



The Journal of Sociology & Social Welfare

Volume 36
Issue 3 *September*

Article 7

2009

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Recommended Citation

Francis, Linda E.; Berger, Candyce S.; Giardini, Marianne; Steinman, Carolyn; and Kim, Karina (2009) "Pregnant and Poor in the Suburb: The Experiences of Economically Disadvantaged Women of Color with Prenatal Services in a Wealthy Suburban County," *The Journal of Sociology & Social Welfare*: Vol. 36 : Iss. 3 , Article 7.

Available at: <https://scholarworks.wmich.edu/jssw/vol36/iss3/7>

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Pregnant and Poor in the Suburb:
The Experiences of Economically
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Services in a Wealthy Suburban County

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This study explores the perinatal care experiences of disadvantaged women of color in a wealthy U.S. suburb. The women were asked to discuss the availability of health and social services during pregnancy, continuity of provider and/or treatment, communication issues with their providers, and the amount and type of support and resources available. Many of the questions covered in literature on urban poverty emerged as well in this suburban sample, including economic and psychosocial barriers, and continuity and communication issues between low-income/minority women and providers of health and social services. Additional barriers in the suburbs were also discussed, including problems of access to care and services, with health insurance/reimbursement or financial accessibility, transportation and housing, and getting needed information. Overall findings support the argument that suburban poverty is an overlooked issue contributing to health disparities in infant mortality.

Key words: barriers, perinatal care, access to care, women of color, suburban poverty

Introduction

This paper did not begin as a study in health disparities, but as an applied investigation into maternal child health services. When the director of a county perinatal services network/coalition first discussed this study with one of the authors, the director had in mind a means of convincing the county to formalize and fund their voluntary network. This collaborative idea produced the original purpose of this study: to conduct a needs assessment in five targeted low-income communities. The proximate goal was to provide feedback to providers on the gaps in prenatal and postpartum care for poor women in their county, and the ultimate goal was to demonstrate the utility of the voluntary network. Emergent from the data, however, was an additional story of what it is like to be poor in one of the wealthiest counties in the nation. This was not a story that was reflected in public discourse in the area. Indeed, the Department of Social Services for the county had to operate on a skeleton budget, on the assumption that they were not really needed. Ideologically committed to the belief in its own elite status, county dialogue seldom admitted the existence of poverty within its borders (Logan, 2006).

This selective blindness is not unique to this particular county. Historically, little attention has been paid to the poor in suburban areas. On the face, one could argue that the greater wealth, higher tax base and more plentiful health care in the suburbs would provide the poor with better access to resources compared to persons with low income living in urban areas. This paper, however, uses qualitative data to show how indigent pregnant women of color often face the same, if not greater, barriers to prenatal care in the suburbs than have been reported in socially disadvantaged urban neighborhoods.

In the United States, approximately 75% of the population now lives within the environs of major metropolitan areas. Of this 75%, however, nearly two-thirds—comprising half the nation's population—live in suburbs surrounding the urban

centers. Until the 2000 census, this 50% of the country's population appeared to have little need for the field of public health (USHMC, 2001). Recent changes in the face of the modern suburb, however, indicate a need to consider a new and rapidly expanding phenomenon—health disparities in suburban minority populations.

The history of suburbs in the United States is one of “white flight” from decaying urban centers. Suburbs have been characterized by high relative incomes, lack of ethnic diversity and a plethora of high quality services readily available to paying clients. On the surface these trends have not substantially changed: most suburbs remain predominantly comprised of white middle to upper class residents. As a result, the issue of health disparities among groups has been largely viewed as irrelevant to suburban residents (Meyer, 2000).

Recent census reports show that the percentage of people of color in the suburbs is growing steadily. In 1990, nationally 18% of suburban residents were people of color. By 2000, that number had grown to 25%, and it continues to rise (SOCDS, 2000). Such increase in minority population does not reflect a corresponding rise in integration within suburbs, nor does it indicate a notable increase in the proportion of people of color in the middle class.

