A STUDY OF THE RESPONSES OF 200 PUBLIC HEALTH NURSES IN OREGON REGARDING FAMILY PLANNING COUNSELING

by

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CHAPTER I

INTRODUCTION

Introduction to the Problem

Explosive population growth is recognized as a major deterrent to economic and social progress. When the population becomes greater than the potential for production, mankind is in for a future of poverty, suffering, and war. (39) Demographers predict that the United States will have about 220 million people by 1975 and 235 million by 1980. By 1975, about 50 percent of the population will be under 25, and the population over 65 will have increased by at least 20 percent. (21) Probably the older population will increase more than this due to chemotherapy, electro-mechanical implants, computer-assisted hospital care, and better management that improves the health of older people. (21, 39)

Without more family planning, the number of unemployable people in the United States will continue to rise. The financial strain caused by continued chronic dependency and public welfare is driving cities and counties to the edge of bankruptcy. (42, 57)

> No greater challenge confronts us than the need to find a way to improve the quality on earth, and to make certain that each child is a wanted child, one who can be loved, clothed, fed, and educated. (44)

President Richard Nixon made the following statement in his Special Message to the Ninety-first Congress on July 18, 1969:

> Whether man's response to that challenge [population growth] will be cause for pride or for despair in the year 2000 A. D. will depend very much on what we do today. If we now begin our work in an appropriate manner, and if we continue to devote a considerable amount of energy to this problem, then mankind will be able to surmount this challenge as it has surmounted so many during the long march of civilization. (43)

Statement of the Problem

At a symposium on Oregon's Infant Mortality and Morbidity held on August 6, 1969, Babson stated that within the past five years, 17,000 babies had been born to women in Oregon in which the infant was her sixth or greater child. He suggested that three children per family are too many to prevent overpopulation. He also stated that in a survey done at Multnomah County Hospital on pregnant women, 95 percent of the pregnancies were unplanned, and only 5 percent of the women had used any kind of a contraceptive. (3)

In 1967 the State of Oregon passed a law pertaining to family planning and birth control. (Appendix H) Nurses are the prime professional servants of the Health Department personnel in assuring the public that the right to receive family planning counseling is more than "just another law" passed by the legislature. The position of the Public Health Nurse as a health educator allows her to make

welcomed recommendations to her patients in regard to family planning. (58)

The following excerpt is from Proposed Accomplishments for Oregon State Government 1969 - 1971 in which Governor Tom McCall made the following recommendations:

> Reduce the number of unwanted and uncared for children by furnishing the opportunity for all parents to plan their families.
>
> Proposed Accomplishment: During 1969-71, increase the number of family planning clinics from 9 to 20 to serve 88 percent of the potential population. (43, 750 medically indigent families)
>
> Proposed Accomplishment: During 1969-71, obtain legislation to permit wider and clearer dissemination of family planning information, obtain cooperation of drug companies to disburse family planning information through a variety of media. (35)

In Oregon's 36 counties, there are 33 Health Departments plus one Visiting Nurse Association. There are 11 part-time family planning clinics in Oregon, including the Planned Parenthood Clinics in Portland as of September 30, 1968. The family planning clinic services are in areas where an estimated 60. 4 percent of the medically indigent patients live. (16; Appendix G)

In a study by Jaffee (29), it was revealed that most Americans have access to family planning guidance. However, there are groups that will come into the clinic only through the use of extensive home visiting and group counseling and discussion techniques. These are

the very low socio-economic groups who are the potential patients for tax supported clinics. They are the people reached by the public health nurse.

> The highest birth rates are recorded consistently by those elements of society in which illiteracy and dependency are concentrated. Families in the lower socio-economic groups want and welcome information and advice in child spacing. (40)

The lower socio-economic groups need the same opportunity for free choice in family planning that other Americans enjoy. (5, 6) Family planning must be maintained in the context of a public health measure; it is not a contraceptive program, nor is it a welfare program. (40)

In August, 1969, Stewart, the Health Officer of Washington County, stated that public health nurses need to be more aggressive in case finding in low income families. He further stated that patients should be encouraged to tell their friends and neighbors that family planning services are available. The family planning clinic services in that county have been open one evening per month and have averaged no more than 120 patients per year. (32)

Therefore, the apparent questions are these:

1. Are public health nurses in Oregon playing a key role in assuring that the right to family planning counseling services has more than a formal meaning to those in need?
2. Is the public health nurse carrying out her responsibility

in recognizing the readiness of the poor to accept family planning counseling?

Purpose of the Study

This descriptive study was undertaken to determine whether or not there was a consensus among practicing public health nurses in Oregon in regard to counseling for family planning.

It was proposed to assess the relationship of four pre-determined background variables, namely: 1) groups of nurses dichotomized at age 29 and younger; 2) the State of Oregon Merit System Rating; 3) length of experience in public health nursing; and 4) whether or not the nurses have had any special education regarding counseling for family planning.

Hypotheses

The following hypotheses were formulated:

1. Groups of nurses dichotomized at age 29 years and younger show no differences in their responses as to whether or not they have had any special education regarding counseling for family planning.
2. Groups of nurses dichotomized at age 29 years and younger show no differences in their responses as to how they introduce the subject of family planning.

3. Groups of nurses ordered according to State of Oregon Merit System Rating show no differences in their responses as to how they introduce the subject of family planning.
4. Groups of nurses ordered according to years of experience in public health nursing show no differences in their responses as to whether or not they have had special education regarding family planning counseling.
5. Groups of nurses ordered according to years of experience in public health nursing show no differences in their responses as to how they introduce the subject of family planning.
6. Groups of nurses dichotomized according to whether or not they have had special education toward counseling for family planning show no differences in their responses on how they introduce the subject of family planning.

In addition to the above hypotheses, the following questions will be discussed:

1. What types of family planning methods do the patients most often wish to discuss?
2. What types of family planning methods are easy for the public health nurse to discuss?
3. What approach is most often used by the public health nurse to introduce the subject of family planning?

4. What referral facilities have been utilized for making family planning available to patients by the public health nurse?
5. What resources would the public health nurse like to see made available within the community toward the better understanding of family planning?

Definitions

For the purpose of this study the following definitions were adopted:

Family Planning: The regulation of pregnancies to enable parents to have their babies when they want them.

Public Health Nurse: A registered nurse who performs generalized public health nursing activities. See Appendix F for job description.

Special Education: Classes offered to nurses concerning family planning.

Counseling: Application of nursing knowledge and skill for the purpose of increasing the competence of individuals to act upon their own health problems. (22)

Home Visit: The family-nurse contact in the patient's home. See Appendix E for various breakdown of Home Visit categories. (27)

Limitations

This study includes the information obtained by the use of a questionnaire distributed to the sample population. The findings subsequently reflect the sensitivity and reliability of the measuring instrument.

The data were collected from 200 registered nurses practicing public health nursing in 24 counties of Oregon and the Visiting Nurses Association.

Research Design

Sources of the Data

The primary sources of data were responses obtained from the 200 registered nurses in Public Health Nursing who responded to a questionnaire.

The secondary source of data was that information obtained from the literature related to family planning counseling.

Procedure for the Study

The steps involved in the development of this study are described as follows:

1. A general survey of the current literature was made concerning family planning counseling practices among the

health profession, the role of the nurse, and current legislation in regard to family planning. From the literature it was anticipated that a frame of reference would be established.

2. The problem was defined.
3. The purpose and the scope of the study were formulated.
4. The limitations were determined.
5. The hypotheses were formulated.
6. The study done by Earl Siegel, M. D. and Ronald C. Dillehay, Ph. D., in 1964, on approaches to family planning counseling by public health nurses and physicians in California, was found to be applicable as a guide in developing the questionnaire. Permission was granted by Siegel to use the findings of his study in the development of the questionnaire. (Appendix A)
7. The questionnaire was constructed. (See Appendix C).
8. Comments and suggestions concerning the questionnaire were obtained from Bernice Peterson, Maternal/Child Health Nurse Consultant for the Oregon State Board of Health; from Jeanne Radow, Clinic Director of the Planned Parenthood Association; and from Flavia Green, Family Planning Coordinator, Multnomah County Division of Public Health.

9. A pilot study was conducted by administering the questionnaire to 20 public health nurses employed by the Multnomah County Division of Public Health. The pilot study consisted of a test-retest, carried out one week apart, for the purpose of determining reliability of the questions, and estimating the time needed to complete the questionnaire. The chi square with Yates correction was employed to test the reliability of the items. The results were analyzed and no modifications of the questionnaire were found to be necessary.

10. Letters of introduction were sent to the Director of the Visiting Nurses Association and to each Director of Nurses or Supervisor of Nurses at each of the 32 Divisions of Public Health, except Multnomah County, in Oregon. The letter stated the purpose of the study, and the possible length of time it would require to complete the form. A card was enclosed to permit each health department to indicate whether or not there was a desire to participate in the study. (See Appendix B)

11. Replies were received from all Divisions of Public Health except one. Twenty-four Divisions of Public Health and the Visiting Nurses Association indicated willingness to participate in the study. Seven Divisions of Public Health

did not find it possible to participate in the study.

12. The questionnaires were mailed to the participating health departments and the Visiting Nurses Association. A stamped self-addressed envelope was enclosed for the return of each data-collecting device. It was assumed that by guaranteeing anonymity the respondents would be frank.
13. Arrangements were made with Multnomah County Division of Public Health to mail the questionnaire with accompanying cover letter to the 77 nurses who had not participated in the pilot study. (Appendix B)
14. Two hundred forty questionnaires were mailed. Two hundred nine questionnaires were returned. Two hundred questionnaires were usable.
15. The data were tabulated and interpreted. Tables were constructed from the tabulated data.
16. The findings were summarized, conclusions were drawn, and recommendations for further study were made.

Overview of the Study

This study is presented in four chapters. Chapter I presents an introduction to the broad problem, defines the purposes of the study and describes the procedure. Chapter II presents a review of the related literature. Chapter III describes the study with an

analysis and interpretation of the data received. Chapter IV includes a summary of the study, the conclusions drawn, and recommendations for further study.

CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

Planning for wanted children who can be loved, adequately clothed, fed and educated is the prime goal of those who concern themselves with family planning. Voluntary family planning is stressed as an essential health measure for families. Planned parenthood is a necessary element in any program for increasing mental health as well as contributing to the peace of the world. (14, 17, 52)

A study done in 1960 by Whelpton, Campbell, and Patterson (64) states that the well educated and the poorly educated couples have similar fertility values. Studies also indicate that the poor want, welcome, and use medically approved contraceptives when they are offered conveniently, systematically and with dignity. (5, 6)

A policy announced by the Secretary of Health, Education, and Welfare in June of 1966 states the goals of family planning:

> The objectives of the Departmental policy are to improve the health of people, to strengthen the integrity of the family, and to provide families the freedom of choice to determine the spacing of their children and the size of their families.

> Programs conducted or supported by the Department shall guarantee freedom from coercion or pressure of mind or conscience. There shall be freedom of choice of method so that individuals can choose in accordance with the dictates of their conscience. (11)

Public Policy

Public institutions have largely adhered to the prevalent ban on giving birth control information. Prior to the late 1950's, there had been scarcely any significant change in public policy since the 1870's when Anthony Comstock persuaded Congress to pass the laws regarding interstate commerce in contraceptives which equated birth control with indecency, pornography, and moral degeneration. (40)

Within the past few years, family planning programs have rapidly gained acceptance as part of the maternal child health services. In March, 1966, President Lyndon Johnson declared:

> It is essential that all families have access to information and services that will allow freedom to choose the number and spacing of the children within the dictates of individual conscience. (31)

In December, 1967, Congress mandated that certain services be included to recipients of public assistance when it approved the Amendments to Social Security. Among these were family planning. In order to implement the service, Congress voted to increase Federal matching funds for state programs to 85 percent for the fiscal year ending June 30, 1969. However, little to no progress

was made in this program. Congress now has extended the program for the fiscal year ending June 30, 1970, as the incentive year for family planning. (28)

On January 31, 1968, Secretary Gardner of the Department of Health, Education, and Welfare announced a new departmental policy for family planning. A new post of Deputy Assistant Secretary for Population and Family Planning was created. (55)

Until recently, publicly financed hospitals and health departments failed to provide education toward family planning. Only those citizens who could afford private physicians had access to fertility control. In Oregon, the law of the 1930's has not yet been repealed concerning the dispensation of any type of contraceptive through a registered pharmacist. Community action is being directed toward the repealing of this law.

Through community efforts, the first Planned Parenthood Family Planning Clinic in Oregon was established on October 2, 1963, in Portland. The clinic was staffed with all volunteer help. The first family planning clinic conducted in a tax supported public health department in Oregon was opened in Multnomah County, September 1, 1966.

In 1967, the State of Oregon passed a statute on Family Planning and Birth Control. (See Appendix H) In 1969, Oregon received $205,000 from federal funds for the fiscal year July 1, 1969 to June

30, 1970, to improve and implement family planning services in the state. According to Press, "It would cost about $1.2 million yearly to provide these services to every low-income family in the state." (20)

Family planning services consist of the establishment of clinics, staffed by physicians and nurses, to offer instruction and advice regarding medically approved forms of contraception, including the rhythm method, if the patient desires. Tubal ligations and abortions are not considered as methods of family planning to be paid for out of state funds. (16)

The improvement and implementation of family planning programs are of high priority on the national level. President Nixon stated in his Special Message to the Ninety-first Congress on July 18, 1969 that "population growth is one of the most important issues we face." (43)

Overpopulation

The human family is growing at a rate never before experienced in history. Overpopulation in the United States is readily observable. Among some of the resultant problems are those of air pollution, inadequate water supply, and lack of space for recreation. Cities are expanding but health care facilities, schools, housing, and highways are most inadequate. Crime is also on the increase.

