

1979

Maternal and child health care patterns among Mexican-American families in an urban community

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DOI: <https://doi.org/10.31979/etd.vptx-6yz9>
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MATERNAL AND CHILD HEALTH CARE PATTERNS
AMONG MEXICAN-AMERICAN FAMILIES
IN AN URBAN COMMUNITY

A Thesis
Presented to
the Faculty of the School of Social Work
San José State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
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May, 1979

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ACKNOWLEDGMENTS

I wish to express my sincere appreciation to Dr. Hector Garcia-Manzanedo for his expert guidance and encouragement throughout the preparation of this thesis. I also especially wish to thank my daughter Monserrat for her understanding and support, which were essential for the successful completion of this project.

TABLE OF CONTENTS

	Page
ACKNOWLEDGMENTS	iii
LIST OF TABLES	vi
LIST OF FIGURES	vii
 Chapter	
1. INTRODUCTION	1
Statement of the Problem	2
Research Questions	6
2. REVIEW OF THE LITERATURE	9
Health and Culture	9
Review of Earlier Studies	15
3. METHODOLOGY OF THE STUDY	24
The Study Design	24
Major Variables and their Operational Definitions	26
The Sample	28
Data Collection and Storage	31
Data Processing	32
Limitations	33
4. INFORMANT SOCIAL PROFILE	34
Family and Ethnic Community Integration	34
Socio-economic Status	43
Adherence to Traditional Health Care Patterns	48

Chapter	Page
5. TRADITIONAL MATERNAL AND CHILD HEALTH CARE PATTERNS	52
Introduction	52
The Prenatal Period	53
The Birth	62
The Postnatal Period	64
Culture-specific Illnesses	72
6. ANALYSIS AND IMPLICATIONS OF THE FINDINGS	80
Quantitative Analysis of the Findings	80
Implications of the Findings	84
BIBLIOGRAPHY	90
APPENDIXES	
A. Perinatal Interview Schedules (English and Spanish)	96
B. Qualitative Data Filing System	102
C. Medicinal Herbs	103

LIST OF TABLES

Table		Page
1.	County-compiled Demographic Data for Target Community	4
2.	Live Birth and Infant Death Rates for Target Community	7
3.	Hot and Cold Foods	18
4.	Ratings of Informant Adherence to Thirteen Traditional Health Care Patterns	81

LIST OF FIGURES

Figure	Page
1. Informant Birthplace by Statistical and Geographical Regions of Mexico	40
2. Years of Formal Education Completed in Mexico by Informants and Spouses (or Partners)... .	44

Chapter 1

INTRODUCTION

In 1959, Margaret Clark concluded her well-known study in which she related many unique patterns of health care described to her by the Mexican-American residents of the Sal Si Puedes barrio (community) of San Jose. Today, twenty years later, it seems appropriate to determine if these and/or other traditional health care patterns are still being practiced in urban San Jose and, further, to determine what impact the adherence to traditional health care patterns has upon the delivery of modern health care services to Mexican-American families.

The primary focus of the present study is on the traditional health care patterns utilized in Mexican-American families for the care of women in both the prenatal and forty-day postnatal periods and for the care of their neonatal infants. Maternal and child health studies in general are recognized as important sources of new information regarding maternal and infant mortality and morbidity. These studies have led to an understanding of the preventive role of prenatal care and nutrition; many mental and/or physical dysfunctions in newborn infants have been thusly explained. As a result of these findings, some steps have been taken by national policy makers to encourage women to seek early

prenatal care and to consume more nutritionally-adequate food. The Maternal and Child Health Program and the Special Supplemental Food Program for Women, Infants, and Children are primary examples of this Federal effort. More research, however, is needed which focuses on minority populations in order to determine the rate of adherence to and the influence of culturally-determined patterns of health care for women and infants. It is with the desire of enlarging this specific area of knowledge that this study has been completed. It is, further, the sincere hope of the author that any new information or insights presented here will be used by the appropriate agencies to improve the delivery of services to Mexican-American families within the current health care system.

For the purpose of this study, the term traditional health care patterns was used to indicate what Hughes (1968) labeled ethnomedicine--"those beliefs relating to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine" (p. 99).

Statement of the Problem

For this study, one of the original barrios of San Jose was selected as a target community for research. This choice was based on recent demographic data compiled by the Santa Clara County Planning Department (1975) and the Santa Clara County Department of Health (1977). Composed of six census tracts, this community encompasses 5.5 square miles.

The religious and social focal point of the community is the centrally-located Catholic Church. Since 1973, a community health center, located adjacent to the Church, has been providing medical services to the community.

According to Census '75, a special countywide census conducted in 1975 by the Santa Clara County Planning Department, 10% of the household population of Santa Clara County identified themselves as being either of Mexican descent or Chicano. Within the target community of this study, however, 41.8% of the household population identified themselves as being either of Mexican descent or Chicano. Given these figures, the importance of conducting culturally-relevant social research within the target community is clear (Table 1).

It should be noted that there has been some debate concerning the criteria used by the Santa Clara County Planning Department in this recent census to ascertain the ethnic breakdown of the residents of the county. Latino residents were asked to distinguish between two confusing ethnic categories, which were Mexican descent/Chicano and Spanish heritage/Latino. It was assumed by the County that those residents who selected the latter category were of other Latino descent, excluding Mexican. Leaders of the Mexican-American community, however, have expressed their concern that the number of County residents of Mexican heritage was not accurately measured since, they believed, many first-generation Mexican residents rejected the term Chicano, and therefore, had identified

Table 1

County-Compiled Demographic Data for Target Community

Census Tract	Total Household Population	Mexican Descent/ Chicano Household Population	% Mexican Descent/Chicano Population (1)	Mean Household Size	% of Unemployment Age 14+ (2)	Median Income 1974 (2)
#1	1123	289	25.7%	2.03	11.4%	\$6000-\$7999
#2	1516	764	50.4%	2.71	12.9%	\$6000-\$7999
#3	3263	1873	57.4%	2.60	15.6%	\$6000-\$7999
#4	4090	1882	46.0%	2.86	8.8%	\$6000-\$7999
#5	4593	1930	42.0%	2.56	11.3%	\$6000-\$7999
#6	3959	1019	25.7%	2.34	10.9%	\$6000-\$7999
Total Target Community	18,544	7757	41.8%	2.55	11.5%	\$6000-\$7999
Countywide	1,144,324	114,441	10.0%	2.92	5.1%	\$14,000-\$15999

Source: Census '75, Santa Clara County planning Department, 1975.

1. As this study deals specifically with Mexican traditional health care patterns, included are only the figures for the population which self-identified as Mexican descent/Chicano.
2. Figures include only those who reported.

themselves as being of Spanish heritage/Latino. Given the dilemma of deciding which census figures were the more representative of the number of Mexican-American residents in the County and in the target community, the author, seeking the most consistent data possible, elected to conform to the categories as prepared for the census, with the understanding that the figures of Table 1 in reality underrepresent the Mexican-American population of Santa Clara County.

Further examination of the data compiled in Census '75 indicated that the target community has a very low overall socio-economic rating within the County. The median income for this community in 1974 was between \$6000 and \$7999, while the overall County median was between \$14,000 and \$15,999. Although the mean household size was slightly lower for this community than for the County in general, that fact alone can not explain the disparate levels of income. A more viable explanation for this phenomenon would be the extremely high rate of unemployment found among residents of the target community, which was more than twice as high as the overall County rate (Table 1).

The second reason for the selection of this community for the study is found in data compiled by the Santa Clara County Department of Health (1977). According to County vital statistics, the birth rate in 1977 for the target community was 26.2/1000, compared to 15.9/1000 countywide; further, the birth rate among the Spanish-surnamed families in

this community was 37.7/1000 (Table 2). These figures indicate that maternal and child health care is of great importance in the target community.

Economic conditions influence to a large degree the health status of a population. Low and unstable income is reflected directly in the nutritional intake of the family; poor housing and crowding often cause a high incidence of disease; also, as this community seems to receive a large number of new County residents, according to local leaders, an unfamiliarity with local health resources may discourage a family from seeking medical treatment when needed. These variables may influence adherence to traditional health care patterns.

Given the high birth rate and the cultural heritage of a large portion of the target community, studies which could increase the knowledge of any traditional maternal and child health care patterns being practiced within the community could, hopefully, lead to the delivery of optimum prenatal and postnatal care for all community residents.

Research Questions

The present study has been designed to be sociocultural in nature. Although the scope of the research is public health oriented, it has been conducted in strict adherence to the objectives and principles of social work. Within this

Table 2

Live Birth and Infant Death Rates for Target Community

Census Tract	Total Live Births	Live Birth Spanish-Surnamed (1)	% Spanish Surnamed Live Births	Total Population Birth Rate (2)	Spanish-surnamed Population Birth Rate (3)	Total Infant Death	Total Infant Death Rate (4)
#1	22	13	59.1%	19.6/1000	42.2/1000	0	00.0/1000
#2	39	27	69.2%	25.7/1000	31.5/1000	2	51.3/1000
#3	101	83	82.2%	31.0/1000	41.9/1000	0	00.0/1000
#4	98	61	62.2%	24.0/1000	30.9/1000	2	20.4/1000
#5	127	87	68.5%	27.7/1000	41.7/1000	3	23.6/1000
#6	99	41	41.4%	25.0/1000	38.3/1000	0	00.0/1000
Total Target Community	486	312	64.2%	26.2/1000	37.7/1000	7	14.4/1000
Countywide	18,140	4835	26.7%	15.9/1000	36.3/1000	189	10.4/1000

Sources: Santa Clara County Department of Health, Vital Statistics Department, 1977.
Census '75, Santa Clara County Planning Department, 1975.

1. The Department of Health Distinguishes only one Latino ethnic group. These figures represent live birth among families who selected either the Mexican Descent/Chicano or Spanish Heritage/Latino category listed in Census '75.
2. Birth Rate = (total live births/total population) X 1000
3. The Spanish-surnamed population birth rate is tabulated by using the combined population data labeled Mexican Descent/Chicano and Spanish Heritage/Latino in Census '75.
4. Death Rate = (total infant deaths/total live births) X 1000.

framework, answers were sought to the following research questions:

1. What are the social characteristics of Mexican-American families residing in the target community?
2. Are there any prevailing cultural beliefs or values found among urban Mexican-American families relating to maternal and child health?
3. What patterns of traditional maternal and child health care are found among urban Mexican-American families?
4. What are the implications of adherence to traditional health care patterns for the delivery of health care within the current health care system?

Chapter 2

REVIEW OF THE LITERATURE

Within the past thirty years, much attention has been focused upon the issues and concepts of maternal and child health care in Mexican-American communities. Researchers from many professional areas, including public health, psychology, anthropology, social work, and agricultural science, have contributed original findings to this growing body of knowledge. This review of the literature includes material from both the classical and the more recent studies. For clarity, the first section will explore the concept that health care patterns and values, and specifically those related to maternal and child health care, are integral factors in the overall cultural patterns of a community; the second section will examine the maternal and child health care patterns previously observed among Mexican-American families.

Health and Culture

"A knowledge of the community and its people . . . is just as important for successful public health work as is a knowledge of epidemiology or medicine" (Rosen, 1954:14). To achieve this knowledge, one must begin by discerning and analyzing the basic cultural values of the community. These values are represented in every aspect of the society, from

the formalized political structure to informal personal interactions. Cultural values, or their visible effects, cultural behaviors, are not inherent, but rather learned. From the moment of birth, a child begins his tutelage in cultural behaviors, both through modeling and verbal teachings. Each of these cultural behaviors is specifically interpreted within the community. This intergenerational transmittal of cultural behaviors provides for the continuity of the cultural values respected by the community. These values, then, provide the basic tenets for the systems of family organization, religion, health and illness, political organization, and the daily regimens of a community.

The concepts and practices of health and illness touch areas of vital concern to the individual (Donabedian, 1974:1), and it is therefore understandable that "popular medical beliefs and practices are ordinarily deeply rooted in the basic assumptions of a culture and provide more or less complete explanations of illness and of the appropriate means for dealing with it" (Lynch, 1969:229). Having been originally developed in response to physiological or psychological conditions perceived as significant by a community, and thereafter having been tempered by the cultural values, popular medical beliefs, or patterns, are firmly upheld.

Kellert (1976) has stated that since the concepts of health and illness are relativistic, that is, labeled and defined according to cultural values and norms, each community in essence establishes a "social screen" through which

medical factors are viewed and explained (p. 225). Examples of such factors include the etiology of symptoms, the visibility of symptoms, the judged seriousness of symptoms, the disruptive factor of symptoms, and a tolerance threshold. Is it no wonder, then, that patients from distinct cultures react to similar symptoms in dissimilar manners? Cultural values provide a screen for interpretation of the individual's physical or emotional state.

In addition to defining and explaining the illness, cultural health patterns also include prescriptions regarding the means of dealing with illness. A well-defined role is adopted by the afflicted one; certain "others" are sought out for their knowledge of cures; and the treatment is effected in adherence to the expectations of the community. Each stage of this process, from identification of the illness to its ultimate treatment, is realized in harmony with the cultural values of the community. "Public health is a social and cultural activity. Both its practitioners and the human targets of its services are, in their various interactions and transactions, fulfilling socially-defined roles in culturally determined ways" (Saunders: 1962).

