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DISPARITIES IN GAINING ACCESS TO PRENATAL CARE: LOW-INCOME MEXICAN AMERICAN WOMEN'S SOCIAL RESOURCE MANAGEMENT

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Molly A. Lauck

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Ann V. Millard
Major professor

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DISPARITIES IN GAINING ACCESS TO PRENATAL CARE: LOW-INCOME MEXICAN AMERICAN WOMEN'S SOCIAL RESOURCE MANAGEMENT

By

Molly A. Lauck

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Anthropology

2000

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ABSTRACT

DISPARITIES IN GAINING ACCESS TO PRENATAL CARE: LOW-INCOME MEXICAN AMERICAN WOMEN'S SOCIAL RESOURCE MANAGEMENT

By

Molly A. Lauck

In this study, I take up prenatal care as a domain in which pregnancy and birth provide opportunities to examine ordinary health issues specific to women in the context of health care institutions and everyday decision making. Specifically, I focus on how low-income Mexican American women gain access to prenatal care and how this process is linked to their management of social resources, health care clinic personnel's perspectives on women's social resource management, and the role "cultural competency" plays in clinic personnel's views of this process.

The participants' views and experiences analyzed in this dissertation were drawn from ethnographic research conducted in Lansing, Michigan. Data were collected in three obstetric/gynecology clinics that serve low-income women — a Latino community health center clinic, a public health clinic, and a hospital based clinic. Data for this research were collected in two phases. The first phase involved participant observation and open-ended interviews with low-income Mexican American women who lived in the Greater Lansing area, addressing the strategies they developed to gain access to biomedical health care during pregnancy and birth. Phase two focused on investigating

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clinic personnel's perspectives of low-income Mexican American women's access to prenatal care using these same methods.

Drawing upon concepts from critical medical anthropology and developing a concept of women's social resource management, I suggest that women make decisions and thus develop strategies to gain access to prenatal care that are shaped by both political and economic issues. For example, women in this study often relied upon a friend to drive them to their prenatal appointments. While clinic personnel identified socioeconomic issues, such as transportation problems, that women faced, they often conceptualized such problems as isolated issues or barriers rather than viewing them as a series of interconnected events that women addressed through the social and economic resources available to them. I argue that this distinction is significant for it addresses a fundamental premise of clinic personnel's conceptualization of the term "barrier." Clinic personnel perceived barriers in terms of a patient's contact with a physician or prenatal clinic. As a result, women in this study perceived "access" as an event that preceded and eventually led to a clinical encounter in contrast to clinic personnel who conceptualized "access" as an action bounded by the clinic.

Recognizing the dichotomy between women and clinic personnel's conceptualizations of what is involved in achieving access to prenatal care sheds new light on the process of gaining access to care. This study concludes that low-income Mexican American women's access to prenatal care is more significantly influenced by women's management of the social resources available to them in contrast to clinic personnel's explanations of access that are premised upon a conceptual framework of cultural competency.

ACKNOWLEDGEMENTS

The completion of this dissertation is a triumph to which I must credit a number of people. My parents, Margaret Schylling and Richard Lauck, gave me their undying support — urging me forward despite the inevitable obstacles inherent of graduate education. In particular this dissertation in a tribute to my father. The endless discussions we have had over the years about anthropological theory and the role of language have shaped not only this dissertation, but also my development as a scholar as a whole.

I owe my committee, Ann V. Millard, Maria Montoya, Judy Pugh, Barbara Rylko-Bauer, and Scott Whiteford, a great deal of thanks as they invested a significant amount of time and energy in both the research and writing processes. In particular, my committee chair, Ann V. Millard, offered me support and compassion that I believe far exceeded the normal bounds of the advisor/advisee relationship.

The process of researching and writing this dissertation was an arduous endeavor that often left me feeling overwhelmed — "Would I ever finish?" Consequently, my father often jokingly referred to me as "the jaded graduate student." Thankfully I had three other "jaded graduate students" whom I could rely upon to help me see the humor of this educational process: Carrie Alexander, Mariaelena Jefferds and Julie Reyes. As a result of many serious and not-so-serious discussions about anthropological issues with these women, I acquired three very dear friends.

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Finally, I give my love and thanks to my husband, Andrew Harris, who supported me emotionally, intellectually, and financially while acting as my technical advisor throughout the writing process. Most importantly however, both he and my son Benjamin showed me the importance of striving to achieve one's goals. Thank you.

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Chapter One: **Introduction**

Women's Resource Management

In this analysis, I take up prenatal care as a domain in which pregnancy and birth provide opportunities to examine ordinary health issues specific to women in the context of health care institutions and everyday decision making. Specifically, I focus on how low-income Mexican American women gain access to prenatal care and how this process is linked to their management of social resources, health care clinic personnel's perspectives on women's social resource management, and the role "cultural competency" plays in clinic personnel's views of this process.

Research on the process of gaining access to health care has traditionally focused on how health services are used (Loue, 1999; Strickland and Strickland, 1996), whether or not people have been able to obtain needed medical services (Chrisman, 1977; Igun, 1979; Suchman, 1965) and barriers that prevent the use of services (Estrada et al., 1990; Kasper, 2000; Trevino et al., 1991). For the most part, these models have focused on aspects of the individual that determine use, deflecting attention away from the process involved in gaining access to health care services. In contrast, I argue that an individual's use of the social resources available to her are a more significant indicator of how she will obtain needed medical care and any barrier that might prevent her from using a specific health service. I shift the focus to women's management of social resources to examine women entering the health care system as an active process of gaining access to prenatal care grounded in everyday experience. My study thus explores the process of gaining access t

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gaining access to health care — that is, the decisions women make and the social resources they manage *prior* to entering a health care facility.

In this analysis, I focus on how the resources that are available to women shape the decisions that they make in the process of gaining access to prenatal care. In this dynamic process women draw upon social, economic, and even medical resources for aid in their decision making. For example, this study finds that a greater Lansing public health department gives a woman a list of prenatal clinics to choose from when she enrolls in Medicaid. Choosing a clinic from the list is not straightforward however. A woman must evaluate variables such as the location of the clinic relative to her home, whether the clinic is on a bus route, and whether she will be able to get time off from work to attend her appointment. While choosing a clinic from a list provided by the public health department might seem like the first step in the process of gaining access to prenatal care for many low-income women, it is presupposed by the action of finding out about and applying for Medicaid. The decision making process of gaining access to prenatal care draws upon women's social resources outside of the medical and Medicaid systems. For example, women in this study often found out about Medicaid through social networks composed of family members, friends and co-workers from whom they learned what services Medicaid covered and where they could enroll in it. Women further relied upon these social networks to facilitate the enrollment process — asking a friend from work to trade shifts with them while they spent the afternoon at the public health department, borrowing a parent's car to drive to the appointment, and depending upon a sister to help fill out the application for Medicaid.

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In his ethnography, "The Quest for Therapy: Medical Pluralism in Lower Zaire," John Janzen presents an "on the ground ethnographic account of how medical clients of one region of Lower Zaire diagnose illness, select therapies, and evaluate treatments," a process he calls "therapy management" (1978:xviii). Through a series of case studies he portrays the various medical options available to the BaKongo people of Lower Zaire as well as the intricate measures of the decision making process taken by what he characterizes as the therapy managing group:

> A therapy managing group comes into being whenever an individual or set of individuals becomes ill or is confronted with overwhelming problems. Various maternal and paternal kinsmen, and occasionally their friends and associates, rally for the purpose of sifting information, lending moral support, making decisions, and arranging details of therapeutic consultation. [Janzen, 1978:4]

Similarly to Janzen's concept of a therapy managing group, the social networks women in this study relied upon fundamentally shaped their knowledge about prenatal care and clinics, lent moral and financial support, and were integral to their decision making process as well as facilitating a woman's access to a clinic by offering childcare and transportation. In contrast to Janzen's concept, where women who were ill passively accepted the decisions made on their behalf by their therapy managing group, the women in this study actively made conscious decisions about their care drawing from the resources available to them through their social networks. In general, women relied upon three types of social networks: family-based networks, friend-based networks, and work-related networks. Family-based networks included women's immediate and extended

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kin, their partners and any relatives of their partners as well. Friend-based networks were comprised of people women met as neighbors and childhood friends, and through school, church, and other social gatherings. Finally, women's work-related networks included colleagues as well as contacts made through their colleagues. While each of these networks were largely separate, women in this study configured their use of the networks differently. For example, one woman might rely primarily upon her family-based network for information about prenatal clinics and to meet her transportation needs whereas another woman might rely upon her friend-based network for information about prenatal clinics and upon her work-related network for transportation. Similarly, some women might have only had one network to draw upon whereas another could rely upon all three of the networks.

As discussed above, finding out about, choosing, and using a clinic for prenatal care is far more involved than simply choosing a clinic from a list. As such, the decisions that women make in gaining access to care are not isolated or independent events but rather a series of actions that are linked together with the aim of achieving a specific goal. The interdependency of these actions is the essence of the strategies that women develop to gain access to prenatal care. For example, after learning about Medicaid from her parents, enrolling in Medicaid with her sister's help, and receiving a list of prenatal clinics from the public health department, a woman might choose a prenatal clinic based upon whether she will have to take a bus or have the use of her husband's car to attend her prenatal appointments. Consequently, women draw upon the resources available to them to create strategies to gain access to prenatal care.

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As women go through pregnancy and birth, they achieve access to prenatal care through a series of decisions and routines that I analyze as social resource management. For the purpose of this study, I define social resource management as a process in which women draw upon their social networks — in the form of kin-based, friend-based and work-related networks — to address issues of childcare, transportation, working both in and out side of the home, and unemployment in facilitating access to prenatal care. Similar to a social capital framework of analysis, I posit that relying upon social networks is a typical strategy of low-income people, as they often have no other resources available to them. Whereas a social capital framework portrays networks as given entities measured in terms of the numbers of ties or connections between people and cost-benefit analysis, I use the concept of social resource management to actively reflect the creativity of each woman in developing her networks (i.e., one woman's networks are not the same as another's) and the role she plays in keeping her networks together. Furthermore, I use the concept of social resource management to portray the contingent nature of a woman's access to resources that are provided by a social network. For example, a woman who relies upon someone else for a ride to her prenatal appointment cannot fire that person and then hire another if the person fails to get her to her appointment.

Finally, unlike social capital frameworks in which individuals are portrayed as hyper-rationalistic entrepreneurs developing resources to maximize profit, I argue that women's resource management is based upon their tacit knowledge of social networks established before they became pregnant. A woman does not suddenly develop social networks when she realizes she is pregnant; she draws upon established resources she is familiar with to address a new issue in her life. The strategies that women develop to gain access to pr

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Clinic Personnel's Misconceptions

Clinic personnel, and their organizations, often conceptualize access to services in terms of socioeconomic issues and ethnicity. This is particularly true of "free," "sliding scale," and "public" clinics that serve low-income populations, for the programs and services they offer are structured in terms of working within the limitations of their clients' financial constraints. For example, clinic personnel perceived transportation, lack of health insurance and the inability to pay for needed services as barriers that must be overcome in order to gain access to health care services. As a disproportionate number of low-income workers who rely upon public clinics belong to an ethnic minority, clinic personnel often equate belonging to an ethnic minority with being low-income.[1] Consequently, many clinic personnel view ethnicity as the primary factor in how low-income Mexican American women gain access to prenatal care. For example, many clinic personnel in this study believed that low-income Mexican American women chose not to work while they were pregnant because they were lazy. Clinic personnel concluded that since women were unemployed and pregnant they relied upon Medicaid and thus had access to prenatal care. In such instances, clinic personnel characterized laziness as a Mexican American trait and perceived laziness, rather than a socioeconomic issue, such choosing to be a homemaker due to the high cost of childcare, as the reason why women were unemployed and using Medicaid.

Using the concept of ethnicity in this manner ultimately does a great disservice to understanding how low-income populations gain access to health care services for it reifies what it means to belong to an ethnic minority. For example, typecasting laziness as a Mexican American trait that explains why women might not work during pregnancy reifies what it means to be Mexican American. More significantly however, it illustrates that clinic personnel, and their organizations, fail to understand the fundamental role resource management plays in shaping low-income, ethnic minorities' access to care. In doing so clinic personnel fail to look beyond the boundaries of their clinics, the Medicaid system, and ethnicity to understand, for example, why some low-income Mexican American women might not work during pregnancy. Consequently, clinic personnel cannot appreciate the dilemma a low-income Mexican American woman faces when she realizes that she does not make enough money at her minimum wage job to pay for health insurance yet combined with her husband's salary she makes too much money to qualify for Medicaid so she quits her job while she is pregnant. In turn, clinic personnel do not understand the role family members and friends play as the resources women rely upon to manage access to prenatal care. Contrary to the beliefs of clinic personnel, this study argues that women's management of social resources plays a far more significant role than ethnicity in shaping low-income Mexican American women's access to prenatal care.

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Theoretical Concepts and Critical Approaches to Health Care

The Politics and Economics of Social Resource Management

Using a critical medical anthropology approach, this study shows that the decisions that low-income Mexican American women make in the process of gaining access to prenatal care are shaped by the politics and economics of their social resource management. As other anthropologists have illustrated, a critical medical anthropology approach addresses

> ... health issues within the context of encompassing political and economic forces — including forces of institutional, national and global scale — that pattern human relationships, shape social behaviors, condition collective experiences, reorder local ecologies, and situate cultural meanings. [Baer et al., 1997:27]

Critical medical anthropology frameworks examine the intersection of politics, economics and social relations within the context of health issues at a variety of levels. Baer et al. (1997) propose the four following levels: the macro-social level — involving the development and expansion of a global economic system; the intermediate level — examining class and institutional control of health care systems; the micro-level — referring to the physician-patient relationship and therapy managing groups (Janzen, 1978); and finally, the individual level — examining the patient's experience.

As have other anthropologists (Lazarus, 1997; Rapp, 1999), in this study, I view the locus of critical medical anthropology analysis on the micro and individual levels. In doing so, I explore individuals' everyday experiences and examine the social, political and economic resources low-income Mexican American women draw upon in their

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everyday experiences to gain access to prenatal care. The value of this approach to studying individual experience is that it "regards culturally informed interactions between social actors and political economic relationships as dialectically related" (Morsy, 1990: 27). I show that women's social resource management is not closed and independent of other systems or individuals but rather a fluid process in which women draw upon a variety of resources, and that they use this approach in gaining access to prenatal care. For example, a woman might find out about prenatal care from an immediate family member, learn about how and where to enroll in Medicaid from a co-worker, and rely upon a friend to drive her to her prenatal appointments.

Libbet Crandon-Malamud develops upon this theoretical perspective in her 1991 ethnography, "From the Fat of Our Souls: Social Change, Political Process, and Medical Pluralism in Bolivia." Her investigation into the reasons people choose or combine indigenous and cosmopolitan medical systems shows that choice of medical care is not based on medical efficacy but rather on political concerns. In a medically plural environment in which people have a variety of medical systems to choose from, Crandon-Malamud argues that medicine restructures social relations outside of the medical context. She illustrates this interaction in examining the medical, religious and ethnic pluralism of Aymara society in Kachitu, Bolivia. Three medical ideologies, or resources, were available to the Aymara in Kachitu: Aymara medicine — dispensed by indigenous healers; medicinas caseras — dispensed by mothers in their own home; and cosmopolitan medicine — dispensed at the local Methodist hospital. Crandon-Malamud posits that the boundaries of these three medical ideologies are not concrete, as each of the ideologies appropriated resources and ideas as needed. Broadly defined in religious and ethnic terms, the people in Kachitu fall into three groups: Aymara Indians — land-based peasants excluded from most political and entrepreneurial life; Methodist Aymara — educated and politically active, they participate in the cash economy; and the Mestizos — Catholics who, while currently less well off, were historically socially, politically, and economically dominant in Kachitu.

For the Aymara people of Kachitu shifting of resources between medical ideologies and medical beliefs is intricately tied to shifts in social relationships. Crandon-Malamud argues that ethnic and religious identities are expressed through diagnostic opinions and the strategies that those identities define (1991:25). For example, having no cash and being in an economically precarious position, an Aymara campesina whose daughter is sick might first seek the knowledge of medicinas caseras before drawing upon other resources, such as the child's Mestizo godmother, in strategizing her daughter's treatment. Recognizing that she is unable to pay the physician's fees, the mother exhausts her knowledge of medicinas caseras before turning to the Mestizo godmother, for the latter option carries with it its own cost. While the godmother would be able to facilitate access to the physician at the Methodist hospital, it would create a social debt between the two women of different religious, ethnic, and economic domains.

Considered within the fluid context of an environment in which a variety of ethnic, religious, and economic systems co-exist, medical dialogue is used to create alliances across boundaries that are permeable (1991:22). The concept of alliance building is the cornerstone of Crandon-Malamud's argument — "that medical ideology is not a single logical construct but rather a series of options that permit the negotiation of social relations" (1991:139). Crandon-Malamud thus posits that medicine is a primary

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resource that people use to gain access to secondary resources that are economic, social, and political. While recognizing that the negotiation and acquisition of resources are shaped by economic conditions and class relations, her argument is formulated upon the notion that individuals actively and consciously select from and use the resources available to them to accomplish their own ends. For Crandon-Malamud this approach is valuable because

> [T]he patient suddenly emerges from this complex, constantly changing, and politically charged situation as a kind of decision maker that most scientists want to avoid: he is not the Rational Man looking for medical efficacy; rather, he is a social and political animal who at times may be looking for meaning through efficacy which becomes a validation for some sociopolitical or economic proposition, but more often is looking for efficacy through meaning in a sociopolitical and economic context. [1991:32-33]

As low-income Mexican American women go through pregnancy and birth they achieve access to prenatal care through a series of decisions and routines that I analyze as social resource management. Drawing from Crandon-Malamud's work with regard to the concept of resource management, I argue that the resources that women draw upon through social and economic networks — alliance building — form the basis of the strategies women develop to gain access to biomedical care. Whereas Crandon-Malamud views medical care as a primary resource, I perceive the social and economic resources women draw upon, such as networks of family and extended kin, as primary resources used to achieve access to a secondary resource, specifically, prenatal care.

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Whereas Crandon-Malamud's study included patients of varied ethnicity this study focuses solely upon Mexican American[2] women and the resources they manage to gain access to prenatal care. The participants in this study however, straddle a socially pluralistic environment similar to that found in Crandon-Malamud's research and my study's participants, loosely defined, fall into two groups: women seeking prenatal care and health care workers providing care. Furthermore, the two groups varied greatly in social class.

Gilbert (1998) presents a model of American class structure that recognizes a small elite class which draws its wealth from return on assets and a large majority who do not own capital. His model stratifies the population into six classes based upon typical occupations and income: 1) the capitalist class (average income, $1.5 million) — investors, heirs, and executives; 2) the upper-middle class ($80,000) — university-trained managers and professionals; 3) the middle class ($45,000) — semi-professionals, craftsmen, and foremen; 4) the working class ($30,000) — low-skill manual labor, clerical and retail sales; 5) the working poor ($20,000) — lowest-paid manual, retail, and service workers; and 6) the underclass ($10,000) — unemployed or part-time menial jobs and public assistance. In this model, the women seeking care in this study belonged to the bottom two classes — the working poor and underclass. In contrast, the clinic personnel straddled social classes ranging from the working class to the upper-middle class.

Broadly defined, women seeking care were pregnant, Mexican or Mexican American, 18 years or older, on average had attended high school through the 11th grade, and were low-income workers.[3] Roughly half of the women were single and employed outside of the

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outside of the home working in maintenance, the food service industry, housekeeping, and as cashiers. Many married women worked within their homes as homemakers and their husbands were employed as gas station attendants or worked in construction and food service. As low-income workers, the women were eligible for state-provided prenatal care through the Medicaid system.

Clinic personnel in this study varied in social class. While all were employed in white-collar jobs, their work ranged from that of reception clerks to physicians. Their annual income subsequently encompassed a wide disparity. Clinic personnel education levels similarly ranged from a General Education Diploma (GED) to a Medical Degree (MD). Whereas all of the women seeking care were Mexican American, clinic personnel's ethnicity was more diverse — "white," Hispanic, and Asian.[4] The majority of clinic personnel were women and roughly half were married. Despite clinic personnel's varying social class and ethnicity and their interest in continuing to offer health care services to low-income people, as a group they did not understand the everyday experiences and challenges facing the low-income Mexican American women they serve. Often clinic personnel expressed frustration with regard to women they served as they perceived them as taking advantage of the Medicaid system yet not fully utilizing the resources, such as mother and infant nutrition programs, that prenatal clinics had to offer.

While each pregnant woman's goal in this study was to gain access to biomedical prenatal care, I use Crandon-Malamud's notion of a fluid environment in which individuals actively and consciously select from and use a variety of resources to accomplish a specific goal to convey the complexity of low-income Mexican American women's resource management. For example, in this study a woman might rely upon a

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friend to find out about a prenatal clinic, a nurse at the clinic to find out about payment options, the public health department to enroll in Medicaid, and a co-worker to drive her to her prenatal appointments. Of fundamental concern is how the woman will pay for prenatal care — will she use a sliding scale or is she eligible for Medicaid coverage? She must rely upon either a payment system offered by the clinic or the Medicaid system administered through the public health department. She similarly draws upon a work-related economic system by relying upon a co-worker to transport her to and from her prenatal appointments.

The economic basis of strategy outlined above is simultaneously influenced by political power — defined as the ability to modify the behavior of others and enforce a monopoly of opinion (Crandon-Malamud, 1991). The information the clinic nurse shares with the woman about payment options is based upon the financial policies of the health care organization for which the nurse works. The process of enrolling in Medicaid is similarly structured by institutional guidelines for enrollment at both the public health department and State levels. Medicaid policy, written by the State's legislature, further shapes the economic basis of a woman's strategy by determining the services that will be covered and thus the services to which a woman will have access (e.g., a clinic that participates with Medicaid, one ultrasound during a pregnancy, and a semi-private hospital room).

I draw on concepts from political economy to analyze low-income Mexican American women's resource management and recognize that women make decisions and thus develop strategies to gain access to prenatal care that are shaped by both political and economic issues. In this context, women's resource management is not a single logical constr

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logical construct that is closed and independent of other systems but rather one of options in which a woman's strategy is shaped by social, economic, political and medical issues. Consequently, the strategies that women develop to gain access to prenatal care thus involve steps that are managed strategically based upon the broad scope of women's social and economic resources.

Medical organizations, clinic personnel, and their clients operate and coexist in a political and economic environment (Crandon-Malamud, 1991:32). By examining the views and behavior of women and clinic personnel as actors and strategists actively navigating a health care system, I analyze the political economy of resource management and address the disparity between low-income Mexican American women's and clinic personnel's views of gaining access to prenatal care.

Conceptualizations of Health Care "Access" and "Barriers"

My study takes up the issue of the process of gaining access to health care — that is, the decisions women make and the social resources they manage *prior* to entering a health care facility. In contrast, research on gaining access to health care has generally focused on catch phrases such as "health care utilization," "access to health care," and, more recently, "barriers to care." Each of these terms implies a very different focus of investigation. "Health care utilization" most often refers to the "kind of services provided, the site of the service, the purpose of the service, the person or the entity that provided the service, and the time interval for the service" (Loue, 1999:65). For example, in a study on rural health, Strickland and Strickland (1996) assessed the use of preventative health services by low-income minority households in the South. Focusing on patterns of

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on patterns of health care utilization and preventative health care access models, the authors concluded that pregnant women most often received medical care and children were more likely than adults to receive physical checkups (Strickland and Strickland, 1996).

The Institute of Medicine as has broadly defined access and barriers to care:

> A shorthand term for a broad set of concerns that center on the degree to which individuals and groups are able to obtain needed services from the medical care system. [1993:4]
>
> Whether opportunities for good health outcomes are systematically denied to groups in society. [1993:4]

Research on "access to health care" and "barriers to care" has focused on issues ranging from elements of access, such as availability, accessibility, accommodation, affordability, and acceptability (Loue 1999:68), to pathway models for seeking care (Chrisman, 1977; Suchman 1965; Weller, 1997), to studies that address factors that affect service use as barriers to health care (Estrada et al., 1990; Kasper, 2000; Trevino et al., 1991). Judith Kasper highlights a recent trend in health care research on access and barriers to care as she points out in her discussion of "Health Care Utilization and Barriers to Health Care," that access to care and barriers to care are often used interchangeably for it reflects a prevalent trend in policy oriented research of the biomedical health care system — "Barriers provide targets for policy intervention" (2000:326).

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Barriers to Entry

Growing interest in research on access to health care and barriers inhibiting access to care has focused on three aspects of health care utilization: 1) barriers to gaining entry to care; 2) barriers in the process of receiving care; and 3) barriers from the consumer's perspective (Kasper, 2000). In this framework, access is conceived of as a two part model in which health care policy lays the foundation for access and characteristics of a population, usually an "at risk" population, determine an individual's use of the system. As Loue (1999:68) explains,

> The health care delivery system consists of two primary elements: (1) resources, such as labor, capital, personnel, and materials, and (2) organization, which refers to the process of entering the health care system and receiving treatment and to the structure of that system. ... The characteristics of the population at risk encompass the enabling, predisposing, and need factors that constitute the individual determinant of utilization.

Working within Loue's two-part model of access, "enabling" factors refer to the resources available to an individual for the use of services, "predisposing" factors are an individual's demographic characteristics, and "need" factors are determined by the extent or degree of an individual's illness.

The aforementioned model focuses on aspects of the individual that determine use, deflecting attention from the process involved in gaining access to health care services. For example, Loue's two part model might suggest that an individual is inclined to use, or not use, a specific health service based upon demographic characteristics such as their age or ethnic background. In contrast, I argue that political and economic aspects

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of an individual's social resource management are a more significant indicator of whether or not she will use available health care services. By shifting the focus to women's social networks and resource management my study examines how women enter the health care system — the active process of gaining access to prenatal care grounded in everyday experiences — rather than presuming that their entrance is determined by a fixed set of individual predisposing factors.

