The Role of a Community-Based Satellite Clinic in the Perinatal Care of Non-English-Speaking Immigrants

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In the provision of health care to non-English-speaking immigrants, cultural and linguistic barriers often deter both access to and use of needed services. This is especially true of the preventive health interventions such as perinatal care and family planning that contribute significantly to reproductive health.

Alternative approaches to overcoming barriers to care are being taken in an urban health department clinic serving as a satellite perinatal resource to a group of low-income Chinese-speaking immigrants. The clinic, with service linkages to San Francisco General Hospital Medical Center and the Health Department of San Francisco City and County, is an example of culturally appropriate comprehensive perinatal care. Such an institution has helped recent immigrants adapt to their new environment and learn to use health services effectively.

The field of international health occupies a singularly minor role in American schools of medicine and public health. Dr John Knowles, President of the Rockefeller Foundation, noted in 1976[1] that there were fewer than 10 independent departments of tropical medicine and international health in 107 US medical schools, and only 5 such departments among 18 US schools of public health. It follows that relatively few American physicians are likely to be fully acquainted with the range of health problems prevalent in recent immigrants, particularly those from developing countries. Of even greater importance from a practical standpoint is the need for awareness of the cultural barriers that hinder immigrants' access to, and effective use of, this country's diverse health care resources.

Immigration to the United States has increased since the middle 1970s, when roughly 400,000 legal immigrants entered the country each year. With the added influx of refugees, legal immigration figures in recent years have risen to between 600,000 and 800,000 a year. Illegal immigration obviously cannot be measured, but is thought to add another 100,000 to 500,000 annually. Whether of regular immigrants, refugees or "undocumented aliens," the flow of new arrivals to the United States continues unabated. Some—the economically self-sufficient, the educated with marketable skills or those with extended family support systems already established in the United States—may experience the transition to their new environment with little disruption of their lives. For most, however, the transition poses special problems of particular relevance to health providers. Most of the medical literature on immigrants, particularly that dealing with the recent influx from Indochinese countries, focuses on abnormalities that appear in screening programs or the prevalence of particular diseases brought with them. However, not only is their health often impaired by undernutrition, parasitic and other infectious diseases, or childhood histories of poor health; in addition, their poverty, their unfamiliarity with and fear of medical institutions and health interventions in the new country, and the language barrier itself make them inefficient and often reluctant consumers of health services. Many come from areas where modern scientific medicine is unavailable, and where indigenous healers and untrained traditional birth attendants were as a rule their only resource for care during illness or pregnancy. For such immigrants, the vast array of preventive and curative

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interventions to which Americans are accustomed (indeed, overdependent, according to Illich![2]) is often completely unintelligible.

These observations are neither new nor controversial; nevertheless, they assume particular importance in the field of reproductive health, in which preventive measures are especially central. We know, for example, that all societies respond to illness and trauma with culturally determined attempts to cure symptoms and restore individual and community well-being. Notions of preventing illness are universal but frequently differ conceptually and in practice from biomedical theory. It is thus not surprising that immigrant women's ideas of optimal perinatal care do not correspond to those of scientific obstetrics.

In view of the large percentage of the immigrant population that is composed of women of childbearing age and young children, it is important to design and deliver services that will ensure maximal use by these especially vulnerable groups. In this context, appropriate cross-cultural communication with immigrant patients to minimize ambiguity and enhance constructive health behavior may in many instances prove more important in its long-term effects on their health than the application of technologic interventions.

Among alternatives in the organization of care for low-income immigrants, several models are available for consideration. The common American private practice, fee-for-service model may be admirably suited to immigrants' special needs when the care is personalized, and the practitioner is linguistically compatible with the patient and has ample time to provide the extra attention required to assure informed compliance with treatment regimens. For those who are in a low-income category and dependent on Medicaid, however, the level of reimbursement to providers hardly permits the added time and energy that such care requires.

Hospital-based clinics, particularly those of large metropolitan institutions with services designed for efficiency and the convenience of providers, tend to be crowded, impersonal and bewildering. Before the clinic is even reached, physical access to services, taken for granted by most Americans, may involve seemingly innocuous but nonetheless important logistic obstacles in the form of appointment procedures, difficult public transportation connections or formidable-appearing buildings and directional signs written in an alien language. Organizational and structural barriers to obtaining clinical care such as these often compound problems of use.

