I, Alexander Lee, hereby submit this original work as part of the requirements for the degree of Master of Public Health in Public Health - Leadership, Management and Policy.

It is entitled:
Well-Child Visits in African-American Mothers: Perceptions of Barriers and Facilitators

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Well-Child Visits in African-American Mothers: 
Perceived Barriers and Facilitators

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Graduate School
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by

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Abstract

Well-child visits (WCV) are an important tool for delivering preventive care to children less than six years of age. Scheduled at regular intervals, these visits serve as avenues for vaccinations, screenings, and other evaluative practices. Researchers have found, however, that adherence with well-child visit recommendations is significantly lower than desired, especially within the African-American population. Barriers to receipt of WCV have been the focus of many studies seeking to understand why well-child visit recommendations are not being met. Despite the wealth of knowledge examining the causes behind well-child visit adherence, there is a lack of studies examining the perception of barriers and facilitators to care among mothers enrolled in home visitation programs. The purpose of this research study is to understand the perceptions of barriers and facilitators to well-child visits in the at-risk, African-American first-time mother population who are enrolled in a home visitation program.

A qualitative research study was conducted to assess these perceptions of barriers and facilitators. The data for the study were obtained through a series of in-depth, semi-structured interviews with a sample of 10 first-time, at-risk mothers enrolled in the Every Child Succeeds (ECS) home visitation program. All of the participants were African-American, and ranged in age from 18 to 28 years, with an average age of 23 years. The age of babies ranged from 12 to 30 months, with 24 months being the most common age.

The results indicate that mothers enrolled in home visitation programs face some similar barriers as mothers who are not enrolled in these programs. The two most commonly cited barriers were problems with obtaining transportation and balancing work/life obligations. Some less commonly cited barriers were long office waits and overcrowded offices. There were four most commonly cited facilitators: assistance with transportation, personal responsibility, value of...
the child, and encouragement from the participants' home visitors. Additionally, the participants had a higher rate of WCV attendance than the general African-American population. It is hypothesized that the mothers possessed high levels of intrinsic motivation driven by their maternal obligation and priority placed on their child, which allowed them to overcome many of the traditional barriers (e.g., transportation).

These results are important because they show that while African-American mothers enrolled in home visitation programs share some similar barriers with the broader population, they are affected by unique facilitators not found in previous literature. Further research should examine the roles these facilitators play in overcoming barriers. If maternal obligation and perceived value of the child are found to significantly affect WCV rates, home visitation programs and other similar curricula can be tailored to foster these perceptions.
Acknowledgements

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I. Introduction

The health of a nation’s children can be an important indicator of that nation’s overall health because infant health is associated with a host of factors, such as maternal health, socioeconomic disparities, and access to quality medical care. The infant mortality rate is the most common measure of infant health (Braveman et al., 2010). The United States, despite being one of the wealthiest nations in the world, has one of the highest infant mortality rates among industrialized nations, ranking 44 in 2010 (Central Intelligence Agency, 2010). There have been a number of proposed strategies to address the United States’ mortality concern, including emphasizing well-child visits and using home visitation programs. These two programs complement each other because home visitation programs can emphasize the importance of the well-child appointment and preventive care. However, despite the benefits of these two concepts, there are still a significant number of infants who are not regularly attending well-child visits (WCV); this is especially true for at-risk populations (Selden, 2006). African-Americans, for example, had a WCV attendance rate of 35% compared to the 58% rate of white infants (Ronsaville & Hakim, 2000), and an infant mortality rate twice that of white infants (MacDorman & Mathews, 2009). Understanding the perceived barriers and facilitators towards WCVs in the context of home visitation is an important step in improving infant health.

The WCV serves as an important source of preventive health care for infants. Unlike typical doctor appointments, the goal of these visits is not to treat an illness, but to prevent future sickness. The visits are scheduled at regular intervals to assess the development and physical health of a growing child; the American Academy of Pediatrics (AAP) recommends a high proportion of these occur in the first twelve months of life (Table 1). As the child ages and emerges from the crucial development period, the necessity of frequent visits decreases. In
contrast to the nine appointments recommended for the first 12 months of life, the AAP recommends only one well-child visit every year thereafter until the child is 21 years old (American Academy of Pediatrics, 2008).

<table>
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<tr>
<th>Infancy</th>
<th>Early Childhood</th>
<th>Middle Childhood</th>
<th>Adolescence</th>
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<tr>
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<td>9 mo.</td>
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The importance of WCVs is highlighted by the array of vital services administered. These visits serve as an opportunity for health providers to deliver crucial screenings, education, and disease prevention tasks. Standard tests for anemia, hearing, and vision ability are conducted, and pertinent issues since the last WCV, such as nutrition and development, are reviewed. WCVs are an opportunity for parents to ask questions or express concerns regarding their infant. One of the key services is the application of childhood immunizations, such as the Hepatitis B and measles, mumps, and rubella (MMR) vaccine series. Immunizations serve the important role of preventing the onset of dangerous childhood diseases, and are also a very cost-effective prevention method. When WCV are missed, immunization schedules recommended by the AAP can be disrupted. If this disruption is great enough, herd immunity can be compromised, and previously rare childhood diseases, such as pertussis, can reemerge. In addition to immunizations, WCVs provide an important opportunity to prevent chronic diseases.
from developing. For example, obesity in many people can be traced back to childhood (Moran, 1999). By attending all of the recommended WCVs, an infant’s growth can be routinely measured and evaluated. Any signs of obesity can be caught early, and appropriate preventive measures, such as diet and behavior modification, can be administered.

