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Women's Resource Centers

Nora Ann Boland

WOMEN'S RESOURCE CENTERS

Nora Ann Boland, B.S.

An Abstract Presented to the Faculty of the Graduate
School of Lindenwood College in Partial
Fulfillment of the Requirements for the
Degree of Master of Business Administration

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ABSTRACT

This study was done to determine if the women of St. Charles County know about the concept of Women's Resource Centers and their preferences as to the types of services they would use.

The survey was conducted in the St. Charles area. The sample consisted primarily of women. The participants were from varied age groups, income levels and educational backgrounds. There were 350 surveys distributed. Two hundred surveys were used for the results.

There were two survey groups; health care workers and the public sector, and results were compared with each other. This comparison was to determine if there was a difference between people who work in the health care field and the general public, with regard to knowledge about Women's Resource Centers.

The findings of the survey did not support the premis that the women of St. Charles would use the services offered at most resource centers because that question was not directly asked. The survey did support

the position that the women polled were interested in the types of services offered at most resource centers. The survey also indicated the preferences of the types of special services the women of this area would want. These included: Gynecology, Obstetrics, mammograms, as well as support groups, educational programs and extended hours.

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COMMITTEE IN CHARGE OF CANDIDACY

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DEDICATION

To my Mother and Father

For teaching me to respect knowledge,
to believe in God and myself
and for showing me how to love.

"Thank-you, thank-you, thank God for you,
You're the wind beneath my wings.
Did I ever tell you that you were my heroes?"

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CHAPTER 1

INTRODUCTION

The purpose of this research was to determine if the women of St. Charles County know about the concept of a Women's Resource Center and their preferences as to the types of services they would use. Because of the rapid growth in St. Charles County, there is a large market of women who might want a different type of health care.

Ever since the publication of Our Bodies, Ourselves, women have been asking for changes in the health care system. There has been a growing recognition nationwide of women's unique health care needs. The survey will be used to determine if the women of St. Charles County are representative of the national trend in the women's health movement, which is calling for a more participatory, prevention-focused approach to health care (Breslow, vii-xiv).

This research is necessary because presently there are two major health care competitors, with various smaller providers in the St. Charles area competing for market share. If the premise that women want an alternative to the present delivery of health care is

proven, then the first provider to develop a Women's Resource Center would be established as the main provider for women and gain a strong market share. This research also hopes to establish the specific types of services that the women of St. Charles would prefer and use.

The population of St. Charles County is rapidly expanding. The 1980 census counted 144,107 people residing in St. Charles. The census estimate for 1988 is 191,000 a growth of 32%. Future predictions for the year 2000 are 221,800, a total increase of 53.9% from the 1980 figures. This increase is compared with a predicted increase of 2.2% for St. Louis County and a decrease of 10.6% for St. Louis City. With this new growth in St. Charles comes an increased need for health care (U. S. Census Bureau).

In past years, the residents of St. Charles received their health care primarily from family practitioners but as physicians' practices became more specialized so did the services offered in St. Charles. These expanded services have both positive and negative aspects. On the positive side, these new speciality doctors offer services that the St. Charles residents used to have to

travel to St. Louis to receive. These new services bring with them more knowledgeable physicians and the newest, most advanced tests and treatments. These advanced tests exclusively for females include mammograms, amniocentesis, fetal ultrasound, breast ultra sound, electronic fetal monitoring and hysterosalpingograms.

Up until 1980, the residents of St. Charles had to travel to St. Louis to benefit from the new medical technology medicine offered. St. Joseph's Health Center has been in St. Charles since 1885 but the services they offered were limited. In fact, in 1955 their labortory purchased their first piece of new equipment since 1935 (Henninger, 4).

The 1980's brought a new competitive market of health care services. St. Joseph's began up-grading their equipment and services to compete with the St. Louis hospitals and the opening of St. Peter's Hospital, their first direct competitor. In 1981, St. Joseph's introduced their vascular labortory and made CAT Scans available. Although mammograms have been offered since the late 70's at St. Joseph's, they recently purchased a new, advanced machine in 1987 that enables them to take

fewer X-rays with improved results. In October of 1987, St. Joseph's opened their Cardiac Catheterization Lab. This lab uses a long hollow tube called a catheter for both heart disease diagnosis and treatment. And St. Joseph's is the only hospital in St. Charles, Lincoln and Warren County, Missouri that provides open-heart surgery. St. Peter's Hospital opened their doors in 1980 and offered general medicine, surgery and emergency room services. In 1984, they expanded their services to include a Stress Center and again expanded in in 1987 with the addition of maternity services . These advances and specialized services provide St. Charles residents with access to new technology without the excessive travel involved with using the St. Louis Hospitals (Henninger, 5).

The negative aspects of these specialized services is that communication between physicians is often poor. Medical problems can be complicated and affect various systems of the body. Money and time could be saved if more consulation and communication between doctors existed. Women in particular face more complications in their health care needs. Sixty-three percent of all

surgeries are performed on women and of the twenty most performed surgeries, eleven are done on women exclusively. None are performed on men only (Suarez, 1989).

Traditionally, women's health care has been fragmented. Women went to one doctor for headaches, another for weight control and another for their Pap smear. Women's Resource Centers ideally provide for a women's total health-care needs. They emphasize the intergration of physical and mental health, education support groups. Aside from catering to the health needs of women, the centers also recognize that women want to be informed. The doctors at the centers work at talking to women and explaining procedures. The centers also recognize that a woman's time is valuable. Many centers guarantee a limited waiting period to see a physician. They also offer early, late and weekend hours.

This research will be presented in three parts. First a short history of the past delivery of health care for females will be reviewed. Then new approaches and alternatives will be introduced. A survey will be distributed to St. Charles County residents and to the

employees of St. Joseph's Health Center and the results assessed to determine what types of health care services the women of St. Charles County want.

This paper will provide research to prove the accuracy of the thesis. It will provide a clear definition of women's resource centers and determine what services the women of St. Charles would prefer and use.

Because medical terminology will be referred to throughout this paper there is a appendix of pertinent definitions provided.

CHAPTER 2

THE HISTORY OF WOMEN'S HEALTH CARE

Since the earliest times, health-care for women has been more concerned with their obstetrical and gynecological needs than their overall health. The problem with this, was that the differences in the female organs were viewed as a source of their inferiority and subsequently the root of all women's health problems (Corea, 88).

According to Ehrenreich and English in their book For Her Own Good, during the early 19th century, women were almost invalids. They were encouraged by their physicians and the church to avoid most activities with the exception of childbearing (123). Women of this century had power through their frailness. Men would rush to protect the weak, timid woman. Women also learned they could use their illnesses as a contraceptive. With illness as an excuse, they wouldn't be seen as trying to avoid their marital duties (Ehrenreich and English, 120-123). These powers were minor in comparison to the power men, particularly physicians, had over women. The bulk of women's health problems, whether physical or emotional, were defined as

caused by diseases of their reproductive organs. Gynecological surgeries were used for all types of female disorders like insanity, headaches, stomach problems as well as general laziness (Barker-Benfield, 13-41).

By the 1900's the popularity of sexual surgeries began to decline. But male doctors were gradually gaining control of childbirth among the upper and middle-classes. This control represented more of a political and economic triumph rather than a scientific necessity (Walsh, 243-245). They deliberately excluded women from medical training. Dorothy Wertz, author of the article "Man-Midwifery", charged "Doctors feared, not without reason, that if women were admitted to the profession, women patients would prefer physicians of their own sex, especially for childbirth." (55).

The Victorian era saw gynecologist (i.e. physicians who specialize in the health maintenance and diseases of women, especially of the reproductive organs) and obstetricians (i.e. physicians who specialize in the treatment of women in childbirth during the period before and after delivery) gain even more control over women.

Middle and upper- class women, admiring education and science and able to afford doctors' fees, changed their allegiances from midwives to scientifically-trained doctors, men of their own class. Men who eventually became advisors in all sorts of matters and went so far as to become judges of their moral conduct (Dreifus, 37). At the same time, working-class women continued to work day and night in factories and fields, their pregnancies and births attended to by local midwives.

Physicians continued to look at midwives as economic threats and threats to the medical order they were trying to establish (Ehrenrich and English, 86). They waged a strong campaign against midwives, calling them ignorant, dirty and irresponsible. Physicians deliberately lied about midwifery outcomes to convince legislators that states should outlaw the practice of midwifery (Dreifus, 243). As medical boards and state legislators systematically suppressed midwifery, women had to move out of their homes into hospitals to give birth (Ehrenrich and English, 88).

The 1930's and 1940's brought with them an organized study of labor and management of obstetric complications (Wertz and Wertz, 25). Around this same time, though,

doctors performed cruel expermental surgeries on many women, especially black and poor white women in the name of science (Corea, 227). The growth of the medical profession and its growing respectability encouraged an increasing number of women to seek its services. The shift of births to hospitals, the development of physician-controlled contraception, government programs providing prenatal care and the use of third-party payment all contributed to establishing how and where health-care for women is now being obtained (Corea, 229).

Although there have been many advances in the technology of treating women, the teaching of medical students and physicians is still archaic. A study conducted by Diana Scully and Pauline Bart in 1974, looked at 27 gynecology text books written for medical students since 1943, they found most contained "traditional sex-role sterotypes in the interest of men and from a male perspective"(Marieskind, 299). The following are excerpts from medical textbooks, the wording of these texts illustrate the study's findings and confirm how physicians are encouraged to act as women's moral judges.

> "1983...The evaluation of the patient's personality need not be a lengthy matter. It begins as she

> enters the consulation room and sits down. Character traits are expressed in her walk, her dress, her make-up, her responses to questions, and in almost every action, both verbal and non verbal in nature. The observant physician can quickly make a judgement as to whether she is overcompliant, over-demanding, aggressive, passive, erotic or infatile...
> Many physicians hesitate to delve into a patient's emotional state because they fear a negative reaction from the patient or even that their question might make the patient feel worse. If they question patients gently and watch for signs of resistance, no harm can be done. Certainly the patient who responds with anger or disgust should be allowed to keep her confidences, but this response in itself indicates that an emotional problem may exist..."
>
> "1981... the frequency of sexual intercourse should depend primarily upon the male sex drive, for the male physiology involved requires active physical stress. The female should be advised to allow her male partner's sex drive to set their pace and she should attempt to gear hers satisfactorily to his. Lack of consideration for the male partner's inherent physical drive is a common cause of impotence and reflects an immature attitude of the female who is using her partner for self-gratification. The patient should be encouraged to discuss her attitude towards intercourse in order that the physician may evaluate her maturity and knowledge... Sexual frigidity by which is meant the inability to respond sexually is not frequent in the female. Although there seems to be little doubt that libido, which is well developed among males, appears to be less highly developed among females." (The New Our Bodies, Ourselves, 569).

The Women's Liberation Movement was largely responsible for the early beginnings of the Women's

Health Movement and the development of the first Women's Centers. During the late sixies and early seventies women were raising their consciousness in all areas of their lives including work, marriage and relationships, childrearing, equal rights, their sexuality and their health. So women joined together to talk about all kinds of problems. They began to see a common pattern in their health-care treatment. According to Gale Maleskey, women were feeling that doctors were often condescending and insensitive to their needs. They were often treated with reassurances "that everything would be fine" instead of the substantial information they wanted (41). Because the Woman's Health Movement began as a grass-roots effort the exact date of their formal beginning is unclear, but 1969 is when most authors credit its inception. Part of the movement began in Chicago and was orginally an underground society that helped women find safe abortions. JANE was the first name this organization was known as because they responded to calls by saying "this is Jane from the Women's Liberation Organization. How may I help you" (Dreifus, 273)?

At the same time, a group of women in Boston organized to discuss women's health care and the result of their many meetings and research was the book, Our

Bodies, Ourselves. This book was and continues to be a collective effort from women of various backgrounds to provide accurate information to women about their bodies and their health options. This group continues to update their original manuscript and a revised edition of Our Bodies, Ourselves was published in 1984 (The New Our Bodies, Ourselves, 1984).

In 1974, in California, a group called the Coalition for Medical Rights of Women got together and with the help of two law firms, filed petitions and lawsuits in an attempt to hold drug companies, medical professionals and state governments responsible to females. This coalition was concerned with the number of unnecessary surgeries, especially radical mastectomies and hysterectomies and with contraception safety. The coalition saw their first victory after the Health Department imposed strict regulations in 1976, concerning the use of Intrauterine Devices (Corea, 256).

In June of 1975, the Women's Health Movement joined together to form what is known now as the National Women's Health Network. This group of lobbyists monitor the F.D.A. and the National Institute of Health to keep

women aware of when hearings are scheduled and what topics are being debated. In the last ten years this organization has been responsible for various bills that have gone before the Senate and the House. Members of the National Institute of Health testified at the F.D.A. hearing against the approval of Depo-Provera for use as a contraceptive in the United States and subsequently filed a class-action suit against the Upjohn Corporation on behalf of the women who suffered complications from using the drug (Corea, 154).

The National Women's Health Network also was responsible for pressuring the Federal Government to spend $1.5 million to study cervical caps and other alternative birth-control methods. They have also joined with other women's organizations in filing a class-action lawsuit against the A.H. Robin Corporation on behalf of the women harmed from using the Dalkon Shield (Corea, 153).

The Women's Health Movement is working to give women back the power over their own bodies. Clinics have been established to provide women with information about their health-care needs. Small informal self-help women's groups are meeting throughout this country to help each

other learn about birth-control, fertility awareness, menopause, breast cancer and many other topics. These groups are organized in a way that every member plays an equal role. The information is free and the belief is that women can understand medical information (Corea, 255-266).

CHAPTER 3

LITERATURE REVIEW

In the last thirty years, women have been evolving into their own identity. Thirty years ago less than one-third of American women attended college. Today more than one-half of the female population goes to college or some form of post-secondary training (Francese, 22). Because women are more educated, they now expect more from their health care providers. They want to be informed about the tests being done, they want their conditions explained, they want to know about the medicines being prescribed and they want facts, not reassurances (Maleskey, 41).

As more women attend college, more choose to work and pursue careers (Smalley, 97). In 1960, about one in every three women who worked between the ages of twenty-five and thirty-four were employed outside of the home. In 1986 about three-fourths of the females in this age bracket were employed (Francese, 22). This employment has contributed to the female's knowledge-base and their ability to be assertive and ask for the information they want (Francese, 23).

Another factor that has contributed to women expecting more information from their physicians is, the fact that women are becoming more independent. There are more single-women heads of households today than ever before. Many women today have only themselves to rely on to make informed decisions (Francese, 22-24).

The media is responsible for some of the worst and best information going out to the public. Women must be careful when relying mainly on the media for their health care information. Reporters have been guilty of reporting inaccuracies through ignorance and lack of investigation. Information has been presented as statements of fact when in truth they were the opinions of the physicians they were interviewing. The media has also been responsible for perpetuating the mistaken assumption that medicine and spectacular medical technology creates good health. Many people choose to ignore health warnings assuming, that whatever happens to them, the doctors can cure (Brown 87-88).

Excellent television shows and many of the women's magazines and health publications do a thorough job of

presenting medical information in a way that the public can easily understand. The media has also brought to the public's attention the human side of doctors. Even though the number of bad or dishonest physicans is small, when the media reports about their mistakes or fraud, the public sees them as human and capable of making mistakes and errors in judgement. This type of reporting, although unpleasant for the physicans involved, forces everyone to look at doctors from a realistic perspective and demand information about the procedures being recommended to them (Goldberg, 20-23).

Health care providers are finally realizing the importance of the media and are sending their messages across the wires. Once thought of as "bad taste" for medical professionals to advertise, it is now becoming routine. Today advertisements inform the public of services they can receive at hospitals, clinics and physician's offices (Kirn, 2171).

Radio and television advertisements can already be heard in major cities promoting the unique services and treatments offered by many Women's Resource Centers. Smaller centers advertise using professionally designed

mailers to inform residents in their general area of the different approach to health care they provide (Lyttle, 1989)

Insurance companies are also forcing everyone to become more informed. Tired of paying for unnecessary tests and treatments, many insurance companies require a second opinion or strong physician justification for services before payment for treatment will be approved (Fowler, 1988).

Because women are more informed consumers, providers are looking at new ways to capture this share of the health care market (Agnew, 9). Market research has shown that sixty-seven percent of all health care decisions are made or influenced by women. Based on this fact alone, providers need to tailor their services to appeal to the female population (Dearing, 30-34).

For most women, their first experience in a hospital often takes place with the birth of their first child. And statistics state that fifty-eight percent of all pregnant women choose a hospital first and a doctor second for maternity care. Based on this statistic,

Women's Centers should develop obstetrical and gynecological services to attract new clients and introduce them to the other services they provide (Dearing, 30-34).

Competition for the health care dollar is fierce and hospitals and other provders are fighting for their share. Marketing professionals have been researching ways to attract new patients and fill empty beds. Women's Resource Centers have provided one way to help hospitals in this area. Many hospitals across this country are realizing the importance of women as health care consumers and are beginning to design programs to attract them. There has been a forty-percent increase of hospitals expanding into specialized women's health services as reported by the American Medical Association in 1988 (Weber, 150-154).

The Women's Pavillion in Denver, Colorado began a health care program in 1986. Their program addresses the health care needs of women of all ages. Their educational programs include: prenatal classes, Lamaze and childbirth preparation courses, seminars on

fertility, osteoporosis, self-esteem and stress. To date over eight thousand clients have participated in the education programs at the Pavillion (For All The Times Of Your Life, 1988).

Mrs. Gretchen Hirsch, coordinator at the Riverside Methodist Hospital's Elizabeth Blackwell Center in Columbus, Ohio describes their center as "a women's health program positioned not as a clinical facility but a unique, hospital-based women's resource center for Columbus." Mrs. Hirch states "that providing information and referral services, they motivate women to use the entire hospital complex. It identifies us as a place that pays attention to women. If women who come to us are satisfied, they'll encourage others to do so" (Hirsch, 1988).

The first Women's Resource Center in Illinois, the Women's Health Resources in Chicago was established in 1982. It offers an all female staff, comprehensive care that emphasizes the intergration of educational materials and services for physical and mental health. The center's personnel are careful when making referrals (for problems not handled at the center) to physicans who are sensitive to women's issues (Evans, 1988).

Donna M. Dress, M.D. of the Charter Women's Center in Des Moines, Iowa, writes that they are thrilled with the response to their center. All clients they treat are asked to complete an evaluation form and the responses show a hundred percent satisfaction rate (Dress, 1988).

In the St. Louis area, the Women's Well, at St. Mary's Health Center in Clayton, offers educational programs, free health screenings and markets early detection of diseases. Linda Langdorf, the center's director stated that she did some research on other centers and followed the market researcher's advice to tailor services to women before opening their center. She is presently keeping track of patients for eighteen months after their first contact to see if their contacts increase the use of the connected Health Center. One of the Well's new concepts is that they offer three special events a year called Discovery Days. They choose a special topic such as "women in mid-life" and have guest speakers and experts in the field lecture to the public (Langdorf, 1988).

Women's health needs are varied and growing (Rynne, 1988). Diseases that were typically thought of as men's diseases are now illnesses women are facing. More women

are suffering from heart attacks today and the sad fact is a larger percentage of women who have heart attacks die from them. Teri Englebart attributes the rise in female heart attacks to the added stress of working and new responsibilities. A recent study between 1978 to 1981 showed an increase of cardiac-related deaths for women of 20,000, ten times the increase experienced in the male population (Englebart, 1987). The Women's Centers polled, did not offer an on-going cardiac program but most of them did have stress classes to educate women on the dangers of stress as it relates to their health. Dr. Marc Frankle, director of the Stress Center at St. Joseph's Health Center stated "that stress can affect women in many different ways. Traditionally women have not been given the appropriate outlets to express their stress. Society still expects women to 'behave' and not display strong feelings. This repression of feelings will often show up later as depression, anxiety or with physical symptoms. Most of the women's centers today recognize that stress is a real factor in women's lives and offer out-patient counseling services, group therapy and educational programs designed to help women cope" (Frankle, 1989).

There are many health problems that women face exclusively and these are conditions that most women's centers choose to offer services for. All the centers offer some type of educational progran on breast cancer and most provide mammograms or referrals to mammogram services. "Medical authorities agree that mammograms are the most effective means of detecting cancer early, when the cure rate approaches eighty-five percent and higher," says Harley Hammerman, M.D. at St. Joseph's Health Center. Follow-up care and groups for women who have survived breast cancer are also available at most centers (Hammerman, 1988).

Premenstrual Syndrome is one of the newer issues for women. Although women have been suffering from the symptoms for years, it was not until recently that the symptoms have been recognized as being connected to a real medical condition. P.M.S. involves numerous symptoms both emotional and physical that re-occur consistently during the phase of a women's cycle that preceeds the on-set of menstruation. The emotional symptoms include irritability, nervous tension, anxiety and depression and physical symptoms like abdominal bloating, breast-tenderness, and food cravings (Dalton, 11-139).

Some women never experience any problems connected with their menstrual cycle, but for women who suffer from P.M.S. the symptoms are often severe. Treatment for P.M.S. is multifaceted and include nutritional guidance counseling, educational programs, and for some, medical intervention (Dalton, 171-196).

Chemical Dependency is another new avenue that health care providers are addressing with women. Women have been suffering from chemical addiction for years, it is only in the past ten years that they have begun to come out of hiding. Many of the issues are the same for chemically dependent women and men but for women they are magnified. It's hard enough for society to accept that a man's behabvior is out of control due to his chemical abuse but it's even harder for them to accept the same disease in a female. The guilt that women suffer after they find recovery is often overwhelming and many of the women's centers provide support groups to help women deal with the guilt associated with their past abuse (Doll, 1989).

CHAPTER 4

METHODS AND PROCEDURE

A survey was conducted to collect data on the current level of knowledge of Women's Resource Centers by St. Charles County residents. The survey was also used to determine what services the respondents prefered. The survey polled a total of 350 people, 150 people at St. Joseph's Health Center and 200 people in the general public category.

A thirteen question survey (See Appendix A) was developed after interviews with administrators of operating Women's Resource Centers (See Appendix C). Information and recommendations of services were discussed and many of these choices were included in the surveys. The survey has some inherent limitations.

The first limitation in this research was the number of people surveyed. The number was small compared to the size of St. Charles County. Businesses were unwilling to allow the survey to be distributed for various reasons. Because of the small number of people polled, it may be difficult to get distributed amounts of different age groups, sexes, salary ranges or educational levels.

Another limitation for this study is the term wellness can be interpreteted in different ways. And although a brief definition of wellness was provided in the cover page of the survey, each person answering the survey will use their own interpretation and background when answering the survey questions. Wellness even in the medical profession is a relatively new concept.

Management personnel of varied local businesses (See Appendix B) were approached and permission to distribute the survey was requested. The vice-president of St. Joseph's Health Center was contacted and permission was granted to distribute the surveys throughout the health center if the supervisors of the various departments agreed. Most of the local businesses contacted were open to the distribution of the surveys, although many of the managers requested that their company's name be omitted from print. Four companies contacted did refuse, stating they considered the surveys a form of soliciting. All the supervisors contacted at St. Joseph's gave permission to distribute the surveys.

Return instructions were different for the two segments. The local businesses that agreed to distribute the surveys were given self-addressed envelopes for their return. Health center personnel taking part in the survey were instructed to return the surveys through the interdepartmental mail system.

Subjects for the surveys were chosen randomly by the supervisors distributing the questionnaires. The only surveys that were eliminated were those with questions that were not answered. The questionnaire was two pages long and a small percentage of the respondents failed to complete the second page.

The results shown in the following chapter are the results of the first one-hundred returned from both the health center and the general public. It is noted that this procedure presents a bias. The respondents who answered the questionnaire quickly may have had a stronger interest in the subject matter than those who took more time. Twenty-three completed surveys were later returned after the results for this thesis were processed. These were not used in this chapter on results.

The completed survey results were separated to determine if health care workers were more informed than the general public concerning the concept of Women's Resource Centers. The results of the questions to rate the importance of various services offered by many of the existing resource centers were also divided to determine if health care workers had different preferences for services than the general public.

CHAPTER 5

SURVEY RESULTS

The following pages provide results of the answered surveys and include graphs for visual comparisons. The first seven questions address demographic information on the subjects surveyed.

Figure 1 shows the age categories of the people surveyed. The age range was between twenty years to over sixty-four years, with the largest group of respondents being between the age of twenty and forty years of age for both the public and the health care workers. The majority of surveys were completed by females (See Figures 2 & 3) in both groups.

