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A Comparison Of Prenatal Help-Seeking Behavior Between Rural Native Americans And Anglo Women

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A COMPARISON OF PRENATAL HELP-SEEKING BEHAVIOR BETWEEN RURAL NATIVE AMERICAN AND ANGLO WOMEN

by

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Abstract

The purpose of this descriptive study was to compare the prenatal help-seeking behaviors of two ethnic groups of rural women in a southeastern state. Three hypotheses guided the study: Ho_1, There will be no relationship between selected demographic variables and help-seeking behaviors in Native Americans; Ho_2, There will be no relationship between selected demographic variables and help-seeking behaviors in Anglo women; and Ho_3, There will be no difference in the factors predicting prenatal help-seeking behavior between Native Americans and Anglo women. This study replicated the work of Ide and Gill (1992). Leininger's Transcultural Nursing Theory was used as a theoretical framework. Two instruments were used to collect data. The Personal Characteristics Questionnaire was utilized to determine demographic variables, such as age, marital status, education level, geographic location, family composition, social support, and ethnicity. The second instrument, Weinert's Personal Resource Questionnaire (PRQ-85), assessed social support networks in relationship to help-seeking behaviors of the prenatal client. Data were analyzed using Multiple Regression Correlations to determine the factors that predict delayed help-seeking behavior while

descriptive statistics were used to determine the areas of specific differences. Since no significance emerged, the researcher failed to reject the null hypotheses. Therefore, the researcher concluded that selected demographics did not significantly correlate to prenatal help-seeking behaviors when comparing Native American and Anglo women. The researcher concluded there was a need for advanced nursing roles in rural outlying clinics to improve access to care. Also, the importance of culturally sensitive nursing assessments could impact on the entry into early prenatal care. The development of educational programs for both clients and health care workers is another way to increase the early entry into prenatal care. Recommendations for future research include replication of the study with the use of different cultural groups using Leininger's Transcultural Nursing Theory and implementation of a study that explores the impact of outlying rural clinics managed by nurse practitioners to increase the entry into early prenatal care.

Dedication

This thesis is dedicated to my family.

My husband, Gary,
who stood beside me throughout the entire process,
continually encouraging me to keep going.

To my oldest son, Marcus,
who spent hours occupying himself
so "mama" could do her work.

To my youngest son, Riley,
who always knew the right time to put
his little arms around me and give me a big hug.

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Chapter I

The Research Problem

Prenatal care standards developed by the American College of Obstetrics and Gynecology state that a woman should monitor her pregnancy with a minimum of 14 visits to a health care provider: three during the first trimester, three during the second trimester, and eight during the third trimester (Indian Health Manual, 1990). In 1991 there were an estimated 4,111,000 live births in the United States. It was reported that 75.9% of the women who delivered these live births received prenatal care in their first trimester of pregnancy, while 6.1% began prenatal care in their third trimester or received no prenatal care. Of those women who sought prenatal care, approximately one third received too few prenatal visits or delayed seeking prenatal care until late in their pregnancy (Hansell, 1991). As a result of the low number of pregnant women seeking prenatal care, the Healthy People 2000: National Health Promotion and Disease Prevention Objectives (1991) proposed to increase the number of pregnant women receiving prenatal care in the first trimester of pregnancy to 90% (IHS Provider, 1991).

Late prenatal care or no prenatal care has been associated with negative birth outcomes, such as low birth weights and infant demise. The infant mortality rate in 1991 for the United States was 8.9 per 1,000 live births. Low birth weight accounted for 4,480 (6.9%) of the total infant mortality rate.

Delayed prenatal care also may have accounted for intrauterine fetal demise (IHS Provider, 1993). Almost one half the total perinatal mortality in the United States has been related to intrauterine fetal deaths. Rural and economically disadvantaged areas have a particularly high rate of low birth weights and fetal demise. For example, in 1990 a southeastern state, which is considered both rural and economically disadvantaged, reported 43,547 live births. Of these live births, 10,645 were premature, while 523 were fetal deaths. This figure accounts for 12 fetal deaths per 1,000 live births while the national average is 8.9 per 1,000 live births. Women receiving no prenatal care accounted for 11.1% of these reported fetal deaths (Mississippi Statistical Abstract, 1990).

Although research has shown that early and adequate prenatal care has been the single factor most likely to prevent infant deaths, no improvements in prenatal care have been shown in the past decade. Certain factors have been identified which impact upon the early entry into the

health care system. This study focused on those help-seeking factors which impact the choice of delayed prenatal care.

Establishment of the Problem

Demographic factors have been identified that impact on the help-seeking behavior of prenatal care. These factors include education, marital status, age, geographic location, and culture (Mississippi Statistical Abstract, 1990). According to the Mississippi Statistical Abstract (1990), the lower the educational level of the women, the more likely entry into health care would be late in pregnancy or that no prenatal care would be sought. Additionally, pregnancy may contribute to lower levels of education. According to the 1990 statistics, a rural southeastern state had 8,932 high school dropouts, and 426 of these dropouts reported pregnancy as the reason for quitting school (Mississippi Statistical Abstract, 1990). Another factor that has been related to delayed prenatal care is marital status. Anderson (1989) found that unmarried women were three times more likely than married women to seek delayed or no prenatal care. The age of the mother has also been found to be a significant factor on determining help-seeking behaviors. The total number of live births delivered to unmarried women in a specific rural southeastern state in 1990 was 17,622. Of these unmarried women, 353 were less than 15 years of age

(Mississippi Statistical Abstract, 1990). Women under the age of 20 and women age 40 or older were more likely to delay or received no prenatal care (Anderson, 1989).

Women in rural areas have been characterized by delayed or late prenatal care (Ide & Gill, 1992). The Mississippi Statistical Abstract (1990) reported that a total of 5.5% of the prenatal patients presenting for health care during the third trimester of pregnancy received no prenatal care. This accounted for a total of 2,385 women with delayed or no prenatal care (Mississippi Statistical Abstract, 1990). Many rural areas have reported a lack of obstetric departments, and as a result women must travel long distances to receive prenatal care (Schleuning, 1991). Often, although funds were available for care, access was denied due to difficulties in arranging reliable transportation. Other reported reasons for delaying care were fear of the reaction of family and friends, fear of the pregnancy itself, and lack of familiarity with the health care system.

Culture may have played a role in delayed help-seeking behavior for prenatal clients. Often the misunderstanding of cultural beliefs among clients and health care providers has led to frustrations and has caused the client to drop out of prenatal care. In many instances, health care workers were unable or unwilling to discuss values and traditions with culturally distinct

clients, contributing to frustrations among clients that may have led to lack of continuation in prenatal care (Uba, 1992).

Culture has been found to play a vivid role in the health care sought by individuals. Language has posed a barrier in many situations where English was not the first language spoken by the client and the caregiver spoke only English. Such a circumstance has required an interpreter, and many words found in the English language could not be adequately translated, thus creating another barrier to the delivery of care (Uba, 1992). Language has caused a barrier among the Native Americans, who are a group of culturally distinct clients and were a focus of this study. This culturally diverse group speaks its own language. The primary language spoken at home and at social events is the native language. The English language is used only when they associate with nontribal members such as health care workers. This could become a barrier to the care sought by the pregnant tribal member. Consultations with tribal leaders and medicine men are still very prevalent among Native Americans, and many women could be receiving this traditional care early in their pregnancies, such care thus becoming another factor related to delayed conventional medical prenatal care. It has been recommended that health care providers incorporate cultural sensitivity into the health care

system. For example, if health care workers could openly discuss the values and traditions with the client, then treatment plans could be made to benefit the client without conflict to cultural beliefs. It was found in 1987 that the proportion of pregnant Native Americans receiving early prenatal care was at a low 60.2% (IHS Provider, 1991), and cultural influences may have been a contributing factor (Uba, 1992).

Although it has been noted that a high number of Native Americans have delayed prenatal care (IHS Provider, 1991), few studies on prenatal care of American Indians have been identified in the literature. One study (Ide & Gill, 1992) attempted to determine what factors delay help-seeking behavior and compared these behaviors of American Indians with Anglo women. This present research study was a replication of the study conducted by Ide and Gill (1992), which attempted to determine what factors delayed prenatal help-seeking behaviors and also compared the help-seeking behaviors of Native Americans and Anglos. Three research questions guided the study:

1. To what degree do delayed help-seeking behaviors occur in a rural population?

2. What is the relationship between delayed help-seeking behaviors and social network influence?

3. What factors are associated with delayed help-seeking behaviors?

The setting of the Ide and Gill (1992) study included four clinics in Northern Wyoming. The sample consisted of Native Americans (n = 82) and Anglo women (n = 81) aged 19 to 42 years who were seeking prenatal care at these clinics. The participation was voluntary and subjects were assured that the decision to participate in no way affected the care they received at these clinics.

Data were collected using two instruments. The Personal Characteristics Questionnaire sought to obtain demographic information, such as age, education, income, distance from care, family composition, social support, and ethnicity. The second instrument, the Weinert Personal Resource Questionnaire (PRQ-85), assessed social support networks in relationship to help-seeking behaviors of the prenatal clients. This brief questionnaire consisted of two parts and took approximately 10 minutes to complete (Weinert, 1987). The first part of the questionnaire evaluated five social relationship dimensions: intimacy, social integration, nurturance, worth, and assistance. The second part of the PRQ-85 determined personal characteristics and the delay interval (reflected by the gestational age at the time of the first visit) in regard to prenatal help-seeking behavior. This section consisted of 25 items that subjects responded to on a 7-point Likert scale ranging from strongly agree to strongly disagree. Brandt and Weinert (1987) reported the

PRQ-85 had a high internal consistency reliability coefficient using Crombach's alpha of .89.