(42, 65) Once people worried about their jobs and income; now it is about their environment, their safety, and "their ability to survive in dignity and happiness." (65)

A study conducted at the University of Pittsburg's Center for Regional Economic Studies in 1965 under the auspices of Planned Parenthood, showed that:

> Without more birth control, the number of unemployable people in the United States will rise, the total tax burden will continue to grow, there will be chronic dependency, and the economy will be hard pressed to maintain improving standards of living. (57)

Presidents Kennedy, Johnson, and Nixon have characterized population control as a matter of prime national importance. In 1966, the co-chairmen of a fund raising campaign for Planned Parenthood were former Presidents Harry Truman and Dwight Eisenhower. (45)

Family planning is not a panacea for the economic and social problems of the United States. (33) The spread of small family ideals and the motivation to use family planning has tended to be more rapid in an urban culture rather than rural culture. Adaptation of contraceptive methods and willingness to use them requires reorientation of social values and attitudes. (24, 60)

It is not realistic to attempt to deal with problems of children who are without families or whose families cannot afford to rear

them properly by a federally supported program such as Aid to Dependent Children. The problems and the costs have been mounting year after year. However, more intangible, but perhaps most important, is the terrible cost in human suffering, ignorance and illness to individuals and families that overpopulation brings. In contrast, if Americans are given the family planning information they desire, there will be a smaller, better educated population that is better equipped to take a productive role in our society. (44)

Psycho-social Implications

> Control of an expanding population by other than catastrophic means, is an extremely complex problems connected with cultural-psychologic factors. (52)

For many years, people have witnessed with appalling regularity the tragic aftermath of distorted "family planning": the fearful, desperately ill victim of self-induced abortion, or a multilation by the so-called qualified abortionist; hungry, disturbed children; angry, disillusioned young people, victims of knifing and other injuries of mob violence, overburdened parents who are driven to be participants in a "battered child syndrome"; the filthy, one or two room apartments shared intimately by two adults and too many children. The story is old. Stability in our culture is the product of healthy, secure family relationships. (53)

Family planning is an essential element in any program for increasing the physical and mental health of society. According to Guttmacher, if only "wanted" children are born to parents, poor as well as affluent, "many of the social ills which beset us today would be eliminated." (25)

All religious denominations "approve of the objectives of family planning, and all approve of some method of birth control to achieve these objectives." (17) The basic objective of family planning is not at controversy, but rather the various methods used to achieve fertility control. (18)

The American Academy of Pediatrics states that family planning should be included within the total health care of children. (30) Menninger has said, "Nothing is more tragic, more fateful in ultimate consequences, than the realization by a child that he was unwanted." (38)

> Where one child reacts to this [being unwanted] in later life with an acute mental illness, dozens of children . . . react to it in more subtle ways by developing self-protective barriers against the inner perception of the feeling of being unwanted. (38)

The psychiatrists, social workers, nurses, and others in the field of mental health are most concerned of the consequences affecting the unwanted child.

More often than not, the illegitimate birth is an unplanned-for

pregnancy which means an unwanted child. Forty percent of out-of-wedlock births are to teenagers. (46)

Many people continue to object to wider use of contraception because of its presumed effect on promiscuity. It is not easy to admit that youngsters do have sexual relations. (7)

Schofield's study done in England in 1965 on premarital contraception consisted of actual interviews with teenagers randomly selected from various social classes. He found that the majority of girls "neither took precaution themselves nor insisted upon their partners using any contraceptive measure." (49) This study demonstrated that lack of contraceptive methods and/or fear of pregnancy will not necessarily prevent premarital intercourse.

Extramarital relationships are going on among young people, and among those who are not so young. Schools have problems of girls dropping out of school because of pregnancy. The community doesn't want them in school and the parents do not have the money to send them away. More educational material about birth control must be developed. Efforts to educate these children must be initiated in the home and then continued in the school. The young people need to be given a higher motivation for parenthood, and at the same time given a stronger understanding of the responsibilities incurred when they become parents, as well as the difficulties and burdens. (7)

> It can never by taught directly [responsibility of parenthood] --never by lectures or telling children how they should behave, but by example, by analogy, by observing failure in one's own family, by observing those who are happy because they have children that they have been able to take care of well--not materially so much as lovingly--and those who are unhappy because they have had children carelessly and are not able to bring them up properly, and those children who are unhappy because their parents have not accepted the responsibility. (7)

Family planning is very closely related not only to mental health but also to maternal and child health. Oregon's Fetal and Infant Mortality rate ranked first to third within the United States in the interim 1940-1949. Between 1950-1959 it ranked thirtieth. (3) The United States stands fifteenth among the nations of the world in infant mortality rates despite its high standard of living. (33)

Infant mortality rises when birth intervals are too close. Day (12) reviewed the literature on the survival of the fetus and child in relation to age of parents and pregnancy spacing. Some of his findings are:

1. An interval of approximately two years between the end of one pregnancy and the beginning of another is associated with the lowest incidence of fetal and neonatal mortality and prematurity.

2. Old parents are more likely to have children with congenital defects of certain types than those who are young.

3. The mother whose baby is at greatest risk from preventable conditions and who would be most likely to benefit from medical care

(including contraceptive advice) would appear to be the young multipara.

The use of contraceptives is accepted by the majority as a normal and acceptable practice in married life. (14, 56) Although contraceptives vary in effectiveness, the method that is acceptable and will be used consistently by the couple is the ultimate in choice. (26, 47) "Taking a chance" is the most common cause of family planning failure. (19, 48)

The casual approach to family planning is fairly prevalent until the couple have all the children they want. (50, 65) There is a relationship between family planning effectiveness and desired family size. The problem of larger families than the parents intended is especially acute at low income and educational levels. (64)

Researchers have classified the obstacles to family planning under four general categories: 1) Knowledge and beliefs; 2) sexual attitudes; 3) values and motivation with respect to family planning; 4) marital relationships. (52)

A study done by Beasely (6) showed that more than 90 percent of the poor showed marked ignorance about reproductive physiology, family planning and the causes of infertility. However, despite their lack of knowledge and low contraceptive practice, the poor are ready to accept family planning. The sexual attitudes held by people play an important role in how effective they are at family planning.

Rainwater found in his study of the working class of people that effective and consistent use of contraception can be attained only when attitudes toward sex are taken into account. (51)

Many persons lack motivation with respect to family planning because many lack "planning for their life situation" and feel it is unimportant. (52) Rainwater found in a study on working class people that the wives felt isolated in their marital relationship. Contrary to popular opinion, sex is not comfortably conveyed in the working class. (51)

Perhaps an important social force which directly determines the outlook of people toward life and customs is liberal education. Education fosters a desire for decent standards of living and kindles aspirations for economic and social promotion. It may also create that rational and questioning attitude which a man must have in order to break away from age long but absolute tradition of uncontrolled fertility if it comes into clash with his cherished goals. New patterns of family and birth control are prevalent only among the highly educated. (7)

Jaffee and Polgar found that whether or not family planning programs were accessible was an important factor contributing to the failure of the poor to use the family planning clinics. The authors stated that the hours the clinics are open may be inconvenient for some families and therefore may be a cause in the failure of the

poor to accept birth control measures. (30)

Manisoff lists several factors that may be responsible for the failure to convert acceptance of birth control into practical application:

1. Lack of available facilities.
2. Lack of knowledge regarding those facilities.
3. Lack of sufficiently wide variety of acceptable birth control methods from which parents can choose.
4. Lack of suitable times when clinic services are available.
5. Need for baby sitters.
6. Cost of the services.
7. Geographical distance from clinic services.
8. Misinformation about family planning techniques and consequences. (33)

Beasely, on close examination of family planning services offered, found them to be very minimal and in some instances, nonexistent. The taxpayer must be educated that "procreation is not the poor man's recreation." (5)

Studies have shown that the poor want as few or fewer children than the affluent. (5, 6) In regard to the reduction of poverty, the Office of Economic Opportunity feels birth control is the most "cost-effective" approach. (33)

Eliot and Meier (15) suggested the following factors as being

influential toward the acceptance of family planning:

1. Special maternity and infant care projects which encourage pre- and post-natal care, including family planning.

2. Addition to hospital programs of social workers and public health nurses who can improve communication with patients including communication on family planning.

3. Major changes in state laws and policies, and local health department regulations permitting the establishment of family planning services.

4. Increased information to patients on family planning services through official notification and informal information for welfare clients; information from public health nurses during home visits and child health conferences; information from anti-poverty program case aides; multi-media publicity concerning family planning programs and methods.

Another group that is often in just as great a need of family planning counseling consists of the 3,500,000 couples in the United States who are unable to have children. However, with much current research on reproductive physiology, particularly toward pregnancy prevention, the fundamental causes and treatment of infertility are making gains. (54)

Finally, there is a tendency to ignore males in many family planning programs. In many Western countries, the decline in birth rates has been achieved primarily through the responsiveness of males to family planning education. "Males cannot be ignored if

family planning programs are to be more widely accepted." (61)

Role of the Nurse in Family Planning

Family planning represents a special field in which the nurse may function. When she does this she must draw upon her knowledge of that which is relevant to nursing in a family planning program. (66)

The hospital nurse and the public health nurse are often sought as professionals who can give advice on family planning. (17, 37)

The Board of Directors of the American Nurses' Association in the Statement on Family Planning made September, 1966, delineated the responsibilities of all registered nurses as:

1. To recognize the right of individuals and families to select and use such methods for family planning as are consistent with their own creed and mores.

2. To recognize the right of individuals and families to receive information about family planning if they wish.

3. To be responsive to the need for family planning.

4. To be knowledgeable about the state laws regarding family planning and the resources available.

5. To assist in informing individuals and families of the existence of approved family planning resources.

6. To assist in directing individuals and families to sources of such aid. (1)

Nurses must become well informed about the effect of overpopulation and sensitive to the health needs of the families with whom they work. (9, 10)

A Survey of Knowledge and Use of Family Planning Methods in a Selected Group of Mothers was conducted by Brown in 1967 on 50 mothers of all age groups living in married student housing. This study sought to determine the amount of knowledge the mothers had concerning family planning, and from whom they had obtained this knowledge. She concluded that printed materials such as books and magazines and friends were the most effective source of family planning information. Nurses had been among the least effective sources of disseminating information regarding family planning. Brown concluded that "doctors and nurses should be prepared for counseling patients in the area of family planning." (8)

The specific role of the nurse in family planning has been and is the subject of much discussion in professional journals. More than any other factor, the burgeoning of clinical research in family planning has added to the work of the nurse. Her patterns of consultation and interviewing have been affected by research studies. (2)

Studies have been made of the attitudes of individual nurses toward family planning and their effects on the patient. The studies demonstrated that no single statement could be made that would apply in all instances. It does seem clear, however, that the nurse must

be informed about problems of unwanted children and the therapeutic effects of family planning. (17, 41)

Robinson states:

> The nurse in a clinic, doctor's office, public health agency, or hospital has a deep and abiding obligation to preserve health, regardless of her own convictions, regardless of public opinion, and regardless of the patient's station in life. To this end, she plays an important role in carrying forward and maintaining health teaching in the area of family planning, an area significant to the perpetuation of sound family relationships. (53)

Siegel and Dillehay conducted a study in California during the spring of 1964 on approaches used by physicians and nurses regarding family planning counseling. The data were collected by questionnaire from approximately 15 percent stratified-random sample of health department personnel. Their findings indicated that the professionals indicated a tendency to expect the mothers to introduce the subject of family planning. (58) However, Rainwater, in his interviews with the poor, found that most women prefer the health worker to be more assertive in discussing family planning. (51)

According to Siegel, the public health nurse is the key professional servant of the health department in relation to family planning counseling. (58) Family planning counseling consists of more than information given by the public health nurse; it is a part of the total maternal/child health service. "For nursing to omit this vital part of maternity service is to give inadequate service." (10)

It is hard to deny that effective family planning is far from being widely practiced. Most of the lack of contraception occurs within marriage. Since the health visitor probably sees more families over a longer period of time, her opportunities and responsibilities become clear in regard to counseling for family planning. (4)

The nurse, because of her professional preparation and experience, is qualified to discuss family planning. The nurse has great responsibilities in the guidance and counseling of mothers to aid them in "projecting good physical, mental and social adjustments, and attitudes" to their daughters and sons, and to aid them to be more knowledgeable parents. (2, 23, 36)

The public health nurse, obviously, cannot establish hospital or health services where they do not exist. However, by proper implementation, family planning resources can be made available one way or another. This is becoming more of a recent trend since the regulation of public assistance for disseminating information regarding contraception, and Medicaid rules are making it possible for the poor as well as the affluent to use the services of a private physician. (34)

Since the role of the public health nurse is that of a teacher of healthful living, "she can easily and logically incorporate this component as it relates to the total family health." (38)

Considering the above factors, the nurse has an opportunity to

assist in identifying men and women for whom family planning counseling would be appropriate.

