

Women of Worth

**Factors Related to Prenatal Care among Women of Greater Fifth
Ward: A qualitative and quantitative project**

Part A

May, 2009

Houston Department of Health and Human Services

Houston, Texas

Contents

EXECUTIVE SUMMARY	3
BACKGROUND	4
Aim of the project.....	4
PROJECT DESIGN AND METHODS OF IMPLEMENTATION	4
Project site	4
Project design	5
FINDINGS	6
Participants' characteristics	6
Focus Group Discussions findings	6
Theme 1: Temporarily limited support system.....	8
Theme 2: Psycho-social challenges	9
Theme 3: Added economic hardship	11
Theme 4: Information gap	12
DISCUSSION	12
CONCLUSIONS	14
RECOMMENDATIONS.....	14
REFERENCES.....	16

EXECUTIVE SUMMARY

The purpose of the project was to understand prenatal health care access patterns, personal choices, barriers to care and familial support among pregnant females (ages 18-44) and/or women with children <2 years of age, who resided in the Greater Fifth Ward. Greater Fifth Ward is characterized as an underserved and predominantly African American community.

Triangulation of modes of data collection was used to address the questions. Five focus group discussions were conducted (total participants=24). Discussions were audio taped, transcribed and analyzed manually. Notes taken during the focus group discussions were also analyzed. In addition, a 25 item structured questionnaire was administered. To provide background and context for the results of the focus group data, prenatal care data were also described for Greater Fifth Ward using the Vital Statistics birth data for years 2005-2008.

Findings suggest that the participants in this study are not utilizing the prenatal health care services optimally. Four themes emerged that partially describe the minimal use of prenatal care services by the study population. These themes also act as the barriers to prenatal care.

- ***Psycho-social challenges*** (the types of challenges that women face during their pregnancy that relates to psychological concerns governed by the social context, eg. emotions/stress related to the condition of pregnancy in the absence of a partner).
- ***Added economic hardships*** (those financial needs that may arise due to a pregnancy that is not planned, e.g. lack of money to maintain healthy pregnancy and lack of money for basic needs).
- ***Temporarily limited support system*** (lack of support during pregnancy that emerges because of unplanned pregnancy and may resolve once the baby is born, eg. lack of emotional and instrumental support from family members).
- ***Information gap*** (access to health service related and self care related, e.g. lack of awareness of the physical and psychological demands of pregnancy and lack of information about available services).

However, the findings of the focus group project are not generalizable to the whole of Greater Fifth Ward because of concerns about the representativeness of the focus group discussion participants, and the limited degree of saturation of information obtained on issues pertinent to the study aims. A larger, more definitive study would provide greater clarity and stronger evidence of the findings presented in this report.

BACKGROUND

Inadequate prenatal care is associated with adverse pregnancy outcomes such as low birth weight (LBW), pre-term birth and conditions such as small for gestational age (SGA) (Heaman et al., 2008; Kiely & Kogan, 2006). Houston Department of Health and Human Services (HDHHS) data from the “Community Health Profiles” suggests that during 1999-2003, close to ninety percent of all women of Greater Fifth Ward (GFW) entered prenatal care at some point during their pregnancy. Of those that received prenatal care, almost two third reported entering prenatal care in their first trimester of pregnancy. Remaining women received prenatal care late in their second and or third trimester of pregnancy. Close to ten percent of women received no care at all, or did not disclose information on prenatal care (HDHHS, 2009 a). The findings of the Vital Statistics birth data analysis (2004-2007), conducted by HDHHS in 2009, also suggest that close to 92% of women of GFW had received prenatal care of some form, although information on the trimester of initial access to prenatal care and adequacy of prenatal care was unavailable (HDHHS, 2009 b).

The infant mortality rate in GFW during 1999-2003 was twice that of Houston (annual average of 12.3 versus 6.2 per 1000 live births), and 2.7 times higher than the Healthy People 2010 objective. Similarly, the percentage of low birth weight babies, another indicator of overall maternal health, has also been reported to be higher in Greater Fifth Ward compared to the Houston average (approximately 11 vs 8 %) during the same period. Vital Statistics birth data analysis indicate that nine percent of black women of GFW, who gave birth during 2004-2007, reported not receiving any prenatal care and almost 17% of those women gave birth to low or very low birth weight babies (HDHHS, 2009 b).

Aim of the project

Given a background of poor birth outcomes in GFW, this project has an overall aim of understanding the prenatal access to care pattern among the women of GFW who have experienced pregnancy at least once in their life time. The specific aims of the project were to:

- Understand their personal choices,
- Understand their barriers to care, and,
- Understand their familial support.

PROJECT DESIGN AND METHODS OF IMPLEMENTATION

Project site

The project site “Greater Fifth Ward” of Houston was identified by the March of Dimes, the funding body for this project. The Greater Fifth Ward Super Neighborhood (referred to as GFW)¹, with a total population of 22,211 (according to the 2000 census), is characterized as predominantly a black community, with nearly half of the population living below the federal poverty level in 1999 (HDHHS, 2009a).