Many health organizations conceptualize "access" as "availability" (Loue, 1999). In this study however, I draw a distinction between the availability of and access to health care. I use availability to describe a health service in relation to patients who are eligible for care. Studies of availability focus on measures such as numbers of insured patients; numbers of physicians, hospital beds, and hospitals per capita; and similar yardsticks as though access to medical care is equitable. I define access to medical care as a process in which a woman is engaged in seeking care, in relation to her particular situation, including finances, insurance, eligibility for a given health service, household decision making, and transportation.

Research on how "populations at risk" gain access, or entry, to health care services has often focused on the process of seeking health care, specifically, "pathway models for seeking care" in which researchers diagram the steps individuals take in obtaining needed medical care (Chrisman, 1977; Igun, 1979; Suchman, 1965). Research on pathway models for seeking care have conceptualized and evaluated disease and access to health services in terms of biomedical care. Suchman (1965), for example, proposed a five-stage model to explain the disease process in which a person first experienced a symptom of a disease, identified himself as sick, established needed biomedical ca

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biomedical care, identified himself as a patient, and, finally, recovered from the disease. At the same time however, Suchman recognized that "an individual's response to medical care is influenced by various group relationships at the community, social group, and family levels" (Loue 1999:69).

Working upon this premise other social science researchers, anthropologists in particular (Crandon-Malamud, 1991; Janzen, 1978), have recognized the significance of individual and group relationships that are intricately entwined with economic and political issues at various societal levels. Fernandez-Kelly (1983), Roseberry (1992), and Wolf (1982), highlight this theme in their respective discussions of household dynamics in the context of historical, political, and economic relationships to the community.

In this vein, studies of barriers to entry to care have focused on characteristics of individuals and their social environments, such as poverty and socioeconomic status (Bushy, 1990; Hunter et al., 1991; Wojtusik and White, 1998), and ethnic minorities and culture (Chang and Fortier, 1998; Harmon et al., 1996; Scribner and Dwyer, 1989). Kasper (2000:327) asserts however, that "[D]espite skepticism about the ability of health services to significantly intervene in the relationship [between poverty and poor health], the extent to which poverty or low socioeconomic status contributes to problems in obtaining care has been a major focus of access studies and remains a key test of health system equity."

In assessing how barriers to care inhibit individuals' access to health care services much attention has been given to ethnic minorities, specifically Latinos, and culture (Browner, 1989; Estrada et al., 1990; Molina and Aguirre-Molina, 1994; Moore and Hepworth, 1994; Solis et al, 1990; Trevino et al., 1991; Valdez et al., 1993). "The use of race as an explanatory variable in health services research has been challenged recently on the grounds that it often functions merely as a proxy for other characteristics, primarily socioeconomic status" (Kasper, 2000:328). LaVeist (1994) for example, asserts that the concept of race is poorly understood because it lacks conceptual clarity. Consequently, comparisons of health indices for racial or ethnic groups in the United States are often presented without stratifying or accounting for socioeconomic conditions (Blanton and LaVeist, 1996). Williams and Collins (1995:366) argue however, that researchers must continue to address race and ethnicity in examining the inequity of health care access because racial and ethnic discrimination persist in the health care system.

Ethnicity and Health Research

Much of the literature on ethnicity and health care reflects researchers' interest in minority populations' use of alternative or indigenous sources of care. Employing a medically pluralistic approach (Janzen, 1978), researchers have worked upon the premise that ethnically diverse populations will seek care from both a provider specific to their ethnic culture as well as a biomedical care provider (Beckerleg, 1994; Janzen, 1978; Rehbun, 1993).

Efforts to understand what is traditionally referred to by the medical community as "complementary" or "alternative" medicine have motivated many researchers to examine ways in which "folk" medicine and biomedicine can be integrated in everyday practice. As Elvia Krajewski-Jaime explains in her chapter on "Folk Medicine Among Mexican American Families" in "Rethinking Ethnicity and Health Care" (1999), clinic

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personnel should consider cultural factors, such as the belief in folk medicine, that shape the ways in which Mexican American families deal with the health problems of their children. She further argues that by attempting to integrate "folk beliefs" and biomedicine the health care practitioner can enhance the intervention process. One example Krajewski-Jaime gives to illustrate how this might be achieved is to keep an infant or child partly covered during a physical examination in the effort to reduce the mother's fears about mal aire (1999:259).

In the literature it appears that two ramifications have burgeoned out of researchers' interest in the interplay of alternative medicine and biomedicine. One has been the recognition that "Hispanics" in the United States are a heterogeneous population that has a diverse cultural, political and historical background (Blea, 1988; Krajewski-Jaime, 1999; Padilla, 1985; Portes and Bach, 1985). As a result, political and economic issues specific to different "Hispanic" groups have come to the forefront of understanding how and why people choose particular clinic personnel. For example, the role that gender, class and nationality play in Mexican and Mexican American women's access to U.S. biomedical health care illustrates socioeconomic aspects of women's choice of medical systems on the U.S.-Mexico border (Guendelman and Jasis, 1992; Estrada et al., 1990; Higginbotham, 1990; Moore and Hepworth, 1994; Solis et al., 1990; and Trevino et al., 1991).

On the other hand, efforts to achieve the practical integration of folk medicine and biomedicine seem to be caught in a backlash of sorts in which folk medicine is perceived as a barrier to biomedical health care (Krajewski-Jaime, 1999:252). This view is supported in particular by biomedical clinic personnel who perceive folk remedies as

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hazardous to patients' health. Most significantly however, clinic personnel's perception of folk medicine as a barrier has spurned a plethora of investigations into research on barriers to health care in general and why ethnic minorities might prefer folk or alternative medicine to biomedicine. For example, in examining access to biomedical health care on the U.S.-Mexico border, Guendelman and Jasis (1992) argue that socioeconomic factors and Mexican women's attitudes towards U.S. obstetrical care determine their choice of utilizing Mexican or U.S. health care services. Higginbotham (1990) tempers this definitively socioeconomic argument in his examination of Mexican Americans' use of *curanderos* and biomedical health care services in which he posits that Mexican American use of a *curandero* is related to cultural orientation and dissatisfaction with biomedical care, but not to income and availability of biomedical services. In contrast, Estrada et al. (1990) identified a number of factors, such as lack of health insurance, the high cost of health care, low income, and lack of transportation, as barriers that affect Mexican Americans' use of biomedical health care services.

Cultural Competency

Health care practitioners' growing awareness of their patients' ethnicity and the role complementary or alternative folk medicine plays when providing health care services has burgeoned into a standardized field of cultural competency training. Whereas folk medicine was previously perceived by biomedical health care practitioners as dangerous and thus a barrier to health care, clinic personnel are now being urged to view folk medicine as a positive resource that should be capitalized upon when treating ethnic minority populations (Krajewski-Jaime, 1999:252).

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Training courses in cultural competency have for the most part, been health care organizations' main venue in helping clinic personnel — from intake workers to physicians — to re-conceptualize folk medicine as a positive resource (Foard, 1995; Rorie et. al., 1996; Salimbene, 1999; Zayas et. al, 1997). Defined as "[t]he knowledge and interpersonal skills that allow clinic personnel to understand, appreciate, and work with individuals from cultures other than their own" (McManus 1988), cultural competency training is based on research that assesses demographic and health status statistics for a given ethnic population in relation to the role of culture in health care. For example, in their article "Meeting the Health Promotion Needs of Hispanic Communities," Delgado et al. (1995) state that compared to other ethnic groups in the United States, Hispanics are less likely to own a home, are less educated, more inclined to live in poverty, and in general, have a lower health status than the non-Hispanic population. Among other solutions, the authors argue that clinic personnel should receive cultural competency training to understand the impact of culture and language on Hispanic health.

Research, and consequently, training in cultural competency has had an unintended side effect in that efforts to recognize the ethnic diversity of populations seeking health care have led to the inadvertent reification of what it means to belong to a particular ethnic group. In response to the unequal status of health and health care access for ethnic minority populations, The Office of Minority Health, the U.S. Department of Health and Human Services and other health science researchers have undertaken the task of documenting the health status of ethnic minority populations in the United States (Xueqin Ma and Henderson, 1999).

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The findings in these task force and research reports have been intended to highlight the health care gap between ethnic minorities and whites, improve access to health care, and raise cultural awareness through cultural competency training; however, much of the research (Davis and Voegtle, 1994; Erzinger, 1999; Franke and Ohene-Frempong, 1999; Jones-Saumty, 1999; Penn et al., 1999; Xueqin Ma and Henderson, 1999) has reified health issues and what it means to belong to minority ethnic groups by boiling complicated health issues and diverse cultural "characteristics" down to the most prevalent illness and ethnic beliefs or traits. In many ways it is not surprising that health researchers have boiled ethnic differences down to a few essential variables as this fits with the biomedical model of reducing a complex series of factors so that they can be plugged into the decision making model of health access and disease.

The American Medical Associations' guide for primary clinic personnel titled, "Culturally Competent Health Care for Adolescents" (Davis and Voegtle, 1994) clearly illustrates this point. Chapter 5, "Portraits of Major U.S. Racial/Ethnic Groups," is intended to give clinic personnel an overview of demographic, socioeconomic, and cultural beliefs and practices for the four major ethnic minority groups in the United States — African American, Asian, Hispanic, and Native American. The authors do suggest that not all of the information in each section applies to all people in each ethnic group however the portraits are intended to highlight "common cultural elements for these groups" (Davis and Voegtle, 1994:39). Although the section on the Hispanic population in the United States recognizes that "Hispanic" refers to a diverse group of people from a variety of Latin American countries, the authors' discussion of "Hispanics'" beliefs about health and illness are shaped by the common belief that poor health, and

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events in their lives in general, "result from luck, fate, or other powers beyond the individual's control" (Davis and Voegtle, 1994:52). The authors thus suggest that recognizing this aspect of Hispanic culture will aid clinic personnel when interacting with Hispanic patients:

> This may be helpful in some cases, for example, when a family views a youth with a chronic disability as not being responsible for his or her condition. However, it may lead to more passive participation in treatment or healing. [Davis and Voegtle, 1994:52]

The goals of such guides are valuable in that they are the most readily accessible resources in educating clinic personnel about the significant role cultural beliefs play in their interactions with patients. Unfortunately, researchers' efforts to disseminate a vast and diverse amount of data about ethnic populations have led to the reification of ethnic groups — diabetes and homicide are viewed as African American issues; early sexual activity and teen pregnancy are viewed as Hispanic issues; and alcoholism is viewed as a Native American issue (Xueqin Ma and Henderson, 1999). Consequently, the fluidity of cultural beliefs and diversity of socioeconomic, demographic and health data are posited as fixed representations of whole populations rather than beliefs, characteristics, and health issues specific to individuals.

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Other Conceptual and Theoretical Issues

Gender Centered Approach

Contemporary work in ethnography and other social sciences shows that recently highlighted dimensions of society need to be taken into account to understand the everyday pursuit of health and healing. One of these dimensions is gender. Within social science, and more specifically the field of anthropology, there has been a growing awareness that gender must play a central role in ethnographic analysis, addressing political and economic aspects of health. Growing advocacy for the centrality of gender in understanding the everyday pursuit of health and healing is illustrated by social scientists, such as Linda Whiteford (1996), who argue that gender must take center stage in the analysis of health and illness. Whiteford posits that rather than adding gender to the list of variables to be considered in analysis, the culture and political economy of health must be situated within a feminist approach from the start (see also di Leonardo, 1991 on the centrality of gender in anthropological analysis). Consequently, she calls for the "gendering" of political economy in anthropology to understand the processes underlying the social production of health (1996). In Whiteford's view, the goal of a gendered perspective of a political economy of health is to create an intersection of global, political, and economic interactions and local systems, communities, and actors — contextualizing local cultural, social, political, and economic processes within a historical perspective. Following her argument that health is socially produced, the dimension of gender thus sheds light on ways in which the social construction of gender roles restrict women's access to resources. As a result, a gendered approach to health illustrates th

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Tacit Knowledge: Negotiating Access to Health Care Services

Pregnancy and birth are events that are between commonplace and unique everyday experiences. As such, women draw upon tacit, or practical, knowledge (on tacit or practical knowledge see, Giddens, 1979) as well as creating new strategies to manage pregnancy and birth. Health care workers similarly negotiate their interactions with patients (Martin, 1987), drawing upon preconceived notions and tacit knowledge of both the health care organization they work for and the people who are attempting to gain access their services.

My interpretation of women's negotiation of health care access and health care workers' views on providing access to low-income Mexican American women is grounded in a practice perspective (Bourdieu, 1980). A practice perspective allows me to center the locus of my investigation on the actor, personhood, and everyday experiences. Consequently, by examining the data from a theoretical approach grounded in practice I analyze how women manage resources in the everyday experience of negotiating child care, working both in and outside of the home, dealing with social and economic issues of unemployment, and living in extended family households. Furthermore, this theoretical approach facilitates the examination of the goods and services of social economies, such as childcare, transportation, and extended family networks that women use in managing access to health care services. Thus, a practice approach conveys the notion of a

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I draw on this approach to examine the views and behavior of clinic personnel as actors and strategists in facilitating low-income Mexican American women's access to prenatal care. Analyzing clinic personnel's perceptions of low-income Mexican American women's expectations of and beliefs about the U.S. biomedical system shows how the politics and economics of resource management influences clinic personnel's understanding of health care access. As illustrated in later chapters, investigating clinic personnel's perceptions of low-income Mexican American women's access to health care in the context of clinic personnel's daily clinical experiences, including waiting room interactions, intake interviews, and consultations, evidences that the process of gaining access to health care services articulates with clinic personnel's preconceived notions of what it means to be poor, female, and Mexican American, as well as with the gender and ethnicity of clinic personnel themselves.

A practice approach portrays the notion of women and clinic personnel actively navigating a health care system as well as how barriers related to gender, ethnicity, and political economy influence clinic personnel's perceptions of access. By revealing how institutional structures, such as types of health care services, payment options, and support services that are offered to, or withheld from women, and everyday experiences influence low-income Mexican American women's social resource management in the process of gaining access to prenatal care, this study provides an understanding of two aspects of access: as a process that women manage individually and, as perceived by clinic personnel, a process that women go through effortlessly in a routine way.

Endnotes

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[1] According to the State of Michigan Department of Social Services, in 1995 172,960 families in Michigan received assistance from the Aid to Families with Dependent Children (AFDC). Based upon ethnicity, of these total recipients 42.8% were white, 51.7% were back, 0.4% were American Indians, and 2.9% were Hispanic. As Fayyaz Hussain points out in his research report, "Social Welfare Reforms in Michigan: Intent and Implications for the Poor" (1996), the 42.8% of white AFDC recipients is significantly less than their proportional population of 82.4% in Michigan. Conversely, the 51.7% of black AFDC recipients are much larger than their proportional population of 13.5%. Hussain thus concludes that "an out of proportion population of blacks, Native Americans, and Hispanics in Michigan are living in poverty . . . and that this uneven poverty leads to an uneven number of welfare recipients across the above-mentioned population subgroups" (Hussain, 1996:4).

[2] I use the term Mexican American to refer to those who belong to an ethnic group also known by various other names, including "Mexican" and "Chicano," and more broadly, "Latino" and "Hispanic."

[3] In this study, low-income is defined in terms of the State of Michigan Family Independence Agency's 1997-1998 guidelines in which family income and number of children are used to calculate eligibility for Medicaid services. For example, a family of three with a monthly income of $1,623.00 or less is considered low-income and thus qualifies for Medicaid coverage. I chose to use the Family Independence Agency's guidelines for defining low-income as the baseline in this study because it provides for parity between the three clinics in which I was collecting data

[4] These ethnic categories are based upon the U.S. Census Bureau's standardized classification system. While conceptually problematic, I use these categories because they reflect the system of ethnic classification that clinic personnel refer to when interacting with patients who belong to an ethnic minority. See Martin N. Marger's book, "Social Inequality: Patterns and Process" (1999), for an in depth discussion of the conceptual problems with this system of racial and ethnic classification.

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Chapter 2: **Methods**

The participants' views and experiences analyzed in this dissertation were drawn from 15 months of ethnographic research conducted in Lansing, Michigan throughout 1997 and 1998. Data were collected through participant observation and open-ended interviews in three OB-Gyn clinics that serve low-income women — a Latino community health center clinic, a public health clinic, and a hospital based clinic. Data for this research were collected in two phases. The first phase involved participant observation and open-ended interviews with low-income Mexican American women who lived in the Greater Lansing area, addressing the strategies women developed to gain access to biomedical health care during pregnancy and birth. Phase two focused on investigating clinic personnel's perspectives of low-income Mexican American women's access to health care during pregnancy and birth using these same methods.

The three clinics in which I collected data were chosen both because of their similarities and their differences to each other. While all three were biomedical clinics that served low-income women, each was structured differently by the parent organization. For example, the community center clinic was housed on the first floor of a Latino community center that sponsored a wide variety of services ranging from after-school childcare to food subsidy for agricultural migrant farm workers to Alcohol Anonymous programs. While the health clinic was a department of the Latino Community Center it was a self-contained unit with its own director and staff. In keeping with the mission of the Community Center, however, the clinic was not solely limited to OB-Gyn care. In fact, the clinic set aside only one morning each week for OB-Gyn care.

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The rest of the week was dedicated to general practice, a pediatrics clinic, and, in the summers, a mobile migrant health clinic which visited local migrant farm worker camps one evening each week.

The Public Health Clinic, housed in the wing of a large Public Heath Department, and the Hospital Clinic, located in a modular unit in one of the hospital's parking lots, were similar to the Latino Community Center Clinic in that they were also departments within larger organizations. Each clinic, however, acted as a self-contained unit with its own director and staff. Unlike the Latino Community Center Clinic, these clinics practiced solely obstetrics and gynecology every day of the week.

Sampling Strategies

The participants in this study were selected using non-probability sampling, specifically judgement and opportunistic sampling methods. I chose the research settings and the participants to deliberately reflect the experiences of low-income Mexican American women using prenatal care. The three clinics in which data were collected were intentionally chosen to represent the variety of biomedical prenatal care available to low-income workers in the greater Lansing area: public, private, and community center funded clinics. As I discuss below, both the women seeking care and the clinic personnel were selected to participant in this study based upon the virtue of their status as either low-income Mexican American women seeking care or clinic personnel working in the prenatal clinic.[1]

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Criteria for Selecting Women

Women seeking prenatal care qualified to participate in this study based upon the following criteria. The women had to be: 1) pregnant or have given birth within the last three months; 2) at least 18 years or older; and 3) of Mexican or Mexican American descent. I invited women who met these criteria to participate in the following manner.

Latino Community Center Clinic

Using the clinic appointment schedule, I approached women in the waiting room to discuss my study, find out if they were interested in participating, and determine if they met the aforementioned selection criteria. If women indicated they were interested in the study I obtained their informed consent to participate.

I approached every woman on the clinic appointment schedule who was in the waiting room and had a Hispanic first or last name — usually 5 to 7 women each day. Of the women I approached, on average, 1 to 2 women would decline to participate because they were busy filling out clinic paperwork, had to watch their children, or simply were not interested in talking with me. On any given day, roughly one third of the women on the schedule did not meet the selection criteria, primarily because of their age or ethnicity. I usually conducted interviews in the waiting room while women were waiting to see the physician.

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Public Health Clinic

Women were identified by the clinic Charge Nurse as potential participants for my study. Based upon the following criteria, each week the Charge Nurse would review patient charts and insert a copy of the consent form for my study into the files of patients she believed to be Hispanic because: 1) their first or last name appeared to be Hispanic; 2) they checked "Hispanic" on their intake sheet; 3) she had first hand knowledge of the woman. The consent form for my study, copied onto bright orange paper so it would stand out from other documents in the patient's chart, served as a flag to the Clinic Nurse who worked with the patient. The Clinic Nurse would explain my study and then ask the patient if she was interested in talking with me. If the woman agreed, the Clinic Nurse escorted her to the coffee/education room where I was waiting.

Upon greeting the patient I discussed my study with her, found out if she was interested in participating, and reviewed the aforementioned selection criteria. If the woman met all of the selection criteria and was interested in my study, I then obtained her informed consent to participate. Interviews were conducted in the coffee/education room in between the patient's assessment interview with the Clinic Nurse and her physical exam with a nurse practitioner or physician.

While the same Charge Nurse was responsible for identifying potential subjects in the study by placing the consent form in a patient's file, all five of the Clinic Nurses were involved in recruiting potential participants. As a result, there was some continuity in the initial selection process whereas I had little control over the way in which the Clinic Nurses were presenting my study and thus recruiting participants. Regardless, the major drawback to the overall process was that I had very little control of the selection and n

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recruitment process. Consequently, I was unable to assess what percent of women who came in to the clinic on a given day were potential subjects, how many were overlooked as potential participants, what percent declined to participate, and, finally, why they declined to participate.

Hospital Clinic

Similarly to my approach at the Latino Community Center Clinic, I used the clinic appointment schedule at the Hospital Clinic to identify women who qualified as potential subjects in my study. Usually, I approached women in the waiting room to discuss my study, find out if they were interested in participating, and determine if they met the aforementioned selection criteria. If women indicated they were interested in the study I invited them to join me in an empty exam room where I conducted the interview after obtaining their informed consent to participate. About a third of the time, however, I interviewed women in their exam room in between their visit with the nurse and the physician.

I approached every woman on the clinic appointment schedule that was in the waiting room and had a Hispanic first or last name — usually 3 to 4 women each day. Of the women I approached, on average, 1 to 2 women would decline to participate for the reasons listed above. On any given day, roughly three fourths of the women on the schedule did not meet the selection criteria, primarily because of their age or ethnicity.

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Criteria for Selecting Clinic Personnel

All of the clinic personnel at each of the three clinics were eligible to participate in this study as I was interested in interviewing front desk workers, receptionists, nurses, and physicians to elicit perspectives of women's access to prenatal care at each step of the process. My goal was to interview a minimum of two receptionists, two nurses, and one physician at each of the three clinics. Since I had been in the clinics conducting participant observation and interviews with patients, the majority of clinic personnel knew me and were familiar with my research. I usually would approach clinic personnel in passing or stop by their offices to ask them if they were interested in participating in my study; thus, I set up interviews in advance as clinic personnel schedules permitted.

At the time of the interview, I re-explained the purpose of my research, confirmed the subject's interest in participating, and then obtained their informed consent to participate. Interviews with clinic personnel were conducted either in clinic personnel's offices or in a quiet, relatively private area, such as a corner of a hallway or vacant office space, at each of the three clinics. On any given day roughly half of the clinic personnel were absent from the clinics due to rotation schedules and part-time employment. Only two of the 19 clinic personnel I approached declined to participate — one because she was too busy and the other because she did not want to "be in a study."

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Open-ended Interviews

Phase I

In Phase I, I conducted 27 semi-structured interviews with open-ended questions with women in the three clinics. Bernard (1988) indicates that interviewing, combined with direct observation, is a useful method for eliciting reliable data. Interviews were loosely structured based upon a written list of questions and topics that I wanted to cover in a particular order in each of the interviews (see Appendix A). After completing two or three interviews, I modified the interview guide to include questions about gaining access to Medicaid as this seemed to be, and continued to be, a major theme in women's discussions.

As discussed above, prospective subjects were first identified by name, as listed on clinic appointment schedules, and then asked to identify their ethnicity at the start of the interview. Interviews were conducted in the waiting room of the community center clinic, in the education and coffee room at the public health clinic, and in an exam room or the social worker's office at the hospital-based clinic. In these interviews I elicited women's experiences and explanations for the kinds of health care services they were seeking or sought during pregnancy and childbirth.[2] More specifically, I noted whether the women reported that family and friends had offered advice, and whether husbands and other family members had participated in making decisions either by facilitating or constraining the process.

I focused on four sets of questions in interviews with women. The first addressed demographic issues such as place of birth, marital status, and number of children. The second set of questions addressed employment and education. The third set investigated what ki

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what kinds of health care services women used, their reasons for using specific services, how constraints such as finances, insurance policies or lack thereof, and transportation influenced their decision making process, and any services women wanted to use but could not. The final set of questions, which were open-ended, focused on women's expectations about labor and birth and, when applicable, how women expected their upcoming labor experience to be different or the same as in previous pregnancies. Interviews took roughly 35 to 70 minutes, depending upon the participant.

Phase II

In Phase II of my research, I conducted open-ended interviews with health clinic personnel at each of the three clinics. Again, interviews were loosely structured based upon a written list of questions and topics that I wanted to cover in a particular order in each of the interviews (see Appendix B). After completing a couple of interviews, I modified the interview guide to include questions about why clinic personnel thought women might not be working during pregnancy as the issue was raised often in the course of the interview.

Women come into contact with a variety of different health care workers, or clinic personnel, in the process of gaining and then managing their access to biomedical health care. In light of this, I interviewed front desk intake workers and receptionists, nurses, and physicians to elicit their perspectives on women's access at each step of the process. I focused interviews with intake workers and receptionists on their perceptions of accessibility of health care at their clinics, their experiences in admitting low-income Mexican American women, and their explanations about barriers to health care.

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Interviews with nurses and physicians similarly focused on their perspectives on the accessibility of health care at their respective organizations, and, specifically, clinic personnel's experiences with low-income Mexican American women in health care settings. A minimum of two intake workers or receptionists, two nurses, and one physician were interviewed at each of the three health care organizations. I conducted a total of 15 interviews. Interviews at the community center clinic were conducted in whatever quiet space could be found, usually two chairs placed in a quiet corner of the hall. In contrast, interviews at both the public health clinic and the hospital-based clinic were conducted in clinic personnel's respective offices or in an empty office or conference space.

Similar to the format used in Phase I, my interviews with clinic personnel began with demographic issues and then addressed education and employment, investigating how and why clinic personnel came to work in a health care profession. The third set of questions elicited clinic personnel's perspectives on issues ranging from why they thought that women sought prenatal care to how women found out about and chose a clinic. The fourth and final set of questions, which were open-ended, investigated clinic personnel's perspectives on barriers they perceived women faced in gaining access to health care, such as having private (commercial) vs. public (Medicaid) health insurance, provider-patient interactions, and language and "cultural" barriers.

