

**Maternal and Child Health in Upstate New York:
A Qualitative Study**

**Final Report to the Community Health Foundation
of Western and Central New York**

**The New York Academy of Medicine's
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Executive Summary

Research has demonstrated that women living in non-metropolitan areas tend to have lower incomes, fewer years of education, and decreased access to healthcare services, placing them at increased risk for poor health outcomes. Women living in the rural communities and small urban centers of Central New York State (NYS), where rates of poverty, teen pregnancy, obesity, and smoking are higher than in other NYS communities, are at particular risk of poor pregnancy and parenting outcomes. Recognizing these facts, the objectives of this study were to identify and examine factors that may impact on healthy pregnancy and parenting in four NYS communities with socioeconomic and health indicators that suggest a significant high risk population. The ultimate goal of the study is to inform funding decisions of the Community Health Foundation of Western and Central New York (CHFWCNY), by providing them with data that represent the perspectives and experiences of expectant and new mothers in the target communities.

The study utilized qualitative research methods so as to elicit rich descriptions of participant experiences and perspectives regarding pregnancy and parenting. Specifically, we conducted 48 semi-structured in-person interviews and one focus group (11 participants) with pregnant and parenting women living in four pre-identified “hot-spot” communities of Oneida, Herkimer, and Oswego Counties. Communities were selected by CHFWCNY according to socioeconomic and health indicators that suggest a significant population at high risk for poor birth and early childhood outcomes. Interview and focus group participants were pregnant women or new mothers from the selected communities who had been identified by local service providers, including WIC program staff, Early Head Start home visit nurses, obstetrics/gynecology clinic staff, and other public health workers. The interviews and focus group were conducted in-person by NYAM staff and project consultants. Interview notes and transcripts were coded and analyzed according to pre-identified and emerging themes.

The majority of participants utilized prenatal care on a timely basis and were satisfied with their providers. Complaints focused on wait times, crowding, distance to providers, lack of choice, and impersonal care. Teen pregnancy and close birth spacing were common. Teen pregnancy was acceptable to youth, and objections from parents were reportedly limited in duration. Most study participants received material and social support from partners, parents, and/or other family members. Despite these supports, stresses remained high, with many participants describing significant hardship, as well as episodes of anxiety and depression. Educational attainment levels and employment rates were low. The few participants who worked, generally had jobs with poor conditions and inadequate benefits. There was significant county-level variability in access and use of home visiting and other supportive services. Participants requested additional education regarding pregnancy and parenting, access to childcare, and respite from parenting responsibilities. In conclusion, data collected through this

study suggest some room for improvement in prenatal care. The more significant and ongoing needs appear to focus on psychosocial and supportive services to address the life challenges of high risk families.

INTRODUCTION

Research has demonstrated that women living in non-metropolitan areas tend to have lower incomes, fewer years of education, and decreased access to healthcare services, placing them at increased risk for poor health (McDonald & Coburn, 1988; Peck & Alexander, 2011; US Department of Health and Human Services, 2006). Women living in the rural communities and small urban centers of Central New York State (NYS), where rates of poverty, teen pregnancy, obesity, and smoking are higher than in other NYS communities are at disproportionate risk of poor pregnancy and parenting outcomes (Barringer, Jarpe-Ratner, Daro, & Wulczyn, 2009). Prior research suggests that access to prenatal care is not problematic for most women in these areas (Barringer et al., 2009), yet there are insufficient reports describing pregnancy and postpartum experiences in general, as well as barriers to positive maternal and child health. Literature on reproductive health in the United States tends to focus on large urban centers, which have more comprehensive service delivery systems than exists in smaller communities (Peck et al., 2011) and significantly different population characteristics.

The objectives of this study were to utilize qualitative methods to identify and examine factors that may impact on healthy pregnancy and parenting in four NYS communities with socioeconomic and health indicators that suggest a significant population at high risk for poor birth and early childhood outcomes. The ultimate goal of the study is to inform funding decisions of the Community Health Foundation of Western and Central New York (CHFWCNY), by providing them with data that represent the perspectives and experiences of expectant and new mothers in the target communities. The study is intended to complement a previously commissioned environmental scan of the target area conducted by Chapin Hall at the University of Chicago, (Barringer et al., 2009) which included analysis of secondary source data, as well as provider interviews. Together, they provide a detailed portrait of factors influencing maternal and child health in low income Central NYS communities.