Ide and Gill (1992) used multiple regression to analyze such factors as age, education, income, access to care, marital status, and social support to predict delayed help-seeking behaviors. The results of the Personal Characteristics Questionnaire indicated that this sample of prenatal Native American women was younger than the prenatal Anglo women. Twenty percent of the Native American prenatal women were age 19 to 20 years compared to 7.4% of the Anglo prenatal women. The Native American women also were less educated, with 29.9% having less than a high school education as compared to 7.4% of the Anglo women. The Native Americans had a lower income, as 45.8% had an annual income of under $5,000 compared with 3.8% in the same economic bracket of the Anglos. The Native American women were more likely to delay initiating prenatal care during the first trimester. The mean time for the Native American women initiating prenatal care was 7.29 weeks in their pregnancy as compared to 4.69 weeks for the Anglo women. When assessing distance from the care sites, it was determined that there was no significant difference; therefore, accessibility to care was determined to be equal for the two samples. Marital status did not appear to significantly affect health-seeking behaviors. However, the authors found that Native

American women who sought prenatal care were not only more likely to live with someone other than a spouse, but were also more likely to have never been married. Ide and Gill (1992) suggested that it was important for the health care provider who is trying to promote earlier prenatal care to determine attitudes toward pregnancy, life goals and expectations, and sociodemographic factors.

Conceptual or Theoretical Framework

Leininger's (1978) Transcultural Nursing Theory guided this research. Transcultural nursing has been a theory derived from anthropology but made unique to nursing. The theory focused upon comparative studies and analysis of different cultures and subcultures in the world. These studies emphasized the concepts of caring behavior, nursing care, and health illness values, beliefs, and patterns of behavior. The goal of the Transcultural Nursing Theory has been to develop a scientific and humanistic body of knowledge in order to provide culture specific and nurture universal nursing care (Marriner-Tomey, 1989).

Leininger (1978) not only wanted nurses to be aware of and appreciate different cultures but also relate nursing knowledge to these cultures. She believed that if nurses did not understand the culture, they could not take care of the person. The general goal of the Transcultural Nursing Theory has been to get an individual's inner views

about medical beliefs and practices. Once this knowledge is obtained, then this source of knowledge should be studied with a nurse's perspective, acknowledging that the goal was to provide care that fit reasonably with the client's needs and realities (Marriner-Tomey, 1989).

Leininger's (1978) ethnoscience and ethnonursing research was the basis of the transcultural theory. Ethnoscience refers to a rigorous and systematic way of studying and classifying emi (local or inside) data. These data consist of the cultural groups' own perceptions, knowledge, and language in terms of how people perceive and interpret their universe (Leininger, 1970). Each cultural group has its own beliefs about the causes of disease and illness. The one factor found in most cultures is the belief that illness is a state of disequilibrium. Many cultures associate disease with the elements of nature and equate disequilibrium with the concept of the illness. Ethnonursing has been defined as the study and analysis of the local or indigenous people's viewpoints, beliefs, and practices about nursing care phenomena and processes of designated cultures (Leininger, 1978). The treatment for the disequilibrium state of illness has often been related to how western nursing is practiced. The meaning or interpretation of factors predicting help-seeking behavior for two different cultures was the goal of this research. Therefore,

Leininger's definition of ethnonursing fit with this study. In both ethnoscience and ethnonursing, the methods are highly appropriate for cross-cultural comparative studies (Leininger, 1978). This study identified recurrent and patterned lifestyles of help-seeking behaviors among Native American and Anglo women and was, therefore, a cross-cultural comparative study.

Assumptions

Three assumptions undergirded this study. These assumptions were the following:

1. Women seek prenatal care at different times during their pregnancy.

2. Identified factors influence help-seeking behaviors.

3. Culture has an impact on a woman's prenatal help-seeking behaviors.

Statement of the Problem

Since the literature suggested that culture greatly influenced an individual's behavior and since help-seeking behaviors can be significantly different between cultures, cultural influence may impact upon seeking prenatal care. Therefore, the problem was to identify the cultural factors that predict help-seeking behaviors among Native Americans and Anglos seeking prenatal care and to identify

the differences of prenatal help-seeking behaviors between these two groups.

Research Hypotheses

Ho_1: There will be no relationship between selected demographic variables and prenatal help-seeking behavior in American Indians.

Ho_2: There will be no relationship between selected demographic variables and prenatal help-seeking behavior in Anglo women.

Ho_3: There will be no difference in the factors predicting prenatal help-seeking behaviors between Native American and Anglo women.

Definition of Terms

For this study five terms were defined. These terms are as follows:

Demographic variables: something that identifies the pregnant woman by utilizing the factors defined in the Personal Characteristics Questionnaire (see Appendix A).

Prenatal help-seeking behavior: Prenatal help-seeking behavior is defined as the health care engaged in by pregnant women. For this study, prenatal help-seeking behavior was defined as prenatal care obtained during an indicated trimester of pregnancy as identified on the Personal Characteristics Questionnaire.

Native American: members of an American Indian tribe. For purposes of this study, Native Americans were individuals who were at least one fourth Indian blood and lived on the reservation or tribally owned land in the selected southeastern state.

Anglo women: Anglo women were defined as Caucasian females who obtained prenatal care at a selected health department in a rural southeastern state.

Factors: something that contributes to a result. For this study, the factors which influenced health care seeking were identified by the PRQ-85 Questionnaire.

Significance to Nursing

Nursing has been defined as a practice in which diagnosis and treatment of human health and illness are identified and evaluated. The degree to which a nurse can engage in this process depends upon his/her knowledge base (American Nurses' Association, 1987). As a part of every nurse's assessment, the culture of the client should be identified. If a nurse provides services in a culturally sensitive manner, the care given by the nurse will be more readily sanctioned by the client and the outcome of the disease process more favorable. Research has shown that early entry into prenatal care has more positive birth outcomes (Malloy, 1992), although many culturally diverse groups seek prenatal care late in their pregnancy. With knowledge gained from this study, nurses could recognize

cultural differences and act upon incorporating these beliefs and values into positive outcomes for the client. The results of this research study could provide the advance nurse practitioner with the knowledge to assess the cultural barriers associated with delayed prenatal care among Native American and Anglo women.

As a result of this study, the nurse practitioner could be made aware of the factors associated with inadequate prenatal care (such as teenage pregnancy, lack of social support, cost, culture, and fear of the health care system). The nurse practitioners could also be made aware of the perceived severity of these factors, such as low birth weight, infant mortality, and preterm deliveries, which would enable them to better intervene with these factors and make a difference in their clients' help-seeking behavior.

Education among clients and health care workers also could help change this trend of delayed help-seeking behavior among prenatal clients. Information gained from studies such as this could be incorporated into the curriculum of undergraduate nursing programs and nurse practitioner programs. New graduates would then be able to educate clients as well as peers on the importance of early prenatal care. Health care workers need to be educated on the significance of teaching prenatal clients the importance of early care.

Research remains a continuing force behind quality prenatal care for all cultures. Without research, nursing does not have the knowledge needed to ascertain if current practices are allowing for early entry into the prenatal health care system. New research will not only provide knowledge, but will allow nursing to change interventions to increase compliance among women receiving prenatal care. Although research has been conducted on inadequate prenatal care and the birth outcomes resulting from this delayed help-seeking behavior, little research has been done on prenatal care among American Indians.

Summary

The goal of this study was to identify the factors that predict help-seeking behaviors among Native American and Anglo women seeking prenatal care. Additionally, it sought to compare prenatal help-seeking behaviors between Native Americans and Anglos. Chapter II and Chapter III will provide a review of the literature and present the design of the study, respectively.

Chapter II

Review of Literature

A review of the literature indicated that although there have been several studies identified on factors affecting prenatal care, there have been few studies about the influence of these factors on prenatal care. Additionally, several studies were found that studied the influence of various cultures on prenatal care, but only one study was identified that related prenatal care with the cultural influences of Native Americans. This selected review of the literature focused on these studies.

A study that investigated prenatal care was conducted by Hansell (1991). The purpose of this study was to determine the quality of prenatal care received by women with identified maternal sociodemographic characteristics. The research questions for the Hansell (1991) study were:

1. Do women seeking prenatal care receive examinations according to the standards accepted by the American College of Obstetrics and Gynecology (ACOG)?

2. Are prenatals educated in the use of salt and diuretics during pregnancy?

3. Is there variability in the quality of care rendered to prenatal patients?

This retrospective study utilized a random sample of 9,941 live births and 6,386 late fetal deaths that occurred in 1980 in the United States. Questionnaires were mailed to the primary care providers of the prenatal clients and the administrators of the hospitals where the women delivered for a chart audit survey.

Hansell (1991) used multiple linear regression to analyze blood pressure monitoring during prenatal care and logistic regression to analyze other factors studied, such as lab tests and health care advice. The results of the study found that 12.9% prenatal visits had no blood pressure recorded. It was found that for each year of education the prenatal client had there was almost a 1% increase in the number of visits during which the blood pressure was checked. When comparing visits, nonmetropolitan and married women had their blood pressure checked more often during pregnancy than the metropolitan and unmarried women.