Miriam Manisoff makes the following comment:

> This would potentially include all women of childbearing age, particularly following the birth of a child, when the last several children were born at intervals of less than 18 months to two years, when the mother appears physically or emotionally burdened by the care of present children, when there is a history of physical or emotional disability in the mother or in the family, and when the patient is under 18 or over 40 years of age. Where tuberculosis, diabetes, or severe heart disease brings the nurse to the patient, the suggestion of delaying pregnancy is a normal part of patient care. (33)

Despite the great need for nurses to initiate the subject of family planning, many are hesitant to do so. The nurse must recognize that family planning is preventive medicine; thus, as such, patients come to the nurse in a different frame of reference than when they are ill or in acute pain. The nurses' attitude toward family planning is most important. (10, 19, 66)

It has been found that whenever nurses are indifferent or even hostile, they can discourage patients from requesting help from physicians or finding out about other sources of family planning assistance. (37) "Where nurses are prepared to inquire into the patient's needs and wishes, the patient's chance of being referred effectively for family planning assistance is much increased." (41)

Studies show that women are reluctant to discuss family

planning with the doctor when they are confined for delivery. However, they will discuss family planning with the nurse because the next child is clearly of "great relevance." (62)

Between 1962 and 1965, a project was conducted in the San Francisco area that illustrates the role of the nurse in family planning. The project, the Oakland Community Health Improvement Project, was sponsored by the Ford Foundation. The project staff included a consultant whose job it was to teach public health nurses how to bring family planning information into the homes of patients. The nurses were given demonstration kits and taught seven non-prescription methods of child spacing. Where indicated, the nurses referred the patients to the clinic or private physician for prescription methods. (40)

A report of this project stated:

> The simple fact that in this carefully studied and previously neglected population, 30 percent of the newcomers visited the clinic, and 80 percent of the high-risk antepartal patients requested family planning help, doesn't begin to tell the story of the enthusiastic acceptance of the project. This individual publich health nurse approach has won the respect of all who have observed it. (40)

In Family Planning, A Teaching Guide for Nurses, Miriam Manisoff summarized the nurse's responsibility in regard to family planning:

1. To present information about family planning in the context of healthful family living, so that the patient can see the relationship and choose intelligently from among methods available the one which best suits her family needs (or reject them if she desires).

2. To assist the patient to express her questions, fears, doubts, concerns, and misgivings.

3. To encourage and support the patient in her desire to achieve her goals as to family size.

4. To understand the obstacles and problems which may exist for the patient--social, psychological, financial, geographical, chronological, and work to overcome them.

5. To provide acceptance, warmth, and understanding that the patient needs in order to be able to begin and continue to use family planning.

6. To provide continuity of guidance and supervision to the patient throughout her productive years.

7. To carry out case-finding and follow-up procedure.

8. To assist the physician in the clinic.

9. To teach methods of family planning to individuals and groups.

10. To help administer programs of family planning and maintain adequate records. (33)

Guttmacher, in 1965, in reference to the nurse's role in informing the public regarding family planning stated: "The nurse's responsibility is one of a missionary, a giver of information, and a salesman." (17) Her help is needed.

Summary of the Literature Reviewed

Many studies have been done in regard to the need for family planning counseling. Each has demonstrated consistently that the poor lack knowledge of reproductive physiology, but that they are ready and willing to accept family planning services if they are offered with convenience and dignity.

Studies have also shown that when nurses are anxious or even indifferent or hostile in counseling patients regarding family planning, they can actually discourage patients from asking physicians about sources of family planning assistance.

The literature indicated the importance of having nurses become aware that child spacing is a basic human right and necessary for the total health of families. It is further important that nurses become informed regarding serious effects of overpopulation; increase their knowledge and develop understanding of all methods of birth control; be sensitive to the health needs and feelings of the families with whom they work; and be effective in communication skills and counseling techniques.

CHAPTER III

REPORT OF THE STUDY

Introduction

This study was undertaken for the purpose of determining whether or not there was a consensus among practicing public health nurses within the State of Oregon in regard to counseling for family planning.

This study follows the steps outlined in Chapter I. The limitations as stated in Chapter I were the defining propositions of the study. The following hypotheses were tested:

1. Groups of nurses dichotomized at age 29 years and younger show no differences in their responses as to whether or not they have had any special education regarding counseling for family planning.
2. Groups of nurses dichotomized at age 29 years and younger show no differences in their responses as to how they introduce the subject of family planning.
3. Groups of nurses ordered according to State of Oregon Merit System Rating show no differences in their responses as to how they introduce the subject of family planning.

4. Groups of nurses ordered according to years of experience in public health nursing show no differences in their responses as to whether or not they have had special education regarding counseling for family planning.
5. Groups of nurses ordered according to years of experience in public health nursing show no differences in their responses as to how they introduce the subject of family planning.
6. Groups of nurses dichotomized according to whether or not they have had special education toward counseling for family planning show no differences in their responses as to how they introduce the subject of family planning.

Design of the Study

Selection and Revision of the Study Instrument

Following the initial review of the literature concerning family planning counseling practices among health professions and current legislation in regard to family planning, the data collecting device was developed in the form of a questionnaire. Principles derived from the survey of the literature served as the bases upon which the tool was constructed. The questionnaire may be found in Appendix C.

Permission was granted from Earl Siegel, M. D., M. P. H.,

Associate Professor of Maternal Child Health at the University of North Carolina, to use his instrument as a guide. The responses to Siegel and Dillehay's study were used in developing question 6, in Part II of the questionnaire. (Appendix A)

Comments and suggestions concerning the questionnaire were obtained from Bernice Peterson, Maternal/Child Health Nurse Consultant for the Oregon State Board of Health; Jeanne Radow, Clinic Director of Planned Parenthood Association, Portland, Oregon; and Flavia Green, Family Planning Coordinator, Multnomah County Division of Public Health.

The questionnaire was divided into three parts. Part I sought information concerning the nurse's age, State of Oregon Merit System Rating, number of years of experience in public health nursing, and whether or not the nurse had any special education toward counseling for family planning.

Part II sought the nurse's responses regarding how she would introduce the subject of family planning.

Part III consisted of questions on types of family planning methods that were easiest for the nurse to discuss and those easiest for the patient to discuss; the approach most often used by the public health nurse to introduce the subject of family planning; and what facilities she had used to make family planning available to her patients. The nurses were also asked what resources they would like

to see made available in their community toward better understanding of family planning.

Pilot Study

Twenty public health nurses from Multnomah County Division of Public Health participated in the pilot study. At this time the questionnaire was tested for reliability and to estimate the time needed to complete the form. The chi square with Yates correction was employed to test the reliability of the items. Reliable items were those where the null hypothesis was found to be tenable. The results of the pilot study were analyzed and no revisions in the device were found to be necessary.

Procedure for Solution

Procedure for Collecting the Data

Letters of introduction were sent to the Director of Nurses or Supervisor of Nurses of each of the 32 Divisions of Public Health (Multnomah County excluded) in Oregon. A letter was also sent to the Visiting Nurses Association of Portland, Oregon. A post card was enclosed to permit the director or supervisor to indicate interest in having her staff participate in the study, and also to indicate how many questionnaires would be needed. (Appendix B)

Arrangements were made with Multnomah County Division of Public Health to mail the data collecting device with an accompanying cover letter to the 77 nurses who had not participated in the pilot study. (See Appendix B)

Anonymity was maintained throughout the study. No names were used, nor was the use of names ever considered necessary. A stamped self-addressed envelope was provided for the return of the questionnaire. If a nurse did not desire to participate in the study, she was requested to return the uncompleted questionnaire. This was done in an effort to make the study as convenient as possible for the participant, and also to attempt to secure a greater participation on the part of the study sample.

Letters were mailed to the director or supervisor of the health departments on April 25, 1969. On May 5, 1969, the questionnaire was mailed to the 77 nurses of Multnomah County Division of Public Health who had not participated in the pilot study. Between May 5, 1969 and May 21, 1969, questionnaires were mailed to 24 county health departments and the Visiting Nurses Association which had consented to participate in the study. Seven counties were unable to participate in the study. One county did not reply to the original letter nor to a second letter requesting participation in the study. Any questionnaire received after June 6, 1969 was not used in the study. This cut-off date was made for the purpose of limiting the

study.

A total of 240 questionnaires were mailed. Two hundred nine questionnaires were returned as follows:

Questionnaires returned not completed	5
Questionnaires returned late	4
Questionnaires returned completed	200
Total number returned	209

Plan for Analysis of Data

The questionnaire served as a record of responses made by each study participant. Numerical data were transferred to a tally sheet from which separate tables and figures could be constructed. Subjective responses were recorded as close to verbatim as possible. The number of returned, completed questionnaires provided a large enough N from which the data could be analyzed. Since the study was primarily designed to elicit the expressions of the nurses regarding counseling for family planning, the major part of the analysis was planned to be in this area. The summary of the data may be found in Appendix D.

Statistical Manipulation and Interpretation of the Data

Part I of the questionnaire served as a basis for describing the sample population which was being studied. The chi square test of

significance was used to analyze the data in Part II of the questionnaire, thus, testing the null hypotheses of no significant differences among the responses. Part III of the questionnaire asked for statements of the public health nurse participants regarding various aspects of their own experience.

The chi square was used because the data were expressed in frequencies. Contingency tables were constructed for each of the items. The responses of each individual were tabulated separately and each one entered into the table. A tally was then placed in each cell. In this manner all of the responses to all of the items by each of the individuals were tallied.

The chi square test requires that the expected frequencies in each cell should not be too small. Siegel states that when this requirement is violated, the results of the test are meaningless. (59) The frequencies were small in cells (C) with difficulty, first time; and (D) with difficulty, after several visits. Therefore, the data are interpreted with the frequencies C and D combined into one category. That is, the chi square test of significance was done using four categories: (A) with ease, first visit; (B) with ease, after several visits; (C and D) with difficulty; and (E) not at all.

The degrees of freedom for chi square were determined by using the formula $df = (r - 1)(c - 1)$, where r equals the number of rows in the contingency table and c equals the number of columns in the

contingency table. Thus, the distribution of chi square of each item is a function of the number of degrees of freedom for each item. (13)

Nurses' Age and Special Education

Table 1 shows the comparison of groups of nurses dichotomized at age 29 years and younger and their responses as to whether or not they have had any special education toward counseling for family planning. It is noted that 66.5 percent of the respondents are 30 years and older.

The critical value of chi square at the .01 level of significance for a 2x2 contingency table with 1 degree of freedom is 6.635. The value obtained from Table 1 is .017 which is lower than the critical value of chi square at the .01 level of significance. The difference between groups of nurses dichotomized at age 29 years and younger and their responses regarding whether or not they have had any special education regarding counseling for family planning is not significant. Therefore, the null hypothesis stating there is no difference between groups of nurses dichotomized at age 29 years and younger and their responses regarding whether or not they have had any special education regarding counseling for family planning is held tenable. There appears to be no difference between each group and their responses regarding special education regarding counseling for family planning.

Table 1. Comparison of Groups of Nurses Dichotomized at Age 29 Years and Younger and Their Responses as to Whether or Not They Have Had Any Special Education Toward Counseling for Family Planning.

Age	Total Responses (N = 200)	Special Education	No Special Education
(1)	(2)	(3)	(4)
29 years and younger	67	37	30
30 years and older	133	74	59

$\chi^2 = .017$

Nurses' Age and Family Planning

Table 2 shows the comparison of groups of nurses dichotomized at age 29 years and younger and their responses regarding counseling for family planning on a home visit which is a new referral. Table 3 shows the comparison of groups of nurses dichotomized at age 29 years and younger and their responses regarding counseling for family planning in a specific situation.

The critical value of chi square at the .01 level of significance for a 2x4 contingency table with 3 degrees of freedom is 11.345. The null hypothesis stating that there is no difference between groups of respondents dichotomized at age 29 years and younger and their responses as to how they introduce the subject of family planning is held tenable for all items except 4, 7, and 11 in Table 2.

Item 9 of the questionnaire requested the nurse to state how she would introduce the subject of family planning on a new post-partum referral. The frequency of responses of parts C, D, and E of item 9 were too small to be of any significant value in the analysis of this item, and therefore were deleted. One factor operating which may be responsible for nurses responding to only categories A and B is that the nurse seems to understand her role in counseling for family planning in post-partum referrals. However, this would be another study. The critical value of chi square at the .01 level of significance for a 2x2 contingency table with 1 degree of freedom is 6.635.

Tables 2 and 3 show the results of 16 chi square tests made on questions 5 and 6 of Part II of the questionnaire. The chi square values obtained were lower than the critical value of chi square at or beyond the .01 level of significance except for items 4, 7, and 11.

Item 4: A new referral to a tuberculosis patient

Item 7: A new referral to parents of a handicapped child

Item 11: A new referral on a patient for mental health reasons

Therefore, the p (probability) that a difference exists between groups of nurses dichotomized at age 29 years and younger and their responses regarding how they introduce the subject of family planning in items 4, 7, and 11 is significant; that is, they appear to be

part of different populations and, therefore, the null hypothesis is rejected.

The hypothesis stating there is no difference between groups of nurses dichotomized at age 29 years and younger and their responses as to how they introduce the subject of family planning is held tenable except for items 4, 7, and 11. This disparity in responses to these items may be due to the fact that nurses are uncertain as to whether or not discussion of family planning in these situations is or is not within the scope of present nursing practice. However, this would be indication for further study.

Table 2. Comparison of Groups of Nurses Dichotomized at Age 29 Years and Younger and Their Responses Regarding Counseling for Family Planning on a New Referral.

Home Visit Category (New Referral)	Total Responses N = 200*	Chi square	df	p
(1)	(2)	(3)	(4)	(5)
1. Premature infant	192	10.74	3	ns
2. School follow-up visit	187	4.91	3	ns
3. Acute illness	189	9.58	3	ns
4. Tuberculosis	189	13.08	3	.01
5. Acute communicable disease	189	2.82	3	ns
6. Chronic disease	190	7.87	3	ns
7. Parents of handicapped children	188	12.18	3	.01
8. Well persons	190	.87	3	ns
9. Post-partum	185	.12	1	ns
10. Prenatal	190	9.68	3	ns
11. Mental health	188	20.41	3	.01

*Totals do not add to 200 as questions permitted a multiple response answer.

Table 3. Comparison of Groups of Nurses Dichotomized at Age 29 Years and Younger and Their Responses on How They Counsel for Family Planning in a Specific Situation.

Situation Category	Total Responses N = 200*	Chi square	df	p
(1)	(2)	(3)	(4)	(5)
1. Woman unable to have children	189	.55	3	ns
2. Unmarried mother	194	.32	3	ns
3. Young girl (age 14 or older who admits having sexual relations)	195	2.09	3	ns
4. Very young parents	195	4.97	3	ns
5. Pre-marital counseling	189	4.48	3	ns

*Totals do not add to 200 as question permitted a multiple response answer.