In most communities, the process of giving birth to a child is not considered pathology--rather, it is a category unto itself, that of motherhood (Van Der Eerden, 1948:8). This birthing process and the extended prenatal and postnatal periods are effectuated in accordance with cultural values and behavioral expectations. Cosminsky (1978) indicated that

"birth is not only a universal biological process but also a socioculturally patterned one" (p. 116). The significance of the maternal status and the role to be adopted by the women are specifically defined within traditional cultural patterns (Newman, 1969:113). According to the customary intergenerational transmittal of cultural values and behaviors, the primigravid woman is usually instructed by an older woman of the community (Ibid:115). This knowledge, which forms the system of traditional maternal health care patterns, includes the following: culturally appropriate prenatal and postnatal care, nutrition (diet), usage of medicines and herbs, behavioral restrictions, and anticipated systems of support (Cosminsky, 1978:116).

One of the systems included in the traditional patterns of general health care and maternal health care which has received much attention is that of nutrition. Cultural factors often influence the choice of foods to be consumed and, thereby, determine the nutritional status of the community. Certain foods have been observed to carry tremendous emotional value within a community. Cultural food patterns are based on the belief of certain qualities attributed to the particular items of food, or on the function the food is believed to fulfill. I. de Garine (1975) of the Centre National de la Recherche Scientifique in Paris stated that "it is now generally admitted that the sociocultural aspects of food behavior should be taken into account and that

traditional diets are organized systems (p. 239). The dietary patterns are learned in early childhood and, due to the emotional value of certain food items, are deep-rooted. "Invariably [nutritional patterns] are one of the last aspects of life to change, long after clothing, language, economy, and religion have yielded to the pressures of cultural change" (Wood, 1979:61).

Primigravid women are instructed in the importance of adherence to culturally-defined appropriate dietary habits during the prenatal and postnatal periods. The qualities and values assigned to the food items are evaluated and the appropriate foods are then commended to the women, either for maintenance of good health or for the improvement of pathological symptoms during the prenatal and postnatal periods. One of the most frequently observed nutritional theories, which is based on the concepts of the "hot" and "cold" qualities of food and bodily states, has been carefully described in the literature (Clark, 1959a; Kelly, 1965; Foster, 1978).

The cultural values of a community determine its health care patterns. It then follows that since every human aggregate, or community, has developed and adheres to a predetermined set of cultural values, every community has an adaptive set of health care patterns. Individuals involved in the delivery of services in an intercultural health care setting must become aware of these pre-existing, culturally-accepted health care patterns. Tentori (1962) indicated that

in some instances "[health educators] act as if the persons concerned had no knowledge, and [the health educators] forget then that they have accumulated through the years a series of experiences that represent a world of knowledge". This "world of knowledge" includes explanations of etiology, methods of diagnosis, development of prognoses, and treatment plans. The community is not merely a receptor or an empty vessel into which intercultural health care workers may pour their ideas (Garcia, 1968:450); rather, the community has its organized system of health care and will therefore accept or reject any innovative health care concepts only after viewing them through its "social screen".

Hence, the important task for community health workers or educators is to evaluate, in as unbiased a manner as possible, the traditional health care patterns practiced within the community. It is usually found that some of the traditional patterns are very positive, other are neutral, and still others are negative (Paul, 1955:4; Read, 1966:57; Garcia, 1968:451; Cosminsky, 1978:116). According to Cosminsky (1978), adherence to the positive health care patterns should be encouraged and adopted into future health education efforts; neutral patterns may be disregarded; and steps should be taken to modify negative patterns (p. 116).

The second section of this chapter reviews several classical and more recent studies which have been conducted with the purpose of identifying, describing, and analyzing the system of traditional maternal and child health care

patterns observed in Mexican-American communities.

Review of Earlier Studies

Many field studies have been conducted within the past thirty years in which systems of traditional maternal and child health care patterns, which had been adaptively developed and maintained by Mexican-American communities, have been observed and recorded. One of the earliest of these studies was conducted within a rural Mexican-American community in New Mexico (Van der Eerden, 1948). This study, which was public health oriented, dealt specifically with the maternal health care patterns practiced within the community--the utilization of local midwives, the utilization of a modern health facility located in a nearby town, the prenatal and postnatal behaviors of the parturient, both the economic and geographic accessibility and the amenability of the services offered in the modern facility as expressed by community members, and the possibility of developing a culturally-acceptable trained midwife service for safe deliveries in the community.

In the same year, Foster (1948) completed the first of many culturally-oriented studies. This original anthropological ethnology, which was conducted in the small village of Tzintzuntzan, Michoacan, Mexico, reported, among many other things, the prenatal and postnatal values and behaviors of the village women.

Some years later, a community public health study was carried out in the Sal Si Puedes barrio of San Jose (Clark, 1959a). Through personal interviews, Clark was able to observe and hear about the traditional health care patterns which were still practiced in this predominantly Mexican-American community. The beliefs and practices adhered to during the prenatal and postnatal periods were amply discussed in the study report.

One of the last classical studies, which were generally very comprehensive ethnographies, was conducted in the rural Laguna Zone of Northern Mexico (Kelly, 1965). The concepts of pregnancy, birth, and postnatal care are discussed in detail; traditional values, expected behavior and the occasionally-required treatments of each period related to the birthing process are included.

Although these four studies were compiled in areas which are geographically removed from one another (New Mexico, Michoacan, California, and Coahuila), and although each Mexican-American community observed had perforce developed its own appropriately-adaptive system of health care patterns, many similarities of health behavior which were based on the most basic cultural values were reported by these researchers.

The most frequently repeated concept of health and illness was that of "hot" and "cold" foods (Foster, 1953; Clark, 1959a; Kelly, 1965; Foster, 1978). Foster (1978) stated that this "hot/cold dichotomy constitutes the single most important etiology for folk or popular medicine" (p.3).

This concept was originally based on Greek humoral pathology, which ascribed certain "qualities" to the four recognized humors: blood was considered hot and wet; phlegm was described as cold and wet; black bile (melancholy) was considered cold and dry; yellow bile (choler) was described as hot and dry (Foster, 1953:202). Explorers, traders, and conquerors extended this system of health beliefs throughout the world. "Social screen" filtering through the ages has altered the original humoral theory; today in many Mexican-American communities, this theory is the basis for the popular belief that certain bodily states, foods, and herbs are characterized by heat and cold (Table 3). It is thought that one must carefully balance the foods consumed according to the hot and cold characteristics ascribed to them. As long as this balance is maintained, it is believed that one will remain healthy and may, therefore, continue to choose liberally of what one wishes to eat from the various categories.

If one becomes ill, however, certain restrictions are immediately placed on the food which may be eaten. Many illnesses are considered to be the result of a disequilibrium of temperature. The usual treatment prescribed includes the use of foods or herbs, internally and/or externally, of the opposite characteristic, being mindful, however, that they not be too extreme. The treatment for exposure to extreme cold, due to aire, too much cold water, or too many "cold" foods, for example, would include the consumption of "hot" food and herbs to the exclusion of all others and topical applications made

Table 3

Hold and Cold Foods

Food Type	Very Hot	Hot	Temperate	Cold	Very Cold
Vegetables and Fruits	Chile Pepper Red and Green Garlic	Onion Figs Mangos Majority of herbs		Apricot Avocado Banana Beans, green Beets Cabbage Carrots Cauliflower Coconut Coriander Jicama Lettuce Maize Parsley Peach Peas Pumpkin Radish Squash Turnip Watermelon	Cucumber
Meat and Milk	Crackles Pork	Capon Fish Milk, goat Turkey Hen or Chicken	Goat	Beef Boar Cheese Duck Eggs Lamb Milk, Cow Milk, donkey Mutton Rabbit	Milk, human

Table 3 (Continued)

Food Type	Very Hot	Hot	Temperate	Cold	Very Cold
Starches and Sweets	Beans, white	Atoles Barley Beans, habas Bread, wheat Chick peas Chocolate Distilled liquors Honey Potato, Irish & Sweet Rice Salt Sugar, brown Sweet Rolls Tortillas, wheat Unrefined sugar Wheat	Beans, pinto Tortillas, Corn	Beans, red Fermented liquors Lentils Oatmeal Refined sugar Vermicelli	Ice Cream Sodas

Sources: Clark, Margaret. 1959. Health in the Mexican-American Culture. 166.

Foster, George M. 1967. Tzintzuntzan: Mexican Peasants in a Changing World.

Informant responses of the present study.

of "hot" herbs until the condition improves. Exposure to extreme heat would invoke a treatment in which "cold" items would be used.

Pregnant and postpartum women are traditionally restricted in their food intake in many Mexican-American communities (Foster, 1967; Clark, 1959a; Kelly, 1965; Acosta, 1972). It has been found that prenatal women are encouraged to restrict the intake of "hot" foods and herbs; as the state of pregnancy is considered "hot", consumption of such items would cause an imbalance of body temperature and thereby irritate the woman and her unborn child. Contrarily, postnatal women are advised to restrict the intake of "cold" foods; as the postparturient is considered to be in a "cold" state during the forty-day postpartum period, the consumption of such foods would, again, disrupt the balance of body temperatures. It is believed that the overbalancing of cold can cause the maternal milk supply to dry.

Recently, many studies in this area have dealt more specifically with the sociocultural implications of the adherence to traditional health care patterns among Mexican-American families. Garcia (1967) examined the process of acculturation and its effect upon the maintenance of traditional health care patterns within an urban community. The adherence to traditional patterns observed was explained through an analysis of factors, such as economics, communication, cultural expectations, and migrant status, which had produced barriers to modern health care services.

Cooper and Cento (1977) found that Mexican-American prenatal patients were faced with not only a language barrier, but also with a cultural one when seeking services within the modern health care system. In response to these barriers, the patients tended to withdraw when confronted by medical authority and to misinterpret or ignore pertinent information. Innovative measures which encouraged the establishment of more traditional emotional support systems among the patients within a non-threatening environment were taken with excellent results.

Vargas (1978) examined the cultural values of Mexican-American immigrants to the United States and how these would lead to an acceptance or rejection of health care services within in this country. He concluded that "the patient, when admitted [to a hospital], is isolated from his family, which added to a number of other factors usually leads him to seek care through his own medical system" (p. 16).

The maintenance and function of traditional health care patterns in urban settings were explored by Press (1978). Contrary to the popular belief that traditional patterns are deeply adhered to only in rural areas and disregarded in urban areas, Press found that traditional systems of health care are very adaptive and functional in the city. They are functional for the Mexican-American community in the following manners: to minimize the trauma of acculturation; to provide a psychotherapeutic device for the reduction of stress; to maintain family solidarity; to provide a means for group identity; and to maintain social control (pp. 76-80).

The effect of adherence to traditional socio-cultural patterns upon the rates of utilization of modern health care services by Mexican-American families has been explored by several social researchers (Nall & Speilberg, 1967; Welch et al, 1973; Hoppe & Heller, 1975). Nall and Speilberg (1967) found that while adherence to traditional health care values and patterns did not negatively affect the rate of utilization of modern health care services, strong ties of familism and cultural integration did deter their sample from seeking modern health care services (pp. 306-307). Contrarily, Welch et al (1973) concluded that adherence to the traditional values of familism and social integration did not lower the modern health care utilization rates of their sample; socio-economic factors were, instead, found to be the primary deterrents (p. 211). Hoppe and Heller (1975) specifically examined the effect of familism upon the utilization of modern health care services. They found, as had Nall and Speilberg (Ibid.), that strong ties of familism did, indeed, deter their sample from seeking modern curative assistance; these same familistic ties, however, had encouraged members of the sample to seek early prenatal care (pp. 311-312).

While most of these earlier studies have been conducted by anthropologists or health professionals, the author, as a social worker, was in a unique position to integrate, rather than dichotomize, the socio-cultural patterns and the health care patterns which emerged in this study. It was the author's hope that this integration and the

subsequent analyses would encourage health professionals working among the Mexican-American population to become aware of the sociocultural values which underlie the health care patterns they observe in their daily practice.

Chapter 3

METHODOLOGY OF THE STUDY

The Study Design

The principal goal of this study was to identify and analyze any traditional maternal and child health care patterns which are currently being maintained and practiced by Mexican-American families residing in an urban community. As a means of realizing this goal, the author developed the following methodology for a descriptive study. The use of a descriptive research design assumes that the investigator has a prior awareness and understanding of the problem to be studied; the investigator is thereby allowed, through this research design, to analyze in depth any significant characteristics which may emerge during the course of the study.

The present study was divided into three main components. The objective of the first component was to adequately and appropriately describe the study informants. To accomplish this, a brief questionnaire was developed, which provided a culturally-relevant informant social profile. Key independent variables were selected for inclusion in the questionnaire with the anticipation that the information gathered would provide relevant criteria for subsequent analyses. These variables included the following: age of informant, birth-

place, habitual lifestyle, length of residence in the United States, clinic/non-clinic patient, family income, and level of education (Appendix A).