METHODS

The study utilized qualitative research methods so as to elicit rich descriptions of participant experiences and perspectives regarding pregnancy and parenting. Specifically, we conducted 48 semi-structured in-person interviews and one focus group (11 participants) with pregnant and parenting women living in four pre-identified “hot-spot” communities of Oneida, Herkimer, and Oswego Counties. Communities were selected by CHFWCNY according to socioeconomic and health indicators that suggest a significant population at high risk for poor birth and early childhood outcomes (see Table 1 for a listing of the communities, as well as relevant indicators). Participants were recruited through health providers, community based organizations (CBOs), and county health department programs (including home visiting programs and WIC) operating in the target communities. Efforts were made to recruit women at

high risk for poor pregnancy and parenting outcomes, including low income mothers. To be eligible for the study, participants had to live in one of hotspot zip codes, and be pregnant or have a baby under one year of age.

Interviews and focus groups were conducted in person by staff and consultants from NYAM between August and December of 2010. All interviewers were trained in qualitative research methods and on the research protocol. Interviews and focus groups followed a written semi-structured guide that included questions on access to and perceptions of prenatal, postpartum, and overall health care; readiness for pregnancy and parenting; community attitudes toward pregnancy and parenting; and available social supports (see Appendix). Interviews were approximately one hour in length; the focus group was approximately 90 minutes.¹ Both were audiotaped to allow for transcription in full or in part. Staff also took notes and wrote a narrative report for each. Transcripts and notes were coded using NVIVO (Version 8, QSR International, Doncaster, Australia), a software package for maintenance and analysis of qualitative data. Interview and focus group participants were asked to fill out a brief survey eliciting basic socio-demographics (e.g. race/ethnicity, number of children, years of education, employment, insurance). Staff also completed a brief survey after each interview, summarizing quantifiable data (e.g. health conditions) that could be derived from the interview.

The research protocol was approved by the NYAM Institutional Review Board (IRB), as well as the New York State Department of Health WIC Program Office. All participants provided signed consent and received a \$25 honorarium.

RESULTS

Participant Characteristics

As noted above, participants were recruited primarily through programs serving low income and high risk mothers, as our interest was in better understanding the lives and behaviors of these specific populations. Participant characteristics, as shown in Table 2,² reflect this recruitment strategy and are not necessarily representative of their wider communities. Participant age ranged from 16 to 40, with a mean of 24; approximately 28% were under age 20. Herkimer participants were the youngest on average (mean = 22), while Rome participants were the oldest (mean = 26). Participants were largely Caucasian (71%), with a small number of African American (19%), Latina (3%) and mixed ethnicity (7%). All non-white participants lived in Oneida County hotspots. Twenty-two percent graduated from college; 31% did not graduate from high school (including five that are still high school students). On average, participants

¹ Although our original research plan included focus groups in each hotspot, the discussion was considered significantly less informative than the individual interviews. Consequently, with the exception of Utica, we conducted interviews only.

² Data reported at the “Hotspot” level is not shown in the tables. Given the small sample size, it is impossible to know whether differences reflect variability in recruitment strategies, actual community-level population differences, or chance.

became parents at a young age (mean = 20.6 years; 53% had their first child before the age of 20). Age at first child was lowest in Herkimer (mean = 19) and highest in Rome (mean = 22). Forty-three percent of participants had two more children; 8% had four children. The average number of children per participant was 1.53, with the highest rate in Herkimer (1.86). Of those reporting the month that they first accessed prenatal care, 82% did so in the first trimester of their current or most recent pregnancy, typically in the second month; 16% accessed prenatal care in their second trimester. One woman was six months pregnant and had not yet utilized prenatal care services. She recognized the importance of prenatal care, but said she had a general fear of doctors and was unhappy with the choices available to her, as a Medicaid recipient.

Fifty-three percent of study participants lived with a husband or partner and 28% lived with their parents (a small number lived with both). Approximately 30% did not live with a husband or a parent. All participants³ described supportive relationships with either a partner, a parent, or another family member. Sixty-five percent described a consistently supportive relationship with a partner. Ninety-one percent described consistently supportive relationship with another family member, most often a parent.

Ninety-five percent of participants had health insurance, most often Medicaid (79%) and PCAP (10%). Thirty-one percent were employed, either full or part time. The highest numbers of working participants were in Utica (42%) and Oswego (38%), as compared to Herkimer (14%) and Rome (11%).

Maternal and Child Health

As noted above, we were interested in finding out about the lives of women at risk of poor pregnancy and parenting outcomes, so recruitment efforts focused specifically on that population. Among this population, there were several notable themes, as discussed in detail below. These include:

- I. Adequate access to, utilization of and satisfaction with prenatal care
- II. Relatively high tolerance of teen parenting
- III. Low employment rates, with available jobs having poor working conditions, little security, and inadequate benefits
- IV. Variable levels of familial support, including significant assistance from parents
- V. Frequent dysfunction, at the family and/or individual level
- VI. Self-identified need for benefit programs, education and support around pregnancy and parenting

Theme I: Access, use and satisfaction with prenatal care

Our original intent was to limit participation to women that received late or no prenatal care. That proved infeasible, however, given the small size of some target communities and seemingly good access to prenatal care. Eighty-three percent of the women in our study did

³ Data available for interview participants only.

receive prenatal care in the first trimester of their most recent pregnancy. Those who did not claimed they not knowing they were pregnant, noted competing priorities (e.g. needed to deal with other health problems first, needed to tell mother first), or ambivalence about the pregnancy.

