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IDENTIFYING COMMUNITY SPECIFIC BARRIERS  
TO PRENATAL CARE SERVICES

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A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

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

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by  
Linda Pearl Helsper

June 1998

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Approved by:



Dr. Lucy Cardona, Project Advisor, Social Work

5/29/98  
Date



Dr. Rosemary McCaslin, Chair of Research Sequence,  
Social Work

## ABSTRACT

This study examined the perceptions of existing barriers to prenatal care for women in a California community with a population of less than 200,000. Snowball sampling was used to identify key respondents. There were seven individual interviews and one group interview resulting in eight transcripts for analysis. The group consisted of fourteen consumers of the maternal health system for a total of twenty-one participants. The qualitative data were analyzed for recurrent themes regarding access to prenatal care. The research uncovered shared perceptions of barriers to prenatal care as well as the conditions that influence a woman's choice to seek care. The study describes the role social workers play in fostering an increase in prenatal care utilization.

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## NATURE AND SCOPE OF PROBLEM

### Intent of the Inquiry

The intent of this research project was to discover the barriers that exist in this community when a woman attempts to access prenatal care. A concern for the well being of the children in the community and a belief in the importance of early intervention to enhance outcomes inspired the idea for this project. The hope was that avenues for improving birth outcomes would be discovered.

The boundaries of the research question kept the focus on the factors that might influence a woman's decision to seek prenatal care in a specific social context. The research literature addressed the relationship between prenatal care and birth outcomes. The research identifies reasons women do not seek care, reasons that exist in the community and in the individual. The intent of this project was to identify the reasons women do not seek prenatal care in this community.

Having experience with clients that had lost a child and knowing that the community had a high infant mortality rate led the researcher to a discovery process of why infant's were dying in the community and the possible measures that could lead to a reduction of poor birth

outcomes in the community. Poor birth outcomes and infant death have consequences for the families and the community.

#### Background

Statistics on infant death in San Bernardino, California and Highland, California from 1989 to 1993 show that 7.6% of women in San Bernardino received late or no prenatal care. The cumulative infant mortality rate (IMR) for those years was 12.2 (San Bernardino Department of Public Health, 1995). An infant mortality rate is calculated by the number of deaths per 1,000 live births. Low birth weight infants weighing less than 2500 grams accounted for about 8% of infants born in these two communities between 1989 and 1993 (San Bernardino Department of Public Health, 1995). The IMR for San Bernardino County, California and the United States were 9.8, 7.9 and 9.2 respectively in 1990. "San Bernardino county has had consistently higher annual infant mortality rates than both the" state and the nation from 1987 to 1990 (San Bernardino Public Health, 1993).

Neonatal mortality and post-neonatal mortality rates were also higher in this county than the state or the nation from 1987 through 1990. Neonatal deaths and fetal deaths are not included in the IMR. Neonatal deaths occur when a



child is less than 28 days old and fetal deaths are measured after twenty weeks gestation.

The research points to the different factors that influence a woman's care seeking behavior. The intent of this study was to gain a better understanding of the factors that influence care seeking behavior in this community. The discovery process was guided by a Constructivist research paradigm. In the context of that paradigm a dialogue was created, based on observations of the problem locally and the research literature, with people that are directly involved with maternal health care services.

The object was to gain a better understanding of the processes that limit any woman's access to prenatal care services in a specific social context. The hope was that given that understanding, community specific remedies could be identified and considered. The research indicates that there is a relationship between poor birth outcomes and a women receiving late or no prenatal care.

What impedes a woman's access to medical care for her own well being and for the well being of her children? There is a range of possibilities that keep women from accessing timely and necessary medical care. Barriers to maternal health care can include a woman's lifestyle

choices, living a long distance from health providers or restrictions placed by managed care policies (Bedics, 1994). Also, doctors or clinics may not be available to treat pregnant women or may not accept Medi-Cal (Fossett, 1990). Managed care plans may have restricted access to local clinics, that is, a pregnant woman's insurance coverage, or lack of, may not be accepted at a clinic that is accessible or familiar to the patient (Perloff, Waldrop, McGuire, 1996). Some women lack the understanding of the importance of maternal health care. Women may not be geographically situated near a clinic and transportation, public or private, may not be available. There are motivation issues for women seeking prenatal care. Women may be limited by the demands of work and family that impose time and logistical constraints on their ability to get to care.

Determining individual traits that influence care seeking behavior will help determine the appropriate remedy to improve the likelihood of seeking prenatal care. The identification of the community specific factors in the family, neighborhood and community that limit care seeking behavior will hopefully lead to community specific remedies.

Comprehensive prenatal care addresses the social, economic and logistical issues that face pregnant women in

addition to their medical needs. Women that avoid prenatal care because they fear the clinical environment, have substance abuse problems or family and transportation problems, can benefit from services that address their overall well being, not only their medical issues. Mahan (1996) suggests that comprehensive care "may be the basic services" that aid in improved birth outcomes. Social workers have a role in providing outreach and case management services to pregnant women to attempt to mediate the social risk factors that can lead to adverse birth outcomes.

Brooks-Gunn, McCormick and Heagarty (1988) considered behavioral and environmental factors that impact IMR. They offered findings that suggested that for poor women access to medical care was a problem. They attempted to improve infant outcome by implementing an outreach program, a transportation allowance and a maternal advocate program. "Interventions must go beyond medical care" to address behavioral and environmental factors and a "comprehensive mix of services seems generally desirable" (Brooks, Gunn, McCormick & Heagarty, 1988). The implementation of managed care policies and practices in the community appeared to influence care seeking behaviors of people with whom the

client had contact. Therefore, the level to which insurance policies influenced care seeking behavior or restricted access to care became an interest for the researcher.

#### Values, Ethics and Assumptions Surrounding the Problem

The researcher held to the ethical considerations of, protecting subjects from harm or unjustifiable deception. Participants were fully apprised of the problem focus, purpose, the method of inquiry and their role in the process. Their participation was voluntary. Each participant was given written informed consent and a debriefing statement giving them further opportunities to address any issues they may have had about the research. Respect was given to each individual and to their contributions to the research problem.

