Women and Birth xxx (2017) xxx–xxx

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi

Original Research – Qualitative

Providers' perspectives of barriers experienced in maternal health care among Marshallese women

Britni L. Ayers[a], Nicola L. Hawley[b], Rachel S. Purvis[a], Sarah J. Moore[a], Pearl A. McElfish[a,*]

[a] Office of Community Health and Research, University of Arkansas for Medical Sciences, Northwest Campus, Fayetteville, AR, United States
[b] Department of Chronic Disease Epidemiology, Yale School of Public Health, New Haven, CT, United States

ARTICLE INFO

Article history:
Received 28 June 2017
Received in revised form 26 September 2017
Accepted 11 October 2017
Available online xxx

Keywords:
Pacific Islanders
Maternal health
Community-based participatory research
Marshallese
Prenatal

ABSTRACT

Problem: Pacific Islanders are disproportionately burdened by poorer maternal health outcomes with higher rates of pre-term births, low birth weight babies, infant mortality, and inadequate or no prenatal care.
Purpose: The purpose of this study was twofold: (1) to explore maternal health care providers' perceptions and experiences of barriers in providing care to Marshallese women, and (2) providers perceived barriers of access to care among Marshallese women. This is the first paper to explore perceived barriers to maternal health care among a Marshallese community from maternal health care providers' perspectives in the United States.
Methods: A phenomenological, qualitative design, using a focus group and in-depth interviews with 20 maternal health care providers residing in northwest Arkansas was chosen.
Findings: Several perceived barriers were noted, including transportation, lack of health insurance, communication and language, and socio-cultural barriers that described an incongruence between traditional and Western medical models of care. There was an overall discord between the collectivist cultural identity of Marshallese families and the individualistic maternal health care system that merits further research.
Discussion: Solutions to these barriers, such as increased cultural competency training for maternal health care providers and the incorporation of community health workers are discussed.

Statement of significance

Problem or issue

Pacific Islanders are disproportionately burdened by poorer maternal health outcomes with higher rates of pre-term births, low birth weight babies, infant mortality, and inadequate or no prenatal care.

What is already known

Pacific Islanders have identified structural and socio-cultural barriers influencing their utilization of early and consistent maternal health care.

What this paper adds

Although a few articles have described Pacific Islanders' perspectives of maternal health care beliefs and experiences, our manuscript is the first to present maternal health care providers' perspectives of the barriers to care among Marshallese women residing in the continental United States.

1. Introduction

The promotion of adequate and consistent maternal health care, starting in the first trimester of pregnancy, is a United States (US) Healthy People 2020 priority.[1,2] Over the past two decades there have been numerous policy initiatives at the federal and state levels intended to increase access and early utilization of quality maternal health care, especially among women who are a racial and/or ethnic minority who have the greatest disparities in maternal outcomes.[3–8] Although these policy efforts have resulted

* Corresponding author.
E-mail addresses: blayers@uams.edu (B.L. Ayers), nicola.hawley@yale.edu (N.L. Hawley), rspurvis@uams.edu (R.S. Purvis), sjmoore@uams.edu (S.J. Moore), pamcelfish@uams.edu (P.A. McElfish).

https://doi.org/10.1016/j.wombi.2017.10.006
1871-5192/

in significant improvements in maternal care access, when data are disaggregated there is evidence of continuing disparities among women who are a racial and/or ethnic minority.[4–6,9–11]

There is increasing recognition that addressing maternal health disparities requires a greater understanding of the barriers to maternal care. For example, African American, Cree, Malawain, and Hispanic mothers in the US report experiencing numerous barriers to accessing care such as lack of language services, transportation, and economic constraints.[10,12–16] Additionally, women who are a racial and/or ethnic minority cite socio-cultural barriers such as fear, paternalistic and prejudiced care from providers, models of care that are incongruent with cultural beliefs, perceptions of mistreatment, and an overall lack of trust for maternal health care providers as barriers to accessing maternal care.[9,12,13,15–18]

Pacific Islanders are disproportionately burdened by poorer maternal health outcomes with higher rates of pre-term births, low birth weight babies, infant mortality, and inadequate or no prenatal care compared to other racial and/or ethnic minorities.[10,11,19,20] Within the US, Pacific Islander groups, including the Samoan, Marshallese, and Tongan communities, are less likely to receive maternal health care in the first trimester compared to other racial and ethnic groups.[11] There is limited literature on perceived barriers to maternal health care among Pacific Islanders residing in the US. However, the available literature on perceived barriers to maternal health care among Pacific Islanders residing outside the US identified: (1) having multiple children; (2) mother's occupation; (3)employment status of both parents; (4) transportation; (5)stressful life events during pregnancy; (6) a lack of respect from health care providers; and (7) limited options to carry out cultural practices as barriers influencing their utilization of early and consistent maternal health care.[10,21,22]

