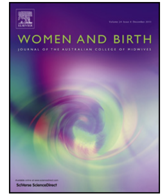
Women and Birth 29 (2016) 160–167

Contents lists available at ScienceDirect

Women and Birth

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



ORIGINAL RESEARCH – QUALITATIVE

Facilitators of prenatal care in an exemplar urban clinic

Julia C. Phillippi [a,*], Sharon L. Holley [a], Kate Payne [b,1], Mavis N. Schorn [a], Sharon M. Karp [a]

[a] Vanderbilt University School of Nursing, 461 21st Ave South, Nashville, TN 37240, United States
[b] Center for Biomedical Ethics and Society, Vanderbilt University Medical Center, 2525 West End, Suite 400, Nashville, TN 37203, United States

A R T I C L E I N F O

Article history:
Received 24 March 2015
Received in revised form 3 August 2015
Accepted 27 September 2015

Keywords:
Midwifery
Health systems accessibility
Access
Prenatal care
Patient-centered care

A B S T R A C T

Background: Perinatal outcomes have complex causes that include biologic, maternal, structural, and societal components. We studied one urban nurse-led clinic serving women at risk for poor perinatal outcomes with superior pre-term birth rates (4%) when compared with the surrounding county (11.2%).
Aim: To explore women's perspectives of their interface with the clinic, staff, and providers to understand this exemplary model.
Methods: A qualitative descriptive approach with semi-structured interviews as the primary data source. Participants ($n = 50$) were recruited from an urban clinic in the Southeast United States designed to serve women of low socio-economic status or who are recent immigrants.
Findings: Women greatly valued a personal connection with the nurse-midwives and staff, and felt this resulted in high-quality care. Convenient appointment times and the lack of wait for initial or subsequent appointments made care accessible. Participants reported the relaxed and helpful approach and attitudes of the office staff were essential components of their positive experience. Women valued unrushed visits to ask questions and receive information. In addition, participants felt that clinic staff were easy to reach.
Conclusion: While qualitative data cannot demonstrate causation, this study provides support that a compassionate and personalized approach to care motivates women to access needed services in pregnancy. Clinic staff are an essential component of the access process. Women overcame barriers to obtain personalized, culturally appropriate care provided by kind, competent practitioners. Clinic staff and practitioners should develop a connection with each woman by providing care that meets her physical, cultural, and personal needs.
© 2015 Australian College of Midwives. Published by Elsevier Australia (a division of Reed International Books Australia Pty Ltd). All rights reserved.

1. Introduction

The Millennium Development Goals of improving maternal health and reducing child mortality focused many nations on ensuring women had appropriate prenatal services to improve perinatal outcomes.[1] As the timeframe to meet the Millennium Development Goals comes to a close, some nations are struggling to meet the demand for care, while other countries are working to decrease over utilization of technology and procedures to ensure women receive only appropriate services.[1,2] While some interventions to improve maternal health are easily measured, the value of prenatal care has been more difficult to quantify. Some research shows a clear benefit to high-quality, content-rich prenatal care while other studies struggle to demonstrate that antenatal care can effectively reverse the effects of biology and societal marginalization.[3–6] Indeed, social marginalization is translated into poor health outcomes across the lifespan beginning with genomic imprinting before birth, cementing the need to find antenatal models of care that support maternal and child health.[7,8]

While not all models of prenatal care are beneficial, some types of care improve perinatal outcomes through maternal behavior change, connecting women with needed services, or other poorly understand mechanisms.[5,6] More information is needed on these effective models of care. While quantitative data can show correlations between health service models and perinatal outcomes, numerical approaches fail to provide rich information on reasons behind improved outcomes. Qualitative information is needed on exemplary clinics and models to assist clinicians in replicating these effective health services. The value and effect of

* Corresponding author at: 517 Godchaux Hall, 461 21st Ave South, Nashville, TN 37240, United States. Tel.: +1 615 343 2683.
E-mail address: julia.c.phillippi@vanderbilt.edu (J.C. Phillippi).
[1] At the time of the study Kate Payne was the Chief Executive of University Community Health Systems, 2410 Franklin Pike, Nashville TN 37204, United States. She is currently a healthcare ethicist and educator.

http://dx.doi.org/10.1016/j.wombi.2015.09.007
1871-5192/© 2015 Australian College of Midwives. Published by Elsevier Australia (a division of Reed International Books Australia Pty Ltd). All rights reserved.

prenatal care has proven difficult to quantify, but qualitative studies provide some insight into women's experiences of care and can allow for future study of beneficial components. The current literature on access to prenatal care has a strong focus on barriers, which is minimally useful to policy-makers, administrators, and clinicians as they work to improve perinatal outcomes.[9] While it can be helpful to create clinics that address common barriers, more research is needed on women's perspectives of what facilitates access to care in pregnancy so new models can incorporate effective aspects of effective models.[9]

We studied one urban clinic in the Southeast United States serving poor and immigrant women with exemplary perinatal outcomes when compared with the surrounding area. Using semi-structured interviews, we explored the women's perspectives on facilitators of prenatal care access, quality care, and effective facets of the clinic. Following qualitative descriptive analysis, we present the results to provide information about components of effective care to assist in creation and study of effective models in other locations.