Merit System Rating and Family Planning

Table 4 shows the comparison of groups of nurses according to State of Oregon Merit System Rating and their responses regarding how they introduce the subject of family planning on a new referral home visit. Table 5 shows the comparison of groups of nurses according to State of Oregon Merit System Rating and their responses regarding how they introduce the subject of family planning in a specific situation.

The critical value of chi square at the .01 level of significance for a 6x4 contingency table with 15 degrees of freedom is 37.697. The null hypothesis stating groups of nurses ordered according to

State of Oregon Merit System Rating show no difference in their responses as to how they introduce the subject of family planning is held tenable.

Only one PHN V responded to the questionnaire, as did only one R. N. III; therefore, the statistical analysis was computed on 198 respondents.

The frequencies were too small to combine (C) with difficulty, first time, and (D) with difficulty, after several visits, in items 1, 5, 8, and 10. The frequencies in the category (E) not at all, were too small to be of any significant value in item 2. Therefore, these categories were omitted when doing the statistical analysis.

The critical value of chi square at the . 01 level of significance for a 6x3 contingency table with 10 degrees of freedom is 23. 209.

Item 9 requested the nurse to state how she would introduce the subject of family planning on a new post-partum referral. The frequency of responses of Parts C, D, and E for item 9 were too small to be of any significant value in the analysis of this item and was therefore deleted. The critical value of chi square at the . 01 level of significance for a 6x2 contingency table with 5 degrees of freedom is 15. 086.

Tables 4 and 5 show the results of 16 chi square tests made on questions 5 and 6 of Part II of the questionnaire. The chi square values obtained were lower than the critical value of chi square at or

beyond the .01 level of significance. The differences among groups of nurses ordered according to State of Oregon Merit System Rating and their responses as to how they introduce the subject of family planning is not significant. Therefore, the null hypothesis stating that groups of nurses ordered according to State of Oregon Merit System Rating show no difference in their responses as to how they introduce the subject of family planning is held tenable.

Table 4. Comparison of Groups of Nurses According to State of Oregon Merit System Rating and Their Responses Regarding Counseling for Family Planning on a New Referral.

	Home Visit Category (New Referral)	Total Responses N = 198*	Chi square	df	p
	(1)	(2)	(3)	(4)	(5)
1.	Premature infant	183	9.09	10	ns
2.	School follow-up visit	185	12.61	15	ns
3.	Acute illness	187	26.13	15	ns
4.	Tuberculosis	188	30.30	15	ns
5.	Acute communicable disease	180	19.40	10	ns
6.	Chronic disease	188	16.21	15	ns
7.	Parents of handicapped children	186	18.23	15	ns
8.	Well persons	186	4.14	10	ns
9.	Post-partum	184	3.51	5	ns
10.	Prenatal	186	11.43	10	ns
11.	Mental health	186	19.47	15	ns

*Totals do not add to 198 as question permitted a multiple response answer.

Table 5. Comparison of Groups of Nurses According to State of Oregon Merit System Rating and Their Responses Regarding Counseling for Family Planning in a Specific Situation.

Situation Category	Total Responses N = 198*	Chi square	df	p
(1)	(2)	(3)	(4)	(5)
1. Woman unable to have children	187	22.02	15	ns
2. Unmarried mother	185	10.25	10	ns
3. Young girl (age 14 or older who admits having sexual relations)	193	12.58	15	ns
4. Very young parents	184	2.12	5	ns
5. Pre-marital counseling	177	1.98	5	ns

*Totals do not add to 198 as question permitted multiple response answer.

Years of Experience and Special Education

Table 6 shows the comparison of groups of nurses according to years of experience in public health nursing as to whether or not they have had special education toward counseling for family planning.

The critical value of chi square at the .01 level of significance for a 2x4 contingency table with 3 degrees of freedom is 11.345. The value obtained from the table is 3.31 which is lower than the critical value of chi square at the .01 level of significance. The null hypothesis stating there is no difference regarding groups of nurses ordered according to years of experience in public health nursing and whether or not they have had special education regarding counseling

for family planning is held tenable. There appears to be no difference between the groups and their responses regarding special education for family planning counseling.

Table 6. Comparison of Groups of Nurses According to Years of Experience in Public Health Nursing and Their Responses as to Whether or Not They Have Had Any Special Education Toward Counseling for Family Planning.

Years of Experience	Total Responses N = 200	Special Education	No Special Education
(1)	(2)	(3)	(4)
Less than 1	28	13	15
1 - 5 years	91	53	38
6 - 10 years	29	13	16
Over 10 years	52	32	20

$$\chi^2 = 3.31$$

Years of Experience and Family Planning

Table 7 shows the comparison of groups of nurses by years of experience in public health nursing and their responses regarding how they introduce the subject of family planning on a home visit that is a new referral. Table 8 shows the comparison of groups of nurses by years of experience in public health nursing and their responses regarding how they would introduce the subject of family planning in

a specific situation.

The critical value of chi square for a 4x4 contingency table with 9 degrees of freedom is 21.666. The null hypothesis stating there is no difference in responses among nurses ordered to years of experience in public health nursing as to how they introduce the subject of family planning is held tenable.

The frequencies were too small to combine (c) with difficulty, first time and (D) with difficulty after several visits, in items 8, 9, and 10. Also, the frequencies in the category (E) not at all, were too small in items 4 and 5. Hence, these categories were omitted when doing the statistical analysis.

Tables 7 and 8 show the results of 16 chi square tests made on questions 5 and 6 of Part II of the questionnaire. The critical value of chi square at the .01 level of significance for a 4x3 contingency table with 6 degrees of freedom is 16.812. The chi square values obtained were lower than the critical value of chi square at or beyond the .01 level of significance. The difference between groups of nurses ordered according to years of experience in public health nursing and their responses as to how they introduce the subject of family planning is not significant. Therefore, the null hypothesis stating that groups of nurses ordered according to years of experience in public health show no difference in their responses regarding how they introduce the subject of family planning is held tenable.

Table 7. Comparison of Groups of Nurses Ordered to Years of Experience in Public Health Nursing and Their Responses Regarding Counseling for Family Planning on a New Referral.

	Home Visit Category (New Referral)	Total Responses N = 200*	Chi square	df	p
	(1)	(2)	(3)	(4)	(5)
1.	Premature infant	192	8.38	9	ns
2.	School follow-up visit	187	14.21	9	ns
3.	Acute illness	189	7.00	9	ns
4.	Tuberculosis	189	18.48	9	ns
5.	Acute communicable disease	189	13.55	9	ns
6.	Chronic disease	190	18.49	9	ns
7.	Parents of handicapped children	188	18.93	9	ns
8.	Well persons	188	12.39	6	ns
9.	Post-partum	191	8.74	6	ns
10.	Prenatal	188	9.29	6	ns
11.	Mental health	188	14.40	9	ns

*Totals do not add to 200 as question permitted a multiple response answer.

Table 8. Comparison of Groups of Nurses Ordered to Years of Experience in Public Health Nursing and Their Responses on How They Introduce the Subject of Family Planning in a Specific Situation.

	Specific Situation	Total Responses N = 200*	Chi square	df	p
	(1)	(2)	(3)	(4)	(5)
1.	Woman unable to have children	189	11.63	9	ns
2.	Unmarried mother	194	12.83	9	ns
3.	Young girl (age 14 or older who admits having sexual relations)	195	7.47	9	ns
4.	Very young parents	192	9.31	6	ns
5.	Pre-marital counseling	177	1.01	6	ns

*Totals do not add to 200 as question permitted a multiple response answer.

Nursing Education and Family Planning

Table 9 shows the comparison of groups of nurses dichotomized as to whether or not they have had special education for family planning counseling and their responses on how they introduce the subject of family planning on a home visit which is a new referral. Table 10 shows the comparison of groups of nurses dichotomized as to whether or not they have had special education for family planning counseling and their responses regarding how they introduce the subject of family planning in a specific situation.

The critical value of chi square at the .01 level of significance for a 2x4 contingency table with 3 degrees of freedom is 11.345. The null hypothesis stating that groups of nurses dichotomized according to whether or not they have special education toward counseling for family planning show no differences in their responses on how they introduce the subject of family planning is held tenable for all items except items 2, 8, and 11 as shown in Table 9 and items 2 and 3 as shown in Table 10.

The frequencies were too small in category (E) not at all, of item 4 of Table 10; therefore, this category was omitted when doing the statistical analysis.

The critical value of chi square at the .01 level of significance in a 2x3 contingency table with 2 degrees of freedom is 9.210.

Tables 9 and 10 show the results of the 16 chi square tests made on questions 5 and 6 of Part II of the questionnaire. The values obtained from chi square statistical analysis were lower than the critical value of chi square at or beyond the .01 level of significance except for items 2, 8, and 11 shown on Table 9 and items 2 and 3 shown on Table 10.

Table 9

Item 2: A school follow-up visit

Item 8: A new referral on a well person

Item 11: A new mental health referral

Table 10

Item 2: Encountering the situation of an unmarried mother

Item 3: Encountering the situation of a young girl age 14 or older who admits having sexual relations.

Therefore, the p (probability) that a difference exists between whether groups of nurses have had special education or not and their responses regarding how they introduce the subject of family planning on items 2, 8, and 11 of Table 9 and items 2 and 3 of Table 10 is significant; i.e., they appear to be part of different populations and, therefore, the hypothesis is rejected.

The null hypothesis stating that groups of nurses dichotomized according to whether or not they have had special education for family planning counseling show no difference in their responses

regarding how they introduce the subject of family planning is held tenable except for items 2, 8, and 11 of Table 9, and items 2 and 3 of Table 10. This disparity in responses to these items may be due to the fact that more of the nurses who had not had special education for counseling for family planning responded more frequently in the categories (C) and (D) with difficulty, and (E) not at all than those who had special education. Also, seven respondents who had had special education commented that they would introduce the subject of family planning with ease, first visit, to a new referral with venereal disease. No comments under (L) Other, of question 5, Part II, were made by those who had not had any special education on counseling for family planning. However, this disparity would be indication for further study.

Table 9. Comparison of Groups of Nurses Dichotomized as to Whether or Not They Have Had Special Education and Their Responses Regarding Counseling for Family Planning on a New Referral.

Home Visit Category (New Referral)	Total Responses N = 200*	Chi square	df	p
(1)	(2)	(3)	(4)	(5)
1. Premature infant	192	9.54	3	ns
2. School follow-up visit	187	12.25	3	.01
3. Acute illness	189	4.49	3	ns
4. Tuberculosis	189	7.98	3	ns
5. Acute communicable disease	189	3.55	3	ns
6. Chronic disease	190	4.33	3	ns
7. Parents of handicapped children	188	10.11	3	ns
8. Well persons	190	17.35	3	.01
9. Post-partum	193	9.97	3	ns
10. Prenatal	190	10.45	3	ns
11. Mental health	188	19.26	3	.01

*Totals do not add to 200 as question permitted a multiple response answer.

Table 10. Comparison of Groups of Nurses Dichotomized as to Whether or Not They Have Had Special Education and Their Responses Regarding Counseling for Family Planning in a Specific Situation.

Situation Category	Total Responses N = 200*	Chi square	df	p
(1)	(2)	(3)	(4)	(5)
1. Woman unable to have children	189	3.78	3	ns
2. Unmarried mother	194	18.88	3	.01
3. Young girl (age 14 or older who admits having sexual relations)	195	18.61	3	.01
4. Very young parents	192	8.71	2	ns
5. Pre-marital counseling	189	1.43	3	ns

*Totals do not add to 200 as question permitted a multiple response answer.

Family Planning Methods

Table 11 shows the responses of 200 public health nurses regarding type of family planning method that was easier for them to discuss compared with the type easier for the patient to discuss. From the results shown in the table, there seems to be a direct relationship between the family planning methods that were easier for the nurse to discuss and the methods the patient wishes to discuss. However, a higher percentage of nurses indicated that it was easier to discuss the use of the condom than the rhythm method, whereas the patient more often wished to discuss the rhythm method rather than the condom.

Three respondents expressed that patients desired tubal ligations as a method of family planning.

Thirty-five respondents indicated that any method of family planning was easy from them to discuss. Two respondents expressed quite emphatically that the douche was not a method of family planning. The douche is not an acceptable method of fertility control in medicine; however, it is still widely practiced throughout the world and accordingly, was included in the questionnaire.

Table 11. Responses of 200 Public Health Nurses Regarding the Type of Family Planning Methods Easier for Them to Discuss Compared with the Type Easier for the Patient to Discuss.

Method of Family Planning	Total Responses Patient Wishes to Discuss N = 200*	Percent of Nurses Responding N = 200	Total Responses Easier for PHN to Discuss N = 200*	Percent of Nurses Responding N = 200
(1)	(2)	(3)	(4)	(5)
1. Contraceptive pills	194	97	182	91
2. Condom	7	3.5	63	31.5
3. Diaphragm	19	9.5	80	40
4. I. U. D.	96	48	116	58
5. Rhythm	11	5.5	57	28.5
6. Vaginal Foam	30	15	82	41
7. Douches	4	2	44	22

*Totals do not add to 200 as question permitted a multiple response answer.

Approach and Family Planning

Table 12 illustrates the responses of 200 public health nurses regarding the approach most often used to introduce the subject of family planning. The greatest percentage of the public health nurses indicated that they most often used the direct approach to introduce the subject of family planning.

One respondent indicated that she approached the subject of family planning by combining the methods shown in Table 12.

Table 12. Responses of 200 Public Health Nurses Regarding Approach Most Often Used to Introduce the Subject of Family Planning.

Approach	Total Responses N = 200*	Percent of Nurses Responding
(1)	(2)	(3)
1. Direct initiation by the family	40	20
2. Indirect initiation by the family	35	17.5
3. Direct initiation by the Public Health Nurse	113	56.5
4. Indirect initiation by the Public Health Nurse	76	38

*Totals do not add to 200 as question permitted a multiple response answer.