I had anticipated that interviews with women seeking care would be conducted in Spanish, however, the majority of the women I interviewed either spoke English as their first language or did not speak Spanish. In all, I conducted only two interviews in Spanish with women who had moved to the Lansing area from Mexico a few months prio

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prior to our meeting. I conducted all of the interviews with clinic personnel were in English as well, although many of the clinic personnel spoke fluent Spanish.

I took extensive handwritten notes during the interviews with both women seeking care and clinic personnel. I was reluctant to use a tape recorder in interviews with pregnant women for two primary reasons: 1) it was difficult to achieve reasonable sound quality in the waiting room of the community center clinic; and, 2) the tape recorder seemed to reinforce the formal context of the interviews conducted at both the public health clinic and the hospital based clinic. While all of my interviews with clinic personnel at each of the clinics were conducted in either clinic personnel's offices or "private" areas, I chose not to tape record these interviews for the similar reason that it promoted a formal or official air. Many of these interviews began with clinic personnel vocalizing their institutions' "formal rap." Only after we had discussed health care access at an abstract or impersonal level would they begin to speak about these issues in the context of their own organizations and personal experiences. Consequently, I used shorthand note taking to record data collected in interviews with both women seeking care and clinic personnel. I then transcribed my handwritten notes after the interview. In a separate field journal I recorded contextual observations about interviews as well as my own thoughts and feelings about my interview experiences.

Participant Observation

While I conducted participant observation at all three of the clinics in both phases of this research, the nature of my participant observation greatly varied at each organization. As previously discussed both the physical and administrative structure of each cli

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each clinic once again influenced my data collection. In its most fundamental form participant observation in the first phase of the research involved: sitting in waiting rooms observing women as they registered for their appointments, occasionally translating for Spanish speaking women during their nurse intake interviews when their "translators" did not show up, and, in a few instances, observing actual physical exams when invited. While all of these activities took place at each of the clinics, both my interview location and how I was incorporated into the organization fundamentally influenced my participant observation. Since interviews at the community center clinic were conducted in the waiting room, due to the tight quarters of the exam rooms, participant observation encompassed informal discussions with women about current issues, their marriages as well as my own, their children, my reproductive history, works issues, etc. In comparison, participant observation at the public health and hospital based clinics was for the most part limited to time I specifically set aside to sit in the waiting rooms and observe.

Participant observation in Phase II of this research was similarly influenced by the physical and administrative structure of each clinic. Coupled with the highly routinized flow of patients through the clinic and the locale of my interviews (the coffee/education room), participant observation with clinic personnel at the public health clinic was limited to informal conversations with staff in the coffee/education room, the central nurses' station, and the hall way of the clinic. Participant observation at the hospital based clinic was similarly structured in that my interactions were limited to informal conversations with clinic staff at either the nurse/physician station, as I waited between intervi

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interviews, and the reception area as I reviewed the physicians' schedules for prospective participants.

While my goal at all three of the clinics in this phase was to observe interaction between clinic staff and patients as well as interaction among receptionists, nurses, physicians, and other staff members, participant observation at the community clinic encompassed far more than it did at the other two clinics. Again, this was greatly due to the physical and administrative structure of the clinic. Not only was the clinic short on space, they were short-staffed as well. My very presence in the clinic, combined with the head nurse's knowledge of my undergraduate coursework in medical microbiology made me a prime volunteer. Consequently, informal discussions in the nurses' station were often co-opted with requests for secretarial, preparatory, and laboratory help. As I filed charts in behind the reception desk, I often observed discussions about payment plans, appointments, and referrals between receptionists and patients. Interactions between nurses and patients were observed as I laid out instruments needed for exams. Similarly, as I centrifuged blood samples and filled out the corresponding lab paperwork, I observed interactions between receptionists, nurses, physicians and social workers.

Data collected through participant observation were recorded in a two-stage process. While in the waiting rooms I would jot down notes about my observations and conversations with people as unobtrusively as possible. I would similarly take notes about my discussions and activities with clinic personnel. I would then flesh out and develop these notes in a field journal, which I kept on my computer at home.

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Data Analysis

Qualitative Data

Analysis of data collected from open-ended interviews and participant observation encompassed a multi-step process that began with review of transcribed interview notes, my journal observations about interviews, and my participant observation journal — all of which were kept on my computer. The first step in this process involved searching the data for themes to develop analytical categories (for example, how women found out about prenatal clinics). Following a process of qualitative data analysis explained by Jennifer Mason in her article, "Linking qualitative and quantitative data analysis" (1994), I grouped themes identified in the data into two analytical categories: descriptive and conceptual. Descriptive categories were a list of main topics in which I was interested. For example:

How women chose a prenatal clinic:

- Family
- Friends
- Clinic/hospital service
- School
- Other
- Not sure

Conceptual categories were intended to identify the theoretical perspectives about women's resource management (for example, data that illustrated the intersection of women's reliance upon both co-workers and family members in developing strategies to gain access to prenatal care).

I then used the descriptive and conceptual categories to index the data in each of the three formats for both phases of the study. This process involved labeling the data with the key terms from each category so that I could then search and retrieve

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information based upon common themes. The primary advantage of this system was that while it allowed me to search for common themes through out all of the data sets, individual interviews and journal entries were left intact thus maintaining the raw ethnographic data of each entry.

Quantitative Data

While open-ended interviews with women seeking care and clinic personnel were intended to elicit primarily qualitative data, some quantitative data were collected. For the most part quantitative data were comprised of demographic information, such as place of birth, marital status, number of children, which addressed household composition. Questions in which I asked women about how they found out about clinical services, and correspondingly, in which I asked clinic personnel about how they thought women found out about clinical services, elicited responses that were quantifiable. For example, 6 women said they found out about a clinic from their mothers, 4 from friends, and 5 from school. In order to display these data, I present them in a pie chart or graph format based on data from the open-ended interview schedules entered an Excel spread sheet.

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Endnotes

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[1] Potential participants in this study were drawn from a pool of women seeking care and clinic personnel with whom I had contact in a clinical setting. I chose to recruit subjects in a clinical setting, as the goal of my study was to discuss the strategies women employed to gain access to biomedical prenatal care. As a result, the clinic and the clinic context bound the process of selecting participants and my data. One limitation of this methodological approach is that I am unable to answer some questions about the significant role the household plays in shaping women's management of social resources in gaining access to prenatal care.

[2] The goal of the interviews was to discuss the decision making process and social resources women drew upon in gaining access to the prenatal clinic. Discussion focused on women's decisions and actions that preceded their arrival at the clinic in contrast to decisions they made about their care within the clinic. In interviews with both women and clinic personnel I made a point of explaining that the interview was not about evaluating the quality of care provided at the clinic.

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Chapter 3: **The Participants and Their Settings**

The three clinics in this study reflect the array of different types of prenatal care for low-income pregnant women (a Latino Community Center Clinic, a Public Health Clinic, and a Hospital Clinic). While all three were biomedical clinics that provided obstetrical and gynecological care to low-income women, each was structured differently by their parent organization. For example, the Latino Community Center Clinic and the Public Health Clinic both dedicated specific times each week for their prenatal clinics, whereas the Hospital Clinic saw prenatal patients five days a week. While all three of the clinics were units of larger organizations the Latino Community Center Clinic and Public Health Clinic, which were each housed in the same building as their parent organization, had far less autonomy than the hospital based clinic, which was located in a modular unit across the street from the hospital.

In the following description of the three clinics it is my goal not only to highlight the similarities and differences listed above but also show the implicit link between the physical layout and the institutional procedures of each of the clinics. The detailed description of the clinics, along with the hand drawn diagram of the layout of each clinic (taken from my field notes), is intended to portray a sense of place and movement, highlighting the interaction of patients and clinic personnel at each station in the institutional process of the clinic.

Finally, the section titled, "The Participants," is intended to give a composite of the subjects of this study — the women seeking care and clinic personnel. Socio-demographic data include "client's" age, education, marital status, employment status,

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and health insurance, giving an overall picture of the women who were seeking prenatal care. Socio-demographic data similarly describe clinic personnel's age, education level, marital status, if they have ever used Medicaid services, and number of years employed with the clinic, and is intended to contrast some of the situational similarities and differences between clinic personnel and client's perspectives.

The Community

Lansing, Michigan's State Capital, is located in the south central part of Michigan's Lower Peninsula. With a population of 127,321 in 1990 (U.S. Bureau of the Census, 1992), the city is home to Lansing Community College, the Oldsmobile Division of General Motors, numerous insurance company headquarters, utility billing offices and banking centers (Lansing Chamber of Commerce, 2000). Oldsmobile, founded in the 1890s, continues to play an influential role in the city's development as is evidenced by its backing of the Lansing Lugnuts Class A baseball team, which is housed in Oldsmobile Park, and the R.E. Olds Museum.

With the State Capital and General Motors located in the city of Lansing, and Michigan State University in nearby East Lansing, the metropolitan area's largest employers are the State of Michigan —20,000 employees, General Motors — 16,000, and Michigan State University — 12,300 (Lansing Chamber of Commerce, 2000). Over the past 10 years however, the most significant changes in the metropolitan area's workforce has been a decline in manufacturing (-21%) and state government (-6%) jobs (Lansing Chamber of Commerce, 2000). In contrast, a number of diverse industries within the retail (+34%) and service sectors (+62%), such as warehouse/grocery retail

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and health care, have been steadily growing over the past decade (Lansing Chamber of Commerce, 2000). The local community college and public school systems have remained significant employers in the area as well.

The city of Lansing is characterized as a blue-collar town since the majority of its residents work in factory, retail, and service industry jobs. The city proper is surrounded by wealthier suburbs where many of the white-collar employees who work in government, the automobile and service industries, and higher education live. Beyond these suburbs the area becomes rural farmland with small towns and villages. While the majority of the participants in this study lived in the city of Lansing, many also lived in outlying towns of the greater Lansing tri-county area, which is comprised of Ingham, Eaton, and Clinton counties. Whereas Ingham County is dominated by state government and GM factories located in Lansing and Michigan State University in East Lansing, Clinton and Eaton Counties are predominately agricultural areas known for grain, bean, and livestock farming (Sommers, Lawrence M., 1977).

While the tri-county area is predominately white (Clinton 97.9%; Eaton 94.3%; Ingham 84.1%), Ingham County is the most ethnically diverse of the three counties with 9.9% of it's population African American and 6.0% categorized as "other" according to the 1990 US Census. A similar trend is evident among the three counties with regard to distribution of household income. Clinton and Eaton counties have median household incomes of $36,180 and $35,754 respectively whereas the median household income distribution for Ingham County is $30,162 (U.S. Bureau of the Census, 1992). Although there are no neighborhoods in the tri-county area that are populated solely by one ethnic minority (i.e., African American or Mexican American) there are clusters of ethnic

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minority populations in concentrated areas. The greater ethnic diversity of Ingham County and it's corresponding lower median household income distribution has, as I discuss later in this chapter, prompted researchers to consider whether neighborhoods such as North Lansing in Ingham County, where there is persistent and concentrated poverty, are underclass barrios.

As early as 1910, Chicanos migrated to the greater Lansing tri-county area (Clinton, Eaton and Ingham counties) as railroad and farm workers although the earliest families to permanently settle in the area are documented as arriving in the 1930s (Haney, 1979). According to Haney, these early arrivals settled in north Lansing near a beet refinery at which they worked. "Later immigrants often moved into the same general area for social as well as economic reasons, so the north side where the sugar refinery was located became the center of Chicano population concentration" (Haney, 1979:117). By the 1950s Chicano migration to, and settlement in, Michigan had become a well established pattern as the tri-county area had become home to a steadily growing automobile industry that required increasing numbers of workers as well as an "important truck crop region with among the highest yields of pickling cucumbers in the country (Haney, 1979:115).

In 1990 the population in Michigan was 9,295,297 (U.S. Bureau of the Census, 1992). Of this, 83.5% were white, 13.8% were black, and 2% were of Hispanic origin. According to the 1990 U.S. Census, the median household income for Hispanics in Michigan was $26,939 with 23.6% of Hispanics living below the poverty line.[1]

From 1990 to 1996 the Hispanic population in Michigan increased by 19% (JSRI Information Sheet #0136). As a result, Michigan has the second highest number of

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Hispanic residents in the Midwest, after Illinois, with the large majority of them residing in the lower portion of the state's lower peninsula (Aponte and Siles, 1994). As Aponte and Siles point out, the Hispanic population in Michigan is quite diverse — including Latinos of Mexican origin, Puerto Ricans, Cubans, and Latinos from South and Central America as well as Spain. Mexicans, however, account for 69% of the Hispanic population in Michigan. While Hispanic are found working within the standard industry categories (i.e., agriculture, construction, manufacturing etc), they are mainly concentrated in manufacturing (20%), the service industry (20%) and retail trade (13%) (Aponte and Siles, 1994).[2]

By the late 1990s 3.5% of the state's Hispanic population resided in the greater Lansing tri-county area: 1,635 in Clinton county; 2,773 in Eaton county; and 16,079 in Ingham county (JSRI Information Sheet #0136). Within Ingham county, the City of Lansing is 8% Hispanic. Within the City of Lansing, North Lansing (discussed at the start of this section) is home to 16.7% of the area's Hispanic population (Siles and Rochin, 1998). As illustrated by Haney (1979) and posited by Siles and Rochin, North Lansing is considered to be the original Hispanic settlement in Lansing, dating back to the 1940s (1998: 2). Despite the high concentration of Hispanic residents however, the community is home to a diverse ethnic population of Anglos, African Americans, Hispanics, Asians and Native Americans.

The large numbers of minorities who reside in North Lansing, in particular Hispanics, who live in poverty, has prompted researchers to consider whether North Lansing is becoming an underclass barrio with persistent and concentrated poverty. In evaluat

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evaluating this question, Siles and Rochin (1998) compiled the following composite of the area in contrast to tri-county area as a whole:

- The poverty rate of Hispanics in North Lansing is almost double the rate of the tri-county area (i.e., Latinos in North Lansing have a poverty rate of 41.4% compared to 23% in the tri--county area.).
- Hispanics in North Lansing earn considerably less income (per capita income for Latinos in North Lansing is $5,832 compared to $8,312 for those in the tri-county area).
- Household composition indicates that a female heads 28.5% of Hispanic households in North Lansing with no husband present compared to a 23.5% rate for the tri-county area.
- Latinos 25 years and older in North Lansing have a high school graduation rate of 44.6% compared to that of 64.3% in the tri-county area.
- The labor force participation rate for males in North Lansing is 74%, and 54.5% for females. In contrast, 77% of males and 61% of females in the tri-county area participate in the labor force.

As a result of these observations the authors were led to conclude that there are two predominant Hispanic communities in the greater Lansing tri-county area — "North Lansing, [which] reflects the 'inner city' characteristics of its 'distressed' neighborhood and another, larger Latino community that appears to be achieving parity with the Lansing community at large" (1998:1).

In this study, both the women seeking care and the clinics they utilized were part of this dynamic community consisting of North Lansing and the tri-county area as a whole.

The Clinics

The Latino Community Center Clinic

The Latino Community Center Clinic was housed in a wing of an old elementary school that had been converted into the Community Center. Located on a quiet street in North Lansing, the Community Center served both the immediate neighborhood and the

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greater Latino community in Lansing. Upon parking in the small paved lot at the north end of the Community Center, walking by a small play ground and the community center's garden, planted in one section of what once was the elementary school's field, patrons entered the Community Center through heavy set of double doors. The Family Health Clinic was located immediately to the right of this entrance, identified by only a small plaque on the left side of the door.

The Latino Community Center offered a wide variety of services ranging from after-school childcare to a food subsidy program for migrant agricultural farm workers to Alcohol Anonymous programs. In keeping with the Community Center's mission, the Family Health Clinic ran a general practice. Specialized clinics, such as pediatrics and obstetrics/gynecology, were run one afternoon or morning each week. During these clinics, the health center staff was augmented by pediatric and obstetric/gynecology specialists who were either in private practice or medical school residents. In the summer, the health center ran a mobile migrant health clinic which visited local migrant farm worker camps one evening each week.

The health center, located on the first floor of the Community Center, was comprised of a waiting room, reception area, and an exam area. Patients entered the clinic through a door off of a main corridor in the Community Center that led to the waiting room, which was a comfortable-sized room filled with vinyl, office style couches and plastic chairs. A television, mounted on a high shelf, was usually turned on to a talk show or soap opera. In one corner a small children's table had been set up where a variety of donated toys were available for kids to play with.

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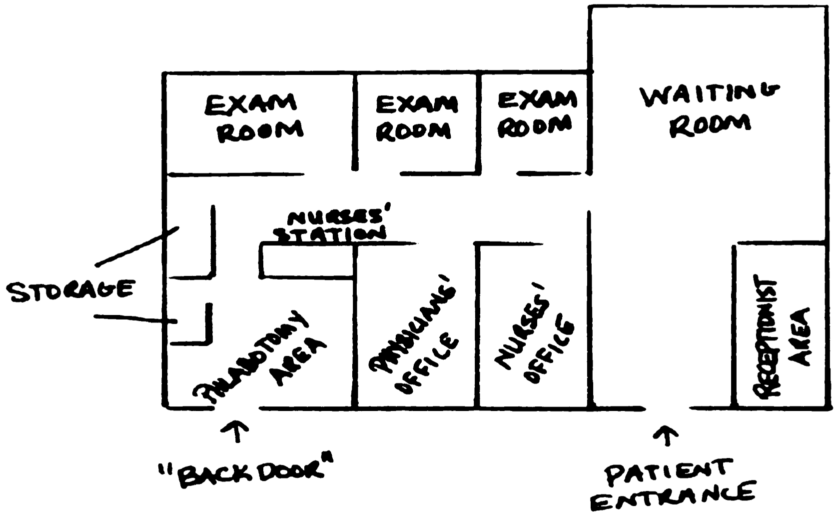

Figure 3.1
Latino Community Center Clinic

The reception window was to one side of the waiting room. Behind the window three receptionists, their computers, and the majority of the patient files were crammed into what had once been a utility closet. Patients signed in at the window upon arrival, at which point the receptionist would pull the patient's file and walk it back to the staff in the exam area. Aside from facilitating patient check-in, the receptionists scheduled appointments, arranged for treatment required at other facilities, such as private offices or a hospital, and handled all of the patient accounts and billing, as well as other routine office business.

The three receptionists were all Mexican American women who spoke Spanish fluently. While almost all of the patients who attended the health clinic spoke English, many preferred to schedule appointments and discuss payment options in Spanish. Two of the receptionists were women in their thirties, married with at least one child each.

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The third, who had recently been hired, was in her early twenties, single, and had two children.

The exam area was entered through a door off of the waiting room. The nurses' station, essentially a counter top with cabinets on one side of a small central hallway, was the focal point of the exam area. Three small exam rooms were on the right side of the hallway with two separate closet sized spaces that served as offices for nurses and physicians respectively. In these small offices the nurses piled their paperwork, reviewed charts, and did patient follow up. Physicians similarly used their space to review charts and dictate chart notes.

With only three full-time nurses and one part-time nurse, the clinic was chronically understaffed. The head nurse, the Program Director, a Mexican American woman in her fifties, was a veteran emergency and obstetrics/gynecology nurse who had worked at a local hospital before joining the Latino Community Center Clinic 13 years ago. She herself came from a family that migrated from Texas to Michigan as agricultural farm workers and spoke Spanish fluently. Her two colleagues had similar nursing background, one having worked in a hospital based obstetric/gynecology unit and in a private practice, and the other as an emergency room nurse in a military hospital. The second nurse spoke Spanish fluently as her husband's family, who were Mexican, spoke primarily Spanish. While the third nurse, who had recently been hired, did not speak Spanish she was trying to learn the language through her interactions with both her clients and her two co-workers.

The part-time nurse, who split her time with a private practice, had been gone on sick leave for almost the entire seven months that I collected data in the clinic. She returne

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returned the last week that I was in the clinic and was not working during the obstetrics/gynecology clinic.

When I began collecting data in the health clinic the Medical Director of the Family Health Clinic had recently resigned. In the interim the Head Nurse was filling in while the Community Center Board of Directors searched for a replacement. While a new Medical Director was hired in the last month or so that I was at the clinic, I came to know the daily routine of the obstetric/gynecology clinic as it was run under the leadership of the Head Nurse. The Obstetric/Gynecology Clinic was open on Thursday mornings from 8 a.m. to noon every week. An obstetrician/gynecologist, who was in private practice, arrived at 8 a.m. and saw patients on a twenty minute rotation non-stop throughout the morning. If a woman needed follow-up care that the clinic was unable to provide the physician would refer her either to his own practice or to a local hospital, depending on the nature of the care needed. The physician, an Asian man in his fifties who emigrated from Korea with this wife 25 years ago, did not speak a word of Spanish. He relied upon the nurses to translate for him when necessary and often joked that he didn't think he would be able to learn a third language.

The Hospital Clinic

Unlike the Latino Community Center Clinic, the Hospital Clinic solely practiced obstetrics and gynecology. Monday through Friday from 8 a.m. to 5 p.m. patients were seen by one of the hospital's 12 residents who were completing a rotation in obstetrics and gynecology. The clinic was created by the hospital to serve two primary purposes: 1) to offer care to low-income women; and 2) to give residents experience in working with

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low-income women. Separate from the Maternity unit, which was located in the hospital, the Hospital Clinic was set up to offer services similar to those offered in private obstetric/gynecology practices.

The Hospital Clinic was located in a small, brown modular unit located in a parking lot across the street from the hospital. The parking lot was originally intended to serve as "overflow" parking for both the hospital and adjacent medical offices. Always jammed with cars, the lot was further congested as a result of a massive construction project (an addition to the hospital) that abutted the access road to the lot. The modular unit had two entrances from the parking lot —one on each end. The entrance to the Hospital Clinic was on the right. The door on the left was for a small set of offices that were vacant. After finding a spot to park and walking through the congested parking lot, patients walked up a weathered set of wooden stairs or a handicapper access ramp to enter the clinic through a small, windowless steel door. Upon entering the building one stepped into a very small waiting room that was lined with plastic chairs around its perimeter. Interspersed among the chairs were a couple of tables strewn with parenting and family magazines. A television, mounted on a wall unit, was usually tuned to a talk show or soap opera. Patients were asked to sign in at the reception window upon their arrival and take a seat until called by the nurse.

The receptionists' area, which was accessible to the waiting room via the reception window, was a cramped space that housed three receptionists, their computers, and all of the patient records, which were filed in tight rows of tall steel case shelving. Behind the receptionists and off to one side of the files was a small desk used by the nurses to make follow-up calls and take incoming phone calls from patients with quest

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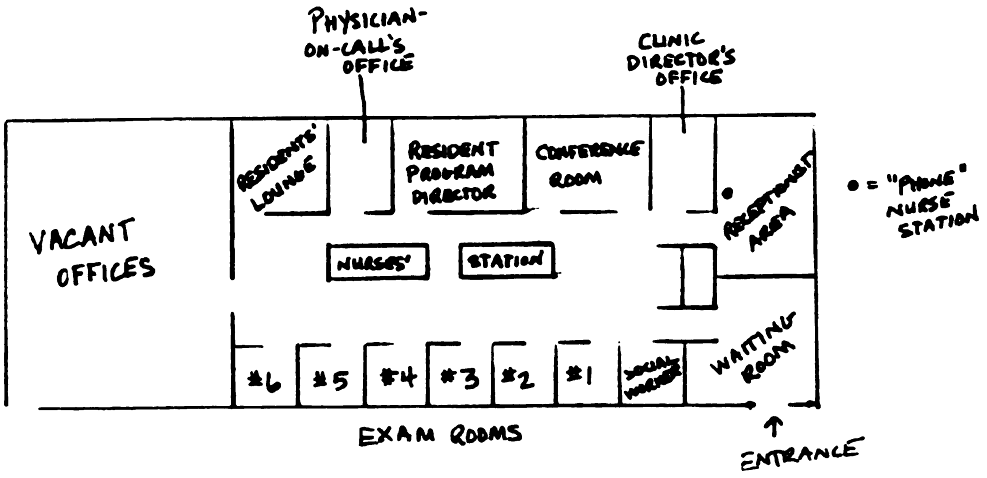

Figure 3.2
Hospital Clinic

questions. The receptionists were responsible for scheduling appointments, checking in patients, and handling patient accounts. One receptionist was single and in her mid-twenties. The other two were both married and in their late thirties, early forties. All three of the women were white and did not speak Spanish.

The "clinic" area was entered through a door off of the waiting room. In the center of this area were two nurses' stations that were large island countertops with cabinets. While residents used this space to confer with the nurses and make notes in patient charts, this was primarily the nurses' space. Three nurses worked at the clinic — one at each station and the third acting as the "phone nurse" in the receptionists' area. Based upon a schedule, the nurses would rotate between the three positions. All three of the nurses were over 40, married, and white. None of them spoke Spanish.

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To the right of the nurses' stations, along the perimeter, was the Clinic Directors' office, a conference room, the Resident Program Director's office, the physician on call's office, and a resident's lounge. The Director of the Clinic was a nurse who coordinated the clinic schedule and liased with the Residency Program Director's office as well as the hospital as a whole. As a result, she was out of the clinic more often than not. While the conference room was open to all for use, it was routinely used by the nurses to conduct intake interviews with new prenatal patients. The door to the Resident Program Director's office was closed most days and the staff in that office seemed to have little interaction with the clinic staff or the daily routine of the clinic.

To the left of the nurses' station was the social worker's office and six exam rooms. The social worker was employed by the hospital full-time; however, she worked in the Hospital Clinic a maximum of 20 hours per week. Although the rest of her hours were spent seeing clients in other areas of the hospital, the Hospital Clinic staff could reach her if needed. The six exam rooms were comfortably sized, simple rooms adorned with various posters depicting fetal development and the male and female reproductive systems. Each exam room had a supply cupboard, an exam table, and stool for the practitioner to sit on.

The 12 residents rotated through the clinic such that usually two residents were in the clinic each day. Each resident's schedule was kept in a blue three-ring binder in the receptionists' area. The receptionists scheduled patients with each resident accordingly. Women were asked to check in at the reception window, wait in the waiting room, and then, were called by a nurse to an exam room where their blood pressure and weight were taken

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taken. The resident would then conduct the rest of the prenatal exam. Although a resident saw patient, there was always a physician on call to consult.