The objective of the second component of the study was to obtain an accurate and unbiased description of any traditional maternal and child health care patterns currently maintained and practiced by the informants. To realize this objective, the author utilized a more personal interview technique which included participant observation and a period of relaxed, informal discussion. The health care patterns which emerged in this component are analyzed in the appropriate chapter (Chapter 5) for their intrinsic values, and are not judged according to standard, technological values as expressed by the modern medical profession.

The objective of the third component was to discuss the implications of the findings of the study. What affect does adherence to traditional maternal and child health care patterns by a specified population have upon the organized delivery of health care services to them? Is the demand for, and acceptability of modern technological health care services affected by this adherence to traditional patterns of care? Critical analyses and discussion of the relationship between appropriately selected variables gathered in the social profile and the degree of adherence to traditional health care patterns as indicated by the informants are used to accomplish this objective.

The successful completion of each of these three components, or objectives, was required for the realization of the principal goal.

Major Variables and their Operational
Definitions

For the purposes of this study, the major variables are defined as follow:

1. Mexican-American: a person is considered a Mexican-American if one of the following statements applies to her:
 - a. born in Mexico; however, currently residing in the United States.
 - b. parents (2) and/or grandparents (4) and/or great-grandparents (8), etc. (forming 100% Mexican heritage) born in Mexico.
 - c. some, but not necessarily all ancestors share a Mexican heritage and the individual self-identifies herself as a Mexican-American.

For this study, which is examining culturally-determined health care patterns and values, all adults living in a home selected for the research sample must be Mexican-American, as defined above.

2. Traditional health care patterns and values: the concepts and practices maintained within a specific population regarding health, health care, illness, and cures. What is health? how does one maintain health?

what is illness (including culturally-defined illnesses)? and how does one become cured? are questions whose answers would help delineate the health care patterns of a given population.

3. Maternal and child health care: all practices related to maintaining or recovering health, as defined within the given culture, for mothers and their infants from the time of conception to forty days postpartum. For the woman, this would include health care patterns relating to prenatal care, delivery, postnatal care, the lactation period, and possible methods of contraception. For the infant, hygiene, nutrition, and developmental patterns would be directly dependent upon the health care patterns practiced.
4. Habitual lifestyle: the customary aggregate living experience of the informant, defined either as rural or urban.
 - a. rural: informant born and raised, or raised only, in a primarily agrarian community; modern health care facilities and government agencies are usually not immediately accessible.
 - b. urban: informant born and raised, or raised only, in a community with a diversified economy; usually larger in size, urban communities have modern health care facilities, government agencies, secondary schools, and public water works.

The distinction between rural and urban communities cannot be based merely on the size of the population; therefore, each informant was asked to describe and define her birthplace or principal place of residence during her formative years.

The Sample

The sample selected for this study was composed of thirty-one prenatal and postnatal Mexican-American women who live in or receive primary health care in one of the original barrios of San Jose. Included were both women who received services from the available community health care center during their prenatal period, and women who sought little or no prenatal care.

Upon receiving permission to review the files of the community health worker of the health care center, the author determined that a purposive or judgmental sampling procedure would be the most appropriate for this study. First, all Mexican-American prenatal patients of the health care center who were in their 34th to 38th week of pregnancy were selected as informants; it was hypothesized that by that time in the pregnancy, any traditional prenatal health care patterns to which the woman adhered would be operative. Secondly, all Mexican-American patients of the health care center who were in the second to sixth week of the postnatal period were selected as informants; again, it was hypothesized that by that time any traditional maternal and/or child

health care patterns unique to the forty-day postnatal period to which the woman adhered would be operative.

The third group of informants was composed of Mexican-American women who did not use the community health center or any other health care facility until late in the pregnancy (≥ 28 weeks). A satellite method of sampling was used to obtain the names of possible informants in this group. Each informant from the community health center was asked for a referral to a friend or relative who had not sought early prenatal care. Due to the difficulty in obtaining a sufficient number of satellite referrals, the informants of this third group included both unattended prenatal women (≥ 28 weeks) and previously unattended postparturient women whose youngest child was twelve months old or less.

The initial contact between the author and the community health center informants was made by telephone when possible. (79% had telephones in their homes.) Depending on the language in which each informant responded to the telephone call, an introductory statement was made either in English or Spanish in which the author identified herself and briefly described the study. The method of sampling was clarified and consent for participation as an informant was sought. An appointment was made to meet either at the informant's home or at the community health center, according to the wishes and convenience of the informant.

The initial contact between the author and the community health center informants who did not have a telephone

occurred at the informant's home. The author went without an appointment; upon meeting, the introductory statement was made, participation was encouraged, and the informant was asked if that moment or another would be more convenient for the interview.

The initial contact with the satellite referral informants was made by the referring informant. In this manner, the referring informant could privately discuss the interview procedure with her friend or relative and personally encourage the latter to participate. The author was then either informed of the time selected by the satellite informant for the interview, or was given the telephone number of the informant in order to directly establish an interview time.

In total there were thirty-one informants; seven women (22.6%) who were receiving prenatal care at the community health center, seventeen women (54.8%) who were receiving postnatal care at the community health center, and seven women (22.6%) who had not sought early prenatal care. It is important to note here that there was a 100% informant acceptance rate. The author attributes this successful sampling primarily to the fact that she was sponsored by the community health center as she made the initial contacts with the health center patients.

At the beginning of the actual interview, the author explained in more detail the purpose of the study and the importance of the participation of the informant. In strict adherence to the ethical tenets of social work research, the

author informed the participants that a final report would be prepared, but that all responses would remain entirely confidential. To assure this confidentiality, a coding system was devised which permitted the retrieval of pertinent data without revealing the identity of the informant.

Data Collection and Storage

To obtain the information required for the compilation of an informant social profile, a brief questionnaire was devised (Appendix A). This research instrument, composed of forty-two items, was developed in both English and Spanish; back translation was used to assure linguistic equivalence between the two versions. (93.5% of the interviews were completed in Spanish.) Two pre-tests were conducted, after which several appropriate revisions were made in the research instrument. The administration time for the questionnaire was approximately twenty minutes. All the interviews except one were conducted in the informant's home; one informant preferred to be interviewed in the community health center. The author administrated all interviews.

The information requested in the questionnaire was of a generally non-threatening nature. This brief structured period permitted a rapprochement between the author and the informant. The successful completion of the second part of the interview, the discussion of traditional maternal and child health care patterns, depended entirely upon this establishment of a more personal, trusting relationship between

the author and the informant. Participant observation and informal open-ended discussion techniques were used to elicit any traditional health care patterns to which the informant adhered. Depending on the individual informant, the time necessary for completion of this component of the interview ranged from thirty minutes to nearly two hours.

The quantitative data collected for the informant social profile was stored in a coded form for subsequent statistical analysis. The qualitative data, which composed the main body of information of the study, was stored in a cultural filing system based on the one developed by Murdock et al, the last edition of which was published in 1971 (Appendix B).

Data Processing

All quantitative data collected was processed by the Statistical Package for the Social Sciences (Nie et al, 1975). Appropriate analyses were made of the compiled social profile data, the frequency of adherence to specific traditional maternal and child health care patterns, and the rate of utilization of available health care facilities.

To avoid merely cataloging the qualitative information, as has been done many times before, the author has, in addition, attempted to define and analyze the traditional maternal and child health care patterns currently practiced by the informants according to etiological groupings, geographical influences, and acculturation processes.

Limitations

It must be noted here that the findings of this study may not be generalized for the larger Mexican-American population for the following reasons: the sample size of thirty-one was relatively small; the three delineated groups of informants were not equally represented; and finally, the Mexican-American women of the community who had sought prenatal care in a health care facility, public or private, other than the community health center, were not included. Therefore, the results of this study should be viewed as only one indicator of the rate of adherence to traditional maternal and child health care patterns found in an urban community.

Chapter 4

INFORMANT SOCIAL PROFILE

The objective of this chapter is to present a clear description of the research sample. This presentation of demographic data, which represents the women interviewed and their families, will facilitate further analyses of the frequency of adherence to specific traditional health care patterns by the sample and the implications thereof. For clarity, the demographic information to be compiled in this social profile has been divided into the following categories of variables: family and ethnic community integration, socio-economic status, and adherence to traditional maternal and child health care pattern.

Family and Ethnic Community Integration

Thirty-one Mexican-American women were included in this study. Ninety per cent of the informants identified themselves as being Mexican, while the remaining 10% identified themselves as being Chicana. During the structured interview and the informal discussion period, all of the former group indicated that they preferred to converse in Spanish; the latter group preferred English.

The importance placed upon family integration, both nuclear and extended, has been considered to be a basic value

within the Mexican-American culture (Van der Eerden, 1948; Clark, 1959a; Nall & Spielberg, 1962; Press, 1978; Vargas, 1978). The term "family integration" indicates, primarily, the adherence to the system of values maintained by the family, and an operative system of mutual support among the various family members. The degree of family integration of the informants was observed in several of the demographic variables of the study, such as those concerning family structure and the availability of emotional, informational, and economic support from members of the family.

Seventy-eight per cent of the informants indicated that they were either married (68%) or living with their partner (10%). They were, thereby, receiving emotional support from within the nuclear family. The remaining 22% of the informants were either single (16%) or separated from their spouse (6%), and, therefore, emotional support was not available to them from within their nuclear family; many of these women, instead, were residing with members of their extended family, who, then, provided this support.

Whereas the Santa Clara County Department of Health (1977) found that the mean household size in the target community, from which the sample was drawn, was 2.55 persons (Table 1), it was found in this study that the average number of children per family within the sample population was 2.55. Therefore, as 78% of the women interviewed indicated that they were living with their spouse or partner, the mean household size of the sample was determined to be 4.33 persons.

As would be expected in most studies dealing with the period surrounding childbirth, the women interviewed were relatively young. The median age of the informants was twenty-three years. The range extended from sixteen years to thirty-eight years; only four (12%) of the informants, however, were in what are medically considered less than optimum maternal age brackets (≤ 18 years or ≥ 35 years). Similarly, the families represented in the study were quite young. In nearly half of them (48%), the eldest child was five years old or younger. The range of ages of the eldest child of each family extended from less than one year to fifteen years.

Evidence of the importance of the extended family was observed in this study. Whereas 45% of the households represented were nuclear, that is composed solely of the informant, her spouse (or partner), and their children, or of the informant as a single female head of the household and her children, 52% of the households represented were shared with at least one member of the informant's or her spouse's (or partner's) extended family. (In one case, which accounted for 3%, the informant and her spouse shared their home with non-related friends.) The number of extended family members residing with an informant and her family ranged from one to eleven, with a median of three.

Seven (23%) of the informants reported that their mother resided with them; the informant's father was present in five (16%) homes. There were no reports of the informant's mother-in-law or father-in-law residing in the home. The

following figures refer to the total number of a specified relatives from both the informant's and/or her spouse's (or partner's) extended family. Ten (32%) of the informants reported sharing their home with at least one sister; nine (29%) shared their home with at least one brother. Nieces and/or nephews resided with four (13%) of the informants; three (10%) of the informants reported having more distant in-laws residing in the home; one (3%) informant shared her home with an aunt and another shared her home with a cousin.

Several questions were included in the interview schedule which, it was hoped, would indicate the utilization by the informants of members of their extended families for emotional, informational, and economic support. It was found that eighteen (55%) of the informants had sought medical advice from someone other than a modern health professional during the prenatal and/or postnatal periods. Of this number, 89% had called upon a member of their extended family for this advice; the informant's mother was the most frequently cited. Of the nine primigravid women, 67% had sought this medical advice. The advice sought, according to the informants, usually included the clarification or confirmation of traditional concepts concerning appropriate prenatal or postnatal foods and/or behaviors. As cultural values, which are the bases for cultural behavioral patterns including health care patterns, are usually emotionally reinforced by members of a group, the author has concluded that by seeking information regarding

traditional health care patterns from a member of the extended family, the informants were, in reality, requesting their emotional support.

In analyses limited to those informants who had attended the community health center (N = 24), it was found that friends were called upon more frequently than members of the extended family for informational support. Fifty per cent of the informants were referred by a friend to the community health center for prenatal care, while 38% were referred by a member of the extended family. A non-personal or agency referral was mentioned by only one informant (4%), while two informants (8%) had sought care through self-referrals.

One example of economic support provided by the extended family was observed in the agreements which had been made regarding shelter payments. Eight (26%) of the informants reported that they shared the rent payments with the members of the extended families living in the home; four (13%) informants indicated that their families were living in a relative's home and were not contributing to the shelter costs at that time. These figures indicate, then, that since 52% of the informants were sharing their home with at least one member of their extended family, 13% of the informants were, in turn, providing economic support to members of their extended families.

The extended family residence patterns and the operative systems of mutual support among members of the extended

families seemed to indicate a moderate level of familism within the sample population.

The term "ethnic community integration" indicates an acceptance of and adherence to culturally-defined values, and a continual interaction with other members of the ethnic community. Analysis of several of the demographic variables of this study indicated the degree of ethnic community integration of the informants.