Emily is 19 and has two children. She did not get prenatal care until she was in her seventh month:

Q So, this last time, so with Cameron, when did you first start to think you might be pregnant?

A I actually had no idea -

Q Really?

A - until I was 7 months. I was still getting my period. I wasn't showing or anything. I had no idea whatsoever...

Q So how did you finally find out you were pregnant?

A I had a UTI, so I went to the doctor... and they were like, "Oh, well, you're pregnant."

Q And how pregnant were you at that point?

A Right around seven months...

Q What about for Arianna? Did you -

A I found out with Arianna, it was, like, about a month.

Q You were a month pregnant?

A Yeah, about normal [LAUGHTER].

Susan is a 20 year old woman with a week old baby. She has had contentious relations with the baby's father and was, at the time of the interview, in a dispute over custody of the child. She accessed prenatal care in her second trimester:

Q By the time you went to the doctor, how far along were you?

A By the time I actually went, I was probably five or six months.

Q Okay. So you waited. Why did you wait?

A I'm not really sure. I think I was just scared.

As noted above, most women did access prenatal care on a timely basis, feeling that it was important to the health of their baby and that regular monitoring of the pregnancy was reassuring to them ("I just want to make sure they're all right and stuff."). Lisa, a 20 year old Utica resident who had her first child at age 16 emphasized the importance of prenatal care:

Q And how important do you think the prenatal care is?

A I think it's very important because it's like you want the best for your baby, you know, and you want to make sure it's healthy and everything, so you've got to get checked out, you've got to make sure everything is going good. I don't know. I wish everybody who's pregnant got it - could get it - because it's like it sets you up right. Like, I don't know. If you know what's going on, you know what to kind of semi-expect when the baby does come.

Several participants alluded to the importance of prenatal vitamins when commenting on prenatal care. Maggie, 4 months pregnant, commented:

I just knew that, you know, when I found out I was pregnant, I have - you know, I have to do, you know - to get, stuff in me, you know, like the prenats and everything, so the baby stays healthy and you know, doesn't, you know, get sick or anything. I mean, because all the stuff that you eat, the baby takes out of you. So, I mean, with the prenats, you know, it actually helps like a little like backup. And, I mean, the stuff that you don't eat, you know, the prenats take up, you know, stuff. So, I mean, the motivation, just like, you know, okay, I'm pregnant. I have to go and get my prenats and my iron ... so that when I have it, it's healthy and there's no complications, that there's no problems.

Participants were generally, if not entirely satisfied with the care they received. Complaints focused primarily on difficulties finding a prenatal care provider that accepted Medicaid, long waits in a crowded waiting room (particularly at one site), and impersonal and unwelcoming staff. Lisa, a 20 year old Utica resident who had her first child at age 16, is seeing a new provider for her current pregnancy. She said she had a bad experience where she received care previously:

I was still young and like they kind of like, I guess, shunned upon it because they like didn't keep their comments to themselves. About me being so young. It's like I know they - everybody has their opinion but it kind of upset me. So I went to ... a different doctor.

June, age 19, lives with her cousin and three month old baby. She received prenatal care at the hospital she was born, but did not like it:

Some of the nurses and the doctors, they were comforting. And a lot of them weren't. A lot of them were kind of just rude, and - they like were there for - it was their job... they didn't even care. They'd just walk in and be like, "blah, blah, blah," and then leave.

Comments such as these were the exception, rather than the rule, however. Most participants were satisfied with their care. Some were enthusiastic:

Q Can you describe a little bit about what made you feel like this was a good place that you were getting your prenatal care from?

A Because the people there got a heart - got a heart of gold. I got along with everybody. Everybody remembered my daughter. They remembered me because they knew my sister that used to work there at the hospital.

Theme II: Relatively high tolerance of teen parenting

Although we did not specifically target programs that served teen mothers, 53% of study participants had their first child before the age of 20. Three women had their first child at age 16 and four at age 17. Participants reported that teen parenting was common. Although providers and parents objected (at least at first), and several participants noted that people “looked down” on them as teen mothers, these negative perceptions appeared to be rather moderate. Teen study participants reported having friends and family members, their age or younger, with children. Crystal, a participant from Utica, discussed the frequency and implications of early childbearing. She is 17, graduated from high school early and has a full scholarship to a local college. She is planning to study psychology and pre-law:

A And I'm actually the first one [inaudible] to have my baby in college and not in high school.... Because I'm the last one out of my friends – out of my group to get pregnant. So all of them had their babies in high school and I waited for college.