[M]inority suburbs tend to be poorer, less safe, and less capable of supporting quality public services. We need to ask whether minority suburbanization is accentuating divisions between successful and unsuccessful communities at the fringe of the metropolis, similar to the familiar disparities associated in much of the country with the city-suburb boundary. ...These demographic trends therefore raise political questions in two ways: whose voice will be heard, and what new issues will have to be addressed in the public arena. (Logan, 2001a)

As evident in this quote, the patterns of urban social and economic divisions appear to be reproducing themselves in suburban communities. Although many people of color who move to the suburbs are middle class individuals seeking the advantages of larger houses and better schools, it is no longer

the case that few poor people live in suburban neighborhoods (Macionis & Parrillo, 2007).

The county in this study is no exception to this trend. Suburban County is a suburb of New York City, and is among the oldest and most established suburbs in the country. Begun with the post-WWII development of affordable housing for veterans and their families, the Suburban County suburbs have followed the pattern of middle and upper class "white flight" from the city. Until 1958, discriminatory housing laws and practices prevented many people of color from living outside of designated communities, and the resulting pattern of residential segregation continued (NFHA, 2006). Many of the early thoroughfares were deliberately constructed to discourage travel of the poor and people of color by creating structural barriers to discourage commercial traffic and public transportation (e.g., bridges too low to accommodate buses or large trucks).

Suburban County is one of the most segregated counties in the United States, as measured by standardized segregation indices (Logan, 2001b). Such indices measure the range of concentration of racial and ethnic groups by geographic area. On a scale of 1 to 100 with 100 being total apartheid, Suburban County's average segregation index score was 74.4 in 2000, compared to the segregation index score for the average suburban region in the U.S. of 56.6. Suburban County's score has barely moved since 1980 when the level was 77.6 (Logan, 2006).

Suburban County has recently been identified as one of the nation's wealthiest counties in terms of per capita income and assets (Hevesi et al., 2007). It also ranks as one of the most expensive places in the country to live. Yet, a rapidly growing population of people of color characterizes it, with nonwhites comprising over 25% of the population (Long Island Index, 2007). Most people of color, regardless of class, are concentrated in a few towns, which are entirely in the southern part of the county, separated from the white and wealthy northern half by freeways, railroad lines and culture. In this regard, Suburban County is nearly an "ideal type" suburb for health disparities, where segregated groups of middle and lower class people of color live in an area more widely known for its wealth and

privileges (SOCDS, 2000).

Despite documented segregation and poverty in the suburbs, little attention has been devoted to the problems of disadvantaged suburban dwellers (Logan, 2001b). Part of the reason is the continuing appearance of affluence outside of urban centers, such as in Suburban County. The rising rate of poverty in the suburb is camouflaged by the often high average income reported at the community or county level. Higher than average rates of insured patients make the problem of the uninsured seem less urgent; and a high number of health care providers per capita give the appearance of accessible health care services (Berube & Kneebone, 2006; Terrazzano, 2005a).

On this basis one can argue that the advantages directed at the suburban middle class whites are also available to their more impoverished neighbors. On the other hand, the very assumption of middle to upper class status in the suburbs may actually exacerbate, rather than ameliorate, the burden of poverty. It is seldom a priority for policy-makers, service providers and average voters to address these issues, because summary statistics obscure suburban poverty. As a result, suburbs frequently lack a social welfare infrastructure that supports lower income individuals and families (Gaines & Kamer, 1994).

The goal of the current study is to demonstrate the impact of this social and economic gap through the juxtaposition of two apparently contradictory facts: 1) Suburban County is consistently among the wealthiest counties in the country; yet, 2) it has a larger than expected disparity in infant mortality rates (IMR) between whites and people of color. In Suburban County, the 2002 rate of infant mortality was 3.7 for whites, versus 12.2 for African Americans (E.R.A.S.E. Racism NY, 2007). This compares to a 2000 rate in New York State of 4.8 vs. 11.2 and a 2004 rate in New York City of 3.5 and 11.6, respectively (NYC Health, 2006).

While the recent improving trend in infant mortality rates (IMR) for New York makes it hard to generalize with data from different years, a racial gap is evident. Suburban County has a higher IMR among African Americans than either New York State or New York City, while the comparable IMR among whites is generally the same or lower. In other words, despite

its overall wealth and plenitude of health care facilities, Suburban County's health care disparity for infant mortality appears slightly worse for people of color relative to those living in New York City.

