

## **Cycling through Preconception, Prenatal, and Interconception Care: A Brief Report from the Palm Beach County Family Study**

**Julie Spielberger  
Marcia Gouvêa  
Carolyn Winje  
Laura Fleischman**

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An overwhelming body of evidence suggests that good maternal health is essential to the early development, well-being, and school readiness of young children (Center on the Developing Child, 2009; Hardie & Landale, 2013; Knitzer, Theberge, & Johnson, 2008; McManus & Poehlmann, 2012; Mensah & Kiernan, 2011). Expanding women’s access to preconception and interconception care has been increasingly acknowledged as an important aspect of improving the health outcomes of both mothers and children (Simon & Handler, 2008; Rosenbaum, 2008). According to Wise, “risk-conveying conditions for birth outcomes begin long before conception occurs” (2008, p. 18). In other words, prevention for adverse birth outcomes requires long-term and sustained intervention.

There is a growing consensus that relying solely on access to prenatal care will not significantly reduce low birth weight and prematurity rates. Rather, increasing the number of healthy births depends on improving maternal health before and after birth as well as during pregnancy (Wise, 2008; Lu et al., 2006; Rosenbaum, 2008). In 2006, the Centers for Disease Control and Prevention (CDC) recommended expanding public and private health insurance coverage for low-income women to improve their access to preventive health and preconception and interconception care (Johnson et al., 2006; Salganicoff & An, 2008).

Recognizing the importance of maternal health for children's well-being and development, the Children's Services Council (CSC) of Palm Beach County has long been engaged in efforts to improve infant and women's health outcomes. The Children's Services Council's work is guided by the lifespan approach, which assumes that the best way to ensure more healthy births in Palm Beach County is to support women's health prior to conception, during pregnancy, and after giving birth.

Towards that end, for close to two decades, CSC and other stakeholders in the county have been developing a system of care to improve service access and

coordination for at-risk families. Implemented as the Healthy Beginnings (HB) System in 2009, the system is a coordinated set of services that are voluntary for prenatal and postnatal women, and families with children birth to age 5. The system is designed to increase healthy births, reduce child maltreatment, and promote children's kindergarten readiness. Families are universally screened to determine their level of risk and eligibility for HB services. Depending on the need identified, families receive referrals, assessments, and services through an array of voluntary, scientifically supported or evidence-based programs within the Healthy Beginnings System.

A fundamental assumption of the HB System is that improving service quality and increasing families' access to services will have positive effects on maternal functioning and parenting practices, and, in turn, on children's well-being and development. However, despite the promise of early intervention programs and systems like the PBC system of care, research tells us that their effects are often modest at best (Brooks-Gunn, 2003; Gomby, 2005). An important factor in the effects of voluntary prevention and early intervention programs is engaging families in services long

### **Box 1. The Palm Beach County Family Study**

A central question for CSC and other stakeholders in Palm Beach County concerns the effectiveness of the early childhood service system. Is the service system functioning and being used by families as expected? Is it achieving its intended outcomes? To help to answer these questions, CSC commissioned a longitudinal study to better understand the characteristics and needs of families, how they use services in and outside of the system, and how service use is related to child well-being, family functioning, and children's readiness for school. The study was informed by an ecological framework, which emphasizes the different contexts in which children develop—including family and neighborhood—and the programs and policies that affect the services and systems they experience.

The study used a mixed methods approach that included analysis of administrative data on service use and key outcomes for all families with children born in the county during 2004 and 2005. The data covered the time from birth until the children entered kindergarten. Data were also collected for 5 years through annual in-person and telephone interviews with a sample of 531 mothers who gave birth to a child in the county during 2004 and 2005. A 3-year qualitative study was conducted, involving in-depth interviews and observations of 40 of these families. Mothers were recruited through two maternal child health programs that were part of the Maternal Child Health Partnership (MCHP) system.

To ensure we had enough mothers who were likely to use services, we oversampled mothers that the MCHP screened as "at risk" around the time of the birth of their child. As a result, mothers in our sample had more risk characteristics than other mothers in the county. For example, 17 percent were teen mothers, 72 percent were not married (although many were living with a partner), 41 percent had graduated high school, and 57 percent were foreign born. Of the 531 mothers who participated in initial interviews soon after the birth of the focal child, 310 were interviewed in all 5 years.

enough to obtain the benefits that high-quality services can provide (see, for example, Daro, McCurdy, Falconnier, & Stojanovic, 2003; Olds et al., 2007; Raikes et al., 2006; Roggman et al., 2008).

This report presents selected findings from a 6-year, mixed methods longitudinal study of service use by a sample of high-risk families in Palm Beach County (see Box 1).<sup>1</sup> Given its importance for children's well-being and development, a critical topic in the study was women's health before, during, and after pregnancy. We first discuss the study mothers' experiences with health care and the ecological, cultural, and individual factors that affected their use of these services. For example, we found that mothers' experiences with Medicaid and community health clinics shape their access and timing of entry into prenatal care and their access to medical care in general. We also found that differences in mothers' individual characteristics—including their nativity, the circumstances of their daily lives, and their personal choices—affect their use of health care. We then conclude with implications of our findings for improving service programs and policies.

