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BARRIERS TO PRENATAL CARE

The University of Arizona M.S. 1985

BARRIERS TO PRENATAL CARE

by

Michele Marie Anzalone

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7/26/85
Date

DEDICATION

This study is dedicated to my husband, Christopher Dow Grantham, whose love and support made the completion of this research possible.

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ABSTRACT

The purpose of this study was to identify the barriers to prenatal care from the perspective of the women who failed to utilize prenatal care services. Barriers to prenatal care are those conditions associated with the failure to utilize prenatal care services. Identification of the barriers to prenatal care was effected through the use of an exploratory descriptive research design. Guided-open-ended interviews were conducted with 17 women who failed to obtain prenatal care as indicated on their children's 1983 Arizona birth certificates. Content analysis of transcribed interviews and field notes revealed 10 barriers to prenatal care: (1) economic barriers, (2) emotional barriers, (3) attitudinal barriers, (4) attributional barriers, (5) availability of care barriers, (6) quality barriers, (7) content barriers, (8) system barriers, (9) family/community support barriers, and (10) transportation barriers.

CHAPTER I

INTRODUCTION

Among all the states in the Union, Arizona ranked fiftieth in the number of women receiving adequate prenatal care and thirty-ninth in infant mortality in 1983. Approximately 2,500 women were delivering annually without prenatal care. Another 2,000 to 4,000 are giving birth with so few prenatal visits that their care was considered inadequate (Arizona Department of Health Services (ADHS), 1984).

There was a sudden increase in the number of Arizona women not receiving prenatal care in Coconino, Cochise, Maricopa, Mohave, Navajo and Yuma counties. One of the most dramatic increases occurred in Maricopa County. Two hundred fifty-four women did not receive prenatal care in 1983, compared with 143 in 1982 (ADHS, 1984). The reason for this has not been fully determined.

There were several ways for all women to obtain prenatal care in Maricopa County in 1983. First, there was the Arizona Health Care Cost Containment System (AHCCCS), an experimental medical program serving the indigent population in the State of Arizona. AHCCCS contracted with many primary providers throughout the county. This program was well advertised. Second, Maricopa County Health Department providers asserted that no woman would be refused prenatal

care regardless of her financial status. The 13 primary care clinics run by the Health Department were well established and strategically located throughout Maricopa County. Also, some of the hospitals and clinics in the Phoenix area provided discount prenatal care services. There was an ample supply of private health care providers in the Phoenix area, as well. Since care through these channels was available for women, the reason they did not receive prenatal care is difficult to understand.

Prenatal care involves the health assessment, medical services, social services, nutritional services, patient education, and psychological support of an expectant mother. Prenatal care promotes improvement in pregnancy outcome by timely recognition of high risk conditions, followed by medical intervention designed to reduce or eradicate the risk condition. Four categories of poor pregnancy outcomes are congenital anomalies, prematurity and low birth weight, fetal death, and maternal morbidity or mortality (Ryan, Sweeny & Solola, 1980). The aim of prenatal care is to ensure that the outcome of pregnancy is a healthy mother and baby.

If it is assumed that prenatal care can improve pregnancy outcome, it is important to understand the reasons why women do not obtain or seek care during the antenatal period. Understanding these reasons or conditions may help direct the planning process of prenatal care programs to

include those women who fail to obtain care. Perhaps then, health care for all pregnant women will be achieved.

The purpose of this study was to identify the barriers that prevent women in Arizona from receiving prenatal care. Barriers are those factors or conditions related to the failure to obtain prenatal care during pregnancy as perceived by the women involved. Joyce et al. (1983) suggests that two types of barriers inhibit women from seeking prenatal care: (1) external barriers, and (2) internal barriers. External barriers to health care include transportation difficulties and financial problems. They are overt, obvious and concrete. Internal barriers are covert and intangible. Examples of internal barriers include denial of pregnancy, fear of physicians, and depression.

This study was designed to describe the barriers to prenatal care from the point of view of those women who failed to receive care. The persons involved in the design and improvement of health care programs have rarely stopped to ask their clients what conditions make it easy or difficult to utilize services. Allowing the women involved (the experts) to identify the barriers they encountered in obtaining prenatal care is undoubtedly a useful approach to creating client sensitive health care services.

Because Maricopa County experienced a 76 percent rise in the rate of women who failed to receive prenatal

care, it was chosen as the study site. All subjects in this study were residents of Maricopa County.

The following section of this chapter describes why it is important for women to receive prenatal care. The final two sections present the purpose of the study and the conceptual framework used to guide this investigation.

Significance of the Problem

Studies published over the years have shown the direct relationship between prenatal care and pregnancy outcome. Most often, prenatal care is reported to prevent low-birth-weight babies. Low birth weight is the single largest determinant of perinatal mortality (Ryan et al., 1980).

Dott and Fort (1975) reported an inverse relationship between infant mortality and number of prenatal visits. The mortality was eight times greater for infants of mothers who received no prenatal care than for those whose mothers received nine or more visits. Furthermore, this relationship--increased risk of infant mortality as a function of inadequate prenatal care--was unchanged even when socioeconomic status and birth weight were held constant.

Eisner et al. (1979) related the proportion of births which resulted in an infant of low birth weight to risk factors ascertainable from birth certificates for single live births in the United States during 1974. The analysis showed that a pregnancy without prenatal care was

the greatest risk factor associated with low birth weight. The risk of low birth weight (less than 2501 grams) from other factors such as maternal age, maternal education, wedlock status, and interpregnancy interval was appreciable but considerably smaller.

An investigation at the Women's Hospital and Prenatal Center of Memphis, Tennessee, during 1979 studied the impact of prenatal care on pregnancy outcome (Ryan, Sweeny and Solola,1980). The study examined 3,000 consecutive records of maternity patients who delivered at the hospital and perinatal center. The women were divided into two groups that were demographically and medically similar, but different in number of prenatal visits. The first group consisted of 1,102 patients who had attended three or fewer prenatal visits (averaging 1.4 visits). The second group consisted of 2,027 women who made four or more prenatal visits (averaging 12.7). Outcomes of these two groups were markedly different in four areas:

(1) Prematurity Rate (less than 2500 grams) - The prematurity rate for the group with inadequate care was 15.8 percent while the other group's rate was 9.9 percent.

(2) Stillbirths - Stillbirths occurred at a rate of 21.8 per 1000 live births in the group with inadequate care. The rate for those with adequate care was a third of this, or 7.1 per 1000 live births.

(3) Neonatal Death Rate - The group with inadequate care had 25.6 neonatal deaths per 1000 live births, as compared with 6.1 in the group with adequate care.

(4) Perinatal Mortality Rate - The group with inadequate care acquired a rate of 47.4 perinatal deaths per 1000 live births. The group with adequate care had a rate of 13.2 per 1000 live births.

These results seem to indicate an association between perinatal outcome and the provision of prenatal care.

Donaldson and Billy (1984) conducted a study in six foreign countries participating in a maternity care monitoring project sponsored by Family Health International. Using a standard delivery sheet record, supplied in several languages, six variables including prenatal care visits were examined for their relationship to birth weight. The sample contained only those women who had term singleton live births. The study showed that the number of prenatal visits had a significantly positive effect on the probability of a woman's having a normal-birth-weight infant except in two countries, Singapore and Egypt. In Singapore the effect was positive but not significant. Problems with coding birth weight were discovered in Egypt. The net impact of prenatal care on birth weight was greater than any other of the six variables.

Hall, Chang and MacGillivary (1980) refute the inverse relationship between perinatal mortality and the

number of antenatal visits. They suggest that those women who attend prenatal visits are often married, have a stable income, are healthier, and are at low risk for poor outcome. Thus according to these authors, the efficacy of routine care cannot be established by comparisons of mortality and total antenatal visits. Rather, an investigation of the rate at which asymptomatic problems occurs despite routine care and the rate at which problems are diagnosed, missed, and overdiagnosed would be a more accurate assessment of the value of prenatal care. Their retrospective analysis of the case records of 1907 women in Aberdeen, England, assessed whether three of the most common asymptomatic complications of pregnancy were detected during routine visits. The complications considered were intrauterine growth retardation, malpresentation, and pre-eclampsia. Ample evidence of overdiagnosis and detection failure was found. They concluded that the number of prenatal visits could be decreased for the normal symptom-free woman. However, the investigators did not recommend reducing the care and attention given to women who present with problems or who are at high risk.

Breart et al. (1981) divided 2,172 women into two groups. The first comprised married women of upper social class with a low risk of prematurity based on age, obstetrical history, and general health status. The second group comprised women with an average risk of prematurity also

based upon the above criteria. Each group was divided into those who attended prenatal care at a hospital maternity unit with a policy of intensive supervision (Unit A) and those women who received the minimum legal requirement of care (Unit B). There was no significant difference between units for the low-risk group although the percentage of low-birth-weight babies was slightly lower for Unit A. In contrast, the average risk group experienced less prematurity in Unit A than in Unit B. This study shows a relationship between close supervision and pregnancy outcome. Prenatal care is an appropriate intervention for the prevention of prematurity.

The Arizona Department of Health Services (1980) conducted a study linking information on several variables from both birth certificate and death records with neonatal mortality on 386 infants in 1978. The neonatal mortality rate improved from a rate of 55.6 per 1,000 live births at zero prenatal visits to 3.2 per 1,000 live births at 15 to 19 prenatal visits. The proportion of infants who died varied by birth weight, being highest for the low-birth-weight babies and lowest for infants who weighed 4,001 to 4,500 grams at birth.

In summary, empirical studies support the relationship of prenatal care to pregnancy outcome. Empirically, pregnancy outcome is most often related to birth weight, and prenatal care is viewed as a preventive measure for

prematurity/low birth weight. Those investigators who question the relationship continue to recommend prenatal care to symptom-free women at a reduced number of visits and do not suggest reducing care and attention given to women who present with problems or are at high risk.

Statement of the Purpose

The purpose of this study was to identify the factors or conditions that prevented women in Arizona from receiving prenatal care. Barriers to utilization of prenatal care services were described from the perspective of the women who received no prenatal care. Guided open-ended interviews were used to elicit data. The subjects were identified from 1983 Arizona birth certificates indicating no prenatal care.

The research question that guided this investigation was: What barriers prevented women from receiving prenatal care in Arizona?

Conceptual Framework

The conceptual framework for this study was principally concerned with the relationship between two constructs, Barriers to Help and the Non-utilization of Resources (see Figure 1). The concepts which reflect these constructs are Barriers to Health Care and the Non-utilization of Health Care Services. At the operational level, the relationship studied in this investigation was between

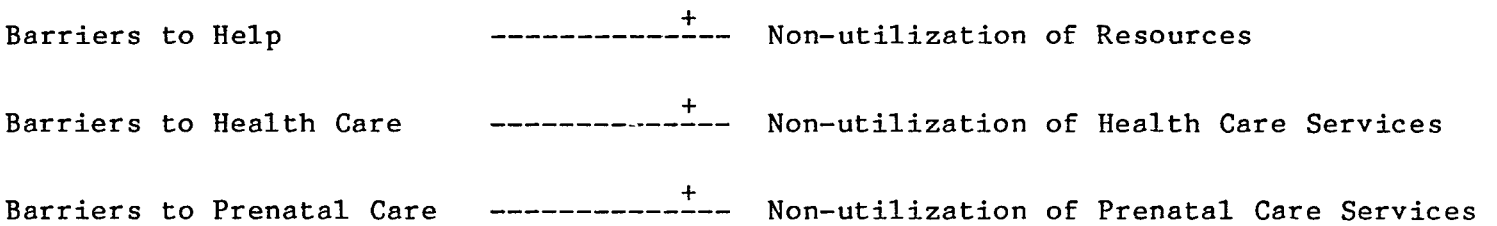

Figure 1. Diagram of Conceptual Framework for this Investigation.

Barriers to Prenatal Care and the Nonutilization of Prenatal Care Services. The following section defines the elements at each level of abstraction mentioned above, along with the relationships specified between the elements.

Barriers to Help and the Non-Utilization of Resources

In this investigation, barriers to help are those conditions (recipient, donor, aid and context characteristics) associated with the non-utilization of resources. Help is defined as "the provision of resources that facilitate attainment of a goal" (Fisher, Nadler & Whitcher-Alagna, 1982, p. 28). The words "aid" and "help" are interchangeable throughout this thesis. Non-utilization of resources is defined as the failure to accept help or to use available help.

Utilization of resources, that is, material aid, instruction, discipline, emotional support, exhortation or some other form of help is often affected by the recipient's reactions to the help offered (Fisher et al., 1982). Recipients frequently view aid as supportive and react positively by accepting aid. They may also experience feelings of failure and inferiority that result in negative reactions such as the refusal of aid.

Factors influencing recipient reactions (and, consequently, the utilization of resources) in the aid-recipient relationship have been organized into a framework described

Gergan is recipient characteristics, which includes relatively stable dispositions, or temporary emotional or cognitive states of the aid recipient. The second factor is donor characteristics, which is the behavior and attributes of the donor as perceived by the recipient. The third factor is aid characteristics, including the presence or absence of aid, as perceived by the recipient. Finally, the fourth factor is context characteristics, the situational variables surrounding the aid transaction.

Barriers to Health Care and the Non-Utilization of Health Care Services

Health Care is the provision of health services to improve the state of health and its emphasis can be preventative and/or curative. Like many forms of aid, health care is often a mixed blessing (Fisher et al., 1982). Health care may be beneficial and result in positive reactions of improved health and compliance. However, other aspects of health care such as dependency and financial strain may cause negative reactions which can result in refusal of care and dissatisfaction.

Barriers to health care negatively affect recipient reactions to health care. For the purposes of this investigation, barriers to health care are those conditions associated with the non-utilization of health care services. The conditions are defined as the characteristics of (1) the recipient, (2) the health care providers, (3) the health

care itself, and (4) the situational variables surrounding the patient-provider interaction. Non-utilization of health care is the failure to accept or use available health care services.

Barriers to Prenatal Care and the Non-Utilization of Prenatal Care Services

Prenatal care is a specialized form of health care. Prenatal care is the professional care of an expectant mother, which includes services such as health assessment, medical services, social services, nutritional services, patient education and psychological support of an expectant mother. The goal of prenatal care is a healthy mother and a healthy baby. Like other forms of health care and aid, it is intended to benefit the recipient and meet important human needs. In doing so, positive reactions to aid are likely to occur. Prenatal care may also contain negative factors such as disruption of a woman's lifestyle or financial strains that result in failure to seek or accept prenatal care services.

Barriers negatively affect recipient reactions to prenatal care. Barriers to prenatal care are the conditions associated with failure to obtain prenatal care. Conditions associated with failure to obtain prenatal care may be classified as recipient, donor, aid and context characteristics. Recipient characteristics are the dispositions, attitudes, beliefs, emotional and cognitive states, and

lifestyles of the women who failed to receive prenatal care. Donor characteristics are the behaviors and attributes of the health care providers and others (social workers, secretaries, etc.) involved in the provision of prenatal care. Aid characteristics refer to the quality and content of the prenatal care services. Context characteristics are the situational variables surrounding the health care transaction. The non-utilization of prenatal care is the failure to accept or use available prenatal care services.

Summary

This chapter introduced the problem and its significance under investigation. Statement of the purpose of this study and the conceptual framework were also presented.

CHAPTER II

REVIEW OF THE LITERATURE

The first part of this chapter presents a conceptually oriented, systematic review of the literature supporting the organizing framework of this investigation. As discussed in Chapter I, the framework comprises three levels (see figure 1), and each level is dealt with separately in the literature review. The final part of this chapter is a brief review of research on the demographic characteristics of underutilizers of prenatal care.

