in primitive religions during this time appears to have been an adaptation response to social conditions which accompanied the change from hunting-gathering to agriculture. As human society evolved away from this time period, other political goals came to be served by the deliberate stimulation of human fertility.[14]

During the course of the Roman Empire direct state interference in birth planning practices was thought to be a violation of the rights of the family. Although contraceptive techniques were inefficient and often crude, abortion and infanticide were common practice. During the early years of the Christian Church, the believers were not interested in such matters as families or population. They were

waiting for the second coming of Christ and were trying to make converts to the faith. As hopes of this diminished, the church developed a philosophy regarding sexuality and reproductivity. In regard to population, the church promulgated the strictest policy possible to allow rapid increase of procreation. It borrowed from the Jewish philosophy which discouraged abortion and contraception and from the Doctrine of the Stoics which called for the suppression of natural bodily desires through rational self-control.

The Stoics believed that sexual organs were given to man not for pleasure but for procreation and demanded that the act of copulation take place without relish or enjoyment. Contraception and abortion were prohibited because these practices implied that sexual intercourse met human needs other than the need to reproduce.[15] The Roman Catholic Church has not come very far in changing these policies to the present day, and as we shall see in later chapters, this rigid stance has contributed to guilt and anxiety in many of its adherents.

Religious Issues

The major religious faiths consider family planning an integral part of family life and an important contributing factor to marital stability. All of the major faiths agree that family planning is an obligation of responsible parenthood. (See Appendix B). All religious faiths approve of child spacing. They disagree only about the method.[16]

In general, Moslems, Hindus, Buddists, Confucionists and most Protestant and Jewish groups have no opposition to delaying pregnancy by any type of mechanical, chemical, or surgical contraception.[17] The Roman Catholic viewpoint, however, stresses the individual's obligations for procreation and parental responsibilities, and approves only the Rhythm Method (or more recently the more sophisticated Sympto-thermal or Billings Method of Birth Control). The Second Vatican Council, in 1962, elevated mutual love to the same level as procreation in Catholic marriage and a large proportion of the Church's leadership - both lay and clerical - have called for a liberalization in Church attitude toward contraception. Pope Paul VI ruled in August 1968 that no change in attitude towards contraceptive practices would be allowed. The United States Bishops in a pastoral letter, 'Human Life in our Day' endorsed the conclusions of Pope Paul's Encyclical Humanae Vitae reaffirming traditional Catholic opposition to artificial contraception. At the same time, the bishops added that "circumstances may reduce moral guilt". They agreed that artificial birth control was an 'objective evil' but held that Catholics who could not in conscience follow the church's teachings should not feel cut off from holy communion.[18] There is ferment among Catholics on this mandate, and recent studies show that Catholic couples are using the various birth control methods in ratios comparable to people of other faiths.[19] This trend is found within Newfoundland society as the present study attests.

Data collected from three National samples(1955, 1960 and 1965) was gathered and analysed by Westoff and Ryder in a study they carried out on American contraceptive attitudes and practices. They found that the greatest change in attitude and use of contraception occurred during the past decade among college educated Roman Catholic women. In 1960, only thirty-nine percent favoured birth control, less than that in any other educational category. By 1965, this figure reached sixty-seven percent and a substantial shift was recorded away from an exclusive endorsement of rhythm toward a more general endorsement of fertility control.[20] They also concluded that Protestant - Catholic differences continue to diminish, and use of contraceptives has increased sharply among the more educated Catholic women.

It appears that women are making their own decisions regarding birth control practices in the face of possible increased guilt and shame often related to strongly held religious convictions.

During the Industrial Revolution emphasis was put on the decision to increase the population of the state. People were workers in a collective sense and there was little concern for the individual. At times pronatalist tendencies were codified in statute. In France, Colbert prevailed on the King to grant large tax exemptions to men with twelve children or more provided the father promised that none of his children would take up the celibate life of the monastery. Canada also introduced the same decree in 1669 adding more restrictions that included

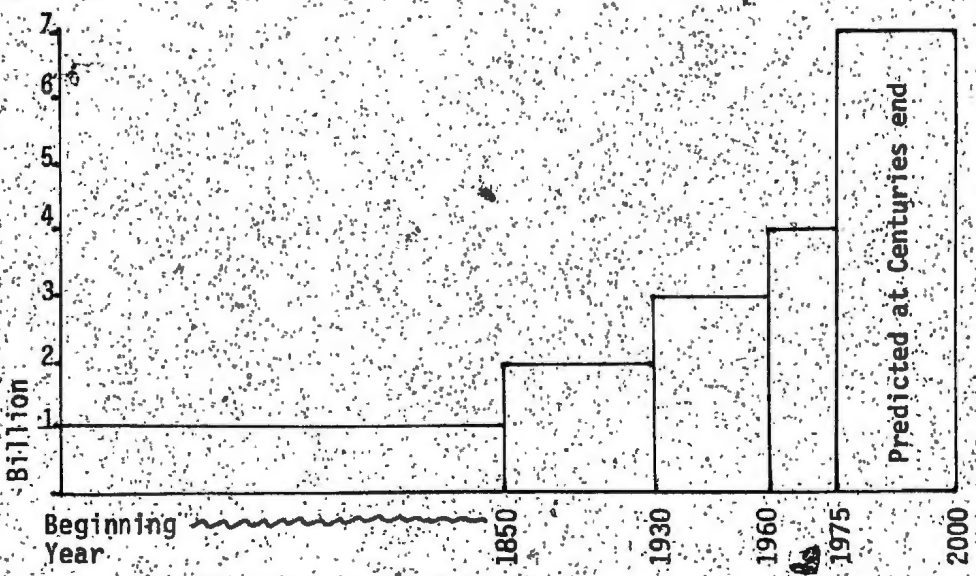
fines imposed on fathers who failed to marry off their sons by the age of twenty, or their daughters by the age of sixteen. Although these measures were introduced purely for economic gain, they were imposed on people already oriented in that direction by religion.[21]

In 1798, Malthus expressed his concern of the great dangers of population growth outstripping food supplies. It is interesting to notice his 'conservative' stance in interpreting his findings. He felt that 'indulgence' should be forbidden outside marriage, and limited during marriage, thereby restricting population growth. This view was quite consistent with the attitudes of the time concerning both premarital and marital sex. While he was very conservative in his approach, and rejected artificial means of birth control, he was nevertheless castigated by fellow clergymen.[22]

Population Problems and Issues

It took all of time until the first half of the nineteenth century to reach a population of one billion. The second billion was added in less than 100 years, the third billion in only thirty years, and by 1975 this figure had reached over four billion. By the century's end, it is predicted that there will be seven billion people on this already crowded earth.

Table 2:1 Population Growth Sequence



At this rate the number of people on Earth is growing more than twice as fast as the food to feed them or the ability countries have to distribute the food. Explosive population growth is becoming recognized as the major obstacle to economic and social progress - especially in the underdeveloped countries of the world.[23]

The danger is most acute in the developing nations where sixty-four percent of the people have incomes below one hundred dollars per year.[24] If fertility is not curbed there is a probability of large scale famine. The World Health Organization estimates that already every year thirty million people die of diseases associated with undernutrition.

Table 2:2 World Population Estimates in Millions*

AFRICA	391	LATIN AMERICA	316
Northern Africa	96	Middle America	76
Western Africa	113	Caribbean	27
Eastern Africa	111	Tropical South America	175
Middle Africa	44	Temperate South America	38
Southern Africa	27		
ASIA	2,208	EUROPE	469
Southwest Asia	86	Northern Europe	81
Middle South Asia	818	Western Europe	152
Southeast Asia	315	Eastern Europe	106
East Asia	989	Southern Europe	131
		USSR	253
NORTH AMERICA	235	OCEANIA	21
Canada	22.5		
United States	211.9	WORLD	3,893

* As of mid-1974 based on interpolation of the mid-1970 population estimate and the mid-1975 "medium variant" projection by the United Nations using the projected rate of growths for the 1970-1975 period. Source Information Service, Population Reference Bureau, Inc. Wash. D.C.

Experts at the 1974 World Food Conference in Rome agreed that close to five hundred million people are chronically malnourished and that an additional five hundred million are so close to the margin that in times of shortfall of food supply they are likely to suffer a similar fate. There is no doubt that the world's population growth rate and its food-producing capacity is part of the ecological crisis.[25]

Current Programs and Policies in Family Planning

In 1968, the United Nations International Conference on Human Rights declared that "any choice or decision with regard to the size of the family must irrevocably rest with the family itself and cannot be made by anyone else".[26] Thirty states, including the United States, signed a statement that said, "We must accord the right of parents to determine the numbers of their children a place of importance at this moment in man's history... on this Human Rights day (the U.N.) feels bound to call attention to a declaration expressing concern with the quality of human life as well as with the number of beings on earth".[27]

International

On the International level, three types of family planning programs can be identified - incentive schemes, disincentives and compulsary law, and voluntary services.

a) Incentive Schemes

Experiences in India and other countries have illustrated that incentive payments can influence the acceptance of such birth control methods as the I.U.D. and vasectomy. The incentive in family planning contexts has been defined as "something of financial value given by an organization to an individual, couple, or group to induce some birth planning behaviour".[28] These incentives can take the form of a one-time only inducement, such as one visit procedures like a vasectomy or insertion of an I.U.D. The Ernakulam Camp experience in India is an

example of this program evidenced by over 63,000 vasectomies performed in a single month. Indonesia uses incentives for fertility control as well. South India and Taiwan offer continual inducements such as a retirement bonus and educational bonds through experimental programs for non-pregnant states or fixed numbers of children. Recently, salary increases have been awarded in Tientsin to 28,000 couples with one child who pledged to have no more children. Each couple reportedly were given a pay increase of $3.24 per month. This amounted to an increase of 8.33%.[29]

Canada, among other countries (Australia, France), still promotes increased population. In Canada Family Allowance cheques increase in value with each child born. For people on welfare, an increase in monthly cheques will also be forthcoming with each additional child. How often do we hear the single girl remarking that she is pleased she is having a second child because with two children welfare entitles her to a two bedroom apartment.

b) Disincentive and Compulsory Programs

The second program for family planning involves the notion of 'forced choice', or legislation that limits the number of children a person has through laws of the state or country.[30] In the past, several Indian states and the Republic of Singapore, have considered, and in some cases enacted, legislation which would make sterilization compulsory for certain groups which have exceeded the two or three child per family limit.[31] Although this plan carries many ethical considerations, which

will not be discussed at this point, suffice it to say that the policy is held to be a program of compulsion. Some governments enact policies that act as a disincentive scheme. For example, the Republic of Singapore provides no state assistance after the third child. As well, welfare benefits are often reduced or discontinued.

c) The Voluntary Program

The third program, that of voluntary family planning, is the program that is most consistently found in the developed countries. This is a program of family planning that provides information, education and service to the individual but the motivation to partake of this service must come from the patient directly. The largest non-governmental organization in the field of family planning is International Planned Parenthood (IPPF) formed in 1952. This is a federation of ninety-one autonomous family planning associations in countries on five continents, each with their own constitutions, although they are required to comply with some general principles agreed to by the IPPF constitution.[32] The IPPF has often been criticized for its alleged objectives of population control in toto, as an agent of genocide, for racial discrimination, as advocates and promoters of abortion, and for providing inaccurate birth control information. But, its philosophy and goals are very clear. IPPF believes that family planning is a fundamental right of individuals and couples. It further believes that the exercise of this right should be entirely voluntary. It insists that no one can exercise a right if they do not have the necessary information and the education to know and choose among the options available and accessible.[33]

The Canadian Family Planning Organization is based on this philosophy of voluntary family planning services. The Planned Parenthood Federation of Canada is a member of IPPF, but has its own constitution.

Canada

The birth control movement was slow to establish roots in Canada, probably because of a lower rate of industrialization, and a large proportion of Roman Catholics in the population. Canada has a very large land area (3,851,809 square miles) with a population of approximately 23,000,000 people.[34] Moreover, there has never been a pressing need in terms of population to reduce birth rate of the country. Economic growth in Canada has required a growing labour force to work the land and exploit natural resources. With such land areas, Canada has not had to be concerned with population overgrowth - on the contrary manpower was needed to ensure family survival.

Historically, Canada saw very little family planning activity as we know it today until the thirties. However, we know that the North American Indian practiced contraception often using preparations that have since been found to have anti-fertility properties. The Maliseet Indians of New Brunswick, for example, brewed dried beaver testicles into a strong tea and drank the mixture because they thought the mixture would prevent fertilization.[35]

Legislation was passed in 1892 forbidding the sale or advertisement

of contraceptive devices and the dissemination of information about birth control. However, in 1929 A.R. Kaufman, a wealthy industrialist from Kitchener, Ontario, became concerned about his workers' problems coping with excess fertility. He set up a program of birth control services for his workers. This was such a successful program that news of its activities spread across the country leading to a Parent's Information Bureau in 1930.[36] This bureau conducted a free mail order service for over 225,000 people. In 1937, Kaufman obtained an important legal judgment from the Supreme Court of Ontario, as a result of the trial of one of his social workers. This judgment stated that contraceptive information and services were possible legally if they were in the public interest.[37]

Similarly, as in the United States and England, the first attempts at family planning in Canada were carried out by non-medical people. In 1932 Mary Hawkins and Gertrude Berger opened the first birth control clinic in Canada in Hamilton.[38] These two women were denounced from every Catholic and some Protestant pulpits. Many of the early patients to the clinic were Catholic women who did not know of the existence of the service until it was denounced by their priests in the Church. We will see a similar pattern when we discuss the Newfoundland birth control clinic.

Assistance from the medical community was slow in coming - mainly because of the medical profession's reluctance to become involved in such a controversial service.[39] However, after one year of operation of

the clinic, Dr. Elizabeth Bagshaw became the first physician in Canada to enter the family planning field and she devoted the rest of her life to promoting family planning. By the late 1950's, the law was largely being ignored, and contraception had become available in some drugstores.

In 1969, an amendment to the Criminal Code of Canada permitted the legal dissemination of birth control information and the sale of contraception.[40] The words 'prevention of conception' were removed from the Code. Also in that year, an amendment to the 1869 Abortion Law was passed which legalized therapeutic abortion only where "the continuation of the pregnancy of such female person would or would be likely to endanger her life or health".[41] Applications were to be submitted to a therapeutic abortion committee of the hospital in which the abortion was to be carried out and this committee was to consist of at least three physicians.[42]

The hospital abortion committee system remains in Canadian Law. In the Canadian House of Commons, Justice Minister John Turner made it clear that the law "imposes no duty on the board of a hospital to set up a therapeutic abortion committee".[43] This led to a lot of confusion and concern. The government was legitimizing a health-care service for Canadian women, but at the same time stating that hospitals, even though they are government and tax-supported, were under no obligation to provide that service.[44]

In 1970, in response to public demand and to the recommendations of the Royal Commission on the Status of Women, and in recognition of the basic rights of Canadians to exercise free individual choice in the practice of family planning, the Government of Canada announced a federal program of public information, training, and research in family planning. In January 1972, the Family Planning Division was created in the Department of National Health and Welfare to provide a focal point for federal programs. This was followed by the first National Conference on family planning held in Ottawa in 1972.[45] At this Conference, John Munro, the Federal Minister of National Health and Welfare, announced the government intention to support family planning programs with these words, "I have said before, and I repeat it now, that in the Federal Government view the use of family planning methods is a matter of free choice for each individual. It is our aim that it should be an informed and responsible choice based upon adequate knowledge and there must be no hint or suggestion of coercion".[46] Among the many recommendations coming from that Conference, was that the Division was to provide curricula materials, and courses in family planning and family life education, to people working in the fields of education, health, and social work.[47] (See Appendix D).

It is interesting to note that as late as 1975 Canadian television stations did not accept advertisements for contraceptives, even though many newspapers did. In March 1979 the Canadian Broadcasting Corporation, after pressure from another organization, removed the advertising of Planned Parenthood from the television stations. They announced that

their policy on a national level had always been that the corporation would not sell commercial time to anyone with controversial issues. (See Appendix E).

Current Family Planning Policy

Present Canadian policies regarding family planning were shaped by the federal government when it established the Family Planning Division of the National Health and Welfare Department in 1972. The official objective is to ensure the accessibility and availability of family planning services to all Canadians who want them. However, three considerations helped shape federal policy in the field:

1. Since family planning involves emotionally charged behaviour in an area traditionally regarded as private and personal, the government must avoid even the appearance of telling people what to do.
2. Since the institutional means of implementing federal programs are largely controlled by the provinces, through their departments of health, education, and welfare, the federal government cannot demand their participation.
3. Voluntary agencies have an important role to play in identifying family planning needs and developing ways of meeting these needs.[48]

These considerations have been perceived as constraints by the Federal Government, with the result that, while officially they approve of the right of every citizen to have access to contraceptive technology,

they can go no further than approve and encourage. If the various provinces choose not to implement any family planning programs, none will be implemented. Furthermore, provincial governments adopt varying attitudes toward establishing policy in family planning. In Ontario the Honorable Frank S. Miller announced a program to commence April 1975. In 1970 Saskatchewan and Nova Scotia had established policy in family planning. In 1972 Quebec's Ministry of Social Affairs announced a policy; but Newfoundland has yet to take an official stand.[49] (See Appendix F).

This means that the current family planning policy across the country is relatively inconsistent, and remains relatively underdeveloped despite the fact that several provinces have established official policies and a few have actual contraceptive programs. Within this relative inconsistency, however, there is a general theme. That is, the general thrust of opinion and public policy in the country is that control of contraceptive use and information should be in the hands of the citizen rather than with the government. Though there are still areas in the country where it is difficult, or impossible, to gain access to contraceptive technology, the numbers of these areas are reducing progressively. A look at the effect of policy making (which is non-existent in some provinces), points out the minor impact the policies have had to date. For example, look at the illegitimacy statistics. (see Table 2;3). The example chosen here is from one province's records, but the pattern is matched in other provinces, and in the United States.[50] As the table shows, the introduction of the Family Planning Division in 1972 has had

no effect on the illegitimacy rate; in Newfoundland, indeed, the rate has continued to increase.

Table 2:3 Illegitimate Births in Newfoundland

YEAR	ILLEGITIMATE BIRTHS	ILLEGITIMACY RATE*	ALL BIRTHS	BIRTH RATE**
1965	773	52.6	14,740	29.6
1966	832	59.4	14,084	28.5
1967	858	66.8	12,744	25.6
1968	948	73.9	12,820	25.3
1969	1,033	79.5	13,000	25.3
1970	1,122	89.5	12,539	24.2
1971	1,229	96.3	12,767	24.5
1972	1,345	104.3	12,898	24.0
1973	1,345	113.0	11,906	22.0
1974	1,187	116.0	10,236	18.9
1975	1,417	139.4	10,166	18.5
1976	1,490	142.7	10,443	18.7

* Rate per 1,000 Live Births

** Rate per 1,000 Population

Source: Department of Health Report, Province of Newfoundland, 1976.

However, with the birth rate as a whole declining, for married as well as single individuals (See Table 2:4), it seems permissible to say that the segment of the population with the least general social

Table 2:4 Comparison of Birth and Marriage Rates in Newfoundland

YEAR	BIRTHS	BIRTH RATE*	MARRIAGES	MARRIAGE RATE**
1966	14,048	28.5	3,728	7.6
1967	12,844	25.7	4,021	8.0
1968	12,820	25.3	4,242	8.4
1969	13,000	25.3	4,279	8.3
1970	12,539	24.2	4,466	8.6
1971	12,767	24.5	4,686	9.0
1972	12,898	24.0	5,106	9.5
1973	11,906	22.0	5,048	9.3
1974	10,236	18.9	4,276	7.9
1975	10,166	18.5	4,313	7.9
1976	10,443	18.7	4,171	7.5

* Rate per 1,000 live births

** Rate per 1,000 population

Source: Department of Health Report, Province of Newfoundland, 1976.

controls with respect to fertility regulation has been least affected by the increasing availability of contraceptives. That is, while there certainly is a general social prohibition against premarital pregnancy, there are few general social controls - such as higher food bills (adolescents don't pay for their own food, generally so don't know what an extra mouth to feed costs). An independent married couple will be more aware of both the internal marital and family costs and the community and social norms about family size than will the adolescent who is not planning to be in the situation where she will have a child in the first place (it just happens). A recognition of a provincial family planning policy, that does not just provide contraceptive availability, but stresses individual responsibility and control of fertility patterns is likely to be much more successful in reducing 'unwanted pregnancy'.

In evaluating family planning programs in Canada, we will continue to examine the three kinds of programs as defined on an international scale in the previous section. Incentive schemes are of two dimensions in Canada. The first is a pronatalistic approach. The baby bonus, or family allowance cheque, as noted earlier, is given to all mothers and increases with each child. For example, mothers are given $20.00 per month for each of their children to the age of sixteen years. In addition, a sliding fee schedule has been introduced that provides a maximum of $200.00 total payment per year for each child in the family if they qualify. This was originally established to promote births as well as for support.

In addition, there are welfare incentives, mother's allowance, and in some areas subsidized day care, which act as positive incentives to encourage an increase in population growth. Contrasted with this we have the more subtle (or less obvious) incentives to family planning and birth control. The recent money allocated by the federal government for family planning programs, and changes in legislation allowing more freedom for dissemination of contraceptive information, contribute to population regulation.

In Canada there are no compulsory laws encompassing population control. This is possible largely due to the large areas of land that are under-populated and the lack of any need to the present time to control or limit births.

The third program is the voluntary type which is most consistent with Canadian life.[51] The philosophy of family planning services in Canada is very much moving towards facilitating individual motivation and control over a woman's own fertility choices. However, as with anything that is voluntary, many different values conflict in decisions and control of money for services. Thus, in Canada as with other countries with voluntary service, we see a conflict arising out of the disagreement between religious and secular attitudes. The churches are actively promoting their views on fertility control, contraception and sexual behaviour. Other interest groups and individuals are attempting to formulate policies that will allow complete individual choice. Various

organizations and action groups, such as non-parents and women's groups, are determined to voice their concerns. There are also groups of a conservative persuasion who believe that discussion with any sexual connotation will lead to promiscuity. A lobby against sex education in the schools, combined with attempts to stop the dissemination of information are common strategies. It is noteworthy that women are caught in the midst of what often emerges as a heated 'battle'.[52]

Planned Parenthood Federation of Canada

One of the largest voluntary organizations in Canada to promote family planning ideals is the Family Planning Federation of Canada, which changed its name to Planned Parenthood Federation in 1975.[53] The name change was implemented partly in order to bring the name into line with the international organization, and partly to convey a slightly different meaning. This organization is one of the members of the larger organization, the International Planned Parenthood Federation. The Planned Parenthood Federation of Canada acts as a pressure group to promote legislative change and is a national resource headquarters for public and professional education regarding family planning. The Federation's goal is to extend information and services on family planning to all Canadians as an essential human right and as a necessary measure for personal and social welfare, through its provincial offices.[54] This organization relies heavily on federal funding, but is presently on a five year cutback that will leave the provincial organizations on their

own within five years. This is to allow provinces to formulate their own family planning policies and to raise funds or allocate monies for preventative care rather than extant maintainance services such as welfare payments and subsidized housing.[55]

The goal of family planning or control of one's own fertility is to help mothers achieve maximum health and well-being between pregnancies and to rebuild the emotional resources of parents between pregnancies. Advocates of family planning are motivated by two principal streams of thought - concern with maternal and infant health and family stability on the one hand, and concern with societal problems caused by world population growth on the other. In developed countries like the United States and Canada, where the population problem is not yet as acute, voluntary family planning is emphasized as an essential health measure for families as a weapon against hunger, disease, and poverty, and as a key to personal freedom, human dignity, and self-fulfilment for the individual. Within this frame of reference, each person is encouraged to have the number of children he/she can handle and care for within their economic means.[56]

Family Planning is recognized now as a preventative health measure encompassing child spacing as well as limitations to family size. Statistics on the risks of pregnancies in the early and late reproductive years, as well as the dangers to the mother resulting from multiple pregnancies are evidence that child spacing is socially,

psychologically, and economically sound. The infant mortality rate is increased by forty-five percent for those born to mothers with more than four previous pregnancies. Babies born to mothers with fewer than fifteen months between pregnancies die at a rate four times the national infant mortality rate. More premature babies are born to mothers under eighteen years of age and more infants with Down's Syndrome to mothers over thirty-five years of age than to mothers at ages in between.[57]

Objections to Family Planning and Common Misconceptions

As with other controversial issues, there are always people who will raise objections to family planning either because of their values, moral/ethical convictions, ignorance, prejudice, and misunderstandings. Some common misconceptions which frequently find expression include notions that family planning is against the will of God, makes women unfaithful and promiscuous, tends to be unmasculine (children are a sign of a man's virility), promotes genocide, exists for the poor (if you have money you can afford children), is needed for manpower, and to continue the existence of certain societies. It is because of these attitudes and problems that family planning programs have had difficulty in changing and motivating people to its use.[58]

The second objection is the cost of running a service when it is thought that it is a duplication of service, or that 'preventative medicine' is not as important as the 'curative' type.

Cost-Effectiveness of Preventative Family Planning Service

The Badgley Committee reviewed health costs and expenditures associated with pregnancy, family planning and abortion and drew this disturbing conclusion:

> ".....more money from the public purse was spent on providing treatment services and facilities for abortion patients than on the public effort to undertake effective preventive measures. In the broad terms of per capita expenditures it was estimated that $0.58 was spent by each Canadian in 1974 to pay for the costs of therapeutic abortions and $1.61 for the immediate costs associated with normal childbirth. At the same time from designated expenditures $0.24 was spent on federal and provincial family planning measures."[59]

An analysis in 1974 by Caspar W. Weinberger, former HEW secretary, found the program of family planning returned more than two dollars for every dollar spent by reducing unwanted births.[60]

In Newfoundland a considerable amount of money is spent each year for Social Assistance to unwed mothers.

Table 2:5 Amount of Money Spent for Social Assistance for Unwed Mothers in Newfoundland for the Months of March 1974-1978

Date	Monthly Cost	Approximate Yearly Cost
March 1974	$170,794.00	$2,049,528.00
March 1975	$208,605.00	$2,503,260.00
March 1976	$265,746.00	$3,188,952.00
March 1977	$347,850.00	$4,174.200.00
March 1978	$380,229.00	$4,562,748.00

There was an increase of $388,548.00 from March 1977 - March 1978.

Source: Social Services - Province of Newfoundland.

This does not include the amounts of money allocated for health care, hospital facilities, staff welfare salaries, social workers, and the multitude of other costs to assist the unwed mother and her child.

The relative cost of providing any kind of preventive service is very small by comparison.

In the following chapter we shall examine the family planning situation currently existing in Newfoundland. We will trace the development of family planning services and particularly the establishment of the clinical service in St. John's.

Footnotes and References: Chapter Two

1. Mariam Manisoff, Family Planning, A Teaching Guide for Nurses, Planned Parenthood Federation of America, Inc. 1969. Page 4. See also: P. Skuy, It All Began in Egypt with an Rx dated 1850 B.C., Drug Merchandising, January 1970.

2. Ibid. p. 4.

3. Wendell W. Watters, Compulsory Parenthood, McClelland and Stewart, 1976. Page 36. See also: Norman E. Himes, Medical History of Contraception, New York: Schocken Books, Inc. 1970, first published Baltimore: Williams and Wilkins Co. 1936, p.3. Note: Virgil J. Vogel, American Indian Medicine, New York: Ballantine Books, 1973. First published by the University of Oklahoma Press, 1970, contests this view and points out that North American Indian tribes used a number of herbs for contraceptive purposes which have since been tested in the laboratory and shown to have some contraceptive properties.

4. See B.E. Finch and Hugh Green, Contraception Through the Ages, Springfield, Ill., Chas. C. Thomas. See also: N.E. Himes, Medical History of Contraception, New York: Gamut Press, 1963.

5. Wendell W. Watters, op. cit. p. 36. See also: Burton Benedict, 'Population Regulation in Primitive Societies', in Population Control, ed. by Anthony Allison, Penguin Books Ltd. England 1970. pp. 165-180.

6. Joseph B. Birdsell, 'Some Predictions for the Pleistocene Based on Equilibrium Systems Among Recent Hunter-Gatherers', in Man and the Hunter, ed. Richard B. Lee and Irven De Vore, Chicago: Aldine Publishing Company, 1968. p. 239.

7. Wendell W. Watters, op. cit. p. 37.

8. Ibid. See also: K. Davis and J. Blake, 'Social Structure and Fertility: An Analytic Framework, Economic Development and Cultural Change, Volume 4, No. 3, 1956. p. 231.

9. P. Spencer, The Samburu, Routledge and Kegan Paul, 1965.

10. George Devereux, 'A Typological Study of Abortion in 350 Primitive Ancient and Pre-Industrial Societies', in Therapeutic Abortion, ed. Harold Rosen, New York: The Julian Press Inc. 1954, p. 98. See also: William Graham Sumner, Folkways, Boston: Ginn and Company, The Athenaeum Press, 1907, p. 315.

11. Wendell W. Watters, op. cit. p. 38.

12. V. Gordon Childe, Man Makes Himself, London: Watts and Co., 1936. p. 78.

13. For a discussion of the use of time and the amount of labor required for a family to secure a livelihood see: Lucy Mair, An Introduction to Social Anthropology, 2nd ed. Oxford: Clarendon Press, 1972.

14. Wendell W. Watters, op. cit. p. 47.

15. John T. Noonan, Jr. Contraception: A History of its Treatment by the Catholic Theologians and Canonists, Cambridge, Mass.: The Belknap Press of Harvard University Press, 1966. p. 46.

16. Miriam Manisoff, ed. Family Planning Training for Social Service, Planned Parenthood Federation of America, Inc. 1972. p. 29. For the vast majority of faiths, responsible parenthood means having only the number of children for whom one can provide - as a sacred obligation of faith.

17. Ibid.

18. New York Times, November 16, 1968.

19. Miriam Manisoff (1972), op. cit. p. 29.

20. Charles F. Westoff and Norman B. Ryder, 'United States: Methods of Fertility Control, 1955, 1960. 1965.' Studies in Family Planning, No. 17, February 1967.

21. Wendell W. Watters, op. cit. p. 64.

22. Graham Wallas, The Life of Francis Place, 1771-1854. London: George Allen and Unwin Limited 1918. p. 169. See also: Elizabeth Draper, Birth Control in the Modern World, Penguin Books Inc. 1972.

23. Ibid. p. 10. See also: O. Freeman, World Without Hunger, New York, Praeger 1969. A. Allison, ed. Population Control, Baltimore, MD.: Penguin Books Inc. 1970., P.M. Hausser, ed. The Population Dilemma, Englewood Cliffs, Prentice-Hall Inc. 1965.

24. New York Times, October 1, 1968.

25. Wendell W. Watters, op. cit. p. 22. See also: Walter E. Howard, 'The Population Crisis is Here Now', Bio-Science, XIX (Sept. 1969).

26. Wendell W. Watters, op. cit. p. 109. See also: Fred Sai, Some Ethical Issues in Family Planning, International Planned Parenthood Federation, 1976.

27. Miriam Manisoff, (1969) op. cit. p. 6.

28. Meredith Minkler, The Use of Incentives in Family Planning Programmes: A Study of Competing Theories Regarding Their Influence on Attitude Change. International Journal of Health Education - supplement to Volume XIX, Issue No. 3. July-Sept. 1976. p. 2. See also: E. Pohlman, (1973) Birth Planning Incentives: Psycholgical Research. In J. T. Fawcett (ed.), Psychological Perspectives on Population, New York: Basic Books Inc., E. Pohlman, How To Kill Population, Philadelphia: The Westminister Press, 1971.

29. Sunday Toronto Star, August 19, 1979.

30. This idea evolved from the discussion by Meredith Minkler, op. cit. p. 8. on 'free choice' and 'no choice' situations. See also: C.A. Insko, Theories of Attitude Change, New York: Appleton Century-Crafts, 1967.

31. Meredith Minkler, op. cit. p. 8.

32. See Appendix C for further statements about the International Planned Parenthood Federation constitution.

33. Fred T. Sai, Some Ethical Issues in Family Planning, International Planned Parenthood Federation, 1976. p. 9.

34. The World Almanac and Book of Facts 1976, Newspaper Enterprise Association, Inc. New York, N.Y. p. 697.

35. Wendell W. Watters, op. cit. p. 121. See also: Elizabeth Draper, Birth Control in the Modern World, Pelican Books Ltd. 1972. Chapter 4.