Figure 4 shows the marital status of the men and women surveyed. There was a larger percent of married respondents in the health care field than was true of the public, where there was a higher percentage of both single and divorced respondents. All the males with the exception of one, were married. Question 4 asked respondents their education. The largest difference

SEX OF THOSE SURVEYED

HOSPITAL

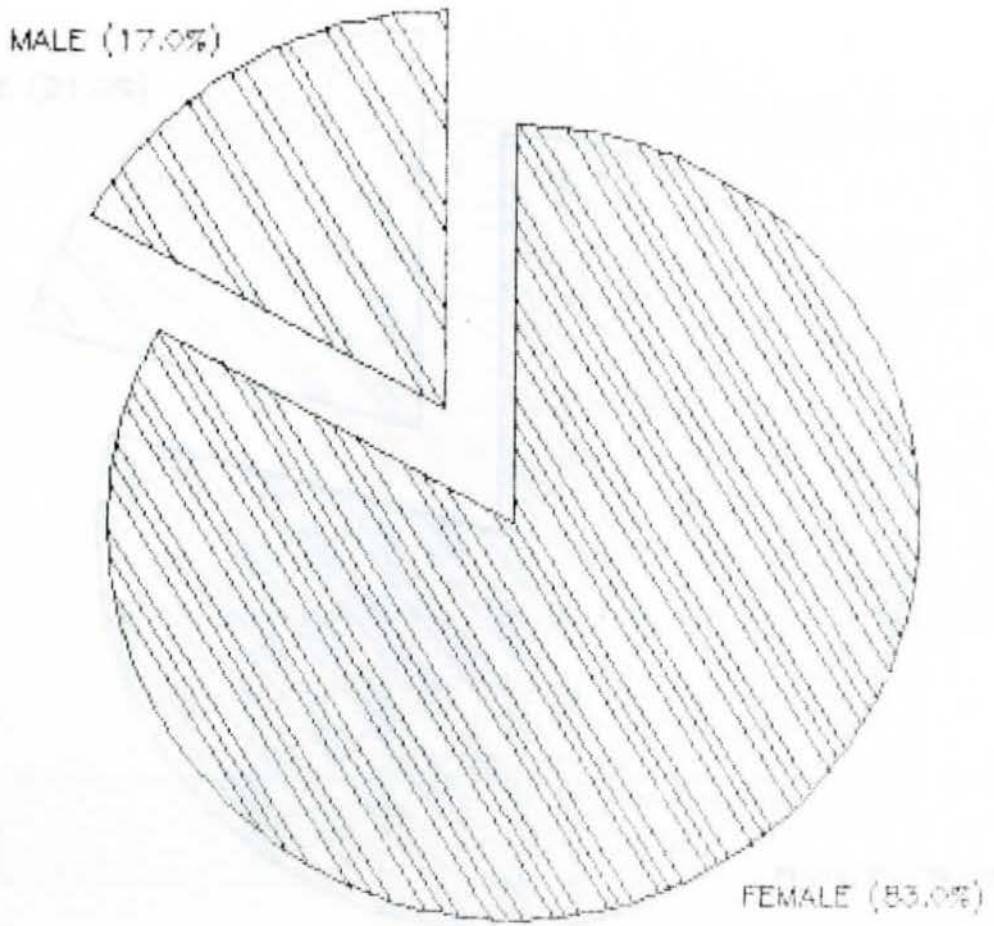

FIGURE 2

SEX OF THOSE SURVEYED

PUBLIC

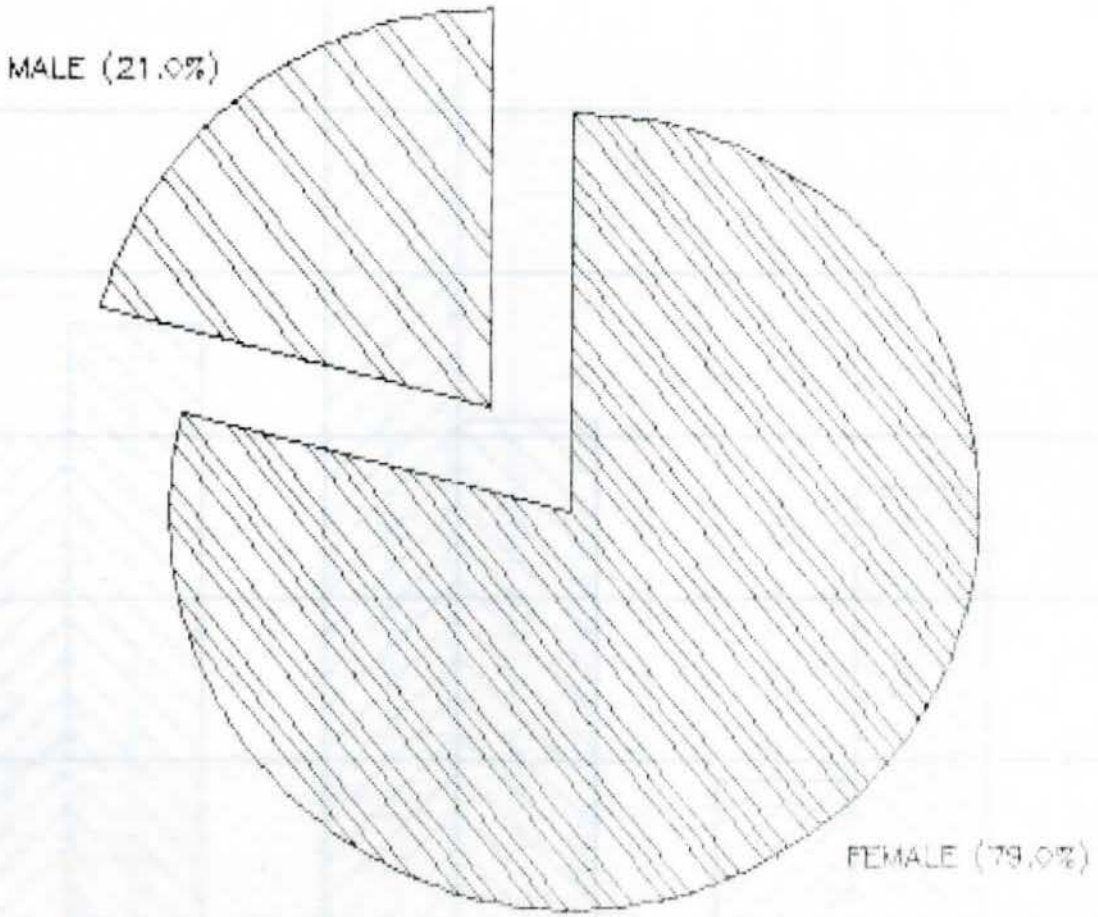

FIGURE 3

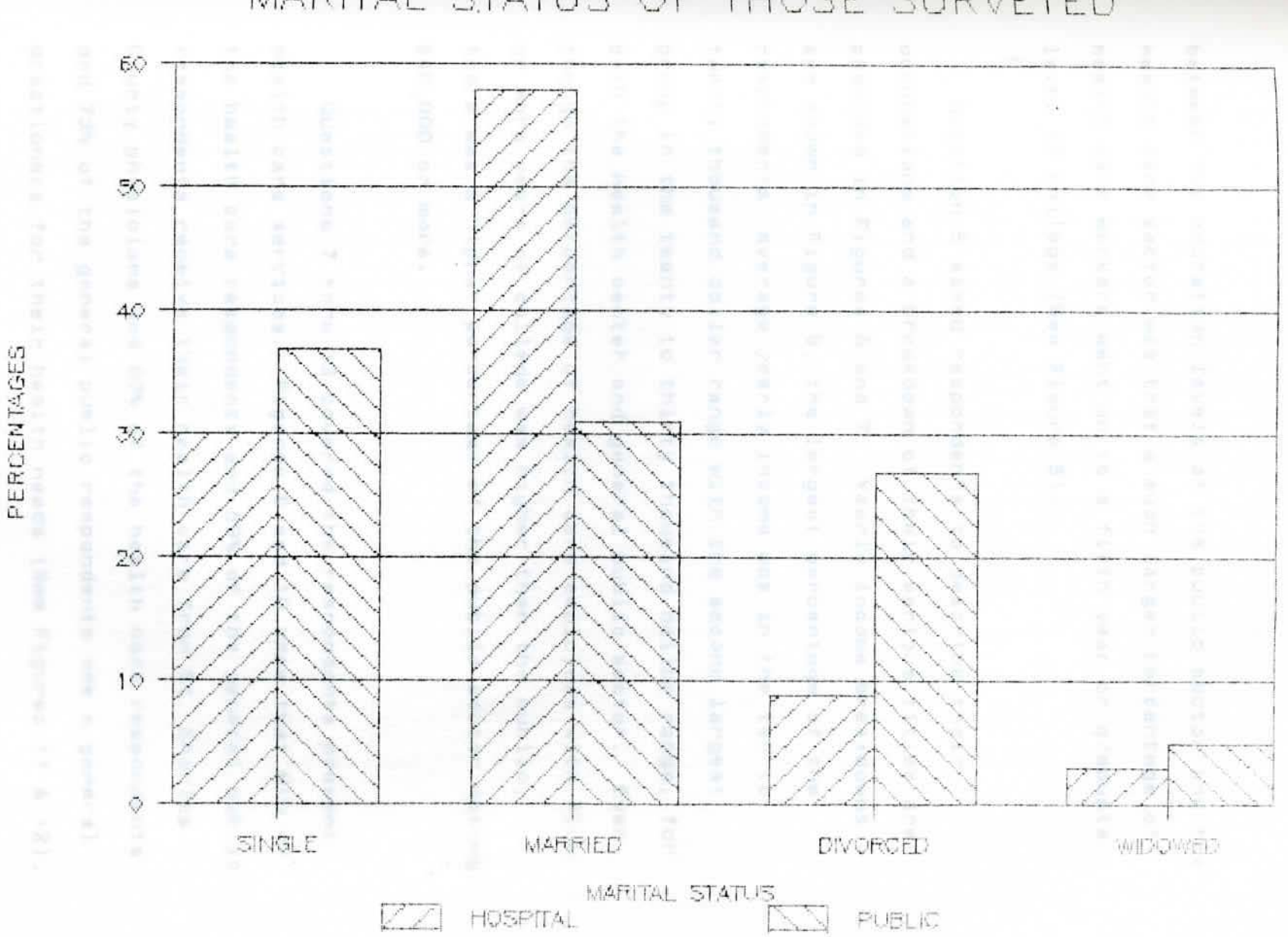
MARITAL STATUS OF THOSE SURVEYED
PERCENTAGES
60
50
40
30
20
10
0
SINGLE
MARRIED
DIVORCED
WIDOWED
MARITAL STATUS
HOSPITAL
PUBLIC

FIGURE 4

between the education levels of the public sector and the health care sector was that a much larger percentage of health care workers went on to a fifth year or graduate level of college (See Figure 5).

Question 5 asked respondents to describe their occupations and a breakdown of their various titles are provided in Figures 6 and 7. Yearly income breakdowns are shown in Figure 8, the largest percentage of the respondents' average yearly income was in the ten to twenty thousand dollar range with the second largest group in the twenty to thirty thousand dollar range, for both the health center and general public sector. Even though the percentage of health care employees with five or more years of college was higher than the public, there was a higher percentage of the public sector making $40,000 or more.

Questions 7 thru 13 covered the respondents present health care services. Figures 9 and 10 show that 61% of the health care respondents and 59% of the general public respondents receive their health care from St. Charles County physicians and 80% of the health care respondents and 73% of the general public respondents see a general practioners for their health needs (See Figures 11 & 12).

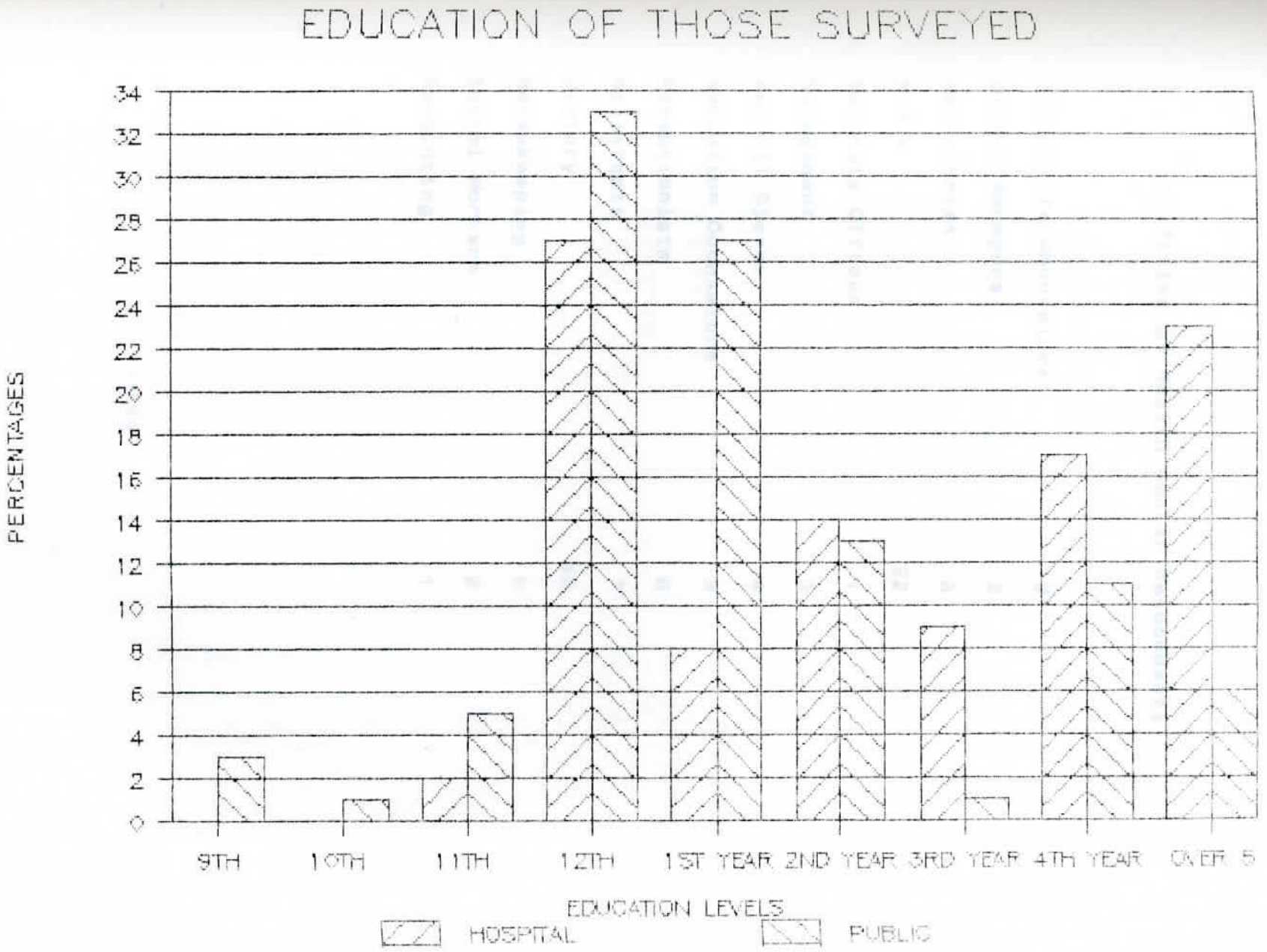
EDUCATION OF THOSE SURVEYED
PERCENTAGES
34
32
30
28
26
24
22
20
18
16
14
12
10
8
6
4
2
0
9TH
10TH
11TH
12TH
1ST YEAR
2ND YEAR
3RD YEAR
4TH YEAR
OVER 5
EDUCATION LEVELS
HOSPITAL
PUBLIC

FIGURE 5

Job Titles of Health Center Respondents

Therapists/Counselors	9
Office Managers	2
Secretaries	8
R.N.s	32
Security Officer	1
Management	3
Payroll Clerks	4
Addiction Counselors	9
Receptionists	6
Assistants	7
Dietary	10
Housekeeping	6
Social Workers	2
Accounting	1

FIGURE 6

Job Titles of Public Sector

Corporate Trainer	1
Teachers	6
Computer Programmers	2
Factory Supervisors	2
Housewives	8
Secretaries	10
Loan Officers	4
Bank Clerks	11
Supervisors	5
Attorneys	2
R.N.s	3
Housekeeping	3
Sales	12
Food Workers	6
Students	4
Unemployed	4
Management	5
Child Care Worker	6
Social Worker	1
Office Managers	5

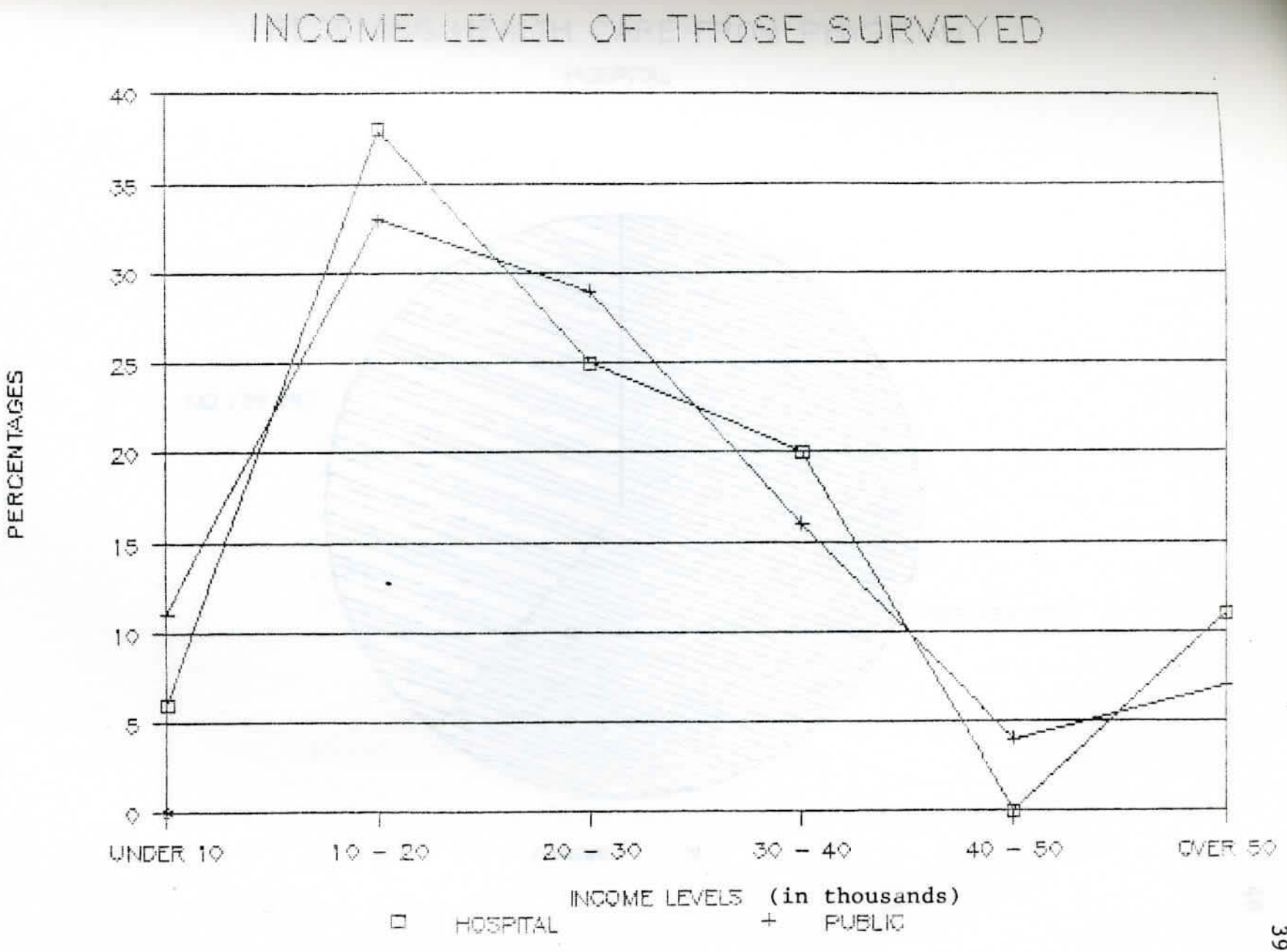
INCOME LEVEL OF THOSE SURVEYED
PERCENTAGES
40
35
30
25
20
15
10
5
0
UNDER 10
10 - 20
20 - 30
30 - 40
40 - 50
OVER 50
INCOME LEVELS (in thousands)
HOSPITAL
PUBLIC

FIGURE 8

RECEIVING HEALTH CARE FROM PHYSICIAN

HOSPITAL

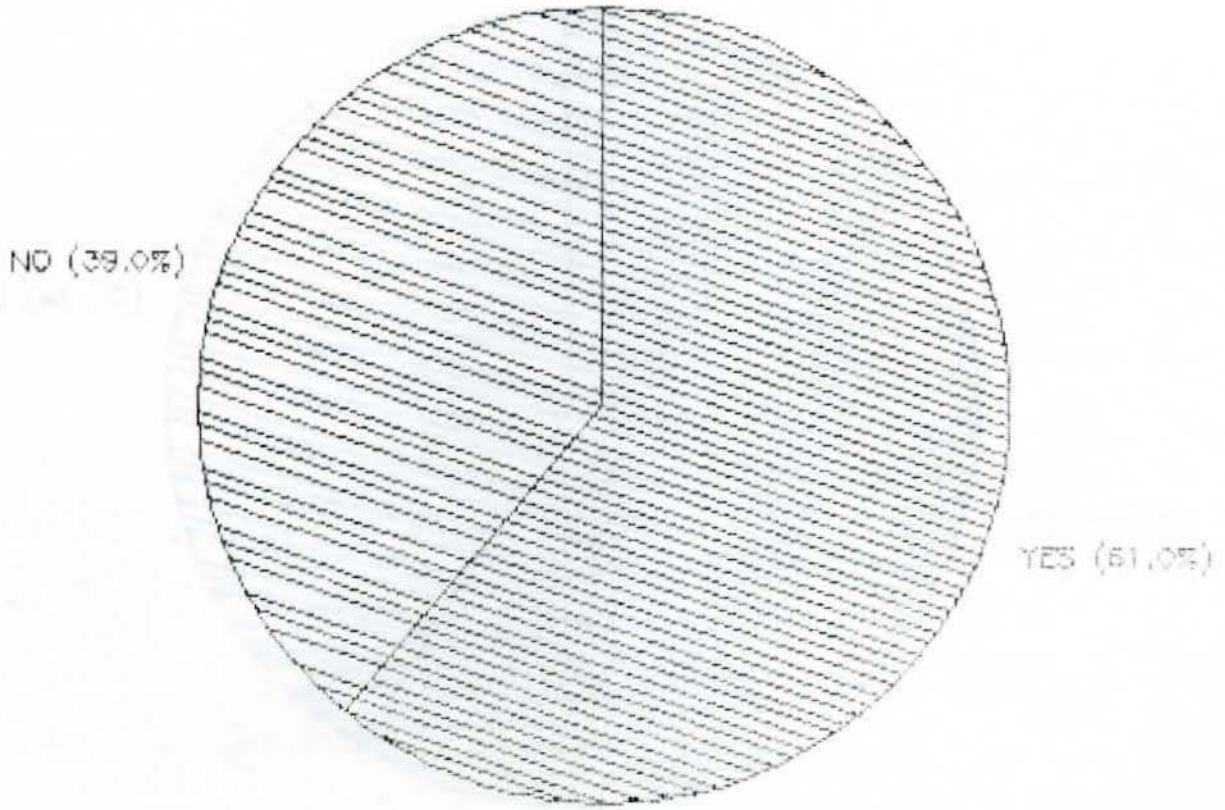

FIGURE 9

RECEIVING HEALTH CARE FROM PHYSICIAN

PUBLIC

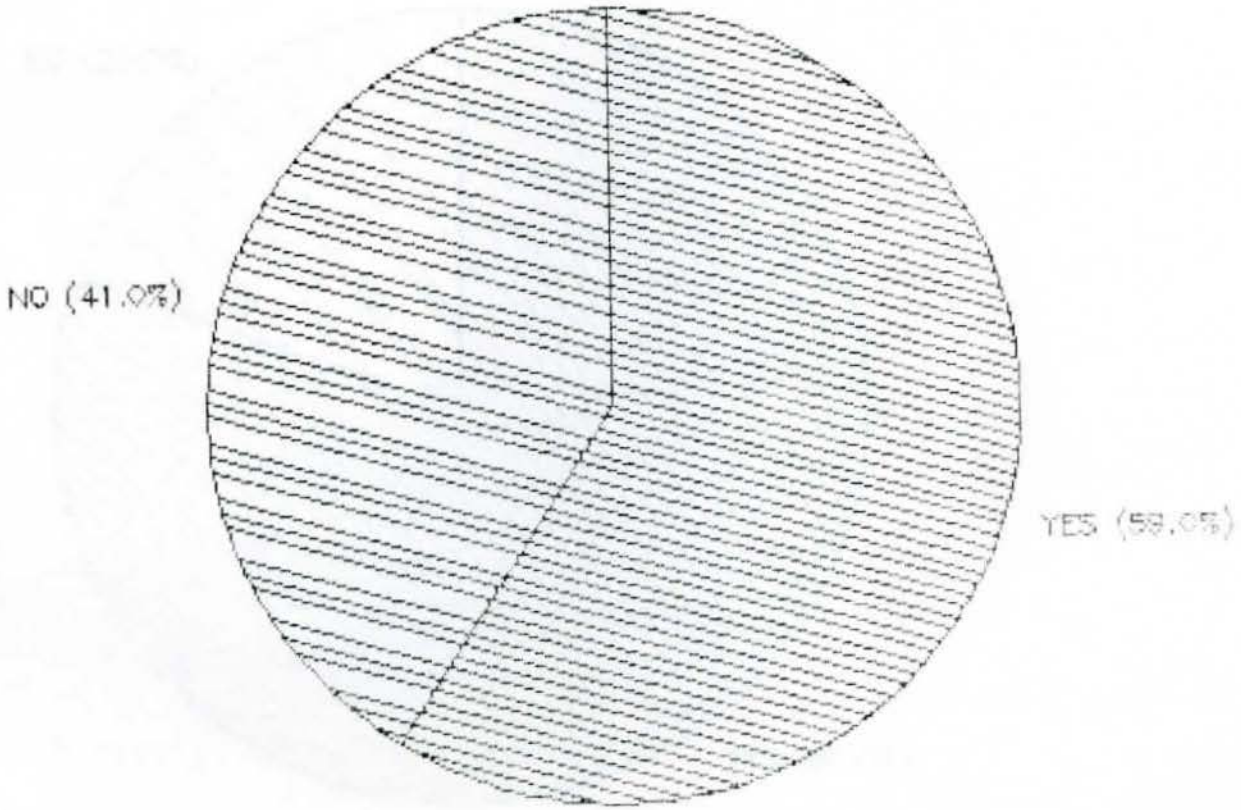

FIGURE 10

RECEIVING HEALTH CARE FROM PRACTITIONER

HOSPITAL

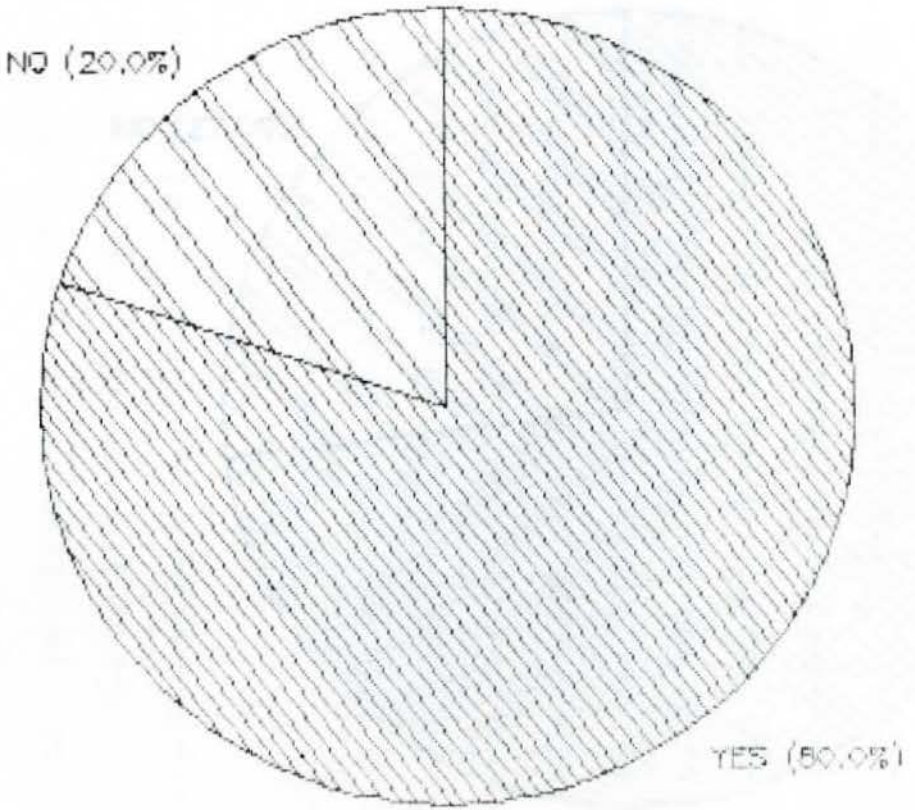

FIGURE 11

RECEIVING HEALTH CARE FROM PRACTITIONER

PUBLIC

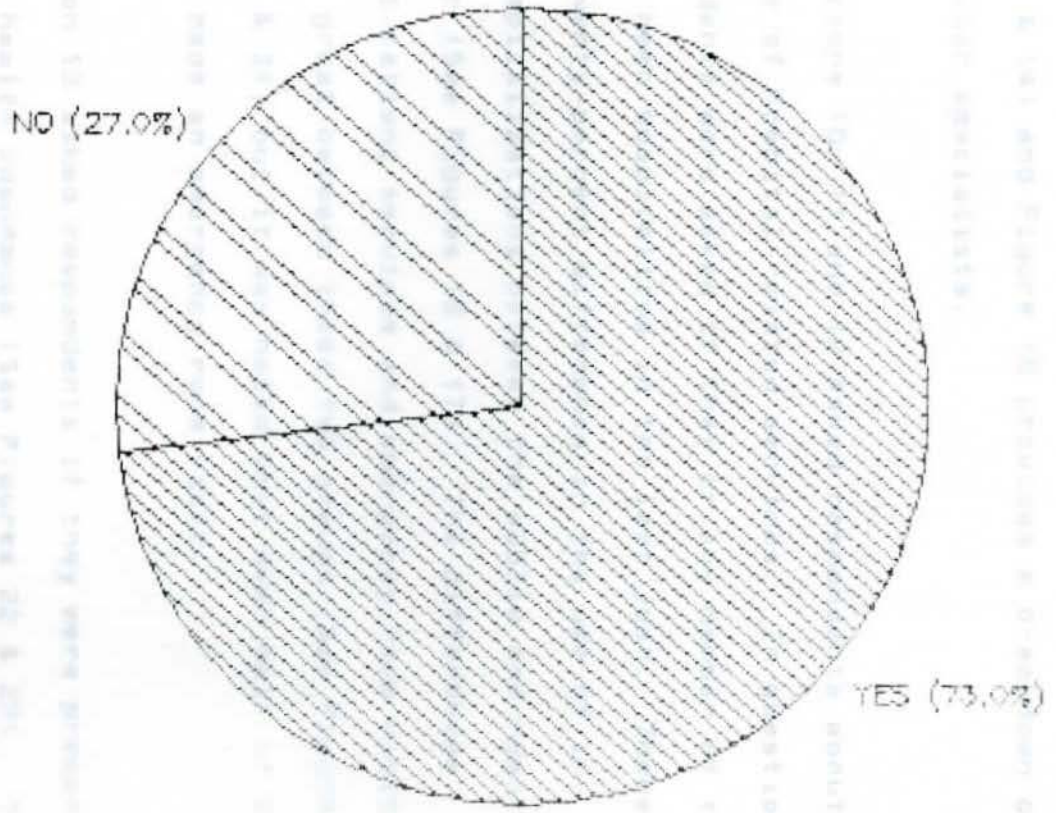

FIGURE 12

When asked about visiting specialists, 64% of the health care respondents and 66% of the general public respondents had visited some type of specialist (See Figures 13 & 14) and Figure 15 provides a breakdown of the particular specialists.