Working with a local voluntary network of service providers for women and children living in the county, we designed an exploratory study to try to tap into the prenatal and postpartum needs of disadvantaged women. Starting with existing literature on prenatal services and barriers to care, we sought insight into the experiences of poor pregnant women in a suburban health care system. We used a qualitative approach to determine whether the experiences of poor women in a wealthy suburb reflect access to the middle class services of the suburb, or if suburban barriers are similar to those faced by their impoverished counterparts in disadvantaged urban areas.

Literature Review

Numerous studies have established that in the United States, disadvantaged women and women of color receive inadequate perinatal care (Aved, Irwin, Cummings, & Findeisen, 1993; Ickovics et al., 2003; Lia-Hoaberg et al., 1990; Sheppard, Zambrana, & O'Malley, 2004; Sword, 1999; Williams & Jackson, 2000). Research has also supported the notion that there are a number of barriers and obstacles to accessing perinatal care for low-income women and women of color (La Veist, Keith, & Guitierrez, 1995; Warner, 1997; Sword, 1999). The serious consequences of such barriers can be seen in complications for both mothers and infants (Sheppard, et al., 2004; Finch, 2003). Data have indicated that women of color and low-income women are at higher risk for low birth weight, preterm babies, and have higher rates of infant mortality than middle and upper class white women (La Veist et al., 1995; U.S. Department of Health and Human Services, 2005). Providing quality perinatal care has been considered the primary strategy to reduce harmful pregnancy outcomes and prevent maternal and infant death (Sheppard et al., 2004).

The literature presents numerous patterns, barriers and psychosocial stressors specific to disadvantaged and

minority women accessing perinatal and prenatal care in the United States. Discrimination, language barriers, and lack of access to transportation are often cited as the most frequent obstacles in the utilization and access of prenatal care by disadvantaged women and women of color (Aved et al., 1993; La Veist et al., 1995; Sword, 1999; Warner, 1997). Psychosocial variables associated with access to prenatal care include ambivalence, fear, or being unaware of pregnancy (Lia-Hoaberg et al., 1990; Harvey & Faber, 1993). Lack of knowledge about available prenatal services, or lack of perceived importance about the need for care has also been correlated with inadequate use of care (Kalmuss & Fennelly, 1990; Aved et al., 1993; Harvey & Faber, 1993). Finally, alcohol and/or drug abuse have also been found to be important factors in utilization of prenatal care, with fear of disclosure as the major deterrent to seeking care (Kalmuss & Fennelly 1990, Poland, Ager, & Sokol, 1991; Aved et al., 1993; Delvaux, Buekens, Godin, Boutsen, & the Study Group on Barriers and Incentives to Prenatal Care in Europe, 2001).

Aved et al. (1993), for instance, report the inability to find a physician willing to accept low-income women as the single largest barrier to obtaining care. Regardless of women's success in obtaining care, lack of transportation was reported as another significant deterrent (Aved et al., 1993). Other significant barriers included the inability to afford services, problems related to health insurance, and inadequate child care.

Significant attention has focused on financial issues related to accessing prenatal care. It has been well documented that financial barriers are a common impediment. For example, uninsured women receive fewer prenatal services and report greater difficulty in obtaining needed care than women with insurance (Andrulis, 1998). Even when financial barriers are removed, other variables have been found to be associated with inadequate prenatal care (Delvaux et al., 2001). Those who report inadequate or no care tend to be younger, less educated, single, and/or have other children as compared with those women who receive adequate care (Lia-Hoaberg et al., 1990; Aved et al., 1993; Harvey & Faber, 1993). Other psychosocial factors identified as obstacles in accessing care include excessive stress, depression, physical problems, job demands,

and the lack of time or energy to deal with personal and family problems (Kalmuss & Fennelly, 1990; Lia-Hoaberg et al., 1990; Kelley, Perloff, Morris, & Liu, 1992).

Last, studies suggest that lack of social support from friends, family and professionals is another important factor that has important consequences for the mother and the infant (Collins, Dunkel-Schetter, Lobel, & Scrimshaw, 1993). Social networks encourage health service utilization through the transmission of advice and information, as well as providing tangible resources such as transportation and economic assistance (Stanton, Sears, Lobel, & DeLuca, 2002; Berkman, 1985).

There are a number of complex and multifaceted factors influencing the utilization of prenatal care for disadvantaged and minority women. Reports from research point to socioeconomic status and race as prominently associated with adverse pregnancy outcomes in the United States. Therefore, "it is essential that the research address the multidimensional concepts that account for interactive relationships between the social context of the pregnant woman and the socioeconomics of prenatal care delivery systems, including community based initiatives" (Sword, 1999, p. 1173).

