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FINAL REPORT:

# A FAMILY PLANNING PROGRAM FOR THE MIGRANT FARMWORKER COMMUNITY

AMSA HEALTH PROMOTION / DISEASE PREVENTION PROJECT

WITH THE

ILLINOIS MIGRANT COUNCIL

SUMMER 1987

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# Introduction

> "Truman Moore, author of The Slaves We Rent, notes that our nation does a more accurate job of counting migratory birds than counting the millions of farmworkers who harvest and process our crops." (Rodriguez, 1982)

The amount of statistical information describing the Migrant Farmworker Population in the US is extremely limited. Available statistics are often contradictory. The Office of Migrant Health estimates that there are about 800,000 migrant farmworkers and dependents nationwide; but other estimates of the same population range from 317,000 to 1.5 million. (Wilk, 1986) Population mobility, undocumentation and lack of association with structured organizations are all factors which prevent accurate demographic assessment.

Similarly, there is little reliable data regarding the health or access to medical care of migrant farmworkers. This population is comprised of a myriad of diverse ethnic groups from Black to Asian to Hispanic. National statistics on migrant health may be meaningless when applied to a specific ethnic group. The midwestern migrant stream is almost exclusively Hispanic. And within this Hispanic population most are Mexican-American. Health care statistics used to describe this migrant population are often derived from such populations as: US urban Hispanic, Mexican-American, rural Mexican, Third-World Countries, Central

American, farmlaborers and low-income families. While migrant workers may be part of one or more of these populations, none represent an accurate appraisal of migrant health.

Moreover, the available health statistics are often contradictory. For example: Slesinger concluded that infant mortality in the migrant population was 2.5 times the national average. (The national average infant mortality rate is less than 10 infant deaths per 1000 live births.) The Chase Study estimated migrant infant mortality at 63 infant deaths per 1000 live births--over 6 times the national average. Rodriquez reports the migrant infant mortality rate to be merely 25% higher than the national average. Although all of these studies conclude that the infant mortality rate for migrant workers is higher than the national average, the difference between 1.25 times the national average and 6 times the national average is statistically preponderant.

Despite differences in specific statistics, five valid generalizations can be made regarding the current health status of migrant workers in the US. One, migrant workers have limited access to preventive medical services and even when such services are available they are not well utilized. In all age groups, clinic visits made by migrant workers are much less likely to be for a routine medical exam than clinic visits made by non-migrants. For example, a 1979 study conducted by the Sparta Health Center in Sparta, Michigan, found that for all non-migrant children ages 1-4 the principal reason for a clinic visit was a medical exam (34%),

but less than 1% of the migrant child visits were for a routine medical check-up. Also, migrant workers are less likely to have seen a dentist and to have adequate immunizations. (Wilk, 1986)

Two, because of poor field sanitation, crowded living conditions and insufficient hygiene education, migrant workers suffer from many infectious diseases which are rare in the US population. The migrant death rates from influenza and pneumonia are 20% higher than the national average, and 25% higher from tuberculosis and other communicable diseases. (Rodriguez, 1982) The few extant studies of migrant farmworker adults and children reveal a higher rate of parasitic infections than either the general US population or even other rural or poor urban populations. (Wilk, 1986)

Three, the occupation of seasonal farm labor entails significant risks to the health of migrant workers. Women and children, as well as men, are exposed to these health hazards. The lack of adequate occupational safety standards and the political impotence of the migrant community to enforce the meager existing standards, further escalate the health risks of seasonal farm labor. Agriculture, even for the traditional family farms of rural America, is the second most dangerous occupation is the US today. Every year, thousands of workers suffer traumatic accidents from farm labor or farm machinery. Non-traumatic but equally debilitating muskuloskeletal injury is also a frequent complaint among farmlaborers. Pesticide exposure, poor field sanitation and heat stress all threaten the health of the migrant worker.

Four, many indicators of poor infant or maternal health are elevated for migrant women. Infant death, premature birth, low

birth weight, miscarriage and stillbirth are all reportedly more common among migrant women. Difficulty in precisely verifying these statistics derives from the fact that migrant births occur outside a hospital 9 time more frequently than non-migrant births. (Constante, 1985) One-third of the eligible migrant women are not enrolled in the federal Women, Infants and Children supplemental food program. (Wilk, 1986)

Five, the majority of migrant farmworkers seek medical treatment for acute ailments rather than chronic conditions. Migrant workers may delay treatment while working in the midwest to maximize the number of hours spent in the fields. Because migrant workers obtain a great percentage of medical care from publically-funded facilities or emergency rooms rather than from private physicians, they are like to receive "band-aid" treatments. Comprehensive examination, assessment of contributing psychosocial factors and follow-up treatment are often unavailable. Continuity of care is non-existent.

The Illinois Migrant Council estimates that between 10,000 and 25,000 persons form the migrant worker population in Illinois. (Hutchinson, 1983) These workers are part of the midwestern migrant stream. The predominant cultural group in this stream is Mexican-American and most of the workers have their "home-base" in the Rio Grande Valley of Texas. A large number of camps in the Midwest are family-based with many family members, including women and children, contributing to the family income by working in the fields or crop processing sheds. The migrant season in Illinois

begins in April with the asparagus harvest and ends after the pumpkin pack and turkey processing in November.

All of the migrant families in the area around Aurora, Illinois, work for a single large grower. They live in trailers at the edge of the fields which are provided free of rent by the grower. Although the trailers are designed to house individual families, it is not uncommon to find grandparents, cousins, brothers or friends all living together in one trailer. During the 1987 season, a total of 156 migrant families from the Aurora area were registered with the Illinois Migrant Council. These families included:

| | | |
|---|---|---|
| Two parent households | 89 | |
| Female headed households | 18 | (14 with dependents) |
| Single male households | 49 | (12 with dependents) |
| | 156 | total families |

Many of the single men working in the midwestern fields have wives, children or parents in Texas or Mexico who rely on their income. The average family size, excluding single person families, is 4.6 people per family. The average reported yearly income for this family size is $6,300.

## Family Planning

There is widespread agreement among many investigators that successful contraceptive use is much less frequent for migrant women than for non-migrant women. Conversely, poor maternal and infant outcomes of pregnancy are more frequent among migrant women than non-migrant women. Thus, migrant women are in greater need of appropriate contraceptive use to prevent high-risk pregnancies. The community in Aurora in no exception. Nurses employed by the Illinois Migrant Council have tried unsuccessfully to promote contraceptive use. The local publically-funded family planning clinic is rarely utilized by this community. Both the nurses and administrators have been frustrated by the lack of responsiveness to contraceptive education. Originally, this particular health promotion/disease prevention project was intended to provide contraceptive education and increase contraceptive use in the migrant community. This proposed educational effort seemed premature and it was decided that a need/demand assessment was necessary to devise and implement an appropriate family planning program for this community.

In order to assess the demand or need for family planning services in the Migrant Farmworker Community, a survey was devised. The original survey was written in a questionnaire format and addressed the following four issues which were delineated by the specific indicators listed below:

I. Poor infant or fetal pregnancy outcome
   1. low birth weight (less than 5.5 lbs.)
   2. premature birth (earlier than 37 weeks gestation)
   3. infant mortality
   4. infant morbidity
   5. miscarriage or stillbirth

II. Poor maternal pregnancy outcome
   1. hemorrhage during delivery
   2. pregnancy-induced hypertension
   3. gestational diabetes

III. Risk factors for poor infant or maternal outcome
   1. age during pregnancy
   2. birth spacing
   3. smoking during pregnancy
   4. education
   5. marital status
   6. prenatal care

IV. Family planning usage and attitudes
   1. desired number of children
   2. current and past contraceptive use
   3. preferred method of contraceptive education
   4. abortion
   5. comfort with discussion regarding contraception
   6. subjective and objective barriers to contraceptive use

The survey was written in simple questions requiring yes/no answers, numbers or check marks. A great deal of difficulty was encountered in phrasing the medically oriented questions in a manner understandable to an individual with a seventh-grade education, the average education of the respondents. The survey was originally written in English and later translated into Spanish by a bilingual, health-care administrator experienced in family planning education in an Hispanic community. The Spanish survey was <u>not</u> re-translated into English by a third person to insure parallelism between the English and Spanish versions. A paragraph of explanation and instruction was included with both versions.

The survey was administered at the camps where the migrant workers live by two female health professionals. One woman was an Hispanic, bilingual nurses-aid employed by the Illinois Migrant Council and personally familiar with most of the migrant workers. The other was a non-bilingual, medical student who had been working occasionally in this community for the past month. The surveys were distributed door-to-door to all the adult migrant women. (Adult was defined as either being at least 18 years old or married.) A verbal explanation was provided in either English or Spanish as necessary. Both an English and Spanish version of the survey in a plain white envelope and a pencil were given to each perspective participant. A "ballot-box" was carried during the distribution and perspective participants were informed that they, themselves, could drop their completed surveys into the box thus insuring confidentiality. Perspective participants were also informed that they would receive a small gift for completing the survey. Surveys were distributed to nearly fifty women.

The surveys were collected 20 to 30 minutes after distribution. Pink and blue bars of perfumed soap were purchased at a reduced price from a local merchant who was eager to facilitate the project (for a small fee). After the participants deposited their completed surveys in the ballot-box, a soap was given to each with a verbal expression of gratitude. Most women seemed happy to participate and pleased with the gift of perfumed soap.

Four women either requested or readily agreed to being interviewed because or poor reading skills. Surveys were read to these women in the language they preferred and their answers were recorded on the survey form. These four surveys, despite possible biased responses due to interviewing as opposed to self-completion, were included in all analyses.

Important factors in securing participation in a cooperative spirit were:

1. The personal familiarity between the nurses-aid and the women of the community.
2. Verbal and written emphasis on the necessity of the survey to improve maternal and infant health care.
3. Assurance that the survey could be completed in ten minutes.
4. Bilingual nurses-aid and provision of a Spanish version of the survey.
5. Insistence that surveys be completed immediately.
6. Innocuous appearance and attitude of the two female, health professionals.
7. Gift of soap which was not only a modest incentive but also a gesture of goodwill.

Contrary to an initial belief, confidentiality of the survey answers did not seem to be important to the participants.

# Illinois Migrant Council

Hello! My name is Margaret Kirkegaard and I am a medical student from Minnesota. Many of you have already met me while I have been helping Pat and Lolita with health screenings. I am working with the Migrant Council this summer to try to improve health care for mothers and their babies. This survey will help us provide you with better health care services. Many health care providers feel that <u>family planning</u> or being able to plan pregnancies and space births is important for the health of both the mother and the baby. I have included some questions about family planning in this survey. This survey is written in both English and Spanish; please choose the language which is best for you. Please take a few moments to answer the questions. <u>Do not</u> write your name on this paper and when you finish the survey, put it in the envelope so your answers are private. I will let you know the results of the survey in a few weeks. Thank you for your help and your time.