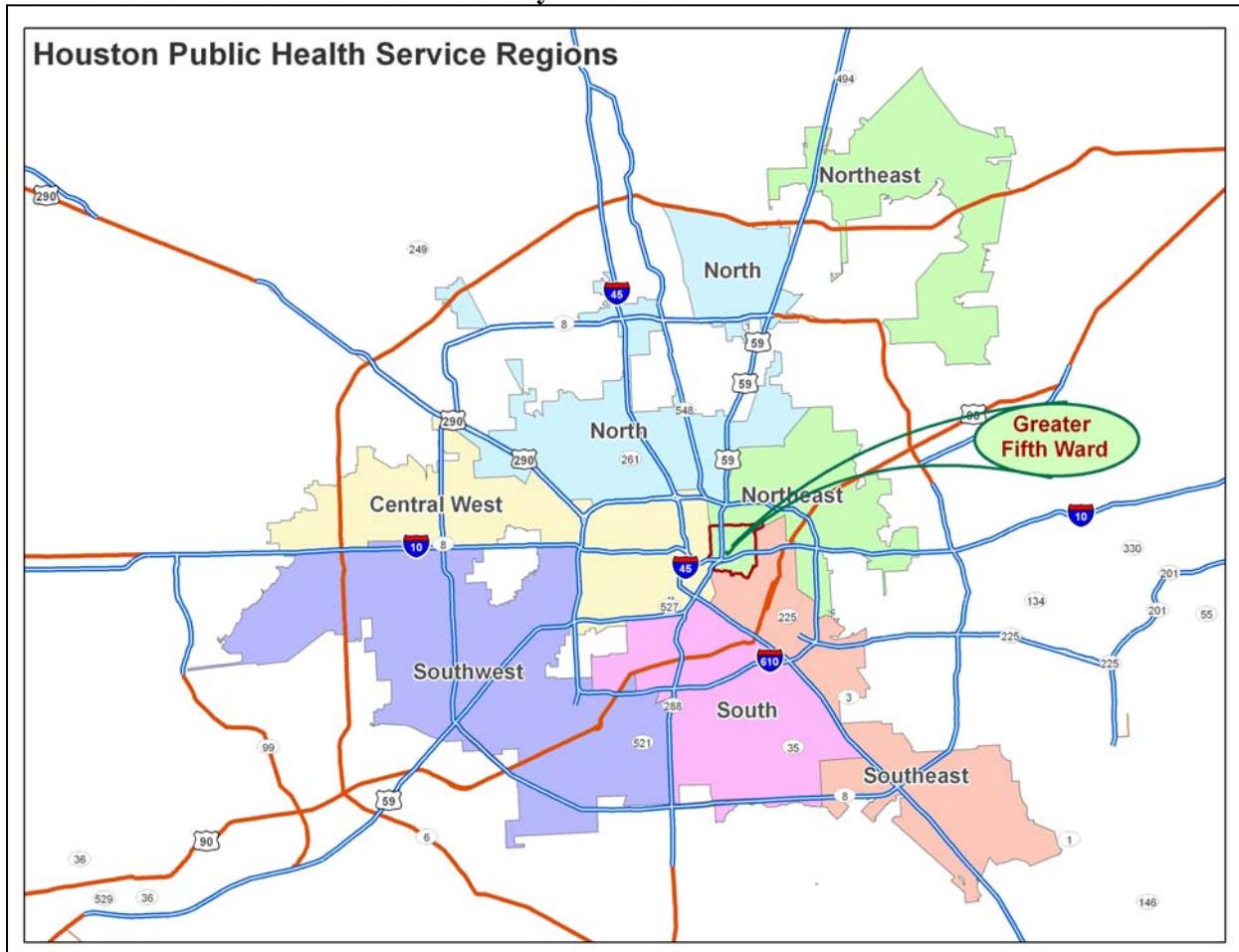
¹ For other health related indicators of Greater Fifth Ward, please visit:
<http://www.houstontx.gov/health/chs/profiles.html>

Project design

A project team of six members, representing different bureaus and divisions, was formed to conduct this project. A mixed method of data collection (comprised of focus group discussions and brief survey) and analysis was used.

A flyer soliciting volunteer participants for pregnancy and prenatal care issues was posted in multiple locations of GFW (See appendix 1 for sample of a flyer). Select apartment managers also volunteered to post the flyers. Venues were provided by the apartment complexes for three of the focus group discussions. One of the focus group discussions was held at a City of Houston (COH) multiservice center and one was held at a COH Community Center Park. Subjects were sampled purposively, using inclusion criteria published on the recruitment flyers.

Greater Fifth Ward location within the City of Houston



A total of three facilitators from HDHHS staff conducted focus group discussions. A co-facilitator was also present during each discussion to help in note taking and other logistical arrangements. Written consents were received from all of the participants for audio-taping the discussions and for utilizing the information for non-commercial purposes. As an incentive for participation a local grocery gift card worth \$15 was provided to each participant. An application for IRB approval was waived by the HDHHS Review Board. Five focus group discussions were planned and conducted. Lead-in questions were finalized by the project team and shared with the facilitators. Focus group discussions were transcribed

verbatim. Notes were refined after listening to the audio tape during analysis. Transcripts were coded using three levels: open coding, axial coding, and selective coding. Themes were identified from the data and a conceptual model was drafted to explain the potential schema of prenatal health care issues as experienced by the women participating in the discussions.

A brief questionnaire consisting of 25 questions was also administered immediately prior to the focus group discussions. Three of the questions were used for screening interested persons for eligibility to participate in the focus group discussions. A volunteer had to meet all three criteria to be eligible to participate. The criteria were 1) residence within GFW (Do you live in GFW?), 2) Age (Do you fall in the age group of 17 to 30?) and 3) pregnancy experience (participant deemed eligible if answered “yes” to any of the following questions: Do you have any children? or Are you currently pregnant? or In the past 2 years, were you ever pregnant?). The remainder of the questions collected background information on the participants, such as their demographics and their access to prenatal health care services. The questionnaire was thus administered to all women who volunteered to participate in the project, though focus group discussions were conducted only with those women who met eligibility criteria.

An attempt was made to improve qualitative rigor of data analysis by sharing the preliminary findings with the facilitators and project team. Feedbacks on the schema, received from three members of the project team, were considered and incorporated into the final report as appropriate.

FINDINGS

Participants’ characteristics

A total of 40 women expressed interest in being involved with the project, but only 24 were eligible for the focus group discussions. Given the non-probability sampling methodology, the degree to which the participants represent all women of child-bearing age in GFW cannot be determined. Thus, the findings in this report may best be said to pertain only to those 24 women who participated in the project. Some of the general characteristics of these participants were:

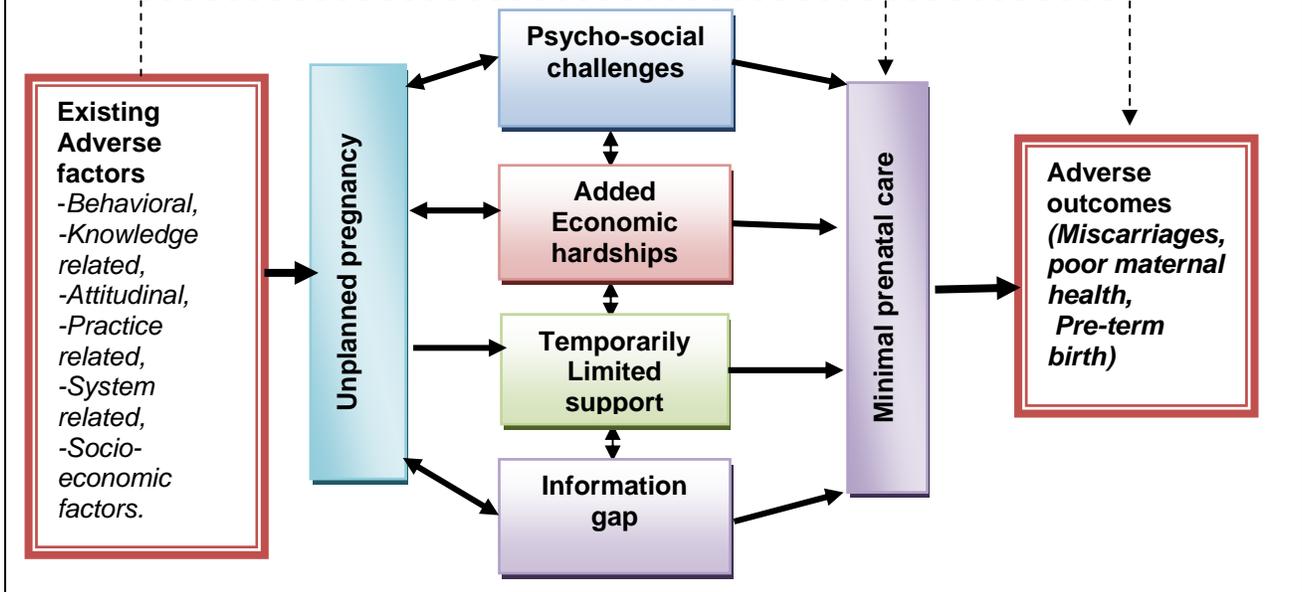
- Most were African American, with a few Hispanics, whites, and others.
- They ranged in age from 17 to 30 years².
- Approximately half the participants had Medicaid coverage during their last pregnancy.
- Most did not use any form of contraception.
- Most received support such as food stamps [Now known as Supplemental Nutrition Assistance Program (SNAP)] and the special supplemental nutrition program for Women, Infants, and Children (WIC).
- Only 9 out of 24 women reported that they could borrow \$50 from someone if they needed financial support.

Focus Group Discussions findings

A pattern emerged from focus group data analysis that suggests answers to questions such as, why women do not appear to be optimally utilizing available prenatal care services, and why they may seek them late in pregnancy. As depicted in Figure 1, the story begins with the existing adverse factors in the community.

² Although the project initially envisioned studying prenatal care issues of women within the age range of 18 to 44, the project team changed this range to 17-30.

Figure 1: Issues related to prenatal care among study women



These factors include: 1) behavioral factors (eg. multiple sex partners, substance abuse/dependency, 2) attitude related factors (eg. “nothing can happen to me”), 3) practice related factors (eg. not using contraceptives), 4) system related factors (eg. service use barriers, location of healthcare provider) 5) knowledge related (eg. lack of knowledge about sex, pregnancy and the importance of prenatal care) and 6) socio-economic factors (eg. low income status) in the context of this study. These factors may result in adverse outcomes of various severities but the path may be different for different population groups. In this study, these factors appear to lead to *unplanned pregnancy*, as is partially reflected in the following narratives:

I cried a lot. Uh, I didn't have anyone to talk to. I was ashamed because I was 15 years old... I was in the 10th grade. I was trying to go through school. Very embarrassed. My body changed (1-1).

I did have a cousin. She started her cycle at 9 years old, but she started having sex about when she was 11 or 12. She got pregnant but she wanted to keep her baby. You know how young girls these days want to keep their babies (2-7).

Underutilization or late utilization of prenatal care services may be partially explained by the fact that the majority of the participants appeared to be unaware of their pregnancies until relatively late.

“And actually um I didn't know that I was pregnant. Um, what happened was...I had a funny a funny and real general distaste in my mouth...everything that went down came up and I had trouble sleeping and 'attitudish' and uh, my mama said something's going on.....went to see the doctor and doctor said I'm 8 weeks pregnant (1-5).

Some women stated it simply;

“It just kinda happened” (5-4).

“Well, actually I didn’t know that I was pregnant, so um...when I found out I was probably already two months” (5-1).

“I found out when I was two months, almost three months” (5-8).

In this same vein, a few teenage girls spoke of their friends who had gone through the process of miscarriage, though their friends were unaware that they had even been pregnant.

“I had a friend, when we were in middle school (We was in the 8th grade) and she had a miscarriage. I didn’t know what she was having. I thought she was dead. She was in the bathroom. It was blood all over”(2-5).

One woman discovered her pregnancy once she was hospitalized in the emergency room for other illnesses;

I actually found out that I was pregnant through the emergency room(3-9).

These narratives indicate how unprepared and unaware some of the girls and women were about their pregnancies and associated consequences until relatively late in pregnancy.

One relevant issue to be noted here is the fact that planned pregnancies may also result in these outcomes. Minimal prenatal care may also exist among women who do not have unplanned pregnancies. Unplanned pregnancy by itself may not be adequate to explain why minimal prenatal care occurs. Still, the focus group discussions conducted with these women suggested unplanned pregnancy as being one of the consistent themes in the study.

Four themes seem to be relatively consistent across the focus group discussions which suggest a prenatal health care service utilization pattern.

Theme 1: Temporarily limited support system

Focus group discussions data suggest that one of the issues revolving around prenatal care among the participants is the *support system* for pregnant women. As per the data, a support system during pregnancy, in general, was described by participants as having three levels: (1) having ample support; (2) not having support at all; and (3) having temporarily limited support. However the overarching theme was that women seemed to have a *temporarily limited support system* during pregnancy. A temporarily limited support system is defined here as meaning that there was an ample and/or significant level of support for the individual before the pregnancy (as perceived by the participants) and that support became limited or disappeared after constituents of the support system learned about the pregnancy of the individual. Dimensions of the *temporarily limited support system* mainly included lack of parental support and lack of spousal/partner support, for the unplanned pregnancy. The loss of such support resonates in the day-to-day life of the pregnant women affecting finances (housing and food), emotional support (for taking care of oneself and of the growing fetus in the womb), which might also have some long term negative health consequences.

“I mean it was a lot my mom kicked me out and not having her support and not knowing what to do...I mean it was a lot. So, I didn’t get to spend time with my other family members and I didn’t get to spend time with them. But, then I think that with all that and the depression and not eating well. And then living with my in-laws and not getting along with her, I think that all of that caused my miscarriage” (4-10).

Whether the pregnant women received support from their spouse/partner depended on their spouse/partner’s 1) availability during the pregnancy, and 2) attitude towards the pregnant woman and the pregnancy. Availability and attitude together, appeared to play a role in determining whether the pregnant woman received any spousal or partner support.