Family Planning Resources

Table 13 shows the responses of 200 public health nurses regarding the resources they have used to make family planning available to their patients.

Nine nurses responding to question 10 of Part II of the questionnaire stated no resources were available in their community. Seven of these stated they had referred patients to private physicians for family planning aid. The other two nurses may function in counties where there were no private physicians; however, this would be another study.

There were nine respondents who had used other resources to make family planning available to their patients. In order from the greatest to least number, these resources are: (1) welfare; (2) Migrant Clinics; (3) University of Oregon Medical School Clinic; (4) films; and (5) "made my own kit."

Table 13. Responses of 200 Public Health Nurses Regarding Resources Used to Make Family Planning Available to Patients.

Resource	Total Responses N = 200*	Percent of Nurses Responding
(1)	(2)	(3)
1. Health Department Family Planning Clinic	130	65
2. Planned Parenthood Family Planning Clinic	104	52
3. Private physician	139	69.5
4. Pamphlets and literature	140	70
5. Religious advisor	25	12.5
6. Family Planning Kit	97	48.5

Nine nurses stated there were no resources available in their community.

*Totals do not add to 200 as question permitted a multiple response answer.

Community Resources and Family Planning

The respondents were queried on what resources they would like to see made available toward better understanding of family planning in question 11 of Part III of the questionnaire. According to the 152 nurses who responded, 69 indicated the need for more family planning clinics with "just plain better advertisement." Others felt in addition to this, the communities needed better utilization of some of the existing resources.

Seven nurses commented in regard to the private physician. As one stated, "I wish, oh, how I wish, the private physician would do his part with family planning." In contrast to this statement, in question 10, 139 nurses stated that they had used the private physician as a resource for making family planning available to their patients.

Other statements concerning resources that the public health nurse would like to see made available within their community which would aid understanding of family planning included:

> Family living units in high schools, and involving parent education.
>
> Better preparation of medical students, so that they will be able to counsel couples.
>
> More awareness of family planning facilities with more community support (not financial).

> Family planning kits and simple visual aids available to all public health nurses.
>
> Workshops for learning to counsel on family planning for public health nurses, Ministers, teachers, church groups, and parents, with which to counsel their children.
>
> In-service education to public health nurses about the most recent developments in family planning.
>
> Counseling available during migrant clinics.
>
> "Shot of motivation" to a certain segment of the population.
>
> Transportation for patients to clinic.
>
> More effective service for about to be married girls.
>
> Pre-natal and post-partum classes at local hospitals throughout the state.

One nurse expressed her feelings about counseling for family planning in Oregon this way:

> Our health department is expanding its family planning service. This will help. It seems that we are trying to improve and increase services. I do not know statistically what the need is; hence, I cannot say how well we are meeting the need. I do recall that when I was a student nurse in 1964, we were not even permitted to discuss family planning techniques. Since that time we have come a long way in our community resources and the public health nurse's approach to family planning.

CHAPTER IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary of the Study

This study was undertaken for the purpose of determining whether or not there was a consensus among practicing public health nurses within the State of Oregon in regard to counseling for family planning. The limitations as outlined in Chapter I were the defining propositions of the study.

Following an initial review of the literautre and current legislation regarding family planning, the data collecting device was developed in the form of a questionnaire. Principles derived from the survey of the literature served as the bases upon which the tool was constructed.

The questionnaire was divided into three parts. Part I consisted of information concerning the nurse's personal background. Part II sought information concerning the nurse's responses regarding how she would introduce the subject of family planning. Part III consisted of questions regarding types of family planning methods that are easier for the nurse and the patient to discuss, approach most often used by the nurse to introduce the subject of family

planning, and the nurse's comments on the availability of community resources.

The questionnaire was tested for reliability. It was administered to a group of 20 public health nurses on two different occasions exactly one week apart. The results of the test were analyzed using the chi square with Yates correction. No revisions were found to be necessary.

Letters requesting participation in the study were mailed to 32 Health Departments (Multnomah County excluded) in Oregon and the Visiting Nurses Association in Portland, Oregon. Individual letters were mailed to the public health nurses in Multnomah County who had not participated in the pilot study.

The participants in the study were 200 public health nurses who were actively employed in public health nursing during May and June, 1969.

The findings were based on the information provided by the responses of the participants to the questionnaire.

Questions 1, 2, 3, and 4 of Part I and questions 5 and 6 of Part II of the survey tool were analyzed statistically using the chi square test of significance.

Findings of the Study

On the basis of this study, the following hypotheses were held tenable in entirety:

1. Groups of nurses dichotomized at age 29 years and younger show no differences as to whether or not they have had special education toward counseling for family planning.
2. Groups of nurses ordered according to the State of Oregon Merit System Rating show no differences in their responses as to how they introduce the subject of family planning.
3. Groups of nurses ordered according to years of experience in public health nursing show no differences as to whether or not they have had special education regarding counseling for family planning.
4. Groups of nurses ordered according to years of experience in public health nursing show no differences in their responses as to how they introduce the subject of family planning.

On the basis of this study, the following hypotheses were held to be tenable in part:

1. Groups of nurses dichotomized at age 29 years and younger show no differences in their responses as to how they introduce the subject of family planning.

2. Groups of nurses dichotomized according to whether or not they have had special education toward counseling for family planning show no differences in their responses as to how they introduce the subject of family planning.

The groups of nurses age 30 years and older expressed that when introducing the subject of family planning on a home visit or in a specific situation, they more frequently chose the category, (A) with ease, first visit, or the category (E) not at all. However, the group of nurses 29 years and younger more frequently expressed that they felt more at ease introducing the subject of family planning after several visits. Also, the group of nurses age 29 years and younger more frequently expressed that they would have difficulty introducing the subject of family planning on a home visit or in a specific situation.

Nurses who had special education regarding counseling for family planning more frequently expressed that they would introduce the subject of family planning with ease on the first home visit or in a specific situation.

Nurses who had not had special education in counseling for family planning more frequently expressed that they would have difficulty introducing the subject of family planning on a home visit, or in a specific situation, or would not introduce the subject at all.

Thirty-seven percent of the nurses indicated that they would

not introduce the subject of family planning to a woman who was unable to have children. Nineteen and six-tenths percent of the nurses stated that they would not introduce the subject of family planning to a tuberculosis patient. Twenty-one percent of the nurses expressed that they would not introduce the subject of family planning to a patient with a chronic disease. Their reasons merit further study.

According to the study, 56.5 percent of the public health nurses indicated that they most often used the direct approach to introduce the subject of family planning. However, only 55.5 percent of the nurses indicated that they have had any special education regarding counseling for family planning. According to this information, it appears that public health nurses in Oregon are under-educated regarding the counseling of patients for family planning.

The nurses indicated that Oregon is in need of family planning clinics. They also expressed the need for better advertisement of family planning facilities within the state, and greater community support which would enable the establishment of new family planning clinics.

Nine nurses stated that there were no family planning counseling services available within their particular community. However, seven of these nine nurses indicated they had made family planning services available to their patients through a private physician.

Conclusions

The findings of this study lead to the following conclusions:

1. State of Oregon Merit System Rating and length of experience in public health nursing had no effect on the expressions of nurses regarding how they would introduce the subject of family planning.
2. Length of experience in public health nursing and age had no relationship on whether or not the nurse had special education toward counseling for family planning.
3. Public health nurses who had special education toward counseling for family planning introduced the subject of family planning more readily on a home visit than those without special education.
4. It appears that family planning counseling is being carried out consistently by public health nurses regarding postpartum referrals.
5. The public health nurses expressed a need for workshops and in-service education regarding recent developments in family planning.
6. Public health nurses in Oregon are in need of special education in counseling for family planning if they are to play a decisive role in providing comprehensive patient care.

7. Public health nurses indicated that there is a need to make family planning services more readily available.
8. Nurses age 29 years and younger more frequently indicated that they felt more at ease introducing the subject of family planning after several visits.

Recommendations for Further Study

1. It is recommended that a study be done to determine why public health nurses are reluctant to introduce the subject of family planning to a patient who is unable to have children, or to a patient with tuberculosis, or to a patient with a chronic disease.
2. It is recommended that a tool be devised for use in evaluating the role of obstetrical nurses and their willingness to counsel for family planning.
3. It is recommended that a study be done on what preparation for family planning counseling is offered by the schools of nursing in Oregon, so that the future nurse will be prepared in the realm of family planning.

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APPENDICES

APPENDIX A

Correspondence

C O P Y

THE UNIVERSITY OF NORTH CAROLINA
AT CHAPEL HILL
27514

School of Public Health
Department of Maternal
and Child Health

February 13, 1969

Miss Ethlyn Fromme
2350 S. W. Kanan
Portland, Oregon 97201

Dear Miss Fromme:

I am please to learn that you plan to do a mail survey of staff public health nurses with regard to their approaches towards family planning. I am afraid that I cannot be of any great help. We used two open ended questions as a part of a larger questionnaire concerned with nurse and physician attitudes toward the expanded role of nursing in child health supervision.

The questions used in relation to family planning were: (a) "In what situations and how do you introduce the subject of family planning to parents?" (b) "What resources have you used for making family planning available to parents?"

We are all aware that community and professional attitudes towards the provision of family planning services in publicly subsidized programs has changed dramatically since 1964. The data you collect should document these changes in attitudes. I would be most interested in receiving a summary of your results once the data are analyzed.

Sincerely yours,

/s/ Earl Siegel, M. D.
Earl Siegel, M. D.
Professor and Chairman
Maternal and Child Health

ES:ew

P. S. An "abused" copy of the coding used for the two questions is enclosed.

Summary of
Categories for Child Health Nursing Questionnaire

Question 16a

1. Responses dealing with reasons family planning seems appropriate

   a. Financial pressures (including unspecified social factors).

   b. Maternal physical health factors (usually mother but may include father and/or children (may be physical, mental or emotional health).

   c. Hereditary factors.

   d. Emotional factors; usually general, unspecified difficulty.

   e. Probable unawareness on part of the family (lack of information re F. P.)

   f. Religious factors.

2. Response dealing with initiation of discussion

   a. Direct initiation by the family (may include desire to <u>have</u> children).

   b. Indirect initiation by family - sometimes demanding inference on part of P. H. worker.

   c. Indirect initiation by the P. H. worker.

   d. Direct initiation by P. H. worker (may be at request of physician).

   e. Refusal or no occasion to discuss.

3. Responses dealing with when the subject is broached.

   a. Post-partum (6 weeks).

   b. Prenatal period.

   c. 1st counseling session.

   d. After birth of new baby.

Categories for Child Health
Nursing Questionnaire
Question 16a

1. Responses dealing with reasons family planning seems appropriate

   a. Financial pressures (including unspecified social factors)

      Examples:
      When 8 or more in low income group.

      Economic factors.

      Father unemployed.

      Father not able to provide necessities.

   b. Maternal physical health factors (usually mother but may include father and/or children)(may be physical, mental, or emotional health)

      Examples:
      Severe illness during last delivery.

      Chronic illness, e.g., heart condition.

      When health of mother is in danger.

      When mother has had difficult pregnancy.

      When mother is not well, physically, mentally, or emotionally.

   c. Hereditary factors.

      Examples:
      Mental retardation.

      When children are born with congenital birth conditions.

      Genetic implications.

1. (Con't)

d. Emotional factors; usually general, unspecified difficulty

Examples:

When mother of large family feels she had "had it."

When family is overwhelmed by responsibilities.

When parents express frustration at trying to cope.

Mother is unable to cope with them (many children).

" . . . they are driving me crazy . . ."

e. Probable unawareness on part of the family (lack of information re F. P.)

Examples:

When the mother has one child a year up until 6 children.

When children spaced too closely.

When parents may not be aware of the facilities available or services offered.

Young marriages, particularly where marriage was result of pregnancy.

Very young parents.

Unwed multipara.

Many children too quickly.

f. Religious factors. Any time religion is given by respondent as a determiner of action taken

Examples:

Non-catholic

2. Response dealing with initiation of discussion

   a. Direct initiation by the family (may include desire to have children)

      Examples:

      When asked directly by family.

      On request only.

   b. Indirect initiation by family - sometimes demanding inference on part of P. H. worker.

      Examples:

      If the patient indicates a desire to discuss the subject . . .

      Whenever they seem interested.

      . . . when they feel the need . . .

      When the mother expresses fear of pregnancy.

   c. Indirect initiation by the P. H. worker.

      Examples:

      I may give some opportunity by mentioning a large family, etc.

      Explore how family feels - have them express desire to limit family.

      Are you planning to have any more children right away?

      How many children have you and your husband planned on?

      . . . discussion of anatomy and physiology might lead in . . .

   d. Direct initiation by P. H. worker (may be at request of physician)

      Examples:

      I would simply ask if they had considered family planning.

      Family should be given information as to where to obtain knowledge.

2d. (Con't)

Asking them if they are aware that there is an organization . . .

e. Refusal or no occasion to discuss

Examples:
Never

None

I do not introduce the subject

3. Responses dealing with when the subject is broached

a. Post-partum (6-week checkup)

b. Prenatal period

c. 1st counseling session

d. After birth of new baby

Categories for Child Health
Nursing Questionnaire
Question 16b

1. Health Department, Public Health (no more explicit; not clinic)

2. County hospital or clinic.

3. Family, private physician (P. M. D.) or private hospital (e. g. , Kaiser).

4. Planned parenthood.

5. Pamphlets, literature.

6. Priest, religious adviser.

7. Personal discussion about contraception, or adoption agencies, giving contraceptives or referring to contraceptive distributors.

8. None or unidentifiable.

9. Family planning agency (not clear private or public)

Note: In Area D(4), the private family planning agency is called Family Planning Clinic, is located in the county hospital, but is affiliated with Planned Parenthood, and was coded #4.

