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Sylvia Blanchard

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PRENATAL CARE IN AFRICAN-AMERICAN WOMEN

by

SYLVIA BLANCHARD

A Thesis
Submitted in Partial Fulfillment of the Requirements
for the Degree of Master of Science in Nursing
in the Division of Nursing
Mississippi University for Women

COLUMBUS, MISSISSIPPI

August 2000
Prenatal Care in African-American Women

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Abstract

Research has shown that adequate and early prenatal care throughout pregnancy is significant in achieving healthy outcomes. Researchers have also shown that low-income women, particularly poor minorities, do not receive adequate prenatal care. Programs to improve rates of prenatal care have been unsuccessful. The focus of this descriptive study was to describe the facilitators and barriers to prenatal care for African-American women in rural northeast Mississippi. Pender’s Health Promotion Model served as the theoretical framework. The research questions were as follows: What are the facilitators to prenatal care for African-American women? And what are the barriers to prenatal care for African-American women? The target population was African-American women who attended a local Women, Infant, and Children (WIC) distribution center in rural northeast Mississippi. A convenience sample design was utilized with a sample of 75. The sample completed a demographic survey and Blanchard’s Prenatal Survey. Descriptive statistics, including frequencies,
percentages, and distributions, were used to analyze the data. The findings of the study indicated that slightly greater than 50% of African-American women in this study received prenatal care. Unplanned pregnancies emerged as the most significant barrier to prenatal care. Knowledge of barriers to prenatal care may be useful in planning interventions to improve early and adequate prenatal care. Recommendations for further research included utilizing a larger sample size and identifying some of the adverse experiences of clients who did not receive prenatal care.
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Chapter I
The Research Problem

Mississippi is ranked third among states in the United States in infant mortality rates (United States Public Health Service, 1997). High infant mortality and morbidity rates persistently exist among socially vulnerable pregnant women despite advances in perinatal technology, especially among African-American women. The goal for Healthy People 2000 is to increase the number of pregnant women receiving prenatal care in the first trimester of pregnancy to 90%, a goal not obtained by African-American women (Public Health Service, 1997).

Prenatal care is invaluable to the health and well-being of all unborn infants. The United States Department of Health and Human Services (DHHS) researchers state that women who receive prenatal care in the first trimester have better birth outcomes than those who receive late or no prenatal care (DHHS, 1997). However, researchers from the Centers for Disease Control and Prevention (CDC) (1999) state three quarters of a million women in the
United States did not receive adequate care, and almost 47,000 received no care. In addition, substantial racial disparities exist in adequate use of prenatal care (Whites, 84%; Blacks, 71%) (CDC, 1999).

Inadequate prenatal care is a factor in the incidence of low-birth-weight and premature infants. The proportion of low-birth-weight infants rose steadily from 6.7% of births in 1984 to 7.4% in 1996 (March of Dimes, 1998). The March of Dimes researchers reported that low-birth-weight infants were 20 times more likely to die within the first year of life (March of Dimes, 1998). These infants also have a greater risk for physical, behavioral, psychological, neurological, intellectual, and emotional problems which incur tremendous cost (Fuller & Gallagher, 1999). The lifetime health care cost of a premature and low-birth-weight infant is conservatively estimated at $500,000 (March of Dimes, 1998). The cost of providing care to a premature or low-birth-weight infant is substantially more than providing prenatal care (Fuller & Gallagher, 1999).

Although researchers have demonstrated that adequate and early prenatal care throughout pregnancy is significant in achieving healthy outcomes, persistent
differences in prenatal care and negative infant outcomes remain among various ethnic and racial groups (Public Health Service, 1997). The aim of this study was to assess prenatal care among African-American women.

Establishment of the Problem

Prenatal care is an accessible predictor for newborn health and birth weight (Institute of Medicine, 1988). Inadequate prenatal care can result in adverse birth outcomes, medical complications, and increased cost related to low-birth-weight infants (Atrash, 1995). Low-birth-weight infants have a greater potential to die within the first year of life and are at increased risk of mental retardation, visual and hearing defects, congenital anomalies, and developmental problems (Mississippi State Department of Health, Public Health Statistics, 1998). The Institute of Medicine reports that appropriate and continuous prenatal care reduces the high costs associated with these adverse outcomes. It is estimated that for every dollar spent on prenatal care, approximately $1.70 to $3.38 is saved based on the pregnant woman’s risk factors (Huntington & Connell, 1994). These researchers indicated that comprehensive prenatal care services costs
ranged from $380 to $1,042 per pregnancy while cost savings after delivery ranged from $347 to $13,616 per pregnancy.

Adequate prenatal care was defined by Kotelchuck's (1994) Adequacy of Prenatal Care Use Index as care initiated by or before the fourth month of pregnancy with 80% to 90% of recommended prenatal visits obtained. Research has established that inadequate prenatal care can substantially increase infant mortality and low birth weight. Researchers at the National Center for Health Statistics (1999) report that African-American infants die at a rate twice that of white infants. In addition, African-American infants are four times more likely to die as a result of low birth weight and prematurity. Gazmararian, Arrington, Bailey, Schwarz, and Koplan (1999) reported in their study of low-income women that many women, particularly poor minorities, did not receive adequate prenatal care.

The Mississippi State Department of Health (1998) statistics on infant mortality rate for the year 1998 was 6.4 deaths per 1,000 live births for white infants and 14.5 deaths per 1,000 live births for black infants. The infant mortality rates for northeast Mississippi, Lee
County, in 1998 were 4.9 deaths per 1,000 live births for white infants and 15.6 deaths per 1,000 live births for black infants. The Lee County Circuit Court records indicate that low-birth-weight infants born to African-American women (13.8) were almost twice that of low-birth-weight infants born to white women (8.2). These indices indicate the problem of adverse birth outcomes among African-American women in Mississippi and the need for improved prenatal care.

Prior research has identified barriers to prenatal care. Mikhail (1999) suggested five significant barriers to inadequate prenatal care use among African-American women of low income. The barriers cited included fear of disclosure about substance abuse, fear of medical examination, belief that prenatal care is not necessary, fear of positive pregnancy, and lack of child care. Though several federal, state, and community-based programs were initiated in an attempt to remove these barriers, the number of women who obtain prenatal care in the first trimester remains at a plateau, thus the gap between black and white infant mortality and low-birth-weight rates have not decreased (Miller, Clarke, Albrecht, & Farmer, 1996; York, Grant, Gibeau, Beecham, & Kessler, 1996).
Although many studies were conducted to identify barriers and factors influencing access to prenatal care, there is little research available documenting why African-American women do not seek early prenatal care. Mikhail (1999) indicated that most previous studies on barriers to prenatal care mainly investigated sociodemographic factors. In addition, the researcher suggested that personal and attitudinal barriers needed to be explored. Mikhail recommended that women who received prenatal care be studied as well as those who did not receive prenatal care.

Mikhail’s (1999) study of prenatal care experiences among African-American women concluded there were obstacles to prenatal care in low-income African-American women, such as transportation, long waiting time, not feeling sick, and afraid they would have to stop smoking or drinking. Burks (1992) suggested that low-income black women who did not initiate prenatal care early also received inadequate prenatal care.

Theoretical Framework

The theoretical framework that guided this study was Pender’s Health Promotion Model. This model served to
The Health Promotion Model recognizes that perceived barriers have been shown in repeated empirical studies to affect intentions to participate in a certain behavior and the actual execution of the behavior. These barriers consist of perceptions concerning expense, unavailability, difficulty, inconvenience, or time-consuming nature of a particular action. These barriers are thought of as hurdles, blocks, and personal cost of attempting certain behavior and promote avoidance in relation to a given behavior. The personal factors relevant of given behaviors are shaped by the nature of the specific behavior being considered. Some personal factors include age, gender, self-esteem, perceived health status, race, ethnicity, education, and socioeconomic status.