Q Was that important to you?

A Yeah, I didn't want a baby in high school. Too much work, you going to college, your baby's 4 and 5 years old. That's not good...My cousin, she's going to college with me.

Q And she has a baby?

A Yeah, he's 3, she's 18. Then my friends, she's 17, her baby's 2 - no, he'll be turning 2 in February. But she's in night school..., she doesn't go to regular school, she goes to night school. So I don't know if she's going to make it out of that. And then her sister got pregnant. And her baby's a couple of months but she's - she's - smart, she don't do dumb stuff but - she'll graduate this year. And then me I'm in college.

Q So you're saying a lot of girls had babies in high school.

A Yeah that's all there is in [inaudible]. And usually it'd be like the seniors or juniors, but now it's freshmen and sophomores. They're crazy. My niece goes to Donovan, that's a middle school, and she told me one girl was pregnant with twins, I'm like - she's not even going to make it to high school.

- Q* Yeah, interesting. Is there anything you thought that if you'd say like women in your community or [inaudible] you know find really challenging or difficult about having a baby?
- A* No, because they make it look fun....they just show your pregnancy off - you know - walk around with tight shirts on. Just crazy stuff.
- Q* (laughter) They don't tell you what it's really like.
- A* Yeah, they make - they show you the glamorous knowing dag gone well when they get home their back hurts and their feet are swollen.

Allison, a teen mother from Rome, was surprised by the acceptance of her pregnancy:

- Q*talk a little about how pregnancy and childbirth are viewed in your - viewed in your family and in your community?
- A* There's a lot more support with it, like, when I was first pregnant I was... a lot more worried because it was, like, "Oh, what's everyone going to say? They're going to say, „I got it with another bad guy and had another kid. What am I going to do?“” ... I was actually worried, but, you know what? There's a lot more, "Congratulations," versus the whole entire what are you going to do now.

Kelley, a 16 year living in Oswego, commented:

[My family] is really supportive about it and they're excited because you can't not be excited when it's a baby. So they're just like being supportive But everyone in school is really good about it too. No one has anything like rude to say. Everybody's just excited about it, jokes about it, whatever.

Theme III: Low employment rates, with available jobs having poor working conditions, little security, and inadequate benefits

Most participants were not working outside the home at the time of the interview.

Jennifer, a 23 year old living in Rome, said:

I'm just nervous now because of our money situation. We don't - neither of us have jobs right now. He just lost his unemployment definitely now...That's - I dwell on that all day long about my money situation.

Jobs (current and previous) participants mentioned were—with just a few exceptions—low-skilled, low paid and without security or adequate benefits. One woman described having—and leaving—a job at Wal-Mart, so that she could access Medicaid benefits. Other positions/placements included child care worker, Licensed Practical Nurse and Certified Nursing

Assistant (both at nursing homes), cafeteria worker, and cleaning staff (office, hotel and nursing home). For example:

- Peggy is a substitute worker in a school cafeteria. As a substitute she doesn't get any benefits, although she does accrue sick time. When she found out she was pregnant, she approached the union representative to see if she could get one week paid sick leave. She said that her boss got angry that she went over his head and reduced her hours. She had been very happy to find out about the pregnancy, but her troubles at work made finances very tight. She was not able to get sick time pay and took a second cleaning job toward the end of her pregnancy.

Given the young age of many participants, including several still in high school, career paths for some are not yet settled. A handful of participants were in college (and one in graduate school), and several others expressed an interest in returning to school in the future. Four participants wanted to be nurses; one planned to pursue a law degree, and one medicine, with a specialty in anesthesiology (*"I've got plans!"* she said).

Theme IV: Variable levels of familial support, including significant assistance from parents

All participants had a partner, parent, or other family member who provided significant support through pregnancy and parenting. Over 80% of participants were born and raised in upstate New York, so they were likely to be living near to family members and to old friends. More participants lived with husbands or partners (53%) than with their parents (32%), yet support from parents (mothers in particular) and siblings was significantly more consistent (91% for parents and siblings compared to 65% for partners). For example:

- Mary (Oswego) has a large family whose perspective, she reports, is ~~the~~ *"the more the merrier."* Family members get very excited when someone is pregnant. With her first pregnancy, two of her sisters were already pregnant so they walked her through the process.
- Catherine (Oswego) finds it very helpful to have family support, even for small things like being able to take a shower while someone watches the baby. With her first pregnancy, she didn't know much about prenatal care. Her sisters-in-law told her where to go for care, and she went to the same facility and had the same doctors as they did.
- Janae (Utica) reported that she gets significant support from nearby family. Her mother is especially involved, as is her sister, her brothers, and their girlfriends. Her mother went with her to all her prenatal appointments and took care of Janae's older son while she was at school last year. Janae's mother will take care of both of her children when she goes back to school. Janae said her mom was angry when she first told her she was pregnant again, but ~~she~~ *"she got over it."*

- Lisa (Utica) reported: —[My mom] watches my son for me when I go to work and ... while I'm at the appointments. What else? Like I said, she's there emotionally, too. She lets me talk when I need to talk.”