A model of comprehensive care with special relevance to the reproductive health needs of immigrant women, the Maternal and Infant Care (MIC) projects, was developed as a result of the 1963 amendments to Title V of the Social Security Act[3] in an effort to reach disadvantaged segments of the population characterized by poverty and high infant mortality. Altogether, 56 such projects had been created by 1974, with 75% of the costs provided by the federal government. The maternal and infant care projects, eclectic in character and designed as demonstrations, were generally successful in promoting earlier prenatal care, improved nutrition and better compliance with a range of services delivered by multidisciplinary teams, and contributed to a reduction in infant mortality and morbidity. Their comprehensiveness derived from the augmentation of routine prenatal care with special outreach activity for early enrollment, social services, health education, nutrition counseling and in some instances special adjuncts such as dental care. They have gradually been absorbed into ongoing delivery systems, but their distinguishing features of comprehensiveness, decentralization and care tailored to the special characteristics of the target population remain valid.

I describe a clinic experience organized generally on the decentralized, comprehensive care model and aimed at a largely non-English-speaking population in the Chinatown area of San Francisco. San Francisco, already known for its multiracial character, has experienced an increase in its Chinese-American population from 65,000 in 1978 to more than 85,000 in 1982. The San Francisco General Hospital Medical Center (SFGH), the public institution serving the city's largely low-income and multiethnic indigent population, is situated at a considerable distance from the city's Chinatown, with indirect and difficult connections via the city's municipal transit system. A conveniently located private Chinese hospital has operated for many years in the heart of Chinatown, but its rates are beyond the means of many recent immigrants, and its use via Medicaid is limited for the reasons noted above. Prior to establishment of the SFGH satellite clinic in Chinatown, newly arrived Chinese-speaking immigrants of low-income status who sought care at SFGH were not only few in number, but also less likely to avail themselves of the early registration and close prenatal surveillance that low-income non-English-speaking patients should have. To rectify this situation, the hospital established a satellite clinic in one of the city's health department district public health centers (Health Center 4) in 1977. Virtually all of its patients, apart from the recent admixture of Indochinese refugees, are Chinese-speaking (about 90% Cantonese, 10% Mandarin) and more than 80% are unable to communicate in English. The Health Center, already actively involved in selected preventive medicine activities for a number of years, had an experienced, largely indigenous and bilingual multidisciplinary staff with ongoing well-child and family planning clinics, and with nutrition, health education, special services and public health nursing components already in place. Prenatal and postpartum care was initiated at weekly clinics at the Health Center, with SFGH providing an attending staff obstetrician and gynecologist and the hospital's high-risk prenatal clinic, other specialty clinics, laboratory and inpatient facilities for backup purposes and complications.

In reconciling the desire for culturally compatible outpatient care within easy reach of patients' homes and the need for an ultimate in-hospital experience for intra- and postpartum care, some exposure to the hospital

environment is desirable. Accordingly, all prenatal visits but two are conducted at the Health Center. Following an intake interview and history taking by a bilingual public health nurse, patients are escorted in small groups to the hospital for registration and preliminary prenatal laboratory tests. This presents an opportunity for a thoughtful guided orientation in which the strange and often frightening scenes of a modern metropolitan hospital are carefully interpreted and access to the necessary paperwork and laboratory tests is made as easy and as understandable as possible. A second, more leisurely and educational visit is made in midpregnancy, when groups of patients with their families are given a guided tour of the hospital along with instruction in where to go and the admission procedure for labor and delivery.

To maintain this degree of sensitivity to the anxieties of transitional immigrants, certain compromises with customary obstetric care are necessary. Screening for risk factors is done according to accepted standards of prenatal care. In the presence of overt intercurrent disease or significant risk factors, patients must of necessity be referred to the hospital high-risk obstetric clinic where the appropriate consultative and technologic resources are at hand. In many instances, subsequent surveillance and treatment regimens can still be achieved at the satellite clinic. The attention of a linguistically compatible staff in tune with a patient's culturally conditioned attitudes and beliefs about sickness and health is seen to compensate for the technologic limitations of the free-standing clinic.

