HEALTH CARE NEEDS OF CLIENTS ATTENDING
A FAMILY PLANNING CLINIC

by
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A Thesis Submitted to the Faculty of the
COLLEGE OF NURSING
In Partial Fulfillment of the Requirements
For the Degree of
MASTER OF SCIENCE
In the Graduate College
THE UNIVERSITY OF ARIZONA

1976
STATEMENT BY AUTHOR

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Date: 4/23/76
ACKNOWLEDGMENTS

This author acknowledges her appreciation for the counsel and assistance of Karen Sechrist, Ph.D., Chairman of the candidate's committee; Margarita Kay, Ph.D.; and Lois Prosser, M.S.; members of this committee. Recognition is extended to Juby Bell, R. N., M.S., Director of Nurses, Santa Cruz County Health Department for her support and permission for the investigator to utilize the clinical facilities for this study.
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ABSTRACT

The theoretical framework for this study was based on the concept that illness is defined culturally and such factors as education and socioeconomic background will affect health care needs and expectations. The study sought to determine the relationship between socioeconomic level and the number of expectations for health care of clients of a family planning clinic.

Thirty clients participated in the study by completing a two-page questionnaire. The first part of the questionnaire included data relating to socioeconomic level, education, and contraceptive practices. The remainder of the questionnaire dealt with expectations for health care.

The findings showed no relationship between socioeconomic level and number of expectations for health care.
CHAPTER I

INTRODUCTION

Studies of Mexican-American health needs reveal that Mexican-Americans are often underserved by health care programs (Cervantes 1972, Clark 1959). Anglo medical services and facilities are often inaccessible in terms of location and cost. Lack of knowledge of Anglo medical ways, lack of Spanish-speaking personnel, and fear of the treatment are additional drawbacks. Most of the healing personnel in the Spanish-speaking culture are women, and females of Spanish descent often fear being examined by a man (Cervantes 1972, Saunders 1954). A strong background in folk medicine often makes Spanish-speaking people reluctant to seek Anglo medical care (Saunders 1954). When scientific preventive health measures and treatments are not compatible with folk medical beliefs, persons often reject what is foreign and contrary to tradition. As a result, Spanish-speaking people may appear to accept counsel but fail to follow through (Baca 1969: 2176).

Health and illness states are influenced and often determined by the cultural background of an individual. Understanding of these differences has relevance to nursing, because the success of any health care program is
dependent not only on medical knowledge and practice but on consideration of cultural and socioeconomic needs of the people (Lynch 1969: 24).

Clinics which offer services to primarily Spanish-speaking clientele can be affected by unique cultural biases (Clark 1959). When a specific health care service is provided, such as family planning, the client may desire or expect additional services from the setting. The client's expectations of health care may be greater than the service provided because of lack of additional facilities for them, misunderstanding about the function of the clinic, or sociocultural reasons. This study of predominately Spanish-speaking clients of a family planning clinic in a southwestern border town, attempts to establish a relationship between health care needs identified by the family planning clients with the socioeconomic, educational, and cultural backgrounds of the clients.

Statement of the Problem

What are the health care expectations of clients attending a family planning clinic in a southwestern border town? Are expectations for health care related to income and/or educational level?
Hypothesis

Clients in lower income and lower educational level groups will have a significantly greater number of expectations for health care than those in higher groups.

Significance of the Problem

The family planning clinic of this southwestern border town is a federal and county funded agency offering the following health care services: family planning, contraceptives, urinalysis, pregnancy testing, pap smears, biopsies, breast examinations, gonorrhea cultures, blood tests for syphilis, blood pressure evaluations, hemoglobin and hematocrit, skin testing for tuberculosis, screening physicals and referrals for sterilization. The staff of this family planning clinic suspect that the health care needs of their clients are not being met by existing health care programs. It has been observed that clients frequently come to the family planning clinic for health care services other than those provided.

The results of this study might also be useful to nurses when working with clients from different cultural backgrounds and/or in relating health care needs of their clients to educational and economic backgrounds.

Delimitations

The delimitations in this study were as follows:
1. The sample was selected from the recipients of one family planning clinic in a southwestern border town.

2. The sample was limited to thirty women.

3. The sample was limited to women who were able to communicate verbally in the English language.

4. The period of time for the data collection was limited to one month.

**Conceptual Framework**

Illness is defined culturally and such factors as education and socioeconomic background affect health care needs and expectations.

Illness and disease, it must be remembered, are social as well as biological phenomena. On the biological level they consist of adaptations of the organism to environmental influences; on the social level they include meanings, roles, relationships, attitudes and techniques that enable members of a cultural group to identify various types of illness and disease, to behave appropriately, and to call upon a body of knowledge for coping with the condition defined as illness. What is recognized as disease or illness is a matter of cultural prescription, and a given biological condition may or may not be considered an illness depending on the particular cultural group in which it occurs. . . . What should be done about a given condition defined culturally as illness, and the proper relationships of a sick person to other people are also culturally prescribed. An individual thus has cultural guides that enable him to know when he or others may be regarded as sick, something about the cause and nature of the sickness, what may be done to alleviate or remedy the condition, and the behavior expected of him and others in the situation (Saunders 1954: 142-143).

Mexican-American culture defines illness as "not feeling well" and embraces a strong belief that illness cannot be
Health and illness are defined in Spanish-American villages in terms of both positive and negative factors. A healthy person is one who is reasonably free from pain, disability, or other disturbing symptoms and who is able (and willing) to assume the obligations of his normal social roles" (Saunders 1961: 61).

According to Maclachlan (1958), culture is the dynamic factor behind health and illness. Food and housing practices and the use of folk medicine, and folk healers, are determined by cultural guidelines. These cultural factors are directly related to health and illness states. Cultural practices related to diet, clothing, and housing can be causes of illness.

Culture is unique to each society of men, and "the members of one society behave differently in some significant respects from the members of every other society" (Shapiro 1956: 168). Culture, the result of social intervention, is the totality of learned behaviors which are exhibited and shared by a particular group of people. Culture is transmitted from generation to generation, is present before an individual's birth and continues after his death (Shapiro 1956: 170). From birth on, the cultural groups people are born into influences their behavior: "... how and what they think; what they consider good and bad; desirable or undesirable; what they work at and
what they do for fun; what they respect and what they fear; what they strive for; and what they shun" (Saunders 1961: 4). Cultural groups have distinctive customs, habits, folkways, values, attitudes, and expectations for behavior (King 1960: 11). People are products of their culture. Their responses and expectations will be influenced by their cultural backgrounds.
CHAPTER II

REVIEW OF THE LITERATURE

The review of the literature focused on studies of family planning, health care and socioeconomic status, and Mexican-American culture.