The Public Health Clinic

The Public Health Clinic, housed within a large Department of Public Health building, was centrally located on the south side of Lansing. The Public Health building, which had four separate main entrances — one for each of its agencies, was surrounded by a massive parking lot filled with a sea of cars. City buses stopped at two bus stops centrally located between the four main entrances as well. Upon entering main entrance #3, patients found themselves in a wide, spacious lobby lit with natural light from the large windows that made up the majority of the front of the building. The Clinic, located on the second floor, was one of many clinics/facilities that offered services ranging from a variety of health care clinics to community health programs. Compared to the Latino Community Center Clinic and the Hospital Clinic, the Public Health Clinic was large and spacious. The clinic was entered through a wide set of double doors off of a second floor lobby that lead to the primary waiting room. Bright and spacious as a result of the floor to ceiling windows on one side of the room, the waiting room offered a variety of cushioned wooden chairs for women to sit on that were interspersed among floor plants, tables full of reading materials, and children's toys. In a corner, housed in a television cabinet, was a TV and VCR that played a variety of educational videos at the top of each hour.

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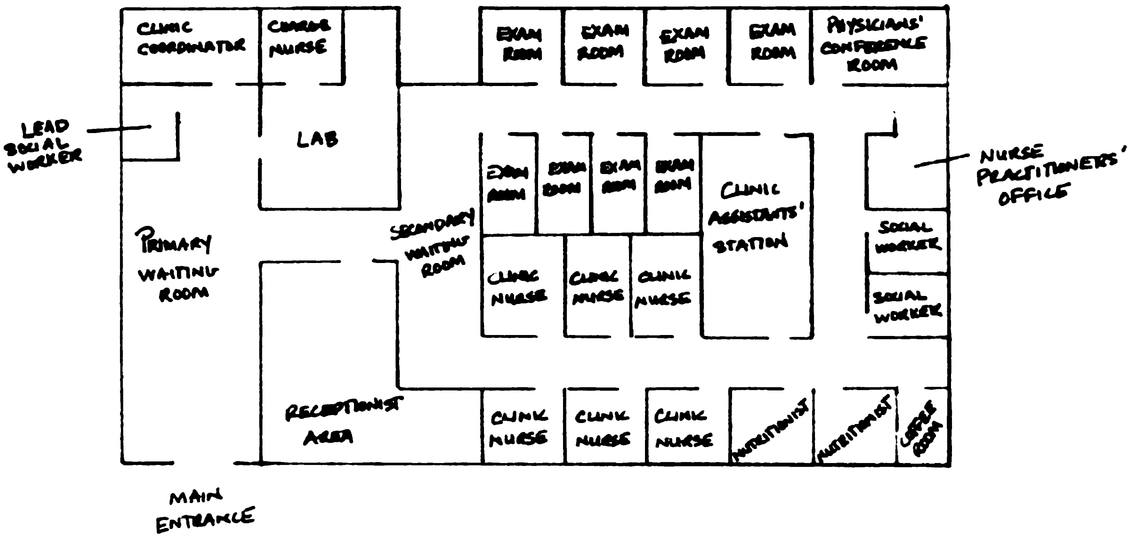

Figure 3.3
Public Health Clinic

The reception area, accessible to the waiting room via the "window," as it was called, was a long open room in which a number of activities took place. The "window" was fronted by two stations at which patients were asked to sign in upon arriving. Two other workstations were to the left and right of the window. In the center of the room was a large counter where patient charts were reviewed and prepared for office visits. At the back of the room was the Front Office Coordinator's desk. This area also housed all of the patient charts as well as the office photocopier. Four women worked in this area, the Front Office Coordinator and three Women's Health Clerks, who were responsible for checking in patients, scheduling appointments, facilitating payment options, providing women with Medicaid forms, and file management. Two of the women were white, one

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African American, and the fourth, Mexican American. They ranged in age from twenty-something to their late fifties. Only the Mexican American women spoke Spanish.

The offices of the Lead Social Worker, Clinic Coordinator, and the Charge Nurse also adjoined the primary waiting room area. As their titles imply, these women were each responsible for running different aspects of the clinic, with the Clinic Coordinator overseeing all aspects of the clinic in its entirety. All three were white, over 40, and did not speak Spanish.

The final area that adjoined that primary waiting room was the Laboratory. Commonly referred to as "the lab," this was the area where women gave urine samples, had blood drawn, and were weighed at each of their prenatal visits. The lab was a fairly good sized room lined with counters and cabinets that held various supplies and had it's own private bathroom. The lab itself was manned by one woman who was in her mid-thirties. She was white and did not speak Spanish.

Through the corridor leading off of the primary waiting room was a smaller secondary waiting room. Lined with cushioned wooden chairs along the perimeter of the room, this was where women waited between their interview with a nurse and their physical exam. Reading material about pregnancy, childbirth, and parenting was available as well as a video on childbirth, played hourly, on the TV mounted on the wall in the corner of the room. Often an outreach educator would hold small group discussions with a number of women and their partners about childbirth while they waited in this area.

To the right of the secondary waiting room was a hallway along which were the Clinic Nurses' offices. These nurses met with women at each of their prenatal exams to discuss the progression of their pregnancies and questions or concerns women might have about their physical health, emotional support, and economic issues as well. The six Clinic Nurses, including the Charge Nurse, ranged in age from their mid-twenties to their late fifties. Four were white and one was Korean. The Korean Clinic Nurse spoke Korean fluently, and while the rest of the Clinic Nurses did not speak a second language, many of them were trying to learn Spanish or kept a Spanish phrase book handy.

At the end of the corridor was the education/coffee room. In reality this room didn't have an official title, it was simply a small back room that overflowed with educational materials, on topics such as sexually transmitted diseases to a variety of pregnancy issues, that were stored in floor to ceiling shelves. Many of the materials were in duplicate as the leaflets were available in both English and Spanish. The staff in the clinic had saved their recyclables and pooled their money to purchase a small refrigerator and a coffee maker in an effort to have a break and coffee room of sorts. While there was barely enough room to stand in the room let alone sit, staff would pop in and out of the room to refill the coffee mugs and talk briefly in between seeing patients.

The hallway to the left of the secondary waiting room led to the exam rooms, the Clinic Assistants' station, the physicians' conference room, and the Nurse Practitioners' office. The six exam rooms along the left-hand side of the hall were for the most part off-limits to all but the Clinic Assistants, the Nurse Practitioners and the physicians. As a result, I was only able to get a quick glimpse into an exam room as I walked down the hall. They appeared to be average sized rooms, without windows, that were furnished in the usual style — exam table, stool, cabinets, chair, and educational pictures on the wall. The Clinic Assistants' Station, on the right of the hallway, was a large room lined with red countertops and white cabinets in which medical supplies were stored. Clinic Assistants reviewed charts and met with Nurse Practitioners and Physicians in this area to discuss patient charts. At the end of the hallway was the Nurse Practitioners' office and the Physicians' conference room. The clinic employed two full-time and two part-time Nurse Practitioners who saw patients for both obstetrics and gynecology. Patients were also seen by university faculty physicians and residents from a nearby hospital-based family practice residency program. While the nurse practitioners shared an office at the back of the clinic the faculty physicians and residents used the conference room as their office and break room. Like the physicians and residents, the nurse practitioners' activities were for the most part confined to the left corridor of the clinic where the exam rooms, Clinic Assistants' Station, Nurse Practitioners' office and physicians' conference room were located. As a result, they not only had very little interaction with the larger clinic staff, but they also seemed to me to be faceless names that worked in a clinic within the clinic.

At each appointment a patient's progression through the clinic followed a precise formula. The patient checked in at the reception window upon arrival and then waited in the primary waiting room. When called, the laboratory assistant would escort the patient into the laboratory where her weight was measured and a urine sample taken. The laboratory assistant would then escort the patient back to the primary waiting room and place the patient's chart in a window that looked into the secondary waiting room. One of the clinic nurses would pick up the patient's chart from the window and then take the patient from the primary waiting room back to her office for a prenatal interview. After the interview the clinic nurse would escort the patient to the secondary waiting room and place the patient's chart in a standing file in the clinic assistants' station. From the secondary waiting room a clinic assistant would escort the patient to an exam room where she would be examined by either a nurse practitioner, a faculty physician or a resident. After her exam the patient would meet with either a social worker or a nutritionist, if needed. On her way out, the patient would stop at the reception desk to schedule her next appointment, and the patient's chart would be returned to the front office by whoever had it last.

The Participants

The Clients

The 27 Mexican American women interviewed in this study were patients at one of the three clinics described above. (See Appendix C, Part A for more detailed demographic data on women who participated in this study.) Women were between the ages of 18 and 36, the average age being 23. Their education levels ranged from completion of the sixth grade to a four-year college degree. Thirteen of the women were born and raised in Lansing, three were born in small communities surrounding the greater Lansing area, four were born in southern states such as Texas and Florida, and the remaining seven were born in Mexico. Women who were born in the southern United States and Mexico either settled out of the agricultural migrant stream with their families when they were quite young or came when they were teenagers or adults to live with boyfriends, husbands or extended family members. Fifteen of the women were single, 11 were married, and one was divorced. Women had anywhere from zero to four children, the average being 1.2. At the time of the interviews 11 women were employed outside of their homes and 16 were not.

As per the State of Michigan Family Independence Agency's 1997-1998 guidelines for Medicaid services, all of the women I interviewed were considered to be low-income clients. For example, a family of three with a monthly income of $1,623 or less was considered low-income and thus qualified for Medicaid coverage. Nineteen of the women I interviewed were on Medicaid, four were in the process of applying for Medicaid, one was covered by her husband's private health insurance policy, and three had no insurance of any kind. Two-thirds of the women used other services, such as Women, Infants, and Children Special Supplemental Feeding Program (WIC).

The Clinic Personnel

Personnel from each of the three clinics were interviewed for this study as well. In all, five Reception Clerks, eight Clinic Nurses, one Nurse Practitioner, and one Physician were interviewed. Clinic personnel were between the age of 21 and 59, the average being 43. (See Appendix D, Part I for more detailed demographic data on clinic personnel who participated in this study). Their education levels ranged from a General Education Diploma (GED) to various Masters' degrees to a MD. Four of the clinic personnel were born in Lansing, six were born in other areas of Michigan, three were born in other US states, and two were born in Asian countries. When asked to identify their ethnicity, clinic personnel answers ranged from White American, Irish-Polish, and Caucasian, to Hispanic, Mexican American, Korean American, and Asian. Based on the

US Census criteria for race/ethnicity, 10 were "white," three were Hispanic, and 2 were Asian.

Of the clinic personnel interviewed, there were 14 women and one man. Two were single, six were married, six were divorced, and one was widowed. Clinic personnel had anywhere from one to four children, the average being two. At the time of the interviews, clinic personnel had an average of 15.4 years of overall experience in the health care profession and had been employed with their respective organizations for an average of 7.3 years.

With the exception of the physician who volunteered his time to the Latino Community Center Clinic, all of the Clinic personnel in this study used private health insurance policies provided to them by their respective employers. Five clinic personnel, however, indicated that they had used Medicaid Services prior to beginning their careers in the health care profession. While none of these clinic personnel cited health insurance coverage as a significant motivation in their career choice they did admit that coverage was a very attractive benefit. Of the five clinic personnel who had used Medicaid, two were employed at the Public Health Clinic and three were employed at the Latino Community Center Clinic.

Entering the Field

The relationship between the clinics and their parent organizations greatly influenced my own access as a researcher to each of the clinics. My entrance into the Latino community center clinic was greatly eased by the fact that I had ridden with the mobile migrant health clinic during the preceding summer. Furthermore, I was introduced to both the director of the community center and the head nurse of the health clinic through a personal contact. The time I could spend in the clinic collecting data was limited, however, as prenatal patients were seen only one morning per week. The attending physician preferred that I review his list of appointments, generated by the "front desk," so as to select women who were potential subjects. Due to the limited schedule and equally limited space, the clinic was often overflowing with patients. As a result, interviews with women at this clinic were, for the most part, conducted in a relatively quiet and private corner of the waiting room.

The administrative structure of the Public Health Department as a whole, and, in turn, the regimented format of the Public Health Clinic, stipulated that I start at the top of the organization in gaining access to the Public Health Clinic. Upon meeting with director of the clinic, she submitted my curriculum vitae, research proposal, and cover letter outlining my study to the Director of the County Health Department. Once this Director gave his approval, I then presented my proposed research to the staff of the clinic at their weekly staff meeting. This entire process took about three months. The physical layout of the clinic itself reflects the administrative hierarchy of the department with regard to both the location of clinic personnel' stations and the order in which patients move through the routinized process of care. Receptionists were stationed at the front of the clinic, nurses, nutritionists, and social workers were housed in offices in the center of the clinic, and the physicians' lounge was located at the back of the clinic. Patients checked in with the receptionist, were assessed by Clinic Nurses, and then seen by a physician in an exam room near the physicians' lounge. In keeping with this routine, the head nurse decided it would be best to insert my interview into this equation as w

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women often had "down time" between their assessment with the nurse and their exam with the physician. Since all of the offices were occupied and exam rooms were often in use, I was given the coffee/education room by the back door of the clinic to conduct my interviews. Neither the Director of the clinic nor the head nurse felt it would be appropriate for me to conduct my interviews in the waiting room as they thought it might inconvenience other patients.

As per clinic protocol, the Charge Nurse would review patient charts each Monday morning. After much discussion about how potential participants for my study would be identified, we agreed that she would insert a copy of the consent form for my study into the files of women whom she believed to be Hispanic. She identified women as potential participants using one of the following criteria: 1) their first or last name; 2) if they had checked "Hispanic" on their intake sheet; or 3) any first hand knowledge of the woman. The presence of the consent form for my study, copied onto bright orange paper so it would stand out from other documents in the patient's chart, thus acted as a flag to Clinic Nurses when they assessed a patient. The Clinic Nurse would explain my study to the patient and then ask her if she was willing to meet with me. If the woman agreed, the Clinic Nurse would escort her to the coffee/education room where I was waiting.

I had anticipated, wrongly so, that the most difficult clinic for me to gain access to would be the Hospital Clinic. Imagining that the atmosphere at this clinic would be highly suspicious of a student conducting research and dreading the lengthy formalities of the hospital's internal review board (IRB) process, I envisioned a process similar to my experience at the Public Health Clinic. I met with the director of the clinic and explained my proposed research, emphasizing that my goal was not to disrupt the clinic's daily routine in any way. The director seemed quite at ease with my proposed activities. She confirmed that I had IRB approval from Michigan State University, said that she would make sure that I did not need approval from the hospital IRB, and then asked me if I wanted to start that very day. We agreed that I would wait until she had confirmed that I did not need approval from the hospital IRB and that, in the meantime, she would explain my study to the nurses in the clinic. Two weeks later, I walked into the clinic, introduced myself to the staff again, and I began collecting data. In retrospect, I realize that my entrance into this clinic was greatly eased by the fact that the clinic was part of a teaching hospital. As a result, the director and the staff were quite used to having students, both as interns and researchers, in the clinic.

The head nurse suggested that I review the physicians' appointment schedules on a weekly basis to screen for patients who would qualify as potential participants in my study. As the clinic was always behind schedule, she thought it would be best that I interview women before their exam, as it would distract them during their wait to see a physician. Located in a small modular unit, the clinic had an extremely small waiting room, a packed receptionist area, a central nurse/physician station, and a couple of exam rooms. It was agreed, as a result, that the best place for me to conduct interviews was an empty exam room. Consequently, I greeted women in the waiting room, explained my study, and then, if they agreed, interviewed them in an empty exam room. After the interview, I would escort them back to the waiting room.

Although my goal was carry out research at the clinics in sequence, due to scheduling I was conducting interviews at all three of the clinics concurrently for a couple of weeks. In this time I became aware of the striking ways in which both the physical structure and administrative structure of each organization in turn influenced the dynamics of my interviews. While all of the interviews were informal, due to both the open-ended format of the questions and the personal/intimate nature of pregnancy and childbirth, it became apparent that interviews conducted at the Public Health Clinic and the Hospital Clinic began with a much more formal air. I had to work harder at establishing a personal rapport with women than I did at the Latino community based clinic. In both the Public Health Clinic and the hospital center clinic participants perceived me as being part of the health care organization. This was mostly due to the fact that at the Public Health Clinic prospective participants were escorted to me by nurses and at the hospital based clinic I came through the closed door separating the waiting room and the "clinic area" to ask women to participate in my study. In comparison, at the Latino Community Center Clinic, I sat in the waiting room with women both during the interview and in between interviews. Although I would often step behind the door to the exam rooms to check in with the nurses or talk with the staff at the front desk, for the most part I was perceived as someone in between these two realms. As a result, I made a special effort in interviews with women at the Public Health Clinic and the Hospital Clinic to explain that I was not affiliated with the clinic in any way. Furthermore, I emphasized that our discussion would have no impact on the care they received as a patient in the clinic.

Endnotes

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[1] Comparatively, in 1990 the median household income for Whites was $32,483 and $18,851 for Blacks with 9.5% of Whites and 33.7% of Blacks living below the poverty line respectively (U.S. Bureau of the Census, 1992).

[2] Aponte and Siles (1994) note that while agricultural workers are shown to account for only 3% of Hispanic workers this number would most likely rise if migrant workers were counted in the census. Migrant workers are often not included in the census however, as they are not in Michigan at the time of the census.

Chapter 4: **Women's Social Resource Management and Strategies**

Low-income Mexican American women manage access to prenatal care by drawing upon a variety of social resources that are economic, political, as well as medical. In doing so they create strategies that are based upon the broad scope of social resources that are available to them. The findings in this chapter identify and discuss the social resources that women in this study most commonly relied upon in gaining access to prenatal care. Women's responses illustrate that the process of gaining access to prenatal care can be roughly broken into three categories: a) finding out about prenatal care; b) finding out about and choosing a clinic that offers prenatal care; and c) figuring out how they will pay for their prenatal care. As such, the social resources that women utilized are examined within the context of these fundamental questions. (See Appendix C, Part II for the quantitative breakdown of women responses.)

Whereas the first half of this chapter discusses the most common social resources women draw upon to gain access to prenatal care the latter half of this chapter will illustrate the strategies women develop to facilitate this process. The decisions that women make in drawing upon the various social resources available to them are not isolated or independent events but rather a series of actions that are linked together with the aim of achieving a specific goal. In drawing upon resources available to them through social networks women create alliances that form the basis of the strategies they develop to gain access to prenatal care. The goal of the latter half of the chapter is thus to exemplify that women are actively and consciously selecting from and using the social resources available to them to gain access to prenatal care.

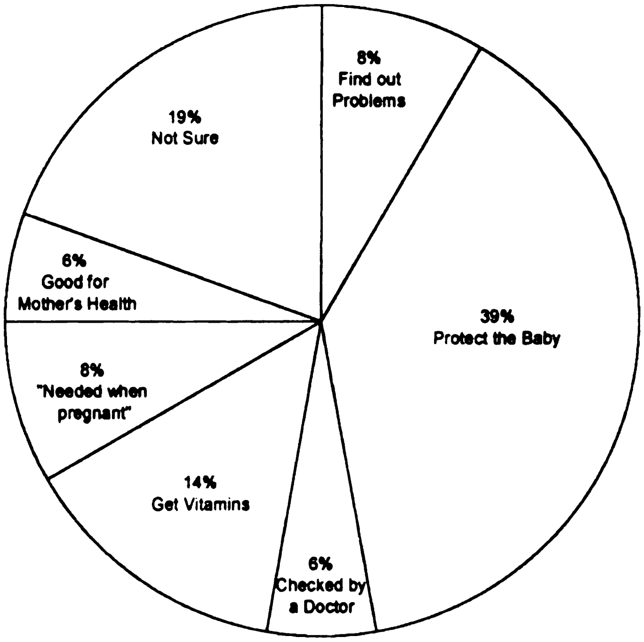
Women's Social Resources

Why Women Think They Need Prenatal Care

Of the 27 women interviewed in this study, 25 had begun receiving prenatal care in the first trimester of their pregnancy. Two women had not started receiving prenatal care until they were well into their 3rd trimester. In both cases this was due in part to travel. Margarita's arrival in Lansing illustrates how travelling from Mexico made it difficult for her to obtain prenatal care. 30 years old, Margarita had been working in a maquiladora in northern Mexico. While in Mexico she met her boyfriend, an American construction worker from Michigan. When Margarita realized that she was three months pregnant she and her boyfriend decided to get married. Once married Margarita and her new husband moved to South Carolina where her husband completed a two-month project for his construction company. When Margarita and her husband finally arrived in Lansing, she was 31 weeks pregnant. Margarita explained that as her husband's construction company did not offer any health benefits, and she was unable to complete the enrollment process for Medicaid since they were in South Carolina for such a short period of time, she had not had any prenatal care thus far during her pregnancy. Furthermore, the short duration of their stay in South Carolina combined with isolated living conditions limited Margarita's chances to develop a social network from which she could learn about clinics that offered free prenatal care. She was waiting for her first prenatal exam at the Latino Community Center Clinic when I interviewed her.

Margarita's situation raises two key points that are central in considering women's access to biomedical health care during pregnancy and birth: 1) why women believe that they need prenatal care; and 2) how they find out about prenatal care. With regard to the first question, why women thought they needed prenatal care, women's responses in this study can be roughly broken into seven categories:

Figure 4.1
Why Women Value Prenatal Care
N, number of responses = 36



The most common reason that women cited for obtaining prenatal care was grounded in a preventative care interest for their baby.[1] Women often responded that they felt prenatal care was important "To make sure that nothing happens to the baby," or that it was good to receive prenatal care so that they could "Find out problems with the baby." A typical response to my interview question was:

> *Something could be wrong and they could find out and correct it before the baby is born. [Jennifer, age 23]*

Embedded within these statements was the underlying premise that biomedical prenatal care would prevent "problems" from happening in the first place.

Many women who cited preventive care as the most important reason for prenatal care also said that they valued prenatal care for the vitamins that were prescribed by the physicians. When asked why they felt it was important to take a prenatal vitamin many women responded: "I need vitamins. I want to have a healthy baby" [Jennifer, age 23]. Such responses supported a curative perception of prenatal vitamins in which the vitamin was thought to not only prevent abnormalities but cure them as well. A few women, however, viewed prenatal vitamins as a supplement — a pill that would boost their nutritional status.

> *I went to a free clinic in California. I knew my eating pattern wasn't the greatest and that prenatal vitamins would help me eat right. The vitamins help my nutrition. [Judy, age 18]*

In contrast to the latter group of women who cited the preventative attributes of prenatal care for the baby only two women perceived prenatal care as being beneficial to their own health. While both of these women first explained the importance of prenatal care with regard to the health of the baby they further articulated the benefits of prenatal care in terms of the health of the mother.

> *It is good for the development of the baby. It's good for myself. I need the nutritional guidelines. [Anna, age 27]*

> *So you know your baby is ok. You hear about kids having babies in bathrooms who didn't get care. It could have died in your body and could have messed your body up. [Patricia, age 22]*

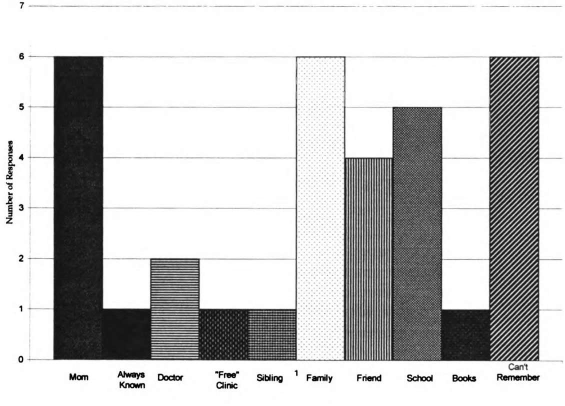
At the time of our interview Anna, a certified Nurse's Aid who was 6 months pregnant, was enrolled in Nursing School. Her perception of prenatal care as being beneficial for both the baby and the mother was greatly influenced by the biomedical model she was learning in school. In contrast, Patricia's argument for the benefits of prenatal care burgeoned out of discussions about teen pregnancy with family, friends, and the media. She explained that as a cashier at a local convenience store, she frequently read the magazines on the store racks. The articles she read prompted her to talk about teen pregnancy with her family and friends; thus she heard similar "real life" stories that confirmed what she had read in magazines. The "real life" stories and magazine articles in turn led Patricia to value prenatal care for both her own and the baby's health and, consequently, reinforced her belief in the biomedical model of prenatal care.

Some women in this study stated that prenatal care was important, yet they were unable to articulate why they believed this to be true. After some probing, this group of women gave responses such as "It is important to be checked by a doctor" and "You need it when you are pregnant." The women viewed prenatal care not as an option but rather a biomedical imperative that they embodied as a "norm" of pregnancy.

> *Prenatal care is normal — I don't know. The clinic tells you you're pregnant. [Maria, age 21]*
>
> *When you get pregnant you go to the doctor. [Jennifer, age 23]*

Whereas women falling into the latter category were ultimately able to reason that prenatal care was an expected routine of pregnancy, women (19%) were unable to articulate any reason for obtaining prenatal care. Although women in this situation were often able to give a general overview of what their prenatal visits involved — meeting with a nurse, being weighed, and being examined by a physician — they were not able to explain the ramifications of these activities. Women often responded with a simple, "I'm not sure," or "I don't know." Such responses seemed to support a notion of prenatal care as a normative expectation of pregnancy as women complied with the routine despite the fact that they didn't understand its purpose; much less were they able to articulate a reason for their compliance. This in turn brings to light the centrality of the second question raised at the start of this discussion: How do women find out about prenatal care? If women are unsure of the purpose of prenatal care yet they seek it, how then do they find out about it in the first place?