Questions 10, 11 and 12 asked respondents about their usage of hospital-related services. In question 10, respondents were asked if they or any member of their family had been hospitalized in the last year. There was almost a twenty-percent difference in the use of in-patient hospitalizations between the public and health care sector (See Figures 16 & 17). The differences between out-patient services and emergency room visits was not as great between these two groups (See Figures 18, 19, 20 & 21) but it was noted that over half of both groups had made an emergency room visit.

Question 13 asked respondents if they were presently covered by health insurance (See Figures 22 & 23). There was a marked difference in this category. St. Joseph's Health Center provides health insurance to all full-time employees at no-cost to them for single coverage and at a small cost for family coverage. Part-time employees are

RECEIVING HEALTH CARE FROM SPECIALIST

HOSPITAL

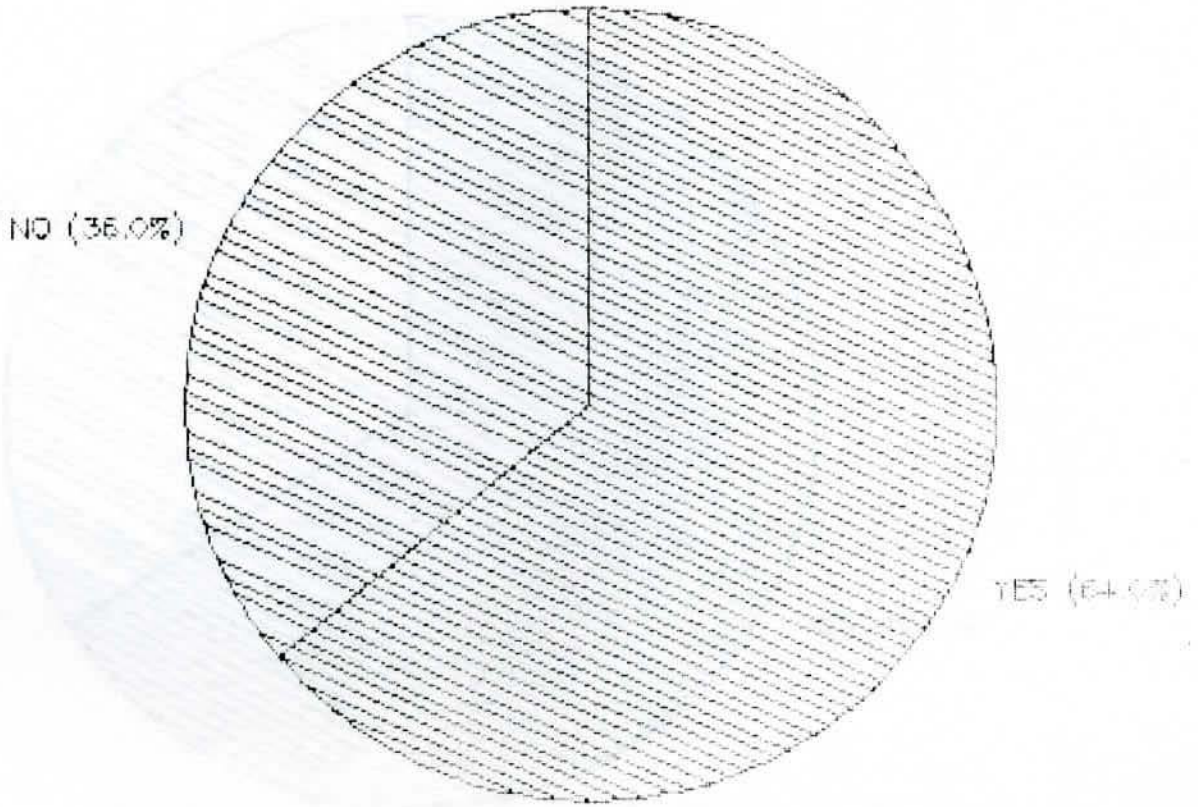

FIGURE 13.

RECEIVING HEALTH CARE FROM SPECIALIST

PUBLIC

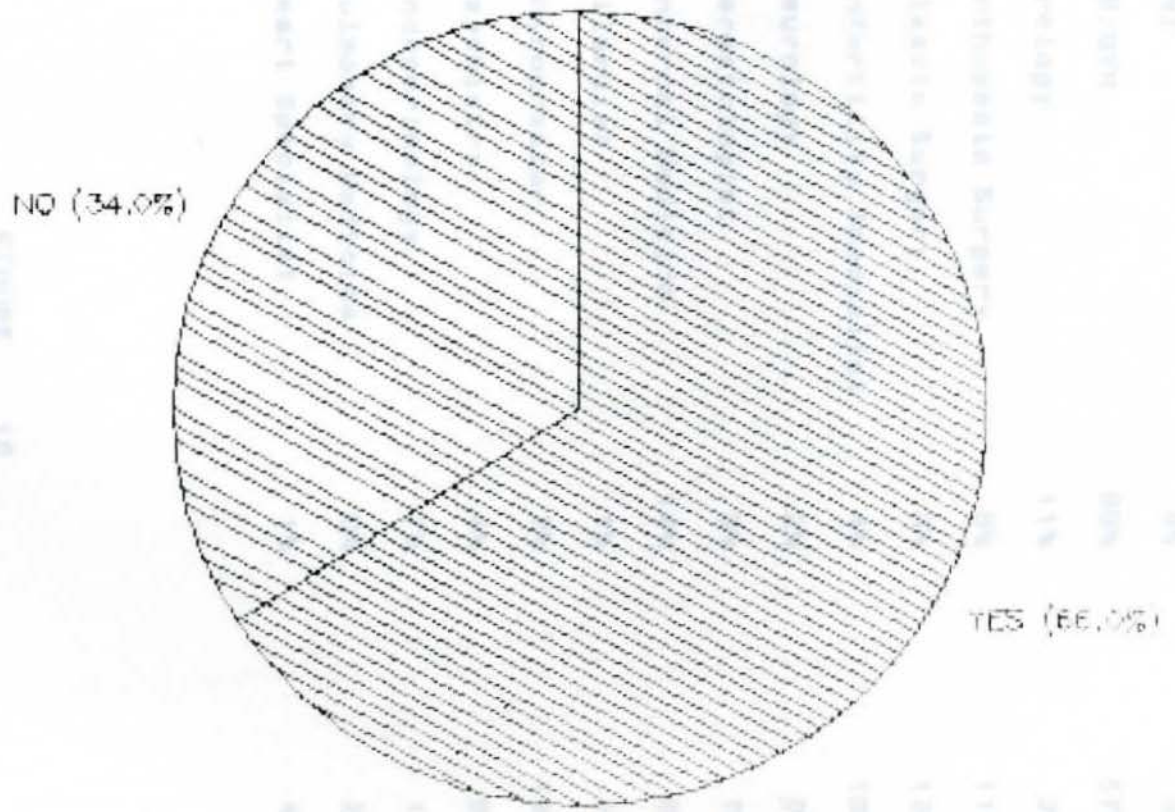

FIGURE 14

Medical Specialists Seen by
Both Groups of Respondents

	Hospital	Public
ENT	5%	3%
OB/GYN	68%	57%
Urology	11%	3%
Orthopedic Surgery	6%	11%
Plastic Surgery	3%	12%
Infertility Specialist	4%	13%
Neurology	2%	0%
Dermatologist	3%	7%
Internal Medicine	14%	6%
Allergist	1%	4%
Chiropractor	2%	19%
Psychiatry	4%	9%
Endrocrinology	7%	1%
Pulmonary Medicine	0%	2%
Heart Specialist	1%	4%