Pender (1996) proposed that health is viewed as a positive state and that individuals are motivated to pursue health. The action of an individual is determined by unique personal characteristics and experiences. The effect of the characteristics and experiences determine the outcome an individual hopes to achieve. Thus, individuals who value health would seek information that would result in healthy behaviors. Pender (1996) also proposed that those individuals who define health as a
positive and stable state are more likely to participate in health-promoting behaviors. If an individual participates in healthy behaviors, he or she must believe that there are benefits of the action and they will receive the benefit of health.

Although Pender’s Health Promotion Model has not been widely utilized in research areas of prenatal care, it has been documented to be widely applicable to a variety of settings. Pender (1996) states that each individual has unique health behavior motivation based on individual characteristics and experiences. The Health Promotion Model’s objective is to incorporate health-promoting behavior changes which will promote optimal health. The purpose of this study was to determine what factors enhance or detour prenatal care use among African-American women. Pender’s Health Promotion Model guided the current researcher’s endeavor to identify these factors.

Significance to Nursing

Practice. Nursing has been described as a practice in which treatment and diagnosis of human illness and health are identified and evaluated (American Nurses Association, 1987). By understanding the prenatal care behaviors of
African-American women in a rural setting, the nurse practitioner can address the prenatal care needs of this ethnic group of women. Knowledge concerning this ethnic group of women may facilitate approaches to change prenatal care behaviors.

Inadequate prenatal care has a major impact on nursing. Adverse birth outcomes require advanced nursing care that affects nurses in clinics, hospitals, and the community. There is absolute necessity to decrease adverse birth outcomes from both the compassionate perspective in relieving suffering and the financial perspective in saving cost. The loss of an infant is detrimental to the family, and the adverse complications associated with low birth weight decreases quality of life for the infant and family. The long-term emotion and financial stress for the nation are unacceptable in this millennium.

An important objective for nurse practitioners and all health care providers is to encourage early prenatal care and to continue to deliver competent prenatal care throughout pregnancy. This study explored specific barriers and facilitators to prenatal care used by African-American women who participate in a Women, Infant, and Children (WIC) program. This finding should be
utilized to influence clinical practice of nurse practitioners. The study developed understanding of expectations for African-American individuals which should improve prenatal care, thus decreasing infant mortality rates and low birth weights. An improved understanding of encouragements or blocks occur related to prenatal care can contribute to improved nurse practitioner prenatal care for African-American women.

Education. Education among health care providers and clients alike can improve prenatal care use among African-American women. Cultural belief was an area that was addressed. Cultural beliefs may contribute to delayed prenatal care. Interventions in prenatal care cannot be conducted until common cultural beliefs and practices are identified. The nurse practitioner should be educated concerning cultural diversity among people and the ethnic client’s beliefs, practices, and viewpoints. Clients must also be educated on the absolute importance of early and continued prenatal care.

Information gained from this study can be incorporated into the curriculum of undergraduate and graduate nursing programs. New graduates would then be better able to educate clients and peers on the importance
of prenatal care. Health care providers also need to be educated on the significance of teaching and encouraging African-American clients to seek and obtain early prenatal care.

Research. Research remains an important factor in culturally sensitive prenatal care for African-American women. Without research, nursing does not have the knowledge needed to determine if prevailing practices provide early access into the prenatal care system. New research will not only provide knowledge for the nursing field, but will also allow nursing to provide measures to increase compliance among African-American women receiving prenatal care.

Statement of the Problem

The evidence from literature indicates that barriers exist to prenatal care for African-American women. Poor levels of satisfactory prenatal care persist in the United States and rural southern counties. Increased access and availability to care have not significantly improved prenatal care rates. Inadequate prenatal care is associated with increased infant mortality and low birth weight. African-American infants die at a rate twice that
of Caucasian infants; however, most African-American women do not receive adequate prenatal care. This research study sought to identify perceived barriers and facilitators to prenatal care among African-American women.

Purpose of the Study

Currently there are no direct studies of barriers and facilitators to prenatal care use among African-American women in rural southern counties. This study was designed to identify specific facilitators and barriers to prenatal care. The purpose of this study was to ascertain what factors encourage or block African-American women participating in WIC programs to initiate prenatal care. If these factors are known, this knowledge could provide valuable insight into methods of intervention to improve prenatal care use for others in the same population.

Assumptions

The following assumptions were made for the purpose of this study:

1. Women will answer questions honestly.

2. African-American women have access to prenatal care.

Research Questions

This study was guided by two research questions:

1. What are the facilitators to prenatal care for African-American women?

2. What are the barriers to prenatal care for African-American women?

Definition of Terms

The following terms were defined for the purpose of this study:

Prenatal care: Theoretical: the care a pregnant woman and her unborn baby receive throughout pregnancy to ensure both are healthy at delivery. Operational: health care of clients during their pregnancy provided at a health care facility that is designated for such services and with the first visit made within the first trimester of pregnancy.

African-American women: Theoretical: a person of the female sex who is of immediate or remote African ancestry. Operational: women of remote African ancestry between the ages of 16 and 35 years as determined from demographic data.
Facilitators: Theoretical: any act or activity that increases or promotes the attainment or use of prenatal care. Operational: all factors listed by subjects that increase or promote attainment or use of prenatal care as defined by the Blanchard’s Prenatal Survey.

Barriers: Theoretical: any act, activity, or obstacle that inhibits the attainment or use of prenatal care. Operational: all factors listed by subjects as an obstacle to the attainment or use of prenatal care as defined by Blanchard’s Prenatal Survey.

Summary

In this chapter the problem is identified as inadequate prenatal care among African-American women participating in WIC programs located in rural northeast Mississippi. Prior studies have shown that several perceived factors contribute to the initiation of prenatal care among African-American women. The impact of inadequate prenatal care on infant health and the subsequent strains on the health care system and society also were discussed. In a review of Pender’s (1996) Health Promotion Model, the health-promoting behaviors were described. The purpose of the study was to determine
specific factors which encourage and block African-American women participation in WIC programs located in rural northeast Mississippi to initiate prenatal care.
Chapter II

Review of Literature

Many studies have been conducted regarding factors affecting the initiation of prenatal care; however, no studies were identified that targeted African-American women in rural southeast Mississippi. The review of literature focused on factors that affect prenatal care in African-American women.

Mikhail (1999) studied the prenatal care experiences of women and their perceived impediments of access to care. The researcher compared reported barriers by women who received inadequate care to those who received intermediate and adequate care. The Health Belief Model was utilized as the conceptual framework.

The settings were a community health center located in an African-American neighborhood, two Women, Infants, and Children (WIC) offices, and the main welfare office of a city in central California. The target population included women who were African American, low income, and had a child one year of age or younger. A total of 130
women met the criteria for study participation. The actual sample consisted of 126 subjects who provided complete data.

Mikhail (1999) utilized a structured interview and questionnaire to collect data. The instrument, which was developed by the researcher, contained three sections. The first section consisted of a collection of questions related to demographic information. The next section consisted of a collection of information about the woman’s past pregnancy. The final section consisted of a collection of information on the woman’s perceived impediments to prenatal care. The instrument was reviewed by three registered nurses experienced in maternal and child health. A pilot sample of four women who met the same criteria determined the tool to be clear and readable.

The participants were interviewed by an African-American research assistant to obtain demographic and last pregnancy data. The subjects then responded to the researcher-developed self-administered questionnaire pertaining to perceived impediments to prenatal care. The assistant remained available to answer questions and collect completed forms.
Prior to determining differences in the adequacy of prenatal care, the Kotelchuck index was employed. This index is based on two dimensions, the adequacy of received services and the adequacy of the timing of initiation. These two dimensions are combined into a single index called Adequacy of Prenatal Care Utilization.