The belief that children are important and that they are a vulnerable group are values that the researcher brought to the discovery process. Children are perceived as vulnerable because of their dependence on others for their physical, psychological and social needs. Children lack the power to advocate for themselves, particularly in the period of infancy. It was also believed that understanding the needs of children at all stages of development, including

the onset of life would increase our aptitude in attending to those needs.

The social work researcher assumed that in the discovery process viable remedies to the problem would be identified. That in the process of exploring the barriers to prenatal care with professionals and consumers of the maternal health care delivery system, the participants would have knowledge and constructs for ways to increase women's participation in prenatal care services.

Another assumption was that those that would have the best understanding of the problem were in the community and that relevant discussion and solutions would come from community members engaged in the maternal health care delivery system. An assumption of the study was that the identified problems and remedies would be unique to this social context.

#### Focus of Inquiry

The focus of inquiry is a process of discovery, attempting to reveal the local, community specific barriers to prenatal care. This study looked at the perception of existing processes in the community that limit women from seeking prenatal care. A dialogue was initiated that considered the possible barriers to local maternal health

care. The dialogue took place in the community drawing on the expertise of individuals directly involved in the well being of pregnant women and their infants, care providers and consumers of the maternal health care delivery system. The consequences of inadequate care for the community and remedies to the research problem were also sought.

#### Literature Review

The research literature cites interventions found effective for reducing low birth weight. It reveals various reasons that impede women's access to prenatal care services. Barriers to decreasing IMR included mothers' behavior, lack of medical insurance, lack of practitioners, or a lack of willing practitioners to accept poor clients (Singh, 1990). The research literature represents a stakeholder in the hermeneutic dialectic circle, providing knowledge that contributes to the understanding of the research problem locally.

Cultural issues that influence care seeking behavior can include language barriers, patient attitudes towards the health care and the public social services systems. There are also cultural differences in attitudes towards the need for prenatal care (Tiedje, Kingry & Stommel, 1992). Singh (1990) cites a study done of infants born at Kaiser

hospital in Northern California that evaluated the cultural factors of African-American and Caucasian women seeking prenatal care. The women had equal access to care and services but the Caucasian women were more likely to seek care suggesting that the African-American did not seek prenatal care for cultural reasons. If equal access to care is a given then failure to seek care "may be more of a social than a medical problem" and appropriate interventions would target cultural beliefs that keep women from prenatal care services (Singh, 1990). Guendelman and Witt (1992) found that less acculturated Hispanic men did not want their wives examined by male doctors. They also found that a lack of bilingual professionals and undocumented status affected Latina care seeking behavior.

A factor that influenced a woman's ability to access or use prenatal care services was health insurance coverage and the timeliness with which they receive benefits once they had applied. Women were more likely to seek care earlier and be enrolled in Medicaid earlier "after the implementation of presumptive eligibility" (Donovan, 1996). Presumptive eligibility allows a doctor to provide care to a woman eligible for, but not enrolled in, the Medicaid program for two months. Another identified barrier to

prenatal care is an unwillingness of some maternal health providers to serve poor and low income women. In one study women did not access medical care because they were discouraged by practitioner's refusal to accept Medicaid (McGuire, O'Brien-Combs & Harman, 1991). Reasons women fail to seek prenatal care include their rejection from medical services or the discouragement of not finding a doctor willing to provide care. These women attempt to seek care but do not find a fit in the prenatal care delivery system because of their income or health insurance status.

Waldrop and his colleagues (1994), found that effective interventions for decreasing infant mortality rates (IMR) included increasing access to Medicaid and the number of providers willing to accept Medicaid patients and by increasing the number of prenatal visits. Infant mortality rates decreased after instituting outreach case management and improved clinical procedures for low birth weight infants (Waldrop, Taylor, 1994).

Environmental factors identified as barriers to prenatal care included family issues, geographical location, availability of providers and psychosocial support networks. Bedics (1994) interviewed 44 women to determine why they did not seek prenatal care. She analyzed verbal accounts of



seekers versus nonseekers of prenatal care. She found that stress in the home environment and conflicts in the clinical environment influenced women's decisions to avoid prenatal care. Some women attempted to receive care but were turned away or given poor information by service providers. Women that believed prenatal care was important, but did not go, were preoccupied with stressful life events and demands of family. The values or conditions of the home environment can influence a woman's decision to seek prenatal care (Guendelman, 1994). Women may have no one to care for younger children so she can seek care or she may work and clinics with evening hours may not be available.

Other environmental factors that can have an impact on a woman's access to prenatal care include her geographical location or proximity to maternal health care providers. Women living in rural areas and in inner cities had a lack of available service providers. Fossett, et al. (1990), compared zip codes with statistics on welfare recipients and found the number of available service providers in Chicago "was inversely related to the number of AFDC recipients." That is, in areas where poor women were clustered there were fewer private providers of prenatal care services. Having an adequate supply of practitioners willing to provide care

is necessary for universal accessibility to prenatal care services. O'Campo (1997) found that adverse environmental conditions such as poor housing, high crime and unemployment rates modified the relationship between individual risk factors and low birth weight indicating an interactive effect between environmental and individual factors. Individual factors were analyzed against census tract variables and it was found that individual risk factors were influenced by the neighborhood in which a woman lived indicating that social risk factors can modify the protective effects of individual care seeking behaviors.

Behaviors of pregnant women also influence their decision to seek prenatal care. Some women fear pelvic examinations, blood tests and the clinic environment (Tiedje, Kingry & Stommel, 1992). Women's beliefs or fears can be a barrier to seeking prenatal care. Bedics, 1994, found behavior characteristics of women not seeking prenatal care included lifestyle issues such as, drug use or a lack of knowledge of the importance of prenatal care. Some nonseekers of prenatal care were women that rejected the pregnancy and did not want the baby. Women's eating habits, use of cigarettes, drugs and/or alcohol can affect the decision of when prenatal care is sought and those behaviors

can affect the birth outcome of their unborn child. An estimate at Washington, D.C. General Hospital was that 60% of infants born had been exposed to drugs or alcohol, although comprehensive prenatal care is offered in Washington, D.C., that city has "the nation's worst IMR" (Singh, 1990). Tiedje (1992) states, "barriers to prenatal care exist in the system and in the self."