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## Access to Maternal Health Care

The number of sample mothers who were covered by health insurance and who received regular medical care was fairly stable over the years of the study.

However, more mothers met these criteria in the first year of the study, around the birth of their child, than in later years (see Table 1). Fifty-eight percent of the mothers were covered by insurance in year 1 whereas in the following years between 41 and 45 percent were covered.<sup>2</sup> Eighty-five percent reported receiving regular health care in the first year; but in subsequent years, around 75 percent of mothers received regular health care. Thus, about one-quarter of the sample did not receive regular medical care.

In addition, US-born mothers were more likely to receive regular care (83%) than foreign-born mothers (72%). Only 19 percent of foreign-born mothers had health insurance in the fifth year of the study, as compared with 75 percent of US-born mothers.<sup>3</sup>

The most common locations for routine medical care were public health clinics and doctors' offices. However, US-born and foreign-born mothers differed in the primary location of their medical care, reflecting differences in their health insurance coverage. Among foreign-born mothers who reported getting regular care, 60 percent received care at a public health clinic, 21 percent at a doctor's office, and 19 percent at another facility. In contrast, 86 percent of the US-born mothers received regular care at a doctor's office and just 8 percent received care at a public health clinic. The evidence shows that whether women were born in the United States or in another country affected how they accessed and used health care.

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<sup>1</sup> For this reason, we sometimes specify in this report whether a finding is drawn from the final survey sample of 310 mothers or the smaller sample of 40 mothers in the qualitative study.

<sup>2</sup> Coverage options for lower-income, uninsured pregnant and interconception women involves a patchwork of programs. Under Presumptively Eligible Pregnant Women (PEPW), most of the study mothers would have been eligible for temporary coverage for prenatal care only. During the temporary coverage period, a pregnant woman would need to submit an application to have her ongoing Medicaid eligibility determined. Individuals found not eligible for ongoing Medicaid might have been able to participate in the Maternity Care Program offered by the Health Care District of Palm Beach County, a special local district. The Maternity Care Program covers prenatal care provided at the local health department and select community clinics for uninsured women, not eligible for Medicaid, with incomes less than 200% of the federal poverty level. Labor and delivery for these participants are covered by the Emergency Medical Assistance program (EMA) under Medicaid. In addition, women who received Medicaid during their pregnancy but would not continue to be eligible postpartum might be able to participate in the Family Planning Medicaid Waiver program. Coverage includes well-woman care, family planning, and related health services for up to two years after giving birth. See <http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf>; [www.ahca.myflorida.com/Medicaid/Family\\_Planning/pdf/FPW\\_Public\\_Notice\\_Doc\\_Extension\\_FINAL\\_4-1-2014.pdf](http://www.ahca.myflorida.com/Medicaid/Family_Planning/pdf/FPW_Public_Notice_Doc_Extension_FINAL_4-1-2014.pdf); [www.guttmacher.org/statecenter/title-X/pdf/FL.pdf](http://www.guttmacher.org/statecenter/title-X/pdf/FL.pdf)

<sup>3</sup> Among the 310 mothers who participated all 5 years of the study, more than half (55%) were foreign born, with the largest percentage of foreign-born mothers coming from Mexico, followed by Guatemala and Haiti.

**Table 1. Characteristics of Mothers' Health Care Over Time**

Characteristic	% of Mothers (N = 310) <sup>a</sup>				
	Year 1	Year 2	Year 3	Year 4	Year 5
Have health insurance coverage*					
All mothers	58	43	42	41	45
US-born mothers	88	70	73	66	75
Foreign-born mothers	32	21	15	19	19
Get regular medical care					
All mothers	85	73	74	73	77
US-born mothers	94	78	80	78	83
Foreign-born mothers	77	69	68	68	72
Location of routine medical care*					
Doctor's office	46	40	41	43	41
Public health department clinic	34	30	26	26	26
Other clinic, health center, or emergency room	5	3	6	3	10

<sup>a</sup> Based on the sample of 310 mothers who were interviewed all 5 years of the study; 143 were US-born and 167 were foreign-born.

\*Paired sample t-tests indicate that the following year-to-year differences for all mothers are statistically significant at  $p < .05$ : insured1 vs. insured2; insured1 vs. insured3; insured1 vs. insured4; insured1 vs. insured5; medical care location1 vs. 2; medical care location1 vs. 3; medical care location1 vs. 4; and medical care location1 vs. 5.

## Foreign-born mothers

Nearly all of the foreign-born mothers in the qualitative sample had access to Medicaid coverage that began during their pregnancy and concluded 60 days after their child's birth. Therefore, the coverage was temporary. Without Medicaid, foreign-born mothers relied primarily on community health clinics and hospital emergency rooms for health care.<sup>4</sup> Mothers reported using community health clinics for a variety of health care needs, such as treatment of illness and minor emergencies; family planning services, prenatal care, and dental care; and to access parenting information.

Mothers' descriptions of their experiences with community health clinics over time revealed several factors that hampered access to health care at community

health clinics. Gabriela's experience (see Box 2) illustrates how barriers such as cost, transportation problems, difficulties communicating in English, long waits, and lack of provider responsiveness discouraged the use of community health clinics.