Barriers to Help and the Non-Utilization of Resources

Barriers to help negatively affect recipient reactions to the proffered aid. Negative reactions to aid include the refusal of help and/or negative donor or aid evaluations. Researchers have used several theoretical frameworks as tools for conceptualizing negative reactions to help: reactance theory, equity theory, attribution theories, and the threat-to-self-esteem models. Each predicts the consequences of one or more of the factors (recipient, donor, aid or context characteristics) influencing reactions to help for several modes of recipient responses (non-utilization of resources, negative donor evaluations, etc.) (Fisher et al., 1982). In the following

pages, each of the four theoretical frameworks is summarized and pertinent research relating to barriers to help and the non-utilization of resources is discussed.

Reactance Theory

According to the theory of reactance (Brehm & Cole, 1966), people strive to maintain their own freedom of choice. Applied to the phenomenon of help, reactance theory suggests that dependence on a source of help may be perceived (by an aid recipient) as a reduction in freedom. Negative feelings may develop toward would-be helpers, resulting in resistance to proffered help (Fisher et al., 1982). This negative state is termed reactance.

Reactance results in behaviors aimed at reestablishment of lost or threatened freedoms. Aid recipients may avoid any actions based on obligatory feelings toward the donor, such as returning the aid or evaluating the donor favorably. Help that poses a threat to autonomy may be rejected entirely. The amount of reactance experienced from any given threat to, or restriction of, freedom increases with the importance of that freedom to the individual. Reactance and associated negative feelings toward assistance should be least when recipients have maximum choice regarding when, where and how they are helped (Fisher et al., 1982; Brehm & Cole 1966).

In the context of reactance theory, barriers to help are those factors (donor, recipient, aid and context characteristics) which create reactance and result in decreased acceptance of help. Aid research that is related to reactance theory has primarily focused on the characteristics of aid.

When aid is offered with stipulations on its use, freedom is threatened and less aid is accepted (Fisher et al., 1982). Recipients perceive lost autonomy and control over their lives because of the type of help prescribed by the donor and the conditions associated with receipt of the aid. To test the reactance theory, sixty officials from a variety of assistance agencies (e.g., United Nations, United States Agency for International Development) and governments (22 represented) were interviewed regarding factors of importance for success of assistance programs (Gergan and Gergan 1971). Ninety percent of the officials identified recipient autonomy as an important factor in aid acceptance and success; the second most cited factor was recipient liking and respect for the donor.

Gergan, Morse and Kristeller (1973) administered a 12-item questionnaire to subjects from eight separate cultures in six different nations to determine factors affecting aid acceptance and donor attraction. Half of the subjects were questioned about their reactions to aid given with stipulations on its use (qualified aid). The other

half were questioned about their reactions to aid without stipulations (unqualified aid). In every case, acceptability of unqualified aid was high because recipient autonomy was not threatened. Acceptability of qualified aid was low because autonomy was threatened. Attraction to the donor closely paralleled acceptability of aid. In every case except one, the donor of qualified aid received negative evaluations. Aid, with stipulations on its use, can create reactance and result in low acceptance of help. Therefore, aid with stipulations acts as a barrier to itself, resulting in the failure to utilize resources.

The reactance model is not supported by some research. Reactance theory would predict that help is more restrictive when it is externally and arbitrarily imposed than when it is requested at the discretion of the recipient (Fisher et al., 1982). This prediction is not demonstrated in a study of locus of help initiation and its relationship to help utilization by Broll, Piliavin and Gross (1974). While solving a difficult logic problem, half the subjects were allowed to request help whenever they wished. The other half could accept help from consultants only when it was offered. Results indicated that 47 percent more units of help were received by subjects who were offered assistance than by those who were required to request it. Thus, having to request help may function as a barrier to aid. Reactance theory is not supported, since it was found that

more help was obtained when it was offered than when it may had been requested by the subjects.

These findings were replicated in a field study involving clients from the Aid to Families with Dependent Children (AFDC) program (Piliavin & Gross, 1977). Recipients who received services and income maintenance from one agency worker who made periodic home visits requested more help than recipients served by two separate workers. Recipients in the latter case did not see the agency workers regularly and were told to request help. The findings of these two studies show that having to request help may inhibit potential help seeking.

Reactance theory applies only when the factors associated with the receipt of aid differentially restrict perceived autonomy. Reactions to aid cannot be predicted unless the factors associated with the receipt of aid are strong enough to arouse a threat to perceived freedom. The reactance model explains a specific response to aid; there are other factors affecting responses to help (Fisher et al. 1982; Gross, Wallston and Piliavin, 1979). Therefore the reactance model is helpful but limited in its ability to identify and predict barriers to help.

Equity Theory

Equity theory (Greenberg, 1980) postulates that people want equable relationships. When an exchange between individuals is imbalanced, feelings of indebtedness are felt

by the recipients in whom receipts outweigh expenditures. The extent of the aid recipient's distress is positively related to the magnitude of the inequity experienced in the exchange (Fisher et al., 1982). This cognitive distress motivates people to restore the equity in their relationships by altering the input/outcome ratio to yield parity. One response in people who believe they are unable to reciprocate in an exchange is to refuse help. Another response is to reduce feelings of indebtedness by cognitively restructuring a situation. That is, people may disparage the help received, or they may inflate the donors' rewards for giving.

Barriers to help within the equity model are those factors which cause perceived inequity and result in low acceptance of aid. The three barriers discussed below are inability to reciprocate (context characteristic), aid that is costly to the donor (aid characteristic) and similarity or dissimilarity of the donor and the recipient (donor characteristic).

Greenberg and Shapiro (1971) predicted that a person who anticipated an inability to reciprocate help received would demonstrate more avoidance in help seeking than a person who anticipated an ability to return help. This hypothesis was tested by randomizing 48 subjects to two experimental conditions. Twenty-four of the subjects were placed in a situation where they could anticipate

reciprocating the help they requested. The other 24 subjects were in a situation in which they could not reciprocate requested help. The following were measured:

(1) The frequency of requests for help, and

(2) The amount of time in seconds (latency score) that elapsed before the requests for help were made.

Sixty-three percent of subjects in the no-anticipated-reciprocity group avoided asking for help, compared with 29 percent in the anticipated-reciprocity group. The mean latency scores in the former group were significantly greater than in the latter group. Another measure of avoidance of help was the percentage of subjects in each group that prevented a confederate from giving help beyond that necessary to complete the defined task. Seventy-five percent of the subjects in the no-anticipated reciprocity group asked the confederate to cease giving help when the task quota was achieved. This contrasts to 25 percent in the anticipated-reciprocity group. The results of this study as well as subsequent investigations (Castro, 1974; Clark, Gotay & Mills, 1974) support the prediction that inability to reciprocate help received will negatively affect future help seeking. Therefore, one may assume that an inability to reciprocate may act as a barrier to help, reducing the amount of help accepted.

Equity theory predicts that more unpleasantness is associated with the donor of costly aid because of larger

inequity from such aid (Fisher et al., 1982). If uneasiness is associated with the donor and he is blamed for creating inequity, it is less likely that the recipient will interact with the donor again. Castro (1974) showed that in the event of costly aid (to the donor), subjects were less willing to request future aid when they could not reciprocate than when they had the opportunity to return the help received. When cost to the donor was perceived to be low, there was no difference in willingness to ask for future aid between those who had the opportunity to reciprocate and those who did not. Subjects were also less willing to request future aid from a third person, following the receipt of costly aid (from the donor), especially when there was no opportunity for reciprocation. These results suggest that unless the recipient has restored equity in his relationship with the donor, he is unwilling to create further inequity by requesting future aid from the donor or other people. Aid that is perceived to be costly to the donor creates inequity and therefore acts as a barrier to help and results in the non-utilization of resources.

Another variable that may influence willingness to accept aid from a potential helper is how similar to oneself the donor is perceived to be. In a study conducted by Clark, Gotay and Mills (1974), college students were teamed up with a confederate of the same sex whom they were led to believe had highly similar values (similar conditions) or

highly dissimilar values (dissimilar conditions). The students were given a task of making an object from balloons while being observed by the confederate. Once the balloon project was finished, the confederate was expected to make an object from wire coat hangers already unwound (no opportunity to repay conditions) or not unwound (opportunity to repay conditions). In preparation for the students' task, the balloons had to be inflated, and the confederate offered to help. The measure of acceptance of help by the college students was the number of balloons the student gave the confederate. Findings of this study corroborate the researchers' hypothesis that acceptance of help when there is anticipated opportunity to repay is greater when the potential helper is similar than when he is dissimilar. The mean number of balloons given to the confederate in the similar-opportunity-to-repay condition was greater than in the dissimilar-opportunity-to-repay condition. Also corroborated is the hypothesis that acceptance of help with no anticipated opportunity to repay is greater when the potential helper is dissimilar than when he is similar. The number of balloons given in the dissimilar-opportunity-to-repay condition was less than in the dissimilar-no-opportunity-to-repay condition. The recipient's desire to maintain equity in relationships and to avoid inequitable relationships is strong when the donor is similar, but not when donor and recipient are dissimilar. Inequitable exchanges

(no opportunity to reciprocate) function as barriers when the donor is similar to the recipient but not when the donor is dissimilar.

Equity theory suggests that any helping relationship that results in greater relative outcomes for the recipient than for the donor produces indebtedness (Greenberg, 1980). This indebtedness can be resolved through reciprocity, refusal of future aid, and/or derogation of the aid or the helper. As with reactance theory, the equity model may not predict actual reactions to aid. A study conducted by Freeman (1977) showed that given the opportunity to compare offers of aid, individuals were most attracted to the donor who offered the highest benefits at the least cost. Recipients were likely to accept large rather than small amounts of aid. This conflicts with equity theory predictions that one should be increasingly likely to avoid help as it leads to greater inequity.

Attribution Theories

In contrast to the theories of reactance and equity which view the aid recipient as a passive individual contending with loss of freedom or inequitable interactions, attribution theories view the recipient as actively attempting to understand the helping interaction (Fisher et al., 1982). Attribution theories are concerned with the analysis of causal explanations, that is, how an individual

ascribes a cause to an effect (Kelley & Michela, 1980). The recipient wants to understand the donor's behavior, his own behavior, and the aid situation. Attribution research makes use of two theoretical frameworks, the theory of correspondent inferences and the theory of external attribution (Fisher et al., 1982).

The theory of correspondent inferences examines the causes an observer attributes to the problems of another person (Jones & Davis, 1965). In the context of the helping interaction, this theory provides a conceptual framework for understanding the recipient's evaluations of the donor and his perceptions of the donor's intent (Fisher et al., 1982). Donor intent, as perceived by the aid recipient, may act as a barrier to help. If the donor appears to be giving primarily to serve his own ends, his help is not appreciated nor are his programs supported. For example, when recipient nations do not agree with American foreign policy, they are more likely to make attributions of manipulative intent for the aid and fail to accept it and fail to accept it (Gergan & Gergan, 1974).

The theory of external attribution examines the causes people construct to explain events happening to themselves. External attribution theory predicts that an individual will ascribe to an event either external causes (relating to his environment) or internal causes (relating to himself) (Kelley, 1967). Applied to the helping

interaction, the recipient may conclude that his need for assistance is caused by external situational factors (e.g., task difficulty) or by internal dispositional factors (e.g., one's personal inadequacy) (Fisher et al., 1982).

Tessler and Schwartz (1972) hypothesized that help is more likely to be sought when attribution for failure is external rather than internal. In their study of 126 male subjects, they manipulated locus of attribution by varying two elements in the instructions so that poor performance on a task would be perceived as externally determined or as reflecting on self deficiencies. Eighty percent of those in the external attribution group sought help during the task, compared with 44 percent of those in the internal attribution group. Negative internal attributions reflecting self deficiencies function as barriers and inhibit the utilization of resources.

The research described earlier in this chapter, by Broll, Piliavin and Gross (1974) and Piliavin and Gross (1977), supports the relationship between internal attribution and less help seeking. Less help was obtained when aid had to be requested by recipients than when it was offered. An attributional explanation of these findings is that acknowledging need by making requests for assistance leads to internal attributions of personal failure or inadequacy. These negative internal attributions function as barriers and inhibit the utilization of resources. Offered help is

less likely to cause internal attribution than is requested help.

Thus the attributional framework suggests that recipients who perceive their need as internally motivated instead of caused by external circumstances may attribute negative characteristics to themselves. Negative internal attributions such as incompetence and inadequacy act as barriers to help.

Threat to Self-Esteem

The final framework used by researchers to conceptualize reactions to aid is the threat to self-esteem model (Fisher et al., 1982). The threat to self-esteem model assumes (a) "that most aid situations contain a mixture of positive and negative self-related elements, and (b) that the conditions associated with the receipt of aid determine whether receipt of aid is experienced as predominantly threatening or supportive" (Fisher et al., 1982, p. 47). The conditions associated with receipt of aid are defined as aid characteristics, donor characteristics, context characteristics and recipient characteristics.

Five hypotheses are presented in the threat-to-self-esteem model (Fisher et al., 1982). The first hypothesis states that there are three sources of positive and negative self-related information inherent in aid relations: (1) self-relevant messages contained in aid itself, (2) values

instilled during socialization, and (3) instrumental qualities of aid.

First, the aid recipient may receive positive or negative self-relevant messages about himself from characteristics of the aid-recipient transaction. These characteristics include the qualities of the donor, the manner in which the aid is given and the type of help offered. For example, highly positive and supportive messages are sent to the recipient when the donor is genuinely concerned about the recipient. Highly threatening messages may result when the donor does not respect the recipient and views him as being unworthy of help (Fisher et al., 1982).

Second, there are three western cultural values relevant to the receipt of aid. The first common value is that people should be independent and self-reliant (Weber, 1930). Help that fosters independence and freedom is supportive. Help that restricts freedom of choice or action is threatening. This value assumes that people should be able to care for themselves. Assistance in an area where an individual is expected to have basic competence reflects failure and results in a threatening message to the recipient. When an individual is not expected to have a basic competence, receipt of aid is not equated with failure and may be supportive (Fisher et al., 1982).

The second common value is the belief of equity in social exchange (Greenberg, 1980). People are socialized to

believe that they should deal fairly with others. As described in equity theory, aid recipients aim to maintain fair relations with donors. When aid recipients are unable to reciprocate, they experience self-threat. If the opportunity to reciprocate occurs, then the aid may contain supportive elements (Fisher et al., 1982).

The third common value is that people should treat others fairly. Aid that exploits or takes advantage of the recipient conflicts with this value and results in self-threatening messages. Fair treatment in an aid transaction is congruent with this value and contains supportive elements (Fisher et al., 1982).

The final source of self-relevant information inherent in aid are the instrumental qualities of aid. This refers to such attributes as the amount and efficacy of aid. Aid that is self-supportive for the recipient provides the opportunity to overcome the current problems and enables them to avoid future dependency. Aid that is self-threatening (1) emphasizes the failure and relative inferiority of the recipient, (2) is inadequate to meet the current problem, and (3) suggests lack of donor concern (Fisher et al., 1982).

The second hypothesis of the threat to self-esteem model states that the aid characteristics, context characteristics, and donor and recipient characteristics associated with the receipt of aid determine whether it is a

supportive or a self-threatening experience. These factors specify the extent to which aid is experienced (1) as containing a positive or negative self-relevant message, (2) as consistent or inconsistent with socialized values, and (3) as meeting or failing to meet the individual's needs (Fisher et al., 1982).

Hypothesis three states, "Other things being equal, whether aid is predominantly self-supportive or threatening determines reactions to aid" (Fisher et al., 1982, p. 49). When aid is predominantly self-threatening, negative reactions to aid occur. Negative reactions to aid are lowered self-concept, negative donor and aid evaluations, low acceptance of aid and increased self-help behavior. When help is predominantly supportive, it elicits positive non-defensive reactions. The positive reactions to aid are enhanced self-concept, positive donor and aid evaluations, high acceptance of aid, and decreased self-help behaviors (Fisher et al., 1982).

The fourth hypothesis suggests that elements of self threat and support mediate between the aid-related conditions and the recipient's reactions to aid (Fisher et al., 1982). Individuals with high and low self-esteem respond to aid differently (Nadler, Altman and Fisher, 1979).

