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A study to determine what factors affect the attendance of Puerto Rican mothers to ante partal clinic

A STUDY TO DETERMINE WHAT FACTORS AFFECT THE ATTENDANCE OF PUERTO RICAN MOTHERS TO ANTE PARTAL CLINIC

BY

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CHAPTER I

INTRODUCTION

Maternity care has been and is still considered by authorities to be one of the most important areas of health care contributing to the reduction of maternal and infant mortality rates. The modern trend in maternity care is to recognize the need for not only physical, but emotional care as well. Physical care can be offered to mothers by taking their blood pressure, obtaining a urine sample and weighing them. More thought and understanding needs to be given to the emotional care of mothers during pregnancy.

We need to realize that mothers need someone with whom they might share their joys, hopes, and anxieties about pregnancy and the birth process. To fulfill this need, those in the helping professions must be ready to accept, listen and try to understand expectant mothers. Good supervision during pregnancy will help mothers end their pregnancy in a healthy physical and emotional condition and with a healthy baby.

I became interested in this study through my observations in a prenatal clinic. Conchita is a mother who was attending the clinic. Her attitude, eyes full of tears, readiness to leave the clinic, and her feelings of being insulted motivated me to give much thought to her. What was happening to this mother? Could personal problems be affecting her behavior? Did she really want to stay in the clinic? I did not know the answer to these questions. To recall the situation briefly:

Conchita had two children and was expecting her third. The children

were born in Puerto Rico, near her family. She understood some English, but did not speak English. She had been attending the clinic accompanied by an interpreter. When I first observed her, she had been waiting for more than two hours to be called to see the doctor. On this particular day she had come alone, and planned to return to her home without receiving care in the clinic. The only possible solution for Conchita was to remove herself from this traumatic situation.

Her thoughts about leaving the clinic were expressed in a loud voice accompanied by tears in her eyes, "I am going, I am going from here, nobody cares about me." At that moment I approached her. I talked to her for a few minutes. From the conversation I gathered that she had been looking for me as the interpreter who was going to help her, but was unable to ask for me because she could not converse in English.

Her experience is typical of many Puerto Rican mothers who attend the clinic. Was this situation due to the way the clinic operated? Was it a result of the patient-staff relationship? Was it due to indifference on the part of the patients? The answers to these questions can not be given without careful thought and study. Certain questions need to be asked. Who are these mothers? Where do they come from? What is their language, culture and education? What do they expect from the clinic?

These people are Puerto Rican women, American citizens and expectant mothers. They, like women in every nation have gone through the physiological process of bearing children. The only difference is that Puerto Rican mothers have added problems and difficulties as they undergo the maternity process.

Motivated by the desire as to the reasons for the mothers' behavior toward the prenatal clinic, I decided to undertake the following study.

STATEMENT OF THE PROBLEM

What factors affect the attendance and the quality of services received by the Puerto Rican mothers in a maternity clinic of the Out-Patient Department of a large general hospital in eastern Massachusetts?

IMPORTANCE OF THE PROBLEM

In my experience as a nurse, I have had the opportunity to perform different roles in an out-patient department. As a basic student I was given the opportunity to work for limited amounts of time in a clinic where there was little opportunity for me to know my patients. As a nurse instructor I was also limited by my position in relation to working on a one to one basis with the patients, since my responsibility was to observe and discuss experiences with students working in the clinic. Through a field experience developed as part of my total program in Maternal and Child Health Nursing, I was able to work with a group of mothers in the maternity clinic of X hospital, and I learned to know and understand the problems of these people.

Breaking appointments, avoiding pelvic examinations, misunderstanding doctor's orders, late registration to the clinic, inability to follow clinic instructions, and the use of unqualified interpreters were behavior patterns observed in these mothers. It seemed that the above situations prevented the mothers from receiving adequate prenatal care during their pregnancy. While working with the mothers, I tried to determine those factors which were affecting the attendance of the mothers in the clinic, and which were preventing them from receiving the quality of health supervision that they needed.

SCOPE AND DELIMITATION

The maternity clinic of the out-patient department where the study was conducted held clinics three times a week, Monday, Wednesday, and Friday morning. The Wednesday clinic had an average census of 90-100 mothers. The Puerto Rican mothers included in this study had recently moved to the area served by this clinic. The study was limited to seventeen Puerto Ricans who were attending the Wednesday clinic. This group of mothers were the first ones with whom the writer became acquainted.

PREVIEW OF THE METHODOLOGY

Data for the study was collected by observations and interviews. The observations were made in the maternity clinic of a large hospital in eastern Massachusetts. Structured interviews were done with a group of seventeen mothers, and unstructured interviews with medical and nursing personnel. A guide was used with open-ended questions, to obtain more complete information from the mothers. Structured interviews averaged between thirty and forty-five minutes in duration.

CHAPTER II

REVIEW OF LITERATURE

Today there is great concern about the importance of the out-patient department, of which the prenatal clinic is an important part. The out-patient department serves a variety of purposes in the hospital. Its functions include the diagnosis and treatment of difficult and obscure cases, it provides medical and surgical advice, follow-up patient discharges from the hospital, and serves as a field for research. The welfare of the patient coming to the out-patient department is a concern of the personnel in the clinic who provide services to the patient. In large clinics there is a great need to consider the welfare of patients by studying their individual needs. Patients need to know why many things occur in out-patient departments and particularly those from other countries. To gain understanding and cooperation from patients, they need information about why clinics function as they do. Hurst states that:

> . . . . the aim of the out-patient department is to ensure that the patient is able to benefit to the maximum from his interview with the medical staff. The best possible pre-medication is a full draught of the milk of human touch on the part of our out-patient department staff.[1]

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[1] E. H. Hurst, "The Welfare of Out Patients," Royal Social Health Journal, (London: July, August 1958), p. 470.