2. Background

Between the 2000 and 2010 census, Pacific Islanders were the second fastest growing population in the US with the fastest growth occurring in the South (66%), primarily in Arkansas (252%), where a majority of Pacific Islanders are Marshallese.[23,24] The US controlled the Marshall Islands as part of the Trust Territory of the Pacific Islands from 1947 to 1986.[25]

Upon signing of a Compact of Free Association (COFA) between the Republic of the Marshall Islands (RMI) and the US in 1986, the RMI became a sovereign nation.[26] The COFA grants Marshallese citizens' rights to enter the US to reside and work without a visa or permanent resident card. Although COFA migrants were eligible for Medicaid when the compact was signed in 1986, in 1996 Marshallese migrants became ineligible for Medicaid with the implementation of the federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA).[27] The PRWORA did not include COFA migrants in the category of qualified immigrants. Although Medicaid coverage can be implemented by states with no federal monies, Arkansas has not funded Medicaid for COFA migrant adults. While non-pregnant persons (adults or children) are not covered by Medicaid, pregnant COFA woman are eligible for Medicaid.[23]

The RMI was the central site of the US's nuclear testing program from 1946 until 1958.[26] The nuclear tests were equivalent in payload to ~7200 times that of Hiroshima-sized bombs.[27] The RMI is documented as having very high levels of nuclear contamination, which exposed islanders to significant levels of nuclear radiation. Researchers conducted studies to assess the effects of the nuclear radiation fallout without informed consent or appropriate language translation, adding to the historical trauma of the Marshallese community.[26] Like other cultures who have experienced historical trauma, the Marshallese community exhibits distrust in health professionals and health research, which may affect the Marshallese community's perceptions of maternal health care providers.[28–32] To overcome these challenges a community-based participatory research (CBPR) team was developed that has been working with the Marshallese community in northwest Arkansas since 2012.[33] CBPR was uniquely suited to engage equitable collaboration among both the community co-investigators and all the research partners thus improving study design, data collection and analysis, interpretation, and dissemination of results.[34] The CBPR approach used in this study has helped the academic and community co-investigators build trust within the community and help improve the capacity to conduct further research on topics the community identified as most important.[35]

There has been a dearth of literature exploring Pacific Islanders perceived barriers to maternal health care residing in the US.[36] This study extends the researchers' CBPR work with the Marshallese community residing in the US that documented Marshallese women's perceptions and experiences with structural barriers to maternal health care such as language barriers, transportation, health insurance, and socio-cultural barriers such as a lack of understanding of the importance of maternal health care, social stigma, and fear.[36] Maternal health care providers are integral to successful perinatal care, birthing experience, and perinatal outcomes; therefore, it is important to understand providers' perspectives. The purpose of this study was twofold: (1) to explore maternal health care providers' perspectives of barriers in providing care to Marshallese women; and (2) providers perceived barriers of access to care among Marshallese women.

3. Methods

A phenomenological, qualitative design, using focus groups and in-depth interviews with maternal health care providers was chosen. The inclusion criteria were that the providers: provided maternal health care, worked with the Marshallese community, were 18 years or older, and practiced in northwest Arkansas. Local providers who were known to work with the Marshallese community were recruited via email and phone calls and additional providers were approached via snowball sampling (i.e. asking maternal health care providers who were interviewed to recommend additional participants for the interviews). Written and verbal information about the study was provided English, and verbal consent was obtained prior to data collection. After consent, providers completed a brief survey that included questions on demographic characteristics, credentials, and the number of years they have provided care to the Marshallese community. (Table 1) Three participants did not complete surveys. Study procedures were reviewed and approved by the University of Arkansas for Medical Sciences (UAMS) Institutional Review Board (IRB) # V4362017.

From March of 2015 to March of 2017, a purposive sample of 20 maternal health care providers were interviewed using a focus group and individual interviews until saturation was achieved. The focus group included 12 providers, and 8 providers chose individual interviews. Three female researchers trained in qualitative research methods, facilitated the focus group and individual interviews. A semi-structured interview guide with open-ended questions was used to encourage providers to speak candidly while maintaining consistent inquiries across the focus group and interviews. (Table 2) Questions focused on maternal health care providers' perceptions and experiences of barriers in providing care to Marshallese women, and providers' perceived barriers of access to care among Marshallese women. The focus group and interviews took approximately thirty minutes to one hour and were conducted in maternal health care providers' offices.

Please cite this article in press as: B.L. Ayers, et al., Providers' perspectives of barriers experienced in maternal health care among Marshallese women, Women Birth (2017), https://doi.org/10.1016/j.wombi.2017.10.006