Paternal involvement was common, but less consistent. As mentioned previously, a little over half the women live with their baby's father. In such cases, the father generally provides financial support and helps to care for the children on a day to day basis. One focus group participant explained that her husband worked 3 jobs, 70 hours per week, —but he's there.” In a few families, the father's parents or siblings also helped with the new baby. However, in many families, paternal involvement was less consistent. A small number of the fathers were incarcerated or in active military service. Others were involved but not providing full support, due to lack of time, commitment, knowledge and/or skills. A portion of the participants (17%) had no relations with their child's father. For example, Heather (from Rome) explained that her boyfriend was excited about the baby but they fought a lot and he wasn't good to her. He was verbally abusive and treated her badly, so she told him she did not want to see him anymore. She feels better without him, explaining that there is less to worry about. She can concentrate on the baby and feels she “*can do it alone.*” Crystal, a teen mother from Utica commented:

Q And then do you mind if I ask you about the father of the baby?

A He's a sperm donor... Until I - um - give him my phone number again.

Kyra, pregnant with her third child, had a poor relationship with the expectant father. He had been seeing two women at the same time and both became pregnant.

Q What are your relations with him, right now?

A Right now – well right now we're kind a working on a friendship I guess you could say. We do this checking in thing once a week. But like from I think it was like March up until July I didn't speak to him. I like cut him off, I changed my phone number, I just didn't speak to him. But then he was trying to get in contact with all my peoples and stuff and I finally kind a was like, “well I need to let him know what's going on because he is the father and I – you know – opened up to him a little bit. He's very stressful though but –

Q Really?

A A lot a drama. But - - we're working – we're working that out, not to be together but just for the baby's sake.

She continued:

With my oldest two, like their father haven't seen them since 2006, but he does like - you know - the web thing with them and text messages and pictures and stuff

with them. But we split. He did his thing, he went away, he went about his business and I went about my business but I still have to be a mom, I still got to be a dad, I still got to be everything to my kids (chuckles) and - you know - I work. At one time I had three jobs and trying to support them because he wasn't paying child support at that time, and I still got to do what I have to do.

Theme V. Frequent hardship, at the family and/or individual level

A significant number of participants lived with significant and complicated problems, including family dysfunction and poor mental health. One woman had attempted suicide after the birth of her son. Another was hospitalized for two weeks, due to severe depression. Several took psychotropic medications for depression or anxiety. Pregnancy and lactation exacerbated mental health issues, because of medication interruptions—for fear that the medicine would pass to their baby.

Kyra, quoted in the previous section, commented:

Like - I mean - a couple days ago I just like cried and cried and cried and cried, because me and my mom had wound up getting into it, me and the baby's father had wound up getting, into it and I just felt like I was alone. And then I called one a my best friends and they didn't call me back until the next day, so I was just like mad at them for not calling me back right away, because I was going through a situation and - but - I can't wait until it's over with....Because I don't know if it's a hormonal thing, I don't really know what it is, but I know my mood swings are up and down. Like my mom, she just thinks I'm like completely crazy sometimes.

Dana, a Rome participant, has a two year old and is six months pregnant. She explained that she works nights cleaning at a local community organization. She hates the work but needs the money, as she is the provider in her household. Her boyfriend works construction seasonally, but she feels like everything is on her. She gets very anxious and has sought help. She feels she needs someone to vent to, someone who will listen and understand. She explained that she went to a counselor recently, but the woman focused on the paperwork rather than Dana and repeatedly checked her watch. She had been prescribed anti-anxiety medicine in the past, but she didn't like how it made her feel so stopped taking it. Her parents were going through a divorce, and her father was on "serious drugs." Dana complained that she has no time to herself and an overwhelming amount of responsibility, including her boyfriend's daughter on the weekends. She feels like she's going to explode, but she tries to hold it in—at least until she is pushed too far. She feels that she has good reason to be so anxious and that her problems are situational. She recognizes the need for help.