The position of the nurse in the clinic needs consideration, when plans for operation are to be considered. In a study done by Osgood the author says that:

> . . . . in some clinics methods of communication between members of the health team made it difficult for the nurse to assume responsibilities for the teaching; in others, inadequate physical facilities failed to provide an environment in which nurses could work with patients. Some members of the staff commented that they did not know what to teach patients or how to teach them.[2]

Fisher refers to the needs of the out-patient department and possible remedies when she states the following:

> First, we need more nursing personnel in our clinics, or we must relieve the nurses we have of non-professional responsibilities. Second, we need a screening system to determine which patients need teaching, referral and a nursing plan for continuity of care. Obviously all patients do not require such service. No patient who does require extensive service should ever leave clinic without a plan for providing it. Third, we need more group teaching than we do.[3]

She goes on to consider the work of the nurse in the clinics and her responsibilities by emphasizing that:

> Nurses have longer contact with patients and therefore more opportunities to observe behavior and to listen. The nurse is usually the first professional person to see the patient. The reception she gives him sets the stage for his experience in the clinic and helps shape his future attitude toward treatment. The nurse plays a key part in continuity of care, because she is in a position to initiate referrals, and to interpret the patient's needs to the physician.[4]

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[2]Gretchen A. Osgood, "Study of Clinic Nursing Service," Nursing Research, Vol. VII:I, (February, 1958), p. 35.

[3]Mercedes Fisher, "Out Patient Departments Have a Long Way to Go," American Journal of Nursing, Vol. LXI:VIII, (August 1961), p. 59.

[4]Ibid., p. 58.

There are many situations in which the nurse-patient relationship can best be accomplished if both work toward the same goal. The patient plays an important part in many things which occur in the clinic setting. In relation to the waiting hours, as one of the situations patients need to understand, Hurst suggests the following:

> Would it be reasonable to suggest that after a wait of more than half an hour past the appointment time and in the absence of any explanation by the sister (nurse), the patient on his own accord should approach her and ask the reason. Perhaps this suggestion might be incorporated in the notices or booklets dealing with waiting and thus encourage the patient to take an active interest in his own welfare. Waiting may, of course, involve persons other than the patient. Because of the emotional stress which can upset a patient when he first attends a hospital, or because of frailty, he may be accompanied by a relative or friend who perforce has to wait until the patient is called into the doctor, then while he is seen by the doctor, possibly by the almoner (social worker), and on occasions while medicine is obtained from pharmacy. All arrangements made to deal with the problem of waiting must therefore encompass the relative or friend. A further problem is that of the care of children. Not all mothers are able to make arrangements for their children to be cared for while attending the hospital. It is probably true to say that in such cases the mother is acutely aware of the problem she creates by bringing the children with her. To be met by lack of understanding, however, only complicates the issue; on the other hand, sympathetic action on the part of the nursing staff can swiftly relieve the mother's mind.[5]

Prevention, diagnosis and treatment, provision for medical and surgical advice, as well as teaching and understanding of patients are some of the most important functions of the out-patient department. Nurses as well as the other members of the health team contribute to the out-patient main goal, that is, the welfare of the patients. More

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[5]Hurst, Op. cit.,pp. 468-469.

nurses with understanding of the patient's needs could help out-patient departments serve their purpose in the hospital unit more effectively.

Let us consider the findings related to prenatal care which may help to strengthen the need for this study.

Every nurse who works with pregnant mothers must recognize that behind each human being there are many problems that require understanding. One of the purposes of prenatal care is to provide support to mothers to help them recognize and work through some of their fears and concerns related to pregnancy. Fitzpatrick states that:

> Childbirth is no longer an event to be awaited helplessly by the expectant mother with what fortitude she is able to muster, instead, it is the climax of a period of preparation, a true state of preparedness attained through the cooperation of the physician, the nurse, and the expectant mother or parents.[6]

Nurses working with mothers need to keep in mind that in addition to the routine of taking blood pressure, receiving urine samples, and weighing mothers there are other important things to do in a prenatal clinic: They need to be aware of the variety of mothers that attend the clinic; the reasons mothers break their appointments; resist guidance and education; or display other types of irritating behavior. In a study done by Stitt, Babbot, and Salber, the authors state that:

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[6]Elise Fitzpatrick, R. N., Nicholson J. Eastman, M. D., Zabriskie's Obstetrics for Nurses, 10th Ed. Rev., (Philadelphia, Montreal, J. B. Lippincott Co., 1960), p. 8.

> With prevention the aim, the focus of concern becomes the prenatal period. Fetal wastage, congenital malformations, cerebral palsy, disturbed parent-child relationships and prematurity which are problems seen in maternal and child health and crippled children's programs have as a common denominator the possibility that optimum care during the prenatal period might prevent or modify their occurrence.[7]

Morris, writing about the maternity unit of the future, considers pregnancy as the time of vital preparation for many things. Marital difficulties can be corrected or alleviated during this period. The author points out the need, or continuity if previously established, for parent classes as an important part of ante-natal preparation.[8]

Many health institutions are stressing the importance of good prenatal care. As a result of this consideration, improvement is observed in the plans developed for the care of mothers and families during pregnancy. The California State Department of Public Health established in their standards for prenatal care that:

> Every expectant mother needs an opportunity to discuss the effects of her pregnancy on herself and her family. Some mothers are helped by just being able to talk to an attentive listener. Others will need more assistance in identifying their problems and gaining insight into them. Still others may need referrals to various community resources such as the welfare department, family-counseling service or one of the services of the local health department. Strengthening the mother's self-confidence through recognition of her abilities as well as her problems, is an important part of prenatal care.[9]

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[7]Joan G. Babbot, Pauline G. Stitt, Eva J. Salber, "Six Years of a Family Health Clinic; Some Prenatal and Pediatric Findings," American Journal of Obstetrics and Gynecology, LXXX, (1960), p. 311.

[8]Norman Morris, "Maternity Unit of the Future," Nursing Mirror, (January 1961), p. 4.

[9]Standards and Recommendations for Public Prenatal Care-California State Department of Public Health, (California: 2151 Berkeley Way, Berkeley, 4), p. 9.