As their children become older, the use of health care services becomes less consistent. Foreign-born mothers talked less frequently about the use of community health clinics. This appears to reflect, in part, a general decline in the use of services for their own health care following the loss of Medicaid coverage. This finding is also reflected in Table 1, which shows a smaller percentage of mothers using health care in years 2 through 5 (between 41 and 45%) compared to year 1 (58%).

<sup>4</sup> These findings are consistent with other research showing that in states with low Medicaid coverage, access to adequate health care is a challenge for low-income adults. For people who cannot afford to pay for health insurance or lack Medicaid, traditional safety net providers such as public hospitals and community health centers play a key role in ensuring access to care. See Mead et al. (2008) and Rosenbaum and Shin (2006).

It is possible that, unless they are pregnant, some women may not feel the need to see a physician on a regular basis. If they do have a medical need, they may decide to postpone a visit to the doctor if they lack health insurance or have inadequate coverage. Data from the qualitative study indicates that mothers (foreign-born and US-born alike) are often more concerned about their children's health care than their own. For example, a mother from Mexico, who has one child, reported that when her husband lost his job they did not have insurance. However, she did not worry because they had Medicaid for their child.

A factor that facilitated foreign-born mothers' access to health care was the support they received from friends, family, and social workers from care coordination programs, such as those run by the Healthy Mothers, Healthy Babies Coalition and the Guatemala-Maya Center. Mothers received help from both informal and formal sources with transportation, child care, language, information, and applications for health care programs and other services.

### US-born mothers

With regard to US-born mothers, the main program factors affecting access to health care were related to the Medicaid application and recertification process after birth and understanding the Medicaid eligibility rules. Although US-born mothers were also negatively affected by impersonal and unhelpful staff at the program office, they were mainly constrained by Medicaid requirements, particularly the necessity to file for child support if unmarried. (In both the

qualitative and survey samples, US-born mothers were less likely to be married than immigrant mothers.) For example, Denise had Medicaid coverage throughout 3 years of qualitative interviews. However, each time she was interviewed, she voiced concern about the possibility of losing health coverage because she had not filed for child support. She was reluctant to do so because her partner was fulfilling his role as father for their children and contributing to the family income. She said, "They wanted to put him [partner] on child support but I don't want them to do that because he [partner] is doing what he is supposed to do. He is taking care of him [son]."

Like foreign-born mothers, US-born mothers cited facilitators of health care access as being support from friends, family, and social workers or caseworkers from community providers within the maternal child health system. This support included help with transportation and child care as well as help with Medicaid applications. For example, Gloria, a mother of four, explained that when she realized that her Medicaid was cut off, she turned to her caseworker, who promptly helped her get Medicaid reinstated. "So when I talk to her, then maybe she can let me know why it's cut off 'cause I want to know. We don't have money like that to be paying for a doctor. That's a lot of money," she said.

Unlike their foreign-born counterparts, many US-born mothers kept their Medicaid coverage over time. These mothers seemed to have a caseworker consistently assisting them. Some of these mothers also had their first baby in their teens, presented multiple health problems, or gave birth prematurely.

#### Box 2. Gabriela's Story

For Gabriela, a 27-year-old Hispanic mother of a 2-year-old girl, a visit to the health clinic means dealing with several issues: transportation problems, lack of provider responsiveness, and out-of-pocket health care expenses. When a trip to the health clinic is needed, Gabriela relies primarily on public transportation. However, going to the clinic by bus is not trivial. She said, "It [takes] like 45 minutes to get there. . . . And with the sun, sometimes it would rain, there was nowhere to cover yourself. I would cry. I would call my husband [to see] if. . . by chance he were around to pick me up. But if not, I would have to tolerate the sun and rain." Furthermore, once at the clinic, Gabriela perceived the clinic frontline staff as rude and angry. Whenever possible, Gabriela avoids seeking health care at the clinic. "I want to avoid [going to the clinic] right now. I am not in the mood to have a bad time," she explains, adding that she will not seek medical care for a recurring ear problem because she was "traumatized" by her previous experience. Finally, having to pay for health care is also problematic, she said. "Well, when I use the clinic, it is not that I don't pay. . . I get into debt."

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## Prenatal Care

The relationship between birth outcomes and prenatal care is not straightforward because there are many factors that affect birth outcomes. However, prenatal care is recognized as being crucial to the health of the mother and of her infant (Wise, 2008). Therefore, improving access to prenatal care services has been a widely adopted measure to reduce neonatal deaths and incidences of low birth weight across many communities in the United States, including Palm Beach County.<sup>5</sup>

Most of the mothers in the study (97%) reported receiving prenatal care for the focal child. When taking into account timing of prenatal care, foreign-born mothers were more likely to receive late or no prenatal care than US-born mothers (11% versus 5%). Also, 62 percent of foreign-born mothers received prenatal care in the first trimester compared to 75 percent of US-born mothers. In subsequent pregnancies, data showed a modest decline in the receipt of prenatal care for mothers who became pregnant again in later years of the study. For subsequent pregnancies, US-born mothers were also more likely to receive prenatal care than their foreign-born counterparts.

