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## Women's Perceptions of Postpartum Appointment Keeping Barriers

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**WOMEN'S PERCEPTIONS OF POSTPARTUM  
APPOINTMENT KEEPING BARRIERS**

**By**

**Carol L. Czuk**

**A THESIS**

**Submitted to  
Grand Valley State University  
in partial fulfillment of the requirements for the  
degree of**

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**1997**

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## **ABSTRACT**

### **WOMEN'S PERCEPTIONS OF POSTPARTUM APPOINTMENT KEEPING BARRIERS**

**By**

**Carol L. Czuk**

An exploratory, descriptive design was used to examine women's perceptions of barriers that inhibited them from keeping their postpartum appointments. The Health Belief Model (HBM) was used as a theoretical framework, with special attention to the barriers dimension. A three-part survey consisting of basic demographic questions, a five point response scale for assessment of perceived barriers, and open-ended questions were used for data collection. A convenience sample of 15 women in a rural southwestern Michigan community who had not kept their postpartum appointment by the sixth week after delivery were included in the study. Data were collected by a structured telephone interview method. The results of the study reveal that a low value attached to postpartum care and logistical (access to care) barriers posed the greatest threat to obtaining postpartum care in the group studied.

## **Dedication**

**Dedicated in remembrance of my mother, B. Lawain Gokey [1934-1996], who stressed upon me at an early age the importance of an education.**

## **Acknowledgments**

**I would like to personally extend my sincere appreciation to Patricia W. Underwood, Ph.D., R.N., the chairperson of my thesis committee. Her knowledge, insight, expertise, and support have been instrumental in my continued education efforts.**

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## CHAPTER ONE

### INTRODUCTION

Lack of adequate and comprehensive maternal care has been a growing concern in this country. Several researchers (Brown, 1988; Ingram, Makuc, & Kleinman, 1986; Singh, Torres, & Forrest, 1985) have addressed it, and state and national programs have been developed to remove barriers to access to care. Unfortunately, little of this concern has focused specifically on health care needs in the postpartum period. Recent studies (Buckley, 1990; Ghilarducci & McCool, 1993; Weinman & Smith, 1994) indicate that only half of the women in the groups studied kept their postpartum appointments. This behavior has many obvious drawbacks and sparks great concern by maternal and family planning care providers. Postponing or missing the postpartum visit can result in potentially negative health effects, not the least of which is the delay or lack of contraception. Pregnancy occurring within one year of a delivery increases the risk of maternal-fetal morbidity and mortality and can stress the financial and emotional reserves of the family. It can take up to two years to replace iron stores lost in pregnancy, and iron deficiency in pregnancy has been associated with poor perinatal outcome as well as a detriment to the overall health and well-being of a woman. The World Health Organization recommends that pregnancies be spaced 2-3 years apart to allow complete pregnancy resolution and return to optimal health and functioning. In addition, spacing of pregnancies is a good way to gradually adjust to the changing structure and needs of a

growing family. Preventive care is of prime importance in the growing family. Many physiologic and psychologic changes occur during and after pregnancy, and early identification of problem areas can facilitate action or adjustment and avert complications.

Key features of the postpartum visit: parenting guidance; self care; infant care; contraception; breastfeeding; identification of social and health problems; and reestablishment of a regular pattern of health care are lost when an appointment is missed. Missed appointments also tax the health care system as a whole. It is likely that missed appointments contribute to health outcomes that significantly burden the health care system. The longer the period between health care contacts, the more likely that problems will remain undiscovered and increase in severity. Clients who miss appointments also require a great devotion of time and resources to recover them back into the health care system. Often this task is time-consuming and formidable.

In reviewing the literature, it was found that few studies existed that specifically addressed postpartum appointment keeping behaviors. Four recent studies conducted by Buckley (1990), Ghilarducci and McCool (1993), Kogan, Leary, and Schaetzel (1990), and Weinman and Smith (1994) will serve as a basis for further exploration into these behaviors. Other similar earlier studies will be examined also. In addition, several indirect correlates to postpartum care will be reviewed, namely, studies addressing prenatal and general medical appointment keeping behaviors.