Data were analyzed using the SPSS computer program and the chi square to determine differences regarding experiences. The study participants ranged in age from 14 to 44 years with a mean age of 23.97 years. The majority (81%) of the participants were single and 14.3% were married. Participants’ level of education included some college (13.5%), 9 to 12 years (67%), and 8 years or less (18%). Ninety percent did not work outside of the home and received Medicaid, whereas 5.6% did not have any type of health care coverage. The number of children per participant ranged from 1 to 8 with a mean of 3.17. The majority (97%) of the participants received public assistance (Mikhail, 1999).

Mikhail (1999) determined that inadequate prenatal care was received by 34% (n = 43) of the women, adequate or adequate plus prenatal care by 50.8% (n = 64) of the women, and intermediate prenatal care by 15% (n = 19) of
the women. Positive experiences about care were described by 67.5%, and negative care was reported by 23.6%.

Seventy-eight percent of the participants stated that last pregnancy was unplanned. Half of the participants stated that they received no encouragement from family or friends, 12% received encouragement from the baby’s father, and 8% received encouragement from health care providers.

Mikhail (1999) related the most frequently reported barriers by all participants were transportation, long waiting time at clinic, having multiple other problems, previous pregnancy was without problems, afraid substance use would be discovered, afraid they would have to stop smoking or drinking, and afraid to have a medical examination. In addition, feeling good, prenatal care not necessary, and afraid of finding out they were pregnant were some other barriers mentioned. Cost was not cited as a major barrier because 90% of the participants were on Medicaid.

In conclusion, Mikhail (1999) determined that five areas of barriers emerged as significantly higher for inadequate prenatal groups including fear of their substance abuse being discovered, afraid of medical
examination, belief that prenatal care was unnecessary, afraid to find out if pregnant, and no babysitter.

Mikhail (1999) recommended that health care providers educate and communicate the importance of prenatal care to women. Mikhail's (1999) finding provided valuable information about perceived barriers to prenatal care as reported by African-American women. This study was germane to the current study because the current researcher will look at perceived barriers to prenatal care by individuals in northeast Mississippi.

In another study, Burks (1992) sought to determine the factors that lead to inadequate prenatal care in low-income black women. The study focused on selected factors in the utilization of prenatal care. The setting included an urban, federally-funded health clinic, and two rural satellite clinics. The target population included black women, at least 18 years of age unless accompanied by a legal guardian or married, who financed 20% or less of the prenatal visit. A total of 69 prenatal clients were randomly selected.

The researcher explored the women's perceptions of health and health values and beliefs about the current pregnancy. A questionnaire developed by Ronald Anderson
was used to measure families' utilization of health services based on predisposing factors (health beliefs), enabling factors (resources), and need factors (symptoms).

Health beliefs were measured by three Guttman scales. The first scale measured value of health services by a 6-item scale with possible scores from 6 to 24. The next scale measured value of good health by a 9-item scale with possible scores from 9 to 36. The last scale measured attitudes toward health services by a 6-item scale with possible scores from 6 to 24. The higher the woman scored on each scale reflected the value placed on each category. Kessner's Index was also utilized to determine adequacy of care. This index was based on the trimester of the first prenatal visit, weeks of gestation, and total number of visits.

Data were analyzed using the chi-square test, t tests, and frequencies. Burks (1992) identified that the subjects ranged from age 18 to 35 years with a mean age of 23. The majority (78%) of the subjects were single, and 73% had completed high school. Seventy-seven percent had only one prior delivery or were primiparous. The majority (82.6%) of the subjects reported transportation or child care were not impediments to prenatal care and they had no
symptoms prior to the first prenatal visit. Seventy-eight percent of the subjects were not found to be at risk.

The researcher identified several significant differences among subjects who obtained adequate prenatal care and those who received inadequate prenatal care. The majority (91.7%) of the women who reported they had not initiated prenatal care early obtained inadequate prenatal care. Of those who received inadequate care, 88.9% were not diagnosed as at risk at the initial visit. The most interesting finding to emerge and the most common reason cited for late initiation of prenatal care was not cognizant of pregnancy. The second most common reason cited for late initiation of prenatal care was ambivalence or denial.

Burks (1992) concluded that enabling factors did not significantly influence the utilization of prenatal services, predisposing factors had some influence on use of prenatal services, and need factors had the greatest influence on use of prenatal services. The researcher’s finding supports previous contention that the best predictors of health service utilization are need factors. The researcher also suggested that lack of awareness of pregnancy was the major reason reported for delayed
prenatal care. This finding was similar to the conclusions of several other studies. Financial barriers, although important, were not identified as a major cause of inadequate prenatal care.

Burks' (1992) study was germane to the current researcher's endeavor and provided valuable information about the percentage of black women who receive inadequate prenatal care because of delay in seeking care. The study also provided information about cited barriers to prenatal care as reported by black women.

Gazmararian, Arrington, Bailey, Schwarz, and Koplan (1999) sought to determine barriers of access to prenatal care among low-income women enrolled in a managed-care program. The researchers focused on selected factors and their relationship to untimely entry to prenatal care and inadequate prenatal visits. The study population included women aged 13 to 45 years (N = 1,136) who were enrolled in the Prudential HealthCare Community Plan. Seven hundred sixteen women were invited to participate in the study. The actual sample consisted of 503 women who completed scheduled interviews. Analysis was further limited to women (n = 33) who were currently pregnant or had given
birth since enrolled in the Prudential HealthCare Community Plan.

The researchers conducted in-person interviews. A questionnaire was developed using information accumulated during focus-group sessions, earlier research, and additional surveys. Informed consent was obtained and confidentiality was assured. Interviews were scheduled by 20 trained interviewers who telephoned eligible women. Interviews were conducted in respondent’s home or other convenient location. To ensure reliability among interviewers, several measures were taken. Each interviewer worked with a partner, the project coordinator made periodic visits with interviewers and provided feedback, weekly meetings were conducted with the coordinator, and all interviewers and all surveys were edited weekly. As an incentive, each respondent who completed the survey was given a $25 certificate.

Gazmararian et al. (1999) utilized data from the most recent medical charts of respondents to measure use of prenatal care. Ninety-eight percent of the completed surveys were linked to medical charts, but six did not contain enough information to calculate use of prenatal care. The researchers studied early initiation of care and
adecacy of the number of visits. Early care was prenatal care initiated in the first trimester. The Kotelchuck (1994) index was employed to determine differences in adequacy of the number of visits. This index was based on two elements, the adequacy of initiation of prenatal care and adequacy of received services. The American College of Obstetricians and Gynecologists' prenatal care standards was used as the format for expected number of visits.

The researchers examined three groups of barriers: sociodemographic factors, personal factors, and system barriers. Data on personal factors and sociodemographic factors were collected during the in-person interviews. Data on system barriers were collected upon enrollment in the Prudential HealthCare Community Plan.

The researchers found more than half (51.3%) of the respondents received inadequate prenatal care, and 53.2% had untimely entry to prenatal care. The majority of the women who completed in-person interviews were 25 years or older, employed, high-school educated, not living in crowded conditions, single, poor, and black. The sociodemographic factors were not significantly associated with initiation or adequacy of care.
Gazmararian et al. (1999) discovered a significant correlation between time of enrollment and women’s perceptions of inconvenient clinic hours to the initiation of care. Those women who stated that clinic hours were inconvenient and those who enrolled in the Prudential HealthCare Community Plan after the first trimester were more likely not to receive early prenatal care.

Overall, positive attitudes toward prenatal care were exhibited by the participants, with no significant relationship to initiation or adequacy of prenatal care. Gazmararian et al. (1999) identified one system and two personal factors significantly correlated to initiation of prenatal care. Women who enrolled in the Prudential HealthCare Community Plan after becoming pregnant were 2.4 times more likely to receive late care than those who entered prior to pregnancy. Women who were too tired to go for prenatal visits were 2.2 times more likely to receive late care. Women physically abused during pregnancy were 3.5 times more likely to receive late care. Women who received little help from the babies’ father were 1.9 times less likely to receive adequate care.