Reyner considers the needs of pregnant women when she says:

> . . . . even those who are shy seem happy to have the opportunity to talk about this important event when the interview offers privacy. On the other hand, the nurse often is called upon to counsel the unhappy mother who has three or four children and who may have problems.[10]

Good prenatal care is considered to be responsible for the reduction of maternal death due to toxemia of pregnancy. Nurses working in the prenatal clinic of our hospitals need to understand this concept when giving care to the community of mothers who come to their clinics. Donnelly states that:

> . . . . toxemia of pregnancy is more frequently observed among women in low socio-economic groups. It is also more common in patients with multiple pregnancy, with a previous history of toxemia, rheumatic heart disease, and certain gastro-intestinal diseases, for example, ulcerative colitis. It is generally accepted that toxemia is a disease of the ill-fed, ill-housed, and ill-clothed. Every expectant mother should see her physician every three to four weeks to the twenty-eighth week of pregnancy, every two weeks from the twenty-eighth to the thirty-sixth week, and every week thereafter. The patient who is potentially toxemic or who develops some complication should be seen more frequently, sometimes every other day.[11]

Consideration of the mother's physical and emotional needs is an important aspect in the care of the pregnant woman. Nurses working in a prenatal clinic need to offer considerable support to the patients who come to them if these needs are so important for the welfare of mothers and their families.

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[10]Roma D. Reyner, "The Pregnant Woman in Industry," American Journal of Nursing, LVIII:VII, (July 1958), p. 1000.

[11]James F. Donnelly, "Toxemia of Pregnancy," American Journal of Nursing, Vol. LXI:IV, (April 1961), p. 98.

With particular reference to the Puerto Rican family, Moore and Faraone found in their study that many factors affect the life of the Puerto Ricans living in the United States. In reference to the living conditions of the Puerto Ricans in Delaware they state:

> We learned that the Puerto Ricans generally knew little about the health, welfare, and recreational facilities in the area in which they lived, presumably because of the language problem. Interestingly, very few of them were known to our welfare agencies. It seems that they invariably try to help one another in financial and domestic difficulties, seeking public assistance only as a last resort. They are a proud and independent people and tend to cling closely to their own group.[12]

They also found that Puerto Rican families living in Delaware were confronted with problems of language, culture and health education. In reference to the language barrier the author states:

> The effects on our staff of this new insight and increasing interest in learning is clearly evident in this situation which involved a nurse who spoke no Spanish and a family who spoke no English. The mother, who was in her fifth month pregnancy, had made no preparation for medical supervision and obviously was unaware of the facilities available to her. The nurse, with the help of our Spanish-speaking medical social consultant and an English-Spanish dictionary, wrote out the appointment for the hospital clinic in Spanish and arranged for a Spanish-speaking volunteer to take the patient to the clinic alone. As a result of the nurse's efforts, the mother is now attending the antepartum clinic alone, using public transportation. She is taking her children regularly to child health conference and has made her own arrangements for the care of her family during her lying-in period.[13]

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[12]Janice Eaton Moore, and Helen Bradley Faraone, "Habla Usted Espanol," American Journal of Nursing, Vol. X:IV, (April 1962), p. 250.

[13]Ibid., p. 251.

The Welfare Department in Delaware is becoming increasingly aware of the Puerto Rican's situation and offered service toward its solution. "Things seem to be moving toward more sponsorship by the welfare department's service to include provision for more interpreters and the translation of applications for public assistance from English to Spanish."[14]

The study being discussed attempted to solve many of the problems, one of which was language.

> At one of our weekly Well Baby Clinics, attendance at one clinic session each month is made up of almost entirely Puerto Ricans. Segregation has not played a part in this; it merely happened as a result of their inherent desire to be with their own people. Also, it seems that those who cannot yet speak English feel more secure when they can be with some one who can interpret for them. We have seen evidence of more expectant mothers registering earlier at prenatal clinic.[15]

In relation to a specific problem of one family, there was evidence of a need for health education as expressed in the following:

> They had been taking medicine for the anemia, but when the prescription was used up, the parents had not gone back to the hospital to have it refilled. This was not because of negligence; they just did not understand that continued treatment was necessary.
>
> Because of the language problem the medical consultant who spoke Spanish accompanied the nurse on her visits until Mr. H. had learned to understand some English and the nurse was able to revive some of her high school Spanish.
>
> When Mrs. H. became pregnant with her ninth child, she registered at the hospital prenatal clinic but, again because of language difficulties, her clinic visits were not satisfactory. We have learned that in order to understand the Puerto Ricans and to help

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[14] Ibid.

[15] Ibid., p. 252.

> them adjust to our way of life, we, too, have had to change our thinking and some of our methods of working with families.[16]

Bernstein and Sauber in their study about deterrents to prenatal care and social services in which Puerto Rican mothers were included, establish that:

> . . . . the two major deterrents to prenatal medical care in this group are that they find it inconvenient chiefly because they are caring for children at home, and that they see no need to go sooner or at all. In addition, a substantial number either wish to conceal the pregnancy or are afraid of medical examinations. The single major deterrent to social agency services is that they see no need for them.
> . . . . further the interviewer evaluation reflects not only deterrents to seeking care early, but to the continuation of prenatal care regularly throughout the pregnancy.[17]

The authors, taking into consideration the mothers' background and its behavioral effect, express their views in the following:

> The individual lives in part, in the large society of the country as a whole and is influenced by its culture and mores, but he is also affected by his particular milieu or sub-cultural group which may be defined by economic level, geographic area, ethnicity, religious affiliation, or educational level, etc. If certain actions are generally acceptable in the smaller society as a whole, their consequences may be for less traumatic and the motivation to seek help may be much weaker.[18]

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[16] Ibid.

[17] Blanche Bernstein and Mignon Sauber, Deterrents to Early Prenatal Care and Social Service Among Women Pregnant Out of Wedlock, New York State Department of Social Welfare, (Albany, New York, 1958), p. 153.

[18] Ibid., p. 93.

Dieppa in a study done on the adjustment of the Puerto Rican living in Boston gives a description of the variety of these problems. Most of the problems were due to language, cultural background and health needs. He says:

> In addition to these problems which are characteristic of blighted areas, the Puerto Rican migrant has other problems which are unique and limit him even more. His language handicap, the climatic change, poor health, different dietary and sanitary habits and different familial patterns affect his health and living. Language problems, that is, need for interpreting or interceding, alone account for forty per cent of the problems presented in the health category.[19]

He also views specific problems related to language and its detrimental effect upon health. . . . "We observed that the pregnant women to not go to the prenatal clinic as early as they should and the young children are not brought to Well Baby Clinic for innoculations when advisable - both observations suggesting the need for better health education as well as the need for interpreters in the clinic."[20]

> . . . . Among the eighty-four clients whose cases were studied, forty-six or 54 per cent were found to be severely handicapped by language. The inability to speak the language increases the migrant's insecurity created by the strangeness of the environment and the struggle to adjust to it.[21]

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[19]Ismael Dieppa, "The Role of the Social Worker in Helping Puerto Rican Migrants Adjust to Urban Life in the South End," (Unpublished Master's Thesis Boston University School of Social Work, June 1961), p.39.