Strobino et al. (1995), studied four strategies and their effectiveness for reducing low birth weight (LBW) and infant mortality rates (IMR) in selected communities in the United States. An effective intervention for reducing low birth weight was "comprehensive prenatal care" which included psychosocial counseling, nutritional and health education in addition to medical care. Other effective interventions were smoking cessation programs and increased use of the federal food program for women, infants and children (WIC) (Strobino, O'Campo, Schoendor, 1995).

Zimmer-Gembeck and Helfand, 1996, determined psychosocial services to be an important component of prenatal care. Their data showed a decreased risk for low birth weight infants in "women who spent at least 45 minutes in psychosocial services" regardless of the conditions that made their pregnancies high risk. The provision of medical

services for pregnant women, complemented by psychosocial support, reduced the incidence of low birth weight infants and IMR.

The research points to reasons prenatal care is avoided and addresses the impact that this lack of care has on the health of the infants. The research also highlights social interventions for increasing adequacy of prenatal care to reduce IMR and reasons women do not seek prenatal care. The research identifies barriers that exist in certain communities across the United States, however the findings cannot be generalized without exploring the available services, gaps in service and patient needs endemic to this California community. The strengths in the maternal health care delivery system that foster utilization will be identified.

## RATIONALE FOR THE STUDY

### Community Practice

Access to maternal health care is critical given the knowledge that failure to provide specific care can result in infant deaths. Attempting to understand the adequacy of the local prenatal care delivery system is in the realm of community practice. The purpose of the study was to identify existing barriers for women seeking prenatal care services in a specific California community. The goal was to identify viable remedies to the problems women face when seeking maternal health care in this community. Increasing participation in prenatal care services, as well as mitigating the effects of social and environmental risks, would hopefully lead to a reduced incidence of poor birth outcomes and infant deaths in the California community.

The intent of the inquiry was to define the community specific factors that impede women's access to health care during pregnancy. Assessing the specific factors that affect prenatal care seeking behaviors could help define a focus for community intervention. Women need to be apprised of the importance of prenatal care and have doctors and clinics available that are willing to provide care. Women also need insurance plans that do not keep them from

receiving timely and necessary medical care. In addition, meeting the medical, practical and psychosocial needs of all pregnant women in the community contributes to the health of the entire community.

#### Research Paradigm

A Constructivist research design was used to investigate the local barriers to prenatal care services. The design provided for naturalistic exploration, gathering data from field excursions. The design was used to explore and identify the local barriers to care through community members that had knowledge of the problem. There was no preset hypothesis about the circumstances of the local barriers to prenatal care. A theory about the processes involved in restricting access to prenatal care, was expected to emerge from the inquiry process.

The constructivist paradigm fit this inquiry because the researcher sought knowledge in the community from people that had experience interfacing with the local maternal health care system. Knowledge came from interactions with community members vested in maternal health care.

Each participant in the dialogue became a stakeholder in the discovery process. Participants in the study included service delivery providers, clients and community members

that could identify the predominant barriers to prenatal care in this community.

The research literature, as a stakeholder, provided information on which to ground inquiry. The literature was shared with other stakeholders and the relevance of its themes to this community was determined in the inquiry process.

The gleaned knowledge was a result of the interviews and the results of any interview "are shaped by the interaction" (Erlandson, 1996). This inquiry was the pursuit of subjective knowledge rather than objective knowledge. The inquiry results depended upon the information subjects choose to share and the issues they preferred to highlight. The researcher position was subjectivist.

The constructivist paradigm provided a framework for the identification of problems and solutions within the context of the existing care network. Positivist research would have developed a theory about barriers to maternal health care based on available research and then developed an instrument to test the theory. The goal in this study was to depict shared constructed realities about the dilemma of access to prenatal care in the community, not to

investigate a specific question about access to prenatal care.

The post-positivist paradigm would have begun with observations in the research setting and then explored a particular question about what was occurring in that setting. There was no presumption of reality in this study, reality became apparent as the "multiple mental constructions" of the respondents (Guba, 1989). The shared constructed realities that emerged were relevant to the context of the inquiry. The study created a social environment where the barriers to maternal health were explored.

The critical theory paradigm would have framed a research question within the context of a political system, the differential treatment of a certain group. Differential treatment may be identified by the respondents as a barrier to local prenatal care services but it is not an assumption of this study.

The constructivist paradigm provided a framework to gain a better understanding of the issues that pertain to women in need of maternal health care in this California community.



## METHODS

### Structure and Fidelity

The methods for collecting data included interviews and observations of respondents. The inquiry addressed the lack of access to medical services for pregnant women.

Consenting participants were interviewed using an interview guide with nine (9) questions pertinent to the inquiry.

Data collected from earlier participants was shared with later participants to determine areas of agreement and disagreement. Research questions were designed to elicit "multiple mental constructions" (Guba, 1989) from community members that interface with the maternal health service delivery system in a California community with a population less than 200,000. The same research questions were used as an interview guide for data collection (Appendix C).

Information related to the research dilemma included technical and nontechnical research. The research literature provides knowledge on the problem of access to care that is integrated with the knowledge of respondents during interviews and member checks. Nontechnical information included local maps, bus routes, clinic sites, hospitals and regional statistics on maternal health and

infant mortality that provided knowledge on the social context.

A tape recorder was used to record interview data when participants assented to same. Four individual interviews were taped and three were not. The one group interview was taped. Notes were taken during each interview. Taped interviews and notes were transcribed into typed documents for analysis and member check purposes.

#### Sampling

The method of snowball sampling was chosen by the researcher and used in this study. Snowball sampling determined which participants were included in the study. Snowball sampling is a type of purposive sampling consistent with naturalistic inquiry.

Since the site was not one institution there was no formal gatekeeper or one individual to allow access to key respondents or participants. Community members were targeted, not one institution. Respondents represented hospitals, local departments of public health and social services and consumers of the maternal health care delivery system.

Snowball sampling was used to select participants after the initial interview. The first voluntary respondent was a

public health nurse. There were seven individual interviews and one group interview conducted. The individual interviewees included three public health nurses, one medical doctor, two social workers and one public social service program specialist. The participants were representative of different local agencies. The group interview included 14 consumers of the maternal health care delivery system. There were a total of 21 participants.