Access to prenatal care varied by the source of care—that is, by program and provider factors—and therefore by nativity status. Consistent with their access to other health care, foreign-born mothers initiated and received prenatal care at the community health clinic once they were approved for Medicaid. However, US-born mothers typically received prenatal care through a private physician covered under Medicaid insurance.

### Foreign-born mothers

Foreign-born mothers spoke about encountering many barriers at the community health clinic, including intake guidelines, long waits, overcrowding, provider responsiveness, transportation problems, and difficulties

communicating in English. For example, Crystal, a mother of four children, indicated that overcrowding and limited resources at the community health clinic contributed to her receiving late prenatal care:

Well, when I went to the clinic with my first babies when I was 6 months pregnant, I got an appointment within 2 weeks and everything was good. . . . Now, because there are more people, they don't have enough [staff] to attend to all of the people. This time I went when I was about 6 months pregnant [but] they gave me the appointment 2 months later. So I did not have a chance to go to the clinic because there was no place to put me. I never took the vitamins nor did I visit the doctor because the baby was born at 8 months.

Crystal also sought prenatal care late in her pregnancy because she prioritized work over prenatal care. She said, “Since I was working I felt tired and well it was my fault for not going to the clinic early.”<sup>6</sup>

Some foreign-born mothers also reported they had negative interactions with office staff and medical providers when they struggled with English or missed appointments. One of those mothers, Juanita, said, “Well, I didn't arrive on time to the appointment, and then the nurse started yelling at me.”

In the case of Laura, scheduling of prenatal care appointments at the clinic and Medicaid application procedures were the main barriers to receiving prenatal care. The health clinic staff advised her to overestimate how far she was into her second pregnancy when requesting an appointment at the clinic, so as to avoid a late prenatal care visit. Despite doing this, Laura still was not able to see a doctor for her first prenatal care appointment for another 2 months. One reason for the delay was that she was unaware that the Medicaid application procedure had changed. She could not complete the application in one day as she had previously and

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<sup>5</sup> At the time of the study (2008), 71 percent of women giving birth in Palm Beach County received prenatal care in the first trimester, while the state rate was 77 percent. In 2012, 76 percent of women received prenatal care in the first trimester; the state rate was 80 percent. See [www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=18](http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=18).

<sup>6</sup> According to Zambrana, Scrimshaw, and Dunkel-Schetter (1996), Mexican-American women who work full-time during pregnancy are more likely to forgo prenatal care than those who do not work during pregnancy.

had to make another appointment for a different day to finish it. She said:

It wasn't like that before. I did everything in one day. I filled out all the papers and they told me to come back next week. I thought this time I would be seen by a doctor [because] I had some pain here. But no. I have to go back on the 19th to fill out the papers, two months later.

Medicaid coverage is required in order to receive prenatal care at the community health clinic. At least a third of the foreign-born mothers in the qualitative sample reported the Medicaid application process as being a barrier to receiving timely prenatal care because of the lag time between submitting the application and its approval. Another factor compromising adequate and early prenatal care was the misinterpretation of the guidelines for Medicaid coverage. Some mothers believed that it only covered a limited amount of time rather than the full gestational period. For example, Flavia told us she delayed seeking Medicaid coverage for prenatal care in order to make sure she had Medicaid coverage for her delivery.

Despite these barriers, foreign-born mothers spoke more often than not about factors that facilitated their receipt of prenatal care at the community health clinic. Again, as with access to general health care, facilitators included information received from friends and families; assistance from social workers and agencies with transportation, Medicaid applications, and scheduling appointments; responsiveness of clinic personnel; and presence of bilingual staff at the time services were provided.

### US-born mothers

Most US-born mothers in the study were eligible for Medicaid, whether pregnant or not, and, thus, had easier access to a private physician. This, in turn, made it more likely that they would initiate prenatal care early (Salganicoff & An, 2008). For example, when Brenda—a 24-year-old mother of four—became pregnant with her fourth child, she went directly to her physician who delivered all of her three other children.

US-born mothers were more likely than their foreign-born counterparts to report their own personal barriers to prenatal care. Nia was not planning to have another child and did not realize she was pregnant until she was about four months into her pregnancy. Like other US-born mothers in the study, Nia's unintended pregnancy and attitude towards her pregnancy contributed to her receiving late prenatal care. Bayle, a mother of four children, provides another example:

[At] six months with a big belly I was still in denial. I felt the baby moving and all. I really was in denial. Then they wanted me in there every other week until my ninth month. Everybody was surprised. They were like, "You're going to have another baby. Are you for real?" I was surprised myself. I really wasn't expecting that one either. My last one I really wasn't expecting her at all.

In addition to mothers' attitudes about their pregnancy, several other individual factors influenced the timing of prenatal care. These included problems in past pregnancies and preexisting health conditions. Some were unaware of their pregnancy because they were using birth control, had irregular periods, or had a health condition that made it unlikely they would become pregnant. Brenda, a mother of four, explained, "See, when you take the Depo [Depo-Provera birth control] shots sometimes you miss your menstruation for 3 or 4 days so I thought it was just the shot but I was pregnant." Marlene, a mother of two adult children, found herself unexpectedly pregnant with a child who she described as her "miracle baby." She said, "I had one tube and [a history of fibroids]. They had told me I could never have any more children after that. . . . And then I got a baby. Who would've thought?"