[20]Ibid., p. 40.

[21]Ibid., p. 55.

BASIS FOR THE HYPOTHESIS

After reviewing the literature it can be said that pregnant mothers' needs are very important and should be considered in planning prenatal care. "Prenatal medical care has long been considered essential to protect the health of the mother, and to insure to the extent possible, the delivery of a healthy child."[22] Prenatal care is considered as a means for the reduction of maternal and infant death. Fitzpatrick states: The reduction in maternal mortality rates since 1915 has been dramatic, but more particularly since 1930 - from a rate of 67.3 in white women in 1930 to 2.8 in 1957, and the corresponding rate in non-white women from 117.4 in 1930 to 11.8 in 1957.[23] Prenatal care is a cycle in which education plays a very important part. The type of education needed by pregnant women should be directed toward helping them and their families to be as healthy as possible.

What type of care can be planned which will consider the pregnant woman as well as her family needs? One way of helping pregnant families to promote their health during pregnancy, as seen by the writer, could be through an orientation about the experience. Mothers should be aware that pregnancy is a normal process. They should understand that the anxieties, worries, hopes, and tensions which they are undergoing are normal and that the personnel in the clinic understand them. Mothers should have the conviction that the staff in a maternity clinic does

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[22]Bernstein, Op. cit., p. 43.

[23]Fitzpatrick, Op. Cit., p. 5.

understand their needs, and that their behavior is expressed sometimes verbally, sometimes with gestures, and sometimes through their attitudes. Pregnant women should also have the true belief that the clinic personnel realizes that they are asking for guidance, for education, and for understanding.

With this brief picture about prenatal care, in relation to what the literature revealed, the following hypothesis has been established for this study.

HYPOTHESIS

Puerto Rican mothers are not able to effectively utilize the services of the prenatal clinic of X hospital because of the influence of their cultural background, language handicap and poor health knowledge.

CHAPTER III

METHODOLOGY

Selection and Description of Sample

The sample for this study was selected from the group of Puerto Rican mothers who attended prenatal clinic of X hospital. Seventeen mothers were selected for participation in the study. The group of mothers were a part of the Puerto Rican population which had recently moved to Boston, Massachusetts. The group may be classified as a low socio-economic class. Their ages ranged from seventeen to thirty-seven years. Each family nucleus comprised an average of three to nine members. The sample included primigravidas as well as multigravidas. Their educational background consisted of a minimum of two years of schooling to a maximum of twelve years. All mothers in the group had a language problem.

The mothers all were American citizens, and were able to move to any place in the United States just as any other citizen moves from one state to another. They had migrated from areas outside of the metropolitan district in Puerto Rico to the United States, without a previous experience of living within an urban area. Some of the mothers came with their husbands and families to farms where their husbands could be employed. Others came directly from their homes in the country after their husbands had settled in large cities in eastern Massachusetts. In the homes of these Puerto Rican mothers, Spanish was the spoken language. Their Spanish is different from the language taught in the

schools (colleges), and learned by English-speaking people. The simple Spanish spoken by country people, with little or no schooling, includes such words as "regla" for menstruation; "algo que me sube y me baja" for heartburn; "achaques" for general disorders.

Puerto Rican families, such as the ones in this study, are poor, belonging to the lower socio-economic class. They are shy and proud. Family members are loyal to one another and ties extend beyond parents and children. Family customs include religious ceremonies symbolized by the term "compadrazgo." The compadre, or God-father, is accepted as a family member with a deep mutual sense of affection. Consensual or common-law marriages make up a considerable percentage of the marriages in the rural areas of Puerto Rico. The family resulting from these marriages are accepted and respected as much as those resulting from civil and religious rites. Children are not regarded as being illegitimate.

Time and Place of Study

The study was conducted in the Out-Patient Department of a large general hospital located in eastern Massachusetts. The prenatal clinic in the Out-Patient Department was held three times a week. The study was conducted in one of these three morning clinics where approximately 90 to 100 mothers were seen. There was an average of four to six doctors, two graduate nurses, two medical social workers, one or two hospital aides, two or three clerks, and a voluntary worker conducting the clinic.

Registration for the prenatal clinic was every Monday, Wednesday and Friday. Laboratory work and chest X-rays were completed for each

mother at the time of registration. Mothers were seen in the clinic every four weeks for the first seven months, every two weeks during the eighth month, and every week during the ninth month. Every mother had a pelvic examination during the last month of pregnancy.

The writer worked with the group of mothers as a nurse and as an interpreter for a period of five months. Data for the study was collected during this time.

Method Used to Collect Data

The data was collected by three methods:

(1) By observations in the prenatal clinic
(2) By structured, or guided interviews with the mothers
(3) By unstructured interviews with some of the doctors, social workers and nurses.

Observations were done in the clinic every Wednesday morning. The purpose of these observations was to obtain information to determine if language, cultural background and education had any effect upon the attendance of the mothers to the prenatal clinic. All situations encountered by the group of mothers in the clinic were recorded. Observations such as the mothers' attendance to the clinic, their attitudes toward the examinations, and their relationship with the clinic staff were all considered pertinent to the study. The observations were written no later than twenty-four hours after the completion of each clinic.

The purpose of the guided interviews was to obtain information from the mothers in relation to the services that they were receiving in the clinic. It also served to avoid bias as much as possible. Opportunity was provided to permit a free, rather than limited, response from each of the mothers. Appendix A includes a sample of the guide used for the data collection.

Unstructured interviews were conducted with some of the doctors, nurses, and social workers with whom the mothers were in contact during clinic visits. The purpose of these interviews was to obtain information related to the mother's attitude toward the clinic staff as observed by them. These interviews were used to determine if there were any observed changes in the mother's attitude toward the staff during the time the writer worked as a nurse and as an interpreter for these mothers.

