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Exploring Lay and Provider Understandings of “Adequate” Prenatal Care in Interior Alaska: An Ongoing Pilot Study

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Introduction

Since the early 1970s, public health indices for defining adequate prenatal care have emphasized utilization: the timing of prenatal care initiation and the number of visits during pregnancy. Such measures are important since early prenatal care initiation followed by regular visits with a maternal health care provider throughout pregnancy is associated with improved maternal and fetal health outcomes.[1] The still widely used Kessner/Institute of Medicine Adequacy of Prenatal Care Index, for example, defines adequate prenatal care as care that begins in the first trimester (weeks 1-12) and includes at least nine visits throughout pregnancy.[2] Yet, this definition clouds other potentially more important factors determining adequacy, such as the content, continuity, and competency of prenatal care.[3] Moreover, it ignores the perspectives of pregnant women themselves.

What does “adequate” prenatal care mean to women who have given birth?

In Alaska, maternal health disparities are pervasive in rural/remote and urban contexts and across all ethnic groups due to challenges related to the physical and social environments as well as health care access and quality. In 2019, only 65.7% of all Alaskan women who delivered a live birth were categorized as receiving adequate prenatal care.[4] State public health data also reveal that pregnant women in Interior Alaska are among those most likely to delay prenatal care and experience preterm birth.[4-5]

While the long-term goal of this study is to identify and compare women’s and providers’ understandings of adequate prenatal care, our focus during this first phase of the project has been to gather women’s perspectives. In this poster, we present a subset of preliminary findings that elucidate women’s understandings of adequacy and their recommendations for improving prenatal care throughout Interior Alaska.

Methods

We recruited and conducted 18 in-depth, semi-structured interviews with women who received prenatal care in Interior Alaska within the past 5 years using purposive sampling. Recruitment occurred by posting study fliers to birth-related social media groups for the Interior Alaska region. Interviews queried knowledge, preferences, and experiences with prenatal care as well as experiences during childbirth. Interviews lasted 1-2 hours and were recorded, transcribed, and qualitatively analyzed following the inductive procedures of Grounded Theory.[4] Participants who completed interviews received a $25 prepaid Visa card as a thank you gift.

Results

Participants are predominately white, multiparous women with annual household incomes over $50k (see Table 1). Four women were born and raised in the Interior, 4 were born elsewhere in Alaska and relocated for family/jobs, and 10 relocated from another state (8 of the 10 are spouses of soldiers stationed in the Interior). In total, women shared pregnancy and birth stories for 24 live births (20 in hospital, 3 at the birthing center, and 1 at home).

All 18 women initiated care in the first trimester and agreed that pregnant women *should* see a provider early in pregnancy with regular visits thereafter. When asked to rate the prenatal care they received in Interior Alaska as either optimal, adequate or inadequate, half rated their care as optimal and half rated their care as adequate. Yet, as their narratives unfolded, four themes emerged as central to their conceptualizations of “adequate” prenatal care. Indeed, despite rating their prenatal care as optimal or adequate, our participants described numerous – less than adequate experiences with their prenatal care.

Table 1: Participant Characteristics (n=18)

Characteristic	*Number*	*%*
Parity		
Primiparous	6	33.33
Multiparous	12	66.67
Age		
20-24	1	5.56
25-29	11	61.11
30-34	4	22.22
35-39	2	11.11
Ethnicity		
American Indian/Alaska Native	1	5.56
Black/African American	2	11.11
White	12	66.67
Multi-Ethnic (includes Hispanic, Korean, or Filipino in combination)	3	16.67
Education		
High school diploma	8	44.44
Associate degree	2	11.11
Bachelor’s degree	5	27.78
Master’s degree	1	5.56
Professional degree (DNP, PT)	2	11.11
Annual Household Income		
$25,000 - 34,999	2	11.11
$35,000 - 49,999	1	5.56
$50,000 - 74,999	6	33.33
$75,000 +	9	50.00

* A note on language: All 18 participants in our study identify as women, which is why we chose to use the descriptor “women” instead of “birthing persons” in this poster.

Relationship with Provider

All 18 women identified a positive relationship with a provider as central to the meaning and experience of adequate prenatal care. Core dimensions of this relationship include feeling respected and heard (good communication), trust (e.g., trusting the provider to make care decisions *with* them, rather than *for* them), and consistent communication at every step, including the postpartum period. Yet, most participants described significant challenges in this area, including distrust, poor communication, feeling pressured to comply with provider’s choices, and weight stigma.