1. How old are you? _____

2. Are you single, married, divorced or widowed? (Please circle)

3. Please circle the last year you completed in school.
1 2 3 4 5 6 7 8 9 10 11 12 education after High School

4. How many times have you been pregnant? (include live births, miscarriages and abortions) _____

5. How many, if any, of these pregnancies ended in miscarriage? _____

6. How many times, if ever, have you had a planned abortion? _____

7. How many children do you have in your family now? _____

8. How old were you during your first pregnancy? _____

9. How old were you during your most recent pregnancy? _____

10. How many, if any, of your children were born more than 2 weeks before they were due? _____ don't know_____

11. How many, if any, of your children died before they were 1 year old? _____

12. How many, if any, of your children were severely ill during their first month of life? _____

13. How many, if any, of your children weighed less than 5.5 pounds (2.5 kilos) at birth? _____

14. Have you ever had high blood pressure while you were pregnant?
yes_____ no_____ don't know_____

15. Have you ever had diabetes (high blood sugar or sugar in your urine) while you were pregnant? yes_____ no_____ don't know_____

16. Have you ever bled so much during birth that you required a blood transfusion? yes_____ no_____ don't know_____

17. When did you usually start to see a doctor or nurse during your pregnancies? 1-3 months_____ 4-6 months_____ 7-9 months_____

18. Have you ever smoked while you were pregnant? yes_____ no_____

19. Have you ever talked about family planning or contraceptives with your husband? yes_____ no_____ not married_____

20. Have you ever talked about family planning or contraceptives with your sisters, mother or friends? yes_____ no_____

21. If you have daughters older than fifteen, have you ever talked about family planning or contraceptives with them?
yes_____ no_____ does not apply_____

22. How many children do you feel it is best for a family to have? _____

23. Do you currently use some form of family planning? yes_____ no_____
If yes, please check which kind:

24. If you are not currently using family planning, have you ever used some form of family planning in the past? yes_____ no_____
If yes, please check which kinds:

| use now | used before | |
|---|---|---|
| _____ | _____ | abstinence or no sex at all |
| _____ | _____ | natural family planning (rhythm) |
| _____ | _____ | withdrawal (man pulls out before he comes) |
| _____ | _____ | female sterilization / hysterectomy or tubes tied |
| _____ | _____ | male sterilization / vasectomy |
| _____ | _____ | condoms and foam |
| _____ | _____ | spermicidal jelly |
| _____ | _____ | diaphragm |
| _____ | _____ | oral contraceptives (Pill) |
| _____ | _____ | IUD |
| _____ | _____ | injectable contraceptives |

25. Would you feel comfortable learning about family planning by:
having you and your husband talk with a nurse? yes_____ no_____
going to a class taught by a nurse? yes_____ no_____
talking with a friend who uses contraceptives? yes_____ no_____
talking in a small group of women? yes_____ no_____
talking to a nurse by yourself? yes_____ no_____
talking to a doctor by yourself? yes_____ no_____

The following sentences describe some women's feelings about family planning. Please check all the sentences that say what <u>you</u> feel.

_____Contraceptives are too expensive.
_____I don't need contraceptives right now because I want to become pregnant.
_____I am embarassed to ask a doctor or nurse about contraceptives.
_____The clinics which provide family planning are too far away.
_____My husband or family does not want me to use family planning or contraceptives.
_____The clinics which provide family planning do not have doctors or nurses who speak Spanish.
_____I am afraid that if I talk to a doctor or nurse, my family or neighbors will find out that I am using contraceptives.
_____I do not know where to get information about family planning.
_____I feel that there are side effects of contraceptives that are bad for my health.
_____Many types of contraceptives interfere with lovemaking.
_____I feel that it is best to have children when they come and not try to change God's plan.
_____I don't want to use contraceptives because it is against the teachings of the Catholic Church.
_____I do not feel comfortable talking to my husband about contraceptives or family planning.

# Illinois Migrant Council

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SALUDOS!

Me llamo Margaret Kirkegaard y yo soy una estudiante de medicina de Minnesota. Muchas de ustedes ya me conocieron mientras les ayudaba a Pat y a Lolita con los exámenes físicos. Estoy trabajando con el Concilio de Migrantes este verano tratando de mejorar la atención médica para las madres y sus niños. Esta encuesta nos ayudará a traerles mejores servicios de salud. Muchos doctores y enfermeras creen que la plaificación familiar o el poder planear los embarazos es importante para la salud de la madre y del recien-nacido. He incluído unas preguntas sobre la planificación familiar en esta encuesta. Está escrita en español y en inglés; favor de escoger la lengua que más le conviene a Ud.

Favor de no escribir su nombre en este papel y cuando termine, métalo en el sobre para que sus respuestas se queden privadas. Tome unos momentos para responder a estas preguntas. Les haré saber los resultados de la encuesta en unas semanas. Gracias por su ayuda y por su tiempo.

# ENCUESTA

1. ¿Cuántos años tiene Ud.? _____

2. ¿Es Ud. soltera casada divorciada viuda ? (Ponga un círculo alrededor)

3. Favor de poner en círculo el último año de la escuela completado.
   1 2 3 4 5 6 7 8 9 10 11 12 Educación después de la secundaria

4. ¿Cuántos embarazos en total ha tenido Ud.? (incluya partos vivos, abortos espontáneos y abortos planeados) _____

5. ¿Cuántos de estos embarazos , si alguno, resultaron en un aborto espontáneo? _____

6. ¿Cuantas veces, si alguna, ha tenido Ud. un aborto planeado? _____

7. ¿Cuántos hijos tiene Ud. en su familia ahora? _____

8. ¿Cuántos años tenía Ud. con su primer embarazo? _____

9. ¿Cuántos años tenía Ud. durante su último embarazo? _____

10. ¿Cuantos, si alguno, de su hijos nacieron más de dos semanas antes de su fecha esperada _____ no sé _____

11. ¿Cuántos de sus hijos, si alguno, se murieron antes de cumplir un año? _____ no sé ___

12. ¿Cuántos de sus hijos, si alguno, estaban gravemente enfermos durante su primer mes de vivir? _____ no sé _____

13. ¿Cuántos de sus hijos, si alguno, pesaron menos de 5.5 libras (2.5 kilos) al nacer? ___

14. ¿Jamás tenia Ud. la alta presión cuando esperaba? Sí _____ No _____ No sé _____

15. ¿Jamás sufría Ud. de la diabetis (alto azúcar de la sangre o azúcar en la orina) mientras esperaba? Sí _____ No _____ No sé _____

16. ¿Jamás sangró Ud. tanto durante el parto que necesitaba una transfusión de sangre?

    Sí _____ No _____ No sé _____

17. ¿Cuando comenzaba Ud. a ver al doctor o a una enfermera cuando estaba embarazada usualmente?
    1 - 3 meses _____ 4 - 6 meses_____ 7 - 9 meses _____

18. ¿Jamás fumaba Ud. cuando estaba embarazada? Sí___ No _____

19. ¿Jamas ha hablado Ud. con su esposo sobre la planificación familiar o los anticonceptiv
    Sí _____ No _____ No soy casada _____

20. ¿Jamás ha hablado Ud. con sus hermanas, su madre o sus amigas sobre la planificación familiar? Sí _____ No _____

21. ¿Si Ud. tiene hijas mayores de 15, jamás ha hablado con ellas a cerca de la planificac familiar? Sí _____ No _____ No tengo hijas de esa edad _____

22. ¿Cuántos niños cree Ud. es mejor tener en una familia? _____

23. ¿Usa Ud. ahora algún método de planificación familiar (anticonceptivos o control de la natalidad)? Si ____ No ____

24. Si ahora no usa Ud. ningun anticonceptivo, ¿jamas ha usado Ud. un método anticonceptivo? Si_____ No _____

Indique con un X todos los que aplican:

| lo que Ud. usa ahora | | lo que usaba antes |
|---|---|---|
| _____ | abstinencia ( no tener relaciones sexuales) | _____ |
| _____ | planificación natural (el ritmo) | _____ |
| _____ | el retiro (cuando el hombre"le cuida") | _____ |
| _____ | la esterilización de la mujer (amarrar los tubos) | _____ |
| _____ | la esterilización del hombre (vasectomía) | _____ |
| _____ | condones (gomas) y espuma | _____ |
| _____ | la jalea espermicida | _____ |
| _____ | el diafragma | _____ |
| _____ | anticonceptivos orales (la pastilla) | _____ |
| _____ | anticonceptivos injectados | _____ |
| _____ | el DIU ( el aparatito) | _____ |

25. ¿Se sentiria Ud. comoda aprendiendo sobre la planificacion familiar:

| | | |
|---|---|---|
| hablando, su esposo y Ud., con una enfermera? | Si ____ | No ____ |
| en una clase dada por una enfermera? | Si ____ | No ____ |
| hablando con una amiga que usa anticonceptivos? | Si ____ | No ____ |
| hablando en un grupo pequeno de mujeres? | Si ____ | No ____ |
| hablando con una enfermera en privado? | Si ____ | No ____ |
| hablando con un doctor en privado ? | Si ____ | No ____ |

Las frases que siguen describen como se sienten algunas mujeres a cerca de la planificació familiar. Favor de indicar con X <u>todas</u> las frases que dicen lo que Ud. cree.

____ Los anticonceptivos cuestan muy caros.
____ No necesito anticonceptivos porque quiero tener (más) familia.
____ Me da vergüenza hablar con un doctor o enfermera sobre los anticonceptivos.
____ Las clínicas de la planificación familiar están muy lejos.
____ Mi esposo o mi familia no quiere que yo use los anticonceptivos.
____ Las clínicas de la planificación familiar no tienen doctores ni enfermeras que hablen español.
____ Tengo miedo que si hablo con un doctor o enfermera, mi familia o mis vecinos van a saber que yo uso anticonceptivos.
____ No sé donde encontrar información sobre la planificación familiar.
____ Yo creo que hay consecuencias de los anticonceptivos que son malas para la salud.
____ Muchos métodos anticonceptivos dificultan las relaciones íntimas.
____ Yo creo que es mejor tener hijos cuando vengan y no tratar de cambiar los planes de Dios.
____ No quiero usar los anticonceptivos porque están en contra de lo que enseña la Iglesia Catolica.
____ No me siento cómoda hablando con mi esposo acerca de los anticonceptivos ni la planificación familiar.

After the survey had been completed, this letter was written to the women of the migrant community in Aurora. The letter was intended for the following purposes:

1. To involve women in making decisions and encourage self-responsibility for personal health.
2. To provide a synopsis of the survey results to the participants.
3. To educate women about the recommended guidelines for safe pregnancies.
4. To thank the women for their cooperation.

It was planned that copies in both English and Spanish would be distributed in the community.

# Letter to Migrant Women

I want to thank all of you who helped with our survey. Many doctors and nurses feel that family planning or being able to plan pregnancies and space births is important for the health of both the mother and the baby. The recommended guidelines for safe pregnancies are:

1. Mothers should be at least 18 years old.
2. Mothers should not be over 35 years old.
3. Babies should be spaced at least 2 years apart.
4. Four babies is the most a woman should have.

Nearly one-half of the women who filled out a survey said that they had been pregnant before they were 18 years old. Until a woman is at least 18 years old, her body is not ready to bear children. Very young mothers have a greater chance of becoming sick during pregnancy, having a difficult delivery or having an unhealthy baby. It is best for a woman to wait until she is 18 years old to start a family. Then her body will be ready to nurture a healthy baby.