FIGURE 15

RECEIVING IN-PATIENT HOSPITALIZATION

HOSPITAL

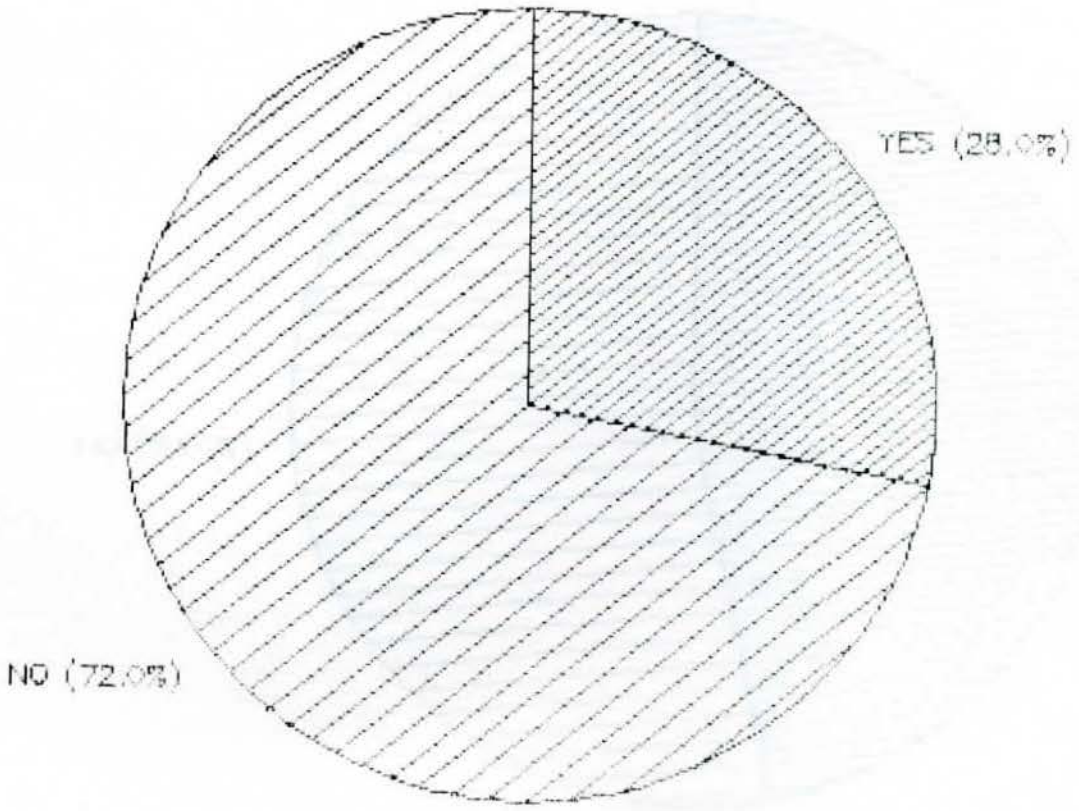

FIGURE 16

RECEIVING IN-PATIENT HOSPITALIZATION

PUBLIC

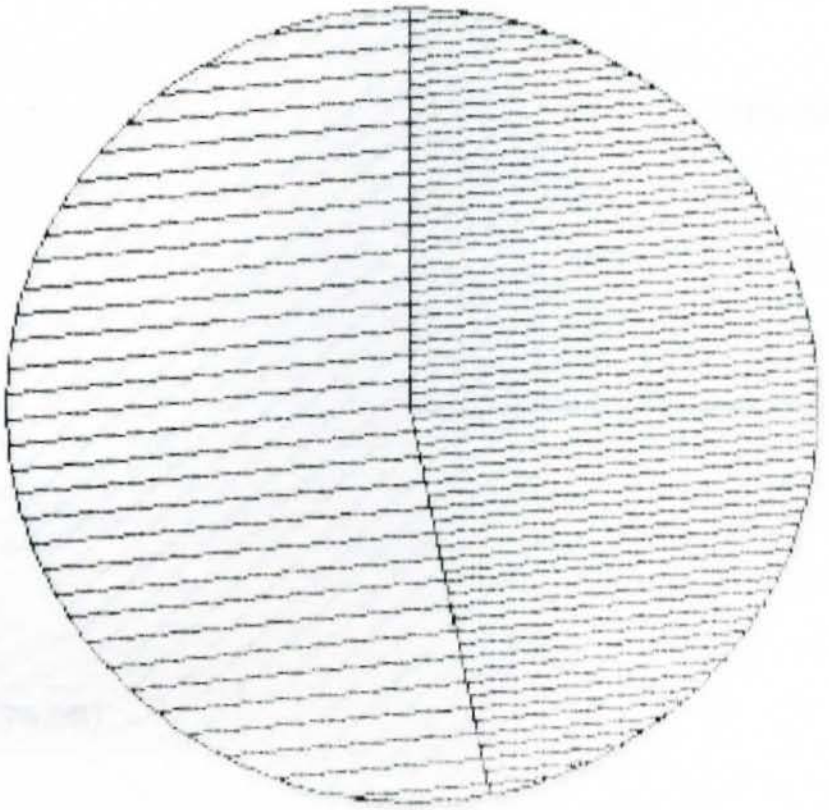

FIGURE 17

RECEIVING OUT-PATIENT TREATMENT

HOSPITAL

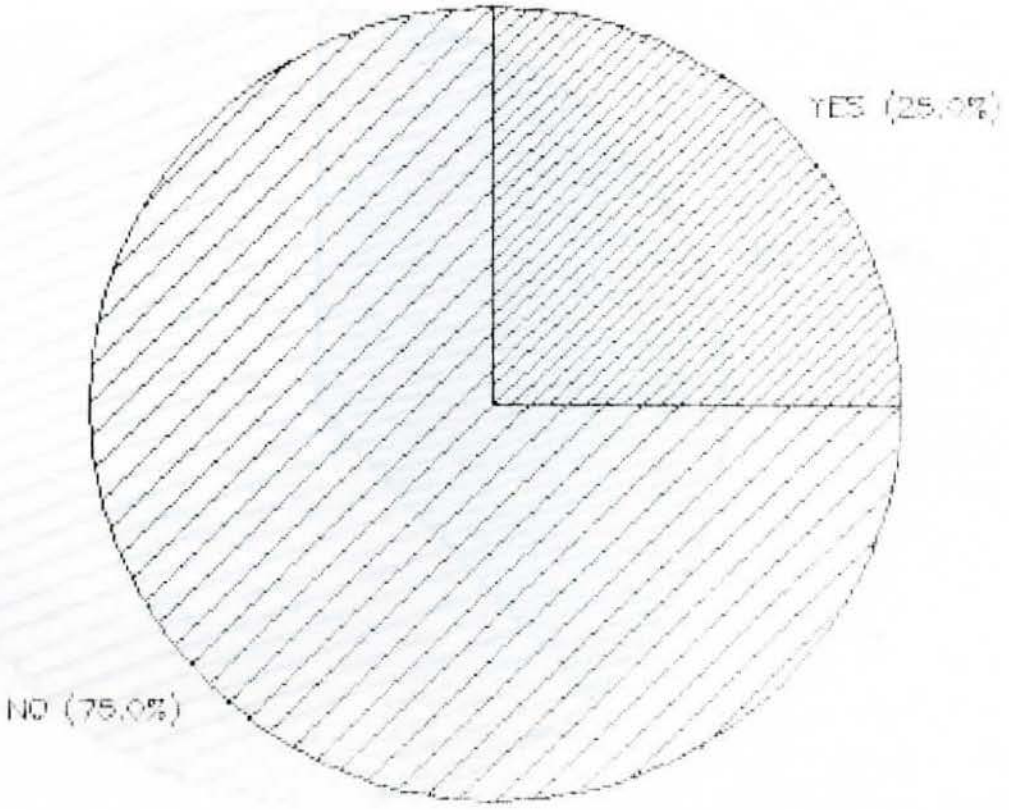

FIGURE 18

RECEIVING OUT-PATIENT TREATMENT

PUBLIC

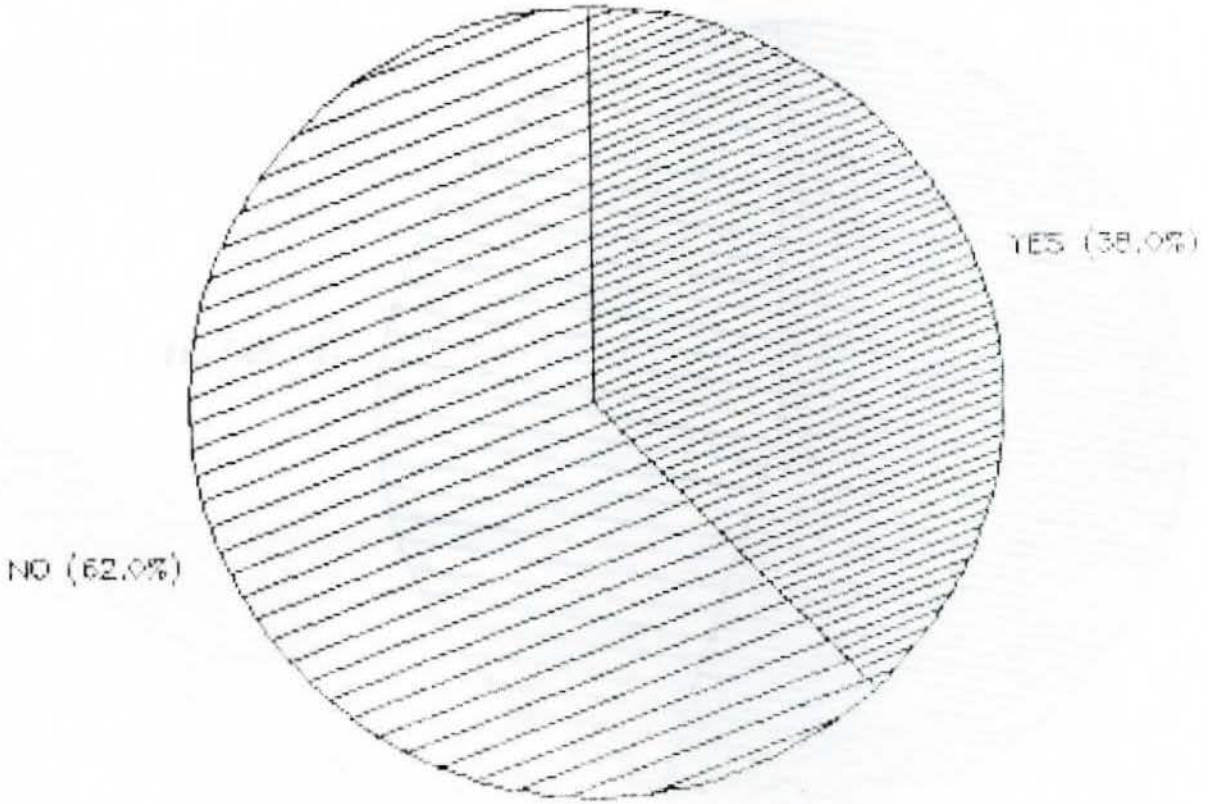

FIGURE 19

RECEIVING EMERGENCY ROOM TREATMENT

HOSPITAL

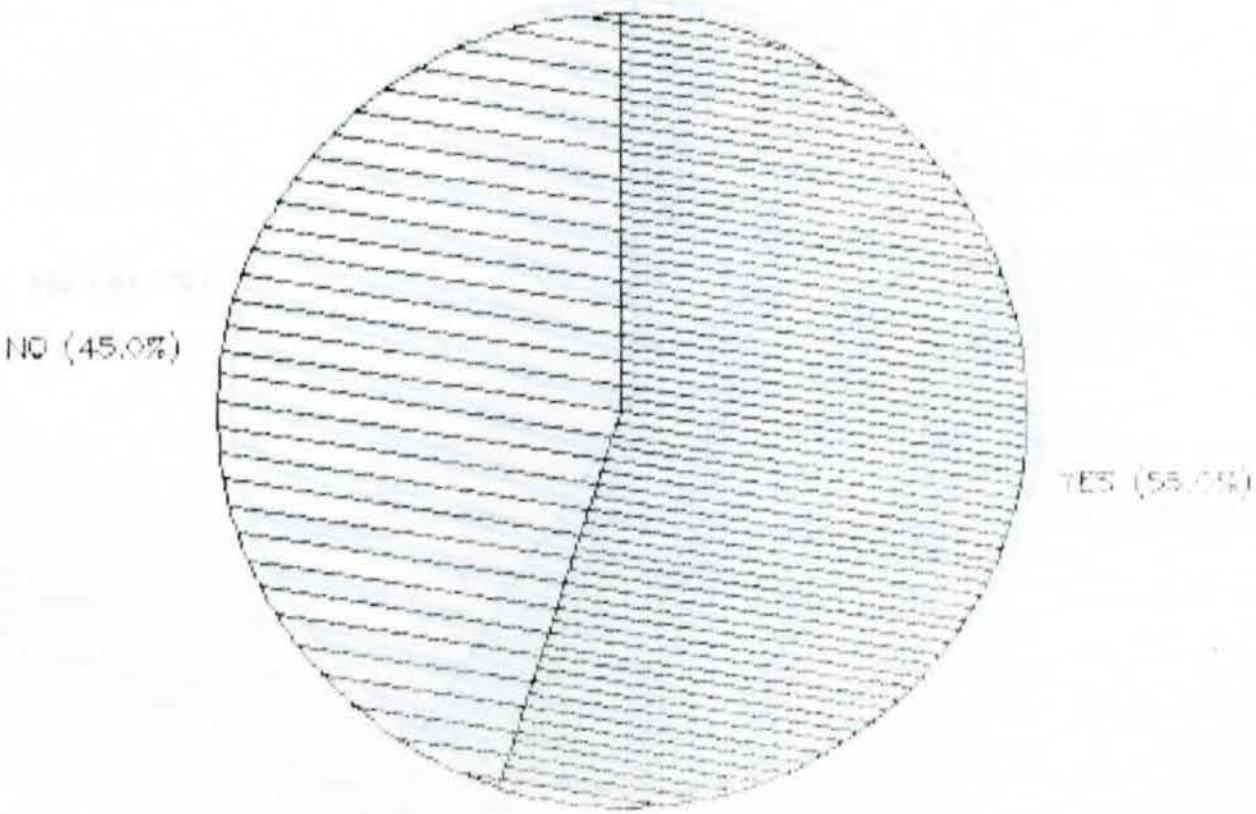

FIGURE 20

RECEIVING EMERGENCY ROOM TREATMENT

PUBLIC

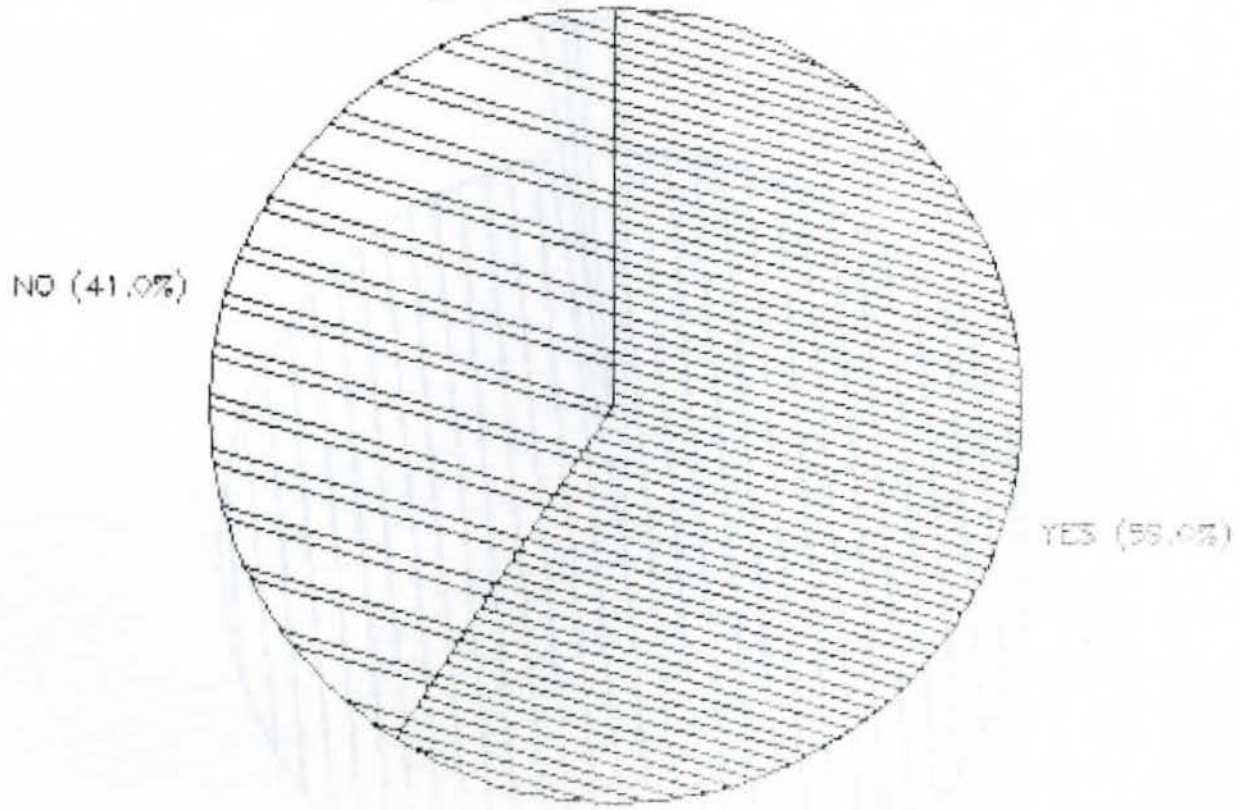

FIGURE 21

RECEIVING HEALTH INSURANCE

HOSPITAL

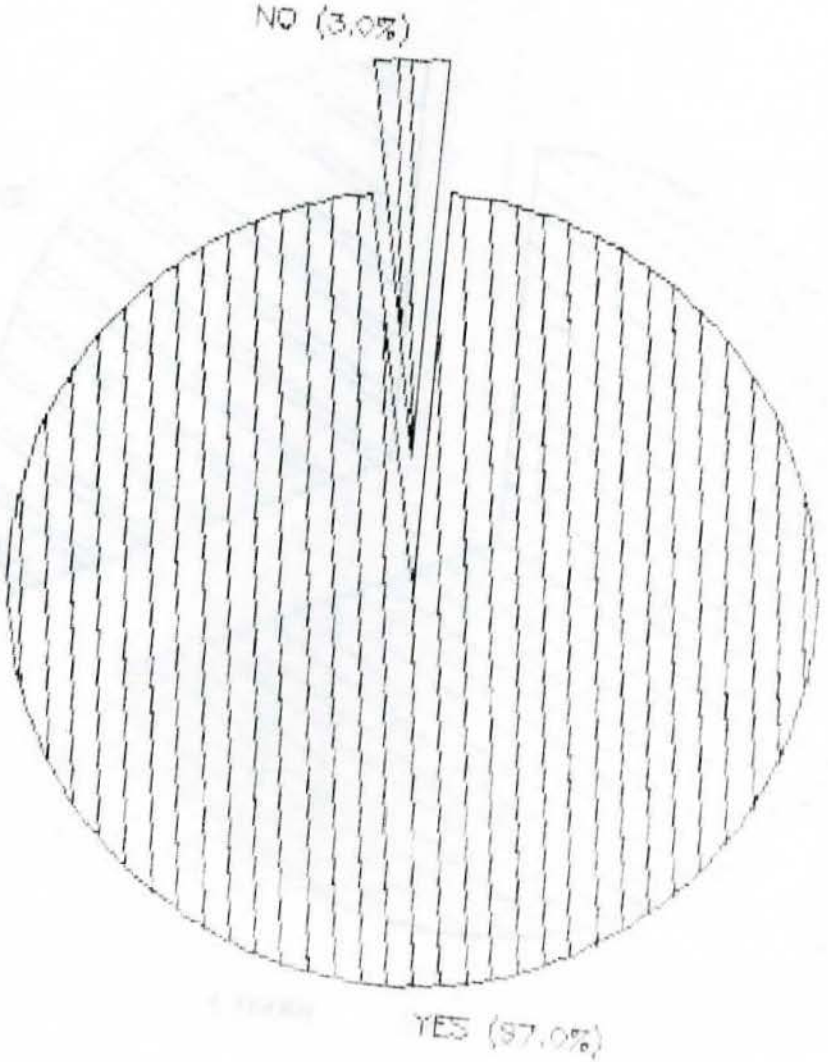

FIGURE 22

RECEIVING HEALTH INSURANCE

PUBLIC

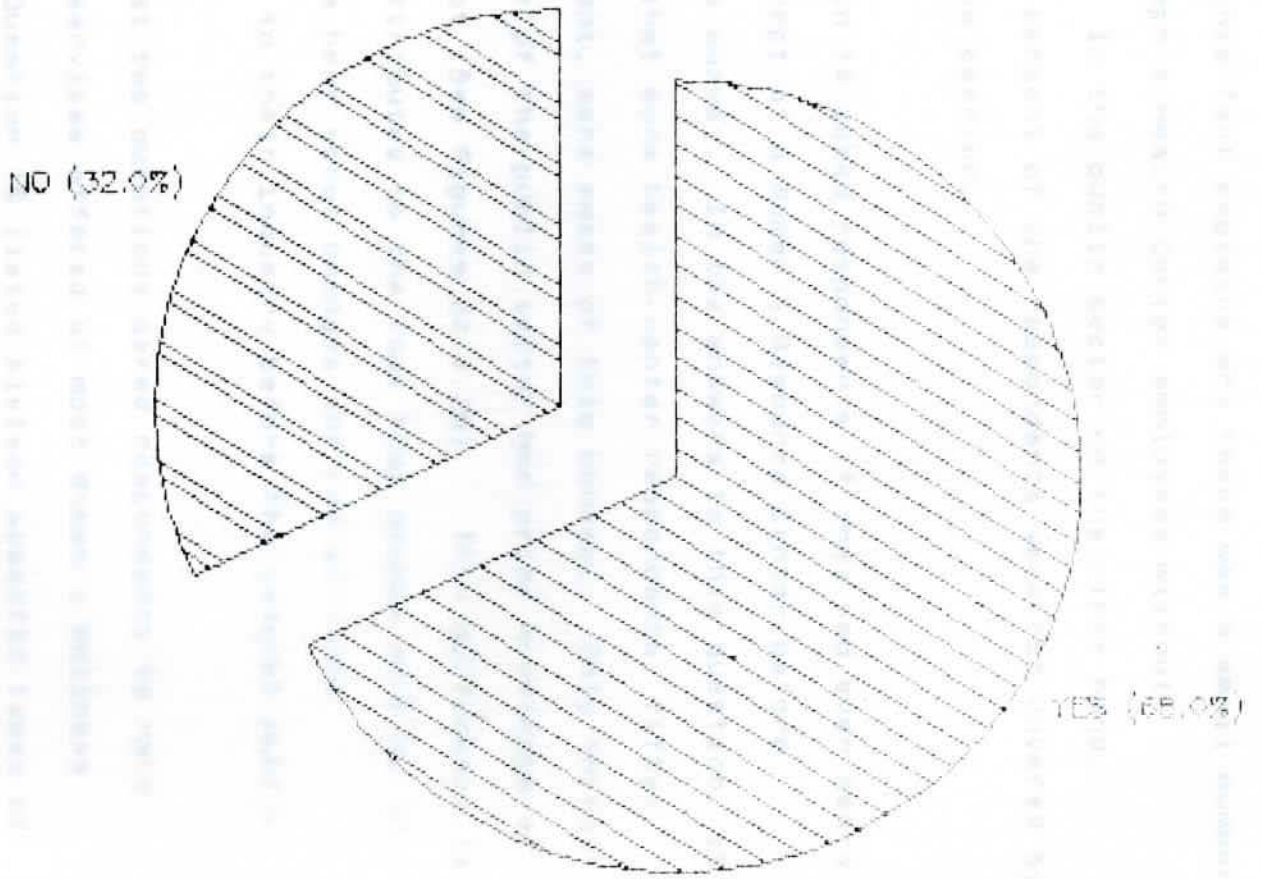

FIGURE 23

required to contribute to both single and family coverage, this fact explains why there was a small number of St. Joseph's Health Center employees without insurance. In the public sector on the other hand, thirty-two percent of the respondents were not covered by an insurance carrier.

Question 14 asked respondents if they had ever heard of the concept of a Women's Resource Center before reading the survey. In the answers to this question, it was noted that more health-center respondents, fifty-eight percent, were aware of this concept. Only thirty-two percent of the public sector had prior knowledge of this concept (See Figures 24 & 25). This difference is probably attributed to the fact that people working in health care hear about changes and new services introduced to their industry before the general public.

The last two questions asked respondents to rate different services offered at most Women's Wellness Centers. Question 15 listed sixteen specific types of medicine and counseling services that can be offered. Respondents were asked to rate these services in the following manner; 1 for very important, 2 for important and 3 for not important.

CONCEPT OF WOMEN'S WELLNESS CENTER

HOSPITAL

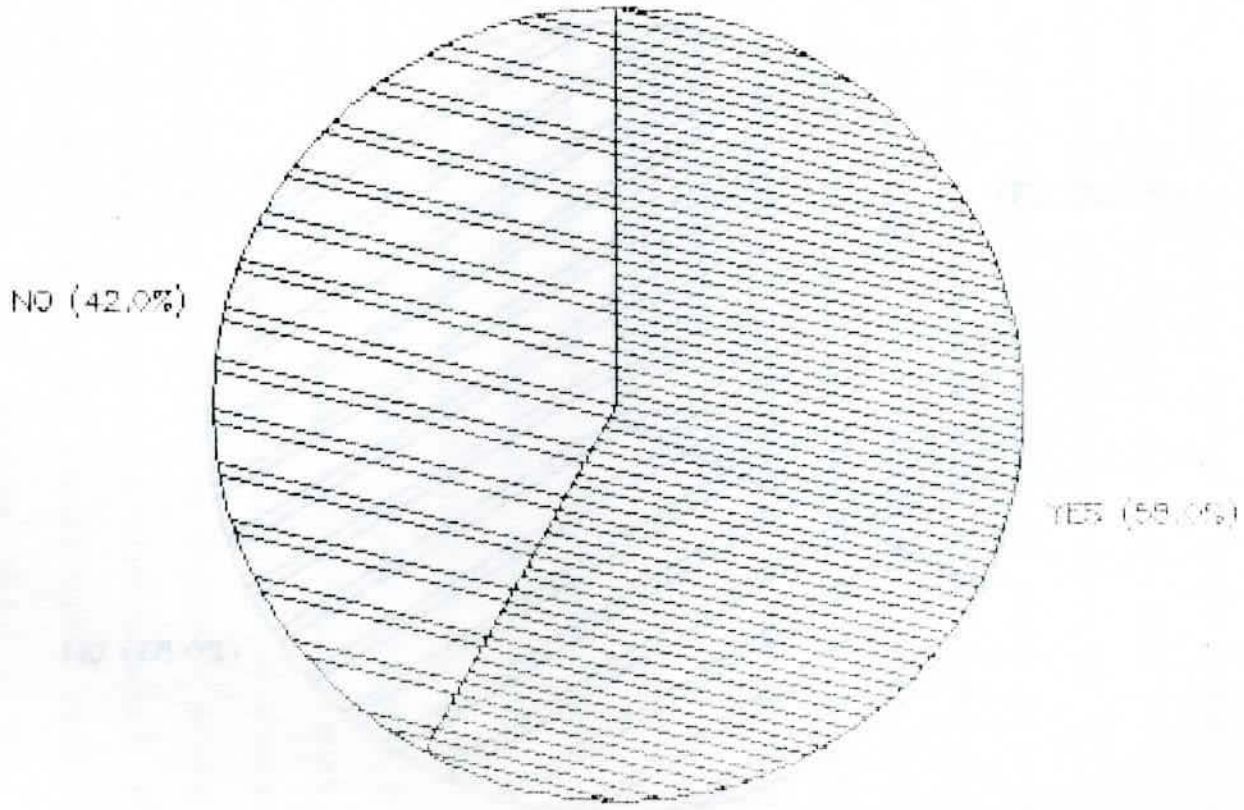

FIGURE 24

CONCEPT OF WOMEN'S WELLNESS CENTER

PUBLIC

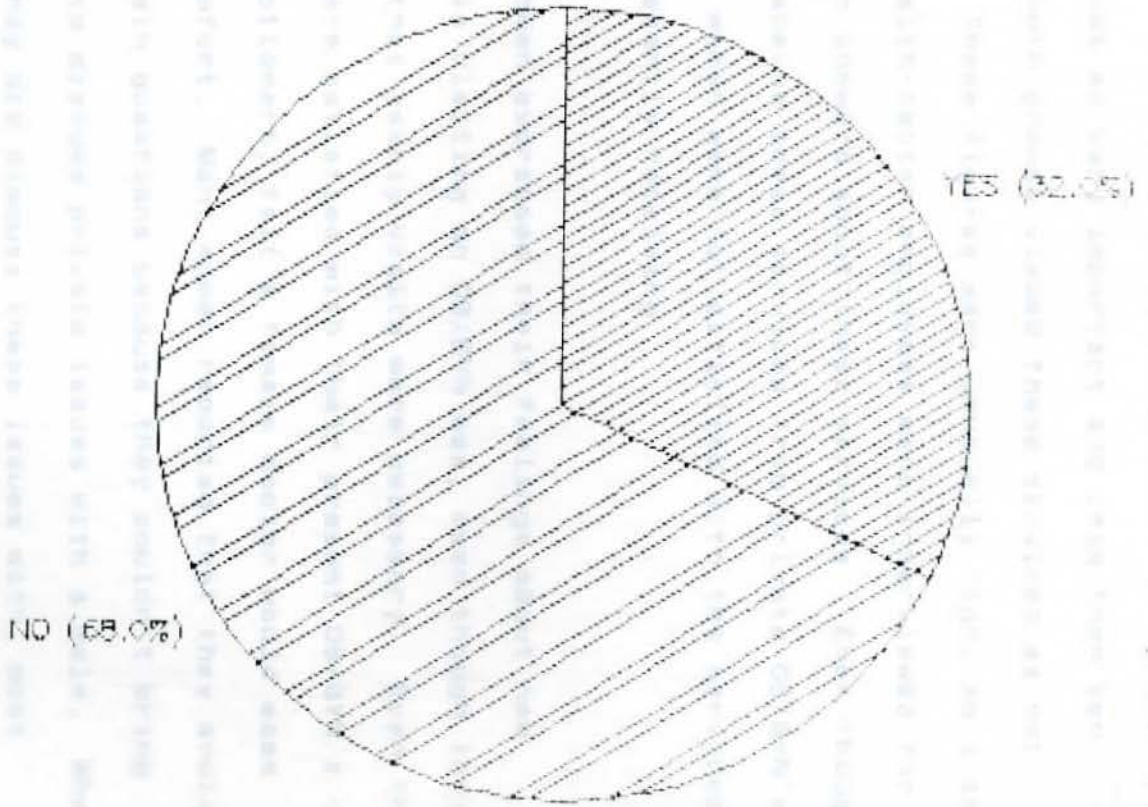

FIGURE 25

Obstetrics and Gynecology rated the highest (See Figures 26 & 27) for both the health care group and the public sector. Over seventy percent of both groups rated these services as very important and less than ten percent of both groups viewed these services as not important. These figures were unusually high, so a small group of health-center employees were interviewed for more indepth answers about these services. Even though women can receive these services from private OB/GYN's, many of the women were not satisfied with the services they are presently receiving.

These women expressed their feelings about how uncomfortable visiting an OB/GYN was, even though they all agreed that yearly visits were necessary. Even the women who were satisfied with their present OB/GYN's or general practioners, felt a female doctor would ease their discomfort. Many women reported that they avoided asking certain questions because they couldn't bring themselves to discuss private issues with a male. When asked who they did discuss these issues with, most respondents stated with other females, these other females included their mothers, sisters, other relatives and friends.

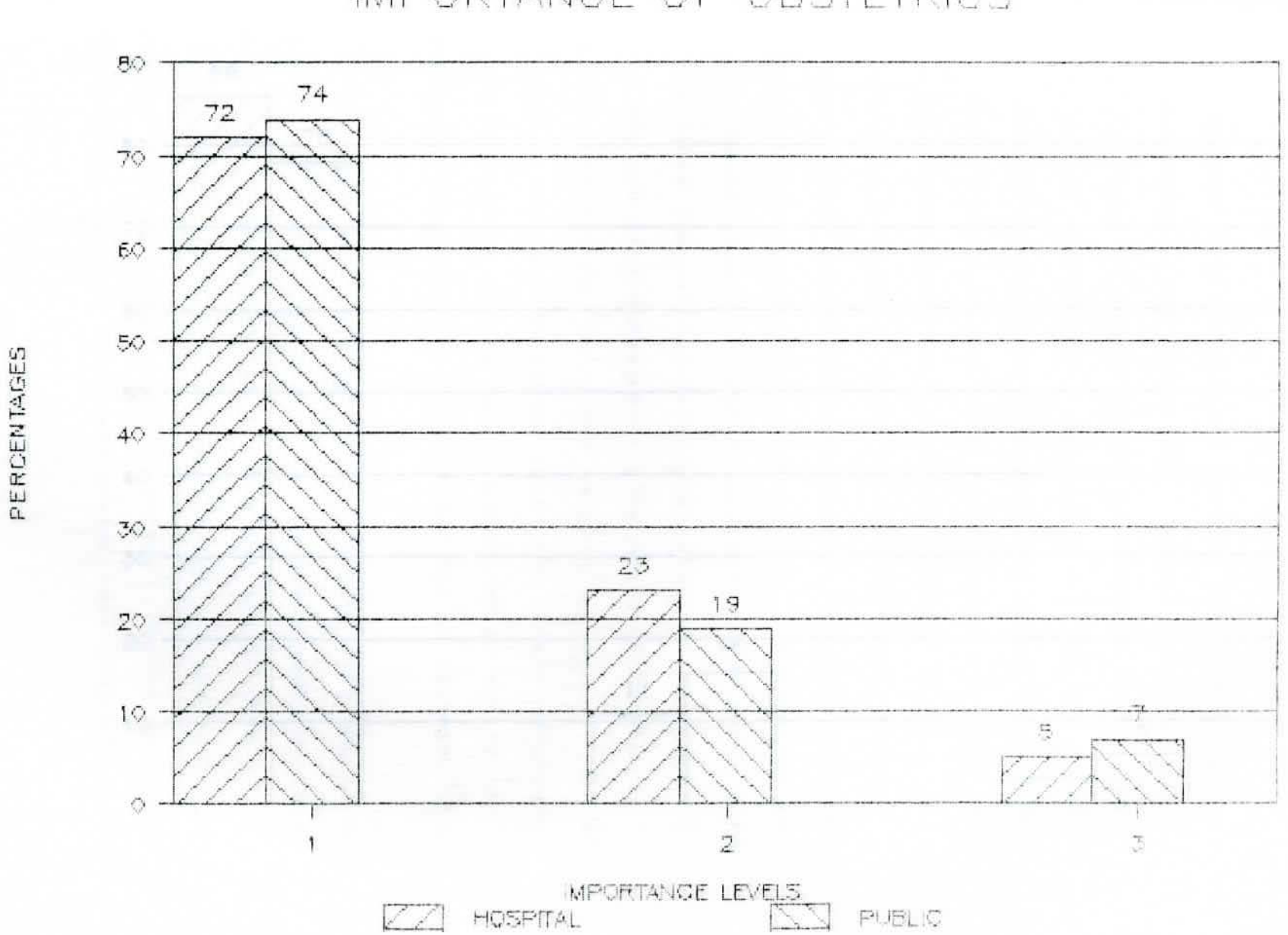
IMPORTANCE OF OBSTETRICS
PERCENTAGES
80
70
60
50
40
30
20
10
0
72
74
23
19
5
7
1
2
3
IMPORTANCE LEVELS
HOSPITAL
PUBLIC

FIGURE 26

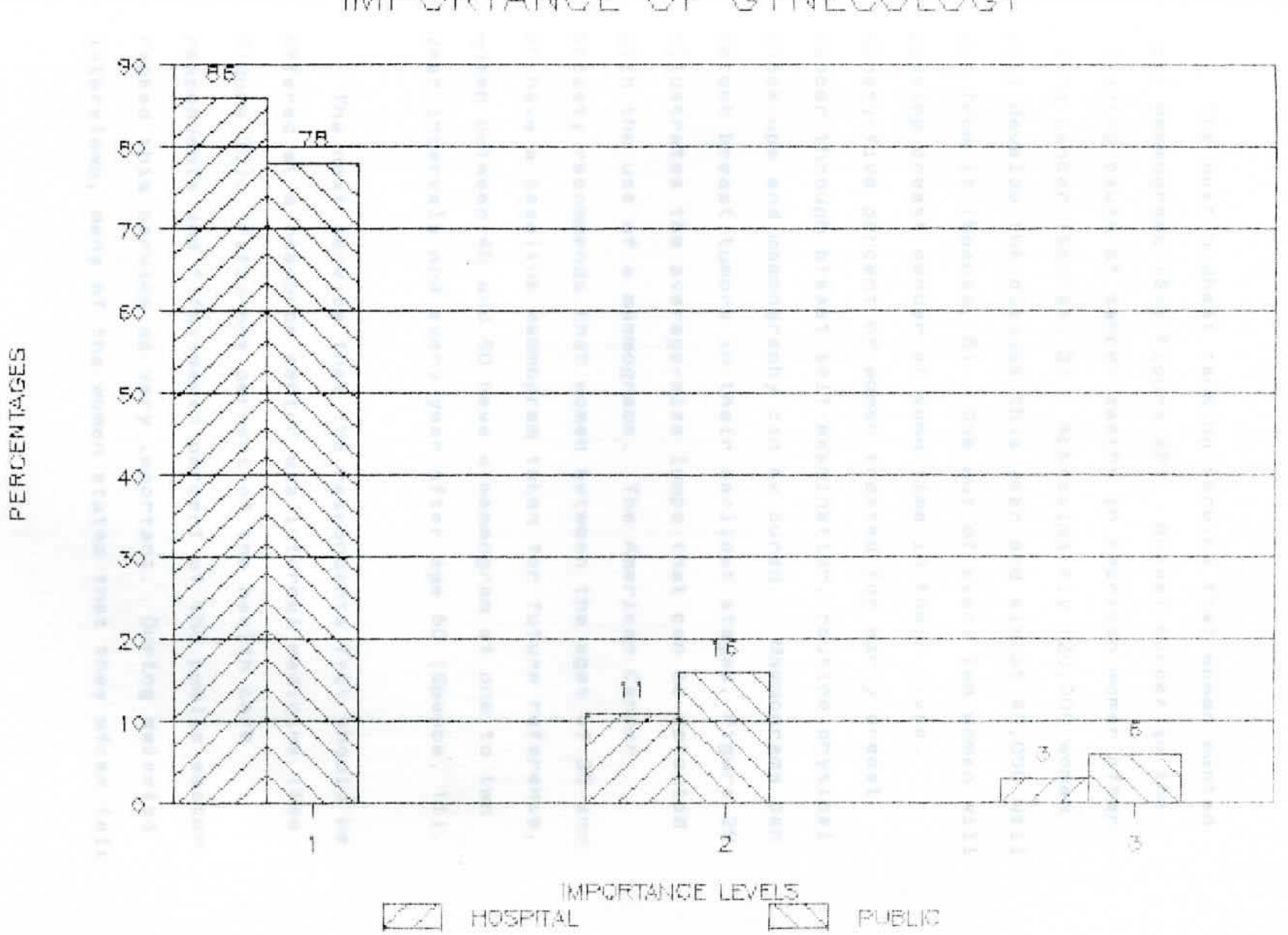
IMPORTANCE OF GYNECOLOGY
PERCENTAGES
90
80
70
60
50
40
30
20
10
0
86
78
11
16
3
8
1
2
3
IMPORTANCE LEVELS
HOSPITAL
PUBLIC

FIGURE 27

The next highest ranking service that women wanted was mammograms (See Figure 28). Breast cancer is the leading cause of cancer deaths in American women after lung cancer (Spense, 3). Approximately 120,000 women will develop the disease this year and almost 40,000 will die from it (Spense, 5). One out of every ten women will develop breast cancer at some time in their lives. Ninety-five percent of women treated for early breast cancer through breast self-examination, routine physical check-ups and mammography can be cured. Mammograms can detect breast tumors in their earliest stages, Figure 29 illustrates the average-size lumps that can be detected with the use of a mammograms. The American Cancer Society recommends that women between the ages of 35 and 40 have a baseline mammogram taken for future reference, women between 40 and 50 have a mammogram at one to two year intervals and every year after age 50 (Spence, 11).

The next service that the respondents felt should be offered at a resource center was internal medicine (See Figure 30). Fifty-one percent of the health care respondents and fifty-seven percent of the public sector ranked this service as very important. During selected interviews, many of the women stated that they often felt

IMPORTANCE OF MAMMOGRAM

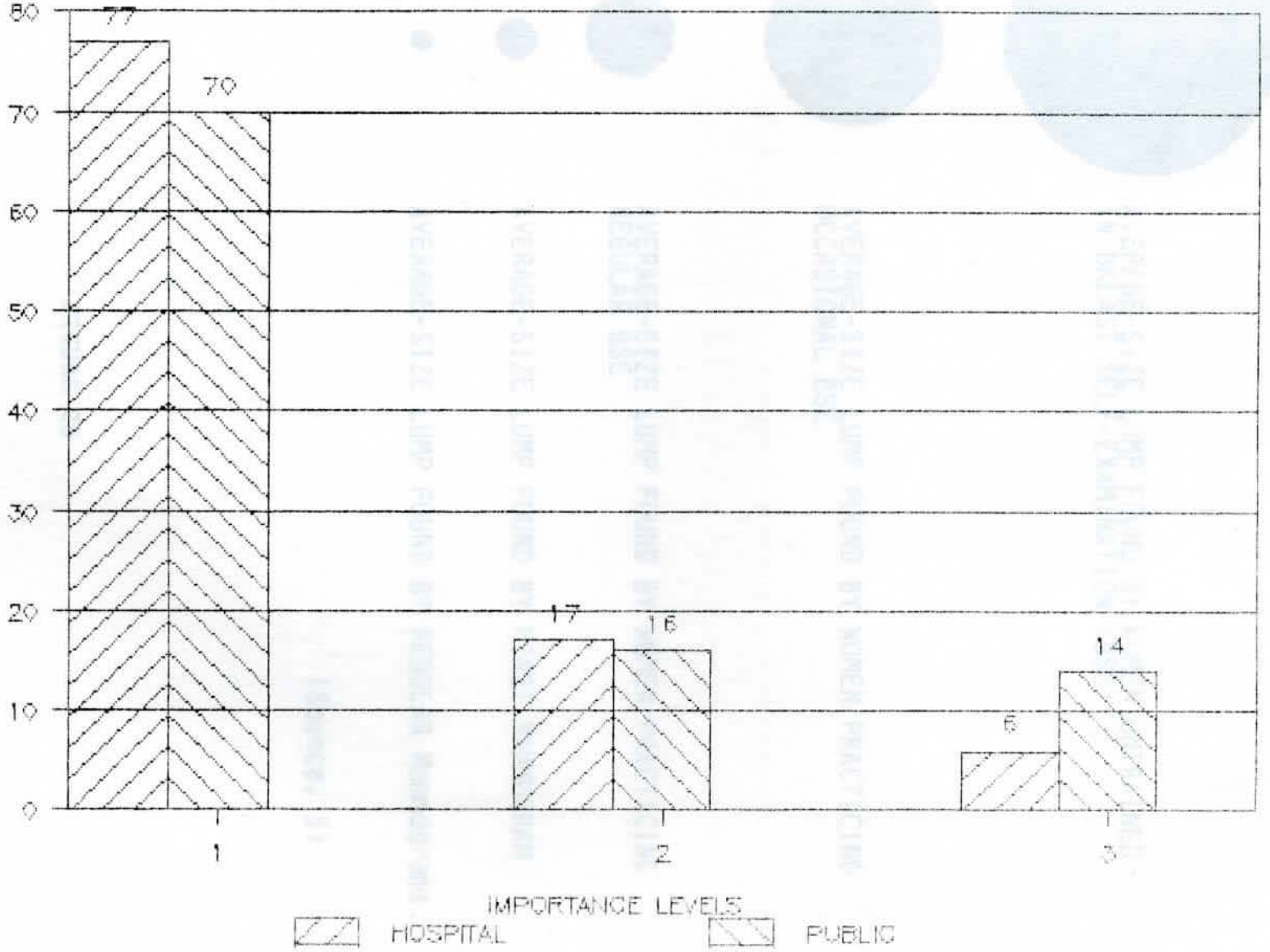

FIGURE 28

AVERAGE-SIZE LUMP FOUND BY WOMEN UNTRAINED IN BREAST SELF-EXAMINATION (BSE)

AVERAGE-SIZE LUMP FOUND BY WOMEN PRACTICING OCCASIONAL BSE

AVERAGE-SIZE LUMP FOUND BY WOMEN PRACTICING REGULAR BSE

AVERAGE-SIZE LUMP FOUND BY FIRST MAMMOGRAM

AVERAGE-SIZE LUMP FOUND BY REGULAR Mammograms.

(Spence, 5)

FIGURE 29

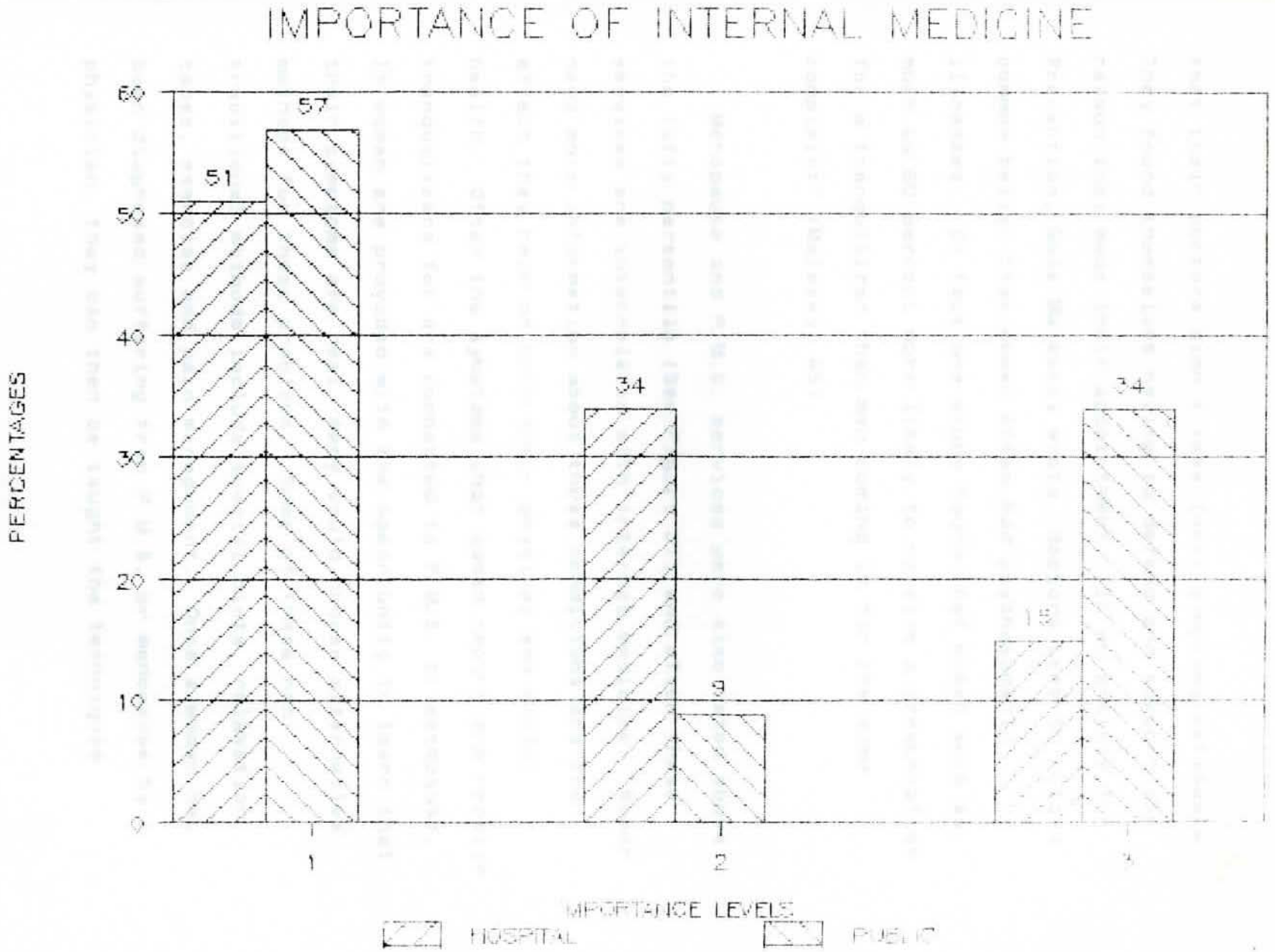
IMPORTANCE OF INTERNAL MEDICINE
PERCENTAGES
60
50
40
30
20
10
0
51
57
34
9
15
34
1
2
3
IMPORTANCE LEVELS
HOSPITAL
PUBLIC

FIGURE 30

that their doctors didn't take their symptoms seriously. They found themselves having to defend and support the reason they made their appointment. In an article for Prevention, Gale Maleskey wrote "doctors seem to hold a common belief that women often had psychosomatic illnesses. In fact one study found that women were as much as 60 percent more likely to receive a prescription for a tranquilizer than men coming in for the same complaint" (Malesky, 45).

