

THE ACTIVE DUTY PRIMIGRAVADA S PERCEPTION OF PRENATAL CARE IN THE MILITARY
HEALTH CARE SYSTEM

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ABSTRACT

The goal of the military health care system is to maintain the fighting strength of the military services by assuring the continued health of the active duty members and their families. High quality, comprehensive care is the best way to accomplish this goal. Patient satisfaction and health status are outcomes of health care services. They are also a measure of its quality. An area of interest for quality improvement is prenatal care. In this study a qualitative descriptive design using the active duty primigravida as the population of interest was used to explore perceptions of and satisfaction with prenatal care in the military health care system.

The researcher used a convenience sample of 6 active duty primigravidas who were still within the first three months of the postpartum period. Data analysis utilized the qualitative methods of categorizing and clustering as presented by Burns and Grove. Four theme categories emerged from the data: (1) One Provider, (1A) developing a relationship, (1B) Provider Concern, (2) Need for Information, (2A) Importance of Prenatal Classes, (2B) Greater Education and Support for Breastfeeding, (3) Preparation for Childbirth, and (4) Parental Role. Significant statements from the participants were used to illustrate each theme more fully.

The findings of this pilot study showed that, for the most part, active duty first time mothers are very satisfied with the care received in the military health care system, at least those who received care in the family practice setting. This potentially has implications for the most appropriate setting for uncomplicated, ambulatory obstetrical care. Because of vast differences in health care delivery at the various types of military health care facilities, it would be helpful to repeat this study at various sites before drawing any conclusions.

Keywords: perceptions, prenatal care, pregnancy, expectations, satisfaction

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MILITARY HEALTH CARE SYSTEM

by

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DEDICATION

I dedicate this work to the most important people in my life, whose love and support made the completion of this work possible.

To my husband, Bret, who always encouraged and believed in me, even when I did not believe in myself.

To my three children, Adam, Malysa, and Grayson, whose warm smiles and unconditional love gave me the strength to face even the darkest days.

This work is a testament to the love we all share and to the power that we have as a whole. Thank you all so much.

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CHAPTER ONE: AIM OF THE STUDY

Introduction

Pregnancy, particularly for the primigravida, can be an exciting and possibly frightening time in a woman's life. There are many changes, both physical and emotional that she has not previously experienced. The nine months of pregnancy allow the first time mother to adapt to the maternal role. This means a transition between two states of being the woman without a child to the woman with a child (Bobak & Jensen, 1987). This time is one of dynamic change that prepares the person for her new responsibilities as a parent and for giving birth to her child. The goal of prenatal care is to help the mother maintain her well being during the pregnancy and to achieve a healthy outcome for herself and her infant (Gabbe, Niebyl, & Simpson, 1991).

The United States is one of the most technologically advanced nations in the world yet it still has an infant mortality rate higher than that of many developing nations (Handler, Raube, Kelley, & Giachello, 1996). The high infant mortality rate added to a high rate of low birth weight has fueled public health efforts to increase access to prenatal care. Prenatal services are critical in ensuring improved pregnancy outcomes (Fischler & Harvey, 1995). The Public Health Service (PHS, 1990), in its publication *Healthy People 2000*, established a goal of 90% participation in prenatal care by the year 2000. Despite extensive efforts, prenatal services are not being used to their full potential (Omar & Schiffman, 1995). As of 1987, only 76% of women received prenatal care in the first trimester, the recommended time for starting care; for minority women the numbers were much lower at 65%. By 1993, 80% of all women age 20 years or older, with at least 12

years of formal education received early prenatal care. When separated by race, black mothers were less likely to receive early prenatal care than white mothers at every educational level (National Center for Health Statistics [NCHS], 1995). Only 55% of black women with less than twelve years of education received prenatal care compared with 65% of white women. Seventy nine percent of black women with twelve or more years of education had prenatal care. This number is still lower than the 92% recorded for white women with the same level of education. Research has proliferated over the last decade to identify reasons for lack of prenatal care. The barriers identified have fallen into four broad categories: (a) financial; (b) inadequate capacity of the health care system; (c) problems in the organization, practices, and atmosphere of prenatal services themselves; and (d) cultural and personal factors (Brown, 1988). Of the barriers identified, financial problems most often correlate with lack of prenatal care (PHS, 1990). Many women in this country have little or no health insurance and one-third of all babies born in America are born to women with incomes less than the federal poverty level (Brown, 1988). This is not an issue for the active duty military female. The military provides comprehensive obstetrical care free of charge and participation is mandatory: however, statistics of cultural and personal factors; organizational practices and atmosphere of prenatal services; or the health care system concerns for pregnant military women are not known. The issue is not financial; the issue is the quality and appropriateness of prenatal care.

Research has found that patient satisfaction is an indicator of the quality of prenatal care (Handler, Raube, Kelley, & Giachello, 1996). The precise factors that

contribute to patient satisfaction are not well researched. There are several studies that examine the expectant or postpartum woman's expectations, perceptions and satisfaction with prenatal care (Handler et al.; 1996, Sequin, Therrien, Champagne, & Larouche, 1989; Lazarus & Philipson, 1990; Omar & Schiffman, 1995). None of them specifically address the needs of the primigravida and none examine the unique experiences of the active duty expectant mother. Therefore nothing is known about the expectations and perceptions of prenatal care among this group of women. A qualitative research design allows in-depth exploration of this phenomenon to gain meaning and insight without considering causal explanations (Munhall & Boyd, 1993). The investigator has an opportunity to examine the prenatal care experience as a whole and possibly determine ways to enhance the quality of prenatal care delivery in the military health care system.

Statement of the Problem

What are the active duty first time expectant mother's perception of prenatal care in the military health care system? What aspects of care are perceived as satisfying or dissatisfying?

Statement of the Purpose

The purpose of the study is to describe the active duty primigravida's perceptions of the prenatal care received in the military health care system.

Justification for the Study

With all the changes occurring in the military health care system, it is extremely important to meet the needs and expectation of the client. If the system is to remain viable, it is imperative to keep costs low and not lose patients to the civilian sector. With

the arrival of TriCare, it is conceivable that the active duty member will have a choice of providers. This was not an option in the past. If the quality of care in the military is wanting, they will take their health care dollars elsewhere. Patient satisfaction is an indicator of the perceived quality of health care services. Another indicator of quality is health status and nowhere is health status more important than in the military. The primary goal of the military health care system is to maintain the fighting force. Negative pregnancy outcomes can have a major impact on readiness since 35% of the active duty forces are women and the majority of them are in their childbearing years (Directorate for Information, Operations, and Reports [DFIOR] 1996). Adequate, appropriate prenatal care can prevent complications of pregnancy and childbirth thus assuring timely return to duty. Prenatal care also contributes to the expectant mother's belief that she is doing something to insure having a healthy baby. Examination of the prenatal care experience through the perceptions of the first time active duty mother can provide insight into the perceived appropriateness, helpfulness and quality of the care presently provided. The researcher may also identify areas for improvement.