A fifth hypothesis asserts that the intensity of the positive or negative reactions to aid is determined by the degree to which aid is predominantly self-supportive or

threatening. To the extent that the help offered is perceived as supportive, positive responses become more numerous and/or intense. Likewise, aid perceived as threatening will elicit more negative responses (Fisher et al., 1982).

Barriers to help within the threat-to-self-esteem model are those conditions that create self threat and result in decreased help-seeking or acceptance of aid. The following research studies highlight the major role that barriers to aid may play in determining recipient use of resources.

The threats of dependency and perceived inferiority act as barriers to seeking help. Durian and De Paulo (1977) created a situation in which subjects could improve their performance on a spelling test by seeking advice from an assigned helper. Half the subjects were assigned adult helpers. Helpers for the remaining half were children. A pre-experimental manipulation was successful in leading the subjects to believe that the child helpers were at least as competent at spelling as the adult helpers and more competent than the subjects to whom they were assigned. The investigators found that subjects were less willing to accept help from children than from adults. Postexperimental interviews revealed that the adult subjects perceived that asking for help was an admission of

inferiority. They found it particularly embarrassing to acknowledge inferiority to a child.

There is cross cultural evidence that threat to self esteem affects willingness to accept aid (Gergan, Morse and Kristeller, 1973). A questionnaire administered to 579 individuals from eight separate cultures revealed that aid which does not engender feelings of inferiority to the donor was preferred. Aid was also more acceptable on a task in which the subjects felt no pride compared to one in which they took pride. Recipient acceptance of aid is negatively affected by the characteristics of aid that may generate feelings of inferiority.

Characteristics of the donor such as physical attractiveness and level of resources have affected the utilization of resources. Nadler (1980) conducted an experiment in which 40 female subjects could request help from another female on a test of rare Hebrew words. Subjects were given photographs which depicted a physically attractive helper or an unattractive helper. Half of the subjects expected to meet their helpers face to face. The remaining half expected no future encounter with their helpers. Subjects sought less help from physically attractive than from unattractive helpers. Expectation of meeting with the helper also adversely affected help-seeking behavior. Experimental analysis indicated that less help

was requested from a physically attractive helper when a face-to-face interaction was expected.

Findings from Nadler's study (1980) suggest that when the subject was deciding whether or not to request assistance, the expectation of a meeting made self-presentation concerns relevant. Subjects seemed relatively unwilling to expose their inadequacy by seeking help. Physical attractiveness in the situation where self-presentation concerns are relevant (i.e., in the case of expected encounters) acts as a barrier to help. That is, physical attractiveness threatens one's public self-esteem resulting in negative reactions to aid.

Donor resources can determine the self-supporting or self-threatening nature of aid and resultant utilization of resources, according to a study conducted by Fisher and Nadler (1976). They hypothesized that aid which represents relatively high cost to the donor conveys positive information of donor liking and concern, which should be a self-supporting experience for the recipient. Low cost aid to the donor should be a self-threatening experience since it serves to stress the relative failure and dependency of the recipient. Low cost aid also fails to provide the self-supporting elements of donor liking and concern. During their experiment, called the Stock Market Game, Fisher and Nadler (1976) found that subjects who received monetary assistance from a low resource donor (high donor cost)

perceived themselves more positively and engaged in less self-help than did subjects who received no funds from their potential low resource donor. Subjects who received monetary aid from a high resource donor (low cost aid) perceived themselves less positively and engaged in more self-help behavior than did participants who received no assistance from a potential high resource donor. Low cost aid is self threatening and results in decreased utilization of resources.

Several recipient characteristics are associated with the nonutilization of resources. Recipients who have strong ego involvement with tasks are more threatened by aid and utilize fewer resources than those who have less involvement. Recipients in whom autonomy and individual achievement are central to their self-concept also seem to be more threatened by aid. Recipients sensitive to negative covert cues given by donors are threatened by the implications of aid and may fail to utilize resources. The following research studies illustrate these barriers to help.

De Paulo and Fisher (1980) studied the effects of self-concept and task ego involvement on help seeking. Sixty-four college women were asked to evaluate 30 expressive photographs consisting of bodies and faces and 30 transcripts also describing people. Subjects chose an appropriate label to describe each photo and transcript from a set of response alternatives. Less help was sought in labeling the photographs and transcripts by women with

college majors in which interpersonal sensitivity (sensitivity to the feelings and emotions of others) was more likely to be highly valued than was sought by subjects with majors in which interpersonal sensitivity was not as relevant. Subjects who asked for help expected the helper to view them as less competent in performing the task. When competence in task performance is important to an individual's self-esteem, it inhibits acceptance of help.

Experimental findings by Tessler and Schwartz (1972) suggest that the threat to self-esteem inherent in seeking help often serves as an inhibitor. In their study, 48 subjects were asked to evaluate the neurotic quality of dialogues presented to them. The subjects' evaluations were then compared with those of a team of clinical psychologists. Subjects were told they could consult a set of guidelines on how to identify neurotic interactions if they felt they needed help. The experimental conditions in which subjects were placed consisted of two levels of centrality (low and high) and two loci of attribution (external and self). Central attributes were assumed to be functionally linked with an individual's self-concept. Centrality was manipulated by varying whether or not the act of seeking help to perform the task shed doubt on two attributes, intelligence and mental health. Locus of attribution was manipulated by varying two elements in the task instructions. Subjects in the external attribution condition were

led to believe that the use of the guidelines was a common phenomenon, and the training procedure was poorly developed. Those in the self-attribution condition were led to believe that use of the guidelines was unusual for most people, and that the training procedure was quite adequate. Subjects were divided into high and low esteem groups according to results on the Rosenberg self-esteem scale. Results of the Tessler and Schwartz study showed that none of the participants with high self-esteem who were exposed to the high centrality and self-attribution manipulations sought consultation of the guidelines. Seeking help was inconsistent and threatening to important self-conceptions. Admission of a need for help was perceived as threatening and acted as a barrier to help seeking. In contrast, all of the low self-esteem subjects exposed to the external attribution and low centrality conditions consulted the guidelines. Subjects low in self-esteem were equally likely to seek help under low or high centrality conditions. There was no inhibition of help seeking when failure did not reflect on central attributes or when the subject held a low evaluation of herself.

In the same study, Tessler and Schwartz (1972) hypothesized that subjects whose need for achievement exceeded their fear of failure at a task were less likely to consult the guidelines than those whose fear of failure outweighed their need for achievement. For these

researchers, achievement motivation was an orientation to obtaining gratification from performing up to a standard of excellence. Gratification was hypothesized to arise from the subject's knowledge that having excelled was evidence of one's own effort and not evidence of overt signs of success. Results indicated that achievement motivation was strongly and negatively related to help seeking. Participants whose need for achievement exceeded their fear of failure were less likely to consult the guidelines than those whose fear of failure exceeded their achievement needs. The need for achievement functions as a barrier to help, resulting in the nonutilization of available resources.

In the helping interaction, a helper may facially express polite compliance while leaking feelings of resentment or annoyance through body language. People sensitive to these covert cues communicated in body language who fail to read the overt facial messages of helpfulness may refrain from requesting help. The relationship between help seeking and sensitivity of the recipient to covert and overt nonverbal cues was studied by De Paulo and Fisher (1981). Sixty-two female subjects were divided into high and low helpseekers according to the total number of requests for help during an assigned task. Sensitivity to facial and bodily cues was determined by ability to correctly label photographs of the face and body of a woman portraying a number of different everyday life situations. High help

seekers were significantly more accurate than low help seekers at interpreting facial cues. However, high help seekers were only slightly less accurate at reading body cues. Sensitivity to negative covert messages from helpers acts as a barrier and may result in the failure to request help.

The threat-to-self-esteem model subsumes the earlier models of reactance, equity and attribution in its predictions of reactions to aid. Reactance theory specifies that limitations on perceived freedom elicit the psychological state of reactance, which creates negative responses to aid. Equity theory predicts that inequitable exchange relations produce discomfort. Both theories are subsumed within the more comprehensive framework of the threat-to-self-esteem model. The first hypothesis of the threat to self-esteem model states that self-reliance and equity in exchange relations are important socializing values. Violation of these values affects one's self-esteem and reactions to aid (Fisher et al., 1982).

Attributions of donor intent also may relate to self-support and/or self-threat. Positive donor motivation may imply liking and respect, which has obvious self-related consequences. When the locus of attribution of failure is internal, threat to one's self-concept may occur (Fisher et al., 1982).

The threat to self-esteem model predicts when aid will be self-threatening or supportive. The model specifies the relationship between self-implications of help and reactions to the help. The threat-to-self-esteem model is more comprehensive than the earlier models. Research from the earlier models supports this new model and current research continues to define further variables responsible for reactions to aid (Fisher et al., 1982).

An important caveat is that these four theories are only attempts to explain real life behaviors in the helping interaction. The evidence used to support these theories was partly derived from highly controlled experimental studies. Such laboratory studies may not be pertinent to the more complex situations of real life.

Through the review of literature on reactions to aid and the theoretical approaches used, the concepts of Barriers to Help and their relationship to the Non-utilization of Resources have been discussed. Barriers to help are those conditions (aid, donor, recipient, context and aid characteristics) associated with the failure to utilize resources. The non-utilization of resources is the failure to accept help or use available help.

Barriers to Health Care and the Non-utilization of Health Care Services

Individuals seek health care as a result of some cue (Ostrove & Baum, 1983). Those seeking care for curative

reasons experience cues such as pain, unusual symptoms and illness. Preventive cues may come as messages from health providers, peers or the media. There are three possible responses to the cues received: getting help, not getting help, or waiting to monitor the cue. The choice of response is dependent upon an analysis of two kinds of cost to the individual. The first involves the cost of not seeking health care. The cost of not seeking help increases as symptomatology and disruption of daily life worsens. Thresholds of cost may differ according to the culture, socioeconomic status, education, etc., such that some people will seek help sooner or later than others; for example, the lower income person is more likely to seek medical relief at an advanced stage of illness than his higher income counterpart (Strauss, 1969). The costs to one's health must become sufficient to warrant and outweigh other costs (Ostrove & Baum, 1983).

The second cost involved in the decision to obtain health care is the elements involved in seeking help (Ostrove & Baum, 1983). The cost of seeking health care is minimal if it is easily accessible, if the financial obligations are within the individual's budget, and if the cost causes little disruption of one's life routine. However, costs of obtaining health care may outweigh the costs of not seeking help if access to health care is difficult, involves long waits in an office, and results in financial burdens.

It is important to note that health care is not always defined as "western medicine" by the patient. In some cases, self care (e.g., over-the-counter medications) and folk practitioners (e.g., "*curanderos*" among Spanish-speaking people) may provide relief for an individual. Regardless of the form of care obtained, decisions to seek care seem to be related to an individual's analysis of costs (Ostrove & Baum, 1983).

Within the cost analysis framework (Ostrove & Baum, 1983), barriers to health care are those conditions/costs that outweigh the perceived benefits or the reliefs obtained through health care. The conditions are defined as characteristics of (1) the health care itself, (2) the situational variables surrounding the patient-provider interaction, (3) the health care provider, and (4) the recipient. When the barriers outweigh the perceived benefits, health care is not obtained.

Barriers to health care are reviewed briefly within three broad explanations for the non-utilization of health care services. These explanations include (1) the financial constraints explanations, (2) the culture of poverty explanation, and (3) the systems barrier explanation (Dutton, 1978).

Financial Constraints

Explanation

The poor or low income populations cannot afford to purchase the health care services they need (Dutton, 1978; Rundall & Wheeler, 1979). Their incomes are low, and they usually do not have insurance. A family's income may be just slightly higher than the income definition of eligibility for public health care assistance programs. Thus, an individual's financial status can act as a barrier to health care.

Medicare and Medicaid have been credited with improving access to medical care for the low-income elderly and medically indigent populations (Aday, 1975). Individuals covered by these programs do utilize health care services more than their uninsured counterparts. However, there is evidence that relative to their respective need for care, the poor, even though insured, continue to use fewer services than those who can afford it.

Culture of Poverty

The "culture of poverty" has been used in explaining the use of health services (Dutton, 1978; Rundall & Wheeler, 1979). According to this perspective, the lifestyles, attitudes and cultural characteristics of people, particularly the poor, may act as barriers to utilization of health care. The lower income person's life is dominated by a crisis existence. Concerns about preventative care or early

symptomatology often seem empty or minor to those who feel they confront more pressing troubles (Strauss, 1969).

Since its initial formation by Oscar Lewis (1966), the culture of poverty explanation has been challenged on various grounds by Dutton (1978) and Langlie (1977), among others. Still, many investigators (Rundall and Wheeler, 1979; Becker et al., 1977) continue to support the importance of attitudes and values as factors in determining the utilization of health care.

In a prospective study (Becker et al., 1977), 250 low socioeconomic women were interviewed about their attitudes and beliefs toward preventive care interventions. Attitudinal measures were correlated to the mothers' utilization of clinic services for their children. The three dimensions of utilization used were (1) well-child visits for preventive care, (2) acute illness visits, and (3) accident-related visits.

Becker et al. (1977) found that mothers with an activist attitude of preventive health care brought their children to the clinic for more well-baby checks than those who revealed a passive attitude. These mothers attributed good health and low illness susceptability to their children and generated few illness/accident visits. In contrast, children of mothers with a passive and fatalistic attitude toward health care made fewer well-child visits and more acute illness/accident visits. Medical care was sought when

the impairment of bodily function became obvious, or great, or outweighed the costs of not seeking care. The acceptance of ailments as natural to living and aging (fatalistic attitude) acts as a barrier to health care utilization.

Systems Barrier

The systems barrier theory holds that low health care utilization by the poor is attributable to problems inherent in the health care systems they patronize. Dutton (1978) examined the relative importance of the three explanations for low use of health services by the poor: (1) the financial coverage explanation, (2) the culture of poverty explanation, and (3) the systems barrier explanation. Using interview data and medical system data from a sample of 681 families, a multiple regression model of ambulatory care use was developed by sequentially adding groups of variables representing each of the three explanations. Dutton concluded that financial considerations and attitudinal problems have been overemphasized as important in explaining underutilization of health services by the poor. Instead, her analysis gives importance to inadequacies in delivery systems used by the poor. The poor use "public" sources--hospital outpatient departments, emergency rooms and public clinics. Such public sources may be costly. Organizational problems are common. The emphasis is disease oriented rather than preventive, and the atmosphere is often dehumanizing. Dutton concluded that inequity

in health care used by the poor could not be improved without structural improvements in existing health care delivery systems.

Culturally incompatible health care policies can lead to non-utilization of health care services. In Saraguro, Equador, a new community hospital instituted a free maternal hospitalization policy (Finerman, 1984). Only 5 of 304 births took place in the hospital despite the policy. Ninety-two percent were delivered at home. The population of Saraguro consisted primarily of Quichua Indians. In interviews, the Quichua women revealed that the indigenous views of parturition were radically different from those of the hospital and professional providers. The high psychological and ideational costs of delivering a baby in the hospital, and failure to correct incompatible policies, resulted in community rejection of the new health care services.

Negative characteristics of health services used by the poor may be barriers. These negative characteristics outweigh the cost of not seeking care.

Barriers to Prenatal Care and the Non-Utilization of Prenatal Care Services

The research supporting the third level of the conceptual framework classifies barriers into two groups: external and internal barriers to prenatal care. External barriers are overt, obvious and concrete. Examples of

external barriers include transportation difficulties, financial problems and health care system idiosyncracies. Internal barriers are covert and intangible. Internal barriers include denial and concealment of pregnancy, fear of physicians, and depression. The following text presents research done on the barriers to prenatal care and the non-utilization of prenatal care services.