Almost 34% of the prenatal visits in the Hansell (1991) study had no record of urine tests. Women with higher education were more likely to be tested. Additionally, married women and women living in the nonmetropolitan areas were more likely to have urine

testing during prenatal care. Hansell also indicated that hemoglobin and hematocrits were performed more often on higher educated women. Married women, lower parity, and older prenatal clients also received blood testing on a more regular basis.

The Hansell (1991) study also compared physician's advice on the use of diuretics and salt restriction during pregnancy. It was noted that being unmarried, living in metropolitan areas, and having a higher parity increased the incidence of advice from the physician regarding these subjects. Additionally, it was noted that more educated women received less advice on diuretics from the physician.

Hansell (1991) concluded that women do receive prenatal care according to different standards of practice and that physicians tend to treat patients according to sociodemographic characteristics instead of medical conditions. Women who are characterized by delayed prenatal care also were the ones who received substandard care when they sought help.

As a result of this study, several areas of potential improvement were recommended by Hansell. First, standards of practice following ACOG guidelines should be developed and followed by all physicians and hospital staff. Second, these standards should be implemented so all prenatal women will be given high quality care. A third

recommendation was that reimbursement rates should be increased, as findings from the study indicated that women with higher reimbursement rates received higher standards of care. Finally, it was recommended that not only should women be given information about the need for early prenatal care, but they should also be made knowledgeable about the basic standard of practice in prenatal care.

Although the goal of the present research study differed from the Hansell (1991) study, many areas were comparable. Both studies looked at factors affecting prenatal care. The design used in both studies was the same. Additionally, both studies used questionnaires to collect data. However, the methodology differed in that in the Hansell (1991) study, data were gathered from a chart review, while in the present study, data were collected directly from the subjects. The settings differed, as the Hansell (1991) study was conducted in a metropolitan area, while the present study was conducted in a rural area. The population studied was the same in that both studies utilized prenatal patients as participants. The present study, however, specifically selected pregnant Native American women and pregnant Anglo women for subjects.

Another prenatal study was conducted by Kieffer in 1992, which looked at various cultures in Hawaii. The purpose of the Kieffer (1992) study was to locate

geographic areas with low levels of adequate prenatal care by analyzing census tracts. A model was to then be developed to analyze the cause of inadequate prenatal care and to evaluate the findings.

Kieffer (1992) reviewed data from 155 census tracts in the State of Hawaii during a 9-year period from 1979 to 1987. Each census tract had a median number of 700 births. The census tract records contained data on health and social characteristics as well as income, education, and number of household members. To determine if prenatal care was adequate, Kieffer (1992) documented the trimester of entry into prenatal care and the number of prenatal care visits received during the pregnancy. The outcome variable of this study was determined as inadequate if the client had no prenatal visits before the third trimester or had no prenatal care during the entire pregnancy.

The independent variables of the Kieffer (1992) study included both maternal and population characteristics. The maternal characteristics included inadequate prenatal care, race, age, marital status, education, age at parity, and any previous fetal deaths. The variables of the sample studied were education status, employment, family income, and size of household.

Kieffer (1992) used multiple regression to analyze the data due to the large number of variables in the sample. A final multiple regression was used to assign

the findings of the study to each census tract. These findings were then developed into statewide maps that formulated a blueprint for areas of inadequate prenatal care that had been identified.

Kieffer (1992) found that, when grouped by age, both the younger and older women were more likely to receive inadequate prenatal care during their pregnancy. Two factors associated with this finding were the lack of child care for multiparous women and the perceived opinion that pregnancy was a healthy state of being and required no medical attention. The results of the Kieffer (1992) study indicated that an average of 7.6% women received inadequate prenatal care per census tract. Inadequate prenatal care was noted to be 15% or more in 8% of the census tracts. Additionally, Kieffer (1992) found that in the census tracts with higher numbers of socially and culturally distinct populations, there was a higher percentage of inadequate prenatal care. These cultures included Samoan, black, Japanese, and other Asian populations. Kieffer (1992), therefore, suggested that care be targeted to the diverse cultural and traditional backgrounds of the ethnic groups living in the identified census tracts. For instance, since the Samoan culture encouraged nonmedical prenatal care and this practice was believed to be associated with inadequate prenatal care, it was recommended that this cultural group be targeted

for specialized prenatal care. It was speculated that comparable traditions may be practiced among other culturally unique populations. The author also suggested replication of this study in other areas where diverse ethnic groups exist and traditional values prevailed. It was also suggested that further studies be conducted using similar variables in order to distinguish elements that indicate values influence the acceptance of prenatal care among ethnic populations.

As in the Kieffer (1992) study, the present study compared different cultures in a small geographic area. Kieffer studied geographic areas with culturally distinct groups and their relationship to adequacy of prenatal care, while the present study analyzed social, demographic, and cultural factors and their influence on prenatal care in two culturally distinct groups. The Kieffer (1992) study focused on Samoan, black, Japanese, and other Asian prenatal populations, while the present study focused on Native American and Anglo prenatal populations. Methodology for the studies also differed. Kieffer (1992) conducted a retrospective study in which data were gathered from census tract records, while the present study used questionnaires to collect data from the subjects.

Another study concerning prenatal care was conducted by Malloy (1992) to determine if women who received

prenatal care have better pregnancy outcomes (full-term births) than women who received no prenatal care during their pregnancy. In this retrospective study, Malloy (1992) reviewed Missouri birth and death certificates (N = 375,858) from 1980-1984. Data were gathered for eight variables: (a) gestation age at entry into prenatal care, (b) gestational age at the time of delivery, (c) outcome of the pregnancy, (d) race, (e) birth number, (f) parity, (g) maternal age, and (h) maternal education. The control group consisted of women between the gestational age range of 19 weeks and less than 51 weeks.

For the adjusted analysis, Malloy (1992) used logistic regression models for comparing the variables. The Mantel-Haenszel test was applied to mortality rates to determine any linear trends in association with gestational age with vital statistics data. As the study evolved, it was noted that entry into early prenatal care influenced a positive pregnancy outcome for women who delivered after 36 weeks of gestation. The longer the pregnancy progressed (37 to 42 weeks), the more negative the pregnancy outcomes were for children who received no prenatal care. A converse finding was that women who entered prenatal care between 1 and 4 weeks of pregnancy and delivered at 25 to 28 weeks of gestation were at a greater risk of undesirable outcomes than women who

delivered at this same gestational age and had no prenatal care.

Malloy (1992) concluded that the advantages to prenatal care were difficult to confirm. Malloy questioned if early entry into prenatal care was the key to desirable pregnancy outcomes or if healthy lifestyle behaviors prior to and during pregnancy were the reasons for positive outcomes. Malloy believed that there was no ideal standard for assessing the association of care and outcome of pregnancy at the present time, resulting in the need for further research into these identified problems.

The Malloy (1992) study was relevant to this study in that its purpose was to explore the assumption that women who received better prenatal care had better prenatal outcomes. The settings differed as the Malloy (1992) study was conducted in the midwestern state of Missouri, while the present study was conducted in a rural southeastern state. Both studies used the time of entry into prenatal care as a variable. The procedural differences of the two studies were that the Malloy (1992) study was a retrospective analysis of birth and death certificates and the present study utilized a questionnaire given directly to the subjects. Both the Malloy (1992) study and the present study used multiple regression to analyze the data.

A prenatal study that examined the effect of socioeconomic factors on prenatal care was conducted by Kreiger (1992). The purpose was twofold: to determine if managed care of prenatal clients in a Medicaid-managed program improved the quality of care as compared to the quality of care for Medicaid fee-for-service programs and to determine if the Medicaid-managed care program promoted uniform quality prenatal care between Medicaid and non-Medicaid users.

Kreiger (1992) conducted this retrospective study in Washington State between July 1983 and September 1988. The information regarding the subjects was taken from computerized discharge records of postpartum women. There were three identified independent variables. The first variable was women who participated in the managed care program and whose health care was paid by Medicaid (n = 1,106). The second variable was women whose health care was paid by Medicaid on a fee-for-service program (n = 4,435). The third variable was women who participated in managed health care programs but health care was paid to the private sector (n = 4,829).

Kreiger (1992) used three indicators in determining the level of care received from the identified group of prenatal clients:

1. Inadequate prenatal care was defined as the initiation of care in the third trimester or no prenatal care at all.

2. Adequate prenatal care was defined by the Kotelchuck Visit Index. This is a tool to determine the ratio of actual prenatal visits in comparison to the recommended visits as developed by the American College of Obstetricians and Gynecologists.

3. Ideal prenatal care was defined as the standard of care that prenatals should expect no matter the gestational age at initiation into care.

Kreiger (1992) measured the percentage of low birth weight infants delivered by women engaged in the programs. Multivariate logistic regression was used to regulate potential factors that could also lead to low birth weight infants. In reviewing the results of the Kreiger (1992) study, Medicaid managed care and Medicaid fee for service were evaluated. The analysis revealed that the odds ratio of inadequate care was comparable for both groups.

However, when comparing the Medicaid managed care groups and non-Medicaid managed care groups of the Kreiger (1992) study, many differences were noted. The Medicaid group was younger in age than the non-Medicaid group. Other dissimilarities included higher enrollment in prenatal care during the last trimester, higher incidence of smoking, and prior pregnancies of the Medicaid groups.

Even after adjustments of the odds ratio, the Medicaid group maintained a higher incidence of inadequate prenatal care, although the proportion of low birth weight infants improved.