CHAPTER TWO: EVOLUTION OF THE STUDY

Background

This study originated from the researcher's own experience of prenatal care in the military health care system and the belief that the needs of the pregnant active duty member were not being completely met. The researcher, an active duty registered nurse and mother of three, became acquainted with a primigravida dependent spouse who was considering going to a civilian provider because she was upset at the quality of the prenatal care that was being delivered in the military health care system. The woman felt that her questions were not being appropriately answered, the wait to be seen was excessive, the prenatal visits were rushed, and it was disconcerting to have to see so many different providers. The researcher, who was pregnant with her third child, had experienced many of the same problems. However, the situation was not as upsetting to the researcher as it was to the primigravida because of the experience gained from the two previous pregnancies. The researcher became curious if other primigravidas had similar feelings about the prenatal care delivered in the military and if these feelings are intensified for the active duty population who, unlike the primigravida dependent spouse, does not even have the option of seeking an outside provider. This prompted a desire to examine clients' perceptions of the quality of the prenatal care received in the military health care system.

Contributing Literature

The importance of adequate prenatal care has long been recognized as essential to improving the health of expectant mothers as well as decreasing the likelihood of

complications for the newborn (Fischler & Harvey, 1995). In spite of efforts to improve access to care, prenatal services are still not being utilized fully. Many studies have been conducted to try and examine the reasons that are behind this occurrence. There are dozens of studies that examine barriers to care, types of providers, care settings, delivery styles, educational differences, and ethnic variations; but only a few studies explore the expectant woman's perceptions of the prenatal care experience as a whole. Omar and Schiffman (1995) conducted a focus group of 22 women in the third trimester of pregnancy to explore their expectations of and satisfaction with the prenatal care that was being received. The subjects were recruited from one of three sources; the local health department (n=8), childbirth education classes (n=6), and a private non-profit women's center (n=8). Inclusion criteria for the study included 28 weeks or more gestation, at least two prenatal visits during the pregnancy, and the ability to understand and speak English. Three focus groups were conducted, one at each site, using semi-structured open-ended questions to facilitate discussion. The entire proceedings were audiotaped as had been previously consented to by the subjects. Each focus group lasted from 1 to 1.5 hours and the participants were given a cash incentive for participating. The data were transcribed verbatim and analyzed by each of the investigators for accuracy and completeness. Dimensions of satisfaction and expectations were identified. Three independent coders, all registered nurses with obstetrical experience, also examined the data for agreement with the dimensions of satisfaction and expectations identified by the researchers. The findings were refined and revised and all parties finally reached consensus.

The results of the study produced three major dimensions of satisfaction with prenatal services: (a) satisfaction with the health care provider(s), (b) satisfaction with support staff and (c) satisfaction with the prenatal health care system. The most commonly identified aspect that resulted in satisfaction or dissatisfaction with the healthcare provider was the attentiveness of the provider to the patient. Most of the women also agreed that the treatment received by the provider was the biggest determinant of overall satisfaction with the prenatal experience and perceptions of the provider generated more discussion than any other topic in the focus groups (Omar & Schiffman, 1995). Elements the women identified as important to their satisfaction / dissatisfaction with the provider and support staff fell into two main categories: caring relationship and information.

When the women were called by their first name, when their young children were welcome in the office, when significant others were included in discussions about the pregnancy, and when the provider/ staff seemed genuinely concerned about the client's well being, then there was a perception of caring. Words such as "nice" and "like" were used to describe the subjects positive perceptions of the provider and staff (Omar & Schiffman, 1995). On the subject of information, all of the women wanted to receive facts about their pregnancies that included: (a) what to expect from the prenatal visits, (b) labor and delivery, and (c) parenting. The expectation was that this data was to be provided by the staff. Educational materials such as pamphlets and videotapes, even if plentiful, were not deemed sufficient sources of information. The subjects wanted the providers to take the time to personally provide adequate explanations and answer their questions.

Satisfaction with the health care system focused on particular aspects of the setting where each of the women-received prenatal care. Elements identified as important to satisfaction or dissatisfaction fell into four categories: (a) consistency of the health care provider, (b) ease of scheduling and accessibility, (c) waiting time, and (d) other services provided (Omar & Schiffman, 1995). Lack of a consistent provider was universally associated with patient dissatisfaction, as was difficulty with accessibility and scheduling. Excessive waiting time was also associated with client dissatisfaction but there was some variation in this based on where the client received care. Additional support services such as a nutritionist or social worker were valued highly by some, but not all, of the participants. Of those that viewed these additional services as contributing greatly to satisfaction or dissatisfaction with prenatal care, it was felt that these services should be available at the place where care was received.

Omar and Schiffman also explored the clients' expectations of prenatal care. There were some different expectation across the groups of women but three common themes emerged: the desire for one provider; the need for adequate explanation about prenatal care, pregnancy, childbirth, and infant care; and the desire for accessible quality care. Of the first time mothers, the desire for one provider was the most often voiced expectation. Everyone expressed their expectation of adequate explanations about prenatal care but, again, this was a greater concern for the primigravadas who stated they did not know what to expect from prenatal care and therefore anticipated being informed about that subject as well as pregnancy, labor and delivery, and parenthood. As for accessible quality care, expectations varied depending on setting of care and previous experience.

The women who were seen at the health department expected to have to wait to be seen the first time while those women who had private physicians did not expect long waits the first or any time. The primigravadas' expectations were colored by those of family and friends with whom they shared the details of their prenatal visits. Prior experience was also a factor in expectations as women who had been treated a certain way, positive or negative, during a previous pregnancy expect to be treated similarly in subsequent pregnancies. This study also discovered an important link between expectations and satisfaction. When anticipated negative experiences did not occur then satisfaction with services was achieved and, not unexpectedly, dissatisfaction occurred when expectations were not met.

There are other studies that examine exactly what aspects of prenatal care are linked with satisfaction and ultimately utilization of prenatal services. In a study by Handler et al. (1996), a group of 50 low income women were interviewed to explore the characteristics of prenatal care that affect women's satisfaction. The subjects were derived from purposive sampling to get an ethnic mix that was one quarter Caucasian, African American, Puerto Rican, and Mexican. All the participants were recruited by research assistants at Women, Infants, and Children (WIC) nutrition program sites in Chicago, Illinois. Inclusion criteria for the study included age greater than 18 years, at least one prenatal care visit, and that the woman was either pregnant or no more than two months postpartum. Data was gathered during focus group sessions held at various community agencies in the Chicago area. The groups were divided by ethnic differences and were facilitated by women from the same ethnic background as the subjects. Although all of

the discussions were conducted in English, the moderators for the Mexican and Puerto Rican groups were also bilingual in Spanish. Each of the eight focus group sessions lasted between 90 and 120 minutes and all discussion was audiotaped. Two observers also recorded any relevant comments.

Another source of data for the study were self administered questionnaires that the participants had filled out at the beginning of each focus group session. These data were analyzed using simple descriptive methods while the focus group data were transcribed in their entirety and coded in consultation with an focus group expert. Two of the four investigators independently reviewed the transcripts and used the coding categories to develop broad themes that emerged from the data (Handler et al., 1996). The five themes identified were: (a) why women seek prenatal care, (b) features of care that affected satisfaction with prenatal care, (c) factors that did not affect satisfaction with prenatal care, (d) features of care that provided a mixed response from the subjects, and (e) how women would design their ideal prenatal care setting.

Interestingly, motivation to seek prenatal care had nothing to do with patient satisfaction. The motivation to seek care seemed to stem from the universal belief that care makes a difference in having a healthy baby (Handler et al., 1996). The women also discussed the importance of hearing the baby's heartbeat as an important step in bonding with the baby. The desire for ultrasound was valued very highly, and all the participants expected this to be a routine part of the prenatal experience.