Family Planning

A study by Van Keep and Rice-Wray (1973) was conducted in a private family planning clinic in Mexico City from December 1970 to February 1971. (Government-sponsored family planning facilities have only been available in Mexico since January 1973.) The objectives of the study were to determine the attitudes of Mexican women toward family planning and to compare their attitudes with those of the general population. The sample consisted of 750 women aged 16-50, married, and living with their husbands. Data was collected from a personal interview and a questionnaire. The results of the study showed a relationship between family planning, socioeconomic level, and age of clients. Clients from the higher socioeconomic groups, those with a higher school-leaving age, and those aged 21 to 30 were the most accepting of family planning programs. The clinic sample was found to be more accepting of family
planning than the general population. Of those using contraceptives, oral contraceptives were the most widely used method.

LeSueur et al. (1972) studied the delivery of female health care in Florida in terms of patient acceptance and quality of service. The clinic provided family planning and related services with the primary provider of health care being a nonphysician. Two nurses and five outreach workers were responsible for the entire family planning program. The target population consisted of 4,429 medically-indigent family planning candidates. The clinic opened in 1970 with four morning clinics and expanded to night clinics. From August 1970 to June 1971, 2,925 women were registered at the clinic. In terms of family planning and contraception, data revealed that women with less than three children favored oral contraceptives and women with four or more children favored other methods. With regards to acceptance, clients were very accepting of allied health professionals providing care.

Mitchell (1974) reported that contraception is acceptable to women of all ethnic groups when the methods are fully and clearly explained. In a survey of 200 Mexican-American women in Los Angeles, most were receptive to family planning when fully and clearly explained.

Rainwater (1965) showed that the availability of medical services does not strongly effect contraceptive
practice. The use of birth control, however, was affected by the husband-wife relationship as well as social class. There was a positive relationship between low socioeconomic class and infrequent use of contraceptives.

**Health Care and Socioeconomic Status**

A study by Koos (1954) supported a positive relationship between socioeconomic level and recognition of health problems. The higher the socioeconomic class the greater was the recognition of symptoms needing medical attention. James (1965) reported a relationship between low socioeconomic status, poor health, and inadequate health care.

**Mexican-American Culture**

King (1960) showed that people respond in multiple ways to the experience of illness and medical care, and it is possible to retain certain magical and folk beliefs and at the same time make good use of scientific medicine. Folk medical beliefs are often important cultural influences. Baca's (1969) work with Mexican-Americans in New Mexico supports the studies of Saunders (1954) and Clark (1959). The ancient beliefs and practices concerning health and illness are still present and play an important part when working with Mexican-American patients.

The purpose of Martinez and Martin's (1966) study was to determine the extent of knowledge of folk medical
beliefs of urban Mexican-Americans. The sample consisted of 75 Mexican-American housewives in a large southwestern city. The subjects ranged in age from 18 to 84, with a median of six years of schooling. Of the sample, 97 percent had knowledge of folk diseases. Folk illnesses were treated by folk healers and were not revealed to physicians.

A study by Clark (1959) stated that Mexican-American communities do not have adequate medical facilities. The clinics are overcrowded and understaffed, most clients do not have health insurance, and there are too few Spanish-speaking health professionals. Medical systems are affected by most categories of culture including economics and education.

A study of health care in California by Cervantes (1972) gave three reasons why health care programs do not help Mexican-Americans: (1) health professionals either do not know enough about or do not consider Mexican-American culture, (2) health care programs are not organized within the Mexican-American community framework, and (3) the meaning comprehensive health has not been stated from a Mexican-American viewpoint (p. 932). For health care programs to be effective, Mexican-Americans' socio-cultural attributes must be recognized. Factors which promote better health care delivery include employing bilingual and bicultural healthworkers, and the use of bilingual health literature. "Health programs to be
effective must recognize Mexican-Americans as individual persons with distinctive sociocultural attributes and health needs" (Cervantes 1972: 93).

Kay's (1972) study of Mexican-American women in one neighborhood in Tucson, Arizona, aimed at describing present-day illness concepts, what these women say and do about illness. The sample consisted of 25 women aged 22-78 of similar socioeconomic background (upper lower class). Kay found that the disease concepts of these women reflected little of either aboriginal or medieval medical theory. The study also indicated that the women knew a great deal about minor illnesses and their treatment and consulted people with special knowledge for serious illness.

Uhlenberg (1973) reported on the fertility patterns within the Mexican-American population. Mexican-Americans have the highest fertility level in the United States. The less educated tended to have more children. Mexican-Americans in lower socioeconomic groups had larger families than whites in the same socioeconomic group. Middle class Mexican-Americans have similar characteristics of middle class whites. No data was available to determine if lower class Mexican-Americans desired large families or were unable to prevent them. The findings suggest involvement in an urban society has a significant effect on reducing fertility.
Lindstrom (1974) studied health and illness of Mexican-American children in Lansing, Michigan. Twenty Mexican-American families were selected from the Child Health Clinic clientele—ten good users and ten poor users of clinic facilities. Ten families who did not attend the clinic were also included in the study. A total of thirty families was studied. Data was collected from personal interviews. The parents generally had low educational and socioeconomic backgrounds. The results of the study showed the majority were aware of folk diseases but did not discuss them freely. The majority used home remedies when their children first got sick and most families participated in both the folk medical system and in Western medical practices.

In summary, the literature has indicated that Mexican-Americans are often underserved by Anglo health care programs. In addition, Mexican-Americans often participate in both the Western medical system and in their folk medical culture. To meet the health care needs of Mexican-Americans, cultural influences on health and illness practices should not be ignored.
CHAPTER III

RESEARCH METHODOLOGY

This chapter describes the research design, the sample, the setting, the data collection instrument, the method of data collection, and the analysis of the data.

Research Design

This descriptive study focused on the health care needs of clients attending a family planning clinic in a southwestern border town. The study was explained to each client. Those clients choosing to participate in the study completed a questionnaire (Appendix A). Through the use of this form, information was gained about the client's age, socioeconomic background, contraceptive history, and current health care expectations.

Written permission to conduct the study was obtained from the deputy director and the nursing supervisor of the Santa Cruz County Health Department before data collection was begun (Appendix B). Written permission was obtained from each client who was informed that all information would be confidential (Appendix C). Each client was informed that participation was optional, and that whether or not she chooses to participate in the study will in no way affect her care at the clinic. The study
was approved by the Human Subjects Committee, University of Arizona.