36. Ibid. p. 122. See also: Ben Schlesinger, Family Planning in Canada - A Source Book, University of Toronto Press, 1974. Raymond Boutin, A History of the Family Planning Movement in Canada, in Family Planning and Social Work, Health and Welfare Canada, 1976.

37. Raymond Boutin, op. cit. p. 18. See also: Birth Control Trial: The Eastview Case, Kitchener, Ontario: Parent's Information Bureau Ltd.: Ian Bain, 'The Development of Family Planning in Canada', Canadian Journal of Public Health, LV 1964, pp. 334-340.

38. Raymond Boutin, ibid. p. 18.

39. C. Greenland, "What Every Young Doctor Should Know About Sex", Medical Aspects of Human Sexuality, Vol. 4, No. 11, November 1974, pp. 5-29.

40. Wendell W. Watters, op. cit. p. 125. See also: Provincial Family Planning and Sex Education Conference Report, May 11, 12, 1973. Family Planning Association of Newfoundland and Labrador: C. Norman Knight, 'Public Family Planning Policy: Formulation and Implementation', in Family Planning and Social Work, Department of Health and Welfare, 1976. p. 48.

41. Wendell W. Watters, op. cit. p. 125. See also: C. Norman Knight, Public Family Planning Policy: Formulation and Implementation, in Family Planning and Social Work, Department of Health and Welfare, p. 48. See also: Canada, House of Commons, Journals, Volume CXIII, 1966-1967. No. 168, p. 1091.

42. Wendell Watters, Ibid. p. 125. See also: Eleanor Wright Pelrine, Abortion in Canada, Toronto: New Press 1971; Kenneth D. Smith and Harris S. Wineberg, 'A Survey of Therapeutic Abortion Committees', The Criminal Law Quarterly, Sept. 1970.

43. Quoted in Gerald Waring, 'Report from Ottawa', Canadian Medical Association Journal, May 10, 1969. p. 870.

44. Wendell W. Watters, op.cit. p. 126.

45. C. Norman Knight, op. cit. p. 53.

46. Speech for delivery by Mr. John Munro, Minister of National Health and Welfare, to the First National Conference on Family Planning, Ottawa, February 1972.

47. Canada, Department of National Health and Welfare, Family Planning Division, Recommendations of the First National Conference on Family Planning (Ottawa - Department of National Health and Welfare 1972), P. 4. (See Appendix D).

48. C. Norman Knight, op, cit. p. 57.

49. See Appendix F for outline of various provincial family planning policies. Refer also to: Fédération du Quebec pour le planning des naissances congrès d'Orientation, Québec, Sept. 16-17, 1972. Rapport, pp. 57-72. No policies exist in Newfoundland on Family Planning to the present time.

50. Catherine Chilman, 'Some Research and Clinical Perspedtives in Adolescent Sexuality', Invited lecturer to the American Psychological Assooiation Conference Division 34, 1977.

51. Most Family Planning Services in Canada are provided by physicians or clinics such as Public Health and Planned Parenthood. People are not required to go to these services, but go on their own volition.

52. Mary Pearson, Background notes on Birth Planning and Conception Control, June 1979. Canadian Advisory Council on the Status of Women. See also: Cenovia Addy 1972, 'Trends in Family Planning' an address to a Public Forum on Family Planning, Saskatoon, Saskatchewan: Lorna R. Marsden, 'Human Rights and Population Growth - a Feminist Perspective'. International Journal of Health Sciences, Volume 3, Number 4, 1973.

53. M.E. Palko, R.H. Lennox and C. R. McQuarrie, Current Status of Family Planning in Canada, Canadian Journal of Public Health, Nov/Dec, issue, Volume 62, p. 516.

54. See Appendix G. Planned Parenthood Canada constitution.

55. Further information on Planned Parenthood funding and future long term policies are available from Planned Parenthood Federation of Canada, National Office, Ottawa, Ontario, and from the Department of National Health and Welfare, Family Planning Division, Ottawa, Ontario.

56. Miriam Manisoff (1969). op. cit. p. 8.

57. Ibid. p. 13.

58. Fred Sai, op, cit. pp. 14-15.

59. Badgley Committee, Report of the Committee on the Operation of the Abortion Law, Supply and Services Canada, Table 15.10, p. 419.

60. C.W. Weinberger, Population and Family Planning, Family Planning Perspectives, 6: 170-172. Summer 1974. For further information on costs and benefits of family planning. See also: W.A. Laing, The Costs and Benefits of Family Planning, Broadsheet 534. Volume XXXVIII, PEP, London, England. Feb. 1972.

Chapter Three - Context, Services and an Introduction to the Clinic in St. John's

Newfoundland entered Confederation in 1949 to become the tenth Canadian province. It is situated off the eastern Atlantic coast, and its main industry is fishing. To understand Newfoundland needs and problems, one has to be aware of the geography of the province. Until 1965 no highway existed to link the eastern with the western coasts. Until 1976, to get to the northern peninsula, 300 miles had to be travelled on a small dirt road. At present there is no direct access road to many of the communities on the island. For most of its history, Newfoundland maintained inter-community travelling through small coastal boats. Helicopters are used for medical emergencies. Medical care given in the outports is often by salaried physicians with isolation pay. Small cottage hospitals, often with only 20 beds and with their own laboratory and x-ray facilities, are the norm. Most physicians have not been trained in family planning skills, thus women have been limited in contraceptive choices. Frequently the physician in the smaller community had different moral values than his patients and for that and other reasons was hesitant in prescribing artificial birth control methods. Confidentiality in small communities tends to be a problem, especially for adolescents. It is difficult for young people to approach a 'family friend', a role the doctor has often assumed, and ask for contraceptives, for they fear he may tell the young person's parents.

The population of Newfoundland is approximately five hundred thousand, with just under half living in the metropolitan St. John's area. (See Table 3:1).

Doctor-patient ratio is about 1:5000 in the outports and 1:600 in the St. John's area.[1] With numbers like this in the outports, any kind of preventative care is fortuitous. Mail orders are often not a viable alternative means of obtaining contraceptives, partly because of confidentiality, and partly because of the limited number of methods available without prescription. It is almost impossible to provide mobile clinics because of confidentiality, transportation difficulties and expenses. Many women would be reluctant to use such a clinic in her community for fear of someone seeing her enter and leave the unit. Unless a mobile clinic has multi-services attached, people will feel self-conscious using that type of facility.

Family life in outports is very male-oriented. Life revolves around the fishing season; women's place is in the kitchen. Sex is seen very much for procreation - to provide manpower for the work to be done. Little is invested in family planning by the male, who sees a large number of children as a help in maintaining his present life style and as a 'pension plan'. This is only slowly decreasing as an attitude, as younger people begin the move to the city. Women still play very traditional roles. Although this too is changing, it used to

Table 3:1 Estimated Population in Districts, Newfoundland, 1976

Bay of Islands	12,762
Bellevue	13,453
Bonavista North	11,101
Bonavista South	8,662
Burgeo - Bay d'Espoir	8,788
Burin - Placentia West	12,996
Carbonear	10,977
Conception Bay South	16,552
Eagle River	4,979
Exploits	13,759
Ferryland	7,522
Fogo	9,692
Fortune - Hermitage	9,540
Gander	11,242
Grand Bank	12,331
Grand Falls	8,729
Green Bay	10,768
Harbour Grace	9,059
Harbour Main - Bell Island	11,890
Humber East	10,233
Humber West	10,677
Humber Valley	12,658
Kilbride	15,327
LaPoile	10,780
Lewisporte	13,241
Menihek	15,799
Mount Pearl	12,687
Mount Scio	10,824
Naskaupi	10,110
Placentia	8,859

Table 3:1/continued

Pleasantville	16,664
Port au Port	9,230
Port de Grave	11,004
St. Barbe	11,516
St. George's	10,328
St. John's Centre	7,120
St. John's East	10,034
St. John's East Extern	12,344
St. John's North	9,231
St. John's South	8,921
St. John's West	8,249
St. Mary's the Capes	8,311
Stephenville	10,624
Strait of Belle Isle	12,448
Terra Nova	9,842
Trinity - Bay de Verde	9,116
Trinity North	10,644
Twillingate	8,412
Waterford - Kenmount	14,322
White Bay	13,075
Windsor - Buchans	10,294
TOTAL	557,725

Department of Health Report on the Births, Marriages and Deaths in the Province of Newfoundland and Labrador, 1976.

be fairly common for a pregnancy to be a status symbol or a 'puberty rite' for young girls. An example of this is portrayed in a fifteen year-old girl 'from out of' the bay communities. When she was told she was pregnant, she breathed a sigh of relief, and announced,

> "Thank goodness, I am the only one in the community of my friends who has not been pregnant".

She felt she was not the same as other members of her peer group.

More common, in Newfoundland, is the phenomenon of the "doll-gift syndrome". This is an occurance when an adolescent has a child, plays with it for a short while, then gives it to her mother as a gift. On many occasions the mother appears to encourage her daughter to get pregnant. One mother had had a hysterectomy and the daughter confided to me that her mother would be so pleased she was pregnant as she had wanted another baby and now could not get pregnant. Very often the baby is brought up as a sister to his/her real mother. We continue to observe the "doll-gift syndrome" - when an adolescent has a child, plays with it for a short while, then gives it to her mother as a gift.

Out of wedlock birth is quite high in this province - in some locations as high as 30%. In the year 1975 the out of wedlock births was 29% in St. Anthony and 24% in Stephenville. But, for the province as a whole, in the year 1976, the percentage of illegitimate births in relation to the total number of births was 14.26%.[2]

Part of this is due to local cultural patterns. Because of the isolation, with access to many communities being very dependent upon the time of year and weather conditions, the priest or minister was only able to make one visit a year, in the summer. Thus, many couples lived together in 'community marriages', rather than legal marriages, and their firstborn would be legally illegitimate.[3] This did not mean that the marriages were any less binding than if the priest had solemnized them in the first place: couples would build their house and have their children knowing they would get married as soon as the summer weather allowed the priest to get into the community.

Unemployment in Newfoundland is the highest in Canada (16-30%), depending on who does the estimate, as is the cost of living. Many people have only high school education or less, so that even if they are working their income tends to be quite low. Partly for this reason nutrition tends to be a problem. What people cannot get from the land, or out of the sea, they do not have access to. There is little fresh fruit or vegetables in the diet.

The religious beliefs of the people of Newfoundland have a profound effect on their attitudes to sex and contraception. In the St. John's area almost half of the females are Roman Catholic.[4] The other half is divided predominantly between the Anglican and United protestant denominations, with a small proportion of other protestant groups, such as Salvation Army and Pentecostal. (See Table 3:2). Outside of the

Table 3:2 Religion Breakdown in St. John's, Newfoundland

	Number	Percent
Population of St. John's	132,605	100%
Catholic	62,560	47.2%
Anglican	34,625	26.1%
United	23,880	18.0%
Others	10,445	7.9%
No religion	1,095	.8%

Females constitute 50.4% of the total population.
Source: Statistics Canada - Census 1971, Catalogue #92724

St. John's area, the Catholic proportion is higher. Although many Catholics are practising methods of birth control other than the natural methods approved by the Church, the all-pervasive belief that this is a sin has added a burden of guilt for many women. Many women are ashamed of their own sexuality and will rarely discuss it openly with their husbands, and certainly not with a stranger, be that stranger clinician or counsellor.[5]

Historically, in Newfoundland medical and contraceptive advice, when given, came from relatives, friends, and the community priest. Birthrates were high, infant mortality was high, and families were

very large.[6] (See Table 3:3). Women breastfed for as long as they could in an attempt to provide some spacing between their children. This has changed in the last thirty years and now breastfeeding is almost absent as a means of contraception, likely because solid foods are added at a much earlier age.

Table 3:3 Infant Mortality Rates, City of St. John's and Province of Newfoundland

Year	City of St. John's	Newfoundland
1966	20.5	28.0
1967	23.0	28.6
1968	10.4	24.1
1969	14.9	21.4
1970	16.8	21.8
1971	19.0	22.9
1972	15.4	20.7
1973	11.6	19.3
1974	12.2	17.7
1975	10.6	17.3
1976	10.1	15.6

* Rates are per 1000 live births.

Source: Department of Health, Newfoundland and Labrador, 1976.

In February and March 1972, Dr. Helen McKilligin, the then Chief of Neonatology at the Grace General Hospital, wrote a series of articles for the Evening Telegram. She discussed the risk to health for both

the mother and the baby in having such large families. In discussing teenage pregnancies, she stated that "official sex values in Newfoundland are so unattainable and hypocritical that young people with a more realistic and balanced outlook can only reject them".[7] She emphasized the inability of women to discuss their needs with their family doctor. In showing the need for family planning, she asked for support from the community as a whole to fill this need. This series of articles coincided with the federal government establishing the Family Planning Division within the Department of National Health and Welfare to take a lead in establishing family planning programs.

On January 6, 1972, Dr. Helen McKilligin received a letter from Dr. H.J. Warrick, M.D., the then Medical Director of the Grace General Hospital, to confirm that the Medical Advisory Committee at its meeting December 7, 1971, requested that she form and chair a committee to consider the best way of achieving the ideals of a Family Life Clinic. He went on in his letter to relate that discussion had centered on the need for service in view of the "abysmal ignorance" of some people on matters of sexuality and contraception. There was also discussion on whether the present hospital clinic, then held at the Grace General Hospital, should be continued or whether it should be more of a 'community' facility.[8]

The first meeting of the ad hoc committee chaired by Dr. McKilligin, and attended by four other doctors with one absent, was held January 10, 1972. At this meeting the general consensus of opinion was that a

hospital facility did not give the flexibility and freedom of practice in such areas as publicity and education, so necessary for the effective delivery of family planning.[9] It was concluded at this meeting that the best approach appeared to be the formation of a group of interested lay people into a branch of the Family Planning Federation of Canada, strongly supported by the medical and nursing profession through such organizations as the Newfoundland Medical Association (N.M.A.), Association of Registered Nurses of Newfoundland (A.R.N.N.), Canadian Public Health Association (C.P.H.A.), and the Newfoundland Social Welfare Council (Canadian Council of Social Development). This approach was endorsed by the Medical Advisory Committee at its meeting January 18, 1972.[10]

The Newfoundland branch of the Canadian Public Health Association called a meeting of the association membership in the new year to formulate a blueprint for providing accessible family planning services in the province. Dr. Boyd Suttie, deputy minister of health as well as president of the provincial CPHA branch, said a blueprint would constitute a 'declaration of needs'.[11]

The Executive Director of the Family Planning Federation of Canada was invited to attend one of the early organizational meetings for information and advice. At that meeting the group agreed to form an interim board of the Federation and work towards the formation of a Family Planning Association with a Board of Directors. An open foundation

meeting was held at City Hall May 18, 1972.

In June 6, 1972, the first official meeting of the Family Planning Association of Newfoundland and Labrador was held in the Board Room at the Grace Hospital. Dr. McKilligin called the meeting to order and acted as Interim President. Subsquently, the Board requested affiliation with the Federation and an operating grant of $4,535 and both requests were forthcoming.[12]

June 27, 1972, office space was rented at 3 Church Hill. This consisted of two rooms and a bathroom and was initially staffed by volunteers, who were professional people, two nights a week and increased as more volunteers joined. The early function of the organization was to induce people to talk about family planning, make people aware of the available contraceptive methods, and to distribute literature and provide speakers to groups. In January 1973, a position of part-time office manager was established to allow for more continuity and control of services. The organization was starting to fill some of the gaps known to exist. In March the service was used by twice the number of community people that received service in the month before. Most of the information received by the client was in the form of a telephone interview. The role of counselling will be discussed in more detail further on in the text. However, the importance of the telephone for anonymity, quick reassurance of a problem, and easy accessibility of service must be

emphasized. A training session was held in February to train the volunteers in correct contraceptive advice and interviewing skills.

In May 1973, the first Provincial Family Planning and Sex Education Conference was held in St. John's, planned by the Family Planning Association of Newfoundland and Labrador, with financial assistance from the Family Planning Division of the Department of National Health and Welfare. It was attended by 163 delegates, who attended from various parts of the Province. The objectives of the Conference were stated as follows:

1. Gather together people who can be effective in assessing the recommendations of the National Conference on Family Planning (1972) and recommending ways and means of implementing approved policies as they apply to Newfoundland and Labrador.
2. Open discussion of local problems; methods of reaching those who are in need; communication; educating public opinion; introducing family life education into the schools; teacher training; etc.
3. Examining the service needs of family planning.
4. Political, sociological and economics of family planning as it relates to future overall-planning for the Province.
5. Further education, information and advice for those attending.[13]

Communication amongst the participants was a keynote of the conference. Out of the recommendations from the delegates at the conference, the

foundation was laid for the subsequent planning and activities of the Family Planning Association of Newfoundland and Labrador (See Appendix L). In general, the conference was successful in opening up discussion of local needs and problems and examining the service needs of contraception and sex information in the province.[14]

In March 1974, the Family Planning Association began carrying out pregnancy testing one day a week to extend its outreach program. It also began to reach people about birth control. By July 1975, the Family Planning Division of the Department of Health and Welfare had financed a three year demonstration project that permitted the hiring of an education director and part-time secretary.[15] The dissemination of information was the main focus of this individual's position and seminars, speaking engagements, professional training sessions and literature distribution were also the responsibility of the Education Director. In May 1976, the Family Planning Association changed its name to Planned Parenthood Newfoundland/Labrador, in keeping with the other provincial organizations across Canada.[16]

In June 1977, the Family Planning Division of Health and Welfare Canada provided a grant for what was the first federally funded birth control clinic and counselling service, affiliated with a Planned Parenthood organization in Canada. This was to complement the educational dimension of Planned Parenthood. The grant was also in the form of a three year demonstration project to determine if there existed

clinical needs in the field of family planning. Prior to the opening of the clinic there was a lot of discussion from the Board and other concerned people about whether a clinic was in fact needed in the St. John's area. Many people felt that a birth control clinic was a duplication of services. It was asserted that the family doctors were providing adequate care in this area. Others felt that there was a lack of communication between patients and their doctors and for various reasons the women were not going for their family planning concerns. Many had no family physician and these women were just not receiving any professional information. It is interesting to note a study focusing on family planning needs carried out in July 1974, revealed that 74.3% of the respondents felt it was very important for doctors and clinics to be provided in their areas.[17]

In spite of expressed concern and doubts, the clinic funding came through in June 1977 and a clinic co-ordinator and full-time secretary were hired. The Planned Parenthood Association moved into larger premises on August 1977 to accommodate the clinical staff and equipment which was purchased for examinations. Physicians were sent a letter to ascertain if they would like to work in the clinic on a roster, and a meeting was set up to discuss procedures and policies. It is interesting to note here that the responses of the physicians on the whole were very positive until the Newfoundland Medical Association (N.M.A.) released a statement unsupportive to the clinic. To quote from the letter sent

by the Newfoundland Medical Association:

> "The St. John's G.P. Association passed a motion opposing the envisaged expansion and scope of activities of the Family Planning Association and recommended that the F.P.A. restrict itself to counselling services only".

Subsequently, several of the physicians would not publicly endorse the clinic.[18] It is possible that the N.M.A. decision played a significant part in the attrition of physicians from the clinic.

The opposition of the N.M.A. and of some of the physicians in the medical community at large appeared to have several main concerns. The first seemed to be their fear of losing patients. As noted earlier, at the present time in the St. John's area, there is a small ratio of patients to physicians: 1:600. Many of the physicians say they are finding it difficult to maintain a practice with the high overhead expenses. However, one of the clinic's policies states that the clinic will see clients with no family physician, or those who find they are unable to communicate with their own physician. Some of the doctors opposing the clinic express their concern in terms of the 'holistic' practice of medicine. They feel that if they are seeing a patient for one aspect of health-care, they should see them for all. While most professionals would agree with the notion of holistic medicine, there appear to be occasions when a patient does not want to share this personal aspect of his or her life with a physician. Also, it is

possible that she would like to go to a 'speciality' service, where she feels that she will receive specialized attention and non-medical counselling.

The third opposition, although this was not voiced publicly, was a conflict of philosophy. The Planned Parenthood organization believes that women have the right to choose the method of contraception which they feel will be best for them, providing it is medically sound, and that in the face of unwanted pregnancies, information on all options will be made available to clients, (i.e., the client-centered approach). The Newfoundland Medical Association in its Code of Ethics, section 16 on Personal Morality does not support this view. Originally, physicians were required that if a patient requested a service that was against the physicians own ethical code and personal morals he/she was required to tell the patient his/her bias. As is written down in section 16 of the Code of Ethics it reads as follows:

> "When his personal morality prevents him from recommending some form of therapy which might benefit his patient will so acquaint the patient".

In 1977, for one year only, the Canadian Medical Association added the words "and refer". The Code of Ethics read as follows:

> "When his personal morality prevents him from recommending some form of therapy, he will so acquaint his patient and will advise the patient of other sources of assistance".

In 1978, because of the controversy, the Canadian Medical Association withdrew the clause "and refer". Because Newfoundland had never changed the situation remained the same.

Therefore, within the medical context, all physicians must feel comfortable with all methods of birth control and with the philosophy of practice and counselling.[19] Despite those physicians who changed their minds about working in the clinic, a sufficient number supported the idea to form a roster and in October 1977 the first medical clinic with a physician present opened. The clinic has now been conducting weekly and bi-weekly clinical sessions for two years with physicians in attendance. Presently, there are physicians phoning to ask if they can work at the clinic. Indeed, some physicians refer all their contraceptive patients to the clinic, and over sixty family physicians, within the city of St. John's, refer their patients for counselling and various testing. Acceptance among the medical community appears to be much improved and the 'team' approach to patient care is beginning to emerge.

The Establishment of the Clinic

With the Federal Grant to implement a clinical service, the subsequent move to new premises, and with the physician roster and organizational policies established, the clinical service began, and the pregnancy testing service, that had previously been done by the Educational section, was transferred over to the clinic.

The objectives of the Birth Control Clinic were defined as follows:

1. To provide a non-judgmental primary care birth control clinic in an area of need.

2. To increase awareness of all possible methods of contraception to enable individual, appropriate choice.
3. To reduce the number of unplanned conceptions.
4. To provide an accessible entrance to the preventative health care system.
5. To refer obstetrical and gynecological problems.[20]

Patients may attend the clinic either by an appointment or 'drop-in' visit.. Referrals can be made from other community resources or from their own family physician although most patients appear to come in by 'word of mouth' referrals.

The Clinic as a Training Center

One of the 'raisons d'etre' for the existence of any resource center is its assistance to the professional community at large. The clinic has continued to promote as one of its main aims interest in the pursuit of knowledge and training in the family planning field.

The facilities are available for all physicians in the area to learn skills of contraception management. In addition, the second year family practice residents work as physicians in the clinic, which both assists with the work load and assists the physicians to learn procedures such as diaphragm fittings, intrauterine insertion techniques, and prescribing.

One of the criticisms of Medical School Programs today has been their lack of interest in, and teaching of, human sexuality and family

planning. One of the problems, of course, is that the medical curriculum has become so broad and comprehensive that it is hard to go in depth into all of its component parts. To do this would require lengthening the course. However, in some schools there are no courses dealing with sexuality and family planning and in those which do have courses, they are often electives and regarded as 'soft options', thus not 'real' mainstream medicine.[21]

At the present time, whether family physicians wax enthusiastic about these problems or not, their patients are going to them for advice. Unless policies are changed so that family planning services do not have to be provided by a physician, there should be more adequate training.

Physicians should also be required to take courses dealing with sexual counselling. Holistic medicine, emphasizing the total person, consists of physical, emotional, and sexual needs, and all three must be considered in management.

A student placement has been maintained for social workers to learn counselling skills and to encourage social workers as a profession to function in the field of family planning and research. Nursing students as well as medical students attend lectures and observe clinic practices.

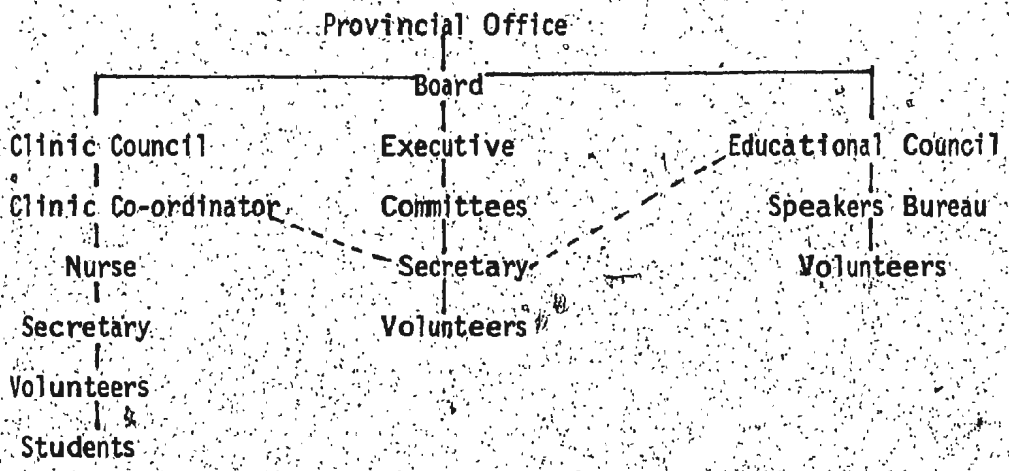
Perhaps, as the field of family planning and sexuality continues to grow, the medical curriculum will make room in its programs for additional training in these areas. However, at present the Planned Parenthood serves to provide essential services in the area of human sexuality.

Administrative Structure of the Clinic

Planned Parenthood has as its policy making body an elected Board structure. This consists of an executive as well as several other community members, which make up the Board. When the Family Planning Division of the Department of Health and Welfare allocated money to establish a birth control clinic, the Board felt there would be many initial decisions of policy making and everyday running problems to be made and that a committee should be assigned, which would be accessible and have the time to make such decisions. Consequently, a Clinic Council was set up to oversee the everyday working of the clinic. This consisted of approximately ten members and had its own executive elected from its membership. Accordingly, the clinic has been able to expand and grow in areas which appear to be meeting the community needs. They have provided strong support and guidance to the clinical staff.

Figure 3:1 shows the organizational structure of the agency since May 1979.

Figure 3:1 Organizational Structure of the Board, May 1979



The Clinic Council has its own terms of reference, as approved by the Board, on May 1978. A rotating chair is elected each year from its members, and the chair of the Clinic Council sits on the Board.

A Typical Working Day at the Clinic

The typical clinical working day is always busier than expected. The number of clinical staff is small. It consists of the Clinical Co-ordinator, a full-time staff member, who runs the clinic as well as counsels patients by appointment and by 'drop-in' visits. In addition, there is a full-time secretary/receptionist who co-ordinates the telephone, appointments, drop-ins, recordings and public relations, and a part-time nurse, who sees patients as well. Due to the constant

flow of patients, the role of the volunteer, traditionally always welcomed, is essential in this agency and has always played a vital part in the carrying out of everyday activities.

The secretary co-ordinates the volunteers, and provides a training session for them to become familiar with the counselling and interviewing skills and accurate birth control information. Volunteers work in the clinic as counsellors, and if they are trained nurses by profession, they use their nursing training to help with procedures in the clinic.

Besides the patients who come in for the various services, attention must be directed towards follow-up care, administrative duties, clinical trials and practices, inservice education and to speaking to a number of groups. Staff meetings have not been consistent over the past year due to lack of time and there is agreement among workers that these must be encouraged to provide uniformity and cohesion to policy and procedures. One of the major concerns of the staff is the question of confidentiality. St. John's is a small city and it is very easy to facilitate the spreading of rumour and gossip if caution is not observed. Great care is taken to prevent the leak of information by numbering the files so no name will show, locking the files and providing access to files to permanent staff members only. Moreover, no client information is given out over the telephone. All staff insist *ab initio* that confidentiality in all cases must be kept. Also of major

concern to the staff is the problem of patients having to wait if the nurse is busy. It is widely held that patients should have unlimited time if they need it and not be made to feel rushed. Because of this, on occasion, some patients have had to wait. To try to combat this problem, it is a routine practice to show continuous educational films on sexuality, birth control methods, and self-breast examination. This provides education as well as relieves boredom.

Other Existing Contraceptive Services in the Community

Prior to the establishment of the Planned Parenthood Birth Control and Counselling Service, there were several other avenues for patients to seek and get contraceptive care.

The most common source of care and information is the family physician. As stated in this chapter the patient-physician ratio is very low so that physician service is readily available in the St. John's area.

The pharmacist is also a source of information and supply. Few people see the pharmacist as an educator and yet he/she is perhaps the most knowledgeable and up-to-date professional in the contraceptive field. The hours of availability are convenient as well as the source of supply.

Hospital-based family planning clinics are very scarce. St. Clare's Hospital has a Natural Family Planning service for teaching and providing

information on the Sympto-Thermal Method of birth control. This is the only method of contraception that is taught because of the philosophy and stance of the Catholic Church. Although this method is limited, the St. Clare's family planning clinic provides the only formalized couple teaching course in the Sympto-Thermal Method.

The hospital-emergency departments at all the general hospitals provide emergency and outpatient care that includes contraceptive and gynecological concerns.

These are the formalized existing services that exist in the St. John's area.

Footnotes and References: Chapter Three

1. Figures given are an estimation of physician-patient ratios in the province of Newfoundland made by a member of the Newfoundland Medical Association. He estimates that outside of the St. John's area the ratio is about one physician to 860 patients. In some areas there is as much as one physician to 6000 patients. In the St. John's area, excluding the residents and the University physicians, the ration is one to 650. When we include the residents and University physicians the ratio drops to one physician to 450 patients. Specialists in the province are mainly in the St. John's area so few resources are available in specialities within the rest of the province.

2. Department of Health Report on the Births, Marriages, and Deaths, in the province of Newfoundland and Labrador for the year 1976.

3. Conversation with Dr. John Ross, Family Practise physician, St. John's, Newfoundland. Dr. Ross has had extensive experience working throughout the island in cottage hospitals and is now working in the St. John's area.

4. Statistics Canada, Census 1971, Catalogue #92724.

5. This is the result of the author's experience with women who have attended the clinic. Similar views are expressed by groups of women spoken with in discussion of attitudes and their own feeling of sexuality and birth control.

6. For further information see Department of Health Report on the Births, Marriages, and Deaths in the Province of Newfoundland and Labrador 1976. See also: Warren E. Kalbach and Wayne W. McVey, Jr. The Canadian Family: A Demographic Profile in The Canadian Family in Comparative Perspective, Prentice Hall, Scarborough, Ontario. 1976. pp. 91-108.: J. Henripin and J. Legare, 'Recent Trends in Canadian Fertility', Canadian Review of Sociology and Anthropology, 8 (2), 1971. See also: Department of Health, Annual Report 1977, Province of Newfoundland.
The birth rate (20.4) shows a progressive decline. The birth rate is, however, still above that for Canada (15.7) and is the highest of the ten provinces. Source: Department of Health, Annual Report 1977, Province of Newfoundland.
The 1971 Census Data of Vital Statistics states that in Urban Areas of Newfoundland 4.3 persons per family and in Rural Areas 4.6 persons per family are the average. This is the highest rate in Canada.

7. The Evening Telegram, Saturday, March 18, 1972.

8. Letter from Dr. H. J. Warrick, M.D. to Dr. Helen McKilligin. See Appendix H.

9. Meeting of the Ad Hoc Committee minutes: January 10, 1972. See Appendix I.

10. Letter to Dr. Helen McKilligin, (Chairperson of the Ad Hoc Committee on the Family Life Clinic) by Dr. H. J. Warrick, (Medical Director of the Medical Advisory Committee) regarding the outcome of its meeting January 18, 1972. See Appendix J.

11. Statement by Dr. Boyd Suttie, president of the provincial Canadian Public Health Association branch. See Appendix K.

12. From minutes of the first official meeting of the Family Planning Association of Newfoundland and Labrador held June 1, 1972.

13. Report: Provincial Family Planning and Sex Education Conference, St. John's, Newfoundland, May 11-12, 1973. Family Planning Association of Newfoundland and Labrador. p. 1.

14. Ibid. p. 91.

15. A demonstration project is a short term project or program that is financed, in this case by the federal government, to demonstrate that there is a need for this type of program or service in the community. All demonstration projects that are funded at the Federal level are supported, at least in principle, by the Provincial government. It is possible that these will be continued financially by the Provincial government if a need is identified in the community.

16. Planned Parenthood Newfoundland/Labrador Constitution. See Appendix M.

17. David J. Kirby, The Final Report of Project Outreach, Attitudes Toward, and Utilization of, Family Planning Services in the city of St. John's. Family Planning Association of Newfoundland and Labrador, July 1975, p. 86.