Many women also said that they had been pregnant after age 35. This can be dangerous for the mother. Older mothers have a greater chance of having high blood sugar or high blood pressure during pregnancy. They also have a greater chance of bleeding too much during delivery. Babies born to women over age 35 are more likely to be born with birth defects

or mentally retarded. Several women over age 35 indicated on the survey that they were not using any contraception. Until a woman goes through her change around age 47 to 50, she can still become pregnant. These women are taking a chance of having a dangerous pregnancy or an unhealthy baby.

A lot of women checked on the survey that they were worried about the health effects of certain methods of contraception. While all methods can have some side-effects, some methods such as the diaphragm or condoms are very safe. It is also important to know that for some older or very young women using contraception is safer than becoming pregnant.

If you have any questions about family planning, please talk to Pat or Mary Jule. They can help a woman decide when is the best time for her to become pregnant. If you want to know more about certain methods of contraception, Pat and Mary Jule can explain.

Family planning is an important part of women's health care. Babies should be healthy and pregnancy should be a wonderful time in a woman's life. Using family planning can help make healthier mothers and healthier babies.

Thank you again for helping with this survey. May God bless you and your families with happy, healthy lives.

Several difficulties were encountered in survey analysis. Overall the greatest difficulty was attempting to draw statistically valid conclusions from such a small population size. Gross generalizations regarding the migrant population in the US may not be valid here, but the survey adequately represents this particular community. A second difficulty was encountered in attempting to determine the appropriate denominator for many of the survey results. Whether total pregnancies or total births provided the best comparison was difficult to determine. Questions regarding contraceptive use were confounded by old age and current pregnancy which preclude the need for contraception. The survey assesses a community over their whole life-times which makes a comparison between these results and many other statistics, which encompass a limited time span, invalid. Comparison statistics were not available for many of the survey results especially for those questions concerning poor maternal outcomes. A chart or birth certificate review would be a far more accurate means of assessment. There also may be innate biological differences between Whites and Hispanics which influence the results. Finally, a health professional interviewer would probably have secured more accurate data regarding infant and maternal pregnancy outcomes. A certain measure of accuracy was knowingly sacrificed by allowing the respondents to complete the survey themselves. It was felt that women would respond more freely to the questions regarding family

planning and contraception if they were guaranteed privacy. The four women who were interviewed in this survey did not seem overly reluctant to answer the questions. It is possible that the survey could be conducted successfully in an interview format if the interviewer was accepted by the community.

A revised version of the survey was written. The revised survey addresses essentially the same four categories as the original survey. Questions regarding poor maternal outcome were deleted due to a lack of comparison statistics and response verification. Another category assessing the risk of unintended pregnancy was added. Several questions were deleted for the sake of brevity and many questions were rewritten to improve clarity. A copy of the revised survey is included.

# SURVEY ANALYSIS

Overview:

1. All surveys which were distributed were completed by the participants and collected.
2. A total of 44 surveys were administered.
3. Only 1 woman declined to participate.
4. Two adult women of the community were unable to be contacted and did not participate.
5. Survey represents 44 of 47 or 94% of the adult women in the community.

Language:

1. 18 surveys were completed in Spanish.
2. 2 surveys were completed in both languages.
3. 24 surveys were completed in English.

There was an overall impression that the English surveys were answered more completely than the Spanish surveys. There are two possible explanations: 1) lower educational level of the Spanish speaking respondents and 2) less comprehensibility of the Spanish version due to translation. For analytical purposes, the two surveys which were completed in both languages were grouped with the Spanish responses.

It is interesting to note that although most of the migrant workers can and do communicate in English to the health-care personnel, almost one-half of the respondents chose to complete the survey in Spanish. This indicates that Spanish may be preferred for expression of sexual and marital issues even though an individual can converse in English.

Age:

1. English respondents
   mean age = 32.8 years
   median age = 27 years
   range = 14 to 56 years
2. Spanish respondents
   mean age = 35.2 years
   median age = 28 years
   range = 20 to 62 years

Marital Status:

| | | |
|---|---|---|
| 1. | married | 77.3% |
| 2. | single | 4.5% |
| 3. | divorced | 9.1% |
| 4. | widowed | 2.3% |
| 5. | blank | 6.8% |

Education: The average educational level for English respondents was 8.7 completed years in school. The average educational level for Spanish respondents was 5.4 completed years in school The achieved educational level is inversely proportional to the age of the respondent. The lower educational level of the Spanish respondents is partially attributable to the greater mean age of this group versus the English respondents.

Rather dismaying is the fact that only four of the English respondents and none of the Spanish respondents had completed High School.

Several surveys were left blank on this question and these were not factored into the average educational levels. Since the survey did not include a choice for zero completed years in school, it is very likely that these questions were left blank to indicate that no formal schooling was ever completed by the respondent. Thus, the average educational level of this community may actually be even lower than the values presented here.

Pregnancies:

| | | | |
|---|---|---|---|
| 1. | total pregnancies | 173 | |
| 2. | abortions | 1 | |
| 3. | miscarriages | 15 | (for 10 women) |
| 4. | current pregnancies | 10 | |
| | (determined by: present age equal to age at most recent pregnancy) | | |
| 5. | live births | 147 | |

Nearly 25% of all the pregnancies in this country are terminated in legal abortion. (Family Planning in Primary Care Centers, 1980) In this survey only 1 of 173 or 0.5% of all pregnancies were terminated in abortion. Five respondents chose not to answer this question. It is difficult to determine whether this indicates a negative answer or an unwillingness to respond. However, even if all of the blank responses actually represented abortions, the abortion rate of this community would still be only one-tenth of the national average. Obviously, abortion is not an acceptable means of contraception for the migrant woman.

The responses show that 15 of 173 or 8.7% of pregnancies ended in miscarriage. When this percentage is compared to the national average of 15% of all pregnancies end in miscarriage, the fetal mortality of the Migrant Farmworker Community appears surprisingly low. Yet it is important to recognize that 10 of 40 or 25% ever pregnant respondents have experienced a miscarriage. The Colorado Migrant Health Program in a 1983 study of pregnant migrant women also reported that "twenty-five percent of the women had one or more fetal deaths". (Littlefield et al, 1986) This percentage is far greater than acceptable given the sophistication of medical care in the United States.

Infant Death: Five infant deaths were reported by four women. Five infant deaths per 147 live births extrapolates to an infant mortality rate of 34 per 1000. This rate seems shockingly high when compared to a reported infant mortality rate of 7.7 per 1000 in an average white, American population. (Maternal and Child Health Profile for Hispanics in California, 1985) However, the infant mortality rate reported for the white, American population represents infant deaths occurring during the previous year; whereas this survey reports all infant deaths occurring during the life-time of the respondents--a span of sixty years. All of the women who reported an infant death were forty years old or older. None of the women less than forty years old had experienced an infant death. Thus, it is inaccurate to extrapolate 5 infant deaths per 147 live births to a rate of 34 per 1000. Nor is it appropriate to compare this statistic to other reported infant mortality rates.

A more valid assessment of the data is to note that 4 of 40 or 10% of ever pregnant respondents had experienced an infant death. This percentage is slightly higher than the seven-percent reported by the Colorado Migrant Health Program.

Low Birth Weight: Low birth weight is the single most significant contributing factor to infant mortality. "A 1973 study of neonatal mortality in six states found that low birth weight infants made up six percent of all births but accounted for 76 percent of all neonatal deaths." (Population Reports, May-June 1984)

In this survey, 10 low birth weight infants were reported by 6 women. An incidence of 10 per 147 live births yields a percentage of 6.8%. This rate compares very favorably with an average rate of 7% for North America and Western Europe. (Population Reports, May-June 1984)

Premature Birth: Seven premature births were reported in this survey. "Infants born prematurely (that is, before the 37th week of gestation) also face a greater risk of death no matter what their birth weight." (Population Reports, May-June 1984) Seven of 147 or 4.8% of live births were born prematurely. No statistics were available for comparison at this time.

Hypertension: There were 35 ever pregnant women who were able to answer this question definitively. Five of the 35 responses were affirmative. Five of 35 yields a percentage of 14.3% of pregnant women have experienced hypertension. No comparison statistics were available at this time. Interpreting the results of this question is made even more difficult by the fact that women whose hypertension is unrelated to pregnancy inevitably answered this question affirmatively. Furthermore, determination of the incidence of gestational hypertension and diabetes is confounded by the fact that "obesity and diabetes are more prevalent among Hispanic women" and "Mexican-American women have significantly higher rates of hypertension than non-Hispanics". (Women's Health, 1984) Overall, this survey did not prove to be valuable in assessing poor maternal outcomes of pregnancy.

Diabetes: There were 38 ever pregnant women who were able to answer this question definitively. Only one women responded affirmatively. One in 38 or 2.6% women in this community have experienced gestational diabetes. A recent study of gestational diabetes among pregnant migrant women reported, "The 2% of women with gestational diabetes uncovered in our community population compares favoraoly to the 2% uncovered by O'Sullivan et al in the 1973 study. The 4% uncovered in our migrant population would seem to reinforce a generally-held view of most migrant health center clinicians that diabetes mellitus is slightly more frequent in the Hispanic migrant farm worker population." (Migrant Health Newsline, April 1986)

The incidence of gestational diabetes in this survey, at 2.6%, is intermediate between the 2% for the white, American community and the 4% for migrant workers reported in the Migrant Health Newsline.

There are two factors that are important to note when comparing these two studies. First, the population sizes of both studies is small, 44 for this survey and 45 for the other. Second, this survey relied on a woman's ability to report gestational diabetes whereas the other study performed a glucose tolerance test on all participants. It is possible that there were women with gestational diabetes where either the diabetes was undiagnosed or the woman was not medically sophisticated enough to be able to report gestational diabetes on the survey.

At this time preliminary evidence suggests that there may be a higher incidence of gestational diabetes among Hispanic migrant women but a definitive conclusion will require more research.

Smoking: Three of 40 ever pregnant women reported that they had smoked while pregnant. This represents a percentage of 7.5%. Considering that 36% of all American women currently smoke and at least two-thirds of these will continue to smoke during pregnancy, the incidence of smoking during pregnancy in the migrant community is significantly infrequent. (Women's Health, 1984) Individual, pregnant women who smoke should certainly be educated about the health risks to the fetus, but wildest smoking-cessation education is not necessary for this community.

Blood Transfusion: Three of 36 or 8.3% of ever pregnant women indicated that they had had a blood transfusion during delivery. Although hemorrhage is a serious complication of delivery, no comparison statistics were available at this time. The likelihood of fatal hemorrhage is reduced by the availability of tranfusable blood in US hospitals. Fatal hemorrhage is the leading cause of maternal death in Third World countries. (Population Reports, May-June 1984)

A total of 44 women completed the survey. Four of these women did not respond to enough of the survey questions to assess their risk status. Three of the 44 respondents had never been pregnant. Thirty-seven respondents were considered in this risk assessment. The results are as follows:

| Risk Factors | frequency | percentage |
|---|---|---|
| Childbearing over 35 years | 6 | 16% |
| Childbearing under 18 years | 16 | 43% |
| Birth-spacing* less than 2 years | 6 | 16% |
| Multiparity (over 4 births) | 11 | 29% |
| Women having 2 risk factors | 9 | 24% |
| Women having 3 risk factors | 4 | 11% |

*Birth-spacing was determined by considering all past and current pregnancies. Abortions and miscarriages were not included. The age at first pregnancy was subtracted from the age at most recent pregnancy to find the span of child-bearing years. The span of child-bearing years was divided by the total number of births or current pregnancies minus one. The resultant birth-spacing represents the average birth-spacing and may significantly underpricing the total number of births spaced less than 2 years apart.