The adverse conditions that women experienced with the absence of a spouse / partner is apparent in the following narratives:

“I went through my pregnancy.... but I didn’t have any one with me. ...I did everything on my own. My problem was.....He’s a repeat offender...”(3-4).

“I had her[baby] when I was in school and everything. Her dad was helping me, but then he went to jail. And he’s been incarcerated for almost six years (4-7).

“Another issue is that he does not have papers and he was deported a couple of months ago and basically I am a single mom now and it’s been hard. I mean the only support I have..” (4-10).

The above-mentioned narratives elucidate three key factors: 1) feelings of isolation and helplessness during pregnancy, 2) having to deal with other competing needs, such as needing to go to school, and 3) having to assume responsibility for themselves during pregnancy possibly as result of diminished support. However, it is noteworthy here that a few participants were able to utilize strategies to overcome such difficulties – for example, by seeking help from their close friends and experienced neighbors. Only a few participants acknowledged that they received an adequate level of support from their family during pregnancy:

“I got a lot of support with this time... very, very supportive and I thank God for that. And my momma? I thank God for her. I thank God for everybody who helped us. That’s not everybody’s responsibility for us (3-10).

Theme 2: Psycho-social challenges

Another theme was the sudden emergence of added *psycho-social challenges*. These challenges had many features and reflect the psychological impacts of isolation from family members, self-stigmatization, separation from the spouse/partner (including divorce), negative attitude of the spouse/partner (such as not assuming responsibility for the pregnancy), unfavorable behaviors of partner (including physical abuse, “not going along”), and the fear of financial insecurity (upcoming bills associated with pregnancy and delivery). These factors may contribute to delays in seeking health care. A large number of focus group discussion participants reported persistent insecurity and fear regarding sustainment of support from their partner or spouse over time. Depression, fear, embarrassment, distress, abuse, loneliness, sadness, anger and disappointment were key experiences that the majority of these participants went through during their pregnancy. These expressions combined with the project team’s observations³ during

³ Although the focus group discussions data (transcripts) did not reveal mental health issues as being one of the key issues of concern for the study women but personal communications with FGD facilitators and others who attended the focus group discussions suggest that mental health issues are one of the key issues for study women with regard

the focus group discussions suggest a presence of a realm of mental health issues associated with pregnancy.

“I was depressed.” (1-17).

“I was kinda of shocked.” (5-3).

“A lot of pressure and a lot of stress.” (4-10).

“Sometimes it’s depressing- sad. I feel lonely. You know but you can’t do nothing but accept it. I have regrets.” (3-7).

Physical abuse was an issue that resonated across all the focus group discussions, and it appeared to contribute to further deterioration of the overall condition of some women:

“Because her baby daddy was the worst baby daddy. He stomped the baby out of her almost. She didn’t even get to have the baby” (3-5).

“He did not want her to have that baby. He felt like if it was his baby, he was going to feel bad. She was just having sex with his friends and everybody. She just made him so mad that he just stomped her. And we couldn’t stop him. It was bad” (2-5).

He tore her insides up(2-5).

Feelings of disappointment in some of the pregnant women, as triggered by perceived lack of cooperation from spouse / partner, resonated in some discussions;

See this one’s [father of her unborn child] not there. He’s there sometimes. He’s not understanding. He don’t... I can’t talk to him. He’s not understanding and I can’t do it... This one’s kinda crazy. When I talk to him, I get mad, angry, disappointed (3-6).

A delay in accessing prenatal health care was likewise an issue that was revealed in the data; a key factor was the mental unpreparedness of the women to have a baby when they learned of their pregnancy:

“Because I was just not ready for another baby at the time...my girls were seven and eight and I felt like they were too old, for me to just start over, with a little baby” (5-8).

Behaviors such as delaying seeking health care can also be attributed, in part, to perceived embarrassment and self-stigmatization. As one participant described her own circumstances,

I think that came from... I wasn’t 7 months. I was 4 months. And you know like...Ok...You had a baby. You took care of this baby. Then you wind up finding you having another baby. You like try to hide it for so long. You try to hide because you be like ‘Ah man! I got pregnant again!’ You know, you start thinking all over again (3-13).

Negotiating with the partner or with the spouse for support, emphasizing the value and of need for a steady relationship, and getting enough rest (sleep) were recommended by a few participants as strategies that they found helpful to deal with psycho-social challenges, and also to secure needed support.

to their pregnancies (Personal communication with project team members: Algia Hickenbotham and Deborah Banerjee).

It appears from the data that these psycho-social challenges in part may have led to minimal utilization of prenatal care by these women. The long term outcomes also noted during the discussion include depression and adverse birth outcomes, etc. Adverse outcomes such as miscarriages and fetal/infant mortality were very familiar issues to the participants:

“Yes, I have been pregnant before but I lost the baby”(2-3).

“And umm...that miscarriage was so hard, that pregnancy was hard” (4-10).

One woman reported how her friend had to compromise her career opportunities;

“She got pregnant. Everybody.. It was a shock because she was a tomboy. And we that Aunt and everybody was going to tell her to get an abortion because of the big career she had”(2-9).

Theme 3: Added economic hardship

Although economic hardship is a very contextual and individual-specific issue, and it may have numerous dimensions and properties, it appears from the focus group discussions to be an important theme as it relates to prenatal health care service access by the participants. *Added* economic hardship – an increased economic burden reported by women as a consequence of pregnancy – included dimensions such as lack of income due to inability to work during pregnancy, decreased familial economic support, and new financial responsibilities. The increased economic burden appears to create hardships for women in terms of taking care of their own health and that of their unborn child (transportation, vitamins, healthy diet etc). The hardship becomes more evident with a lack of parental/family support. Perceived added economic stress of rearing a new baby was also expressed by the participants as were new financial responsibilities (such as food, housing, general health care, childcare, and transportation issues).

It's like, how do I do this by myself? I'm pregnant. Then like you have to take it from there.....That hurts! (3-10).

And then people don't have transportation. You know (others agree) they might not have transportation. And then you don't have a job. You start getting frustrated. Then you get on the bus and you don't even have a dollar to go one way. You can't even afford a Q-card. The economy is like really taking all of the expenses in just holed up in one little area. They not dividing it like they used to (3-13).