Maximum gains in health promotion require active collaboration of the recipient and provider. It is responsibility of the provider to ensure that the content of care addresses the perceived needs of the recipient and is delivered in a manner and format that ensures its accessibility. Recipient's must take responsibility to make their needs known

and mutually participate in the goal setting process. To actualize this philosophy, it is essential to understand the factors that influence a women's appointment keeping behavior. The main focus of this study was the reasons given by postpartum women for not attending postpartum appointments. Women who had not completed a postpartum visit by six weeks post-delivery were surveyed. Demographic and situational variables were also be collected to get a better perspective of the population being studied.

The purpose of the study was to identify barriers perceived by women to relate to their appointment keeping behaviors. The Health Belief Model (HBM) was the theoretical framework in which this phenomena was viewed. The results of this research will aid maternal and child health providers and educators to improve postpartum care outcomes by better planning of community outreach which will improve continuity of care.

## **CHAPTER TWO**

### **THEORETICAL FRAMEWORK AND LITERATURE REVIEW**

#### **Theoretical Framework**

The Health Belief Model (HBM) will be used as the theoretical framework for this study. The HBM is a psychosocial compliance model developed to explain health-related behavior at the level of individual decision making. The model originated in the 1950s by Hochbaum, Kegeles, Leventhal, and Rosenstock (Becker, 1974). The model grew out of several research projects that investigators of the Public Health Service confronted between 1950 and 1960. Thus, theory development and the model grew simultaneously with the solution to the problems. The model serves to analyze an individual's motivation to act as a function of the expectancy of goal attainment in the area of health behavior. It assumes that motivation is a necessary condition for action and that motives selectively determine an individual's perceptions of the environment.

The HBM assumes that the subjective world of the perceiver determines behavior, and the objective environment comes into play only as a representation in the perceiver's mind. The model places more emphasis on the current subjective state of the individual than on historical antecedents. However, recent reformulations have begun to place more emphasis on prior experience and interpersonal relationships.

Since its origination, the HBM (Becker, 1974) has been used to explain behavior as a result of the combination of attitudes and beliefs related to four basic concepts:

perceived susceptibility, perceived severity, perceived benefit, and perceived barriers.

Recent reformulations have expanded and clarified the HBM to include all preventive actions, illnesses, and sick-role behaviors (Figure 1). Over the past three decades, the four basic concepts have taken on new breadth to make the HBM one of the most influential and widely used psychosocial approaches to explaining health-related behavior (Rosenstock, 1990):

1. Perceived susceptibility refers to a person's view of the likelihood of experiencing a potentially harmful condition. In recent years this has been expanded to explain health behaviors in those with already established illness to include acceptance of diagnosis, personal estimates of resusceptibility, and susceptibility of illness in general.
2. Perceived severity (seriousness) represents the degree of emotional arousal or difficulty that an individual believes a given health condition may create for them (e.g. the consequences of contracting a disease). This dimension includes evaluations of both medical/clinical consequences and possible social consequences.
3. Perceived benefit focuses on the efficaciousness and feasibility of a specific behavior in reducing the threat of the health condition.
4. Perceived barriers relate to the negative aspects of the anticipated behavior (e.g., perception of physical, psychological, social, economic, and other costs), and may act as an impediment to undertaking a recommended health behavior. Recent research has also demonstrated the importance of the variables of social approval taken from the works of Ajzen and Fishbein (1980) and self-efficacy taken from the works of Bandura (1977) as logical refinements of the benefits and barriers dimension. Rosenstock, Strecher, and Becker (1988) go as far as to propose that adding self-efficacy as an independent