The Sample

The sample was selected from the clients of a family planning clinic. The sample was limited to clients who could communicate verbally in English. However, they were allowed to complete the questionnaire in either English or Spanish. The number of clients in the study was limited to thirty women. The first thirty women willing to participate in the study were selected.

The Setting

The study was conducted at a family planning clinic in a southwestern border town. The clinic serves a county population of 14,000 and a city population of 9,000. This is broken down into over 3,000 families; 445 of these families have a female head, and 605 of the families have an income below poverty level (24.4 percent of the population). The mean yearly income for the county is $9,000 with the range being from less than $1,000 a year to over $50,000 a year (interview with Edgar Condes).

The median school completed for males in the community is 11.1 years and 9.9 years for females. Forty-five percent of the population are high school graduates, but 33 percent of the population over age 25 have less than a
7th grade education. The population is predominately Catholic and Spanish-speaking (interview May 1975, Edgar Condes).

The family planning clinic receives federal and county funds and services are provided free of charge to the clients. The clinic is located in the Health Department Building and utilizes two examination rooms, a room for blood pressure evaluations and weight checks, a room for drawing blood samples, two bathrooms, an office for the director of nurses, a waiting room, and a reception and file room. The family planning clinic operates from 8-5 on Saturday with a gynecology resident and a nurse clinician in attendance; and Tuesday through Friday by appointment with a nurse clinician in attendance. The number of clients seen varies during the week, but 20-40 clients are usually seen during the Saturday clinic.

There are 2,500 female clients enrolled at the clinic. Clients range in age from 15 to over 65, are predominately Spanish-speaking, have incomes ranging from over $35,000 a year to welfare recipients, and have educational backgrounds from college graduates to grade school. The average family size is six children with the range from no children to over fourteen children (interviews January 1976 with Calita Levy and Juby Bell).

The clinic staff consists of gynecology residents from The University of Arizona, a registered nurse with a master's degree in nursing, two licensed practical nurses,
a health aide, a receptionist, and an outreach worker. On busy days staff from other health department clinics are recruited to family planning. The staff is predominately bilingual and of Mexican-American heritage.

With the Mexican border so close, some family planning clients seek additional health care across the border. With the belief that Anglo health care is better and knowing that contraceptives are free at the clinic, Mexican citizens frequent the clinic giving false addresses on the United States side of the border.

The Data Collection Instrument

The data collection instrument used in this study was a questionnaire designed by the investigator (Appendix A). The data was collected from written responses to questions presented to the subjects. A combination of open-ended and multiple choice answer questions was used. Questions with multiple choice answers were used at the suggestion of the clinic staff. Past experiences at the clinic indicated clients tended to omit open-ended questions.

The questionnaire was pretested on eight clients at the family planning clinic. From the results of the pretest it was decided to limit the study to clients who understood English to eliminate the variable of having someone other than the investigator giving directions and answering questions. Also, it was found that clients completed more items on the questionnaire when directions were explained
by the investigator. It was found that approaching clients following treatment at the clinic was more acceptable to clients than approaching them upon arrival at the clinic. The questionnaire was reviewed by the investigator's thesis committee and by the director of nurses at the family planning clinic.

**Data Collection**

The researcher visited the family planning clinic every Saturday for one month for the purpose of selecting clients for the study. All clients appearing at the clinic were approached concerning participation in the study. The purpose of the study was explained to the client and a copy of the questionnaire was available for review by the client. The questionnaire was available in both English and Spanish but clients had to be able to communicate verbally in English to participate in the study. Clients were told that participation was optional and were assured that refusal to participate would in no way affect their care or their relationship with any person at the clinic. They were told that their name would be kept confidential and that data would be used only for the stated purpose of the study. All clients willing to participate were asked to sign a consent form (Appendix C). Clinic staff involved with family planning participated by referring clients to the
investigator following their treatment at the clinic. The questionnaire took from 10-20 minutes to complete.

**Data Analysis**

To measure the socioeconomic status of the subjects, Green's (1970) method for scoring socioeconomic status was used. "Socioeconomic status is defined in this system as the relative position of a person, family, or neighborhood in a hierarchy which maximally reflects differences in health behavior" (Green 1970: 816).

Green uses a two-factor index of education of the mother and income or occupation to determine the socioeconomic status score [SES]. Scores are weighed differently for whites and nonwhites. SES is determined as follows, using the two-factor index:

\[
\text{SES (nonwhite)} = (0.5 \times \text{education}) + (0.6 \times \text{income}/ \text{or occupation}).
\]

\[
\text{SES (white)} = (0.7 \times \text{education}) + (0.4 \times \text{income}/ \text{or occupation}).
\]

For example, a Mexican family (considered nonwhite in this study) in which the mother has eight years of education and a family income of $5,000 a year would have an SES score of:

\[
0.5 \times 81 \text{ (education)} = 20.5
\]

\[
0.6 \times 42 \text{ (income)} = \frac{25.2}{45.7}
\]

The range of weighted scores is between 30 to 85. To shift the scale downward between 0 and 55, subtract 30 from
each score. This does not affect the scales' statistical properties. The Mexican family in the example above would have an SES of 15.7.

Correlational analysis was used to compare the SES with the number of responses made indicating a desire for health care services at the family planning clinic. Correlation coefficients are used to provide a numerical indication of the magnitude of the relationship between two sets of data (Fox 1966).
CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

This chapter describes the characteristics of the sample, subject responses concerning their health care needs, findings related to the hypothesis, and additional findings.

Characteristics of the Sample

The sample consisted of thirty female clients of a family planning clinic. Thirty-three clients were asked to participate in this study. Three refused, two stated they were too old to participate, and one stated that she was too ill to participate having come to the clinic with a high fever and abdominal pain. The average age of the clients was 35, with a range of 20 to 67 years. Table 1 presents the distribution of subjects by age.

Table 1. Distribution of Subjects by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>20-30</th>
<th>31-40</th>
<th>41-50</th>
<th>51-60</th>
<th>Over 60</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>12</td>
<td>9</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>Percent</td>
<td>40</td>
<td>30</td>
<td>13</td>
<td>10</td>
<td>7</td>
<td>100</td>
</tr>
</tbody>
</table>
Thirty-three percent of the subjects were Mexican-American, 54 percent Mexican, and 13 percent Anglo. The majority were married (77 percent). Ten percent were never married, 3 percent divorced, 7 percent widowed, and 3 percent separated. Eighty percent were Catholic, 13 percent Protestant, and 7 percent did not respond. Sixty-three percent were housewives, 25 percent were employed outside the home, 3 percent were retired, and 7 percent did not respond.