The above mentioned excerpts, and the fact that a majority of the women who took part in the discussions had received food stamps and WIC, suggest ways in which participants are affected by the added financial burden of *unplanned pregnancy*, a broken *support system* and added *psycho-social challenges*. The data are suggestive at best, as it is to be noted that no information was collected on the socio-economic status of any of these women prior to or during their pregnancies. The sample may have been overly representative of women from lower socio-economic circumstances (partially due to the location of recruitment of participants), who may have been more adversely affected by economic changes than those of other circumstances.

Despite these difficulties, a few women were able to explore ways of overcoming hardships, indicating some degree of resiliency. For example, a few found support (financial and mental) among extended family and their social network to deal with the added challenges due to pregnancy.

Theme 4: Information gap

Another potentially representative theme is *information gap*. Dimensions of the *information gap* include, as revealed from the focus group discussions, mainly two broad areas: 1) lack of knowledge about health services (clinical and preventative), and 2) lack of knowledge about healthy pregnancy-related issues, such as prenatal care and sexual-reproductive health concerns. The following narrative highlights this theme:

I didn't know what it was- that I was pregnant. You know, but when it happened, I was just bleeding a whole lot. I know that my cycle that they usually come bad but I'm like this can't be a cycle because I was bleeding and I was crawling on the floor. I was asking a friend (2-6.)

Focus group discussions have revealed that participants had a perception that going to any health facility carries stigma:

"...I mean I don't have no problem going, but a lot of people tell me..... going to the clinic and get things to put into you so you're pregnant or diseases and they say because people that go to the clinic just look sick"(1-24).

"And they probably have something. Most likely...they had to have something to go to the clinic, you know so...it's not me it's just what I've heard" (1-24).

Data suggest that a few women were able to mobilize the existing networks of experienced older friends for information. A few were able also to obtain access to the internet for acquiring needed information.

"You might not be comfortable with your parents so you can ask a good older neighbor or wise older friend, Like _____ because she be knowing her information"(2-11).

Data suggest that even when there is a family support mechanism in place, receiving information related to pregnancy and pre-natal health care could be easier to obtain from a circle of friends rather than from parents. Few participants opined that pregnancy-related information could be received from school, however.

They have a program at the school and some of the teenage girls be going up there and telling what clinic to go to.....So from school... School is one of the sources where people find...[information](2-10).

DISCUSSION

The findings of the focus group project are not generalizable to the whole of Greater Fifth Ward because of concerns about the representativeness of the focus group discussions participants. A larger, more definitive study would provide greater clarity and stronger evidence of the findings presented in this report. To enrich the available data, triangulation was attempted using data from the participant questionnaires and from an analysis of birth data for 2005-2008, specific to GFW.

As illustrated in Figure 1, *unplanned pregnancy* is likely to be one of the outcomes of existing adverse factors prevalent in GFW. Very little exists in terms of literature providing definition for *unplanned pregnancy*, however, there are proposed indicators of unplanned pregnancy that include: (1) expressed intentions; (2) desire for motherhood; (3) contraceptive use; (4) pre-conceptual preparations; (5) personal circumstances/ timing; and (6) partner influences (Barrett, G. et al, 2004). In general terms, *unplanned*

pregnancy can be described as a condition of pregnancy that results without any planning for being pregnant including lack of intention or desire for pregnancy on the part of those involved. The data from this project tend to suggest that *unplanned pregnancy* gives rise to four thematic areas which are the processes of minimal utilization of prenatal care services. These potential thematic areas are: *psycho-social challenges*, *added economic hardships*, *temporarily limited support system* and *information gap*. These variables seem to be interacting with each other and also with the existing factors. *Unplanned pregnancy* seems to be interacting with existing psycho-social conditions of the study women in a bidirectional fashion while generating more psycho-social burdens to the pregnant women. Similarly, *unplanned pregnancy* appears to have interacted with existing *economic hardships* and prevalent *information gap* in a bi-directional manner adding newer categories of economic hardships and increasing the information gap, respectively.

Psycho-social challenges incorporate those unique internal processes that occur within an individual as affected by the social environment (Egan et al, 2008). Thoughts and emotions related to the stress of managing the pregnancy in the absence of other supports, and in managing and overcoming regrets and corresponding self-stigmatization all are the examples of *psycho-social challenges* experienced by participants. Such psycho-social challenges appear to interact with *added economic hardships* in a bi-directional fashion, and thus, may contribute to further deterioration of the overall psychological outcomes, and also to have adverse impact on health care utilization patterns. This finding is in conformity with finding of Katz et al, 2008. Their finding was that the interaction between the individual and the social environment, with overarching contextual factors may influence psychosocial stresses, health behaviors and pregnancy outcomes (Katz et al, 2008).

Added economic hardships highlight the challenges of not being able to manage a circumstance of added needs of financial resources during the pregnancy period. Being unable to ensure financial support for needs during and after the pregnancy appears to be one of the key concerns for the participants. Lack of money for basic needs such as transportation, and healthy / nourishing food on a day-to-day basis may have dissuaded women from accessing prenatal care services. The corresponding psychological as well as general health outcomes may be affected. *Added economic hardships* appear to have been interacting with both *psycho-social challenges* and *temporarily limited support system* in a bi-directional manner.

Temporarily limited support system incorporates the concept of a weak or non-existent support mechanism available to the women during and after pregnancy. Lack of parental support for teenage pregnancy (being considered a deviant behavior by the parent) or discipline-related issues are evident in the data. Lack of spousal/partner support is associated with the existing social environment. Some of the spouses and partners were reported as incarcerated, or as having been deported to the native country, during the pregnancy. Support mechanisms are further weakened by the lack of preparedness to have a family life and assume family responsibility on the part of male partners. Focus group data suggest that pregnant women sometimes do not reveal their pregnancy to any one until the pregnancy becomes conspicuous to everyone. This choice appears to be associated with an outcome such as having to go through pregnancy without support. Having *temporarily limited support systems* also interacts with *information gap* and vice versa.

Information gap incorporates the lack, on part of an individual pregnant woman, of knowledge and skills required for handling pregnancy related needs such as identifying available and affordable services, handling costs of services, understanding when to start seeking health services and at what frequency etc. In the context of teen pregnancy, this lack of information becomes even more gaping, requiring a multi-sectoral intervention.