Through the observations and the interviews, pertinent information was collected to see what effect language, cultural background, and education had upon the mother's attendance to the prenatal clinic. Consideration as to years of school, years of residence in the United States, and the area of study (specifically notions about health) were considered within the range of the factors to be studied.

CHAPTER IV

PRESENTATION AND DISCUSSION OF DATA

Interviews held with the personnel in the clinic showed that all seemed to be concerned about the needs of the Puerto Rican mothers. Few, however, knew the cultural, language and educational problems that remained unsolved. They wanted to understand the mothers, but the language barrier permitted little communication. The doctors felt that the mother's physical needs were met, but that the whole purpose of prenatal care was not carried out. The social workers felt that the mothers presented problems which must be solved, but because of the types of interpreters they brought to the clinic (relatives, neighbors) little guidance could be given. Nurses and other personnel expressed that the Puerto Rican mothers seemed to need more help than they were receiving, but the language barrier was a handicap in their relationship.

Findings:

The twenty questions directly related to the factors studied showed interesting findings. Mothers were asked at what time during pregnancy did they make their first visit to the clinic. Eight mothers attended the clinic from the 8th to the 12th week of pregnancy; 7 mothers began their initial attendance during the 16th to the 28th week of pregnancy; and 2 mothers from the 32nd to the 36th week of pregnancy. These findings revealed that less than 50% of the mothers attended the

clinic for the first time during the early months of pregnancy.

Mothers were asked to give what they considered the most important reasons for late registration in the clinic. From a question with 6 alternatives, they were asked to check three in order of preference. Language, fear of medical examination, and lack of baby sitters were selected as the most important reasons for their late attendance at the clinic. The alternatives were checked as follows:

Reasons	Mothers
Language	15
Fear of medical Examination	12
Lack of baby sitters	11

The writer's observations offered evidence about the possibility of other factors influencing late clinic registration. The majority of these mothers are used to midwifery deliveries, since some of them come from areas where this method is frequently practiced. A firm religious conviction that things occur according to a Divine will has some bearing on late registration, that is, they believe that no harm will come to them if they have faith.

The writer observed that women who had never been seen or examined by a doctor exhibited the greatest amount of apprehension in the clinic. This necessitated a later appointment date and additional help in assisting these mothers in adjusting satisfactorily to the medical examination. Examples of these findings can be appreciated in the following. Three mothers refused medical examination. All of them were emotionally upset when called for examination. For two, the procedure had to be postponed for a later appointment. When examination was done, the mothers showed

their resistance by great perspiration, tears, and other signs of anxiety.

Length of residence in the United States was another element found to affect attendance of mothers to the maternity clinic. When asked how long they had been living in the United States, it was found that 11 mothers with a residence of 6 to 27 months made their first visit to the clinic within the 16th to the 28th week of pregnancy. Four mothers with the same time of residence, made their visit to the clinic early in pregnancy. One of these four had completed her high school education, and received advice to visit the clinic by a relative, who was a doctor. Another told the director of a neighborhood house that she might be pregnant. She was advised to register at the clinic and was offered the assistance of an interpreter. The two other mothers had a Pentecostal minister's wife as interpreter all the time. They were advised to register early in the clinic.

Six women with a residency of 3 to 9 years in the United States made their first visit to the clinic within the 8th and 12th week of pregnancy. Two women in the group attended the clinic during the 8th and 9th month of pregnancy. The reasons given were: the mother registered early to the clinic, but had to leave to go to Puerto Rico because of a death in the family. In Puerto Rico she did not attend any clinic. Upon returning to Massachusetts she again registered in the clinic. She was in her last month of pregnancy. In the other case, registration was delayed because the mother did not find an interpreter to go with her to the clinic. See table I.

TABLE I--PART A

RELATIONSHIP OF THE NUMBER OF MONTHS IN RESIDENCE IN THE UNITED STATES TO THE FIRST PRENATAL VISIT

Mother	Month of residence in the U. S.	Months of residence in eastern Massachusetts	Month of pregnancy at the first visit to the clinic
#1	20	20	5
#3	27	27	6
#4	6	6	7
#5	18	18	7
#7	8	8	3
#8	12	12	3
#9	21	21	3
#11	26	26	4
#13	11	11	6
#15	12	12	3
#16	12	12	7

Part A shows that eleven women who resided in the United States from six months to 27 months made their first visit to the clinic within the 16th and 28th weeks of pregnancy. Only four mothers made their first visit to the clinic during the first trimester of pregnancy.

TABLE I--PART B

Mother	Month of residence in the U. S.	Months of residence in eastern Massachusetts	Month of pregnancy at the first visit to the clinic
# 2	72	36	3
# 6	48	29	2
# 10	36	36	2
# 12	41	17	9
# 14	44	44	8
# 17	108	24	3

Part B shows that six women who resided in the United States from three to nine years made their first visit to the clinic within the 8th and 12th week of pregnancy. However, two women in this group attended the clinic during the 8th and 9th month of pregnancy.

In a question asked to determine who influenced the mother's visit to the clinic, it was found that seven mothers came because they knew they had to do it; six were influenced by another person; two were advised by a social worker, and two by a relative. The findings showed that ten mothers had to be advised of the necessity for attending the clinic. In my opinion the length of time of residency in the United States may also influence the decision of early clinic attendance. Table I shows that the group of mothers living in the United States for more than three years had more understanding for the need to attend the clinic. It seemed that once the mothers became aware of the existing community

resources they were more willing to use them.

The Neighborhood Newcomers program (a community resource) also seemed to have an effect upon the decisions of mothers to attend the maternity clinic. An inquiry made to see if the mothers were acquainted with this program revealed that twelve were familiar with it. Another question directed at finding out whether this program was helpful to the mother in contacting the clinic, showed that nine mothers were benefited to a certain degree. The assistance of an interpreter was the nature of aid received in most cases. Almost all the mothers registered in the clinic used the services of this institution for their registration.

The findings showed that once the decision to come to the clinic was established and registration was done, mothers seemed to begin to miss their appointments to the clinic. In relation to the first and subsequent visits to the clinic I found that the number of years of education had an effect upon the visits. The analysis in relation to the question of how many visits mothers made to the clinic after the first one, showed that all mothers registered at an average of 18 weeks of pregnancy. During the whole period of pregnancy, it was found that 4.8 or 5 visits were made by each mother. (See table II). Mothers should attend the maternity clinic every month during the first seven months, every two weeks for the eighth month and every week during the last month of pregnancy.