18. Letter sent to Dr. Helen McKilligin from Dr. P. J. Dobbin, Secretary, Newfoundland Medical Association, August 2, 1977. See Appendix N.

19. For further confirmation of this point see: An Exploration of the Limitations of Contraception: Proceedings of a Conference Ontario

Science Centre. November 1975. Sponsored by Ortho Pharmaceuticals. See also: Dialogues in Oral Contraception. November 1975 to October 1976. Volume I-VI. Sponsored by Department of Obstetrics and Gynecology, University of California School of Medicine and others.

20. Objectives of the Birth Control Clinic as defined in Policy Book, Planned Parenthood, Newfoundland/Labrador. June 1977.

21. For further discussion see: Sanford R. Wolf, and Elsie L. Ferguson, "The Physicians' Influence on the Nonacceptance of Birth Control", American Journal Obstetrics and Gynecology, Volume 104, Number 5. July 1, 1969. p. 753. Also: Morton A. Silver, "Birth Control and the Private Physician", Family Planning Perspectives, Volume 4, Number 2, April 1972. M.E. Palko, R.H. Lennox, C.R. McQuarrie, "Current Status of Family Planning in Canada", Canadian Journal of Public Health, November/December 1971 Issue. Volume 62.

Chapter Four - The Clinical Patient and Services*

The Patient as Perceived by the Public

The typical patient attending a family planning clinic is frequently stereotyped as being poor, from a lower socio-economic class, poorly educated, usually having many children, and often on welfare. Certainly clinics in North America as they were originally set up were for the poor women who needed help to control their own fertility. However, from a special survey carried out by the United States Census Bureau, the Research Department of Planned Parenthood - World Population has put together significant information about the five million impoverished American women in need of subsidized family planning services. This survey shatters many long held stereotypes. Of the 5.3 million women the survey reveals the following:

- 70% are white. Only 30% are non-white.
- Three out of five are married and currently living with their husband. One out of four is separated, widowed or divorced. One in six is single.
- Seven out of eight lived in the same country for at least the preceding twelve months. Two out of three did not move at all.
- Two-thirds live in big cities. More than half of them in the country's 110 largest standard metropolitan areas. Only 7.5% live on farms.
- Three-fourths have attended high school. Four out of ten are high school graduates. One in ten has had a college education.

* All patient quotes are in English and not in Newfoundland Dialect.

> They are predominantly young. Almost half range between 18 and 29. Another 19% are between ages 30 and 34. The other 32% are from 34 - 44 years old. Their babies are born early. In the 18 to 19 age group, one out of five has already had at least one child as compared to one out of twelve among the non-poor. Almost one-sixth of the 2,600,000 poor women under 30 has already had four or more children as compared to one out of twenty-eight multipara among middle class women.[1]

Profile of the Clinic Patient

The patient who comes to the St. John's clinic cannot be stereotyped into 'poor patient', 'adolescent girl', 'harried housewife', or whatever. She is any person in the community who seeks the clinic for advice and counselling or fertility planning. The clinic has reached all age levels of reproductive years, (age 14-54), and has encompassed all socio-economic classes, and all professional levels. Housewives, as well as adolescents and menopausal women, have attended the clinic. Single as well as married women have come in equal numbers. The patient is, in effect, any woman from the St. John's and surrounding areas. If we can narrow it down further, she probably does not have a family physician or has been referred to the clinic by one. Some women are unhappy with their present physician and are looking for a change. This is often their first attempt at any 'preventative' kind of health care.

We tend to think that only females need the service provided by

contraceptive information. However, men are often equally concerned about protection against pregnancy and sexual and reproductive concerns. A man will often come in to the clinic either by himself, or with his partner. There also appears to be a need to provide venereal disease testing for the male, especially the homosexual. The gay male tends to be uncomfortable going to a Public Health clinic or to the private physician. He feels he will be 'put down' or made to feel embarrassed. The male attending the clinic includes ages 14-60 years, all socio-economic classes and all professional levels. We will elaborate the patient 'profile' throughout this study.

When the clinic opened its doors to the public, there was some concern over whether or not women in the community would use this type of facility for their health needs. In a comparative study with a Family Planning Clinic in the Ottawa area, it is evident that not only have the women in the community seen the need for this service but have made more use of the service it provides than have those women using the Ottawa family planning service. One of the reasons for this might be that there are alternate services in the Ottawa area, whereas in the St. John's area the clinic is the only comprehensive birth control and counselling service available.

In the year June 1978 - May 31, 1979, the second year of clinic operation, the clinic received 1932 new patients and 1629 repeat patients for a total of 3575 clinical visits. This has increased from June 1977

to May 81, 1978, by 1629 patients. In comparison with Ottawa's Family Planning Clinic, which saw 2000 patients their first year, increasing to 11,000 visits in five years of operation, we can project in excess of 16,246 visits to the St. John's clinic in five years.[2]

When comparing these figures, we must be conscious of the difference in population base between St. John's and Ottawa, as well as acceptance of service in the community. Ottawa has a population of 302,341 (1971 census) compared to St. John's of 88,102 (1971 census). Furthermore, community acceptance is much more readily available in the province of Ontario, which has had a family planning policy since December 1974,[3] than it is in Newfoundland, which has as yet to formulate a policy on family planning.

Table 4:1 Comparison of Patient Visits at Two Family Planning Clinics

Year	Ottawa Patients	St. John's Clients
1st	2,000	1,946
2nd	-	3,575
5th	11,000	16,246 projected

Services Available

The following services are available in the St. John's Birth Control Clinic and Counselling Service. Case histories are given to show the

breadth of services rendered. Unfortunately, they do not show the depth of problem areas. Many of these cases demand several hours of counselling time, follow-up and supportive care. Only the highlights of often a much deeper problem are given in the studies presented here.

1. Pregnancy Testing

This is perhaps the clinic's most utilized service. The pregnancy test is used as a means of 'outreach' rather than duplication of service, to provide a 'reason' for people to come for counselling. There are many different types of patients who come to the clinic for testing.

Pre-menopausal Anxiety

Ann, a 54 year old married woman, has had three children. Her youngest child is fourteen years old. Ann is just about to embark on a new job when she realises she has not had her period for two months. Ann comes in for a pregnancy test on the advice of her physician. She has never heard of the clinic and is eager to learn of its other services. A pregnancy test, which takes two minutes and has a high rate of accuracy is performed on her first morning urine sample. The results of the test are negative. Ann is quite relieved and explains that up until about two months ago she has had regular periods. She is not using any form of birth control as she feels she is 'too old to have a baby'. Further discussion centers around the risk of pregnancy until she completes her menopause and reviews the methods of contraception available for her at her age. The

need for a repeat test is explained to her if she continues to experience amennhorea and a referral is made back to her family physician. The importance of self-breast examination is discussed and the patient is instructed in its procedure.

Fertility Evaluation

Jane is a young married woman of twenty-five years. She has one child and has been trying to get pregnant for three months. Her pregnancy test result is positive and Jane is delighted. Further counselling, centers on the need for early pre-natal care, available resources for pre-natal classes, and any other pertinent needs. Pamphlets pertaining to pregnancy and early baby care are provided.

Coping with Infertility (Counselling)

Julie is thirty-one years old. She has been married for twelve years. The first two years of marriage she and her husband used condoms and foam so they would not have a baby until they could become financially secure. Since that time, she has been trying to get pregnant with no success. However, Julie has missed her period by three weeks and although this has happened before, she is hoping to be pregnant. The results of her test are negative. Julie is advised to repeat the test if she has no period within two weeks. She is also referred back to her family physician to ask for an infertility work-up. Further discussion by Julie continues and she asks questions about her most fertile time and about pregnancy signs.

Counselling includes information about Julie's anatomy and mucous charts and the procedure for trying to pinpoint ovulation is discussed.

Many of the Clinic's patients are referred by the guidance teachers at the school or brought in by their parents for counselling.

Sex Education

Susan is a fifteen year old girl who is referred by the guidance teacher at her school. She has been failing her subjects for the last two months and has been found several times 'staring off into space'. In the course of discussion with her teacher, Susan confides her concern about missing two periods. A test on Susan's urine reveals that she is pregnant. After further counselling Susan is helped to tell her parents of her pregnancy. Additionally, preparations are made to enable Susan to finish her school year, and she is referred to Planned Parenthood's Single Girls Prenatal Classes.[4] Following the second session of her classes, she chose to join the Sunday afternoon support group, an activity group for single girls who are pregnant or immediate post partum.[5] Through this group, participants meet other girls in the same life space and can share anxieties, problems, and joys. Susan is also referred to a physician for medical care during her pregnancy.

Jennifer is a seventeen year old single girl who has been going with her 'steady' boyfriend for one year. They have been engaging lately in heavy petting but several times in the last three months their petting led to intercourse using 'coitus interruptus'. She is very frightened that she is pregnant and now finds that she is overdue on her period. Results of her test are negative and birth control methods are discussed. It is pointed out to Jennifer the unreliability of the method of birth control she and her boyfriend are using and she subsequently requests to go on the pill. Jennifer does not want to go to her family physician because as she put it, "He will tell my parents". Discussion continues about her relationship with her boyfriend and her parents and she asks if she can see one of the clinic physicians to further discuss her problem. An appointment is made for the next clinic.

The Pregnancy Test in Diagnosis

Pamela has been bleeding off and on for several days. She has had two pregnancy tests at the hospital but they are both negative. In spite of this, she feels sick and experiences 'funny feelings' in her stomach. A first morning sample of urine is tested using a new, very sensitive pregnancy test.[6] Results of this test are positive for Pamela. She is referred that day to her family physician, who admits her to the hospital. Subsequently, an operation is performed on her for an ectopic pregnancy.

The Pregnancy Test as a Tool

For counselling, referral, diagnostic purposes, relieving anxiety, and for the provision of information regarding birth control, it an important resource in the community. From the patients point of view it is convenient; results are immediate and the service is confidential.

2. The Clinic and the Physician

The second function of the clinic is to facilitate the patients need to see a physician for medical problems, predominantly related to venereal disease and birth control. A wide range of cases as seen in the clinic in this area of service, are as follows:

Gail is seventeen years old. She has gone to two physicians in town and has not been able to get the kind of birth control she wants. She has either received a 'moral' lecture or has been told to learn to say 'no'. Her friend has heard about the clinic and told her to 'drop-in'. Gail is ill-informed as to the various methods available. She sees a counsellor, who discusses the available methods with her and she views a film which goes into all aspects of birth control. She is then referred to a clinic physician, who manages the medical aspect of her visit.

Joe has been going with a girl for two years. Recently she informed him that she had been named a contact for gonnorrhea,

Joe is tested for venereal disease and appropriate treatment is provided.

Debbie is nineteen years old. She has been to the clinic previously and has had a positive pregnancy test. She has no family physician as she has only lived in Newfoundland for six months and is 'never sick'. She wants the physician to confirm her pregnancy before she informs her parents.

Mary is twenty-six years old and single. She works in the theatre and travels throughout North America. She has an intrauterine device in place, but lately it has been giving her some trouble. She is aware of the existence of Planned Parenthood and uses these clinics in all the places she visits. She reports that she feels safer knowing she is at a clinic that is monitored rather than just looking in the phone book and 'picking out any physician'.

Patients can see a physician twice a week for birth control, venereal disease testing, and related gynecological concerns. It is preferable they have an appointment, but 'drop-ins' are welcome. All patient information is kept in strictest confidence. Physicians, in general, family physicians, relatives, and other resource workers will only be given access to files at the request of the patient or with the patient's permission.

3. Counselling Problems

A number of patients have problems they want to discuss, which do not require the services of a physician. These may be summarized as follows:

Sally is a single twenty-six year old girl. She has been going with a boyfriend for six years and they are contemplating marriage. She has a good relationship with him but they have never been able to have intercourse with penetration. She has been to several specialists and they have led her to believe she is a 'sexual cripple' and needs psychiatric care. She is worried and anxious to discover the nature of her problem. Following an exploratory inquiry into Sally's and her boyfriend's relationship and past history, it was evident that they had a good relationship. There did seem to be a medical problem, however, and with referral and subsequent careful examination, she was found to have a vaginal septum - certainly a barrier to any possible penetration. Had Sally not come in for counselling, she would probably have broken up an excellent and mature relationship and been left an 'emotional cripple'. Perhaps a little more time spent with Sally several years before, when she first went for help, would have saved much anxiety and frustration.

Judy is sixteen years old and in her first year of high school,

She has been dating for the past six months and is concerned with her role as a female on dates. She feels that she is expected to have intercourse as a part of her going out on dates, but finds it is painful and she doesn't really like it anyways. Furthermore, it seems to always happen when she babysits and she is afraid the people she sits for will come home and catch her at an embarrassing moment. Counselling Judy helps her define her role in dating and tries to encourage her to accept responsibility for her own lifestance. Discussion includes contraception and venereal disease symptoms, so she will be prepared but somehow, the likelihood of Judy needing these methods is probably somewhat premature. She really just needed the approval of being able to say 'no'.

Carol and John are a twenty-one and twenty-two year old couple who are getting married in the near future. They have discussed birth control and planning their family, but have decided they would like to wait two years for their first child. They are both of the Roman Catholic faith and are only comfortable using the method of birth control condoned by their Church, the Sympto-thermal Method. Instructions are given in this method, charts and audio-visual aids are utilized. They will be followed up at frequent intervals.

Mrs. Jones and Patsy, her twelve year old daughter, come into the clinic together. Mrs. Jones is concerned that Patsy will be starting her periods soon and will not be too well-informed. She says that her parents have never told her anything about sex and that she had always had a lot of trouble with her periods. She does not want Patsy to follow in her footsteps and to be afraid of becoming a woman. They discuss the menstrual cycle, how a baby is born, and a film is shown. Patsy and her mother go through the literature and take the pamphlets they feel will help them.

Anyone from the community can come into the clinic for counselling or information on any sexually related problem or for reproductive knowledge. Parents bring daughters and sons; couples seek information on contraception, as well as problems in their relationships. Individuals come for personal answers to questions as well as answers to information needed regarding their birth control methods, or health problems.

4. A Call for Help: The Use of the Telephone

Not all patients visit the clinic. Frequently the telephone becomes the medium through which the counselling process takes place. Initially, when the family planning association started, the early patients came for 'drop-in' service or they telephoned. The first calls came for

information on birth control, abortion and pregnancy.[7] The clinic now receives over one hundred calls a week. These seem to be of four types:

The Anxious Client in Need of Reassurance

The Professional Referral

The Second Opinion Seeker

The Obscene Caller

Reassurance and Anxiety

This is the patient who needs to be sure she is doing the 'right' thing- taking her pill correctly, putting the diaphragm in as instructed, or checking her mucous symptoms correctly. Many times this patient is afraid of birth control. She is afraid of getting pregnant, getting caught. She generally lacks information and is anxious. This patient needs extra attention in detail so her mind will be relieved of anxieties. Very often this patient has listened to many 'old wives tales' and these create an exaggerated fear of the unknown.

Professional Referral Cases

This group has increased substantially over the past two years. One can only surmise that the proliferation of these calls is due to increased acceptance and credibility of service as well as further knowledge of the existence of the service. Examples of this type of call include the local pharmacies phoning for information on specific pills or intra-uterine devices, research teams from the university seeking information

about natural condoms for experimental purposes, and physicians from St. John's and as far north as Labrador seeking information on methods and gynecological resources available. Social Workers will phone for sexual counselling advice, and teachers frequently request advice on pregnant schoolgirls.

The Second Opinion Seekers

This is becoming a very common phone call. The patient who sees her physician, is given a prescription for a pill and then phones the clinic to see if the pill is safe for her to take. Many patients are concerned about lack of instruction they have received when given medication. Often, the patient is given appropriate instructions by her physician, but due to nervousness or some other emotional state, does not 'hear' what has been said. She then gets home and tries to find out the correct instructions and symptoms she must know.

The Obscene Caller

These are few in number but seem to be children who are likely bored and want to have some fun. There are also a small number of people, mostly men, who seem to derive some sort of satisfaction in discussing sexual fantasies on the phone. Whenever possible, these people are referred for professional help.

The telephone is an important resource. It gives the patient ultimate confidentiality, is cost-effective in terms of clinic time, and provides a ready source of information and assistance.

5. Communication by Correspondence

The fifth service available is through the mail system. This has been a small part of the service, but has been particularly useful in providing help to outlying areas of St. John's, as well as communities in Newfoundland and Labrador. People can write in for answers to questions in the area of sexuality as well as receive literature and referral information. (See Appendix O).

Unfortunately some people choose the mail medium to vent their feelings or to express their own attitudes and values to others without knowledge or thought as to what is actually being provided. Most often these letters have their sole benefit in the expression of frustrations on the part of the writer and have little visible impact on the target of the attack. (See Appendix P).

In this study an attempt was made to interview total populations in various weeks to try to replicate the percentage breakdown in the total population of clinical patients.

The breakdown of patients interviewed in the various service categories is provided in Table 4:2.

Table 4:2 Patients Seen in Clinic and Other Service Categories *

Service	Number	Percentage	Total Population
Pregnancy Testing	101	71.1%	60%
Physician Clinics	25	17.6%	20%
Counselling	16	11.3%	20%
Totals	142	100%	100%

* This does not represent total population of clinic patients but only those interviewed in the study.

As may be seen in the table, there were 101 patients who came in for pregnancy testing, 25 to see a physician in the clinic, and 16 for help with problems in areas of gynecological health, or sexuality. This represented 71.1% of patients for pregnancy testing, 17.6% for physician visits, and 11.3% for counselling only. In relation to the total population of clinic patients served this is quite representative. Total population percentages of all the patients seen at the clinic would be closer to 60% for pregnancy testing, 20% for both physician visits and counselling patients.

Occupation Breakdown of Patients Attending the Clinic

The largest percentage of patients were housewives. It is hard, of course, to know how many of these women were professionals in their own right and might have been working but considered themselves to be housewives first. Of the 13.4% that were unemployed or did not answer,

these women might also have been in the housewife category. It is interesting to note that 14.8% of the population served are students. Students usually have their own medical services provided. University students have access to medical care, and nursing students are provided with their own service (which in some schools of nursing it is mandatory for the girls to use). However, as one girl from St. Clare's Hospital School of Nursing informed me: "They would never approve of me going on the pill; I would be kicked out of the program". St. Clare's is a Catholic hospital which, according to Church Doctrine, does not condone any artificial method of birth control. Therefore, whether or not it is true that she would be dismissed from the program, her perceptions are that she will be expelled, and for her it is not worth taking a chance. Additionally, student nurses expressed anxiety about not wanting to use their own services for fear of being found out and seeing their friends at Student Health, or being "talked about".

A wide range of occupations encompasses the clinic patients. There are low-status jobs, such as domestic occupations; a number of skilled trade people; some highly professional people; and those with artistic skills. (See Table 4:3).

Table 4:3 Occupations Among Women Surveyed at Family Planning Clinic

Occupation	Number	Percentage
Unemployed or no answer	19	13.4%
Domestic	1	.7%
Housewife	35	24.6%
Student	21	14.8%
Hair Stylist	1	.7%
Clerk, housemother, nursing assistant	17	12%
Receptionist	1	.7%
Computer Operator	3	2.1%
Secretary	10	7%
Service Rep./Dietary Ass't./Underwriter	4	2.8%
Dental Assistant	1	.7%
Bank Teller/Manager Store	2	1.4%
Computer Programmer/Artist	5	3.5%
Lab Technician/Nurse	12	8.4%
Teacher/Vocational Instructor	10	7.0%
Total	142	100%

As we would expect from the population in the St. John's area (shown in Table 4:4), almost half of the clinic's patients are Roman Catholic. Although the Roman Catholic Church does not believe in artificial means of birth control, the patients of that faith either perceived the clinic as a needed resource to teach the Sympto-thermal Method of birth control, or they had decided that they would go against that aspect of the Church teaching and seek artificial means of birth control. Of the fourteen patients who chose not to answer this question some patients did not see the relevance of the question to the service they sought. A few had no religious affiliation and some were Catholic (by their own admission) but were embarrassed to reveal this. The three main religions, Roman Catholic, Anglican, and United Church patients comprised 88.3% of those surveyed. As shown in Table 4:4 the religions breakdown seen at the clinic is very similar to that in the population of St. John's as a whole.

Table 4:4 Religions of Patients Surveyed in Family Planning Clinic

Religion	Number	Percentage (adjusted frequency)	St. John's General Population
Roman Catholic	59	46.1%	47.2%
Anglican	37	28.9%	26.1%
United	17	13.3%	18.0%
Pentecostal	3	2.3%	
Salvation Army	6	4.7%	
Presbyterian	1	0.8%	7.9%
Moslem	2	1.6%	
Other	3	2.3%	-
No Answer	14	-	

As mentioned earlier, the profile of the patient who comes to family planning clinics is usually the young, single girl, or the girl on welfare. Few people consider married women as clinic users. They are usually seen as going to their family physician. However, this is changing. In our study, 65.5% of the patients surveyed are in the married category. Since a majority of these are for pregnancy tests, many of them come for confirmation of pregnancy before "bothering" their family physicians.

Table 4:5 Marital Status of Women Attending the Clinic

Status	Number	Percentage
Single	42	29.6%
Married	93	65.5%
Separated/Divorced	3	2.1%
No Answer	4	2.8%
Total	142	

As shown in Table 4:6 the mean age of our patients is 24.6 years and the range is from 16 to 50 years of age. It is also interesting to notice that the age breakdown of the patients includes the largest category in the young adult range. (i.e. 19-22, 25.5%; 23-26, 38%; and 27-29, 15.5%).

Table 4:6 Age Distribution of Women Attending the Clinic

Age	Number	Percentage
16-18	11	7.7%
19-22	36	25.5%
23-26	54	38.0%
27-29	22	15.5%
30-35	9	6.3%
36-50	6	4.0%
No age given	4	3.0%
Total	142	100.0%

This is expected as this is usually when the majority of women come to grips with the rational planning of their fertility and are more willing to seek out services of clinics such as this one. There is also a group of older women, in the over 35 age group that are coming into the clinic. These are often women who think that their fertility years are over and then find themselves worried about pregnancy. Many of these women have gone through most of their lives quite ignorant as to their own bodily functions and ways to prevent pregnancies. Some of them have teenagers who are asking questions that they find they are unable or inadequate to answer and they come in seeking counselling for help with their own family questions. As one woman put it:

> "If only I had known these answers years ago I would have had fewer children".

Most of the women seen want a different life for their own children and are determined to help in any way they can.

The third group of women presenting are the teenage population. However, this is a small proportion of the caseload. This is probably because many of the girls are afraid they will be refused service without their parents consent. We know that this proportion of our society is sexually active. Some studies would put this figure as high as 50% of the high school population, but there is a denial of this activity taking place among parents, professionals, and teachers. In one school, a number of the teachers report that the girls in that school are not sexually active. They denied the need for any type of sex education, and yet four girls from this school had visited the clinic that particular month, and they were all pregnant. A further discussion of this age group will be presented in a later chapter.

Patients who had received birth control information at other clinics prior to coming to Planned Parenthood are shown in Table 4:7.

Table 4:7 Other Sources of Birth Control Information Received by Patients

Family Physician	106	75.0%
Hospital Family Planning Clinic	9	6.3%
Local Drugstore	12	8.5%
Hospital Outpatients	6	4.2%
Educational Programs	25	17.6%

Over seventy-five percent of the patients have had some contact with a family physician in the past and have been given some birth control information. This supports those past studies which reveal that women see their family physician as an important source of information on birth control. In a study of attitudes toward and utilization of Family Planning services carried out in the city of St. John's in 1975 - 62.6% gave the family physician as their preference for family planning and birth control services.[8] In a 1976 American National Ambulatory medical care survey there were 6.8 million visits to private physicians for family planning services.[9] In the National Population Survey carried out by the Badgley Committee, the major sources of information about contraception cited by women and men showed that almost half of the women (45.9%) and a third of the men (33.5%) gave the main source of information about contraception as the physician.[10] A study by Hoyos revealed that the family physician had the potential for greater patient compliance with contraception than had the family planning clinics.[11] However, when we allow for the 35% of patients who are referred for service to the clinic we still have 40% who for various reasons have not returned to their physicians.

The number of individuals who had received information from other existing services was small by comparision. The women who had been to family planning clinics in a hospital were either women who had moved into Newfoundland and had previously attended hospital-based

Planned Parenthood or other clinics, or women who wanted further help and information on the Sympto-thermal Method and had previously gone to St. Clare's. The drugstore was used in a small number of cases, mainly for purchasing barrier methods, or for discussion about risks associated with the pill. The pharmacist was not seen as an educator in the field, but certainly this is changing, especially in areas like California, where promotions on prevention of pregnancy as well as venereal disease, are made in many of the drugstores.[12] Educational programs are always considered one of the most effective ways of transmitting knowledge to larger numbers of people. It is not surprising, then, that 17.6% of those surveyed in the present study have received some information from educational programs in the area. What is most puzzling is why the number is not higher. All the women seen at the clinic have been through a school educational system, most gave a religious affiliation, and probably attend church, but few reported that educational sources were the source of their knowledge of human sexuality in general, and birth control in particular.

Footnotes and References: Chapter Four

1. Miriam Manisoff (1969) loc. cit. p. 28.

2. J.C. Whyte, S.J. Corber, C.H. Keys, "Ottawa Family Planning Clinic: Experience with 3862 Registrants", Canadian Medical Association Journal, February 18, 1978. Volume 118, p. 401-402.

3. C. Norman Knight, "Public Family Planning Policy: Formulation and Implementation" in Family Planning and Social Work, Department of Health and Welfare, 1976. p. 60.

4. Planned Parenthood initiated a program in May 1978 in cooperation with the Public Health Nurses of the Department of Health for pre-natal classes for the single, pregnant woman. These are held once a week for a period of eight weeks.

5. This is a new program started in January 1979 to lend continued support and care to the single pregnant woman throughout her pregnancy and immediate post partum period. This program was established to fulfill a need expressed by the girls from the prenatal class that they were lonely and isolated.

6. During the period September 1978 to September 1979 a clinical trial was run on a new pregnancy test. This is a two hour hemagglutination inhibition tube test having ten-fold sensitivity: that is 0.2 International units of human chorionic gonadotropin per millimeter of urine can be detected. This test will show a positive result at the time of the first missed period and appears to be particularly valuable in early diagnosis. (Paper presented by May Johnson and Rita Prodell, American Public Health Meeting, November 4-8, 1979, New York, N.Y.)

7. Fran Innes, 'Family Planning in Newfoundland', presented at the Provincial Family Planning and Sex Education Conference, St. John's, Newfoundland, May 11-12, 1973. p. 23.

8. David Kirby, 1975, loc. cit. p.82.

9. National Center for Health Statistics, DHEW, 1976. National Ambulatory Medical Care Survey, Washington, D.C. 1978. (mimeo).

10. Mary Pearson, Background Notes on Birth Planning and Conception Control, Canadian Advisory Council on the Status of Women, June 1979, p. 23.

11. Michael D. Hoyos and Karl A. Smith, 'Contraceptive Compliance in Family Medicine: A Comparison of the Family Physician and the Family Planning Clinics', The Journal of Family Practise, Volume 7, Number 5, 1978, p. 965.

12. Carl F. Grindstaff, The Canadian Pharmacist and Family Planning, Family Planning Perspectives, Volume 9, Number 2, March/April 1977, pp. 81-84.

Chapter Five - The Clinic and Its Functions

The clinic service was examined by seeking opinions and suggestions from the people for whom the clinic was established. Notice was taken when the patient said:

> "Why don't you advertise more. I never knew you were here."
>
> "I don't like sitting in the waiting room. Everyone can see me there. It is so public."
>
> "This place is so hard to find. Why aren't there better signs."
>
> "It is so nice and relaxing. I like the bright waiting room."

In this section a discussion of the patients, who they are, their perceptions of service, and what they think is important to them in receiving family planning care will be undertaken.

Patients were asked why they came to the clinic.

Why Do People Use the Clinic?

The most common reason given for attending the clinic was that clinic testing was quicker than that carried out at the hospital. It was noted by the patients that the results at the clinic were given to them whereas in the hospital they were given only to the physician. The results were received earlier thereby creating a lot less anxiety. Also it was considered more convenient to attend the clinic. One patient mentioned

the ease of parking. Some patients wanted to get the results of their pregnancy test before they saw their physician. Thus, they would be saved a trip down to the clinic or up to the hospital after their appointment. One patient reported that she wanted a pregnancy test and was informed that 'you can come here without a doctor's prescription'. She did not want the 'hassle' of waiting for an appointment merely to obtain a note from the physician to the laboratory.

The next largest group that came to the clinic were the patients referred by their own physician. Many physicians in the community use the clinic for rapid test results for diagnostic purposes. This trend increased since the clinic obtained the new sensitive test which shows two weeks after conception.[1] Some physicians also use the clinic for counselling services. Others, believe that their patients are more comfortable at the clinic than they are at the hospital because of the former's smaller size and less bureaucratic structure.

A number of patients attended the clinic because they did not want their physicians 'to know' they were sexually active. Others stated that they did not know his views about 'unwanted pregnancy options' and they wanted to know if they were pregnant first. One was convinced that her physician was too busy to discuss contraceptives. Another believed that the physician she went to 'just didn't like

discussing contraceptives'.

> "No satisfaction from Doctor. He has no time to discuss contraception with me."

Some patients reported that they found that the clinic staff had higher comfort levels than those offered by the hospital.

> "I feel very embarrassed discussing birth control with my doctor."
>
> "He is good with my children, but I am so embarrassed talking about myself."
>
> "Because I know they would be better equipped to meet my needs in a more pleasant and comfortable atmosphere."

Table 5:1 Reasons Patients Gave for Attending the Clinic

Reasons	Total number
Convenience, quicker results	44
Physician referral	18
More knowledgeable and understanding	13
More comfortable at clinic	15
Referred by friends	10
Knew of Planned Parenthood from elsewhere	7
More private	6
Didn't want own physician to know	6
Follow up appointment	5
No family physician - wanted clinic	5
Referred from other professionals	5
Physician out of town	4
Shorter wait for service	4
Total	142

One of the best recommendations of any service is from patients who have used the service and recommend the clinic to their friends.[2] Many of the clinic's patients come in with friends who have attended prior sessions. As some patients have voiced:

> "A friend told me it was a neat place."
>
> "I was told by a friend that the staff was really kind and friendly to you."

Others liked the clinic's specialization of service, and the staff's knowledge and understanding of contraception:

> "Because I can discuss my problem more openly."
>
> "The clinic has a casual atmosphere. It is never a chore to come here. Anyways, they are mostly women and understand my problems."

Many transients from across Canada and people moving from other parts of the province come to St. John's. These people do not have a physician and have heard of Planned Parenthood, because it is an International agency. Because of its international reputation they are confident in obtaining advice and seeking service. One of the circus performers who was in town encountered some difficulty with a contraceptive she was using. She stated:

> "I always use Planned Parenthood. When you move like I do you aren't able to get your own doctor and you always know they have good doctors on staff at Planned Parenthood."

Reasons are many and varied and show the broad needs of people for an alternate family planning service in the community.

Of the patients surveyed 106 or 74.6% said they had a family physician. About 35% of the total patients are referred to the clinic by their physician for testing or counselling needs. Therefore, approximately 40% of the patients have family physicians, but for reasons we will explore further, have chosen to go elsewhere for service. When we look at whether the physicians intiate family planning needs with their patients we see that 45.8% do take the initiative, but 33% leave it to the patient to initiate discussion. The thirty who did not respond were the thirty patients who did not have a family physician and so therefore had no basis to answer this question.

Table 5:2 Patients Having Their Own Family Physician and Initiation of Contraceptive Discussion

Family Physician		
yes	no	no answer
106 (74.6%)	30 (21.2%)	6 (4.2%)

Physician Initiates Discussion		
yes	no	no answer
65 (45.8%)	47 (33%)	30 (21.2%)

When patients have their own family physician why do they not go to them for contraceptives or family planning services? The replies we received can probably be discussed within the context of the three services which the clinic offers.

Anxious patients wanted 'quick results' because they felt they just "couldn't sleep one more night without knowing". One described the procedure she would have to go through with her physician. She would often wait for up to two hours only to be given a slip of paper to go to the hospital for a pregnancy test. She would then be told to come back in a week for the results. Following this she would receive a preliminary examination. She was concerned that this was an infringement on her time, which she felt was as valuable as anyone elses. Also some women referred to the government funding that went into these visits. They objected to the physician receiving payment for what they considered was 'no help' for services. Another described going to the hospital for a test, and one week later discovering that the hospital had lost the results.