Twenty-seven (87%) of the informants were born in Mexico; twenty-nine (94%) of them were raised in Mexico. Of the remaining two informants, one was born and raised in a border town in Texas and the other was born and raised in California. All of the sample population were of 100% Mexican descent, and therefore shared a common Mexican cultural heritage. Figure 1 indicates the birthplace of each informant according to the Statistical and Geographical Regions of Mexico. These regions are composed of the following states:

- Northern Region: Tamulipas, Nuevo Leon, Coahuila, Durango, Zacatecas, San Luis Potosí
- Northwestern Region: Baja California, Sonora, Sinaloa, Chihuahua, Baja California Sur, Nayarit
- Central Region: Federal District of Mexico, Mexico, Puebla, Tlaxcala, Morelos, Michoacan, Hidalgo, Querétaro, Guanajuato, Jalisco, Aguascalientes
- Southern Region: Colima, Guerrero, Oaxaca, Chiapas
- Gulf Region: Veracruz, Tabasco, Campeche, Yucatan, Quintana Roo

As can be observed, familiar patterns of migration have been followed by the informants and their families.

Figure 1

Informant Birthplace by Statistical
and Geographical Regions
of Mexico



Contrary to general opinion, the greater number of these Mexican-American informants (55%) originally came from an urban setting. There are at least two possible explanations for this, which are a) Mexico is no longer a predominantly rural, agrarian society, and b) as San Jose is an urban setting, it has attracted Mexican-Americans who are accustomed to the urban way of life. Further research is needed to clarify these hypotheses.

Although two (7%) of the women interviewed indicated they had no church affiliation, and another two (7%) indicated they were Seventh Day Adventists, the overwhelming majority (93%) reported belonging to the Catholic Church. As most of these informants and their families presumably attended one of the Catholic Churches in which Mass was said in Spanish, the occasions for interacting with other members of the ethnic community were numerous.

It was found that the informants of the study represented both the recent and the well-established County resident. Forty-two per cent of the women interviewed had lived in Santa Clara County for 1½ years or less; on the other hand, 35% had lived in the County for more than 4½ years. The median length of residence was three years. Similarly, based on analysis of the responses of the informants who were raised in Mexico, it was found that 38% of the women had resided in the United States for one year or less. The range of the length of residence in the United States extended from less than one year to fourteen years, with a median of, again, only three

years. In most instances, the informants came directly to San Jose from their homes in Mexico. The relatively short median length of residence in the United States and the adherence to the traditional religious values, seemed to suggest that Mexican cultural values and behaviors were still predominant within the sample population, and, hence, the degree of ethnic community integration was high.

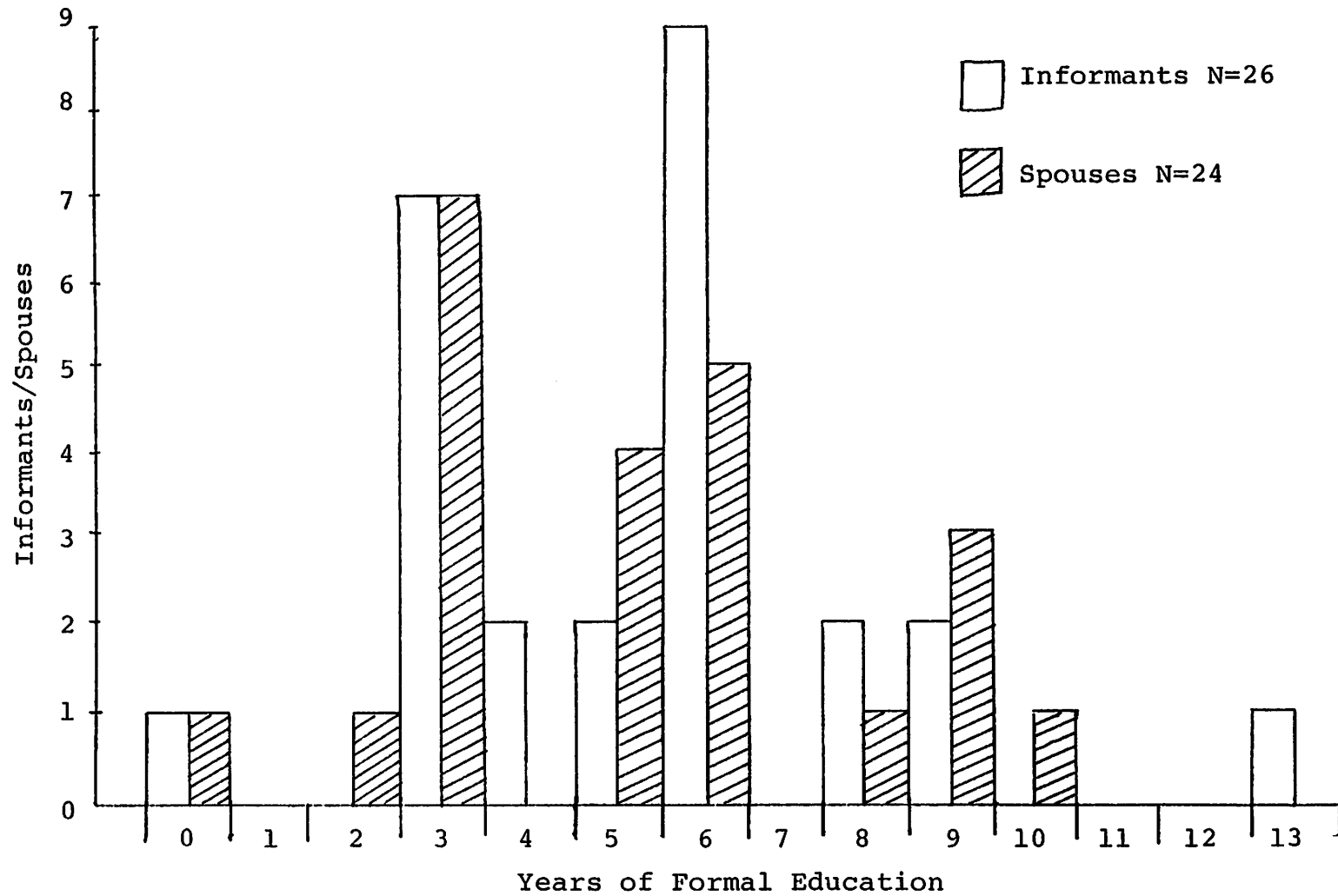
Socio-economic Status

Census '75 (Santa Clara County Planning Department, 1975) placed the target community of this study low on a countywide socio-economic rating scale. This section presents an analysis of the socio-economic variables included in the present study.

The median number of years of formal education completed by the informants was six years. For those informants who attended school only in Mexico (81%), the range extended from zero years to thirteen years of formal education. Similarly, it was reported that the median number of years of formal education completed by the informants' spouse (or partner) was six years. For those men who attended school only in Mexico (90%), the range extended from zero years to ten years. Figure 2 graphically presents the distribution of years of formal education completed in Mexico by the informants and their spouses (or partners). The distribution is bi-modal, peaking at three years and at six years of schooling completed. According to the informants, in many rural areas

Figure 2

Years of Formal Education Completed in Mexico
by Informants and Spouses (or Partners)



of Mexico, facilities were provided for only three years of formal education for the children; therefore, many terminated their studies at that point. Similarly, in other areas, facilities were provided for six years of formal education. If a child from a rural area wished to continue his/her education, he/she would then have to leave the family and move to a larger town.¹

The range of family income reported by the informants extended from less than \$300 per month (23%) to more than \$900 per month (6%), with a median of \$451 to \$600 per month. The median annual income of the families represented in this study, therefore, was between \$5412 and \$7200. Based on these figures and the mean household size determined in this study, the average per capita income within the sample population was between \$1250 and \$1663, as compared with the County per capita income of between \$4795 and \$5479 (Santa Clara County Planning Department, 1975).

Twenty-seven (87%) of the informants were not employed outside of the home. Of those women who were employed, three worked on factory assembly lines and one was employed in a restaurant.

¹As the author realized that the system of education of Mexico and the United States are distinct, those informants (five) and their spouses or partners (three) who attended school only in the United States, or who attended school in both Mexico and the United States, were not included in Figure 2. They were included in the determination of the median number of years of formal education; however, the resultant figure of six years was not affected by their inclusion.

In analysis limited to those families in which the spouse (or partner) was present (N = 24), the following data was found regarding male employment status, based on Hollingshead's Two Factor Index of Social Position, Part I--the occupational scale (Miller, 1977:230): 17% were unemployed at the time of the interview, primarily due to seasonal lay-offs; 33% were employed in unskilled positions; 33% were semi-skilled; 13% were skilled craftsmen; and 4% were major professionals.

None of the women who were either single or separated from their spouse or partner (22%) received monetary support from him.

Although the median family income reported by the informants was exceedingly low, few families received governmental assistance or work-related benefits. Only 6% of the informants received an Aid to Families With Dependent Children (AFDC) grant; only 13% received food stamps. While 19% of the women received Medicaid (MediCal), and an additional 10% received partial spouse work-related medical coverage, 71% of the informants had absolutely no medical insurance to assist them in the payment of the high costs related to childbirth.

The only Federally-funded program to which the majority of women interviewed had applied was the Supplemental Food Program for Women, Infants, and Children (WIC), sponsored by the community health center. Of the informants who had attended the health center during the prenatal period, 87% had received the supplemental food vouchers.

Seventeen (58%) of the informants and their families lived in an apartment; the remaining 42% lived either in a duplex or in a private dwelling. While only one family (3%) was buying its home, eighteen (58%) were renting, eight (26%) were sharing the rent with members of their extended family, and four (13%) were living with relatives and not contributing towards the shelter costs at the time of the interview.

According to the revised 1977 San Jose Municipal Code, Section 5503.3(b),² there must be seventy square feet of sleeping room for the first two occupants of a home; for each additional occupant, there must be another fifty square feet. All rooms may be used as sleeping rooms except the kitchen, bathroom, hall, laundry, or those rooms with any one dimension less than seven feet. If the sleeping space per occupant of a home is less than these recommended figures, the family is considered to be crowded. As the approximate size of an apartment bedroom or living room was usually about 110 square feet, it was found in this study that nearly one-third (29%) of the families represented were living in crowded conditions.

The final measurement of socio-economic status of this study was determined by the customary mode of transportation utilized by the informant and her family. Almost one-third (32%) of the women indicated that they had no private

²Telephone conversation with Ms. Peggy Rollis, Health Inspector for the San José Housing Code Enforcement.

means of transportation. In order to attend the health center and to accomplish the daily errands, 22% reported using the transit system; a smaller number (10%) relied upon members of their extended family for needed transportation.

Adherence to Traditional Health Care Patterns

Before examining the specific traditional maternal and child health care patterns described and adhered to by the informants, a general discussion of the frequency of adherence to traditional health care patterns and an initial analysis of factors which seem likely to have influenced this adherence are presented in this section.

It was found that every one of the Mexican-American women interviewed was familiar with and was able to elaborate upon at least three traditional maternal and child health care patterns. Traditional health care patterns, as conceptualized in this study, included any culturally adaptive health care practice which was not explicitly derived from the scientific concepts of modern medicine. Traditional maternal and child health care patterns, then, referred to any of these adaptive health care practices which were adhered to during the prenatal and/or forty-day postnatal periods.

Upon completion of the informal portion of the interview in which the author and the informant discussed these traditional patterns, the author rated the informant's overall degree of adherence to the traditional patterns. This rating

was determined through analysis of the informant's adherence or non-adherence to thirteen of the most predominant maternal and child health care patterns. These patterns are individually identified and analyzed in Chapter 6. The criteria for the overall adherence rating was as follows: those informants who indicated that they practiced zero to one of the traditional health care patterns discussed were given a rating of no adherence; those who reported practicing from two to eleven of the traditional patterns discussed, and who had rejected at least one pattern, were given a rating of moderate adherence; those who indicated that they practiced all of the traditional health care patterns discussed were given a rating of high adherence. It was so determined that three informants (10%) did not adhere to any of the traditional patterns and three others (10%) had maintained a high level of adherence. Between these two extremes, a wide spectrum of adherence levels was found.

Analyses were conducted in an attempt to determine if any of the demographic factors considered above (pp. 34-48) might have significantly influenced the informant's overall adherence to traditional values and behaviors, represented in this case by traditional maternal and child health care patterns. Although the extremely limited number of informants who demonstrated either a high or low degree of overall adherence to the traditional health care patterns precluded the search for statistical significance or reliable findings in these analyses, several interesting trends were revealed. Age of the informant, which has often been considered an

important factor in studies dealing with the maintenance of tradition (Clark, 1959a:153), was not found to have significantly influenced the women's degree of adherence. Other demographic variables too, which had been used to measure the degree of family integration, such as marital status, number of children, and the presence of the informant's mother in the home, showed equal and, therefore, non-significant distributions among the women in the three levels of adherence established.

Among the variables which had been used to measure the informants' degree of ethnic community integration, several findings, although not statistically significant, were of interest. Firstly, while there was variance in the responses of religious preference among the informants who either rejected or only moderately adhered to the traditional health care patterns, all of the informants who adhered strongly to the traditional patterns were affiliated with the Catholic Church. Secondly, the three informants who had identified themselves as being Chicana were rated as moderately adherent to the traditional health care patterns; the three who stated complete rejection of the use of these patterns were born and raised in Mexico. Thirdly, contrary to earlier findings (Clark, 1959a:153), the length of informant residence in the United States was not observed to have been an important factor in the degree of adherence to traditional patterns. As anticipated, it was found that the informants who indicated a high level of adherence had resided in the United States

for one year or less; however, identical findings were observed for the informants who indicated no adherence whatsoever.