APPENDIX B

Cover Letters

2350 S. W. Kanan
Portland, Oregon 97201
April 25, 1969

Dear

In partial fulfillment of requirements for a Master of Science degree at the University of Oregon School of Nursing, I am undertaking a study to determine the opinions of public health nurses within the State of Oregon in regard to family planning counseling.

Your staff is invited to participate in this study. It will take about ten minutes of each staff member's time to complete the questionnaire. A stamped self-addressed envelope will be provided for each return. Kindly indicate on the enclosed card your willingness to participate and the number of questionnaires to be sent.

Upon completion of the study, copies of the report will be placed in the library of the University of Oregon Medical School.

Thank you very much for your assistance.

Yours sincerely,

(Mrs.) Lynn Fromme

Mrs. Fromme is a regularly enrolled graduate student at the University of Oregon School of Nursing. Any assistance you can offer Mrs. Fromme will be greatly appreciated.

Lucile Gregerson
Thesis Adviser

2350 S. W. Kanan
Portland, Oregon 97201
May 5, 1969

Dear Public Health Nurse:

In partial fulfillment of requirements for a Master of Science degree at the University of Oregon School of Nursing, I am undertaking a study to determine the opinions of public health nurses within the State of Oregon in regard to family planning counseling.

You are invited to participate in this study. It will take about 10 minutes of your time to complete the enclosed questionnaire. Please return the questionnaire in the enclosed stamped self-address envelope by June 6, 1969. If you do not desire to participate in the study, please return the uncompleted questionnaire.

Upon completion of the study, copies of the report will be placed in the library of the University of Oregon Medical School.

Thank you very much for your assistance.

Yours sincerely,

(Mrs.) Lynn Fromme

. . . . . .

Mrs. Fromme is a regularly enrolled graduate student at the University of Oregon School of Nursing. Any assistance you can offer Mrs. Fromme will be greatly appreciated.

Lucile Gregerson
Thesis Adviser

APPENDIX C

Questionnaire

QUESTIONNAIRE

Part I

Directions: Place an "X" in the appropriate space across from the answer which most accurately describes you. There are no right or wrong answers. Please do not put your name on the questionnaire.

1. Age group
   a. 29 years and younger _____
   b. 30 years and older _____

2. Present Public Health Nurse Rating
   a. R. N. I _____
   b. R. N. II _____
   c. P. H. N. I _____
   d. P. H. N. II _____
   e. P. H. N. III _____
   f. P. H. N. IV _____
   g. P. H. N. V _____

3. Years of experience in Public Health Nursing
   a. Less than 1 year _____
   b. 1-5 years _____
   c. 6-10 years _____
   d. Over 10 years _____

4. Have you had any special education (in-service or Continuing Education classes) toward counseling for family planning?
   a. Yes _____
   b. No _____

Part II

Directions: In the space next to each of the following types of home visits (item 5) and situations (item 6), please place the letter of the statements listed below that most adequately reflects how you introduce the subject of family planning. There are no right or wrong answers.

A. With ease, first visit
B. With ease, after several visits
C. With difficulty, first time
D. With difficulty, after several visits
E. Not at all

5. Assume that each type of home visit is a new referral.

a.	Premature infant	a. _____
b.	School follow-up visit	b. _____
c.	Acute illness	c. _____
d.	Tuberculosis	d. _____
e.	Acute communicable disease	e. _____
f.	Chronic disease	f. _____
g.	Parents of handicapped children	g. _____
h.	Well persons	h. _____
i.	Post-partum	i. _____
j.	Prenatal	j. _____
k.	Mental health	k. _____
l.	Other (state)_____	l. _____

6. Assume that you encounter the following situations.

a.	Woman unable to have children	a. _____
b.	Unmarried mother	b. _____
c.	Young girl (age 14 or older who admits having sexual relations)	c. _____
d.	Very young parents	d. _____
e.	Pre-marital counseling	e. _____

Part III

Directions: Please place an "X" in the appropriate space across from the answer(s) which most accurately describes your experience. There are no right or wrong answers.

7. What type of Family Planning methods do patients most often wish to discuss?

a. Contraceptive Pills	a. _____
b. Condom	b. _____
c. Diaphragm	c. _____
d. I. U. D.	d. _____
e. Rhythm	e. _____
f. Vaginal Foam	f. _____
g. Douches	g. _____

8. Which method is easier for you to discuss?

a. Contraceptive Pills	a. _____
b. Condom	b. _____
c. Diaphragm	c. _____
d. I. U. D.	d. _____
e. Rhythm	e. _____
f. Vaginal Foam	f. _____
g. Douches	g. _____

9. What approach do you most often use to introduce the subject of family planning?

a. Direct initiation by the family	a. _____
b. Indirect initiation by the family	b. _____
c. Direct initiation by you, the public health nurse	c. _____
d. Indirect initiation by you, the public health nurse	d. _____
e. Other (state)_____	e. _____

10. What resources have you used for making family planning available to your patients?

a.	Health Department Family Planning	a. _____
b.	Planned Parenthood Family Planning Clinics	b. _____
c.	Private physician	c. _____
d.	Pamphlets and literature	d. _____
e.	Religious adviser	e. _____
f.	No resources available in my community	f. _____
g.	Family Planning Kit	g. _____
h.	Other (state)_____	h. _____

11. What resources would you like to see made available in your community toward better understanding of family planning?

_____

_____

_____

_____

Thank you for your participation in this study.

Lynn Fromme
2350 S. W. Kanan
Portland, Oregon 97201

APPENDIX D

Summary of Data

QUESTIONNAIRE

Part I

Directions: Place an "X" in the appropriate space accorss from the answer which most accurately describes you. There are no right or wrong answers. Please do not put your name on the questionnaire.

1. Age group

a. 29 years and younger	a. 67
b. 30 years and older	b. 133

2. Present Public Health Nurse Rating

a. R. N. I	a. 9
b. R. N. II	b. 48
c. P. H. N. I	c. 48
d. P. H. N. II	d. 71
e. P. H. N. III	e. 6
f. P. H. N. IV	f. 16
g. P. H. N. V	g. 1
h. R. N. III	h. 1

3. Years of experience in Public Health Nursing

a. Less than 1 year	a. 28
b. 1-5 years	b. 91
c. 6-10 years	c. 29
d. Over 10 years	d. 52

4. Have you had any special education (in-service or Continuing Education classes) toward counseling for family planning?

a. Yes	a. 111
b. No	b. 89

Part II

Directions: In the space next to each of the following types of home visits (item 5) and situations (item 6), please place the letter of the statements listed below that most adequately reflects how you introduce the subject of family planning. There are no right or wrong answers.

A. With ease, first visit
B. With ease, after several visits
C. With difficulty, first time
D. With difficulty, after several visits
E. Not at all

5. Assume that each type of home visit is a new referral.

a.	Premature infant	a. 192
b.	School follow-up visit	b. 187
c.	Acute illness	c. 189
d.	Tuberculosis	d. 189
e.	Acute communicable disease	e. 189
f.	Chronic disease	f. 190
g.	Parents of handicapped children	g. 188
h.	Well persons	h. 190
i.	Post-partum	i. 193
j.	Prenatal	j. 190
k.	Mental health	k. 188
l.	Other (state)_____	l. _____

6. Assume that you encounter the following situations.

a.	Woman unable to have children	a. 189
b.	Unmarried mother	b. 194
c.	Young girl (age 14 or older who admits having sexual relations)	c. 195
d.	Very young parents	d. 195
e.	Pre-marital counseling	e. 189

TABULATION OF QUESTIONS 5 AND 6

Question 5
n = 200

		A	B	C	D	E	NR**
a.	Premature infant	111	62	5	2	12	8
b.	School follow-up visit	53	75	4	6	49	13
c.	Acute illness	36	58	6	3	86	11
d.	Tuberculosis	65	81	4	2	37	11
e.	Acute communicable disease	39	58	3	4	85	11
f.	Chronic disease	62	75	1	12	40	10
g.	Parents of handicapped children	62	89	7	14	16	12
h.	Well persons	96	70	2	1	21	10
i.	Post-partum	165	19	1	1	5	7
j.	Prenatal	100	74	1	1	14	10
k.	Mental health	46	103	11	14	14	12
l.	Other*	7					193

*Seven respondents listed venereal disease as a separate category.
**NR = No Response

Question 6
n = 200

a.	Woman unable to have children	65	42	9	3	70	11
b.	Unmarried mother	111	47	19	10	7	6
c.	Young girl (age 14 or older who admits having sexual relations)	118	31	26	9	11	5
d.	Very young parents	137	48	6	1	3	5
e.	Premarital counseling	152	25	6	1	5	11

Part III

Directions: Please place an "X" in the appropriate space across from the answer(s) which most accurately describes your experience. There are no right or wrong answers.

7. What type of Family Planning methods do patients most often wish to discuss?

a. Contraceptive Pills	a. 194
b. Condom	b. 7
c. Diaphragm	c. 19
d. I. U. D.	d. 96
e. Rhythm	e. 11
f. Vaginal Foam	f. 30
g. Douches	g. 4

8. Which method is easier for you to discuss?

a. Contraceptive Pills	a. 182
b. Condom	b. 63
c. Diaphragm	c. 80
d. I. U. D.	d. 116
e. Rhythm	e. 57
f. Vaginal Foam	f. 82
g. Douches	g. 44

9. What approach do you most often use to introduce the subject of family planning?

a. Direct initiation by the family	a. 40
b. Indirect initiation by the family	b. 35
c. Direct initiation by you, the public health nurse	c. 113
d. Indirect initiation by you, the public health nurse	d. 76
e. Other (state)_____	e. _____

10. What resources have you used for making family planning available to your patients?

a. Health Department Family Planning	a. 130
b. Planned Parenthood Family Planning Clinics	b. 104
c. Private physician	c. 139
d. Pamphlets and literature	d. 140
e. Religious adviser	e. 25
f. No resources available in my community	f. 9
g. Family Planning Kit	g. 97
h. Other (state)_____	h. 9

APPENDIX E

Definitions of Home Visits

DEFINITION OF HOME VISITS

a. Premature infant: A premature is defined as an infant weighing 5 1/2 pounds or less at birth.

b. School follow-up visit: This classification includes visits made to parents of children with special health problems following a health screening at school.

c. Acute illness: Care of injuries and acute illnesses that are non-communicable and follow-up on poisoning cases are examples of this service.

d. Tuberculosis: All services with respect to Tuberculosis Control, regardless of physical findings, should be included under this program. This includes services in behalf of cases, suspects, or contacts.

e. Acute communicable disease: This classification includes all Communicable Disease services except Venereal Disease, Hepatitis and Tuberculosis. It includes all persons, regardless of age, who have or are suspected of having a Communicable Disease or who are carriers of the causative organism. Also included are outbreaks of Food Poisoning and head lice and immunization program services.

f. Chronic disease: This classification includes services given in behalf of all chronic diseases and conditions not specifically categorized. Such a chronic condition may be described as one which may be permanent, leave residual disability, as caused by nonreversible pathological alteration, or which has existed or can be expected to exist for three months or longer.

g. Parents of handicapped children: Handicap is a child who has or is suspected of having abnormalities of the bones, joints, muscles, nerves, and related structures, which have caused or may reasonably be expected to cause a deformity or impairment of the function of the head, neck, trunk, or extremities. Cerebral Palsy, Cleft Lip, and Cleft Palate are included in this category.

h. Well persons: This is identified as health guidance or supervision or health maintenance services. Emphasis is on guiding persons in healthful living in an effort to prevent illness and to promote optimum health. This could include questions regarding family nutrition, growth and development, sex education and maternal and child health services.

i. Post-partum: This classification includes services to mothers and fathers to six weeks after delivery or until after the post-partum examination.

j. Prenatal: This classification includes services to mothers (and fathers) from time of conception until delivery.

k. Mental health: All services and activities in behalf of mental and emotional problems (diagnosed or suspected).

APPENDIX F

State of Oregon Merit System Rating

REGISTERED NURSE 1 (CLINIC)

GENERAL STATEMENT OF DUTIES

Under direct public health nursing supervision, performs nursing duties and related work as assigned.

EXAMPLES OF DUTIES

1. Assist in clinics and conferences conducted by the health department.
2. Maintains equipment and supplies.
3. Takes patient histories, and assists doctor with examinations and treatments.
4. Does treatments and tests as directed.
5. Keeps files, records and reports as required.
6. Prepares and labels specimens for laboratory.
7. Interviews and inspects children for return to school.
8. Refers problem situations to health officer and public health nurse.

MINIMUM QUALIFICATIONS

1. Graduation from a school of professional nursing with state accreditation at time of graduation.
2. Possession of a current liscense to practice as a registered professional nurse in the state of Oregon.

KNOWLEDGE AND ABILITY REQUIREMENTS

1. Ability to apply nursing knowledge and principles to health department situations.
2. Ability to grasp and appreciate the principles and policies underlying the administration of a public health program.
3. Ability to exercise tact, initiative and good judgment in dealing with people.

REGISTERED NURSE 2 (FIELD)

GENERAL STATEMENT

Under public health nursing supervision in a local health department, performs professional nursing work in a generalized public health nursing program involving home visits, school nursing, and related work as required.

DISTINGUISHING FEATURES OF WORK

This is a registered professional nurse, who has not completed all requirements as a public health nurse. Works as a staff nurse giving generalized nursing services or as the only nurse of the health department.

EXAMPLES OF DUTIES

1. Carries out nursing services in a planned public health program.
2. Provides family health services through home and office visits.
3. Gives nursing care in home; teaches and demonstrates to patient and his family the nursing care they may safely assume.
4. Participates in school health programs.
5. Keeps necessary records and assists in preparing reports as required by local and state departments.

MINIMUM QUALIFICATIONS

1. Licensure: Possession of a current license to practice as a registered professional nurse in the State of Oregon.
2. Education: Graduation from a school of professional nursing with state accreditation at time of graduation preferably supplemented by orientation, training, or experience in a public health nursing program.