Menopause and P.M.S. services were also rated above the fifty percentile (See Figure 31) and often these services are interrelated with internal medicine. Women need more information about these conditions and the effect they have on both their physical and mental health. Often the symptoms that women report and receive tranquilizers for are connected to P.M.S. or menopause. If women are provided with the opportunity to learn that their symptoms are real, many could choose alternative methods for these problems. Some of these non-traditional methods include special diets, relaxation tapes, exercise and pain management. Once a woman has been diagnosed suffering from P.M.S. or menopause by a physician, they can then be taught the techniques

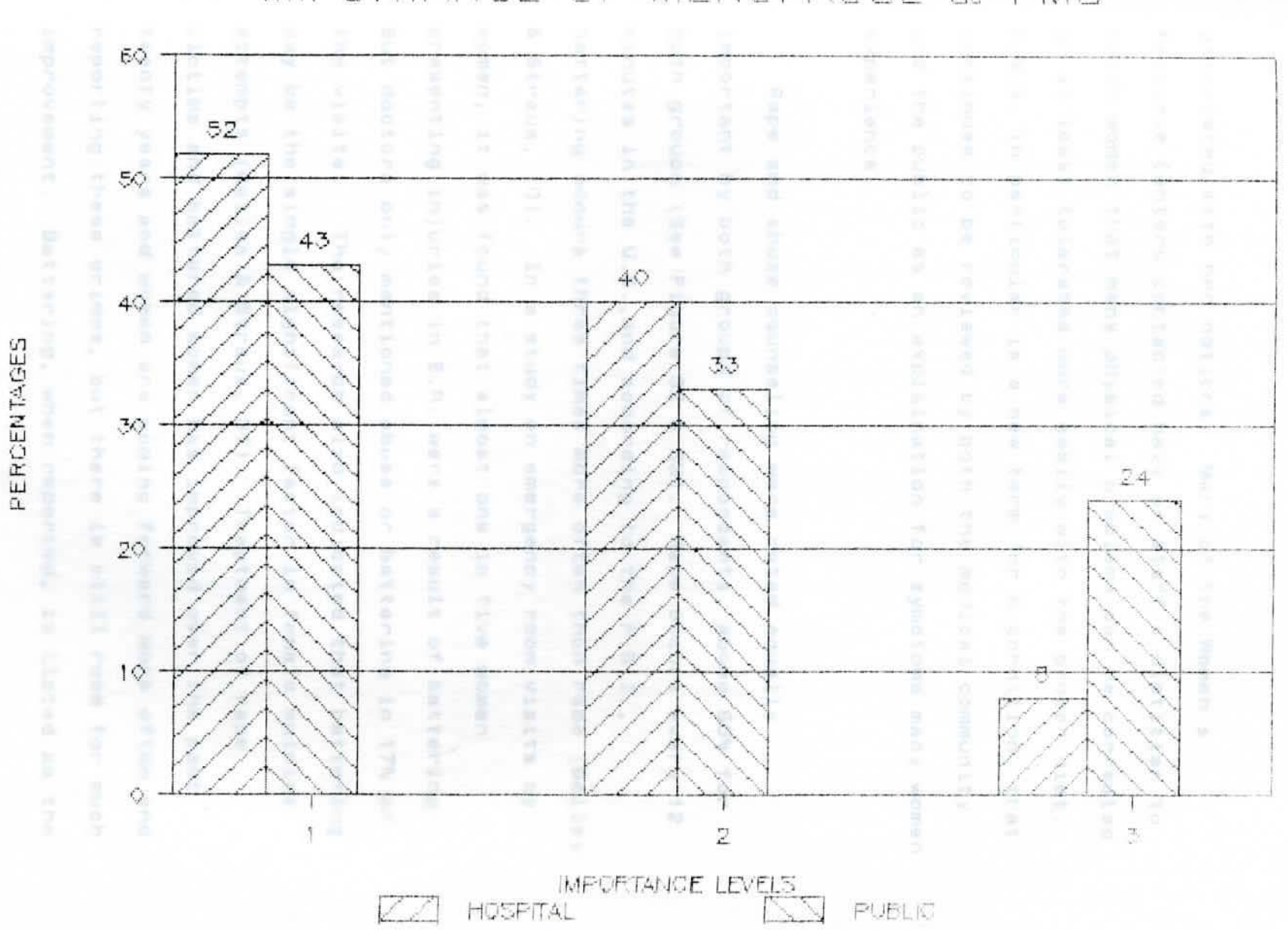
IMPORTANCE OF MENOPAUSE & PMS
PERCENTAGES
60
50
40
30
20
10
0
52
43
40
33
8
24
1
2
3
IMPORTANCE LEVELS
HOSPITAL
PUBLIC

FIGURE 31

associated with her options. Many of the Women's Resource Centers contacted have on staff a dietitian to teach women that many physical problems can be corrected or at least tolerated more easily with the proper diet. P.M.S. in particular is a new term for a condition, that continues to be reviewed by both the medical community and the public as an explaination for symptoms many women experience.

Rape and abuse counseling were rated equally important by both groups of respondents, above 60% for both groups (See Figure 32 & 33). Rape occurs every 12 minutes in the U.S.,and according to the F.B.I., battering occurs three times more often than rape (Gelles & Straus, 10). In a study on emergency room visits by women, it was found that almost one in five women presenting injuries in E.R. were a result of battering. But doctors only mentioned abuse or battering in 17% of the visits. The research also indicated that battering may be the single significant factor in female suicide attempts (Gelles & Straus, 37). Treatment of rape victims and battered women has improved over the past twenty years and women are coming forward more often and reporting these crimes, but there is still room for much improvement. Battering, when reported, is listed as the

IMPORTANCE OF RAPE COUNSEL

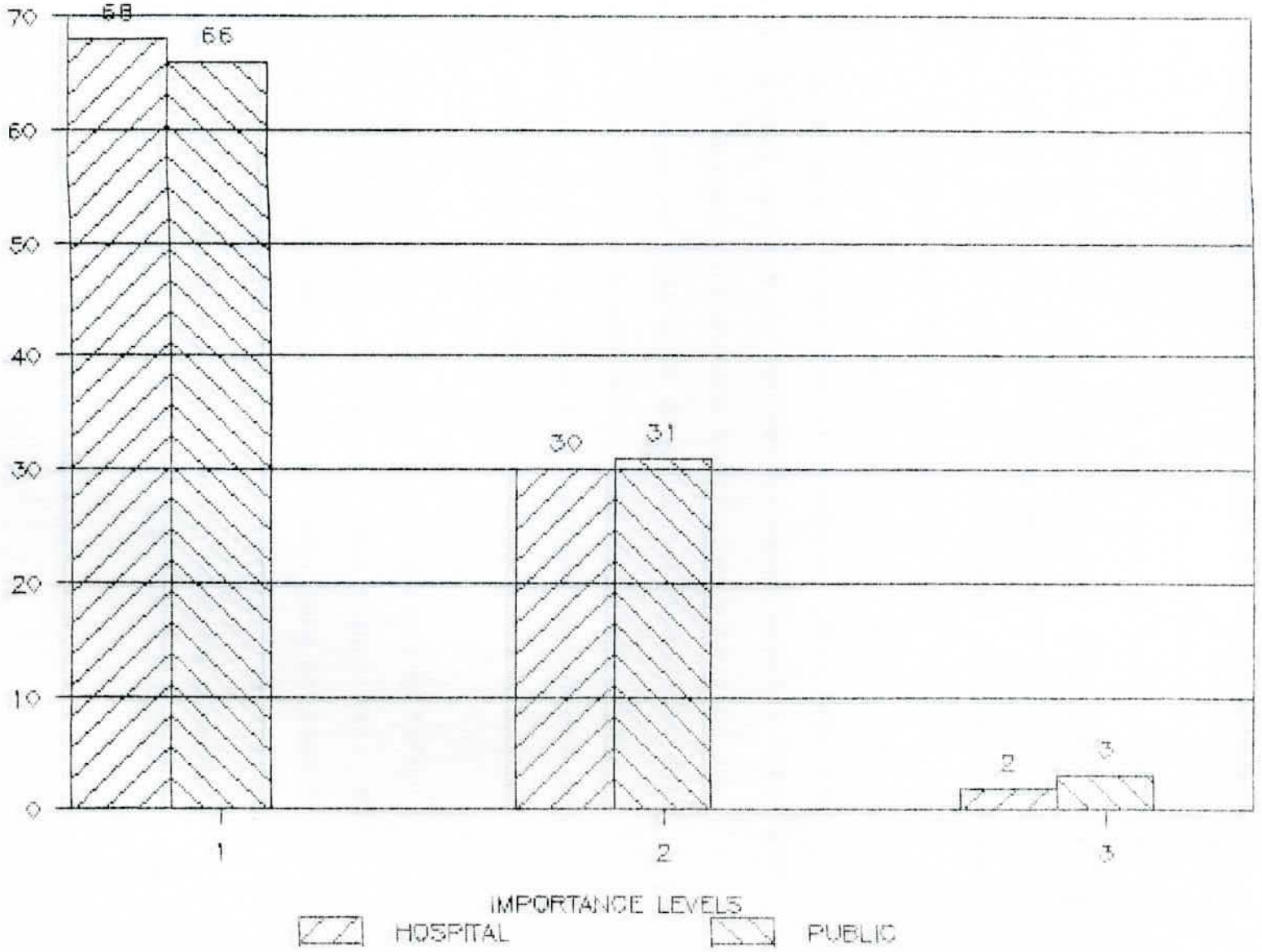

FIGURE 32

IMPORTANCE OF ABUSE COUNSEL

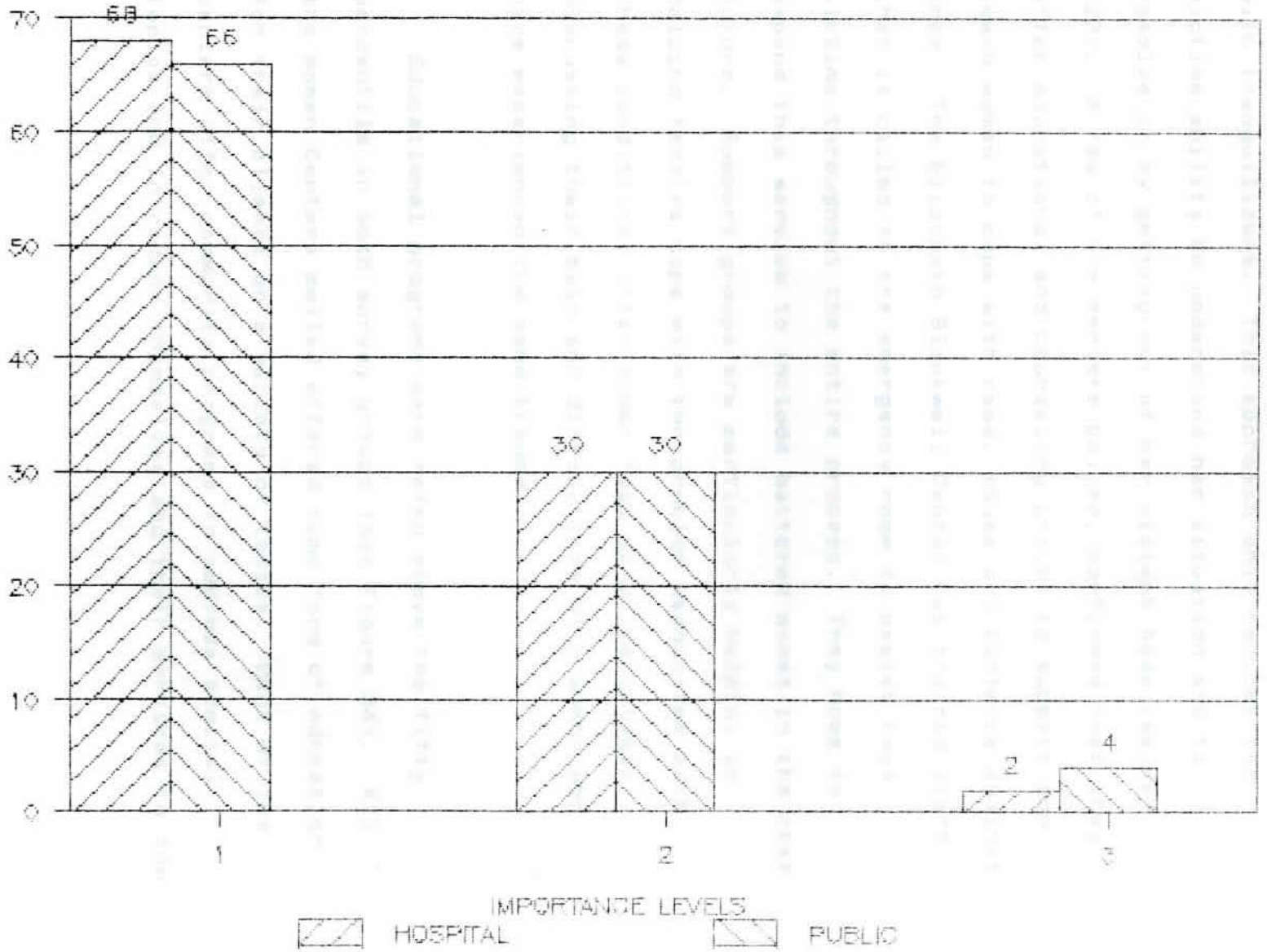

FIGURE 33

victim's psychiatric problem. Often the medical professions approach to help is to medicate the victim with tranquilizers. This approach only reduces the victims ability to understand her situation and to resolve it by getting out of her violent home (Walker, 123). A few of the centers polled, confirmed that they offer educational and counseling groups to support and teach women to cope with rape, abuse and violence against them. The Elizabeth Blackwell Center has trained staff that is called to the emergency room to assist rape victims throughout the entire process. They hope to expand this service to include battered women in the near future. Support groups are particularly helpful in helping females cope with the problem associated with these conditions, often women feel more comfortable discussing their pain and difficulties with women who have experienced the same trauma.

Educational programs were rated above the fifty percentile in both survey groups (See Figure 34). All the Women Centers polled offered some form of education for their clients on a variety of topics. Many of the centers offer community programs to address special topics and introduce themselves and their services to the

IMPORTANCE OF EDUCATIONAL PROGRAMS

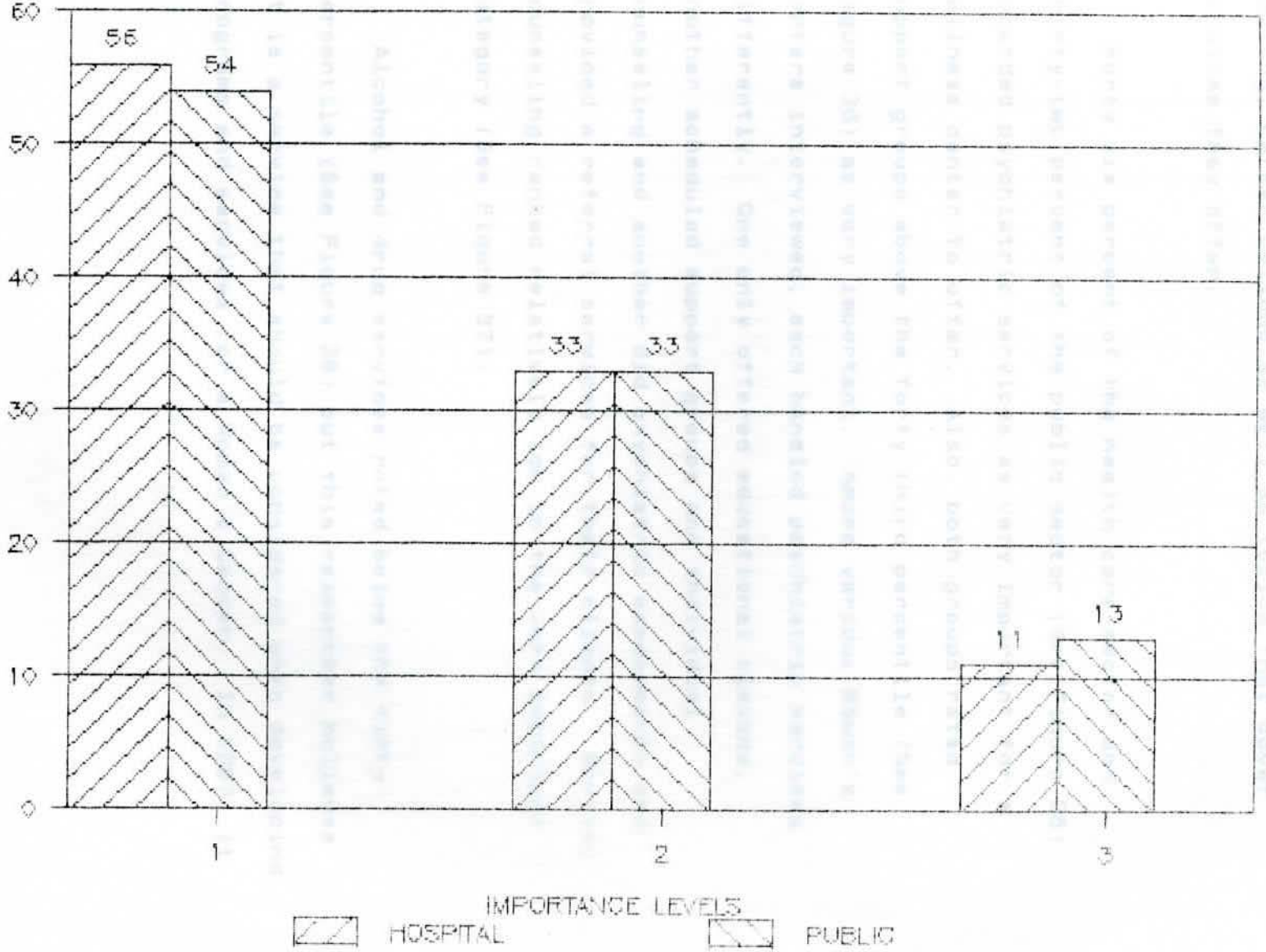

FIGURE 34

public. Example of topics often included; life stages and lifestyles, stress management, weight control, child rearing, career options as well as topics that cover services they offer.

Forty six percent of the health care sector and thirty-two percent of the public sector (See Figure 35) regarded psychiatric services as very important for a wellness center to offer. Also, both groups rated support groups above the forty third percentile (See Figure 36) as very important. Among various Women's Centers interviewed, each handled psychiatric services differently. One only offered educational classes, another scheduled support groups and individual counseling and another did psychiatric assessments and provided a referral services for their clients. Marital Counseling ranked relatively low in the very important category (See Figure 37).

Alcohol and drug services rated below the fifty percentile (See Figure 38) but this researcher believes it is a service that should be considered when developing programs and services for a Women's Center. In 1987, it

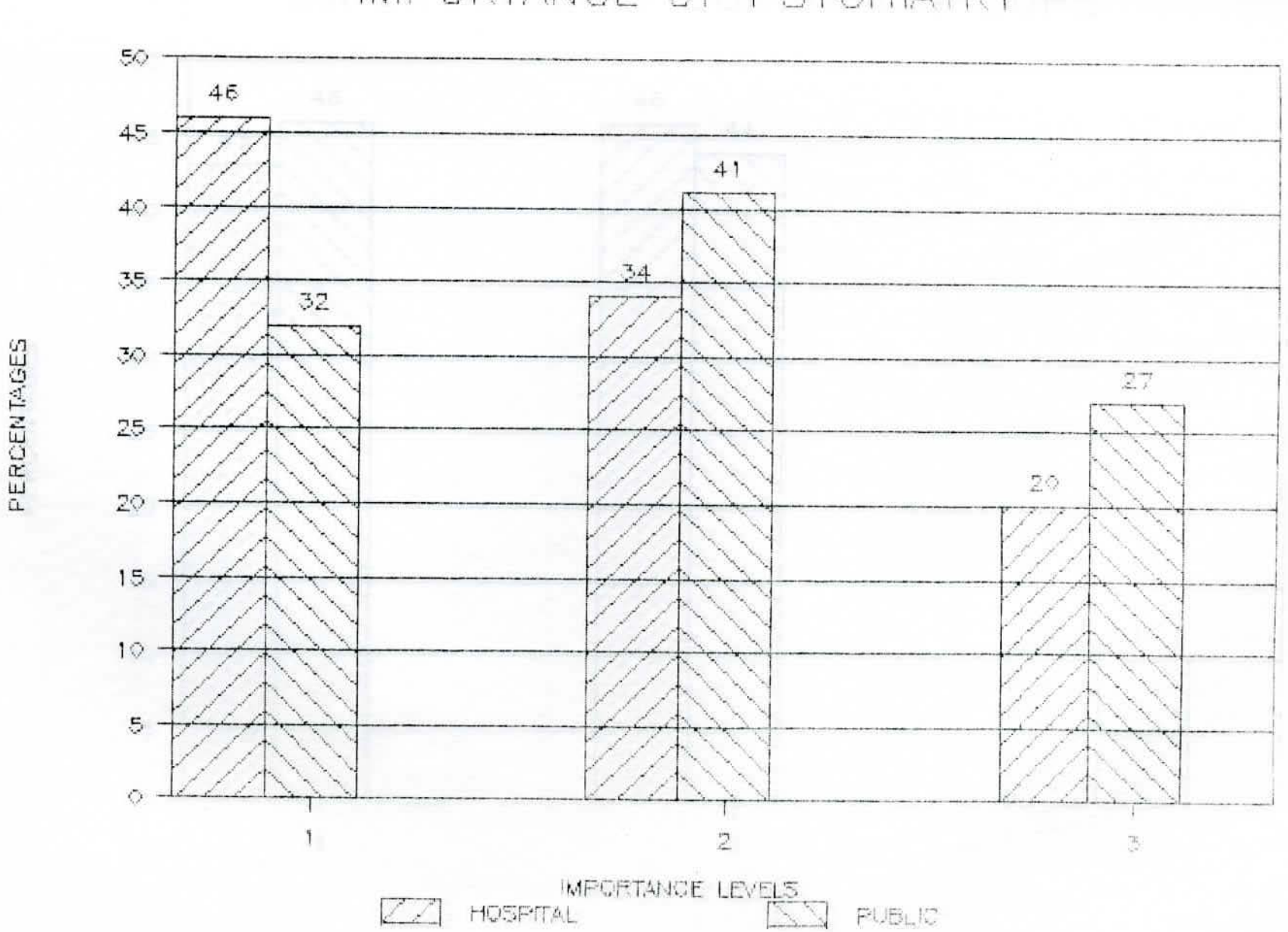
IMPORTANCE OF PSYCHIATRY
PERCENTAGES
50
45
40
35
30
25
20
15
10
5
0
46
32
34
41
20
27
1
2
3
IMPORTANCE LEVELS
HOSPITAL
PUBLIC

FIGURE 35

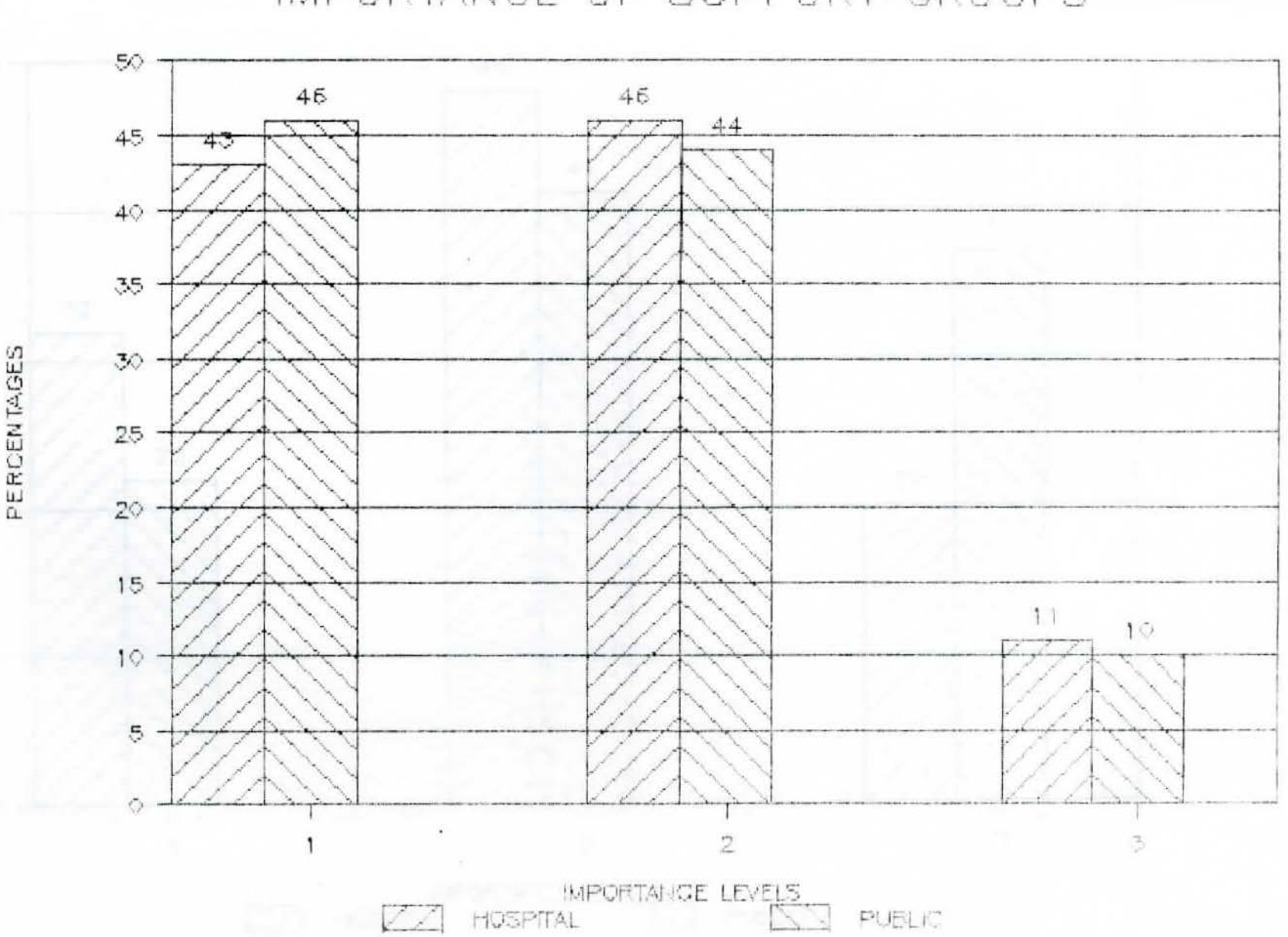
IMPORTANCE OF SUPPORT GROUPS
PERCENTAGES
50
45
40
35
30
25
20
15
10
5
0
46
43
46
44
11
10
1
2
3
IMPORTANCE LEVELS
HOSPITAL
PUBLIC