To date, knowledge about barriers to prenatal care "has evolved largely through positivist research approaches and, therefore, is based on what service providers and researchers perceive as important factors" (Sword, 1999, pp. 1174-75). Considering that the rates of preterm birth, low birth weight infants and maternal and infant mortality have not decreased with the knowledge and information acquired over the last decade, data have not been sufficient to implement policy and procedure changes in health care provision. The use of quantitative methods may "oversimplify" the notion of barriers, as they do not allow for the exploration of the process that determines use of services.

Qualitative methods can expand our understanding through the exploration of personal perspectives and the contextual meaning of events, experiences and structure (Sword, 1999). It also allows for the discovery and exploration of the range of factors and issues identified as relevant to the women themselves (Miles & Huberman, 1994).

Qualitative research offers a unique opportunity to enrich our understanding of how neighborhoods affect individuals and families. In addition to unearthing the mechanisms through which place helps shape human development and socioeconomic opportunity in America—the “how” of such effects—qualitative research can provide corroboration for the aggregate trends detailed in quantitative survey-based research—the “what.” Qualitative research can also provide dramatic illustrations of these trends and processes in action. (Briggs & Jacobs, 2002)

Based on this existing literature, the current study attempts to capture these issues by asking questions about disadvantaged women’s experiences with prenatal medical care, social services and other non-medical resources, personal challenges and stigmas, social networks, and information. Using qualitative methods, we provided an opportunity for women to communicate and explain their experiences with perinatal services. Women could thoroughly describe their experiences with structural problems and access to care, the psychosocial factors including psychological and emotional stressors that affect their pregnancy, their social support systems and other available resources, communication and trust issues with their providers, the language or cultural issues influencing their health care, and their overall concerns with the adequacy of the care they received. These essential questions needed to be asked with enough time for these women to comprehensively explain and express their experiences.

Data and Methods

Our study design involved focus groups with consumers of maternal and child health services. Flyers were sent to agencies participating in the network, instructing them to give copies of these flyers to their clients. Potential subjects contacted the County Perinatal Network to register for one of six focus groups: adolescent motherhood, substance abuse treatment, and African-American or Latina ethnicity. Due to the small number of teens and substance abusers who agreed to participate, only one group was run for each, compared to two groups

each for Latina and African American women. Interestingly, there were very few white, non-Latina women seeking services from the perinatal services network. This population, therefore, was not included as its own group, though they were not excluded from the teen or substance abuse groups (each had one white participant). Each group had from 8-10 participants who met the criteria for the group session (e.g., teenager, diagnosis of substance abuse, etc.). The Latina groups were run in Spanish by a bilingual moderator specially trained by the first author and a bilingual facilitator. The first author (who speaks some Spanish) was present as an observer. The remaining groups were run with a senior author as moderator, and a graduate student assistant as facilitator.

We ran the focus groups in a semi-structured interview format. Each group had 5 open-ended questions presented to the participants on a flip chart, with each question on a separate page. The moderator read each question and encouraged response. Once discussion was underway, the moderator intervened only as necessary to refocus, probe, or provide support as needed.

Audiotapes of the groups were transcribed verbatim and checked against the tape by the moderator. Spanish groups were transcribed in Spanish, translated into English, and then checked against the tape by a bilingual colleague to assure accuracy of translation. All transcripts were independently coded by the two senior authors, with frequent meetings to resolve differences in interpretation and clarify codes and coding procedures. Coding was accomplished in three stages. Transcripts were first hand-coded on the transcripts themselves, striving to capture the meaning expressed by each speaker. Then the codes were separately analyzed. Finally, emergent themes were tested against the raw data for fit and completeness. Due to the "single shot" nature of focus group data collection, we were unable to collect additional data based on initial findings, so a true grounded theory approach was not achievable (Charmaz, 2003). The resulting narrative was presented at a Perinatal Network meeting, and feedback was incorporated and checked against the data and coding scheme to increase validity.

There are many limitations to the design of this study. The

sampling frame is comprised of the clients of a single services organization in one county, and the participating sample was self-selected. The only contacts with the research informants in the study were the focus groups in which they participated, and no other data were collected. As is typical of qualitative research, the sample size is small, and the open-ended nature of the questions limits reliability.