On the other hand, mothers who were high risk in previous pregnancies or who had a preexisting health condition were more inclined to seek prenatal care as soon as they knew they were pregnant. These mothers seemed aware of the consequences of not seeking health care given their health history (Elam-Evans, Adams, Gargiullo, Kiely, & Marks, 1996). For example, Linda explained her prenatal care regimen during her second pregnancy, "I had to go to my OB every month, and I had

to go to a specialist because I had problems every two weeks or every week.” When Denise, another high-risk mother because of her asthma, was pregnant with her third child, she “went to see a doctor right away. [I] would go every month and because I was at high risk, because I have asthma real bad, I had to go there.”

Other individual factors—their personal resources, characteristics, and social networks—also positively influenced mothers’ access to prenatal care. For example, mothers received help with transportation from friends and families to go to their prenatal care appointments. As Gloria, a mother of four children, related, “My parents [or] my sisters would drive me over there. Every appointment I went to they drove me. I never had to take a bus or anything or cab, nothing.”

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## Family Planning Services: US- and Foreign-born Mothers

Low-income women without health coverage are less likely to access family planning and are at greater risk of having an unintended pregnancy, which is associated with increased risk for adverse pregnancy outcomes (Kaiser Family Foundation & Alan Guttmacher Institute, 2005; Johnson et al., 2006; Melnick, Rdesinskim, Creach, Choi, & Harvey, 2008). As with other aspects of health care, multiple factors influenced the use of family planning services, including individual characteristics as well as program- and provider-level factors.

Again, US-born mothers were much more likely than foreign-born mothers to have access to health insurance and somewhat more likely to receive regular health care services, regardless of pregnancy status. These mothers received family planning services at their doctor’s office. In contrast, nearly all of the foreign-born mothers had only temporary access to Medicaid, primarily during the time before and just after giving birth. If they did receive family planning services, they did so through the community health clinics. Other than these differences, US-born and foreign-born mothers reported similar barriers and facilitators to using family planning services. Thus, this section is not structured by nativity status as previous sections in this brief have been.

## Access and quality

Limited or no coverage for family planning services was a dominant theme when mothers talked about access to family planning services. This means that mothers could be required to pay the costs of the clinic visit and contraceptives. For example, Teresa, a mother of two, avoided seeking care for an ailment derived from oral contraceptive pills. She did not want to risk paying for an expensive clinic visit. She explained, “I don’t know. I have never gone, because I don’t know if it is expensive or cheap [so] I haven’t risked going.”

In the case of Julia, also a mother of two, getting access to free contraceptive pills was the main concern. Julia was not planning to have additional children but was informed at the clinic that she would only receive birth control pills for free for 90 days, and after that she would have to pay for them. Laura also discussed encountering financial barriers to accessing contraceptive pills. She said, “They’re getting too restricted. . . . The injection is not free anymore. Before everything was free. . . now we have to pay.”

For Tracy, limits on Medicaid coverage for contraceptives affected her choice of method: “I take the patch now, but I’ll switch to [Depo-Provera shots] ’cause my Medicaid doesn’t cover the patch.” A handful of mothers echoed these experiences. The contraceptive method suitable for them was not affordable or not covered under their insurance. Ivana, a mother of one child, had many reproductive health problems and was advised by her doctor to use an intrauterine device (IUD) instead of oral contraceptives. However, she could not afford the cost. These barriers sometimes forced mothers, especially foreign-born mothers, to seek more affordable alternatives. For example, some mothers had their contraceptive pills shipped from their country of origin. These alternatives were not necessarily more dependable, however.

Despite these barriers, mothers’ access to family planning services was facilitated by the availability of low-cost health clinics in their communities and Medicaid coverage, albeit limited, for foreign-born and US-born mothers respectively. Most of the US-born mothers talked about getting Medicaid coverage for a



limited range of contraceptive methods and some of the foreign-born mothers reported receiving free family planning services and oral contraceptive pills at community health clinics.

As is the case with other types of health care, access to family planning services was hindered by restrictive office hours, administrative protocols, and program policies. Lariza, for example, complained that the program office hours were not compatible with her work schedule. Debra talked about feeling trapped by the age restriction policy for the birth control method of her choice. “They are not going to tie [my fallopian tubes]. I have to be 25 and older to get them tied.”

The quality of family planning services featured prominently in mothers’ narratives. When Gabriela went to the community health clinic to get free birth control pills, she recalled getting very upset with the staff’s lack of responsiveness. She had arrived very early in the morning to ensure she would be seen but lost her position in line when the clinic opened its doors. Although she tried to explain the situation to a clinic staff person, the staff person was rude and insensitive to Gabriela’s pleas:

... So I spoke with the secretary, with the woman who was going to give us the appointments. I said, “Look, I was here. It’s my turn. I was on the line since 6 in the morning.” And she (front desk clerk) said, “No, I have not seen you. I don’t remember you.” I almost started to cry with anger, I wanted to hit her.