# The Health Belief Model

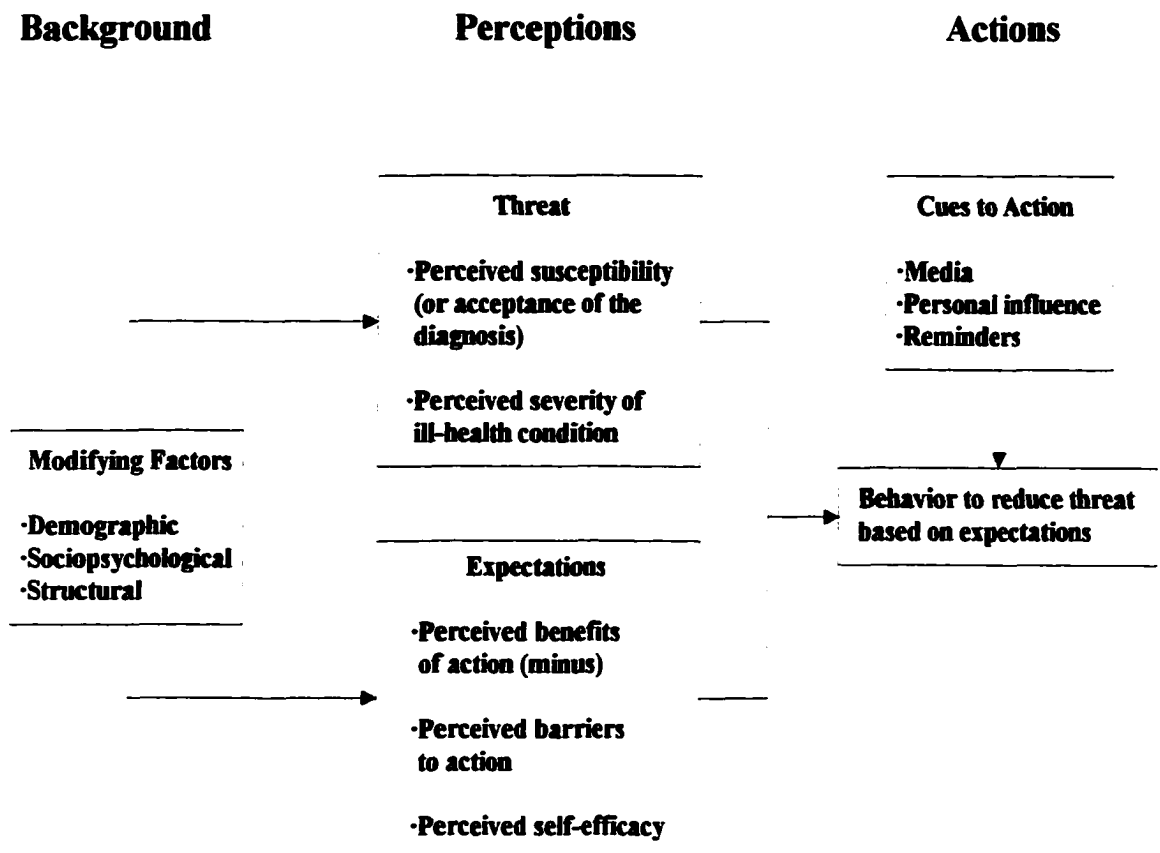


Figure 1. The Health Belief Model (adapted from Rosenstock, Strecher, and Becker, 1994)



variable along with traditional health belief variables, would delimit the barriers dimension.

In essence, the model asserts that individuals will take action to ward off, screen for, and control ill-health conditions if they regard themselves as susceptible to the condition, if they believe it to have potentially serious consequences, if they believe that a course of action available to them would be beneficial in reducing either their susceptibility to or the severity of the condition, and if they believe the anticipated barriers to (costs of) taking an action are outweighed by its benefits and they feel competent to implement the behavior needed to accomplish the desired outcome (Rosenstock, 1990). The combined levels of susceptibility and severity (perceived threat) provide the energy or force to act and the perception of benefits (minus barriers) provides a preferred path of action (Becker, 1974).

Perceived barriers has been the most powerful single predictor of the HBM across all studies and behaviors (Janz & Becker, 1984) . While both perceived susceptibility and perceived benefits are important, perceived susceptibility is a stronger predictor of preventive health behaviors. Overall, perceived severity has been the least powerful predictor and is most strongly associated with sick-role behaviors. Janz and Becker (1984) have developed significance ratios for the HBM dimensions. They examined the number of positive and statistically significant findings for the HBM dimensions and divided them by the total number of studies done that reported significance levels. The best results are in the barriers dimension (89%), followed by susceptibility (81%), benefits (78%), and severity (65%).