All these processes act as the barriers to prenatal care for the given women on one hand and on the other hand, existing resources and factors in the community also prevent women from accessing services when

needed. According to Kiely and Kogan (2006), Institute of Medicine (IOM) report has identified three categories of barriers to prenatal care: system related, attitude related and socio-economic demographic related. Issues identified in this project such as unplanned pregnancy, lack of recognition of pregnancy and prenatal care not being valued are described in the IOM report under the category of attitude related barriers. Similarly, socio-economic factors and lack of knowledge are described in IOM report under the category of socio-demographic related barriers. Likewise, inadequate transportation services and information gap are treated under the IOM report as system related barriers. Barriers such as *psycho-social challenges* of individuals and *added economic hardships* are not included in the IOM report as barriers to prenatal care. However, IOM identified several other barriers to prenatal care under each categories were not revealed in this study. This may be explained by the inadequate saturation of data in this project.

For the women participating in this study, strategies such as seeking help from experienced women, utilizing their social network including friends and extended family may help them cope with the problems that they go through during pregnancy. Building and accessing an informal support system could be valuable for ensuring better health outcomes.

Raising awareness about the importance of prenatal care (including information about available services) among the target women, providing easy-to-access and fast-track services (psycho-social counseling, prenatal care), building a mechanism for a tangible, temporary support system for pregnant women at the local level (such as temporary shelter, healthy foods and some financial assistance) may be fruitful approaches for maximizing use of prenatal care services.

CONCLUSIONS

One consistent finding of the investigation is that the available services, both public and private, are not being optimally utilized by the participants. The project has also identified and attempted to outline processes and pathways that appear to indicate how minimal prenatal care manifests among the study women. These processes also act as the barriers to care such as: *information gap, psycho-social challenges, added economic hardships and, a temporarily limited support system. Information gap* exists mainly in two areas: knowledge about available prenatal care services and awareness of pregnancy related physical and mental health needs. *Psychosocial challenges* appear to be a cross-cutting issue among the remaining processes. A lack of “familial support” as triggered by *unplanned pregnancy* seems to have contributed to *added economic hardships*.

However, this investigation was unable to provide a more detailed portrayal of prenatal care among women of GFW because of i) challenges with recruitment in spite of the incentives provided for participation, ii) the methodological inconsistencies, and iii) lack of saturation on various issues of interest under study.

RECOMMENDATIONS

It is *not recommended* that broad, or population level interventions be pursued on the basis of the limited findings of this investigation, alone. However, the information of this report can be utilized to identify some factors to consider when attempting to improve information dissemination to women who may be pregnant. The data can also be used to inform and design a more definitive investigation of prenatal care behaviors.

Future endeavors in this regard may attempt to answer the following questions:

- Why are women unable to access adequate prenatal care services (entering prenatal care in first trimester of pregnancy, completing recommended numbers of visits, etc)? Comparing the experiences of those who received adequate prenatal care with that of those who did not receive adequate prenatal care and examining the other significant moderating variables may be a valuable strategy.
- Prenatal care access issues and birth outcomes appear to differ for different age groups and race groups in GFW. Importance of understanding the moderating variables becomes apparent from the fact that almost two third of the total women giving birth in GFW during 2005-2008, reported being of Hispanic origin although population statistics indicates that a majority of residents in Greater Fifth Ward were Black as per 2000 census (HDHHS, 2009a). Additionally, more than 16% of women who reported *not* being of Hispanic origin gave birth to low or very low birth weight babies (HDHHS, 2009b).
- HDHHS analysis has also suggested that almost two thirds (63.43%) of the women of GFW who gave birth during 2005-2008 reported being “not currently married”. Another question of interest is: do patterns of access to prenatal care differ among those who report as being married versus those who report as not being married during pregnancy, and if so, why?

REFERENCES

- Kiely, J.L and Kogan, M.D. (2006). CDC's Public Health Surveillance for Women, Infants, and Children CDC's Maternal & Child Health (Retrieved from <http://www.cdc.gov/reproductivehealth/Products&Pubs/DatatoAction/pdf/rhow8.pdf> on March 2009).
- HDHHS (2009 a). Community Health Profile: Greater Fifth Ward. (Retrieved from <http://www.houstontx.gov/health/chs/FifthWard/FifthWard.pdf#page=8> on April 2009).
- HDHHS (2009 b). Vital Statistics Birth Data Analysis. Unpublished.
- Heaman MI, et al. Inadequate prenatal care and its association with adverse pregnancy outcomes: A comparison of indices..[PMCID: 2386440]
- Barrett G, et al. Conceptualisation, development, and evaluation of a measure of unplanned pregnancy. J Epidemiol Community Health. 2004 May; 58(5): 426–433.
- Egan et al (2008). Psychosocial risk factors in home and community settings and their associations with population health and health inequalities: A systematic meta-review. BMC Public Health. 2008; 8: 239.
- Katz, K S et al (2008). The design, implementation and acceptability of an integrated intervention to address multiple behavioral and psychosocial risk factors among pregnant African American women. BMC Pregnancy Childbirth. 2008; 8: 22.

Women of Worth

Factors Related to Prenatal Care among Women of Greater Fifth Ward: A qualitative and quantitative project

Part B

NOTE: This section addresses the secondary research question that was of interest to HDHHS.

Thus, the study background and methods are identical to that of the previous section. Only the findings and discussions as they relate to secondary research question are presented here.

May, 2009

**Houston Department of Health and Human Services
Houston, Texas**

Contents

SUMMARY OF FINDINGS OF FOCUS GROUP DISCUSSIONS	3
AIM OF THE PROJECT	4
FINDINGS	4
Participants' characteristics of interest to HDHHS	4
Focus Group Discussions Findings	4
CONCLUSION	6
RECOMMENDATION	7
MISSED OPPORTUNITIES	7
REFERENCES.....	8

SUMMARY OF FINDINGS OF FOCUS GROUP DISCUSSIONS

- **The women of Greater Fifth Ward received prenatal services from various service providers.** These service providers can be grouped into two categories: Private facilities (including private hospitals and clinics), and Public facilities (including COH clinics and country hospitals).

- **The choice of service providers appeared to be related to factors such as:**
 - Distance of the service providers' location from home
 - Location of residence during the need for services
 - Familial tradition
 - Availability of information
 - Access to information

- **The barriers to service use at HDHHS health facilities:**
 - System related barriers (e.g. lack of information about the available services, transportation)
 - Attitude related barriers (e.g. rude people, trust related issues)
 - Individual level (e.g. lack of knowledge about the importance of prenatal care)

- **The features that the participants appreciated about HDHHS clinic facilities:**
 - Comprehensiveness of the services (staff provide needed services without any prompting or special requests)
 - Privacy of the services

AIM OF THE PROJECT

Given a background of poor pregnancy outcomes in Greater Fifth Ward and an assumption that “the annual average number of women utilizing city clinic services for the prenatal care has been decreasing in the recent years”, this project aimed at understanding “Why are women not utilizing prenatal care services through the HDHHS facilities?”