Home visitation programs have recently been considered complements to well-child visits. These programs are initiatives that partner directly with parents with the broad purpose of improving parenting skills and providing support during pregnancy and the first three years of life (Pew Center on the States, 2010). They are a new strategy that was proposed by the Healthy Start Program to reduce infant mortality and improve child and maternal health (Sharp, 1993). These programs aim to provide a variety of services, including education, resources, and support for the client, with the general goal of improving child and maternal health (Wasik, 1993). Home visitation programs have been associated with positive effects in a variety of areas, including the reduction of unintentional injury, reduction of child abuse, improvement of parenting skills, and enhanced social support for the mother (American Academy of Pediatrics, Council on Community Pediatrics, 2009). Intensive home visitation in at-risk populations has also been linked with a decrease in infant death (Donovan et al., 2007). Additionally, the varying range of these programs and amount of contact with the families allow home visitors to develop important provider-family relationships. These relationships enable the home visitor to identify day-to-day needs and assist in providing support, such as addressing issues related to Women, Infants, and Children (WIC) and food (Schuster et al., 1998).

Despite the importance of WCVs, especially in the first three years of life, a significant number of families do not attend the regular visits. In fact, in 2006, less than 50% of children younger than five years of age attended the full number of appointments recommended by the
AAP (Selden, 2006); African-American rates were even lower at 35% (Ronsaville & Hakim, 2000). Even more striking is that only 20% of Medicaid-eligible children receive any sort of preventive health care (Schor, 2004). While there have been a number of studies examining the reasons for missed WCVs, there have been few studies examining the perceptions of barriers and facilitators among families enrolled in home visitation programs. Current studies have instead looked primarily at at-risk mothers in general, without specification of enrollment in visitation programs.

The purpose of this study is to understand the perceptions of barriers and facilitators to WCVs among African-American women in this at-risk population. With WCVs providing crucial services such as vaccinations and screening, it is critical that infants maintain regular appointment schedules. Examining how these at-risk mothers perceive barriers and challenges is a crucial step in discovering why these mothers have different outcomes than other mothers who are enrolled in the same visitation program. Understanding this problem can lead to more effective home visitation curricula and higher rates of WCV adherence.
II. Literature Synthesis

The Problem of No-Shows: Rates and Barriers

Adherence Trends

The problem of well-child visit (WCV) no-shows is not a new one, and has been documented for decades. Data from the 1988 National Maternal and Infant Health Survey (NMIHS) show that only 51.7% of US infants born in 1988 attended all recommended WCVs in the first year of life (Ronsaville & Hakim, 2000). Analysis of the more recent 2000-2002 Medical Expenditure Panel Survey (MEPS) found that only 60% of all children received all well-child care over a period of 2 years (Selden, 2006). Chung et al. (2006) found in 2004 that privately insured infants attended 67% of recommended WCVs, with lower rates for Medicaid-insured infants (45%). The researchers also suggested that, though surveys may have underestimated the rate of adherence, many infants do not meet the recommended number of visits (Chung et al., 2006).

Additionally, these numbers are overall percentages of attendance and do not reflect the individual adherence rates of subpopulations. In many at-risk subpopulations, attendance rates are far lower (Selden, 2006). At-risk characteristics include low-income families, low levels of maternal education, families that lack a medical home, and mothers who received poor prenatal care. Insurance coverage also contributes to adherence rates. Children without any coverage have adherence rates of only 35.3% compared to 63% for children with insurance coverage (Selden, 2006). The lack of a medical home significantly hinders adherence, with such children attending only 26.9% of recommended visits (Selden, 2006).

In addition, different racial groups have different adherence rates. Ronsaville and Hakim (2000) found that white infants had a 58% rate of attendance, while African American and
Hispanic infants had significantly lower rates of 35% and 37%, respectively (Ronsaville & Hakim, 2000). Buescher et al. (2003) found that African Americans enrolled in Medicaid utilized preventive services, including well-child care, at a much lower rate than their white counterparts (Buescher et al., 2003).

**Barriers to Care**

Barriers to receipt of well-child care have been the focus of many studies seeking to understand why WCV recommendations are not being met. These studies have uncovered a variety of barriers, which can be generalized into two groups. In the first group are those barriers at the individual level, such as transportation difficulties and inconvenience for the mother. In fact, transportation and financial challenges appear to be the most common barriers to care (Pesata et al., 1999; Earle & Burman, 1998; Chung et al., 2006). Insurance coverage especially was important in influencing the rate of well-child care. The State Children’s Health Insurance Program (SCHIP), for example, was found to substantially increase well-child visits (Chung et al., 2006). Other barriers include perceived inconvenience of attending visits (Earle & Burman, 1998), inability to communicate with providers outside of appointments (Coker et al., 2009), and simply forgetting the appointment (Pesata et al., 1999).

In the second group are those barriers at the systematic level, such as fragmentation of health services. These are barriers that originate because of how the healthcare system is structured. Chung et al. (2006) found that continuity of care, i.e., a long-term relationship between patient and provider, strongly increased the likelihood of fulfilling WCV recommendations. Fragmentation of services, where a patient might be referred to multiple specialists, was also found to detrimentally affect well-child attendance because of traditional barriers such as transportation and financial issues (Amen & Pacquiao, 2004). Additionally, long
wait times can deter mothers of multiple children from keeping an appointment (Pesata et al., 1999), while the lack of providers can reduce the number of appointment slots (Earle & Burman, 1998).

The research also suggests that these barriers are not always exclusive to one another, with some barriers acting as the source for another barrier. Difficulties in obtaining transportation, for example, can originate from lack of money to purchase public transportation tokens. The barrier caused by fragmentation of services is further compounded by the need to arrange transportation to the referral, as well as the need to obtain money for the additional medical visit (Amen & Pacquiao, 2004).

**Strategies Addressing the Problem**

Given the severity of the non-adherence problem, numerous strategies have been proposed and attempted to address the issue. Interventions range from using patient-specific reminder mailings to changes at the local and practice level, and have been met by varying degrees of success. Personalized mailings, for example, were found to be no more effective than postcard reminders at achieving higher WCV rates regardless of race (Campbell et al., 1994). Among African-Americans, changes at the community, family, and practice levels (including improved communication between practices and implementation of home visitation programs) have shown promise, with an increase of appointment attendance from 37% pre-intervention to 57% post-intervention (Margolis et al., 2001). Utilizing focus groups to gather community input was found to be useful for identifying successful areas of well child care and those components that needed improvement (Coker et al., 2009).