Results

There were two main themes that emerged from the data analysis which illuminated the experience of indigent prenatal care in the suburbs—disparities in medical care and barriers to services. The first theme was evident in a wide variation in quality of care received by different women, which was largely attributable to differences in continuity of care. Most women who were able to obtain care from a single provider or medical group practice had a consistent provider to oversee their care. Women using public clinics for their care tended to report seeing a different provider at each visit. Women with continuity of care were usually, but not always, those with private insurance or active Medicaid throughout their pregnancy. One woman praised her experience at one hospital because, “You can have your own private doctor.” Two others shared the importance of having a consistent provider:

I went to [name of hospital]. I had my two other kids there. Every time I had no complaints. I always seen the same doctors. All the doctors are great—delivery and everything. (African American Post-Partum Group)

[Name of hospital], they is nice. They don't switch work, with all these doctors. You have one doctor, and he check on you two to three times a week. (Adolescent Group)

These women had a good experience over all, with the best reports coming from women who felt their doctors had time to give them attention. Such providers were described as being thorough and responding to the women's concerns, allowing them to ask questions and providing clear and appropriate

answers. The women in these situations made statements like: "They [the hospital] checked on me constantly. It was a great experience..." and "All my pregnancies were excellent. I felt they listened to me. I have no complaints ever. They were great doctors."

Also of importance was the perceived attentiveness to the patient's needs. This depicted the provider as being caring, as promoting a trusting relationship, as showing respectfulness and as giving good care. They described the provider as taking the time to address the patient's needs (i.e., not feeling rushed) and helping them deal with difficulties related to their care. (See Francis, Berger, & Kim, 2008 for more on this point.) One woman said: "...You can ask as many questions as you want. No attitude; they didn't rush me out the room. They gave me their full attention with full answers." An interesting finding was that no one in any of the focus groups identified "locating a doctor" as a problem. This does not support the predominant findings in the literature that low-income women have difficulty locating providers. We can speculate that this may be a reflection of the greater number of doctors practicing in a suburban locale.

Several other factors identified as promoting a positive experience included: the perceived quality of care, defined as close monitoring, frequent medical tests, and treatment similar to middle class women; gentle physical care by the physician; and having a short waiting time to see a provider. A typical positive comment was: "Let me tell you, when you go to [name of hospital] and...you have an appointment they get you out in a half hour or forty-five minutes." Another indicated she had heard that others had not had her luck:

I like the female doctor 'cause she is very nice and she is very attentive since I walked in. She asks me how I am doing and wants to know how I am doing with the pregnancy. However, some of the women have told me that they have doctors which are not very nice. For example, they are very rough when they are examining you, while my female doctor is very gentle. (Latina Pregnant Group)

Ultimately, the medical experience of pregnancy was a positive one if the woman was able to develop a trusting relationship with her provider(s), for which continuity of care appeared to be a necessary, though not always sufficient, criterion.

For women who did not have access to a consistent provider—usually those who relied on public clinics and teaching hospitals' outpatient services for all their care—the experience was a very different one. These women generally had no insurance, or had not yet received their Medicaid card, though at least two women appeared to use a clinic because of transportation issues. Many of the negative factors for women who lacked continuity of care were polar opposites of the positive factors given by women who had consistent care. For women faced with fragmented, impersonal care, their pregnancies were marked by the constant struggle to obtain care. For the unlucky ones, these struggles devolved into nightmares.

My doctor told me nothing. First of all if he keep checking me he will see I would lose 10 lbs. This is not normal when you are pregnant. I went into the emergency room. They had to put a tube down my nose to pump out my blood in my stomach. He's reading the information to me telling me you're fine. I think every other day I was in the emergency room. And he would tell me, go ahead, go home. I would throw up on the table, he would see the bile, coming out of the lining of the stomach, he would see me throwing this up, and he would say you be ok, you're ok. And when they told me my son was dead inside me, it was like...it was so unprofessional. I wouldn't want a dog to go there. (African American Pregnant Group)

The variation in quality of care experienced by these women was dramatic, and the impact of poor care could be devastating to the women's experience.