In addition to mental health issues, family dysfunction was not uncommon. For example:

- Maggie, 4 months pregnant, has two other children. Her first born, Nikki (age 2), lives with her mother. Maggie was married to Nikki's father, but it was an extremely troubled and abusive relationship. Maggie's mother was granted custody of Nikki more than 2 years ago and has taken care of her ever since. Maggie and her mother do not get along very well and don't see each other very often. However, Maggie is allowed to see Nikki at a family center for 2 hours every weekend. She is normally on medication for anxiety and depression, but is not taking them due to the pregnancy. She commented, *"I might be emotional, I might be very, you know, teary-eyed, but other than that, I mean, I'm doing really good."*
- June, age 19, lives with her three month old baby, her cousin, her cousin's husband, and their cousin's four children. She has no other family nearby and her fiancé is incarcerated. She visits him occasionally and sends pictures of the baby. She reports that her neighborhood has a lot of drug use, so she tends to go out infrequently. She estimates that there are probably 10 pregnant women nearby, *"But most of them probably won't end up keeping their kids."*
- Ashley has had troubled relationship with the father of her two month old baby. She explained:
 - A We were together, and we actually just recently broke up, and he took him from me. I haven't seen him in three weeks. I had the - go file a petition and now we're going through custody stuff, so -*
 - Q I'm so sorry. Does he - do you have him right now? Do you still have -*
 - A He has him. Well, his parents have him.*
- Felicia is 22 and pregnant with her third child. She, her husband and their children are currently staying with one of her friends (and her friends' two children). They lost their apartment after the landlord sold the building. He kept their security deposit and last month's rent, setting them back financially. Catholic Charities is intervening on their behalf.
- Deborah, age 40, has a one month old baby girl. She has a second daughter (age 10) with spinal bifida, but does not have custody of her. She has no contact with the baby's father, who she says is bipolar and schizophrenic. He is a drug dealer and left her for another woman (also a drug dealer). She has a new boyfriend now that treats her really well and loves her child. First child's baby father committed suicide. She says she slips in and out of depression and *"beats herself up"* about her first child. She feels that her drug use and her epilepsy medicine caused the spinal bifida.

Theme VI: Self-identified need for benefit programs, education and support around pregnancy and parenting

Given study recruitment methods (i.e. recruitment through home visiting, WIC and health care providers), it is not surprising that participants received a range of supportive services. Availability varied by location, however, and a number of participants expressed unmet needs. In sum:

- Participants were most likely to utilize Medicaid, PCAP, WIC, food stamps, Head Start and Early Head Start. Satisfaction levels for Head Start and Early Head Start were high. They also appreciated the money saved through WIC. Medicaid and Food Stamp eligibility were

occasionally problematic, and there were complaints regarding the limited number of providers that accepted Medicaid.

- A Utica High School teacher with the Community Health Workers Program was a significant source of support for pregnant students. According to one of her students: she “*was like a mother*” and always had answers, information, hand-me-downs, and diapers. She gave the student a car seat and helped her install it correctly. She also did prenatal and postpartum home visits and “*asks tons of questions; she is nosy but nice.*”
- Home visiting services were considered very helpful and close connections were made to the nurse visitors. Participants appreciated the opportunity to talk about themselves and how they are feeling, the baby and his/her development, about breastfeeding, and about how to access needed services. They also appreciated information on nutrition, self-care, and baby care. Participant comments included:

It's definitely helpful like the pamphlets that you gave me like as far as eating and like the fruits and the - the - wheat and stuff like that I've been definitely try to keep up with that. (chuckles) And I think along with Ensure and trying to eat right, that's been helping me gain weight, you know what I'm saying? So that's definitely been helpful. And just - sometimes you need someone to vent to and sometimes I feel like ventin', sometimes I don't, sometimes I'll just hold my head down and cry. (Kyra)

You know, they're there for support. Anything I'm worried about, you know, I can talk to them about. So, it's good. Especially living out in the country, you know, I'm away from the socializing too. (Allison)

I have a lady coming. She comes from Healthy Families and she comes once a week and it's just kind of nice to, like, I don't know, talk to her about what's going on and stuff. Changes with the kids and behavior issues. So I was doing that for a while and she kind of helped me and stuff, but it was called Healthy Families.

In Oneida County, however, there was an apparent abundance of home visiting services.

A: I have, um - oh, my gosh. I have Angel, but I have another worker. Who's that other worker, Walt?

Male Which one?

A I mean, I have Angel that comes in, right?

Male You have Angel, then you have Stacy, you got Katie from, uh, Family Resolutions. And then you had [inaudible].

Q Was that -

Male Antoinette Phillips.

- A Antoinette Phillips from Healthy Families....And then I have my case manager....Meagan. I don't know her last name, but -*
- Male From the Neighborhood Center.*
- A So she comes and sees me once a month. Um -*
- Q And what does she talk to you about?*
- A They're mostly - she comes and like gives me services and hooks me up with services like if I need any services, or she helped me get like - she helped me get this house and ... furniture.*
- Q And what does Antoinette Phillips do?*
- A She's like a parenting....She comes in and like sees how the baby's doing, and if you have any questions, you know, she'll answer. Or like when the baby gets older, she'll do activities and stuff.*
- Q Who is that [inaudible]?*
- Maggie Oh, yeah. She's a dietician.*

Conclusions

Study participants described a number of facilitators and impediments to good pregnancy and early childhood outcomes. In particular, women saw the value of, and were likely to access, timely and consistent prenatal care. In addition, social support systems were strong. Slightly over half the participants lived with a partner, and significant support from other family members—primarily parents—was widespread. Women were also interested in learning how to best care for their children and appreciated the advice and assistance of home visitors, where available.