The most significant result of this assessment is that nearly half of the women in this community become pregnant when they are less than 18 years old. A logical supposition would be that the age at first pregnancy is increasing. While this supposition holds true for the general population, it is not true for this community. The age at first pregnancy is actually decreasing. For example, the average age at first pregnancy for a 20 year old woman is 18 years old, but the average age at first pregnancy for a 40 year old woman is 19.6 years old. (see graph)

Most of the present contraceptive education efforts for this community are directed at women in their early twenties and will not help to decrease the incidence of early pregnancy. Greater effort in contraceptive and reproductive health education must be directed at the adolescent age group. Current contraceptive education for this age group in the general population is aimed at preventing sexually-transmitted diseases and preventing out-of-wedlock pregnancies. However, most of the pregnancies that occur to migrant women less than 18 years old are not unwanted, out-of-wedlock pregnancies. These young women are likely to be married and consider themselves ready to undertake the role of wife and mother. This mindset poses an extra challenge to educators who must convince these women that it is important for her own health and the health of her baby to postpone childbearing until she is at least 18 years old.

Another group especially at risk are women ages 35 to 50. Age 35 is the recommended upper limit of safe childbirth and age 50 was chosen as the upper limit of biological, reproductive capability. (The average age of menopause in the US is 49.2 years) Twelve of the 44 respondents fall into this age bracket. Only 2 of these 12 indicated that they were using any form of contraception. Both had had hysterectomies. Two of the 12 were not currently married and, given the sexual ethics of the community, probably do not need contraception. Two of the 12 chose not to answer the question. Six of the 12 or one-half of the women ages 35-50 were not using any form of contraception. All six of these women indicated that they had already achieved their desired family size. Therefore, these women are at risk for both an unwanted and a high-risk pregnancy. Furthermore, 3 of the 6 women had 4 or more births and would fall into two of the categories for high-risk pregnancy.

In summary, at least one-half of the women ages 35 to 50 are in need of contraceptive education to prevent high-risk pregnancies. These women, because of their age and lower educational level, will require special education efforts to convince them of the medical value of contraception. Because oral contraceptives (the most popular method of contraception in this community) pose a greater health hazard to older women, previously unsuccessful methods such as Natural Family Planning or unacceptable methods such as the diaphragm will have to be promoted to these women. Currently, if a woman desires a tubal ligation, she must apply for Public Aid and pay an out-of-pocket "spend-down" which may be over a thousand dollars--a significant deterrent to tubal ligation. Greater effort must be made to provide affordable tubal ligation procedures for these women.

Contraceptive Education: Women were asked to indicate whether or not they would feel comfortable learning about family planning or contraception in a variety of situations. The methods of education and the percentage of women who responded that they would feel comfortable learning in this manner are shown:

| Method | percentage |
|---|---|
| Wife alone talks with nurse | 73% |
| Husband and wife talk with nurse | 68% |
| Small group discussion | 67% |
| Attending a class | 64% |
| Wife alone talks with physician | 43% |
| Talking with a friend who uses contraception | 38% |

Talking alone with a nurse proved to be the preferred method of contraceptive education. Talking with a physician is less preferred than talking with a nurse presumably because of the traditional male sex of physicians. Originally, it was hypothesized that a peer education program may be successful, but the results of this survey indicate that talking with a friend who uses contraception is not an acceptable method of education. There are two possible explanations. One, a peer educator may threaten confidentiality and two, many women are concerned about the adverse health effects of contraception and desire education from a health professional.

Discussion: Women were asked if they had ever discussed contraception with their husbands, friends or adult daughters. There were 39 married respondents who answered this question. Thirty of 39 indicated that they had discussed contraception with their husbands. Only 7 of these 30 women or 23% were never users of contraception. Nine of the married respondents had not discussed contraception with their husbands. Of these 9, 7 or 78% were never users of contraception. A strong correlation between husband-wife communication and contraceptive use exists. This data verifies the conclusion of a study performed in El Salvador where lack of husband-wife communication was the single most important obstacle to contraceptive use. (Journal of Health Education, 1982) Thus, opening a dialogue between husbands and wives appears to be an effective strategy to increasing the acceptance of contraception.

Fifty-four percent of the respondents indicated that they had discussed contraception with their friends. This suggests that informal, peer education does not regularly occur in this community.

Finally, 15 of the respondents indicated that they had adult daughters. Only 5 of these women admitted that they had ever discussed contraception with their daughters. This statistic emphasizes the need for health professionals to assume responsibility for reproductive and contraceptive education of adolescents in this community.

Prenatal Care: There were 39 ever pregnant women who responded to this question. Of these, 29 or 74.4% indicated that they usually received prenatal care in the first trimester; 5 or 12.8% indicated that they usually received prenatal care in the second trimester; and 5 or 12.8% indicated that they usually received prenatal care in the third trimester.

At first glance it is disconcerting to note that over 25% of these women are receiving inadequate prenatal care (starting in the second or third trimester). However, the average age of the women indicating third trimester prenatal care is 44.8 years. Most of the pregnancies considered in the response occurred twenty years ago. Thus, the number of women currently receiving inadequate prenatal care is actually closer to 13%. The average age of the women reporting second trimester prenatal care is 28.4 years. The pregnancies considered in this response are recent pregnancies.

A recent study showed that 75% of all California mothers reported receiving care in the first trimester. (Maternal and Child Health Profile for Hispanics in California, 1985) The percentage of women receiving first trimester care in this survey is virtually identical to the overall population of California. In conclusion, while efforts to bring individual pregnant women into care must continue, the number of migrant women receiving first trimester prenatal care is comparable to the average population.

Family size: The average number of pregnancies for English respondents was 4.0 pregnancies per woman. The average number of children currently in the family was 3.2 children per family unit.

The average number of pregnancies for Spanish respondents was 4.2 pregnancies per woman. The average number of children currently in the family was 3.3 children per family unit.

The average number of children reported as "best" family size was 3.4 considering the English and Spanish respondents together. This number is higher than the average number of children desired by white Americans. This survey confirms the evidence presented by Littlefield et al (1986) that "higher fertility among Los Angelos Chicanas was a consequence of their desire for larger families rather than unsuccessful family planning" and "Mexican-Americans desired more children than either Whites or Blacks".

An initial hypothesis that younger women would desire less children was made, so women ages 14 to 34 were considered separately. Fourteen was the age of the youngest respondent and age 35 was selected as the upper limit of safe child-bearing years. The average number of pregnancies for this group was 2.4 pregnancies per woman. The average number of children in the family was 2.0 children per family unit.

The "best" number of children or desired family size reported by this group was 3.5. Surprisingly, this number is slightly greater than the desired family size reported by all women in the community.

None of the women in the group ages 14 to 34 reported current family sizes that were larger than their desired family size. It is reasonable to conclude that these women are purposely endeavoring to become pregnant and that contraceptive education will not be well-received.

Contraceptive Use

Definition of never user: a woman who indicates no current or past use of contraception. Women who indicated using withdrawal only were also included in this group. Women who indicated having a hysterectomy and have never used any other method of contraception were also included in this group. Women who specified female sterilization or tubal ligation were not included in this group.

Definition of user: a woman who indicates either current or past contraceptive use of any method other than withdrawal. Women who indicated using Natural Family Planning were included in this group.

Of 44 total respondents, 16 or 36.4% were never users of contraception. This percentage agrees with the report of a previous study that, "Over one-third of the migrant women had never used any contraceptive method." (Wilk, 1986) Twenty-three or 52.3% were users and 5 women or 11.4% chose not to respond to the question. Only 5 of the 23 users indicated that they are currently using any method of contraception.

The users and the never users are characterized as follows:

| | user | never user |
|---|---|---|
| average age in years | 29.4 | 37.0 |
| average completed years in school | 8.0 | 6.7 |
| average births* | 3.0 | 4.4 |

*Average births includes current pregnancies but excludes miscarriages or abortions.

Assuming that older women are less likely to have used contraception and that education is positively correlated with contraceptive use, it is impossible to assess the independent effects of age and education on contraceptive use in this community. In order to further delineate these variables, women ages 14 to 34 were considered separately. These women are characterized as follows:

| (women ages 14-34) | user | never user |
|---|---|---|
| average age in years | 25.0 | 25.0 |
| average completed years in school | 8.3 | 8.8 |
| average births* | 2.5 | 2.0 |

The following barriers were addressed and the frequency and percentage of response is shown:

| Barrier | frequency | percentage |
|---|---|---|
| Adverse health effects of contraception | 16 | 55.2% |
| Desire to abide by God's plan | 11 | 37.9% |
| Distance | 10 | 34.5% |
| Expense | 8 | 27.6% |
| Husband objects | 6 | 20.7% |
| Lack of husband-wife communication | 6 | 20.7% |
| Desire pregnancy | 5 | 17.2% |
| Lack of information | 3 | 10.3% |
| Interference with lovemaking | 3 | 10.3% |
| Embarrassed to seek contraception | 2 | 6.9% |
| Lack of bilingual educators | 2 | 6.9% |
| Lack of confidentiality | 2 | 6.9% |

Concern regarding the adverse effects of contraception was the most frequent response. All contraceptive education efforts should emphasize the adverse maternal and fetal health effects of a high-risk pregnancy. Women should be advised as to the possible side-effects of all methods of contraception but effort must be made to dispel any unfounded fears women may have. Contraceptive education must be performed by health professional whose medical judgement is respected by these women.

Many women indicated that they felt it is best to leave control of conception to God. While no effort should be made to undermine the personal religious views of any woman, a sensitive health educator may be able to teach a couple to use Natural Family Planning.

Contraceptive Need: The universally recognized risk factors which increase the chances of a poor pregnancy outcome and related poor maternal, infant and child health are:

1. Childbearing over 35 years
2. Childbearing under 18 years
3. Multiparity (over 4 births)
4. Births spaced less than 2 years apart
5. Pre-existing disease conditions

An assessment of the percentage of women in the Hispanic, migrant community who fall into one or more of these risk categories was made from the survey data.

These results are indeed perplexing. Given the same average age of both users and never users, the educational level of the never users is slightly higher than that of the users. The number of births for the never user group is significantly lower than the user group, despite their non-use of contraception.

The methods of contraception indicated by the user group are as follows in order of frequency per 44 total respondents:

| Method | frequency |
|---|---|
| Oral contraceptives | 15 |
| Withdrawal | 8 |
| Condoms and foam | 6 |
| Abstinence | 5 |
| Female sterilization | 5 |
| IUD | 4 |
| Spermicidal jelly | 4 |
| Natural Family Planning | 4 |
| Diaphragm | 1 |
| Male sterilization | 0 |

In summary, oral contraceptives are the preferred method of contraception in this community. Methods which require insertion into the vagina are rejected by the Hispanic, migrant women. This is consistent with Poma's observation that "tampon use is low and a few persons may think they cause cancer". (Illinois Medical Journal, December 1979) The fact that withdrawal is the second most frequent method of contraception underscores the need for reproductive and contraceptive education.