#### Hermeneutic Dialectic Circle

Each respondent would assist in identifying a person as the next respondent. A goal was to include diverse perspectives and to get data from a variety of sources. The participants represented a variety of perspectives and contributed unique information to the presenting dilemma. Participants agreed that the information they gave could be shared with other respondents. Information received in the beginning interviews was shared in later interviews, and all participants were invited to a group discussion on the constructions and themes that emerged from the data. In the hermeneutic dialectic circle each respondent confronted the constructions of the others. The hermeneutic aspect consists of depicting or interpreting constructions as accurately as possible. The dialectic aspect consists of

comparing and contrasting individual constructions (Erlandson, et al. 1993). The hope was that a new awareness of the local barriers to prenatal care would emerge from the data.

Each respondent was asked to recommend a person or group of persons that could address an aspect of barriers to prenatal care. The circle included seven individuals and one subgroup. The constructed realities of the subgroup became part of the data in the study. One person represented the subgroup in the roundtable discussion.

One participant recommended the researcher speak to someone "in Medi-Cal" and two other respondents named particular individuals to participate. The group of consumers was chosen so the perspective of clients as well as providers could be represented. Potential new stakeholders were contacted and asked about their willingness to participate. No new stakeholders were sought when several perspectives had been included in the circle and information became redundant. The researcher attempted to be aware of the possible motivations for the stakeholders participation in the study.

Participants were selected to participate in the hermeneutic dialect circle to create dialogue regarding

women's access to care. Respondents were presumed to be able to give information relevant to this social context. All interviews were done face to face except one. The medical doctor was interviewed over the telephone.

Each participant signed an informed consent and was given a copy of the same sample questions. Sample questions were open ended and focused on issues that would illicit information on the perceived barriers or limits to prenatal care in the community (Appendix D).

#### Data Collection

Data was gathered from technical and nontechnical sources: interviews, publications, research literature, brochures and artifacts (Strauss & Corbin, p. 48). Artifacts included information on local bus schedules, maternal health clinics and insurance programs. Conflicting information was clarified and dissonant opinions were included in the data. Respondents were given an opportunity to compare and contrast their constructs with those of previous respondents.

The study used between method triangulation using information from interviews, observations and literature for data collection. The degree of convergence from multiple sources of data is important for the evaluation of the study

(Erlandson, 1993). The researcher also used reference materials that helped to understand the context under study.

The data collection was qualitative, collecting words from interviews and observations regarding a specific topic. Gathering data from multiple sources provided a check against inadequate information. Often agency representatives will give an ideal representation of what occurs rather than actual problems agencies or clients face in accessing services. Talking with other representatives from the agency or clients would give another perspective on the effectiveness of the delivery of maternal health services.

#### Phases of Inquiry

The overview and orientation phase of the project involved initial contact and interviews with respondents. Respondents were apprised of the research problem and the purpose of the interview. Every interview was conducted with the sample questions as an interview guide. Information from beginning respondents was shared with later respondents to refine areas of agreement, disagreement and divergent perspectives. Interview skills were used to elicit, further and clarify responses from participants. The researcher learned about the problem from respondents

and clarified information given by each respondent to make sure the information they gave was understood and accurately interpreted.

Quality control was met through two criteria of prolonged engagement. Researcher presence in the community was not a novelty and the researcher had established rapport with members of the maternal health and public social services delivery systems.

In phase two, focused exploration, the knowledge acquired from orientation and overview was taken and used in a second interview with respondents and subgroups. Focused exploration was executed in a roundtable discussion to which all participants were invited. Contextual data, research and verbal data from interviews were interpreted and synthesized to shared constructions of reality, these findings were reported at the roundtable discussion. Four participants attended the meeting, the remaining four let the researcher know they could not attend. All participants received results of the data findings and were invited to respond to their contents, either at the roundtable discussion or by phone or mail.

A representative of the consumer subgroup, a substance abuse counselor, attended; two public health nurses, one

from the adolescent parenting program and one from infant mortality review; and a Medi-Cal program specialist attended. The researcher facilitated the meeting and made contributions to its content. The meeting, or roundtable discussion, was held to review and validate the findings from the data. Participants discussed areas of agreement, disagreement and areas where remedies might be implemented.

All eight participants responded to the invitation to the meeting on whether or not they could attend, four attended and four did not. All respondents received a copy of the final findings and a bibliography. Notes and recordings from the round table discussion were transcribed. Remedies, recommendations and persistent barriers to prenatal care were identified.

The focused exploration pursued shared constructions and the discussion was more narrowly focused on the research dilemma than in orientation and overview. There was a "continuing interactive process" that continued to the "point of redundancy" in focused exploration (Erlandson, 1993). The second phase was more focused as respondents spoke to established data and information rather than to open-ended questions. Final copies of the findings were reviewed by "a panel of respondents" to check the final



constructions against the information given to the researcher (Erlandson, 1993).

In phase 3, the member check, data and interpretations obtained were verified by respondents. Respondents were solicited for their reactions to the analyses of reconstructions formed from the information they had given. That is, did the respondents believe the constructions were plausible and could they accept the new cognitive structures attributed to the given problem (Kincheloe & McLaren, 1994). Data not verified through member checks were not included in the study.

Member checks were done in two ways. Member checks were done during interviews to clarify and verify the accuracy of the researcher's interpretations of the information. After the interviews, all participants were given copies of the findings and asked to inform the researcher of misrepresentations or inaccuracies in the interpretations. Member checks were also done by sending an interview transcript back to respondents with a thank you letter for their participation and a request for feedback on the accuracy of the transcript. The member check established credibility because respondents validated the authenticity and accuracy of the data. Member checks were

done orally with respondents and in written form by having parts of the written report checked by the study participants (Erlandson, 1993).

The purpose of member checks is to verify the accuracy of the data collected and to clarify information given. The member checks determined whether the respondents agreed to the interpretations of the data. The member check allows the researcher to assess which data have relevance or concurrence in the group, to assess disagreement about data and to determine which reconstructed realities have no resonance with stakeholders.

#### Instrumentation

The interview process was thorough and comprehensive. Respondents participated in an interactive process with the researcher. There was equal participation of respondents and the researcher learned from the information they shared. The researcher prepared for the interview by appreciating the perspective and motivations of the respondent, by understanding interview questions and practicing interviewing skills. Interview skills utilized included active listening, empathizing, clarifying and a nonjudgmental attitude toward information given by respondents. The researcher was clear about the purpose of

the interview. The time, date and location of each interview were arranged with each participant and the researcher was prompt and prepared for the interview. The researcher understood the context of the interview by attempting to understand the participants and their ability to speak to the problem. Research questions began with generalities and moved to specific, focused questions. The feature of flexibility was a factor in the study.