FIGURE 36

IMPORTANCE OF MARITAL COUNSEL

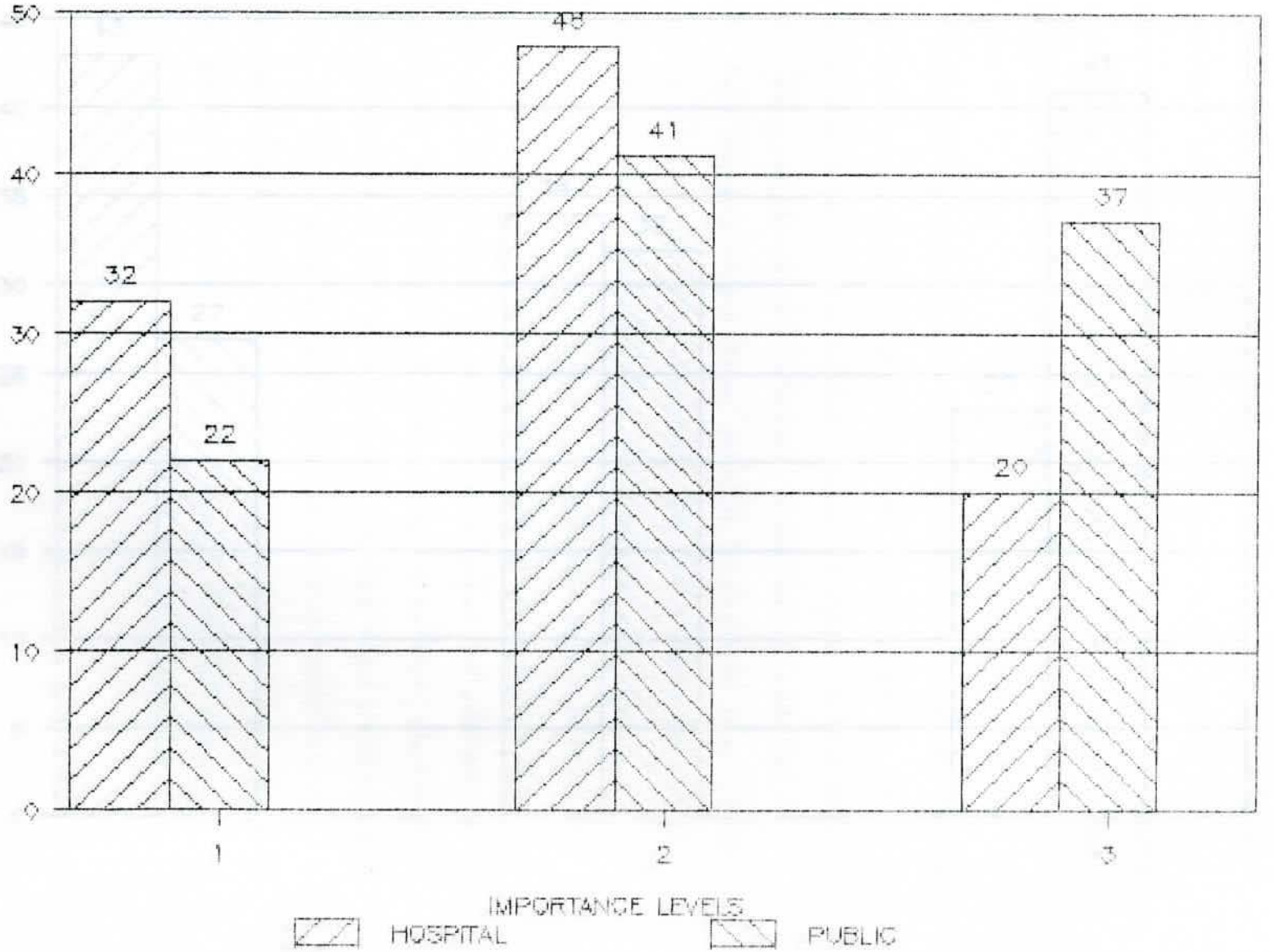

FIGURE 37

IMPORTANCE OF ALCOHOL & DRUG SCREENING

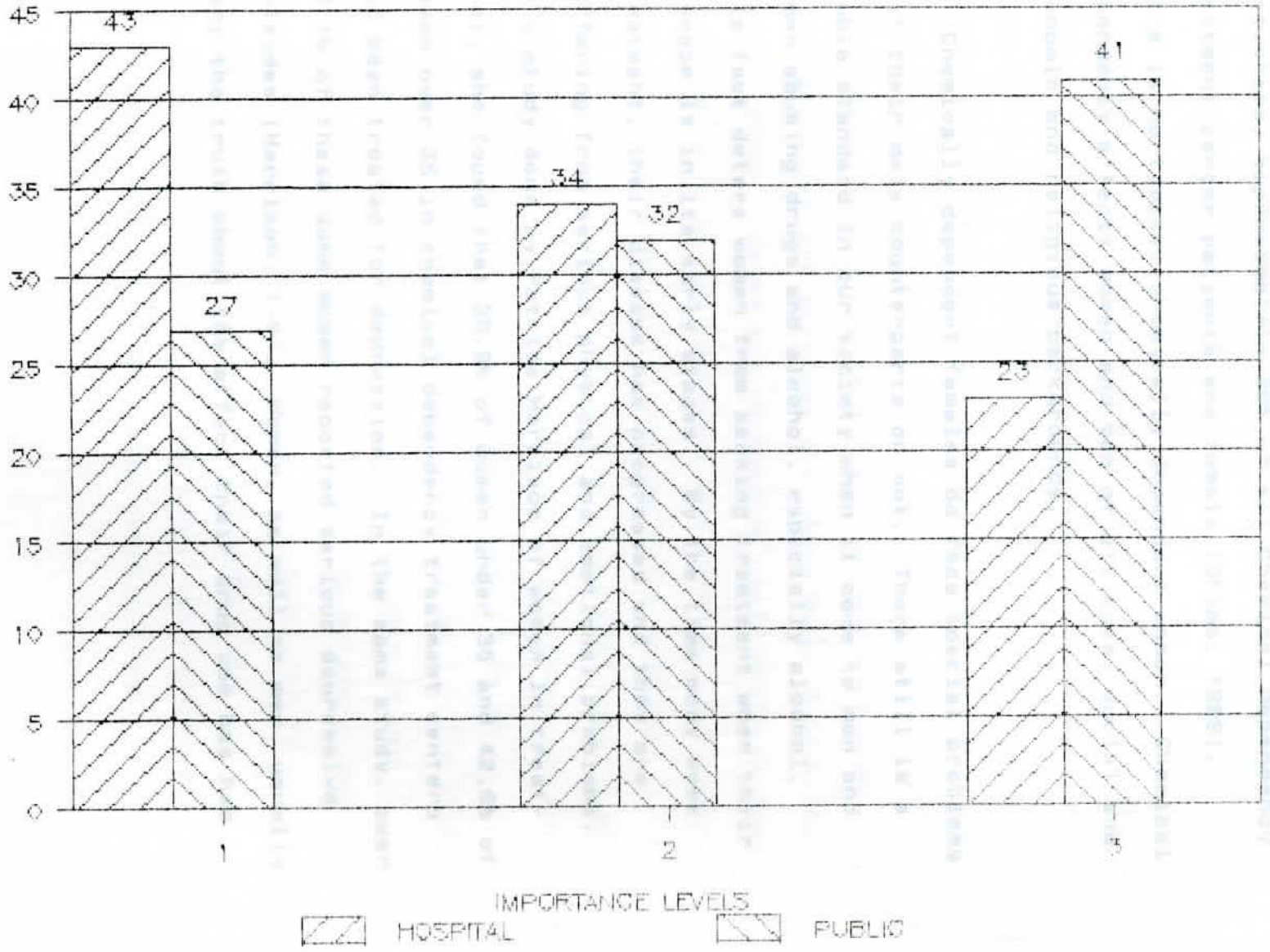

FIGURE 38

was estimated that there were 2.25 million women with alcohol-related problems in the U.S. According to statistics, approximately 30% of all Chemical Dependency treatment center patients are female (Ohlms, 1989). There is no typical chemically dependent woman. Chemical dependency affects women and men of all ages, social and economic and religious backgrounds.

Chemically dependent females do face special problems that their male counterparts do not. There still is a double standard in our society when it come to men and women abusing drugs and alcohol, especially alcohol. This fact deters women from seeking treatment when their disease is in its early stages. By the time many seek treatment, their disease has progressed and they are suffering from serious physical and emotional problems. In a study done by Patrica Harrison of women in treatment, she found that 38.8% of women under 35 and 42.6% of women over 35 in chemical dependency treatment centers had been treated for depression. In the same study, over 62.1% of these same women reported serious depressive episodes (Harrison, 1-4). Women, as well as men, usually deny the truth about the affect their drug use has had

has had on their lives. It can take a trained professional to help identify the source of their problem and make the appropriate referrals.

Although high-risk pregnancy clinics ranked at fifty percent as very important by the health care sector, they only ranked in the thirty-two percentile by the public sector. Both groups also only ranked fertility services under the fifty percentile (See Figure 39 & 40). Even though both these services did not receive very high rankings, these are services that many Women's Resource Centers offer. Women are postponing child-birth in their early years to pursue education and careers. With this, comes problems with conceiving and extra problems associated with pregnancy. It has long been known that older women had more difficulty with conceiving but a recent study of fertility suggests that it is an increasing problem for younger women as well. The study concluded that among women of 20 to 24 year of age, infertility problems have tripled to 10.6% since 1965. The author attributed this rise in infertility to an increase of sexually transmitted diseases and complications with I.U.D.'s and other contraceptives (Gabernisk, 112-113). High-risk complications are also

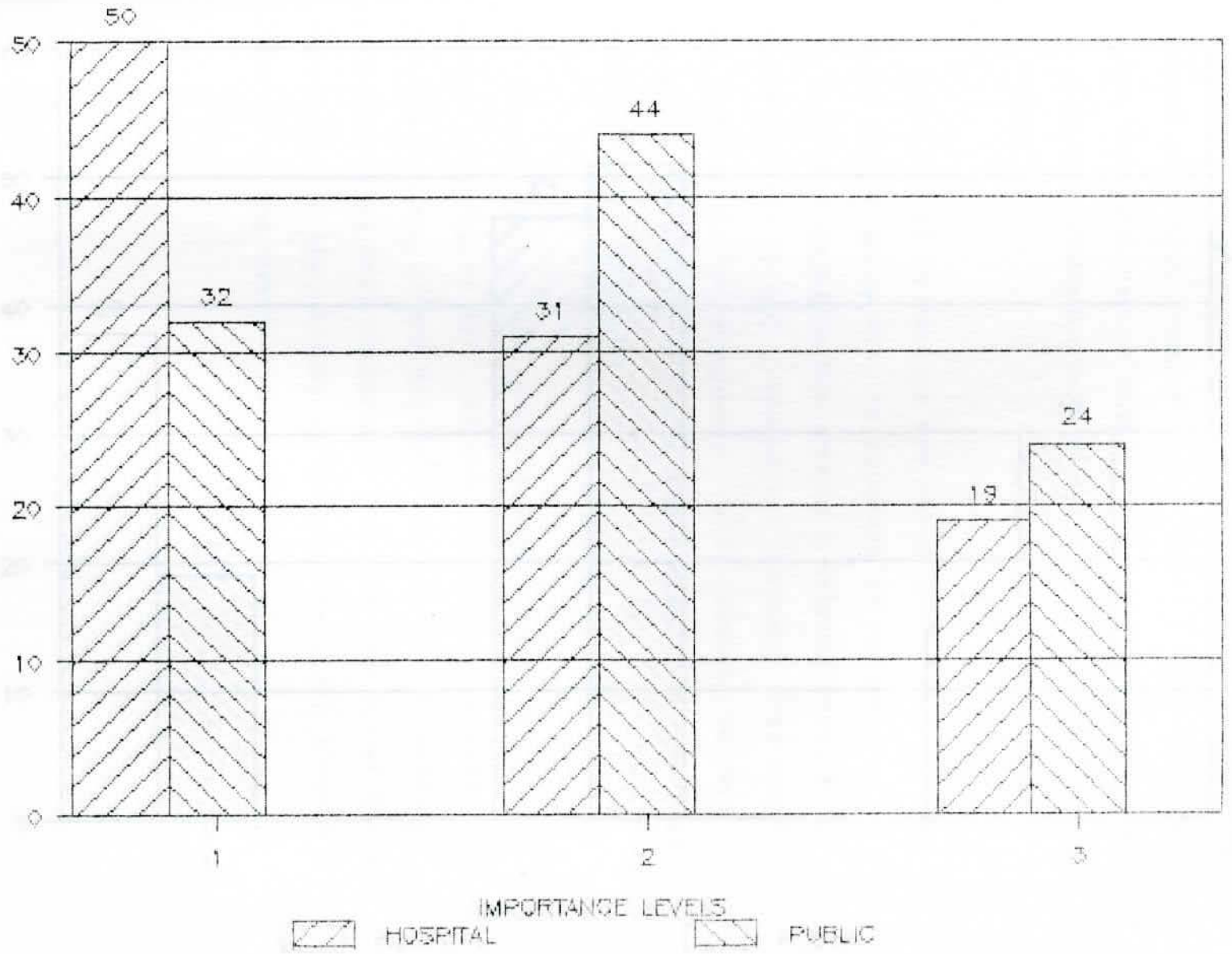
IMPORTANCE OF HIGH RISK PREGNANCY CLIN.
PERCENTAGES
50
40
30
20
10
0
50
32
31
44
19
24
1
2
3
IMPORTANCE LEVELS
HOSPITAL
PUBLIC

FIGURE 39

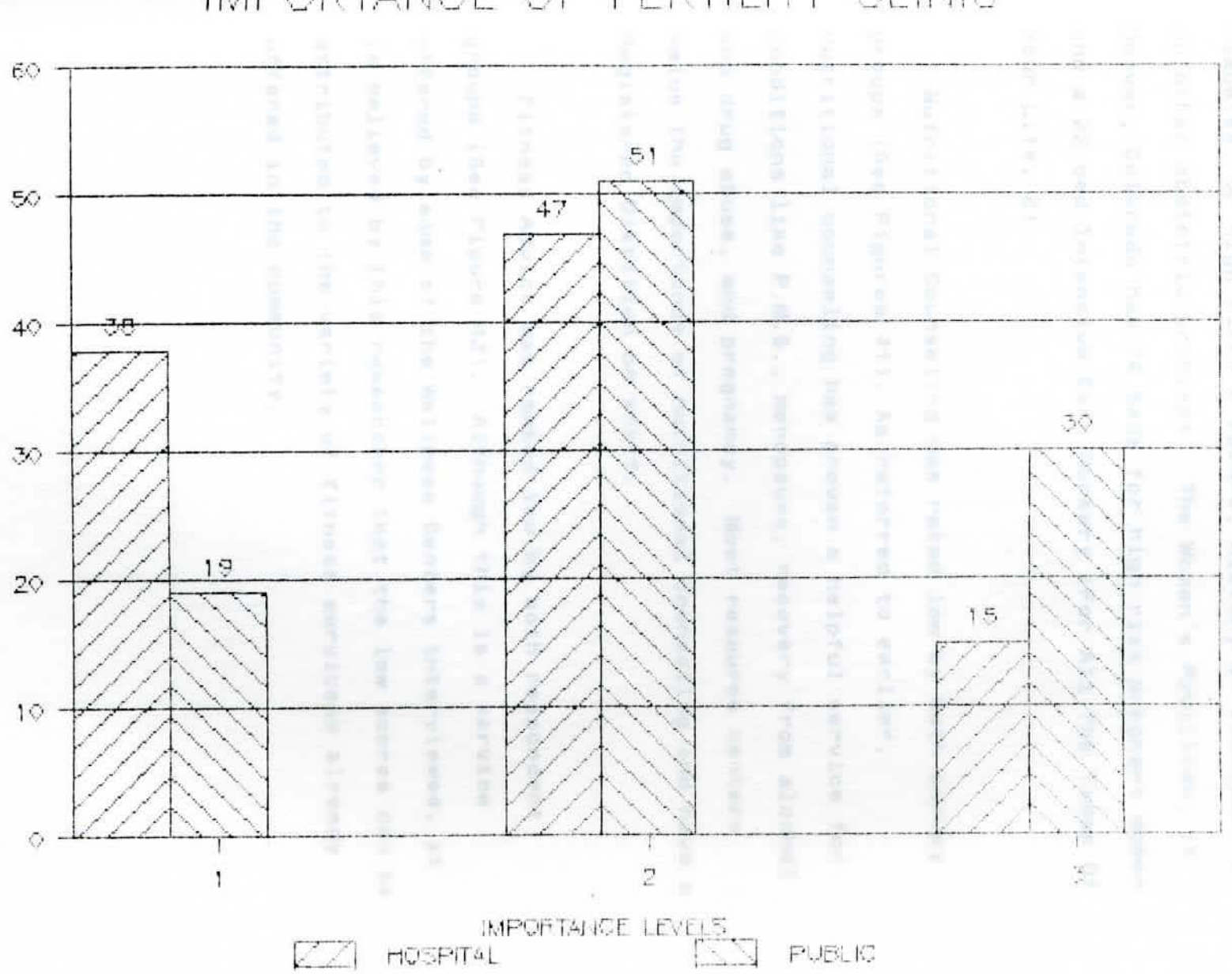
IMPORTANCE OF FERTILITY CLINIC
PERCENTAGES
60
50
40
30
20
10
0
38
19
47
51
15
30
1
2
3
IMPORTANCE LEVELS
HOSPITAL
PUBLIC

FIGURE 40

increasing due to older women giving birth but other high-risk problems include: maternal heart trouble, diabetes, or high blood pressure, history of stillbirths or other obstetric problems. The Women's Pavillion, in Denver, Colarado has 14 beds for high risk pregnant women and a 22 bed Intensive Care Nursery (For All The Times Of Your Life, 2).

Nutritional Counseling was rated low by both survey groups (See Figures 41). As referred to earlier, nutritional counseling has proven a helpful service for conditions like P.M.S., menopause, recovery from alcohol and drug abuse, and pregnancy. Most resource centers value the importance of nutritional counseling and have a Registered Dietitian on staff.

Fitness Advice was ranked low by both respondent groups (See Figure 42). Although this is a service offered by some of the Wellness Centers interviewed, it is believed by this researcher that the low scores can be attributed to the variety of fitness servicess already offered in the community.

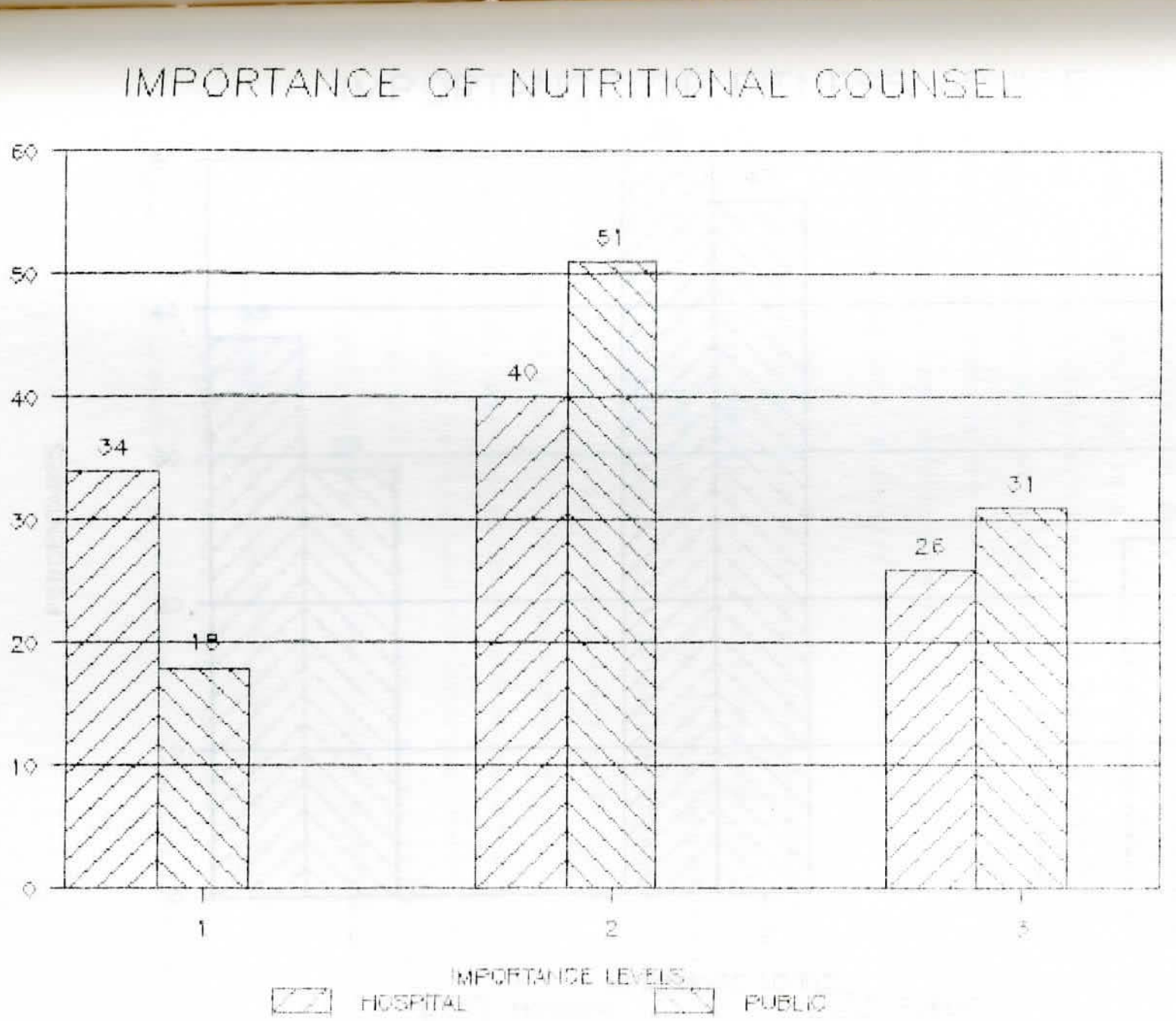
IMPORTANCE OF NUTRITIONAL COUNSEL
PERCENTAGES
60
50
40
30
20
10
0
34
18
40
51
26
31
1
2
3
IMPORTANCE LEVELS
HOSPITAL
PUBLIC

FIGURE 41

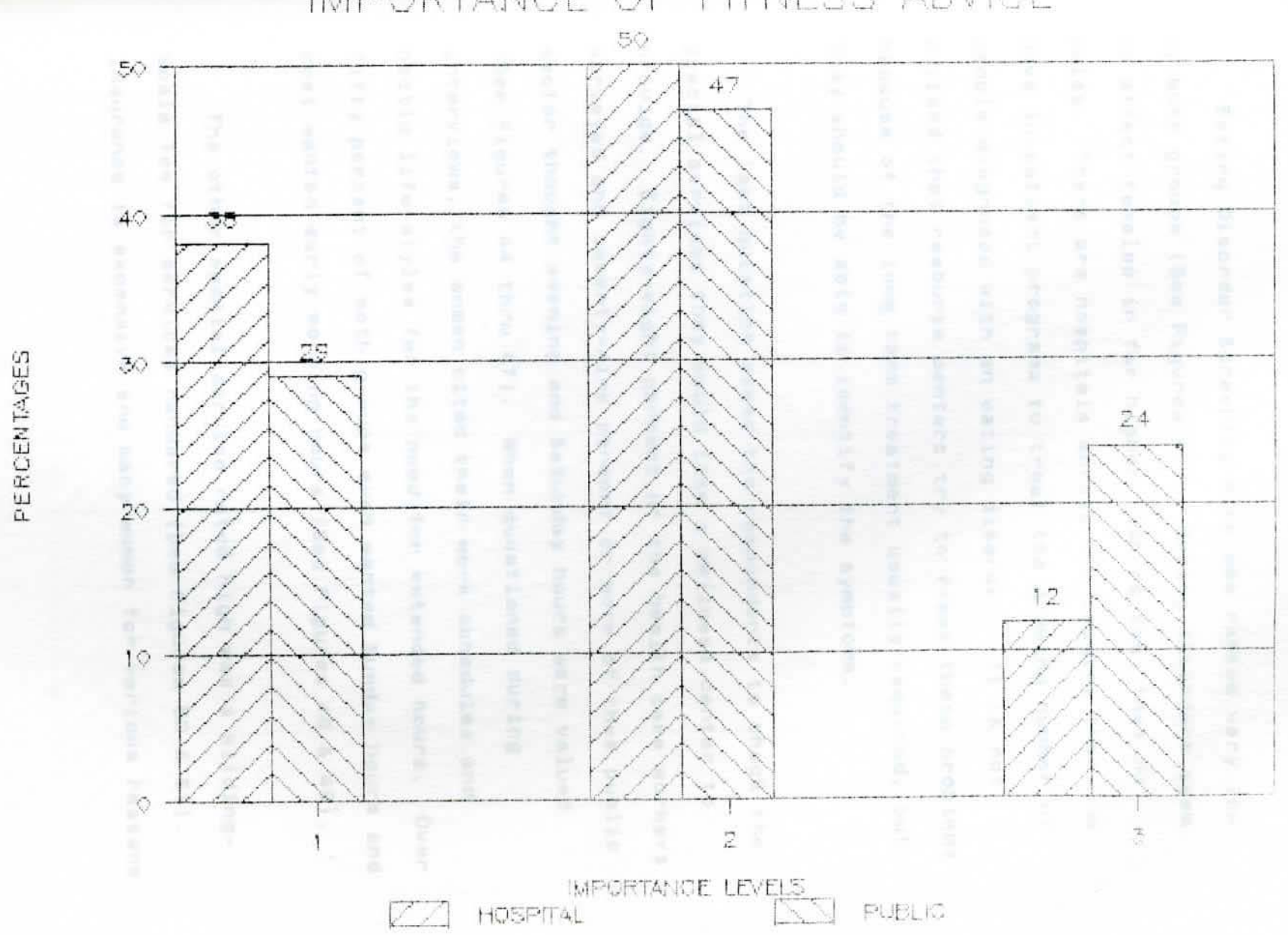
IMPORTANCE OF FITNESS ADVICE
50
50
40
30
20
10
0
38
28
47
12
24
1
2
3
PERCENTAGES
IMPORTANCE LEVELS
HOSPITAL
PUBLIC

FIGURE 42

Eating Disorder Screening also was ranked very low by both groups (See Figures 43). Eating disorders seem to effect females in far higher numbers than they do males. There are hospitals across the country that now have in-patient programs to treat the growing number of people diagnosed with an eating disorder. It is not advised that resource centers try to treat these problems because of the long term treatment usually required, but they should be able to identify the symptoms.

The last question asked the respondents to check the special services they would like a wellness center to provide. Eighty-eight percent of the health care workers surveyed and seventy-nine percent or more of thee public sector thought evening and Saturday hours were valued (See Figures 44 thru 47). When questioned during interviews, the women cited their work schedules and hectic life-styles for the need for extended hours. Over fifty percent of both groups even wanted Sunday hours and most wanted early morning hours (See Figures 48 & 49).