FINDINGS

Participants’ characteristics of interest to HDHHS

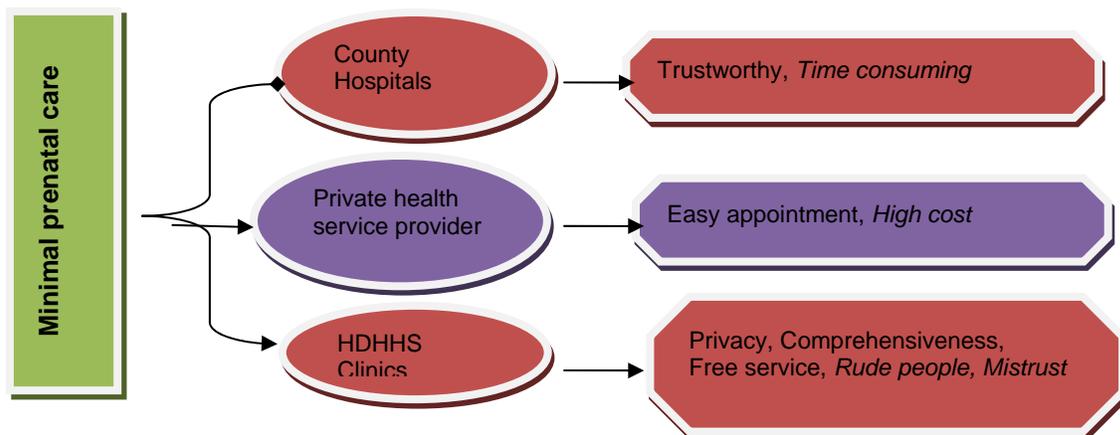
- Approximately half the participants had Medicaid coverage during their last pregnancy.
- Most did not use any form of contraception.
- Most received support such as food stamps [Now known as Supplemental Nutrition Assistance Program (SNAP)] and the special supplemental nutrition program for Women, Infants, and Children (WIC).
- Only 9 out of 24 women reported that they could borrow \$50 from someone if they needed financial support.
- Fourteen out of twenty-four women had been to a City of Houston Clinic in the past.

Focus Group Discussions Findings

This section makes an attempt to answer two key secondary questions that are of interest to HDHHS: Where do women of Greater Fifth Ward (GFW) go for prenatal services and, what are the barriers for specifically seeking services at HDHHS clinics, if any?

As depicted in Figure 1, information revealed through focus group discussions suggest that the participants received prenatal care services from both public and private health service providers. Private health service providers were often characterized negatively due to the expenses related to the visit. Few participants characterized the private clinics and private hospitals as having “easy to make” appointments.

Figure 1: Prenatal health care: Minimal service use pattern



Moderating variables

Distance, Location of residence during the need for services, Familial tradition, Availability and knowledge of existing services

One possible moderator of whether the women in this project receive care from private service providers seems to be family tradition, or familiarity with a particular family doctor in a particular clinic or hospital:

My momma was delivered with all of us. She was like more of a family friend doctor and like a normal regular doctor that you just go see. She took care of my family” (3-8).

Only a few participants mentioned the utilization of private clinics, and this might be explained by the fact that all are residents of an area considered as a lower-income community (three-quarters of all residents in this neighborhood had income less than twice the poverty level from 1999-2003 [HDHHS, 2009]). Most of the participants reported using either HDHHS clinics or county facilities and hospitals. County hospitals were characterized as trustworthy places for services but also as requiring long waiting periods to obtain services. The HDHHS clinics were characterized, by a few women as “free” and/or as providing services at minimal cost. Some mentioned their appreciation for their privacy being maintained at the city clinics, as apparent in following narrative:

“At the Lyons clinic, like when you pregnant and you go up in there and you go with your parents or whatever, then they be like, they ain’t going to tell your parents that your pregnant or whatever (More side chatter)...like if you under age, they won’t tell you parents that you pregnant, if you don’t want them to tell.” (2-15).

Comprehensiveness of services of the city clinic was also highlighted by some participants:

“The city clinics you know they check everything, and I feel like if I don’t have to ask them to check for it and they check for it anyway” (5-5).

A few women utilized other HDHHS services such as WIC centers as a strategy to fulfill their economic and basic needs (Also see **Out of the box**):

“And food is kind of high and you get vouchers for food, healthy foods, you know, food that you really need to eat. So, if wasn’t for the City of Houston Health Department to provide us with those a lot of people wouldn’t you know, do without. So, I appreciate the City of Houston Clinics, that’s why I go there” (5-9).

Out of the box
Per a nurse, who works at Sunnyside prenatal clinic, a significant number of women (mostly African American) come to the clinic towards the end of their first trimester so that they have the proof of pregnancy, which is required to be eligible to apply for Medicaid. Once they (estimated as 50-70%) have an initial check-up and have received Medicaid, they go to private hospitals and private clinics. This leaves only a small portion of pregnant women who would receive maternity and prenatal care from city clinics for an extended period.

A few participants, however, were not happy about the delivery of services at city clinics, as reflected in following narratives:

I went with a friend to Lyons for the free...[service]. They service was kinda nice but they have some rude people (2-14).

“Some of the employees is rude” (2-14).

And quite a few also expressed a concern of trust over services provided by HDHHS clinics:

“My cousin went there and she had went to the lady. And the lady had told her that she was having a boy. Then she went back to her original doctor found out she was having a girl” (2-15).

Some described HDHHS clinics as “last resort” for health care services as affirmed in the following narrative:

“Not really like...you know...that’s just your designated place to go when you can’t, you know go anywhere else..... Um, I mean, some people just I don’t know don’t want to be seen in the clinic.” (1-24)

These system related barriers, were not explored to any depth by the focus groups, and the few narratives derived from this investigation can provide only minimal evidence of barriers to the use of the city health facilities by the women in the group.

The distance between the place of residence and the point of service seemed to be another moderating variable that determined the choices that women made for seeking health services during pregnancy. Women chose to go to seek prenatal care in the health facilities that are in close proximity.

“Because they [city clinic] was close to me. For transportation wise, I could ride the bus” (3-8).

“It’s closer to my momma house...” (5-4).