The last question on the survey was designed to assess the objective and subjective barriers to contraceptive use in this community. The question included a list of several sentences which described possible barriers to contraceptive use. Women were instructed to check the sentence if they agreed with the statement. There was an overall poor response to this question with 15 of 44 total surveys left completely blank. While it is possible that a woman could disagree with all of the statements and her blank response was actually a valid answer, it is more likely that the question was poorly comprehended. Twenty-nine women agreed with one or more of the statements. The percentage of respondents who agreed with each statement is based on a total of 29 respondents.

## Assessment

Daniel E. Costello defines objective barriers as those which "involve a lack of certain desired elements in the individual's physical environment, or the individual lacks resources that would enable him to change his physical environment." (Proceedings of the Conference on Communicating with Mexican-Americans: For Their Good Health) The many objective barriers to family planning services for migrant women are self-evident:

- lack of money
- failure to qualify for public assistance
- time constraints
- lack of education
- population mobility
- lack of confidentiality
- social isolation
- lack of transportation
- language barriers

The power to surmount these barriers lies with policy-makers and health care providers. On the other hand, subjective barriers are attitudinal or cultural; they alter how an individual perceives information and, therefore, influence his reaction to the information. The subjective barriers to family planning are more subtle and may be more consequential to the success of family planning programs in the migrant community.

In the Mexican-American culture, the family is not merely a biological phenomenon. The family bond provides vital spiritual and emotional support for individual family members. One Latin American author writes, "The giving, the sharing, the building together, the tolerance of intolerable actions, the faith, the spirit of the familia are drawing forces which we cannot easily turn our backs on." (Littlefield et al, 1986) Within the family, children have a place of special importance. Children may be unplanned but not unwanted. Several studies have shown that Mexican-Americans desire larger families than other ethnic groups. Just as the fertility of the soil, from which they derive their very existence, is revered, their own fertility is recognized as a blessing from Above. More practically, the migrant family also represents an economic unit. Children are valued by parents as a means of social and financial support in old age. Contraceptive education may be perceived as a threat to this family unity.

Mothers, too, fulfill a special role in the family. Poma writes, "For the children, mother is the most important person on this earth, and is probably second only to God." (Illinois Medical Journal, 1979) During pregnancy a woman acquires an even more cherished position. "She may be placed on a pedestal and receive personal attention and tribute." This sentiment was echoed in informal conversations among migrant women and by the staff at the Will County Health Department Family Planning Program. Pregnancy may be the only justified excuse for not participating in arduous farm labor. Without educational, career and social opportunities, the role of mother may be the only gratifying aspect of a migrant woman's life. Contraception may deprive her of this reward.

Conception is sacred. Procreation is the one pure instance where human existence partakes of the divine. Where mere mortals, in a fusion of energies, are able to create life--to re-enact God's benevolent and all-powerful creation of the Universe. Procreation is the only moment when human life transcends time to participate in eternity, transcends mortality to participate in immortality, and transcends the mundane to participate in a miracle. Curtailing procreation by a chemical or plastic device violates a deeply rooted belief in the sanctity of conception. This belief extends far beyond the traditional Catholic prohibitions against artificial birth control and abortion; it has permeated the Mexican-American culture and profoundly influences their feelings towards contraception.

Finally, Carl Djerassi, in the preface to his book The Politics of Contraception, neatly summarizes the prevalent modern attitude towards contraception, "Except for the prevention of a nuclear holocaust, achieving effective human fertility control during the balance of the century will be the overriding social action affecting the quality of life on this planet for decades. Consider just three problem areas--food, energy and pollution--which are directly related to population." Contraception is considered a socioeconomic issue and the desired goal is world population limitation. For people with an 8th grade education and daily doubts about the welfare of their own family, this type of global concern surpasses the scope of their existence. Contraception as a means of socioeconomic improvement will certainly be rejected by the migrant community and may even be perceived as a subtle form of genocide.

## Recommendations

Consider the difference between contraception and family planning. Although the two terms are often used interchangeably, contraception denotes a limited, negative action--the prevention of conception. Family planning implies determining the best time to have children and preparing well for the pregnancy and birth. The difference between the two concepts is the same as the difference between not eating any ice cream at all and deciding what flavor of ice cream to eat. Family planning, not contraception, must be promoted to the Hispanic migrant community. Current family planning programs and education converge on helping a woman decide what method of contraception is right for her. Family planning needs to be promulgated as a medical issue--an integral part of maternal and infant health care.

In this light, the migrant community may be more receptive to family planning efforts. The strong family bond which prohibits contraception can be used positively to promote family planning. Trotter writes, "Decisions are not made just on the basis of an individual's need, but on the needs and resources of the entire family group." Family planning, which secures the well-being of the family, may be acceptable. Husbands may be motivated to practice family planning out of concern for their wife's health. Mothers may be convinced that the role of wife and mother is more

rewarding if she preserves her own health and prepares for a healthy pregnancy with family planning. This approach may not engender global awareness but it does foster concern for the well-being of the family and community.

Specific information about the recommended guidelines for safe pregnancies must be provided to a woman. More importantly, education must focus an eliciting attitudes and information from a woman. She needs an opportunity to discuss her feelings about her desired number of children, her health status and her child-rearing resources. Only by taking all these things into consideration can she make an informed choice regarding her fertility. Communication must pivot on interaction between concerned adults rather than on an imposition of medical facts. Husbands should be included in family planning education so they can participate in the decision-making process. Education "should take into account the reliance on the family, particularly mothers and grandmothers, for information and advice." (Proceedings of the Conference on Communicating With Mexican-Americans: For Their Good Health, 1981) Educating older women, though past child-bearing years, may increase the overall acceptance of family planning programs in the community.

Although the male-originated idea of treating pregnancy as a disease has been rejected by modern women, this model does have some practical applications for family planning programs. Adequate family planning must include the same elements as chronic disease management, such as: preventive screenings, yearly check-ups, education and behavior modification. Availability of modern

prenatal care, medically supervised deliveries and intensive neonatal care may obviate the need for child-bearing by the recommended guidelines. But the migrant population does not have regular access to these services; thus, preventing a high-risk pregnancy rather than treating one is a sound medical judgement.

In the optimum situation, a family planning program would be an integral part of comprehensive women's care. Women would be able to receive gynecological care, obstetrical services, family planning counseling and mental health care all from the same clinic. Family planning services would include reproductive education, information on safe child-bearing guidelines, contraceptive supplies, education on the health risks of various methods of contraception, male and female infertility work-ups and genetic counseling. In this setting, family planning would also serve to identify a high-risk pregnancy before the pregnancy actually occurred. Positive pregnancy tests would initiate immediate intensive prenatal care and education. Pregnant women could be advised on the importance of not becoming pregnant again too soon. There would be complete continuity of care. In the real world, providing all of these services through one clinic is not feasible, therefore education will have to suffice to promote healthier mothers and healthier babies through family planning.

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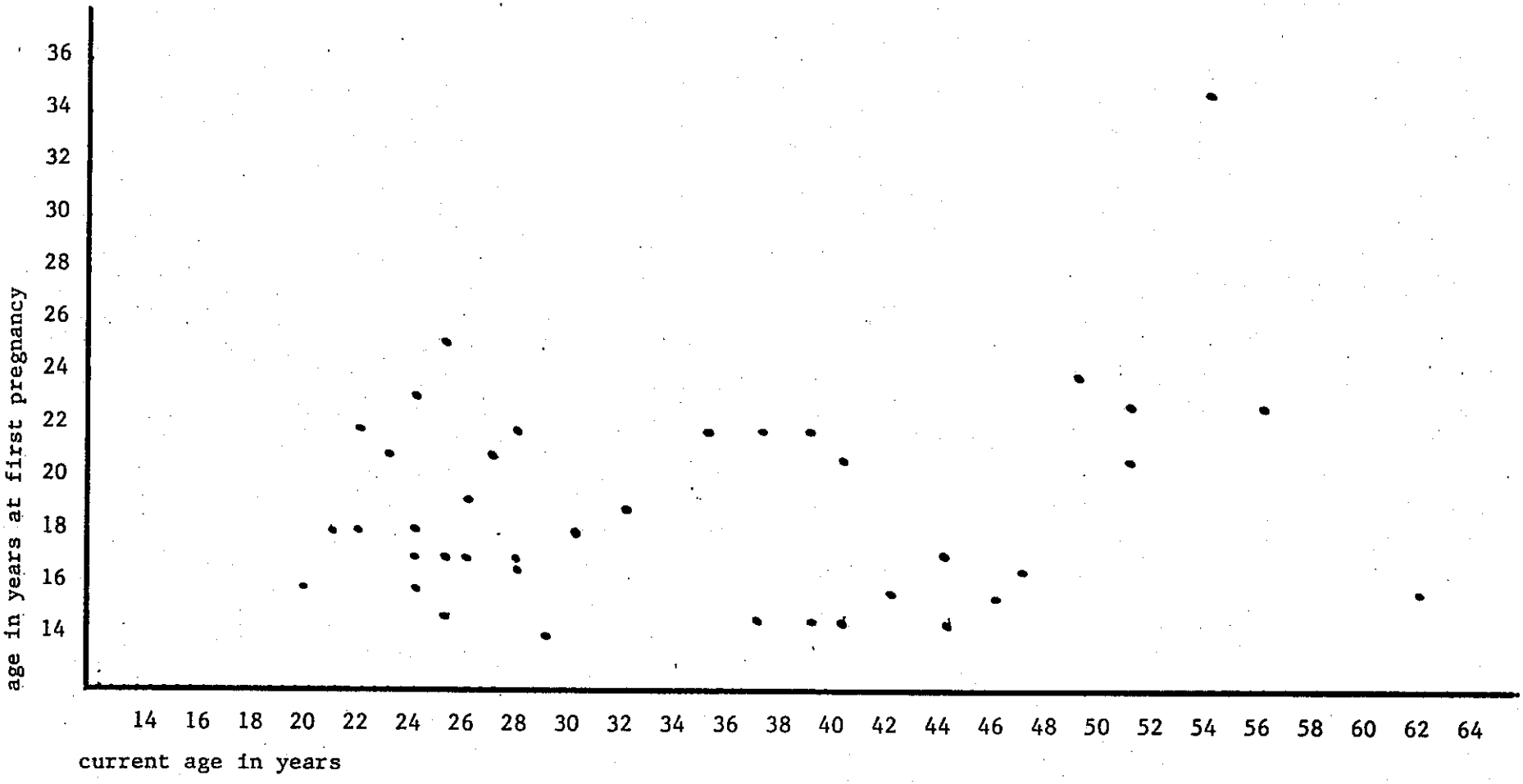
# AGE VS AGE AT FIRST PREGNANCY



## Will County Health Department Family Planning Program

By the current protocol, migrant women who express interest in family planning or contraceptives are referred the the Family Planning Clinic in Joliet. The Will County Health Department provides this Family Planning Program to meet the needs of low-income residents of the county. The Will County Health Department has informally agreed to supply oral contraceptives, condoms and spermicides to the Illinois Migrant Council for distribution to women who have undergone an initial intake and annual physical at the Family Planning Clinic. The informational brochure for the Will County Health Department Family Planning Program lists the following services:

1. Physical examination by a gynecologist. Examination includes: blood pressure, height/weight, pelvic exam, gonorrhea exam, pap smear, urinalysis, hemoglobin test, and other tests as ordered by the physician.
2. Pregnancy testing-requires a pelvic examination.
3. Contraceptive supplies: oral contraceptives, IUD's, diaphragms, condoms and foam.
4. Counseling and guidance: clients are interviewed by the nurse prior to and following their examination.
5. Health information and education: audiovisual and written information is provided to the clients to assist them in selecting their method of choice and for understanding available services.