The analysis of the relation between the level of informant education, one of the socio-economic variables, and the degree of informant adherence to traditional health care patterns revealed an interesting trend. The mean number of years of formal education completed in Mexico by each of the three groups of informants were as follows: 3.6 years for the women who indicated strong traditional adherence; 5.0 years for the women who indicated moderate adherence; 9.3 years for the women who indicated no adherence to traditional health care patterns.³ Given the frequent inaccessibility of facilities for formal education beyond three years and six years in many of the rural towns and villages of Mexico, the author hypothesized that the relationship between the years of formal education completed and the adherence to traditional health care patterns might, in reality, be symptomatic of the influences of rural or urban life-styles upon the rates of adherence. Subsequent analyses of these variables, however, were not conclusive; in each of the extreme levels of adherence, high and low, two of the informants were originally from rural areas and one from an urban area.

³As each of the three Chicanas included in the study indicated moderate adherence to traditional health care patterns, analysis of the median years of formal education completed in the United States for each of the adherence levels was unnecessary.

Chapter 5

TRADITIONAL MATERNAL AND CHILD HEALTH CARE PATTERNS

Introduction

Although many earlier studies (Van Der Eerden, 1948; Clark, 1959a; Foster, 1967) have amply catalogued the more predominant traditional maternal and child health care patterns observed and described by residents of various Mexican-American communities, the author has included in this chapter a brief discussion regarding the traditional maternal and child health care patterns of the prenatal period, the birthing process, and the postnatal period to which the informants of this study indicated adherence. It should be noted that, although the informants were oftentimes very familiar with many traditional health care patterns, only those to which they actually adhered have been presented. Usually, it was learned, the women knew of the traditional patterns predominant in their natal region, however, they became actively adherent to specific patterns only after one of the following situations had occurred: a) the woman personally experienced the specific symptoms or treatment of the health care pattern; b) a member of the woman's family or a close friend experienced the specific symptoms or treatment; or c) a trusted friend or family member shared personal knowledge of the specific health care pattern.

This chapter was designed to accomplish three objectives: 1) to describe, in the most accurate and unbiased manner possible, the traditional maternal and child health care patterns currently being practiced by the Mexican-American families interviewed in this study; 2) to analyze the adherence to specific traditional maternal and child health care patterns in relation to key demographic factors; and 3) to serve as the rationale for a discussion in which the implications of these findings upon the delivery of modern health care services to Mexican-American families will be discussed (chapter 6).

The Prenatal Period

Conception. Conception and the resultant state of pregnancy were viewed by the informants as natural events in their lives which ordinarily required little intervention. Therefore, very few of them were aware of any traditional methods used to facilitate conception or to terminate an unwanted pregnancy. Three women were able to describe treatments for barrenness. One informant recommended that a woman who wished to conceive should drink gobernadora tea on an empty stomach for nine days. (For a complete list of medicinal herbs mentioned in the study, see Appendix C.) Another informant suggested that the tail of a mountain cat be boiled in water, which was then used to make a chocolate drink; this was heated and given to the woman on an empty stomach, for, again, nine days. The third method suggested for facilitating

conception was as follows: goat's fat was toasted on a comal, a traditional flat cooking instrument similar to a griddle, and applied, while still warm, to the woman's back and abdomen. The informant who described this treatment had not been able to conceive for thirteen years; she attributed her recent pregnancy to the effectiveness of this method. This third method seemed to be based on the concept described by Kelly (1967:7) which stated that a cold womb prevents a woman from conceiving a child; hot applications, such as the one described, were thought to heat the womb and thereby facilitate conception.

Traditional methods used for inducing abortions were not well known by most of the informants. While many of them indicated that they believed the use of some strong bitter herbs could cause an abortion, few were able to specify the herbs. However, it was indicated by a few of the informants that teas made of the following herbs, when taken in large quantities and on an empty stomach, were effective in producing an abortion in the early weeks of pregnancy: rue, chamomile, or cassia followed by prodigiosa.

It was found in this study that during the prenatal period the informants modified very few of their behaviors for reasons of their own health. Modifications of their daily patterns were made, instead, solely for the well-being of their unborn child. The basic rationale of most of the traditional maternal health care patterns of the prenatal period mentioned was the prevention of both temporary and permanent birth defects, which ranged in seriousness from red, irritated skin to a cleft palate.

Eclipses. Lunar and solar eclipses were thought by many of the informants to be very powerful and, therefore, potentially harmful to an unborn child. They explained that if the shadow of the eclipsed moon or sun fell on an unprotected woman, the baby she was carrying would be born "eclipsed", that is, born with some physical defect. The most common defects mentioned were the following: hare lip and cleft palate, undeveloped outer ear, extra, missing, or twisted toes or fingers, and red, black, or blue birthmarks. According to the informants, however, a woman could easily protect her unborn child by wearing red underclothing, or by affixing a safety pin or metal key to her clothing over the abdomen.

A few of the women distinguished between the effects of a lunar eclipse and a solar eclipse. They indicated that a lunar eclipse took something away from the baby or left some part of his body undeveloped, while the solar eclipse added something extra. These informants indicated, however, that the same methods of protection mentioned above were effective against the powers of both types of eclipses.

During the period of interviewing for this study, there was a publicized solar eclipse. The author visited three pregnant women that day; two of them indicated that they had safety pins fastened to their clothing, while the third had a key over abdomen, held in place by a safety pin.

A possible indication of adaptation of this traditional maternal health care pattern to modern thoughts on fetal development was observed by the author. Two informants

indicated that the effects of an eclipse were most harmful to an unborn baby during the first two or three months of pregnancy. According to them, even if a woman witnessed an eclipse during the later months of her pregnancy without taking the normal precautions, the baby would probably not be harmed.

Several informants indicated that they also believed the full moon, if observed by a pregnant woman, could harm the unborn child. It was thought that if the woman had not protected her baby by wearing a red string around her abdomen, the baby would be born with dark birthmarks. As the color red had been mentioned twice, the author asked several women if they knew why a red string or red underclothing was thought to protect the unborn child; there was, however, no definitive response.

Prenatal Dietary Restrictions. Most of the informants indicated that they had not changed their diet during the prenatal period. Those who restricted the intake of certain foods, however, did so, again, for the well-being of their baby. The most frequently limited food item was hot chile. It was thought that if the woman ate this, her baby would be born with red, irritated skin, especially on the buttocks (chincuales). One informant also mentioned that if the woman ate hot chiles, her baby would always have a delicate stomach and be more likely to develop food allergies. The consumption of other irritating foods, such as coconut, peanuts, and beans, was also considered by some to result

in the baby being born with red, irritated skin. This dietary restriction seems to conform to the concept of the hot and cold dichotomy; the pregnant woman is considered to be in a hot state and, therefore, she should avoid eating hot or irritating foods which would upset her bodily balance or that of her baby (Cosminsky, 1978:120).

Fish was the second most frequently restricted food item, according to the informants. It was thought that if the expectant mother ate fish, her baby would be born with scaly or blotchy skin, particularly on the ears, forehead, and neck. Other food items were limited by some women of the sample for the following reasons: sodas were believed to be too cold and to cause the baby to be born with gas in his stomach; lemons were thought to cause the baby to be born with weakened vision (aigrioso de la vista); the consumption of sweet bread was thought by one informant to cause the baby to be born with a whitish film over his body.

Cravings. In many cultures, the intense craving of certain food items by an expectant mother is an accepted behavior. In traditional Mexican maternal health care patterns, the satisfying of these craving has become very important. Over half of the women interviewed indicated that they adhered to the concept that states that if a pregnant woman sees someone eating an item of food, which she thereafter craves, she must ask that person to share some with her; if that is not possible, she should try to obtain the same item elsewhere.

If she does not do this, it is believed that one of the following will happen: 1) the woman will almost immediately develop symptoms of abortion, which can be halted only by seeking out the person who originally was eating the craved food item and beseeching him/her to send some of it to the woman; or 2) the baby will be born with a birthmark in the form of the food item which had been craved and left unsatisfied; or 3) the baby will be "born with its mouth open," this is, as he grows up, the child will tend to extend his tongue slightly out of his mouth; this is interpreted as meaning that the child has not been able to satisfy his craving. It was believed that the cravings felt by an expectant woman were really cravings of the unborn child. Some babies were thought to be more delicate than others, thereby craving particular foods more frequently than other babies.

Four of the informants indicated that they had nearly aborted as a result of not having satisfied a craving. The following experience was related to the author by one of the informants:

When I was eight months pregnant, I went outside to go to the outhouse. While walking across the yard, I saw a neighbor giving her husband some nice watermelon. Right away I turned back as I didn't want them to see how much I wanted some of it. Walking back, I felt that my waters (fuelle) burst. I told my mother-in-law, who lived with us. As soon as my husband came home, she sent him to get some watermelon. The one he brought back was just as nice as the one I had seen, but it didn't stop the waters. The next day, my mother-in-law went to the neighbor and told her just what had happened.

The neighbor brought me some watermelon right away. It wasn't as nice as the one she had had the day before, but she herself gave it to me and the waters stopped right away. My baby was born a month later.

While most of the women interviewed indicated that they had craved certain foods, usually fruits, a few of them spoke of having craved non-food items, particularly dirt. The consumption of soil or clay is referred to as pica or geophagy. Only certain types of soil were eaten. Among the most frequently mentioned were the following: soft pebbles found in the river which can be mashed down with the fingers, dirt balls (tierra negra) found among the beans purchased in the marketplace, dirt of the countryside freshly moistened by rain, the inside of new small earthen jugs (tierra olorosa) which are broken for this purpose, small pieces of adobe from the houses, moist sand from the beach, and the white soil (tierra blanca) of which the religious pictures of San Juan de los Lagos, Jalisco, Mexico, are made. If a woman was not able to obtain one of these kinds of soil when she craved it, the informants indicated that they had known women who had satisfied their craving by eating cigarette ashes, or by eating small small pieces of the cubes of magnesium as sold in the pharmacies, which, when eaten without water, tasted somewhat like dirt. None of the informants, however, had tried these last two items. When asked why they thought they had craved dirt, the women were not certain; one thought it indicated her blood had been weak, another thought she had

lacked calcium, and a third thought it indicated that her baby had needed more iron.

Exercise. The women interviewed indicated that, except for the heavier tasks, they continued their normal daily chores during the prenatal period. Two informants reported having discontinued sexual relations after the seventh month of pregnancy for fear of harming the baby.

Prediction of the Baby's Sex. Although the informants were unable to define with certainty any traditional methods for predicting the sex of their baby, the possibility of knowing beforehand was an interesting thought for most of the women. The most frequently mentioned method was the following: if the expectant mother filled out evenly around the abdomen and hips, it was thought that she would have a baby girl; if, on the other hand, only the abdomen showed distinctive development and tended to be rather pointy, it was thought that she would have a baby boy.

Parteras. Several of the informants had been assisted at previous births in Mexico by a midwife. Although there are trained midwives (nurse practitioners) and special government medical training programs for local midwives in Mexico, the midwives (parteras) these informants spoke of were local women who had been trained in their profession by other midwives, often older members of the trainee's own extended family. The mother of one of the informants was a practicing midwife. She herself was a grand multipara; having had twenty children,

she said she had had much experience with good and bad midwives. Two of her aunts and her grandmother had been midwives. As the informant's mother became more interested in carrying on the tradition, her aunts began to instruct her in the techniques they used, to which the woman incorporated her own experiences with various midwives. The first birth she attended alone was an emergency situation. The birth was successful and soon her clientele grew.

The women who had been attended by a midwife indicated that if at any time during the pregnancy they had felt uncomfortable, they had visited the midwife's home. There the midwife massaged the woman's abdomen with oil and gently repositioned (acomodar) the baby. The most frequently reported distress was side pain (dolor de ijar) caused by the baby being carried more to one side than the other; according to the informants, this was easily remedied through massages.

In about the sixth month of pregnancy, it was advisable for the woman to again visit the midwife, who then determined if the baby was correctly positioned for the birth. If it was not, the midwife gently massaged the woman over the next months, turning the baby little by little, until it was presenting correctly. In the last month of pregnancy, the midwife approximated the date the baby would be born according to the period of the moon--at full moon, in the new moon, when the moon was waxing, or waning. All of these informants reported that the calculations made by the midwife had been correct.

The Birth

The informants who indicated that they had been assisted by a midwife in a home birth reported that the attending manner of the midwife was very personal. Through shared cultural values, the role of the midwife and that of the parturient were well-known. The expectant woman was to have certain items in her home in readiness for the birth. These included the following: alcohol, principally used for disinfecting purposes; cotton; a cord made from several sewing threads crocheted or twisted together for tying off the umbilical cord; mercurochrome or merthiolate for sterilization of the infant's navel; umbilical bands; olive oil, used for facilitating a dry birth through application along the birth canal, for cleaning the baby's orifices, as a purgative for the baby, which was given one time only to facilitate the expulsion of the meconium, and for massaging on the woman's abdomen after the birth to prevent her from getting chilled; and clothing for the mother and her new baby. The midwife, in addition to attending the birth, was expected to provide a continuity of care and support to the new mother especially during the days immediately following the birth, but also during the entire postnatal period.