Another strategy to combat no-show rates is the use of home visitation programs. Home visitation programs, when used to address other public health matters such as child abuse and
injury prevention, have achieved high degrees of success (American Academy of Pediatrics, 2009). However, the results have been more varied when visitation programs are used to address WCV adherence. Larson’s study on the effectiveness of prenatal and postpartum home visits found that there was no significant difference in WCVs between the intervention and control groups (Larson, 1980). In contrast, other studies show more promise. Hambidge et al. (2009) found that a stepped intervention utilizing home visitation focused on chronically non-compliant mothers resulted in an 18% increase of attendance rate when compared to the control group. In studies focusing on African-Americans, the results were just as varied. Home visitation intervention did not significantly change the rate of WCV utilization among African-Americans, although there was a 13% increase in immunization rates (Schuster et al., 1998). In another study, home visitations did increase well-child visit (WCV) rates among African-Americans, from 55.2% in the control group to 68.0% in the intervention group (Szilagyi et al., 2011).

Home visitation agencies linked with a pediatric provider have been shown to increase well-child care use (American Academy of Pediatrics, 2009).

**Missing Knowledge**

Despite the wealth of knowledge examining the causes behind WCV adherence, there are still gaps in knowledge. One such gap is the lack of studies examining the perception of barriers and facilitators to care among African-American mothers enrolled in home visitation programs. Because African-American mothers have a high no-show rate and are significantly affected by barriers, and because home visitation programs are a viable strategy to combat the no-show problem, it is important to understand how these mothers enrolled in a visitation program perceive barriers. For a similar reason, examining the facilitators to care is also important because this can reveal the perceived positive effects of visitation programs. This knowledge
can help refine or focus home visitation curricula, possibly making these programs more effective in promoting well-child care use.

Existing research has shown that major barriers include financial challenges and transportation, with understanding of well-child care also a contributing factor. Because home visitation programs tend to focus on education and changes to belief systems (American Academy of Pediatrics, 2009), it is suspected that many of the “physical” barriers such as transportation will still be present and “soft” barriers like perceived unimportance of well-child visits will be absent.
III. Research Methods

Research Design. A qualitative research study was conducted to assess the perceptions of barriers and facilitators to well-child visit attendance in at-risk African-American, first time mothers. The data for the study was obtained through a series of in-depth, semi-structured interviews with a sample of 10 first-time, at-risk mothers enrolled in the Every Child Succeeds (ECS) home visitation program. The general population of the ECS program is comprised of mothers who have at least one of the following four risk characteristics: unmarried, inadequate income (up to 300% of poverty level, receipt of Medicaid, or reported concerns about finances), less than or equal to 18 years of age, or received late or no prenatal care.

Subjects. Study subjects were selected from a pool of African-American mothers enrolled in ECS who attend the Avondale Moms on a Mission (AMOM) support group. Inclusion criteria were a residence with an Avondale zip code (45217, 45219, 45220, 45229), first time mother with a baby of 12 months to 36 months of age, and between 18 and 28 years of age. African-American mothers were selected as subjects for this study because all of the AMOM participants are African-American, and African-Americans have higher infant mortality rates and lower WCV attendance rates than other racial groups.

A total of 10 study subjects were selected. The sample size was selected for two reasons. First, it was believed that interviewing 10 subjects would reach the point of theoretical saturation where responses would be similar. A point of saturation appeared to have been reached after interviewing 10 participants. Secondly, the sample size was chosen because of limited financial resources supporting the study. Because subjects were compensated with grocery gift cards, the limited budget restricted the sample size to 10 individuals.
Study subjects were selected from the AMOM support group for several reasons. To avoid transportation being a hindrance to recruitment, the interviews were scheduled to occur on the same date and at the same location as support meetings. In addition, the AMOM environment provided a method for the researcher to build rapport with the participants before interviewing them. There was a concern that the responses would not be genuine because the potential participants would be distrustful of an unfamiliar researcher asking them personal questions.

The researcher participated in two AMOM meetings in order to gain the trust of the mothers and to identify an appropriate interview location within the church. To accomplish this, the researcher assisted with the AMOM meetings by helping with activities and talking with mothers to establish a relationship with them. The researcher also located an acceptable interview location near the back of the church. This area was secluded and set apart from the main meeting room, affording the researcher and participants some privacy. After gaining their trust, the researcher began recruitment.

Recruitment of subjects began by identifying mothers from the AMOM group who met the inclusion criteria by examining ECS records. The eligible mothers were selected at random from this group. At the AMOM meeting, these participants were asked if they would like to participate in the study. If they agreed, they were asked to review and sign a consent form (See Appendix A), and the interview was conducted. Interviews were conducted over the course of four AMOM group meetings. No participants refused to be interviewed.

Methods. Interviews were conducted at the AMOM support group meeting location, a local church, in a separate room to ensure privacy. This area was carpeted and brightly lit, with couches and other similar furniture along the walls. The interview area was set up with the
participant sitting at one side of a table and the interviewer on the other side. Children were left in the care of the mother's home visitor or were present during the interview. The interviews ranged in length from approximately 10 minutes to 20 minutes, with an average of 13 minutes.

The interviews were audio recorded. After transcription, the audio records were deleted. Subjects received a reimbursement in the form of a $20 gift card from a local grocery store chain upon completion of the interview.

The interview questions sought to examine the participants’ perceptions of the barriers and facilitators pertaining to adherence with WCV recommendations while enrolled in home visitation programs (See Appendix B). These questions obtained information about the subject’s (1) living conditions and general background information; (2) experiences with ECS and the home visitation programs; and, (3) experiences with her baby’s pediatrician and her views towards well-child visits.