The researchers recommended routine screening for physical violence and increased efforts by managed-care
organizations and other community agencies to increase family planning. The study was germane to the current researcher’s endeavor as Gazmararian et al.’s (1999) findings provided valuable information about barriers to prenatal care in African-American women with a low income. The researchers’ findings reflected that even when prenatal care was available and affordable, many black low-income women did not utilize it. The previous research is relevant because of the focus on facilitators and barriers to prenatal care in African-American women.

Omar and Schiffman (1995) sought to determine pregnant women’s perceptions of prenatal care. They focused on the areas of expectation of prenatal care and dimensions of satisfaction with prenatal care.

The researchers gathered data using a focus group and planned interviews designed to obtain people’s perceptions about prenatal care. Information was obtained directly from clients utilizing an interview guide of open-ended questions.

The study setting included a local health department, a private not-for-profit women’s center, and a childbirth education class. The target population included women who were 28 or more weeks pregnant, had received at least two
prenatal care checkups during this pregnancy, and who were able to speak and understand English. The actual sample consisted of 22 subjects in their third trimester who were receiving prenatal care at the time of the focus group.

Omar and Schiffman (1995) conducted a focus group at each of the three sites according to guidelines from previous research by Krueger (1988) and Morgan (1998). Each group was audiotaped in its entirety. The focus groups were conducted using semi-structured, open-ended questions. Each question was sequenced and developed according to consultation and the literature. Three experts in the field reviewed each question. The approximate length of each focus group was 1 to 1½ hours, and each participant was given a cash incentive to participate.

Data were analyzed after both researchers had transcribed the audiotapes verbatim and reviewed them for accuracy and completeness. The researchers then individually analyzed the transcripts using methods described by Miles and Huberman (1984). Expectations of prenatal care and dimensions of satisfaction were examined. The researchers identified three dimensions of satisfaction: (a) satisfaction with prenatal care
provider(s), (b) satisfaction with support staff, and (c) satisfaction with prenatal health care system. All participants clearly distinguished a prenatal care provider (physician, midwife, or nurse practitioner) from support staff (nurse, nutritionist, and social worker).

Three independent coders, all nurses with previous obstetrical experience, reviewed selected segments of the transcripts for agreement with expectation and dimensions of satisfaction. The expectation and dimensions of satisfaction were then revised and refined by consensual agreement of the independent coders and the researchers.

Omar and Schiffman (1995) explored clients’ expectation of prenatal care. Differences and similarities were noted among all three groups. The researchers identified three major categories of expectations of prenatal care: (a) having one provider, (b) receiving an explanation about prenatal care, and (c) getting accessible quality care.

The most frequently voiced expectation was having one provider. All first-time pregnant women voiced this expectation. They stated that they expected to be seen by one provider for the majority of their pregnancy.
All three focus groups expressed the expectation of consistent prenatal care. First-time pregnant women from all three focus groups expected to be informed about their care and services provided. These women expected to be informed of pregnancy, labor and delivery, and parenthood.

Omar and Schiffman (1995) determined the participants who attended health departments did not expect the same care as those women who attended private clinics. They also expected longer waiting times. All women from each group expected to be treated humanely.

The researchers found that the participants' overall feeling of satisfaction or dissatisfaction with prenatal care related to the attentiveness of the provider. This finding was consistent among all three focus groups. The participants viewed the provider as the most important person in their prenatal care.

The researchers identified four categories of elements that all participants identified as important to their satisfaction or dissatisfaction with the prenatal health care system: (a) provider consistency, (b) accessibility and scheduling, (c) waiting time, and (d) other services provided. The researchers discovered that
all three groups were dissatisfied with lack of provider consistency and ease of scheduling and access.

Omar and Schiffman (1995) suggested participants were dissatisfied with having different providers during their prenatal care. The participants stated that providers were unable to know them personally because they changed. Participants were dissatisfied with having to "tell their story" each time to a different provider.

The researchers discovered that participants from all three groups were dissatisfied with ease of getting an appointment for an initial prenatal visit. Participants stated that when they called for an appointment during the first trimester of pregnancy they had to wait a month before being seen for prenatal care. The researchers identified that this delay meant women in the low socioeconomic groups did not enter care until their second trimester of pregnancy. Daytime only office hours was another area of dissatisfaction for most participants. The limited schedule resulted in women having to take off work, which resulted in loss of pay or accrued leave time. The major source of dissatisfaction among all participants who used publicly-funded clinics was waiting time.
Participants reported spending 30 minutes to 3 hours or more at the clinic.

Participants of the low socioeconomic population reported dissatisfaction with other services provided, such as a nutritionist, public health nurse, and social worker. These participants felt that these services should be available to them where they received their care. Not all participants perceived the need to use those additional support services.

In conclusion, Omar and Schiffman (1995) were able to identify expectations of pregnant women and satisfaction and dissatisfaction with prenatal care services. Their finding supported the conceptual framework that a woman’s perception represents reality and is based on past experiences and information. Women are encouraged to seek and continue prenatal care if positive encounters with providers and staff occur.

Omar and Schiffman (1995) concluded that providers had the greatest influence on women’s satisfaction with prenatal care. They also suggested that a caring attitude presented by staff was also influential in promoting women to adhere to prenatal care. Finally, the researchers concluded that women’s dissatisfaction with prenatal care
services was related to long waiting times, ease of access and scheduling, and provider consistency. This study was germane to the current researcher’s endeavor because it identified pregnant women’s perceptions of prenatal care and their specific areas of satisfaction and dissatisfaction with prenatal care services.

Ganong (1993) sought to determine if patients were stereotyped by nurses on the basis of the patient’s marital status. Ganong also sought to determine the potential effects of marital status stereotyping on the cognitive processing of patient information. The researcher assessed both controlled and automatic dimensions of stereotyped belief systems.

The study population was randomly selected from a list of registered nurses from Missouri. One hundred and sixty participants were selected and asked to participate in the study. The actual sample consisted of 71 female registered nurses. The participants’ mean age was 40.6 years and had an average of 14.9 years of nursing experience. Half of the sample were graduates of diploma programs, 19% were graduates of associate degree programs, 24% were graduates of bachelor degree programs, and 7% had graduate degrees. Eighty-three percent of the actual
population was married, 14% were divorced, and 3% had never been married.

A packet, which contained a letter of explanation, request for participation, a brief description of a patient, a battery of questionnaires, and a self-addressed envelope, was sent to each participant. The description of the patient, one married and one unmarried, was followed by a two-page "transcript" of the interview. The participants were asked to read the transcripts, respond to questionnaires, and return questionnaires in the envelope provided. The packet contained four questionnaires: the First Impressions Questionnaire, the Predicted Behavior of a Hospitalized Patient Behavior Questionnaire, the Family Role Stereotype Instrument, and the Assessment Checklist. A one-page demographic survey was also provided.

The First Impressions Questionnaire was a 40-item questionnaire designed to measure attitudes toward an individual. Each item was scored on a scale from 1 to 7, with 7 being the most positive and 1 being the most negative. Each item scored was added with higher scores indicating more positive perceptions. The Predicted Behavior of a Hospitalized Patient Behavior Questionnaire
was developed to evaluate the prediction of how the client would respond if hospitalized. This questionnaire consisted of nine items that predict the clients' cooperation with nursing staff, ability to cope, knowledge of pregnancy, receptivity to teaching, compliance, family support, tolerance of procedures, behavior, and tolerance to childbirth pain. Items were measured utilizing a 7-point semantic differential format with each score added together to form the score using the Predicted Behavior of a Hospitalized Patient Behavior Questionnaire. Higher scores indicated more positive predictions of a client's behavior. The Family Role Stereotype Instrument consisted of 25 descriptors of cultural stereotypes about married mothers and 29 about never-married mothers. Two different scores were derived from the descriptors. The attribution score, which represented the proportion of cultural stereotypes for the role attributed to the patient, ranged from 0 to 1.00; and the adherence score, which evaluated how closely the participants' perceptions of the patient matched cultural stereotypes, also ranged from 0 to 1.00. The Assessment Checklist was a 24-item checklist that consisted of a variety of topics which a nurse might ask a pregnant patient. This checklist contained three
categories: Psychosocial Information, General Health, and Sexual Health. Demographic data consisted of participants’ age, years of nursing experience, marital status, and level of nursing education.