Annual income of the subjects ranged from $2,368 to $12,000. Thirty-three percent of the subjects did not respond, indicating they did not want to reveal their income. Table 2 presents the distribution of subjects by income.

Table 2. Distribution of Subjects by Income

<table>
<thead>
<tr>
<th>Income</th>
<th>Under $5,000</th>
<th>$5,000–$7,999</th>
<th>Over $8,000</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>5</td>
<td>8</td>
<td>7</td>
<td>20*</td>
</tr>
<tr>
<td>Percent</td>
<td>17</td>
<td>27</td>
<td>23</td>
<td>67*</td>
</tr>
</tbody>
</table>

*Thirty-three percent of the subjects did not respond.

Education of the subjects ranged from 1 to 16 years of education. The average number of years of education was
10.1 years compared to 9.9 years for females in the community. Fifty percent were high school graduates compared to 45 percent of the community. Table 3 presents the distribution of subjects by years of education and age.

Table 3. Distribution of Subjects by Years of Education and Age

<table>
<thead>
<tr>
<th>Age</th>
<th>1-7</th>
<th>8-11</th>
<th>12</th>
<th>13-15</th>
<th>Over 15</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-25</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>26-30</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>31-35</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>36-40</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>41-45</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Over 45</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>8</td>
<td>10</td>
<td>4</td>
<td>1</td>
<td>30</td>
</tr>
</tbody>
</table>

The socioeconomic status scores [SES] of the subjects ranged from 9.2 to 44.1 on a scale of 0-55. The mode was 30.8, the median 28.0, and the mean 24.6. SES was computed using education and income scores for twenty subjects, and education and occupation scores for ten subjects. Table 4 presents the distribution of subjects by SES scores. (See Appendix D for detailed listing.)
Sixty-one percent of the subjects had three or fewer children, 26 percent had more than three children, and 13 percent did not respond. Thirty-three percent did not utilize any method of contraception (half of the clients in this group were over 45), 53 percent used some method of contraception, and 14 percent did not respond (half of the clients in the group were over age 45). Table 5 presents the distribution of subjects by method of contraception used. The pill was the most frequently used form of contraception. The one response to vasectomy as the type of contraception used was by an Anglo client.

This was the first visit to the clinic for 30 percent of the clients, the second visit for 17 percent, the fourth visit for 3 percent, and more than four visits for 47 percent (3 percent did not respond).

**Client Responses to Questions About Health Care Needs**

Of the thirty clients, 36 percent came to the clinic for birth control, 53 percent for cancer checks, 3 percent for pregnancy testing, 3 percent for breast examination, 3 percent for postoperative check, and 10 percent for other problems. Some clients came to the clinic for more than one reason which accounts for the total percent being over 100.
Table 4. Distribution of Subjects by SES Scores

<table>
<thead>
<tr>
<th>SES Score</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 and under</td>
<td>2</td>
</tr>
<tr>
<td>12-16</td>
<td>3</td>
</tr>
<tr>
<td>17-21</td>
<td>4</td>
</tr>
<tr>
<td>22-26</td>
<td>5</td>
</tr>
<tr>
<td>27-32</td>
<td>13</td>
</tr>
<tr>
<td>33-43</td>
<td>2</td>
</tr>
<tr>
<td>44-55</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
</tr>
</tbody>
</table>

Table 5. Distribution of Subjects by Method of Contraception Used

<table>
<thead>
<tr>
<th>Method of Contraception</th>
<th>Number</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>10*</td>
<td>33</td>
</tr>
<tr>
<td>Pill</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>IUD</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Foam</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>No Response</td>
<td>4*</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

*Half of the subjects were over age 45.
Sixty percent of the clients did not respond to the question: What other health care problems are bothering you today? Ten percent stated they had other health problems. These included chronic ulcerative colitis, gall bladder trouble, and menstrual problems.

When asked who they preferred to see, 3 percent of the clients preferred to be seen by a male health worker, 30 percent a female health worker, 27 percent any health worker, and 40 percent did not respond. In the second part of this question 3 percent preferred to be seen by a nurse, 50 percent by a doctor, 40 percent by either, and 7 percent did not respond. This item was apparently not well understood as 93 percent replied to the second part of the question but only 60 percent replied to the first part.

Fifty percent of the clients responded that they go to a doctor when first seeking health care services, 20 percent go to the health department clinics, 10 percent rely on themselves first for health care problems, 7 percent consult a nurse, 7 percent consult the drug store, and 6 percent did not respond.

Seventy-six percent of the clients responded that this clinic met all their health care needs; 17 percent responded that the clinic did not meet all their health care needs; 7 percent did not respond.
Fifty-three percent of the clients responded that this clinic needs to provide more health care. (Note the item above where 76 percent responded that the clinic met all their health care needs.) Thirty percent responded that this clinic does not need to provide more health care and 17 percent did not respond.

Ninety percent of the clients responded that this clinic should provide care for any member of the family. Seven percent responded that this clinic should provide care for women and children only, and three percent did not respond. No one responded to the item to provide care for women only.

Of the thirty health care needs listed, cancer checks (93 percent), pregnancy testing (76 percent), birth control (73 percent), tuberculosis (67 percent), family planning (67 percent), high blood pressure (63 percent), sex education (60 percent), routine physicals (60 percent), venereal disease (60 percent), and diabetes (53 percent) were the health care needs for which over fifty percent of the clients thought a clinic should provide. Table 6 presents the distribution of responses to the question: Which of the following health care needs do you think a clinic should provide care for?

A comparison of the distribution of clients according to SES scores and number of responses to health care
Table 6. Frequency Distribution of Responses to the Question: Which of the Following Health Care Needs Do You Think a Clinic Should Provide Care For?