The interview explored the constructs of “physical” and “soft” barriers. Physical barriers are those that physically impede access to care, such as transportation and scheduling difficulties. Questions such as the method of travel to the doctor’s office were asked to explore these barriers. Soft barriers are those that involve the mother’s beliefs towards well-child care. In order to explore this construct, questions probed the mother’s view of the purpose and importance of well-child care.

Data Analysis. Interview recordings were transcribed, and the transcripts were analyzed using content analysis to find trends in responses. One researcher, the study investigator, grouped together common trends/responses and assigned categories. Categories were based on the interview data, with some guidance coming from pre-existing knowledge. Observations were categorized primarily based on their relationship to the barriers and facilitators to well-child visit
attendance. A qualitative researcher experienced with analyzing qualitative data reviewed the transcripts and provided feedback.

Trustworthiness of the data was addressed in the following ways. Credibility was established through sampling saturation and taking constructs from the literature. Previous studies using non-home visitation program participants found that major barriers include transportation, financial, and time barriers; these served as guiding constructs for this study. Dependability was addressed by conducting the study over a brief period of time, approximately four months.
IV. Results

The interviews collected data on the participants' views towards well-child visits (WCVs) and the process of attending and scheduling these visits. Additionally, the participants were asked about the role the home visitation program played and its relation to attending WCVs.

Participant and Child Characteristics

Ten first-time mothers enrolled in the ECS home visitation program who were members of the Avondale Moms on a Mission group participated in this interview study. All of the mothers were African-American, compared to 33% of the ECS general population (Table 2). The participants' age ranged from 18 to 28 years, with an average of 23 years. The average age of ECS clients is 20 years. The age of the babies ranged from 12 to 30 months, with 24 months being the most common age. The age range of ECS children is 12 to 36 months.

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<th>Table 2. Participant Characteristics</th>
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<td><strong>Child Age Range</strong></td>
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<td><strong>Mom Age Avg</strong></td>
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Seven of ten mothers reported attending all scheduled WCVs, one reported missing one appointment and two reported missing three appointments. Of the three who missed appointments, only the mother who missed one appointment did not reschedule. It should be noted that none of the mothers scheduled enough appointments to meet the number of appointments recommended by the AAP for children under 3 years of age. Specifically, seven of the mothers scheduled one fewer WCV than the recommended number, while the other three scheduled two fewer appointments.
Perceived Purpose of Well-Child Care

<table>
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<th>Table 3. Perceived Purpose of WCV</th>
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<tr>
<td>Immunization</td>
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<td>Preventive care</td>
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<tr>
<td>Health tracking</td>
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<td>Health testing</td>
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<td>Answering questions</td>
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When asked what was the purpose of a WCV, participants responded with one of two commonly cited responses (Table 3). The first was administration of immunizations, cited by seven of ten mothers. Responses in this category dominated other types of responses. One woman said, "It's like to keep up with his shots and stuff." Another woman replied, "Getting her immunizations on time. It's a big priority because... without all her immunizations caught up to date, she can get real sick, especially with the flu." A third mother simply stated "for her [child's] shots." The responses did not indicate what types of routine immunizations were received during the WCVs, although two mothers did specifically mention seasonal flu shots.

The second was general preventive care, cited by three participants. One mother indicated WCVs were a critical tool in detecting future illnesses by saying, "If I don't go, and something comes up, and I think something's not right with him, and I take too long to get in, it may be something that could have helped in the beginning." Another mother echoed those thoughts by responding, "It might be too late for them to do something about it."

While immunizations and preventive care were the two most commonly given purposes of WCVs, mothers also indicated that WCVs played a role in answering questions they may have ("Ask any questions I feel I don't understand. [The home visitor] told me to ask questions."), and to run general tests ("[The doctors] want to do a test on them."). Additionally, one mother indicated that WCVs affected her son's education: "If [he]'s not healthy, he can't learn."
**Barriers to Care**

When asked about the barriers impeding WCV attendance, mothers responded with two common responses (Table 4). The first response was transportation issues. Seven mothers reported that taking a bus was their primary mode of transportation, or was used in combination with some other method, such as walking or accepting a car ride from friends or family. Of the mothers who utilized the bus system, four took a single bus route, while three made two transfers before reaching the doctor's office. Four mothers who endured two bus transfers or long bus rides (30 minutes to an hour) perceived going to the appointment as difficult, with one mother describing it as "very tough." When asked what might keep her from making a checkup, she responded, "I try to make it unless transportation is the only thing that stops me." Another mother who routinely rode the bus stated that "getting a car" would make attending the appointments easier because she would not have to "rely on anybody else." Finally, the cost of bus fare can be a hindrance, as one mother explained, "[We take the bus] if we have bus fare; if we don't, we walk it."

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<tr>
<th>Perceived Barriers</th>
<th>Perceived Facilitators</th>
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<tr>
<td><strong>Transportation</strong></td>
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<td>Lack of adequate transportation</td>
<td>Assistance with Transportation</td>
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<tr>
<td>Cost of bus fare</td>
<td>Assistance from friends/family</td>
</tr>
<tr>
<td>Number of bus transfers</td>
<td>Maternal Obligation</td>
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<td>Child's health</td>
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<td><strong>Work/Life Balance</strong></td>
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<td>Priority of Child in Life</td>
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<tr>
<td>Inconvenient office hours</td>
<td>Influence of Home Visitor</td>
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<tr>
<td><strong>Miscellaneous</strong></td>
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<tr>
<td>Long office waits</td>
<td>Reminder to attend WCV</td>
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<td>Overcrowded offices</td>
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<td>Strict attendance policies</td>
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Table 4. Perceived Barriers and Facilitators
Walking and receiving a ride from friends or family were the next two commonly used forms of transportation. Two mothers walked for about ten minutes before reaching the doctors' office, and car rides lasted about ten minutes as well. However, one mother reported walking nearly forty-five minutes before arriving at the doctor's office. She described the process as "not easy." When asked what could be done to help her, she suggested that doctor offices assist with transportation: "Provide a bus for people who live so far away."