Another theme that emerged was factors that affected the women's satisfaction with prenatal care. Some of these were respect, treatment as individuals, and

understanding of their personal experiences. The subjects expressed the desire to have procedures explained, their questions answered, and to be queried about their emotional as well as their physical status. Technical competence was also very highly prized though the majority of the participants did not have the knowledge to judge the technical abilities of the caregivers. Most of them judged technical competence by the outcome of the pregnancy (Handler et al., 1996).

Another factor affecting satisfaction with prenatal care was how well the patients felt their time was respected. They did not want to be penalized for being a few minutes late or to be left waiting for long periods of time to see the health care provider. The waiting was considered particularly dissatisfying when the women perceived that the long wait only resulted in a five minute visit with a provider who did not talk with them about the pregnancy or answer any of their questions. Having the same caregiver throughout the pregnancy was highly valued as was quality interactions with the support staff. The physical environment was also identified as contributing to overall satisfaction or dissatisfaction with the prenatal care experience. The women wanted a warm friendly waiting room and plenty of space for older children if this was not the first pregnancy. Many of the complaints verbalized about waiting rooms centered around the lack of child friendly waiting areas.

One aspect of care that did not impact satisfaction was the ethnic background of the caregiver. No one seemed to care if the provider was of a different race as long as the provider communicated effectively, was respectful, and was clinically competent. Gender received mixed responses from the participants. There was no clear cut preference for a

same sex provider versus an opposite sex provider. The value of ancillary services such as a nutritionist or social worker available during the prenatal period also received mixed responses. It was difficult for the researchers to ascertain if some of the women truly saw no value in these extra services or if they simply did not know that such things might be part of the prenatal care package.

When it came to discussion about designing the ideal prenatal care setting communication was once again identified as a key element. Cleanliness was prized as well as a child friendly environment that provided a waiting room for other children. All the women expressed a strong desire for education about the physical changes of pregnancy, procedures and tests involved in prenatal care, and what to expect during labor and delivery. Many of the women also desired access to other expectant mothers for support and asked the researchers if they could facilitate the development of a support group.

Both of the studies discussed above identified some major themes and areas of satisfaction and dissatisfaction with prenatal services, but neither of them specifically examined the primigravida or the active duty military female. Data gathered on this population could add to the growing interest in the prenatal care experience as viewed from the aspect of the expectant or postpartum female and can also provide valuable data to the health care provider that can be used to improve the quality and appropriateness of the prenatal care being provided in the military system.

CHAPTER THREE: METHOD OF INQUIRY: GENERAL

Qualitative Approach

The qualitative method of inquiry is used to try and gain insights through meaning revealed by the data (Burns & Grove, 1993). Qualitative research is a holistic approach to examining a question or phenomenon because it recognizes that human realities are complex (Munhall & Boyd, 1993). The focus is on human realities and involves a high level of researcher involvement with the subjects and the data produced usually provide a narrative description of people living through or having lived through events or situations . The emphasis of qualitative research is on achieving understanding that will provide new perspectives and open up new options for action.

According to Knarfl and Howard (1986), there are typically four purposes to qualitative research: instrumentation, illustration, sensitization, and conceptualization. Instrumentation can be accomplished by using qualitative methods such as in depth interviews to gain insight into phenomena in order to create a research tool with more validity and meaning. Illustration, can be used to 'paint a picture' of a particular experience or event. All qualitative studies serve the purpose of sensitization in that they all provide some insight into experiences that need to be understood vicariously; findings from these studies can aid research consumers to be more sensitive to their patients and thereby contribute to improved quality of care (Munhall & Boyd, 1993).

Conceptualization uses qualitative methods such as interview or observation to help develop theories or frameworks based on the data obtained. Whatever the purpose of qualitative research, inherent in all qualitative approaches is the belief that 1) there is not

a single reality and 2) what we know only has meaning within a certain context (Burns & Grove, 1993). It is for this reason that the intent of qualitative research is to discover meanings and develop understandings rather than to test theory or solve problems.

In the phenomenological approach to qualitative research, the goal is to describe the experience as it is and to describe it directly without considering the various causal relationships that may exist. This makes it a particularly useful design for descriptive examination of a phenomenon because the principle tenet is that human existence is meaningful and interesting only in the sense that we are always aware of something. Inherent in this is the belief that perception provides access to experience as it is prior to analysis. Perception provides a look at individual reality because it presents us with evidence of the world, not as it is thought, but as it is lived (Munhall & Boyd,1993).

The principal data collection method used in phenomenological research is the in-depth interview. This method is useful in that it can provide a large amount of data for a relatively small sample size. It also provides the researcher with rich data because the participant is able to describe the experience fully. The interviewing process can range from rigidly structured to completely unstructured depending on the phenomenon under study. The researcher may explore a few general topics to help uncover the participant's meaning perspective but otherwise respects how the participant frames and structures responses (Marshall & Rossman, 1995). This is important in that it allows the subject's views and not the researcher's to emerge.

There are three basic steps in phenomenological interview; (a) Epoche, (b) phenomenological reduction and (c) structural synthesis (Marshall & Rossman, 1995).

Epoche is the first step and occurs when the researcher looks at his or her biases in relation to the phenomenon under study and tries to remove any personal involvement. The self examination that accompanies this process is ongoing to eliminate or clarify any preconceptions that may exist. Phenomenological reduction is the point at which the researcher brackets any presuppositions with which he or she approaches the subject of interest. This may require the researcher to write down any personal experiences they may have with the subject and set them aside to allow the identification of the subject in its pure form uncontaminated by extraneous intrusions.

After this process is completed, the researcher can then more objectively view the data collected and cluster it around recurrent themes and concepts that emerge. The final step, structural synthesis, is the point at which the essence of the experience of the phenomenon is articulated and the deeper structure is described. This occurs after repeated, systematic review of the data collected and the themes, categories or clusters the data seem to suggest. Their relationship one to another is also explored. This provides thick data that allows the consumer of the research to experience the phenomenon vicariously.

Rationale for Method

The purpose of this study is to research the active duty primigravida's perceptions of prenatal care in the military health care system. Little is known about this phenomenon and nothing has been researched on this particular population, thus making it virtually impossible to test theory or hypotheses, or to examine causal relationships. To gain insight into this experience, it is necessary to allow the participants to "tell their story" as

they experienced it. The qualitative approach is most suited to this goal in that it is a holistic method that focuses on the subjective realities of the population studied (Munhall & Boyd, 1993). Examination of these realities can expand knowledge of the phenomenon of prenatal care in the military health care system and possibly provide grounds for further study.

CHAPTER FOUR: METHOD OF INQUIRY: APPLIED

Background

A qualitative approach was used to collect, synthesize, and analyze the data for this research project. A qualitative methodology was chosen because of its focus on human experience and its use of broadly stated questions about human experiences and realities that are studied through sustained contact with persons in their natural environments, producing rich descriptive data that helps the researcher to understand those persons' experiences (Munhall & Boyd, 1993). The application of the qualitative methodology to this particular study was done as follows.