The informants indicated that besides the midwife and the expectant mother, another woman was usually present in the room during the birth. The function of this third woman was to apply pressure to the uppermost part of the

parturient's uterus during the contractions, either by pushing with the heel of her hand, or by twisting and thereby tightening the knot of a long cloth which had previously been tied around the woman. It was thought that this pressure helped the baby push downwards, while, at the same time, it prevented the blood from surging upwards and asphyxiating the woman.

Both the informants who had previously delivered at home and those who had delivered only in hospitals or clinics indicated that when labor began, they often drank an herbal tea of either chamomile, cinnamon bark or cumin to facilitate and hasten the birthing process. It was thought that, if indeed true labor had begun, the tea would make the contractions stronger and more frequent; if, however, it was a false labor, the tea would make the contractions cease. One informant indicated that when her labor began, she ate little pieces of lard, which, she said, helped the baby slide out more easily.

Traditional beliefs have developed around the occurrence of unusual births. For example, informants indicated that if a baby was heard to cry before it was born, that child would be able to look into the future and would have great knowledge or, as another woman indicated, he would be lucky and rich. The mother, it was thought, must not reveal this secret knowledge to anyone until the child was seven years old, or he would lose his special talents. While almost all of the women had heard of this concept, only four actually adhered to it; the others had not personally known of anyone to

whom this had occurred and, therefore, were doubtful of the veracity of the concept.

Another example of a traditional concept associated with an unusual birth was related by one informant. She believed that if a child was born feet first, he would always land on his feet and, and as an adult, be able to make the best of any situation.

The Postnatal Period

Whereas the Mexican-American women interviewed in this study reported having modified certain behaviors during the prenatal period for the well-being of their unborn child, during the postnatal period, it was deemed essential that the women take especially good care of themselves. The forty-day postnatal period (cuarentena) was considered a very sensitive and delicate time for the women. Many patterns of the women's daily lives were modified during the cuarentena. It was frequently indicated to the author that the aches and pains many women were said to experience as they got older were the result of not having properly cared for themselves during the postnatal period; perhaps it was this belief which had encouraged the greater part of the informants to adhere to many of the traditional maternal health care patterns of the postnatal period. In this section, the traditional patterns to which the women interviewed actually adhered are discussed.

Clothing. Approximately one-half of the study sample indicated that special clothing should be worn during this period. The two reasons most frequently mentioned were, first, to support the weakened abdomen and lower back as the internal reproductive organs and the pelvic and hip bones resumed their normal positions, and second, to protect the woman's body, especially the head, legs, and breasts, from the "coldness" of the air.

Many of the informants indicated that they wore a girdle, or abdominal binding (faja), during the postnatal period. It was thought that the use of this garment prevented the uterus from falling as it resumed its proper size and position. Secondly, the informants indicated that, during the birthing process, the hip and pelvic bones "opened" to allow the baby to be born; the use of this garment held the bones in the correct position for their proper realignment. If a woman did not use the faja or worked too arduously in a bending position, it was reported that the bones would not heal correctly, and the woman would have much pain in the lower back and waist areas. Traditionally this faja was made of poplin cloth, just wide enough to cover the entire abdomen. The binding was wrapped around the body and fastened. If the woman was able to rest for the first part of the postnatal period, the binding was fastened loosely; if, on the other hand, she had to resume her tasks soon after the birth, the binding was fastened more tightly.

Protection from Air or Cold. Women were considered to be in a "cold" state during the postnatal period. Therefore, about one-third of the informants indicated that it was necessary to be well-covered to prevent the "coldness" of the air from harming them. The pores of the body were said to be dilated during this period; the air could, therefore, easily enter the body and cause it to swell (ventearse). One informant mentioned that if a woman did not protect herself from the air during these forty days, she could suffer from arthritis later. Most frequently the informants reported wearing a scarf or other head covering which also protected the ears if they had to go outside. This was done to prevent severe headaches (punzadas) and earaches which they attributed to the "cold" air. One informant indicated that these earaches could lead to deafness.

Some women indicated that they wore heavy stockings to prevent the air from entering the feet and legs; this "cold" air was thought to cause leg pains and varicose veins. Other informants indicated that they always wore a sweater, even in their homes, during the postnatal period to protect their back from getting cold; it was thought that this "coldness" would cause the maternal milk to dry.

Bathing. The informants mentioned that traditionally it was thought that a woman should not bathe frequently during the postnatal period, and when they did bathe, it was with great care to avoid becoming chilled by the air. Only two

informants interviewed, however, indicated that they still preferred to wait nine to fifteen days after the birth for their first bath.

Exercise. Almost unanimously the informants commented that during these forty days, women should not exercise too strenuously. It was indicated that lifting or moving heavy objects, descending stairs, mopping or sweeping, or squatting down carelessly could cause hemorrhaging, dislocation of the pelvic and hip bones, or incorrect repositioning of the internal organs, especially the uterus. Regarding this last possibility, it was mentioned by several informants that the uterus could "fall" out of its correct position. When this happened, the woman experienced great pain and discomfort while walking, and further, she could not conceive another child until the uterus had been repositioned, traditionally accomplished by a midwife. As this affliction was considered to be "cold", the treatment included massaging the woman's abdomen with hot olive oil and "hot" herbs, after which the woman was again bound.

Postnatal Dietary Restrictions. Restriction of the intake of certain food items was frequently mentioned by the informants. There seemed to be two major reasons for the restrictions; first, as mentioned earlier, a woman was considered to be in a "cold" state during the postnatal period and, therefore, "cold" foods, and, likewise, extremely "hot" foods were restricted in order to maintain the balances of

body temperatures; secondly, if the woman was breastfeeding, certain foods were considered to be harmful to the baby. Two-thirds of the women with whom the subject of postnatal food restrictions was discussed did, indeed, limit the consumption of some foods.

The "cold" or "fresh" foods which were most frequently limited by the informants included the following: watermelon, banana, peach, apricot, cucumber, jícama, lettuce, avocado, and acidy fruits, such as lemons and oranges. It was thought that the consumption of these foods could cause stomach cramping and halt the postnatal menstrual flow. Eggs were also restricted by some women as they believed the white of the egg, which is "cold", caused the postnatal flow to smell badly. The consumption of very "hot" or "irritating" foods was also limited. Pork was considered to be the most irritating food. The informants indicated that pork should not be eaten during this delicate postnatal period as it could cause a woman to get varicose veins, an enlarged abdomen, or skin irritations or markings. Other irritating foods, such as freshly-cooked beans, were also restricted.

Women who were breastfeeding their baby indicated that several more foods were not eaten, as they were thought to harm the baby. These included the following: very "hot" and greasy foods were thought to inflame the baby's stomach; shrimp, squash, and cabbage caused the baby to have gases; ice cream was thought to make the baby cough and catch a cold;

oranges, which allowed "air" to get into the milk, resulted in watery stools; chiles, besides inflaming the baby's stomach, caused constipation.

Most of the informants (71%) preferred to breastfeed their baby. Frequently these informants reported having prepared a special corn meal gruel (atoles de masa) during the first few days after the birth, which they ate or drank, depending on the consistency, as often as they wished to stimulate and augment the supply of maternal milk. Although usually made solely of corn meal and water, some informants added sugar, milk, cinnamon, and chocolate for more flavor (atoles de champurrada).

Sexual Restrictions. The most important thing a woman should do to take care of herself during the postnatal period, according to almost all the informants, was to refrain from having sexual relations until the forty days were complete. It was generally thought that the woman's body was not completely healed before that time. Most of the women were not sure what might happen if they did not wait the forty days, however some ventured that they would get an infection.

All but one of the informants who were originally from the states of Michoacan, Nayarit, Sinaloa, and Jalisco, however, identified specific symptoms of and treatment for an illness that was known in their regions to strike any woman who did not refrain from sexual relations during the forty-day postnatal period. Most of these informants mentioned a

particular person known to them, often a member of their extended family, who had been afflicted with this illness; it was thought that some of them had died from it. Referred to as empacho de hombre, the symptoms were described as follow: nausea, loss of appetite, a "full" feeling in the stomach, stomach pains, diarrhea, loss of energy; after a time, the woman became extremely thin and dried-out looking, and her hair, eyebrows, and eyelashes fell out. One woman commented that this was a very sad illness for the woman. Doctors and modern medicine, according to the informants, were unable to alleviate this condition; they specified that unless the woman was treated according to the traditional patterns, she would die. The basic treatment used was as follows: semen from the woman's husband was mixed with water, fruit juice, or chocolate and given to the woman to drink. Other informants indicated that the semen was toasted on the griddle-like comal until it became hard; it was then ground to a powder, mixed into water, and given to the woman. Varying slightly, one informant indicated that either the man or the woman could be afflicted by this empacho if they did not refrain from sexual relations during the postnatal period. While the symptoms and prognosis she described were similar to the ones mentioned above, the treatment plan differed. She indicated that a piece of the discarded umbilical cord of a first-born child was to be placed in boiling water; the resultant "tea" was given to the afflicted person, man or woman, on an empty stomach for nine consecutive days.

Care of the Newborn. Newborn infants received special care in adherence to traditional child health care patterns during the forty-day postnatal period. Special care of the navel was the most frequently reported practice. Traditionally, the navel was treated with a sterilizing or drying substance, such as mercurochrome, merthiolate, or alcohol, covered with a clean piece of cloth, and then bound with an umbilical band. This treatment was renewed every day until the cord fell off. At that point, some of the informants ceased binding the baby's abdomen, however, others continued to apply the binding. There were several reasons given for this. One woman said that even after the cord had fallen off, the navel was not completely healed or closed; therefore, to prevent air from entering the baby (ventearse) through these little holes in the navel, which could cause death, she continued applying merthiolate and binding the abdomen until the navel was completely healed. Other informants continued binding their baby to prevent the navel from protruding as a result of baby crying, coughing, or sneezing; these women often continued binding the baby for the entire forty days.

While, traditionally, the proper disposition of the discarded umbilical cord was important, only a few of the informants of this study had adhered to this traditional pattern. None of the women had buried the cord; however, several had wrapped it in a paper or cloth and saved it.

Several other traditional child health care patterns were mentioned and adhered to by some of the informants. It

was thought by a few women, for example, that the baby's fingernails should not be cut with metal scissors or nail clippers, but rather with the mother's teeth, until the baby was about one year old; these women believed that if a metal object were used, the child would either be near-sighted or would be slow in learning to speak.

Small amounts of herbal tea were sometimes given to very young babies. Several of the women described the usages of the following herbs: chamomile, peppermint, lemon grass, or oregano tea was used to calm a baby's stomach colic; orange leaf tea calmed a baby's nerves; cumin tea quieted a fussy, crying baby; and comfrey tea mixed into the formula milk stopped diarrhea. For a complete listing of the medicinal herbs used by the women in this study, see Appendix C.

Culture-specific Illnesses

Earlier researchers (Clark, 1959a; Kelly, 1967; Foster, 1967) observed and discussed the concepts of specific illnesses which were unique to the Mexican-American communities they studied. Classified later by Foster (1976:774) as culture-specific illnesses, these included empacho, mollera caída, mal ojo, and susto. As this study encompassed the perinatal period, only the first three culture-specific illnesses, which were thought to affect infants, are discussed in this section.

Empacho. In general, this illness, which was thought to be caused by some item of food, such as gum, sticking to

the stomach walls, was considered to be more prevalent among older children than among newborn infants who consumed only milk. However, many of the informants commented upon a variation of empacho which was unique to the newborn period. Informants indicated that a bottle-fed infant could become enlechado if the bottles or nipples were not well cleaned, if the milk had soured, or if the formula had been changed. Breast-fed babies were also susceptible to this illness. According to the informants, if the mother had been doing her housework, making tortillas, or was at all agitated, she should cool down her body by drinking water before feeding the baby; in that overheated state, the maternal milk was considered to be irritating and could, thusly, cause the baby to become empa-
chado, or enlechado. One informant mentioned that a baby could be afflicted by this illness also if his mother ate coconut. These etiological explanations confirmed empacho as a naturalistic illness, that is, an illness caused by natural forces (Foster, 1976:775).

Whereas the symptoms of empacho in the older child included loss of appetite, diarrhea, and a distended abdomen, the most characteristic symptom in the infant was the presence of whitish mucus in the stools, which, according to one informant, smelled like boiled milk.

The treatment plans suggested by the informants were varied; all of the women who adhered to this traditional pattern effected the treatment themselves without the aid of a special curer. Several women indicated that the baby should

be given sweetened chamomile or bay leaf tea until the symptoms disappeared; others indicated that a little olive oil should be given to the baby for three days before breakfast. One informant suggested that first a tea made from toasted chirimoya seeds be given to the baby, followed by one teaspoon of olive oil. As the presumed causative factor of an illness was often included in its treatment, one informant explained that the maternal milk should be collected, boiled with peppermint, and given to the baby by spoonfuls until the symptoms disappeared.