The other special service rated high was a sliding-scale fee for services rendered (See Figures 50 & 51). Insurance is expensive and many women for various reasons

IMPORTANCE OF EATING DISORDERS

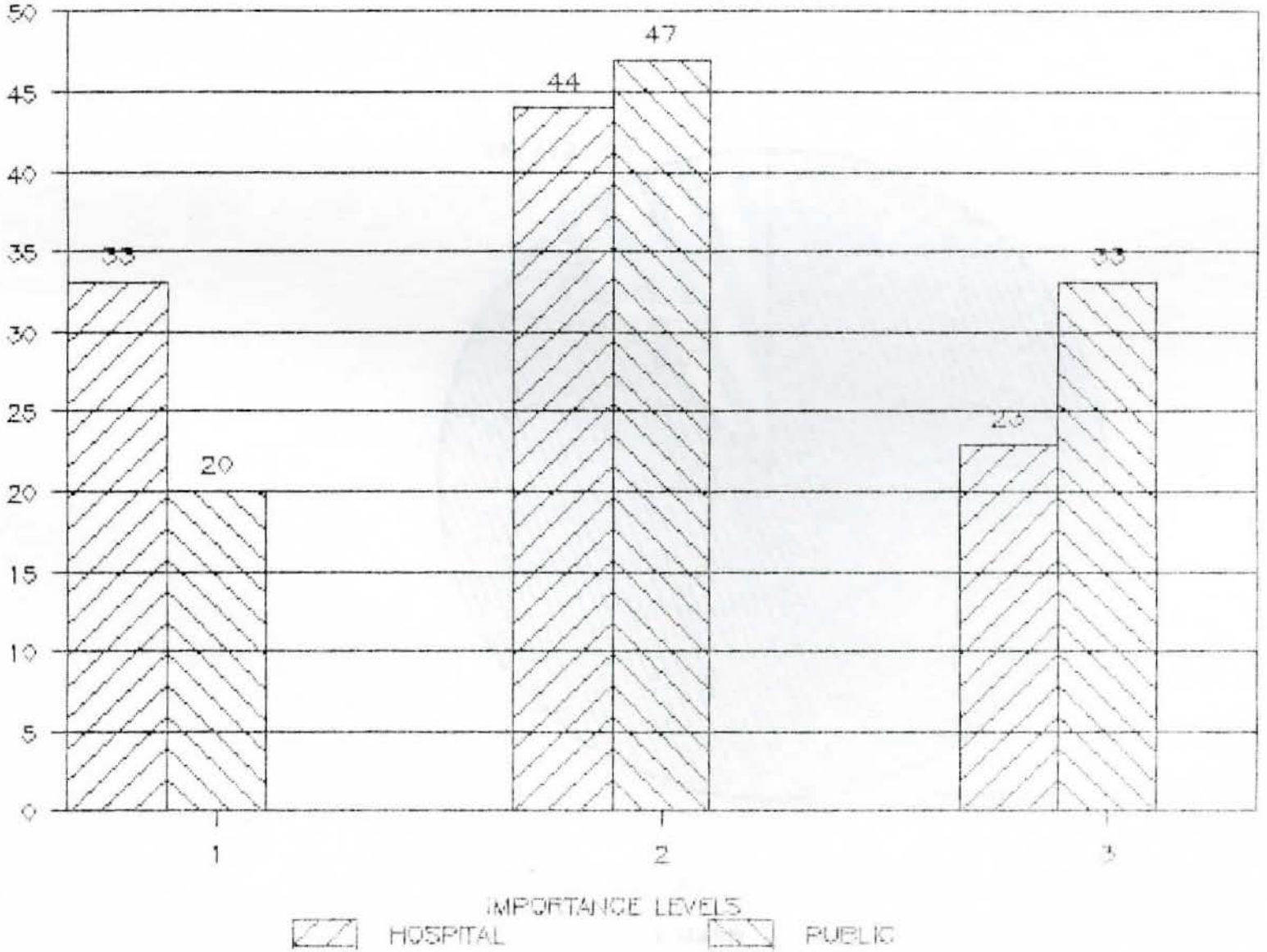

FIGURE 43

IMPORTANCE OF SATURDAY APPOINTMENTS

HOSPITAL

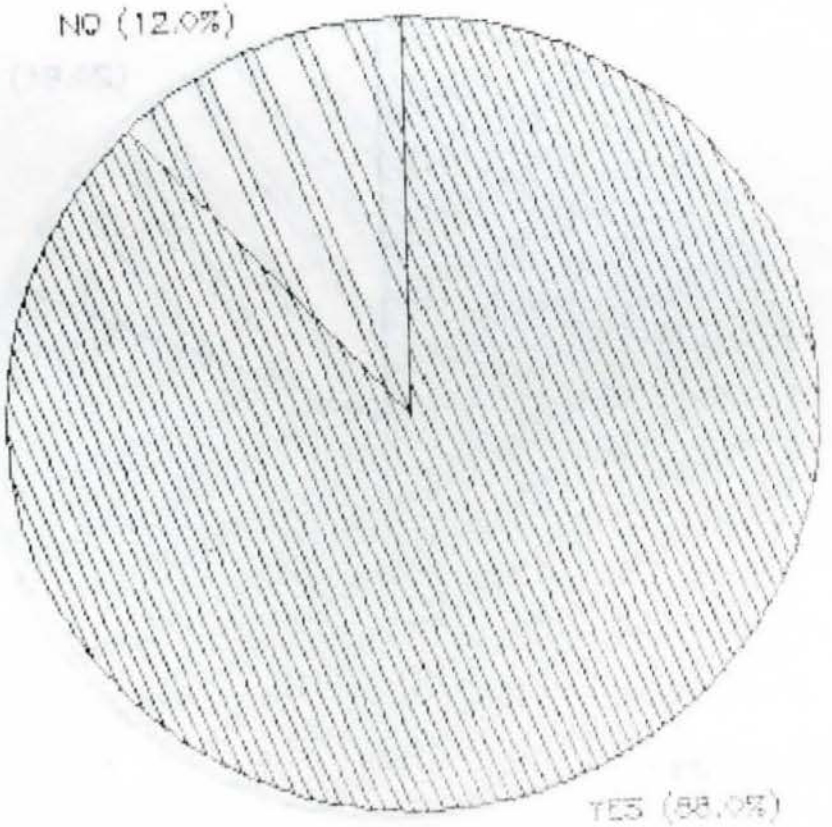

FIGURE 44

IMPORTANCE OF SATURDAY APPOINTMENTS

PUBLIC

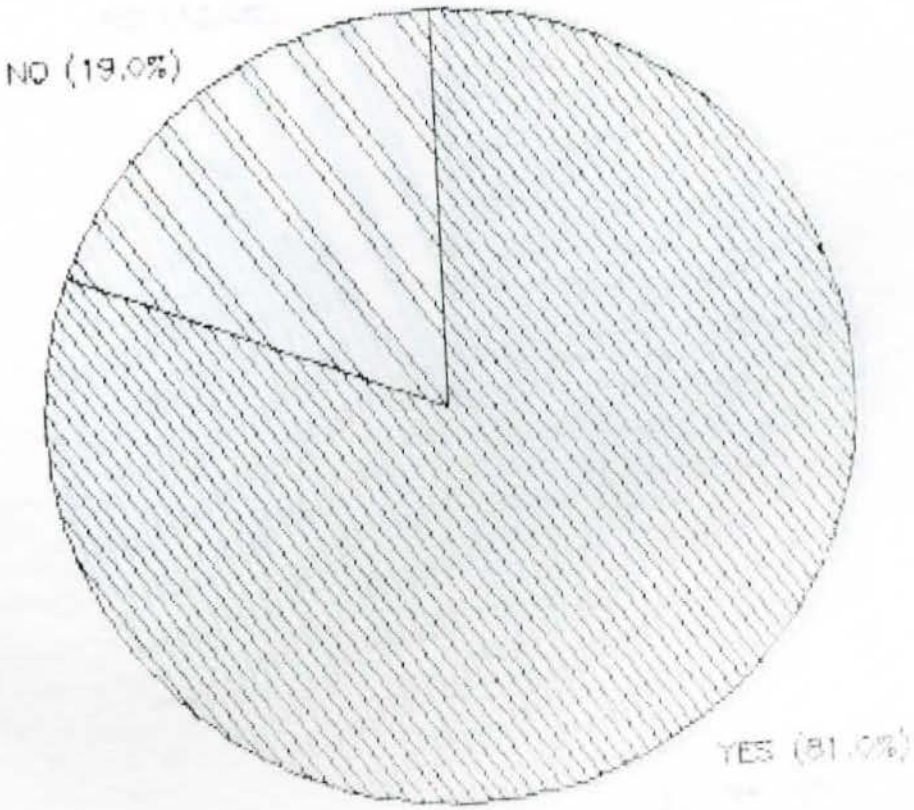

FIGURE 45

IMPORTANCE OF EVENING APPOINTMENTS

HOSPITAL

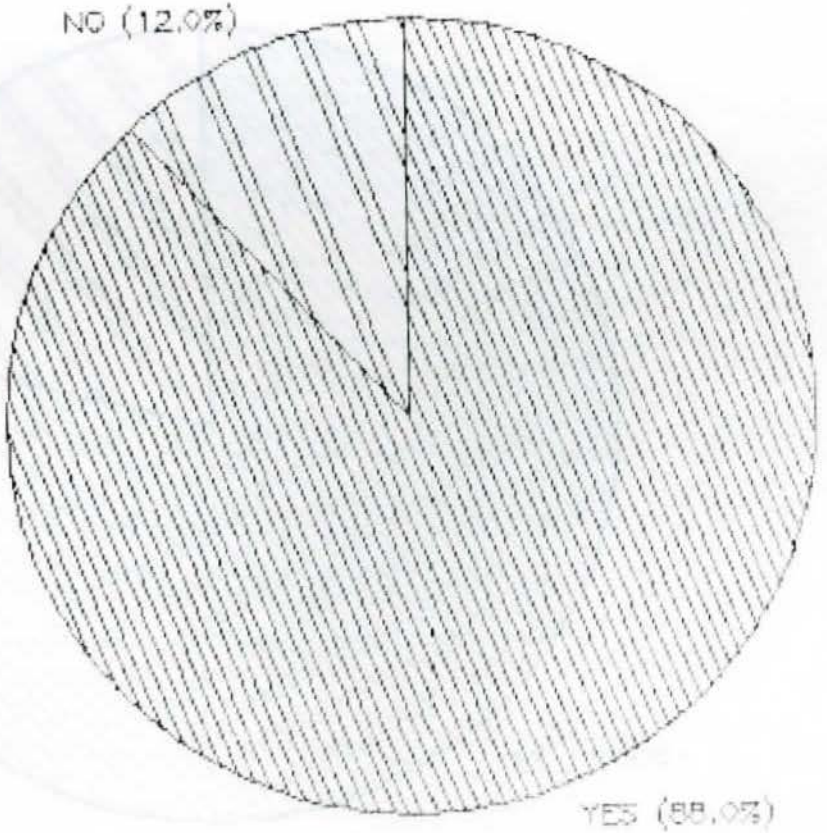

FIGURE 46

IMPORTANCE OF EVENING APPOINTMENTS

PUBLIC

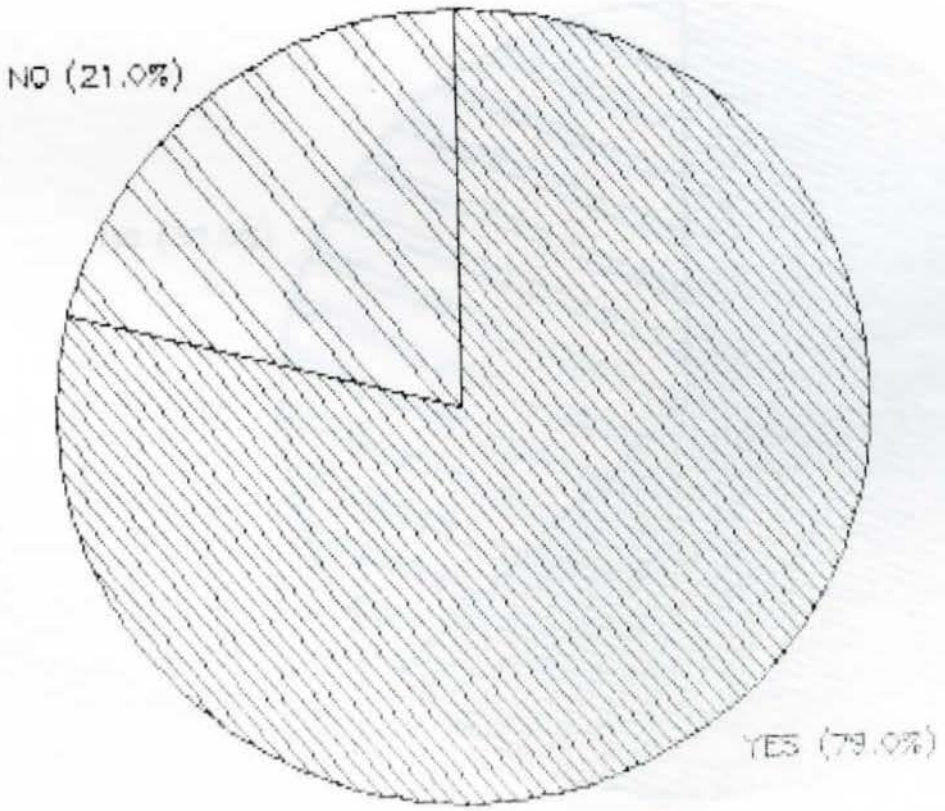

FIGURE 47

IMPORTANCE OF SUNDAY APPOINTMENTS

HOSPITAL

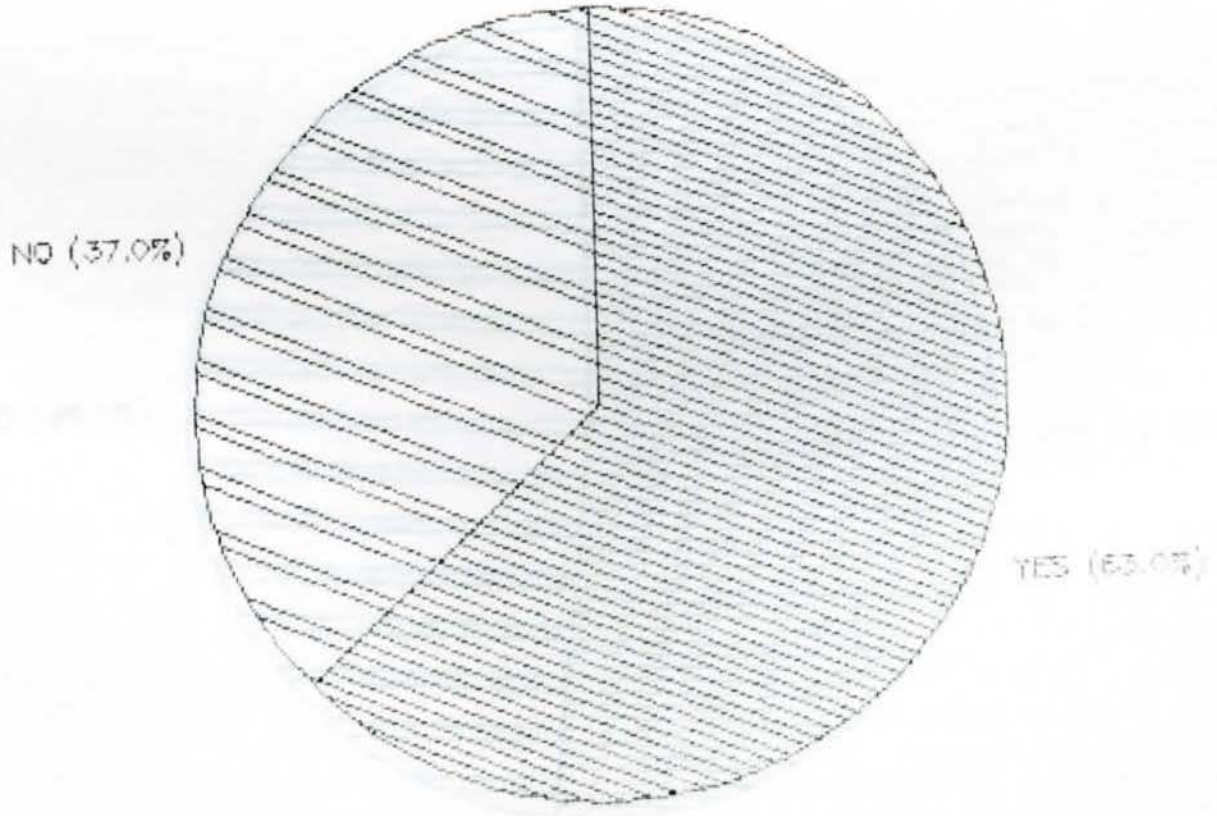

FIGURE 48

IMPORTANCE OF SUNDAY APPOINTMENTS

PUBLIC

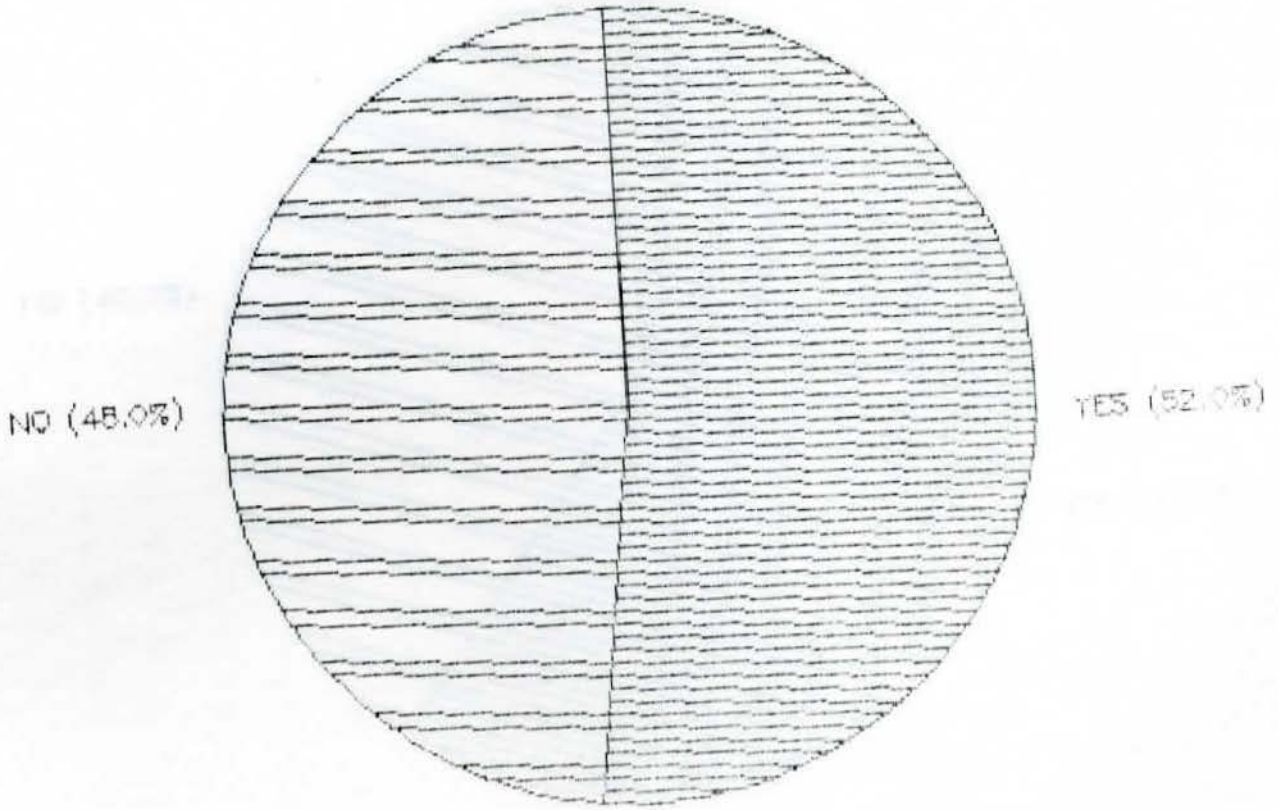

FIGURE 49

IMPORTANCE OF SLIDING SCALE FEES

HOSPITAL

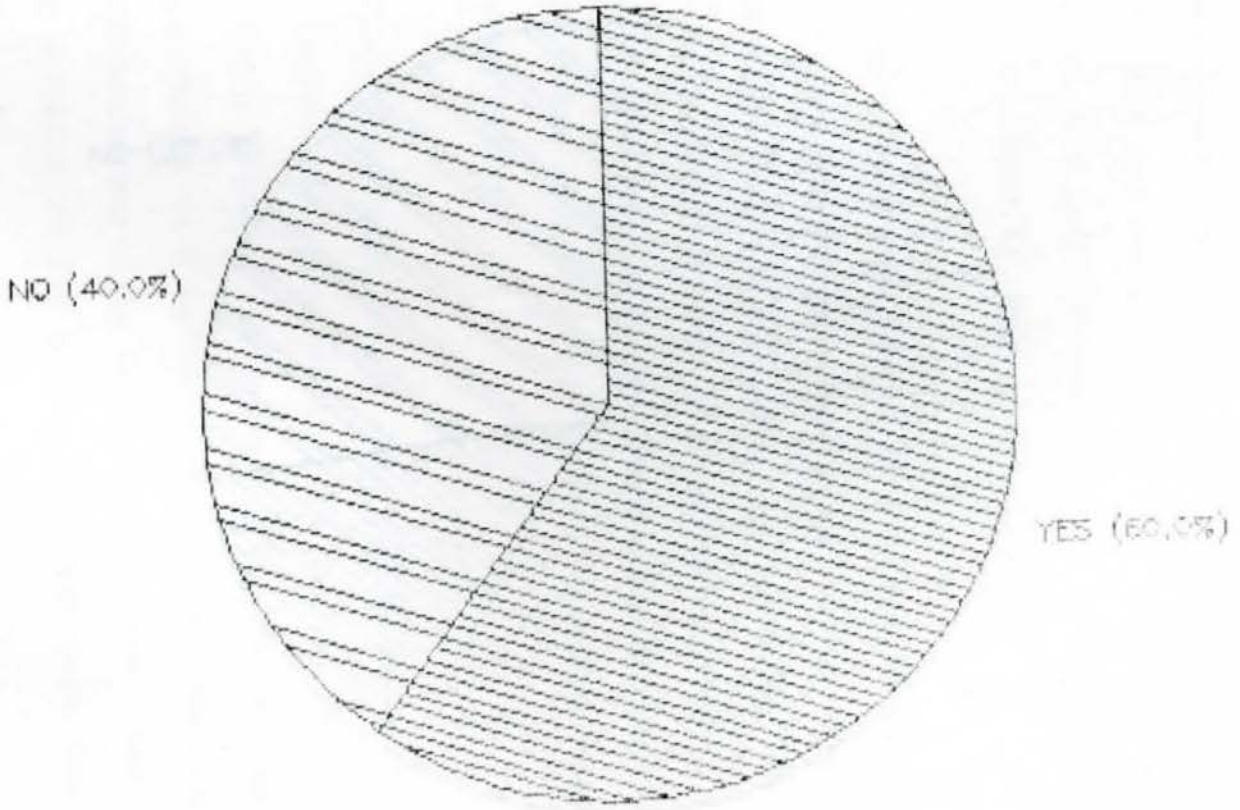

FIGURE 50

IMPORTANCE OF SLIDING SCALE FEES

PUBLIC

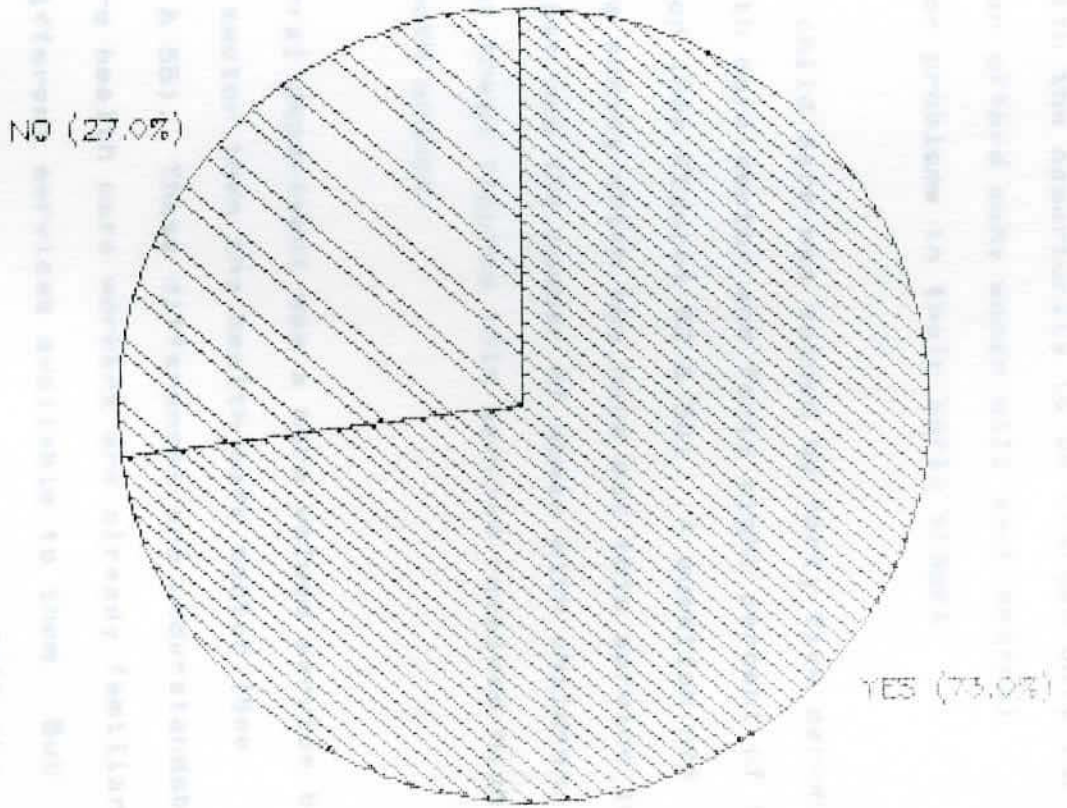

FIGURE 51

are not covered as seen in their answer to question 13 of the survey. Many women delay seeing a doctor because of the high costs associated with health care. When presented with the opportunity to be charged only for what they can afford many women will seek medical attention for problems in their early stages.

On-site child care was valued by forty five percent of the health care sector and forty eight percent of the public sector (See Figures 52 & 53). A question not asked in the survey which may have put this service in a higher bracket was the number of women with children. Even without these figures this service received high scores by both groups.

A referral department was a more valued service by the public sector than the health care sector (See Figures 54 & 55). These differences are understandable because more health care workers are already familiar with the different services available to them. But sixty-seven percent of the public surveyed felt this was a needed service.