Figure 4.2
How Women Found Out About Prenatal Care
N, number of responses = 33



As the previous graph (Figure 4.2) shows, women indicated that they found out about prenatal care in a variety of ways. The most common sources of information about prenatal care were their mothers, other family members (including both immediate and extended family), friends, and school. Each of these resources however, translated the need for or expectation of prenatal care in a variety of ways. For example, women's responses reflected passive statements such as "I was raised to have it" to more interactive scenarios:

> *Mom had four kids. When she first found out I was pregnant she said, "we have to get you some prenatal care." [Rosie, age 19]*
>
> *My mother taught me. You grow up knowing things. She saw that we had check ups. When you get pregnant you go to the doctor. [Jennifer, age 23]*
>
> *My mom made me go because I have such low iron. [Emma, age 28]*

Women who found out about prenatal care from both immediate and extended family members as well as from friends often related more involved explanations that wove together broad familial, social, and work-related networks. For example, Veronica, age 25 and pregnant for the first time, explained that she learned "the process" from her sister who had two children and was also pregnant.

> *When I first found out I was pregnant I just had to sit back and take it all in but Stephanie was like now we have to this and this and that. She knew what to do because she has two kids. It's all new to me and I had to sit back and think about it.*

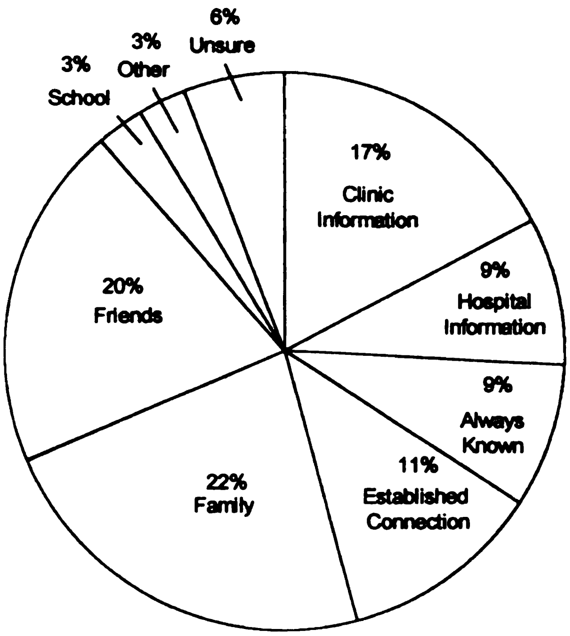
Veronica was further "educated about the process" by her neighbors whom she described as older friends who had children. Since she owned her own car, Veronica often helped her friends out with childcare, rides to prenatal appointments, and food shopping. She thus learned about prenatal care from an immediate family member, her sister, and friends with whom she had developed a social and economic relationship as well.

How Women Find Out About And Choose A Clinic

Examining why women believed prenatal care was important and how they found out about prenatal care in turn raises the question of how women found out about, and ultimately chose, a clinic for obstetrical care. Women interviewed in this study were patients at one of three "health clinics" —each clinic representing a different biomedical organization. When I asked women shy they had come to a particular clinic, their responses revealed that they used a variety of resources to inform their decisions as well as strategies influenced by their perceptions of the organizations themselves.

Regardless of the organization, women most commonly indicated that they found out about and chose a clinic based on the suggestions of family and friends (Figure 4.3). For some women, finding and choosing a clinic was as straightforward as having a friend or a sister who referred them to the clinic they had used when they were pregnant. Other women similarly chose to use the clinic at which a sister or friend worked. For example, Tina explained that she never thought to go to any other clinic than the one at the Latino Community Center where her sister worked as a receptionist. Although friends had told her about other clinics in the area her "inside connection" at the Latino Community Center Clinic clinched the decision.

Figure 4.3
Basis of Women's Clinic Choice
N, number of responses = 35



*"Hospital Information" refers to information about prenatal clinical services gathered by women from both hospital personnel and hospital brochures about prenatal care.

Many women, however, were not as fortunate as Tina was with her inside connection. Furthermore, the majority of women who found out about and chose a clinic based upon the insights of family and friends gave responses that reflected far more complicated pathways. For them, finding out about and choosing a clinic involved negotiating a complex network of familial, social, and work-related resources. For example, Veronica's path to finding the Hospital Clinic began with a friend of her sister.

> *A friend of my sister had to get help from the State. My sister called her to find out what to do. She referred us to Planned Parenthood. I went there and got a pregnancy test and they told me about [the*

> *Hospital Clinic]. After that we were like, "Oh, what now?" [Veronica, age 25]*

Rosalinda, age 23, married, and pregnant with her second child illustrates yet an even more complex path to choosing a clinic for it transcends two countries, a social network born out of her husband's work relations, and two biomedical clinics. Born and raised in Mexico, Rosalinda met her husband when his company was building a golf course near the city in which she lived in Mexico. They married and soon found out that Rosalinda was pregnant. Rosalinda had one child already, so she went back to the same physician she had seen during her first pregnancy. Her husband's company, however, had finished building the golf course so Rosalinda and her daughter moved to Michigan with her husband. Since she did not know how to drive and her husband worked during the day, Rosalinda's husband's employer's wife offered to drive Rosalinda to the County Health Department where she was given a list of clinics to choose from. Although Rosalinda lived almost 40 minutes outside of Lansing, she chose the Latino Community Center Clinic because it had the first available opening for prenatal care. Rosalinda's decision thus followed a complex path that was fundamentally shaped by a broad spectrum of familial, social, and work related networks that spanned two countries and two biomedical health organizations.

While family and friends played significant roles in how women found out about clinics, other factors such as location, appointment availability, and the reputation of a clinic were also central to women's choice of a clinic. For example, Sara, age 25, married with three children, lived in the neighborhood where the Latino Community Center Clinic was located. As Sara did not have a car, the close proximity of the clinic thus was the mitigating factor in her choice. Although Sara would have preferred to see a physician at the Public Health Clinic, as she had for her first two pregnancies, she realized that it would be unrealistic for her to ride her bike to the southern part of town where the Public Health Clinic was located. She did not discuss using a bus. Thus she chose the Latino Community Center Clinic, to which she could easily walk.

Although location was an issue in Rosalinda's case, since she depended upon her husband's employer's wife to make the 40-minute drive to the Latino Community Center Clinic, it was not the deciding factor for Rosalinda. Since all of her clinic choices were some distance away from her home, appointment availability outweighed location. When Rosalinda and her husband arrived in Michigan, she was 18 weeks pregnant. Consequently, she felt that waiting two to three weeks for a prenatal appointment was not an option. Thus, despite the drive, Rosalinda chose the Latino Community Center Clinic because they could schedule her first prenatal appointment the very same week that she called to inquire about the clinic.

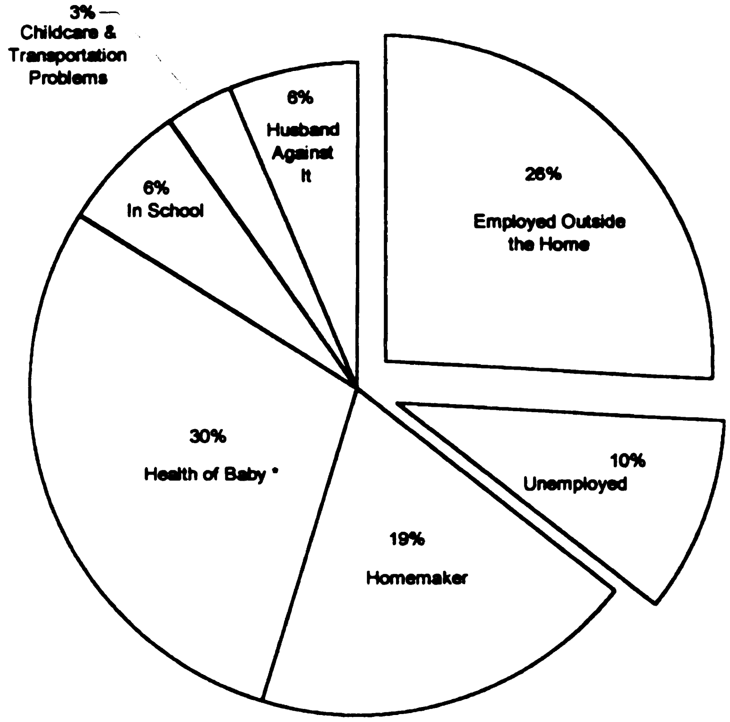
The reputation of a clinic also factored into women's decisions. In the most fundamental sense, friends and family who recommended it established a clinic's reputation as "good." Women also equated the reputation of a clinic with the hospital at which a clinic's physicians had admitting rights. This was especially true in the case of the Hospital Clinic. Finally, some women based their decision upon the reputation of the clinic, and its larger parent organization, within their communities. For example, Theresa, age 21, married with one child, lived in the same neighborhood as the Latino Community Center Clinic but she chose the Hospital Clinic because it seemed more "professional." She perceived the Latino Community Center Clinic, which also handed out free food and clothing, as being for "poor" people. In contrast, Theresa interpreted the primarily clinical services provided by the Hospital Clinic as more professional — meaning that it had more modern equipment and "better" staff. Thus for Theresa, professional reputation, not location or appointment availability, was the determining factor in her clinic choice.

Finding Out about and Enrolling In Medicaid

Of the 27 women interviewed in this study, one woman had private health insurance, four were in the process of applying for Medicaid, 19 were enrolled in Medicaid, and three had no insurance of any kind. At first glance, these numbers seem to indicate that low-income women, specifically Mexican American women, do not have health insurance because they are unemployed and thus must use Medicaid. When considered in the context of women's social and economic everyday experiences however, the numbers actually tell a very different and complex story.

As Figure 4.4 illustrates, only 10% of women considered themselves unemployed whereas a majority of the women who participated in this study were employed outside of the home either at the time of the interview or before they became pregnant. The jobs women worked in ranged from maintenance to a security guard to a nursery school assistant; however, nearly half of the women worked in the food service industry as cashiers and waitresses. Despite the fact that the women were all employed, none had private health insurance. For the most part women in this study worked in jobs that did not include health insurance benefits, as either full benefit packages or pro-rated group plans in which a premium is deducted from the employee's paycheck. Although a few women did have the latter option, they found that they were not able to make ends meet after the premium had been deducted from their paycheck.

Figure 4.4
Women's Work Activities in Pregnancy
N, number of responses = 23



The five contiguous categories in the pie chart represent responses women gave for not being employed outside of the home during pregnancy. Women in these categories, with the exception of "Homemaker," considered themselves employed yet not working because they were pregnant.

*Includes reasons such as pregnancy complications, jobs considered to be potentially hazardous to both the mother and baby's health, and general belief that working while pregnant adversely affects the baby's health.

The story that the numbers tell becomes even more complex when juxtaposed with the number of women who were actually employed at the time of their interview. Although sixteen women identified themselves as having occupations outside of the home only eight of the sixteen women were actually working at the time of the interview.

The eight women who were not working cited a variety of reasons for their decision not to work, ranging from pregnancy complications, belief that it was better for the health of the baby, and their husbands' being their against working while pregnant. For five of the eight women, the primary reason for not working while pregnant was that they believed their job to be potentially too hazardous to the health of their baby. This belief crossed the spectrum of jobs, from working in food service to security. For example, Monica, age 18 and single, waitressed at a bar before she became pregnant. She quit a couple of months into her pregnancy because the smoke in the bar made her feel sick and she worried about slipping on the wet floors behind the bar area. Gina, age 23 and single, stopped working as a housekeeper soon after she found out she was pregnant for similar reasons. The cleaning chemicals made her feel ill and it became harder and harder for her to carry a vacuum or a bucket of water to wash floors. Finally, Emma, age 28 and single, stopped working as a security guard when she was four months pregnant when she began feel that she was no longer physically capable of carrying out her duties. She also worried about her baby's safety if she should have to pursue an intruder or intervene in a fight.

For all of the scenarios discussed above, women's use of Medicaid to cover their prenatal care raises the fundamental question of how women find out about Medicaid in the first place. Interestingly, none of the women in this study who were working outside of the home indicated that they found out about Medicaid through their employers. Similarly, few women found out about Medicaid through advertising, such as locally televised public health messages. In general, women cited family, friends, and clinicians as their primary source of information about Medicaid. The ways in which women found

out about Medicaid however, were often not quite so straightforward. Gina, age 23, single, and the mother of two children explained:

> *The father of [the] kids was born and raised on Welfare. He told me about it because my mom and dad never had to be on it. Dad said not to be on it for life, just to use it for an emergency. I haven't been able to get back on my feet since.*

When Gina was pregnant with her first child, a daughter, she was still covered by her father's Blue Cross and Blue Shield policy. No longer covered by her father's policy when she was pregnant with her second child and realizing that her parents did not have any experience with the Medicaid system, she relied upon the father of her child to find out about and navigate the system.

Gina's story raises the further question of how women navigate the process of enrolling in Medicaid. Not surprisingly the majority of women in this study felt that a friend or relative was instrumental in facilitating the application process because they offered childcare, transportation to the public health department, or help filling out the Medicaid application. For example, the first time Maria, age 21 and married, found out she was pregnant, her sister-in-law told her about Medicaid and helped her get enrolled. She drove Maria to the county health department, sat with her in the waiting room, and helped her fill out all of the paperwork.

For many women the process of finding out about and choosing a clinic was integrally tied to the process of finding out about and enrolling in Medicaid. For example, Ruth, age 21, married, and pregnant with her first child was frustrated that she had to use Medicaid for prenatal care despite the fact that both she and her husband were employed full time. Their jobs in a bakery did not offer any health benefits. When she found out that she was pregnant, her sister, who had children of her own, told her to go to the county health department to get help signing up for Medicaid. At the county health department, Ruth received a list of physicians and clinics to choose from.

Sara, age 20, single, and pregnant for the first time found herself in a situation similar to Ruth's. Covered under her father's private health insurance plan until she was 19, when Sara turned 20 she did not think about having health insurance until she found out she was pregnant. Sara was working at a fast food restaurant that offered health benefits, but she had to have worked there for a minimum of year to qualify for coverage. Sara had been working at the restaurant for four months when she found out she was pregnant. Convinced by her mother that she needed prenatal care, but realizing that she could not pay for it out of pocket, she enrolled in Medicaid at her mother's urging. Sara's mother was instrumental in telling her about Medicaid and helping her fill out the Medicaid application. She also helped Sara choose the Hospital Clinic, where she had had her own children, and sign up for WIC as well. Thus for Sara, the process of finding out about and choosing a clinic was entwined with the process of finding out about and enrolling in Medicaid and WIC.

Women's Social Resource Management and Strategies

Pregnancy and birth provide opportunities to examine ordinary health issues specific to women in the context of health care institutions and household decision making. As women go through pregnancy and birth they achieve access to health care through a series of decisions and routines that I analyze as resource management. As previously discussed, I argue that the resources that women draw upon through social and economic networks — alliance building — form the basis of the strategies they develop to gain access to biomedical care. The following interviews convey the complexity of low-income Mexican American women's resource management elucidating the fluid environment in which women actively and consciously select from and use a variety of resources in creating strategies to achieve access to prenatal care.

Viewed in this context, women's resource management is not a single logical construct that is closed and independent of other systems but rather one of options in which a woman's strategy is shaped by social, economic, political and medical issues. As the following interviews and discussion will illustrate, gender plays a significant role in how women's resource management is shaped by the latter issues. By situating analysis of women's resource management within a gender centered approach, I find that I can advance the analysis of access to prenatal care further in terms of the ways in which the social construction of gender roles shape women's access to and management of resources. Consequently, the strategies that women develop to gain access to prenatal care thus involve steps that are managed strategically based upon the broad scope of women's social and economic resources.

Interview —*Maria*

As Maria and I talk, her two-year-old son sits on the floor of the exam room coloring in a Superman comic book. The interview had been interrupted earlier when she was called in for her prenatal exam and I am hesitant to pick up where we left off since Maria and her son have been at the clinic for the better part of the afternoon. Maria reassures me, however, that she's in no hurry —"It's boring at home," she exclaims with a grimace.

Maria, age 21, is seven months pregnant. Born and raised in the Lansing area, she lives with her husband and their two-year-old son in an apartment on the West Side of town. Maria finished 10th grade but then dropped out to get married when she found out she was pregnant; her husband graduated from high school. This is Maria's third pregnancy; she lost a set of twins when she miscarried halfway through her second pregnancy.

Before her current pregnancy, Maria had been working at a grocery store stocking merchandise. When I ask if she stopped working because she was pregnant she laughs and after a drawn out "no" explains:

> *My husband got laid off — he used to work at a warehouse. He's been looking for a job for awhile. I stopped because of personal problems at home. I need to be at home.*

As our conversation shifts towards what she will do after the baby is born Maria shrugs, and explains:

> *He's looking for a job but he doesn't want me to work. He says it's not right —that the husband should work and the wife should be*

> *at home. I'm hoping that it won't be so*
> *boring with a little baby around the house.*

As with her two previous pregnancies, Maria relied upon Medicaid for her health insurance. Although she worked at a grocery store through her previous pregnancies, she pointed out that she could not afford to have the premium for the health insurance plan offered by the store deducted from her paycheck. The first time Maria found out she was pregnant her sister-in-law told her about Medicaid, and helped her get enrolled. She drove Maria to the county health department, sat with her in the waiting room, and helped her fill out all of the paperwork.

Maria has had prenatal care for all three of her pregnancies. With her first two pregnancies she went to a public health clinic for her prenatal care and delivered at a local hospital. Her sister-in-law drove her to her prenatal appointments at the public health clinic and, since Maria lived across the street from the hospital, she walked over when she went into labor. While she now has her own car, she felt that with a toddler to carry around with her she should look for a clinic closer to her apartment — so she looked through the phone book and chose the clinic closest to her.

Interview — *Rosie*

Rosie, 19, had graduated from high school a year ago and was working as a teacher's assistant at a nursery school. She lived with her parents on the south side of Lansing but she and her boyfriend, who lived in her neighborhood and attended a local college, pooled their income to meet their financial needs. This was Rosie's first pregnancy — she was five and a half months pregnant, worked full-time at the nursery school, and planned to take the summer off when she her baby and then return to work in the fall. She hoped that within a year or so she will be able to go to college herself. "I'll work for a year after the baby is born. I just need to get past the first year with the baby and then it will be easier for my mom to watch her when I am at class."

When Rosie first found out she was pregnant, her parents told her that she needed prenatal care and health insurance.

> *My mom had 4 kids. When she first found out that I was pregnant she said, "We have to get you some prenatal care." Now I know that it is good to have prenatal care so that you can find out problems early and prevent the long-term effects.*
>
> *My dad explained that we are low-income and told me to go down to the health department and apply for Medicaid. He warned me that it would take a long time.*

When Rosie first suspected that she was pregnant she went to a local public health clinic for a pregnancy test. The nurse at the clinic explained that the clinic was really full and suggested that she try an OB-Gyn clinic at a local hospital. Rosie agreed and the nurse set up a prenatal appointment at and gave her one month's worth of prenatal "pills" to tide her over. Using her mom's car, Rosie drove herself to her first prenatal exam, and continued to do so through out her entire pregnancy. The social worker at the hospital-based clinic helped her fill out an application for the WIC program.

As we discussed how Rosie first found out about the two clinics and services she had used, and the steps she had taken to gain access to these services, she pointed out that she had managed to find a physician and get into the WIC program but she was still trying to become enrolled in Medicaid.

> *With Medicaid I feel like I'm running in circles. My caseworker is not very helpful. She's not specific about what I need to do — she just sent me a form. She's supposed to help me. WIC has been very accommodating. The people at the clinic are good. I don't have to wait too long and I can always call with questions. They should make Medicaid more easy to access for people who need it. This is just taking too long.*

As we discuss Rosie's expectations about labor and birth, it becomes apparent that she is preoccupied with the issue of who will be with her while she is in labor. Rosie explains that she has thought a long time about this because her baby is due right around finals time for her boyfriend. "If he is in a final, then my mom will drive me to the hospital and stay with me. If not, then he will." Although Rosie says she is satisfied with this plan, she explains that what she is really worried about is her mom. "My mom is scared. She never had her husband with her when she was in labor. It was different then." Rosie believes that her mother is afraid because she didn't have any support when she was giving birth to her children and that, as a result, it was a bad experience for her. In light of her mother's fears about labor, Rosie contacted her aunt who works in the radiology department at a local hospital. They decided that when Rosie goes into labor she will "beep" her aunt who will then come to the hospital and explain everything to her mom as it happens. Rosie points out, "My aunt is around patients all the time so she will be able to help my mother and tell us what's going on."

Interview —*Theresa*

Theresa, her three-year-old daughter Stacia, and I talked in an empty exam room at the hospital-based clinic. At the time of our interview she was eight months pregnant. Although she said she was engaged, Theresa, who is 18, lives with a girl friend. The first time Theresa was pregnant she was 15 years old and had just finished 9th grade. When Theresa's mother found out that she was pregnant she kicked her out of the house and told her she was on her own. Theresa dropped out of high school and moved in with a her girl friend as the father "dropped out of the scene" as soon as he found out she was pregnant. Three years later she is still living with the same friend.

Eventually Theresa and her mother repaired their relationship, although she did not move back home, and her mother brought her to her prenatal visits at the clinic. Despite this Theresa recalls that her first pregnancy was harder because she was by herself. She explains,

> *This pregnancy is easier now because I know more. When I was 15 and my Mom kicked me out I didn't know anything. Now I have a house and a boyfriend for support.*

On top of being older, having been pregnant once, and repairing her relationship with her mother, Theresa could not emphasize enough how significant her fiancé support has been in helping her through her second pregnancy. Although he could not attend her prenatal appointments with her, since he was working during the day, he lent her his truck so that she could drive to her appointments. From Theresa's perspective, access to his truck, the money he contributed towards her grocery bills, and his overall support made her second pregnancy easier. She expected the birth to be different not only in that her fiancé would drive her to the hospital but that he, as well as her mother, would coach her through labor.

Theresa had been working as a waitress in a bar before she was pregnant. The smoky environment made her feel sick, and when she found out she was pregnant, she decided to quit for both her own and the baby's health. Even when she was working as a waitress, Theresa could not afford private health insurance so, as with her first pregnancy, she enrolled in Medicaid. Initially Theresa found out about Medicaid through the receptionists and nurses at the hospital based clinic, who gave her the Medicaid paperwork and directions to the county health department. Theresa didn't expect, however, to be on Medicaid for much longer. Her fiancé worked for a local construction company delivering windows, siding, and doors. Since Blue Cross and Blue Shield health insurance covered him through his job, they planned to add the baby to his policy. When married, Theresa and Stacia would be covered under his plan as well.

Theresa's decision to use the hospital-based clinic was based on recommendations from friends and her general belief that the OB-Gyn clinic was part of a good hospital. Born and raised in Lansing, Theresa's mom as well as the friend she lives with, reside in the same neighborhood as the community center based clinic. When asked why she did not use the clinic at the community center she replied,

> *They just do food stuff and clothing for people. [The hospital based clinic] has more stuff. It seems more professional.*

Since Theresa had used the Hospital Clinic when she was pregnant with Stacia, I asked her how she chose her physician for both her first and current pregnancies. She couldn't remember how she "got her doctor" the first time. She explained, however, the second time she was asked by the intake nurse if she preferred to have a man or a woman as her physician. Theresa indicated that she didn't really care who she got as long as it was a "lady." When asked why it was important for her to have a woman physician she explained that she wanted a "lady" because she would feel more comfortable with her.

Discussion

Examining low-income Mexican American women's resource management from the perspective of the individual illustrates the centrality of gender in analyzing the political economy of everyday issues, such as employment or unemployment, transportation, childcare, and household composition, in the strategies women develop to gain access to health care during pregnancy and birth. The dynamic relationship between employment and health insurance illustrate a multi-faceted view of access in which women's strategies address weighing the costs and benefits of insurance premiums for private health insurance; working in jobs that do not offer health benefits; and highlight the intersection of martial status and qualifying for spousal benefits. A gender-centered perspective of resource management thus illustrates that women's strategies articulate with the specific characteristics of the economic situation of their households.

In the first case study, the dynamic relationship between employment and health insurance is illustrated by Maria's realization that she would not have enough money to sustain her family if she had the health insurance premium deducted from her paycheck each month. This cost/benefit analysis was a determining factor in her decision to use Medicaid when she was pregnant. In turn, Maria's sister-in-law became a significant resource in managing access to health care for she told Maria about Medicaid, helped her to get enrolled, and then drove Maria to her prenatal appointments at the public health clinic. Three pregnancies later, transportation and childcare still remain a central issue in Maria's access to health care. Although she now owns her own car, her choice of what clinic to use for prenatal care was influenced by location and the child she had to bring with her to her appointments. As she pointed out, she went through the phone book and chose the clinic closest to her.

Maria's husband's expectations about her role as a wife and mother further highlight a gender-centered political economy which structures their household in such a way that she did not work outside of the home even though her husband was unemployed. While Maria's previous job did not offer her any viable health insurance benefits, working outside of her home gave her access to a larger social network she could rely upon for child care and transportation needs. In a pinch she could ask a friend from work to watch her little boy for a couple of hours or to give her a ride to an appointment. Although her sister-in-law was able to fill this gap for her to some extent, and she now has her own care, Maria's access to social resources was limited. As a result, the location of the clinic and the childcare became primary issues that influenced her strategies in managing access to health care services.

Rosie's strategy to gain access to prenatal care was fundamentally shaped by the political economy of her work situation in that the child care center where she worked did not offer employees health insurance. In Rosie's case, her mother and father were fundamental resources in gaining access to health care during her pregnancy. Although Rosie went to the Public Health Clinic on her own initiative when she first suspected that she was pregnant and the nurse set up a prenatal appointment for her at the Hospital

Clinic, her mother's statement that she needed prenatal care validated for Rosie the necessity of prenatal care. Rosie's father's explanation that they were "low-income" fundamentally shaped Rosie's strategy in that he identified a source of insurance, a physical location for her to gain access to it, and an intimation of what the process would entail.

The role gender issues play in influencing women's access to health care is also evidenced by the strategy that Rosie developed to address her mother's fears about labor. Aware that her mother might have to be her labor coach if her boyfriend was in the middle of a final exam, Rosie realized that she needed to come up with a viable plan to ease her mother's fears. Having deduced that her mother's fears were rooted in her own childbirth experiences — in which she did not have any labor support from her own family — Rosie arranged to have her aunt, who worked in a medical setting, coach her mother when Rosie was in labor. From Rosie's perspective, the need for a plan to deal with her mother's fears burgeoned from an event shaped by gender. As Rosie stated, "She [Rosie's mother] never had her husband with her when she was in labor. It was different then." Aside from necessitating this plan, her mother's labor experiences also led Rosie to decide that she would have her boyfriend with her while she labored. This decision illustrates another way in which gender shaped the resources Rosie managed in managing access to health care.