Kreiger (1992) determined pregnant women in either Medicaid group sought prenatal care later than pregnant women in the non-Medicaid program. The author suggested that more public education on prenatal care and improvements in social support systems be incorporated as a means to increase earlier entry into the prenatal Medicaid health care system.

When comparing Kreiger's (1992) study to the present study, several differences emerged. Kreiger's (1992) study utilized the independent variables of Medicaid and non-Medicaid programs while the present study used income levels as an independent variable to explore initiation into prenatal care. Kreiger relied on a retrospective analysis, whereas the present study collected data directly from women who were currently pregnant and seeking prenatal care. The setting differed in that Kreiger (1992) study was conducted in a northwestern state, whereas the present study was conducted in a rural southeastern state.

Summary

Although the present study was a replication of the Ide and Gill (1992) research, each of the studies cited in

this review of literature highlighted important factors that were included in the purpose, design, methodology, and/or analysis of the data in the intended research. The Hansell (1992) study emphasized the need to look for trends between prenatal clients' help-seeking behaviors and their perceptions of the health care workers' willingness to deliver high quality care. The Kieffer (1992) study underscored the need for research in order to understand cultural factors and social networks when analyzing data. The results of the Malloy (1990) study suggested the need for different techniques of data collection and analysis to avoid common assumptions about potential relationships between help-seeking behaviors and pregnancy outcome. Finally, Kreiger (1992) reinforced the need for the present research to investigate socioeconomic support systems and help-seeking behavior to determine if it is generally true that low income prenatal patients are less likely to seek prenatal care at an earlier stage in pregnancy. All studies reviewed indicated the need for further research concerning prenatal care. Specific suggestions for areas of study included rural and cultural factors, social support systems, as well as other socioeconomic factors in relationship to help-seeking behaviors of prenatal women. Therefore, research was deemed necessary for all aspects of rural prenatal help-seeking behaviors.

Chapter III

The Method

The purpose of this study was to obtain information about factors that predict prenatal help-seeking behaviors. This study compared two culturally distinct groups of rural prenatal clients, Native Americans and Anglos. Empiricalization of these factors is discussed in this chapter.

Design of the Study

This research replicated the Ide and Gill (1992) study which assessed the cultural influence on help-seeking behaviors among pregnant clients in Wyoming. This present study investigated the help-seeking prenatal care among Native Americans and Anglos in a rural southeastern state. A correlational descriptive design was chosen for this study. Correlational research has been defined as an investigation that explores the interrelationships among variables of interest without any active interventions on the part of the researcher (Polit & Hungler, 1983). This study examined interrelationships of selected variables for prenatal women. Since these interrelationships concerned factors that predict their prenatal help-seeking

behavior and required no interventions by the researcher, a correlational design was deemed appropriate.

Variables. The two dependent variables of this research were social support and help-seeking behaviors. These dependent variables were measured by the Personal Resource Questionnaire (PRQ-85). The independent variables were age, ethnicity, family composition, education, income, and distance from care. These independent variables were measured by the Personal Characteristics Questionnaire (see Appendix B).

Limitations. This study had limited external validity. The sample of subjects was not randomly selected, as a sample of convenience was used. The sample included only women who sought prenatal care at two selected clinics during the sample period and who elected to return the questionnaire. Therefore, the results of the study may not be generalized to other settings or populations.

Setting, Population, and Sample

The setting for the present research was two government operated prenatal clinics in a rural southeastern state. The primary population of one of the prenatal clinics was Native American women, while the population of the other clinic was Anglo women. Both of the clinics had nurse practitioners assessing the prenatal clients. The Native American clinic had two full-time

practitioners compared to the Anglo clinic that operated with one nurse practitioner 2 days a week. The population consisted of prenatal women who sought care at these prenatal clinics. The actual sample consisted of 70 prenatal clients: 41 Native American and 29 Anglo women 12 years of age or older. Participation was voluntary and subjects were assured that the decision to participate in no way affected the care they received at these clinics.

Methods of Data Collection

Instrumentation. Two questionnaires were used to gather data. The first was a researcher-developed Personal Characteristics Questionnaire utilized to obtain demographic information, such as age, education, income, distance from care, family composition, and ethnicity. This questionnaire had face validity, as it was reviewed by a panel of experts. Time of entry into prenatal care was obtained and placed on the Personal Characteristics Questionnaire. The gestational age was used to define the initial time that help-seeking behavior was sought by the prenatal clients. The first, second, and third trimesters of prenatal engagement as classified by the American College of Obstetricians and Gynecologists was used to determine time of entry into prenatal care. The second tool, Weinert's Personal Resource Questionnaire (PRQ-85), was used to assess social support in relationship to help-seeking behaviors of the prenatal clients. This brief

questionnaire consisted of two parts and took approximately 10 minutes to complete. The first part of the questionnaire evaluated five social relationship dimensions: intimacy, social integration, nurturance, worth, and assistance. The validity coefficient was reported to be between .30 and .44 (.001) (Brandt & Weinert, 1987). The second part of the PRQ-85 determined how personal characteristics and the social support received (reflected by the gestational age at the time of the first visit) affected help-seeking behavior. This section consisted of 25 items that subjects responded to on a 7-point Likert scale ranging from strongly agree to strongly disagree. Each response was given a numerical value of 1 to 7. The higher score indicated a higher level of perceived social support. Upon receipt of the questionnaire, the researcher reordered items d, g, j, p, and x in the questionnaire to 7 = 1, 6 = 2, 5 = 3, 3 = 5, 2 = 6, 1 = 7 for analysis to reflect the positive direction of the other 20 items in Part II. The responses from the PRQ-85 were totaled to obtain a final score. The data collection for this research took place from April 1993 through September 1993. Brandt and Weinert (1987) reported that the PRQ-85 had a high consistency reliability coefficient using Crombach's alpha of .89 on Part II of the PRQ-85 (Brandt & Weinert, 1987).

Procedure. Permission from Ide and Gill (1992) was obtained to conduct a replication of their study (see Appendix C). Prior to collecting data for this study, permission was obtained from the Committee on Use of Human Subjects in Experimentation from Mississippi University for Women (see Appendix D). Additionally, permission was obtained from the tribal chief as the administrator of prenatal clinics on the reservation site and from the State Department of Health (see Appendix E) as administrator of the health department's prenatal clinics. The researcher then contacted the director of each clinical site selected for the study. A letter explaining the intent of the study (see Appendix F) with an attached sample questionnaire was sent to the clinic directors. Two women case managers who agreed to administer the questionnaires were selected from each clinic site. The researcher met with both case managers to explain the purpose of the study, how to administer the questionnaire, and how to answer any questions. A script containing instructions for completion of the survey was given to the case managers agreeing to assist in the data collection. The questionnaires were distributed directly by the case managers. Consent forms (see Appendix G) were given to each potential participant. To protect the rights of the subjects, participants were informed that return of the questionnaire was voluntary and anonymity was assured.

Subjects also were informed that no risks had been identified for participation in the study. After receiving the questionnaire, the subjects were assured that they could withdraw at any time. Time of entry into prenatal care and the estimated date of delivery were entered on the Personal Characteristics Questionnaire by the case manager. The completed questionnaires were collected by the researcher at the end of the 2-week period and variables compiled into grouped categories.

Methods of Data Analysis

The present research used multiple regression to predict help-seeking behavior of prenatal clients. The use of multiple regression allowed for the inference of cause and effect, thus permitting the dependent variables to be predicated by observing the independent variables (Polit & Hungler, 1983). The independent variables of the Personal Characteristics Questionnaire were coded and analyzed to determine if there was a correlation of these variables and the dependent variable, time of entry into prenatal care. Correlation as a measurement of these variables was done to determine a variation in one variable related to a variation in another variable (Polit & Hungler, 1983). Further, the descriptive statistic of *t* test was employed to discern differences between the two ethnic groups.

Summary

Chapter III described empiricalization of this study. The setting, sample, and the population were discussed. The conclusion of the data collection, instrumentation, and methods of data analysis, and the results of data analysis will be discussed in Chapter IV.

Chapter IV

The Findings

The purpose of this comparison study was twofold: to identify factors that predict prenatal help-seeking behavior and to compare prenatal help-seeking behavior between Native American and Anglo women in a rural southeastern setting. Data were collected using two instruments: the Personal Characteristics Questionnaire and Weinert's Personal Resource Questionnaire (PRQ-85). Leininger's Transcultural Nursing Theory formed the basis for this study. This chapter delineates the sample and the results of data analysis.

Description of the Sample

The sample consisted of two ethnic groups, Native Americans (n = 41) and Anglos (n = 29) for a total of 70 prenatal clients presenting to two health departments in a rural southeastern state. The mean age of the Native American group was 22 years of age, while the mean age of the Anglo group was 21 years of age. Results of the Personal Characteristics Questionnaire revealed that the majority of Anglos were married (72%) with only 21% having never been married. This contrasted with the Native American group where 29% were married compared to 61%

having never been married. The remaining 7% of Anglos and 10% of Native Americans were either divorced or widowed. For the variable of education, Native Americans (56%) were more apt to have graduated from high school as compared to the Anglo (28%) group. The distance traveled to obtain health care differed between the two groups, as Native Americans (22%) traveled further than 30 minutes to seek health care, while only 3% of the Anglo group traveled further than 30 minutes to seek health care. Sixty-three percent of the Native Americans had incomes of less than $5,000 annually compared to 31% of the Anglos, while 12% of the Native Americans had incomes greater than $20,000 compared to 3% of the Anglos (see Table 1).