REGISTERED NURSE 2 (FIELD) (continued)

KNOWLEDGE AND ABILITY REQUIRED

1. Knowledge of the principles and practices underlying professional nursing techniques and professional ethics.

2. Ability to carry out general instructions relating to the application of nursing skills; ability to grasp readily the principles underlying the administration and operation of public health programs; ability to exercise tact, initiative and good judgment in dealing with people; to present ideas accurately; to understand and carry out precise detailed instruction of a professional nature.

PUBLIC HEALTH NURSE I

GENERAL STATEMENT OF DUTIES

Under public health nursing supervision, performs generalized public health nursing activities and does related work as assigned.

EXAMPLES OF DUTIES

1. Gives family health counseling and nursing services in a planned community health program through home visiting, school health, clinics and conferences.

2. Gives skilled nursing service in homes; demonstrates and teaches nursing care to a family member who will provide care in her absence.

3. Assists families or individuals in carrying out recommendations made by their physician, and in making necessary adjustments in order that medical orders and measures for rehabilitation may be followed.

4. Plans and exchanges information with physicians and other health workers for more effective care of the individual patient.

5. Maintains records for nursing services to families, schools, clinics and makes reports as required.

6. Participates in planning and operation of public health clinics; interviews patients; performs diagnostic tests; gives prescribed treatments, records data and makes necessary referrals.

7. Finds suspect cases of physical or emotional illness and refers to medical care.

8. Interprets and utilizes community resources, and promotes understanding of the public health nursing services.

9. Assists in coordinating public health nursing with services of the health unit, private physicians, and other community agencies.

PUBLIC HEALTH NURSE I (continued)

10. Refers matters of policy to the health officer, or supervising nurse.

MINIMUM QUALIFICATIONS

A. Preparation in Basic Nursing

1. Graduation from a school of professional nursing with state accreditation at time of graduation,

2. Possession of a current license to practice as a registered professional nurse in the state of Oregon,

and

B. Preparation in public health nursing as evidenced by

1. Baccalaureate degree from a university program in nursing approved for public health nursing preparation by the National League for Nursing,

or

Completion of one year's program of study in public health nursing which carried academic credit and approved by the National League for Nursing.

KNOWLEDGE AND ABILITY REQUIREMENTS

1. Fundamental knowledge of the principles and objectives of public health nursing.

2. Fundamental knowledge of the significance of preventive measures in the maintenance of health in the community.

3. Fundamental knowledge of health department organization and practice.

4. Ability to interpret laws and regulations pertaining to public health programs.

5. Ability to carry out general instructions and to exercise individual judgment in relation to application of nursing principles.

PUBLIC HEALTH NURSE I (continued)

6. Ability to work productively with other professional groups in a health program.

7. Ability to interpret and utilize community resources.

8. Ability to accept and utilize supervision.

PUBLIC HEALTH NURSE II

GENERAL STATEMENT OF DUTIES

Under public health nursing supervision, performs generalized public health nursing activities requiring a high degree of professional judgment and skill; in selected instances, participates in supervisory activities; and does related work as assigned.

EXAMPLES OF DUTIES

1. In addition to the duties described under Public Health Nurse I, provides public health nursing services in instances where the problems are of particular difficulty.

2. Participates in orientation, teaching and supervision of inexperienced staff nurses and student public health nurses and members of allied agencies.

3. In absence of the appointed supervisor, carries administrative and supervisory responsibilities as required.

4. Takes considerable responsibility in the development of community organization and planning for health services with community groups.

MINIMUM QUALIFICATIONS

A. Preparation in Basic Nursing

1. Graduation from a school of professional nursing with state accreditation at time of graduation,

and

2. Possession of a current license to practice as a registered professional nurse in Oregon,

and

B. Preparation in public health nursing as evidenced by

1. Baccalaureate degree from a university program in nursing, approved for public health nursing preparation by the National League for Nursing

PUBLIC HEALTH NURSE II (continued)

or

Completion of one year's program of study in public health nursing which carries academic credit and approved by the National League for Nursing

and

C. Experience

At least two years of public health nursing experience under nursing supervision; or any equivalent combination of experience and training.

KNOWLEDGE AND ABILITY REQUIREMENTS

1. Fundamental knowledge of the principles, practices and objectives of public health nursing, including substantial knowledge of relevant social and economic forces and family and group relationships.

2. Demonstrated skill in the practice of public health nursing.

3. Demonstrated ability to work productively with professional and other groups of the community.

4. Demonstrated ability to perform teaching and interpretive functions of a public health nurse.

5. Knowledge of goals and general methods of practice used by other disciplines participating in public health programs.

6. Knowledge of objectives of other agencies concerned with health or welfare of community.

7. Ability to accept and utilize supervision.

PUBLIC HEALTH NURSE III

GENERAL STATEMENT OF DUTIES

Under medical direction of a part-time local health officer, is responsible for providing general public health nursing service involving a considerable degree of independent judgment in program planning and administration.

EXAMPLES OF DUTIES

1. Plans and implements a program of public health nursing service on a county-wide basis.

2. Assists in administration of the county health office; supervises the clerical personnel and general office procedure including records, reports, budget preparation, and maintenance of supplies and equipment.

3. Participates in organization of community groups to best utilize local health resources and limited public health nursing personnel.

4. Confers with health officer for interpretation of problems and development of improved practices.

5. Provides field observations for student nurses.

6. Recruits, trains, and supervises volunteer workers.

MINIMUM QUALIFICATIONS

A. Preparation in Basic Nursing

1. Graduation from a school of professional nursing with state accreditation at time of graduation

and

2. Possession of a current license to practice as a registered professional nurse in Oregon

and

PUBLIC HEALTH NURSE III (continued)

B. Preparation in public health nursing as evidenced by

1. Baccalaureate degree from a university program in nursing, approved for public health nursing preparation by the National League for Nursing

or

Completion of one year's program of study in public health nursing which carries academic credit and approved by the National League for Nursing.

C. Experience

At least three years of public health nursing experience under nursing supervision; or any equivalent combination of experience and training.

KNOWLEDGE AND ABILITY REQUIREMENTS

In addition to the knowledge and abilities outlined under PHN II-

1. Comprehensive knowledge and ability to apply principles and practices of public health nursing.

2. Knowledge of principles of public health administration.

3. Knowledge of goals and general methods of practice used by other disciplines participating in public health programs.

4. Knowledge of public relation techniques and ability to work harmoniously with co-workers and community groups.

5. Ability to seek, and utilize, consultative assistance.

PUBLIC HEALTH NURSE IV

GENERAL STATEMENT OF DUTIES

Under the administrative direction of the local director of public health nursing, or the local health officer, supervises the nursing personnel and performs related work as assigned.

EXAMPLES OF DUTIES

1. Participates with the health officer and the other members of the staff in planning and implementing the local health program.

2. Has responsibility for the professional direction, supervision and guidance of the nursing personnel.

3. Observes and maintains evaluation of individual nursing performance.

4. Responsible for individual and group conferences and a continuous staff education program.

5. Develops plans for the nursing service and makes related budget estimate for submission to health officer.

6. Recruits nursing personnel and makes recommendations on selection and assignment of nurses.

7. Studies, analyzes, and interprets nursing records and statistics significant to the development of health services, both current and anticipated.

8. Has responsibility for maintaining and interpreting standards of public health nursing and for providing services according to agency policy and program.

9. Makes periodic cost, time, and activity studies to determine if expenditures for nursing are utilized and distributed on a justifiable basis according to the agency budget and community needs.

10. Promotes desirable community health action through collaborating with other professionals and citizens' groups in

PUBLIC HEALTH NURSE IV (continued)

studying, planning and putting into action the community health program.

11. Participates in correlating available community nursing service for hospitals, clinics, schools, industries, and homes.

MINIMUM QUALIFICATIONS

A. Preparation in Basic Nursing

1. Graduation from a school of professional nursing with state accreditation at time of graduation,

and

2. Possession of a current license to practice as a registered professional nurse in Oregon,

and

B. Preparation in public health nursing as evidenced by

Baccalaureate degree from a university program in nursing approved by the National League for Nursing for public health nursing preparation which included, or was supplemented by, academic preparation in supervision,

and

C. Experience

At least 3 years of experience in general public health nursing under supervision, one of which included assisting the supervisor in administrative functions, and in the orientation, teaching, and supervision of other staff nurses or students; or any equivalent combination of experience and training.

PUBLIC HEALTH NURSE IV (continued)

KNOWLEDGE AND ABILITY REQUIREMENTS

1. Comprehensive knowledge of principles of public health nursing including knowledge of relevant social and economic forces and family and group relationships.

2. Considerable knowledge of principles of public health administration including the organization and services of local, state and federal health agencies.

3. Effective application of the basic principles of public health nursing supervision.

4. Ability to seek and utilize consultant service.

5. Considerable knowledge of goals and general methods of practice used by other disciplines participating in public health programs.

6. Knowledge of public relation techniques and ability to work harmoniously with professional and civic leaders.

7. Knowledge of trends in general nursing education.

PUBLIC HEALTH NURSE V

GENERAL STATEMENT OF DUTIES

Under the administrative direction of the local health officer of a county health department, is responsible for planning, organizing, and directing the total public health nursing services for a staff of at least 12 nurses.

EXAMPLES OF PRINCIPAL DUTIES

1. Assumes responsibility directly with health officer for public health nursing program planning, development, evaluation and co-ordination with all health department activities.

2. Prepares with health officer, budget estimates, statistical and routine reports.

3. Plans and coordinates a program of supervision and consultation to meet the needs of the staff.

4. Develops methods of providing service and patterns of staffing suitable to the agency program.

5. Recruits, employs, or recommends for employment and assigns personnel for nursing services. Recommends transfer, promotion, or separation from service.

6. Utilizes state nursing consultant services in evaluation and further development of nursing program.

7. Plans and participates in educational program for co-workers such as teachers, sanitary engineers.

8. Promotes and plans with supervising nurses for effective public health nursing service.

9. Advises and counsels with public health nurses about professional growth and advanced education. Offers opportunities for leadership training.

10. Directs staff in their responsibilities for community-wide programs and in inter-relationships of community facilities and resources.

PUBLIC HEALTH NURSE V (continued)

11. Interprets and promotes public health nursing services with community groups, agencies, local physicians and professional organizations.

12. Serves on committees to represent public health nursing.

13. Participates in general planning for student public health experience.

MINIMUM QUALIFICATIONS

A. Preparation in Basic Nursing

1. Graduation from a school of professional nursing with state accreditation at time of graduation,

and

2. Possession of a current license to practice as a registered professional nurse in Oregon,

and

B. Completion of preparation in public health nursing, administration, and supervision as evidenced by

A baccalaureate degree from a university program in nursing, approved by the National League for Nursing, for public health nursing preparation which included, or was supplemented by, academic preparation in supervision and public health administration.

C. Experience

Five years of experience in generalized public health nursing which included at least three years of supervisory experience which involved substantial administrative responsibility; or any equivalent combination of experience and training.

PUBLIC HEALTH NURSE V (continued)

KNOWLEDGE AND ABILITY REQUIREMENTS

1. Comprehensive knowledge of public health laws and regulations.

2. Comprehensive knowledge of public health nursing objectives, theory, principles, and practices.

3. Comprehensive knowledge and ability to utilize understanding of relationship of functions and delegation of responsibilities.

4. Ability to recognize and adapt nursing knowledge and skills to meet progressive changes in public health programs.

5. Ability to work effectively and harmoniously with professional and community groups.

APPENDIX G

Medically Indigent Potential Planned Parenthood Patients

MEDICALLY INDIGENT POTENTIAL PLANNED PARENTHOOD PATIENTS BASED ON POPULATION WITH ANNUAL FAMILY INCOME UNDER $3,000*

County	Total Population	Income Under $3,000		Potential Contraceptive Patients
		Percent	Number	
OREGON	1,999,780	17.0	339,963	43,570
Baker (P)+	15,900	21.3	3,387	434
Benton	47,000	16.6	7,802	1,000
Clackamas	139,000	16.5	22,935	2,939
Clatsop	27,800	20.3	5,643	723
Columbia (P)	24,700	21.6	5,335	684
Coos	52,500	15.3	8,033	966
Crook	8,950	17.6	1,575	202
Curry (P)	12,800	13.4	1,715	220
Deschutes	27,600	18.2	5,023	644
Douglas	76,000	16.4	12,464	1,598
Gilliam (P)	3,150	15.0	473	61
Grant (P)	7,550	16.8	1,268	162
Harney (P)	7,200	19.2	1,382	177
Hood River (P)	14,500	18.5	2,683	344
Jackson	95,000	19.9	18,905	2,422
Jefferson	10,300	16.2	1,669	214
Josephine	36,600	23.9	8,747	1,121
Klamath	48,300	14.4	6,955	890
Lake (P)	6,230	14.4	897	50
Lane	201,000	14.6	29,346	3,762
Lincoln (P)	23,400	24.1	5,639	723
Linn	66,300	19.0	12,597	1,614
Malheur (P)	25,700	28.5	7,325	939
Marion	148,500	20.9	31,037	3,978
Morrow (P)	4,600	16.6	764	98
Multnomah	558,000	14.4	80,352	10,298
Polk (P)	33,700	22.7	7,650	982

County	Total Population	Income Under $3,000		Potential Contraceptive Patients
		Percent	Number	
Sherman	3,150	13.1	413	54
Tillamook (P)	16,000	20.2	3,232	414
Umatilla	43,500	17.3	7,526	965
Union (P)	17,900	21.9	3,920	502
Wallowa (P)	6,000	22.4	1,344	188
Wasco	23,400	16.3	3,814	489
Washington	125,000	14.2	17,750	2,275
Wheeler (P)	1,750	14.5	254	33
Yamhill	40,800	26.8	10,934	1,401

*Percentages from 1960 census; population figures from July 1966.