Sociodemographic factors presented great challenges, however. Women had children at young ages and with close birth spacing. They readily described ongoing hardships related to their own mental health, dysfunctional relationships with partners, financial difficulties, housing instability and limited economic opportunities. Services to address these challenges may provide the greatest benefit to low income women and children in Central NYS communities.

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Reference List

Barringer, E., Jarpe-Ratner, E., Daro, D., & Wulczyn, F. (2009). *Improving Services for Pregnant Women and Children 0-1 in Central New York State: Environmental Scan and Recommendations* Chicago, IL: Chapin Hall at the University of Chicago.

McDonald, T. P. & Coburn, A. F. (1988). Predictors of prenatal care utilization. *Soc.Sci.Med.*, 27, 167-172.

Peck, J. & Alexander, K. (2011). *Maternal, Infant, and Child Health in Rural Areas: A Literature Review, Rural Healthy People 2010* College Station, TX: The Texas A&M University Health Science Center.

US Department of Health and Human Services, H. R. a. S. A. (2006). *Women's Health USA 2006: Rural and Urban Women* Rockville, MD.

Table 1
Characteristics of Hotspot Communities

Hot Spot (zip code)	Overall Risk	Poverty Rate	Utilization of Prenatal Care	Teen Pregnancy Rate
Herkimer County				
Cold Brook (13324)	Moderate	High	Low	Moderate
Little Falls (13365)	High	High	Low	High
Oneida County				
Blossvale (13308)	High	Low	Low	Moderate
Rome (13440)	High	High	Low	High
Taberg (13471)	High	High	Low	High
Utica (13501)	High	High	Low	High
Utica (13502)	High	High	Low	High
Oswego County				
Altmar (13302)	High	High	Low	High
Pulaski (13142)	Moderate	High	Low	Moderate
Richland (13144)	High	High	Low	High
Williamstown (13493)	High	High	Low	High

Table 2
Participant Characteristics (n = 59)

	Total	Interview (n = 48)	Focus Groups (n = 11)
"Hotspot"			
Herkimer County	12%	15%	0%
Oswego County	36%	44%	0%
Oneida County			
Rome	15%	19%	0%
Utica	37%	23%	100%
Age			
<= 19	28%	28%	27%
20 - 24	28%	30%	18%
25 - 29	26%	28%	18%
30+	19%	15%	36%
Currently Pregnant			
Yes	49%	50%	45%
No	51%	50%	55%
Ethnicity			
African American/Black	19%	17%	27%
Latina	3%	2%	9%
White	71%	77%	45%
Mixed	7%	4%	18%
Lives With:*			
Partner/spouse	53%	54%	45%
Parents	32%	29%	45%
Neither parent or partner	31%	19%	18%
Number of Children			
0 (pregnant)	15%	17%	9%
1	41%	40%	45%
2	27%	23%	45%
3	8%	10%	0%
4	8%	10%	0%
Age Became Mother			
<= 19	53%	55%	45%
20 - 24	31%	30%	36%
25 - 29	14%	13%	18%
30+	2%	2%	0%
Education			
Not a high school grad	31%	34%	18%
<i>currently in high school</i>		11%	na
High school diploma or GED	40%	36%	55%
Some college	22%	21%	27%
College graduate	7%	9%	0%
Employment			
Working full time	19%	19%	20%
Working part time	12%	10%	20%
Not working	69%	71%	60%

Table 3
Sources of Social Support

Sources of Support	Number
Paternal (n = 48)	
Consistent	65%
Partial/Occasional	19%
None	17%
Parents and/or other family (n = 46)	
Consistent	91%
Partial/Occasional	4%
None	4%

Appendix

Interview/Focus Group⁴ Guide

Thank you for participating in this interview. We would like to find out about the kind of services pregnant women and new mothers need, what you think of the services that are available, and what should be added or changed. Your answers will help us understand more about the programs and services that are most helpful to pregnant women and new mothers.

Just to remind you, your participation in this interview is completely voluntary. You do not have to do the interview, and you can skip individual questions if you like. Your answers will be kept private.

Introduction:

[IF PREGNANT] To start:

1. How many months (pregnant) are you?*
- a. Do you know if you're having a boy or a girl? (small talk/breaking the ice)

2. Do you have other children?*
- a. [If yes] how old are they?
- b. How do they feel about the new baby?

[IF NOT PREGNANT] To start:

1. I understand you have a new baby. Did you have a boy or a girl?*
- a. How old is s/he? (small talk/breaking the ice)
- b. How are you both doing?