Ganong (1993) analyzed the responses on the First Impressions Questionnaire with a one-way multivariate analysis of variance (MANOVA). The Adherence score and the Attribution score of the cultural stereotypes were analyzed using the t test to measure if they differed from 0, which was the score expected if participants did not make stereotyped judgments about patients. The t test was also used to compare the scores on the Predicted Behavior Scale. The Assessment Checklist’s categories were analyzed with a one-way multivariate analysis.

The researcher discovered that married clients were evaluated more positively, viewed as more active, secure, and satisfied, had more personal power, and were more stable than unmarried clients. Ganong (1993) also suggested participants were willing to attribute stereotyped characteristics to clients. Married clients were given more positive attributes as compared to negative evaluations of unmarried women, such as promiscuous, unhappy, and stupid. Married clients were
also predicted to have more positive behaviors than unmarried clients. No differences were found in the amount of information sought by nurses from married or unmarried clients.

Ganong (1993) concluded that nurses do share cultural beliefs about married and unmarried pregnant women which are automatic cognitive processes. Also, nurses hold more negative perceptions about unmarried pregnant women than married pregnant women. The study is relevant to the current researcher’s study as it identifies potential barriers to prenatal care related to nurses’ attitudes toward their patients.

The review of literature underscored important factors that were entailed in the purpose, design, methodology, and analysis of data in the current research. The Mikhail (1999) study focused on perceived impediments to prenatal care among low-income African-American women. The Gazmararian et al. (1999) study concentrated on selected factors and their relationship to untimely entry into prenatal care and inadequate prenatal visits. The Burks (1992) study focused on factors that lead to inadequate prenatal care in low-income black women. These three reviews reinforced the need for the present research
to investigate further to determine if it is generally true that African-American women are less likely to seek prenatal care at an earlier stage in pregnancy. Omar and Schiffman’s (1995) study emphasized the need to look at pregnant women’s expectation of prenatal care and their satisfaction with prenatal care. The review by Ganong (1993) suggested the need for research in order to understand if nurses stereotype pregnant women on the basis of marital status.

All studies reviewed indicated the need for additional research concerning prenatal care in African-American women. Areas of study suggested included rural factors, social support systems, and socioeconomic factors. Therefore, the current research was deemed necessary for all aspects of African-American prenatal care.
Chapter III
The Method

The purpose of the current study was to identify facilitators and barriers to prenatal care among African-American women in rural northeast Mississippi. The focus was on African-American women between the ages of 16 and 35 years who resided in a rural setting. This study was designed to increase understanding of the utilization of prenatal care services among African-American women. In this chapter, the design of the study will be explained in detail, along with data collection and analysis procedures.

Design of the Study

The researcher utilized a nonexperimental, descriptive research design. Descriptive research specifies the frequency with which certain phenomena occur (Polit & Hungler, 1999). Phenomena of interest were the facilitators and barriers to prenatal care among rural African-American women. Data were collected from
African-American women from the local Women, Infants, and Children (WIC) distribution center; therefore, no researcher intervention occurred (Polit & Hungler, 1999).

Setting, Population, and Sample

The setting selected for this study was a local WIC distribution center in rural northeast Mississippi. The center was located in a small rural town with a population of 33,000. The population of the people who visited the center was diverse and covered the age span from 15 to 45 years. The population included African-American women (46%), Caucasians (38%), and Hispanics (16%). The majority were Medicaid recipients. The number of people visiting the center averaged 100 to 150 people per day. The population for this study consisted of African-American women between the ages of 16 and 35 years. All African-American women who were between the ages of 16 and 35 years and were willing to participate in the study were included in the sample. The researcher gathered data on two consecutive days from the lobby area of the local WIC distribution center. Each woman was approached upon entering the lobby, and after determining that she met criteria was asked to participate in the study.
Participation was voluntary and participants were assured that their participation would not in any way interfere with their service at the center. All data remained confidential by . . .

Method of Data Collection

Instrumentation. The two questionnaires used to gather data were developed by the researcher. The first was the Demographic Survey (see Appendix A). Data collected contained information about sociodemographic factors: age, marital status, level of education, medical coverage, and number of children and pregnancies. In addition, prenatal care received and week of pregnancy when prenatal care was started were obtained. Following the demographic survey, a second questionnaire was used, Blanchard’s Prenatal Survey (see Appendix B). This questionnaire was developed, reviewed, and amended with input from a team of graduate-prepared nurse practitioners. Blanchard’s Prenatal Survey elicited information about perceived facilitators and barriers to prenatal care. Questions 1-4 asked if cost, transportation, getting off work or out of school, or long waiting time in clinics made it difficult to obtain
prenatal care. Questions 5-6 assessed their knowledge of prenatal care and the Medicaid program. Question 7 sought information about the clinic environment and encouragement to return to the clinic. Question 8 explored the subject’s knowledge of her pregnancy before the 4 months. Questions 9-10 sought to determine if pregnancy was planned, and questions 11-13 assessed family and friend support. Questions 14-15 assessed subjects’ views of the importance of prenatal care and if prenatal care was received previously.

Procedure. Permission to conduct the study was obtained from the Mississippi University for Women’s Committee on Use of Human Subjects in Experimentation (IRB) (see Appendix C). Additionally, the researcher obtained permission from the district office manager of the WIC program. A letter explaining the purpose of the study (see Appendix D) and a sample of both questionnaires were sent to the district manager. The researcher visited the center and invited prospective participants to take part in the study. Convenience sampling was done to obtain the sample size of 100. The researcher explained the purpose of the study to participants, assured confidentiality, and obtained an informed consent (see
Appendix E). The researcher explained the data collection procedure to each participant who agreed to participate in the study. Data collection packets containing a cover letter with consent form and a survey were distributed to each participant. Participants were instructed to return the completed survey to the researcher before leaving the distribution center. The researcher placed each survey in a secured envelope and kept them in a locked file in the researcher’s home office.

Data Analysis

Data analysis was conducted using descriptive statistics to determine the frequency and percentage of responses. Each response was assessed using item-by-item analysis regarding whether the respondent considered the statement to be a facilitator or a barrier to prenatal care.
Chapter IV

The Findings

The purpose of this descriptive study was to identify the perceived facilitators and barriers to prenatal care among African-American women who reside in a rural setting. Data for the study were obtained using two surveys, the Demographic Survey Sheet and Blanchard's Prenatal Survey. This chapter delineates the sample and the results of data analysis.

Description of the Sample

The sample for this study was comprised of African-American women (N = 75) who were eligible to participate in a local Women, Infants, and Children (WIC) program (see Appendix F) and who were pregnant or had been pregnant. Of the 75 participants in the final sample, 42 participants (56%) received prenatal care and 33 participants (44%) did not receive prenatal care. The average number of pregnancies, including current pregnancy, was 1.78 pregnancies, with a range of one to five pregnancies. The
respondents ranged from age 16 to 35 years with a mean age of 20.32 years. The majority were single (77.3%). Married participants accounted for 21.7% of the sample size, divorced 1% of the sample size, and widowed 0% of the sample size. Descriptive information regarding demographic characteristics of the sample is depicted in Table 1.