2. Methods

2.1. Theoretical framework

Critical realism was the theoretical underpinning to the study.[10] This theoretical framework, previously used in nursing and maternal–child health research, acknowledges that observable phenomena have multiple casual mechanisms that include biology, societal expectations, and the interface of people and structures.[11,12] Consistent with this framework, we wanted to study the relationship of the women and the clinic structures and processes, with an emphasis on the woman's perception of her interface with the clinic and providers.

2.2. Setting

The study was conducted in a women's health services clinic part of a federally qualified health center (FQHC) cluster in a large metropolitan city in the Southeast United States (see Fig. 1). The FQHC opened in 1991 to provide access to health services to underserved populations, especially local uninsured and immigrant populations. Most women seeking care at the clinic were at risk for poor perinatal outcomes related to non-medical factors including low socio-economic status or marginalized race and ethnicity. In addition, 52% of the clinic population did not speak English as a first language. Characteristics of the clinic population at the time of the study are displayed in Table 1.

The clinic was devoted to women's gynecologic and prenatal care, and all clinic staff and providers were female. Prenatal and well-woman care was provided by eight certified nurse-midwives (CNMs) and one women's health nurse-practitioner (WHNP). Women received prenatal care at the clinic and gave birth at a tertiary care hospital 2 miles away attended by nurse-midwives from the practice. Office medical staff also included 1 registered nurse, 1 licensed practical nurse, and 1 medical assistant. The clinic phones were answered by 2 women fluent in both English and Spanish. While 3 of the nurse-midwives spoke Spanish, additional translation services were provided by other employees of the FQHC and via a telephone translation service. Women were scheduled for prenatal visits with any available provider, no attempt was made to ensure the women had a primary midwife for continuity of care. The women were told that they were being cared for by the entire group of midwives and complete antepartum, intrapartum and postpartum care was provided by the practice midwives for low-risk women. The first prenatal visit was 40 min long, and subsequent appointments were allotted 20 min. Women at increased biologic risk for complications would also receive care from physicians as well as midwifery care. Birth outcomes for women receiving care at this clinic were better than the county-wide average, with a preterm birth rate of 4% when compared with 11.2% for the surrounding county at the same time period. In addition, the clinic had low rates of missed prenatal visits, low primary cesarean rates, and high rates of breast-feeding.

2.3. Sample

Adult pregnant women seeking care at the clinic from August to December 2013 were eligible for study participation. Participants were recruited though clinic staff recommendation and flyers. If a woman was interested in participating, she could call the number on the flyer, or if the researcher was available, just come to a room in the clinic to be interviewed. The number of women not choosing to participate after being approached by clinic staff was not recorded. In the beginning of the study, all pregnant women seeking care were approached by clinic staff for participation. However, after the first 30 interviews, a review of interview transcripts in conjunction with demographic information revealed saturation of findings for white, non-Hispanic women. After interview 30, only non-white or non-English speaking women were approached for participation, but the flyers remained up to recruit all women. Racial and ethnic identification of the participants, using categories consistent with United States birth certificate and census data are shown in Table 1. However, these categories were not easily understood by participants and fail to show the diversity of the sample. For instance when a woman of Kurdish descent was asked about her race and ethnicity, she replied that she was Muslim, as this was her ethnic group in her native Iraq, rather than 'White' as her group is categorized in the United States. The first language of participants provided more information on the participants' cultural origin (see Table 2). Additional demographic information about participants is shown in Table 3. In addition to parity, we asked women the number of children in their home during the day as the literature suggests that having children to care for is a major barrier to prenatal care.[9] If a woman's children live in another residence or are in school during the day, they may not act as a barrier to care.

2.4. Data collection

All women who expressed interest in participation were interviewed at the clinic following their prenatal visit or during antenatal testing (non-stress test). The primary author, a female, PhD-prepared certified nurse-midwife with training in qualitative methods, completed all the interviews. The primary author had never been employed by the clinic and prior to the interviews had never met any of the participants. The Vanderbilt Institutional Review Board reviewed all study documentation and procedures prior to participant recruitment. Verbal consent was obtained in the woman's language of choice and involved using a structured consent that was read to the women, with opportunity to ask questions. As part of the verbal consent process, women were informed that they could stop at any time during the interview and were told of the goals of the study and how data would be handled. Women were offered anonymity as their full names were never collected and therefore, confidentiality could be assured. In addition, we promised participants that their words would never be associated with enough context that they could potentially be identified. We intentionally did not create a link between the participant name and the interview audio to protect the women's identity. Vulnerable women, especially those in the country illegally, might feel less protected with this link in place. If a woman was not fluent in English, the telephone translation service

Download English Version:

https://daneshyari.com/en/article/2635860

Download Persian Version:

https://daneshyari.com/article/2635860

Daneshyari.com