There's just a couple interactions I had with the midwife, I knew she had no ill-intention. It was just the language she used with me and I knew as a provider it wasn't very client-sensitive language when it came to gestational diabetes. “Oh, well, our assumption is that you had diabetes before you came in” and I'm like, “Well, you don't have to assume. I got an A1c drawn four months ago and I was not diabetic.” “Oh OK. Well, we're still going to assume that.” I'm like, ”here's objective evidence showing you that's not the case.” So that was really the only thing that pissed me off, honestly.

Continuity of Prenatal Care

Most women cited continuity of care as an essential part of adequate prenatal care. Being able to build rapport with one provider was a rare occurrence, yet deeply desired. Women described frustration with not knowing who they would see from one visit to the next, or if a new provider would violate the choices they had already affirmed with a prior provider.

I was really upset when I found out that my prenatal doctor from the get go wasn't going to be able to deliver her. She was always going to be my doctor that delivered her. And then she got word from the hospital that she was unable to…and that really, really frustrated me…it was infuriating. I have all this trust and this relationship I built with my doctor and to suddenly have to switch over to a new doctor. And it kind of stumped me because the policy at FMH was, whoever the OB is on the floor that week would be the one delivering. So even if I were to go with an OB from the hospital originally, they may not be the one to deliver her. So the actual OB that I was seeing once I switched over to the hospital was another guy. So I basically had three doctors.

Access to Care & Resources

Over 93% of all Interior births take place in the region’s two hospitals, Fairbanks Memorial Hospital (FMH) and Basset Army Community Hospital on base at Fort Wainwright. The women in our study, especially military spouses, described the impact of insurance limitations with regard to adequate care in terms of access to tests, mental health, auxiliary care, and new parent support. Many expressed concern for the lack of choice for an out-of-hospital birth (home birth or birthing center), and the risk of being separated from their newborn, since only FMH has a NICU.

I have Tricare-Prime, and it really only gives you one choice. It won’t let you go nowhere else… In a way, I do feel like my choices are honored, but then again, honestly if it was really up to me, I would want a natural childbirth and to not to give birth on my back.

They said if she's born and she needs a blood transfusion, she will be moved to FMH, I will not necessarily go with her – it depends on how she's born. If I have a C-section, they can't discharge me, which, I understand that, you know, but at the same time, it’s kind of like, well, if that's a risk then just send me to FMH to deliver, then I could stay with her.

Health systems conditions/constraints

Lastly, most women described the need for significant improvements in systemic factors in Interior health care to achieve adequate prenatal care for all, citing staffing shortages, inexperienced or poorly trained health personnel, lack of redress, and unclear fee structures.

My care is optimal now…yeah, now that I’m actually getting to go to the birth center because for a while, they were short staffed and couldn’t take any new patients.

Conclusions

Women’s perspectives about the meaning of adequate prenatal care highlight key dimensions of care that remain outside of authoritative definitions of adequacy. Why do authoritative measures focus exclusively on the behaviors and characteristics of pregnant women? Why aren’t social, cultural, and systemic factors deemed just as important? Indeed, a systematic review by the WHO demonstrated, on a global scale, that respectful maternity care based on trust improves outcomes.[6] We argue that women’s expertise *should* be central to developing more robust and holistic measures of adequate prenatal care.

A surprising finding was that despite numerous challenges with their care, all of our participants rated their prenatal care as either optimal or adequate. While more investigation is needed, we believe that women may be retrospectively balancing the scales, so to speak. On one hand, women who felt they had more choices rated their care as adequate or better because they got most of what they wanted, even though it was expensive and riddled with challenges (and their baby is alive). On the other hand, women who felt they did not get what they wanted, but had free care – felt “lucky” that their baby was born and survived. In other words, the positive ratings seem to be rooted in gratitude for a positive birth outcome – rather than expectations for optimal prenatal care alongside a positive birth outcome.

In conclusion, we aim for this study to open a space for dialogue across lay and biomedical perspectives regarding expectations for the timing, frequency and content of prenatal care; better communication between people and institutions; cultural humility and technical competency of providers and other health personnel; and respect for women’s autonomy.

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