Thorough preparation for the interview process included framing questions that provided a guide for the interviews. Questions were based on information from the literature review, observations from the field and information from the respondents during the study. The interview was a dialogue with a purpose. The researcher planned to learn from the participant respondents and incorporate their knowledge into a more focused and grounded inquiry.

## SUBSTANTIVE CONSIDERATIONS

### Audit Trail

Notes and tape recordings of each interview were transcribed into a word processor document. Each transcript was assigned a Roman numeral value, I-VIII, based on when it occurred in the sequence of interviews, the value "I" was given to the first interview and so on. The pages of each transcript were numbered sequentially, as were each individual line of the documents. Data retrieved from transcripts were identified by the transcript, the page number then the line number. For example, datum from the sixth page of the third interview, line eight would be labeled as III.6.8. This numerical identification provided an audit trail so themes and constructions could be traced to the raw data.

### Content Analysis

Data was analyzed systematically throughout the processes of data collection. The "constant comparative method" was followed and provided a vehicle for ongoing analysis, comparing units of data, the categories and properties around which they were organized (Strauss & Corbin, p. 63). Each transcript was analyzed line by line, as soon as it was transcribed. Analysis consisted of

comparing incidents and asking questions about the meanings of the data (Strauss & Corbin, p. 62). Words, phrases and pieces of information were looked at for their similarities and differences. The information from each transcript was organized into themes and categories. Each category encompassed a group of properties that helped define the category. Properties were further explained by their dimensions. Subsequent interview transcripts were analyzed and categorized, those categories were then compared to the categories of earlier interviews. Incidents and interpretations were compared with other properties and dimensions to determine where they most aptly fit among the existing categories. The process of comparing categories, properties and their dimensions helped refine the inquiry by revealing where redundancy was occurring and where there were gaps in information, leading to more focused questions.

#### Axial Coding

Axial coding was used to further develop the salient phenomenon of care seeking behavior. Axial coding functions to make "connections between categories" (Strauss & Corbin, p. 96). The care seeking phenomenon was compared in a matrix. The relationships between care seeking behavior and the conditions that arise under different contexts were

explored. Axial coding helped refine the understanding of the conditions under which a woman may be more likely to seek or avoid care. The conditions that influence a woman either to pursue care or avoid care were derived from the matrix.

#### Peer Debriefing

Peer debriefing was a component of the study whereby the researcher solicited feedback from peers and research advisors following field excursions. Peer debriefing reduced the researcher's isolation and provided an objective perspective on the researcher's ideas and data analysis. The researcher consulted with other researchers using the Constructivist paradigm and a research advisor for feedback on content, process and adherence to paradigm structure.

## SALIENT PHENOMENA

Salient phenomenon emerged from the data were the identification of the variables that influenced a woman's decision to seek prenatal care. The strategies a woman uses to deal with prenatal care either moves her in a direction towards care or in a direction to away from care. The conditions that influence the direction a woman takes towards care are described for each category. Each category provides a context for the conditions that influence care seeking behavior and are derived directly from the data.

There was consensus in the data that there are consequences for the entire community when women do not seek care. Microlevel consequences include a fetal death or poor birth outcome. The loss of a child has a grievous impact on the immediate and extended family. The financial and emotional costs to a family with a high risk infant can be extreme. Macrolevel consequences involve short and long term costs to the community, and society at large, in caring for sick children. Those costs are interpreted as the loss of healthy children as potential resources to the community and the loss the children experience if they have long term deficits in physical, emotional or intellectual functioning. The financial costs include the use of hospital intensive

care units, special education services and specialized medical care that become necessary when children have poor birth outcomes.

Interestingly, a variance that became apparent was the concept of prenatal care, how it has existed in the past, what it is now and what form it should take in the future. Consumers and service providers are concerned about the quality of care, what needs to occur for increased participation in care, as well as to address the comprehensive and complex needs of each woman when she arrives for care. Participants in the maternal health care delivery system appear willing to consider the appropriateness of different prenatal care treatment regimes to enhance participation and compliance with care. It questions the form that prenatal care takes, when visits should be scheduled, and what services should be available to women that seek care.

#### Issues that Influence Care Seeking Behavior in Women

A condition that influenced a woman to pursue prenatal care services was the strength and quality of her support system. Teens that had the support of the father of their baby were more likely to seek early care than the teens that lived with their mothers (Wiemann, Berenson, Garcia-del Pina



& McCombs, 1997). Teens avoid care if they don't want their parents to find out they are pregnant. The participants suggested that teens need a group and a role model to demonstrate the importance of prenatal care and to pursue prenatal care services. The quality of the support system influences whether a woman will pursue care. For example, does a woman with other children have a family member or neighbor that will sit with her children while she seeks care? Another important factor is the availability of transportation, a way to get to the appointment. Women involved in supportive relationships would be more likely to have transportation available to them.

Understanding the importance of care and being able to get to appointments are issues for women in need of prenatal care. Case management services attempt look at ways to assist women with child care and transportation that need prenatal care. Developing support services in the care network could provide necessary support to women when their natural support systems do not.

Care is avoided when women have inadequate support structure and when women fear exposure or are mistrustful of the system. Women using drugs or alcohol during pregnancy avoid care because they fear their use will be exposed or

because they are perceived "as scum". Women that use drugs fear exposure or they may deny that they are pregnant. It was also discovered that a women with a substance dependence condition may be "too out of it" to pursue care. Women living in this community without legal immigration status avoid care because they fear exposure to the authorities of their undocumented status.

Women also avoid care because of negative feelings associated with the clinic environment. Women that are not comfortable with the English language may avoid care because they do not understand the medical staff. Efforts are made to employ bilingual staff locally. Women said they did not want to return for appointments when they did not feel respected or felt they were treated "too rough" by the examiner. Women also spoke of feeling intimidated by the clinic environment and the treatment they received there. Some women spoke of the discomfort of being seen by male examiners.

Other issues that drive women's care seeking behavior include personal problems and their perception of the value of care. Women may not seek care because their lives contain multiple stresses, because of the ways they perceive themselves, the experiences and level of stigma they have

internalized may influence their care seeking behavior.