<table>
<thead>
<tr>
<th>Health Care Needs</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Checks</td>
<td>28</td>
<td>93</td>
</tr>
<tr>
<td>Pregnancy Test</td>
<td>23</td>
<td>76</td>
</tr>
<tr>
<td>Birth Control</td>
<td>22</td>
<td>73</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>20</td>
<td>67</td>
</tr>
<tr>
<td>Family Planning</td>
<td>20</td>
<td>67</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>22</td>
<td>63</td>
</tr>
<tr>
<td>Sex Education</td>
<td>18</td>
<td>60</td>
</tr>
<tr>
<td>Routine Physical</td>
<td>18</td>
<td>60</td>
</tr>
<tr>
<td>Veneral Disease</td>
<td>18</td>
<td>60</td>
</tr>
<tr>
<td>Diabetes</td>
<td>16</td>
<td>53</td>
</tr>
<tr>
<td>Urinary Tract Infections</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>Heart Problems</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>Immunizations</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>Chronic Lung Disease</td>
<td>14</td>
<td>47</td>
</tr>
<tr>
<td>Arthritis</td>
<td>13</td>
<td>43</td>
</tr>
<tr>
<td>Intestinal Parasites</td>
<td>11</td>
<td>37</td>
</tr>
<tr>
<td>Inflammed Uterus</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>Diet and Nutrition</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>Abortion</td>
<td>9</td>
<td>30</td>
</tr>
<tr>
<td>Infertility</td>
<td>9</td>
<td>30</td>
</tr>
<tr>
<td>Sore Throat</td>
<td>9</td>
<td>30</td>
</tr>
<tr>
<td>Headache</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>Varicose Veins</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>Colds</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>Stomach Ailments</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>Head Lice</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td>Fever</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Backache</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Foot Care</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>No Response</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>
needs is shown in Table 7 (see Appendix D for more complete listing). There was no relationship between SES scores and clients' number of health care need responses.

Table 7. Comparison of Clients According to SES Scores and Number of Health Care Need Responses

<table>
<thead>
<tr>
<th>Number of Health Care Responses</th>
<th>SES Scores</th>
<th>Under 11</th>
<th>12-16</th>
<th>17-21</th>
<th>22-26</th>
<th>27-32</th>
<th>33-55</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>6-10</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>11-15</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>16-20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>21-30</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>13</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

In response to the open-ended question: What other health care needs would you like this clinic to provide care for, 7 percent of the clients responded that they would like this clinic to provide care for men. Seven percent responded that no additional health care should be provided, and 70 percent did not respond. This was an open-ended question accounting for the large number of persons not responding to the question. (Clients at the family planning clinic tended to omit open-ended
questions.) Table 8 presents the distribution of responses to the question of what other health care needs would you like this clinic to provide care for.

Table 8. Distribution of Responses to Additional Health Care Needs For Which Clients Would Like the Clinic to Provide Care

<table>
<thead>
<tr>
<th>Health Care Needs</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care for Men</td>
<td>2</td>
</tr>
<tr>
<td>Allergies</td>
<td>1</td>
</tr>
<tr>
<td>Broken Bones</td>
<td>1</td>
</tr>
<tr>
<td>EKG</td>
<td>1</td>
</tr>
<tr>
<td>Dental Exams</td>
<td>1</td>
</tr>
<tr>
<td>Blood Sugar Tests</td>
<td>1</td>
</tr>
<tr>
<td>Minor Operations</td>
<td>1</td>
</tr>
<tr>
<td>Emergency Help</td>
<td>1</td>
</tr>
<tr>
<td>Analysis of Everything</td>
<td>1</td>
</tr>
<tr>
<td>Eye Exams</td>
<td>1</td>
</tr>
<tr>
<td>No Other Health Care</td>
<td>2</td>
</tr>
<tr>
<td>No Response</td>
<td>21</td>
</tr>
</tbody>
</table>

Total 34*

*Some clients had more than one response which is the reason for the total responses being over 30.

In response to the question: Of all your health care needs, list the three health care needs that are most important to you? 27 percent did not respond. The three most frequently listed health care needs were cancer checks (60 percent), birth control (37 percent), and immunizations and heart problems (each had 17 percent).
Forty-six percent did not respond to the section for additional comments. Fifty-six percent responded. Positive comments included: this clinic is all you need; the clinic is well operated; everyone is very nice; they explain things to you; it's very good; it's OK; good doctors; and lucky to have services free, especially for low income families. Other responses included: should have a resident doctor; more money to help people; and the public needs to be more informed about the clinic.

Findings Related to the Hypothesis

The study hypothesis stated that clients in lower income and educational level groups will have a significantly greater number of expectations for health care than those in the higher groups. This hypothesis was not supported by the data. Clients in high income and educational level groups exhibited similar expectations for health care as clients in lower groups (see Appendix D, Table D-2).

Intercorrelations between clients' SES scores and the number of responses to the thirty health care needs check list were analyzed by the Pearson product-moment correlation coefficient. The results showed no correlation \( r = 0.08 \). Correlations were also run comparing the age of the client with the number of health care need responses and the education of the client with
the number of health care need responses. Again the results showed no correlation (r = 0.22 and r = -0.14).

Additional Findings

Fifty percent of the clients completed the questionnaire in Spanish and fifty percent in English. The difference was not significant in terms of client responses. The number of clinic visits in relation to the number of health care responses was not significant. Although, there was a tendency for the number of health care need responses to decrease with clients with over four visits to the clinic and to be high with clients coming to the clinic for the first time. The four Anglo clients tended to have fewer responses to health care needs than the Spanish-speaking clients.

There were additional findings related to family planning. In the group of clients aged 30 to 45, 54 percent used some form of birth control. The use of contraceptives and the number of children were related to the client's SES and years of education. Of the clients aged 30 to 45 not using contraceptives, the average education was 8.6 years and average number of children was 5.0. Of the clients aged 30 to 45 using contraceptives, the average education was 11.1 years and the average number of children was 3.0. In the group of clients aged 20 to 29, 75 percent used some form of contraceptives. There was
no relationship between use of contraceptives and number of children with the client's SES and years of education. The average number of children was 1.2 and the average years of education was 12.2 for all clients in the age group 20 to 29.

Clients' length of exposure to Western medicine, their degree of enculturation into Anglo society, the amount of previous health care teaching, and degree of access and exposure to preventive medical literature were not known.
CHAPTER V

DISCUSSION OF THE FINDINGS

In the following chapter, the results of the study are discussed in relationship to the theoretical framework and literature review. Implications and conclusions are presented, and suggestions are made for further research.

Findings in Relation to the Theoretical Framework

Illness is defined culturally and such factors as education and socioeconomic background affect health care needs and expectations. People have cultural guidelines to define health and illness and their treatment.

Expectations for health care were not significantly affected by clients' education or socioeconomic background. Eighty-seven percent of the clients were Spanish-speaking and 13 percent were not. There was not a significant number of clients in the second group to make an accurate comparison, however, clients in the second group had fewer expectations for health care than the Spanish-speaking clients.

Cultural beliefs that illness is something that cannot be prevented, and that as long as you look
healthy and can continue to function in society and perform your daily activities you are well (Clark 1959, Saunders 1954), were not supported by the clinic sample. Clients were aware of and expressed a need for preventive medicine. Fifty-three percent of the clients came to the clinic for cancer checks. The most important health care needs listed were cancer checks (60 percent), birth control (37 percent), immunizations (17 percent), and heart problems (17 percent). (Only 37 percent of the sample responded to this question concerning their three most important health care needs.) The five health care needs with the most client responses to the question: Which of the following health care needs do you think a client should provide care for? were cancer checks (93 percent), pregnancy testing (76 percent), birth control (73 percent), tuberculosis (67 percent), and high blood pressure (63 percent).