Finally, Theresa's situation can be used to analyze a gender-centered perspective of political economy in which she tied her health care strategy to her marital status. Having decided not to work at the bar while she was pregnant because of her concern for her own health, as well as her baby's, Theresa enrolled in Medicaid. She anticipated however, that she would not be on Medicaid for long as she and her fiancé were soon to be married. Once married she, as well as her daughter Stacia, would be eligible for coverage on her husband's health insurance plan. Theresa's choice of clinic similarly evidences the political economy of her health care strategy. Although she lived in the same neighborhood as the Latino Community Center Clinic, Theresa chose the Hospital Clinic because it seemed more "professional." As Theresa in essence articulated, she perceived the Latino Community Center Clinic, which also handed out food and clothing, as being for "poor" people. In contrast, Theresa interpreted the primarily clinical services provided by the Hospital Clinic as more professional —meaning that the Hospital Clinic had more modern equipment and "better" staff.

While Theresa's plan to gain access to health insurance through her future husband is clearly an example of a gender-centered political economy of access; her strategy was influenced by gender in other ways as well. Theresa perceived pregnancy as being easier the second time around not only because she was now "experienced" but because of the support she received from her fiancée with regard to money, the use of his truck, and moral support. Furthermore, Theresa's plan to have her fiancée drive her to the hospital and coach her through labor introduced an element of support that Theresa perceived as being gender-centered since her fiancée would add a "male" presence.

Gender also played a similar role in Theresa's choice of physician. When asked if she preferred a man or a woman as her physician Theresa chose a "lady." Her choice was not influenced by the prospective physician's qualifications, approach to prenatal care or childbirth, or personality, but rather was solely based upon gender. Theresa assumed that she would feel more comfortable discussing her pregnancy and being examined by a woman rather than a man.

Pregnancy and birth are events that are both commonplace to clinic personnel and unique everyday experiences for pregnant women. Giddens (1979) developed a concept of "tacit," or "practical knowledge," to describe the ways in which people go through life using familiar assumptions to deals with various situations where conscious decision making is carried out. In this analysis I use the concept of tacit knowledge to address resources women draw upon in creating new strategies to manage access to health care services during pregnancy and birth. Maria, Rosie, and Theresa's everyday experiences illustrate that there are steps involved in access health care services that women strategically manage based upon the broad scope of their economic and social resources. As I will discuss in the following chapter, these complex pathways, which are structured by gender, political, and economic factors, are in stark contrast to clinic personnel's perception of the decision making process involved in low-income Mexican American women's efforts to gain access to prenatal care.

Endnotes

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[1] In interviews, both women seeking care and clinic personnel used the term "baby" to refer to both a fetus as well as a baby that was already born.

Chapter 5: **Clinic Personnel's Views of Women's Access to Prenatal Care**

As low-income Mexican American women go through pregnancy and birth they achieve access to prenatal care through a series of decisions and routines that I analyze as social resource management. As discussed in the previous chapter, the resources that women draw upon in the form of family, friends, and co-workers as social networks of information and support, help them to address issues related to childcare, transportation, working both in and outside of the home, and unemployment in facilitating access to prenatal care. The strategies that low-income Mexican American women develop in this process thus involve steps, or alliance building, that are managed strategically based upon the broad scope of their social resources.

Clinic personnel, and their organizations, in this study often conceptualized access to health services in terms of socioeconomic issues however, their understanding of the elements involved in gaining access to prenatal care did not encompass women's social resource management. Whereas clinic personnel identified transportation, lack of health insurance, and the inability to pay for needed medical care as socioeconomic issues that low-income women must overcome in achieving access to care, they viewed these issues as isolated events, or barriers, rather than a series of interconnected issues that women addressed by drawing upon the social resources available to them. Perceived in isolation, clinic personnel consequently concluded that barriers, such as the aforementioned, had been successfully overcome once women attended a clinic appointment and enrolled in Medicaid. In the first half of this chapter I analyze clinic personnel's perspectives of low-income Mexican American women's access to prenatal care with respect to their understanding of why women obtain prenatal care, how they find out about and choose a clinic, and how women enroll in Medicaid. In doing so, my goal is to examine the common themes of clinic personnel's perceptions.

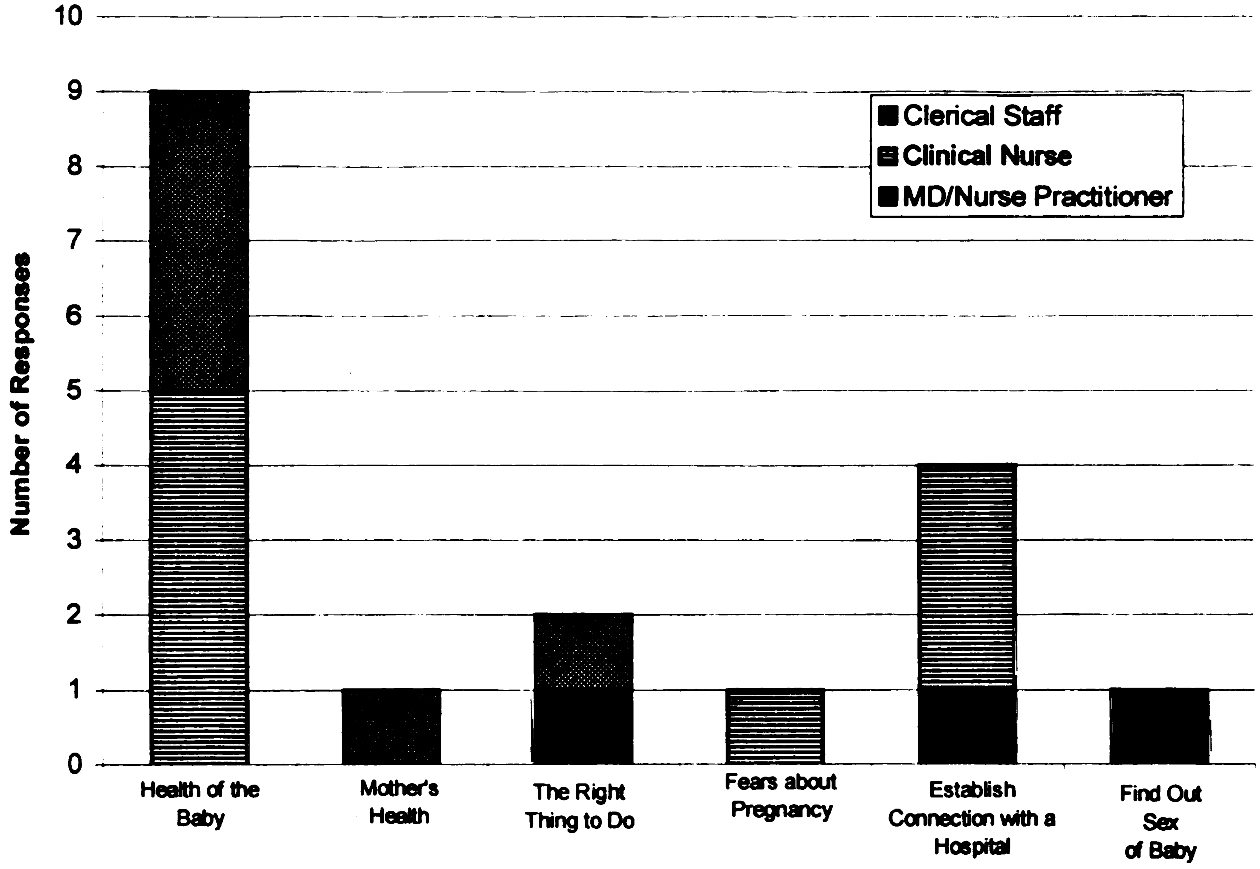
Clinic personnel in this study often viewed socioeconomic barriers inhibiting low-income women's access to prenatal care in the context of ethnicity. Structured in terms of working within the limits of their clients' financial constraints, clinic personnel working at "free," "sliding scale," and "public" clinics, such as the ones in this study, often equated low-income with belonging to an ethnic minority. For the most part, this was due to the fact that the majority of low-income women clinic personnel served in their clinics belonged to an ethnic minority. As a result, many clinic personnel in this study viewed ethnicity as an integral factor that shaped low-income Mexican American women's access to prenatal care. Consequently, in the second half of the chapter, I examine how gender, socioeconomic issues, and belonging to an ethnic minority influence clinic personnel understanding of women's social resource management and strategies to gain access to prenatal care.

Clinic Personnel's Perspectives

Why Women Obtain Prenatal Care

In general clinic personnel, like their patients, cited the health of the baby as the primary reason why women obtained prenatal care (see figure 5.1). This response, however, is not as straightforward as it may seem. Many clinic personnel linked women's concern about the health of their baby with specific health problems or complications that their patients experienced during their pregnancy.

Figure 5.1
Clinic Personnel's Views on Why Women Obtain Prenatal Care
N, number of responses = 18 from 15 Clinic Personnel



For example, Margarita, a nurse practitioner at the Latino Community Center Clinic indicated that many of the women she saw did not think that prenatal care was important. "Health is the last thing on their mind. They're more concerned with their children or getting food for the next day." In Margarita's view, women didn't think about prenatal care until a specific complication arose and then they came into the clinic for help. The health of their baby thus becomes their primary reason for obtaining prenatal care.

Margarita's explanation for women's concern with the health of their baby highlights an interesting class dichotomy in clinic personnel's overall responses to the question of why women seek prenatal care. Clinic nurses and clerical staff strongly believed that a mother's concern for her baby's health was a major motivating factor in women's decision to obtain prenatal care. While some of the clinic nurses and one provider from the MD/Nurse Practitioner group believed that women sought prenatal care to establish a connection with the hospital at which they would give birth none of the clerical staff responded in this manner. I believe that this dichotomy is due in part to Clinic Nurses and MD/Nurse Practitioners' educational backgrounds and roles as health care providers, both of which brought them in contact with the hospital itself. Consequently, their vision of health care access encompassed a broader locale than the prenatal clinic. Clinic Nurses and MD/Nurse Practitioners were also strong advocates of childbirth education classes yet realized that the majority of their patients could not afford to participate in such classes. Their belief that women sought prenatal care to establish a connection with a hospital may have also been founded in their support of these courses, which are oriented around hospitalized labor and delivery.

Clinic personnel often cited secondary motivations for why women obtained prenatal care as well. These secondary motivations ran the gamut, ranging from finding out the sex of the baby to having an "in" to delivering at a hospital. As one Family Nurse Practitioner explained:

> *Some don't think they need it [prenatal care] because it's not important — especially if they've had a healthy baby. They know they're going to go to the hospital [to have the baby] and they have to hook in [to the system] somehow. [Tanya, Public Health Clinic]*

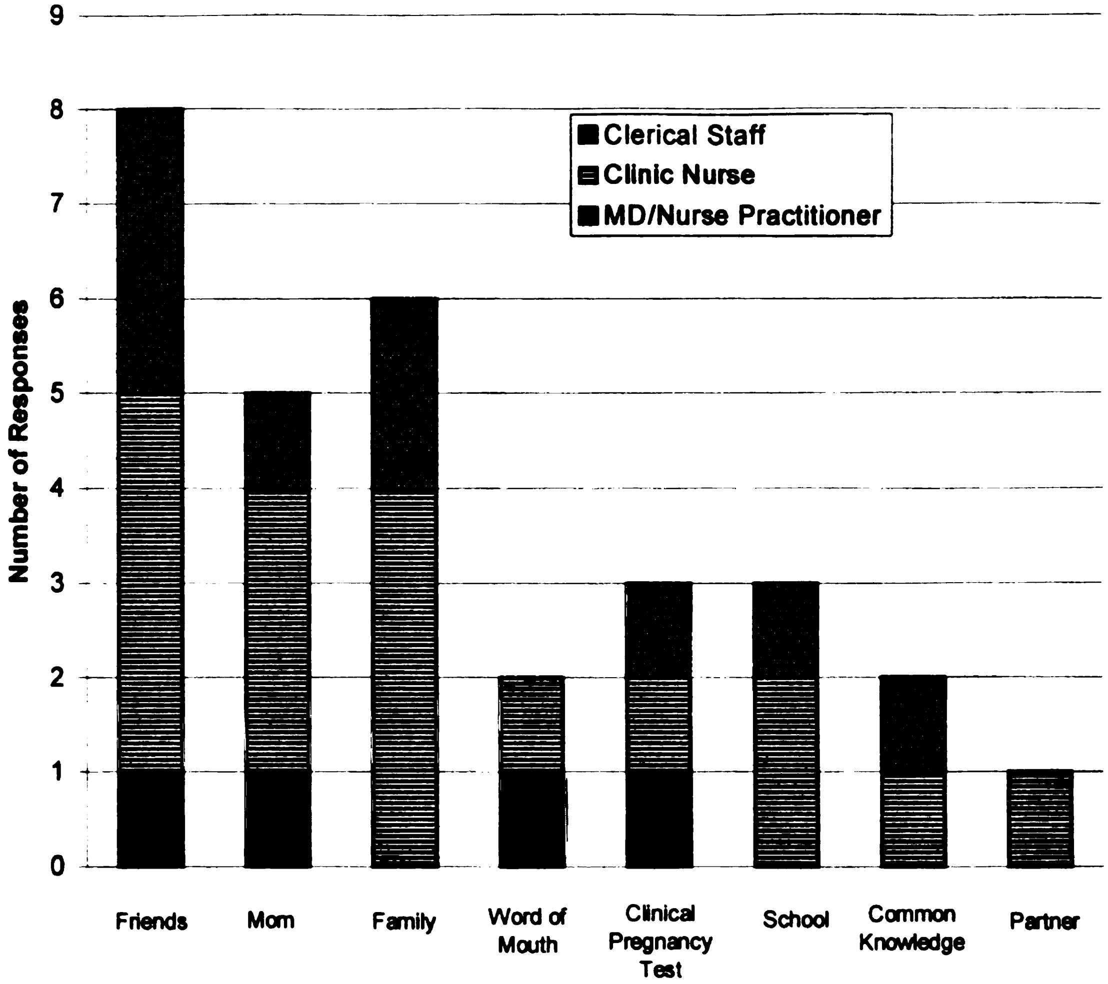
The latter of these secondary motivations illuminates the more complex nature of the strategies women develop to gain access to health care during pregnancy and birth. Many clinic personnel expressed the belief that women do not really understand why prenatal care is important, especially if they have a healthy and uneventful pregnancy. Despite efforts to explain its importance and the procedures involved in prenatal care, many clinic personnel realized that to patients it might not seem as though much is really being done. One aspect of prenatal care that clinic personnel felt patients did grasp however, was the ultrasound. Clinic personnel felt that whereas they placed the value of the ultrasound squarely on establishing the health of the baby, patients viewed it solely as a tool for determining the sex of their baby. Clinic personnel thus viewed the ultrasound as a powerful secondary motivation in women's reasons for obtaining prenatal care.

How Women Find Out About and Choose a Clinic

In general clinic personnel in this study believed that women found out about prenatal care from friends and family, and more specifically, from their mothers (see Figure 5.2). In these instances clinic personnel envisioned scenarios in which their patient's mothers or sisters had used the clinic to give birth to their own children. Clinic personnel often referred to these patients as "repeat customers" as they usually belonged to families that frequented the clinic on a regular basis — year after year.

Clinic personnel's ideas about how women found out about prenatal care were closely linked to their perceptions of how and why women chose to patronize a clinic. Generally, they surmised that women found out about a clinic based on information gathered from friends and family. Clinic personnel felt however, that a woman's actual decision to use a particular clinic was also influenced by cost, location, and her own familiarity with the clinic. The clinic personnel who articulated economic factors women might consider in choosing a clinic stressed the importance of a "free clinic" in which women knew that they would not have to pay for their care regardless of whether they had Medicaid coverage. They similarly discussed the implications of a clinic's location, realizing that a woman might choose one clinic over another if she could walk or easily take the bus to a clinic. Finally, clinic personnel realized that a women's familiarity with

Figure 5.2
Clinic Personnel's Explanations of How Women Find Out About Prenatal Care
N, number of responses = 30 from 15 Clinic Personnel



a clinic also contributed to the decision making process as well. In this sense, a woman might be more inclined to obtain prenatal care at a clinic she also used for gynecological care, as she would be familiar with the staff, routines, and the clinic itself. In particular this was true of the Latino Community Center Clinic, which was essentially a general practice. Many of the women who attended their prenatal clinic on Thursday mornings had been seen by other clinic personnel for a variety of health related concerns.

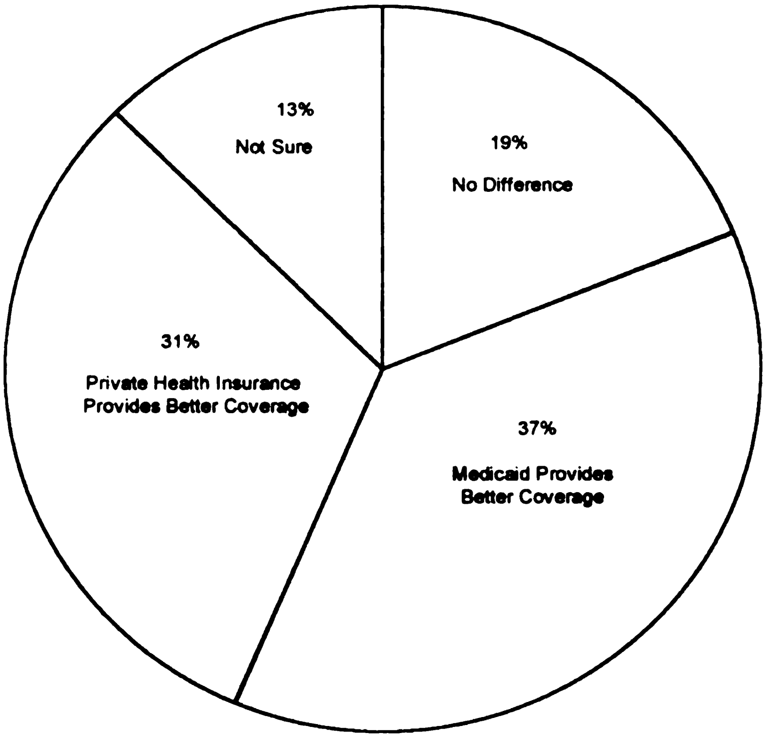
Finding Out about and Enrolling In Medicaid

As did the women in this study, clinic personnel similarly perceived gaining access to health care as being integrally linked to the process of finding out about and enrolling in Medicaid. This belief was due mostly to the fact that clinic personnel viewed family, friends, and clinics as the main purveyors of information about prenatal care as well as Medicaid. Despite this similarity, clinic personnel viewed the process of finding out about and enrolling in Medicaid much differently than their clients.

As previously discussed, women often felt that enrolling in Medicaid was a cumbersome process which involved travelling to the county health department, figuring out how to fill out application forms, miscommunication with Medicaid case workers, and a lengthy enrollment period. As Rosie explained in Chapter 4, she had managed to find a physician and enroll in the WIC program yet five and a half months into her pregnancy she was still waiting to have her application approved by Medicaid. In contrast, clinic personnel overlooked the process involved in enrolling in Medicaid and instead viewed it as a foregone conclusion. While they recognized that travelling to the county health department to enroll in Medicaid and that the process itself was complicated and lengthy were both issues that inhibited the enrollment process, clinic personnel presumed that women would overcome these "barriers" to have the benefit of Medicaid coverage.

Although many clinic personnel understood there to be barriers, such as the ones mentioned above, inhibiting low-income Mexican American women's access to Medicaid they were almost evenly split with regard to the notion that Medicaid offered low-income women coverage comparable to that of a private health insurance plan.

Figure 5.3
Quality of Coverage: Medicaid vs. Private Health Insurance
N, number of responses = 16 from 15 Clinic Personnel

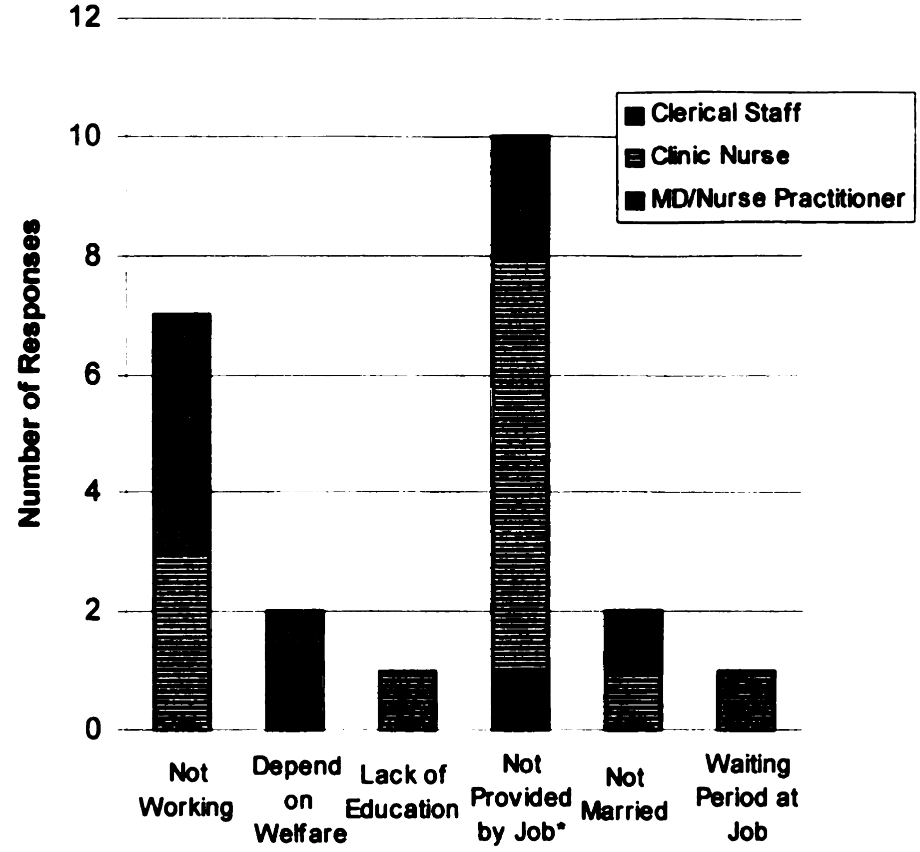


The issue of whether Medicaid offers better or worse coverage than private insurance at first may seem irrelevant to low-income women's access to prenatal care however it illuminates a basic premise that many clinic staff espouse — that low-income women should be thankful for the coverage that Medicaid provides. As the following vignettes illustrate, clinic personnel often felt that Medicaid offered excellent coverage and access to a variety of resources. As a result, clinic personnel concluded that women on Medicaid had no reason to complain about the care they receive and, furthermore, should be thankful for it.

> *Once they [women] get in they have wonderful coverage. I haven't noticed anything they can't have — ultrasound etc. [Cory, Clinic Nurse, Public Health Clinic]*
>
> *It [Medicaid] covers everything and then the baby for two years. [Diane, Reception Clerk, Public Health Clinic]*
>
> *I think so, personally, but not a lot of the clients do. For example, Medicaid only covers one ultrasound — they want another one to find out the sex. Their expectation is higher than our standard. [Mindy, Clinic Nurse, Public Health Clinic]*

Discussion with clinic personnel about women's expectations of Medicaid coverage and prenatal care always included speculation about why women did not have private health insurance in the first place. Despite espousing the argument that women should be "thankful" and feel "lucky" for Medicaid coverage, clinic personnel readily placed a significant portion of the burden of the underinsured and non-insured upon employers. As figure 5.4 illustrates, the majority of clinic personnel interviewed believed that one of the main reasons women did not have private health insurance was because their employers did not offer health benefits or women could not afford to pay the premium for private coverage. As such, clinic personnel conceptualized their clients as being more than "low-income" — using the term "working poor" to describe women who held steady jobs but yet did not make enough money to pay for even the basic necessities of life.

Figure 5.4
Why Clients Do Not Have Health Insurance: Clinic Personnel's Explanations
N, number of responses = 23 from 15 clinic personnel



* Includes explanations that health insurance was not a benefit provided by an employer as well as instances where a woman was not able to afford having the insurance premium deducted from her paycheck.

Figure 5.4 also illustrates however, that a large number of clinic personnel also believed that women did not have private health insurance because they were not working. Interestingly, this belief was articulated by only clinic nurses and clerical staff.

Clinical nurses, however, were careful to distinguish between "not working" and "unemployed" for they realized that many women considered themselves "employed" yet they were not working during their pregnancy. Women in the "not working" category thus not only held a job before they were pregnant they intended to return to their job, or a similar one with a different employer, after their baby was born.

Despite consciously distinguishing between "not working" and "unemployed" clinic personnel, both clinical nurses and clerical staff, were not very sympathetic of the notion that women did not work when they were pregnant. For the most part, clinic personnel felt that women made the conscious decision not to work while they were pregnant and, as a result, had to rely upon Medicaid. Realizing that most women, working poor or not, only have 12 weeks of maternity leave after the birth of a child, clinic personnel thought that it was unrealistic of women, low-income women to boot, to stop working when they were pregnant. Karen, a Registered Nurse at the Hospital Clinic, explained that many women asked for work releases or excuses because they were pregnant. She told them that they had to "rise above the pain and just do it."

Clinic Personnel's Perspectives

Analyzing clinic personnel's perceptions of low-income Mexican American women's expectations of and beliefs about access to prenatal care, illuminates how variables such as gender, politics and economics and belonging to an ethnic minority influence clinic personnel's perceptions of health care access. In the following case studies, drawn from interviews with clinic personnel, I present the everyday experiences of clinic personnel actively navigating a health care system in examining how barriers related gender and politics and economics influence clinic personnel's perceptions of access. As such, interviews with clinic personnel show that the quality, availability, and process of accessing health care articulates with clinic personnel's preconceived notions of what it means to be poor, female, and Mexican American.