In addition to the four original concepts, health motivation has been incorporated into the model. The original model dealt only with the negative aspects of health, namely, threat of disease or condition. The addition of health motivation suggests that positive

health motivation exists and accounts for some portion of health-related behavior. Health motivation refers to a generalized state of intent that results in behaviors to maintain or improve health. Health motivation can be expressed in concern about general health matters, intent and willingness to seek and accept care, attitudes toward medical providers and the health care system, as well as preventive health care orientation.

The HBM was predicated on the premise that "health" is a highly valued concern or goal for most individuals. All five concepts have been tested individually and in combination and have shown significant predictive ability (Becker, Haefner, Kasl, Kirscht, Maiman, & Rosenstock, 1977). While it is assumed that diverse demographical, sociopsychological, and structural factors can affect an individual's health motivations and perceptions, these variables are not seen as directly causal for health action. A readiness to take action as well as internal and external "cues to action" or triggers are also felt to be necessary and widely prevalent in order to initiate appropriate health behavior.

As mentioned earlier, the addition of the concepts of self-efficacy and social approval have allowed for further refinement and increase in the explanatory power of the benefits and barriers dimensions. For a person to implement a behavior change for health-related reasons, they must believe in the expected health benefit and also believe that they are capable (self-efficacious) of making the change. In order to do so they must possess at least minimal levels of relevant health motivation and knowledge to understand a recommendation. A history of previous successes and failures may impact a person's feelings of self-efficacy to take on a new health-related behavior change as a benefit or barrier. Engaging in a socially-approved behavior (e.g., jogging) may be perceived as a benefit, while engaging in a socially disapproved behavior (e.g., a teen seeking

contraceptive advice) might prove to be a barrier (Janz & Becker, 1984). Inclusion of these concepts further defines the impact that internal forces (e.g., attitudes and beliefs) and external forces (e.g., reference group or social position) together have on preventive health behaviors.

The HBM provides a framework to explain preventive health behaviors. Its motivational and attitudinal elements also serve to explain illness behaviors (sick sole behaviors). Health-related behavior is a particularly relevant topic for nurses. A thorough understanding of such behavior is essential to obtain cooperation and participation of clients in their own care. The HBM is one approach that may help us to more fully understand health-related behaviors and provide a mind set from which to work to attempt to influence behaviors of clients. By having a better understanding of our client's motives and beliefs, we can provide care tailored to fit their needs.

The HBM can easily be modified and adapted to predict and explain postpartum appointment keeping behaviors. By better understanding the motives and health beliefs of postpartum women, we can more appropriately attempt to influence their behaviors and help educate them as to the benefits of these behaviors. Barriers to action can be evaluated in terms of resources available and assistance can be offered to develop strategies for handling barriers.

The HBM is a partially developed model in need of further refinement. Nurses, by virtue of their numbers and amount of patient contact, have great potential to influence health-related behaviors. Nurses can make important contributions to the development of the model by refining and testing the model in clinical situations with various populations. For models to be of value to public health, they must be tested in real situations. Nurses

herein hold the key. Nurses can operationalize the HBM concepts, and with the addition of their technical expertise, can add substance to them. Improvements in theory and practice must go hand in hand.

General health motivation can be assessed during any nurse-client interaction. The concept can then be measured and interventions for belief change developed as deemed necessary. The model can also serve as a valuable tool to identify clients with potential for noncompliance.

A limitation of the HBM addressed in the literature (Janz & Becker, 1984), is the need for further evaluative research aimed at providing strategies for necessary improvement and individual acceptance of health-related recommendations, and for the reduction of the deleterious effects of noncompliance. Perhaps future research will be aimed at such a provision. The model is further limited, in that it can assist one to explain health-related behaviors only to the extent that can be explained by attitudes and beliefs. It is evident that other factors influence health actions as well; for example: behaviors with a habitual component, behaviors undertaken for other than health reasons, and economic and environmental factors that inhibit behavior change. Modifiers as such, may include sociodemographic attributes, psychosocial, and structural factors ( Bluestein & Rutledge, 1993). Actions that are largely motivated by health matters tend to be more successful than those that simultaneously satisfy a variety of motives (Haefner & Kirscht, 1970). For the purpose of understanding postpartum appointment keeping behaviors, the HBM provides valuable insights into the reasons (barriers) for less than optimal rates of postpartum appointment keeping.