Sample

The sample for this study was selected from a group of active duty primigravadas who had given birth at a large Air Force medical center located in the northeastern United States. The subjects were chosen by reviewing the delivery logs of the Labor and Delivery ward at the medical center. To be included in the study, the women had to be at least four but not more than 12 weeks post partum and had received their prenatal care at this facility. Ten patients were found that met the criteria and six mothers agreed to participate. Each person was contacted by phone and informed of the study requirements, the purpose and intent of the study and given some background data on the researcher. Originally, the sample was going to be limited to active duty Air Force personnel who were not involved in the medical field, but due to a much lower proportion than expected of active duty first time mothers compared to beneficiary wives and daughters it was not possible to limit the sample in this way. Therefore, the sample

consists of all active duty primigravidas regardless of service affiliation or career field. Further demographic data is presented in Chapter Five.

Setting

All of the interviews were conducted in the subjects' homes. There were other persons besides the researcher and subject present for all but one of the interviews. Each interview was completed while the researcher and subject were either seated in the living room or at the dining room table. The settings are discussed in more depth in Chapter Five.

Data Collection

Each subject was interviewed in her home and the interaction was audio-recorded. Prior to starting the study, the interview questions were reviewed by the researcher's thesis committee members and another active duty first time mother for accuracy and appropriateness. Before beginning the interview process, the researcher wrote a narrative of her own experiences with prenatal care in and out of the military health care system and bracketed this data to prevent her personal experiences from biasing the data she collected from the research subjects. Each person was queried about their expectations of and experiences with prenatal care in the military health care system and the least and most satisfying aspects of that care (see Appendix A). They were also asked about their preparation for the childbirth experience and what it has been like since bringing the baby home. Open ended questions were used and the subjects were encouraged to provide narrative responses. Great care was taken by the researcher to ask

the questions in such a way as not to lead the participants to provide any particular response. Answers were summarized and restated to insure the researcher was interpreting the subjects' responses correctly. Any question that was misunderstood by the respondent was restated in a different way. The interview data was reviewed with each subject to insure that her true perceptions and feelings were being conveyed correctly. Mental field notes were also taken and added to the interview data to insure completeness.

Data Analysis

The interviews were transcribed verbatim and the transcripts were continuously reviewed to the point of complete immersion by the researcher. The data were coded using descriptive terms to try and focus and find meaning in the data. As commonalities began to emerge, the data were clustered into themes and theme groups that aid in describing the phenomena of prenatal care in the military health care system as it was perceived by the research subjects. Restructuring of previous categories was necessary as new data was gathered. A doctorally prepared nurse researcher with expertise in qualitative research also analyzed and categorized the data to validate the findings of the principal researcher. If differences were found, the two researchers worked together to reanalyze the data until consensus was reached. This provided an opportunity to identify any biases the principal researcher may have added to the data as well as provide an alternative viewpoint. This adds to the credibility of the study. The comprehensive descriptions obtained provides rich, descriptive data which makes it easier to replicate the study or apply the findings to other populations. This provides evidence of the

transferability and dependability of the study, which is comparable to reliability in quantitative research. Confirmability, or the extent to which the data conveys the reality of the research subjects versus the researcher, was obtained by restating the participants responses. In this way, the researcher was able to assure she was correctly interpreting the respondents statements.

Ethical Considerations

Because of the intimate nature of qualitative research there were certain ethical considerations that had to be addressed. Each participant was given a number that identified the participant throughout the study. This number was written on the informed consent form and was the only means to identify the subjects by name. The data were in the possession of the principal researcher at all times and were kept in a locked safe. The interviews were transcribed by a professional transcriptionist, but each audio tape bore only the identification number. The findings from the data were only shared with the doctorally prepared nurse researcher and the principal researcher's thesis committee chairperson, both who only know the subjects by their identification number. Informed consent was obtained from each subject prior to participation in the study and after a detailed explanation of the aim and goals for the study. They were all given data on the researcher to include name, home phone number and address, professional background, and the name of the thesis committee chairperson. Prior to initiation of the study, the thesis proposal was submitted to the Institutional Review Board of the Uniformed Services University of The Health Sciences for approval. The proposal was also

submitted to the Institutional Review Board at Malcolm Grow Medical Center. Approval from both bodies was obtained before data collection was initiated.

CHAPTER FIVE: FINDINGS

Introduction

To have a better appreciation of the findings of this study it is important to know more about the subjects themselves; thus a description of the sample will be presented prior to discussion of the results of the study. A description of the various settings will also be presented to provide a complete picture of the interactions.

Description of the Sample

The research subjects are all active duty first time mother s who had their prenatal care at a large military medical center in the northeastern United States. Five of the subjects were seen in the Family Practice Clinic and one in the OB-Gyn clinic. The sample consisted of three Caucasian females, one Hispanic female, one Asian female, and one female of mixed ethnicity. Their ages ranged from 19 to 38 years. Three of the women were married, one was engaged, and the other two were single. Two of the subjects had spouses that were also active duty service members. The fianc of the one research subject was also active duty. Of the six women, one is a member of the Army, one is a member of the Navy, and the remaining four were serving in the Air Force. Years of active duty service ranged from two to sixteen years and three of the women were at their first duty station. Two of the subjects worked in career fields associated with health care while the others were in the line of their respective services. Two of the Air Force personnel were separating from the service.

Description of the Environment

Each of the interviews was conducted in the home of the research subjects, so every setting was somewhat different. Two of the married Air Force personnel live with their spouses in quarters on Andrews Air Force base. The Navy service member lived in quarters on Bolling Air

Force base in Washington, DC. Another of the married subjects owned her own home in Springfield, VA. One of the single subjects lived in a first story apartment in Laurel, Maryland and the other lived at home with her parents. Some commonalties among the settings was the obvious presence of a new baby in the house as evidenced by nursery monitors, infant carriers, baby swings and cradles in plain sight. Each home was very clean but slightly cluttered. For two of the encounters, only the researcher and the subject were present. In all of the other instances at least one other person was in close proximity; either sitting quietly in the same room or in the next room. In every instance but one, the infant was either asleep in the room during the interview or was held in the arms of either the subject or a nearby family member. In every home, the researcher and the subject were either seated side by side on the living room couch or across from one another at the kitchen table. Several times the television was on for the amusement of others who were present, but always at a low volume so as not to interfere with the conversation between the researcher and the subject. All the homes were well lighted and at a comfortable temperature.

Theme Categories and Clusters

After completing analysis of the data, four theme categories and related theme clusters emerged. Each of these is described and followed by statements from the interviews that best exemplify the meaning behind the themes.

Table 1

Theme Categories and Clusters

Theme	Title	Theme Cluster
Theme Category 1:	One Provider	
	Theme Cluster 1A:	Developing a relationship
	Theme Cluster 1B:	Concern/Caring
Theme Category 2:	Need for Information	
	Theme Cluster 2A:	Prenatal Classes
	Theme Cluster 2B:	Breastfeeding
Theme Category 3:	Preparation for Labor/Childbirth	
Theme Category 4:	The Parental Role	

Theme Category 1: One Provider

It was very important to all of the respondents that they have the same provider throughout the entire prenatal experience.

Significant Statements,

I'd have been able to see the same doctor over there you see the same doctor over and over and that actual doctor will come in and deliver you if you have the chance. I'd be able to see the same doctor so he'd be able to follow my care.

I knew a lot of girls who have been pregnant where I work, every female in the office has been pregnant now, and everybody in my office says that's the number one thing, having the same provider. Everybody ended up having a different provider. It doesn't work.

I picked family practice because I just wanted one doctor it's nice to have one person that sees you through all your visits and talks to you, he understands you rather than different doctors that come in and don't know your situation.