A study conducted among a predominantly Spanish lower socioeconomic group in San Antonio, Texas, classified the reasons 1,323 women gave for lack of prenatal care attendance into situational and attitudinal factors (Gibbs, Martin & Gutierrez, 1974). Situational factors included those concrete reasons of cost, problems with child care and transportation, and inconveniences created by the health care system. Attitudinal factors consisted of strong concerns or fears regarding physical exams and expressions of personal indifference. Also included in attitudinal factors was the desire of women under 14 to conceal their pregnancies. Two thirds of the women interviewed indicated situational factors; the remainder (35 percent) cited attitudinal factors. The two most common patterns of utilization of antepartum services among these subjects were women of some parity who made one to three visits after 32 weeks, and those who sought care early for a specific symptom and who then did not return again until near term.

Slatin (1971) interviewed and studied a sample of 64 women who received no prenatal care and found that 30 percent did not feel that prenatal care was important. Forty-seven percent reported concrete reasons for no prenatal care, such as problems of transportation and cost. New association with the community was identified by 9 percent of the women. After intervening to correct for some of the concrete barriers to care identified by the original sample, another 16 women were interviewed. Although the overt problems were corrected, covert problems persisted with prenatal care attendance. This suggests that health providers must discover the nature of those less tangible reasons women do not seek care in order to improve utilization of prenatal care services.

Parsons and Perkins (1982) identified three types of non-users of prenatal care services. These were "frightened teenagers," competent childbearers, and those with social problems. Eleven of the 22 women interviewed were classified as "frightened teenagers." All of these mothers were single, 9 were primiparas, 3 were in their early twenties, and the remainder were in their teens. The common factor shared by these women was fear of revealing their pregnancy. This fear was great enough to effectively prevent them from obtaining care. Nine women were categorized into the competent childbearers group. All of them were married. These women recognized no need for professional help since they

had no problems with their pregnancies. Only two women fell into the social problems category. Both had obstetrical histories and social problems which ably interfered with their use of prenatal care.

In 1979 a prenatal care survey of 82 maternity patients who had attended a Maricopa County Health Department prenatal clinic and delivered at Maricopa County General Hospital was conducted to determine barriers to early and continuing prenatal care (Ayres, 1980). The questionnaire consisted of yes-or-no type questions and short answer responses. Thirty-five percent of the responses indicated that prenatal care had no value to the women. Sixteen percent of the responses indicated that the women did not know services were available. Other barriers listed included inability to get a prenatal care appointment, transportation and financial problems, unpleasant experiences at the clinic, lack of citizenship, and denial of pregnancy.

Data regarding utilization of prenatal care and other variables are stored on a perinatal file collected prospectively for all women who deliver at Cleveland Metropolitan General/Highland View Hospital. Patients reporting no prenatal care are referred for an OB/GYN Social Services evaluation in the postpartum period. Joyce et al., (1983) abstracted the reasons women did not receive prenatal care from these hospital records and social workers' notes.

The ethnic composition of the women whose charts were sampled consisted of 54 percent non-white and 46 percent white. Sixty-one percent were single, 23 percent were married, and the rest were separated or divorced. The mean age was 23, with a range of 15 to 40 (Joyce et al., 1983).

The reasons collected from the chart review were collapsed into three categories: internal barriers, external barriers, and no reason/felt fine. Internal barriers consisted of items such as depression, denial of pregnancy, fear of doctors, and unplanned pregnancy. External barriers included financial problems, lack of transportation, no child care, inability to obtain clinic appointment, and too long a wait in clinics. The category "no reason/felt fine" included women who stated that they had no particular reason for not seeking care or they indicated no problems with their pregnancies (Joyce et al., 1983).

Most women (47 percent) identified internal barriers that prevented their participation in prenatal care. Fifty percent of the teenaged and 52 percent of the young adult women indicated internal barriers to care, compared with 33 percent of the adult and older group. More adult and older women fell into the no reason/felt fine group. Twenty-three percent of the entire sample indicated external barriers as the deterrents to care (Joyce et al., 1983).

This study shows that concrete problems such as transportation, child care, and finances still present problems. More significantly, it begins to identify the more complicated and less tangible reasons, the internal barriers, to utilization of prenatal care services.

Characteristics of Underutilizers

The final section of this literature review presents some of the research describing demographic characteristics of women who failed to utilize maternal health care services. The demographics of the sample in this study are similar to those in other studies.

An exploratory study conducted by McKinlay & McKinlay (1972) compared the social characteristics of lower working class utilizers and underutilizers of maternity care services. The sample consisted of 48 women classified as underutilizers and 39 women classified as utilizers. A woman was considered an underutilizer if she: (1) had no prenatal preparation, or (2) attended for some form of care after 28 weeks but not before, or (3) was an emergency admission during labor without previous prenatal care, or (4) defaulted from clinic appointments more than three times consecutively. A woman was considered a utilizer if she: (1) attended the clinic for her first antenatal visit before 18 weeks gestation, and (2) having had her pregnancy confirmed, attended regularly for antenatal care. Subjects

were interviewed four times over a period of a year and a half.

Cluster analysis of the variables revealed that underutilizers of maternity care demonstrated an unstable pattern of housing. These families were dependent upon provision of housing by a succession of relatives until public housing became available. Husbands of these women showed unstable patterns of employment. The women were more often pregnant before marriage took place. Underutilizers appeared to sustain a "crisis" existence, being threatened constantly by a lack of permanent accommodation, overcrowding, marital instability, and financial difficulties (McKinlay & McKinlay, 1972).

Women classified as utilizers had stable independent housing arrangements, moving only once after marriage. All the utilizers' husbands were fully employed and working overtime. A large majority of women themselves were employed as well. Marriages were usually planned and seldom followed prenuptial conception (McKinlay & McKinlay, 1972).

Adolescent women seek less prenatal care than older women, both having fewer visits and starting later in pregnancy (Dott & Fort, 1976). Hendry and Shea (1980) divided a sample of 22 mothers into two groups. Group A mothers were 14 to 16 years of age at the time of delivery. They were all unmarried, had used no contraception, and all of their pregnancies were unplanned. Group B mothers ranged in age

from 25 to 38 years at the time of delivery; all were married; eight used no contraception; eight of the eleven pregnancies were planned.

The adolescent mothers made an average of 9.0 prenatal visits as compared with 12.1 visits made by adult mothers. The teenagers began prenatal care between the eighth and twentieth weeks. First prenatal visits for the adult mothers occurred between six and ten weeks gestation. Although mean birth weights were very similar, the mean APGAR scores at one and five minutes were higher by 1.3 and 0.6 for the adult mothers.

In 1972, France instituted a program designed to reduce perinatal mortality and morbidity by providing free prenatal care. Blondel, Kaminski and Breart (1980) conducted a study to evaluate the effectiveness of the program between 1972 and 1976. Interviews with the women taking place six days after delivery used a standardized questionnaire regarding their pregnancies, antenatal care, previous pregnancies, and sociocultural characteristics. In 1976 they found that women younger than 20, or those with a premarital conception or with a short interval between the first two births, or women of high parity continued to lack adequate prenatal care. In 1972, as well as in 1976, the level of care was also closely associated with the social class of the children's fathers. Women married to professionals, management personnel, clerical workers or shop

assistants were more likely to have adequate prenatal care. Women married to self-employed workers and unskilled workers continued to have no or poor care.

Greenberg (1983) explored the interactions between prenatal care and maternal race and education. He found that at each education level, a greater proportion of black women versus white women failed to seek prenatal care. Within these two racial groups a larger proportion of less educated women failed to obtain prenatal care. This study suggests that maternal race and education may have influence, each separately, on prenatal care utilization.

Finally, Scott-Samuel (1980) states that there are two broad groups of dissatisfied users of antenatal care services. Members of the first group believed prenatal care should be more patient centered and should enlist the full participation of the woman in her pregnancy by allowing her to make choices in her care management. The second group of dissatisfied nonutilizers was demographically described. This group comprises the youngest and the oldest age groups of fertile women, those of zero and high parity, the unmarried, and those of low social class.

Summary

This chapter reviews the literature supporting the conceptual framework for this investigation. First, barriers as they relate to the nonutilization of resources were discussed within four theoretical frameworks: (1)

reactance theory, (2) equity theory, (3) attribution theories, and (4) the threat-to-self-esteem model. Second, barriers as they relate to non-utilization of health care were discussed. A cost analysis model was presented. Third, research specific to barriers to prenatal care was introduced. Finally, studies pertaining to the demographic characteristics of non-utilizers of maternal care were presented.

CHAPTER 3

METHODOLOGY

This chapter presents the research design and plan for data analysis of this investigation. Details regarding the setting, sample selection, operational definitions, protection of human subjects, research protocol, validity, reliability and limitations of the study are also explained.

Research Design and Data Analysis

An exploratory-descriptive design was chosen to answer the question: What barriers prevent women from receiving prenatal care in Arizona? The exploratory-descriptive design was selected to generate qualitative data on the nature of the barriers which have been largely unexplored in this population.

In exploratory research, the subjects are considered the experts. The researcher becomes the student, willing to learn from the "experts." In this investigation the experts were the women who were recorded as not receiving prenatal care on 1983 Arizona birth certificates. These women were considered the experts because they live in the situation being studied (failure to obtain prenatal care), and they were capable of describing the conditions relating to the non-utilization of prenatal care.

This study was conducted to find out what the barriers to prenatal care were from the perspective of the women who did not receive prenatal care. Data were obtained directly from the women through guided open-ended interviews. An open-ended interview was selected to elicit free responses from the clients rather than an interview limited to stated alternatives. Lofland (1971) states the following rationale for using semi-structured interviews:

> Its objective is not to elicit choices between alternative answers to preformed questions, but rather, to elicit from the interviewee what he considers to be important questions relative to a given topic, his descriptions of situations being explored. Its object is to carry on a guided conversation and to elicit rich, detailed materials that can be used in qualitative analysis. Its object is to find out what kinds of things are happening, rather than to determine the frequency of predetermined things that the researchers already believe can happen (pp. 75-76).

A structured questionnaire would have limited the investigation to the identificattion of barriers to those listed. Interviewing the women involved and allowing them to explain what the barriers were helps to provide relevant information for questionnaire development.

The transcribed interviews and field notes were analyzed by content analysis. Content analysis is any technique for making inferences by systematically and objectively identifying specified characteristics of messages (Holsti, 1968, p. 601). The most common application of content analysis has been to answer the question of "what,"

that is, to describe the characteristics of the message's content (Polit & Hunger, 1983, p. 345).

There are three general steps in performing content analysis. First, the analyst selects the variables or concepts to be recorded and the unit of analysis. The next step is the development of a category system for classifying units of content. The researcher may develop an original category system based on the data, an established classification system, or a combination of the two. Finally, enumeration of recorded occurrences of the units of analysis in each category is used to quantify the qualitative materials (Polit & Hunger, 1983).

The quality of content analysis is as good as its categories. Each category created must answer the research question. Categories must be mutually exclusive. Therefore, every category must be completely and thoroughly defined. The categories must be exhaustive. If a miscellaneous category is included, it should account for a very small percentage of all the data analyzed (Budd, Thorp & Donohew, 1967).

In this investigation the concepts recorded were the barriers to prenatal care. Referential units from the transcribed or field note data were used as the units of analysis. Referential units are defined as "particular objects, events, persons, acts, countries, or ideas to which an expression refers" (Kreppendorff, 1980, p. 61). The

classification categories were derived from the data and the literature. A demographic description of the sample was also collected.

The following operational definitions were used in this investigation.

Subject

For the purpose of this study, the subjects are mothers from Maricopa County who received no prenatal care in 1983, as indicated on their infants' birth certificates.

Prenatal Care

Prenatal care is the professional care of an expectant mother which includes services such as health assessment, medical services, social services, nutritional services, patient education and psychological. This can be provided through private medical services and/or public assistance medical aid programs.

Barriers to Prenatal Care

Barriers to prenatal care are those conditions, stated in interviews, that prevented the subjects from obtaining prenatal care.

Non-utilization of Prenatal Care

The non-utilization of prenatal care was the failure of the subject to visit a health practitioner routinely throughout her pregnancy.

Setting

The location of the interviews was established when the subjects gave their consent to participate in a research project. The subjects were given the choice of an interview location in order to provide a comfortable atmosphere appropriate for free and open conversation. All of the subjects chose to be interviewed in their homes. Two chose to have their husbands with them.

Sample Selection

The sample was systematically selected from a pool of 215 mothers from Maricopa County who, according to their children's birth certificates, received no prenatal care in 1983. The mothers of those babies who were deceased or remained in neonatal intensive care units were screened out of the original pool. The purpose of this exclusion was to protect these mothers from further emotional insult or feelings of inadequacy. Also, most had been interviewed through the Newborn Intensive Care Project, and there was no need to subject them twice to an inquiry of their prenatal status.

Every third birth certificate, in chronological order, from the first ten months of the year was chosen. Birth certificates from the first ten months of 1983 were chosen because they were available. This yielded a sample of 55. Many of these women could not be located.

Therefore, a second sample of every fourth birth certificate in chronological order was chosen from the remaining pool of 160. This yielded a sample of 33. The total sample for this study consisted of 88 mothers.

From this sample of 88 women, 62 women could not be found. Thirty-four women could not be located from the first sample and 28 could not be located from the second sample. Although a few homes looked inhabited with no one present, the majority of the 62 certificates indicated false addresses or abandoned homes. Several residences were week-to-week rental apartments or trailers. Often there was no record of residence or the women left no forwarding address.

Twenty-six potential subjects were contacted, of which 20 agreed to be interviewed. Three of the 20 birth certificates incorrectly recorded the women as not receiving prenatal care. Thus, the sample for this investigation consisted of 17 women who did not receive prenatal care.

Protection of Human Subjects

The rights of the subjects were protected in accordance with guidelines established by the Human Subjects Committee (see Appendix A). Human subjects approval was also obtained from the State Family Health Services Department. Each subject was made aware of the voluntary nature of the study, including her right to withdraw or refuse to participate at any time. The study's purpose, procedure, and time involved were explained to each subject. The

Subject Disclaimer Form (see Appendix B) explained these details in written form. Every attempt was made to safeguard the rights and privacy of the subjects.

Research Protocol

Potential subjects were contacted through an initial home visit to arrange for an interview at a time and place convenient to the subject. Each subject was given the Subject Disclaimer Form and the investigator's name and telephone number. The purpose of the study and the subject's rights were verbally explained at the beginning of each interview. Permission for tape recording and note taking was requested. Interviews were conducted by a single investigator in the subject's preferred language (English or Spanish). Interviews were 45 minutes long.

The interviews consisted of open-direct questions. Open questions solicit the subject's viewpoint, experiences, thoughts and feelings (Benjamin, 1981). The questions were direct because they were specific queries into the context of prenatal care utilization. A sample of questions used is listed in Appendix C.

Two response techniques, restatement and clarification, were used to keep the subject at the center of conversation and to encourage her to continue speaking. Restatement is summary or repetition of the subject's words by the interviewer (Benjamin, 1981). This tells the subject that

the interviewer is interested enough to be able to repeat what the subject has said. Restatement gives the subject time to consider the impact of her own words (Benjamin, 1981). Clarification is clearly rephrasing of what the subject has stated or tried to express (Benjamin, 1981). Subjects often have a difficult time telling an experience clearly. The technique of clarification allows the interviewer to submit a verbal synthesis of the subject's ideas for approval, correction or rejection.

After each interview, field notes were written or tape recorded. The tapes were subsequently transcribed. All tapes and field notes were assigned numbers to ensure informant anonymity.

A significant amount of time was spent on finding and scheduling interviews with several of the women who were living at different addresses from those indicated on their records. Very few of them had phones and disclaimers had to be left with friends or relatives with the hope that they could be passed on to the women and the messages obtained.

Validity

Validity is defined as the extent to which an instrument is measuring what it is intended to measure. The validity of the category labels used in this study was tested. First, a community mental health nurse specialist and a physician were asked to construct their own labels for each clustering of raw data. These extemporaneous labels

were then compared with the labels used by the investigator. There was, respectively, 95 and 98 percent agreement. An adult nurse specialist with maternal care experience was then asked to match the revised labels used by the investigator with the categories. This resulted in 98 percent agreement.