The need also exists for standardization and refinement of tools to measure HBM dimensions. For the most part, individual investigators studying the HBM have developed unique approaches to operationalize the variables. In spite of this, the model has proven to be predictive, a sure sign of its robustness. Another important area of possible future focus may be on practitioner and health care delivery system variables influencing health beliefs. For the purpose of this study, only the barriers dimension will be addressed.

### Literature Review

Since its inception, the HBM has been tested extensively in attempt to explain preventive health practices, health screening behaviors (e.g., breast self-exam, immunizations, routine dental care, and prenatal care), risk factor behaviors (e.g., obesity, smoking, and regular physical activity), sick role behaviors (e.g., medication taking and antihypertensive and diabetic regimen compliance), and so forth. It has not been used to specifically explain preventive health care practices of postpartum women. However, studies have been done that identify barriers for postpartum women that easily lend themselves to interpretation within the theoretical framework of the HBM. A look at some studies done in relation to prenatal care and general medical appointment keeping behaviors will also further enhance this interpretation.

Physiologically, the postpartum period is the interval between the termination of labor and the return of the reproductive organs to their normal nonpregnant state, generally by the sixth week. It is a time of significant anatomical, physiologic, endocrinologic, psychologic, and social change. It is often referred to as the fourth trimester. This time frame encompasses one of the most difficult periods of a woman's lifetime. A mother is sent home to involute, heal, and rest. Yet, most mothers experience

great fatigue and some degree of crisis in relation to their personal needs and family relationships. In one study, only 72% of vaginally-delivered women and 43% cesarean-delivered women reported having regained usual energy levels at six weeks postpartum and 20% had not returned to their usual household activities (Tulman & Fawcett, 1988). An obvious gap exists in health services for new mothers in this period. The postpartum health needs of new mothers from the time of hospital discharge to their postpartum follow up visit go largely unmet. Often, mothers lack effective and available resources, guidance, and support.

It is not just wellness care that is inadequate during the postpartum period. The first year post-delivery is a time when mothers experience many acute care problems (Gjerdingen, Froberg, & Kochevar, 1991). The health care system, as it is currently organized, is based on an assumption that after childbirth women take only a short time to recover and are then essentially well. Research does not support that assumption (Jones & Parks, 1990). The traditional six week recovery period after childbirth, upon which health policy has been based may not be adequate for most to return to prepregnancy functional status. The postpartum period offers health care providers with a unique opportunity to interact with women in promoting their health and the health of their families.

In the literature, postpartum health needs are generally neglected. In the few studies that exist, failed postpartum appointments have been noted to range from 42-48%, with even greater failures noted among teens and Hispanics (Buckley, 1990; Ghilarducci & McCool, 1993; Weinman & Smith, 1994). When specific interventions were employed to improve these behaviors (e.g. postpartum hospital and home visits, telephone follow up, mail reminders, extended comprehensive education and resource availability, child care

provision, financial assistance, transportation assistance) appointment keeping failure rates dropped to 15-26% (Buckley, 1990; Ghilarducci & McCool, 1993; Kogan et al., 1990; Weinman & Smith, 1994; Westheimer, Cattell, Connell, Kaufman, & Swartz, 1970). These figures differ little from figures for general medical appointment keeping. Research on general medical appointment keeping yields ranges from 40-50% even for curative regimens (Peck & King, 1986). Exceptions to this occur when children are involved or the appointment is initiated by the client. In these circumstances, appointment keeping rates rise to roughly 75% (Haynes, Taylor, & Sackett, 1979).

In spite of the limitations in the available literature, the studies on postpartum appointment keeping that do exist lend themselves to interpretation within the framework of the HBM. In an early study done in New York, Westheimer et al. (1970) described characteristics of women failing postpartum appointments. Women who failed to keep their appointments by week six were referred to the study group. The study group consisted of 1,841 women who tended to be women of high parity ( $>3$ ), older women ( $>31$  years), of African American or Puerto Rican descent, and single, separated, or divorced. Among the reasons found for missed appointments were: not being able to miss work, unable to secure a babysitter, dislike of examination, not seeing the need for the follow-up, and not being locatable. The investigators felt that some of these reasons were evident, in that it is more difficult to change patterns of health care at a later age, and more difficult for women with several children to keep appointments. With intervention (utilization of trained paraprofessional home visits, phone calls, letters, and various modes of logistical assistance) and the use of an experimental approach, appointment failures dropped slightly from 35% to 21%. With even better results, Moore, Ballinger, and

Beasley (1974) used the same method to study 1,800 low income women who had missed their initial six week postpartum appointment. These investigators were able to demonstrate a significant decrease in appointment failures after paraprofessional home visitation.