Table 1

Demographic Characteristics of the Sample by Frequency and Percentage

<table>
<thead>
<tr>
<th>Demographic variable</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td></td>
<td>20.32</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>58</td>
<td>77.3</td>
</tr>
<tr>
<td>Married</td>
<td>16</td>
<td>21.7</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Level of education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8th grade or less</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>9th grade to 12th grade</td>
<td>31</td>
<td>41.0</td>
</tr>
<tr>
<td>High school graduate</td>
<td>20</td>
<td>26.0</td>
</tr>
<tr>
<td>Some college</td>
<td>19</td>
<td>25.0</td>
</tr>
<tr>
<td>College graduate</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>Medical coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>42</td>
<td>56.0</td>
</tr>
<tr>
<td>Private</td>
<td>16</td>
<td>22.0</td>
</tr>
<tr>
<td>None</td>
<td>17</td>
<td>22.0</td>
</tr>
</tbody>
</table>

(table continues)
Table 1 (continued)

<table>
<thead>
<tr>
<th>Demographic variable</th>
<th>f²</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean number of pregnancies</td>
<td>1.78</td>
<td></td>
</tr>
<tr>
<td>Mean number of children</td>
<td>1.42</td>
<td></td>
</tr>
<tr>
<td>Prenatal care received</td>
<td>42.00</td>
<td>56.0</td>
</tr>
<tr>
<td>Prenatal care not received</td>
<td>33.00</td>
<td>44.0</td>
</tr>
<tr>
<td>Mean number of prenatal visits</td>
<td>5.32</td>
<td></td>
</tr>
</tbody>
</table>

Note. Percentages rounded to the nearest 10⁰ place.

*N = 75.

Results of Data Analysis

Two research questions guided this investigation. The questions are as follows:

1. What are the facilitators to prenatal care for African-American women?

2. What are the barriers to prenatal care for African-American women?

To answer the research questions, the participants were asked 16 questions from Blanchard’s Prenatal Survey. The participants could choose either “yes” or “no” to answer each question. An answer of “yes” to questions 1
through 4 and "no" to questions 5 through 16 was considered barriers to prenatal care. An answer of "no" to questions 1 through 4 and "yes" to questions 5 through 16 was considered facilitators to prenatal care. Over 82% stated the pregnancies were not planned by either mother or father. Eighty-five percent stated that they thought prenatal care was important. Listed in Table 2 are the participants' responses to the questionnaire.

Table 2
Participant Responses by Percentage to Blanchard's Prenatal Survey

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did having to get off work or out of school make it difficult for you to receive prenatal care?</td>
<td>26.7</td>
<td>73.3</td>
</tr>
<tr>
<td>2. Did cost of prenatal care make it difficult for you to receive prenatal care?</td>
<td>40.0</td>
<td>60.0</td>
</tr>
<tr>
<td>3. Did finding transportation to the clinic make it difficult for you to get prenatal care?</td>
<td>32.0</td>
<td>68.0</td>
</tr>
<tr>
<td>4. Did long waiting time at the clinic make it difficult for you to get prenatal care?</td>
<td>22.7</td>
<td>77.3</td>
</tr>
<tr>
<td>5. Have you ever received any education about prenatal care before you got pregnant?</td>
<td>44.0</td>
<td>56.0</td>
</tr>
</tbody>
</table>

(table continues)
Table 2 (continued)

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Did you know about the Healthy Start Program?</td>
<td>58.7</td>
<td>41.3</td>
</tr>
<tr>
<td>7. Did you know about the Medicaid program?</td>
<td>74.7</td>
<td>25.3</td>
</tr>
<tr>
<td>8. Did the clinic environment encourage your return to the clinic?</td>
<td>48.0</td>
<td>52.0</td>
</tr>
<tr>
<td>9. Did you know you were pregnant before the 13th week of pregnancy?</td>
<td>54.7</td>
<td>45.3</td>
</tr>
<tr>
<td>10. Did you plan this pregnancy?</td>
<td>17.4</td>
<td>82.6</td>
</tr>
<tr>
<td>11. Did the father of the baby plan this pregnancy?</td>
<td>17.4</td>
<td>82.6</td>
</tr>
<tr>
<td>12. Did you have family support during your pregnancy?</td>
<td>68.0</td>
<td>32.0</td>
</tr>
<tr>
<td>13. Did your family encourage prenatal care?</td>
<td>70.7</td>
<td>29.3</td>
</tr>
<tr>
<td>14. Did your friends encourage prenatal care?</td>
<td>77.3</td>
<td>22.7</td>
</tr>
<tr>
<td>15. Do you think prenatal care is important?</td>
<td>85.3</td>
<td>14.7</td>
</tr>
<tr>
<td>16. Did you receive prenatal care with past pregnancy?</td>
<td>56.0</td>
<td>44.0</td>
</tr>
</tbody>
</table>

Note. Participants were asked to select either "yes" or "no."

Percentages rounded to the nearest 10th.
Summary

Data collected and analyzed for this study have been presented in Chapter IV. Data were presented using the Demographic Survey Sheet and Blanchard's Prenatal Survey. This chapter presented the results of data analysis using descriptive statistics. Results of the data were reported in narrative and table format.
Chapter V

The Outcomes

In 1998, 8,734 infants were born in Mississippi without the benefit of adequate prenatal care. The researcher sought to discover what facilitators and barriers existed to prenatal care of African-American women in rural northeast Mississippi. Prior research studies identified several barriers to prenatal care and that early prenatal care has a positive impact in reducing adverse birth outcomes. Researchers also discovered little achievement in attempts to remove barriers to prenatal care, especially among minority, rural, and poor populations. Some researchers concluded that African-American women perceived barriers of access to prenatal care (Mikhail, 1999). Therefore, those findings prompted this researcher to conduct a descriptive, nonexperimental study to identify what facilitators and barriers existed to prenatal care among African-American women in a rural setting.
The research questions answered in this study were as follows:

1. What are the facilitators to prenatal care of African American women?

2. What are the barriers to prenatal care of African American women?

Pender’s Health Promotion Model served as the theoretical framework for this study. Pender (1996) stated that each individual has a unique health behavior motivation based on individual characteristics and experiences. A descriptive design was selected to identify facilitators and barriers to prenatal care.

In this chapter, a summary of the findings was presented. In addition, implications for nursing, education, research, and practice were explored. Suggestions about recognized limitations of the study and recommendations for future studies were presented.

Summary of Findings

The sample consisted of 75 African-American women who participated in a rural Women, Infants, and Children (WIC) program in northeast Mississippi. Participants were surveyed to ascertain perceptions concerning facilitators
and barriers to prenatal care among African American women. Participants were all below the federal poverty level, as defined by their WIC eligible status. Ages of the participants ranged from 16 to 35 years. The average total number of pregnancies per participant was 1.78 pregnancies. The majority of the participants were single, and over half were reliant on Medicaid to cover health care costs. The researcher found the majority of the participants to have ninth- to 12th-grade educations.

The Demographic Survey Form and Blanchard’s Prenatal Survey were used to elicit data needed for this study. Each participant was approached upon entry into the WIC distribution center. The researcher introduced self and explained the purpose of current research study. Participants were asked to take part in the survey and confidentiality was assured. Each person who agreed to participate in the survey was provided the questionnaires and a pen. Each participant was asked to complete the surveys and return them to the researcher who sat at the table. Each completed survey was placed in a sealed envelope.