Payment is based on a sliding scale determined by income. Clients are asked to provide documentation of income.

Although this Family Planning Clinic provides physician-supervised, confidential contraceptive services to low-income women, it is not well utilized by the local Migrant Farmworker Community. In fact, a recent chart review showed that only four migrant women have used this service since January 1987. Nor have there been greater numbers of migrant clients in previous years.

There are many possible explanations for this low utilization. Primarily, if women go to this clinic, they have already made a decision to contracept. The clinic provides information on the various methods of contraception and assists a woman in deciding what method of contraception is best for her. The annual and initial history forms, as well as the many consent forms, are all focused towards identifying possible contraindications to certain methods of contraception or side effects of contraception. Even more likely is that only a woman who has already decided to use oral contraceptives will present to the clinic for the necessary pelvic exam and supply of pills. On the Family Planning Flow Sheet used by the Will County Health Department, 22 out of 32 questions regarding menstrual and contraceptive histories pertain to contraindications, complications or usage of the Pill. Because migrant women have such limited access to health and medical information, family planning services for migrant women need to begin prior to a woman's decision

to contracept. She needs education on whether or not this is the best time for her to become pregnant in consideration of her own health, the health of the baby and the well-being of her family.

Although the Will County Health Department makes the following policy statement: "The Family Planning Clinic does not discriminate on the basis of age race or marital status", there are many aspects of their program which effectively deter migrant women from this clinic even after they have made the decision to contracept. A Spanish-speaking nurse is provided if the receptionist assesses that a particular client does not speak English. None of the physicians speak Spanish; nor are any of the audiovisual materials, the primary method of education, provided in Spanish. Many women from the migrant community can converse in English but they may prefer to discuss such personal matters as sex, pregnancy and contraception in Spanish. These women may not be identified by the receptionist and not have the benefit of a Spanish-speaking nurse. Pedro Poma, an Hispanic physician, writes, "Spanish remains the language of the family, the vehicle of intimacy, the mode of expression during stress situations (sickness, rage and exhaustion)...Intimate situations, marital and sexual matters, are easily expressed in the maternal tongue." (Illinois Medical Journal, December 1979) The opportunity to speak in Spanish is an important factor in patient comprehension and comfort.

Although Joliet is geographically closer than Aurora to the camp where most of the migrant farmworkers live, 34.5% of the respondents to the survey agreed that, "The clinics which provide family

planning are too far away." This was the third most frequent response on the survey question which attempted to elicit reasons for not using contraception (after fear of adverse side effects of contraception , 55.2%, and a belief that such matters should be left to the will of God, 37.9%). The migrant workers consider Aurora, where they do their shopping, laundry and banking, to be the center of their community. They also receive all of their health care in Aurora. Using the Family Planning Clinic in Joliet requires a special trip which is made even more difficult by their lack of transportation. Moreover, the Family Planning Clinic is located on an obscure side street in Joliet and difficult to find. Slesinger, in her paper on the "Medical Utilization Patterns of Hispanic Migrant Farmworkers in Wisconsin", demonstrated that "proximity of the migrants' work camp to the Wisconsin Migrant Dental Clinic seemed to influence the migrants' use of dental care in Wisconsin." (Slesinger et al) Although her evidence is for a specific situation, her conclusion can justifiably be generalized for all migrant health care. Providing health care services that are close, central to the community and easily located is a significant factor in the utilization patterns of migrant workers.

The Family Planning Clinic is made even less accessible to the migrant community by only taking appointments on Wednesday and Fridays during business hours. The clinic does not offer any evening or weekend appointments. Many migrant women either work in the fields themselves or do not have a source of transportation until their spouses return from the fields. The lack of evening

hours entirely precludes any husband from accompanying his wife to the clinic. A visit for an annual physical takes at least two and one-half hours in addition to travel time. Nearly half of a day is spent obtaining contraceptives from the clinic--a significant loss in wages for women who must work to support their families.

All women who use this clinic must undergo a complete physical examination including a breast exam, pelvic exam and pap smear. This is indeed a medically (and legally sound) policy but discourages women who have had their yearly gynecological exam in Texas and merely want to refill their prescriptions or ask questions. Even women who choose to obtain condoms and spermicides from this clinic must submit to (and pay for) a complete examination. If a gynecological problem is suspected, the client is referred elsewhere for diagnosis and treatment. Any woman experiencing gynecological symptoms unrelated to contraceptive use is discouraged from seeing a physician through this clinic. In other words, despite the mandatory, comprehensive exam, women do not receive gynecological care from this clinic; they are eligible only for contraceptive services. In addition, there are no female physicians at the clinic to perform these personal exams. Poma notes, "If a woman needs a genital exam, a woman-physician is preferred." (Illinois Medical Journal, December 1979) The survey of this community also showed that women feel much more comfortable talking to a nurse about family planning than talking to a physician. Although it was not specified, the preference for a nurse over a physician is most likely attributable to the traditional male sex of doctors.

Finally, there is a certain ambience of the Will County Health Department Family Planning Program that may be offensive to the Hispanic migrant woman. The clinic is shrouded in institutionalism. The building itself is surrounded by a high chain-link fence topped by barbed wire. Any woman receiving contraceptive services must sign several consent forms. Almost all of the clients who utilize the clinic are unmarried women in their teens or early twenties. The Will County Health Department also conducts an STD clinic through the same personnel and facilities. Thus, the clinic may be perceived as a service aimed at promiscuous women. Women seeking contraceptive services in the migrant community are usually married. Pre-marital or extra-marital sexual relationships, at least for women, seem to be rare.

WILL COUNTY HEALTH DEPARTMENT

# FAMILY PLANNING FLOW SHEET



**Visit Code**
I = Initial S = Supply
A = Annual P = Problem

NAME: _____
Last First Initial

ID Number _____

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Visit Code | | | | | | | |
| Date | | | | | | | |
| I. Height | | | | | | | |
| Weight | | | | | | | |
| B/P | | | | | | | |
| Gravida/Para/ABORTION | | | | | | | |
| Hgb/Hct | | | | | | | |
| Pap Smear/G.C. | | | | | | | |
| Micro-Urine | | | | | | | |
| Pregnancy Test | | | | | | | |
| LMP | | | | | | | |
| II. Menstrual History | | | | | | | |
| How are your periods? | | | | | | | |
| Was this a normal period? | | | | | | | |
| How many cigarettes do you smoke each day? | | | | | | | |
| DES Exposure | | | | | | | |
| III. Contraceptive History | | | | | | | |
| A. Missed or forgotten pills | | | | | | | |
| Taking pills late | | | | | | | |
| Taking pills at different times | | | | | | | |
| Spotting/bleeding between periods | | | | | | | |
| B. Bleeding after intercourse | | | | | | | |
| Unusual vaginal discharge, itching, odor | | | | | | | |
| Frequent or burning urination | | | | | | | |
| Painful sex | | | | | | | |
| Severe abdominal (belly) pain | | | | | | | |
| Increased menstrual cramps | | | | | | | |
| C. Severe chest pain | | | | | | | |
| Difficulty breathing | | | | | | | |
| Severe pain, numbness, tingling of arms or legs | | | | | | | |
| Blurred, double vision or flashing lights | | | | | | | |
| Problems with contact lenses | | | | | | | |
| Speech problems | | | | | | | |
| Blackouts, fits, fainting, seizures | | | | | | | |
| Mood change, depression, irritability | | | | | | | |
| Decrease in sexual desire | | | | | | | |
| Bloating, swelling | | | | | | | |
| Large weight gain or loss | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Nausea, vomiting, diarrhea | | | | | | |
| | Breast tenderness, enlargement, breast lump | | | | | | |
| | Hair loss or unusual hair growth | | | | | | |
| | Increased acne or pimples | | | | | | |
| | Skin rash, increase in color | | | | | | |
| | Headaches | | | | | | |
| IV. | Tests | | | | | | |
| | Optional Lab | | | | | | |
| | | | | | | | |
| V. | Medical/Social History Obtained/Updated | | | | | | |
| | Partners Single/Multiple | | | | | | |
| VI. | Education Sessions and/or Method fact sheet given | | | | | | |
| | Immunization for Rubella | | | | | | |
| | Breast self examination | | | | | | |
| VII. | Supplies to be given: | | | | | | |
| | Initials | | | | | | |

REV. 4-2-85

# INITIAL HISTORY

No. _____

PLEASE PRINT

Date _____

Name _____ (First / Last / Maiden) Birth Date ___/___/___ (Mo. / Day / Yr.) Age ___

Address _____ (Street / City / State) Zip _____ Phone (___) _____ (Area)

May we contact you at the above address? ☐Yes ☐No If not, where else can we contact you?

C/O _____ Address _____ Phone (___) _____ (Area)

Sex: ☐Female ☐Male Are you of Hispanic Origin or Descent? ☐Yes ☐No

Race: ☐White ☐Black ☐American Indian or Alaskan Native ☐Asian or Pacific Islander

Do you have Medical Assistance? ☐Yes ☐No Number _____ Expiration Date _____

Do you have a private insurance plan? ☐Yes ☐No Name of Company _____

Policy No. _____ Group No. _____

What is your primary source of support? ☐Self ☐Spouse/Partner ☐Parents ☐Public Assistance ☐Other _____

What is your total gross weekly or monthly income before deductions? (Include yours PLUS spouse/partner, but not parents)

$ _____ /week or $ _____ /month How many persons are supported by this income? (Include yourself) _____

How many school years have you completed? _____

Are you a student now (or between academic years)? ☐Yes ☐No

Have you ever been seen at this or any other clinic for family planning medical services? ☐Yes ☐No If YES

Where? _____ Date of last visit ___/___ (Mo. / Yr.)

I am here today because _____

_____

| CLINIC USE ONLY |
|---|
| |
| |
| |
| |
| |

## PREGNANCY HISTORY

Do you think you might be pregnant? ☐Yes ☐No

Have you ever been pregnant? ☐Yes ☐No

If YES, complete Pregnancy History :-

Total number of times pregnant _____

Number of live births _____

(Number of these now living _____)

Number of stillbirths _____

Number of miscarriages _____

Number of induced abortions _____

(Number since Jan. 1973 _____)

Your age at time of first pregnancy _____

When did your last pregnancy end? ___/___ (Mo. / Yr.)

Types of deliveries: ☐Cesarean ☐Vaginal

Did you have any complications with your pregnancy?

☐Yes ☐No

Have you ever had an ectopic (tubal) pregnancy?

☐Yes ☐No

_____

_____

## CONTRACEPTIVE HISTORY

Have you ever used a method of birth control? ☐Yes ☐No

If YES, what method(s) have you used?

☐Oral (pill) ☐Condom

☐IUD ☐Withdrawal

☐Diaphragm ☐Injection

☐Foam/jelly/cream ☐Self sterile

☐Natural (including rhythm) ☐Partner sterile

Last method used (one only) _____

Are you using that method now? ☐Yes ☐No

If NO, when did you stop: ___/___ (Mo. / Yr.)