+Part-time health officer

PERTINENT BASELINE DATA FOR AREAS SERVED

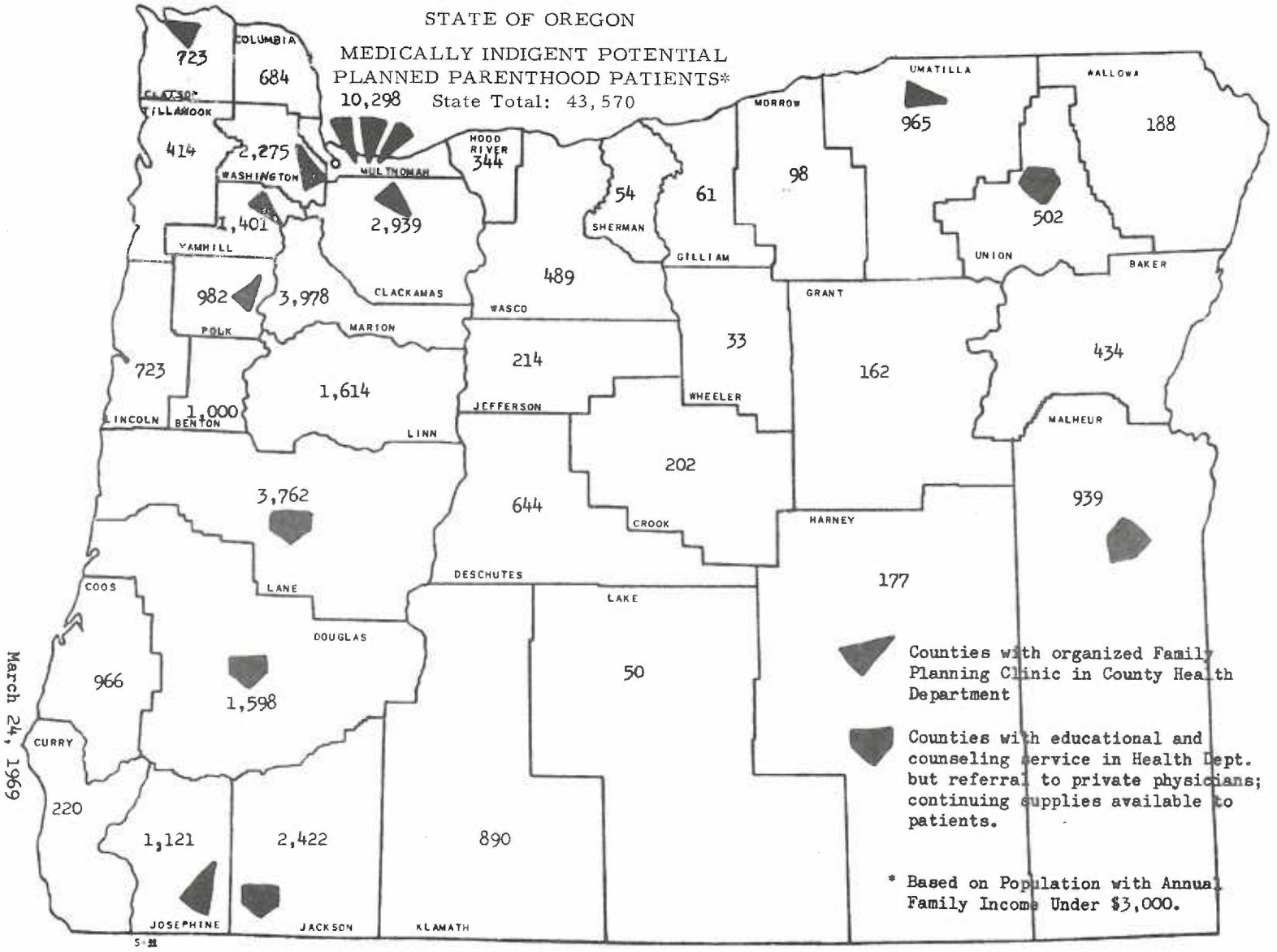
County	Population[1]	Live Births[1]		Immature Births[1]		Infant Deaths[1]		Illegitimate Births[1]		A. D. C.[2]	A. D. C.[2]	Population[3] at
		Number	Rate	Number	Rate	Number	Rate	Number	Ratio	Families	Persons	Risk
STATE	2,006,360	31,446	15.7	2,036	64.7	616	19.6	2,478	78.8	10,985	43,688	43,570
September 30, 1968												
Clackamas	142,000	2,246	15.8	145	64.6	42	18.7	108	48.1	570	2,360	2,939
Clatsop	27,800	366	13.2	16	43.7	5	13.7	24	65.6	98	376	723
Douglas	75,000	1,124	15.0	81	72.1	22	19.6	74	65.8	514	2,093	1,598
Jackson	95,000	1,288	13.6	76	59.0	21	16.3	87	67.5	363	1,350	2,422
Marion	149,500	2,199	14.7	134	60.9	49	22.3	142	64.6	1,168	5,311	3,978
Multnomah	555,700	8,844	15.9	652	73.7	169	19.1	1,092	123.5	4,031	15,398	10,298
(Portland)	384,000	5,726	14.9	455	79.4	109	19.0	838	146.3	N.A.	N.A.	N.A.
Polk	33,700	478	14.2	22	46.0	14	29.3	34	71.1	204	851	982
Umatilla	43,800	699	16.0	44	62.9	15	21.5	48	68.7	254	965	965
Washington	128,000	2,199	17.2	115	52.3	35	15.9	112	50.9	346	1,436	2,275
Yamhill	41,000	529	12.9	25	47.2	10	18.9	30	56.7	222	1,026	1,401
June 30, 1969												
Central Oregon Tri-County												
Crook	8,900	141	15.8	10	70.9	---	----	15	106.4	( )	( )	202
Deschutes	27,630	444	16.1	41	92.3	10	22.5	27	60.8	(192)	(753)	644
Jefferson	10,200	201	19.7	10	49.7	6	29.9	17	84.6	( )	( )	214
Lane	204,000	3,325	16.3	197	59.2	54	16.2	254	76.4	1,096	4,069	3,762

All rates per 1,000 live births

[1] CY 1967 Supplementary Report, Vital Statistics

[2] FY 1968 Tabulation of L. H. H. in Oregon

[3] CY 1966 Medically Indigent Potential Planned Parenthood Patients



March 24, 1969

APPENDIX H

Oregon Statute: 435. 205

Oregon Statute 435.205
Family Planning and Birth Control

435.205 Family planning and birth control services by county agencies.

(1) Any county health department or any county welfare department, or both departments jointly, may offer family planning and birth control services to every parent whose is a member of a family whose annual income in the aggregate does not exceed $6,000. However, no county health department is required by this section to seek out such persons, provided that welfare department caseworkers shall initiate and conduct discussions of family planning with each welfare recipient who might have an interest in and benefit from such service.

(2) Family planning and birth control services may include interview with trained personnel; distribution of literature; referral to a licensed physician for consultation, examination, medical treatment and prescription; and, to the extent so prescribed, the distribution of rhythm charts, the initial supply of a drug or other medical preparation, contraceptive devices and similar products.

435.215 Right to refuse services protected.

The refusal of any person to accept family planning and birth control services shall in no way affect the right of such person to receive public assistance or to avail himself of any other public benefit and every person to whom such services are offered shall be so advised initially both orally and in writing. County employees engaged in the administration of ORS 435.205 to 435.235 shall recognize that the right to make decisions concerning family planning and birth control is a fundamental personal right of the individual and nothing in ORS 435.205 to 435.235 shall in any way abridge such individual right, nor shall any individual be required to state his reason for refusing the offer of family planning and birth control services.

435.225 Refusal by county employee to offer services.

Any county employee may refuse to accept the duty of offering family planning and birth control services to the extent that such duty is contrary to his personal or religious beliefs; however,

such employee shall notify his immediate supervisor in writing of such refusal in order that arrangements may be made for eligible persons to obtain such information and services from another employee. Such refusal shall not be grounds for any disciplinary action, for dismissal, for any interdepartmental transfer, for any other discrimination in his employment, or for suspension from employment with the county, or for any loss in pay or other benefits.

435.235 Construction of ORS 435.205 to 435.235.

ORS 435.205 to 435.235 shall be liberally construed to protect the rights of all individuals to pursue their religious beliefs, to follow the dictates of their own consciences, to prevent the imposition upon any individual of practices offensive to the individual's moral standards, to respect the right of every individual to self-determination in the procreation of children, and to insure a complete freedom of choice in pursuance of his constitutional rights.

AN ABSTRACT OF THE THESIS OF

ETHLYN R. FROMME

For the MASTER OF SCIENCE in NURSING EDUCATION

Date of receiving this degree: June 12, 1970

Title: A STUDY OF THE RESPONSES OF 200 PUBLIC HEALTH NURSES IN OREGON REGARDING FAMILY PLANNING COUNSELING

Approved: [redacted]
(Associate Professor in Charge of Thesis)

The purpose of this study was to determine whether or not there was a consensus among public health nurses within the State of Oregon in regard to counseling for family planning. The data were collected by means of a mailed questionnaire consisting of three parts. Principles derived from a survey of the literature and current legislation served as a basis upon which the questionnaire was constructed.

The questionnaire was tested for reliability. It was administered to a group of 20 public health nurses on two different occasions exactly one week apart. The results of the test were analyzed using

chi square with Yates correction. No revisions were found to be necessary.

Letters requesting participation in the study were mailed to 32 Health Departments (Multnomah County excluded) in the State of Oregon and the Visiting Nurses Association in Portland, Oregon. Individual letters were mailed to the public health nurses in Multnomah County who had not participated in the pilot study.

The participants in the study were 200 public health nurses who were actively employed in public health nursing during May and June of 1969. Two hundred forty questionnaires were mailed; 209 responded, and of that total, 200 questionnaires were usable.

Findings

On the basis of this study, the following hypotheses were held tenable in entirety:

1. Groups of nurses dichotomized at age 29 years and younger show no differences as to whether or not they have had special education toward counseling for family planning.
2. Groups of nurses ordered according to the State of Oregon Merit System Rating show no differences in their responses as to how they introduce the subject of family planning.
3. Groups of nurses ordered according to years of experience in public health nursing show no differences as to whether

or not they have had special education regarding counseling for family planning.

4. Groups of nurses ordered according to years of experience in public health nursing show no differences in their responses as to how they introduce the subject of family planning.

On the basis of this study, the following hypotheses were held tenable in part:

1. Groups of nurses dichotomized at age 29 years and younger show no differences in their responses as to how they introduce the subject of family planning.
2. Groups of nurses dichotomized according to whether or not they have had special education toward counseling for family planning show no differences in their responses as to how they introduce the subject of family planning.

The group of nurses age 30 years and older expressed that when introducing the subject of family planning on a home visit or in a specific situation, they more frequently chose the category, (A) with ease, first visit, or the category (E) not at all. However, the group of nurses 29 years and younger more frequently expressed that they felt more at ease introducing the subject of family planning after several visits. Also, the group of nurses age 29 years and younger more frequently expressed that they would have difficulty

introducing the subject of family planning on a home visit or in a specific situation.

Nurses who had special education regarding counseling for family planning more frequently expressed that they would introduce the subject of family planning with ease on the first home visit or in a specific situation.

Nurses who had not had special education in counseling for family planning more frequently expressed that they would have difficulty introducing the subject of family planning on a home visit, or in a specific situation, or would not introduce the subject at all.

Thirty-seven percent of the nurses indicated that they would not introduce the subject of family planning to a woman who was unable to have children. Nineteen and six-tenths percent of the nurses stated that they would not introduce the subject of family planning to a tuberculosis patient. Twenty-one percent of the nurses expressed that they would not introduce the subject of family planning to a patient with a chronic disease. Their reasons merit further study.

According to the study, 56.5 percent of the public health nurses indicated that they most often used the direct approach to introduce the subject of family planning. Fifty-five and five-tenths percent of the nurses indicated that they had any special education regarding counseling for family planning. According to this information, it appears that public health nurses in Oregon are

under-educated regarding the counseling of patients for family planning.

The nurses also indicated that Oregon is in need of family planning clinics. They also expressed the need for better advertisement of family planning facilities in the state and greater community support which would enable the establishment of new family planning clinics.

Nine nurses stated that there were no family planning counseling services available within their particular community. However, seven of these nurses indicated that they had referred patients to a private physician for family planning counseling.

Conclusions

The findings of this study lead to the following conclusions:

1. State of Oregon Merit System Rating and length of experience in public health nursing had no effect on the expressions of nurses regarding how they would introduce the subject of family planning.
2. Length of experience in public health nursing and age had no relationship on whether or not the nurse had special education toward counseling for family planning.
3. Public health nurses who had special education toward counseling for family planning introduced the subject of

family planning more readily on a home visit than those without special education.

4. It appears that family planning counseling is being carried out consistently by public health nurses regarding post-partum referrals.
5. The public health nurses expressed a need for workshops and in-service education regarding recent developments in family planning.
6. Public health nurses in Oregon are in need of special education in counseling for family planning if they are to play a decisive role in providing comprehensive patient care.
7. Public health nurses indicated that there is a need to make family planning services more readily available.
8. Nurses age 29 years and younger more frequently indicated that they felt more at ease introducing the subject of family planning after several visits.

Recommendations for Further Study

1. It is recommended that a study be done to determine why public health nurses are reluctant to introduce the subject of family planning to a patient who is unable to have children, or to a patient with tuberculosis, or to a patient with a chronic disease.

2. It is recommended that a tool be devised for use in evaluating the role of obstetrical nurses and their willingness to counsel for family planning.
3. It is recommended that a study be done on what preparation for family planning counseling is offered by the schools of nursing in Oregon, so that the future nurse will be prepared in the realm of family planning.

Typed by Barbara Glenn