Content validity of the categories was discussed with Phyllis Primas, Ph.D., R.N., an expert in the field of maternal child health. She considered the content validity to be acceptable.

Reliability

Reliability means repeatability with consistency of results (Budd, Thorp and Donohew 1967, p. 66). Repetitive interviews with subjects did not take place; thus, no measure of data reliability can be estimated. Efforts in this report to describe the procedures of this research accurately may enhance the measurement of reliability in future studies. Interrater reliability was not tested with respect to assignment of referential units to their categories.

Limitations of the Study

This investigation represents only an initial step toward identifying and understanding the barriers to prenatal care. Results can be generalized only to the population studied. Sixty-two of the women in the sample

were not interviewed because they could not be located. They may have identified additional barriers.

This was a retrospective study in which data were collected in one interview with each subject. It is sometimes difficult to establish rapport with a stranger (the investigator) in one interview. The subjects may have biased some information, either intentionally or unintentionally, to avoid damaging self esteem and to gain approval from the interviewer. Another limitation is imposed by the informant's memory.

This study looks at barriers from a specific perspective, that of the potential recipients. Health care donors might identify entirely different reasons for nonutilization of prenatal care. Finally, the attitude, interpretation, and biases of the researcher may also influence the reliability of the data.

Summary

This chapter described the methodology of this investigation. The following items were presented: (1) research design and method for data analysis, (2) the setting, (3) the sample, (4) operational definitions, (5) protection of human rights, (6) research protocol, (7) validity and reliability, and (8) limitations of the study.

CHAPTER IV

PRESENTATION OF THE DATA

This chapter describes the barriers women encountered that prevented them from receiving prenatal care. The chapter includes the characteristics of the sample and interview results.

Characteristics of the Sample

The sample consisted of 17 women identified from 1983 Arizona birth certificates as not obtaining prenatal care (see Table 1). The women ranged in age from 18 to 31 years old. The mean age of the sample was 24. Nine of the women were married, seven were single, and one was separated. All but four of the women were multiparas.

Nine of the subjects described their financial status as "just making it." Two said they were "broke." Six subjects felt they were "doing okay" financially.

Ten of the 17 women sought prenatal care but failed to obtain it. There were seven women who made no attempt to secure prenatal care. Two of the women were pregnant again (since 1983) and not receiving prenatal care.

Of the 17 women interviewed in this investigation, five spoke Spanish and the remainder spoke English. The majority of women were residents of Phoenix. Four subjects

Table 1. Demographic Characteristics of the Subjects of this Investigation.

Informant	Age	Marital Status	Parity	Ethnicity	City	Education (years)
A	24	married	G3 P3	Mexican American	Phoenix	13
B	26	separated	G4 P3 D1	White	Phoenix	8
C - SS*	24	single	G4 P4	Mexican National	Phoenix	6
D	27	married	G5 P3 A2	American Indian	Phoenix	6
E - SS*	33	married	G8 P7 D1	Mexican National	Phoenix	0
F	23	married	G3 P2 preg.	Mexican American	Phoenix	10
G	19	married	G3 P2 preg.	Mexican American	Phoenix	11
H	23	married	G5 P5	White	Phoenix	10
I - SS*	29	married	G5 P5	Mexican National	Phoenix	8
J	22	single	G1 P1	Mexican American	Phoenix	11
K	19	single	G4 P4	Mexican American	Phoenix	11
L	25	married	G4 P4	White	Phoenix	12
M - SS*	28	single	G6 P6	Mexican National	Phoenix	5
N	21	single	G1 P1	Mexican American	Glendale	12
O	18	single	G1 P1	White	Peoria	12
P	31	single	G4 P4	Spanish-American	Mesa	12
Q	22	married	G3 P3	Mexican American	Glendale	10

* Spanish speaking

were residents of Phoenix suburbs. All subjects lived in Maricopa County.

The number of completed years of education ranged from zero to 13. The average number of completed years of education for the sample was 9.

Interview Results

The data consisted of 17 interviews (5 Spanish and 12 English) and 17 field notes. Eleven English interviews were tape recorded and transcribed. One English interview was only documented and described in a field note. Four of the Spanish interviews were tape recorded and subsequently reviewed by the researcher and a Spanish teacher for content. Data from the Spanish interviews were recorded in field notes (4 of the 17 field notes). One of the Spanish interviews was only documented in a field note because it was not recorded. The interview data were analyzed for content, and statements referring to perceived barriers to aid were retrieved and categorized under the four following headings:

1) donor characteristics - the behaviors and attributes of the donor as perceived by the recipients;
2) recipient characteristics - the dispositions, stable or temporary, emotional or cognitive states of the recipient of aid;
3) aid characteristics - the type, quality, presence or absence of help; and

4) context characteristics - the situational variables surrounding the aid transaction.

Then statements were eliminated which did not specifically refer to barriers to prenatal care. The definitions guiding this step were:

1) donor characteristics - the behaviors and attributes of the health care providers and others (social workers, secretaries, eligibility workers, etc.) involved in the provision of prenatal care;
2) recipient characteristics - the dispositions, attitudes, beliefs, emotional and cognitive states, and lifestyles of the women who failed to receive prenatal care;
3) aid characteristics - the type, quality and content of the prenatal care services; and
4) context characteristics - the situational variables surrounding the health care transaction.

Each statement was individually coded into a specific category. Statements reflecting the same ideas were grouped and labeled. The category labels were tested for validity.

The categories were organized under the definitions of Barriers to Prenatal Care (recipient, donor, aid, context characteristics). Categories were then collapsed into 10 barriers to prenatal care. This step was reviewed by an expert in community health. The categories are subsequently

subsequently presented within the divisions of recipient, donor, aid and context characteristics (see figure 2).

Recipient Barriers to Prenatal Care

Recipient barriers are the dispositions, attitudes, beliefs, emotional and cognitive states, and lifestyles of the women who failed to receive prenatal care. Three barriers conform to this definition: (1) Economic Barriers, (2) Emotional Barriers, and (3) Attitudinal Barriers.

Economic barriers. The women stated that they could not afford prenatal care. Insurance coverage was too expensive. Their husbands' jobs provided no insurance benefits or provided inadequate coverage. The women who had insurance were unaware that they had it or did not understand how to use it. Six of the women interviewed mentioned economic barriers (see Table 2).

Emotional barriers. There were three emotional reasons associated with failure to obtain prenatal care: (1) desire to conceal the pregnancy; (2) denial of pregnancy; and (3) embarrassment. The majority of these feelings were expressed by three young, single and primiparous women. Three women concealed their pregnancies from family and friends until the days of delivery of their infants. The concealments were effected by dressing inconspicuously and by maintaining normal, active lifestyles. They reported taking good care of themselves by exercising,

Recipient Characteristics

A. Economic Barriers
B. Emotional Barriers

1. Desire to conceal pregnancy
2. Denial
3. Embarrassment

C. Attitudinal Barriers

1. Curative orientation
2. Self care
3. Ignorance
4. Importance of prenatal care

Donor Characteristics

D. Attributional Barriers

1. Condescending attitudes ("put downs")
2. Non-supportive attitudes
3. Mercenary attitudes

Aid Characteristics

E. Availability of Care Barriers

1. Strictly defined aid
2. "Money up front"
3. Inequitable aid

F. Quality Barriers

G. Content Barriers

Context Characteristics

H. System Barriers

1. No referral
2. Untimely scheduling
3. Prolonged waits
4. "Run-arounds"

I. Family and/or Community Support Barriers

J. Transportation Barriers

Figure 2. Outline of Data Categories Pertaining to Barriers to Prenatal Care as Perceived by Subjects in This Investigation.

Table 2. Selected Comments from Subjects Concerning Economic Barriers.

Subject	Comment
(F)	Where, I wasn't working, and he was only working, and we had all of these bills, and you know.
(B)	Now with my son I didn't get no care because I couldn't afford it and ...
(L)	I don't have it. I don't have cash.
(L)	... to buy insurance through anyplace as an individual is outrageous.
(L)	No, what had happened was we found out we had insurance, which we didn't know.
(A)	I mean, my husband didn't have any insurance back then or anything.
(D)	I don't have any insurance and my husband hasn't recently had enough insurance to cover all our medical bills or hospital bills.

eating well and reading relevant books (on pregnancy, self-health, etc.). They confided in no one and feared that seeking prenatal care would lead to discovery of their pregnancies. Examples of comments pertaining to concealment of pregnancy are listed in Table 3.

One woman did not recognize that she was pregnant. She was a mother of seven children. She was illiterate and spoke Spanish only. Most of her children were born in Mexico without prenatal care.

(E) field note: She didn't go for prenatal care with her daughter because she didn't know that she was pregnant. Evidently, after the birth of the baby before her daughter, she was breast feeding and she got pregnant.

All three single primiparas who wished to conceal their pregnancies also described feelings of embarrassment. They believed that others would evaluate them unfavorably because they were young, single and pregnant. Two Spanish-speaking women were embarrassed to have their bodies examined by doctors. Examples of comments revealing embarrassment are listed in Table 4.

Attitudinal barriers. A part of each interview was devoted to exploring the woman's understanding and knowledge about prenatal care. Four different perspectives were revealed in the data: (1) a curative orientation, (2) the

Table 3. Selected Comments from Subjects Concerning Emotional Barriers: Desire to Conceal Pregnancy.

Subject	Comment
(N)	I couldn't say nothing cause I was keeping it all to myself, you know.
(J)	I guess that I didn't want anybody to know in my family. ...nobody knew I was pregnant. People would find out if I went.
(O)	I wanted it to just stay out of their business.
	Cause I was young and everything, and if a lot of people knew I was going and stuff, they would, you know, it wouldn't set right with them, you know, because it's kind of scarey, you have to kind of like sneak around, you know, to people and, you know.
	I didn't want...that's the most inconvenient part. Then everyone would know it.

Table 4. Selected Comments from Subjects Concerning Emotional Barriers: Embarrassment.

Subject	Comment
(O)	I was so embarrassed, cause it's hard and you get embarrassed.
(O)	They were always looking at me, and I'm going, oh no. ...people look at you kind of weird and everything.
(J)	I don't know, I just couldn't come out and tell my mom even though I have always been real close to her, I just couldn't come out and tell her, I would want to at times but I just couldn't, I don't know why.
(N)	Cause I was the last one he expected this kind of thing, see he believes in me a lot, you know, and I put him down, you know, and he couldn't handle that.
(M)	field note: She doesn't like to take her clothes off.
(C)	field note: She does not want the physician to see her body.

belief in self care, (3) ignorance of prenatal care, and (4) an understanding of prenatal care.

A curative orientation was evident in 7 of the 17 women interviewed. They commented that they felt that prenatal care was necessary only if they felt sick, if they had problems, or if they were in labor. The majority of these women reported having no problems with their pregnancy (see Table 5).

Four of the 17 subjects preferred self-care to professional care during their pregnancy. The multiparas of this group believed that they kept themselves healthy by eating well and getting lots of rest. One mother reported using herbs to cure minor aches and pains experienced during her pregnancy (see Table 6).

Three of the women did not understand the purpose of prenatal care. One woman stated, "I would go but I didn't know I should visit a physician when I'm pregnant." She was a Mexican National and spoke Spanish only. The other two women were both enrolled in AHCCCS but chose not to seek care. A subject stated, "It's really up to you, if you want to go, and I didn't bother with it. I don't see any point in it."

Another six of the subjects expressed an understanding of the importance of prenatal care. This attitude is not considered a barrier. Four women who felt prenatal care was important related it directly to their own

Table 5. Selected Comments from Subjects Concerning Attitudinal Barriers: Curative Orientation.

Subject	Comment
(Q)	I just didn't want to bother with it that much, but, you know, when I got sick, I did... Well, when I was sick, you know, when I was having a hard time, feeling really weak, dizzy, seeing blind spots, you know, blacking out or something.
(M)	field note: She has never had any problems with having a baby. She doesn't go for prenatal care because there is no need to. She feels that to go to the doctor, she must have some kind of problem.
(L)	Now, if I would have had any problems I would have gone, but it is not worth it for me.
(G)	field note: She didn't go to the physician with her daughter because she didn't have any problems, she didn't even get sick. She doesn't see any point in going to the physician when she doesn't feel sick. When she feels sick she will, and with this baby right now she is feeling pains, getting false labor, so she thinks that it is getting close and she thinks she would like to go. ...she feels that she is a good judge of when she is not feeling very well and when she needs to see a physician.
(F)	Now with this one I am getting morning sickness, but I didn't have it with the first two. I am having a lot of other symptoms that I never had with the other ones. So that is what is making me want to go and find something.

Table 6. Selected Comments from Subjects Concerning Attitudinal Barriers: Self Care

Subject	Comment
(8)	field note: She had care from her mother who knows about pregnancy and they use grasses and herbs and other natural medicines that the whole neighborhood uses.
(50)	I prefer to be, you know, on my own, and keep myself, you know, healthy and stuff and like I was jogging a lot when I was pregnant, you know. I was doing a lot of exercises and stuff, you know.
(17)	field note: She can take care of herself while she is pregnant, she knows that the baby is well because it is moving around. She says she eats well and gets lots of rest.

experiences. Each of the four stated that she had experienced problems such as toxemia, emergency home birth, Caesarian sections or premature birth. These women failed to get prenatal care for various other reasons. Two primaparas were concealing their pregnancies, some could not afford care and others could not get an appointment (see Table 7).

Donor Characteristics as Barriers to Prenatal Care

Donor barriers are the behaviors and attributes of the health care providers and others (social workers, secretaries, etc.) involved that contribute to the non-utilization of prenatal care.

Attributional barriers. In analyzing comments pertaining to the donor (secretaries, eligibility workers, health professionals), three negative donor attributes can be identified as barriers to prenatal care: (1) condescending attitudes/"put downs," (2) non-supportive attitudes, and (3) mercenary attitudes. Eight of 17 women ascribed some negative attributes to the donor. Impersonal, uncaring and condescending donor behavior was perceived as "put downs" or class bias by six of the subjects (see Table 8).

Three of the women did not believe that the donors understood their concerns or problems (see Table 9).

Table 7. Selected Comments from Subjects Concerning Attitudes About Prenatal Care: Importance of Prenatal Care.

Subject	Comment
(O)	Just because I know that there is a lot of risk involved and I'd want to try to avoid that if necessary.
(P)	Why, because you want a healthy baby, you know, and I think that it is important to find out how you are coming along. I was kind of scared to have her because I wasn't sure everything was all right.
(D)	During the time when you are pregnant you wonder if you are healthy and if you have enough strength so you can be strong during your labor. That's what I think. You think about a lot of things during the pregnancy and you want to know if you are eating the right food or you want to know if you are getting enough rest and you want to know if you are in good shape to be ready for the baby. Another thing you want to know if your baby is fine and how the baby is doing. You want to hear the heart beat and all that. You wonder if the baby is doing okay, wonder if the baby is fine and most of the time you think about that. It's hard during your pregnancy.
(J)	For my health for one thing, I will never do that again, without telling anyone.

Table 8. Selected Comments from Subjects Concerning Attributional Barriers: Condescending Attitudes ("put downs").

Subject	Comment
(F)	...she just looked at me like I was the garbage sitting there or something, you know.
(Q)	...they just throw you out. They say, "Well, I can't help you." ...they just turn them down, like they own the damn place.
(L)	But they think you know, that I want it for free, I guess.
(O)	...look down and, you know, like try to lecture you or something or kind of think you were stupid to get pregnant or make you feel lower.
(N)	...they put you down.
(A)	...they ought to have nurses with a better attitude. I mean, you go in there and I dont know, they, um, just like, push, like ignore you.
(B)	...they don't help you.

Table 9. Selected Comments from Subjects Concerning Attributional Barriers: Non-Supportive Attitudes.

Subject	Comment
(O)	...they react weird to teenagers having babies.... I don't think they know how scared that the girls are when they come in.
(J)	field note: She did not perceive prenatal care as being a place where she could ventilate some of her feelings and release some of her stress.
(D)	...they were blaming it all on me.