The second frequently cited barrier was the difficulty of balancing life obligations with appointments. Four mothers responded that because they were either working or in school, the available days and times for well-child appointments were limited. One participant responded, "It's kind of tough because I go to school Monday through Thursday, and I don't want to be dropped as a student because I don't make it, so the only time I have to squeeze in all those Friday appointments." Another participant said, "Like it's kind of hard to fit time in, you know, I work and go to school, and sometimes you just don't have time to get in there, to get a free day to go do it."

There were other less frequently mentioned barriers that were cited as discouraging WCV attendance. One such barrier is the office wait experienced by two of the mothers: "Sometimes depending on how many people, patients they have to see, sometimes it usually takes a while before they get to me ... almost an hour." Another mother explained, "Sometimes they schedule like twenty or ten people, and they got to be at the appointment at once," resulting in a wait of about thirty minutes.

**Perceived Facilitators**

Participants were asked to explain what factors facilitated WCV attendance. Four things were most commonly cited by the subjects (Table 4). First, assistance with transportation proved
to be very helpful. One mother said, "If I was trying to make it there and it's hard to make it to my appointments, [the doctors] try to help me and give me as many [bus] tokens as they can."

Another mother said that she sometimes gets a ride with her uncle. There was a unique case where a mother had regular access to a car and always drove to the WCV. When asked about the difficulty of traveling to the doctor's office, she said, "I don't have any difficulties getting there or anything."

Second, personal responsibility appears to be another important facilitator. When asked why they did their best to attend WCVs despite the difficulties, these mothers uniformly responded that either maternal obligation or the health of their child was a significant motivating factor. One mother responded, "I'm responsible for my own child's doctor's appointment" and further explained, "I want to keep her healthy and strong, and I don't want her to be sick like some of these other kids."

The value or role the child played in the mother's life was a third facilitator. These mothers stated that the child is the largest priority in their lives. One mother, who walks thirty minutes to the doctor's office, explained why she will walk to an appointment even through harsh weather, "My daughter is the one reason why I do everything. The reason why I get up in the morning, the reason why I am breathing. She's my number one in everything." Another participant, when asked about remembering WCV appointments, emphasized her son's importance by stating, "I might forget my own [appointments], but not his." One mother, while explaining the difficulties of being a single mother trying to balance school, child, and other obligations, ended her explanation with, "It's kind of hard, but I try to make it for [him]."

The encouragement and assistance of the home visitor was a fourth facilitator. Subjects said that the home visitor provided them with advice, material support (e.g. diapers), and general
encouragement. One mother reported, "I do get a lot of help from my worker here. She does check to see if I need anything, if I need help in general ... If everything's okay." Another mother said, "I feel like [the home visitation program] helped me use all of my resources from day care to everything." Finally, five of the mothers reported that the home visitors did remind them of their well-child appointments: "Every two weeks we meet, and [the home visitor's] always like 'When's his doctor's appointment, have you been to the appointment yet?' She always writes it down."

While not expressly stated as a facilitator, all participants indicated that they liked their child's doctor. Seven mothers specifically mentioned the doctor's listening and communication skills. One mother explained, "She listens to me, she talks about things, we discuss things." Another mother responded with, "She gives me a chance to ask her questions, don't just tell me what to do and see you next time. She actually lets me ask her questions, since I might be concerned about something." Four mothers valued the interpersonal relationship between the doctor and them. One mother replied, "He's also my doctor, so we all already knew him since I was little." Another mother stated simply, "She just cares." Four specified that the doctor did a good job, and two responded that the doctor kept the WCV quick and short.

**WCV Appointment Scheduling**

Participants were asked how they scheduled WCV appointments and the method they used to keep track of these appointments (Table 5). Eight of ten mothers said they were able to schedule appointments either at the doctor's office or via phone, while two mothers specified that they were only allowed to call to make appointments and could not make appointments in person. None of the participants indicated that the scheduling process was a barrier.
The responses indicated that three primary ways were used to keep track of the appointments: reminder cards from the doctor's office, reminder phone calls, and calendars. The mothers indicated that they used a combination of these methods. Three mothers indicated they relied on the reminder cards and the phone call to keep track of the appointments, while three said they utilized a calendar and the phone call. Three mothers used all of the three methods. One mother indicated that she relied solely on her memory, and when asked to explain, she said, "I remember [the appointments]. When it's about him, I remember him. I might forget my own, but not his."

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<th>WCV Schedule Methods</th>
<th>WCV Appointment Tracking</th>
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<td>Schedule at doctor’s office</td>
<td>Reminder card + reminder call</td>
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<td>Schedule over the phone</td>
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<td>Schedule only over the phone</td>
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V. Discussion

Ten African-American, first-time mothers were interviewed to examine the perceived barriers and facilitators towards well-child visits (WCV) among mothers enrolled in home visitation programs. Unlike previous studies, this study is unique in that it focuses specifically on African-American mothers involved in a home visitation program and participating in the Avondale Moms on a Mission (AMOM) support group. Additionally, this was a qualitative descriptive study involving one-on-one interviews, which differs from previous studies that utilized focus groups or surveys. While focusing on the perceptions of barriers and facilitators, the study also investigated other factors that might influence these perceptions, including patient-provider relationships, how WCV appointments were scheduled, and how participants kept track of WCV appointments.

Among the participants, WCV attendance rates did not appear to be a problem. Seven of the ten interviewed mothers reported attending all of their scheduled WCV appointments. Compared with the broader population, the 70% attendance rate for the study subjects is higher than the 35% attendance rate found in the general African-American population (Ronsaville & Hakim, 2000), and is also higher than the 60% found in the general population (Selden, 2006). The results do not clearly indicate whether this higher rate is caused by participation in the home visitation program, the nature of the study subjects, or other factors not investigated. It is hypothesized, however, that the subjects’ high motivation driven by the value and priority of their child allowed them to overcome the traditional barriers (e.g. transportation problems) and maintain a high rate of attendance.