Results of the Personal Characteristics Questionnaire also included information on transportation, primary care provider, and reasons for not seeking prenatal care (see Table 2).

Table 1

Demographic Characteristics of Native American and Anglo Prenatal Women

Variable	Anglo[a]		Native American[b]	
	F	%	F	%
Mean age	21			22
Family composition				
Married	21	72	12	29
Unmarried	6	21	25	61
Educational level				
< 12 years	21	72	18	44
> 12 years	8	28	23	56
Distant from care				
< 20 miles	10	35	20	49
> 20 miles	18	62	12	29
> 30 miles	1	3	9	22
Income				
< $5,000	9	31	26	63
> $20,000	1	3	5	12
Transportation				
Own car	24	83	24	59
Dependent on others	5	17	17	41
Primary care provider				
Annually	13	45	14	34
Never been seen	5	17	15	37
Reason for not seeking prenatal care (more than one answer given)				
Employment	8	28	11	27
Student	7	24	11	27
Caring for children	3	10	4	10
Not necessary unless sick	0	0	4	10
Not necessary till close to delivery	0	0	2	5
As soon as you know you are pregnant	29	100	37	90

Note. Percentages do not add to 100 because of missing values.

[a] $n = 29$. [b] $n = 41$.

Results of Data Analysis

Hypothesis 1. The researcher hypothesized that there would be no relationship between selected demographic variables, such as age, education, income, distance from health care, and marital status and the help-seeking behaviors of Native American prenatal women. Data were submitted to the Multiple Regression/Correlation R^2 (44) = .21, p = .12. Since there was no significant correlation, the researcher failed to reject the null hypothesis. This finding indicated that there was no relationship among the demographic variables of age, education, income, distance from health care, and marital status with the help-seeking behaviors of Native American prenatal women.

In order to compute to what extent the variables could predict help-seeking behavior, Multiple Linear Regression was used. This analysis revealed: age, p = .43; education, p = .15; income, p = .24; distance from health care, p = .18; and marital status, p = .64. The variable producing the most predictive potential was education, p = .15. This result suggests that more educated Native Americans might seek help earlier in their pregnancy (see Table 2).

Table 2

Regression Analysis of Selected Demographic Variables and Help-Seeking Behavior Among Native American Prenatal Women[a]

Variable	SE	t	p
Age	1.88	-0.80	0.43
Education	19.95	-1.47	0.15
Income	19.29	1.18	0.24
Distance from health care	15.53	1.37	0.18
Marital status	18.33	0.48	0.64

Note. $F(5, 36) = 1.88$, $p < .12$. Adjusted $R^2 = .09$.

[a]$n = 41$.

$p < .05$.

Hypothesis 2. The second hypothesis stated that there would be no relationship between selected demographic variables, such as age, education, income, distance from health care, and marital status and the help-seeking behavior of Anglo women. Data were submitted to the Multiple Regression/Correlation Analysis R^2 (30) = .15, $p = .53$. Since there was no significant correlation, the researcher failed to reject the null hypothesis. This finding indicated that there was no relationship among the variables of age, education, income, distance from health

care, and marital status and help-seeking behavior of Anglo prenatal women.

In order to compute to what extent the variable could predict help-seeking behaviors, Multiple Linear Regression was used. This analysis revealed the following findings: age, $p = .61$; education, $p = .93$; income, $p = .45$; distance to health care, $p = .59$; and marital status, $p = .53$. These findings indicated that none of the variables were strong predictors of help-seeking behavior among Anglo women (see Table 3).

Table 3

Regression Analysis of Selected Demographic Variables and Help-Seeking Behavior Among Anglo Prenatal Women[a]

Variable	SE	t	p
Age	1.59	-0.51	0.61
Education	16.55	-0.09	0.93
Income	18.12	-0.77	0.45
Distance from health care	15.90	-0.54	0.59
Marital status	16.35	0.63	0.53

Note. $F(5, 24) = .84$, $p < .53$. Adjusted $R^2 = 0.02$.

[a]$n = 29$.

$p < .05$.

Hypothesis 3. The third hypothesis stated that there will be no difference in the factors predicating prenatal help-seeking behaviors between Native American and Anglo women. Data were submitted to the Multiple Regression/Correlation Analysis R^2 (72) = 0.16, p = .12. Although the p value of 0.12 was not significant, when the researcher controlled for other independent variables, the Anglo women were more likely to seek help earlier in their pregnancy than the Native Americans. Since no statistical significance was found, the researcher failed to reject null Hypothesis 3 (see Table 4).

Table 4

Regression Analysis of Selected Demographic Variables and Help-Seeking Behavior Among Native American and Anglo Prenatal Women[a]

Variable	SE	t	p
Age	1.30	-0.89	0.37
Education	13.77	-1.28	0.21
Income	13.63	0.79	0.43
Distance from health care	11.91	0.58	0.56
Marital status	13.06	1.05	0.30
Ethnicity	12.51	1.59	0.12

Note. $F(6, 65) = 2.06$, $p < .07$. Adjusted $R^2 = .08$.
[a]$N = 70$.
$p < .05$.

Additional Findings

Part of the PRQ-85 questionnaire dealt with the independent factor of social support so the researcher was interested in determining whether there was a difference in social support between the two groups of Native American and Anglo women. Data were submitted to the Multiple Regression/Correlation R^2 (74) = .07, p = .59. Since no significance emerged, the researcher failed to determine difference between social support and the help-seeking behaviors for these two groups.

In order to compute to what extent the variables could predict social support, Multiple Linear Regression was used. This analysis revealed the following findings: age, p = .28; education, p = .80; income, p = .28; distance from health care, p = .26; and marital status, p = .74. There was no difference in the variable of social support among Native Americans and Anglos when controlling for other variables (see Table 5).

Table 5

Regression Analysis of Selected Demographic Variables and Social Support Among Native American and Anglo Prenatal Women

Variable	SE	t	p
Age	0.71	-0.27	0.79
Education	7.55	-0.26	0.80
Income	7.48	1.08	0.28
Distance from health care	6.54	-1.13	0.26
Marital status	7.17	-0.34	0.74
Ethnicity	6.86	-0.67	0.50

Note. $F(6, 65) = .78$, $p < .59$. Adjusted $R^2 = 0.02$.

[a]$N = 71$.

$p < .05$.

Summary

This chapter presented data obtained using the Personal Characteristics Questionnaire and the PRQ-85. Results of the data collection were described in narrative and table format.

Chapter V

The Outcomes

Research has identified that the help-seeking behavior of prenatal clients has been impacted by the variables of age, education, income, distance from health care, and marital status; but few studies comparing prenatal care of Native American and Anglo women have been identified. Although evidence has been found indicating that early and adequate prenatal care is the single factor that would improve fetal outcome, no improvements indicating earlier prenatal care have been shown in the last decade. Since large numbers of women enter prenatal care at a late gestational age, educational interventions to increase knowledge, alter help-seeking behaviors, and improve social support strategies become more significant as means of improving fetal outcomes.

The purpose of this correlational research was to compare two ethnic groups of rural women seeking prenatal care who resided in a rural southeastern state. The study was guided by three hypotheses:

Ho_1: There will be no relationship between selected demographic variables and help-seeking behaviors in Native American women.

Ho_2: There will be no relationship between selected demographic variables and help-seeking behaviors in Anglo women.

Ho_3: There will be no difference in the factors predicting prenatal help-seeking behavior between Native American and Anglo women.

This research was a replication of a study by Ide and Gill (1992) of the University of Wyoming. Leininger's Transcultural Nursing Theory was utilized as the theoretical framework for this current study.

Two instruments were used to collect data. The Personal Characteristics Questionnaire was utilized to determine demographic variables, such as age, marital status, education level, geographic location, family composition, social support, and ethnicity. The second instrument, Weinert's Personal Resource Questionnaire (PRQ-85), assessed social support networks in relationship to help-seeking behaviors of the prenatal client. Data were analyzed using Multiple Regression/Correlation to determine the factors that predict delayed help-seeking behavior. Descriptive statistics were used to determine the areas of specific differences. The level of significance was set at .05 prior to data collection.

This chapter includes a discussion of the findings of the study. The conclusions, implications, and

recommendations which evolved from the findings also are presented.

Summary of Findings

The sample consisted of two ethnic groups, Native Americans and Anglos, for a total of 70 prenatal clients presenting to two government operated health departments in a rural southeastern state between April 1993 and September 1993. The mean age of the clients was 22 years.

The demographic findings from this replication study varied between the two cultural groups. The classic profile of the Native American prenatal client in this study was a 22-year-old, unmarried, high school graduate with an annual income of less than $5,000 who lived more than 30 minutes from her health care provider. This compared to the image of the Anglo prenatal client who was a 21-year-old high school dropout with an annual income of less than $5,000, living within 20 miles of her health care provider.

The first null hypothesis, there will be no relationship between selected demographic variables and help-seeking behaviors in Native American women, was accepted because no significant correlation between the variables was found using the Multiple Regression/ Correlation $\underline{R}^2$ at the .05 level of significance. This finding indicated that no significant relationship existed among the demographic variables of age, education, income,

distance from health care, and marital status and prenatal help-seeking behaviors. This researcher failed to reject null Hypothesis 1. The variable, education ($p = .15$), suggested that the more educated Native American women sought help earlier in their pregnancy.