What also emerged from the data was that prenatal care is a low priority, perhaps the need for prenatal care is not clearly understood. Our medical system is built on a disease or illness model, why go to the doctor if you don't feel bad? Women don't understand the need for prenatal care if they feel fine indicating a lack of knowledge about the intent and purpose of prenatal care. Women may avoid care if they have had no problems in other pregnancies and they don't understand the value of prenatal care.

#### Issues in the Provider that Influence Care Seeking Behavior

The issues in the provider that direct women towards care seeking behavior include continuity of care, availability of evening and weekend hours and providers that take the time to answer questions and explain things to their clients. Continuity of care involves seeing the same practitioner at each visit. Consumers complained that in some clinics a different doctor provides care at each visit and subsequent doctors don't always take the time to read what previous doctors have done in the way of patient care. Consumers said they were also put off by providers that gave them recommendations or referrals for tests but didn't explain the rationale for the tests or recommendations.

Consumers were happier with doctors that took the time to explain procedures and medical progress with them and that took the time to answer their questions. This point of view was countered with the perception that doctors are "busy". Given both points of view, the idea of a nurse or social worker in the provider's office to assist with explanations, referrals and other details was suggested. The utilization of psychosocial support services for women seeking care was associated with positive outcomes in the research literature.

Other issues that lie in the provider include their ability to communicate in English. Some doctors are "foreign born" and are difficult to understand. Another issue is gender, a woman's comfort level can be effected by whether the doctor is male or female.

Getting paid is an issue for providers and there is competition for dollars. Training is available to doctors on how to bill Medi-Cal and there are phone numbers for them to call if they have billing problems. Presumptive eligibility allows a doctor to treat a pregnant woman for two months while she pursues her Medi-cal eligibility and the provider is paid retroactively for service provided before the women had her Medi-cal in place.

## Insurance Benefits

Processes that facilitate access to insurance and prenatal care included linkage with competent eligibility workers that were helpful with the Medi-cal application process. Expanded insurance programs are inclusive and appear to provide universal care to pregnant women in California. Currently there are various low cost health insurance programs in California for pregnant women, so if a woman is not eligible for Medi-cal she may be eligible for one of the other insurance programs. Insurance enrollment processes have been streamlined by eliminating the need to go to a welfare office to apply and giving providers financial incentives for helping applicants fill out the paper work. If women aren't eligible for full Medi-cal benefits they may be eligible with a share of cost, for example if they are working or have a limited income. Teen parents are typically covered under their parent's plan.

Presumptive eligibility is aimed at getting care as early as possible. All county providers and some private providers can treat patients under the presumptive eligibility criteria. Immediate need guidelines for Medi-cal can avoid delays in enrollment and therefore delays in receiving care. Outstation workers hired by the county or

the hospital can take Medi-cal applications from women avoiding the need to make a trip to the welfare office.

There are restrictions on sanctioning a woman's Medi-cal benefits while she is pregnant for a lack of cooperation with the district attorney or public social services offices.

Processes that impede access to insurance and prenatal care include problems getting to the Medi-cal office. A woman that works may not be able to keep an appointment during work hours. Women may not follow-through with the application process. Women with undocumented legal status are not be eligible for Medi-cal payments because of their immigration status. However, once the baby is born, the baby becomes eligible for Medi-cal and the woman becomes eligible for post-partum care. An immigrant woman may avoid prenatal care because of a lack of insurance, but once she begins the delivery process, she can present to the hospital emergency room and become eligible for benefits.

#### Maternal Health Care Modalities

Comprehensive prenatal care services include enhanced, ancillary services. Those services are nutrition education, health education, car seat classes. Comprehensive prenatal care services require face-to-face interactions and

physicians do the assessments, those services are available locally through specific providers. Providers receive augmented funding for providing enhanced prenatal care services. Comprehensive prenatal care services involves different professional disciplines, doctors, nurses, social workers, health educators and dietitians. The incidence of low birth weight was reduced when women received comprehensive prenatal care services.

Case management allows for services to help women problem solve, outreach services and linkage with necessary and relevant resources. Women could receive services from a case manager while they are waiting to see the doctor, waits that sometimes last up to two hours.

Case management and comprehensive prenatal care are provided in addition to the scheduled medical examinations that monitor the health of the mother and the health of the fetus.

## DISCUSSION

Universal health care for pregnant women in California appears to be on the horizon with various new programs set to go into effect on July 1, 1998. With health benefits coverage in place it will be important that consumers and providers are familiar with the programs. Consumers will also need to know how to successfully negotiate the enrollment process so a lack of benefits does not become an unnecessary barrier to prenatal care services. Hopefully these programs will lead to increased use of prenatal care and eliminate the Medi-cal application process as a barrier to care. Donovan (1995) found that prenatal care utilization increased after the policy and practice of presumptive eligibility was introduced.

Education about the importance of prenatal care was recommended at different levels. The purpose of education would be to increase individual and community knowledge about prenatal care and the value in it. It was recommended that adult women be educated on how to get the most from their care: what questions to ask, how to choose a doctor and the purposes of the tests that are performed. In other words, it was considered important to educate consumers



about prenatal care services so they can make informed decisions about their care.

Informing the general public about the importance of prenatal care was also recommended by the participants of this study. Education for the support networks of the woman, spouse, parents, partners, may impress them with the value of prenatal care. Education was also a recommendation retrieved by Guendelman and Witt (1992), their participants recommended education that "stressed the importance of prenatal care" and for improving participation in prenatal care 98).

Education for children was also recommended. Children could be educated about prenatal care during the latency stage, before they are biologically ready to have children. Children should have an awareness of the consequences and role of sexuality, pregnancy and parenting in their lives. Educating sixth grade children about prenatal care would be a component of this awareness.

For teens, peer advocates were recommended for accessing prenatal care since teens imitate their peers and identify with groups. It was suggested that teens would be more likely to seek prenatal care if they could go with a team of support people, go to the doctor's office with a

group of female relatives or friends. Teens that maintain their relationship with the father of the baby were more likely to enter prenatal care early, suggesting the importance of emotional support and resources, such as transportation (Wiemann, etal. 1997).