Theme Cluster1A: Developing a Relationship

The importance of developing a relationship with the health care provider was clearly shown by the data.

Significant Statements,

So that's what I liked about Family Practice, that Dr. .. knew what I did last month. This is what I'm going to do this month. So I would give that advice. Go to Family Practice that reason, you can have a relationship. You can see him before and during and after. It's more like, when you're a civilian, you're going to keep going to the same doctor.

I think the relationship I had with my doctor made everything go smoothly as far as the whole pregnancy because he knew me as a person. As far as he knew the type of changes that I was going through, so he could keep up with the process on the other hand if somebody else was doing (it), they would have to go over the chart and see, okay, this and this, he already knows this,

(What) Helped me the most? That's a good question. I'd have to say just my relationship with my doctor. It was easy just talking to him.

Theme Cluster 1B: Provider Concern

All of the informants expressed desire for genuine concern from their health care provider. Some felt that their providers had been concerned for them but others did not.

Significant Statements,

-- and before I even went to my doctor, I was asking the other doctors that I worked with if they've heard of him. They had good words to say about him and I liked that, so when I finally did meet him, everything they said about him was right and I was impressed about that. He went over past medical history with me and told me about what risks I'll be exposed to and I appreciated that and one of the things about my past medical history, I had frequent UTI's and he was concerned about that, so he just told me to do UA s almost every month and he'll follow-up on it, which I really liked basically he made us feel that he was really concerned about the pregnancy and basically just accommodated us.

I just didn't feel that I got the care that I needed. I mean, they were just there to just say, Oh yeah, OK, you're at 36 weeks. Or you're 20 weeks. And OK, see you next week. See you in a month. And I had all these problems and they were like it didn't even matter to them. You know, they didn't care I mean its like nobody paid me any attention I was just another person that was pregnant.

I think if I would have had a doctor that didn't really care didn't sit down and take time out with me when I needed time out and just made sure everything was great for me as far as my health, he made sure I was eating right and even sat down and talked to me on a personal level, if I had any questions as far as my relationship and just different things. He'd allowed me to sit there and talk if I needed to talk. He gave his time.

Theme Category 2: Need for information

Since all of the respondents were pregnant for the first time, none of them knew what to expect from the experience. The data clearly shows how important it was to them to have information about the pregnancy.

Significant Statements,

I guess because I didn't know what to expect, I think it went rather smooth because my doctor was great. He sat down and talked and explained everything, what was going to be

going on, what should I expect from every visit and just went over everything as far as me eating healthy and changing my habits and just keep up exercising as long as I could and stuff so that would make the pregnancy probably a little easier and just explained everything as far as what to expect.

They didn't explain to me as far as like, well, you're four months your baby should be growing she has arms, legs, eyes, whatever. I mean they didn't explain to me-- I had to go out to the libraries and actually get books to read to find out what was inside of me and what was growing and how it was growing.

I think that with me being pregnant and stuff and with me talking to other moms and civilians, I mean I have a lot of civilian friends, that the care that they got was just so much better than what I got. I mean it was that they explained everything to them and I didn't get explained anything. They basically just said, Yeah, you're fine, OK. See you next month.

It's hard -- I'm a first time mom and didn't really have any expectations. I was trying to write questions that I had so I won't forget when I met my provider, I was extremely satisfied because for the most part like all the questions that I had for him, he had answers for them and he was very gracious. He was a good provider. I was impressed the first time that we met.

Theme Cluster 2A: Importance of Prenatal Classes

All of the women expressed an appreciation for the prenatal classes. All of the mothers attended the Lamaze classes as well as the initial and seventh month orientation classes and all but one of the subjects attended the breastfeeding class. Opinions differed over which classes were the most helpful but, everyone found the information to be invaluable.

Significant Statements,

I think the seven month orientation was really good. I got a lot out of that. They gave you so many pamphlets and they taught dental there for the infants and for ourselves. They told you, as you're getting closer, different things that's going to be happening, different techniques to take the labor off like the cat rolls and all that other exercise stuff. They gave you a lot of books. That's what I liked the most. That you could read through the difference between breast feeding and bottle feeding and all that different kinds of things. And you get to bring your husband with you too.

I think the Lamaze was great. I mean it, they covered everything if you had a question and they couldn't answer it, they found out the question [sic] for you and then the answers to the question, and they came back and gave you that I liked the classes that they offered.

We went to the Lamaze class. They had a breast feeding class, but I couldn't fit it into my schedule. I wish I had cause I would have known what to expect...cause I'm a first time mom, everything is needed for me. All of the classes that I look at I think I need to sign up for that, I need to sign up for that.

Theme Cluster 2B: Education and support with breastfeeding

All of the mothers in the sample breastfed their infants with mixed degrees of success.

The data clearly shows their need for education and support during the prenatal and early postpartum periods.

Significant Statements,

Even breast feeding, I gave-up on that. I'm pumping now. That's why I wish I went to the breast feeding class cause I couldn't do it the nurses in the postpartum ward, they tried to keep track of mothers who are breast feeding, so they are like, do you feel like your milk ducts are clogged you would feel kind of hard and if it is, you just put warm compress, and that's about it. The only education I got. I just gave up. As soon as we came home I started pumping, I couldn't do it after (discharge) the lactation nurse tried to get a hold of us and we went to the breast feeding class after, but I was pumping by then.

I think the thing that really annoyed me was since I missed my breast feeding (class) there was only one nurse there that really helped me try to breast feed him, to try to teach him to latch-on and try to teach me how to keep him on when he's not latched-on properly and all that other stuff. I was really annoyed with that because the one nurse, she only worked one of the days that I was there and she really took time out of her busy schedule to help me, and I was really annoyed with some of the -- there was one nurse, in particular, that just didn't understand where I was coming from. She was, I know it was a late night shift, but she was like you're not doing it right, and she was just criticizing and I really didn't appreciate that very much, it makes it really hard

Yeah. At first, after I had him I wanted to stop breast feeding, but the nurses and the doctor-- they were great about it because when my milk started coming in, I think I had what they called engorgement, and I was going through that and I was changing my

mind. I was like, I don't want to breast feed, I don't want to breast feed, can I put him on the bottle, but the staff was great. They came in, they sent in one of the doctors that talked to me she sat down and she explained a lot to me and they told me how breast milk was one of the best things for the baby. It helps as far as ear infections and fights off all kind of stuff as far as getting colds I think if they hadn't came in there and talked to me, I would not have breast fed after that because that day I was (ready to) give it up.

Theme Category 3: Preparation for Childbirth

As first time mothers, the research subjects were all apprehensive about the childbirth experience. Their statements indicate that although they did receive education re the childbirth experience, it was not possible to be completely prepared.

Significant Statements,

I thought I was prepared but you think you're prepared until you have the child and it's like, oh, oh when I delivered it all went too fast and I couldn't, I didn't concentrate about whatever we learned from the Lamaze class I forgot about the counting and everything, the breathing, I was a bad patient.