It is unrealistic to assume that such bilingual, culturally sensitive care can be provided to most immigrants in the "melting pot" of America, with its multiplicity of linguistic or national origins. However, where geographic concentrations in neighborhoods of homogeneous ethnicity occur, and a critical mass of population to justify a local health care resource exists, the advantages of satellite clinics are many. This is particularly true among the Asian-American population, for whom the mastery of English is especially difficult.[4] The Chinese language has a basic structure that differs from that of English, has a tonal pronunciation and lacks a phonetic alphabet. Accordingly, few Chinese-speaking immigrants have even a partial or rudimentary familiarity with English. Linguistic subgroups and variable literacy, even in the native language, compound the problem, but are effectively dealt with by a bilingual staff that is familiar with the cultural nuances and economic class differences of the country of origin and less vulnerable to simplistic generalizations about persons of common ethnicity. None of these subtle features of clinic care appear in annual reports or clinic statistics, but they are nonetheless evident in the day-by-day interaction with patients. They call for a special tolerance of beliefs and attitudes toward health and disease that differ from the scientific system to which these patients are now expected to conform, and they affect compliance accordingly. A few examples from the Chinatown satellite clinic may suffice.

Obstetric screening procedures are often difficult for asymptomatic Chinese immigrants to comprehend. Many of them have had prior experience in rural settings or in Asian communities where Western technology does not exist, and where pregnancy outcomes were nevertheless generally satisfactory. In this context, amniocentesis, glucose tolerance tests, ultrasonography and non-stress testing are often perceived as meddlesome, dangerous, unnecessary and frightening. Compliance with these measures is, not surprisingly, less than complete. Accordingly, a special effort is made to explain procedures in readily understandable terms. More importantly, the clinic staff has learned to request such procedures with greater discretion, with a tendency to forego them when the indications are borderline and to insist on them only when serious consequences of noncompliance are anticipated.

Certain traditional health practices are tolerated or accepted with modifications, especially in the realm of nutrition and drugs. Chinese-American immigrants are admonished, as are their American counterparts, to avoid over-the-counter drugs during pregnancy. However, it is well known that many of them use herbal remedies either as "tonics" or for nuisance symptoms of pregnancy such as nasal congestion or constipation. To the extent that these are naturally occurring substances they are generally regarded as harmless, yet their widespread use and poorly understood ingredients suggest that more scientific investigation is needed to assume their safety when used during pregnancy. High sugar intakes are common, and in late pregnancy eggs scrambled with rock sugar are commonly used "to clean the system and lubricate the passage." Following delivery, restoration of the body's heat-cold balance assumes importance, and the hospital's labor and delivery staff are aware that drinking water offered to a just-delivered mother must be hot. In early puerperium, pig's feet in vinegar and later *gai jow* ("chicken whiskey") are consumed to contribute to the restoration of balance. Whether the latter contributes also to a predisposition to a late postpartum hemorrhage, as alleged by some Western obstetricians, remains conjectural.

A troubling phenomenon among recent Chinese immigrants is a predominant antipathy to breast-feeding. A study recently conducted in the Health Center 4 clinic showed that only 18% intended to start their babies on full breast-feeding, with 8% intending partial breast-feeding, 60% committed to bottle-feed and 13% undecided. It is recognized that most of these patients are working women (chiefly seamstresses) but only 15% of those who chose bottle-feeding listed the need to return to work as the reason. Moreover, nutritional counseling regarding the advantages to a child of even short-term breast-feeding in the six weeks before the mother's customary return to work is generally unheeded. While a variety of factors may be responsible for this phenomenon, the clinic's consensus regarding the resistance to breast-feeding despite health education and nutritional counseling is that it reflects a cultural

identification of breast-feeding with a primitive or agrarian past and a perceived adaptation to modern, urbanized and Western life-style. A special effort is currently under way to publicize among the clinic patients the resurgence of breast-feeding among American women and to provide additional educational reinforcement for breast-feeding during the critical early puerperal period.

Culture-specific family planning preferences appear in the postpartum clinic experience. Many of the patients observe a long period of postpartum abstinence that corresponds to the "doing the month" custom described by Pillsbury.[5] Hence, starting these patients on contraceptive regimens can be safely delayed. Among contraceptive alternatives, the combination of foam and condom is the most frequently preferred, and a high level of use and effectiveness results from both the additive effect of using dual methods and the self-discipline characteristic of this population. While interest in puerperal sterilization is often expressed, the degree of assimilation to a patient's new environment is heavily considered in sterilization counseling in order to avoid decisions that may later be regretted. A carry-over of traditional Chinese preference for male children is often expressed with a request for puerperal sterilization conditional on the sex of the newborn.[6]