How long have/had you been using that method? _____

Where did you get it? _____

Problems with method _____

_____

_____

_____

What method do you want to use now? _____

_____

_____

ASSURANCE OF CONFIDENTIALITY — All information which would permit identification of an individual, a practice or an establishment will be held confidential. Provision of services is in no way contingent on your providing any information for this page.



(Continued on Reverse Side

First day of last period . . . . . / / (Mo. Day Yr.)

Number of days from start of one period to start of next . . . . . _____

Number of days flow . . . . . _____

Average number of pads/tampons used a day . . . . . _____

Are your periods regular? . . . . . ☐ Yes ☐ No

Age periods began . . . . . _____

Date of last Pap smear . . . . . _____

Age at first intercourse . . . . . _____

Did your mother take DES (hormone) to prevent miscarriage? . . . ☐ Yes ☐ No ☐ Don't know

## MENSTRUAL/GYNECOLOGICAL HISTORY

## MEDICAL/SURGICAL HISTORY

| DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? | YES | NO | When | COMMENTS BY CLINIC STAFF |
|---|---|---|---|---|
| 1 Frequent vaginal infections | | | | |
| 2 Unusual vaginal discharge | | | | |
| 3 Vaginal odor/itching/burning | | | | |
| 4 V.D. (gonorrhea/syphilis) | | | | |
| 5 Infection in uterus/tubes/ovaries | | | | |
| 6 Pain or bleeding with intercourse | | | | |
| 7 Missed periods | | | | |
| 8 Unusual periods in the last year | | | | |
| 9 Severe premenstrual discomfort | | | | |
| 10 Severe menstrual cramps | | | | |
| 11 Uterine growths | | | | |
| 12 Abnormal Pap smears | | | | |
| 13 Stroke | | | | |
| 14 Seizures/fainting spells | | | | |
| 15 Mental/emotional problems/depression | | | | |
| 16 Severe headaches | | | | |
| 17 Vision problems | | | | |
| 18 Contact lenses | | | | |
| 19 Thyroid disease | | | | |
| 20 Heart problems/murmurs/rheumatic fever | | | | |
| 21 Chest pain/difficult breathing | | | | |
| 22 High blood pressure | | | | |
| 23 Blood clots in veins | | | | |
| 24 High blood fat levels | | | | |
| 25 Anemia | | | | |
| 26 Breast lumps/discharge | | | | |
| 27 Stomach/intestinal problems | | | | |
| 28 Gall bladder disease | | | | |
| 29 Hepatitis/mono/jaundice | | | | |
| 30 Diabetes | | | | |
| 31 Bladder/kidney problems | | | | |
| 32 Frequent urination/burning | | | | |
| 33 German measles | | | | |
| 34 Cancer | | | | |
| 35 Genetic problems | | | | |
| 36 ALLERGIES | | | | |
| 37 Hospitalization/surgery | | | | |
| 38 Other medical problems | | | | |



(Continued on Next Page)

(If adopted, disregard questions 39 through 43)

FAMILY HX

| Have your parents, brothers or sisters ever had? | Yes | No | When | COMMENTS BY CLINIC STAFF |
|---|---|---|---|---|
| 39. Heart attack (under 50).. | | | | |
| 40. High blood pressure..... | | | | |
| 41. Breast or uterine cancer. | | | | |
| 42. Diabetes..... | | | | |
| 43. Genetic problems..... | | | | |

CURRENT HX

44. Private doctor(s) _____

45. Have you received medical care in the past year? Yes___ No___

46. Do you take medications or any other drugs? No ___ Yes ___, list _____

To the best of my knowledge, the above information is complete and accurate.

_____
Patient's Signature

MB:cch
1-85, REV: 6-9-86

# ANNUAL HISTORY

No. _____

PLEASE PRINT

Date _____

Name _____ Birth Date ___/___/___ Age ___.
First Last Maiden Mo. Day Yr.

Address _____ Zip _____ Phone (___) _____
Street City State Area

May we contact you at the above address? ☐Yes ☐No If not, where else can we contact you?

C/O _____ Address _____ Phone (___) _____
Area

Race _____

Do you have Medical Assistance? ☐Yes ☐No Number _____ Expiration Date _____

Do you have a private insurance plan? ☐Yes ☐No Name of Company _____

Policy No. _____ Group No. _____

What is your primary source of support? ☐Self ☐Spouse/Partner ☐Parents ☐Public Assistance ☐Other _____

What is your total gross weekly or monthly income before deductions? (Include yours PLUS spouse/partner, but not parents)

$ _____ /week or $ _____ /month How many persons are supported by this income? (Include yourself) _____

How many school years have you completed? _____

Are you a student now (or between academic years)? ☐Yes ☐No

I am here today because _____

_____

CLINIC USE ONLY

_____

_____

_____

_____

## INTERIM HISTORY

### PREGNANCY HISTORY

Do you think you might be pregnant? ☐Yes ☐No

Have you ever been pregnant? ☐Yes ☐No

If YES, complete Pregnancy History

Total number of times pregnant _____

Number of live births _____

(Number of these now living _____)

Number of stillbirths _____

Number of miscarriages _____

Number of induced abortions _____

(Number since Jan. 1973 _____)

Your age at time of first pregnancy _____

When did your last pregnancy end? ___/___
Mo. Yr.

Types of deliveries: ☐Cesarean ☐Vaginal

Did you have any complications with your pregnancy?

☐Yes ☐No

Have you ever had an ectopic (tubal) pregnancy?

☐Yes ☐No

_____

_____

### CONTRACEPTIVE HISTORY

Since your last visit
have you used a method of birth control? ☐Yes ☐No

If YES, what method(s) have you used?

☐Oral (pill) ☐Condom
☐IUD ☐Withdrawal
☐Diaphragm ☐Injection
☐Foam/jelly/cream ☐Self sterile
☐Natural (including rhythm) ☐Partner sterile

Last method used (one only) _____

Are you using that method now? ☐Yes ☐No

If NO, when did you stop: ___/___
Mo. Yr.

How long have/had you been using that method? _____

Where did you get it? _____

Problems with method _____

_____

_____

_____

What method do you want to use now? _____

_____

_____

ASSURANCE OF CONFIDENTIALITY – All information which would permit identification of an individual, a practice or an establishment will be held confidential. Provision of services is in no way contingent on your providing any information for this page

MB : cch

We are trying to improve health care for mothers and their babies. This survey will help us provide you with better health care services. Many health care providers feel that family planning or being able to plan pregnancies and space births is important for the health of both the mother and the baby. We have included some questions about family planning in this survey. This survey is written in both English and Spanish; please choose the language which is best for you. Please take a few moments to answer the questions. Do not write your name on this paper and when you finish the survey, put it in the envelope so your answers are private. We will let you know the results of the survey in a few weeks. Thank you for your help and your time.

1. How old are you? _____

2. Please circle the last year you completed in school.
   0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

3. How many times have you been pregnant? (include live births, miscarriages and abortions) _____

4. How many, if any, of these pregnancies ended in miscarriage? _____

5. How many times, if ever, have you had a planned abortion? _____

6. How many children do you have in your family now? _____

7. How old were you during your first pregnancy? _____

8. How old were you during your most recent pregnancy? _____

10. How many, if any, of your children died before they were 1 year old? _____

11. How many, if any, of your children weighed less than 5.5 pounds (2.5 kilos) at birth? _____

12. When did you start to see a doctor or nurse during your last pregnancy? 1-3 months_____ 4-6 months_____ 7-9 months_____

13. How many children do you feel it is best for a family to have? _____

14. Have you ever talked about family planning or birth control with your husband? yes_____ no_____ not married_____

15. Have you ever talked about family planning or birth control with your sisters, mother or friends? yes_____ no_____

16. If you have daughters older than fifteen, have you ever talked about family planning or birth control with them? yes_____ no_____ does not apply_____

17. Are you pregnant now? yes_____ no_____

18. If you are not pregnant now, are you trying to become pregnant? yes_____ no_____ pregnant now_____

19. Have you had a hysterectomy (removal of womb or uterus)? yes_____ no_____ don't know_____

20. Are you currently having sexual relations? yes_____ no_____

21. Do you currently use some form of family planning or birth control? yes_____ no_____

22. If you are not currently using birth control, have you ever used some form of birth control in the past? yes_____ no_____

Please check all types of birth control which you have ever tried.

_____NONE

_____Pill (oral contraceptives)
_____IUD
_____natural family planning
_____withdrawal (man pulls out before he comes)
_____tubes tied
_____vasectomy
_____condoms and foam
_____spermicidal jelly, sponges or suppositories
_____diaphragm
_____injectable contraceptives
_____rhythm or calendar method

23. What would be the best way for you to learn about family planning or birth control? (Please check one.)

_____talking to a nurse by yourself
_____going to a class taught by a nurse
_____talking to a friend who uses birth control
_____reading pamphlets about birth control or family planning

24. Would you feel comfortable talking to a male doctor about birth control or being examined by him? yes_____ no_____

The following sentences describe reasons why some women choose not to use family planning or birth control. Please check whether <u>you</u> agree or disagree with these statements. If you cannot understand the statement or are not sure if you agree or disagree, please check "not sure".

| agree | disagree | not sure | |
|---|---|---|---|
| _____ | _____ | _____ | Birth control is too expensive. |
| _____ | _____ | _____ | I am embarassed to ask a doctor or nurse about birth control. |
| _____ | _____ | _____ | The clinics which provide family planning or birth control are too far away. |
| _____ | _____ | _____ | My husband or family does not want me to use family planning or birth control. |
| _____ | _____ | _____ | The clinics which provide family planning or birth control do not have doctors or nurses who speak Spanish. |
| _____ | _____ | _____ | I am afraid that if I talk to a doctor or nurse, my family or neighbors will find out that I am using birth control. |
| _____ | _____ | _____ | I do not know where to get information about family planning or birth control. |
| _____ | _____ | _____ | I feel that there are side effects of birth control that are bad for my health. |
| _____ | _____ | _____ | Many types of birth control interfere with lovemaking. |
| _____ | _____ | _____ | I feel that it is best to have children when they come and not try to change God's plan. |
| _____ | _____ | _____ | I don't want to use birth control because it is against the teachings of the Catholic Church. |
| _____ | _____ | _____ | When I make love I do not always have time to think about birth control. |
| _____ | _____ | _____ | The clinics which provide family planning or birth control are not open in the evening or weekends. |