Findings in Relation to the Literature Review

This study revealed that 36 percent of the clients came to the clinic for birth control, 73 percent checked birth control as one of the health care needs they would like a clinic to provide, and 53 percent of the clients used some method of contraception. There was a relationship between family planning, socioeconomic level, and age of the clients similar to the results of the study
by Van Keep and Rice-Wray (1973). (Clients from the higher socioeconomic groups, those with a higher school-leaving age, and those aged 21 to 30 were the most accepting of family planning.) A higher percentage of younger clients used some form of contraception and checked birth control as one of the health care needs they would like a clinic to provide. In terms of socioeconomic level, there was not much difference in this study in clients under age 30. However, clients over 30 in lower socioeconomic groups used contraceptives less and had larger families than clients who were of the same age group but in higher socioeconomic levels. School-leaving age was a factor for clients over 30, but there was no relationship between school-leaving age and use of contraceptives with clients under 30. Rainwater's (1965) report of a positive relationship between low socioeconomic class and infrequent use of contraceptives was true for older clients but not true for clients under age 30. In this study age of the client was the most significant variable. As in previous studies (LeSueur et al. 1972, Van Keep and Rice-Wray 1973) oral contraceptives were the most widely used method of contraception. The one response to vasectomy as the type of contraception used was by an Anglo client. The literature supports the idea that vasectomy is not acceptable to Mexican-Americans (Van Keep and Rice-Wray 1973).
Uhlenberg's (1973) report that the less educated tend to have more children was true for clients over age 30. In the group of clients under age 30, there was no significant difference in the number of children in relation to the mother's education.

In terms of delivery of health care by nonphysician, clients were generally accepting (LeSueur et al. 1972). Thirty percent of the clients stated they would prefer to see a female health worker, 27 percent any health worker, and 3 percent a male health worker. When given the choice between seeing a doctor, a nurse, or either, 50 percent preferred to see a doctor, 40 percent either a doctor or a nurse, and 3 percent a nurse. (Percent do not total 100 because not every client responded.) Under additional comments, 3 percent responded that the clinic should have a resident doctor.

Koos (1954) supports a positive relationship between socioeconomic level and recognition of health problems. The recognition of individual health problems was not evaluated in this study, only clients' responses to health care needs they would like a clinic to provide care for. There was no relationship in this study of the number of health care needs responded to and the clients' socioeconomic level.

Clients' folk medical beliefs were not directly questioned. No responses to open-ended questions were
made concerning folk illnesses and no one responded to the question of seeing the Señora first for illness. Martinez and Martin (1966) report that folk illnesses are not discussed with Western medical practitioners.

Clark (1959) reports that Mexican-Americans have inadequate medical facilities and overcrowded and understaffed clinics. This study did not specifically evaluate the physical clinic facilities or the delivery of care. Personnel at the clinic are predominately bilingual and staffing was adequate on the days the researcher was present. Overcrowding was not noticed, and waiting times for treatment were similar or shorter than in private clinics. More funds for laboratory work and supplies were the needs personnel expressed most. Seventy-six percent responded that this clinic met all their health care needs with 17 percent responding that the clinic did not meet all their health care needs.

To the question: Does this clinic need to provide more health care? 53 percent responded yes and 30 percent no. (Percent do not total 100 because all clients did not respond to every question.) Also, 90 percent of the clients responded that this clinic should provide care for any member of the family (the health department clinics currently provide care for women and children). This clinic exhibits Cervantes' (1972) suggestions of
employing bilingual and bicultural healthworkers and using bicultural health literature.

Kay's (1972) study demonstrated that it is not advisable to apply data from one group of Spanish-speakers to another. Very little data from this study supported generalizations made about Mexican-Americans from other studies.

Implications and Conclusions

The findings in this study did not support the existence of a significant positive relationship between clients' SES scores and the number of health care needs responded to. The sample was limited to 30 clients, possibly a larger sample would have supported a positive relationship (the hypothesis). Clients' degree of exposure to health care and health care teaching was not known, and clients' exposure to this clinic varied (from the first visit to more than four visits). From a comparison with the previous literature, clients over age 30 exhibited similar characteristics in terms of family planning and contraceptive practices as subjects in the literature. Clients were generally more aware of preventive health care as an individual health care need, were more informed about health care and family planning, and were more assimilated into the Anglo culture than subjects in other studies.
With the majority of personnel being bilingual, with bilingual health literature available, and with the primary provider of health care being female and bilingual, some of the cultural needs of the clients are already being met. This could be one explanation for clients in this study not exhibiting characteristics of subjects in other studies.

The following conclusions were made on the basis of the research findings:

1. Clients were aware of and expected preventive health care at the clinic.
2. Clients' most important health care need was cancer screening.
3. Clients would like the clinic to provide more health care.
4. Clients would like the clinic to provide health care for any member of the family.
5. Clients had positive feelings about the clinic.

Recommendations

On the basis of the study findings, the following recommendations for further investigation were made:

1. Comparison of clinic subjects' responses with responses of nonclinic subjects in the community.
2. Include a larger sample of clients and include the clients who cannot communicate verbally in English.
3. Compare client responses about health care with actual health care received.
4. Compare client responses with those of clients from another family planning clinic.
5. Compare clients' degree of medical knowledge with their health care expectations.

Recommendations for nursing practice were made on the basis of this study:

1. Nurses must be aware of cultural differences in relation to health care but not expect all people from the same cultural group to exhibit the same behavior.
2. Nurses working predominately with people of another culture should make an effort to communicate in the language of the people they work with.
CHAPTER VI

SUMMARY

The purpose of this study was to determine the health care needs of clients attending a family planning clinic. The researcher was interested in relating the number of health care needs the clients expected a clinic to provide with the clients' socioeconomic status score (SES).

The significance of this study is based on the importance of identifying individual health care needs when providing health care. Cultural background, socioeconomic level, and educational background affect an individual's health care expectations. Personnel of a family planning clinic in a southwestern border town observed that clients frequently come to the clinic for health care services other than those provided. It was suspected that health care needs of the clients were not being met by existing health care programs.

This study consisted of an analysis of questionnaire responses by thirty clients of a family planning clinic. The sample was limited to clients who could communicate verbally in English. Clients willing to participate in the study signed a consent form and completed a
two-page questionnaire (both were available in English and Spanish).