Some adolescents who thought they might be pregnant with an unplanned child did not want their physician to know. In a number of cases the physician knew their parents and they were afraid he/she would inform them. Others were undecided as to what they wanted to do about the pregnancy, and believed that the physician would not explain

the options. A few girls came to the clinic for a second opinion because their own physician would not make available the contraceptive of their choice.

Some patients who came for counselling discussed the lack of time which they felt their physician had:

> "When you know he has a room full of patients waiting you don't like to take his time."
>
> "When I finally get into his office I forget all my questions. When I come down here (to the clinic) I am more relaxed and can ask all my little problems."

Whether the patient sees the physician as an 'authority' figure and finds it hard to talk to him, or whether she just feels her needs are small compared to "really sick people", is difficult to assess. It may also be the case that some patients 'shop around' to get different opinions and reassurance.

To initiate discussion of such a personal matter as contraception is often a difficult task. Some physicians think that the patient should determine the course of discussion of birth control. Many will argue that if the topic is not raised the patients understands it.[3] Others think that contraception is a private concern and if the patient wants to discuss birth control she will ask appropriate questions. Some physicians are uncomfortable with the whole topic. Others think that they have not had adequate training in the subject and feel incompetent to deal with it.[4] One study found a significant "proportion of

physician confusion regarding birth control methods".[5] Certainly, all evidence suggests that medical schools have not given adequate time or training to this aspect of health care.

Ease of Service

People under stress, or in a state of anxiety, tend to go for help at the most convenient, easily accessible place. It is very frustrating when concerned about a problem, or under any pain or stress, to have to drive around while attempting to look for parking and find an address.

One of the major complaints Planned Parenthood faces is how difficult it is to find. Patients describe spending many minutes going from building to building, looking for signs. Planned Parenthood is nestled off a side street with very little in the way of directions for newcomers. Unlike a physician's office, or drug store which is usually easily found and well labled, patients have difficulty and find they are embarrassed asking for directions to a 'specific specialized service'.

"If I ask everyone will know what I'm going for."

To find services in a hospital is often very confusing for people. The hospitals themselves are very easy to locate, but once found there seems to be a maze of stairways, corridors, and people one can "run into".

Many of the clinic's patients had never heard of a 'hospital-based' family planning clinic. This was surprising when there is much more advertising as well as contact with all post partum patients in St. Clare's thereby providing considerable information about the hospital based family planning service at that location. A second hospital (Grace) had the first family planning clinic in Newfoundland situated on its premises. Many patients expressed a lack of desire or motivation to visiting a hospital structure. One of the reasons prenatal classes were commenced for single pregnant girls at Planned Parenthood was the failure of the girls to attend the hospital's prenatal classes. They expressed fear of entering the large hospital structure and chose to stay away. We believed that Planned Parenthood would be a difficult place to find. However, the patients who came to the clinic on the whole did not view this as a problem. In fact, 63.6% found that it was very easy to find Planned Parenthood.

As expected the physicians office and the local drugstore were both viewed as being relatively easy to find. Most difficulty was encountered locating the hospital-based family planning clinics and the hospital emergency/outpatient services.

As will be observed throughout much of this analysis, many of the clinic's patients did not answer the questions in response to a hospital-based family planning clinic. It appears that, at least in the present study, many of the women are not aware of this type of service in St. John's. (See Table 5:3).

Table 5:3 Ease of Finding Service

Service	very easy	easy	not easy	not at all easy	Total Responded
Planned Parenthood	63.6%	29.5%	4.7%	2.3%	129
Doctor	70.5%	24.8%	3.9%	0.8%	129
Drugstore	71.0%	21.8%	6.5%	0.8%	124
Hospital Based Family Planning	27.3%	40.0%	18.2%	14.5%	55
Hospital Outpatients	58.1%	36.2%	2.9%	2.9%	105

* All percentages are adjusted frequencies.

Travelling Time to Family Planning Services

People with cars or easy access to transportation, do not have too much difficulty as St. John's is quite a small city and there are few areas that take much longer than fifteen minutes to locate. (See Table 5:4).

However, those that do not have transportation have a problem seeking medical services, unless the service is within walking distance. Bus transportation is quite limited in St. John's, and taxi travel is expensive.

A study by Collver et al[6] of low income obstetric patients in the United States, sought to establish that the distance of clinics from the patients home had a substancial effect on attendance. Other studies have produced apparently conflicting findings on this relationship.[7,8]

In the present study 45.3% of patients found they could get to the clinic in less than fifteen minutes. However, 56.4% found they could get to a physician, and 85.9% to a drugstore, in the same amount of time. The hospitals seemed to be more costly in terms of time to the patient with only 33.3% and 34.9% finding they could gain access to the service in less than fifteen minutes.

Table 5:4 Travelling Time to Get to Family Planning Services

Service	less than 15 minutes	15-30 min.	30-60 min.	over one hour	Total Responded
Planned Parenthood	45.3%	45.3%	3.6%	5.8%	137
Physicians	56.4%	32.3%	6.8%	4.5%	133
Local Drugstore	85.9%	12.6%	1.5%	0	135
Hospital-Based Clinic	33.3%	40.4%	15.8%	10.5%	57
Emergency/Outpatient Hospital	34.9%	54.0%	8.7%	2.4%	126

* All Percentages are adjusted frequencies.

For some people time is not a factor in obtaining service. But for those employed, or trying to make an appointment during their lunch break, or for mothers paying babysitters, time can be a very costly item, both in terms of social cost as well as monetary cost. The clinic will assist in minding babies and children while the mother is obtaining counselling to allow her privacy and relaxation when she is seeking service.

At the outset of this study it was expected that time and accessibility would be a negative component of attending the clinic. This was confirmed by survey results.

Convenience of Hours for Patients Attending Family Planning Services

One of the advantages of clinics, especially speciality clinics, is that they are usually more flexible in terms of hours because they do not have to share their time and facilities with other professionals. Therefore, clinics are often open evenings, lunch hours, and weekends to accomodate the employed or people who rely on others for transportation.[9] However, hospital facilities tend to be administered much more bureaucratically. Staff work from nine to five, take lunches when they are scheduled, and don't work extra hours because of the extra cost involved due to union rules requiring staff to be paid extra for after-hours service. Therefore, they will not accomodate the tardy or late patient, or those who can only get in on their lunch hour. At one

large hospital clinic in California patients were all given the same appointment time. At the end of the clinic's time allotment those who had not been seen had to return at a later date. This was found to be sufficient to deter people from attending a hospital-based clinic which could not "fit them in".

In a study carried out in Gainsville, Florida it was revealed that more than one-third of the population surveyed expressed difficulty in attending clinics because of inadequate transportation. Only nineteen percent felt babysitting difficulties created an impediment to attendance.[10]

Teenagers in particular experience problems with transportation facilities for their contraceptive needs and for related counselling. They must attend after school, or on Saturdays, as many do not want parents or relatives to know where they are going, and it is difficult for them to get out at night, especially during school nights. (See Table 5:5).

Drugstores are perhaps the most easily accessible in terms of the hours they are open. Many are open seven days a week and most evenings. However, not all people use the methods that are readily available over the counter at the drugstore, and these people have to seek other services with medical help.

Table 5:5. Convenience of Hours for Patients of Family Planning Services

Service	very convenient	convenient	not convenient	not at all convenient	Total Responded
Planned Parenthood	42.0%	46.4%	9.4%	2.2%	138
Physician	39.1%	42.9%	17.3%	0.8%	133
Local Pharmacy	62.7%	34.3%	3.0%	0	134
Hospital-Based Family Planning	40.4%	44.2%	9.6%	5.8%	52
Emergency/ Outpatient	45.0%	41.7%	12.5%	0.8%	120

* All percentages are adjusted frequencies

In this study the drugstore was certainly seen as being most accessible with 62.7% feeling it was very convenient to get to in terms of hours open. The other services were about equal with a small range of 39.1% to 45.0%.

We view all medical services at this point as relative costs to the patient both because of lack of transportation and too few hours open for service (predominantly the evenings and week-ends) to allow more accessibility for the teenagers, the employed, and the mother with small children.

Atmosphere of Service

"How bright the place is."

"The plants are so pretty."

"I didn't expect the clinic to be so warm."

"Is this ever a nice place you have here."

Proxemics is very important. When architects and hospital designers began to look at what constituted a relaxing environment for the therapeutic process, colors, plants, a feeling of peace and solitude were very important. Thus, nurses began to wear colored uniforms; curtains and spreads moved away from 'clinical white' to colors, and waiting rooms utilized more comfortable furniture.

People are more relaxed in a happy, quiet atmosphere. Thus, when people are anxious or under stress, or seeking personal and often

embarrassing information they need a place where they feel comfortable 'being'.[11]

Drugstores and hospital facilities are not usually the most cheerful places to visit. They are not set up to facilitate counselling but are more efficient and businesslike in their approach to health problems.[12]

Physicians generally attempt to provide a reasonable place for the patients to wait and be attended. Most offices have magazines and books to look at, pictures and health charts on the walls, (often educational) and some even have piped in 'mood music'.

Planned Parenthood has made a special effort to provide quiet, bright, cheerful surroundings. It is a purposive attempt to create a place where women can relax, away from the stresses of their everyday lives, and comfortably communicate their concerns. This is reflected in the number of people who found Planned Parenthood, compared to the other existing services, bright and cheerful. (See Table 5:6).

Friendliness of Existing Services for Contraception

Patients attending the clinic view their contraceptive needs and sexual concerns as a very private, personal matter. They do not like

Table 5:6 Patients Perception of Atmosphere of Service

Service	very bright	bright	not bright	not at all bright	Total Response
Planned Parenthood	44.5%	52.6%	2.9%	0	137
Physician	22.3%	54.6%	18.5%	4.6%	130
Drugstore	7.1%	63.0%	25.2%	6.0%	127
Hospital-Based Family Planning	7.4%	55.6%	25.9%	11.1%	27
Hospital/Emergency Outpatient	2.9%	31.7%	51.9%	13.5%	104

* All percentages are adjusted frequencies

to feel 'put down'. Many teenagers are very scared. One girl came to the door three times and ran away each time before she could muster the courage to enter the clinic. Had the first person who received her appeared 'unfriendly', it is almost certain that she would have left for good.

Many patients arrive at Planned Parenthood because it is a secular organization. They fear going to religious based agencies, or to physicians who they believe are very much influenced by religion. They fear that they might receive a moral lecture. However, although patients seek a secular based service they are often very religious people themselves. Over 46.1% of the clinic's patients are Catholic and 97.7% of the women in our survey named a religion on the questionnaire. In The Faith of the Counsellors[13], Halmos states that religious faith is transposed to faith in a friend at a time of need. He goes on to say that this faith is not found in the form of moral lectures, but rather in a secular meaning and 'facts'. People coming to Planned Parenthood are not looking for religious counselling, they are looking for a solution, not by prayer, but in a secular way through technology (contraception).

Patients may be seen to respond to someone they feel is their friend. If they don't feel that way they will 'shop around' until they find someone they can respond to.

One patient had been to three other agencies and physicians before she came to Planned Parenthood. She remarked:

> "They don't really care about me. In fact, the people I talked to didn't even look me in the eye."

We expected that Planned Parenthood would be viewed as a friendly place. (See Table 5:7). This was confirmed in the study with 85.9% agreeing with this assumption. Only 43.9% saw the physician's office as a friendly place, and less than 31% saw the other three services as being very friendly.

Perceptions of How Patients Feel That the Services Care for Them

While all the existing services probably care very much for patients it is the patient's perception of whether or not the services care which motivated them to use these services. If an individual feels that the place does not care about her, then she will not return unless she has no choice. Often an indication of how successfully a clinic demonstrates caring is indicated by the patient's return for further service.

Another indication of caring is how often patients are followed up. Unfortunately, this is often an area which is neglected because of time limitations. Too often, especially in a large clinic flow, busy medical practice, or a multi-service agency such as a hospital emergency/outpatient clinic, it is difficult to follow up all patients

Table 5:7 Patients Perception of the Friendliness Found at Existing Family Planning Services

Service	very friendly	friendly	not friendly	not at all friendly	Total Responses
Planned Parenthood	85.9%	9.9%	0.7%	0	137
Physician	43.9%	49.2%	6.8%	0	127
Drugstore	18.1%	65.4%	16.5%	0	94
Hospital-Based Family Planning	31.0%	55.2%	10.3%	3.4%	29
Hospital Emergency/ Outpatient	10.6%	51.1%	38.3%	0	120

* All percentages are adjusted frequencies.

to see if they are taking their pills as instructed, (i.e. compliance), or if their diaphragms fit well, or other instructions are being followed. The Planned Parenthood clinic had the opportunity this past year to carry out an extensive follow-up service on a new pregnancy test. This was a clinical trial, and because accurate clinical findings were required, every patient with a positive result was phoned to determine if the laboratory findings coincided with the clinical findings. An important outcome of this follow-up were the responses by the patients.

> "It is so nice to know you care."
>
> "I was feeling so depressed this morning. I was having some bleeding and I was afraid I was having a miscarriage. Your call made me feel like I wasn't alone and it was so reassuring."
>
> "Thanks for calling. I am so happy. I wanted to share it with someone again."

Patients expressed considerable gratitude for the phone calls. They reported their fear of the first pregnancy, how they felt isolated with their problems, and they 'hated to bother the physician' with what they thought was something 'so silly'. It was concluded that the follow-up was certainly much more than purely good medical care. Rather, it provided a very positive support system.

Reynolds[14] in his study states:

> "In clinics where staff were full-time specialists in family planning, we noted a greater committment to family planning, a greater concern for the welfare of the patients and a greater talent for communicating critical information."

In a survey of family planning clinics in Canada (1972) the two most frequently given reasons as to why women prefer clinics were the non-judgmental attitudes of the staff and high quality counselling.[15] One patient in the present study voiced a similar conclusion:

> "Planned Parenthood is specifically designed to be so helpful; a hospital-based family planning clinic may not be as objective as Planned Parenthood as it will reflect the policies of the hospital about birth control."

Hoyos shows the potential of the physician in the area of family planning to be often greater than any other existing services. He cites the advantage of the physician over the often frequently changing staff of a large and sometimes impersonal clinic (especially in the larger centres) as ",....he has a personal knowledge of the patient, her family, education, and socio-economic circumstances".[16]

A small number of individuals do not perceive the pharmatist as being the caring person he often is. In a recent Canadian survey ninety percent (90.0%) of pharmacists under the age of forty-five years indicated that they regard contraceptive counselling as an integral component of their professional committments.[17] However, women seldom ask their pharmacists for advice in this area. (See Table 5:8).

As expected, women coming to Planned Parenthood saw this follow-up as a relative reward or positive aspect of service. Indeed, 42.5% of the patients felt that Planned Parenthood cared about their health and

Table 5:8 Perceptions of Caring Found at the Existing Family Planning Services

Service	really care	care	seldom care	don't care at all	Total Responses
Planned Parenthood	42.5%	55.8%	1.7%	0	132
Physicians	37.0%	63.6%	7.6%	0.8%	105
Local Drugstore	6.7%	29.5%	43.8%	20.0%	83
Hospital-Based Family Planning	22.7%	54.5%	13.6%	9.1%	22
Emergency/ Outpatient	7.2%	53.0%	33.7%	6.0%	83

* All percentages are adjusted frequencies

welfare. Physicians and the hospital-based family planning services averaged 22.7% and 28.0% and the drugstore and outpatient/emergency service was viewed by the patient as a cost or negative outcome in terms of caring.

Levels of Knowledge

One of the advantages of a specialized medical service is that the breadth of the body of knowledge to be learned is much less than the total content of the medical health package. The patient seeks specialized attention, and the clinic with its well-defined focus is able to provide this service. One patient commented:

> "Planned Parenthood knew their stuff. The Doctor's office is fairly good if doctor acceptable."

Counselling is a top priority of the clinic. All too often women worry needlessly because of rumors, misconceptions, or half truths. Many times instructions they have been given by their physicians or other existing services are incomplete, or more often than not they have not 'heard' them all. It is difficult for a patient to 'hear' everything she is told at a visit - especially if she is a little anxious, embarrassed, or fearful. A great majority of the clinic's patients are not familiar with their own biology and reproductive cycle:

> "I had just finished menstruating a few days before. I thought I couldn't get pregnant."

Incomplete instructions or lack of alternatives are a common occurrence. Consequently, incomplete advice from a physician may have unanticipated consequences.

> "I was told to stop taking the pill for a month. I never thought I could get pregnant. Nobody told me to use another method."

A patient informed me that she once went home and cut a hole in her diaphragm. She returned six weeks later pregnant. She said she had been fitted with 'rings' and she assumed her diaphragm should be the same. It seems that one can never give enough instructions or be too explicit. Insufficient information (and explanation) was responsible for her pregnancy. She had not been given sufficient instructions, and it was assumed she knew more than she did.

The use of the clinic for elaboration and clarification of the patient's particular birth control method (reassurance or correction) is a common practice. Clarification and reassurance is frequently sought:

> "How long should I keep my thermometer in when I do my temperature charts?"
>
> "I have just been put on _____ by my doctor. Is this a good pill?"
>
> "What is the best kind of foam to get?"

A survey was carried out in 1965 by Bakker and Dightman who found only 3% of those surveyed believed that they had received their most useful information on birth control from a physician as opposed to other sources.[18] This is a very small percentage.

Unfortunately professional people, often unknowingly cause much needless concern and worry for the patient. Many women, for example, have been told, "You have a tipped uterus", or "I can't feel your ovaries". Although to medical people this is often routine and nothing serious,[19] patients hear these comments and worry about them. In one research sample 10% believed, on the basis of something the physician had said, that there was going to be some problem with fertility. Half of them believed this because of a comment about a 'tipped uterus'.[20]

The pharmacist could be one of our best educators. Studies show that they want to become involved and possibly they have the most complete information on the risks of medication and best available barrier methods. However, as was shown in Grindstaff's study, "The customer either does not perceive that he or she needs information about contraception, or does not view the pharmacist as a knowledgeable professional in this field",[21] (See Table 5:9).

We expected that Planned Parenthood would be seen as a positive source of knowledge. In the present study 42.2% showed both Planned Parenthood and the physician were perceived as being knowledgeable on the subject of birth control. The hospital-based family planning service was seen as being knowledgeable in the field by 54.2% of our sample.

Table 5:9 Patients' Perceptions of Levels of Birth Control Knowledge Found Among Staff Involved in Family Planning

Service	know a lot	know quite a lot	know a little	don't know much at all	Total Responses
Planned Parenthood	42.2%	56.3%	0	1.4%	135
Physicians	42.3%	53.1%	4.6%	0	130
Local Pharmacy	30.5%	15.9%	39.0%	14.6%	82
Hospital-Based Family Planning	54.2%	42.4%	1.7%	1.7%	59
Emergency/ Outpatient	35.4%	34.1%	24.4%	6.1%	82

* All percentages are adjusted frequencies.

This could be explained by the very specialized service of the hospital-based family planning service in the St. John's area as there is probably only one such service that patients would likely identify with. This is a service which deals specifically with instruction in the Sympto-thermal Method of birth control. Only 30.5% and 35.4% of patients perceived drugstores and outpatient/emergency services as knowledgeable in the field of contraceptive knowledge.

Privacy

It was first necessary to determine if patients were concerned whether or not their information was considered confidential and kept private. We find that 62.7% believed that it was very important, and 12% thought it was quite important that their information be kept private. Another 15.5% rated privacy of information as moderately important. Therefore, we may conclude that confidentiality is something that patients consider important when discussing family planning needs.

Patients are concerned about who has access to their charts. They worry about lab tests going to the hospitals. Many girls work at the hospitals, or have relatives and friends there. They are reluctant to let them know they are sexually active for fear of rejection or disapproval. Many patients worry about who might see them in the waiting room. Planned Parenthood does not have a very private waiting room and this is a major concern for many patients.

Table 5:10 The Importance of Privacy to Patients

	Number	Percentage
Very important	89	62.7%
Quite important	17	12.0%
Moderately important	22	15.5%
Not important	2	1.4%
Not at all important	1	0.7%
Total Cases	131	
Missing Cases	11	

Patients often become almost obsessive about privacy. At times fictitious names are given, Medical Care Plan (MCP) numbers (a system of medical insurance in Newfoundland) are often incorrect, or addresses are fictitious. One one occasion a girl came in for a pregnancy test. Her test was negative and she was referred to a clinic physician for further evaluation as she did not have her own family physician. The procedure for clinic visits to see a physician requires a medical history and the service is charged through MCP. Thus, the patients MCP number is required. At this point she stated:

> "That is not my real name I gave you. I was afraid and didn't want anyone to know I was here. I didn't know what the place would be like."

Trust is the sine qua non of the counselling process.

It is hard for teenagers to believe in the medical system if they encounter a situation similar to that experienced by Janice:

> Janice, a sixteen year old single girl in high school thought she might be pregnant. She had not had a period for two months and she had some nausea in the mornings. She went to the hospital emergency room and asked to see the doctor. She also asked to see him in privacy because she had something personal to discuss. She sat waiting for over an hour. Suddenly her mother appeared to see what was wrong. (The mother had been called by the hospital staff because the patient was under the legal age of consent and they thought she might need parental consent). The girl quickly made up an excuse for being there. She said she had had a bad cough and thought she had 'better see about it'. Hurt, confused, and bitter she left the hospital and found her way to Planned Parenthood.

In the future this girl will have a hard time trusting 'the establishment' as she defines it. Nobody asked her permission to call her parents, or extended her the courtesy of inquiring what was wrong with her.

Sometimes professional staff are not too discreet with a patient's information:

> Susan, a single fifteen year old girl, went into a drugstore to get her prescription filled. She had been having dysmennorhea and heavy menstrual flow for over a year and this was beginning

to affect her attendance at school. Her family physician had prescribed the birth control pill as a medication to promote her comfort. Susan was not sexually active. In fact she had never even dated. A youth she went to school with was working in the pharmacy. Next day at school he told everyone that Susan was "on the pill". Susan never forgot the embarrassment she felt from this youth who did not respect her right to confidentiality.

We thought that Planned Parenthood would be seen as a rewarding factor for privacy and confidentiality. There is limited access to files and all of the files are locked and numbered, and confidentiality is assured the patient. As expected over half (51.3%) thought the service was very 'private'. Physicians offices have a little more difficulty with privacy, especially if several doctors are in one clinic. However, over 34.5% think this service is private and is fairly rewarding. (See Table 5:11).

Patient Comfort Levels

A patient's comfort level is often altered by her self-image as well as by the perceptions or expectations of what she fears she may encounter. Although, in many cases, the perceptions she may have of a medical service are inaccurate, or even largely exaggerated, nevertheless they exist and are of paramount importance to how the patient

Table 5:11 Patient's Expectation Regarding Privacy of Files

Service	very private	private	little privacy	no privacy	Total Responses
Planned Parenthood	51.3%	46.1%	2.6%	1	115
Physicians	34.5%	56.9%	6.0%	2.6%	116
Local Drugstore	9.9%	36.6%	28.2%	25.4%	71
Hospital-based Family Planning	27.7%	57.4%	14.9%	-	47
Outpatient/ Emergency	13.0%	43.5%	37.7%	5.8%	69

* All percentages are adjusted frequencies

will feel and act toward a service. Many of the patient's attitudes and expectations are shaped by parental, religious, and school teachings.

"I'm afraid of a doctor's office" is a comment frequently expressed by patients. This is usually because of some prior negative experience or a fear of the 'unknown'.[22] To many people, medicine is a very mystifying experience. Many patients, especially adolescents, have difficulty finding the courage to come to the office.

Many women fear the teachings of the church. Recent polls suggest that 65 to 75% of sexually active Catholic women in the United States are currently using a contraceptive method other than rhythm.[23] In our study almost half the patients are Catholic and are using some form of artificial birth control. However, in spite of their choosing this alternative, they often feel guilty and sinful, and because of this many girls feel very uncomfortable seeking information which may violate both the church creed and exacerbate their guilt.

The relationship the woman has with the professional she is dealing with has a lot to do with how comfortable she will feel when discussing contraception. If the patient knows that the counsellor is not in agreement with her views, she will probably not feel comfortable in any further discussion. For example, if the physician tells the patient the pill is her "best method" and she chooses not to use

it (which 50% discontinue without the physician knowing, and some get a prescription but never start) then she is not comfortable returning and declaring: "I can't take your advice". If, however, she chooses (or at least feels that she has made the choice) amongst the alternatives she has, then she has the option of going back and saying, "This didn't work for me and I would like to change my method".

Teenagers feel quite uncomfortable with what they consider "the establishment". Establishment often includes the physicians "their parents use". Some of the larger cities in Canada have adolescent clinics attached to their pediatric hospitals. Thirty-eight percent of all the problems presented at those clinics in Toronto and Montreal deal with problems of sexuality, pregnancy, and birth control. In Newfoundland, Planned Parenthood comes closest to providing a milieu with which adolescents can attempt to identify. However, few teenagers know about the clinic and therefore go without any kind of service. One of the reasons for this lack of knowledge is the absence of sex education in the schools. Although some schools will provide information to their students regarding existing services, and even refer to the clinic, such education is relatively inconsistent in the St. John's area.

Parental attitudes will, to a large extent, determine an individual's orientation to contraception and subsequently their comfort level. One mother of a teenager continually espoused negative attitudes towards

Planned Parenthood. She had never used the services - in fact she was not familiar with the location. However, she believed it was an abortion clinic because of the misconceptions in the community, and she forbade her daughter to make contact with the clinic. The daughter, unbeknown to her mother was two months pregnant. She hadn't known where to go for help but because of the negative communication the patient was very wary and nervous about what she would encounter at the agency. However, she came into the clinic and after some counselling brought her mother to the clinic. In the light of the help they received they have referred many friends to the clinic.[24] Coming to terms with their feelings and receiving the counselling help needed to continue the pregnancy, relieved their discomfort and they are now able to talk openly and honestly with each other.

A recent study, as mentioned earlier showed, that neither women, nor men, regard the pharmacist as a prime source for birth control information. However, they go on to state that it may be that most pharmacists are men, and women feel uncomfortable discussing this subject with a stranger of the opposite sex.[25] In the Planned Parenthood clinic there are a number of requests for female physicians and since most of the staff are female, many girls report how much they like this:

> "I feel a woman understands me more".
>
> "I think that women must know more about pregnancy, as they have the babies."

However, some girls prefer male physicians, because as one put it:

"I am more used to going to a male doctor."

Moreover, some feel they can relate more to an older male physician. (See Table 5:12).

It was thought that Planned Parenthood would be a place where women would feel comfortable discussing contraception. It is predominantly staffed by women, allows for "client-centered discussion" as well as decision-making, and the patient is given time to relax. As expected, 68.8% of the people questioned agreed with this. About half of the patients also felt comfortable talking to their physician, and just over half felt comfortable attending hospital-based family planning clinics. It appeared to be relatively costly to the patients' comfort to discuss birth control with the pharmacist or staff at the hospital-emergency departments.

Shame and Guilt

People are often ashamed because of a low self-image, or behavior that is against parental, social, or religious teaching. If an individual has these attitudes and the professional they seek help from reinforces these, either with a moral lecture or by 'putting them down', or stereotyping them, feelings of shame will be strengthened.

> "I am so guilty needing contraception. I was taught that pre-marital sex is wrong, but I don't want to get pregnant and we can't get married for at least two more years."

> "You maybe won't understand, but my husband was so busy at work and I was so lonely, I thought maybe he'd realize how lonely I was if I had an affair. I guess secretly I wanted to get pregnant - really show him."

Table 5:12 Patients Comfort Levels While Discussing Birth Control

Service	very comfortable	comfortable	seldom comfortable	not comfortable	Total Responses
Planned Parenthood	68,8%	25,8%	3,1%	2,3%	128
Physicians	49,6%	33,6%	11,5%	5,3%	131
Local Drugstore	11,5%	11,5%	25,0%	52,1%	96
Hospital-based Family Planning	58,1%	25,8%	9,7%	6,5%	31
Outpatient/ Emergency	22,7%	26,7%	20,0%	30,7%	75

* All percentages are adjusted frequencies

Many times a patient's value structure is different from the professionals she seeks services from. If a professional cannot be non-judgemental and objective, the stance he/she projects will augment the guilt and shame the person seeking counselling is already experiencing.

Some patients think they should be punished for the 'sins' they are committing through their coital activity. To relieve them of guilt they minimize contraception and are at risk for their 'sin'. Often, the result of their risk is pregnancy and this is "living punishment" for the woman. Often a patient will say:

> "I should have used birth control. This is God's way of punishing me."

Professionals consider it unethical to make a person feel ashamed for asking personal questions, for having lifestyles different than their own, or for having different sexual values and attitudes. (See Table 5:13).

We see that over 60% of the clients had never been made to feel ashamed to talk about contraception in any of the services offering contraception. This would appear to be consistent with the high level of professional ethics that exists.

Fear of Refusal of Service

A Canadian opinion survey of one hundred and twenty doctors

Table 5;13 Patients Perceptions of Shame When Discussing Birth Control

Service	not ashamed	seldom ashamed	ashamed	very ashamed	Total Responses
Planned Parenthood	92.1%	7.9%	0	0	126
Physicians	77.2%	17.9%	4.9%	0	123
Local Drugstore	60.6%	12.7%	26.8%	0	71
Hospital-based Family Planning	86.0%	7.0%	7.0%	0	43
Outpatient/ Emergency	75.0%	11.7%	13.3%	0	60

* All percentages are adjusted frequencies

suggested that a single girl aged seventeen had only a 50/50 chance of obtaining contraceptives without parental consent.[26] Another survey revealed that twelve percent of the patients had been refused contraceptives by a physician at some time in the past. Seven percent had been advised to abstain as the best approach for dealing with sexual needs.[27]

This is a very serious concern, both for physicians and for their patients. The legal age in Newfoundland for dispensing contraceptives without parental consent to minors is nineteen years old. However, we know from National studies that over fifty percent of the teenagers are sexually active by that time and sixteen percent of these, it is estimated, will get pregnant at first intercourse.[28] It is a significant dilemma as the medical and psychosocial risks associated with adolescent pregnancy are well known. Very few teenagers will acknowledge to their parents the fact that they are, or want to be, sexually active. Even if they did, many parents would not give permission for contraceptives until it was too late. Studies have shown that teenagers will be much more motivated and responsible in their contraceptive practices if they have parental support.[29]

A teenager comments:

> "I would have gone to the doctor for 'the pill' but my friend told me I had to be nineteen or tell my parents. My mother would never let me see my boyfriend again."

Thus, they cling to the misconception that, 'it won't happen to me', believing that if they went to their physicians they would not receive 'the pill' because of their age, and unable to comprehend that their mother might understand and be pleased they were responsible enough to not take chances.

In practice many physicians will meet the adolescent's contraceptive needs, but the individual is not always aware of those physicians who will be sympathetic to her problem.

Some patients fear refusal of service by physicians and other professionals who do not share their views on abortion, adoption, and contraception. For one year only, a physician who was going to refuse service was required to refer in Canada but not in Newfoundland. However, as stated previously, the Canadian Medical Association has now deleted this clause and a physician is not required to refer.[30] The following case graphically illustrates this problem.

> A sixteen year old girl was sexually active. She went to four different doctors who refused to give her any contraception. Instead she got, in her perceptions, four different moral lectures and was told to say 'no'. She finally discovered she was pregnant. She is very bitter about the 'medical' experiences she has encountered. It is surprising she tried four times. She probably will be lost to the medical profession for a long time.

The decision to abort, to use contraception for the first time, or to seek personal counselling, is a difficult, often agonizing struggle for the woman who finds herself with an unwanted pregnancy. It produces a great deal of anxiety and stress and rarely comes easy.

Reports of religious attitudes entering into the doctor-patient relationship in the context of contraceptive usage show a wide variation ranging from the straight forward opposition to birth control of some hospital boards to an instance of a nurse sabotaging contraceptive prescriptions in the United States. There have been instances in a St. John's religiously based hospital of opposition to birth control. Until recently birth control pills could not be dispensed at St. Clare's, a Catholic hospital, even if the patient was on the pill before entering the hospital. As of now, intrauterine insertions are not done in the Catholic hospital in the daytime hours. Furthermore, nurses have refused to work service in the gynecology clinic if abortion is the medical procedure being performed. This refusal affects most hospitals in North America, including Newfoundland.