Blanchard’s Prenatal Survey was used to determine answers to the research questions. The first research
question was as follows: What are the facilitators to prenatal care of African-American women? This research question produced the following facilitators. A majority of the participants (85.3%) felt that prenatal care was important; however, only 56% of participants received prenatal care. The second most common facilitator to emerge (77.3%) were friends encouraged prenatal care and long waiting time at the clinic did not make receiving prenatal care difficult. A majority of the participants (74.7%) were aware of the Medicaid program and enrolled or getting enrolled in it. Sixty percent reported cost was not a barrier which is consistent with the study conducted by Mikhail (1999) who found cost to be a facilitator to prenatal care. Seventy-three percent of participants reported that getting off work or out of school was not a barrier to prenatal care. The next facilitators to prenatal care were family encouraged prenatal care (70.7%) and had family support during pregnancy (68%). Sixty-eight percent of participants surveyed reported transportation was not a barrier to prenatal care. Over half (58.7%) were aware of the Healthy Start program, and 54.7% were aware of pregnancy prior to the 13th week and prenatal care was initiated.
The second research question was as follows: What are the barriers to prenatal care of African-American women? The most cited barrier identified in the current study (82.6%) was pregnancies were not planned by either the mother or the father. This finding was consistent with the study by Mikhail (1999) who found that unplanned pregnancy was a major cause of inadequate prenatal care in African-American women. The second barrier identified in the current study was that participants (56%) received no prenatal education prior to becoming pregnant. The third barrier (52%) to prenatal care access was identified as the clinic environment did not encourage return visits to the clinic. Almost half (45.3%) of the participants stated that not being aware of pregnancy before the 13th week was a barrier to early prenatal care. This barrier was consistent with the study by Burks (1992) that cited a major barrier to initiation of early prenatal care was unawareness of pregnancy. Twenty-five of the participants (34%) stated that they did not receive care due to the fact that they “did not want my parents to find out.” Twelve participants (16%) stated that no one knew of their pregnancy until the day of delivery. Less than half (40%) stated cost as a barrier to prenatal care.
Discussion of the Findings

The first research question reflected the facilitators to prenatal care for African-American women. The majority of the participants (85.3%) felt prenatal care was important. However, the current researcher had to explain to several participants the meaning of prenatal care. This leads the researcher to believe that after participants became aware of what prenatal care was they felt the obligation to answer yes to the question. Due to the scant amount of research regarding how African-American women view prenatal care, this finding could not be supported or refuted by the literature. Pender’s model indicates that contributors to a health-promoting lifestyle includes the individual's importance of health, perceived control of health, apparent benefits of health-promoting behaviors, and barriers to health-promoting behavior (Pender, 1996). Participants who placed a high value on their health and who see themselves as having some control over their health are more likely to take promotive actions, in this case prenatal care. It appears that a majority of the study participants placed high value on their health and the health of their infants.
Omar and Schiffman (1995) concluded that a long waiting time was the most cited barrier to prenatal care. Mikhail (1999) also concluded that a long waiting time was a barrier. These findings do not correlate with the current researcher’s finding in that a long waiting time was not an obstacle for a majority of participants (77.3%). Omar and Schiffman (1995) also concluded day time office hours and having to get off work for an appointment presented a barrier. This was unlike the current researcher’s finding which concluded that 77.3% and 73% of participants reported a long waiting time and getting off work were not barriers to prenatal care. Perhaps, the prior studies were conducted in busy, urban clinics rather than small, rural clinics, thus accounting for the long waiting time. Also, the researcher found most of the participants came to the WIC center during early office hours. This leads the researcher to believe that getting off work was not an issue.

Mikhail (1999) concluded that women who did not receive encouragement and support from family and friends did not receive adequate prenatal care. However, the majority of participants in the current study received family support (68%), family encouragement (70.75%), and
friends encouragement (77.3%). Gazmararian et al. (1999) also found that women who received help from the babies’ fathers were more likely to receive prenatal care. Although family support is beneficial, it is not as influential as knowledge.

In the previous study by Mikhail (1999), the researcher cited transportation as a barrier to prenatal care for African-American women. However, the current researcher found 68% of participants cited transportation was not an obstacle. Again, this leads the researcher to believe that although transportation was available, participants chose not to obtain prenatal care. The current researcher found some similarities between the present study and past studies. Mikhail (1999) found the majority of subjects were receiving Medicaid and cost was not a barrier to prenatal care. Burks (1992) also found cost was not a barrier. These findings were significant to the current findings that 56% of participants were receiving Medicaid and 60% reported cost was not a problem. However, the researcher was disturbed to find 22% of participants had no medical coverage.

The second research question was directed to explore the barriers to prenatal care for African-American women.
The researcher concluded the majority of African-American women (82.6%) did not plan pregnancies. This finding is similar to the conclusions of Mikhail (1999) in which the majority of subjects reported unplanned pregnancies (78%). Based on this finding of the large number of unplanned pregnancies, it appears this population needs increased education in family planning.

Two other major barriers to prenatal care were identified by the current researcher. The first, no prenatal education, was cited by more than half (56%) of the participants. This finding was not supported in any of the previous studies. This appears to go hand in hand with the previously identified need for family planning. The next barrier, clinic environment, was also cited by more than half (52%) of the participants. These participants reported the clinic environment did not encourage them to make follow-up visits. This may be related to the reason women did not go to clinics to receive prenatal care. In a previous study by Omar and Schiffman (1995), the researchers found that a caring attitude by office staff promoted women to adhere to prenatal care and health care providers had the greatest influence on women’s satisfaction with prenatal care. Based on this finding,
maybe health care professionals need workshops focused on promoting caring attitudes toward clients. This approach may improve staff and client relationships and improve willingness to return for visits.

Gazmararian et al. (1999) concluded that even when prenatal care was available, many black low-income women did not utilize it. This finding correlated with the current researcher’s finding that although the Healthy Start program (a prenatal clinic for low-income women) was available, only 56% of participants received prenatal care. The researcher was dismayed to find that this may be due in part to the fact that 34% of participants stated they did not receive care in order to prevent their family from discovering the pregnancy. This may be due in part to the fact that high school girls are not educated enough to utilize health care facilities and the fact that they did not want parents to find out. In addition, this compounds the lack of health care use. Also, only 54.7% of participants were aware of pregnancy prior to the 13th week of pregnancy. These findings were supported by previous research by Burks (1992) and Mikhail (1999). Mikhail (1999) found that fear of revealing the pregnancy was a barrier to prenatal care. Burks (1992) concluded the most
cited barrier to late prenatal care was unawareness of pregnancy. Again, this may be related to the young age of the mothers and the lack of education.

The findings of this study validated the use of Pender’s model in viewing prenatal care utilization. The area of health promotion in practice seems to be well-served by Pender’s (1996) Health Promotion Model. Health promotion is recognized as an important aspect of health care and is stressed in the United States Public Health Services (1999) publication Healthy People 2000: The National Health Promotion and Disease Prevention Objectives. This publication provides direction for nurse practitioners and all health care providers. Pender’s (1996) grounded theory seeks to build a framework for understanding these health-promoting behaviors and how they can facilitate health care delivery. Based on what Pender proposes, each of study participants would benefit from education geared toward health-promoting behaviors. This would enable them to gain knowledge of the importance of prenatal care and facilitate the use of prenatal care services.
Conclusions

Based on the findings from this research, the following conclusions were drawn:

1. The number one facilitator to prenatal care for African-American women in rural northeast Mississippi was their belief that prenatal care was important.

2. The number one barrier to prenatal care for African-American women in rural northeast Mississippi was unplanned pregnancies.

3. Another barrier to prenatal care was lack of family planning and lack of education obtained prior to pregnancy.

4. Available prenatal care was found to be a facilitator; however, inadequate utilization of services was found to be a barrier.

Limitations of the Study

This study was limited by the use of a convenience sample which reduces the ability to generalize findings. The research instrument was limited in that it was self-administered. Blanchard’s Prenatal Survey had not been used in prior studies and, therefore, had only face validity. Because a convenience sample was utilized, this
sample had an uneven geographical distribution of participants from one rural county in a southern state. Additionally, the validity of self-report is always dependent on the participants' willingness to communicate personal issues.

Implications for Nursing

This research study was conducted to determine the prenatal care practices of African-American women. Knowledge of the prenatal care utilization by African-American women may aid the nurse practitioner in providing a more preventive approach to practice. Findings from this study have implications for nursing, education, research, and practice.

Nursing. Nurses are at the forefront of the practice of health promotion and disease prevention. As primary care providers, nurses are in an ideal position to improve all preventive services. Early and adequate prenatal care has significant benefits to the individual, the family, and the community. Consequently, prenatal care is a particularly important area for improvement of health care delivery. This current study provides data for improving the prenatal care of African-American women in rural
populations. This study indicates that the key to prenatal care in African-American women is education of clients.