Other_____

First day of last period _____/_____ _____ Number days of flow _____

Was this a normal period? ☐ Yes ☐ No

PROBLEMS SINCE LAST VISIT

| | Yes | No | When | | Yes | No | When | |
|---|---|---|---|---|---|---|---|---|
| 1. | ☐ | ☐ | ____ | Depression/irritability | ☐ | ☐ | ____ | Hospitalization |
| 2. | ☐ | ☐ | ____ | Headaches/dizziness | ☐ | ☐ | ____ | Allergies, List: _____ |
| 3. | ☐ | ☐ | ____ | Vision problems | ☐ | ☐ | ____ | VD (gonorrhea/syphilis) |
| 4. | ☐ | ☐ | ____ | Do you use contact lenses? | ☐ | ☐ | ____ | Infection in uterus/tubes/ ovaries |
| 5. | ☐ | ☐ | ____ | Chest pain/difficult breathing | ☐ | ☐ | ____ | Changes in periods over the last year |
| 6. | ☐ | ☐ | ____ | Severe pain/numbness/ tingling in arm/leg | ☐ | ☐ | ____ | Missed periods |
| 7. | ☐ | ☐ | ____ | Breast lump/discharge | ☐ | ☐ | ____ | Severe cramps |
| 8. | ☐ | ☐ | ____ | Hepatitis/mononucleosis/ jaundice | ☐ | ☐ | ____ | Frequent vaginal infection |
| 9. | ☐ | ☐ | ____ | Severe abdominal pain | ☐ | ☐ | ____ | Unusual vaginal discharge |
| 10. | ☐ | ☐ | ____ | Frequent nausea/vomiting | ☐ | ☐ | ____ | Vaginal odor/itching/burni |
| 11. | ☐ | ☐ | ____ | Kidney/bladder problem | ☐ | ☐ | ____ | Pain or bleeding with inte course |
| 12. | ☐ | ☐ | ____ | Frequent urination/burning | ☐ | ☐ | ____ | Spotting/bleeding between periods |
| 13. | ☐ | ☐ | ____ | Bloating/swelling | | | | |

Since your last visit have your parents, brothers or sisters developed any of the following?

| | Yes | No | | | Yes | No | |
|---|---|---|---|---|---|---|---|
| 26. | ☐ | ☐ | Heart attack (under age 50) | 29. | ☐ | ☐ | Diabetes |
| 27. | ☐ | ☐ | High blood pressure | 30. | ☐ | ☐ | Genetic problems |
| 28. | ☐ | ☐ | Breast or uterine cancer | | | | |

31. Private doctor(s)

32. Have you received medical care in the past year? ☐ Yes ☐ No

33. Do you take medications or any other drugs? ☐ No ☐ Yes, list _____

GENERAL HEALTH

34. Do you drink alcoholic beverages? ☐ No ☐ Yes

35. Do you smoke? ☐ No ☐ Yes What? _____ How many per day? _____

36. On a typical day, how many servings of the following do you eat?

___ fruits ___ vegetables ___ breads/cereals ___ milk products

___ meats ___ sweets ___ eggs

37. How many hours sleep do you normally get?

38. Do you participate in some form of physical exercise at least three times a week?

☐ Yes ☐ No

To the best of my knowledge, the above information is complete and accurate.

_____
Patient's Signature

WILL COUNTY HEALTH DEPARTMENT

501 Ella Avenue 727-8670 Joliet, IL 60433

I have been fully informed about the possible side effects, risks and benefits of contraceptives. I am also aware of the fact that NO method of birth control is 100% effective and that there is a chance of my becoming pregnant.

Knowing this, the method of birth control which I choose is _____.

I also agree to come back to the clinic for follow-up care and to report any unusual side effects to the staff. I was given the opportunity to ask both the doctor and the interviewer questions regarding my health care and my method of birth control. I feel that I am fully informed.

_____ _____ _____

SIGNATURE WITNESS DATE

**********

FOR PATIENTS CHOOSING ORAL CONTRACEPTIVES

A pill instruction sheet was given to me. I have read and understand it. I am also aware of the minor side effects and the more serious side effects. If I notice any of the following conditions, I will call the clinic or my family doctor:

* increased vaginal discharge, odor, or itching
* severe chest pain
* severe headaches
* eye problems: blurred vision, dizziness, flashing lights
* severe leg pains, swelling or redness

THESE SIGNS REQUIRE IMMEDIATE MEDICAL CARE. I will call the clinic, my family doctor or an emergency room immediately.

_____

SIGNATURE

**********

FOR PATIENTS CHOOSING AN INTRA-UTERINE DEVICE

I realize that even though the IUD is a very effective means of birth control, it is not 100% effective. An instruction sheet has been given to me. I have checked and felt the strings of my IUD, and know that this must be done frequently for the next few months, then after each period or any time I have cramping. I will return for an IUD string check after my next period. Yearly pap tests and breast exams are still necessary.

The possible side effects - heavier and longer periods, expulsion of the device, cramping, infection, uterine perforation and complications of pregnancy - have been explained to me. Knowing these, my choice of birth control is an intra-uterine device.

_____

SIGNATURE

**********

FOR PATIENTS CHOOSING A DIAPHRAGM

Insertion and correct use of the diaphragm has been explained to me, and I feel that I understand the proper procedure. A diaphragm instruction sheet was given to me. I agree to come back to the clinic within a month wearing the diaphragm to make sure that I have it in correctly.

There are no side effects except possible allergic reaction to the rubber and/or spermicidal agent or growth of microorganisms if the diaphragm is left in place too long. If I notice any unusual side effects, I will call the clinic.

_____

SIGNATURE

**********

FOR PATIENTS CHOOSING FOAM/CREAM AND CONDOM

The proper use of both foam and condom has been explained to me. I understand this, and am also aware that by my using the foam or cream and my partner wearing a condom (rubber), the effectiveness is increased. I have received instruction sheets on correct use of both, and feel fully informed. Knowing that the effectiveness for proper use of foam and condom together is about 99+%, condom alone about 90% and foam alone about 78%, my choice of birth control is: foam/cream and condom, foam/cream alone, condom alone.

WILL COUNTY HEALTH DEPARTMENT

Joliet, IL 60433 501 Ella Avenue (815) 727-8670

Request and Consent for Family Planning Services

Name _____ Birth Date _____ Date _____

Address _____ Telephone _____

I do hereby consent to and authorize the administration of Family Planning services provided by the Will County Health Department (WCHD).

I understand that the Family Planning services include a physical examination including exams of the breasts and pelvis and blood and urine tests.

I further understand that any laboratory tests which indicate the presence of a communicable disease will be handled by WCHD in compliance with the rules and regulations of the State of Illinois, which may require the administration of drugs and medications.

I hereby confirm that I will comply with the recommendations of the physicians and staff of WCHD and understand that my failure to do so may result in my record being closed. I have been informed that my record will be closed 15 months following my last scheduled visit.

I hereby agree to call for the results of my tests and assume all responsibility for securing this information.

I hereby acknowledge being informed that the Family Planning Clinic is not an entitlement program, but rather a service provided by the WCHD under contract with the Illinois Department of Public Health.

I hereby assume full responsibility for the accuracy and currency of the information I have supplied and declare under penalty of perjury that I have provided all information pertaining to my family's income, health insurance, or any other information having any bearing upon my status and ability to provide payment for my health care.

I hereby release the Will County Board of Health and it's agents, employees, laboratory and nursing staff and physicians from any and all liability for any adverse results which may occur in connection with these services.

_____ _____

Date Patient's Signature

_____

Witness

BJ:cch
2-4-85

FAMILY PLANNING Will Co.

| PATIENT SERVICE DISCOUNT | Level 1 0% - 100% | | Level 2 101% - 150% | | Level 3 151% - 200% | | Level 4 201% - 250% | | Level 5 251% or more | |
|---|---|---|---|---|---|---|---|---|---|---|
| | CHRG | ADJ | CHRG | ADJ | CHRG | ADJ | CHRG | ADJ | CHRG | ADJ |
| INITIAL VISIT | 0 | 78.00 | 18.00 | 60.00 | 38.00 | 40.00 | 58.00 | 20.00 | 78.00 | 0 |
| ANNUAL VISIT | 0 | 78.00 | 18.00 | 60.00 | 38.00 | 40.00 | 58.00 | 20.00 | 78.00 | 0 |
| PREGNANCY TEST & PELVIC CONFIRMATION | 0 | 44.00 | 11.00 | 33.00 | 22.00 | 22.00 | 33.00 | 11.00 | 44.00 | 0 |
| PREGNANCY TEST LAB | 0 | 9.00 | 2.00 | 7.00 | 4.00 | 5.00 | 6.00 | 3.00 | 9.00 | 0 |
| INTERMEDIATE VISIT - M.D. | 0 | 35.00 | 8.00 | 27.00 | 16.00 | 19.00 | 24.00 | 11.00 | 35.00 | 0 |
| COUNSELING | 0 | 30.00 | 7.00 | 23.00 | 14.00 | 16.00 | 22.00 | 8.00 | 30.00 | 0 |
| MONITORING VISIT | 0 | 10.00 | 0 | 10.00 | 3.00 | 7.00 | 6.00 | 4.00 | 10.00 | 0 |
| SUPPLY VISIT/COUNSELING - R.N. | 0 | 30.00 | 7.00 | 23.00 | 14.00 | 16.00 | 22.00 | 8.00 | 30.00 | 0 |
| PILLS - 1 CYCLE | 0 | 2.00 | 2.00 | 0 | 2.00 | 0 | 2.00 | 0 | 2.00 | 0 |
| - 2 CYCLES | 0 | 4.00 | 4.00 | 0 | 4.00 | 0 | 4.00 | 0 | 4.00 | 0 |
| - 3 CYCLES | 0 | 6.00 | 6.00 | 0 | 6.00 | 0 | 6.00 | 0 | 6.00 | 0 |
| - 4 CYCLES | 0 | 8.00 | 8.00 | 0 | 8.00 | 0 | 8.00 | 0 | 8.00 | 0 |
| - 5 CYCLES | 0 | 10.00 | 10.00 | 0 | 10.00 | 0 | 10.00 | 0 | 10.00 | 0 |
| - 6 CYCLES | 0 | 12.00 | 12.00 | 0 | 12.00 | 0 | 12.00 | 0 | 12.00 | 0 |
| DIAPHRAGM (1) | 0 | 5.00 | 5.00 | 0 | 5.00 | 0 | 5.00 | 0 | 5.00 | 0 |
| IUD | 0 | 50.00 | 10.00 | 40.00 | 30.00 | 20.00 | 40.00 | 10.00 | 50.00 | 0 |
| SULTRIN CREAM (1 TUBE) | 0 | 7.00 | 7.00 | 0 | 7.00 | 0 | 7.00 | 0 | 7.00 | 0 |
| MONISTAT CREAM (1 TUBE) | 0 | 7.00 | 7.00 | 0 | 7.00 | 0 | 7.00 | 0 | 7.00 | 0 |
| ORTHO GYNOL GEL (1 TUBE) | 0 | 6.00 | 6.00 | 0 | 6.00 | 0 | 6.00 | 0 | 6.00 | 0 |
| DELFEN FOAM (STARTER KIT) | 0 | 2.00 | 2.00 | 0 | 2.00 | 0 | 2.00 | 0 | 2.00 | 0 |
| DELFEN FOAM (REFILL) | 0 | 2.00 | 2.00 | 0 | 2.00 | 0 | 2.00 | 0 | 2.00 | 0 |
| MONISTAT SUPPOSITORIES (1 BOX) | 0 | 6.00 | 6.00 | 0 | 6.00 | 0 | 6.00 | 0 | 6.00 | 0 |
| ORTHO PROTOSTAT (1TABLET) | 0 | .65 | .65 | 0 | .65 | 0 | .65 | 0 | .65 | 0 |
| CONDOMS (1 DOZEN) | 0 | 2.00 | 2.00 | 0 | 2.00 | 0 | 2.00 | 0 | 2.00 | 0 |

JCB:pp
4-10-86