The lack of convenient transportation was cited by participants as a primary hindrance towards attending WCVs, which is consistent with findings in the existing literature (Pesata et
al., 1999; Earle & Burman, 1998; Chung et al., 2006). However, despite this barrier, all of the mothers made the majority of their scheduled appointments and missed appointments were not necessarily due to the inability to find adequate transportation. In fact, only three of the ten participants reported missing any of their scheduled appointments. This finding is interesting because it shows that, in this population, transportation issues may be perceived as more of an inconvenience towards attendance rather than actually preventing mothers from attending the appointment. The responses from the mothers who missed an appointment may support this idea. For example, one mother whose trip to the doctor's office included an hour bus ride explained that she missed her appointment because of personal illness and not the long bus ride.

This finding may be linked with the finding that participants universally viewed maternal obligation and the value of the child as very high priorities. These characteristics were not presented in previous literature, and may serve as significant facilitators towards attending WCVs, as evidenced by many of the mothers' responses. For example, the mother who walks over 30 minutes to the doctor's office does so for the sake of her daughter's health. Another mother places such high priority on her son's appointments that she will always remember his, even at the expense of her own. If these motivations are very strong, they may trump whatever challenges problematic transportation may bring, resulting in higher rates of WCV attendance. As a result, the mothers may perceive transportation problems as inconveniences rather than impenetrable barriers.

The valuing of the child may have been fostered by the encouragement and presence of the home visitors, although the potential link was not mentioned by the mothers. Similar results were found in previous studies, which showed that the maternal behavior (e.g., mother's positive emotional involvement with baby) of mothers improved when enrolled in intensive home
visitation programs (Larson, 1980). The participants uniformly expressed the positive relationship between their home visitors and them, and the value provided by the ECS program. The mothers indicated that the home visitors provide both moral and material support, as well as offering advice and teaching them how to best foster their child's growth. For example, one mother indicated that her home visitor "had her back" even when she was on the cusp of giving up.

Another interesting finding is the universal like the participants had for their child's pediatrician. All of the interviewed mothers indicated that they liked their child's pediatrician and had a positive relationship with the provider, specifically mentioning the relationship with the doctor and the doctor's communication skills. While the mothers did not expressly indicate that this patient-provider relationship was a facilitator, the high regard they held for the doctors may have played a role in the otherwise relatively high adherence rates to WCV appointments. Additionally, existing literature does support the idea that strong patient-provider relationships substantially increase the likelihood of fulfilling WCV recommendations (Chung et al., 2006).

Ultimately, the results show that the participants are a motivated group who place a high value on the value of their child and their obligations as a mother, and are willing to go to great lengths to maintain the health of their child. Even though they faced some similar barriers as other mothers, such as transportation and difficulty balancing life obligations, they were able to overcome these barriers and maintain a high rate of WCV attendance. This motivation may have been fostered by their home visitors, whom the mothers routinely spoke highly of, and were valued for their insights and moral/material support.
Contributions

The findings show that despite being at-risk African-American mothers, the participants maintained a high level of adherence to scheduled WCV appointments, unlike the general African-American population. This suggests that when properly guided, such as through home visitation programs and support groups, these mothers can overcome significant barriers such as transportation barriers.

Studying this population has brought to light some findings not presented in previous literature. First, the findings show that the mothers view transportation barriers as an inconvenience and not as a preventer of WCV attendance, which is contrary to what is presented in previous studies. Instead of missing WCVs because of transportation barriers, these mothers found ways to work around the problem. Additionally, the mothers indicated that maternal obligation and perceived value of their baby served as significant facilitators, to the extent that they allowed the mothers to overcome significant barriers. Previous studies did not report on this type of intrinsic motivation within the participants.

Additionally, the results affirm that there are some overlaps between the barriers faced by mothers enrolled in home visitation programs and mothers who are not enrolled. Difficulty securing adequate transportation is one such shared barrier. Another barrier similar to both groups is dissatisfaction with the wait times at the doctor’s offices. The study also shows that both types of mothers share some similar facilitators. The most evident of these is assistance with securing transportation.

Limitations

There are several limitations of this study. First, there was an issue with theoretical sampling. The interviewed mothers all had high rates of WCV attendance. As a result, the
responses may not represent the full range of possible responses because those mothers with chronic attendance problems were not selected and interviewed.

Secondly, the participants are not only enrolled in a home visitation program, but are also involved in the AMOM group, which is an ECS-sponsored support group. Participation in an additional support group outside of the ECS home visitation program is not the norm for the overall ECS population. More importantly, these mothers may be different in that they may be more motivated in general than the broader at-risk, first time mothers population. As a result, the participants of the study may be predisposed towards attending WCVs, and their perceptions of barriers and facilitators may not be representative of the greater population.

The sample size and selection method may also be limitations. A sample of 10 participants limits the ability to generalize the findings to a population that differs from the demographics of the study group. Additionally, because the sample pool was limited, participants were selected based on who was attending the support group at any given meeting. This may have resulted in selection of more motivated mothers who prioritized attending the AMOM meeting.

Another limitation of this study is that of anonymity. Because the study used a series of personal interviews with the subjects, there is the risk that the participants may not have responded entirely honestly. Participants may have been intimidated by the researcher, or because the researcher spent time getting to know them, they may have been wishing to give a good impression. As a result, the responses may not have been entirely genuine.

**Implications for Clinical Practices**

The results of this study suggest that there may be some areas for consideration by pediatric practices. First, because many of the mothers were either full-time students or
employed, they found it difficult to balance WCV appointments with life obligations. This suggests that pediatric offices may need to be more flexible when working with at-risk mothers in order to encourage WCV attendance. For example, practices can consider extending office hours or offer weekend hours to those mothers who cannot schedule an appointment during regular times.