The second hypothesis, which stated that there would be no relationship between selected demographic variables and the help-seeking behavior of Anglo women, was also accepted because no significant correlation between the variables was found using the Multiple Regression/ Correlation R^2 at the .05 level of significance. This finding indicated that there was no relationship among the variables of age, education, income, distance from health care, and marital status and the help-seeking behaviors of Anglo women. Thus, the researcher failed to reject Hypothesis 2.

The third hypothesis stated that there will be no difference in the factors predicating prenatal help-seeking behaviors between Native American and Anglo women. Using the Multiple Regression/Correlation R at the .05 level of significance, ethnicity, with a p level of .12, was found to be the most significant indicator of the independent variables consisting of age, education, income, distance from health care, and marital status. The researcher assumed that while controlling for other

independent variables, Anglo women were more likely to seek help at an earlier gestational age than the Native American women. The researcher failed to reject Hypothesis 3.

Discussion of Findings

The researcher failed to demonstrate significant correlations for indices of help-seeking behavior and selected demographics; therefore, findings do not support Ide and Gill's (1992) study. However, demographic findings from this replication study did vary between the two cultural groups. The profile of the Native American prenatal client in this study was a 22-year-old, unmarried, high school graduate with an annual income of less than $5,000, who lived more than 30 minutes from her health care provider. This compared to the image of the Anglo prenatal client that emerged: a 21-year-old, married, high school dropout, with an annual income of less than $5,000, who lived within 20 miles of her health care provider.

When contrasting the current sample with that of Ide and Gill (1992), the researcher notes that in the present study, subjects' mean age of 22 years for the Native American women corresponded to the mean age of 21 years for the Anglo women. Thus, these two groups were comparable on the variable of age. However, the sample for the Ide and Gill (1992) research was comprised of a

disproportionate representation of ethnic groups by age. Only 20% were Native American women, and 7.4% of the Anglo prenatal women were aged 19 to 20 years. Thus, Ide and Gill's sample was older. Further, when addressing the variable of education the current study had Native American women who were more educated than the Anglo women. The majority of the Native Americans (45%) in this study had graduated from high school compared to only 33% of the Anglo women. A factor to be noted is the Native Americans in this study had a high school with dormitories located on the reservation that is available for students living in the outlying rural communities, a situation which discourages school dropout. Ide and Gill's sample included Native American women who were less educated and Anglo women who were better educated. Samples for the two studies were conspicuously different.

Although there was no significant difference found in the relationship between the demographic variables and the help-seeking behaviors of the Native American women, the most notable variable of education ($p = .12$) suggested that the more educated Native American women in this study sought care earlier in their pregnancy. This finding could have been related to the fact that more educated individuals have an increased interest in understanding pregnancy and were more apt to seek information and initiated prenatal care earlier. Additionally, they may

have been more health conscious due to an increased knowledge about consequences of aberrant health behaviors. This finding refutes Ide and Gill's (1992) conclusion that less educated Native Americans were less likely to delay initiating prenatal care. Yet, Hansell (1991) found that the more educated an individual, the more likely he/she will seek health care which supports the education premise.

The researcher noted that although no significance emerged when analyzing these ethnic groups separately when comparing the factor of ethnicity, Anglo women were found to seek prenatal care at an earlier gestational age than the Native American women. One explanation for this finding may have been due to the income of the clients. Sixty-one percent of the Native Americans had an income of less than $5,000 annually while the Anglo women had substantially higher incomes indicating financial status impacts the likelihood of seeking prenatal care at an earlier gestational age. This supposition is comparable to Ide and Gill's (1992) findings. Further, Kreiger (1992) indicated that the lower the socioeconomic status of a prenatal client, the higher the incidence of inadequate prenatal care, thus concluding that income does impact the help-seeking behavior of prenatal care. However, this researcher does not clearly comprehend how income affected these Native American women as health care

was provided at reduced rates on the reservation. Perhaps, their behaviors are closely associated with ancestral interpretation related to pregnancy.

Cultural difference may also have explained the varying viewpoints of Native American and Anglo clients regarding the best time to first seek prenatal care. The majority of the Anglo women (96%) felt that prenatal care was necessary as soon as they found out they were pregnant while only 84% of the Native Americans felt this way. Additionally, 10% of the Native Americans did not feel prenatal care was necessary unless they were sick or close to delivery. A possible explanation could be that Native Americans viewed pregnancy as a normal function and that primary care was not needed unless they were sick. This assumption was supported as 34% of the Native Americans had not been seen by a primary care provider in the past 5 years compared to only 16% of the Anglos. Although Ide and Gill (1992) did not use culture as an indicator, this finding reflects Leininger's (1978) Transcultural Nursing Theory which proposes that delayed help-seeking behavior of Native American women may have been based on their views related to the necessity of early prenatal care.

Kieffer (1992) also determined that certain groups with distinct cultures are more likely to receive inadequate prenatal care as determined by traditional western medicine, but these individuals were found to have

increased social support within their cultures. Thus, the Native American did not seek prenatal care at an earlier gestational age due to cultural supports and/or cultural beliefs. These same findings were found in a study of Uba (1992) where cultural barriers interfered with the continuation of prenatal care.

Lastly, another factor that may have impacted the help-seeking behaviors of Native American and the Anglo clients was the distance traveled to seek prenatal care. Ide and Gill (1992) found no significant difference in the distance traveled between the two groups, but this current study noted the distance traveled to obtain health care varied more greatly among the Native Americans than the Anglos. While only 3% of the Anglos traveled more than 30 miles for prenatal care, 25% of the Native Americans traveled this same distance to receive their prenatal care. Further, the Anglos sought care at a health department located in the county in which they lived while many Native Americans sought prenatal care at the health department located on the reservation which was in another county. Many of the Native Americans lived in smaller communities located in nearby counties causing a greater distance to travel. While distance traveled to obtain care showed a high level of variation in this study, further investigation revealed that Anglos (83%) also were more likely to own their own car as compared to the Native

Americans (47%) who owned their own car. Schleuning (1991) concluded that long distance travel to obtain care and the lack of availability of obstetrical facilities do influence the prenatal help-seeking behavior. Additional support to this finding was noted in that Native Americans were found more likely to depend on family or friends for transportation to seek prenatal care as compared to only 16% of the Anglos who were dependent on another for their means of transportation.

According to Anderson (1989), age and marital status were significant factors related to prenatal help-seeking behaviors. Anderson determined that unmarried women were three times more likely than married women to seek delayed or no prenatal care. The present research sample consisted of 59% unmarried Native Americans and 20% unmarried Anglos. This current study substantiates the assumption that unmarried women are more likely to seek prenatal care at a later gestational age. These findings contrast to Ide and Gill (1992), where no significance between marital status and prenatal help-seeking behavior emerged.

Conclusions

The researcher concludes that there is no significant relationship in the variables of age, education, income, distance from health care, and marital status and the help-seeking behavior of Native American prenatal women.

The variable of education was the most noteworthy and may indicate that the more educated prenatal Native American would seek prenatal care at an earlier gestational age. Further, the researcher failed to identify any strong relationship when comparing the above variables with the Anglo prenatal women. Ethnicity was the only significant variable when controlling for other independent variables. Anglo women were more likely to seek help earlier in their pregnancy than the Native Americans. Contributing to this conclusion are cultural beliefs, economics, and health care availability.

Implications for Nursing

Findings indicated that culture may have played a part in help-seeking behaviors. Therefore, as part of every nurse's assessment, the cultural beliefs of the client should be identified and respected. Advanced practice nurses must recognize and respond to diverse groups and unique individuals within their practice. Help-seeking behavior is a phenomenon nurse practitioners need to explore and promote among culturally distinct groups. Research has shown that early entry into prenatal care has more positive birth outcomes (Malloy, 1992) and, with the nurse's awareness and culturally sensitive manner of providing care to the client, more positive outcomes for the client will be seen.

Although the results of this study indicated no significance, the nurse practitioner needs to be aware of potential factors that may predict or impact delayed prenatal care. Several of the factors researched were age, education, income, distance from health care, and marital status. With the nurse practitioner being more aware of the potential impact of these factors, help-seeking behavior intervention could be designed to identify and help those women seek earlier prenatal health care. For instance, education could be used with identified high-risk prenatal clients. This factor could impact the outcomes on such factors as low birth weight, infant mortality, and preterm deliveries.

The information gained from this study also could be utilized in undergraduate nursing programs and nurse practitioner programs to make the new nurse more aware of the diverse cultural groups and how culture impacts on an individual's health-seeking behavior. Additionally, curriculum could incorporate the importance of early prenatal care and the factors that are impacted by delayed help-seeking behavior into course content.

Not only is education of the nurse important in the early entry into prenatal care, but education of the client also is essential. With the results of this study, nurses could be made aware of the image of clients who have a tendency to delay prenatal help-seeking care and

could intervene to increase prenatal care to earlier gestational ages. If care was not available within the client's means, then she should be taught where care could be obtained. The client should be informed of the importance of early prenatal care as necessary for a positive birth outcome. Nurse practitioners could be vital role models in this education process. Many nurse practitioners function in clinics in rural areas where prenatal care has not always been available. With the nurse practitioner being available and accessible, the appropriate education for these prenatal clients could be attained and the early entry into prenatal care could be achieved. Additionally, since nurse practitioners also function as case managers, results of this study could help guide nurse practitioners to better manage the care of prenatal clients. Through this role, nurse practitioners could identify clients with the financial, sociocultural, and psychological barriers associated with prevention of the client entering prenatal care at an earlier gestational age and make appropriate referrals and interventions.