Donor priority, as perceived by 3 of the subjects in the study sample, was financial compensation (see Table 10).

Characteristics of the Aid as Barriers to Prenatal Care

Aid barriers are the characteristics of prenatal care that hindered the utilization of services. Three aid barriers were identified in the data: (1) Availability of Care Barriers, (2) Quality Barriers, and (3) Content Barriers.

Availability of care barriers. According to 5 of the subjects, restrictive financial and eligibility requirements of various programs prevented them from receiving care. The majority of these women attempted to secure prenatal care while they were pregnant in 1983, and they were denied access to the state or federally-funded programs. Two women were denied care because of eligibility criteria. One was a Mexican National, who was told there were no programs for non-citizens of the United States. The other was a Mexican American, carrying an American Indian child. She was refused care in the American Indian health care programs. Three women made too much money to be eligible for low income programs, but health care was not perceived to be available because it was seen as financially prohibitive (see Table 11).

Other low income prenatal programs offered a discount but required down payments or payments in full before

Table 10. Selected Comments from Subjects Concerning Attributional Barriers: Mercenary Attitudes.

Subject	Comment
(N)	...if you don't pay I don't think that they care.
(B)	You know, hey, you are there for nothin', it's not like they have to hurry, cuz you're not paying.

Table 11. Selected Comments from Subjects Concerning Availability of Care: Strictly Defined Aid.

Subject	Comment
(B)	...that I couldn't get on the AHCCCS program or find anything for low income where I could get any so I couldn't, you know, afford it.
(A)	...they refused me again because I was not Indian.
(A)	This second pregnancy, they refused to see me at the Indian Hospital, because of that Reagan cut, and I received a letter, it said that I wasn't eligible for the Indian Hospital any more. The only time I'll be eligible is if I was pregnant and carrying an Indian child, which I was, and they still refused me. So I went through my pregnancy with this one without seeing no doctors.
(F)	I got a letter saying I was denied.
(C)	field note: AHCCCS said that they wouldn't provide for her because she was a Mexican National.
(L)	They said that I make $3,000 too much a year, you're only allowed to make $5,000 for a family of four.

care was given. Four of the women stated they could not meet these terms (see Table 12).

Negative feelings about receiving charity in the form of health care made it unavailable. Three women expressed a desire to pay for their care as they were able, according to their income constraints. They did not want to be enrolled in programs for "handouts." They felt the only options they had were state and federally-funded programs ("handouts") or care that was beyond their budget (see Table 13).

Quality barriers. Four of the subjects felt the prenatal care available to them was inferior in quality. All of their remarks were based upon experiences in the prenatal care settings. Three women discussed negative transactional experiences with health care providers, and one complained about the clinic environment (see Table 14).

Content barriers. Three of the subjects reported an aversion to the content of the prenatal care. They did not like "needles, the vaginal exams, or doctors" (see Table 15).

Context Characteristics as Barriers to Prenatal Care

Context barriers are the situational variables surrounding the health care transaction that deter the use of prenatal care services. Three context characteristics were

Table 12. Selected Comments from Subjects Concerning Availability of Care Barriers: "Money Up Front."

Subject	Comment
(A)	Yeah, I went to the hospital, but like I said they wanted up-front money like $900.00. Yeah, and just for my first checkup and you had to like pay them off before the baby comes, too. Another hospital wanted me to pay like $500.00 and I couldn't just get the money out of, you know, my husband, he was the only one working then.
(B)	Like I had called other hospitals and people had told me that there were other low income hospitals that had the care but I tried a bunch of them and they were either filled up or you had to have so much down or the program had quit for a while, or you know the minor things that didn't put me goin' anywhere, so like I said, I figured just wait until it's time and then just go out to the county hospital, I mean, what else could I do? I mean I tried everything. You have to be eligible for either AHCCCS or you don't get care or else you pay for it right there on the spot and what they want down there you can go to a normal doctor ...
(F)	You know, I have heard of the --- Clinic, and all of these other clinics, but yet they always said, well, you have to pay at least, you know, half.
(L)	That's all I wanted, was to go in there and have someone say, well, okay, you can pay us $20 a month. The hospital wants it right there. They want $800 cash before you go in.

Table 13. Selected Comments from Subjects Concerning Availability of Care Barriers: Inequitable Aid.

Subject	Comment
(N)	I don't like no body to give me money. If I can, you know, if I can do my own thing and work I would prefer it that way. I have always been independent like that.
(B)	...as long as I can find a doctor who will let me pay a little at a time or something like that, then I'm fine, unless it's something major like going to a hospital or something like that.
(L)	I had this bill, I had only $4.00. They sent me back my four dollars. They said it was paid off. They said, "We'll send back any payments you make because it's not reasonable to pay only $4.00 a month." "You don't want my money," I said, "I know someone else who will take this $4.00." I don't like handouts.

Table 14. Selected Comments from Subjects Concerning the Inferior Quality of Prenatal Care.

Subject	Comment
(C)	field note: All they do is measure her stomach and I guess they don't speak Spanish very well.
(G)	field note: It was an awful lot of money just to shove her right through the system. She said, "They just feel me and tell me the baby is doing fine and send me out the door. I know that much."
(L)	Oh, yeah, I had ankles this big and I go in and I had this woman, Iranian doctor with an earring in her nose, and she goes, "Well, you're fine." I mean, I would sleep with my legs elevated, everything, and she goes, "Oh, you're fine," and they hurt, they hurt really bad, they felt like they were going to explode. She goes, "Oh, you're fine." I go to a man doctor and he sits down with me and he explains to me, okay, I can give you these pills to release the water, but they could be toxic to the baby, so I suggest, why don't you try to stay off your feet as much as possible and eat beans and watermelon rinds and stuff like this and this will decrease the water. All she had to do was say, "Okay, why don't we try this," you know, instead of "Oh, you're fine." I refuse to go back there.
(K)	I don't, I wouldn't like my prenatal care at any of them clinics down there, I wouldn't. That is why I never went, I never bothered.
(K)	The clinic, it looks unsanitary just by looking at it, you know, even the county gives me the creeps. The county and clinics like that, you know, they are unsanitary and I didn't like them so I never went.

Table 15. Selected Comments from Subjects Concerning Content Barriers.

Subject	Comment
( )	I don't like shots, I don't like having blood drawn out of me, or nothing. ...how embarrassing, oh, I hated that exam. I feel it is the most degrading thing. I just don't like it, I don't like to go in there. I just hated it, that's why I stopped going, that's why I didn't like going ...
(K)	When they stick their hand in ya, and that, I don't like it. ...I didn't like going to a doctor.
(17)	field note: She also talks about how she didn't like needles. She doesn't understand why she needs to have these blood tests.

identified in the data: (1) System Barriers, (2) Family and Community Support Barriers, and (3) Transportation Barriers.

System barriers. Thirteen of the 17 women interviewed discussed difficulties encountered with the organizational structure in their quest to obtain prenatal care. When five of the women were denied care, they were not referred elsewhere (see Table 16).

For three subjects in the sample, appointments were made for dates that were too late. That is, they had already delivered before their first prenatal appointment. Two of these women called for their appointments at three or four months gestation. The secretaries were aware of their approximate due dates. One primipara tried to get care at eight months gestation and was given an appointment three months after her due date (see Table 17).

Prolonged waiting for appointments and waiting in clinics were barriers to attendance of prenatal care for 6 of the women interviewed (see Table 18).

Eight of 17 women felt that getting prenatal care was a "hassle" and a "big run-around." Eligibility workers "wanted too much information;" and informants claimed that the AHCCCS program sent them confusing messages in the mail with different colored cards, and they were reassigned to different primary health providers several times (see Table

Table 16. Selected Comments from Subjects Concerning System Barriers: No Referral.

Subject	Comment
(B)	You see, I explained to the lady that I was not eligible for AHCCCS, I have already been through AHCCCS. She says, well, I'm sorry to tell you that there isn't anything else I can do. There is no program out there of any sort, low income program or anything like that.
(A)	I don't know nothing about the County Health Services. I just know they have AHCCCS and I know WIC, that's all I know.

Table 17. Selected Comments from Subjects Concerning System Barriers: Untimely Scheduling.

Subject	Comment
(N)	Yeah, I told them I go, you know, I think I'm due in November, and she goes, well, have you seen the doctor, and I said no, I haven't, I go, that's why I want to have an appointment earlier, and so the lady said that the earliest she could get me in was in January. So I took the date in January but it was already too late.
(D)	The month of April I was three months and I called into the Indian Hospital to get prenatal clinic and they told me that they have to, they told me that I can be scheduled for the month of July, that was the only vacancy date that they had, and I told them it was okay and so I had mine scheduled, I don't remember the date, but it was in the month of July. Well, in the month of July I couldn't make it so I called them about one week ahead and told them that I was going to be away and I wanted to make another appointment and they told me that I can be scheduled for the month of September, and in the month of September I went over there.... I went over there for the month of September and they told me that the prenatal clinic was opened all day so I went over there and when I got there after 12, I went to the OB and they told me that the OB clinic is just opened up until noon time, morning to noon, and afternoon they have other patients to treat and the OB clinic was clsoed, so I just came back and told them that I wanted to be seen as soon as possible so they set up another appointment for the month of October and on October 3 I went over there and I was in labor. That was my first prenatal clinic.
(A)	At the Indian. I was already three months pregnant at this time, so my first prenatal checkup would be like September 6th, no 26th, and I had him September 4th, and they refused me, and I don't know why they refused me again. I was supposed to have been seen by you on September 26th, and I told the nurse that I had to have it earlier than that, cause I knew I would have the baby by then. And they told me to talk to the head tribe chief or whatever.

Table 18. Selected Comments from Subjects Concerning System Inefficiencies: Prolonged Waits

Subject	Comment
(H)	...hate to wait
(B)	...it was just the waiting that gets to you. You know you get impatient having to sit there and sit there and sit there. That is the only bad thing about it.
(G)	field note: ...the main problem is that when she calls for an appointment they give it to her 3 to 4 weeks from the time that she called, and by that time her problem is taken care of by herself.
(M)	...is very frustrating to have to sit in the clinic.
(N)	...you can sit there, you can have an appointment at 3:00 and you won't see the doctor until 7:00.

19). The women felt confused and stopped trying to get care.

Family and community support barriers. Seven of 17 women expressed a lack of family and community support. Two single primiparas described relationships with their fathers that were factors in the concealment of their pregnancies. Two multiparas characterized their husbands as unwilling to finance prenatal care. Another described her husband as unwilling to provide her with transportation and to wait with her at the clinic. One mother was new to the community and did not feel that she had developed enough rapport in the neighborhood to ask someone to take her to appointments. A teenage mother commented that in the small community she lived in, people were critical and unsupportive when young girls were pregnant (see Table 20).

Transportation barriers. Five of 17 women related transportation problems in getting to clinic appointments. If their husbands needed the car for work, they were left without transportation during the day. One mother, who had previously walked to the clinic for health care, had moved to the outskirts of Phoenix, away from facilities. Another subject complained that transportation services were not coordinated with AHCCCS clinic hours. See Table 21 for examples of the comments made by these women.

The data indicate that these ten barriers were conditions that contributed to the women's failure to

Table 19. Selected Comments from Subjects Concerning System Barriers: "Run-Arounds."

Subject	Comment
(B)	They're getting paid all that money to sit there and give you a big hassle and not help you, I don't understand that but that's the run-around that you get and believe me I know about them run-arounds.
(E)	Going for care is a struggle.
(C)	It is too much hassle.
(F)	...they wanted too much information. She says, we need recent bills, what I didn't have.
(P)	I went on that AHCCCS and they gave me a doctor who pushed me back to another doctor and I didn't know which one to go to and everything was messed up, the phone number and everything. I just didn't go. It got later and later and that is why I didn't go.
(P)	...they send you to different places and they are always telling you different information.
(P)	They kept giving me numbers to call and I could never get a hold of anybody because it was busy a lot, they are busy a lot over there.
(Q)	Well, I went to the doctor at the County and he gave me some prenatal vitamins and those little red pills, those iron pills, and I was supposed to make an appointment here. Also, at times when I wanted to go there I wasn't on the, I didn't have a card, see, now that I come and think about it, so I had to wait and get a card and all this other, you know, stuff...
(Q)	...every time I get my card a couple of months or maybe 3 to 4 months later it's expired, and that's some shit, you know, I don't know what they're trying to pull.
(K)	And then like I had AHCCCS, that messed me up this time, because I was going to go have prenatal care, but they had me all messed p, so you know, I didn't go and then, but, then I had the baby, it was all straightened out, you know.

Table 20. Selected Comments from Subjects Concerning Family and Community Support Barriers.

Subject	Comment
(H)	I just moved here and I didn't hardly know anybody in Arizona. I didn't bother asking them for a ride. But I made it through.
(F)	I felt like I was, you know, a burden on him, so I just let it go and let it go, and I thought, God, you know. I am putting all this burden on him. So I just, you know. Well, I know that if I would have said, Ernie, I want to go to, you know, a doctor, he would have said, well go, you know, I will have to sacrifice something, you know, stopping one thing for, you know....
field note: (G)	The problem is that he gets very impatient in the waiting room. He feels that they also wait too long. She doesn't like to sit in the waiting room with him or with the children because it is such a pain to wait for so long and so they often get up and just walk out and they have done that a couple of times.
(B)	I am in a bind where I make too much and my husband wouldn't help me with medical bills.
(N)	I was confused because of my father, he wasn't going to understand, you know, and he had separated from his wife, you know, because of me, you know, and they were having a lot of problems, you know, and I didn't know how, you know, me and my dad were close and I didn't know how he was going to take it. So she kinda had me thrown out, you know, and then my dad came with you know, and then when he found out I was pregnant he was really hurt you know.
(O)	...you don't change and people, they don't realize that, they just think, oh, you know, they get bad impressions.
(J)	I don't think my father would understand. He would have thrown me out of the house.

Table 21. Selected Comments from Subjects Concerning Transportation Barriers.

Subject	Comment
(G)	I would make an appointment and I would miss it, then I would say well maybe I can find a ride, so I would make another appointment and I couldn't find a ride, so I would miss that one too.
(Q)	Okay. Usually for the prenatal care you have to be there early, it's, like I remember, it was early in the morning and Dial-a-Ride, you know, sometime, I think at the very first it started about 8 or 9 o'clock and then they would make the appointments earlier, see they had to get maternity over and done with before other people came and that's why I didn't get the Dial-a-Ride.
(E)	field note: It was hard to get to the clinic. Her husband works during the day.
(P)	Transportation was mostly the reason why I didn't go. I don't have a car for when they send you back and forth.
(I)	field note: She moved away from the clinic. She used to walk to her appointments. She does not drive.

receive prenatal care. No one barrier was solely responsible for a woman's failure to get care. Each woman identified several barriers during her interviews. The number of barriers mentioned by subjects ranged from 1 to 10. The average number was 8 (see Table 22).

System barriers were identified 22 times by the subjects in this investigation. This is almost twice as many times as any other barriers. System barriers also contained the most frequently mentioned element, "run-arounds." Women mentioned "run-arounds" eight times.

Attitudinal barriers were identified 14 times. The number of women with a curative orientation equalled the number of women who preferred self care and/or were ignorant about prenatal care.

Availability of care and attributional barriers were identified 12 times by the women in this investigation. Emotional barriers were identified 10 times. Denial, an element of emotional barriers, was mentioned only once.

Family and community support barriers were mentioned seven times followed by economic barriers which were identified six times. Transportation barriers were mentioned five times. Quality barriers were identified four times. The least mentioned barrier to prenatal care was content barriers.

Table 22. Barriers to Prenatal Care as Identified by Subjects.