Secondly, the participants universally responded positively towards their child’s pediatrician. Of particular note is that when asked what traits they specifically liked about the provider, mothers most commonly responded that they appreciated the doctor’s listening skills and willingness to take time to answer questions. These responses support the previous finding that longer visit times are associated with increased likelihood of attending WCVs (Chung et al., 2006). While significantly increasing appointment times may not be feasible, physicians and other health professionals (e.g. nurses) should attempt to spend as much time as possible answering questions and developing meaningful relationships with mothers.

Finally, because transportation still appears to be a major barrier, assisting with transportation may help alleviate this difficulty. As indicated by participant responses, assisting with bus fare or taxi vouchers can be of great help. Because the costs of such an assistance program may be prohibitive, a previous study suggested that clinics be taken to the patients (Pesata et al., 1999). Clinics could be held in nearby community centers to lessen the transportation burden borne by the mothers.

**Implications for Home Visitation Programs**

There are several avenues on which home visitation programs can focus. First, mothers highly valued the personal relationship developed with the home visitor, and cited the social support and parenting advice as very helpful and encouraging. The findings emphasize how
important it is for home visitors to act as more than just a guide or advisor, but also to fulfill the role of friend or role model. Doing so develops trust between the client and the home visitor, and from there positive moral support can develop. Also, in addition to providing parenting advice, home visitation programs can consider teaching mothers how to utilize local resources. Doing so may help the mothers develop independent thinking and problem solving skills to overcome some of the barriers they may face.

Additionally, because maternal obligation and increased priority of the child were strong motivators, home visitation programs should explore opportunities to foster these qualities in their clients. Mothers reported overcoming transportation barriers because they placed such a high value on their child, so tailoring home visitation programs to develop this quality could help client mothers successfully combat the barriers they may face. Teaching the reasons for WCVs and the importance of regularly attending these appointments, along with emphasizing how WCVs directly benefit the child's development may be avenues for developing these qualities.

**Recommendations for Future Research**

The findings of the study illustrate the need for future research in several areas. First, while transportation problems remain a major barrier, the study participants still managed to attend the majority of their scheduled WCVs. Unlike in previous studies, the transportation barrier appears to be more of an inconvenience than a preventer of attendance. This effect was not fully investigated in this study, and future research should examine how exactly mothers in a similar population are affected by transportation barriers, and why some populations are able to maintain high rates of WCV attendance while others are not. Fully exploring this effect may be beneficial in developing programs to assist mothers in overcoming transportation barriers.
Secondly, many of the mothers cited a strong, internalized sense of maternal responsibility as a key motivator towards attending WCVs, which was not found in previous research. Examining how this quality was developed and how much of a role it plays in overcoming adversity can be important in understanding how different populations may respond to barriers and difficulties. If maternal obligation and perceived value of the child are found to significantly affect WCV rates, home visitation programs and other similar curricula can be tailored to foster these perceptions.

Additionally, the interviewed mothers were participants of the AMOM program, as well as the ECS home visitation program, and had high WCV attendance rates. It is recommended that future research compare AMOM with non-AMOM participants, explore the effectiveness of a support group similar to the AMOM program, and how the support group affects WCV attendance and perceptions of barriers and facilitators in conjunction with or independent of home visitation programs. Understanding the positives and negatives of each type of program may lead to better application of resources and development of similar programs.

Future studies should also examine those mothers who have low rates of WCV attendance. The participants in this study all had high attendance rates, so the results may not be representative of the full range of responses. For example, those mothers with low attendance rates may not be as motivated by a sense of maternal responsibility, or they may view barriers in a completely different fashion.

Additionally, this study did not explore why WCV attendance rates were higher in this group than in the general African-American, at-risk population. While this study's findings suggest that the increased rate may be due to the mother's sense of maternal responsibility and participation in the support group and home visitation programs, the results do not clearly
indicate what factor is the cause. As a result, future studies may wish to examine the causes behind this finding.

Finally, most research has focused on the mother's perceptions of barriers and facilitators, while ignoring the role the father plays in the child-rearing process. It would be interesting to examine what effects the presence of the father in the household has on the mother's perceptions towards these barriers and facilitators. Similarly, examining how family, friends, and other social support structures influence WCV attendance rates and the mother's ability to overcome barriers and utilize facilitators may also provide further insight on the field of WCV attendance.
References


Appendix A: Consent Form

Adult Consent Form for Research
University of Cincinnati
Department: Family and Community Medicine
Principal Investigator: Alexander Lee, BA
Faculty Advisor: Robert Ludke, Ph.D.
(513) 293-9940 / Leeax@mail.uc.edu

Title of Study: Adherence with Well-Child Visits by Mothers in a Home Visitation Program: Perceived Barriers and Facilitators

Introduction
You are being asked to take part in a research study. Please read this paper carefully and ask questions about anything that you do not understand.

Who is Doing this Research study?
The persons in charge of this research study are Alexander Lee, BA of the University of Cincinnati (UC) Department of Family and Community Medicine. He is being guided in this research by Robert Ludke, Ph.D.

What is the purpose of this research study?
We are looking at the views mothers have on taking their child to the doctor, and what makes going to these visits easier or harder. We would like to interview you to get your opinion on these doctor visits.

Who will be in this research study?
Up to 17 people will participate in this research study. You may be in this study if the following are true:
- You are over 18 years old.
- You have an Avondale zip code (45217, 45219, 45220, 45229).
- You are a first time mother with a baby of 12 to 36 months of age and enrolled in Every Child Succeeds.
- You are either a single mother, have low income or received late or no prenatal care.