Interview — *Cory*

Cory, a Clinic Nurse at the Hospital Clinic, and I met in her office for our interview. A petite woman with boundless amounts of energy, she always found time to stop in the hall and chat with me whenever I was at the clinic. Cory often joked that she "did it backwards" — meaning that she got married and raised a family and then went to college and graduate school in her late thirties. Married and now the mother of two adult children, she has earned a number of nursing degrees: BSN, RN, and LPN. At the time of our interview, Cory had worked at the Hospital Clinic for 10 of the 15 years she had been a nurse. She chose to become a nurse because many of the women in her family had been nurses.

While Cory articulated responses commonly expressed by her colleagues about how women find out about prenatal care and choose a clinic, Medicaid was a central theme that encompassed her perspective of women's access to prenatal care. She similarly speculated that women found out about prenatal care through their friends and family and that women's primary motivation for obtaining prenatal care was to monitor their pregnancy. From her perspective women believe that if " they have the testing then they think that their pregnancy will be o.k." It was Cory's belief however, that finding out about prenatal care was fundamentally linked with finding out about Medicaid. In her view, the process was one and the same.

> *Women find out about Medicaid by word of mouth through friends and it is common knowledge. They find out about [our clinic] through the Family Independence Agency, and via word of mouth through friends and family.*

Cory's belief of the integral link between finding out about prenatal care and Medicaid access seemed to indicate a presumption on her part that the process of actually gaining access to a clinic for prenatal care was similarly straightforward. With this in mind I asked her if she thought women faced any problems in finding and using a clinic. In response she speculated about "late care" — women who do not begin prenatal care until late in their pregnancy. Although she was not sure what barriers women might face, she was sure that "late care" was the result of problems in signing up for Medicaid:

> *Late care. They [women] put it off so I'm sure there's barriers. It used to be that people were embarrassed to be on Medicaid but things have changed. They've [her clients] . . . attitudes have changed.*

With the issue of "late care" in mind, Cory went on to discuss the care women receive upon enrolling in Medicaid:

> *Once they get it they have wonderful coverage. I haven't noticed anything they can't have — ultrasounds, referrals, tests.*

The significance of Cory's Medicaid theme throughout our discussion of how women gain access to prenatal care became apparent towards the end of the interview when she commented that hardly any of the women she saw in the clinic had private health insurance. Curious as to why she had raised this issue I asked her if she believed that women on Medicaid received different care from women with private health insurance. Cory hedged in her response, explaining that while it might be true at other clinics it was definitely not the case at her clinic. She went on to point out that women seen at the Hospital Clinic get much better care than women with private insurance, explaining that "[T]hey get better care [here] because they get more education, they see a nutritionist, and they have access to a social worker." As an after thought Cory added that women on Medicaid were perceived differently by clinic personnel in general since the care that women received was thought of as a gift. "We're paying for them to have babies."

Interview — *Diane*

Diane worked as a Clinic receptionist at the front desk of the Public Health Clinic. Since three other women occupied the front desk area Diane and I met in the clinic personnel's lounge at the back of the clinic. In her late fifties, Diane was a matronly woman who radiated an air of obstinacy and an attitude that implied one should be thankful for her help. Born and raised in the greater Lansing area she began working for the Public Health Clinic when she graduated from high school. Now, the divorced mother of four adult children, she has been employed with the Public Health Clinic for 21 years. As Diane explained, "I was a housewife with a station wagon before I started working at the [Public Health Clinic]." At 38 her husband divorced her and through a friend she found out about a part time job at the Public Health Clinic as a front desk receptionist. Eventually she was offered a full time position and she took the job because she need the money and the benefits.

Diane asserted that women found out about prenatal care when they came in for a pregnancy test, at which point clinic staff encourage women to get early prenatal care. She explained that while some women are non-compliant, others will get it if they care. Curious as to Diane's definition of "non-compliant" I asked her what she meant by this statement. She replied, "They're non-complaint because they just don't care about their health and the health of their baby."

As in many other interviews with clinic personnel the locus of our discussion about health care access seemed to be centered in the clinic. In an effort to redirect Diane's attention to issues women might face before they even entered the clinic I asked her how she thought women found out about her particular clinic. Again, she responded similarly to her colleagues stating that women found out about the public health clinic from friends and family, especially ones who had used the clinic. When pressed, Diane could not, however, think of any barriers that might prevent women from finding out about or using the clinic for prenatal care. She pointed out that there were lots of advertisements about the clinic and prenatal care. Furthermore, she asserted,

> *Women need a "clinical test" [pregnancy test] to apply for Medicaid so there is always early access.*

Diane thought that women found out about Medicaid in a similar fashion — primarily through family members but also through social networks and the public health clinic. She reasoned that if a mother was on Medicaid then her daughter would know about it if she didn't have any health insurance. Again, Diane did not know of any barriers that might inhibit women's access to Medicaid. After thinking for a bit however she tentatively suggested that perhaps language might be a barrier but she was hesitant to endorse this as a barrier since refugee services provided an interpreter for women who do not speak English. From her point of view Diane believed that language might be a deterrent at first but not for a long period of time if the woman really wanted care. As we continued to talk about the problems language might present, specifically for Mexican American women who might not speak English, it became apparent that Diane made a clear distinction between a "barrier" and "deterrent" — a barrier kept people away whereas a deterrent was an obstacle that could be overcome. To illustrate this distinction Diane further explained:

> *We have staff here that speak Spanish, there are interpreters or they bring a family member [who speaks English]."*

In conjunction with our discussion about barriers that inhibit women's access to prenatal care, Diane explained that in her view Medicaid alleviated many of the barriers women might be faced with since " it covers everything and then the baby for 2 years through the child care clinic." Although postpartum care is not covered by Medicaid Diane pointed out that the public health clinic has a sliding fee scale for postpartum care thus, in her mind, alleviating any deterrent there might be. As an aside Diane explained that outreach programs had done a lot for women with regard to obtaining prenatal care — "We used to confront these women because they didn't think they needed it."

Eventually Diane's lecture on how Medicaid alleviated barriers to health care centered in on a central theme of clinical access — that women should be thankful for the services they received through Medicaid and the public health clinic. As did many of her colleagues, she too pointed out that in "her clinic" women had access to a nutritionist, a social worker and much more regardless of whether they used Medicaid or private insurance. Furthermore, she argued that women seen in her clinic had access to more services than women with private insurance who are seen in "private" doctors' offices. To illustrate her point Diane used her own prenatal care experiences, covered under her husband's private health insurance policy, as an example. Diane explained that when she was pregnant she had to go to many different places for her prenatal care — a laboratory on one side of town for blood tests, a pharmacy on the other side of town to have prescriptions filled, and her doctor's office, in the middle of town, for prenatal visits — whereas women at the public health clinic can receive all of these services in one location. Diane's belief that the public health clinic, and Medicaid, afforded a woman better care was further validated by a medical school resident on rotation at the clinic who echoed the same opinion. In closing, Diane articulated that the "one stop shopping" provided by the clinic was especially important since almost all of the women seen in the clinic were "non-compliant" and "low-income."

Discussion

While the views and perspectives expressed in the latter two interviews address only two clinic personnel's thoughts on the strategies low-income Mexican American women employ to gain access to prenatal care, they highlight aspects of a gender centered approach to political and economic issues that were common themes in many of my interviews with clinic personnel. As I illustrate in both of these case studies, gender, politics and economics shaped the decisions each health care provider made in choosing her profession. In turn, gender, politics and economics similarly figure into each clinic personnel's perception that health care access and Medicaid access are one and the same.

The pathways that led Cory and Diane to a career in health care were not unique among the clinic personnel interviewed in this study. Many clinic personnel found themselves entering the work force after they had married and raised their children. Clinic personnel's average age was 43. Cory and Diane's stories thus illustrate how gender roles shaped their choice of career as well as their motivation to enter the work force. In Cory's case, gender informed her role as a wife and mother first, and then as a nurse later. Cory was raised with the expectation that she would marry and fulfill her roles as a wife and mother before choosing a career outside of the home for herself. Once her children had grown and moved out of the house she then began considering her career options. Using the social resources available to her through her family network she talked with other women in her family, the majority of whom were nurses. As a result Cory too decided to pursue a career in nursing. Gender thus shaped Cory's decision to pursue a career outside of her home and her choice of career as well.

Gender similarly shaped Diane's career path in that she too fulfilled expectations that she marry and stay at home while she raised her children. Gender issues similarly shaped her entrance into the work force in that had her husband not divorced her she would not have found it necessary to work outside of the home. Diane indicated that she was satisfied with her previous role as a wife and mother in her statement — "I was a housewife with a station wagon before I started working at the [Public Health Clinic]." Relying upon her social network, a friend told her about a job with the public health clinic as a receptionist. As Diane indicated, her change in marital status and the fact the job with the public health clinic offered her both the income she needed as well as health benefits motivated her career choice. To this extent, political and economic issues also played a role in Diane's entrance into the work force as she needed to earn enough money to support herself and her four children.

Political and economic issues fundamentally shaped both Cory and Diane's views of health care access as they equated health care access with Medicaid access. Again, this was a theme commonly expressed by many clinic personnel I interviewed. For Cory gaining access to prenatal care was integrally linked to Medicaid with regard to the process of finding out about and choosing a clinic. As Cory indicated in our interview she believed that women found out about Medicaid from friends and family and in the process they also found out about the clinics available to them for prenatal care. Cory's discussion of "late care" further illustrates how politics and economics shape clinic personnel's view of health care access. Although she was not able to identify any barriers that might inhibit women's access to prenatal care or Medicaid Cory perceived the wait to obtain prenatal care — "late care"— as the result of a woman's hesitation to enroll in Medicaid due to a stigma associated with being a Medicaid recipient.

Diane expressed similar views as Cory about the link between health care access and Medicaid. Her statement that women needed a "clinical test" [pregnancy test] to apply for Medicaid clearly articulated the practical linkage of these two components in that Diane concluded that a pregnancy test for Medicaid is an guarantee of early access to prenatal care. Like Cory, Diane reasoned that women found out about prenatal care in the process of finding out about Medicaid. However, Diane took this rationale one step further in her presumption that a daughter would automatically know about Medicaid and the resources available to her if her mother was on Medicaid.

Both Cory and Diane expressed that they felt women on Medicaid received better care through Medicaid than they would if covered by a private health insurance plan. Both supported this argument by citing the variety of resources available to women at their clinics: a nutritionist, a social worker and much more regardless of whether they used Medicaid or private insurance. In essence Cory and Diane were presenting a politics and economics argument that highlighted the attributes of their clinics and, from their points of view, alleviated any barriers that could possibly inhibit women's access to prenatal care. Diane's argument that women seen in her clinic had access to more services than women with private insurance, who were seen in "private" doctors' offices, illustrates this point. By drawing upon her own prenatal care experiences, Diane' experiences portray the political and economic nature of having to travel from one provider to another (the laboratory, the pharmacy, and her doctor's office) to comply with her prenatal care regime. Diane's resulting advocacy of the "one-stop-shopping" offered by the public health clinic thus articulates a political and economic premise of health care access that precludes barriers that might inhibit women's access to prenatal care.

Chapter 6: **Cultural Competency**

In this study, clinic personnel's discussions of low-income Mexican American women's access to prenatal care revolved around two central themes: barriers and ethnicity. While many clinic personnel recognized that barriers and ethnicity simultaneously shaped the ways in which women gained access to prenatal care, oftentimes portraying the two as synonymous, the majority of clinic personnel were not able to give examples of barriers, other than language, specific to Mexican American women's experiences. Shifting the focus away from barriers however, to a broader discussion of women's use of clinical services and resources, elicited explanations that espoused the ethnic basis of clinic personnel's view of access. As I illustrate in the first half of this chapter, clinic personnel's discussions about how low-income Mexican American women find out about and use Medicaid, problems that might inhibit or restrict women's use of prenatal clinics, and reasons why women might not work during pregnancy highlight the integral way in which ethnicity shapes their understanding of access.

The complex nature of clinic personnel's inability, or unwillingness, to recognize the ethnic basis of their explanations of access as barriers is, in part, due to two prevailing public health conceptual frameworks. The first, as I argue in the first half of this chapter, is that public health and health care research has traditionally conceptualized "access" and "barriers" to health care in terms of "health care utilization" — meaning the kinds of services provided, the location of service, who provides and uses the service etc (Loue, 1999). As such, clinic personnel perceive barriers in terms of patients' contact with a physician or clinic.

The second conceptual framework, which advocates the need for clinic personnel to be aware of their patient's ethnicity and cultural beliefs, is cultural competency — a process through which clinic personnel were taught what behavior to expect of and how to frame their interactions with different ethnic populations. As such, manuals used in cultural competency training offer portraits of ethnic minority groups, such as African American, Asian, Hispanic, and Native American, that are intended to give clinic personnel an overview of their respective demographic, socioeconomic, and cultural beliefs and practices. In turn, clinic personnel are taught that recognizing the cultural basis of minority populations' beliefs about health and illness will help them to better facilitate their interactions with patients who belong to an ethnic minority. A major goal in cultural competency training is thus to help clinic personnel, who previously perceived ethnic and cultural beliefs about health and illness (i.e., folk medicine) as a barrier to health care, view cultural beliefs as a positive resource that they can capitalize upon when treating patients who belong to an ethnic minority.

The majority of clinic personnel in this study had received some sort of cultural competency training either through the organizations they worked for or through their schooling. As I illustrate in the second half of this chapter, the ethnic basis of clinic personnel's explanations of low-income Mexican American women's access to prenatal care and their understanding of what it means to belong to an ethnic minority were fundamentally premised upon the conceptual framework of cultural competency. Their reliance upon this framework in part explains clinic personnel's inability to understand how why they equate socioeconomic barriers with ethnicity. I argue that using the concept of ethnicity in this manner ultimately does a great disservice to clinic personnel's understanding of how low-income populations gain access to health care services for it reifies what it means to belong to an ethnic minority. As such, I examine how cultural competency training leads clinic personnel to conclude that ethnicity, rather than women's resource management, plays a more significant role in shaping low-income Mexican American women's access to prenatal care.

Obtaining Prenatal Care: Barriers and Ethnicity

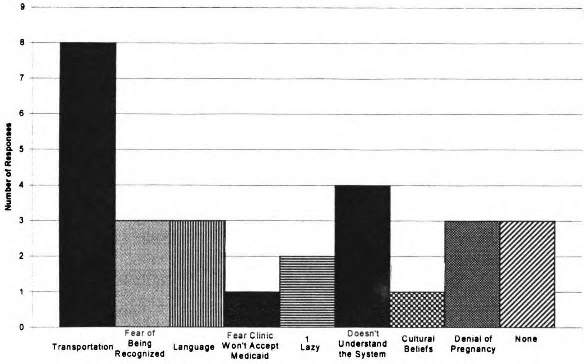
Clinic personnel in this study identified socioeconomic issues, such as transportation problems and lack of health insurance, that women must overcome in gaining access to prenatal care. As discussed in the previous chapter, clinic personnel often conceptualized these "issues" as isolated events or barriers rather than viewing them as a series of interconnected issues that women addressed through the social and economic resources available to them. As such, clinic personnel perceived barriers inhibiting low-income Mexican American women's access to prenatal care in terms of their contact with a physician or prenatal clinic. This distinction is significant for it addresses a fundamental premise of clinic personnel's conceptualization and use of the term "barrier." As I illustrate in the following discussion, clinic personnel's focus on barriers presumed that access to prenatal care was a given since their organizations — clinics — provided a variety of services and resources that they perceived as being readily available to women. In identifying barriers clinic personnel referred to women's individual characteristics and their social environments, such as socioeconomic status, culture, and ethnicity, that inhibited their entry into the clinic or use of clinic services and resources.

Many clinic personnel in this study did not distinguish between socioeconomic issues and ethnicity in their discussion of barriers to gaining entry to a prenatal clinic. Rather, they perceived ethnicity and socioeconomic status as integrally entwined. This was mostly due to the fact that the majority of the low-income women they served belonged to an ethnic minority. As such, clinic personnel often equated being poor with belong to an ethnic minority. Consequently, however, many clinic personnel concluded that ethnicity, or cultural beliefs, not only fundamentally shaped women's access to prenatal care but was in and of itself a barrier that inhibited their use of prenatal services.

Socioeconomic Barriers and the Ethnic Context

In response to the question "Are there any barriers women might encounter in finding out about and/or using prenatal care," clinic personnel articulated a number of socioeconomic barriers ranging from fear that the clinic would not accept Medicaid to laziness. As figure 6.1 illustrates however, the majority of clinic personnel cited transportation as the main barrier to gaining access to prenatal care. Although clinic personnel recognized lack of transportation as a barrier, and more significantly, perceived it as a significant factor in patients' non-compliance — meaning that women did not show up for their scheduled appointments — many clinic personnel felt that lack of transportation was a poor excuse for missing appointments because their clinic offered

Figure 6.1
Socioeconomic Barriers to Gaining Access to Prenatal Care
N, number of responses = 28



free bus tokens and vouchers for taxi rides. Mindy, an Asian Registered Nurse at the Public Health Clinic, articulated this position:

> *Lack of transportation —no car —is a main barrier. Their house might be too far from the bus or they might have car problems but they can call for help — arrange rides via the mother/infant outreach [program]. We also have bus tokens and taxi vouchers for them.*

Recognizing that women might not know about the services available to them, some clinic personnel considered not knowing how the "system" works to be a barrier to gaining access to prenatal care. The "system" to which these clinic personnel referred encompassed both the resources available through their clinics, such as bus tokens and taxi vouchers, and Medicaid in general. Jim, a physician, and Tanya, a family nurse practitioner, both articulated this point:

> *There is a perception of rejection because of Medicaid. Lots of clinics reject them [women who use Medicaid] so they are afraid to call the doctor's office. As a result they don't know what's available.*
> *[Jim, Physician, Latino Community Center Clinic]*

> *Not everyone knows they can apply for Medicaid . . . They think they are saving money by waiting [to apply] and don't realize how the system works — that it's more available for pregnant women.*
> *[Tanya, Family Nurse Practitioner, Public Health Clinic]*

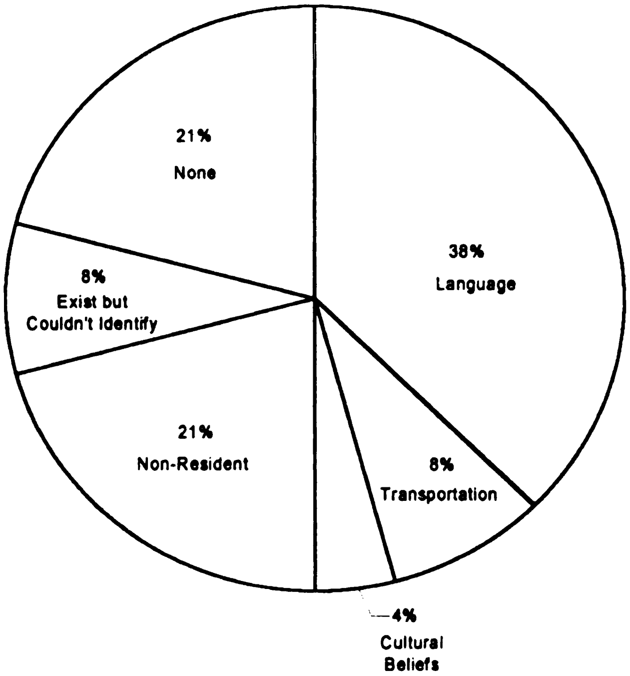
When pressed to identify "barriers" that might be specific to low-income Mexican American women's experiences, the majority of clinic personnel interviewed replied that they could not think of any. Three clinic personnel did however, identify language as a barrier. Two of the clinic personnel, a nurse and a physician, felt that Mexican American, and Mexican, women who could not speak English were at a disadvantage because they would not be able to understand the clinic staff or be able to follow prescriptions. Lucinda, an intake worker at the Public Health Clinic who spoke Spanish as her first language however, perceived not speaking English as a far more fundamental barrier to gaining access to health care. In Lucinda's view:

> *Some patients are treated nicer than others. If a Hispanic woman does not speak English they [the front desk] get frustrated. One of the women who works up there will turn away and tell her to sit until her interpreter arrives or reschedule her appointment unless I can catch them.*

Lucinda further pointed out that as English speakers we take much for granted in terms of getting through the application and appointment process. Lucinda thus considered language to be a primary barrier faced by low-income Mexican American women in gaining access to health care.

Although only three clinic personnel identified barriers specific to Mexican American women, discussion of ethnicity and cultural beliefs permeated the majority of clinic personnel's explanations of how low-income Mexican American women gained access to prenatal care. For example, health care found women's reliance upon friends and family to be a major deterrent in women's access to Medicaid. As figure 6.2 illustrates, many clinic personnel realized that issues such as residency, language, social stigmas, and the application process negatively influenced low-income Mexican American women's access to Medicaid.

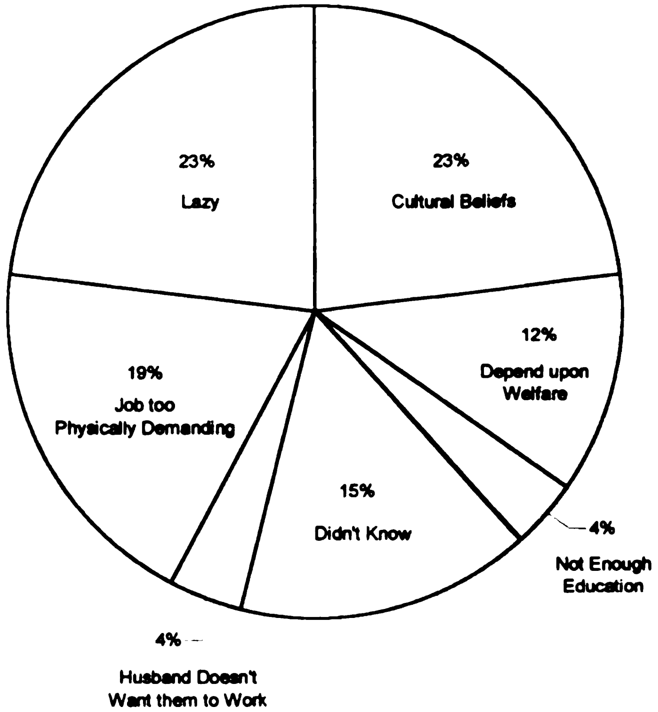
Figure 6.2
Barriers Specific to Low-income Mexican American Women
N, number of responses = 24



From clinic personnel's view, these barriers were fundamentally based, and in many ways promoted, by the families of their patients. For example, a non-resident who did not speak English would not be able to rely upon her family, who were also non-residents and non-English speakers, to help her facilitate the process of applying for Medicaid. As a result, she would not be able to complete the application forms and, more generally, understand the Medicaid system as a whole. Pam, a registered nurse at the Latino Community Center Clinic, expressed frustration with this scenario explaining that the information low-income Mexican American families often do have is based on conflicting stories about what services and resources are available through Medicaid. Pam further explained that women, and their families, who are legally in the United States as non-residents often do not trust services or people they are not familiar with, much less a government that they perceive as being suspicious and hostile towards them.

Clinic personnel inclination to equate low socioeconomic status with belonging to an ethnic minority was similarly articulated when I pressed clinic personnel for the reason they thought low-income Mexican American women chose not to work when pregnant. Clinic personnel responses encompassed educational, physical, motivational, and cultural variables (see figure 6.3 below). A number of clinic personnel believed that women did not work simply because they were lazy. Their responses were simple and straightforward — "I don't know, they're lazy" [Angela, Reception Clerk, Hospital Clinic]. When pressed further, clinic personnel such as Angela explained that women used pregnancy as an excuse not to work because they are basically lazy.

Figure 6.3
Why Women Do Not Work During Pregnancy
N, number of responses = 26



In contrast, a number of clinic personnel believed that women's reasons for not working while pregnant were based on cultural beliefs and their upbringing. A few clinic personnel believed that Mexican American women perceived pregnancy as an illness. As a result, it would only make sense that they would not work when "sick." Two Asian clinic personnel, one a physician and the other a registered nurse, felt that Mexican American women's cultural backgrounds played a significant role in not only women's decision not to work but established behavioral expectations for women during their pregnancy.

> *Cultural background in Mexican and*
> *Korean people taught that women have to be*

> *resting — not to do anything. I can relate. That is my cultural upbringing. [Jim, physician, Latino Community Center Clinic]*

Similarly, some clinic personnel believed that family perceptions of pregnancy greatly influenced low-income Mexican American women's decision not to work. Building upon the notion of cultural beliefs, clinic personnel who articulated this view thought that a woman's upbringing framed a woman's expectations of her pregnancy. If a mother did not work when she was pregnant than her daughter would not do so either. Cory, a registered nurse at the Public Health Clinic, explained:

> *[A woman will] ask when she can stop. Must perceive that working and pregnancy do not go together after a certain point. [It used to be that a] teacher or nurse could not show in pregnancy — they had to quit when they did. These are their parent's attitudes . . . . don't realize that it has changed — pregnancy is normal.*

Cultural Competency

While the low-income Mexican American interviewed in this study did not articulate that ethnicity influenced their access to health care, ethnicity figured centrally in clinic personnel perceptions of low-income Mexican American women's access to prenatal care. As illustrated in the first half of this chapter, ethnicity shaped clinic personnel perceptions of why women did not work during pregnancy and why they did not have private health insurance. Ethnicity also shaped clinic personnel interactions with low-income Mexican American women at the most fundamental level as well. If a woman, or the person accompanying her to prenatal visits, did not speak English and there was no one in the reception area who spoke Spanish then she was rescheduled for a time when she could bring an interpreter — either a family member or friend that could speak English or an interpreter from Refugee Services.

The ethnic basis of clinic personnel's explanations of low-income Mexican American women's access to prenatal care is shaped by their understanding of what it means to belong to an ethnic minority. In the following discussion, I argue that provider's understanding of what it means to belong to an ethnic minority is premised upon the conceptual framework of cultural competency. Based upon research that assesses demographic and health status statistics for a given ethnic minority population in relation to the role of culture in health care, cultural competency training has been defined as "[t]he knowledge and interpersonal skills that allow clinic personnel to understand, appreciate, and work with individuals from cultures other than their own. It involves an awareness and acceptance of cultural differences; self-awareness; knowledge of the patient's culture; and adaptation of skills" (McManus, 1998).