Mollera Caída (Fallen Fontanel). The culture-specific illness of mollera caída, by its very nature of concerning the sensitive fontanel area, affected only infants in their first year. Although the principal symptom of this illness was the depressed fontanel area, the women interviewed mentioned several other symptoms, including the following: diarrhea, vomiting, fever, nervousness, much crying, and the inability to suck.

No one factor was found which was unanimously thought to be the primary cause of mollera caída. In fact, two major etiological frameworks were suggested in the explanations of the causative factors given by the informants. Most informants indicated that mollera caída was caused by picking up the baby too quickly, by a fall taken by the baby, or by suddenly removing the nipple from the baby's mouth; these explanations confirmed mollera caída as a naturalistic illness. Other informants, however, indicated that this illness was caused by

fear. These women explained that if, for example, a baby fell, it was not the fall itself but the fear provoked by the fall which caused the illness; in this manner, then, mollera caída was confirmed as an illness of emotional origin (Clark, 1959a).

The treatment plans indicated by the informants ranged from the simple to the complex. In all cases, however, as it was thought that when the baby had mollera caída his palate was also dislocated, part of the treatment always included the repositioning or lifting of the palate. The informants reported the following components of the treatment for this illness, in the order in which they were usually performed: the baby's entire body and head were gently massaged; the person effecting the cure, who was usually a recognized curer within the community, put water into his/her mouth and sucked gently on the fontanel; the baby was held head down by the ankles and the soles of his feet were slapped three times; the curer moistened his/her thumb with olive oil and gently pressed against the baby's palate to reposition it; finally, the baby was given some herbal tea and put to bed. In extreme cases in which the above treatments were not successful, one informant indicated that the fontanel area was shaved and covered with a paste made of flour and egg. A piece of paper was then placed on top of the head; this was left on for several days, after which the symptoms of the mollera caída should have disappeared.

Mal Ojo (Evil Eye). "I don't believe it very much, but I don't doubt it"; "It's better, or safer, to believe than not to believe". In this manner, many of the informants prefaced their comments about the culture-specific illness of mal ojo. Many of the women interviewed reported having had some experience with this illness, which has been classified by Foster (1976) as personalistic, that is, afflicted upon one person, usually a child, by another person (p. 775), and by Clark (1959a) as being of magical origin.

All of the informants who adhered to this traditional pattern concurred in the etiological explanation of this illness. Certain people, it was thought, had "strong eyes" (la mirada fuerte); if one of these people admired a child and did not touch him, either by making the sign of the Cross on the child's forehead or by giving him a little slap on the buttocks, the child would soon after develop the symptoms of mal ojo. It was said that the child's blood became irritated by the "heat" which emanated from the "strong eyes" (le calienta la sangre al niño). The person who caused the affliction was not thought to have caused this intentionally.

The symptoms indicated by the informants for mal ojo generally included the following: fever, vomiting, diarrhea, restlessness, and one eye appearing smaller than the other. If the child did not receive the appropriate treatment, it was thought he would die. The person who had caused the illness was oftentimes reported to suffer either the same symptoms as the child or to suddenly be afflicted with a very painful headache.

Three basic methods of treatment were described by the women interviewed. First, if it were known who had caused the mal ojo and that person had left behind some article of used clothing, the mother, usually, would sweep her child with the clothing while reciting either the Apostles' Creed or the Lord's Prayer three times. This sweeping motion was in the form of the Cross. Second, if it were known who had caused the mal ojo, but that person had not left behind any article of personal clothing, someone would be sent to fetch that person to perform the healing. This person could cure the afflicted child by merely touching him; usually the sign of the Cross was made three times with a finger moistened with saliva--once on the forehead and once on each temple--and the child's head and cheeks were gently massaged.

Third, if it were not known who had caused the affliction, a more complex treatment was performed by the child's mother. The child was first swept with an unbroken egg while the Apostles' Creed or the Lord's Prayer was recited three times; the sweeping motion was in the form of a Cross. The egg was then broken into a crystal glass which had been half-filled with water; three crosses made from pieces of broom sticks were placed on top of the water. The glass with the egg was placed under the child's bed. The next morning, the egg was examined, the child was considered cured if the egg looked cooked (the child's fever was thought to have passed into the egg, thereby cooking it) and an "eye" was visible in the yolk. The egg was then discarded, either by burying

it, by throwing it into the intersection of a road, or by disposing of it in the toilet. As the symptoms disappeared from the afflicted child, so too did they disappear from the person who caused the mal ojo.

Two informants suggested variations of the treatment for mal ojo. The first reported using three dry red chiles, which had been heated over a flame, to sweep the afflicted child's body; again the Apostles' Creed was recited during the sweeping. The second informant indicated that she swept the child with an unbroken egg; the egg was then broken under the stove, where there was usually no flooring, and was mixed with the dirt found there. This mixture was placed on the child's stomach and covered with a cloth which had been soaked in alcohol. Within three days, the child was cured.

It should be noted that, although many of the other cures which have been mentioned throughout this chapter have included the number three, each component of the treatment for mal ojo was consistently based on the number three. The author has hypothesized that, as the illness was considered to be of a magical origin, by including such an overwhelming number of references to the Trinity, the treatment was thought to be more powerful.

Two informants indicated that, if a child were frequently afflicted with mal ojo, there were two methods of prevention which could be used. Either the child could wear a red T-shirt under his outer clothing, or he could wear a deer's eye seed (ojo de venado) on a red string around his

neck or wrist. Again, as in the method of protection from the harmful effects of an eclipse (P.55), the color red has been identified as having special qualities.

Chapter 6

ANALYSIS AND IMPLICATIONS OF THE FINDINGS

Quantitative Analysis of the Findings

The adherence or non-adherence of each informant to the thirteen predominant maternal and child health care patterns revealed in this study was recorded for subsequent statistical analysis. These thirteen areas of traditional thought included the following: prenatal food restrictions, prenatal cravings, lunar and solar eclipses, the medicinal usage of herbs, postnatal food restrictions, sexual relations during the postnatal period, special clothing during the postnatal period, care of the infant's fingernails, care of the infant's navel, empacho, empacho de hombre, mal ojo (evil eye), and mollera caída (fallen fontanel). Table 4 indicates the basic rates of adherence of the informants to the thirteen predominant health care patterns discussed in the study as determined through frequency analyses within the Statistical Package for the Social Sciences. Eight traditional maternal and child health care patterns, excluding empacho de hombre (see Table 4, note 2), were found in this study to be adhered to by more than half of the Mexican-American women interviewed.

In an attempt to determine which factors have influenced the maintenance of these traditional patterns,

Table 4

Ratings of Informant Adherence to Thirteen
Traditional Health Care Patterns

Traditional Health Care Pattern	Rate of Adherence	Rate of Non-adherence
Prenatal Food Restrictions	32% ¹	68%
Prenatal cravings	48%	52%
Lunar and Solar Eclipses	59%	41%
Medicinal Herbal Teas	86%	14%
Postnatal Food Restrictions	67%	33%
Postnatal Sexual Relations	81%	19%
Special Post- natal Clothing	62%	38%
Care of Infant's Fingernails	20%	80%
Care of Infant's Navel	48%	62%
<u>Empacho</u>	88%	12%
<u>Empacho de Hombre</u>	91% ²	9%
<u>Mollera Caída</u>	59%	41%
<u>Mal ojo</u>	68%	32%

1. It should be noted that not all health care patterns were discussed with each informant; these figures therefore represent the rates of adherence/non-adherence of the women with whom each pattern was discussed (median N = 25).
2. This figure is not representative of the entire sample. This concept was thoroughly discussed only with those informants who reported having had prior knowledge of this traditional pattern (N = 11).

further statistical analyses in the form of cross-tabulations, were conducted to identify any significant relationships or trends which might exist between the adherence to specific health care patterns and key independent demographic variables; several interesting results are highlighted in the following section.

The birthplace of the informant was observed to have influenced the rate of adherence to three traditional maternal and child health care patterns. Empacho, which was adhered to by 88% of all the informants, was adhered to by 95% of those informants born and/or raised in Mexico (N = 28). The women who were born and raised in the United States and who had identified themselves as Chicana tended not to adhere to the concept of empacho. Length of residence in the United States, even when extended over many years, was not found to have greatly altered the rate of adherence to this pattern among the women born in Mexico.

Adherence to the concept of empacho de hombre was greatly influenced by the informant's birthplace. It was found that only those women who were born and/or raised in Michoacan, Jalisco, Sinaloa or Nayarit (N = 11) were familiar with this culture-specific illness. Of these women, 91% adhered to this traditional health care pattern. It was found that this adherence remained completely unaltered even after many years of residence in the United States.

The birthplace of the informant also was observed to have influenced the rate of adherence to the traditional concept of mal ojo. Women born and raised in the United States, Northern Mexico, or Northwestern Mexico indicated

a greater rate of adherence to this traditional health care pattern than did women who were born and raised in Central Mexico.

The informant's habitual lifestyle seemed to have been a primary factor in the rates of adherence to two traditional child health care patterns. It was found that the greater number of the women who habitually lived in urban centers did not adhere to the traditional concepts of Mollera caída; women from the rural areas, however, continued to maintain the traditional concepts of this illness. The author has hypothesized that the accessibility of modern health care facilities and health education programs which have been implemented in the urban areas have been influential in bringing about this change.

Contrarily, and unexpectedly, analyses indicated that those informants who had spent most of their life in rural areas tended not to adhere so strongly to the traditional patterns regarding the care of the infant's navel as did the women who had lived most of their life in urban areas (statistical significance of .08). Further analysis showed that as the length of residence in the United States increased, adherence to this traditional concept diminished.

The use of herbs for medicinal purposes and the adherence to the traditional health care patterns concerning the restriction of certain foods, the restriction of sexual relations, and the usage of special clothing during the post-natal period were found to be influenced in a most unexpected manner by the length of time the informant had resided in the

United States. The analyses indicated that the longer the women had resided in the United States, the more consistent and probable was their adherence to these traditional patterns. As no other independent variable has apparently influenced this finding, two possible explanations are offered. First, adherence to these specific patterns, which relate to the culturally important postnatal period, may represent a conscious or unconscious effort on the part of the informants to preserve their cultural group identity; or, secondly, adherence to these traditional health care patterns may indicate that relevant modern health care services and health education programs have not been sufficiently accessible to this population.

Analysis in which other demographic variables, such as the number of children in the family and whether or not the informant had sought early prenatal care, were conducted; however no significant correlations or trends were revealed.

Implications of the Findings

The principal goal of this study was to identify and analyze the traditional maternal and child health care patterns currently being practiced among Mexican-American families in an urban community. In the previous chapter many traditional patterns were discussed at length. However, as the author did not wish to merely catalog the patterns observed in the study, but rather to present them in a manner which would be useful to persons dealing with matters of

health care among Mexican-American families, the present section discusses what the implications of adherence to these traditional health care patterns seem to be for the delivery of modern health care services to this population.

The sampling process was initially developed with the anticipation of having an equal representation of women who attended the community health center for early prenatal care and of women who had not sought care until late in their pregnancy; in this manner, complete analyses of the possible correlation between adherence to traditional health care patterns and the utilization of modern health care facilities could have been conducted. This was not possible due to the limited number of informants in the final sample who had not sought early care. Certain implications regarding the utilization of modern health care facilities, however, were revealed. It was found that all of the informants, both those who had attended the community health center and those who had not, were familiar with at least three traditional and child health care patterns; 90% of these women adhered to some or all of these patterns. As the etiological frameworks and the role expectations maintained by the traditional health care system and the modern health care system are disparate, the author suggests that unless measures have been taken to bridge the two systems, the utilization rates of modern health care services or successful medical follow-ups will be negatively affected. A distrust of the modern medical system (including diagnosis and

treatment plans), personal discomfort in the patient-doctor relationship, and economic factors were the reasons most frequently cited by the informants for not having sought early prenatal care.

The traditional health care patterns revealed in this study were the result of social, cultural, and environmental adaptations realized over a long period of time. It is important for health professionals to examine these patterns carefully before attempting to replace them with modern scientific values and patterns. As previously indicated by several researchers (Paul, 1955:4; Read, 1966: 57; Garcia, 1968:451; Cosminsky, 1978:116), traditional health care patterns may have positive, neutral, or negative values for the maintenance or improvement of health status. Indeed, examples of each can be found among the thirteen predominant traditional maternal and child health care patterns revealed in this study.

The usage of herbs for medicinal purposes when accurately selected may have very positive effects upon a person's health status; the medicinal qualities of certain herbs have, in fact, been incorporated into the preparation of some patent and prescription drugs. Further, the use of natural medicinal herbs causes fewer negative side-effects than chemical pharmaceutical products. Adherence to the traditional health care patterns which exhibit such positive values should be encouraged within the modern health care delivery system.

The traditional method used by pregnant women to protect their unborn child from the powerful rays of the lunar or solar eclipses is an example of the traditional health care patterns which have a neutral effect upon the maintenance of optimum health status. As adherence to such patterns neither improve nor diminish the health status of an individual, no action need be taken to discourage their use.