(Did you feel prepared) Well, not really, because my labor that I had with him, we had a difficult labor so, it wasn't anything that I was prepared for; once I started having the contractions and stuff and dilating and all that, it was fine, but then we were running into difficulties so, I wasn't expecting any of that. I was ready to push, that was all I was prepared for, but we had a emergency cesarean through the class they talked to us about if the baby was breach, if the cord was wrapped around their neck --if he pooped in his sack, or whatever we had to get him out soon, so

Probably the childbirth classes because I was pretty, I was nervous about the actual childbirth so --I felt pretty much prepared. I mean I didn't, I tried not to worry about it too much, you know, get too nervous but everyone has to, all women who have babies have to go through it so I wasn't, you know, it can't be that awful. The part I didn't like, was I couldn't, they couldn't admit me until I was like 4 cm and I was really uncomfortable I didn't, I don't think in any of the classes we really went over how exactly you push. I don't think, I think maybe if I would have known a little more of how to push I think maybe it would have helped.

they went through all the breathing. I mean they went through, you know, like your dilation. I didn't know any, none of the doctors talked to me about if, you know, being dilated and you know, effacing --or anything like that. None of the doctors talked to me about that they didn't tell me anything about that. I found all that out through the actual

Lamaze class I didn't feel too prepared but I knew that I had my mother, my father, and I knew and my great-grandmother was here when I had her. My sister came so I knew that, you know, I'd get a lot of help. But I don't think that I was real prepared.

Theme Category Four: The Parent Role

All of the subjects acknowledge that parenting comes from experience, but they did express a desire for help getting started with the basics.

Significant Statements,

They went through all that stuff before I left. In fact the doctor did too. Before I was discharged (they) made sure that if I had any problems to call so I can talk to someone and as far as the baby, they went over all that stuff that I might be scared that I'm doing something wrong...especially like with the cord. That was the one thing I was scared to death of...and his circumcision, that was another thing I was scared of too...but they went through everything and made sure I knew some of them wrote some stuff down for me to make sure that I understood and that if I had any problems I could relate to it.

(any classes on baby care?) We had that. It was part of the discharge instructions in the postpartum and I'm glad they did. I think we also had it in the Lamaze class because there's a video tape that looks so familiar just tapes to watch. I felt like, well yeah, we can change diapers. And I would give the baby a sponge bath.

I read a lot. I read because they gave me a lot of books at the orientation, and then I checked out books at the library and I got a lot of stuff from this program with Similac and they sent me a lot of literature so I read everything I could. And then my mom, you know my mom just answered a lot of my questions, too. And then just, things came naturally to me.

I think as far as stuff you needed I was prepared in that sense, but as far being a mother and taking care of my son by myself I don't think I was really prepared because it took me a while to get adjusted. It was like, my mother came up and stayed with me for a while, but after she left I was like oh, God. Now it's just me and him and when he's crying, I'm like what do I do, so in that aspect it's not something that they can prepare you for because they can't say why this cry is for this, this cry is for that, so they can't really pinpoint what's going to happen. It's a growing process. It's something that you have to learn on your own.

Additional Findings

During the data analysis process, many other findings emerged that could not be clustered into a theme category. It is important to briefly discuss these in order to give the reader a more complete understanding of some of the unique problems encountered by the active duty first time mother.

All of the mothers verbalized the importance of the prenatal classes, but many of them were unable to take full advantage of them due to issues such as distance and scheduling problems. Many of the subjects expressed dissatisfaction with the number of class times that were available while others who did not have problems with scheduling were often too busy or too tired to drive the distance required to attend the classes. Some statements reflective of this include:

Significant Statements,

I didn't get my Lamaze or my breast feeding class until two weeks before I was supposed to deliver because they said they didn't have the appointment books open, and then they said they were over-booked and then I would have to wait to the next month and I kept saying I only have three more months, I only have two more months, hey, this is my last month, can I get in? I mean, they only open the books so long and it gets booked-up so fast that you only get in if you call at certain times I just can't drop everything to call, so they got booked-up or their computers would be down and they couldn't schedule any patients. And I felt that was kind of hindering I mean I've been through Lamaze before with one of my friends when she was pregnant, so I knew kind of what to expect, but it's different when it's your own situation.

They could have had more classes -- I know it's hard, there's only a certain amount of nurses that can take out of their own time, but if they would have had maybe two days - they have one class that you can take that's during my work hours, that's a three or four hour class, I think it is -- and then they have the ones at night some of us are medical and we just can't get out of our schedules that easy. Even if we're pregnant, we have to follow the rules.

We went to the Lamaze class. They had a breast feeding class, but I couldn't fit it into my schedule. I was in school and they only had it every Wednesday. I think it's a third Wednesday of the month and it's from 5:30 to whatever, but I had class.

I think the longest one (class) was, that I really had to wait was the breast feeding -- it took me a while to get -- no, no, it was Lamaze because they was booked up, so having other appoints and then trying to meet their appointment at a time when they had a schedule, so it was difficult staying here and then trying to get back up there.

Several of the participants also expressed desire for more depth from the prenatal classes.

All of them felt the information that they were given in the classes, especially the Lamaze class, was very valuable, but many of them still wanted/needed more. This is illustrated by statements such as these:

and the breast-feeding class, it was, I could have read that in a book, you know? I don't know if anybody would have done it; I mean actually somebody coming in and showing, we're all women or whatever. I don't know if they could have got a tape that actually showed somebody doing it because they use a lot of just drawings and so forth I mean, I thought that a videotape that actually showed the steps or that showed, you know, do it this way, and if you're having problems then you try this or try that. It was just the positions basically of how to do it and that was all that I can remember I got a little bit (of information) but not a lot.

I wouldn't say the least helpful, but maybe they could have been more helpful --with the, probably I'd say the exercises. They talked about what you need to do, that to me you don't really have the time to do that, like stretch your back or whatever every day -- I never did do that, but in consequence I had frequent back pains and then I kind of like maybe if they told us you're going to have back pain, then you could have done your stretch right, your exercises I think that's about it. Other than that, everything else went pretty good.

These additional findings, along with the data previously presented, illustrate the important issues and concerns related to prenatal care expressed by the research subjects. Each theme category is discussed in greater depth in Chapter Six.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

Discussion

The purpose of this study was to investigate the active duty first time mother s perceptions of the prenatal care she received in the military healthcare system; examining the phenomenon in its entirety, to gain insight into the aspects of the experience that were important to the women. Analysis of the data produced four theme categories and clusters that demonstrate these elements: 1) One Provider, Theme Cluster 1A) Developing a Relationship, Theme Cluster 1B) Concern/Caring, 2) Need for Information, Theme Cluster 2A) Prenatal Classes, Theme Cluster 2B) Breastfeeding, 3) Preparation for Labor/Childbirth, and 4) The Parental Role. Each of these areas will be discussed individually in order to provide greater understanding.

In this study, the importance of having one provider is clearly evident from the statements made by the participants on this subject. All of the participants felt that the continuity of care derived from having the same provider over and over was probably the most important aspect of prenatal care. All of the participants who chose to have their care in the Family Practice Clinic made that decision based solely on the fact that there, they could have one provider for their entire pregnancy. In the instances where some of these women had to see another provider for one or more visits, they still experienced a high degree of satisfaction if they knew this was going to happen ahead of time and felt that their primary provider had made arrangements for their care. The dissatisfaction that the one mother experienced with the care she received in the Obstetrics and Gynecology clinic was based predominately on the fact that she did not have one provider and felt that she had to keep repeating her story at every visit. This is consistent with

the findings by Handler et al, who stated that although many of their research subjects expressed a desire for one provider throughout the pregnancy, those who were seen by several practitioners did not appear to mind if they understood this to be the case ahead of time and if they were certain that the practitioners were sharing complete information with each other about the patient's medical status (Handler et al., 1996).