Research remains a continuing force behind quality prenatal care for all cultures. Without research, the quality of prenatal care of all cultures would be jeopardized. Research allows nursing to have the knowledge needed to ascertain if current practices are

allowing for early entry into the prenatal health care system. New research, such as this study, will allow for not only increased knowledge but also allow for earlier interventions of women seeking prenatal care.

Recommendations for Further Study

This study suggests several areas for future investigation. Based on the findings of this study, the following recommendations are made for future research in nursing:

1. Replication of the study as a longitudinal research looking at birth outcomes among the two cultures of Native American and Anglo women.

2. Replication of this study comparing different cultural groups.

3. Conduction of research to explore the impact of outlying rural clinics managed by nurse practitioners to increase the entry into early prenatal care.

4. Replication of this study comparing adolescent prenatal Native American clients and Anglo clients.

5. Conduction of research utilizing an initial health interview emphasizing potential factors of ethnicity.

6. Development of prenatal educational programs which appreciate ethnic variation.

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APPENDIX A

PERSONAL CHARACTERISTICS QUESTIONNAIRE

Personal Characteristics Questionnaire

Directions. Circle or write in the answer that best describes you.

1. What was your age at your last birthday?_____

2. Who do you presently live with? (✓ as many as apply)
   _____ a. Alone
   _____ b. With my spouse
   _____ c. With my boyfriend
   _____ d. With a roommate/friend
   _____ e. With a family member(s)
   _____ f. Other:_____

3. What is your marital status?
   _____ a. Married
   _____ b. Never married
   _____ c. Divorced/separated
   _____ d. Widowed

4. What best describes your ethnic background?
   _____ a. Anglo/Caucasian
   _____ b. American Indian
   _____ c. Black
   _____ d. Other

5. What is your highest educational background?
   _____ a. 8 years or less
   _____ b. 9-11 years
   _____ c. High school graduate
   _____ d. College graduate
   _____ e. College graduate
   _____ f. Post-graduate education

6. How far, in minutes, is the nearest health care facility from your home?
   _____ a. 5-10 minutes
   _____ b. 11-20 minutes
   _____ c. 21-30 minutes
   _____ d. More than 30 minutes

7. What is your annual household income?
   _____ a. Less than $5,000
   _____ b. $5,000-$9,999
   _____ c. $10,000-$19,999
   _____ d. $20,000-$29,999

8. What transportation do you use to get to your health care facility?
   _____ a. Own car
   _____ b. Hospital transportation
   _____ c. Family or friends
   _____ d. Other (Please specify:_____)

9. How long did you wait to contact or call your doctor after you suspected you were pregnant? (Please specify in number of days, weeks, or months)

_____

10. What event caused you to first go to the doctor?

_____

_____

11. When is your baby due?_____

12. When did you have your pregnancy test?

_____

13. What date was your first prenatal visit following the pregnancy test to your clinic?_____

14. Thinking back over the last 5 years, how often did you see your health care provider for a complete checkup?

_____ a. At least every year
_____ b. Four times
_____ c. Three times
_____ d. Twice
_____ e. Once
_____ f. Never
_____ g. Don't know

15. What prevented you from seeking health care more often?

_____ a. Employment
_____ b. Student at school
_____ c. Tribal job
_____ d. Caring for children at home
_____ e. No transportation
_____ f. Other (Please specify:_____)

16. What are your beliefs about prenatal care?

_____ a. Not necessary unless sick
_____ b. Not necessary until close to delivery
_____ c. Necessary as soon as you know you are pregnant
_____ d. Other (Please specify:_____)

17. What do you like about prenatal care?

_____

_____

18. What do you <u>not</u> like about prenatal care?

_____

_____

For Nurse's Use Only

EDC_____
G.A. @ 1st_____

APPENDIX B

WEINERT'S PERSONAL RESOURCE QUESTIONNAIRE (PRQ-85)

Personal Resource Questionnaire (PRQ-85)

In our everyday lives there are personal and family situations or problems that we must deal with. Some of these are listed below. Please consider each statement in light of your own situation. CIRCLE the number before the person(s) that you could count on in each situation that is described. You may circle more than one number if there is more than one source of help that you count on. In addition, we would like to know if you have had this situation or a similar one in the past SIX MONTHS, and how satisfied you are with the help you received.

==========

Q-1a If you were to experience urgent needs (crisis), who would you turn to for help? (Please CIRCLE all that apply.)

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain):_____
_____

b. Have you had urgent needs (crisis) in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-2a)

c. If you have experienced urgent needs (crisis) in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-2a If you needed help for an extended period of time in caring for a family member who is sick or handicapped, who would you turn to for help? (Please CIRCLE all that apply.)

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain):_____
_____

b. Have you needed help in caring for a sick or handicapped family member in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-3a.)

c. If you have needed help in caring for a sick or handicapped family member in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-3a. If you were concerned about your relationship with your spouse, partner, or intimate other, who would you turn to for help? (Please CIRCLE all that apply.)

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain):_____
_____

b. Have you had concerns about your relationship with your spouse, partner, or intimate other in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-4a.)

c. If you have had concerns about your relationship with your spouse, partner, or intimate other in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-4a. If you needed help or advice for a problem with a family member or friend, who would you turn to for help? (Please CIRCLE all that apply.)

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain):_____
_____

b. Have you needed help or advice regarding a problem with a family member or friend in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-5a.)

c. If you have needed help or advice in the past SIX MONTHS regarding a problem with a member or friend, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED

Q-5a. If you were having financial problems, who would you turn to for help? (Please CIRCLE all that apply.)

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain):_____
_____

b. Have you had financial problems in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-6a.)

c. If you have had financial problems in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-6a. If you felt lonely, who would you turn to? (Please CIRCLE all that apply.)

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain):_____
_____

b. Have you felt lonely in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-7a.)

c. If you have felt lonely, in the past SIX MONTHS, to what extent do you feel satisfied with the help you have received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-7a. If you were sick and not able to carry out your usual activities for a week or so, who would you turn to for help?

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain):_____

b. During the past SIX MONTHS have you been sick for a week and not able to carry out your usual activities?

1 YES
2 NO (If NO, skip to Q-8a.)

c. If you have been sick for a week during the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-8a. If you were upset and frustrated with the conditions of your life, who would you turn to for help?

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain):_____

b. Have you been upset and frustrated with the conditions of your life in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-9a.)

c. If you have been upset and frustrated with the conditions of your life in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-9a. If you were having problems with your work at home or at your place of employment, who would you turn to for help?

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain):_____
_____

b. Have you had problems related to your work in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-10a.)

c. If you have had problems with your work situation in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-10a. If you needed someone to talk to about your day-to-day personal concerns, who would you turn to for help?

1 PARENT
2 CHILD OR CHILDREN
3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
4 A RELATIVE OR FAMILY MEMBER
5 FRIEND
6 NEIGHBOR OR CO-WORKER
7 SPIRITUAL ADVISOR (minister, priest, etc.)
8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
9 AGENCY
10 SELF-HELP GROUP
11 NO ONE (No one available)
12 NO ONE (Prefer to handle it alone)
13 OTHER (Please explain):_____
_____

b. Have you needed someone to talk to about day-to-day personal concerns in the past SIX MONTHS?

1 YES
2 NO (If NO, skip to Q-11.)

c. If you have needed someone to talk to about day-to-day personal concerns in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED
2 FAIRLY DISSATISFIED
3 A LITTLE DISSATISFIED
4 A LITTLE SATISFIED
5 FAIRLY SATISFIED
6 VERY SATISFIED

Q-11. Below are some statements with which some people agree and others disagree. Please read each statement and CIRCLE the response most appropriate for you. There is no right or wrong answer.

1 = STRONGLY AGREE
2 = DISAGREE
3 = SOMEWHAT DISAGREE
4 = NEUTRAL
5 = SOMEWHAT AGREE
6 = AGREE
7 = STRONGLY AGREE

STATEMENTS

a.	There is someone I feel close to who makes me feel secure	1	2	3	4	5	6	7
b.	I belong to a group in which I feel important	1	2	3	4	5	6	7
c.	People let me know that I do well at my work (job, homemaking)	1	2	3	4	5	6	7
d.	I can't count on my relatives and friends to help me with problems	1	2	3	4	5	6	7
e.	I have enough contact with the person who makes me feel special	1	2	3	4	5	6	7
f.	I spend time with others who have the same interests that I do	1	2	3	4	5	6	7
g.	There is little opportunity in my life to be giving and caring to another person	1	2	3	4	5	6	7
h.	Others let me know that they enjoy working with me (job, committees, projects)	1	2	3	4	5	6	7
i.	There are people who are available if I needed help over an extended period of time	1	2	3	4	5	6	7
j.	There is no one to talk to about how I am feeling	1	2	3	4	5	6	7
k.	Among my group of friends we do favors for each other	1	2	3	4	5	6	7
l.	I have the opportunity to encourage others to develop their interests and skills	1	2	3	4	5	6	7