After this experience, Gabriela swore never to go back to that clinic. But over time, she realized that she could not take on the financial burden of paying for these services herself and decided she would have to tolerate mistreatment in exchange for the free services.

Mothers also reported having interactions with health professionals in which they misunderstood the information they received. Bayle, for example, did not understand her doctor’s information about contraceptive methods and perceived his rhetoric to be intrusive.

He was like, “You ever thought about [an] IUD?” Whatever it is called; something they stick up there and there is a string hanging out. I am like, “Just the

thought of that would drive me crazy.” He was like, “You need to do something.” I was like, “Hold on now, you can’t tell me how to live my life.”

Although mothers’ accounts focused on their disappointments with the quality of family planning services provided, there were mothers whose experiences with these services were more mixed or even positive. Although Gabriela stressed the negative experiences dealing with the staff at the community health clinic in her early interviews, in later interviews she praised the nurses for the way they attended to her health concerns.

Elvia also spoke positively about her experience, saying, “The staff at the community health clinic don’t leave you waiting for a long time. . . and if they don’t speak English they take me to a Spanish translator and they help you a lot.” And Julia expressed satisfaction with the efficiency of service provided: “They gave me the [tubal ligation] operation quickly. They called me and told me when they were going to do it. I got the letter quickly.”

### **Individual characteristics, attitudes, and beliefs**

Use of family planning services seemed to be as much, if not more, affected by individual factors as by provider or program factors. These included, but were not limited to, mothers’ knowledge and available information about contraceptive methods, the emotional and financial strain of raising children, the state of their health, and their partners’ desires for children. These individual factors were not mutually exclusive; they also interacted with the program and provider factors discussed above.

**Contraceptive knowledge and information.** A lack of knowledge about contraception reflects having insufficient personal resources and a lack of access to providers with sound and accurate information on contraceptive methods. Many mothers who spoke about family planning methods expressed confusion about the contraceptive information they had received and fear of their side effects. This lack of understanding, in turn, made mothers perceive these methods as untrustworthy. Two participants, Sandra and Debra, illustrated these perceptions. Sandra, a 21-year-old mother of two, said

There are so many different things to protect yourself. . . . I am very confused about pills. I don't know if I'm supposed to start taking it when my cycle is off. . . . color changes, what does that mean? . . . I've asked them about the IUD but I'm kind of afraid, I don't want a Depo shot. I don't want anybody shooting me in my buttocks every three months.

Debra, a mother of two children, said, "So when I got the pills there I did a lot of reading. I went to reading all of the side effects [and] I said 'Goodness gracious,' this whole long paragraph with words that I didn't understand but I know they didn't sound right."

Contraceptive side effects, especially those related to mothers' physical appearance (e.g., changes in complexion and hair loss), also shaped mothers' family planning decisions and decreased use of some contraceptive methods.

**Personal and financial challenges of children.** Most of the mothers who talked about their family planning decisions expressed concern about the personal challenges—in terms of their time and energy—and financial challenges of rearing additional children. Holly indicated she was not sure she wanted to take on responsibility for younger and less independent children now that her older children were growing up. She said, "Once [the kids] leave this stage right here and get to doing things on themselves, I don't think that I will want to go through it again." Elvia shared similar view, "No, not another baby anymore I mean I don't want one right now, with another baby it gets more difficult, it's more responsibility, you can't even go anywhere you have to take them both."

Holly also believed that additional children would jeopardize the financial security of her current children. "I don't want any more [kids] because I want to have a good life [and] clothe them; when school starts everybody has to have a certain amount of clothing." Elvia predicted that having more children would add to family financial strain. "It is beautiful [having children] but if you have two it is impossible to help your husband with the bills. If you put them in daycare now they charge you double." Sandra was determined to improve her financial circumstances before having

another child, saying, "It takes money to raise a child and I want to make sure I am situated."

For some mothers, financial concerns translated into a concrete commitment to having a small family. Lariza, who chose a permanent solution after unexpectedly becoming pregnant with her second child, said, "They asked me questions about if I wanted to be operated on right away. I told them yes. . . . My husband earns little, and my son. . . was not in my plans." For other mothers, the financial and personal implications of raising more children did not lead to concrete steps to prevent another pregnancy.

**Physical and emotional health.** Mothers' health was another significant factor in family planning decisions. The risk of severe health problems due to the use of a contraceptive, pregnancy conditions, and miscarriages factored into mothers' decisions to have more children. Norma, a mother of two children, said she could not use birth control pills because she was "prone to get blood clots." Tania, also a mother of two, planned to have a tubal ligation, explaining, "I don't need any more kids. They are telling you that if you got kids they could kill you, it is risky and you don't need to do it." Ana, a mother of one child, also expressed concern about her physical health. "The doctor told us that, like with the boy I had had problems, too, and the threat of miscarriage. . . he said that the womb was very fragile. So, it is better to wait," she said.