Besides the issue of continuity of care, two additional points regarding medical care were particularly intriguing: women were very aware of the disparities in their treatment, and they often lacked basic health information. In the case of the former, the women in our study were often receiving care in the same

hospitals as the wealthy women in the county. They got to see very clearly how having middle class status and private insurance meant better preventive care ("Why didn't I get these prenatal vitamins that this lady got?") and shorter waiting times ("All these women got to go in before me and I was there first!"), not to mention more consideration. Even women with a consistent provider perceived differences in attitudes toward them—especially from staff—compared to middle class white women.

Second, despite their concern for their infants, many women did not have the basic knowledge or resources to provide proper nutrition for their infants. A repeated concern voiced by many women was the cost of formula, and the limited amount provided by WIC (supplemental nutritional assistance for Women, Infants and Children). Only one woman in the entire study was breast-feeding her infant, and no one reported that breast-feeding was discussed with them by their providers. Several women admitted to resorting to poor health practices with the baby's formula, including re-using formula from unfinished bottles, and diluting formula with water to stretch the amount. In an area with a high rate of infant mortality, appropriate nutrition and food safety should be huge concerns. Breast-feeding information is a common part of prenatal care in most obstetric offices now. Given that some women were receiving care in private practice or medical center settings alongside wealthier patients, it is particularly striking that they did not recall receiving counseling on the benefits of breast-feeding. While we have no data on the doctors or hospitals directly, future research might inquire as to whether this is a function of the assumption that patients in suburban hospitals are middle class, educated, and well-informed.

The second theme relating to prenatal health disparities in the suburbs was that of barriers to services for meeting basic needs. Probably the biggest complaint among these women was also the most intimately connected with medical care—the extreme difficulties and delays in getting Medicaid. As discussed in the previous section, the most important distinction we found in quality of medical care had to do with whether or not the women had insurance, including Medicaid. Thus, in this study, barriers to this service were among the fundamental

sources of problems with prenatal care over all.

By law in New York, a pregnant woman without insurance is supposed to be automatically eligible for Medicaid. However, at the time of our study, the average wait in Suburban County for approval of a Medicaid application was six months. As many of the women pointed out, a delay that long meant that many women did not have their medical benefits in place until just before the baby was due. This wait cannot be attributed to the state, as it stands in stark contrast to the two counties that flank the county under study. The neighboring suburban county has an average wait of six weeks for Medicaid approval. The urban county at the other border reported getting approvals for pregnant applicants in about three weeks. In Suburban County, Medicaid approval delays were a huge and consistent burden on participants, as captured in the following comments from several of the participants. "The bills keep coming in, and I just keep putting them aside, 'cause I got nothing to pay them with" (African American Pregnant Group). "I'm just hoping [the doctor] won't stop seeing me" (Substance Abuse Group). "The doctor tells me to ignore the bills, 'cause it's not my fault that Medicaid hasn't come through, but it's stressing me out" (Adolescent Group). One woman reported waiting exactly 40 weeks—the length of a pregnancy—to receive her benefits. Such delay undermines the goal of automatic eligibility for Medicaid to ensure prenatal care.

The next most consistent negative discussions across all groups related to the issues of public assistance programs and housing. Both were broad concerns expressed (often emphatically) across all groups of women in the study.

Public Assistance

Not one participant reported a positive experience with public assistance. While complaints were too numerous to describe in detail, the litany of problems included:

- (1) Having to gather required information multiple times (e.g., given a list of material, bringing these to the next meeting, and being told to gather 3 more pieces of evidence and come back again).
- (2) Department of Social Services not giving information

about needed services unless asked, and not having the information easily available to women.

(3) Confusing rules and perceived inconsistency in their application.

(4) Internal contradictions—e.g. one needs a stable address to get public assistance, but needs the assistance to obtain/maintain a stable address.

(5) Lack of credibility—applicants assumed to be untruthful or withholding information.

(6) Disrespect—long waiting times, dirty and uncomfortable waiting rooms, rude staff.

(7) Lack of cooperation—some participants described having to be “aggressive” to get service, but were then perceived as difficult or hostile.