Unavailability of transportation and/or lengthy travel time to service sites is documented by other researchers as one of the system related barriers of prenatal care (Kiely and Kogan, 2006). Women are likely choose to select health service providers based, in part, on where they live.

“Like different times like if I go with my cousin like if I stay at my cousin’s house and I’d go over there...” (1_11)

These system barriers may have had some degree of impact upon delays that participants reported in seeking prenatal care. The evidence of this association from the focus group discussions is thin, but the outcome is suggested in other data. The Community Health profile of Greater Fifth Ward, 1999-2003, indicates that the proportion of mothers who gave birth during that period and who sought prenatal care services in the first trimester of pregnancy was low (close to two-thirds) compared to the Healthy People 2010¹ target of ninety percent (HDHHS, 2009).

Related to this outcome may be another moderating variable, knowledge about existing services that affects the choices of women in terms of where they seek prenatal care services. The results from the background questionnaire that all participants filled out indicate that most of the women did not know about free/sliding scale services available at HDHHS health facilities. Such a lack of knowledge may have resulted in minimal use of HDHHS services by participants in the project.

CONCLUSION

The assumption, which guided this inquiry, that the available services are not being optimally utilized by the women of GFW women seems to be true but further exploration is needed to make a valid conclusion. This investigation could not provide a detailed portrayal of prenatal care access among women of GFW. Following issues were recorded during data analysis: i)lack of saturation on the various issues of interest

¹ More information on U.S. 2010 objectives can be obtained from <http://www.healthypeople.gov/>.

under study and ii) the methodological inconsistencies in data collection. Added to this, the project team acknowledged that there were challenges with recruitment in spite of the incentives provided for participants in the community.

Following are some of the inferences that tend to be surfacing (**Note:** Further exploration is required to validate these “tends to be surfacing” findings:

- Focus group discussions data indicate that women of Greater Fifth Ward received prenatal services from various service providers. Those service providers can be grouped into two categories as, Private facilities (including private hospitals and clinics), and Public facilities (including COH clinics and country hospitals).
- The choice of service providers seems to be influenced by various factors including:
 - Distance of the service providers from home,
 - Location of residence during the need for services,
 - Familial tradition,
 - Availability and knowledge of existing services and,
- Barriers to service use at HDHHS health facilities, as reported by focus group discussion participants, seems to include:
 - System related barriers (e.g. lack of information about the available services, transportation)
 - Attitude related barriers (e.g. rude people, trust related issues)
 - Individual level (e.g. lack of knowledge about the importance of prenatal care)

RECOMMENDATION

It is not recommended that broad, or population level interventions be pursued on the basis of the limited findings of this investigation, alone (See missed opportunities below). However, the findings can best be utilized by suggesting some factors to consider when attempting to improve knowledge of services and information dissemination about HDHHS clinics to women who are of reproductive age range. The data should also be used to inform and design a more definitive investigation of prenatal care behaviors and barriers, should any be considered in the future.

MISSED OPPORTUNITIES

❖ Recruitment and sampling

- The choice of a purposive sampling strategy was not inappropriate, but might have been planned and executed with a more hands-on approach, ensuring that the mix of participants was more reflective of the target population (perhaps using quota sampling as one possible method).
- The actual target population was not clearly defined and it is not clear whether the investigators obtained information on the population that they intended to study: the study proposal described the target as being women between the ages of 18 and 44 years, with recent pregnancy or birth experience; the recruiting posters and the final sample included women between 17 and 30 years of age.
- Recruitment of participants through apartment managers, alone, may have biased the sample in ways that cannot be determined. If the purpose was to describe prenatal care among all women 17-30 years of age in GFW, some attempt to sample more representatively, throughout the super neighborhood (in multiple venues – clinics, schools, businesses, corner grocery stores, etc) might

- The number of participants assigned to focus group discussions was irregular (ranged from two to twelve) due to recruitment challenges and was not conducive to group discussion. The qualitative research literature suggests optimal focus group sizes between 6 and 8 (Smithson, 2000).

❖ **Data collection**

- Additional training could have been provided to the facilitators to ensure consistency in data collection. Facilitators should be available to attend all training sessions so as to ensure uniformity of the facilitation and integrity of the focus group discussion data. Paying special attention to strategies such as not asking individual-specific questions in a focus group, not losing sight of the key research questions during the interview, not conducting individualized interviews in a group setting, encouraging interaction and discussion among focus group participants, being sure to listen to group responses and to probe more deeply into those responses could all ensure richer and better quality data from group interviews.
- The participants of one group were so diverse that the facilitator was required to switch back and forth between two different languages (English and Spanish). Literature suggests a homogeneous group of participants for focus group discussions as being more productive. Homogeneity in culture, ethnicity and age ensures better communication, and improves group dynamics (Creswell, 2007).
- Several items on the questionnaire required discordant “yes/no” responses that could not be appropriately answered by the participants. More attention could be given to the design of the questionnaire, and orientation to the team prior to actual the questionnaire’s administration could have been planned so as to make sure that the instrument produced better interpretable information.

❖ **Project design/ management:**

- More attention could have been provided to define the project goal and specific aims. Reinforcement of project aims to the facilitators and all project team members could have resulted in more consistent collection of data.

REFERENCES

- Kiely, J.L and Kogan, M.D. (2006). CDC's Public Health Surveillance for Women, Infants, and Children CDC's Maternal & Child Health (Retrieved from <http://www.cdc.gov/reproductivehealth/Products&Pubs/DatatoAction/pdf/rhow8.pdf> on March 2009)
- HDHHS (2009). Community Health Profile: Greater Fifth Ward. (Retrieved from <http://www.houstontx.gov/health/chs/FifthWard/FifthWard.pdf#page=8> on April 2009)
- Heaman MI, et al. Inadequate prenatal care and its association with adverse pregnancy outcomes: A comparison of indices..[PMCID: 2386440]
- Barrett G, et al. Conceptualisation, development, and evaluation of a measure of unplanned pregnancy. J Epidemiol Community Health. 2004 May; 58(5): 426–433.
- Egan et al (2008). Psychosocial risk factors in home and community settings and their associations with population health and health inequalities: A systematic meta-review. BMC Public Health. 2008; 8: 239.
- Smithson, J. (2000). Using and analysing focus groups: Limitations and possibilities. International Journal of Social Research Methodology, 3(2), 103-119.
- Creswell, J.W (2007). Qualitative inquiry and research design: Choosing among five approaches. (2nd edition). Sage publications Inc.