Certain traditional health care patterns revealed in this study have been found to have negative effects upon a person's health. The restriction of the intake of certain protein and mineral-rich foods, if adhered to during the entire forty-day postnatal period, could lead to a state of malnutrition in the postparturient. Also the concept of the mollera caída has been found to have negative effects upon the infant's health status. According to the traditional concept, the depression of the fontanel area is the result of fall; modern medicine has determined, however, that the noticeable depression of the fontanel is, instead, symptomatic of extreme dehydration. If adequate treatment is delayed, the risk of death is high. When negative traditional patterns such as these are observed, measures must be undertaken immediately to change them; this should be done, however, in the most culturally-relevant manner possible. Brody (1976) stated that "the utilization of (health) programs depends not only on their accessibility but also on their acceptability to the person in need" (p. 27).

Based on the large number of Mexican-American families residing in certain areas of Santa Clara County, and on the findings of this study which revealed that 90% of the sample population currently maintain and practice traditional maternal and child health care patterns, the author offers the following suggestions for the improved delivery of needed health care services to this special population:

1. Direct care providers must learn to recognize health behaviors associated with traditional health care patterns. Before deciding if a specific traditional health care pattern should be reinforced or discouraged, efforts must be made to understand the underlying cultural, social, and physical function of the pattern.
2. Direct care providers should reinforce and encourage the adherence to traditional health care patterns which have a positive value in the maintenance and/or improvement of an individual's health status. If, on the other hand, the health care provider determines that use of a specific traditional health care pattern must be discouraged, the measures adopted for this change should be culturally-relevant for the patient; respect for the socio-cultural values underlying the original health care pattern must not be discarded but rather built upon in order to effectively improve the health status of the individual.
3. Direct care providers should consider including the following criteria in their assessment of the prenatal risk factor for Mexican-American women:
 - a. income level
 - b. nutritional patterns
 - c. language abilities
 - d. cultural risk--determined by the rate of adherence to traditional health care patterns
4. Health care administrators should encourage and facilitate active and meaningful community involvement in policy-making procedures.

5. Appropriate policies should be developed which would accomplish the following:
 - a. increase the availability of health care facilities within the County which offer culturally-relevant health care services.
 - b. establish and implement culturally-relevant public health education programs within the County
 - c. facilitate the implementation of health care services in the accordance with the unique values and needs of the community served.
6. Periodic local workshops concerning traditional health care values and patterns should be offered to all direct care providers and health care administrators who serve the Mexican-American community. Further, it is suggested that similar workshops which would encourage an awareness and unbiased examination of the values of traditional health care patterns be presented within the medical schools.

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APPENDIX A

PERINATAL INTERVIEW SCHEDULE - ENGLISH

ID Number _____ Survey Code _____

Type of Dwelling _____

Do you have a telephone? _____

What is your marital status? _____ (S,M,W,D,Sep,Cohab)

What is your age? _____

Where were you born? _____

Have you spent most of your life in _____ rural areas
_____ urban areas
_____ migratory life style

What is your ethnic background? _____

Survey conducted in _____ English _____ Spanish

If you belong to a religious group, which one? _____

How old is your husband/partner? _____

What is your husband's/partner's ethnic background? _____

What is your usual means of transportation? _____

How long have you lived in Santa Clara County? _____
U.S.? _____

Who referred you to the Community Clinic? _____

When you came to the Clinic during your current (recent) pregnancy, were you a _____ new patient _____ return patient
_____ not applicable.

Are you currently employed? _____

If yes, what is your occupation? _____

Is your husband/partner employed?

If yes, what is his occupation?

What is the total monthly income of your family?

_____ < \$300
 _____ \$301 - \$450
 _____ \$451 - \$600
 _____ \$601 - \$750
 _____ \$751 - \$900
 _____ > \$900

Do you (or your children) receive AFDC? _____

Do you (or your children) receive Food Stamps? _____

Do you (or your children) receive MediCal? _____

Do you (or your children) receive WIC? _____

Do you have any medical insurance? _____ Which one? _____

Level of Education U.S. Mexico Other,
 specify

Patient _____

Partner _____

How many children do you have? _____

What are your children's ages: a. _____ f. _____
 b. _____ g. _____
 c. _____ h. _____
 d. _____ i. _____
 e. _____ j. _____

What is the total number of persons residing in your home? _____

How many children (<16) live in your home? _____

How many adults live in your home? _____

Does anyone other than your immediate family live with you? ____
 If yes, how many? _____

If yes, please specify the relationship.

a. _____ e. _____
 b. _____ f. _____
 c. _____ g. _____
 d. _____ h. _____

Are you buying or renting your home? _____ buying
 _____ renting
 _____ sharing rent
 _____ not paying rent

How many bedrooms do you have in your home? _____

Who usually prepares the meals? _____

How did you know that you were pregnant (most recent pregnancy)? _____ (doctor, relative, prior experience - probe)

During what month of pregnancy did you begin prenatal care? _____

Did you attend any prenatal classes? _____ If yes, how many? _____

Apart from the doctor and nurse, is there any other person you ask for medical advice? _____

Do you plan to breast feed (are you breast feeding) your baby? _____

Interviewer Comments:

Adherence to traditional beliefs	No	Somewhat	Yes
Able to relate traditional beliefs	No	Yes	N/A

Census Tract

APPENDIX A

ENCUESTA PERINATAL - SPANISH

ID Number _____ Survey Code _____

Tipo de casa _____

Tiene Ud. un teléfono en casa? _____

Cuál es su estado civil? _____ (S,M,W,D,Sep.Cohab)

Cuántos años tiene Ud.?

Dónde nació Ud.? _____

Ha vivido Ud. casi siempre en _____ areas rurales
_____ areas urbanas

Ud. se considera: Chicano Mexicana Norteamericana

Encuesta hecha en _____ inglés _____ español

Practica Ud. alguna religión? _____ Cuál? _____

Cuántos años tiene su esposo? _____

Su esposo se considera: Chicano Mexico Norteamericano

Qué modo de transportación tiene Ud.? _____

Cuánto tiempo lleva Ud. en el Condado de Santa Clara
_____/US

Cómo supo Ud. de la Clínica? _____

Cuando Ud. vino a la Clínica para empezar el control prenatal
para este embarazo, _____ era la primera vez que se atendía
_____ en la Clínica.
_____ se había atendida en la Clinica antes.
_____ not applicable.

Trabaja Ud. ahora? _____ Cuál es su ocupación? _____

Trabaja su esposo? _____ Cuál es su ocupación? _____

Cuánto dinero en total gana la familia al mes?

_____ <\$300
 _____ \$301 - \$450
 _____ \$451 - \$600
 _____ \$601 - \$750
 _____ \$751 - \$900
 _____ >\$900

Recibe Ud. (o sus hijos) ayuda del gobierno (AFDC)? _____

Recibe Ud. (o. sus hijos) estampillas de comida? _____

Recibe Ud. (o sus hijos) MediCal? _____

Recibe Ud. (o sus hijos) los cupones de WIC? _____

Tiene Ud. alguna aseguranza médica? _____ Cual? _____

Nivel de Educación U.S. México Otro,
 Cual?

Paciente _____

Esposo _____

Cuántos niños tiene Ud.? _____

Cuántos años tienen sus hijos?

a. _____	f. _____
b. _____	g. _____
c. _____	h. _____
d. _____	i. _____
e. _____	j. _____

Cuántas personas en total viven en su casa? _____

Cuántos niños de menos de 16 años viven en su casa? _____

Cuántos adultos viven en su casa? _____

Vive alguien más que su familia inmediata con Ud.? _____
 Cuántos? _____

If yes, especifique la relación (e.g., tío, amigo, comadre)

a. _____	e. _____
b. _____	f. _____
c. _____	g. _____
d. _____	h. _____

Ud. está comprando o alquilando su casa?

- ☐ comprando
☐ alquilando
☐ compartiendo renta
☐ no paga renta

Cuántos dormitorios hay en su casa? _____

Quién suele preparar la comida? _____

Cómo supo Ud. que estaba embarazada? _____
 (probe - doctor, pariente, experiencia previa)

Cuántos meses de embarazo tenía Ud. cuando empezó el control prenatal en la Clínica? _____

Asistió Ud. a las clases prenatales? _____ A cuántas? _____

Además del doctor y la enfermera, hay alguien a quien Ud. pide consejos médicos? _____

Piensa Ud. dar pecho (está dando pecho) a su bebé? _____

Interviewers Comments:

Adherence to traditional beliefs	No	Somewhat	Yes
Able to relate traditional beliefs	No	Yes	N/A
Census Tract			

APPENDIX B

QUALITATIVE DATA FILING SYSTEM

Postnatal Care (TITLE)

(TARGET AREA)
(INFORMANT ID)
(DATE, INITIALS)

846 (FILING CODE)

Postnatal Food (SUBTITLE)

(INFORMATION RELATED) To increase the amount
of breast milk, a woman should eat atoles de masa.

(CROSS REFERENCES)

See 264 Eating - Postnatal foods

853 Infant Feeding - lactation

APPENDIX C

MEDICINAL HERBS

Name of Herb	Method	Usage
Albahaca (sweet basil)	Tea	Relieves stomach aches
Anis de estrella	Tea	Relaxant for children
Avocado seed	Tea	Included in treatment for <u>empacho</u>
Cáncel	External washing	Facilitates healing of wounds
Canela (cinnamon bark)	Tea	Intensifies and hurries labor Reduces intestinal gases Relieves colic pain in infants Replaces coffee as hot beverage
Carmolina	Powder	Included in treatment for <u>empacho</u>
Casia (cassia bark)	Tea	Induces abortion
Cebito de chivo (goat's fat)	Topical Application	Facilitate conception
Chirimoya seed	Tea	Included in treatment for <u>empacho</u>
Comino (cumin)	Tea	Reduces colic pain in infants Intensifies and hurries labor
Comino con cebolla (cumin with onion)	Syrup	Relieves coughing
Contrahierba	Tea	Relieves flu symptoms
Cuachalalá	Tea	Eases bilious pain
Epazote (saltwort)	Tea	Relieves stomach pains
Garoróna (La)	Tea	Facilitates conception
Gobernadora (creosote bush)	Tea	Facilitates conception

APPENDIX C (Continued)

Name of Herb	Method	Usage
Gordolobo (gnaphalium)	Tea	Relieves cold symptoms Relieves coughing Replaces coffee as hot beverage
Hierba buena (peppermint)	Tea	Relieves colic pains in infants Relieves stomach aches Included in treatment for <u>empacho</u> Removes bad taste in mouth Relieves constipation in infants Included in treatment for pains of postpartum clotting
Hierba de la víbora (snake herb)	Tea	Relieves flu symptoms
Hoja de naranja (orange leaves)	Tea	Reduces nervousness in infants Included in treatment for <u>mollera</u> <u>caída</u>
Injerto de mezquite	Tea	Used as a method of birth control
Istafiate	Tea	Stops diarrhea Relieves stomach pains
Laurel	Tea	Included in treatment for <u>empacho</u> in infants (<u>enlechado</u>) Relieves pains caused by "air" Reduces intestinal gases Replaces coffee as hot beverage
Limón (Lemon grass)	Tea	Relieves colic pain in infants Relaxant for children Replaces coffee as hot beverage
Manzanilla de Castilla (chamomile)	Tea	Reduces cold symptoms Used for determining pregnancy Induces abortion Intensifies and hurries labor Relieves colic pains in infants Reduces intestinal gases Calms menstrual cramping Relieves constipation in infants Included in treatment for <u>empacho</u> Stops diarrhea caused by <u>enlechado</u> Given to infants until maternal milk is available

APPENDIX C (continued)

Name of Herb	Method	Usage
Mata de trompilla	External Washing	Relieves diaper rash (chincuales)
Ojo de venado (deer's eye)	Worn	Protective agent against <u>mal ojo</u>
Orégano (oregano)	Tea	Relieves colic pains in infants Relieves constipation in infants Reduces coughing
Palo tres costillas	Tea	Relieves kidney pains
Poleo	Tea	Relaxant for children
Polvo de azarcón (zinc oxide)	Powder	Included in treatment for <u>empacho</u>
Prodigiosa	Tea	Cleans out the stomach Included in treatment for <u>empacho de bilis</u>
Romero (rosemary)	Tea	Included in treatment for pains of postpartum clotting
Rosa de Castilla (rose of Castille)	Tea	Included in treatment for <u>empacho</u> Relieves constipation
	External washing	Added to bath water to reduce skin irritations in infants
Ruda (rue)	Tea	Included in treatment for pains of postpartum clotting Reduces pain from "air" in back Relieves headaches Used for determining pregnancy Induces abortion Reduces flu symptoms Reduces coughing
	Topical Application	Relieves earaches Relieves rheumatic pains
Sinvergüenza	Tea	Stops diarrhea Reduces nausea

APPENDIX C (continued)

Name of Herb	Method	Usage
Suelda (comfrey)	Tea	Stops diarrhea in infants
Tila (tilia)	Tea	Relaxant for adults and children Included in treatment for <u>mollera caída</u>
Toloache (datura)	Topical application	Heals skin irritations
Umbilical cord	Tea	Included in treatment for <u>empacho de hombre</u>