In describing their experiences with the office of social services, the women’s comments were peppered with expressions of their feelings of degradation:

I was supposed to have pregnancy allowance. No one gave it to me. I heard about it but when I applied I was supposed to get unborn child budget allowance and three months back pay and I didn’t receive it. I felt treated like a piece of garbage...(Substance Abuse Group)

Thus Public Assistance issues not only serve as barriers to access to care but become burdens in and of themselves. The emotional strain of not receiving much-needed benefits, which the recipient was entitled to receive during that critical time, created additional stress. This stress was exacerbated by the need to make numerous phone calls for people with limited access to phones, extra visits to offices with long waits for people with no transportation and little money, and by the loss of income due to receiving no pay when absent from work. Added to this is the lack of respect by many or all of the staff and the providers towards pregnant women whose physical and emotional reserves are already stretched.

Housing

A second huge basic needs issue was housing. For all of the

participants, regardless of group, housing was a large and pervasive concern—unsurprising, given that Suburban County has one of the highest housing costs in the country. Many described living with family members who did not have adequate room for them and a baby, or did not want them there. Stress from overcrowded housing arrangements often had the side effect of undermining family relationships that were the woman's main source of support. Section XIII housing is limited, and the Suburban County office was reportedly closed to new applications. Subsidy allowances that were available were not adequate to cover the cost of housing to live alone, but the women could be penalized if it was reported that they were living with a partner with an income (another internal contradiction).

DSS is telling me they granted me like almost \$400 a month for rent and they're telling me I have to go out and look for an apartment with \$400 a month for rent and I'm telling her well how am I suppose to find an apartment for \$400? Well you have to find somebody to pay the difference for you. And I'm like, if I had somebody to pay the difference do you think I would be in this situation in the first place? (Substance Abuse Group)

Many reported having to live in crowded conditions, moving frequently, or having to depend on or take in unwilling relatives.

Well, my main [need] right now is just for a place to stay for me and my child, because right now I'm staying with my grandmother there. And it's like I have nowhere stable to go and I don't want my baby to be taken away from me. You know after I have it, not having a, you know, a place and permanent address and nothing and then I have to try to get on social service, to support. And you know and that really bothers me and sometimes it causes depression you know, so sometimes I just pray to God and ask God to just help me out. But besides that everything else is fine. (African American Post-Partum Group)

In the Latina groups, the women expressed a fear of losing housing because of the reluctance of landlords to rent to families with children.

Now that I am pregnant, I have had problems with the rent, and in the last few months I have been in a number of places, renting rooms. It has been very difficult for me to keep moving from one place to another. But today, we are planning to find a house because with children, they tell us that with children, they will not rent us rooms. (Latina Pregnant Group)

Because they were not citizens and were therefore unable to get housing benefits, finding and keeping housing was an on-going concern for Latina mothers.

A related concern was transportation. Participants said they had trouble getting to work and to medical appointments because of inadequate public transportation. "Being pregnant and walking down the street isn't easy." Some members talked about having to take taxi cabs. "I took a cab, it's \$3 each way." One added, "Cab fare can add up after a while." This comment about cab fare engendered a chorus of agreement in the adolescent focus group, followed by frustration about the inadequate bus system and the length of time it took to use. Despite the population and density of Suburban County, the lack of public transportation (and even sidewalks, in most communities) still reflects the expectation that everyone has a car.

The barriers to social services described relate both directly and indirectly to the first theme of this paper—disparities in medical care. The delay in receiving Medicaid is, of course, the most evident connection; women with health insurance of any sort were more likely to receive consistent and comprehensive care. Yet other factors discussed also play a role. The difficulty of finding affordable or subsidized housing means that, like their urban counterparts, most of the poor are concentrated in geographic pockets of poverty. Unlike the more densely populated city, however, in Suburban County these pockets can be quite far from needed services, such as medical care. The difficulties of transportation to reach such services sap time, energy, and finances and reduce motivation to seek

help unless absolutely necessary. For women who have or are able to acquire the basic resources—housing, transportation, health insurance—the suburb seems to hold promise of access to middle class health care. But for women who are stymied by these fundamental needs, this study shows their experience may be comparable to or even worse than that of the urban poor. As the reality of suburban poverty grows, these possibilities need further study.

Discussion

The information that the women provided in these focus groups in many ways reflects the literature reported earlier in this paper, lending both validity and generalizability to the research. For instance, in keeping with the findings of Andrulis (1998), we find that having health insurance is likely to be a substantial predictor of better outcomes. In our study, the importance of insurance seems to be indirect, through increasing the likelihood of having continuity of care with a single provider or office. We also found many of the same barriers of language, discrimination and transportation described by other studies (Aved, et al., 1993; La Veist, et al., 1995; Sword, 1999; Warner, 1997).