The goal of cultural competency training classes has been to help clinic personnel perceive their patients' cultural beliefs about health and illness as a positive tool in the treatment process. The traditional venue of disseminating information about ethnic minority populations however, in which portraits of ethnic minority groups are intended to provide a general overview of demographic, socioeconomic, and cultural beliefs, has permeated not only how clinic personnel's shape their interactions with minority patients in the clinical setting but clinic personnel's expectations about their patients' everyday experiences and behavior outside of the clinic as well. For example, Lucinda, an intake worker at the Public Health Clinic, reasoned that low-income Mexican American women did not have private health insurance because of: residency issues (as new immigrants they would be unemployed), not having a job that offered medical benefits, not wanting to hold a 9 to 5 job that would provide benefits, and because they were lazy — "It's sad to say but they believe that welfare will take care of them if them if they don't work." She further pointed out that the majority of low-income Mexican American women she saw in the Public Health Clinic did not have much education, arguing that this is due to "the way that they were raised." As she explained, Lucinda bracketed the latter phrase in quotes because she believed that the parents of the women she saw in the clinic passed their values on to their children. Consequently, Lucinda perceived laziness, not wanting to hold a 9 to 5 job, and little education as had little education themselves, as cultural beliefs, or values, that shaped low-income Mexican American women's reliance upon Medicaid and use of clinic services.

In learning to be culturally sensitive of the beliefs and practices their patients adhere to, clinic personnel have been given a boilerplate of ethnic and cultural characteristics upon which to frame their interactions. Instead of assessing a patient based upon individual qualities, clinic personnel's frame their expectations and interactions with patients upon generalized behaviors and beliefs of what it means to belong to a particular ethnic or cultural group. Linda Hunt (1998) has similarly argued this point in her assertion that physicians' explanations of illness and moral reasoning are shaped in terms of generalized presumptions about how "groups" of people behave. In this sense, I argue that efforts to help biomedical practitioners become culturally sensitive to minority populations beliefs and perspectives have reified ethnicity. Diane, a Reception Clerk at the Public Health Clinic, illustrated this point when asked if Mexican

American women on Medicaid are perceived or treated differently by health care professionals than white or other ethnic women in Medicaid.

> *No, in fact the Asian women are so sweet. We've all had some kind of ethnic training. Muslims are wonderful — don't mind waiting, using an interpreter — lots of smiles. Hispanic women, now they used to have their babies in the field. The last generation did not seek prenatal care unless [there was] a problem. They had midwives but that's changing.*

The barriers facing low-income Mexican Americans women's access to health care have been similarly reified — just as "ethnicity" has been reified in the cultural competency training of clinic personnel. Understandably, efforts to conceptualize the overwhelming barriers inhibiting low-income women's access to health care necessitated boiling the complexity of health care access down to a fundamental level in which tangible solutions could be devised and implemented. The issues presented above and throughout this entire document clearly indicate that clinic personnel are not only conscious of these barriers but, more significantly, working to overcome many of the barriers. For example, both women and clinic personnel in this study cited transportation as a major barrier to women's access to prenatal care. In response to this barrier, all three of the clinics in this study made bus tokens and taxi vouchers available to their clients. Similarly, clinic personnel understood that despite being employed many of their clients relied upon Medicaid because their employers either did not offer health benefits or women could not afford to pay a premium for private health insurance.

I argue however, that despite recognizing and attempting to remedy these barriers, gaining access to prenatal care is far more complex than the barriers lead clinic personnel to believe. While it is understandable that complex barriers have been oversimplified in an effort to implement manageable remedies, clinic personnel, and their organizations, response to barriers inhibiting low-income Mexican American women's access to prenatal care as been formatted upon the guise of the cultural competency framework. The remedies clinics offer to help women gain access to care are conceived upon portraits, or generalizations, of the barriers clinic personnel perceive women to be faced with. In essence, the remedies are formulated upon abstract notions that become fixed perceptions of what it means to belong to an ethnic minority. As such, the reified barriers equate with reified solutions that do not recognize the process women negotiate or the social resources they manage to gain access to prenatal care. While bus tokens and taxi vouchers are tangible, and manageable, remedies for a lack of transportation, they can not begin to address the underlying dynamics that make transportation an issue in a low-income woman's life to begin with.

Problematizing ethnicity in this manner ultimately does a great disservice to clinic personnel's understanding of how low-income populations gain access to health services for it reifies what it means to belong to an ethnic minority. As a result, clinic personnel conclude that ethnicity, rather than women's social resource management, plays a more significant role in shaping low-income Mexican American women's access to prenatal care.

Chapter 7: **Conclusions**

Social Resource Management: Women's Strategies & Clinic Personnel's Misconceptions

As low-income Mexican American women go through pregnancy and birth they achieve access to prenatal care through a series of decision and routines that I have analyzed as social resource management. The social resources that women draw upon in the form of family, friends, and co-workers as social networks of information and support, help them to address issues related to childcare, transportation, working both in and outside of the home, and unemployment in gaining access to prenatal care. The strategies that low-income Mexican American women develop in this process consequently involve steps — alliance building — that they strategically manage based upon the broad scope of their social resources.

Drawing upon concepts from critical medical anthropology to analyze women's social resource management I have shown that women make decisions and develop strategies to gain access to prenatal care that are shaped by both political and economic issues. For example, women in this study often relied upon a friend to drive them to their prenatal appointments and expressed concern about the lengthy Medicaid enrollment process. Transportation and payment for needed medical services, both fundamentally economic and political issues, thus shaped the strategies that many women developed to gain access to prenatal care. In this context, women's social resource management is not a single logical construct that is closed and independent of other systems but rather one of options in which women's strategies are shaped by social, economic, political, and medical issues.

Clinic personnel's understanding of the elements involved in gaining access to prenatal care did not encompass women's social resource management. While clinic personnel identified socioeconomic issues, such as transportation, lack of health insurance, and the inability to pay for needed medical care, that low-income women must overcome in achieving access to care, they viewed these issues as isolated events, or barriers, rather than a series of interconnected issues that women addressed by drawing upon the social resources available to them. Perceived in isolation, clinic personnel consequently concluded that barriers, such as the aforementioned, had been successfully overcome once women attended a clinic appointment and enrolled in Medicaid.

Clinic personnel further contextualized socioeconomic barriers inhibiting low-income Mexican American women's access to prenatal care in terms of ethnicity — equating low income with belonging to an ethnic minority. As I have discussed, many clinic personnel consequently viewed ethnicity as a primary factor in shaping low-income Mexican American women's access to prenatal care. For example, many clinic personnel in this study believed that low-income Mexican American women chose not to work while they were pregnant because they were lazy. Clinic personnel concluded that since women were unemployed and pregnant they relied upon Medicaid and thus had access to prenatal care. In such instances, clinic personnel characterized laziness as a Mexican American trait and perceived laziness, rather than a socioeconomic issue, such choosing to be a homemaker due to the high cost of childcare, as the reason why women were unemployed and using Medicaid. Using the concept of ethnicity in this manner ultimately does a great disservice to understanding how low-income populations gain access to health care services for it reifies what it means to belong to an ethnic minority. More significantly however, it illustrates that clinic personnel, and their organizations, fail to understand the fundamental role social resource management plays in shaping low-income, ethnic minorities access to care. In doing so clinic personnel fail to look beyond the boundaries of their clinics, the Medicaid system, and ethnicity to understand, for example, why some low-income Mexican American women might not work during pregnancy.

Diverging Perspectives of Access

Examining low-income Mexican American women's social resource management from the perspective of both the woman who is negotiating access to prenatal care and the clinic personnel giving care illuminates the divergence of their perspectives on gaining access to care. In the most fundamental sense, many clinic personnel in this study could not begin to conceptualize the integral role social resource management played in low-income women's strategies to gain access to care. Clinic personnel's references to "one-stop-shopping" of services offered at their clinics, as Diane, a Reception Clerk at the Public Health Clinic, made (Chapter 5), unwittingly acknowledged the role social resource management plays in developing a strategy to gain access to care. This statement indicates that clinic personnel recognized that for an individual to travel from a physician's office, to a laboratory, and then to a pharmacy depended upon the resources, such as a car or bus, a person had access to. Despite this, clinic personnel were unable to conceptualize how having access to social resources in turn promotes or limits a woman's access to prenatal care.

The concept of "one-stop-shopping" is indicative of a second divergence between women and health are clinic personnel's understanding of gaining access to prenatal care. While clinic personnel identified socioeconomic issues, such as transportation problems, that women were faced with in gaining access to prenatal care, they often conceptualized transportation problems as isolated issues or barriers rather than viewing them in a series of interconnected events that women addressed through the social and economic resources available to them. "One-stop-shopping," where many services were provided by the clinic, was thus seen as remedy to this barrier. I believe that this distinction is significant for it addresses a fundamental premise of clinic personnel's conceptualization and use of the term "barrier." Clinic personnel perceived barriers inhibiting low-income Mexican American women's access to prenatal care in terms of their contact with a physician or prenatal clinic. They presumed that despite any possible barriers that might exist, access to prenatal care was a given since their organizations — clinics — provided a variety of services and resources that they perceived as being readily available to women.

Ethnicity also figured centrally in clinic personnel's understanding of "barriers," and, consequently, their perceptions of low-income Mexican American women's access to prenatal care. As I have previously discussed, ethnicity shaped clinic personnel's perceptions of why women did not work during pregnancy and why they did not have private health insurance. Ethnicity also shaped clinic personnel interactions with low-income Mexican American women in the clinical setting as well. In light of this, I argue that the ethnic basis of clinic personnel's explanations of low-income Mexican American women's access to prenatal care is shaped by their understanding of what it means to belong to an ethnic minority. I further posit that clinic personnel's understanding of what it means to belong to an ethnic minority is premised upon the conceptual framework of cultural competency. In learning to be culturally sensitive to the beliefs and practices their patients adhere to, clinic personnel have been given a boilerplate of ethnic and cultural characteristics upon which to frame their interactions. Instead of assessing a patient based upon individual qualities, clinic personnel frame their expectations and interactions with patients upon generalized behaviors and beliefs of what it means to belong to a particular ethnic or cultural group. As a result, cultural competency training has led clinic personnel to reify ethnicity. The barriers facing low-income Mexican Americans women's access to health care have been similarly reified — just as "ethnicity" has been reified in the cultural competency training of clinic personnel. Remedies clinics offer to help women gain access to care, such as bus tokens or taxi vouchers, are conceived upon portraits, or generalizations, of the barriers clinic personnel perceive women to be faced with. The reified barriers equate with reified solutions that do not recognize the process women negotiate or the social resources they manage to gain access to prenatal care. Problematizing ethnicity in this manner ultimately does a great disservice to clinic personnel's understanding of how low-income populations gain access to health services for it reifies what it means to belong to an ethnic minority. As a result, clinic personnel conclude that ethnicity, rather than women's social resource management, plays a more significant role in shaping low-income Mexican American women's access to prenatal care.

A final divergence between women and health care provider's perspectives of health care access is the actual locus of "access." As I have discussed, clinic personnel perceived the locus of access as centered within the clinic itself whereas women placed it outside of the clinic — as something that precedes the clinic. For many women strategizing ways to gain access to prenatal care this meant juggling a husband's expectations about their role as a wife and mother with the cost of health insurance premiums, lack of transportation, limited work related networks, and dependence upon familial networks. For others it meant working in a job that did not offer health insurance benefits, relying upon parents for advice about prenatal care and Medicaid.

In contrast, many clinic personnel in this study firmly perceived "access" as action within the realm of Medicaid and, more specifically, the clinic. While some clinic personnel recognized the link between enrolling in Medicaid and gaining access to a clinic, they perceived "access" as a clinical issue grounded in quality of care. In doing so they asserted that once women were in the clinic they received "wonderful" care — meaning that they have access to physicians, ultrasounds, nutritionists, social workers, and the laboratory.

By drawing on concepts from critical medical anthropology to analyze low-income Mexican American women's access to prenatal care during pregnancy and birth, my goal has been to portray a picture of how women consciously negotiate a decision making process grounded in social resource management. The strategies that women develop to gain access to prenatal care involve steps that they manage based upon the broad scope of their social resources. I define social resource management as a process in which women draw upon their social networks — in the form of kin-based, friend-based and work-related networks — to address issues of childcare, transportation, working both in and outside of the home, and unemployment in facilitating access to prenatal care. While each of these networks were largely separate, women in this study configured their use of the networks differently. For example, one woman might rely primarily upon her family-based network for information about prenatal clinics and to meet her transportation needs whereas another woman might rely upon her friend-based network for information about prenatal clinics and upon her work-related network for transportation. Some women might have only had one network to draw upon whereas another could rely upon all three of the networks. As such, women's social resource management is not a single logical construct that is closed and independent of other systems but rather one of options in which women's strategies are shaped by social, economic, political, and medical issues.

In examining the views of women and clinic personnel as actors and strategists actively navigating a health care system I have addressed some of the disparities between low-income Mexican American women's and clinic personnel's views of gaining access to prenatal care. Most significantly, women's perception of "access" as a process that preceded and eventually led to a clinical encounter, in contrast to clinic personnel's conceptualization of "access" as an action bounded by the clinic. Recognizing the dichotomy between women's and clinic personnel's conceptualizations of what is involved in achieving access to prenatal care sheds new light on the process of gaining access to care. The disparity between women's and clinic personnel's views of access to prenatal care have distinct implications for the ways in which clinic personnel and policy makers attempt to remedy the barriers low-income women belonging to an ethnic minority are faced with in managing access to prenatal care. These solutions in turn, directly impact the ways in which low-income Mexican American women manage social resources to gain access to care.

APPENDICES

Appendix A: **Interview Guide — Women Seeking Care**

Name
Age
Ethnicity
Marital status
Current residence
Born where
Considers to be from
Education
Employed ($)
Spouse/partner employed ($)
Do you combine your income?
Other additional income (from people/organizations)
Number of children
Pregnancy number
Weeks pregnant

Extended family
    Parents from
    Grand parents from
    Number of siblings
    Where do the above live
    What kind of work do they do?
Who do you live with?

<u>Current Pregnancy</u>
Health insurance
Prenatal care
    When started
    Found out about how
Found out about clinic how
Chose physician how
Transportation to clinic
Other services used
    Found out about these services how
Plans to give birth where
Problems with pregnancy
Relationship with physician/nurse practitioner
Relationship with clinic staff (nurses, receptionists etc.)
Problems using the clinic
Clinic you wanted to use but couldn't
Services you wanted to use but couldn't

Previous Pregnancy
* If applicable ask questions listed above.
Is this pregnancy different from your previous one(s)? How?

Birth Plan/Experiences
Describe birth plan
    Deliver where
    Get there how
    Who will be there with you?
    Who will watch your children?
Do you think this birth/delivery will be different or the same as the previous one(s)? How?

Appendix B: **Interview Guide — Clinic Personnel**

Name
Age
Ethnicity
Marital Status
Born where
Considers to be from
Education
Children
Prenatal care
Welfare/Medicaid
Occupation/yrs.
Organization/yrs.
How profession was chosen

Women's reasons for obtaining prenatal care (why they think they need it)
How do women find out about prenatal care?
How do women find out about a clinic?
How do women choose a clinic?
Are there barriers to finding out about prenatal care?
Are there barriers to using prenatal care?
Are there barriers to using this clinic?

How do women find out about Medicaid?
Are there barriers to gaining access to Medicaid?
Does Medicaid provide enough coverage?
Do women on Medicaid receive different care from women with private insurance?
Are women who use Medicaid perceived or treated differently by medical staff than women with private insurance?
Problems with the Medicaid system?

Are there barriers specific to Mexican American women in gaining access to prenatal care?
Are there barriers specific to Mexican American women in gaining access to your clinic?
Are there barriers specific to Mexican American women in gaining access to Medicaid?
Does ethnicity play a role in the provider/patient relationship?
Does your ethnicity influence your relationship (positively or negatively) with patients?

Are Mexican American women on Medicaid perceived or treated differently by medical staff than "white" (or other ethnic) women on Medicaid?
Mexican American women might not work while pregnant because?
Mexican American women might not have private health insurance because?

Appendix C: **Aggregate Data from Interviews with Women Seeking Prenatal Care**

Part I

	A. Location of Interview	Number of Interviews	
	Latino Community Center Clinic	8	
	Public Health Clinic	7	
	Hospital Clinic	12	
	Total	27	
B.	Average Age	23	Standard Deviation = 3.9 Sample Range = 18-36
C.	Marital Status		
	Single	15	
	Married	11	
	Divorced	1	
	Widowed	0	
D.	Born in:		
	Lansing	13	
	Greater Lansing Area	3	
	Southwestern United States	4	
	Mexico	7	
E.	Current Residence:		
	Lansing	21	
	Greater Lansing Area	6	
F.	Considers herself From:		
	Lansing	13	
	Greater Lansing Area	3	
	Texas	3	
	California	2	
	Mexico	6	

G. Education:	
Completed 6th Grade	1
Completed 8th Grade	1
Completed 9th Grade	2
Completed 10th Grade	4
Completed 11th Grade	3
Graduated from High School	3
Completed GED	4
Attending Community College	3
Graduated from College	1
Attending Nursing School	1
Unknown	4

H. Occupation:	
Homemaker	6
Food service	8
Cashier	2
Retail	1
Childcare	2
Security Officer	1
Maintenance/Housekeeping	2
Student	2

I. Women's Work Activities in Pregnancy	
Employed Outside the Home	8
Unemployed	3
Homemaker	6
Not Working because of Baby's Health	9
In School	2
Not Working because of Childcare & Transportation Problems	1
Not Working because Husband is Against it	2

J.	Plans to Return to Work after Birth of Baby:		
	Yes	9	
	No	2	
K.	Partner's Occupation:		
	Food Service	6	
	Construction	4	
	Computer Technician	1	
	Cableman	1	
	Artist	1	
	Gas Station Attendant	1	
	Machinist	1	
	Unemployed	3	
	Unknown	3	
	No Partner	6	
L.	Do you and your partner combine your income?		
	Yes	17	
	No	3	
M.	Additional income from government programs:		
	WIC	10	
	Food Stamps	1	
	Welfare	9	
	None	12	
N.	Additional income from family members:		
	Parent/Guardian	2	
	Child Support from Ex	2	
	None	23	
O.	Average Number of Children	1.2	Standard Deviation = 0.7 Sample Range = 0-4

P.	Average Number of Pregnancies	2.4	Standard Deviation = 1.0 Sample Range = 1-6
Q.	Number of Weeks Pregnant (Median)	28	Sample Range = 12-40
R.	Other Relatives in the Area:		
	Parent/Guardian	13	
	Siblings	15	
	Aunt/Uncle	4	
	Cousins	4	
	Grandparents	8	
	None	7	
S.	Household Includes:		
	Parent/Guardian	4	
	Husband/Partner	14	
	Children	10	
	Roommate	1	
	Sibling	4	
	Alone	1	
T.	Health Insurance for Current Pregnancy:		
	Applying for Medicaid	5	
	Medicaid	18	
	Private Insurance	1	
	None	3	
U.	Health Insurance with Previous Pregnancy:		
	Medicaid	13	
	Private Insurance	3	
	Used Health System in Mexico	1	
	None	1	

Part II

A. Found out About Prenatal Care From:	
Mother	6
Always Known About It	1
Doctor	2
A "Free Clinic"	1
A Sibling	1
Other Family Members	6
Friends	4
School	5
Books	1
Can't Remember	6

B. Reason for Obtaining Prenatal Care:	
Find out problems with the pregnancy.	3
To make sure nothing happens to the baby.	14
Important to be checked by a doctor.	2
Get vitamins.	5
Needed when pregnant.	3
Good for the mother's health.	2
Not sure.	7

C. Found Out About the Clinic From:	
Information handed out at a clinic.	6
Information handed out at the hospital.	3
Always known about it.	3
Had used the clinic previously or knew someone who worked there.	4
Family	8
Friends	7
School	1
Other	1
Not sure	2

D. Chose Physician Based Upon:	
Friends' recommendation	1
Discussion with nurse	2
Assigned by clinic	20
Chose from a list	3
Not sure who is their doctor	1

E. Transportation to the Clinic:	
Owns a car	13
Partner	6
Parent/Guardian	2
Friend	2
Relative	2
Bus	4
Bike	1
Walk	1

F. Found Out About Prenatal Care From:	
Partner	1
Family	2
Friends	3
Clinic	4
County Health Department	3
Not Sure	2

G. Problems you've had using the clinic:	
Always see a different provider.	3
Not in one place long enough to use the same clinic.	4
No problems but would use different clinic if had private insurance.	2
Don't have a phone to call the clinic.	2
Don't understand the Medicaid paperwork.	4
Period for enrolling in Medicaid too long.	4

Appendix D: **Aggregate Data from Interviews with Clinic Personnel**

Part I

A. Location of Interview:	Number of Interviews:
Latino Community Center Clinic	5
Public Health Clinic	5
Hospital Clinic	5
Total	15

B. Average Age	43	Standard Deviation = 12.0 Sample Range = 21-59

C. Ethnicity (assigned by interviewee):	
Asian	1
Caucasian	1
Hispanic	2
Irish/Polish	1
Korean American	1
Mexican American	1
Norwegian	1
Swedish/Finnish	1
White	4
White American	1
White/Polish	1

D. Marital Status	
Single	2
Married	6
Divorced	6
Widowed	1

E.	Born in:		
	Lansing	4	
	Greater Lansing Area	5	
	Upper Peninsula of Michigan	1	
	Midwestern United States	1	
	Southwestern United States	2	
	Korea	1	
	Taiwan	1	
F.	Education:		
	Completed High School		
	Completed GED	1	
	1 Year Associate's Course	1	
	Associate's Degree	2	
	2 Year College/Nursing School	1	
	Military Medical Training	5	
	Bachelor's Degree	1	
	Master's Degree	4	
	Medical Degree	3	
G.	Average Number of Children	2.1	Standard Deviation = 0.7 Sample Range = 0-4
H.	Did you, or your partner, receive prenatal care when pregnant?		
	Yes	13	
	No	0	
I.	Have you ever used Medicaid?		
	Yes	5	
	No	10	

J.	Occupation:		
	Reception Clerk	5	
	Clinic Nurse	7	
	Nurse Practitioner	1	
	Physician	1	
	Clinic Coordinator	1	
K.	Average Number Years of Experience:	15.4	Standard Deviation = 7.4 Sample Range = 2-30
L.	Average Number of Years with Organization:	7.3	Standard Deviation = 6.9 Sample Range = 0.8-21

Part II

A.	Why Women Obtain Prenatal Care:	
	Health of the Baby	9
	Find Out Sex of the Baby (Ultrasound)	1
	The "Right" Thing to Do	2
	Fears about Pregnancy	1
	To Establish a Connection with a Hospital	4
	Mother's Health	1
B.	How Women Find Out About Prenatal Care:	
	Friends	8
	Mother	5
	Other Family Members	6
	By Word of Mouth	2
	Clinic Where Pregnancy Test was Done	3
	Common Knowledge	2
	School Programs	3
	Husband/Partner	1

C. How Women Find Out About/Choose a Clinic:	
Friends	10
Mother	2
Other Family Members	2
Health Department	4
Other Clinics	2
Used the Clinic Previously	4
Word of Mouth	4

D. Basis of Women's Choice of Clinic:	
Know the Clinic is Free	4
Don't Want Parents to Know	1
Location	2
Health Department	4
Not Sure	8

E. Barriers to Using Prenatal Care:	
Transportation	8
Fear of Being Recognized by Friends or Relatives	3
Language	3
Fear that a Clinic Won't Accept Medicaid	1
Lazy	2
Doesn't Understand the System	4
Cultural Beliefs	1
Denial of Pregnancy	3
None	3

F. How Women Find Out About Medicaid:	
Friends	3
Mother	2
Other Family Members	5
Clinic Information	7
Word of Mouth	3
Common Knowledge	3
Through Use of Other Services	3
Advertisements	1
Health Department	3
"Inside Contact"	1

G. Barriers to Gaining Access to Medicaid:	
Non-resident	4
Language/Illiterate	4
Cultural Beliefs	1
Associated Stigma	3
Doesn't Understand the Application Process	5
Make Too Much Money to Qualify	1
Know They Exist but Couldn't Identify Any	2
None	2

H. Quality of Coverage — Medicaid vs. Private Health Insurance:	
No Difference	3
Medicaid Provides Better Coverage	6
Private Health Insurance Provides Better Coverage	5
Not Sure	2

I. Are Women on Medicaid Perceived or Treated Differently than Women with Private Health Insurance:	
Yes	8
No	6
Maybe	1

J. Barriers Specific to Low-income Mexican American Women Gaining Access to Prenatal Care:	
Language	9
Transportation	2
Cultural Beliefs	1
Non-resident	5
Exist bust Couldn't Identify	2
None	5

K.	Role of Ethnicity in the Provider/Patient Relationship:	
	Language Problems	3
	Clinic Personnel Might have Problems with Patients	1
	Patients Might have Problems with Clinic Personnel	1
	Culture Clash	1
	Ethnicity Influences the Relationship but Not Sure How	4
	No	7

L.	Influence of Clinic Personnel's Ethnicity on their Relationship with Patients:	
	No Influence	8
	Positive Influence	4
	Negative Influence	3

M.	Mexican American Women using Medicaid Perceived or Treated Differently by Clinic Personnel than Others on Medicaid:	
	Yes	2
	Depends on the Person	4
	Maybe	1
	No	8

N.	Mexican American Women Do Not Work While they are Pregnant Because:	
	Lazy	6
	Depend on Welfare	3
	Do Not Have Enough Education	1
	Husband Doesn't Want them to Work	1
	Job too Physically Demanding	5
	Cultural Beliefs	6
	Didn't Know	4

O. Mexican American Women Do Not Have Private Health Insurance Because:	
They're Not Working	7
Depend on Welfare	2
Not Enough Education	1
Job Does Offer it/Can't Afford it	10
Required Waiting Period at Job	1
Not Married	2

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