Contraceptives are mostly purchased from pharmacies. There are places in remote areas in the province where contraceptives cannot be purchased. Often condoms and foams are locked up or shelved in out of the way places. The "Summer of '42" had a film sequence of a young boy entering into the store for condoms. The pharmacist made a point

of pretending he did not know what the boy was asking for. The boy finally walked out. Although this was a comical scene, it continues to be 'acted out' in some places in Newfoundland.

The fear of refusal of service probably accounts for a considerable number of unwanted pregnancies. We expected to find that refusal of service might be a social cost to Planned Parenthood not because a patient, in reality, would be refused service, but because of the misconceptions and lack of knowledge people have about clinics generally, and the Planned Parenthood clinic in particular. However, we were proved wrong in this study. Over 80% of the Planned Parenthood patients did not expect to be refused service. By comparison, about 50% of the patients expected to be refused service if they went to physicians or hospitals. (See Table 5:14)

Feelings of Being Rushed

"The disadvantages of using terms like 'too hurried' or 'too ambiguous' or in being too hurried or perfunctory are well documented."[32] How often do patients go to their private doctor with a number of questions and then fail to ask them because they forgot, felt rushed, or didn't like to take up the doctor's time. Said one woman about her pre-natal visits;

> "I think of so many questions before I see him and then I forget them all when I get there."
>
> "He asks me so many interesting questions that I get sidetracked and then get home and realize he hasn't answered any of my questions."

Table 5:14 Patients Perception of Fear of Refusal of Service

Service	not afraid	seldom afraid	afraid	very afraid	Total Responses
Planned Parenthood	80.8%	12.3%	3.1%	3.8%	130
Physicians	68.8%	21.6%	3.2%	6.4%	125
Local Drugstore	64.7%	20.6%	9.8%	4.9%	102
Hospital-based Family Planning	73.3%	11.7%	5.0%	10%	60
Outpatient/ Emergency	63.6%	18.2%	11.4%	6.8%	88

* All percentages are adjusted frequencies

"Some people have complained that private physicians do not have time to do enough counselling and that many offer their patient little choice as to method of contraception."[33] Time is a factor in a large, busy practice. Many times both clinics and physicians have full waiting rooms. The hospital/emergency department is almost always busy. People 'feel' rushed when they know others are waiting, even if the professional would take all the time they needed. Many times patients "think" that other people probably have more serious, important questions than they do. Research findings from the United States suggest "that working-class people are apt to feel they are imposing on a doctor if they take up too much of his time; compared to those with more education, income, or better jobs, they were more likely to agree with the statement: "I don't like to bother the doctor unless it's necessary".[34] The clinic patients perhaps had attitudes of this type and appreciated the unhurried approach.

At times the professionals of a multi-service agency view family planning needs and routine prenatal visits as low priorities and therefore tend to rush the patient through. To be able to discuss a problem or personal medical concern thoroughly most people require time. Sometimes they have a hard time expressing their concerns. They need an opportunity to 'warm up', and to gain confidence in the person who is counselling them. They need to know that the person to whom they are communicating their private concerns, really cares about them.

In Planned Parenthood there has been a serious attempt made to create an unrushed atmosphere. It is the clinic's policy to allow the patient as much time as needed to give her adequate knowledge which will enable her to make informed decisions. As one patient stated:

> "You feel at ease and are not rushed. Also, they are willing to talk."

We would also expect to find similar unrushed pace at hospital family planning services due to their specialization of service. On the other hand, the physician, pharmacy, and outpatient/emergency department are multi-purpose. We would therefore, not expect them to have as much time to devote to any one area. (See Table 5:15).

As shown in Table 5:15, the outcome we expected has been confirmed. 90.2% did not feel rushed at Planned Parenthood. This was a much higher percentage than at any of the other four existing contraceptive services.

Embarrassment

One of the problems confronting a clinic such as Planned Parenthood or a hospital-based family planning service, is that it offers a very specialized service and people worry about being seen coming through the door. They also find sitting in the waiting room to be a source of embarrassment. Many times a single girl is afraid she will be called "Miss Smith" out loud - especially if she is single. Considerable

Table 5:15 Perceptions of How Rushed Patients Feel When Obtaining Service

Service	very rushed	rushed	seldom rushed	not rushed	Total Responses
Planned Parenthood	0.8%	0	9.0%	90.2%	133
Physicians	5.2%	17.2%	33.6%	44.0%	134
Local Drugstore	3.4%	35.2%	34.1%	27.3%	88
Hospital-based Family Planning	6.7%	16.7%	23.3%	53.3%	30
Outpatient/ Emergency	8.7%	38.7%	26.2%	26.2%	80

* All percentages are adjusted frequencies.

fear is displayed by the teenage population, whose presence in the clinic is thought to reveal evidence of their sexual activity. Although patients can come into the clinic for pap smears, breast checks, and routine annual medical preventative care, the public image of a family planning clinic is for birth control, and logically these clients must be sexually active. Here it is useful to remember that when things are defined as real they are real in their consequences.

To many people it is embarrassing to talk about sexual matters which often come up when dealing with areas of family planning. Many people have been socialized from early childhood that 'sex is private', 'sex is bad'. Family discussions have often centered on not talking about such subjects. Little girls are taught they must always be fully clothed: "ladylike" was the term so often used. Words were made up for anatomical parts of the body, 'dicky', 'my thing', and other euphemisms were coined to use instead of penis; for females 'my privates', 'special places', and so on were used in place of vulvas, vaginas, and breasts. For most girls and boys growing up, sex was mystified, with very little discussion of what happens both biologically and emotionally in the growing up process. When people lack information or knowledge of something that is happening to them, they become anxious and repress their feelings. Because these feelings are repressed in the growing formative years for so many people, these same people find it very difficult to discuss this same subject when they mature and seek service for sexual needs.

For the same type of reasons many persons working in professional fields and focusing on human sexuality are very uncomfortable. Often they have not worked out their own feelings on sexual matters, and find it very difficult to open the subject up for their patients, or even to listen and advise their patients accordingly when they have to deal with human sexuality problems.

There is a lot of controversy and discussion on whether or not physicians should open up the subject of family planning, spacing children, fertility, and other related areas at a medical visit, or whether the patient should be the one to initiate the discussions. In most studies researchers state embarrassment as being the main reason why patients don't bring up the topic first. Both the Wolf and the Rainwater's studies suggest that the professional should volunteer information.[35]

Sometimes a patient's sexual practices are different from the 'accepted' practices of the professional. If the professional cannot be objective and value free in dealing with his/her patients, the patient will sense this often causing embarrassment.

A physician who worked at a practice in a small rural community in the United States stated that he never took pharyngeal or rectal swabs from his patients for venereal disease because his patients

'didn't do things like that'. Clearly, if the message was communicated to the patient that a venereal disease swab meant a urethral or cervical culture only, many active cases of gonorrhea could be overlooked by professional bias.

We believed that Planned Parenthood would be seen to be a relative cost to the patient in the area of embarrassment discussing birth control. (See Table 5:16). However, we were proved to be wrong. Eight-seven percent of the people in our survey stated that they were not embarrassed discussing birth control.

It was obvious that patients coming to the clinic did not feel that the negative publicity that has often been afforded the Planned Parenthood by media, radio, and the public at large, did any harm in clouding the patient's perceptions of the service they would receive. What probably has more effect is the security patients have in their own sexuality. The more secure patients are, the more confidence they will have that they will get the service they request. If patients feel secure, it is likely they will also be more relaxed and take more time explaining their needs.

Table 5:16 Patients' Embarrassment Levels When Discussing Birth Control at Contraceptive Services

Service	very embarrassed	embarrassed	seldom embarrassed	not embarrassed	Total Responses
Planned Parenthood	0.8%	1.6%	10.6%	87.0%	123
Physicians	1.6%	10.2%	20.5%	67.7%	127
Local Drugstore	5.6%	25.0%	23.6%	45.8%	72
Hospital-based Family Planning	5.0%	2.5%	22.5%	70.0%	40
Outpatient/ Emergency	0	13.6%	23.7%	62.7%	59

* All percentages are adjusted frequencies.

Footnotes and References: Chapter Five

1. The test referred to was a clinical trial of a new pregnancy test that could diagnose early pregnancy at the time of the first missed period with a high degree of accuracy. See footnote #6, Chapter 4.

2. Robert W. Noyes, Marvin I. Levy, Charles L. Chase, and J. Richard Udry, "Expectation Fulfillment as a Measure of Patient Satisfaction" International Journal of Obstetrics and Gynecology, Volume 118, March/April 1974. p. 809.

3. Sanford R. Wolf, and Elsie L. Ferguson, "The Physicians' Influence on the Non-Acceptance of Birth Control", American Journal Obstetrics and Gynecology, Volume 104, Number 5, July 1, 1969. p. 754.

4. Morton A. Silver, Birth Control and the Private Physician, Family Planning Perspectives, Volume 4, Number 2, April 1972. p. 45. See also: Allan Rosenfield, "Medical Supervision for Contraception: Too Little or Too Much?" International Journal Gynecology and Obstetrics, 15: pp. 105-110, 1977.

5. R.C. Hulbert and R.H. Settlage, "Birth Control and the Private Physician: The View from Los Angeles", Family Planning Perspectives, 6:50, 1974.

6. A. Collver et al, "Factors Influencing the Use of Maternal Health Services", Social Science and Medicine 1967. (Sept.) pp. 293-308.

7. M. Lerner et al, "Data on Social Background, Medical Care Utilization and Attitudes of Outpatients, by Hospital, New York, Municipal General Hospital Outpatient Population Study," Columbia University 1968.

8. C. Metzner et al, "Choice of Health Care Plans" University of Michigan: Ann Arbor, School of Public Health 1965.

9. Jack Reynolds, "Delivery Family Planning Services: Autonomous Versus Integrated Clinics", Family Planning Perspectives, Volume 2, Number 1, January 1970. p. 17.

10. Carol Jolly, Berel Held, A.F. Caraway, and Harry Prystowsky, "Research in the Delivery of Female Health Care: The Recipients Reaction", American Journal of Obstetrics and Gynecology, Volume 110, Number 3, June 1, 1971. p. 292.

11. This statement results from the authors experience with counselling distressed patients. It also includes the many occasions when a patient has verbalized her feelings in this same way.

12. For further discussion of this see: E. Hall, The Hidden Dimension, Doubleday, Garden City, New York, 1969.: R. Sommer, Personal Space, Inglewood Cliffs, New Jersey, Prentice Hall, 1969.

13. Paul Halmos, The Faith of the Counsellors, Constable and Company Ltd., London, 1965.

14. Jack Reynolds, op. cit. p. 19.

15. National Research Division, Department of Health and Welfare, Survey of Family Planning Clinics in Canada, 1972.

16. Michael D. Hoyos and Karl A. Smith, "Contraceptive Compliance in Family Medicine: A Comparison of the Family Physician and the Family Planning Clinics, The Journal of Family Practice, Volume 7, Number 5, 1978. p. 964.

17. Carl F. Grindstaff, (1977) loc. cit. p. 84.

18. C.B. Bakker and C.R. Dightman, 'Physicians and Family Planning: A Persistent Ambivalence'. Obstetrics and Gynecology 25: p. 279. 1965.

19. In this sense we very often see a type of 'linguistic iatrogenesis' where the physicians' "talking-out-loud" or "thinking-out-loud" while examining the patient precipitates considerable anxiety.

20. Felicia Stewart, Speech on Research of Contraceptive Motivation, from An Exploration of the Limitations of Contraception: Proceedings of a conference Ontario Science Centre, November 1975. p. 33.

21. Carl Grindstaff, loc. cit. p. 84.

22. When patients are asked during an interview why they are so afraid of a doctor's office, the most frequent response that was stated was that she did not know what to expect, or that she had had a very bad experience with doctors previously.

23. Eugene Sandberg, speaker at conference Ontario Science Centre, supra, p. 5.

24. It is a frequent occurrence to have referrals come this way. For further information see: Hope J. Leichter and William E. Mitchell, Kinship and Casework, Russell Sage Foundation, New York, N.Y. 1967.

25. Carl Grindstaff, loc. cit. p. 84.

26. Paul MacKenzie, "Family Planning and the Private Physician", Bulletin, Family Planning Federation of Canada, Spring/Summer, Volume 2, Number 1, 1974.

27. Felicia Stewart, op. cit. p. 32.

28. Robert Kinch, Proceedings of a Conference Ontario Science Centre, November 1975. op. cit. p. 64.

29. Jerry Cahn, The Needs of Adolescent Women Utilizing Family Planning Services, The Journal of Sex Research, Volume 13, Number 3, August 1977, pp. 216-217.

30. This resolution was passed at the business meeting Canadian Medical Association, 1978. In Newfoundland the change was never added so the resolution to delete the change had no effect. In Newfoundland a physician has never had to refer to another physician if he did not want to inform a patient of a procedure.

31. Sanford R. Wolf and Elsie L. Ferguson, op. cit. p. 753.

32. John B. McKinlay, Some Approaches and Problems in the Study of the Use of Services - An Overview. Journal of Health and Social Behavior, June 13, 1972, p. 136. See also: G.E. Collins, "Do We Really Advise the Patient?" Journal of Florida Medical Association, 42 (August) pp. 111-115. M. Davis and R. Eidhorn, "Compliance with Medical Regimens". Journal of Health and Human Behavior, 4 (Winter) pp. 240-249.: M.C. Dye, "Clarifying Patients Communications", American Journal of Nursing 63: (August) 56f.: J.K. Skipper, H.O. Mauksch, and D. Tagliarozzo, "Some Barriers to Communication Between Patients and Hospital Functionaries". Nursing Forum 2 (number 1): pp. 14-23.

33. National Research Division, Department of National Health and Welfare, 1972.

34. John E. Moyer and Noel Timms, The Client Speaks, Routledge and Kegan Paul 1970. p. 83.

35. Sanford R. Wolf, and Elsie L. Ferguson, op. cit. pp. 752-757. L. Rainwater, Family Design. Aldine: Chicago 1965.

Chapter Six - The Counselling Process

In a public agency such as Planned Parenthood the primary objective is to provide counselling for the general population of users, and not for any special interest group. For example, the agency does not have any one religious affiliation, but rather it is non-denominational. Similarly, it does not specialize in helping any one specific socio-economic, sex, or age group. The only specification for receiving counselling is that the prospective patient's problem be in the area of sexuality or contraception. When the personal need of the patient is paramount it is necessary for the counsellor to be as empathetic as possible and learn to control his/her own needs, desires, values, and attitudes so as not to bias the interview. When a patient presents a problem which is either distressingly similar to, or uncomfortably different from, the counsellor's own life situation, it is easy for the counsellor to respond with moralizing, or intellectualizing statements, or simply confront the patient with silence and to omit relevant questions. It is also simple to give inadequate or inappropriate information because of the counsellor's anxiety. An emotional 'climate' may be created which will limit the patient's ability to absorb or to use the information presented. To avoid this the counsellor must be reflexive and become comfortable with his/her own sexual values and behavior before attempting to help patients.

There appear to be three basic elements inherent in the process of family planning counselling, all of them employing different types of skills.

1. Information and Education

This is primarily rational and factual, and includes the elimination of myths, misconceptions, and misunderstandings, in addition to the communication of new information. Much of the counselling at Planned Parenthood falls into this category.

2. Making of Referrals

This involves the counsellor being aware of existing resources and services in the community, combined with the ability to motivate and help the patient use these avenues of assistance. Referrals from Planned Parenthood are mainly medical consultation referrals, and social work referrals for more extended counselling service.

3. Individual or group counselling

This requires counselling skills which provide understanding, communication, and rapport. The goal is to use family planning as a vehicle for increasing the patient's ability to achieve control within her total life situation.[1]

There appear to be some major impediments which obstruct the counsellor from carrying out effective family planning counselling. These can be categorized in three parts, patient-related barriers, worker-agency related barriers, and situational-structural barriers.[2]

Patient-Related Barriers

Amanda was taught from early childhood that her greatest achievement in life would be to produce children and be a 'good wife'. She started dating at the age of thirteen and began having intercourse when she was fourteen. Although she knew about contraception she had the need to show her parents that she could live up to their expectations. She felt that if she became pregnant, she would force the male concerned into marriage and achieve what she perceived to be her parent's wish - to produce a child. As soon as Amanda became pregnant, however, the male partner left the scene. The plan had not worked and Amanda felt used and rejected. Her quest to prove her femininity and to please her parents had resulted in a pregnancy at a very early age that she now did not desire. No amount of contraceptive information would have helped to change this action.

The role of the counsellor in this case was to encourage Amanda to believe in herself, to gain back her self-esteem and to understand the reasons that led to the pregnancy. Although the problem appears to be easily defined, it often takes many hours of counselling to understand behavior which a person seeks to change.

This case illustrates only one aspect of the numerous patient-related problems which often interfere with effective use of contraception.

Past history of contraceptive failures, ambivalence or fear of any one method of birth control, often provide an 'excuse' for failure to use a particular method. Emotional and intellectual problems can form many barriers. Low intelligence, hostility to a partner, parent or close associate, and low self-esteem will sometimes predispose patients to 'forget' a method resulting in an unconscious desire for a pregnancy as a punishment either for themselves or their partners. Many patients, as noted earlier, lack correct information regarding birth control, menstrual cycles, and reproduction. Through incorrect information a pregnancy can develop.

> Mary was unsure of the reproductive cycle. She had never been able to discuss this aspect of her life, and had learned most of her information through 'peer talk' or 'life experience'. She lived on a farm and used to watch the animals while she was working at her duties. Observing that dogs 'in heat' were capable of reproduction, and knowing that some bleeding took place at that time, she concluded that humans reproduced at the time of menstruation. Therefore, she was 'safe' during the middle of her menstrual cycle. Mary was having intercourse during the most fertile time of the month instead of what she thought to be the safest time.

At certain times in a patient's life birth control is a low priority in the overwhelming number of the problems of day-to-day living. Following a separation, death of a partner or close friend, or any

stressful situation it is difficult to give priority to family planning. Many times the need to be loved overrides the more rational approach to protection against pregnancy, and knowledge of birth control is neglected.

During these times when patient related barriers exist the counsellors must be aware of the outside influences which could impede successful communication thereby affording assistance.

Worker-Agency Related Barriers

The counsellor's task is to help the individual assume responsibility for his/her own actions and attitudes in his/her own way. That is, the counsellor tries to help the patient live within society, by understanding what her personal values are and how they can best be used to bring about the most fulfilling life for herself and those with whom she relates, while taking the responsibility for not hurting others.[3] Therefore, the counsellor must be highly value conscious. If the counsellor has a stereotype of what a patient should think, or has rigid ideas regarding pre-marital intercourse, homosexuality or other alternative sexual life styles, it will be difficult for that counsellor to listen to the patient and be objective in responding to what the patient is saying.

> Sid and Carol went to a counsellor. Carol was pregnant and they were afraid that their parents would be most upset by a pregnancy prior to marriage. They approached the counsellor

to assist them prepare to discuss this problem with their parents. The counsellor felt that pre-marital intercourse was wrong and that pregnancy should only take place within the context of the marriage. Her advice to the couple was to get married secretly and tell people they got married two months before, and "nobody would know the difference". Her bias clearly clouded the advice she gave to the couple.

Communication problems, both in language and cultural differences, can create a counsellor-patient barrier. Often expressions have different meanings depending on the culture that a person has experienced. In Newfoundland language barriers (specifically dialectal) are a major problem in physician-patient communication. Many physicians are "from away"* and have difficulty with Newfoundland dialects.

Restrictive agency policies can be a barrier to counselling, especially to the adolescent population. In Newfoundland, for example, the legal age of medical consent is nineteen years unless a parent is involved. This often reduces contraceptive options to a patient who will not permit any parental involvement.

Other agency barriers include daily hours of operation, access to service, adequate staff, and other daily operational concerns. These have been discussed in Chapter Five in relation to the patients perceptions of service.

* Popularly referred to as CFA's (come-from-aways)

Situational-Structural Barriers

These include problems of group pressure: pressures on women to bear more children than they can adequately support, negative group attitudes toward specific or general contraceptive methods, and negative attitudes toward family planning programs. In Newfoundland, an example of this is the popular misconception that Planned Parenthood is an agency for 'abortion on demand' counselling. (See Appendix Q). This can be likened to the suspicions that family planning programs are aimed at limiting the number of births within particular ethnic groups. Such 'genocidal' fears and suspicions are often heard, but research evidence suggests that they are not highly important deterrents to those actually in need of family planning.[4] In research focused on a black population Long, Bradshaw, and Burge show a distinction between actual services and the purveyors of these services. In the community studied, there was acceptance of, and a need for, family planning services; at the same time there was distrust of the motives of the officials and administrators who set policies and ran programs.[5] As stated in previous chapters, negative publicity has served to 'advertise' services available to the public in Newfoundland and, as demonstrated in studies carried out elsewhere, people seek out the services which they need, regardless of and perhaps even because of, such misrepresentation.

Negative propaganda becomes prevailing mythology, and the question

of its veracity rarely receives attention. Daily problems of living, such as severe economic problems, housing problems., unemployment and severe interpersonal difficulties often assume priority over utilization of family planning services. Motivation to use contraception often occurs only after the patient realizes that the counsellor is helpful in resolving other problems which are of immediate concern albeit not directly perceived as related to the centrality of contraception. When one has a 'patient' focus in counselling, a dependency on the medical model exists with emphasis on curative rather than preventative care. However, when the emphasis becomes client-centered,[6] the focus on counselling becomes more focused on the person as a whole, including the person's physical, emotional, and mental state. When the client is the focus of counselling, a general type of client response to the counselling process seems to evolve. No matter how individual the service is, and how empathetic the counsellor, there remains a range of client perceptions to counselling which seems to follow along a continuum of very satisfied to very dissatisfied with the whole counselling process.[7] The perceptions of the satisfaction level of the patient are not necessarily a function of the counselling process, but can be a function of the patient herself and are often related to expectation. For example, if a patient has a low self-esteem, and feels 'guilty' about her sexual activity, she may be dissatisfied with the service because of her own guilt feelings which have no relation to the existing service being offered. Because of these feelings, she

expects (and often wants) to have a negative experience, and will perceive the counselling in that light.

The Role of the Male

While the focus of discussion thus far has been on counselling the female patient, as noted previously the St. John's clinic does provide service to the male. All too often the role of the male in family planning is forgotten. This is probably because biologically the woman is the one who becomes pregnant, and of course, technologically most of the methods of birth control are designed for women.

When the clinic first opened there were few men who attended. However, at present there are a number of men attending the clinic seeking a wide array of services.

Who are the men attending the clinic?

1. The Shared Experience

There are many women, who because they want to personally control their own fertility do not involve their partner or partners in their decision to use or not to use contraception. They believe that they want to be in control, and are often the patients, who if it is medically suitable go on the birth control pill. However, there is another type of patient who feels contraception is a dual responsibility. The male partner in the relationship wants to be involved as much as the female. This type of individual enters the counselling relationship

with her partner to make a joint decision which they will both be happy with. One will reinforce the other for maximum compliance.

> Joe and Judy, a young couple in their twenties attended the clinic one evening. They had been going together about three months and felt they wanted to become more intimate. However, he had three more years of college to finish and a pregnancy in the relationship at this stage would impede his career. He was reasonably knowledgeable about contraception, having had some discussion of this in his college classes, but she was very naive and was not always convinced that the information which he imparted to her was accurate. Being aware of this, he felt that she would be more comfortable talking to an outsider who, he believed, would be more objective.

Experience in counselling practice indicates that couples who can openly discuss sexual relationships and protection against unwanted pregnancy have a much more honest relationship, and tend to be better contraceptive users. Some girls tend to feel used when they think they are always the ones who make decisions about contraception. Frequently, they believe it is unfair that they should be the ones to take the pill, or have an intrauterine device inserted. If the male partner shows support and interest in this decision-making process she feels less used and usually more emotionally warm with the partner.

Couples also come in for counselling on sexually related matters. These come in two categories: the couple in which the girl is pregnant, or wants to be, and the couple which want to discuss an area of their relationship that just isn't working out right.

> John and Susan, seventeen year old high school students, came down to the clinic. They had been having intercourse sporadically, and fearing that their search for contraception would be rejected by medical personnel, they were using withdrawal as a method of pregnancy prevention.

This is not uncommon among teenagers who either do not know where to obtain service, or are afraid of rejection. Susan now finds herself pregnant, and John comes into clinic with her for assistance. Presently most family planning agencies have only marginally involved the male in such cases. Girls like Susan, will receive counselling and be referred for prenatal care. Additionally financial help is available, and social workers may enter the picture.

A male, whose girl friend becomes pregnant when they had not planned it goes through a very traumatic experience. Because there are no physical changes noticeable in the girl at these early stages of pregnancy, the whole scene seems very unreal and it is 'defensive' to deny that something unpleasant is happening, especially if one is unable to see it happening. The male also needs to know his role in this

future pregnancy. Legally a male is responsible for the birth of his child until the child is eighteen years old. For a young man attending school, or beginning a career, this is a big financial drain. Studies show that men who marry in their teens are more likely to have unskilled, low-paying jobs which provide less job security or chance for advancement.[8] This is often because the higher paid jobs and career paths require higher education. However, in Newfoundland this is not always the case. Many times, especially in the outport communities, sons leave school early to help with the family work such as fishing or farming. They learn their trade from early years, and do not need any formal education to do it well. Another consideration includes the high rate of unemployment in Newfoundland. Even if the male were to receive a higher education, very often the job that he was trained and educated for would not be available. However, the pregnancy of a partner is frequently a source of anxiety for the male who often feels emotionally unable to cope with the responsibility of an unplanned child.

Thus, the male partner has a lot to think about. Often he has no one to talk to at this time. His parents, if involved at all, are often unable to help and become too emotional. He may not want to share his problem with his peers, and he has no one else to turn to. It is for these reasons that the clinic encourages the male to come in with his girl friend to mutually discuss any problem. Also, he may be seen alone if this is required.

2. Father of the Teenage Daughter

When a young girl becomes pregnant considerable time is spent with her with her decision making, and frequently the mother comes in with her. But what about the father? Is it that he is not involved at home and probably as upset as the mother? This possibility is raised in the following case:

> Mary and her mother Mrs. H. attended the clinic following Mary's disclosure that she was pregnant. Mary had been seen on three occasions earlier to assist her to gain the confidence to inform her parents. Following one session with the two of them the mother asked if the husband could 'drop in for a chat, to make sure things were under control'. She explained that he usually made the household decisions and she just wanted him to meet the counsellor and discover 'first hand' what had been done. She was asked how he was reacting to the situation and she replied, "Oh just fine".
>
> The following week Mr. and Mrs. H. came in together. For five minutes he squirmed in his seat. Throughout the entire interview he looked at the floor. He was asked how he was feeling about the situation. With that he shed a tear and said, "This is the very worst thing that could ever happen to me. I am a very strong Catholic and do not believe in pre-marital intercourse. I can hardly cope at work. I am thinking about it all day." This man was deeply troubled.

Frequently, those in the caring professions forget that when a crisis occurs there is often more than one person who is caught up in the emotional web of anxiety, stress, and pain. The involvement of the adolescent's father is often an important part of the counselling process.

3. Disease Testing

As a clinical service Planned Parenthood also offers venereal disease testing. This is, of course, available to both men and women. In the St. John's area venereal disease testing is available from private physicians, and from the Public Health Departments. Because of the nature of transmission of venereal disease, usually through sexual experience, many men are embarrassed to see their family physician. The Public Health Department, although it is available to all, has the reputation among some people that it is only for the 'lower-classes' or the 'prostitutes'. Therefore, the Planned Parenthood clinic provides an alternative setting for this service.

There is one type of male who is often on the fringe of medical service and that is the 'gay male'. The reasons for this appear to be related to societal and professional prejudices and attitudes. As mentioned in the previous chapters, people have generally varying life styles and specifically different sexual behaviors. Hetero-sexual vaginal-penile coitus is not necessarily the only intercourse practised by individuals.

It is often necessary for the professional to carry out an open discussion of sexual behavior with the patient in order to ascertain sexual proclivities. This involves asking such questions as; "Are you concerned about anal or oral disease?". Counsellors frequently must be the initiators of discussion on such sensitive topics.

4. Guilt Ridden

Occasionally people in a vulnerable position will engage in sexual acts which they later feel guilty about.

> Sam, a man in his fifties, was on a business trip. He had been married a long time and had never had an outside affair. Once, while on a trip, he was very lonely and went to a prostitute. Although he did not have intercourse he did have oral sex with her. On returning home he could not sleep, and felt terribly guilty. Concerned that his wife would find out, he did not know what to do. He phoned several times trying to get reassurance on the phone, and finally arrived at the office. His tests were all negative, but sessions were needed for him to try to overcome his guilt.
>
> Bill, a forty-four year old executive, recently moved into town. Caught up in the excitement of his new job, and involved in nightly meetings, his wife felt left out. One night she had an affair and thought she was pregnant. She was very much

afraid as Bill had had a vasectomy, and she 'knew' that if he found out he would leave her. She came to the clinic for a pregnancy test and in the course of discussion it became evident that their marriage would not survive if Bill was not made aware of the depth of her loneliness. With her permission, he was contacted and they were referred for marriage counselling.

Male Birth Control Information and Levels of Knowledge

Clearly, short of abstinence, there are only two effective methods of birth control available to the male - condoms and vasectomy. Vasectomy is a form of sterilization, which at this point in technology, must be seen as a permanent procedure. It is an efficacious method of contraception and is sought after frequently when a couple has had all the children they want or have chosen the option of having no children at all. The condom is a method of birth control which is probably much more popular in other areas than it is in Newfoundland. In a study by Gilbert and Mathews (1972) a male population in college was surveyed as to their knowledge, attitudes and use of condoms. The average age of first condom use was 16.5 years. Of those, 12% stole their first condom and 41% received their first condoms from brothers or friends. This study indicates that more than half were reluctant to go to pharmacists, the main source for obtaining these devices. When asked where they felt most comfortable obtaining condoms, 64% reported that they preferred to purchase condoms at vending machines.[9]

In Newfoundland the main source of condoms is through pharmacies, or large outlet stores such as K Mart and Woolco. There are few vending machines. There appear to be none in the womens' washrooms. Interestingly more than 50% of the condom purchases in department stores in Sweden were made by women.[10]

The folklore of the sexually active male is that he is instantly knowledgeable on the subjects of sexual behavior, contraception, anatomy, love-making, and interpersonal relationships. Too often the onus is placed on him to be more knowledgeable than he in fact is. Many males know very little about anatomy or the area of human sexuality at all. They have sexual drives and emotional and physical needs from puberty, often with little control over their feelings. Because of this lack of knowledge they frequently do not have confidence in themselves and are vulnerable to being hurt by girls who are insensitive, or by boys making fun of them in locker rooms.

The males who attend the clinic ask questions about condom use, correct ways to put them on, questions about female feelings, desires, and moods. Many males need to understand the basic differences between themselves and females, both physically and emotionally. Increasingly, males are coming to the clinic for this type of information.

The level of knowledge found among males attending the Planned Parenthood clinic is typified by the male who entered the office and

asked if he could buy "some condominiums." Although there is humor in this statement, it does illustrate the seriousness of the problem.

Typifications

From our observation of the patients that seek service at the clinic we have categorized them into ten types as follows:

Discontented Shopper
The Happily Misled
The Satisfied Realist
The Motivated Information Seeker
The Personally Responsible
The Sadly Misled
The High Risk Patient or the Multiple Excuse Patient
The Impulsive Contraceptor
The Unmotivated Patient
The "Blame the Other Person"

The Discontented Shopper

This is a patient who manipulates existing services. She will go from one physician to another, from service to service. Often she will complain about the places she has been before - sometimes with good reason, but often as a form of manipulation to the clinic where she seeks help. This type of patient is often the recipient of considerable

medication, and in the family planning field this usually means several different prescriptions for a birth control pill.

Jane, a nineteen year old college student, came into the clinic one day with her boyfriend. She said that she would like the birth control pill. After taking a family and patient history from Jane to enable her to see the clinic physician, the counsellor sensed that Jane was not telling the complete truth about her medical background. After much discussion she finally admitted that she had been on the birth control pill previously and had suffered from the complication of blood clots in her lungs. She had been hospitalized and told by the physician in charge that the pill was contra-indicated and that other methods of contraception should be employed.

However, Jane and her boyfriend did not find any other method acceptable to them. Determined to procure a prescription for 'the pill' she had gone from physician to physician in her pursuit of a prescription. None of them had given her the pill after listening to her history and she was feeling quite unjustifiably angry with the medical profession. Determined to obtain this particular method of birth control she had decided to come to the clinic and not tell the physician that part of her medical history.