IMPORTANCE OF ON-SITE CHILD CARE

HOSPITAL

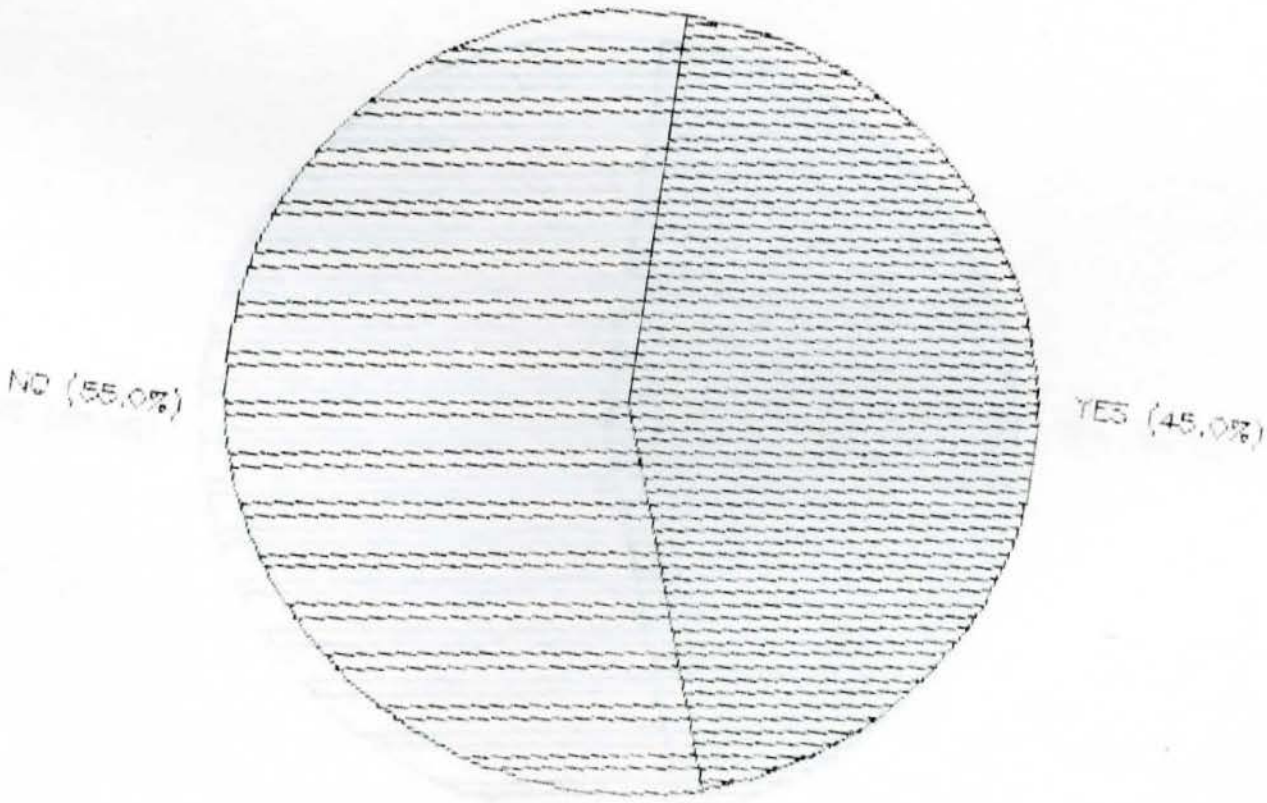

FIGURE 52

IMPORTANCE OF ON-SITE CHILD CARE
PUBLIC

FIGURE 53

IMPORTANCE OF A REFERRAL DEPARTMENT

HOSPITAL

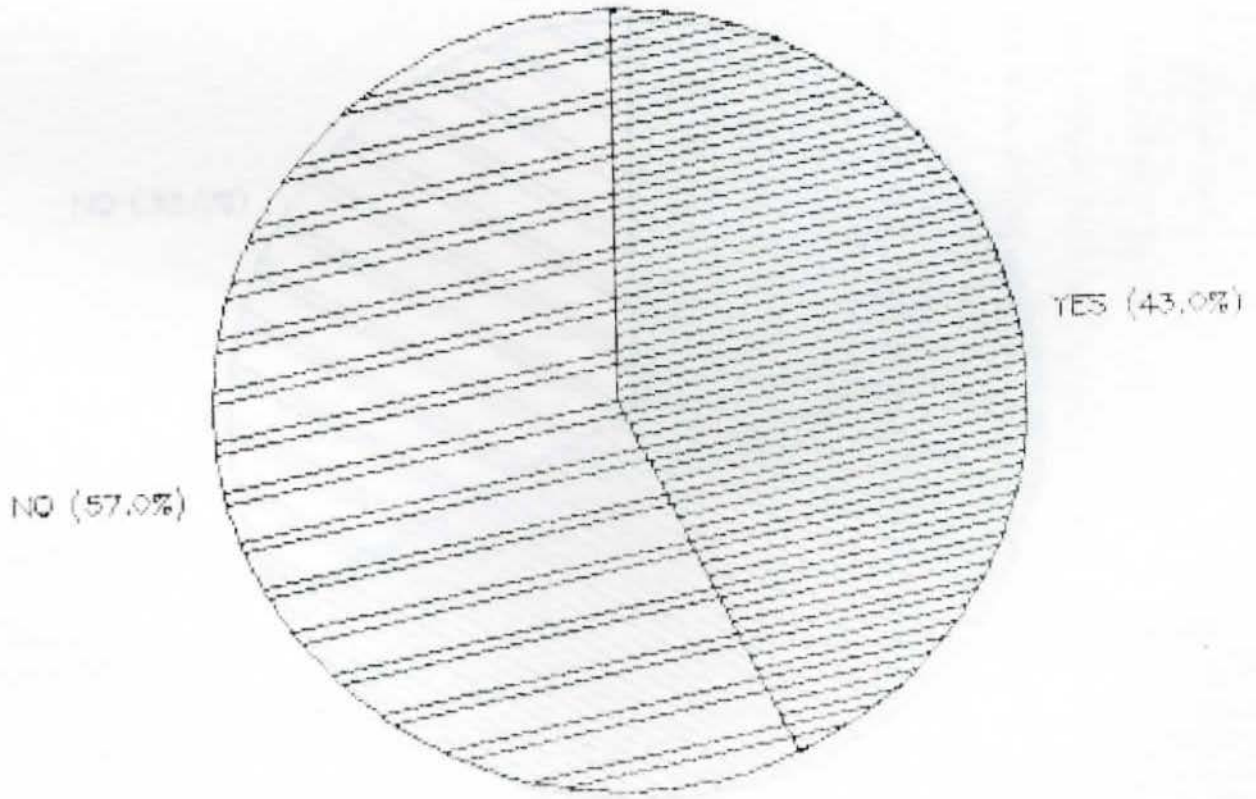

FIGURE 54

IMPORTANCE OF A REFERRAL DEPARTMENT

PUBLIC

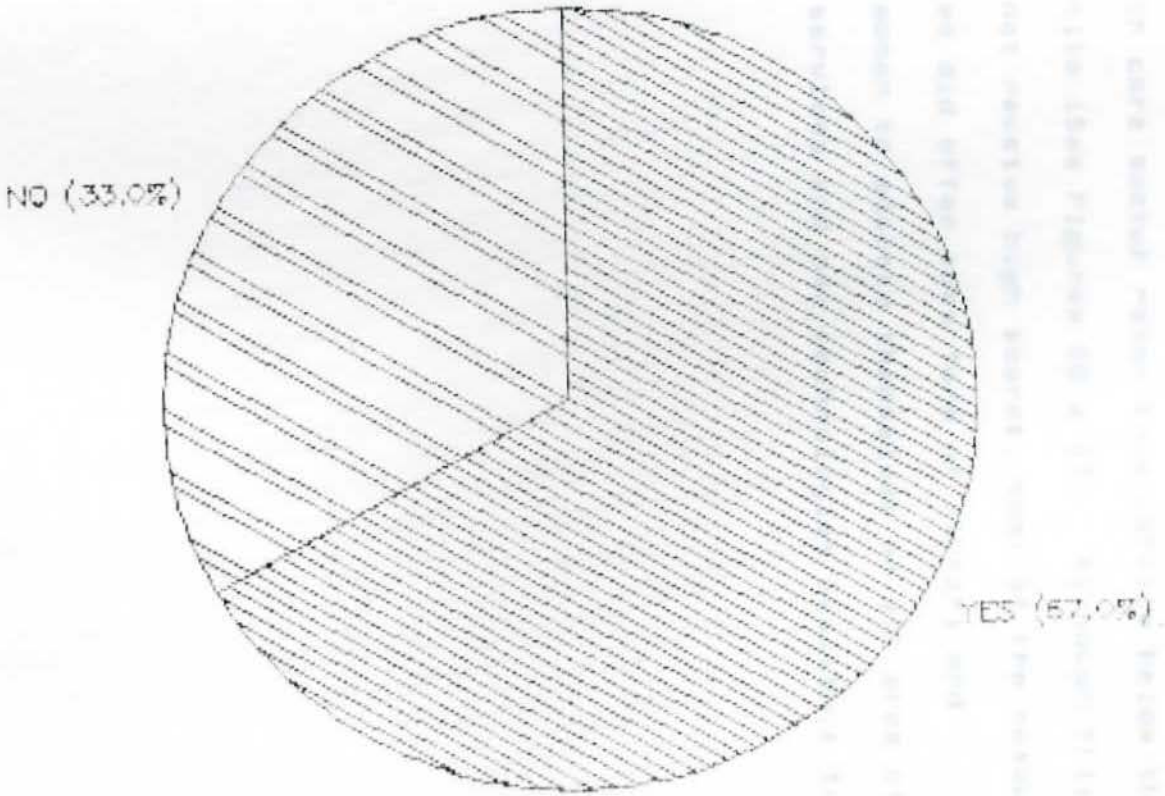

FIGURE 55

A public library was the last special service asked to be rated by the survey participants. Both the public and the health care sector rated this service below the fifty percentile (See Figures 56 & 57). Although this service did not receive high scores, most of the resource centers polled did offer some form of library and encourgaged women to educate themselves on all area of health care services and new technologies available to them.

IMPORTANCE OF A PUBLIC LIBRARY

HOSPITAL

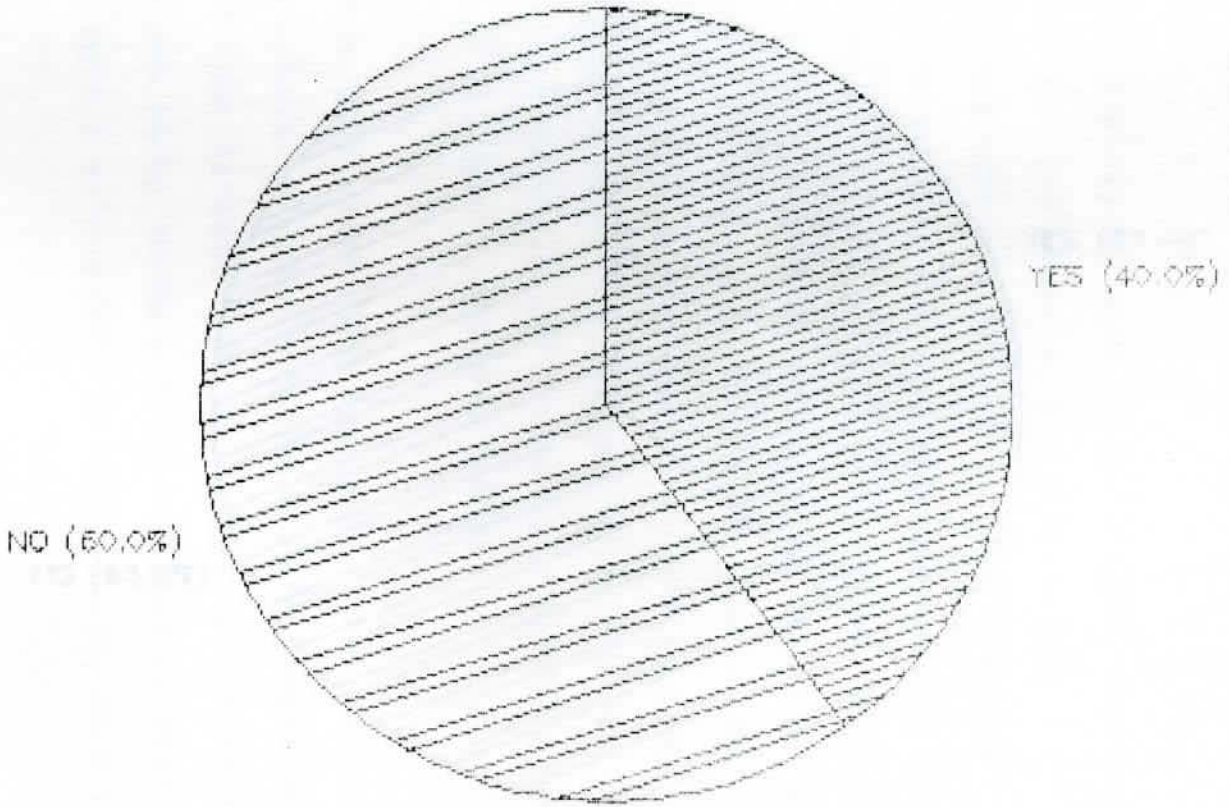

FIGURE 56

IMPORTANCE OF A PUBLIC LIBRARY

PUBLIC

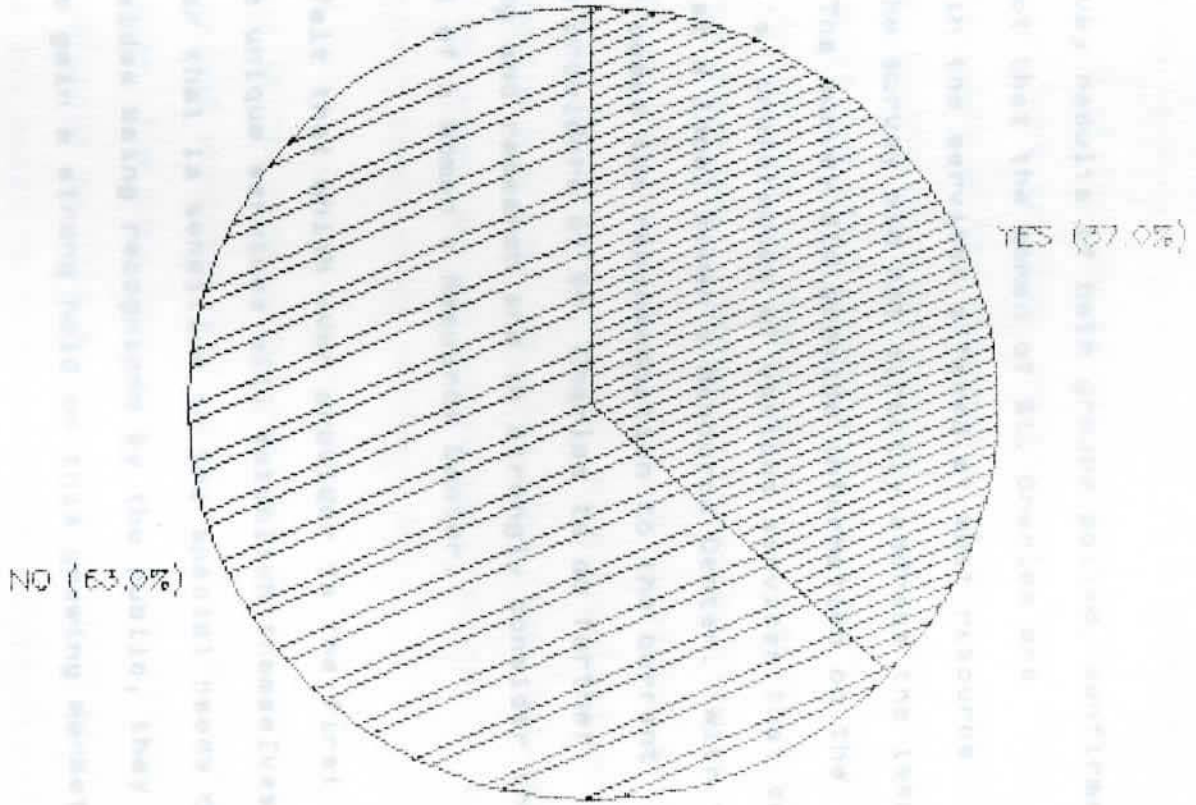

FIGURE 57

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

The survey results of both groups polled, confirmed only the fact that the women of St. Charles are interested in the services offered at most resource centers. The survey did not directly address the issue of usage. The survey did provide information on the participant's preferences of various services that could be offered at a local Women's Resource Center. With this information comes the recommendation to the current health care providers of St. Charles to do further interviewing and research and to strongly consider the development of a Women's Resource Center.

It is felt that which ever provider is the first to offer these unique services will establish themselves as the provider that is sensitive to the special needs of women. Besides being recognized by the public, they should also gain a strong hold on this growing market.

At this point interested providers need to conduct a survey of their own, on a larger scale to determine the

services that the women of this area want to use. Using these extended surveys, interested providers can concentrate on services and programs they want to develop. It is at this point that established health-centers have an edge. Often these hospitals already offer many of the services offered by resource centers. By moving or re-packaging these services and using equipment and staff already in existance, money can be saved. An article in "Business Week", estimated that it would cost $500,000 to set-up a freestanding, full-service clinic and that it can take several years for the clinics to show a profit. With hospital-operated clinics, showing a profit can also take time, but when combined with in-patient referrals they can see a faster return on their investments (Deveny, 81).

Staffing is the next issue that should be considered. The services and programs that will be provided dictate, to some degree, the type and number of staff needed. Also, the decision to hire an all-female staff or a male-female mix needs to be considered. This is not to say that time may change this decision, but often an a female staff is used as a marketing incentive. Recruiting an "all, female staff", especially female

physicians may be difficult, especially in the St. Charles, Missouri area. If hiring male physicians is necessary, special attention must be paid to recruiting males who are sensitive to female issues.

The next decision to be made by administrators is whether to locate their resource center within the hospital complex, move to an existing house or office building or to build a center. Because of the costs involved in constructing a new building, unless funds are extraordinary, the other options should be considered first. If there is adequate unused space at the existing hospital and if there is a seperate entrance, this option could be considered. One drawback to this option is, many people relate hospitals to illness and may have difficulty connecting the wellness concept to the services being offered.

An existing office or house would be the better option. Especially a house, since it can easily promote the friendly, caring atmosphere suggested by most directors who operate wellness centers. If using a house or office, the decision to move large equipment ie.;

Mammography and X-ray machines must also be made. Most centers offer on-site mammograms, but a few make the initial contacts and educate at their centers and then send the client to the hospital complex for the actual procedure.

It is also recommended that an interested provider hire a consultant that is familiar and experienced in setting up a women's resource center. On-site visits to successful resource centers should also be done before opening a new center. It is only through direct contact with these centers that a real feel of the atmosphere and attitude of the center can be evaluated and duplicated. All of the directors interviewed, on the phone, provided helpful information for this paper. They all appeared to believe in the purpose of their centers and were encouraging the development of services similiar to the ones they offer. It was felt that any one of the directors would make themselves available for a detailed interview with an interested provider.

All the literature and directors polled were quick to point out, that while their centers were designed to be esthetically appealing to women, it takes more than fancy

furniture to draw female clients to their centers. So providers are advised to design centers that appeal to women's tastes, but reserve most of their resources for the development of valuable services and programs that women want.

Another r commendation suggests that interested providers hire an experienced health care marketer. Most resource center's market to young women as their primary target market. Advertising is an effective tool to reach women. In a recent survey by the National Research Corporation concluded that women were almost twice as aware of services offered by hospitals when the advertisements highlighted special services for women (Jensen, 66).

The same study concluded that women between the ages of 18 to 44 years old were more likely to listen to advertisement and to recall the services that were being promoted. Of the 540 women who participated in this survey, over a third stated they would be willing to pay above average prices if they were receiving specialized health care for females (Jensen, 66).

The costs for television and radio advertisements is high and these mediums are designed tc reach a large audience. It would be wise to spend advertising dollars at least initially, on methods that target the women in the St. Charles catchment area such as mailers. Display booths at local mall, participation in local health fairs and providing guest speakers for women's groups are all low cost methods of providing information on the services being offered.

An interested provider should work closely with their marketing staff to determine what services are already offered in their community. The decision to compete for their competitor's market or create a new niche should be made early in their business plan. Developing a new, unique product is difficult but market researchers agree that the women's market is growing and a woman's resource center can be just the key to increasing a health care provider's market share (Breslow, 19).

Finally selecting and training the entire staff needs to be addressed. Attention must be paid to selecting personnel that understand the philosophy and purpsoe that the center wants to promote. Training staff to be

sensitive to the clients, to provide information and facts and to always treat their clients with respect is vital to a center's continued survival in this now competitive market.

The surveys did not indicate the number of women who would be willing to use a resource center and this question needs further research to determine a more accurate estimate of usage. The survey did indicate a dissatification with the present delivery of health care and a desire to try a better way. With extended research, the different service preferences would be confirmed and an interested provider could move to create their own Woman's Resource Center.

APPENDIX A

WOMEN'S WELLNESS CENTERS

Women's Wellness Centers is a recent concept to provide all-inclusive, total health-care to women. These clinics are usually places where a woman can receive their gynecological exam or mammogram, treatment for P.M.S. or osteoporsis, advice on nutrition, weight loss counseling, information on cosmetic surgery and counseling for psychological problems and stress issues. Many of the clinics around the country offer free screenings for drug & alcohol addiction, eating disorders and referral services.

The clinics use a team approach, the team usually includes an internal medicine physician, OB/GYN, a registered nurse, a registered dietician, therapists for counseling, fitness specialists and other qualified personnel depending upon the services they offer.

This survey is part of my graduate thesis for Lindenwood College. The purpose is to establish whether a Woman's Wellness Center is needed in St. Charles County.

Directions: Please read the questions and circle the answer that bests describes your opinion (if you are male, please circle the answer you think your wife or mother would believe).

1. AGE:_____ 2. SEX: M F

3. MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

4. EDUCATION: 6 7 8 9 10 11 12 COLLEGE 1 2 3 4 5

5. OCCUPATION:_____

6. YEARLY INCOME: UNDER $10,000 $10,000-$20,000
$20,000-$30,000 $30,000-$40,000
$40,000-$50,000 OVER $50,000

7. DO YOU PRESENTLY RECEIVE YOUR HEALTH CARE FROM A ST. CHARLES COUNTY PHYSICAN? YES NO

8. IS YOUR PHYSICAN A GENERAL PRACTITIONER? YES NO

9. HAVE YOU EVER BEEN SEEN BY A SPECIALIST FOR A MEDICAL PROBLEM OR MEDICAL CONDITION YES NO
IF YES, WHAT WAS THEIR SPECIALITY?_____

10. HAVE YOU OR ANY MEMBER OF YOUR HOUSEHOLD BEEN HOSPITALIZED FOR MORE THAN 2 DAYS IN THE LAST YEAR? YES NO

11. HAVE YOU OR ANY MEMBER OF YOUR HOUSEHOLD BEEN HOSPITALIZED FOR OUT-PATIENT TREATMENT IN THE LAST YEAR? YES NO

12. HAVE YOU OR ANY MEMBER OF YOUR HOUSEHOLD BEEN TO THE EMERGENCY ROOM IN THE LAST YEAR? YES NO

13. ARE YOU PRESENTLY COVERED BY HEALTH INSURANCE? YES NO

14. HAVE YOU EVER HEARD OF THE CONCEPT OF A WOMEN'S WELLNESS CENTER BEFORE THIS SURVEY? YES NO

15. IF A WOMEN'S WELLNESS CENTER WERE LOCATED IN ST.CHARLES COUNTY WHAT SERVICES WOULD YOU LIKE TO SEE OFFERED?
(please rank the following choices with 1-very important 2-important or 3-not important)

INTERNAL MEDICINE _____
OBSTETRICS _____
GYNECOLOGY _____
PSYCHIATRY _____
SUPPORT GROUPS _____
MENOPAUSE & P.M.S. COUNSELING _____
EATING DISORDER SCREENINGS _____
MAMMOGRAM & BREAST CANCER SCREENINGS _____
ALCOHOL & DRUG ADDICTION SCREENINGS _____
HIGH RISK PREGNANCY CLINIC _____
NUTRITIONAL COUNSELING _____
MARITAL COUNSELING _____
FITNESS ADVICE _____
ABUSE COUNSELING _____
RAPE COUNSELING _____
FERTILITY CLINIC _____
EDUCATIONAL PROGRAMS _____

16. WHAT SPECIAL SERVICES DO YOU FEEL WOULD ATTRACT YOU TO USING A WELLNESS CENTER OVER THE TRADITIONAL PHYSICIAN VISITS?
(mark as many as apply)

ON-SITE CHILD CARE DURING APPOINTMENTS_____
EARLY MORNING APPOINTMENTS_____
EVENING APPOINTMENTS_____
SATURDAY APPOINTMENTS_____
SUNDAY APPOINTMENTS_____
SLIDING SCALE FEES (fees based on income) _____
PUBLIC HEALTH LIBRARY_____
REFFERAL DEPARTMENT _____

APPENDIX B

SURVEY SAMPLING

The survey sample was taken from the St. Charles area. Friends who worked at local businesses, were asked to contact their employers for permission to distribute the surveys. Two of the business that were approached, refused to allow any type of surveying of their employees. The majority of the companies allowed the survey, with the promise of anonymity. The survey sampled the following types of industries in the St. Charles area.

- two major banks
- a private school
- two law firms
- a small retail company
- a day care center
- a manufacturing company

The sampling was of employees chosen within each company. It was requested that different level of employess both skill and income be selected. Besides the businesses that were used, friends also submitted completed surveys from friends and neighbors whose identities are unknown to this author.

APPENDIX C

RESOURCE CENTERS CONTACTED

Charter Women's Center
Charter Community Hospital
Des Moines, Iowa

The Elizabeth Blackwell Health Center
for Women
1124 Walnut St.
Philadelphia, Pa. 19107

Elizabeth Blackwell Center
Riverside Methodist Hospital
Columbus, Ohio 45476

Emma Goldman Clinic for Women
715 N. Dodge St.
Iowa City, Iowa 52240

The Feminist Women's Health Center
6411 Hollywood Blvd.
Hollywood, Calif. 90028

The Health Center for Women
Ramsey Clinic and St. Paul-Ramsey
Medical Center
258 E. University Ave.
St. Paul, Minnesota

The New Hampshire Feminist Health Center
38 S. Main St.
Concord, New Hampshire 03301

Women's Resource Center
Illinosis Masonic Medical Center
Chicago, Ill.

The Woman's Pavilion
1835 Franklin St.
Denver, Colorado 80218

Women's Well
St. Mary's Health Center
Clayton, Mo. 63117

APPENDIX D

PERTINENT MEDICAL DEFINITIONS

Throughout this thesis paper there are medical terms used to describe diseases and treatments. The following are definitions of these diseases an treatments for those for readers unfamiliar with this medical terminology.

AMNIOCENTESIS; A diagnostic procedure in which a hollow needle is inserted through the abdominal wall of a pregnant woman into the fluid-filled sac surrounding the fetus. The cells in this fluid can be examined for evidence of genetic or developmental defects.

ARTIFICAL INSEMINATION; The fertilization of a female sex cell by a male sex cell other than by sexual intercourse.

CANCER; Any of various diseases characterized by an abnormal and uncontrolled growth of body cells.

CERVICAL CAP; A birth-control device that is fitted by a physician. This device acts as a barrier, it is fitted over a woman's cervix and blocks the passage of sperm.

CERVICAL SMEAR/PAP SMEAR; A routine test for cancer of the cervix. The cervical smear is a technique in which a few cells are scraped from the cervix and spread on a slide and examined.

CESAREAN SECTION; The removal of a fetus from the uterus by means of a surgical incision through the abdominal wall and into the uterus.

CONTRACEPTION; Any process, device or method that prevents the fertilization of an ovum by a sperm cell.

DALKON SHIELD; One type of intrauterine device.

DEPO-PROVERA: An injected contraceptive that provides long-lasting results. The injection contains many of the same chemicals found in oral contraceptives but at increased dosages. These injections will provide protection for up to six months but the side effects connected with this form of birth-control are risky.

DIAGNOSIS: The art or process of identifying the nature of a particular disease or disorder.

FETAL MONITORING: An electronic method used to measure the heart rate and evaluate the general state of health of a fetus.

FETAL ULTRASOUND: A test using sound waves to produce an image of a fetus. The test is used to determine how old the fetus is, the presence of a fetal heartbeat and the position of the fetus in the womb.

HYSTERECTOMY: Surgical removal of the uterus.

HYSTEROSALPINGOGRAM: A fertility test for women to determine if their fallopian tubes are open. Dye is injected in through the cervix into the fallopian tubes and then an X-ray is taken to see if there are any abnormalities.

INFERTILITY: The inability or greatly reduced ability to conceive children. The condition may be present in either males or females.

I.U.D./INTRAUTERINE DEVICE: Different shaped objects that are inserted into the uterus and remain there for a prescribed length of time to prevent conception.

MAMMOGRAPHY: X-ray or other radiographic examination of the breast used in the diagnosis of breast cancer.

MASTECTOMY: Surgical removal of a breast, usually as treatment for breast cancer.

ORAL CONTRACEPTIVE: Any of various pills designed to prevent conception.

OSTEOPOROSIS: A disorder of the bones in which they loose calcium and other minerals and become less dense.

P.M.S./PREMENSTRUAL SYNDROME: A condition or symptoms some women experience prior to their menstrual period.

UTERUS: The organ in females designed to contain and nourish a developing embryo and fetus from the fertilized ovum (egg) implantation to the time of childbirth.

V.D./VENERAL DISEASE: Any disease transmitted almost exclusively during sexual intercourse with an infected partner.

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