One of the primary reasons that having one provider was so important to the mothers was that they felt they could develop a relationship with that person. It was very important to the subjects that the providers see them as individuals and not just as another pregnant woman. In the Handler study, a few women mentioned having a practitioner who provided care for themselves and their families over a number of years, and as a consequence, felt that they could really trust this individual (Handler et al., 1996). Several of the subjects involved in this study also expressed a desire to continue with the same provider even after delivery because of the rapport they had developed during the prenatal period. These same individuals expressed very positive feelings about the fact that they and their infants could be seen by the same provider.

The clients' ability to develop a relationship with the provider is strongly linked to their perception that the provider genuinely cared for them and wanted them to have a positive outcome. For the participants in this study, part of displaying a caring, concerned attitude was taking time with them during the prenatal visits. Nearly all of the mothers stated an awareness that their providers were busy and had a lot of patients waiting, but stated they never felt rushed. When the providers took the time to answer their questions and would go the extra step, for example, when one of the providers came to see the research subject while she was undergoing a procedure just to make sure everything was going smoothly, then the patients felt

cared for. The subjects in Handler's study made similar comments about the relationship with the provider stating that they expected respect, treatment as individuals, and understanding of their personal experiences. These findings are consistent with the results of Omar and Schiffman (1995) who state an important message given by the women (in the study) was that the provider relationship had the greatest influence on their satisfaction with prenatal care. All of these data seem to suggest that having a consistently caring, empathetic relationship with the expectant mother during the prenatal period can strongly affect the degree of satisfaction she experiences with care, even in the event it is impossible to have the same provider throughout the entire prenatal period.

The second theme that emerged from the data was the need for information. As first time mothers, all of the participants had a strong desire to know what to expect during the pregnancy, signs of any problems they might be having, what to expect during labor and delivery, and basics of baby care. An interesting phenomenon in this study was the across the board desire for information regarding breastfeeding. These findings differ somewhat from the results of Freda's study which showed only 59.4% of the participants verbalized interest in learning about breastfeeding (Freda, Andersen, Damus, & Merkatz, 1992). All of the participants in this study verbalized a great interest in and appreciation of the prenatal classes, but virtually all of them also expressed a need for greater depth in the classes. Several of the subjects stated that the classes offered did not have enough discussion and demonstration of: (a) the various positions in which to labor in, (b) techniques for pushing and practicing of those techniques, (c) breathing and relaxation exercises, (d) exercises to minimize the discomforts of pregnancy, and (e) the mechanics of breastfeeding. The subjects all stated that they wanted more hands on from the

instructors, especially with the laboring and breastfeeding portions. All expressed an appreciation for the handouts and pamphlets they received, since this provided an additional source of information if they had questions outside of class, but they would have liked more live demonstrations, or barring that, at least some videos to watch. The drawings that showed the positions for breastfeeding were found to be particularly unhelpful by one of the subjects. These findings agree with the Freda study results that showed statistically significant differences in the level of interest in regards to topics of prenatal education between multiparous and nulliparous clients with first time mothers showing the greater interest (Freda et al., 1992). This implies that perhaps a woman s obstetric history should be considered when planning prenatal health education and that it may be appropriate to plan some prenatal classes just with the primigravada in mind.

Other comments made by the subjects had to do with the scheduling and distance required to attend some of the prenatal classes. In the military healthcare system, certain types of services are only offered at specific facilities, so clients may have to travel quite a distance to access care. Of the six subjects who participated in the study, four of them lived at least twenty miles away from the medical center and found it difficult, either because of work responsibilities or the decreased energy level associated with pregnancy, to take advantage of all of the classes offered. Several of the subjects, most notably the two women who worked in the healthcare field, mentioned either having difficulty getting off work or feeling guilt about taking off for extended periods of time to go to the prenatal classes. These findings may indicate a need to decentralize care or at least the prenatal classes so that the expectant mothers can take advantage

of all the classes available to them. A variety of class times to include evenings or weekends may also be beneficial.

The third theme identified in the study was Preparation for Childbirth. All of the subjects stated feeling somewhat unprepared for labor and delivery but no one equated this to a lack of education or as a failing of their prenatal care, but simply to their own inexperience. As stated previously, several of the mothers expressed that having more demonstration and practice of labor and delivery techniques would have been helpful but still could not have made them feel completely ready for the experience. Several of the mothers stated that it is possible to be prepared only so far and that when the pains begin everything you learned leaves you. There are no similar findings identified in the few studies conducted to examine client perceptions of prenatal care simply because this aspect was not previously addressed. These findings have implications for providers in that it is important to know that no matter how much prenatal education the nulliparous client has received, she still does not feel completely ready for the childbirth experience and is going to require more support than the multiparous client.

The fourth and final theme category is The Parental Role. The data collected strongly displayed the subjects' desire for education about the basics of infant care in preparation for taking their infant home. All of the mothers admit that the art of parenting is something that comes with time and practice, but all stated a need for teaching on subjects such as bathing the infant, cord care, care of the circumcision, etc. The subjects all received some of this teaching during the early postpartum period, but the quality and quantity were widely varied. Just as with the prenatal classes, the mothers all stated a desire for more live demonstrations, the opportunity

to ask questions, and written information to take home. These findings suggest the mothers need for more individual teaching about infant care.

In summary, the four themes identified in this study reflect the active duty primigravida's perceptions of prenatal care in the military healthcare system. These themes represent elements that impacted the individuals' satisfaction or dissatisfaction with that care. This is not to imply that these are the only elements that play a role in patient satisfaction but that having one provider, the need for information, preparation for childbirth classes, and the parental role are the most important ones for these subjects.

Significance

The significance of this study is that it provides an opportunity to examine the perception of prenatal care from a perspective that has not been examined before, that of the active duty first time mother. The data derived from this study provides insight into the aspects of prenatal care in the military healthcare system that these subjects found to be important. This is valuable for two reasons. First, it is valuable simply from the perspective of examining a phenomenon through the people who experienced it and to better see things from their point of view. Second, by discerning areas that the subjects found to be valuable, satisfying or dissatisfying about their prenatal care experience, it is possible for providers to do a better job of anticipating and meeting the needs of the active duty primigravida, or for that matter, any first time mother. The universal satisfaction the subjects felt with the prenatal care received in the family practice clinic as compared with the mother who received care in the OB-Gyn clinic, and the reasons for this, also has implications for nurse practitioner practice. Continuity of care, in-depth patient teaching, anticipatory guidance and looking at the patient holistically are some of the things that

distinguish family practitioners in general and nurse practitioners in particular, from others in the healthcare field. Perhaps if family nurse practitioners took a more active role in uncomplicated, ambulatory obstetrics, patients' perceived needs may be more effectively met and their satisfaction with care may increase.

Limitations

As a result of the patient population used for this study, there are several limitations. First, the sample is not truly representative of all the prenatal care offered at Malcolm Grow Medical Center because only one of the participants was cared for in the Obstetrics and Gynecology clinic, and none of them were cared for by nurse midwives. Second, because of the many different types of military treatment facilities that exist, it is impossible to extrapolate that the style of prenatal care delivered at this center would be duplicated at any other. Third, due to the small sample size, it is difficult to say that the sample is truly representative, and therefore this research project functions more as a pilot study. Fourth, because this patient population has not been specifically studied in the past, it is always unwise to draw any hard and fast conclusions based on one study, therefore it is important to replicate this project in order to substantiate these findings.