2. Do you have other children?*
- a. [If yes] how old are they? How do they feel about the new baby?

Prenatal

You mentioned that you are [xx] weeks pregnant./[OR] I'd like to ask you about your recent pregnancy.

⁴ All questions will be used for interviews. For focus groups, only starred questions will be used.

3. When did you first start to think you might be pregnant?*
- a. What kind of symptoms did you have?
- b. Were you looking to have a baby?

4. What did you do when you thought you were pregnant? (like a pregnancy test, talking to family or friends)*
- a. What was the time period for this (days, weeks, months)?

5. How long before you found out you were pregnant, for sure?
- a. How did you find out?

6. How did you feel about having a baby – first, physically?*
- a. Did you feel well during your pregnancy?

7. How about emotionally – how did you feel about having a baby?*
- a. Were you nervous? Were you happy?
- b. Did you feel ready?
- c. Did you feel that you knew what you'd have to do – both during your pregnancy and once the baby is/was born?
- d. How about the baby's dad – is he involved? If yes, how did he feel?

We've been talking about your own experiences. For these next questions, I'd like to ask about your community – for example, friends, neighbors, and/or relatives.

8. Can you talk a little about how pregnancy and childbirth are viewed in your family and community?*
- a. Are there expectations around what pregnant women should and shouldn't do that are the same or different from other women?
- b. Do women find it difficult to meet those expectations?

9. Do most women go to see a doctor/nurse/midwife regularly when they are pregnant?*
- a. When do they start (e.g. right when they think they are pregnant, at a certain number of months?)

10. How about in the days and months after a baby is born – can you talk, again, about what's expected and what's typical for the mother and the baby?*

11. In general, what would women in your community say is helpful to them—both during pregnancy and when they have a new baby?*
- a. Are there helpful supports that exist among family, friends or neighbors; help from community organizations; and/or useful health services or social services?
12. Similarly, what would women in your community say is particularly frustrating or challenging about pregnancy and being a new mother?
- a. What kinds of supports or services are missing from the community?
- b. What needs improvement?
- c. What suggestions do you have?

To return to your own experiences...

13. Did you know much about prenatal care? (the special health care services for pregnant women)?*
- a. Did you know about the process and why it might be helpful?
- b. Did you know where to go?
- c. Where did you get that information from?
14. When did you start receiving prenatal care?
- a. How long did you wait? (if waited, why did you wait?)
- b. What motivated you to get care when you did?
15. Did you have any problems getting prenatal care?*
- a. Were there any cost issues - did you have (or get) insurance?
- b. Was – or is – transportation a problem for you?
- c. How about other responsibilities (work, family, school)?
16. Can you talk some about how you dealt with or overcame these problems?*
17. Did anyone help you (or encourage you) to get prenatal care (this could be a family member, a friend or a service provider, like a doctor or social worker)?*
- a. Who?
- b. What kind of help (or encouragement) did they provide?
18. Where do/did you go for prenatal care?*
19. How did you find out about [*this place*]? How did you choose it?*
- a. Did anyone help you to find [*this place*]? (if so, who)

- b. Did anyone help you to get care there (for example, making appointments, getting insurance, arranging transportation)
20. Do/did you like the care that you receive there?*
- a. Do you have any suggestions for improvement, or things you think should be done differently?
 - b. Do/did you feel you are/were treated well and treated with respect? Do/did you feel that they care about you and your baby?
 - i. Can you describe what made you feel like the place you went was a good (or not so good) place for prenatal care?
21. Did you/Have you had a nurse or social worker come talk to you in your home about your pregnancy and/or the baby?*
- a. What kind of things does/did s/he talk to you about?
 - b. Is/was it helpful?
22. What do/did you think of having someone come to your home?
- a. Are/were/would you [be] comfortable or uncomfortable with it?
23. Before you became pregnant, did you have a doctor you saw regularly (for check-ups or health problems)?
- a. Where did you go for care?
 - b. How often did you go?
 - c. For what kinds of care?

Post-natal

Changing topics here, I'd like to ask some questions focused on the time after the baby is born:

24. Do you know where the baby will get health care? Have you identified a doctor or clinic to take him or her to?*
25. Do you think you'll want to have more children after this one?
- a. [If yes], how long do you think you'll wait?
 - b. Will you use birth control in the meantime?

For women with other children

26. Are you finding/did you find it easier to be pregnant when it's not your first time?

27. Have you treated this pregnancy different than your other(s) one? Can you explain what's been different?
 - a. Have you felt differently?
 - b. Have your expectations changed?

 28. Has it been difficult to take care of yourself and the pregnancy when you have a young child at home?*
- a. Have you had help?
-
29. Is there anything you would like to add – a question we missed or some extra information?*
-
30. Is there anything you would like to ask me?*

Thank you so much for your time.