However, there were also differences that have the potential to add to existing knowledge. Some of these differences are issues that can be viewed as positive, but which also illuminate negative dimensions of the problem. For example, Aved, et al. (1993) found the single largest barrier to obtaining care was the inability to find a physician who treated low-income women. The participants within our focus groups did not find this to be an issue; however, that did not guarantee that their experiences would be positive, nor did it guarantee parity in treatment. Those with insurance or active Medicaid usually had access to better continuity of care which produced notable differences in treatment, such as more preventive care measures, better communication, and higher satisfaction with care.

This issue of insurance and continuity of care highlights a contribution of this qualitative work that might not be uncovered by a survey study. Technically, many of the women

in our study qualified for Medicaid, and were in the process of getting it—in the sense that their applications had been approved and they were merely awaiting for an account and a card. These women were insured, in that their medical bills would ultimately be covered, and therefore would logically be marked as having Medicaid on a survey. However, the lengthy wait for a card and “provable” insurance left these women as *de facto* uninsured, and relegated them to the free clinics and public outpatient facilities that accept patients who are unable to pay. Health clinics, designed on an acute care model, are not necessarily a good fit for the developmental nature of pregnancy. The cost for these women manifested not in money, therefore, but in continuity of care.

A key finding of our study, then, is that the lack of infrastructure in community resources and social services may have played ultimately a larger role than medical care facilities in the disparities of IMR in Suburban County. While some women reported very good experiences with their medical care, experiences with the office of social services were uniformly negative. Many of the most difficult struggles these women faced during the prenatal and post-partum period were not medical issues at all. Social factors such as food, housing, transportation, and health insurance often were identified as having a greater effect on the health and health care of the women and their babies. Although other research has confirmed the relationship between the welfare state and health outcomes (Navarro et al., 2006; Chung & Muntaner, 2006), such aggregate-level data do not clarify the specific needs of the suburbs.

The issues in question fall squarely in the domain of social services, and despite the wealth of Suburban County, funding to such services was very low priority. As a result, the office of social services was severely under-staffed and under-funded, paralyzed by a long-standing hiring freeze, and burdened with dilapidated facilities and poor coordination (Rauch Foundation, 2003). The perception of staff working for the perinatal network organizations was that Suburban County was worse than the surrounding counties in terms of social services support. Popular news sources also report the poor state of local social services and Medicaid (Amon, 2008; Terrazzano, 2005a, 2005b). Little wonder, then, that staff had

so little ability, either materially or emotionally, to support the women in this study. Given such reports as emerged in this study, further research should address the issue of how much of Suburban County's disparity in IMR is due to problems of medical care, and how much to a dearth of "social care."

While we certainly cannot generalize our study beyond the county in question, we nonetheless recognize that there are many other wealthy, conservative, suburban counties in the country that put little emphasis on services for the poor. For them, the issues raised in this research may merit consideration. Indeed, some of the insights raised in this paper have been discussed for years in non-suburban contexts (Harvey & Faber, 1993; Ickovics et al., 2003; Kalmuss & Fennelly, 1990). With a growing population of suburban poor, issues once thought to concern only urban or rural settings are now increasingly affecting suburban areas as well. Suburban poverty has its own set of barriers, with resemblances, perhaps, to both urban and rural issues. The invisibility of the suburban poor, and the fact that they remain largely unacknowledged, potentially creates a unique system of obstacles to health care.

Conclusion

The United States, as compared with other industrialized nations, is one of the wealthiest countries in the world, yet we rank poorly on health status by race, class, socioeconomic status and infant mortality (Organization for Economic Co-operation and Development [OECD], 2003). This paradox is exemplified by the wealthy suburb of Suburban County. The overall wealth in a county continues to mask the barriers to access to care for the poor, and enables the powerful to continue to ignore the needs of women of color who are pregnant and poor. In the particular county studied here, the lack of public infrastructure to meet the needs of poor, pregnant women may have more to do with the high disparities in infant mortality than does actual medical care. To the degree that suburbs continue to avoid recognition of suburban poverty in their policies, funding, and priorities, such disparities will likely endure.

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