Reasons offered by mothers for being absent to the clinic can be classified under culture and language. Among the various reasons given by the mothers are: they did not want to register early for the clinic; mothers did not have a baby sitter with whom to leave their children; they cannot converse in English, and they do not like to be examined.

TABLE 2

RELATIONSHIP OF YEARS OF SCHOOL TO FIRST AND SUBSEQUENT VISITS OF MOTHERS TO THE CLINIC

PART A

Mother	Years of School	First Visit, Weeks of Pregnancy	Subsequent visits (number of)
# 8	2nd. grade	8	7
# 15	2nd. grade	12	7
# 6	3rd grade	8	6
# 11	3rd grade	16	5
# 12	3rd grade	36	1
# 17	4th grade	12	8
# 14	5th grade	32	3
# 13	5th grade	20	3
# 5	5th grade	12	1
# 10	6th grade	8	9
# 4	6th grade	28	3

PART B

# 16	8th grade	28	3
# 9	8th grade	12	4
# 1	8th grade	16	5
# 3	10th grade	24	5
# 2	11th grade	12	10
# 7	12th grade	12	3

Table 2 gives the relationship between the number of years of school to the first and subsequent visits to the clinic. In part A the table shows that the group of mothers with no school up to 6 years of school attended the clinic for the first time at 4.5 months of pregnancy. The group in part B also had an average number of 5 visits to the clinic per mother.

Language was studied to find out if it had any effect on the attendance of mothers to the clinic. Many of the questions used in the guide revealed this factor as a salient point contributing to the attendance of mothers to the clinic.

Mothers were asked if they had any opportunity to converse with the doctors and to tell them about their complaints. Nine mothers answered in a positive way; 8 mothers answered the question by saying that they had the opportunity when the interpreter was present. From my observations it seemed that all mothers needed the nurse interpreter to tell doctors about their complaints. It was observed that problems arose when the mothers tried to communicate their complaints to the doctors or used a lay interpreter for that purpose. The following are observations made in relation to this question:

> Carmen was receiving Maalox on almost every visit, for heartburn. This morning when she came to the clinic, her interpreter, a 13 year old girl, told the doctor about Carmen's condition. The doctor was informed that Carmen was having constipation. A prescription for mineral oil was given to her. When I asked Carmen if she had any particular need, I found that there was a misunderstanding about what the doctor was told about this mother's condition. Carmen explained the situation. I talked to the doctor and the prescription for mineral oil was changed.

> Juanita was seen by the doctor and was found to have a thrombophlebitis. She was with her interpreter who spoke both English and Spanish. The interpreter was asked to tell Juanita that if she was not hospitalized for that condition, complications might result. The interpreter told Juanita that if she did not stay in the hospital, the blood clot in her leg might move from its location and would go to her heart and kill her. I later on had to explain to Juanita what thrombophlebitis is and the importance for her to stay in bed until she had further orders from the doctor.
>
> Librada is an expectant mother who I had to leave in the clinic to be helped by a second expectant mother. The next time I saw both women, the one who served as an interpreter told the following: "I left her alone when the doctor asked me when she had her last menstrual period". Why, I asked: "Because I was not going to tell the doctor that Librada had her last menstrual period three days before she got married. We are not supposed to tell these things to a man."

A question was asked to find out the reasons why mothers did not communicate their complaints to the doctors. Some of the answers given by the mothers were that they did not do it because there was not always an interpreter available. This answer was given by five mothers. Six mothers thought they were not supposed to tell doctors everything. Six mothers said they were afraid to talk to the doctors. They also were ashamed.

From the observations in the clinic it seemed that language was a factor that affected the attendance to the clinic, the quality of service and the understanding of the Puerto Rican mothers by the personnel in the clinic. Due to the language barrier, mothers faced many problems in the clinic. Mothers cannot communicate with the personnel. This was a problem in itself. The problem of communication accounted for other problems, such as absence to the clinic, mothers speaking loudly in the clinic, and misunderstanding of some of the instructions received.

Many left the clinic without their medical examination. They did not understand what the doctors were asking. Some mothers answered when a name similar to theirs was called: Elia Sanchez was called for an examination. Crucita Sanchez went and had the medical examination by mistake. When the examination was over Crucita said, "the doctor saw me, but did not give me an appointment." I told her she had not been called. Crucita again said: "Yes I was called and I was examined." I investigated the situation and found that Crucita was examined in place of Elia.

Mothers were given their appointments for two or four weeks but they did not know how to ask for appointments. Many mothers left the clinic without their appointments. One day a mother was given an appointment for the following week. This mother understood the instructions, but went home without the appointment written on her card. The next time she came she had to wait until the last patient was seen. When I saw her and asked why she was there, the mother answered that she came early but had not been called. She had a yellow ticket that placed her on the list of mothers to be seen last. The above situation was the reason for the long wait for this mother.

During November and December from a registration of 12 mothers 4 did not bring a urine sample on their first appointment. This situation was repeated in every first visit mothers made to the clinic. The reason for this problem was that most of the mothers could not read the instructions given to them on the appointment card. They were expected to read and interpret the instructions on the card. I oriented the mothers in respect to this instruction. In January, 8 mothers were registered and only one did not bring her urine sample. In February, 8 mothers were registered and 3 did not bring their urine sample. During

that period of time I was absent from the clinic. After my return to the clinic a form was written in Spanish and English which gave information related to the clinic. This was given to all mothers. During March, April and May all mothers brought their urine sample. Table III shows this information.

TABLE 3

NUMBER OF MOTHERS ATTENDING THE CLINIC FOR THE FIRST TIME AND THEIR UNDERSTANDING ABOUT INSTRUCTIONS-NOV./61-MAY/62

Month and Year	Number of Mothers Visiting the Clinic for the first time		Total
	with urine sample	without urine sample	
Nov. 1961	6	2	8
Dec. 1961	6	2	8
Jan. 1962	8	1	9
Feb. 1962	8	3	11
March 1962	13	0	13
April 1962	10	0	10
May 1962	10	0	10
Total	61	8	69

During November and December 1961, twelve mothers attended the clinic for the first time. Four mothers did not bring a urine sample requested in their appointment card.