For the record, a recent analysis of nonrefugee Chinese immigrant patients treated at Health Center 4 in 1982 showed a mean maternal weight gain of 13 kg (29 lb) and a mean infant birth weight of 3,276 grams (7 lb). Whereas it is believed that the combination of managerial and attitudinal approaches to this clinic population contributes to better pregnancy outcomes, this claim remains subjective and cannot be based on pregnancy outcome statistics. In the first place, the clinic population is admittedly selected for low or, at most, borderline risk status, with the remainder referred to the hospital clinics for more intensive care. Second, the Chinese-American population in San Francisco (including those recently immigrated) has long had a known record of low infant mortality and a low incidence of low birth weights. The reasons for this are largely rooted in traditional Chinese values and beliefs that are reflected in personal hygiene, nutritional habits and health behaviors, for which the clinic cannot take credit and from which much can be learned. By and large, such problems as out-of-wedlock adolescent pregnancy and smoking, alcohol and other substance abuse in pregnancy, which contribute so heavily to poor pregnancy outcomes, are rarely encountered in Chinese-American immigrants.

Thus, the success of this exemplary clinic experience is not measurable in organic terms. Nor can it be measured in utilization statistics because many of its patients are very recent immigrants who had some prenatal care before immigrating. Its achievement, in the minds of the clinic staff, lies not simply in the safe medical management of pregnancy, but rather in the use of prenatal care as a vehicle to assist recent non-English-speaking immigrants in their assimilation into American society. It consists of a conscious effort to seize each transaction implicit in prenatal care as an opportunity to promote self-reliance in the new immigrant. Thus, nutrition counseling not only assists in adaptation to new and unfamiliar Western foods, but uses this transaction to encourage familiarity with new English words pertaining to nutrition and food shopping. Health education and social services transcend immediate health concerns and assist in a variety of problem-solving situations in which the health center is seen as responsive to the felt needs of the community it serves. Moreover, the homogeneity and shared community interests of its clientele help to make the clinic a meeting place and attendance there a social event, a phenomenon that is readily apparent in the camaraderie and lively conversation occurring in the waiting room. Childbirth classes (and corresponding educational materials) are given in Chinese, and family participation in the obstetric experience is encouraged. A plan for an expanded project using essential prenatal education as a medium for the teaching of English as a second language has been proposed but has not yet materialized.

The acceptability of the Health Center 4 satellite clinic is reflected in its record of growth since its inception in 1977. From 55 mothers attended in 1977 with an average of about ten visits per mother, it grew to serve 245 in 1982, and once-a-week clinic sessions in 1977 have been progressively expanded to four sessions a week as the clientele continues to grow.

The lessons learned over the past five years in adapting community-based prenatal care to the Chinese immigrant population have recently been further applied to the care of Indochinese refugees. Many of the large influx of refugees arriving in San Francisco since 1978 have established residence within the catchment area of the Health Center 4 clinic. While they share many of the same problems of assimilation with Chinese-speaking immigrants from Hong Kong, Taiwan and the People's Republic of China, they exhibit much more cultural and linguistic diversity and have additional health problems related to poor conditions in their countries of origin. The experience of the Health Center 4 clinic in cross-cultural communication makes it a natural resource for care of this group with unique needs. It has required the establishment of separate clinic sessions where such interpreters of Vietnamese and Laotian dialects as are available can be used. (Khmer-speaking refugees have an alternative clinic resource.) The remainder of the support network arising out of the clinic's experience with Chinese-speaking immigrants and the relationship with San Francisco General Hospital Medical Center for inpatient care provides the comprehensiveness described earlier in this paper.

As noted, the focus of this clinic on a low-risk group precludes any objective measure of its impact on the health status of its clients. For the same reasons, cost-benefit analysis is likewise difficult. Clearly, comprehensive prenatal care, to the extent that it requires more time and the application of multidisciplinary skills, is

costlier than "standard" obstetric care. In this case, however, cost is kept to a minimum by integration of the clinic into a maternal and child health package of services including perinatal, well-child and family planning clinics that draw equally on the nutrition, health education, social service and outreach resources of the health center. The less readily measurable but equally important contribution that this approach to the health care of immigrants makes toward their self-sufficiency and sophistication as consumers of American health services must also be weighed in the cost-benefit balance.

The example of this clinic shows that if the constraints to participation by non-English-speaking immigrants are to be overcome, greater attention needs to be given in the organization of services to the cultural determinants of health behavior. In the effort to assist new immigrants into the mainstream of American life, medicine would do well to join forces with the growing field of medical anthropology.

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