1 = STRONGLY AGREE
2 = DISAGREE
3 = SOMEWHAT DISAGREE
4 = NEUTRAL
5 = SOMEWHAT AGREE
6 = AGREE
7 = STRONGLY AGREE

STATEMENTS

---

m.	My family lets me know that I am important for keeping the family running	1	2	3	4	5	6	7
n.	I have relatives or friends that will help me out even if I can't pay them back	1	2	3	4	5	6	7
o.	When I am upset there is someone I can be with who lets me be myself	1	2	3	4	5	6	7
p.	I feel no one has the same problems as I	1	2	3	4	5	6	7
q.	I enjoy doing little "extra" things that make another person's life more pleasant	1	2	3	4	5	6	7
r.	I know that others appreciate me as a person	1	2	3	4	5	6	7
s.	There is someone who loves and cares for me	1	2	3	4	5	6	7
t.	I have people to share social events and fun activities with	1	2	3	4	5	6	7
u.	I am responsible for helping provide for another person's needs	1	2	3	4	5	6	7
v.	If I need advice there is someone who would assist me to work out a plan for dealing with the situation	1	2	3	4	5	6	7
w.	I have a sense of being needed by another person	1	2	3	4	5	6	7
x.	People think that I'm not as good a friend as I should be	1	2	3	4	5	6	7
y.	If I got sick, there is someone to give me advice about caring for myself	1	2	3	4	5	6	7

APPENDIX C

PERMISSION FROM IDE AND GILL TO REPLICATE STUDY

Bridgette M. Gill, R.N.C., M.S., O.G.N.P.
392 Pheasant Place
Sheridan, Wyoming 82801
(307) 674-8645

3 Nov 92

Jan Todd, R.N., B.S.N.
17 Country Lane
Philadelphia, MS 39350

Dear Ms. Todd,

I am pleased that you are interested in replicating my study. You have my permission to do so, and use my Personal Characteristic Questionnaire. In my study, I incorporated the PRQ85 Part II Questionnaire to obtain perceived social support scores. Permission to use this tool will need to be obtained from Clarann Weinert, S.C., Ph.D., R.N. , Montana State University, Sherrick Hall, Bozeman, Montana 59717-0005.

The Personal Characteristic Questionnaire was designed to obtain personal and demographic factors possibly affecting help-seeking behaviors. My initial study was The Influence of Social Networks on Rural Help-Seeking Behavior. The study presented in Tucson resulted from further analysis of the data obtained.

Enclosed is the Personal Characteristic Questionnaire and Methodology. I am interested in your study and findings. If you need further information or have questions, please contact me. Good luck in your research.

Sincerely yours,

Bridgette M. Gill

Bridgette M. Gill, R.N.

APPENDIX D

APPROVAL OF MISSISSIPPI UNIVERSITY FOR WOMEN COMMITTEE ON USE OF HUMAN SUBJECTS IN EXPERIMENTATION

MISSISSIPPI UNIVERSITY FOR WOMEN
Columbus, MS 39701

Office of the Vice President for Academic Affairs
Eudora Welty Hall
P.O. Box W-1603
(601) 329-7142

April 1, 1993

Ms. LaSteffia Jan Todd
c/o Graduate Nursing Program
Campus

Dear Ms. Todd:

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed research.

I wish you much success in your research.

Sincerely,

Thomas C. Richardson
Vice President
for Academic Affairs

TR:wr

cc: Mr. Jim Davidson
Ms. Jeri England
Dr. Nancy Hill
Dr. Rent

APPENDIX E

AGENCY CONSENT FORMS

MISSISSIPPI BAND OF CHOCTAW INDIANS
Planning Department

TRIBAL OFFICE BUILDING
P. O. BOX 6010
PHILADELPHIA, MISSISSIPPI 39350
TELEPHONE (601) 656-5251

March 4, 1993

Memorandum

To: Chief Phillip Martin

From: Nell Rogers, Planner

Re: **Request for Approval for Thesis Research on Women's Wellness**

Jan Todd, OPD/ER Coordinator, Choctaw Health Center, is nearing completion of a graduate program at Mississippi University for Women. For her thesis, she is completing a comparative study of women seeking prenatal care. She is seeking your permission to administer a questionnaire (attached) to women at the women's wellness center. Participation would be voluntary. The study would yield useful information for the CHC, at no cost, in these areas: (1) why women delay prenatal care; and (2) the birth outcome of delayed care. The resulting data could be used to plan prenatal care activities more likely to reach women much earlier in their pregnancy.

Jim Wallace has reviewed and approved the proposed study. I have reviewed and it seems sound, non-intrusive and beneficial.

Please let me know if there are questions and return response to me. Thank you.

NR:tdw

cc: Jim Wallace

[redacted]

☑ Approved
☐ Disapproved
☐ Further Discussion

Phillip Martin, Tribal Chief

3/8/93
Date

MISSISSIPPI
STATE DEPARTMENT OF
HEALTH

Post Office Box 1700 • 2423 North State Street • Jackson, Mississippi 39215-1700 • 601/960-7400 • FAX 601/960-7948

March 11, 1993

Ms. Jan Todd, RN, BSN
17 Country Lane
Philadelphia, MS 39350

Dear Jan :

I received your request to collect data in the Neshoba County Health Department relative to the completion of your thesis entitled " A Comparison of Factors Predicting the Help-Seeking Behavior of Prenatal Care in Rural American Indians and Anglo Women". We can approve your request contingent upon the following mutual agreement components :

1. The clients you access for the study must have the component of your informed consent which states that their "services will not be affected by (their) decision regarding participation in the study" reinforced at the time of the data collection encounter.

2. The information must be reported in the aggregate, as you described.

3. No health department staff may be utilized as data collectors.

4. The agency should receive a copy of the final thesis.

You may contact Gayle Gray, District VI Supervising Nurse at 482-3171 to arrange the time to begin your data collection. She will advise you regarding district procedures relative to clinic schedules, etc.

I wish you much success with your study.

Sincerely,

Kaye Bender

Kaye Bender, RN, MS, Chief
Office of the State Health Officer

cc: Gayle Gray

attachment

APPENDIX F

LETTERS OF INTENT

17 Country Lane
Philadelphia, MS 39350
(601) 656-6200
September 23, 1992

Betty A. Ide, PhD, RN
University of Wyoming School of Nursing
P. O. Box 3065
Laramie, WY 82071-3065

Dear Mrs. Ide:

I am employed with the Mississippi Band of Choctaw Indians as the Outpatient/Emergency Room Supervisor. I am also attending the graduate program at the Mississippi University for Women in the Family Nurse Practitioner track.

While attending the 5th Annual IHS Research Conference on Indian Health in May 1992, I became interested in your research paper, "Factors Predicting Delayed Help-Seeking Behavior in Rural Native American and Anglo Women Seeking Prenatal Care." I am asking your permission to do a replication of your study using the rural Native Americans in my area.

I can be reached at (601) 656-6200 at home after 5:00 p.m. or (601) 656-2211, extension 223 at work. I am very interested in continuing your research and am looking forward to working with you.

Thank you,

Jan Todd, RN, BSN
Student Nurse Practitioner

17 Country Lane
Philadelphia, MS 39350
December 22, 1992

Jimmy Wallace, Director
Choctaw Health Center
Route 7, Box R50
Philadelphia, MS 39350

Dear Mr. Wallace:

As you are aware, I am attending graduate school at Mississippi University for Women in the Family Nurse Practitioner track. As partial fulfillment of the graduate program, I must submit a thesis. For my thesis I have selected to do a comparative study of Native American Indians and Anglo women seeking prenatal care. I am asking your permission to offer my questionnaire to the prenatal patients in Women Wellness. This questionnaire will be on a voluntary basis only. Enclosed is a copy of the questionnaire.

The results of this study will be made available to Choctaw Health Center. These results may be used to increase the number of prenatal visits for an individual during their pregnancy, thus possibly providing improved monitoring of the pregnancy.

Sincerely,

Jan Todd, RN, BSN
OPD/ER Coordinator

17 Country Lane
Philadelphia, MS 39350
(601) 656-6200

Kaye Bender
Mississippi State Department of Health
P. O. Box 1700/2423
North State Street
Jackson, MS 39215-1700

Dear Mrs. Bender:

I am currently a student at Mississippi University for Women working on my graduate degree in the Family Nurse Practitioner track. As a requirement for my master's degree, I must complete a thesis. As my topic I have chosen, "A Comparison of Factors Predicting the Help-Seeking Behavior of Prenatal Care in Rural American Indians and Anglo women."

I am currently employed with the Mississippi Band of Choctaw Indians and will receive my information on Native Americans with the Choctaw tribe. I am asking permission to use prenatal patients at the Neshoba County Health Department for my Anglo women.

Thank you for considering my request.

Sincerely yours,

Jan Todd, RN, BSN

APPENDIX G

INFORMED CONSENT FORM

Informed Consent Form

My name is Jan Todd. I am a registered nurse attending graduate school at Mississippi University for Women. I am conducting research on prenatal help-seeking behaviors. The study requires completion of a questionnaire. This questionnaire will take about 10 minutes to complete. The information obtained from the questionnaire will be used to identify prenatal help-seeking behaviors. There is no identified risk to you. The benefits of this research will be to improve health care to prenatal clients.

The choice to participate or not to participate is voluntary and has no influence on the care you receive at this facility. You may withdraw from the study at any time up to the analysis of data. Answers to your questions will be part of the group study and will in no way identify you.

Your cooperation would be most appreciated.

I have read the above statements. I understand that this study will not interfere with the care I receive at this facility.

_____ Yes, I will participate.

Signed:_____

Date:_____

If you have any questions regarding this study, please contact:

Jan Todd
17 Country Lane
Philadelphia, MS 39350
(601) 656-6200