Changes in the clinic environment were also recommended for improving the likelihood that a woman will seek care. Those changes included having female doctors and creating obstetric clinics exclusively for teens.

Time was a recurring incident, giving the woman the time she needs, answering questions, writing things out, explaining things. The time spent with the client wouldn't necessarily have to be time with the doctor, but time with someone who could respond to their questions and concerns, a nurse or a social worker. Someone to help the doctor help the woman. Waiting periods could be filled with health education classes about parenting and child care (Guendelman and Witt, 1992). The participants in this study suggested that the time waiting could be used to offer case management services, providing referrals to other agencies, bus passes, counseling or other supportive services needed by the client.

Providing case management services would help women with the environmental and social barriers that keep them from seeking care. Providing co-ops and vouchers for transportation and child care were recommended for increasing women's participation in prenatal care. Child care and transportation were identified as the "two biggest barriers." Case management also includes outreach services, hiring people from the neighborhoods to go out and find pregnant women and encourage them to seek care. Providing comprehensive care services to pregnant women was associated with reductions in the incidence of low birth weight babies (Strobino, et al., 1995).

Providers should solicit feedback from their patients on the level of service, was the wait too long, did clinic personnel behave professionally, did the woman get her questions answered. Participants believed that improvements in the clinic environment would increase consumers compliance with care. Those improvements included reducing the amount of time patients have to wait to be seen and improving the interpersonal skills of clinic staff.

Women also present to care with other problems and those problems need to be assessed. Issues that are not medically related could be assessed by a professional

assisting the doctor in addressing the other needs of pregnant women. Women interested in smoking cessation programs or drug treatment could be identified and referred to appropriate programs. The lack of a sufficient number of drug treatment services for pregnant women in this community was another dilemma. Women also present with emotional or psychological problems, problems that may influence their choice to pursue or avoid care. Other interventions may be required to help get past those barriers, such as one to one counseling. A mix of services, including social and educational components, has proven effective for improving birth outcomes for teen mothers (Brooks-Gunn & McCormick, 1988). Brooks-Gunn and McCormick (p. 98) indicate that a "comprehensive mix of services seems to be generally desirable."

## IMPLICATIONS

Social workers have a role to play in providing the intervening and supportive services necessary to foster prenatal care utilization. Social work practice is consistent with the need for case management services to overcome prenatal care barriers. Social workers also have a role in assessing the efficacy the services provided to women for improving participation in prenatal care and reducing the incidence of poor birth outcomes. Social workers have a place in the realm of public health to explicate and advocate for the client's perspective and needs. Social workers play a role in helping clients understand the health care delivery system by educating clients and "advocating for policies that will improve access to care for the poor" (Perloff, 1996). Social workers can identify instances of underservice and make efforts to assure that vulnerable populations have relevant health care.

The implications for policy are programs to educate the public and to provide comprehensive services for women seeking prenatal care. Those services need to include smoking cessation programs and treatment for substance dependence. Labor policies should address giving women paid

time off from work to seek prenatal care and the provision of health care benefits that cover comprehensive prenatal care.

Further research is needed on the specific factors of the clinic environment that alienate a woman from seeking care. Exit satisfaction surveys were suggested to identify the strengths and weaknesses of the clinic environment based on client perceptions. Identification of the factors that make women comfortable in the clinic environment could influence the way care is provided.

The research literature suggests that there are multi-level risk factors that influence birth outcome. The investigation of those factors in this community would identify relevant areas for intervention to mediate those risk factors. Public health researchers should be concerned with social risk factors as well as individual risk factors (O'Campo, 1997). Selection bias attempts to identify which women will choose to seek care when they become pregnant. Selection bias may influence the relationship between prenatal care and birth outcome (Lantz & Penrod, 1996).

Research also needs to be done to assess the most effective ways to educate people about the importance of prenatal care and whether the value of prenatal care be

taught and conveyed into improved participation in prenatal care services.

## SUMMARY

This study attempted to uncover the relevant factors that keep women from utilizing prenatal care services in a specific social context. Diverse perspectives on the research dilemma were solicited from nurses, social workers, doctors, and consumers that interface with the local maternal health care delivery system. The self-selected participants were able to describe the community specific problems women have in seeking or participating in care. Rather than identifying specific barriers to care the study revealed the conditions that influence whether a woman chooses to seek care or avoid care. The salient features were issues in the clinic environment, lifestyle choices of the woman and a lack in the community perception of the value of prenatal care. The salient features are relevant to the specific context under study at a specific point in time, perceptions may change as opportunities and values in the community change.

Target areas for change included education on the importance of prenatal care and in negotiating the health care system. Other identified target areas for change included improving the clinic environment and increasing the



availability of necessary and supportive services to women, transportation, child care and drug treatment.

Social workers play a role in continuing the assessment of the aptness of services for pregnant women and evaluating the efficacy of intervening services for reducing deleterious birth outcomes in this community. Social workers have a role to play in the health of their clients and public health services, determining whether the services are relevant and enhance an individual's ability to thrive in their environment.

## APPENDIX A

### INFORMED CONSENT

I am a graduate student in the Department of Social Work at California State University, San Bernardino conducting a study to identify the barriers that interfere with a woman's ability to access prenatal care services in the community. It is also hoped that remedies to the identified barriers to care can be explored, identified and that participants will find agreement on ways to overcome the barriers to prenatal care in the community. This study will gather information from selected respondents in the community about the problems women face when they seek prenatal care services. The research data consists of the verbal information gathered from individuals that interface with the prenatal care delivery system in the community. The research design and methods are approved by the Institutional Review Board at CSUSB and supervised by a professor from the Department of Social Work.

Each participant will be asked to make a commitment to honest, forthright and open communication and to the process of identifying the issues that affect any woman's prenatal care services seeking behavior(s). Participants agree to refrain from tactics or behaviors that may undermine the

completion or integrity of the study. Participants should not provide deceptive or misleading information and a commitment should be made to share the most accurate information possible and to share power with the other participants. Participation requires an individual interview and involvement in an interactive dialogue with other participants about the limits to prenatal care services and how utilization of those services might be improved. Participants will be expected to share their perspective as well as to listen to the perspectives of others and to agree that the perspectives of each are considered equally important. As a participant, you should be willing to be contacted by phone to verify or clarify statements you have made.