BARRIERS TO PRENATAL CARE	SUBJECTS																Total # Times Barrier Mentioned
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	
Economic Barriers	X	X	X	X		X						X						6
Emotional Barriers																		
Desire to conceal										X				X	X			3
Denial					X													1
Embarrassment		X				X				X			X	X	X			6
Attitudinal Barriers																		
Curative orientation	X					X	X	X				X	X				X	7
Self care			X				X						X		X			4
Ignorance					X						X		X					3
Attributional Barriers																		
Condescending attitudes	X	X				X						X			X		X	6
Nonsupportive attitudes				X						X					X			3
Mercenary attitudes		X				X								X				3
Availability of Care Barriers																		
Strictly defined aid	X	X	X			X						X						5
"Money up front"	X	X				X						X						4
Inequitable aid		X										X		X				3
Quality Barriers							X				X	X	X					4
Content Barriers							X				X	X						3
System Barriers																		
No referral	X	X				X								X			X	5
Untimely scheduling	X			X										X				3
Prolonged waits		X					X	X					X	X			X	6
"Run arounds"		X	X		X	X					X			X		X	X	8
Family/community support barriers		X				X	X	X		X				X	X			7
Transportation Barriers					X			X	X							X	X	5
Total # Barriers Ident.	7	10	5	3	4	10	6	4	1	4	4	8	6	9	6	2	7	

Summary

Chapter IV presented data from interviews with 17 women who failed to obtain prenatal care in 1983. Analysis of the data revealed ten barriers to prenatal care. Characteristics of the sample were also presented.

CHAPTER V

CONCLUSIONS

The purpose of this study was to identify and describe the barriers that prevented women in Maricopa County, Arizona, from receiving prenatal care. An exploratory-descriptive research design was implemented. Guided open-ended interviews were employed to identify the barriers expreienced from the perspective of the woman who had failed to receive prenatal care. Content analysis of the data revealed 10 barriers to prenatal care (see Table 23).

This chapter discusses the 10 barriers to prenatal care identified in this study. Interview results and the literature are used to support the discussion. Implications for health care professionals and recommendations for further research are also presented.

Economic Barriers

Poor and low income women face more severe income constraints and cannot afford to purchase preventive care. The uninsured poor have the lowest rates of health care utilization relative to their respective need (Aday, 1975). Anderson and Aday (1978) found that insurance coverage had a direct positive effect on the number of visits people make to the physician.

Table 23. The Barriers to Prenatal Care Identified by Subjects.

Recipient Characteristics	Aid Characteristics
Economic Barriers	Care Availability Barriers
Emotional Barriers	Quality Barriers
Attitudinal Barriers	Content Barriers
Donor Characteristics	**Context Characteristics**
Attributional Barriers	System Barriers
	Family and Community Support Barriers
	Transportation Barriers

Five women in this study discussed economic barriers to prenatal care. They did not have the capital to pay either for insurance or for the care. They described their income status as "broke" or "just making it" when they were pregnant; however, these five women did not qualify for any health care aid programs.

Many subjects perceived prenatal care as a luxury that they could not afford. Their families lived in crowded conditions; homes were sparsely furnished; their children's clothes were very worn and sometimes ragged. They stated that income was first used to pay the necessities of food, rent and utilities. Prenatal care, then, was not an income priority.

Results from this study support the presence of economic barriers that inhibit the utilization of prenatal care services. Five women in this study could not afford to pay for prenatal care services. This prevented them from obtaining care.

Emotional Barriers

Three emotional factors were identified by the women in this investigation: (1) embarrassment, (2) the desire to conceal the pregnancy, and (3) denial of pregnancy. Embarrassment is discussed in relation to the concealment of pregnancy and in relation to women's feelings about going to the doctor. Denial is also discussed.

Embarrassment and Concealment of Pregnancy

Embarrassment is "a noxious psychological state that arises from beliefs that others who know of one's behavior evaluate one unfavorably because one's behavior has violated situational expectations" (Shapiro, 1983, p. 145). Individuals will avoid circumstances in which they anticipate being embarrassed. The greater the perceived embarrassment, the greater will be the desire to avoid the situation. The strength of this avoidance is determined by two factors: (1) the belief that unfavorable evaluations will result from the action of seeking help, and (2) the degree to which the person is concerned about these unfavorable conditions (Shapiro, 1983).

The three subjects who felt embarrassed about their pregnancy believed family, friends and neighbors would evaluate them negatively. They also perceived the health care environment as a potentially embarrassing situation. They were concerned enough about these evaluations that they concealed their pregnancies from family and friends until the days of delivery, and also failed to receive prenatal care.

A study conducted by Nadler and Porat (1978) showed that adolescents refrain from asking for help when they must identify themselves. An identifiable request for help makes helpseeking comparable to public admission of failure and poses a threat to one's public self esteem. If an

adolescent woman wishes to remain anonymously pregnant, a request for prenatal care will be inhibited. Past studies specific to prenatal care (Gibbs, Martin & Gutierrez, 1974; Parsons & Perkins, 1982) also support the finding that embarrassment and the desire to conceal pregnancy act as barriers and result in the non-utilization of prenatal care services.

Embarrassment and Prenatal Visits

Two Spanish-speaking women said they were too embarrassed to visit the doctor when they were pregnant. Privacy and personal dignity are important in the Mexican American culture. In Mexico, many male physicians do prenatal examinations through cloth by means of a gown that extends from the patient's neck to her ankles (Kay, 1978). The pelvic examination as performed in the United States is not acceptable and is embarrassing to many Mexican American women and their mates. To avoid embarrassment, some women in this study failed to obtain prenatal care. Embarrassment functions as an emotional barrier to prenatal care and inhibits the utilization of services.

Denial

A woman must first be aware that she is pregnant to be aware of the need for obtaining help. One subject who had experienced seven pregnancies did not recognize her eighth (most recent) pregnancy until she was in active

labor. She obviously did not perceive a need for visits during an unrecognized pregnancy. She was not particularly obese, and it is difficult to understand how she did not recognize her pregnancy. The subject may have been engaging in denial. Denial is an unconscious defense mechanism in which an aspect of external or internal reality is rejected (Freedman, Kaplan & Sadock, 1976). This defense mechanism may or may not have been operative in this specific case. Denial can be a barrier to prenatal care because it thwarts the seeking of aid.

Attitudinal Barriers

Three perspectives comprise this barrier: (1) a curative orientation, (2) preference for self care, and (3) ignorance of the purpose of prenatal care. Each perspective is discussed. A fourth perspective identified by this sample, understanding of the importance of prenatal care, is considered a stimulus to seeking prenatal care. However, it is also dealt with in the following section.

Curative Orientation

Preventive helpseeking usually deals with anticipated conditions, or conditions that might occur. The cues are usually not urgent or obvious. They may consist of health educational messages, etc. The purpose of preventative helpseeking is to ensure that problems do not occur, do

not go unnoticed, and do not become unmanageable (Ostrove & Baum, 1983).

The orientation of prenatal care is primarily preventative. Its purpose is to ensure a healthy mother and baby. Pregnancy is a normal physiologic process; however, there are a great many physiological adjustments for the mother and fetus to make during those nine months. A healthy woman can be expected to tolerate these changes with a minimum of stress. Pregnancy is a stress, because each organ of the body compensates for the growth of the fetus. There are discomforts associated with pregnancy and minor health problems may become more prominent, affecting both the mother and the developing fetus. Pregnancy is also a psychosocial stress that involves a change in lifestyle. Prenatal care assists the mother and infant through the pregnancy by monitoring bodily changes, adjustments, and growth.

Curative helpseeking results from situations in which the cues are salient and immediate. The individual seeks help because her condition has become bothersome or a cause for concern (Ostrove & Baum, 1983).

Seven of the 17 women interviewed described a curative orientation toward the use of health care services. They believed visits to a physician were reserved for more urgent or critical conditions than pregnancy. All 7 were multiparas. Most had received some prenatal care with

previous children. The knowledge gained from their personal experiences during prior pregnancies had the function of reducing anxiety and uncertainty. These women recognized no need for professional help since the cues were not present to initiate action. The curative helpseeking perspective poses a barrier to prenatal care. Other studies (Parsons & Perkins, 1982; Joyce et al., 1983) support this finding.

Self Care

Four of the women preferred self care to professional care. They felt they were good judges of their health and their babies' health. They did not want to waste time away from home trying to obtain professional prenatal care. They had family and friends who could assist them while they were pregnant. These women believed that self care at home was as good as any institutional prenatal care.

Strong family networks can act as a barrier to prenatal care by promoting self care or home care in lieu of professional care. When these four women sought and failed to obtain professional care, self care was supported by family networks. One subject stated her mother helped her use folk remedies commonly used by other relatives. Three of the women described close family networks with extended family living nearby.

The characteristics of social networks affect preventative health care utilization. Birkel and Reppucci (1983) designed a voluntary parent education program for low

income, high risk mothers to provide them with a preventive-oriented non-therapy group experience promoting individual strengths and parenting skills. The investigators found that the number of sessions attended by the sample of 31 women was significantly related to the overall network density. Overall network was defined as a single combined unit of kin and friends. Women with less dense, less proximate, smaller, and less frequently contacted networks attended the sessions more frequently.

Recipients' attitudes about self care and home care are barriers when utilization of such care precludes utilization of professional prenatal care. Social networks can compound the effects of this barrier.

Ignorance of the Purpose of Prenatal Care

Knowledge about personal health is less sophisticated among low income groups (Strauss, 1969). This may stem from illiteracy, poor education, lack of interest in health issues, and language barriers.

Two of the women who did not understand the purpose of prenatal care spoke only Spanish and could not read. Health care workers often cannot speak a second language such as Spanish. Staff may have time only to distribute reading material. Distribution of reading material does not ensure that the patients can read it, will read it, or will understand it. Two of the three women in this category

could not read the material even if it was printed in their native language.

A third subject said she did not seek prenatal care because there was nothing to learn that she didn't already know about pregnancy. This mother was literate and spoke English. She had prenatal care through a private physician with her first child at age 15. During her teenage years she bore three more children, going through each pregnancy without prenatal care.

Teenage mothers require close follow-ups and repetitive emphasis on appropriate care for themselves and their babies. There are many conflicts between the teenage level of development and the role of a parent. For example, this mother, with four young children, talked about how she "likes to party," leaving the children with their grandmother or on their own. There may also have been some psychological conflicts influencing her ideas on prenatal care, but she did not volunteer such information, and any conclusions about these factors would only be speculative. The reasons for this teenager's failure to obtain prenatal care are complex. However, ignorance of her high risk status and her need for prenatal care was an important factor.

Understanding the Importance of Prenatal Care

For seven women, an understanding of the need for prenatal care led to efforts to find care during the pregnancy. This understanding was not enough in these cases to overcome the impact of other barriers, and these women ultimately failed to obtain prenatal care.

Attributional Barriers

Three negative donor attitudes comprise this barrier: (1) condescending attitudes, (2) nonsupportive attitudes, and (3) mercenary attitudes.

Condescending Attitudes

Huber and Form (1973) asked 354 adults from Muskegon, Michigan, (1) Why are rich people rich? (2) Why are poor people poor? (3) Back in the years of the Great Depression in the 1930s, what do you suppose was the main reason that most people went on relief? (4) Why have most people gone on relief in the last six years? Thirty-six percent of the respondents ascribed negative personal traits ("don't work as hard," "no ambition or motivation") to the plight of the poor. Only 4 percent named personal traits to the cause of being on relief during the thirties. In contrast, 54 percent of the respondents ascribed personal traits to today's poor on relief. The Muskegon respondents applied positive traits (congruent with western values) to describe why the rich were rich. Huber and Form term this

"the dominant ideology." That is, wealth is a result of hard work, ability and motivation, while poverty results from indolence, stupidity and indifference.

In general, health professionals are a highly motivated group. Training in specialized schools results in characteristic objectives and perspectives toward health care. The low income patient frequently sabotages these objectives by lack of punctuality in keeping appointments, failure to comply with prescribed treatments, etc. Health providers become frustrated and annoyed, and develop fatalistic attitudes toward their patients. They may apply the "dominant ideology" to low income patients, and those on public assistance in particular. Low income patients are often described as "children and must be treated like children." They cannot keep appointments, having little sense of time or responsibility. They are shiftless and irresponsible. They have children out of wedlock; they are dirty, unkempt, unclean" (Strauss, 1969, p. 151).

These attitudes are often engendered by the medical education system. Characteristically, there are two classes of patients cared for in teaching hospitals, private and public (clinic) patients. Private patients usually pay for care through insurance and are seen by the attending (faculty) physician. They are treated respectfully, are rarely subjected to multiple exams, and residents caring for them are closely supervised. In contrast, the public

patients regarded as "teaching material" are often subject to the indignities of multiple examinations. The attending physicians may be minimally involved in the care and supervision of residents may be lax. Regardless of how blatant or subtle the distinctions between private and public patients in each institution, the physician leaves his training with the concept that medical care delivery is two-tiered, with premium care given to the paying patients.

Sometimes this class bias is expressed both overtly and covertly by personnel. Patients frequently comprehend the staff's attitudes about them, and the patients may either tolerate this class bias or choose not to return to the health care service (Strauss, 1969).

In 1983 the Maricopa County Health Department (MCHD) lost its contract with AHCCCS. Until then, MCHD provided health care for the indigent population. The county health providers were experienced with the lifestyles and problems of the low income population. Subjects evaluated this donor (MCHD) positively in interviews. AHCCCS subsequently contracted with private health providers who were, for the most part, inexperienced in dealing with the indigent patient population. The majority of negative donor evaluations were directed as these new AHCCCS providers or eligibility workers.

Subjects in this investigation were humiliated by donor brusqueness. They believed that the donors looked

down on them because of their need for aid and their low income. One subject stated, "When I go to the doctor, I just feel lower than him, like I am a lower class and maybe I am because he is making all this money, he knows more than I do ... but I don't make him feel like that." These perceptions inhibited the utilization of prenatal care for these women.

Nonsupportive Attitudes

The adolescent primaparas in this investigation felt they would be rebuked by health care personnel for being pregnant and unmarried. They did not perceive prenatal care as a place where they could receive empathy and support over their situation and condition. They refrained from obtaining prenatal care. Perceptions of nonsupportive donor attitudes inhibit the utilization of prenatal care services.

Mercenary Attitudes

As donor costs in providing aid increase, recipients attribute more care and concern to the donor (Fisher & Nadler, 1976). Answering questions, explaining procedures and so forth are costly to the health care provider (time is money). Conversely, low cost aid (to the donor) results in self threatening messages of lack of care and concern. Self threatening messages result in negative reactions to aid such as refusal of help. The clinics utilized by subjects were described as understaffed and overloaded with patients.

That is, they believed the donors created the overload to increase their own profits. Subjects ascribed these conditions to mercenary donor intent. These perceptions resulted in the failure to obtain prenatal care.

Condescending attitudes, nonsupportive attitudes, and mercenary attitudes precipitate feelings of inferiority, inadequacy, fears of failure, etc., in aid recipients. All three of these negative donor attitudes were threatening self-relevant messages for the subjects and therefore act as barriers to prenatal care.

Availability of Care Barriers

Six of 17 women felt there was no care available to them while they were pregnant. Some family incomes exceeded AHCCCS eligibility limits. Care through Maricopa County Health Department was fee for service and lower in price than private medical care, but most of the women were unaware of this care coverage through the county. Some Phoenix hospitals offered discount services, provided the women made down payments. The majority of the subjects described their financial status as "broke" or "just making it." They had no savings available for the initial payment.

Essentially, these subjects were excluded from prenatal care in Arizona by their income, which is just above that qualifying them for low income programs but not enough to be able to afford other sources of prenatal care.

There was care available for the very poor (AHCCCS), those who had some savings (hospital programs), and those who could afford it and/or had insurance. There was no care available for women who were marginally above the poverty income level. Therefore, the nonavailability of care functions as a barrier and resulted in the failure to obtain prenatal care services.

In addition, a few women were uncomfortable with the feelings of dependency experienced while enrolled in state and federally funded programs. They wanted to pay for the services they received.