From January to May 1962, forty-nine mothers attended the clinic for the first time. Four mothers did not bring a urine sample as requested on their appointment card.

The mothers were asked to check from a list of six, four items which they felt influenced them in the selection of a prenatal clinic. Mothers would like nurses to understand them. Fourteen mothers chose this answer. Ten said they would like the doctors and social workers to understand them. Twelve mothers indicated that they would like expectant mothers classes. Five mothers preferred that there should be no medical examination. Seven said they would like government surplus food.

The replies seemed to prove that even when mothers enjoyed the visits to the clinic and were satisfied with the services received, they would like the personnel in the clinic to understand them. They would like to have an opportunity to express themselves and to ask questions as well.

After working directly with this group of mothers I felt that they would like to know why many things happened in the clinic. Questions such as "Why do I have to wait until the last moment? Why do I have to go through this examination? Why do I have this pain in my legs? I am having pain in all my abdomen." "I am having heart burn." "I am having some watery discharge." "I am not eating many things, why do I gain so much weight." This list of questions which were asked by mothers show the interest they have in learning the why of things going on in the clinic. The mothers seemed to be demanding, through these questions, the need for a person who will understand them during their visit to the clinic.

The findings related to health education show a need for health guidance for this group. One of the most important problems in this area is the need for an orientation related to nutrition and special

diets. In theory, the mothers seemed to understand the doctor's advice, but in practice there was a big difference. The mothers were asked if they considered following the doctor's orders as important. In response to a question related to the reduction of salt in the diet, the answers were as follows: thirteen mothers said it is necessary to follow the doctor's orders. Two mothers said, "doctors know what we need." Two did not consider the reduction of salt from the diet as important. In practice it was observed that the mothers who were supposed to have a salt-free diet refused to follow this advice.

When the mothers were asked to select foods that they considered important for a balanced diet during pregnancy, they chose the following:

Choice # 1----milk
fruits
malted beer (a beverage full of calories but with a relative low nutritive value)

Choice # 2----meat
vegetables

Choice # 3----eggs
cereals

From observations made in their homes, it appeared that rice, beans coffee, malted beer, meat and milk were used by the mothers and their families in their every day diet.

All mothers attending the clinic received some kind of medicine samples (iron and vitamins). The doctors recommended that once the sample was finished they should purchase their own medicine. When the medication sample was finished they often did not purchase a new supply. This group of mothers is used to taking cool medicines during their pregnancy. They consider cool medicines as good for them and their babies.

It seemed that when the nurse talked to these mothers about the importance of taking other medicines besides cool ones their attitude toward medication changed. Cool medicines are considered those which are liquid in form and have a plant or root base. An example could be: peletaria plant used as a diuretic.

A special need for health education for this group of mothers is indicated by the above data. The mothers appeared to need nutrition knowledge, knowledge of clinic procedures, and knowledge of how to derive more benefit from the health programs in the community where they lived.

In general, they seemed to enjoy their visits to the clinic. It may be said that whenever they had the opportunity, they have recommended it to their friends and neighbors. When asked, 15 said they enjoyed visiting the clinic and had recommended the clinic to their neighbors and friends. Seven did not recommend the clinic to their friends because they had not had the opportunity to do so.

Interpretation

Analysis of data reveals that such factors as culture, language, and health education affect the attendance and the service received by and to the Puerto Rican mothers in the prenatal clinic. Decisions to attend the clinic as well as continuous attendance were affected by various elements that could be considered related to all three factors.

The years of residency, amount of education, language handicap, knowledge of community resources, and the use of lay interpreters affected the attendance of the mothers to the clinic. These findings show a relationship between health education and certain features of good supervision such as time of registration, continuity of attendance to the

clinic and utilization of medical and nursing advice. The mother's attitudes, and the use of balanced diet show a lack of health education by this group.

The findings concerning observations and unstructured interviews supported the findings obtained from the data collected through the interview method. The writer observed that mothers had a need to understand the importance of early registration to the clinic. The mothers needed an orientation to the importance of purchasing and taking medicines, the need for medical examination, and the need to follow diets prescribed for them. The mothers' need for acculturation is also very important in this group. They need to learn how to obtain services by themselves, and to utilize services in the United States but which were unknown to them in Puerto Rico. They need help in accepting the type of care and the way in which it is offered. They also need help to understand that independence is needed to profit from life as it is lived here in the states. Inability to use the English language handicapped the communication of the mothers when they tried to use the services of the clinic.

CHAPTER V

SUMMARY AND RECOMMENDATIONS

The study was conducted to determine problems which interfered with the attendance of the Puerto Rican mothers at a maternity clinic, and the quality of service they received.

The data was collected in a maternity clinic of a general hospital in eastern Massachusetts. Seventeen mothers were selected to participate in the study.

The methodology consisted of structured interviews with mothers and incidental interviews with doctors, nurses, and social workers. For the structured interviews a guide consisting of twenty questions was used. Open-ended questions were utilized in order to obtain a more complete picture of the mother's attitude toward the clinic. Findings from the writer's observations, over a five-month period of time within the clinic area, were also included within the study.

The literature was reviewed for relevant material pertaining to the study. From this review the following hypothesis was established:

> Puerto Rican mothers are not able to effectively utilize the services of the prenatal clinic of X hospital, because of the influence of their cultural background, language handicap and poor health knowledge.

Culture, language and health education were found to affect the attendance and quality of services received by the Puerto Rican mothers.

The influence of the cultural background upon the attendance and service rendered within the clinic were:

1. The Puerto Rican woman is usually confined to the home because it is virtuous and expected by the

husband. Even a visit to the clinic is frequently not considered a necessity.

2. Puerto Rican women are not accustomed to leave their children with baby sitters who are not relatives.

3. Many of the mothers had their other children with midwives at home.

4. Puerto Rican mothers are shy people and are afraid to express themselves in English.

5. Fear of the medical examination.

The findings related to language also showed the effect upon the attendance and service received by the mothers in the clinic. The observations indicated that mothers did not ask questions of any one in the clinic. On some occasions a mother would respond to another mother's name when called. Many mothers have the same surname and names which sound much alike. They also did not know how to ask questions related to the doctor's and the clinic's regulations.