Questionnaire responses were tabulated into frequency distributions. All results were reported by group, and subject names were kept confidential. The Pearson product-moment correlation coefficient was used to evaluate the relationship between clients' SES scores and the number of health care needs they expected a clinic to provide care for.

The results showed no correlation \( r = 0.08 \) between clients' SES scores and the number of health care expectations. Correlations were also run comparing the age of the client with the number of health care need responses and the education of the client with number of health care need responses. Again the results showed no correlation \( r = 0.22 \) and \( r = -0.14 \).

There was a tendency for clients with more than four clinic visits to have fewer expectations for health care than clients coming to the clinic for the first time. There was a relationship between clients' age and family planning practices. Socioeconomic level and years of education were not significant in terms of family planning for women under age 30. Clients under age 30 had similar contraceptive practices and number of children.

There was a relationship between socioeconomic level and
years of education when compared to family planning practices of women over 30. Women over 30 in lower socio-economic levels and less education used fewer contraceptives and had more children than women of the same age group but in higher socioeconomic levels and with more education.

Conclusions were made on the basis of the research findings: clients were aware of and expected preventive health care at the family planning clinic; clients' most important health care need was cancer screening; clients would like this clinic to provide more health care; clients would like the clinic to take care of any member of the family; and, the clients had positive feelings about the clinic.

Recommendations for further study included: comparison of clinic subjects' responses with responses of nonclinic subjects in the community; include a larger sample of clients and include the clients who cannot communicate verbally in English; compare client responses about health care with actual health care received; compare client responses with those of clients from another family planning clinic; and compare clients' degree of medical knowledge with their health care expectations.
APPENDIX A

QUESTIONNAIRE CONCERNING HEALTH CARE EXPECTATIONS OF
CLIENTS ATTENDING A FAMILY PLANNING CLINIC IN A
SOUTHWESTERN BORDER TOWN

Age: ________ Occupation: ________________________________

Ethnic Group: ____________________ Marital Status: __________

Mexican-American____ Never Married____
Mexican____ Married_____ Indian____ Divorced____
Indian____ Widowed____ Anglo____ Separated____
Other____

Religion: ____________ Income: __________________________

Number of living children: ______

Contraception that you are now using:
( Check as many as are appropriate)

None____ Foam____
Pill____ Diaphragm____
IUD____ Jelly____
Condom____ Other____

Highest Year Reached in School: (Circle one)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 or more
Elementary High School College Post Graduate

If you are married and living with your husband,
What is your husband's occupation? _______________________
What is your husband's highest year reached in
school? ____________________

Number of visits to this clinic:
First visit____ 2nd visit____ 3rd____ 4th____ More than 4____

Why did you come to the clinic today? (You may check more
than one.)
Birth Control____ Inflammation of Uterus____
Cancer Check____ Veneral Disease____
Pregnancy Test____ Other Problem____

44
What other health problems are bothering you today?

When you come to the clinic who do you prefer to see?
(Choose one answer in column A and one answer in column B.)
A  Male health worker  B. Nurse
Female health worker  Doctor
Any health worker  Either

Who do you go to First for health care services?
Self  Hospital
Nurse  Other family member
Señora  Neighbor
Drug Store  Health department clinic
Herb Store  Other
Doctor

Does this clinic meet all your health care needs?
Yes  No

Does this clinic need to provide more health care services?
Yes  No

Should this clinic take care of:  Women only
Women and children
Any member of family

Which of the following health care needs to you think a clinic should provide care for? (You may choose as many items as you like.)

Birth Control  Sex Education
High Blood Pressure  Family Planning
Back Ache  Inflamed Uterus
Headaches  Cancer Checks
 Abortions  Routine Physical
Varicose Veins  Diabetes
Pregnancy Test  Heart Problems
Infertility  Diet and Nutrition
Colds  Sore Throat
Diarrhea  Venereal Disease
Urinary Infections  Stomach Ailments
Fever  Chronic Lung Disease
Tuberculosis  Immunizations
Arthritis  Foot Care
Intestinal Parasites  Head Lice
Other
What other health care needs would you like this clinic to take care of?

Of all your health care needs, list the three health care needs that are most important to you?

Additional comments about this clinic:
QUESTIONARIO CONCERNIENTE A LAS EXPECTACIONES MEDICAS QUE ESPERAN LOS CLIENTES QUE SE ATIENDEN EN UNA CLINICA DE PLANEACION FAMILIAR

Edad:______ Ocupacion:_____________________________

Grupo Etnico:________________ Estado Civil:________________
Mexicano Americano__ Soltera__
Mexicano____ Casada____
Indio____ Divorciada____
Anglo____ Viuda____
Otro____ Separada____

Religion:______________ Entrada anual o mensual:_____

Numero de ninos vivos:_____

Anticonceptivo que este usando ahora:
(Senele tantos como sea apropiado)
Nada____ Espuma____
Pildora____ Diafragma____
Deposito____ Jalea____
Condon____ Otro____

Ultimo ano de escuela alcanzando: (Circule uno)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 y mas
Elemental secundaria y colegio posgraduado preparatoria

Trabajo del esposo:_________
Ultimo ano de escuela alcanzando del esposo:_____

Numero de visitas a esta clinica:
Primera visita__2da___3ra___4ta___mas de 4____

Porque viene a la clinica ahora? (Puede Ud. senalar mas de una rason)
Control de la natalidad___ Inflamacion del utero___
Examen de cancer___ Enfermedades venereas___
Examen de embarazo___ Otros problemas___

Que otro problema de salud le esta molestando ahora?

Cuando viene a la clinica a quien prefiere Ud. ver?
(Escoja uno en cada columna)
Trabajador Social___ Enfermera___
Trabajadora Social___ Doctor___
Cualquier empleado___ Cualquiera de los dos___
A quien acude Ud. primero para servicios médicos?

- Ud misma___ Hospital___
- Otro miembro de la familia__ Doctor___
- Enfermera___ Vecina___
- Señora___ Departamento de Salubridad___
- Botica___ Yerbearia___
- Otros___

Cubre esta clínica todas sus necesidades Médicas?

- Si___ No___

Necesita proveer esta clínica más servicios Médicos?

- Si___ No___

Debería esta Clínica proveer Servicios a:

- Mujeres únicamente___
- Mujeres y niños___
- Cualquier miembro de la familia___

Cuales de los siguientes servicios médicos Ud. piensa debería la Clínica proveer? (Puede Ud. escojer los que Ud. desee.)