Jane wanted to manipulate the services to fill her own needs. She perceived the medical community as being against her, when in actual fact they were trying to protect her from any medical complications. There is probably little doubt that she will continue to pursue her attempts to get a prescription for the pill, in spite of the information she was given.

The importance of continuous care for these patients by one service or physician cannot be over emphasized but the difficulty comes in satisfying the patients with one method of medical care.

The Happily Misled

There are two polarizations of misled patients. The satisfied patient (or more highly rewarded) will be the patient who expects to come to the clinic and find a negative experience but instead has a very positive and satisfying visit. The change in expectation from a negative experience to a positive experience is exemplified in the cases of Becky, Melanie, and Greta.

> Becky, a forty year old patient, married with two teenagers, came into clinic one afternoon. She had missed two periods and feared she might be pregnant. She and her husband had not used birth control for about a year because her friend told her she was 'too old' to have a baby. As she left the office she said, "I was so embarrassed to come down today.

I really should have known better and taken precautions. However, everyone has been so understanding and helpful, and I found I could really talk without being embarrassed."

Becky now recommends the clinic to all her friends and especially to the teenagers that chum with her two children. She is one of the 'word of mouth' advertisers - a change in expectation for positive reward.

Melanie, a sixteen year old girl, came to the clinic from her physicians office. She had gone to him to see if she was pregnant. He had examined her and discovered that she was eight weeks pregnant. He then went on and gave her a moralistic lecture of how 'bad' she was to have 'sinned' so. Her physician was quick to give moralistic lectures, but forgot that she also needed medical attention. Ashamed and hurt Melanie found her way to the clinic. She expected that 'all adults would give her a moral lecture' but hoped that at the end she would at least get some help.

Melanie was seen at the clinic by a counsellor who referred her for early prenatal care, prenatal classes and discussed the Sunday activity group for teenage pregnant girls. Melanie was pleasantly surprised and positively directed. She had her expectation level changed, in a positive direction.

Greta is fifteen years old and in high school. She has been a straight A student all through her school years and just recently acquired a new boyfriend. Since she had not had any access to sex information or birth control, either from the school or her family, she was ignorant about such issues. Her boyfriend, of the same age was as unknowledgeable as Greta. When Greta was two months pregnant she tried to find out where she could get medical help. She wanted to be sure she was indeed pregnant before she told her parents. Her family, strong Catholics, were adamantly opposed to abortion. One night her mother read a clipping in one of the newspapers which implied that Planned Parenthood was an abortion clinic. She went on to discuss the evils of going to a place such as that. Greta finally knew someone who might help. Scared, she entered the clinic. She did not want an abortion, but thought maybe someone would at least tell her if she was pregnant and she would listen to the 'expected propaganda on abortion' and leave.

Greta is an example of a point made earlier in the chapter that people will seek out the service they need regardless of misrepresentation. In this case, Greta did not experience the negative counselling which she feared.

The Satisfied Realist

This patient usually adjusts well to the reality of the clinic. These patients can adjust to the hours which the clinic is open and they usually find it a convenient and quick service. Once they are given the parameters of service offered they are able to adjust accordingly.

Many of these patients are referred by their own physicians and believe that they would only be referred to a good 'medical' place. Therefore they come with preconceived positive expectations. This group also does not mind the clinical roster of community physicians which has been set up. These patients usually see the full-time staff at the clinic as the connecting link between themselves and the physician. Therefore, the physician is perceived by them to be a consultant for specialized care and procedures. There is not much research available in the area of seeing one physician only, the same at each visit, or a different physician at each visit.[11] However, what has been done concludes that it is a very individual choice and that some patients object to having a number of physicians looking after them, and others do not.

The Motivated Information Seeker

The motivated patient is the patient who comes to the clinic because she feels she needs a service. She has not been forced, or pushed to

come in by other professionals, family, or peers. Moreover, she wants to prevent pregnancy, or deal with some other related matter, and is interested in the knowledge to be acquired to attain this goal. She is not interested in being told what to use but rather seeks information which allows her to make a decision based on her own lifestyle. It seems logical to contracept or not contracept only if one knows how to do both. This patient usually listens carefully to all instructions and discussions and will likely be a good contraceptive user. Lack of instructions produce lack of trust and confidence in methods and leads to unwanted pregnancy.

The Personally Responsible

This is the woman who realized that biologically she is the person who will get pregnant. To prevent a pregnancy she bears the responsibility of contraception herself, or by a joint decision with her partner. This patient is usually more mature in accepting responsibility. She is able to control the 'pleasure of the moment' with more realistic long term careers and goals. It is this long range focus which allows contraceptive compliance. Often, the user of contraception receives no on-going reinforcement. Unlike the patient with an ear infection who can experience immediate gratification with the use of antibiotics, the contraceptive user has to consider consequences nine months away.

The Sadly Misled

The sadly misled patient is the patient who understands a service is provided, has positive expectations that she will be helped, and then reacts very negatively when her expectations are not met. Perhaps the largest group in this category attending the clinic is the group that expects to find abortion services available on demand. This is exemplified by Dorothy:

> A patient by the name of Dorothy phoned the clinic one evening. She said, "I'd like to have an abortion at ten in the morning on Saturday please". When she was informed that this request was out of the question she became quite angry. She stated quite clearly that she had been told that the clinic performed such a service as a matter of routine and she demanded an appointment for termination.

That someone would think that the clinic provides this service when the whole philosophy of Planned Parenthood is prevention of unwanted pregnancies seems unbelievable. Indeed, the whole program is based on the premise that an unwanted pregnancy is detrimental both to the unborn child and the mother carrying the child. Few women who find themselves in an unwanted pregnant state find the event easy. Marriages may be destroyed. Mental breakdowns, child abuse, wife battering, financial problems and worries, are just a few of the many crises which often follow the birth of an unwanted child. So what is

it that would make a girls think that she could have an abortion as a matter of routine? Frequently people who have never attended Planned Parenthood, or even phoned to find out what services are offered, will put in 'letters to the editor' about 'supposed practice', making false accusations, and inaccurate suggestions. Anti-abortion organizations spread rumors that Planned Parenthood is an 'abortion clinic'. (See Appendix Q). There often appears to be a need to focus ones prejudice on another group in any organization seeking to create unity within its ranks.

However, there are occasions when some women find that the only alternative they can cope with is the termination of a pregnancy which was unplanned and unwanted. Of all the areas of counselling, this is perhaps the most difficult and controversial area to work in. First and foremost, as the law exists in Canada today, the decision to terminate does not rest solely with the woman who is pregnant and the physician who would eventually perform the medical procedure. Within the context of Canadian law a termination lies in the province of the physician who is himself controlled very rigidly by the Federal requirements for therapeutic abortions. To obtain an abortion in Canada a physician must be able to demonstrate that for the woman to carry the pregnancy to term would be detrimental to her physical or mental health. In Newfoundland she is referred by a physician to the gynecology clinic at the Health Sciences Center where she is seen by a gynecologist,

psychiatrist, and social worker. Her case is then brought up to the therapeutic abortion committee which ensures that the legal requirements are met.

This is all very time consuming and stressful to the already emotionally disturbed woman. It is a fact that early terminations are safest and yet there is at least a two week delay period in Newfoundland from the time the pregnancy is confirmed to the time the termination is performed. Most women who find themselves with an unwanted pregnancy go through a lengthy decision-making process. There are times when family histories, finances, illness, emotional problems, and other areas of life appear to the woman too insurmountable to be able to cope with the added stress of a pregnancy. Many of these women seek counselling to examine the options which are available to them.

The counselling process is often a lengthy one. It usually consists of four stages:

1. Exploration of family history
2. Exploration of personal feelings and concerns
3. Alternatives to the problem
4. Referral process

As was shown in Chapter Two, throughout the beginning of historical times, we have observed the practice of abortion. As long as women

deny that they are sexually active or continue 'risk-taking' by not using contraception, the unwanted pregnancy will exist. Until we have 100% effective contraception, there will continue to be contraceptive failures. If a woman has decided to terminate a pregnancy she will usually go to any length to do so. If she can not get the pregnancy terminated in a safe, medical, legal way, she will search until she finds an illegal avenue. Many times these women become so desperate they try to terminate the pregnancy themselves, causing injury and harm. Because of these factors, the therapeutic abortion will continue to be a last resort option for these women.

The High Risk Patient

Helen, a single twenty-two year old girl who has been going with Jim for four years. She wants to get married, but he says that he is not ready. They have been sexually active but so far she has not 'got caught'. She comes to Planned Parenthood to discuss alternative methods of birth control. As each method is discussed she thinks of a reason to not use it. The pill is too risky, the intrauterine device has given her friends some trouble. She would never use the diaphragm or jelly. They are too messy and 'spoil the fun of lovemaking'. The condom would dull the sensation for her lover, and she does not trust the rhythm method (Sympto-thermal). So what is left? It is doubtful that sterilization is the answer.

> Furthermore, modern technology has as yet to provide additional alternatives. This patient emphasizes the importance of efficacious birth control and then thinks of how each one is unsuitable. If they try any one method it will be with reluctance and possibly will not be used for long.

This patient is bargaining with herself. She is trying to calculate the method which will give her most rewards and least costs. She will likely not be satisfied because Planned Parenthood has not provided her with the alternative she probably wants, the green light to encourage her to get pregnant.

The Impulsive Contraceptor

> Debbie wants protection now. She comes to the clinic for a method which will protect her that evening. It is the sixteenth day of her period and she has decided tonight she will have intercourse. She will only use the pill, which she asserts is the safest method against pregnancy. She comes to bargain. She believes that if she gets the pill today she will be safe tonight and she does not listen to an explanation of how the action of the pill prevents pregnancy and the reasons why 'popping a pill' before intercourse does not provide protection from pregnancy.

Because the counsellor is concerned that she will do this, she is

advised to return during her next period so she can begin her pill at the right time. She storms out of the office.

The Unmotivated Patient

This is the patient that is sent in by someone she knows, often a boyfriend, friend, or relative. She does not care if she gets pregnant, and can't be bothered knowing how to prevent it. She does not want to be an active participant in the control of her fertility. She wants the decision to be made by the counsellor.

> Joan, a twenty-two year old married woman, was sent into the clinic by her welfare worker. She had already had four children and they were living in a two room apartment. She was run down and having trouble looking after her children. She kept saying, "What method do you use? What method do you want me to use?"

The counsellor's position is not to advise a contraceptive method for a patient. The St. John's clinic believes it is the right of the patient to make this decision given accurate and complete information to deal with it.

The "Blame the Other Person"

This is the person who puts the responsibility for contraception on anyone but herself. Adolescents often do not use contraception in order

to deny that they are having intercourse. When they find out that they are pregnant they will be heard commenting:

"My boyfriend said, 'I'm Catholic. You can't use the pill'."

"I just assumed he would pull out in time."

"He said that he had had a vasectomy."

Although the girl knows that she will be the one who gets pregnant she puts the responsibility on the boy. He, on the other hand, is also capable of denying personal responsibilities. There are male adolescents who assume their girlfriend is using the pill. Others will not really care, and some deliberately try to get the girl pregnant. These people are often the seekers of immediate gratification. It must be kept in mind that the using of contraception produces no intangible rewards. One does not know for certain if they would have become pregnant had none been used. In any event it is three months before the consequences will be noticed. Counselling for this type of patient is often time consuming, and involves discussions of maturity and responsibility and immediate versus long term consequences. This patient is usually too immature or irresponsible to listen. She perceives the counsellors to be 'establishment' 'authority figures'. As many of them are adolescents they are experiencing many of the well-known 'teenage problems'. Often they leave the clinic none the wiser, and disappointed with the service because no 'quick answer' was provided.

Discussion

Of the ten types of patients we have described, we would categorize five as satisfied with the service and five dissatisfied with the service. There are two sources of obtaining satisfaction levels in the counselling process. One of these is the process itself and the other evolves from the person being counselled. The satisfaction level we are concerned with in this chapter evolves from the person herself - expectations of what service she receives and what she does not receive.

An extensive analysis of patient-practitioner relationships has been presented by Wilson (1963) in a dynamic frame of reference. He sees the physician's role as being partially defined by the patient's expectations (and vice versa) and these expectations about the other's behavior constitute the essence of the role relationship. When the juxtaposition of these expectations is imperfect, there will be a problem in social interaction.[12] There has been a fairly well defined expectation of traditional medical services to the present time. People have a reasonably good idea of what to expect from a physicians visit. They also have a fairly good knowledge of service in a hospital and of conventional services such as received from lawyers and ministers. However, there is no popular imagery or preconception of family planning services as yet as these are comparatively new services. Therefore, we feel that patients will be satisfied or dissatisfied with the services

they receive depending on their expectations of the family planning clinic which they attend as well as by their perceptions of what they expect the counselling role to produce in the way of change.

Studies have indicated that past experience with illness and with physicians appears to be related to patient satisfaction with medical care.[13] The patients who tend to be satisfied with clinic care, especially the new visits, usually have had no negative experiences with medical personnel in the past.

The question has been raised as to whether or not patients attending the St. John's clinit report a high rate of satisfaction. This is probably best evaluated in the number of word-of-mouth referrals from previously satisfied patients which is well over sixty percent of the patients and the percentage of patients who would tell their friends about Planned Parenthood, (93.4%). (See Table 6:1).

In a study by Fisher evaluating outpatient medical care, patients were asked to rate fifteen factors in order of their perceptions of what constituted a good clinic.[14] They rated as most important good doctors, well trained staff, and information received from doctors. Regarded important were: Personal interest in patient, pleasant staff, and privacy discussing illness. In a comparative study made with the Case-Western Reserve study it was concluded that the two most important

Table 6:I Patients' Rating of Services Most Helpful for Their Friends

Service	most helpful	helpful	not helpful	not at all helpful	Total Responses
Planned Parenthood	93.4%	6.6%	-	-	137
Physicians	46.0%	50.0%	3.2%	0.8%	126
Local Drugstore	2.3%	18.4%	54.0%	25.3%	87
Hospital-based Family Planning	34.9%	60.5%	2.3%	2.3%	43
Hospital Outpatient/ Emergency	8.6%	43.1%	39.7%	8.6%	58

* All percentages are adjusted frequencies.

factors affecting patient satisfaction were the amount of time spent with the physician and the information (or explanation) patients' received about their condition. The amount of time that the doctor spends with the patient may be interpreted as either thoroughness and/or interest, and the patients in this study rated both of these as important.[15]

It is interesting to note that comparable results were collected in the present study where patients were asked what they liked about the clinic. The main reasons stated as to why patients find the clinic important are listed in order of importance in Table 6:2.

Table 6:2 Reasons Why Patients Find the Clinic an Important Alternative Service

1. Training and understanding of staff.
2. Explanations of procedures and bodily functions.
3. Current information on contraception. (concept of specialization).
4. Accessibility - Convenience of service.
5. Objectivity - non-secular service.
6. Confidentiality of service
7. Unlimited time, unrushed service. Defined often as interest.
8. Pleasant, relaxed, friendly atmosphere.
9. Less embarrassing. Run mainly by women.

As found in others studies, children's play areas seemed to rank low on the list of priorities of the patient.[16] It appears that people either have friends who will help them with their children or find no inconvenience bringing them into clinics or physicians offices, especially if, as with the St. John's clinic, a play area with toys is provided.

The patients we interviewed were asked if they thought Planned Parenthood was an important resource in the community. It is evident from the following table that most people find this service to be an important community facility.

Table 6:3 Perceived Importance of Planned Parenthood as a Resource in the Community

	number	percentage
very important	126	92.0%
quite important	9	6.6%
moderately important	2	1.5%
not important	-	-
not at all important	-	-
Total	142	100.0%
Missing cases	0	

In this chapter we have discussed the counselling role, its structure and its problems. The discussion has also addressed itself

to the role of the male, and the reasons for him seeking counselling. Finally we have attempted to categorize the patients who seek out clinical services instead of, or as well as, other existing services.

In the last chapter conclusions will be drawn and recommendations will be discussed.

Footnotes and References: Chapter Six

1. Barbara R. Bradshaw, Walter McIlhaney Wolfe, Jr., Theresa J. Wood, and Lucy Stanbury Tyler, Counselling on Family Planning and Human Sexuality, Family Association of America, New York, 1977. p. 83.

2. This categorization of barriers is derived from many discussions of obstacles to contraceptive utilization found in the literature. See: Miriam Manisoff, Family Planning Training for Social Services, New York: Planned Parenthood Federation of America 1970.; Katherine Kendall, ed. Population Dynamics and Family Planning: The New Responsibility for Social Work Education, New York: Council on Social Work Education, 1971: , Frederick S. Jaffe and Steven Polgar, "Family Planning and Public Policy: Is the 'Culture of Poverty' the new Cop-Out?". Journal of Marriage and the Family, May 1968, 30. pp. 228-235.

3. Robert R. Wilson, Introduction to Sexual Counselling, Carolina Population Center, Chapel Hill, N. Carolina, 1974. p. 12.

4. William Dorrity, B.B. Turner, and Jean Thiebaux, 'An Exploratory Study on Barriers to Family Planning: Race Consciousness and Fears of Black Genocide as a Basis' (Paper presented at the Ninth Annual Meeting of the American Association of Planned Parenthood Physicians, Kansas City, Mo. April 1971).

5. W. Newton Long, Barbara R. Bradshaw, and M. Burge, 'Black Attitudes Regarding Contraception, Abortion, and Sterilization', in Abortion Techniques and Services: Proceedings of the Conference, ed. Sarah Lewitt (Amsterdam: Excerpta Medica, 1972) pp. 151-160.

6. Client-centered is used here in the sense developed by Carl R. Rogers in Client-Centered Therapy: Its Current Practice, Implications and Theory. The Houghton Mifflin Psychological Series. Boston: Houghton Mifflin 1951.

7. Satisfaction is defined as follows: The goal of service is that the client receives some benefit from the service and the way she feels about the benefit she receives is her level of satisfaction.

8. F. Ivan Nye and Felix M. Berardo, The Family: Its Structure and Interaction, New York: The Macmillan Company, 1973. See also: F. Ivan Nye, School-Age Parenthood, Extension Bulletin 667, Cooperative Extensive Service, Washington State University, Pullman, April 1976.

9. Rosa Gilbert and Vicki G. Mathews, Young Males' Attitudes Toward Condom Use. The Condom - Increasing Utilization in the United States, Myrom Redford, Gordon Duncan, and Denis Praeger, (ed.) San Francisco Press, Inc. CA. 1974. p. 168.

10. Lennart Ajax, How to Market a Nonmedical Contraceptive: A Case Study from Sweden. The Condom - Increasing Utilization in the United States. op. cit. p. 13.

11. M. B. Sussman, E.K. Caplan, E.K. Haug, M.R. Stern, The Walking Patient: A Study of Outpatient Care. Cleveland, Ohio: The Press of Western Reserve University, 1967.

12. John B. McKinlay (1972) loc. cit. p. 136.

13. Andrew W. Fisher, Patients' Evaluation of Outpatient Medical Care, Journal of Medical Education, Volume 46, March 1971. p. 239.

14. Ibid. pp. 241-242.

15. M. B. Sussman et al. op. cit.

16. Fisher 1971, op. cit. p. 242. See also: Sussman, supra.

Chapter Seven - Discussion, Conclusions and Recommendations

Much has been written about medical technological research, benefits and risks of contraception, processes of counselling, and the decisions made by professionals in the field of family planning pertaining to patient needs for service. However, little has been written about what the patients' themselves seek when they have a family planning problem, and what is important to them when going for service.

Using a multiple-methodological approach, this thesis has attempted to determine some of the reasons why patients will go to a specialized clinic, in particular Planned Parenthood Birth Control Clinic, for their family planning needs. Perceptions held by patients of clinical service was examined by seeking opinions and suggestions from the people for whom the clinic was established. Patients described what type of service they expected to find and what was important to them in determining control of their own fertility.

This study focuses only on those patients who made use of the St. John's clinic. However, this clinic is probably representative of the clinical model of service which is common throughout most of North America.

Several key issues became apparent when conducting the study. The major one appeared to be the concept of clinical service. As discussed

in an earlier chapter, we examined the viability of the medical model as related to counselling and family planning. On analysis, while the Planned Parenthood Birth Control and Counselling Clinic operates predominantly on a medical model, there seems to be a distinct division of service. There is a technical side, which is set down by Canadian medical practice and requires the attendance of trained physicians for procedures such as prescriptions for medication, intra-uterine device insertions, and physical assessments. However, there is another side to the service which appears to be very much greater in scope and much more time consuming. This is the area of counselling and choice. It is in this area, that the 'patient' ceases to be a patient and is moved into the dimension of 'client-centered' therapy. The 'Client' is encouraged to analyze her own problems, to think independently, and to make decisions, given adequate information, on individual life interests. It is in this area that attitudes, values, problems of guilt and anxiety can be discussed in depth, so that contra-ceptive compliance, or fertility responsibility can be maximized.

There are other dangers inherent in using the medical model as the primary model in family planning and problems of human sexuality. At present medical problems are usually viewed in terms of illness behavior.

> Mary, a thirteen year old patient sees her family physician regarding severe dysmennorhea. In the course of discussion he tells her she will be 'sick' like that every month from now on.

From the medical model is percolated down through folk medicine and 'old wives tales' a mythology of beliefs. When this carries over into an individual's sexuality we frequently hear tales with regard to menstruation, labor, and delivery.

> Karen, a twelve year old, began having her menstrual periods. Mrs. J. came over to her, patted her on the shoulder, and said, "You poor child. You'll be 'sick' like this each month now the rest of your life".

Instead of Karen being proud of 'growing up' and encouraged to see menstruation as a necessary stage in her life, she is socialized into thinking each month she will be 'sick'.

The second major focus of the medical model is its idea of pathology. (e.g. the disease model).

It was only in 1974 that the American Psychiatric Association removed homosexuality from the category of a pathological illness.[1] The issue of concern is how can a behavior be classed as pathological one day and not the next, and secondly what is the effect of this classification on society as a whole? It would appear to make more sense to deal with sexual behavior, family planning and contraceptive needs, with models drawn from the social and behavior science, (namely client-centered), rather than from a pure medical model.

The lack of sex education and sexual responsibility, especially in the schools, is very apparent. Very little knowledge is available to persons seeking contraceptive or sexuality information. This is evidenced by the counselling cases previously described. There is little sex education in the schools;[2] many times parents lack adequate knowledge or feel uncomfortable dealing with this topic, and professionals are often inadequately trained. The age at which fertility begins is lower each generation, as is the age of entry into sexual activity. A large number of young people are exposed to pregnancy for a number of years before they are legally and emotionally ready to become parents. If the law is made more open, young people who are highly motivated and knowledgeable will be able to obtain contraceptives. But most young people are not this motivated or knowledgeable. Education regarding the importance and the use of birth prevention must be made more aggressive, so that the decision a young person makes is less "Should I find out about contraceptives?" and more, "Do I want to become pregnant tonight?"

While at the policy level it is stated that a woman should have access to services and information, there is little presented to distinguish between pregnancy and sexuality. For example, a woman may only want pregnancy two or three times in a lifetime but she has to deal with the problem of potential pregnancy for a reproductive lifespan of perhaps forty years. To recognise that sex is not just for procreation,

but is a large part of human emotions, allows for greater freedom of informational access and comprehensive service for fertility awareness and control.

Kleinberg discusses the occurence of two separate drives, sexual desire and reproductive drive. He says in the relations between male and female it is in fact sex which constitutes the primary force, whereas procreation is only a by-product. The end product of procreation is rarely considered at the time of the sexual act. However, in contrast to Kleinberg thought must be given to the opposite statement. That procreation is the primary force and to ensure this, both males and females are orgasmic. (No other animal is). Added to this notion are strong attractions and pleasures designed to make the act as frequent as possible.

Therefore, contraceptive techniques, though aimed at the prevention of conception, should in no way impair the sexual satisfaction of either male or female. No degree of persuasion to practice birth control methods can really be effective in the absence of assurance that there will be no interference with sexual satisfaction.[3] As long as there was ineffective contraception and inadequate dissemination of biological and sexual knowledge, persons had to <u>think</u> before having intercourse with someone or women would be pregnant all the time. Now however, there are means of providing adequate contraception and everyone legally

is entitled to information of this nature. But sex continues to be mystified and problems of communication abound. Therefore, if this knowledge becomes easily accessible the continual fear of pregnancy in women will be greatly diminished and sexual expression and control of fertility will be a freedom of all women.

Patients had definite opinions about the kind of service they wanted when seeking contraceptive needs. Although some patients liked the idea of a small personal clinic structure, the main reasons patients sought the particular clinic being studied was their perception of the kind of behavior and treatment they thought necessary to share their private concerns. As noted earlier in previous studies, the two most important considerations by patients in receiving care was the amount of time spent with the patient and the information which they received. It is easier for a clinic to provide this because the staff is on salary, not fee for service as are many physicians, thus the staff can afford to give the patient considerable time. Moreover, with the relatively small body of knowledge to be learned by a specialized clinic, it is easier to stay current on the topic.

Patients tend to go where the service is most convenient. This is not simply determined by the physical structure or location of the facility, but includes hours of opening as well. Teenagers and employed people find daytime hours very difficult to fit into their schedule.

Follow-up care is an essential part of good service as perceived by the patient. People often feel 'just a number' - especially if they see the waiting room is full and they will be 'processed' through the line. They tend to worry if they don't understand a statement made by the professional as was described earlier. Therefore, follow-up care becomes important not just for confirmation of self-worth, but also to clear up any misunderstandings or problems if they exist.

Most patients find it difficult to talk about sexual problems. They frequently arrive at the clinic, voice a partial problem and then hope the counsellor will make them feel comfortable and thereby facilitate further discussion. The counsellors are cautious in that they will sometimes express their own attitudes and values, and give advice rather than open up discussion and let the patient explore the problem. It is of paramount importance that the counsellor be aware of any bias, or prejudices that might exist, as well as examine their own values and attitudes.

Finally, the recognition of the role of the male was seen as an important part of family planning. Women expressed frustration at having to be the main contraceptor. They wanted their partner to take an active part in the control of pregnancy. Also, the male needs a place to go where he can be comfortable obtaining the information which he feels he should be knowledgeable about.

It should be recognized that any policies established, either at the National, Provincial, or local levels, should be flexible and always open to evaluation, for with social change, even successful programs outlive their usefulness. No government policy or set of programs can make individual families function better. All policies can do is establish an opportunity structure which makes certain that society does not interfere or restrain the family's efforts to meet its collective needs.

As a Result of the Study the Following Recommendations are Suggested:

1. Medical personnel should work towards a "well patient" and "client-centered" focus for the field of family planning rather than a rigid medical model of delivery.

2. To encourage more male involvement in the field of family planning. All too often the male feels left out of the decision making process and should be encouraged to take an active part, both for better communication as well as to encourage better compliance in contraception.

3. Research: The administration of research funds should be directed towards emphasizing more effective contraception as well as the determining of cultural differences and motivation of patients attending medical services for contraception. Research should also be directed at the evaluation of existing clinical services, methods of delivery, patient motivation, and continuity.

4. To lower the age of consent, already the highest in Canada at nineteen years, to at least the age of sixteen. This would clarify the already ambiguous policy and allow physicians the right to provide contraception to minors if they believed that this was advisable.

5. That sex education be established in all the schools for children from kindergarten upwards. This should be incorporated in a life skills program which teaches personal responsibility as well as provides adequate information to enable the child to make his/her own decisions on individual sexual related behavior.

6. Because of the late start (1969) for dissemination of information on contraception in Canada, there is a scarcity of Canadian publications. It is recommended that the Department of Health and Welfare as well as the local family planning people be persuaded to encourage the preparation of current family planning issues.

7. Workshops should be established to enable parents to obtain knowledge about child spacing as well as to prepare them to be able to communicate with their own children's developmental questions and to answer the questions with accuracy and confidence. Workshops should also be encouraged to assist teenagers who are already designated by their own peer group as leaders to gain further skills in these areas.

8. That there be an implementation of family planning content in all human service areas. This will require that professionals have more extensive training to carry out this mandate by implementing courses of study in the curriculum content of all training of professionals working in the counselling field.

9. That an attempt is made to have consistent policies on family planning across provinces.

10. The Government of Newfoundland should develop a Provincial Family Planning Policy. An advisory task force should be set up immediately to implement discussion of this policy. Attention should be particularily paid to long-term planning and funding.

11. A second Provincial Family Planning and Sex Education conference should be planned for 1983 to discuss recommendations which were suggested at the last conference and to encourage future direction in family planning for the Province of Newfoundland.

Footnotes and References: Chapter Seven

1. Vern L. Bullough, Sex and the Medical Model, The Journal of Sex Research, Volume 11, Number 5, pp. 291-303, November 1975.

2. From Hope Toumishey's MSc thesis 'Punishing the Pregnant Innocents' (1978) it seemed that all schools believed that they were providing adequate sex education. The implication seemed to be that whilst some sex education was provided it was often either nominal or presented by ignorant or otherwise unsuitable personnel and that knowledge of contraception was rarely, if ever, given and that in any case the subject was treated in a heavily moralistic context.

3. Otto Kleinberg, Social Psychology, New York: Holt 1954.

BIBLIOGRAPHY

Allison, A., Population Control, Penguin Books Inc., Baltimore, MD, 1970.

Badgley, R.F., Caron, D.F., Powell, M.G. The Abortion Law Committee on the Operation of the Abortion Law, Minister of Supply Services, Ottawa, 1977.

Bain, Ian. "The Development of Family Planning in Canada", Canadian Journal of Public Health, L.V. 1964.

Bakker, C.B., Dightman, C.R. "Physicians and Family Planning: A Persistent Ambivalence", Obstetrics and Gynecology, 25:279. 1965.

Becker, H., 'Problems of inference and proof in participant observation', American Sociological Review. Vol. 23, December 1958: pp. 652-650.

Benedict, Burton, "Population Regulation in Primitive Societies", Population Control, ed. Anthony Allison, Penguin Books Ltd, England, 1970.

Bensman, Joseph and Vidich, Arthur, "Social Theory in Field Research", Sociology on Trial, ed. Maurice Stein and Arthur Vidich, Prentice Hall, Inc. New Jersey, 1960.

Birdsell, Joseph B., "Some Predictions for the Pleistocene based on Equilibrium Systems among Recent Hunter-Gatherers", in Man the Hunter, ed. Richard B. Lee and Irven DeVore, Aldine Publishing Co., Chicago, p. 239, 1968.

Boutin, Raymond, "A History of the Family Planning Movement in Canada", Family Planning and Social Work, Health and Welfare Canada, 1976.

Bradshaw, Barbara R., McIlhaney Wolfe Jr., Walter, Wood, Theresa J. and Tyler, Lucy Stambury, Counselling on Family Planning and Human Sexuality, Family Planning Association of America, New York, N.Y. 1977.

Bredemeir, Harry C., Contemporary Sociology: A Journal of Reviews, Volume 6, Number 6, p. 647, November 1977.

Bullough, Vern. L., Sex and the Medical Model, The Journal of Sex Research, Volume 11, Number 4, pp. 291-303, November 1975.

Bumpass, Larry, and Westoff, Charles F., "The Perfect Contraceptive Population", Science, Volume 169, Number 3951, September 1970.

Cahn, Jerry, "The Needs of Adolescent Women Utilizing Family Planning Services", The Journal of Sex Research, Volume 13, Number 3, pp. 210-222, August 1977.

Campbell, Donald T. and Stanley, Julian, "Experimental and Quasi-Experimental Designs for Research", Chicago: Rand McNally and Co., 1963.

Chadwick-Jones, J.K., Social Exchange Theory: Its Structure and Influence in Social Psychology, Academic Press, New York, N.Y. 1976.

Childe, V.Gordon, Man Makes Himself, London: Watts and Co. 1936.

Chilman, Catherine, "Some Research and Clinical Perspectives in Adolescent Sexuality", Invited lecture to the American Psychological Assoc. Conference Division 34, 1977.

Collins, G.E. "Do We Really Advise the Patient?" Journal of Florida Medical Association, (42) August 1955. pp. 111-115.

Collver, A., et al, "Factors Influencing the Use of Maternal Health Services", Social Science and Medicine, pp. 293-308, September 1967.

Dailey, Wilda J., Ives, Kenneth, 'Exploring Client Reactions to Agency Service', Social Casework, pp. 233-245, April 1978.

Davis, K., and Blake, J., 'Social Structure and Fertility: An Analytic Framework', Economic Development and Cultural Change, Volume 4, Number 3, 1956.

Davis, M. and Eidhorn, R. "Compliance with Medical Regimens", Journal of Health and Human Behavior, 4 (Winter) pp. 240-249. 1963.