Many of the mothers' narratives showed they experienced emotional distress when dealing with reproductive health problems (e.g., miscarriages) and unintended pregnancies. Although these mothers either accepted or struggled to come to terms with the pregnancy, they all felt emotionally vulnerable. Sandra, for example, described a miscarriage she had less than a year after giving birth to her first child:

I was 6, almost 7, months. I had a feeling I was kind of pregnant but I was afraid of what my mom might think or what my family might say about [my son] not being one year old yet and then having another child. And I was already young. I just kept it to myself until one day I went to apply for food stamps and Medicaid. I couldn't even sit in the ladies' office I was hurting so

bad and bleeding. I thought it was a regular menstrual cycle and cramps but it was a miscarriage.

The fear of going through another miscarriage fed into Sandra's anxiety about her second pregnancy. Sandra was also struggling with depression that had persisted after giving birth to her first child. She said, "I want to be a new person. I don't want to be that person that's crying all the time like I used to. I don't want to be that person that has to depend on people like I used to."

**Partner influence.** Another influence on family planning decisions was mothers' partners, whether it was a current partner or the potential of having a partner in the future. Sabrina, for example, told us she would not have any more children unless she got married. She said, "I don't think I will have more. But if I did it would be because I am married. I don't even plan on getting married." Similarly, Miriam said she might have more children if she fell deeply in love with a man who wanted to have another child, while Brenda vowed that she would only have another child if her partner married her. "Whenever [her boyfriend] thinks of marrying me that is when I'll think of having another child," Brenda said.

The relationships between mothers and their partners also influenced their decision to have another child. Several mothers described tensions between their desires and those of their partners. Typically, partners wanted more children, and mothers did not. Angelina expressed this tension as follows: "Why would you want another child after 7 years? . . . I told him I'm not going to be having time to raise more kids. I'm not going to put that on [the older kids]." Ivana, a mother of two, expressed similar tensions with her partner but also seemed willing to meet his desires: "He says he only wants to have three. . . I'm fine with just one but not him. If he wants more I'll have more."

Less frequently, partners did not want to have children but mothers did. Ana's partner believed that they should put off having more children until their financial situation improved. However, Ana believed

that their family financial status should not be a deterrent for a bigger family. "With how things are with his job, there isn't much work. I tell him we can't suspend something like that . . . leaving off having a family."

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## Conclusions and Implications

Again, an overwhelming body of evidence suggests that good maternal health is essential to the early development, well-being, and school readiness of young children (e.g., Knitzer et al., 2008; Mensah & Kiernan, 2011). Most of the mothers in the study received prenatal care at some point during their pregnancy. Most US-born mothers received prenatal care at a doctor's office whereas nearly all foreign-born mothers received prenatal care at a community health clinic. However, all mothers in the study were much less likely to use health services in between their pregnancies. Table 2 summarizes the primary barriers among the study families to receiving health care. These barriers reflect both individual factors and factors related to the requirements of public supports and the responsiveness and quality of providers.

By the end of the study, almost half (45%) of the mothers did not have health insurance coverage for physical and psychological care. Only 19 percent of foreign-born mothers reported having health insurance compared to 75 percent of US-born mothers. A quarter of our study participants reported going without routine medical care during most years of the study. This can lead to late identification of physical and mental health problems that could affect child development.

The findings reported here highlight the challenges faced by low-income mothers in accessing health care. These findings suggest that individual factors play a role in mothers' willingness to seek or accept services, as do program and provider factors such as the availability, accessibility, and quality of health services.<sup>7</sup> Many factors (e.g., cost, the state of the mother's health, and her beliefs) shape women's family planning decisions at multiple levels (individual, program, and

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<sup>7</sup> With regard to service quality, we remind the reader that these data reflect mothers' reports of the services they received during the study period, 2004–09. During this time CSC and other agencies developed and implemented new trainings to improve the cultural sensitivity of service providers.

provider). Programs that address women’s ecological and cultural factors may help them understand their options and assess their emotional status to help them make meaningful decisions that are in line with their circumstances.

These findings lead to several recommendations for ways to improve the quality and use of health care by low-income families in Palm Beach County.

- **Improve access to insurance.** Many low-income uninsured women—especially foreign-born women—are not eligible for Medicaid until they become pregnant, making it difficult for them to access preconception care and initiate early prenatal care. Therefore, efforts by CSC to promote early prenatal care may be hampered by administrative

hurdles during the application process for so-called Emergency Medical Assistance (EMA). During pregnancy, all mothers are eligible for Medicaid, which covers them during their pregnancy and two months after giving birth (Florida Department of Children and Families, 2013). Even though the flexible eligibility criteria facilitate service use, the time between enrollment and service receipt may be a barrier to receiving early prenatal care. Women without readily accessible health care, including family planning, may delay or forgo prenatal care.