Your identity and information will be shared with other participants, confidentiality is not possible in this research framework as a common understanding of a problem and its remedies are sought from various members of the community and the sharing of ideas is essential to that process.

I understand my participation is voluntary and that I may choose to withdraw from the study without penalty. I understand that sharing knowledge with other participants

can improve community understanding of the local barriers to prenatal care and it can begin a dialogue about ways to improve a women's ability to access prenatal care. I agree to respond thoughtfully to questions regarding the research question and to participate in the process of uncovering the barriers to prenatal care services in this community.

Any further questions or concerns can be addressed to:

Professor Lucy Cardona, Ph.D.  
909-880-5559

I agree to participate as a respondent in this research project and I agree to conform to the stipulations of this consent. I understand that I can contact Dr. Cardona at the Department of Social Work with any concerns.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I understand that I am entitled to a copy of this consent form.

\_\_\_\_\_  
Initial

## APPENDIX B

### DEBRIEFING STATEMENT

Thank you for your involvement and participation in this study. The intent was to treat all respondents with consideration, respect and fairness so accurate and relevant information about the barriers to prenatal care could be identified. If you have any questions or concerns as a result of your participation in this study you may contact: Dr. Lucy Cardona at California State University, San Bernardino, Department of Social Work at 880-5501 or the Counseling Center at CSUSB at 880-5035.

The results of the study will be made available to you upon request.

## APPENDIX C

### INTERVIEW GUIDE

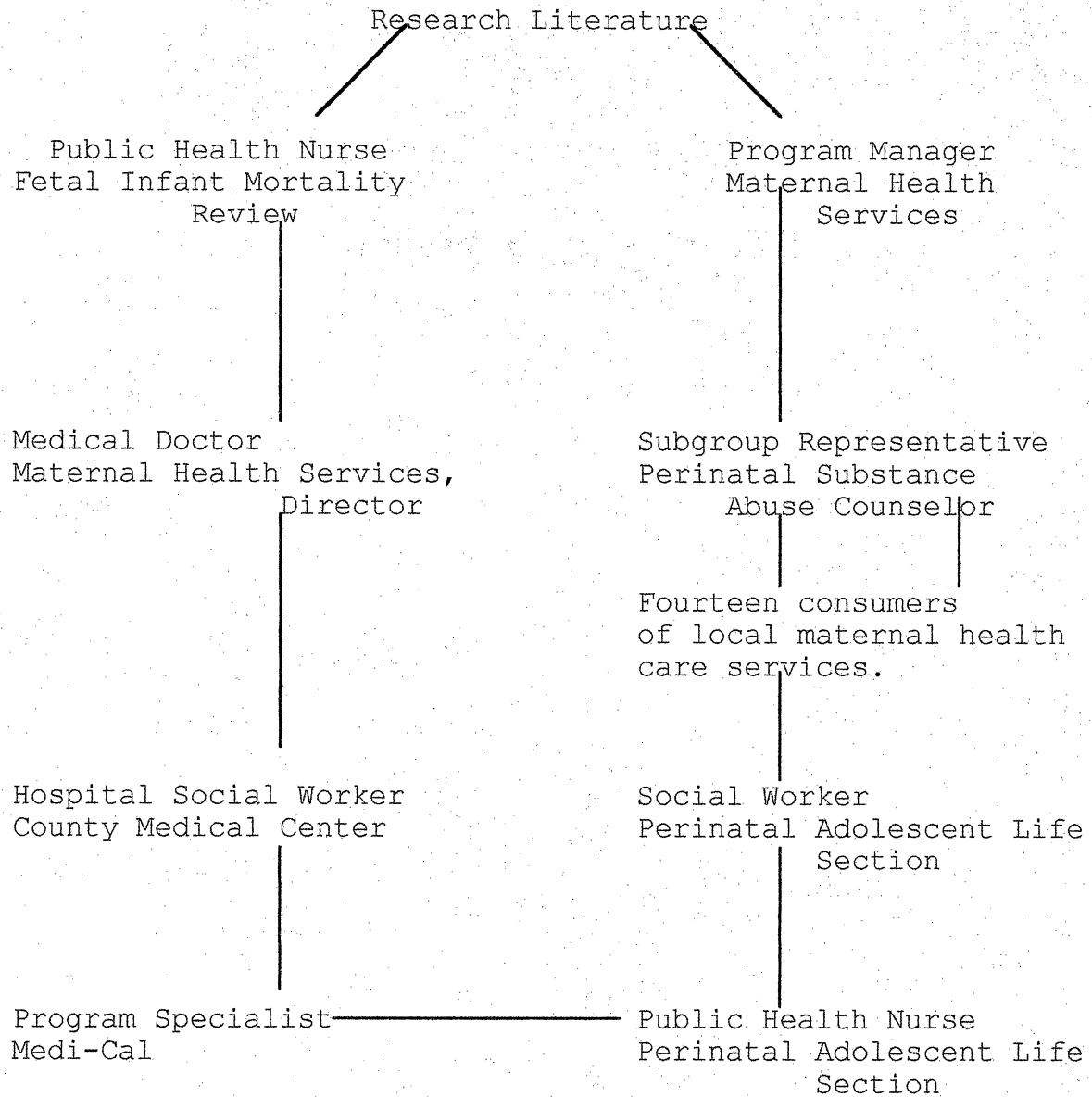
- From your point of view as a (SW, Phn, Consumer, MD, Eligibility Worker), what are the reasons women avoid or have limited access to prenatal care?
- What specifically can be done to increase women's participation in available prenatal care services?
- The research states that prenatal care services are not utilized because of problems of the individual and of the system. What are the barriers in the system that keep women from seeking prenatal care? What issues do women have that keep them from seeking prenatal care?
- What issues do the women that do not seek prenatal care have in common? (for example, medical insurance, family issues, physical challenges, substance use problems, language barriers, age, or place of residency.) What things are being done or could be done to deal with those issues so women can access prenatal care services?
- What changes need to be made in the health care delivery system so that all pregnant women are included? Where

are the gaps in service and could those gaps be closed or narrowed?

- If prenatal care contributes to the health of each newborn, what can be done to increase the number of women seeking prenatal care in the community?
- What do you think the consequences are for the community and its children when women cannot access prenatal care?

## APPENDIX D

### HERMENEUTIC DIALECTIC CIRCLE GRAPHIC





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