What will you be asked to do in this research study, and how long will it take?
You must sign this consent form before answering any questions. An interviewer will ask you questions in a private area of the church. The questions will focus on your interaction with your baby's doctor and your views on going to the doctor appointments. Your answers will be recorded by a digital audio recorder. You must agree to be audio recorded in order to participate. You have the option of stopping the interview at any time. The interview will take about 30 minutes.
Are there any risks to being in this research study?
You may feel some discomfort because of the questions being asked. You can choose to stop answering questions at any time. Also, you do not need to answer any question that you do not want to answer. You are at risk of loss of some privacy if persons other than yourself and the researchers listen to the recorded answers or read the interview transcripts. However, we will make every effort to keep your answers confidential.

Are there any benefits from being in this research study?
You will not receive any direct benefit from being in this study. However, your participation may help the researchers understand barriers to well-child visits with first time mothers.

What will you get because of being in this research study?
You will receive a $20 Kroger gift card for participating in this study. You will receive the gift card at the end of the interview. You will receive the gift card even if you choose not to answer all of the questions.

Do you have choices about taking part in this research study?
You may choose to not be in the study. Taking part in the study, or saying no, is up to you.

How will your research information be kept confidential?
No one except the research team will see or hear your answers. Your name will be removed from the audio recording and the audio recording of the interview will be destroyed at the end of the study.

The results from the study may be presented at meetings or published. However, you will never be identified by name.

Agents of the University of Cincinnati may inspect the study records for audit or quality assurance purposes.

What are your legal rights in this research study?
Nothing in this consent form waives any legal rights you may have. This consent form also does not release the investigator, the institution, or its agents from liability for negligence.

What if you have questions about this research study?
If you have any questions about this study, you may call Alex Lee at 513-293-9940. Or you may contact Robert Ludke, Ph.D. at Robert.ludke@uc.edu.

The UC Institutional Review Board (IRB) reviews all research projects that involve human participants to be sure the rights and welfare of participants are protected.

If you have questions about your rights as a participant or complaints about the study, you may contact the Chairperson of the UC IRB at (513) 558-5259. Or, you may call the UC Research Adherence Hotline at (800) 889-1547, or write to the IRB, 300 University Hall, ML 0567, 51 Goodman Drive, Cincinnati, OH 45221-0567, or email the IRB office at irb@ucmail.uc.edu.
**Right to Refuse or Withdraw:** Being in the study is entirely up to you. You may refuse to be in the study or may stop taking part in the study AT ANY TIME, without any penalty. Refusing to be in the study will not affect in any way the support you receive through the AMOM support group or through Every Child Succeeds.

We have the right to stop you from being in the study AT ANY TIME. This may be for reasons related solely to you (for example, not following directions) or because the entire study has been ended.

**Agreement:**
I have read this information and have received answers to any questions I asked. I give my consent to participate in this research study. I will receive a copy of this signed and dated consent form to keep.

___________________________________________  __________________
Participant Name (Please Print)  Date

___________________________________________  __________________
Participant Signature  Date

___________________________________________  __________________
Signature and Title of Person Obtaining Consent  Date
Appendix B: Interview Questions

Hello, my name is Alex Lee, and I’m currently a graduate student at the University of Cincinnati. I’m working on a research project to gather feedback from mothers on their experiences with doctor visits for their babies.

This interview will take about 15 minutes. You can stop the interview at any time.

The interview will be audio recorded. This will simply make my job a bit easier as I can focus on talking with you instead of taking notes. Any time you want to, I can stop the digital recorder. I will be transcribing the interview, and any identifying information such as your name will be replaced with a code. This will keep your identity confidential. After I transcribe the recording, I will delete the recording.

Do you have any questions?

Background
1) May I address you by your first name?
2) How old is your baby?
3) Is your baby a boy or a girl?
4) What’s your baby’s name?
5) In general, would you say that your baby’s health is excellent, very good, good, fair, or poor?

Doctor-related Questions
1) Do you have a regular doctor that you take your baby to for checkups or when (he/she) is sick?
2) How far is his/her office located from your home?
   a. How do you typically get to the doctor’s office?
3) How easy or difficult is it to get to your baby’s doctor? Please explain.
4) What do you like about your baby’s doctor? What do you dislike about your baby’s doctor?

WCV Questions
1) Since (Baby’s Name) was born, how many times have you taken your baby to the doctor?
   a. Were these for sick visits or regular check-ups?
2) Were there times when you had problems getting an appointment to see the doctor? Please tell me about the problems you had.
3) Were there times when you had problems getting to the doctor’s office? Please tell me about the problems you had.
4) Were there times when you had problems once you were at the doctor’s office? Please tell me about the problems you had.

5) What would make taking your baby to the doctor easier for you? What should the doctor’s office do to make seeing the doctor easier and more enjoyable?

6) In general, how easy or difficult is it for you to take your baby to the doctor when your baby is sick? Please explain why?

7) Did the doctor ever talk to you about a schedule of checkup visits for your baby? These would be visits to the doctor for a checkup when your baby is not sick. If yes, can you tell me what the doctor said about bringing your baby in for a checkup?

8) Did anyone at Every Child Succeeds ever talk to you about a schedule of checkup visits for your baby? If yes, do you remember what they told you?

9) Was there a time when you were not able to make it to the doctor’s office for one of the checkups? Please tell me about why you were not able to make it to the visit? What could have been done differently for you to make the visit?

10) Do you know when you need to take your baby to the doctor for the next checkup?
   a. How do you keep track of these visits?
   b. Does the doctor’s office remind you? If so, how do they remind you?
   c. Does anyone at Every Child Succeeds remind you? If so, how do they remind you?

11) What would keep you from taking your baby for this checkup visit? What could be done to make it easier for you to take your baby for this checkup visit?

12) Is there anything else that I should know that would help mothers like you with taking their children to the doctor for checkup visits? When the child is sick?

Conclusion

1) That’s all the questions I have for you. Do you have any questions for me? Thank you, (Participant's Name) for your participation.