Denzin, N., The Research Act (A Theoretical Introduction to Sociological Methods) Chicago: Aldine Publishing Co. p. 26.

Devereux, George, "A Typological Study of Abortion in 350 Primitive, Ancient and Pre-Industrial Societies", in Therapeutic Abortion, ed. Harold Rosen, The Julian Press Inc. New York, p. 98, 1954.

Douglas, E.T., Margaret Sanger: Pioneer of the Future, Holt, Rhinehart and Winston, New York, N.Y. 1970.

Draper, Elizabeth, Birth Control in the Modern World, Penguin Books Inc. 1972.

Dye, M.C., 'Clarifying Patient's Communications', American Journal of Nursing, 63: August 56f, 1963.

Ekeh, Peter P., Social Exchange Theory: The Two Traditions, Harvard University Press, Cambridge, Mass. 1974.

Family Planning Association, Report of the Family Planning and Sex Education Conference, St. John's, Newfoundland. May 1973.

Fédération du Québec pour le planning des naissances congrès d'orientation Québec, Rapport, September 16-17, 1972.

Filstead, William J., (ed.), Qualitative Methodology, Chicago: Markham Publishing Co., 1970. p. 150.

Finch, B.E., and Green, Hugh, Contraception Through the Ages, Chas. C. Thomas, Springfield, Illinois.

Fisher, Andrew W., 'Patients Evaluation of Outpatient Medical Care', Journal of Medical Education, Volume 46, pp. 238-244, March 1971.

Freeman, Howard E., 'Conceptual Approaches to Assessing Impacts of Large-Scale Intervention Programs', 1964 Social Statistics Proceedings, American Statistical Association, pp. 193-194.

Freeman, O., World Without Hunger, Praeger: New York, 1969.

Grindstaff, Carl F., 'The Canadian Pharmacist and Family Planning', Family Planning Perspectives, Volume 9, Number 2, pp. 81-84, March/April 1977.

Gurin, Gerald, Veroff, Joseph, and Feld, Sheila, Americans View Their Mental Health, New York Basic Books, 1960.

Gilbert, Rosa, and Mathews, Vicki G., Young Males Attitudes Toward Condom Use, The Condom: Increasing Utilization in the United States, Redford, Myron H., Duncan, Gordon, and Praeger, Denis. pp. 164-172. 1972.

Gray, Mary Jane and Tyson, Judith. Evolution of a Women's Clinic: An Alternate System of Medical Care. American Journal Obstetrics Gynecology, Volume 126, Number 7, pp. 760-765. December 1976.

Hall, E. The Hidden Dimension, Doubleday Books, Garden City, New York, 1969.

Halmos, Paul, The Faith of the Counsellors, Constable and Company Ltd. London, 1965.

Hausser, P.M., ed. The Population Dilemma, Englewood Cliffs: Prentice-Hall Inc. 1965.

Health and Welfare, National Center for Health Statistics, D.H.E.W. 1976. National Ambulatory Medical Care Survey, Washington, D.C. 1978. (mimeo).

Health and Welfare Canada, Family Planning Division, Recommendation of the First National Conference on Family Planning, Ottawa 1972.

Heath, Anthony, Rational Choice and Social Exchange, Cambridge University Press, New York, 1976.

Henripin, J., and Légaré, J. 'Recent Trends in Canadian Fertility', Canadian Review of Sociology and Anthropology, 8 (2), 1971.

Himes, Norman E., Medical History of Contraception, New York: Schocken Books Inc.; first published Baltimore: Williams and Wilkins Company, 1936. Revised Publication 1970.

Homans, George Caspar, Sentiments and Activities, The Free Press of Glencoe, New York, N.Y. 1962.

House of Commons, Canada. Journals, Volume CXIII - 1966-1967. Number 168.

Howard, Walter E. 'The Population Crisis is Here Now', Bio-Science, XIX September 1969.

Hoyos, Michael D. and Smith, Karl A. 'Contraceptive Compliance in Family Medicine: A Comparison of the Family Physician and the Family Planning Clinics'. The Journal of Family Practice, Volume 7, Number 5, (pp. 961-965) 1978.

Hulbert, R.C. and Sutlage, R.H. 'Birth Control and the Private Physician: The View from Los Angeles', Family Planning Perspectives, 6:50, 1974.

Insko, C.A. Theories of Attitude Change, Appleton Century Crafts, New York, 1967.

International Planned Parenthood Federation, 'Community Distributions Around the World', People, Volume 2, Number 4, 1975.

Jaffe, Frederick S. and Polgar, Steven, 'Family Planning and Public Policy: Is the Culture of Poverty the New Cop-out?' Journal of Marriage and the Family, May 1968.

Johnson, Frank C. and Johnson, May R. 'New Directions in Family Planning Policy', Resources and Education 1979.

Johnson, May and Prodell, Rita. Early Pregnancy Detection in a Planned Parenthood Facility, Presented at the American Public Health Meeting, November 4-8, 1979. New York.

Jolly, Carol, Held, Berel, Caraway, A.F., and Prystowsky, Harry. 'Research in the Delivery of Female Health Care: The Recipient's Reaction'. American Journal of Obstetrics and Gynecology, Volume 110, Number 3, pp. 291-294. June, 1971.

Kalbach, Warren E., and McVey Jr., Wayne W., 'The Canadian Family: A Demographic Profile in The Canadian Family in Comparative Perspective, ed. Lyle Larson, Scarborough, Ontario: Prentice-Hall 1976.

Kane, Robert L., 'Determination of Health Care Priorities and Expectations Among Rural Consumers', Health Services Research, Volume 4, pp. 142-151. Summer 1969.

Katatsky, Marilynn E. 'The Health Belief Model as a Conceptual Framework for Explaining Contraceptive Compliance', Health Education Monographs, Volume 5, Number 3, pp. 232-243. Fall 1977.

Kendall, Katherine, ed. Population Dynamics and Family Planning: The New Responsibility for Social Work Education, Council on Social Work Education, New York. 1971.

Kennedy, D. Birth Control in America: The Career of Margaret Sanger. Yale University Press, 1970.

Kimball, S.T. and Pearsall, M., The Talladega Story: A Study of Community Process, University of Alabama Press, 1954.

Kirby, David J. 'Final Report of Project Outreach', Attitudes Toward and Utilization of Family Planning Services in the City of St. John's. July 1975.

Klineberg, Otto, Social Psychology, Holt: New York, 1954.

Kluckhohn, F., 'Participant Observer Techniques in Small Communities', American Journal of Sociology, Vol. 46, November 1940: p. 331.

Knight, C. Norman, 'Public Family Planning Policy: Formulation and Implementation', Family Planning and Social Work, Department of Health and Welfare, 1976.

Laing, W.A., The Costs and Benefits of Family Planning, Broadsheet 534, Volume XXXVIII, PEP, London, England. February 1972.

Lazarsfeld, Paul F., Sewell, William, and Wilensky, Harold, (ed.), The Uses of Sociology, Basic Books, Inc. New York, 1967. p. 514.

Lebow, Joy L. 'Consumer Assessments of the Quality of Medical Care', Medical Care, Volume XII, Number 4, pp. 328-337, April 1974.

Leichter, Hope J. and Mitchell, Wm. E., Kinship and Casework, Russell Sage Foundation: New York. 1967.

Lennard, Henry L., and Bernstein, Arnold, Patterns in Human Interaction, Jossey-Bass Inc. Publishers. 1970. p. 51.

Lerner, M. et al, "Data on Social Background, Medical Care Utilization and Attitudes of Outpatients by Hospital, New York, Municipal General Hospital Outpatient Population Study", Columbia University. 1968.

Lofland, John, Analyzing Social Settings, Wadsworth Publishing Company, California. 1971.

Long, W. Newton, Bradshaw, Barbara R., and Burge, M. "Black Attitudes Regarding Contraception, Abortion, and Sterilization", Abortion Techniques and Services, proceedings of the Conference, ed. Sarah Lewitt (Amsterdam: Excerpta Medica, 1972).

MacKenzie, Paul, 'Family Planning and the Private Physician', Bulletin, Family Planning Federation of Canada, Volume 2, Number 1, Spring-Summer 1974.

Mair, Lucy, An Introduction to Social Anthropology, 2nd ed. Clarendon Press: Oxford. 1972.

Malinowski, B., Crime and Custom in Savage Society, International Library for Psychology, Philosophy, and Scientific Method, London 1926.

Manisoff, Miriam, Family Planning: A Teaching Guide for Nurses. Planned Parenthood Federation of America, Inc. 1969.

Manisoff, Miriam ed. Family Training for Social Service, Planned Parenthood Federation of America Inc. 1972.

Marsden, Lorna R., 'Human Rights and Population Growth: A Feminist Perspective', International Journal of Health Sciences, Volume 3, Number 4. 1973.

Mayo, E., The Social Problems of an Industrial Civilization, Boston, Harvard Business School, 1945.

McKinlay, John B., 'Social Networks and Utilization Behavior', Aberdeen: Paper to second International Conference on Social Science and Medicine.

McKinlay, John B., 'Some Approaches and Problems in the Study of the Use of Services - An Overview', Journal of Health and Social Behavior, pp. 115-151. June 1972.

Mennell, Stephen, Sociological Theory: Uses and Unities, Nelson and Sons, Ltd. Great Britain, 1974.

Metzner, C. et al, 'Choice of Health Care Plans', University of Michigan: Ann Arbor, School of Public Health. 1965.

Minkler, Meredith, 'The Use of Incentives in Family Planning Programmes: A Study of Competing Theories Regarding their Influence on Attitude Change'. International Journal of Health Education: Supplement Volume XIX, Issue Number 3. July-September 1976.

Morley, Peter and Wallis, Roy, ed. Culture and Curing, Peter Owen Ltd. London. 1978.

Moyer, John E. and Timms, Noel. The Client Speaks, Routledge and Kegan Paul Ltd. London. 1970.

Newspaper Enterprise Association Inc., The World Almanac and Book of Facts, New York, N.Y. 1976.

Noonan, John T.Jr., Contraception: A History of its Treatment by the Catholic Theologians and Canonists, The Belknap Press of Harvard University Press, Cambridge, Mass. 1966.

Noyes, Robert W., Levy, Marvin I., Chase, Charles, and Udry, Richard, 'Expectation Fulfillment as a Measure of Patient Satisfaction', International Journal Obstetrics and Gynecology, Volume 118, pp. 809-814. March/April 1974.

Nye, F.Ivan, and Berardo, Felix M., The Family: Its Structure and Interaction, The Macmillan Company: New York. 1973.

Nye, F. Ivan, School Age Parenthood, Extension Bulletin 667. Cooperative Extension Service, Washington State University, Pullman, April 1976.

Ortho Pharmaceuticals, 'An Exploration of the Limitations of Contraception', Proceedings of a Conference Ontario Science Centre. November 1975.

Palko, M.E., Lennox, R.H., and McQuarrie, C.R. Current Status of Family Planning in Canada, Canadian Journal of Public Health, Volume 62, November/December Issue.

Parents Information Bureau Ltd., Birth Control Trial: The Eastview Case. Kitchener, Ontario.

Pearson, Mary. Background Notes on Birth Planning and Conception Control, Canadian Advisory Council on the Status of Women. June 1979.

Pelrine, Eleanor Wright, Abortion in Canada, New Press: Toronto. 1971.

Pohlman, E., How to Kill Population, The Westminister Press: Philadelphia. 1971.

Pohlman, E., Birth Planning Incentives: Psychological Research, in J.T. Fawcett ed. Psychological Perspectives on Population, Basic Books Inc.: New York. 1973.

Population Information Program, Population Reports, 'Training Non Physicians in Family Planning Services', Series J, Number 6. Washington, D.C. September 1975.

Radcliffe-Brown, A.R., Structure and Function in Primitive Society, N.Y. The Free Press, 1952.

Rainwater, Lee, Family Design, Aldine: Chicago 1965.

Reynolds, Jack, 'Delivering Family Planning Services: Autonomous versus Integrated Clinics', Family Planning Perspectives, Volume 2, Number 1, pp. 15-22. January 1970.

Rogers, Carl, Client-Centered Therapy: Its Current Practice, Implications and Theory. The Houghton-Mifflin Psychological Series: Boston. 1951.

Rosenberg, Charles and Rosenberg, Carol-Smith, ed. Birth Control and Family Planning in Nineteenth Century America, Arna Press: New York. 1974.

Rosenfield, Allan G., Family Planning: An Expanded Role for Paramedical Personnel, American Journal of Obstetrics and Gynecology, Volume 110, Number 7, pp. 1030-1039. August 1971.

Rosenfield, Allan, 'Medical Supervision for Contraception: Too Little or Too Much?' International Journal Gynecology Obstetrics, 15: pp. 105-110. 1977.

Sai, Fred T. Some Ethical Issues in Family Planning, International Planned Parenthood Federation, 1976.

Sai, Fred T. Defining Family Health Needs, Standards of Care and Priorities, Occasional Essay Number 4, International Planned Parenthood Federation, May 1977.

Schutz, Alfred, 'Commonsense and Scientific Interpretation of Human Action', Philosophy and Phenomenological Research, Vol. XIV, Number 1, (Sept. 1953). pp. 3-47.

Schlesinger, Ben, Family Planning in Canada: A Source Book. University of Toronto Press, 1974.

Silver, Morton A. 'Birth Control and the Private Physician', Family Planning Perspectives, Volume 4, Number 2, pp. 42-46. April 1972.

Simpson, Richard, Theories of Social Exchange, General Learning Press, New York, N.Y. 1972.

Skipper, J.K., Mauksch, H.O., and Tagliarozzo, D., 'Some Barriers to Communication between Patients and Hospital Functionaries', Nursing Forum, 2, Number 1, pp. 14-23. 1963.

Skuy, P., It All Began in Egypt with an Rx Dated 1850 B.C., Drug Merchandising, January 1970.

Smith, Kenneth D., and Wineberg, Harris S., 'A Survey of Therapeutic Abortion Committees', The Criminal Law Quarterly, September 1970.

Sommer, R., Personal Space, Inglewood Cliffs, Prentice-Hall, New Jersey, 1969.

Spencer, P., The Samburu, Routledge and Kegan Paul, 1965.

Spradley, James P. and McCurdy, David W., The Cultural Experience: Ethnography in Complex Society. Science Research Associates, 1972. p. 6.

Spradley, James P., You Owe Yourself a Drunk: An Ethnography of Urban Nomads, Boston: Little Brown, 1970.

Sussman, M. B., Caplan, E.K., Haug, M.R., and Stern, M.R., The Walking Patient: A Study of Outpatient Care, The Press of Western Reserve University, Cleveland, Ohio. 1967.

Tournishey, Hope, Unpublished MSc thesis, 'Punishing the Pregnant Innocents', Memorial University of Newfoundland. 1978.

Trussel, James Jr. and Hatcher, Robert A., Women in Need, The Macmillan Company, New York, N.Y. 1972.

University of Southern California, Dialogues in Oral Contraception, Volume I-VI. November 1975 to October 1976.

Vogel, Virgil J., American Indian Medicine, Ballantine Books, New York, N.Y. 1973.

Wallis, Graham, The Life of Francis Place, 1771-1854, George Allen and Unwin Ltd. 1918.

Waring, Gerald, 'Report from Ottawa', Canadian Medical Association Journal, May 1969.

Watters, Wendell W., Compulsory Parenthood, McClelland and Stewart Ltd. Toronto. 1976.

Webb, Eugene J., Campbell, Donald T., Schwartz, Richard and Sechrest, Lee, Unobtrusive Measures: Nonreactive Research in the Social Sciences, Rand McNally Publishing Co. 1966. p. 114.

Weinberger, C.W., Population and Family Planning, Family Planning Perspectives, 6: Summer 1974.

Westoff, C. and Ryder, N., National Fertility Study, 1965. Report presented at University of Michigan conference, Fertility and Family Planning, Ann Arbor, November 1967.

Westoff, Charles F., and Ryder, Norman B., 'United States: Methods of Fertility Control, 1955, 1960, 1965'. Studies in Family Planning, Number 17, February 1967.

Whyte, J.C., Corber, S.J. and Keys, C.H., 'Ottawa Family Planning Clinic: experience with 3862 registrants', Canadian Medical Journal, Volume 118, pp. 401-402. February 1978.

Whyte, W.F., Street Corner Society, Chicago, University of Chicago Press, 1955.

Wilson, Robert R., Introduction to Sexual Counselling, Carolina Population Center, Chapel Hill, North Carolina, 1974.

Wolf, Sanford R., and Ferguson, Elsie L., 'The Physicians' Influence on the Nonacceptance of Birth Control', American Journal Obstetrics and Gynecology, Volume 104, Number 5, pp. 752-757. July 1969.

* Demographic date was recorded on a face sheet by the interviewer.

PRIVATE INFORMATION

We are trying to improve the services at the Clinic and are asking selected patients for their opinions. By filling out the answers to the following questions you will help us to make the Clinic a better place for you and your friends.

Please compare each of the following places where birth control information is obtained by checking the answer that most indicates your opinion.

All information received will be kept private. Please do not put any identifying information on the sheets. Your participation is voluntary.

1. Please check if you have ever received birth control information at the following places.

   Planned Parenthood family planning clinic ___

   Your family doctor ___

   Family planning clinic in hospital ___

   Local drugstore ___

   Hospital emergency/outpatient department ___

   Other ___

Accessibility of Service

2. How easy is it to find each of the following?

	very easy	easy	uncertain	not easy	not at all easy
Your doctor's office	___	___	___	___	___
A hospital-based family planning clinic	___	___	___	___	___
Pharmacy	___	___	___	___	___
Planned Parenthood family planning clinic	___	___	___	___	___
Hospital emergency/ outpatient department	___	___	___	___	___

3. How much time does it take you to get to each of the following?	under 15 minutes	15-30 minutes	uncertain	30-60 minutes	over 1 hour
Planned Parenthood family planning clinic					
Your doctor's office					
A hospital-based family planning clinic					
Local drugstore					
Hospital emergency/ outpatient department					

4. Do you find it easy to get to the following places during the hours they are open?	very easy	easy	don't know	not easy	not at all easy
Hospital emergency/outpatient department					
Your doctor's office					
A hospital-based family planning clinic					
Local drugstore					
Planned Parenthood family planning clinic					

Atmosphere of Service

5. How bright and cheerful do you find each of the following places?	not at all bright	not bright	don't know	bright	very bright
A hospital-based family planning clinic					
Local drugstore					
Planned Parenthood family planning clinic					
Your doctor's office					
Hospital emergency/outpatient department					

6. How friendly do you find each of the following places?	very friendly	friendly	don't know	not friendly	not at all friendly
Planned Parenthood family planning clinic					
Local drugstore					
Hospital emergency/ outpatient department					
Your doctor's office					
Hospital-based family planning clinic					

7. How much do each of the places care for you and how you feel?	don't care at all	seldom care	don't know	care	really care
Hospital-based family planning clinic					
Your doctor's office					
Planned Parenthood family planning clinic					
Local drugstore					
Hospital emergency/ outpatient department					

Personalization of Service

8. How much do you think the people in each of the following places know about birth control?	know a lot	know quite a lot	uncertain	know a little	don't know much at all
Hospital-based family planning clinic					
Local drugstore					
Hospital emergency/ outpatient department					
Your doctor's office					
Planned Parenthood family planning clinic					

9. How private do you think your personal information is kept at the following places?

	no privacy	little privacy	don't know	private	very private
Hospital emergency/ outpatient department	___	___	___	___	___
Your doctor' office	___	___	___	___	___
Planned Parenthood family planning clinic	___	___	___	___	___
Local drugstore	___	___	___	___	___
A hospital-based family planning clinic	___	___	___	___	___

10. How important is it to you that your personal information be kept private?
very important ___ quite important ___ moderately important ___
not important ___ not at all important ___ other ___

11. How comfortable are you talking about birth control at each of the following places?

	very comfort-able	comfort-able	don't know	seldom comfort-able	not comfort-able
Planned Parenthood family planning clinic	___	___	___	___	___
Your doctor's office	___	___	___	___	___
A hospital-based family planning clinic	___	___	___	___	___
Local drugstore	___	___	___	___	___
Hospital emergency/ outpatient department	___	___	___	___	___

12. Have you ever been made to feel ashamed when discussing birth control at the following places?

	not ashamed	seldom ashamed	don't know	ashamed	very ashamed
A hospital-based family planning clinic	___	___	___	___	___
Local drugstore	___	___	___	___	___
Hospital emergency/ outpatient department	___	___	___	___	___
Your doctor's office	___	___	___	___	___
Planned Parenthood family planning clinic	___	___	___	___	___

Attitudes toward Services

13. How afraid are you that you will be refused the services you want at the following places?

	very afraid	afraid	don't know	seldom afraid	not afraid
Hospital emergency/ outpatient department	___	___	___	___	___
Local drugstore	___	___	___	___	___
Planned Parenthood family planning clinic	___	___	___	___	___
Your doctor's office	___	___	___	___	___
A hospital-based family planning clinic	___	___	___	___	___

14. How rushed do you feel when you are talking to people working at the following places?

	not rushed	seldom rushed	don't know	rushed	very rushed
Planned Parenthood family planning clinic	___	___	___	___	___
Your doctor's office	___	___	___	___	___
A hospital-based family planning clinic	___	___	___	___	___
Local drugstore	___	___	___	___	___
Hospital emergency/ outpatient department	___	___	___	___	___

15. Have you ever been made to feel embarrassed when discussing birth control at the following places?

	very embar- rassed	embar- rassed	don't know	seldom embar- rassed	not embar- rassed
A hospital-based family planning clinic	___	___	___	___	___
Local drugstore	___	___	___	___	___
Hospital emergency/ outpatient department	___	___	___	___	___
Your doctor's office	___	___	___	___	___
Planned Parenthood family planning clinic	___	___	___	___	___

16. How well thought of in the community is each of the following places?

	not at all well	not well	uncertain	quite well	very well
Hospital emergency/ outpatient department	___	___	___	___	___
Your doctor's office	___	___	___	___	___
A hospital-based family planning clinic	___	___	___	___	___
Local drugstore	___	___	___	___	___
Planned Parenthood family planning clinic	___	___	___	___	___

17. If you had a friend who needed birth control information which services do you think would be most helpful?

	most helpful	helpful	don't know	not helpful	not at all helpful
Planned Parenthood family planning clinic	___	___	___	___	___
Local drugstore	___	___	___	___	___
A hospital-based family planning clinic	___	___	___	___	___
Your doctor's office	___	___	___	___	___
Hospital emergency/ outpatient department	___	___	___	___	___

Why?

18. Do you feel Planned Parenthood Birth Control Clinic is an important resource in the community?

Very important ___ Quite important ___ Moderately important ___
not important ___ not at all important ___ Other ___

Why?

19. Would you like to make any suggestions or comments that might improve our service?

Thank you for taking the time to answer questions about contraceptive services in the community and specifically our Birth Control Clinic. We hope to improve our services to make the Clinic a better place for you to come.

Source: Miriam Manisoff (ed.) Family Planning Training for Social Service. Planned Parenthood Federation of America, Inc. 1973. pp. 77-80.

CHURCH ATTITUDES ON BIRTH CONTROL

Anglican, Episcopal:

The responsibility for deciding upon the number and frequency of children has been laid by God upon the consciences of parents everywhere; this planning, in such ways as are mutually acceptable to husband and wife in Christian conscience, is a right and important factor in Christian family life and should be the result of positive choice before God...The responsible procreation of children is a primary obligation...The choice must be made by parents together, in prayerful consideration of their resources, the society in which they live, and the problems they face... The means of family planning are in large measure matters of clinical and aesthetic choice, subject to the requirement that they be admissible to the Christian conscience. Scientific studies can rightly help, and do, in assessing the effects and the usefulness of any particular means; the Christians have every right to use the gifts of science for proper ends.

Lambeth Conference, 1958, of Bishops of the Anglican Communion affirmed in 1959 by the National Council of the Protestant Episcopal Church in the U.S.

Baptist:

We commend those who assume responsibility for gaining world acceptance of the simple techniques of planned parenthood and large scale population control. We particularly commend...organizations which have taken strong and successful stands for the responsible public administration of legalized methods of birth control and family planning.

American Baptist Convention, 1959.

Christian Scientist:

Married couples are free to follow their own judgment as to having and as to the number they will have.

George Channing, Christian Science lecturer; formerly First Reader of the Mother Church in Boston.

Disciples:

A majority of Discipline ministers believe that birth control is justifiable under certain circumstances. In general, Disciples are content to leave such matters to the individual consciences of husband and wife.

James E. Craig, Life Elder and Trustee, Park Avenue Christian Church, New York.

Jehovah's Witnesses:

Jehovah's Witnesses regard birth control as an entirely personal matter.

Milton G. Henschel, Minister;
Director Watch Tower Bible and Tract Society.

Jewish:

We favor the wider dissemination of birth control information and medical assistance, both by private groups such as the Planned Parenthood Association, and health agencies of local, state and the federal government as a vital service to be rendered in the field of public health.

Union of American Hebrew Congregations, 1959.

Proper education in contraception and birth control will not destroy, but rather enhance, the spiritual values inherent in the family and will make for the advancement of human happiness and welfare.

Rabbinical Assembly.

We urge the recognition of the importance of the control of parenthood as one of the methods of coping with social problems.

Central Conference of American Rabbis.

Lutheran:

Husband and wife are called to exercise the power of procreation responsibility before God. This implies planning their parenthood in accordance with their ability to provide for their children and carefully nurture them in fullness of Christian faith and life...Choice as to means of conception control should be made upon professional medical advice.

United Lutheran Church in America,
20th Biennial Convention, 1956.

A married couple should so plan and govern their sexual relations that any child born to their union will be desired for itself and in relation to the time of its birth. So long as it causes no harm to those involved, none of the methods for controlling the number and spacing of children has any special moral merit or demerit. The power to reproduce is His blessing, not a penalty upon the sexual relationship in marriage.

Augustana Lutheran Church
95th Synod, 1954.

Methodist:

Planned parenthood, practiced in Christian conscience, fulfills rather than violates the will of God.

Methodist Church General Conference, 1960.

Quaker:

The proper use of approved contraceptives may contribute to the social and economic welfare of the home and to physical and mental health of parents of children.

Philadelphia Yearly Meeting of Friends (Arch Street).

Presbyterian:

The 171st General Assembly approves the principle of voluntary family planning and responsible parenthood, affirms that the proper use of medically approved contraceptives may contribute to the spiritual, emotional and economic welfare of the family, and urges the repeal of laws prohibiting the availability of contraceptives and information about them for use within the marriage relationship.

United Presbyterian Church, 1959.

Roman Catholic:

If, then, there are serious motives to space out births, which derive from the physical or psychological conditions of husband and wife, or from external conditions, the church teaches that it is then licit to take into account the natural rhythms imminent in the generative functions, for the use of marriage in the infecund periods only, and in this way to regulate birth without offending the moral principles which have been recalled earlier.

Pope Paul VI, Humanae Vitae, July, 1968.

Unitarian:

The American Unitarian Association recommends to its constituent churches and members an earnest consideration of the fundamental, social, economic and eugenic importance of birth control to the end that they may support all reasonable efforts in their communities for the promotion of the birth control movement.

American Unitarian Association

United Church of Christ:

Responsible family planning is today a clear moral duty. We believe that public law and public institutions should sanction the distribution through authorized channels of reliable information and contraceptive devices. Laws which forbid doctors, social workers and ministers to provide such information and service are infringements to the rights of free citizens and should be removed from the statute books. Any hospital which receives public funds should permit doctors to provide all services they consider necessary.

Council for the Christian Social Action, United Church of Christ, 1960. (Comprising the Congregational Church, and the Evangelical and Reformed Church).

APPENDIX C

Source: Family Planning for Doctors, IPPF, London, 1974.

AIMS OF THE INTERNATIONAL PLANNED PARENTHOOD FEDERATION

In the belief that knowledge of planned parenthood is a fundamental human right, and in the further belief that a balance between the population of the world and its natural resources and productivity is a necessary condition of human happiness, prosperity and peace, the International Planned Parenthood Federation aims:

(a) to advance the education of the countries of the world in family planning and responsible parenthood in the interest of family welfare, community well-being and international goodwill;

(b) to increase the understanding by people and governments of the demographic problems of their own communities and of the world;

(c) to promote population education, sex education and marriage counselling;

(d) to stimulate appropriate research in the following subjects: the biological, demographic, economic, eugenic, psychological and social implications of human fertility and its regulation; methods of contraception, fertility, sub-fertility and sterility; and to collect and make known the findings of such research;

(e) to stimulate and assist the formation of family planning associations in all countries;

(f) to stimulate and promote family planning in all countries through other appropriate organizations;

(g) to encourage and organize the training of all appropriate professional workers such as medical and health personnel, educationalists, social and community development workers in the implementation of the objectives of the Federation;

(h) to organize regional or international workshops, seminars and conferences;

(i) to take all appropriate measures to further the above objectives.

APPENDIX D

Policy recommendations were first assembled at the First National Conference on Family Planning held in Ottawa the spring of 1972. This was attended by three hundred and ten delegates from across Canada including people such as public officials, physicians, nurses, legislators, social workers, educators, researchers, and consumers. Fifteen recommendations were devised as follows:

Findings and Recommendations as Amended at Final Plenary Session:

General Principles:

RECOGNIZED AND EMPHASIZED THAT, FREEDOM OF CHOICE BEING UNDERSTOOD,

1. The right of all Canadians to family planning services involves an obligation on the part of individuals and families to determine, responsibly and realistically, the number and spacing of their children; and

2. Informed judgement and action by individuals and families requires not only availability of the full spectrum of birth control information and services, but knowledge and understanding concerning inter alia human growth and development, human sexuality and psychosocial relationships, the privileges and demands of parenthood, and the relationships among population growth and density, production and consumption of resources, and natural and man-made environments; and

3. Family life education and family planning involves responsibilities and opportunities not only for the individual and the family but also for religious institutions and other voluntary and community groups, the educational system, health and welfare agencies and professions, commercial enterprises, the media of communication, and governments at all levels; and

4. Family planning information and services as an essential part of a system of health and social services is a necessary but not a sufficient approach to public family and social policy, (by way of example, family and social policy also includes migration and settlement, housing, taxation, social security, environmental protection, etc.); and

5. Coordination will therefore be essential at all levels in policy development, program planning, and organization and delivery of information and services.

Conference Recommendations

1. Family planning policy, programs and services should encompass the full range of birth control methods, sterilization (vasectomy, and tubal ligation), abortion, fertility and genetics, as well as marriage and family (including adoption) counselling, and assessment, diagnostic, referral, and follow-up functions.

2. Family planning information and services should be available to any individual in Canada:

(a) Without economic, geographic or other barriers to access.

(b) Without reference to age or marital status.

(c) Without legal liability (apart from negligence) to the provider of the service.

3. (a) Family planning services should become an integral component of all community-based health and/or social (personal) services.

(b) Appropriate representation should be made to the governmental task force on community health centres, reporting to the federal and provincial cabinet ministers, to include family planning in the functions and services of such centres.

(c) The further development of family planning clinics, mobile units, "store-front" services, youth service centres and similar programs, public and voluntary, should be encouraged and assisted to meet the needs of individuals and groups

who are unable or unwilling to seek information and/or services in other ways.

(d) A family planning clinic or equivalent service should be made a prerequisite for the accreditation of all general hospitals.

4. The federal government should develop, review continuously, and keep the public informed concerning, a national population policy; the policy should take careful account of such variables as fertility and mortality rates, immigration and emigration, and internal migration.

5. (a) Provincial and territorial governments should develop clear family life education and family planning policies, program priorities, and where relevant, standards, in the relevant areas of information and education, services, research, and teaching and training.

(b) Through earmarking a percentage of their health and welfare budgets, or in some other identifiable fashion, provincial governments should provide expanded financial and staff support for family life education and family planning services public and voluntary.

6. High priority should be given in all Canadian provinces and territories to the provision of family life education programs, family planning information, and health and social services (including family planning) to relatively 'isolated' communities and groups, including, for example, people in remote rural and northern areas, native peoples living in self-contained settlements, and adolescents living away from home.

7. Provincial, territorial and municipal governments should develop as rapidly as possible a network of community health or personal service centres, designed to ensure maximum participation of people from the local community in policy development and program and service planning and evaluation.

8. Provincial, territorial and municipal governments should employ social workers and others in their health units to complement the family planning services provided by health professionals.

9. The proceedings and recommendations of the First National Conference on Family Planning should be on the agenda in the immediate future of meetings of Ministers of Health, Social Welfare and Education, and various government departments, for discussion and coordinated planning and action.