When individuals are unable to reciprocate (pay for services), they refrain from seeking help, are slower to ask for it, and are less likely to seek help in the future (Castro, 1974; Greenberg & Shapiro, 1971). Acceptance of aid that cannot be reciprocated encroaches upon the norm of equity in social relations. Aid that requires inequitably high repayment is also perceived as contradictory to the norm of equity in social relations (Fisher et al., 1982). Some health care aid programs act as barriers because they are perceived as inequitable exchanges. This discourages women from utilizing services.

Quality Barriers

The health care facilities utilized by low income patients usually operate on limited budgets with unreliable sources of money. The money and resources available may not

be adequate or realistic since the poor have consistently exhibited lower limits of health and more disability than the non-poor (Aday, 1975). Providers cannot allocate their resources equally to the private payers and low income patients due to the financial realities of the situation.

Low income programs service large numbers of people, resulting in long waits in the office and crowded waiting rooms. To cope with the patient overloads, personnel (professional and others) will often develop routines for handling patients efficiently and expeditiously. Such treatment may be perceived as impersonal, brusque or insulting. Physicians go from patient to patient, spending only brief moments with each. The practitioners often assume that if a patient wants something, they will ask for it (Kasl, 1975). The overworked provider is subject to "burnout," which severely reduces his sensitivity to patient concerns. The health provider may use medical terminology instead of taking the time to explain in layman's language. The heavy use of medical jargon may intimidate patients and deprive them of the information and empathy they want (Cosper, 1977).

Subjects in this study perceived a difference between their treatment and the treatment of paying patients. They were dissatisfied with the information they received about their condition and that of their babies.

In their past experiences the amount of time they were able to spend with the health care practitioner did not justify the costs of their own time.

Perceived low cost aid is self-threatening and reminds the patient of her dependency on the aid. Self-threatening elements of aid result in negative reactions to aid such as refusal of aid, negative evaluations of the donor, and so on (Fisher et al., 1982). These subjects perceived low cost aid as inferior quality aid. This perception was a barrier to prenatal care.

Content Barriers

The gap between patient and health provider understanding of health care treatments and prevention is great. The greater the specialization of health provider, the more arcane and abstruse his knowledge and abilities will seem to the patient, who will therefore have to accept more on trust. Some procedures may seem senseless or even dangerous as perceived by the patient (Strauss, 1969).

The subjects did not know the significance of certain procedures done in routine prenatal care, such as blood tests for anemia and vaginal exams. Likewise, they did not like submitting to the procedures. One subject said that she always slipped out of the office before her blood could be drawn. Another subject had her blood drawn for a pregnancy test and initial prenatal lab tests, but she never

went back to inquire about the results. She said, "I'm doing fine without knowing what the test says."

For these subjects, the perceived benefits of these procedures were less than the costs (perceived risks, pain, time, money) of submitting to them. Dislike for the content of prenatal care acted as a barrier and inhibited the utilization of services.

System Barriers

Four aspects of the health care system were identified as barriers to prenatal care by the women in this study. These were (1) "run arounds," (2) failure to refer patients, (3) prolonged waits in clinics, and (4) the untimely scheduling of appointments. More women (13) mentioned system barriers than any other type of barrier.

"Run Arounds"

The health care organization in the United States is large, complex and confusing to everyone. Lower income people are less equipped by education and experience to understand complicated health care organization or to cope with it (Strauss, 1969). The paperwork involved in applying for and receiving care may be intimidating to these patients. Directions may seem inadequate and the complex organization of aid systems may seem confusing. They perceive the system as giving them "the run-around" or a "hassle."

In 1983 AHCCCS failed to contract with the Maricopa County Health Department. The change in providers, from county to various private medical organizations, was confusing to indigent and low income patients who had been accustomed to the county system.

Enrollment in AHCCCS involved assignment to a primary provider who in turn referred the patient to another provider for prenatal care. This process was complicated, time consuming and inconvenient to the subjects in this study. Thus, throughout their 1983 pregnancies, several women were without a regular physician. Research (Aday, 1975) has shown that people who have no place they routinely go for medical advice and treatment have fewer visits relative to their need for care than those who have some place or practitioner they regularly consult. Confusing system changes causing patients "run arounds" inhibits the use of prenatal care services.

No Referral

As discussed earlier, a portion of the women in this sample were not eligible for AHCCCS. Evidently they had been eligible for county services in the past, which had less stringent financial requirements than AHCCCS. According to these subjects, they were required to apply for AHCCCS in 1983. When they were denied enrollment, they were not informed where they could go for care, or back to the County Health Department. According to some state and

county sources, care could have been provided for these women with funds from a special grant. The women were not referred, and so they failed to receive prenatal care.

Prolonged Waiting

The women stated that waiting times in AHCCCS providers' offices was excessively long. They described crowded waiting rooms with standing room only. The subjects were given appointments months in advance, but when they arrived at the provider's office they were required to wait hours to be seen. To wait is to be powerless (Morrow, 1984, p. 65). Waiting is likened to a form of punishment. One is serving time not because of one's own fault but because of the inefficiencies of those who impose the wait. The women perceived the waiting unfair and inconsiderate treatment.

The common consensus among state and county health care officials was that there were many more patients than available AHCCCS providers. There may have been too many patients because of three reasons. First, all the patients previously seen by the County Health Department applied to AHCCCS. Second, many new patients applied who had never had any health care coverage before. This was partially because of the prior absence of a Medicaid program in Arizona. Finally, copper miners and other newly unemployed families applied as a result of a slumping economy. The abundance of

patients may have contributed to the long waits in AHCCCS provider clinics.

Untimely Scheduling

The patient glut in AHCCCS may have been responsible for the untimely scheduling of appointments. Untimely scheduling of appointments also occurred with two women who normally obtained care from the Indian Health Service. Giving appointments to women late in pregnancy or in the month of delivery is not providing prenatal care. Late appointments are barriers to prenatal care utilization.

Long waits in doctors' offices and for appointments can be interpreted as lack of respect by the donor. Giving a woman her first prenatal care appointment a couple of months after her due date or even at six months is interpreted as rejection of the client's need for care. Perceptions of unfair treatment and lack of donor respect and concern are self-threatening. Self-threatening elements of aid result in negative reactions of aid (Fisher et al., 1982). These women failed to receive prenatal care.

System barriers are important factors in determining the use of prenatal care services. Prolonged waiting, untimely appointments, lack of referral and confusing system changes ("run arounds") all result in the failure to utilize prenatal care services. Other research studies (Dutton, 1978; Rundal & Wheeler, 1979) also support the evidence of this barrier.

Family and Community Support Barriers

There can be a cultural and/or family influence on a woman's ability to obtain prenatal care. Four of the seven women who experienced lack of family and community support were of Mexican American descent. The males in this culture are dominant and usually are the decision makers. Personal dignity is important and they do not like to ask for help (Linstrom, 1975). Subject husbands were unsupportive of prenatal care for their wives. Not understanding the significance of prenatal care, they directed family resources (time, money, transportation) to other priorities. Linstrom (1975) found that Mexican American women who failed to utilize a certain health care facility were more likely to be living with their spouses.

When an unwed daughter from a Hispanic family becomes pregnant, she is subject to family condemnation (Kay, 1978). This lack of acceptance by family members is strong enough to cause the woman to conceal her pregnancy (Gibbs, Martin & Gutierrez, 1974). The family may isolate the pregnant girl from others until she has delivered. Both can result in a failure to receive prenatal care.

Unwed and teenage mothers are also subject to negative American societal stigmata. Though moral standards have become more tolerant, attitudes toward these pregnancies are still negative. Unwed women are stereotypically

depicted as dependent on welfare with four or more children (Williamson, 1974). Teachers, health providers, parents and many others may unintentionally reveal their own negative uninformed bias and inhibit young women's attempts at seeking help.

Violation of cultural roles, rules and expectations is self-threatening to these women and their families. To actively enlist family support when a pregnancy is not accepted is to risk disapproval and may imply a failure to measure up to personal values. Going for prenatal care when one's husband does not support it may cause conflicts. Encouraging an unwed pregnant daughter to attend prenatal care may be threatening to a family's reputation. Thus lack of family and community support can act as a barrier to prenatal care and result in the failure to utilize services.

Transportation Barriers

Several studies (Joyce et al., 1983; Ayers, 1980; Gibbs, Martin & Gutierrez, 1974) document the lack of transportation as a barrier to prenatal care. Clinic hours and available transportation (private and/or public) were not coordinated according to this study's informants.

Aday (1975) found that the uninsured poor and insured poor were more apt to visit a physician when the need arose if they lived closer to care. Informants in this study, on the AHCCCS program, were often assigned to providers across town. The metropolitan Phoenix area spreads

over 1400 square miles. It takes a long time to commute across the city in the unusually heavy traffic. The hot climate contributes to the unpleasantness of car or bus travel. Thus, for some of these women, the perceived benefits of prenatal care did not justify the problems and unpleasantness associated with trying to get there. Transportation barriers prevent women from utilizing prenatal care service.

Joyce et al., (1983) who also studied women's failure to obtain prenatal care, used an internal-external classification system of the barriers. Internal barriers were covert and intangible. Four categories of internal barriers in this study were (1) emotional barriers, (2) attributional barriers, (3) attitudinal barriers, and (4) family and community support barriers. These internal barriers are embedded in cultural and cognitive processes of human beings. External barriers identified in this study were (1) economic barriers, (2) availability of care barriers, (3) quality barriers, (4) content barriers, (5) system barriers, and (6) transportation barriers. They are external barriers because they represent policies, procedures and nonhuman resources. Unlike internal barriers, external barriers can be uniformly manipulated.

System barriers were mentioned nearly twice as many times as any other barrier. More external barriers were mentioned than internal. This would lead to the conclusion

that the inadequacies of the health care system and external factors pose as prominent barriers to prenatal care.

Implications for Health Professionals

The major goal of this research was to identify the barriers to prenatal care as perceived by the women who did not obtain prenatal care. Women who do not receive prenatal care are at high risk for complications of pregnancy and negative pregnancy outcomes such as premature delivery, infant deaths and low birth weight babies. Barriers are detrimental to the optimal health of mothers and their infants. Prenatal care must be made available and acceptable to all expectant mothers. Knowing what barriers exist from the patients' point of view enables the nurse and other health care providers to develop a patient-centered approach to the availability of health care.

The findings of this study have direct implications for nursing practice and improvement of access to prenatal care. The following recommendations are directed at eliminating barriers to prenatal care.

Education about the significance of prenatal care should be directed to three groups: (1) women of childbearing age, (2) spouses and other members of the social network, and (3) teenagers (girls and boys) at the high school level. Prenatal care education should include the following objectives:

(1) To present the goals and benefits of prenatal care.

(2) To re-orient health-seeking behavior from curative to preventative intent.

(3) To educate people to the sources of prenatal care available.

Pregnant adolescents need unthreatening guidance into the appropriate health care system. A telephone "hot line" for pregnant teenagers could facilitate their entry into prenatal care programs. This may allow them to maintain distance and anonymity until information is obtained and some rapport is established.

Pregnant women, particularly those of low income, need an advocate in the health care organization. The bureaucracy of low income programs is often unintelligible and confusing to the potential recipient. These women need someone who will assist their successful entry and completion of prenatal care.

Health care and social aid organizations should make special efforts to improve referral practices and communication with one another. If an agency cannot take responsibility for a particular patient, attempts to direct her to other public health and community agencies should be made.

The use of a sliding fee scale for prenatal care should be considered. The woman can be charged a nominal fee based upon her ability to pay.

Attempts should be made at sensitizing health personnel to lessen their class and professional biases about lower income patients. Since attitudes and styles are notably more difficult to change than medical organization and procedure, this recommendation suggests a long-term process. Inservice training would be beneficial. However, professional schools need to emphasize community realities and educate students to understand the social backgrounds and home life of low income patients. Command of a second language should be encouraged.

Health care providers to low income patients must make special efforts to determine how many patients they can handle. Women failed to obtain prenatal care because they could not get appointments and clinics appeared overloaded with patients. Realistic estimates of patient load may allow health care services to prepare themselves with the resources (e.g., providers) necessary to care for all patients efficiently and fairly.

Mechanisms for scheduling should be improved so that women enter the prenatal care system expeditiously, with first prenatal visits assigned as early as possible in the pregnancy.

Ideally, prenatal care is a multidisciplinay effort. Nurses collaborate and plan comprehensive care with physicians, social workers, nutritionists and other health care personnel. However, nurses are in a particularly strong

position to act as advocates for women who encounter barriers to prenatal care. Nurses come in contact with patients in clinics and have direct responsibility for providing physical care or supervising others who provide care. Community health and school nurses are working directly with families, students and community agencies. This closeness to patients provides nurses the opportunity to function as advocates whenever and wherever barriers to prenatal care occur.

Recommendations for Further Research

The following are recommendations for further research:

(1) Replication of this study with post-partum women still in the hospital will allow interviewing of all women who failed to obtain prenatal care.

(2) Replication of this study in a rural county of Arizona. Barriers to prenatal care may be different for the rural population.

(3) Replication of this study with personnel involved in the provision of care to elicit their perceptions of barriers to prenatal care.

(4) A study conducted to elicit responses from women who overcame the barriers and received prenatal care.

Summary

This final chapter presented discussions of the 10 identified barriers to prenatal care. Implications for health care professionals and recommendations for further research were also presented.

APPENDIX A

LETTER OF APPROVAL

THE UNIVERSITY OF ARIZONA
TUCSON, ARIZONA 85721

COLLEGE OF NURSING

MEMORANDUM

TO: Michele M. Anzalone, BSN, RN
2926 E. Malvern Street
Tucson, AZ 85716

FROM: Ada Sue Hinshaw, PhD, RN
Director of Research

Katherine Young, PhD, RN
Chairman, Research Committee

DATE: August 6, 1984

RE: Human Subjects Review: Barriers to Prenatal Care

Your project has been reviewed and approved as exempt from University review by the College of Nursing Ethical Review Subcommittee of the Research Committee and the Director of Research. A consent form with subject signature is not required for projects exempt from full University review. Please use only a disclaimer format for subjects to read before giving their oral consent to the research. The Human Subjects Project Approval Form is filed in the office of the Director of Research if you need access to it.

We wish you a valuable and stimulating experience with your research.

ASH/fp

APPENDIX B

DISCLAIMER STATEMENT

Project Title: Barriers to Prenatal Care

My name is Michele Anzalone. I am concerned about the health of mothers and their children. I am conducting a study to find out about the health services mothers feel are available to them during their pregnancy and how they feel about them. It seems that many mothers are not able to get health care for themselves while they are pregnant. I think that people planning clinics and other health services should understand how women feel so they can plan services to meet the needs of pregnant women.

I would like to talk with you for about one hour. I would like to use a tape recorder during our interview. If you do not wish to be taped, I would like to take notes so I will remember what we have discussed.

Participation is voluntary and greatly appreciated. You are free not to participate and you are free to withdraw from the project at any time. You may ask questions at any time and I will be happy to answer them. You may also decide not to answer a question. Nothing will happen to you or to your family if you choose not to participate.

All information will be kept strictly confidential. No individual or family will ever be identified as a result of your participation in this project.

At the end of this project I will be presenting a report to the State Health Department. I hope this research will help them plan health services for pregnant women. Results of this study will also be available to you upon your request.

If you have any questions about the study, you can contact me at 968-6461, Ext. 307.

Thank you for your time and help.

Michele Anzalone, R.N.
Graduate Student
College of Nursing
University of Arizona

APPENDIX C

SAMPLE DATA COLLECTION QUESTIONS

(English)

1. How did you know you were pregnant?
2. Were you able to go to anyone for help or advice during your pregnancy?
3. How did you feel during your pregnancy?
4. What was involved in getting prenatal care?
5. What services did you feel were available to you?
6. When do you go to the doctor?
7. Why did you not get prenatal care?
8. Tell me your feelings about prenatal care.
9. What encourages/discourages you from going for prenatal care?
10. Who helps you and gives you advice about having a baby?

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