Education. Education must be aimed at demonstrating to the clients what health is, what their health state is, how their behaviors influence their health, and how they can control their own lives. Such education cannot be initiated during pregnancy and be expected to have a significant impact on the current pregnancy. Education must be initiated much earlier for maximum effect. However, education of this type is beyond the scope of this study. Nurses, especially nurse practitioners, have the best opportunity to initiate such education. Nurses are providing education on a daily basis and have the best opportunity of any health care provider to impact the next generation of mothers. Findings from this study underscore the importance of nurses providing educationally appropriate health teaching about prenatal care.

Research. This study sought to determine the prenatal care practices of African-American women in rural populations. Findings from this study revealed that barriers to prenatal care do exist. Findings from this study can potentially serve as a foundation for future prenatal care research. This study presumably provides
data for clinical and practice decisions. This study and previous research have addressed the problem of prenatal care utilization, such as lack of knowledge and education. Accurate identification of specific barriers and facilitators to prenatal care among African American women through research establishes the potential to take corrective measures.

Practice. Nurses or nurse practitioners who practice in community-based clinics or any other health care setting should be made knowledgeable of the factors that contribute to prenatal care utilization in African-American women so that the best effective care can be provided. For the nurse practitioner who desires to promote prenatal care utilization, this research provided information which may contribute to prenatal care use.

Recommendations

Based on the findings of this study, the following recommendations for future research were made:

1. Conduction of a study utilizing a larger sample.

2. Conduction of a study in an urban population and other regions of the country.
3. Conduction of a study examining some of the negative experiences of clients not receiving prenatal care.

4. Conduction of a study to explore how prenatal education before pregnancy might impact the initiation of prenatal care.

5. Adaptation of Blanchard's Prenatal Survey allowing African-American women an opportunity to give narrative responses regarding barriers and facilitators to prenatal care.
References


APPENDIX A

DEMOGRAPHIC SURVEY FORM
Demographic Survey Sheet

Please fill in the blank or check (✓) your appropriate response to the following questions.

1. Age: __________

2. Marital status
   □ a. Single
   □ b. Married
   □ c. Divorced
   □ d. Widowed

3. Level of education
   □ a. 8th grade or less
   □ b. 9th to 12th grade
   □ c. High school grade
   □ d. Some college
   □ e. College graduate

4. Medical coverage
   □ a. Medicaid
   □ b. Private
   □ c. None

5. Total number of pregnancies: __________
   Total number of children: __________

6. Did you receive prenatal care?
   □ a. Yes
   □ b. No

   If yes, how many visits? __________
APPENDIX B

BLANCHARD'S PRENATAL SURVEY
Blanchard's Prenatal Survey

1. Did having to get off work or out of school make it difficult for you to receive prenatal care? □ Yes □ No

2. Did cost of prenatal care make it difficult for you to receive prenatal care? □ Yes □ No

3. Did finding transportation to the clinic make it difficult for you to get prenatal care? □ Yes □ No

4. Did long waiting time at the clinic make it difficult for you to get prenatal care? □ Yes □ No

5. Have you ever received any education about prenatal care before you got pregnant? □ Yes □ No

6. Did you know about the Healthy Start Program? □ Yes □ No

7. Did you know about the Medicaid program? □ Yes □ No

8. Did the clinic environment encourage your return to the clinic? □ Yes □ No

9. Did you know you were pregnant before the 13th week of pregnancy? □ Yes □ No

10. Did you plan this pregnancy? □ Yes □ No

11. Did the father of the baby plan this pregnancy? □ Yes □ No

12. Did you have family support during your pregnancy? □ Yes □ No

13. Did your family encourage prenatal care? □ Yes □ No

14. Did your friends encourage prenatal care? □ Yes □ No

15. Do you think prenatal care is important? □ Yes □ No

16. Did you receive prenatal care with past pregnancy? □ Yes □ No
APPENDIX C

APPROVAL OF MISSISSIPPI UNIVERSITY FOR WOMEN’S COMMITTEE ON USE OF HUMAN SUBJECTS IN EXPERIMENTATION
April 26, 2000

Ms. Sylvia Blanchard  
P. O. Box W-910  
Campus

Dear Ms. Blanchard:

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed research as submitted provided your advisor signs the proposal.

I wish you much success in your research.

Sincerely,

Sheila V. Adams, Ed.D.  
Interim Vice President 
for Academic Affairs

SA: wr

cc: Mr. Jim Davidson  
Dr. Melinda Rush
APPENDIX D

LETTER FOR PERMISSION FROM WIC
Prebble Foster  
District II Office  
532 Church Street  
Tupelo, MS 38801  

Dear Ms. Foster:

I am a graduate student at Mississippi University for Women in Columbus, MS. I am currently pursuing a Master of Science degree in Nursing with a speciality as a Family Nurse Practitioner. I am currently conducting a research study of barriers to prenatal care in African-American women.

I am writing this letter to request permission to conduct a portion of my study at the WIC distribution center in Tupelo. I am attempting to determine what barriers prohibit African-American women from participating in prenatal care programs. I am targeting women of childbearing age 16 to 40 years. Consent forms would be completed prior to completion of questionnaire, and confidentiality will be assured to all participants.

I would appreciate your assistance. If you have any questions regarding this study, you may contact me at (662) 841-3540 or (662) 680-4614.

Sincerely,

Sylvia Blanchard
May 8, 2000

Sylvia Blanchard
142 Suzanne Lane
Saltillo, MS 38866

Dear Ms. Blanchard,

This is to inform you that your proposed study to be conducted in the Lee County WIC Distribution center has been approved. Attached is a copy of the E-mail from our Deputy State Health Officer with approval for your study. Please note that she did request that you send the additional pages from your proposal. If you will send these to me, I will forward them to her.

The Lee County Distribution Center Manager is Sandra Lothrop, and she has been informed that you will be conducting your study in her distribution center.

Please let me know if I may be of further help.

Sincerely yours,

Prebble Foster, R.D
District II WIC Coordinator

Attachment

cc: Dr. Robert Trotter
Roger Riley
Susie Jobe

Serving Alcorn, Benton, Itawamba, Lafayette, Lee, Marshall, Pontotoc, Prentiss, Tippah, Tishomingo, and Union Counties

Equal Opportunity in Employment/Services
The research proposal submitted by Ms. Blanchard has been reviewed and can be implemented if it's o.k. with you all. This type of study does not require full IRB review.

Pages 7-11 are missing from my copy of the document. If she can give those pages to you, I will insert them so my files are complete.

Thanks. Let me know if you need anything else.
APPENDIX E

LETTER OF INTRODUCTION AND INFORMED CONSENT
Informed Consent

My name is Sylvia Blanchard. I am a registered nurse and a graduate student at Mississippi University for Women. I am conducting a study on prenatal care in African-American women. I am requesting that you participate in this study. Taking part in the study is voluntary and will in no way affect your care at WIC. Your identity will remain anonymous, and your privacy will be protected. Your participation in this study will not directly benefit you, but information gained from this study might contribute to improved prenatal care in African-American women.

If you agree to participate in this study, you will be asked to:

1. Sign consent form.
2. Complete a demographic questionnaire.
3. Complete a prenatal survey.

Your participation and willingness to help are greatly appreciated.

Sincerely,

Sylvia Blanchard

I agree to participate in this study.

____________________  _______________________
Date                  Signature of Participant
APPENDIX F

UNITED STATES DEPARTMENT OF AGRICULTURE'S INCOME POVERTY GUIDELINES APPLIED TO WIC
UNITED STATES DEPARTMENT OF AGRICULTURE'S
INCOME POVERTY GUIDELINES APPLIED TO WIC

<table>
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<tr>
<th>Family size&lt;sup&gt;a&lt;/sup&gt;</th>
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</tbody>
</table>

<sup>a</sup>For each additional member, add $5,217/year, $435/month, and $10/month.

<sup>b</sup>If family income no more than indicated per year, month, and week.