10. (a) Federal funds should be earmarked to encourage and assist conferences or workshops on family planning in the territories, the provinces and the metropolitan centres.

(b) The planning and development of regional conferences or workshops should be a responsibility and an opportunity for interested individuals, groups and organizations in the particular area, especially for those from the areas attending this conference.

(c) The planners of these conferences should aim for an equal balance in their conference participants between laymen and professionals.

11. Through delegates to this conference, voluntary organizations and other appropriate channels, provincial and/or municipal governments should be pressed to take initiative and responsibility for the establishment of planning and development bodies (where they do not already exist), concerned with family planning and family life education, and involving representatives of health, welfare, and education, voluntary agencies, and consumers groups or others.

12. Recognizing that language, ethnic, religious and similar differences frequently impede the availability of family planning information and services:

(a) Indigenous people should be trained and used to provide information, referral when requested, and follow-up activity concerning family planning for their particular groups or communities.

(b) Indigenous people should also be involved in the planning and preparation of family planning information and educational material appropriate to their particular groups or communities.

(c) Family Planning publications, audio-visual and other resource materials should be made available in a variety of forms and languages, understandable to all sections of the population.

(d) The federal Department of Manpower and Immigration should make available on arrival to new Canadians, in their mother tongue, information on Canadian health and social welfare programs, including family planning services.

13. Since a significant increase in information and education on family life and family planning is clearly required and acceptable, the federal government and provincial and territorial governments should earmark substancial funds for the production of resource materials appropriate to particular provinces, regions or groups, and for their dissemination through the media of communication.

14. Federal consultative services and financial assistance should be continued and expanded for experimental research and demonstration projects in both family life education and family planning services, especially for adolescents and young adults.

15. Federal financial assistance should be assured to foster required expansion of research in all aspects of family planning, for example, research on attitudes toward family planning, on psychological aspects of sterilization and of abortion on the effectiveness of different methods of birth control and of organization and delivery of family planning services, on the socio-economic determinants and consequences of fertility, mortality and migration in Canada, on the consequences for population size and distribution of existing or projected socio-economic policies and programs.

16. (a) Through separate courses, through the systematic and coordinated introduction of material in established curricula, or through a combination of the two, education in human development, human sexuality and relationships, parenthood, family planning and demography (sometimes encompassed in the term "family life education") should be included in all school curricula from kindergarten through secondary school.

(b) Parents, students, teachers, and specialists from all relevant disciplines and professions should be involved in the planning, delivery and evaluation of family life education programs and content in primary and secondary schools.

17. Governments at all levels should provide encouragement and financial assistance for the planning and development of family life education programs for adults by volunteer organizations, schools, colleges, universities, and other appropriate bodies.

18. Federal and provincial encouragement and assistance, financial and otherwise, should be provided to ensure the planning and development of:

(a) Training programs for specialists in the planning of family life education programs, and in the related education of teachers, social workers, health and other professionals in this area.

(b) Curriculum, materials and courses in family planning and family planning education, in education, social work, health and other university faculties or departments.

19. The federal government should establish a professional training program on birth control for all relevant professions and disciplines, including medicine, social work, nursing, sexology, psychology, etc.

20. The federal government should amend the Food and Drug Act and any other relevant legislation to eliminate restrictions preventing

the advertisement of effective birth control devices and family planning pills on the same basis as other (advertised) prescribed drugs or products.

21. The federal government, with the cooperation of the provincial governments and other relevant bodies, should develop a directory of organizations and other resources active in family planning.

22. A representative of Metis Associations and others should be invited to attend all future conferences on family planning, national, provincial, territorial and local.

Recommendations of the Special Interest Group on Research in Family Planning

1. A national fertility study, to examine the attitudes and behavior of Canadians regarding fertility and family planning.

2. Operational research on the provision of family planning information and services is urgently required. Demonstration projects should be undertaken under a wide variety of conditions to examine different approaches to groups of different age, sex, socio-economic level, and ethnic character. These demonstration projects should be concerned with different uses of manpower and methods, evaluate results and measure the relative cost-effectiveness of various approaches.

3. The relationship of family planning to social and health indicators.

4. Ongoing evaluation of family planning activities across Canada is urgently required.

Recommendations of the Special Interest Group on the Development of Family Planning Services

1. We recommend that provincial and territorial governments ensure that public hospitals provide family planning services including surgical procedures and counselling in accord with the principles of universality of services and freedom of choice by patients.

2. That this conference most strongly urges on the governments of the provinces and territories the desirability of establishing inter-departmental family planning committees to consist of representatives of all departments involved with the family and to be charged with the responsibility for planning and implementing integrated family planning services appropriate to the province or territory. Copies of this recommendation should be forwarded to the voluntary family planning associations.

3. We further recommend that these provincial family planning committees be assisted by advisory committees representing interested voluntary citizen groups as well as local health, education and welfare agencies to advise on policies and services.

4. A plan for funding family planning services be developed by the federal government in cooperation with provincial governments to ensure that financial barriers do not prevent the development of provincially and locally coordinated comprehensive family planning services.

APPENDIX E

Source: Article appearing in Daily News, March 9, 1979
St. John's, Newfoundland

CBC SLAMMED: BLATANT CRUSADERS FOR ABORTION

A Roman Catholic priest claims that CBC in Newfoundland is riddled with "blatant crusaders for abortion," as indicated by their refusal to accept paid advertising from the Pro-Life organization (see Live Letters, Page 4) but a CBC spokesman says it is national policy that the corporation won't sell commercial time to anyone on controversial issues.

Rev. Patrick J. Kennedy, parish priest at St. Edward's, Topsail, wrote CBC regional director John Power to complain of an "arbitrary and discriminatory" decision to refuse paid ads from Pro-Life while providing "free time" to a "local family planning group which is blatantly pro-abortion."

Mr. Power admitted to The Daily News Thursday that ads were carried from Planned Parenthood but were dropped after it was determined they did not comply with national policy.

He explained that "the CBC does not permit advertisers to buy time for the broadcast of controversial material."

He defined "controversial material" as "a matter of public interest about which there is a significant difference of opinion and which is or is likely to be the subject of public debate."

Mr. Power quoted that "the principle of the policy is that the air waves must not come under the control of any individual or group who because of wealth, special position, etc. might be better able to influence listener or viewer atittudes on a contentious issue."

Instead, the corporation tries to present both sides of such issues in public affairs programming.

Rev. Kennedy told him that "I and many, many others feel that the majority of your spokespeople and commentators in both radio and TV are blatant crusaders for abortion and against any group or organization which is trying to uphold and protect human values and human dignity."

In short, he added, "in my view your top policy making and program decisions have fallen into the hands of one group with one mind set. This would be tolerable if it were a private foundation or interest or lobbying group.

"It is not acceptable, however, in view of the tax supported nature of CBC."

This is the second time within a week that Roman Catholic church representatives have tackled the news media on matters of high public interest.

Their earlier blast against Weekend Magazine, for the article "Confessions of an ex-priest" distributed locally by The Evening Telegram resulted Wednesday in about 1,000 copies of the magazine being returned to the Telegram offices.

The newspaper says that a statement on the matter will be carried in its weekend edition Saturday.

APPENDIX F

CANADIAN FAMILY PLANNING POLICY STATEMENTS

Government of Canada

Honourable John Munro, Minister of National Health and Welfare, spoke as follows in outlining the Government program of research, training and public information in family planning (September 18, 1970):

> The Government recognizes and supports the right of Canadians to exercise free individual choice in the practice of family planning. It is our hope, through the program, that family planning information and services will become available to all who want them... There is good reason to believe that effective programs for family planning would reduce the incidence of unwanted children, of child neglect, abandonment, desertion, welfare dependency and child abuse... Family planning services must be known and available to all citizens - not just those in high income levels.

In a later statement (May 6, 1971), Mr. Munro reviewed Government policy and its implementation since 1968:

> The first reading of Bill S15 on October 29, 1968, was a landmark in the establishment of family planning as an integral part of public health and welfare services. Up to that time the development of government programs in this matter had been effectively discouraged by the general prohibition in the Criminal Code of the dissemination of information about contraceptives. Bill S15 led to the removal of this barrier.
>
> The resulting amendments to the Criminal Code and the Food and Drugs Act had the effect of removing, as an offence under Section 150 of the Criminal Code, the dissemination of information relating to the prevention of conception. The parallel amendments to the Food and Drugs Act made it clear that devices as dealt with under that Act included contraceptive devices but in connection therewith prohibited the advertising of such devices or of drugs sold for the purpose of preventing conception, except as authorized by regulation.
>
> Corresponding changes in the Food and Drug Regulations then made it clear that, with the exception of intrauterine devices and drugs that were required to be sold only on the prescription of a physician, contraceptives and drugs could be advertised to the general public in any way except through the mails or by distribution of samples by door-to-door delivery.

The result of these changes is that, except as mentioned above, information and contraceptive materials may be disseminated and sold freely in Canada -- unless, of course, that such practice might be modified by provincial law.

On September 18, 1970, I announced a federal government program of public information, training and research in family planning. I emphasized that in adopting this program the government recognized and supported the right of Canadians to exercise free individual choice in the practice of family planning. I expressed the hope that through the program, family planning information and services would become available to all who want them.

A very important contribution was made to the whole Canadian effort in family planning by the release on December 8, 1970, of the report of a special committee which I had appointed to advise the Food and Drug Directorate on all aspects of the safety and efficacy of oral contraceptives marketed in Canada. This report was distributed to all physicians and to members of certain allied health professions.

The Department supported the effort of the Family Planning Federation of Canada to obtain the status of a charitable organization under the Income Tax Act. This was granted in 1970, with the result that donations to the work of the Federation are now income-tax exempt.

For the past several months health and welfare officials of my Department have been engaged in launching a Canada-wide family planning program in cooperation with the provinces and with professional and voluntary organizations. Our aim has been to include both health and welfare interests and responsibilities of the Department, ensuring coordination and making full use of the resources and capacities available. The Department is also working with The Medical Research Council and with The International Development Research Centre in this program.

To assist my Department to determine Canada's needs and priorities, we invited a number of specialists in family planning to meet with us in Ottawa on February 8 and 9, 1971. The meeting provided a full exchange of information about existing services and federal resources available for their further development.

As the next step, my officials met on the 22nd and 23rd of March, 1971, with representatives of the provinces and territories.

The primary purpose of this meeting was to discuss current needs, available resources and ways to implement family planning programs on a cooperative basis.

The foregoing events helped to develop and to begin to realize the department's family planning objectives. Their purpose is to ensure, in cooperation with provincial health and welfare departments, professional organizations, universities and voluntary organizations, the availability of family planning services and facilities to those who need and desire them. These objectives are as follows:

1. To inform Canadians about the purpose and methods of family planning so that the exercise of free individual choice will be based on adequate knowledge.

2. To promote the training of health and welfare professional and other staff involved in family planning services.

3. To promote relevant research in family planning, including population studies and research in human behaviour and reproductive physiology.

4. To support public or private family planning programs through federal grants-in-aid and joint federal-provincial shared-cost programs.

Simultaneously with Mr. Munro's statement of September 18, 1970, the Canadian International Development Agency released the following announcement:

Recognizing the economic and social problems the developing nations have to face as a result of too rapid population growth, Canada will be prepared, the Secretary of State for External Affairs, the Hon. Mitchell Sharp announced today, to provide assistance to such countries in the field of population and family planning, as part of its international development assistance. Increasing awareness in many developing countries of the implications of the population problem has already resulted in the establishment in these countries of some large scale voluntary family planning programs. The United Nations and the World Bank are also giving high priority to support of programs in the population field.

In order that Canada may make an appropriate contribution to the global efforts to alleviate the population problem, the Canadian International Development Agency has been authorized to

develop a program of assistance in this field. Mr. Sharp indicated that assistance could include contributions to intergovernmental multilateral organizations and internationally recognized private organizations, support of population research, and that bilateral assistance be in response to specific requests from developing countries for the kind of assistance which Canada is capable of supplying.

From the Report of the Royal Commission on the Status of Women in Canada

201. Control of human reproduction has far-reaching consequences. It enables parents to plan the size of their families and the spacing of their children. It helps individuals and couples to reach a better sexual adjustment. Like many forms of scientific progress, it reduces the tyranny of natural forces over human beings; it increases personal freedom. All this requires readjustments in the law, and reshaping of social customs and attitudes. Women, as the child-bearers, will be most affected by this new freedom and responsibility.

202. In one sense, birth control is a social problem in Canada. Families with higher education and in higher income brackets have had easy access to birth control methods; the poor and less well-educated have not..

211. The Commission strongly believes that information and medical assistance on contraceptives should be made available to Canadian women in all walks of life. The same services should be available for men. The right to these services has been recognized by the United Nations in the 1968 Proclamation of Teheran which declared family planning to be a basic human right.

(September 1970)

The federal government created a family planning program in 1972. The government preferred establishing grants, information and consultation services rather than making a specific policy statement. It did, however, state that its objective was to 'ensure the accessibility and availability of family planning services to all Canadians who want them.

Prince Edward Island

The province has consistently maintained that although it has no specific policy or program in family planning, it has integrated its family planning information within perinatal visits by its public health nurses with services provided by medical practitioners. In 1978, the province applied for and received a grant of $37,700 from the Family Planning Division for a combined research, demonstration and training project.

Nova Scotia

The province has no specific policy or provincial family planning program. It has, however, been supportive of projects put forth by the voluntary agencies. The provincial department of health is presently working on a proposal to have a provincial position funded by the federal family planning division in order to plan, research and train its professionals in family planning. It appears that the province is content to allow services to be provided through well women's clinics, local hospitals and private physicians. The provincial project should be operational by the end of March 1979.

New Brunswick

The provincial government has continued the funding of a special project (family planning clinic) at the Edmunston clinic initiated through federal funding. The government contends that services are provided by private physicians and public health nurses. It has recently encouraged a survey of physicians practising in the province. It does not appear that further action on the part of the province will be forthcoming, at this time.

Quebec

This province has the most advanced comprehensive provincial plan. It initiated sex education courses within the secondary school system with the Ministère des Affaires Sociales being directly responsible for these rather than the Department of Education. This first phase was followed

by the establishment of family planning services within the C.L.S.C. (Centre local de services communautaires). The third stage that of providing more specialized services (abortions and sterilizations within the hospital centres) is now in effect in 18 areas of the province.

Ontario

The province provides $2,600,000 to its local health units for special family planning programs. The initiative and application for funds rests with the local medical officer of health. There is therefore, some disparity in regional services. The federal family planning division has funded service projects in specific areas of the province or geared to special groups (handicapped) as well as research and fellowships.

Manitoba

There is no specific policy or program within the provincial government. The previous NDP government in the province appointed an advisory committee to review the matter. It's report was released in November 1978. It is unlikely that the province will act upon this in the near future.

Saskatchewan

This province has a policy statement and a provincial plan of integrated services within the regular health and social services systems.

Alberta

The province has a comprehensive plan of service with community health nurses providing an integrated program. In addition 6 local health units operate education outreach and counselling programs. Calgary and Edmonton each have a specific family planning clinic.

British Columbia

The province has not become directly involved in the provision of family planning services. It has purchased the service for $100,000/year from the Planned Parenthood Federation of British Columbia. In 1978, the family planning division provided a grant of $24,698 in order to plan the province's route.

APPENDIX G

Source: Planned Parenthood Federation of Canada. Background Information for a Fund Raising Study. Mary Mills, March 1977.

OBJECTIVES OF PLANNED PARENTHOOD FEDERATION OF CANADA

Where We Are

The defined objectives in the Constitution of Planned Parenthood Federation of Canada are;

a) To promote the understanding and adoption of family planning and to encourage good citizenship through responsible family life;

b) To provide a national organization for societies and organizations with similar objects and to represent such societies before any international planned parenthood association;

c) To promote research and education on population problems, both domestic and international;

d) To inform the public on problems arising from uncontrolled population growth.

PPFC is a national voluntary organization for voluntary parenthood. Our goal is to extend information, education, and services on family planning to all Canadians as a basic human right. Everyone should have the opportunity and means to make informed decisions about the number and spacing of their children through the provision of good health services; safe, effective contraceptives; and educational programs on responsible parenthood.

Planned Parenthood Federation of Canada is the Canadian Member of the International Planned Parenthood Federation. The IPPF has 94 member countries and programmes in more than 120 countries. The IPPF has Category 1 Status with ECOSOC and is in consultative status with specialized agencies of the United Nations such as FAO, WHO, ILO, UNESCO, and UNICEF.

PPFC has affiliates who actively support the work of the Federation including the Canadian Home Economics Association, the Presbyterian Church in Canada, the Salvation Army and the United Church in Canada.

APPENDIX H

THE SALVATION ARMY

WILLIAM BOOTH
Founder
ERIK WICKBERG
General
CLARENCE D. WISEMAN
Commissioner

GRACE GENERAL HOSPITAL
ST. JOHN'S TEL. 579-5071

January 6th 1972

Dr. Helen McKilligin,
Chief,
Department of Neonatology,
Grace General Hospital,
St John's, Newfoundland.

Dear Dr. McKilligin:

This is to confirm that the Medical Advisory Committee at its meeting on 7th December 1971 requested that you form and head up a committee to consider the best way of achieving the ideals of a Family Life Clinic. It is understood that the work of the Committee in the first instance would be exploratory and that you would report back with recommendations to the M.A.C.

You already have the submissions of Dr. George Flight which will give you the background and the approach to the Family Life Clinic which was established here at the Grace General and you also have details of the attendance at this Clinic during 1971.

At the M.A.C. meeting in December there was enthusiastic support for the development of the Clinic or for perhaps a different type of facility which could effectively present information on human reproduction and its many facets as well as giving individual advice. Some members of the Termination of Pregnancy Committee in particular spoke of the need for such a service in view of the abysmal ignorance of some people on matters of sexuality and contraception.

There was some discussion on whether the present Clinic should be continued in the hospital or whether it would be far better to establish a community clinic elsewhere possibly near the hospital to facilitate participation in the service by staff members. One viewpoint put forward was that the present clinic had not achieved its potential because it was being operated in unsuitable physical facilities.

Another question arising was whether the problem was being tackled too late in providing clinics or facilities for adults with a suggestion that education to be effective should start in the schools. Along the same lines it was suggested that the clinic in a way should be taken to people rather than expecting them to present themselves formally.

It was also felt at the meeting that Federal funds would be available at least for the initial development of this project. As you know such funds would be channelled through our local Department of Health.

It is understood that the Committee comprises beside yourself Dr. G. Flight, Dr. J. Seviour, Dr. D. Shedden, Dr. Boyd Suttie and Dr. J.G. Williams. I wish you every success in developing this important community service.

Yours sincerely,

H.J. Warrick, M.D.,
Medical Director.

HJW/sjy

APPENDIX I

Meeting of the Ad Hoc Committee - Family Life Clinic 10th January 1972

The Ad Hoc Committee of the Medical Advisory Committee re Family Life Clinic held its first meeting at 8 p.m., January 10th 1972.

Those present were: Dr. H. McKilligin, Chairman
Dr. G.H. Flight
Dr. D. Shedden
Dr. B. Suttie
Dr. J.G. Williams

Dr. J. Seviour was unable to attend.

The letter from Dr. H.J. Warrick stating the broad terms of reference from the M.A.C. was read.

The Committee then began by discussing the present methods of office and hospital practice in the field of family planning in the province. They came to the conclusion that the delivery of this type of health care in Newfoundland is grossly inadequate; this being especially so for those who could most benefit from such help.

They further identified the need for professional education in this subject.

It appears that the Family Life Clinic in the Grace General Hospital has met with little success and has had no significant support from the medical staff.

The general consensus of opinion was that a hospital facility does not give the flexibility and freedom of practice such as publicity and education, so necessary for the effective delivery of family planning. It was felt that the Family Life Clinic could have a place as part of a provincial family planning programme.

The document on Family Planning issued by the Federal Department of Health and Welfare (May 1971) was then studied along with the speech delivered by the Hon. John Monro to the Annual Meeting of the Family Planning Federation of Canada in Halifax (November 1971).

Dr. Shedden said that although the Provincial Department of Health was unlikely to initiate family planning clinics he felt they would be very ready to support any efforts in this direction by an interested group. He suggested the Newfoundland Social Welfare Council.

Dr. Suttie, in his capacity as President of the Newfoundland Branch of the Canadian Public Health Association then expressed the strong interests of this Association particularly the public health nurses, in this area of health delivery.

The best approach seemed the formation of a group of interested lay people as a branch of the Family Planning Federation of Canada strongly supported by the medical and nursing profession via N.M.A., A.R.N.N. and the C.P.H.A. and the Nfld. Social Welfare Council (Canadian Council of Social Development).

It was decided that Dr. Suttie phone the Toronto office of the Family Planning Federation of Canada for further information and that he take the views of the Committee to the local executive of the C.P.H.A.

The Committee asks the Medical Advisory Committee to endorse this approach and have agreed to hold a second meeting in one week.

The meeting adjourned at 9:25 p.m.

Respectfully submitted,

H. McKilligin, M.D.,
Chairman

HMcK/sjy

APPENDIX J

THE SALVATION ARMY

WILLIAM BOOTH
Founder
ERIK WICKBERG
General
CLARENCE D. WISEMAN
Commissioner

GRACE GENERAL HOSPITAL
ST. JOHN'S TEL. 579-5071

February 8th 1972

Dr. Helen McKilligin,
Grace General Hospital,
St John's, Newfoundland.

Dear Dr. McKilligin:

As you know your first report of the Ad Hoc Committee on the Family Life Clinic was enthusiastically received by the Medical Advisory Committee at it meeting of 18th January 1972.

It was unanimously agreed to endorse the approach which the Committee had taken and it also recommended that a report of the Committee's activities be included on the Agenda of the forthcoming Annual Staff Meeting.

I shall remind Dr. J. Seary, Secretary of the Medical Staff Executive, of this point. I would presume that you will be preparing a brief report for presentation at that time.

Yours sincerely,

H.J. Warrick, M.D.,
Medical Director.

HJW/sjy

APPENDIX K

Source: Evening Telegram, December 1972

MEETING CALLED TO SET UP FAMILY PLANNING SERVICE

The Newfoundland branch of the Canadian Public Health Association (CPHA) will call a meeting early in the new year of associations and individuals who wish to help formulate a blueprint for providing accessible family planning services in the province.

Dr. Boyd Suttie, president of the provincial CPHA branch, told the Telegram that such a blueprint would constitute a "declaration of needs." He said that as a non-government, voluntary association concerned with issues of public health, the CPHA was an ideal organization to explore the ways and means of setting up a family planning agency in Newfoundland and Labrador.

It must be very clear to those who have been reading the newspapers over the past few days that something has to be done about the provision of family planning services in Newfoundland, Dr. Suttie said in a prepared statement.

A 19-year old St. John's girl has been charged in connection with the discovery of the body of a fully formed but premature infant found in a laneway in central St. John's Dec. 10. Dr. Suttie would not connect the CPHA decision to call a public meeting to investigate the formation of a family planning service with the events of Dec. 10 but said there is definitely a need for such a service.

The basic theme underlying the development of family planning services is that all families, by their own choice, should have the opportunity to space pregnancies and to limit family size, Dr. Suttie said.

This is not simply for the comfort or the convenience of the parents or for the health of the mother, he said. Sensible timing of births and limitation of the family to an appropriate number will allow families to marshall their resources for the best possible social, educational, and financial support of each child.

Dr. Suttie said the federal government has gone on record to say it will contribute to the cost of family planning services provided the provincial authorities request this.

"We cannot comfortably abdicate all responsibility for action to the department of health," Dr. Suttie said. "Religious and educational bodies also have important roles in public education and in counselling services."

He said that across Canada members of the general public are insisting on more say in the development of public health services.

The date for the meeting will be announced before the end of the month. However, Dr. Suttie said the CPHA would like to hear from other members of health services and particularly from the general public regarding the setting up of a family planning service for the province.

The address is the Canadian Public Health Association, P.O. Box 9002, St. John's, Nfld.

APPENDIX L

POLICIES AND RECOMMENDATIONS OF FIRST PROVINCIAL FAMILY PLANNING AND SEX EDUCATION CONFERENCE ST. JOHN'S

Newfoundland held the first Provincial Family Planning and Sex Education Conference in St. John's, May 1973. This was attended by one hundred and sixty-three delegates from various segments of the province. From this conference developed a set of provincial recommendations for family planning in the areas of education in schools, education through voluntary organizations, education through the media, family planning services, teenage counselling, legal age of consent, therapeutic abortions, conferences and funding. Of interest in our study are three of the following areas of recommendations as follows:

Partial Recommendations suggested by delegates at Newfoundland Provincial Conference:

Education Through Voluntary Organizations:

1. The policy of the Family Planning Association should be to provide information to people so that they may make their own decision regarding family size. Emphasis should be placed on the philosophy, "Education for all, the choice is yours".

2. Efforts should be made to provide schools, parents, churches and all community agencies involved with the guidance and care of children with information on sexuality and birth control.

3. The Family Planning Association should encourage cooperation among various service organizations involved in family life education throughout the province.

4. At the community level it is desirous to invite the local clergy, teachers, and other community leaders to cooperate in providing family life education and family planning services.

5. An attempt should be made wherever feasible to provide education through organized youth groups.

6. The Family Planning Association should seek out the "Family Law Study Report for Newfoundland (1969-70)" and study its recommendations regarding family life education.

Family Planning Services

1. Emphasis should be placed on providing information and services to groups with the highest apparent need.

2. The Family Planning Association should endeavour to set up branches in the major centres of the Province.

3. Funds should be sought to finance a mobile unit to travel throughout the Province.

4. Family Planning resource centres, offering information and contraceptive devices, should be established.

5. Contraceptives should be available at low cost with provision for information and understanding of their use and limitations.

6. Public Health nurses, welfare officers and social workers should be encouraged to discuss family planning with their clients, and they should be properly trained to do so.

Teenage Counselling:

1. The priority for teenage services should be counselling, including preventative, developmental and crisis. This counselling should be both non judgemental and confidential.

2. Complete services should be made available and known to the pregnant teenager to enable her to continue her education in an accepting atmosphere.

3. Teenagers should be encouraged to indicate how services and facilities might be provided relative to their needs.

4. Teenagers should be informed of their legal rights regarding marriage and pregnancy.

APPENDIX M

CONSTITUTION

1. NAME: The name of the Association is "Planned Parenthood Newfoundland/Labrador".

2. AREA OF OPERATIONS: The registered office of the Association will be situated at the City of St. John's, Province of Newfoundland and Labrador. The operations of the Association shall be carried on throughout the Province of Newfoundland and Labrador.

3. OBJECTS: The objects for which the Association is established are:

   A. To promote the provision and use of family planning services in Newfoundland and Labrador as a fundamental right of all people, as an aid to responsible parenthood and as a means of improving the quality of human life.

   B. To encourage and carry out the training of professional and voluntary personnel for the practical implementation and promotion of the use of such services.

   C. To promote public education and discussion, research, meetings and conferences on the social, economic and political problems arising from population growth and distribution, in Canada and abroad.

   D. To co-operate with recognised provincial, national and international bodies having similar aims.

   E. To receive, acquire and hold grants, donations and legacies and to make grants for the promotion of the above objects.

   F. To solicit funds to carry on the work of the Association.

   G. To acquire, to take by purchase, donation or otherwise, and to own land or personal property, to call, exchange, mortgage, lease, let, improve and develop it, and to erect and maintain any building necessary for the purposes of the Association.

   H. To borrow, raise or secure the payment of money to further the objects of the Association.

   I. To be a non-profit organisation, independent of commercial control.

Telephone 726-7424

Newfoundland Medical Association
(Canadian Medical Association—Newfoundland Division)
O'MARA MARTIN BUILDING, RAWLINS CROSS
ST. JOHN'S, NEWFOUNDLAND
A1C 2E4

August 2, 1977

Dr. Helen McKilligin
President
Family Planning Association
Medical Arts Building
Empire Avenue
St. John's, Newfoundland
A1C 3G2

Dear Dr. McKilligin:

The Canadian Medical Association at its 1977 General Meeting in Quebec indicated that it was not in favour of Family Planning Clinics carrying out services other than counselling. The logic supporting this position is that the other services suggested for these clinics are presently available through physicians' offices with the result that such centres would be a duplication of existing services.

The Newfoundland Medical Association supports the position taken by the CMA.

The St. John's General Practitioners Association held a meeting on July 26th to discuss the recent development regarding the Family Planning attempts at changing its scope of activities. The St. John's G.P. Association passed a motion opposing the envisaged expansion and scope of activities of the Family Planning Association and recommended that the F.P.A. restrict itself to counselling services only.

The St. John's General Practitioners Association strongly supported the position taken by the CMA and NMA regarding Family Planning Clinics

Yours truly,

P J Dobbin

Dr. P.J. Dobbin
Secretary
Newfoundland Medical Association

PJD/rbr

Dear Planned Parenthood

I am 12 years old and have started my period, but would like to know more about it. Also I have a younger sister (10) who would like to know what to expect.

So mom told me to write you and ask for the same books you sent (my friend)

① The Miracle of you
② Your years of discovery
③ You and your Daughter
④ Accent on you

Since I will be holidays please send it to my friend. at this address

10 - 1978

Dear Miss Johnson.

Hearing you on radio last week about the problems of unwed teenagers I was amazed that you - as a woman - would fail to even mention in passing the moral issue - moral values. Contraceptives are not the solution. Contraceptives and abortion are directly related. Oh - of course, you with your materialistic atheistic approach would try to say the with the right birth control methods there'd be no need for the murder of the unborn. Not so. Contraception leads to murder - abortion to you. They are directly related.

The solution is so - so obvious - self control! The girl must say No! - and mean it. That's the 100% sure method. Try it sometime.

Oh, you will say. Would you suppress the sex urge? Yes! Every day you suppress the urge to hate, lie, steal and kill - yes to murder. Our civilization is based on what you people call suppression!! It flourished under Victorian values.

What about the horrible Venereal disease epidemic. That's the fruits of your "sex freedom" and "new morality".

You and your kind are a foul menace and should be silenced. You pollute our children. You should be stricken speechless!

I'm not giving my address. I want no correspondence with your kind. I have complained to the radio station to never allow you on again.

Source: Daily News, March 9, 1979

R.C. Priest Charges

Decision by CBC was Discriminatory

Editor: The following letter has been sent to Mr. John Power, Director of CBC (Nfld.)

"COPY"

Dear Mr. Power: I wish to bring to your attention and that of the policy makers at CBC my concern regarding your refusal to allow paid ads from the local Pro-life organization.

The following circumstances make the decision arbitrary and discriminatory:

1 - The prior free time given to a local family planning group which is blatantly pro-abortion.

2 - Your refusal of the ads sight unseen. Isn't that prejudicial in the strongest sense?

3 - Your PR man stated that the viewpoint espoused by Pro-Life is adequately treated in your public affairs programs. In whose view? Your own surely! I and many, many others feel that the majority of your spokespeople and commentators in both radio and TV are blatant crusaders for abortion and against any group or organization which is trying to uphold and protect human values and human dignity.

In short, in my view your top policy making and program decisions have fallen into the hands of ONE group with ONE mind set. This would be tolerable if it were a private foundation or interest or lobbying group. It is not however acceptable in view of the tax support nature of CBC. The Broadcast Act was designed to free CBC from political and governmental manipulation. Legislators are at least elected! Policy and decision making in CBC has now become the perogative of unidentified and unresponsive careerists who coincidentally (?) have the same mind set.

I would suggest that content analysis done by an independent agency over a cross-section of your programming would confirm my claim.

To my mind the local decision affecting Pro-Life is only the tip of the iceberg.

I would remind you that the original purpose of the establishment of the CBC was to serve and unite Canada.

CBC is now serving one "mind set". That would be fine if they were identifiable and paying the shot.

I trust you will consider my viewpoint.

Sincerely yours,
Patrick J. Kennedy
Parish Priest (Graduate Carlton Journalism School and University of St. Paul's Communication School.)

P.S.

A further example: this morning, March 2, 1979 at 8:40 a.m.! Doug Laite spoke with Valerie ? regarding the anti-abortion protest at the Health Science Complex.

Valerie got there late (a good way to cover a story), so there were only seven or so protesters still at the scene. She dismissed the protest as "thought up by their teacher"..."it's too bad that religion has to get mixed up in this"..."they were from Holy Heart." Presumably if they were from some other school the protest would have more credence.

Ironically, Mr. Laite followed up that classic in prejudicial commentary by urging all to attend the ecumenical service for sealers. Presumably he and CBC have graciously consented to allow religion to get mixed up in the sealing issue.