An outstanding finding was that fourteen mothers expressed the wish for a clinic where staff personnel could understand them. Fifteen mothers considered language as a reason for late registration in the clinic.

The findings about health education show that mothers need more health instruction. This factor also affected their attendance to the clinic and the services which they received. On the average, these mothers were four to five months pregnant when they were first registered . An average of five visits per mother for the whole pregnancy was recorded. These five visits are less than fifty per cent of the visits pregnant women are expected to have. Every pregnant woman is expected to visit the clinic every month for the first seven months, every two weeks during the 8th month of pregnancy, and every week for

the 9th month.

Recommendations

Based upon the findings of this study the following recommendations are presented:

1. A similar study to compare the need of a lay interpreter in contrast to a Spanish speaking nurse to determine who is of most value to the mothers.
2. A similar study by nurses in other areas of the United States where Puerto Rican mothers might be receiving prenatal care to determine if the problems are the same.
3. The services of a Spanish speaking nurse with knowledge about the culture of these mothers, as well as good understanding of mothers and family needs, be employed by X hospital.
4. The personnel working in X hospital maintain continued interest in learning more about the needs presented by the Puerto Rican mothers and other similar groups.
5. That consideration be given to developing an orientation program for these mothers, about what to expect from the prenatal clinic.
6. Written instructions both in English and in Spanish pertaining to the policies of the clinic, be given to pregnant mothers to help them obtain a more complete service.
7. That nursing education programs include as much information as they can about the cultural background of

patients, applying this in terms of observational skills in meeting their physical and emotional needs.

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APPENDIX A

GUIDE USED WITH THE STRUCTURED INTERVIEWS

INTERVIEW GUIDE

Introduction

As you have observed during the past months, I have been working with you in the clinic. Through that experience I had the opportunity to observe some of the problems you have had while attending the clinic. I am doing a study to see the reason or reasons for those problems. I am here to talk with you regarding your experiences in the clinic. As you know I am not an employee in the hospital, but as a student am having some of my field experience there.

Guide

1. At what time during pregnancy did you make your first visit to the clinic?
2. How many visits did you make to the clinic after your first one.
3. Can you give reasons for absence from the clinic after first visit?
4. Was the decision for your visit to the clinic done under the advice of a relative, a social worker, the public health nurse or another person?
5. Some of our mothers, as you know, come late to the clinic during pregnancy. Some of them come at six or seven months of pregnancy, others wait until the last month. What do you think might be the three most important reasons for this? Check them from the following:

    ----fearful of medical examination
    ----afraid to express themselves clearly
    ----there is no need to come early to the clinic unless there is a complication
    ----there is not enough money for the bus

----do not have a person to stay with the children
----do not know the directions for coming to clinic

6. As you know, every mother who comes to the clinic has an appointment to talk with the doctor. In this conversation she is supposed to tell him all her complaints. Have you had the opportunity to tell the doctor all your complaints?

7. If the above answer is no, will you please state the reason why?

8. You know that in the visit to the clinic, the doctor advises every mother to omit salt from the diet. As you know, many of the mothers do not follow this advice. Do you feel it is necessary to follow the doctor's orders? Why?

9. Almost every mother who comes to the clinic receives some samples of medicines from the doctor. Mothers are asked to buy the same medicine when the samples are finished. Some mothers do not purchase these medicines. Why do you think a mother might not purchase more medicines?

10. After your visit to the prenatal clinic, can you tell me what some of the things are that you liked most about it? What are the things you liked least?

11. Is the service that you are getting from the clinic what you expected it to be?

12. How long have you been living in the United States?

13. How long have you been living in Boston?

14. Are you acquainted with the Neighborhood Newcomers Program?

15. Does the above program enable you to get in touch with the prenatal clinic at X hospital? How?

16. Do you feel most of the personnel are interested in you and your welfare? Why?

17. Of course you want all these things, but which of the following items influence you most when it comes to choosing your prenatal clinic? Check four items.

    ----nurses will understand mothers
    ----doctors and social workers will understand mothers
    ----there will be an opportunity to ask question
    ----no examinations (vaginal)
    ----classes for mothers to be
    ----supplementary help with governmental surplus food

18. Plus other advice, you have been told to eat a balanced diet during pregnancy. This diet is beneficial for you and your baby. Can you mention some foods that you consider important for a pregnant mother?

19. Do you enjoy your visits to the clinic? Have you recommended coming to the clinic to any mother in your neighborhood?

20. Have any mothers in your neighborhood come to the clinic? If they have not, do you know the reason why?

APPENDIX B

FORM WRITTEN BY THE WRITER IN SPANISH AND ENGLISH TO HELP MOTHERS UNDERSTAND THE FUNCTIONING OF THE CLINIC

TO THE SPANISH SPEAKING MOTHERS WHO ATTEND THE PRENATAL CLINIC AT X HOSPITAL

A LAS MADRES DE HABLA HISPANA QUE ATIENDEN LA CLINICA PRENATAL EN EL HOSPITAL X

KEEP IN MIND:

RECUERDE:

1. Bring a fresh urine specimen of urine in every visit.
   Traer una muestra de orina fresca cada vez que venga a cita.
2. Be sure to have your appointment written on your card.
   Estar segura de tener la proxima cita escrita en su tarjeta de cita.
3. If the doctor indicates an examination, be sure to wait for it on the seats in the hall.
   Estar segura de esperar por el examen en los asientos en el pasillo si el doctor asi lo ordena.
4. Bring your marriage certificate, (if you have one), to the first visit because the social worker will ask you for it.
   Traer a la primer visita su certificado de matrimonio, (si lo tiene), la trabajadora social va a pedirselo.
5. Be sure to come early to the clinic, if you need a nurse interpreter.
   Llegar temprano a la clinica si necesita de la enfermera que sirve de ineterprete.
6. Use the nurse interpreter for your consultations with

the doctor or the social worker.

Utilizar la enfermera que sirve de interprete para consultar al medico o trabajadora social.

7. Remember the nurse interpreter is in the clinic to help you. Be sure to ask for her help.

   La enfermera que sirve de intérprete esta en la clinica para ayudarla. Pidale que la ayude.

8. Keep these suggestions. . . . . .They will help you.

   Guarde estas sugestiones. . . . . .Le ayudaran.