Suggested Further Research

This pilot study provides some insight into the phenomenon of prenatal care in the military healthcare system as it is perceived by the active duty primigravida, but it is far from conclusive. First it would be useful to repeat the study using a larger sample size to see if the results would be similar. It would also be beneficial to repeat the study at the various types of military medical facilities, i.e. medical centers, regional hospitals, and clinics to see if the results

would be the same. The study did provide some interesting data on how positive the prenatal experience was for the mothers who were cared for in Family Practice. It would be very helpful to examine this phenomenon more closely to see if perhaps a family practice setting is a more appropriate setting for uncomplicated obstetrics due to the continuity in care available before, during, and after the pregnancy. The additional findings that emerged from the data regarding patients needs for prenatal education also provide the basis for further research into the content and format of prenatal classes.

Conclusions

This study provides a preliminary look into the active duty primigravida s perceptions of prenatal care in the military health care system. The four themes and theme clusters that emerged from the data give insight into the aspects of prenatal care that they perceive to be important and how these impacted their satisfaction or dissatisfaction with care. The knowledge derived from this study can expand the knowledge that exists about the prenatal experience and give providers an opportunity to tailor the prenatal care delivered to the patient s perceived wants and needs.

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APPENDICES

Appendix A: IRB Approval Letter Uniformed Services University

Appendix B: IRB Approval Letter participating facility.

Appendix C: Interview Questions

Appendix D: Informed Consent

Appendix A: IRB Approval Letter Uniformed Services University



UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4799



December 2, 1997

MEMORANDUM FOR CAPTAIN VICKI L. BRADY, GRADUATE SCHOOL OF NURSING

SUBJECT: IRB Approval for **Protocol T06148-01** Involving Human Subject Use

The new protocol entitled "***Active Duty Primigravida's Perceptions of Prenatal Care in the Military Health Care System***" received an expedited review and was **APPROVED** by Edmund G. Howe, M.D., J.D., Chairperson, Institutional Review Board on 12/1/97 in accordance with 32 CFR 219.110 (b) (1) Supplements 6 & 9. This review will be read into the minutes of the next IRB meeting scheduled for 12/11/97.

The consent form approved for use is attached. It is your responsibility to review and maintain an accurate and accessible file of all consent forms used in this study for each study site. This research study will be reviewed within one year of this date, unless otherwise completed.

Please note that since part of this study is being conducted at Andrews AFB, approval from the approval authority there must be received in the USUHS Office of Research before this study can be initiated.

Please notify this office of any amendments you wish to propose and of any untoward events which may occur in the conduct of this project. If you have any questions regarding this memorandum or human subject research, in general, please call me at 301-295-3303.

Michael J. McCreery, Ph.D.

LTC, MS, USA

Director, Research Programs and
Executive Secretary, IRB

Attachments: A/S

cc: Director, Grants Administration



Appendix B: IRB Approval letter participating facility.



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS 99TH AIRLIFT WING (AMC)



23 Jul 97

MEMORANDUM FOR CAPT VICKI BRADY

USUHS

FAX: (301) 295-1967

HOME: (301) 963-2974

FROM: 89 MDG/SGI

1050 W. PERIMETER RD

ANDREWS AFB MD 20762-6600

SUBJ: Approval of Protocol: "Active Duly Primigravada's Perceptions of Prenatal care in the Military Health Care System."

1. At the 9 Jul 97 meeting, the Institutional Review Board (IRB) approved the subject protocol. You may begin your study,
2. Ensure all required reports are forwarded to this office promptly.

WILLIAM H. AUSSIKER, Col, USAF, DC
Director, Career Development Function

faxed 24 July 97 KA.

Appendix C: Interview Questions

1. I would like to explore your expectations with prenatal care. What did you expect?
2. Describe your experience with prenatal care in the military system.
3. Describe any problems you experienced accessing prenatal care.
4. Describe what was the most needed aspect. What was the least needed?
5. Describe what was most beneficial about the experience. What was the least beneficial?
6. What would you describe as the most satisfying experiences of prenatal care? What were the least satisfying?
7. Describe how well prepared you felt for the childbirth experience.
8. Describe what your experience has been like since bringing the baby home.
9. If you had an opportunity to give advice to another first time active duty mother about the prenatal experience what would you say?
10. Is there anything else you would like to share with me about this experience?

Appendix D: Informed Consent

Informed Consent Form

Research Study Title: Active duty primigravida s perceptions of prenatal care in the military health care system

Introduction

You are being asked to take part in a research study. Before you decide if you would like to participate, you need to understand what is expected of you and any potential risks and benefits involved. This enables you to make an informed decision about participation. Once you understand the purpose of the study and the data collection methods used, you will be asked to sign this form if you wish to take part in this research project. Your participation is completely voluntary and there is no penalty for deciding not to participate.

About the Researcher

Captain Vicki Brady is a graduate nursing student at the Uniformed Services University of the Health Sciences and is completing this study in partial requirement for a Masters of Science in Nursing degree. She has been an active duty Air Force member for the past 7 years. Her interest in this project stems from her own experiences with prenatal care in the military health care system.

Purpose and Procedures

The Graduate School of Nursing at the Uniformed Services University of the Health Sciences (USUHS) is carrying out a study that involves research into the active duty first time mother s perceptions of the overall quality and appropriateness of the prenatal care she received in the military health care system. The purpose of the study is to examine if the participants are satisfied with the prenatal care they have received. Participation in the study is limited to active duty mothers who recently delivered their first baby. Each participant must be at least four weeks but no more than 3 months postpartum. To participate in the study, each subject will be asked to fill out a four page questionnaire and then consent to a one-on-one, in depth, interview that will discuss the research subject s feelings about the prenatal care she received. Each interview will be audiotaped in its entirety and transcribed verbatim. A second brief interview may be required to validate the accuracy of the data obtained. Total time required to fill out the questionnaire and complete the interview(s) is approximately 2-2 1/2 hours.

Possible Risks and Benefits

There are no physical risks involved with participation in this research project. Possible benefits to the participant is the opportunity to fully explore their feelings about the quality and appropriateness of the prenatal care they received and to help identify possible weaknesses in

the system and areas for improvement. This will help to insure that the prenatal care provided to the active duty first time mother is the best available.

Privacy

The results of this research study will be shared with the members of the researcher's thesis committee and the Institutional Review Board at USUHS. Except for these people, no one else will have access to your records. All participants will be identified by a numerical code and the confidentiality of the data will be protected to the best extent of the law.

Questions

If you have any questions about this research study feel free to contact the person in charge of the study, Captain Brady, at (301)963-2974. If you have questions about your rights as a research subject, call the Director of Research Programs in the Office of Research at USUHS. The phone number is (301) 295-3303. This person is your representative and has no connection with the research study.

By signing this consent form you are agreeing that the study has been explained to you and that you understand the purpose and procedures involved. Your signature indicates that you agree to take part in the research project, but you have the right to withdraw from the study at any time. You will be given a copy of the signed consent form..

I certify that the research study has been explained to the individual signed below by myself and that the individual understands the nature and purpose and possible risks and benefits associated with taking part in this research study. Any questions have been raised and answered.

Date Subject Signed: _____ Investigator's Signature: _____

Subject's Signature: _____

Printed Name: _____

I certify that I have received a copy of this form:_____