- Control de la natalidad___
- Educación Sexual___
- Alta Presión___
- Planeación Familiar___
- Dolor de espalda___
- Inflamación del Utero___
- Dolor de cabeza___
- Examen del Cáncer___
- Abortos___
- Examen Físico Rutinario___
- Venas Varicosas___
- Diabetes___
- Examen de Embarazo___
- Problemas Cardíacos___
- Infertilidad___
- Dieta y Nutrición___
- Catarro___
- Dolor de Garganta___
- Diarrea___
- Enfermedades Venéreas___
- Infecciones de la corina___
- Problemas estomacales___
- Fiebre___
- Enfermedades crónicas del pulmon___
- Tuberculosis___
- Inmunizaciones___
- Artritis___
- Enfermedades Venéreas___
- Parasitos Intestinales___
- Cuidado de los pies___
- Otros___

Que otras necesidades de salud quisiera Ud. que se atendiera en esta clínica?

De todas las necesidades de salud, enumere las tres más importantes para Ud?

Su comentario adicional acerca de esta clínica:
APPENDIX B

LETTER OF CONSENT FROM THE SANTA CRUZ COUNTY HEALTH DEPARTMENT

July 23, 1975

Ms. Delores Farmer R.N.
2333 East Glenn
Apt. #218
Tucson, Arizona 85719

Dear Ms. Farmer,

We are pleased to grant permission for you to pursue your line of research in our health department setting. We want to assure you that there will be an interpreter available at all times, and that you have our fullest cooperation in any other area where it is needed.

As discussed between us previously the following conditions will be met; the patient will have a choice of whether or not to participate in the study, and her choice will in no way affect her care here in the clinic.

We are looking forward to seeing you.

Sincerely;

Edgar Condes
Deputy Director

Judy Bell, R.N. Nursing Supervisor
APPENDIX C

SUBJECT'S CONSENT FORM

Project Title: Health Care Needs of Clients Attending a Family Planning Clinic

The purpose of this study is to determine health care needs and health care expectations of clients attending this clinic. This project is concerned with the following questions: What are your individual health care needs? and Does this clinic meet your health care needs?

A short questionnaire will be used to gather this information. The questionnaire will ask you questions about the kinds of health care services you might need from a clinic. It will also ask you some personal information about your income and education.

The questionnaire will take about twenty minutes of your time to complete. It is not part of the clinic procedure and you do not have to fill it out if you do not wish to do so. If you decide not to participate your decision will in no way affect your medical care or your relationship with any of the clinic personnel.

If you decide to participate, all information you give on the questionnaire will be kept confidential. Only the person compiling the data and the translator will see the questionnaires. Your name is not required on the
The answers you give will be recorded with those
given by all other participants so that no individual
can be identified.

You may omit items on the questionnaire if you
do not want to answer them. The researcher will be
available if you have questions and you are free to ask
questions at any time.

Although you may not immediately benefit from
this study personally, you may benefit eventually by
identifying health care needs which the community needs
to consider providing. There are no risks to you for
participating and you will not be paid.

Please read over the questionnaire before making
a decision to participate or not.

The nature, demands, risks, and benefits of the project
have been explained to me and I understand what my partic-
ipation involves. Furthermore, I understand that I am
free to ask questions and withdraw from the project at any
time without affecting my relationship with any instituion
or person.

Subject's Signature: Date:

I have carefully explained to the subject the nature of
the above project. I certify that to the best of my
knowledge the subject signing this consent form under-
stands clearly the nature, demands, benefits and risks
involved in her participation in this study. A medical
problem or language or educational barrier has not pre-
cluded a clear understanding of her involvement in this
project.

Investigator's Signature: Date:
CONSENTIMIENTO DEL SUJETO

TITULO DEL PROYECTO: NECESIDADES MEDICAS DE CLIENTES QUE SE ATIENDEN EN UNA CLINICA DE PLANEACION FAMILIAR

El motivo de este estudio es con el objeto de determinar las necesidades medicas y las expectaciones medicas que esperan los clientes que se atienden en esta clinica. Las siguientes preguntas conciernen a este proyecto: ¿Cuáles son sus necesidades individuales de salud? ¿Cubre esta clinica todas sus necesidades de salud?

Un corto questionario sera usado para recabar esta informacion. El questionario le preguntara acerca de las clases de servicios medicos que Ud. pueda necesitar de la clinica. Tambien le pediran alguna informacion personal acerca de su economia y educacion.

El questionario tomara unicamente veinte minutos de su tiempo para completarlo. No es parte de la clinica este procedimiento y Ud. no lo tiene que llenar si no lo desea. Si Ud. no desea participar, su decision no afectara en ninguna forma su atencion medical o su relacion con ningun persona del personal de esta clinica.

Si Ud. decide participar, toda la informacion que el de en el questionario sera confidential. Unicamente la persona que esta recabando la informacion y el traductor veran los questionarios. No se requiere que su nombre aparezca en la forma. Las contestaciones que Ud.
de seran recopiladas con todas aquellas dadas por otros participantes y asi ningun individuo sera identificado.

Usted podra omitir cualquier parte del questionario que no quiera contestar. El investigador estara a la mano por si tiene Ud. alguna pregunta que hacer; esta usted libre de hacer todas las preguntas que desee.

A pesar de que Ud. personalmente no se beneficiara inmediatamente con este estudio, si se beneficiara eventualmente identificando las necesidades de salud que la comunidad necesita considerar y proveer. No habra ningun riesgo por participar y no sera pagado por ello.

Por favor relea el questionario antes de hacer su decision de participar o no.

La naturaleza, demandas, riesgos y beneficios de este proyecto me han sido explicados y yo entiendo que envuelve mi participacion. Ademas, yo entiendo que soy libre de pregunar o retirarme del proyecto en cualquier tiempo sin afectar mi relacion con ninguna institucion o persona.

Firma del Sujeto: Fecha:

Yo, muy cuidadosamente he explicado al sujeto la naturaleza de este proyecto. Yo certifico con lo mejor de mi sabiduría que el sujeto que esta firmando este consentimiento entiende claramente la naturaleza, demandas, beneficios y riesgos que envuelven su participacion en este estudio. Ninguna barrera se ha interpuesto, como problema medico, de lenguaje o educacional para que no entienda su envolvimiento en este proyecto.

Firmadel Investigador: Fecha:
APPENDIX D

DISTRIBUTION TABLES OF CLIENTS' SES SCORES AND NUMBER OF HEALTH CARE NEED RESPONSES
Table D-1. Distribution of Clients According to SES Scores, -- Socioeconomic Status of Subjects

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