- **Increase awareness and promotion of Medicaid-funded family planning services.** This recommendation is related to the one above. Medical providers, home visitors, and other providers in the early childhood development

Table 2. Primary Barriers to Health Care Nativity <sup>a</sup>	
US-born Mothers	Foreign-born Mothers
<b>Barriers to General Health Care</b>	
Understanding the Medicaid eligibility rules	Limited access to Medicaid (only eligible when pregnant)
Medicaid application and recertification process after birth	Cost of care
Medicaid requirements (e.g., child support filing if unmarried)	Transportation problems
	Difficulties communicating in English
	Long waits and responsiveness of providers
	More concerned about children’s health than own
<b>Prenatal Care</b>	
Personal attitude about pregnancy (e.g., unplanned pregnancy)	Medicaid application process (time between enrollment and service receipt; misinterpretation of the guidelines for Medicaid coverage)
Problems in past pregnancies and preexisting health conditions which made mothers think they could not become pregnant	Long waits, overcrowding, and responsiveness of providers
	Transportation problems
	Difficulties communicating in English
<b>Family Planning Services</b>	
Individual factors, including personal beliefs; mothers’ knowledge of and information on contraceptive methods; emotional and financial strain of raising children; mother’s health and partners’ desires for children	
Limited or no coverage for family planning services because of cost, limits on Medicaid coverage for preferred method, state of the mother’s health	
Limited office hours	
Administrative protocols and program policies	
Mothers’ miscommunication with health professionals around information received	

<sup>a</sup> Based on qualitative findings from interviews with 40 mothers participating in the Palm Beach County Family Study (2005–09).

system should make women aware of their options for receiving family planning services. Although Medicaid only provides coverage for 2 months of care after birth, it also provides a waiver that Medicaid-eligible (US-born) women can use after they give birth to receive family planning, birth control, and related health services for 2 more years. Women are automatically enrolled after they give birth but can only receive services through an authorized provider—the Department of Health—and need to reapply to receive services for a second year. While family planning services do not provide full medical care, they are often a gateway to access health care services and an ongoing source for important primary care services for low-income women. However, not all women in need of these publicly funded services use them (for example, because of their lack of a regular health provider, language barriers, or past experiences with public health clinics).

- **Improve information and communication channels.** Women often have substantial waiting times at community health clinics. This may be an opportunity to provide onsite information about pregnancy, women’s health care, contraceptive methods, and health insurance. A challenge for programs and practitioners, however, may be reaching out to mothers who become pregnant unintentionally. There were a handful of mothers whose attitude towards their pregnancy prevented them from seeking early prenatal care. Information about how to interpret health coverage eligibility rules may also be helpful, especially for foreign-born mothers. Some foreign-born mothers thought that the emergency Medicaid for pregnant women had a preset time limit and was not tied to the full gestational period. This inaccurate interpretation of the coverage limits of Medicaid for pregnant women may contribute to late entry into prenatal care. For example, one mother thought that she could extend the period of Medicaid until delivery and avoid reenrollment by applying for coverage late in her pregnancy.

- **Expand access to care coordination and social support services.** Care coordination, navigation services, and other programs that provide information, help with Medicaid applications, and offer transportation support also seemed to improve mothers’ access to prenatal care. Study mothers recognized the value of these programs’ scope of services. This suggests that families assisted by a worker in the HB System or another service system may engage in more adequate prenatal and postnatal services.
- **Expand access to community health clinics.** Mothers without health care coverage used community health clinics for family planning services and primary health issues. These clinics also helped mothers connect to other programs, including the Healthy Mothers, Healthy Babies Coalition; Women, Infants, and Children (WIC); and Medicaid. When they learned or suspected that they were pregnant, the first step was to visit “the clinic.” Mothers learned about the clinic mostly through their social and personal networks as well as through outreach workers and other community providers in the HB System. Community health clinics and home visiting programs (e.g., Healthy Mothers, Healthy Babies) may offer a great opportunity to promote and improve family planning services for mothers without health care coverage or who have limited health care coverage. As suggested by Melnick et al.’s (2008) findings, providing quality preconception and interconception care within these programs—including offering sound information and counseling on the spacing of births and contraceptive methods—may promote effective contraceptive use and may help families achieve their fertility objectives.
- **Allow for more individual choice.** Our findings indicate that if low-income women are provided more low-cost choices in their health care, including contraceptive methods, it will increase the likelihood that their health care is consistent with their ecological and cultural circumstances (beliefs, health status, etc.).

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## Recommended Citation

**Spielberger, J., Gouvea, M., Winje, C., & Fleischman, L.** (2014). *Cycling through preconception, prenatal, and interconception care: A brief report from the Palm Beach County Family Study*. Chicago, IL: Chapin Hall at the University of Chicago.

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**Spielberger, J., Rich, L., Winje, C., Scannell, M., & Gouvea, M.** (2012). *Supporting low-income parents of young children: The Palm Beach County Family Study Fifth Annual Report*. Chicago, IL: Chapin Hall at the University of Chicago.

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## Acknowledgments

We acknowledge the support of the Children's Services Council (CSC) of Palm Beach County and the contributions of the CSC Research and Evaluation Staff—Grace Watson, Jeff Goodman, Kim Lu, Tanya Palmer, and Serenia P. Beckton—in the preparation of this report. We also thank Matthew Brenner for his editorial support.

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## Contact

**Chapin Hall  
at the University of Chicago**  
1313 East 60th Street  
Chicago, IL 60637  
T: 773.753.5900  
F: 773.753.5940  
[www.chapinhall.org](http://www.chapinhall.org)