More recently, Kogan et al. (1990) conducted a study of 13,921 women in a maternal and infant care program over a three year period. The women failing appointments in this study tended to have less adequate prenatal care, less than an 11th grade education, were of African American or Hispanic descent, less than 26 years old, more likely to have experienced a poor birth outcome, were of higher parity ( $>1$ ), were not involved in a structured maternal and infant care program, and were single, separated, or divorced. The strongest association with postpartum appointment keeping was prenatal care appointment keeping behaviors. The odds that a women who had had inadequate prenatal care would not return for a postpartum appointment were almost three times greater than the odds for a woman who had had adequate prenatal care. The women's reasons for failed appointments were not examined in this study. Their conclusions and recommendations included a combination of financial access improvements and better education and follow-up to ensure a comprehensive prenatal and postpartum care program. Appointment failure rates with intervention (structured maternal and infant care programming involving education and postpartum home visitation) averaged 22% in the study.

Buckley (1990), in a quasi experimental approach, studied postpartum appointment keeping in relation to nurse practitioner intervention (phone calls, education, and postpartum hospital visitation). The 59 women studied were identified in the literature



as being at risk for appointment failure based on their age (average 18 years), recent births, and low income, reflected in the need for public assistance. Results revealed appointment failures at 48% without intervention and 26% with intervention. The study demonstrated that nurse practitioners without additional financial resources or support could improve postpartum appointment keeping behaviors by establishing effective provider-client rapport crucial to client satisfaction and appointment keeping, and educating clients to understand the need for an appointment. It was felt that face-to-face postpartum visits were more effective than telephone calls.

Another quite similar study conducted by Ghilarducci and McCool (1993) also used a quasi experimental approach to examine the influence of midwifery postpartum home visits on clinic attendance at six week appointments. Clients for this study were identified through a southern New England urban community health clinic as receiving or not receiving a midwifery postpartum home visit. The clients were followed antenatally and postnatally by the same group of midwives. The 82 clients studied were mainly of low socioeconomic status (61% public assistance), single (65%), had less than ten years education, and were of a minority race (69%). Of the clients who were not visited, 42% failed their initial six week postpartum appointment; 26% of those visited failed their appointment, demonstrating a 16% reduction in failure rate among those receiving the home visitation approach. The most important result revealed by their findings was that the home visited group had a better established pattern of clinic attendance over time. When one of those women missed their initial postpartum appointment, she required less effort to reschedule prior to coming in. The number of missed appointments was also felt to be a good indicator of the client's psychological and personal links with the system

(connectedness) which was reflective of the efforts undertaken to ensure continuity of care. Qualitative exploration to look at barriers to care was not a part of this study, however, barriers for midwife providers was addressed. These included reimbursement issues, time constraints, safety issues, and costs incurred. Although, it was pointed out, for midwives practicing in a small area with a low volume client load, home visitation may be a source of economic and professional fulfillment.

The most recent study found was conducted by Weinman and Smith (1994). This study focused on postpartum appointment keeping behaviors among 289 U.S.-born and Mexican-born Hispanic teen mothers. The teens were studied sequentially over a period of two years. The study results revealed, regardless of country of origin, teens largely did not return for postpartum care. The small percentage (17%) of the mothers who did return were those least likely to have had prenatal care, least likely to have educational plans, but most likely to have a support system. A large portion (75%) of the teen mothers studied reported they had no support system. The Spanish-speaking group was less likely to be in school, more likely to be economically depressed, and more likely to be married. Willingness to access preventive services among Hispanic teens was felt by the investigators to be directly related to poverty, lack of health insurance, and poor knowledge of English. Cultural factors clearly set this study group apart from the others reviewed. In the review of both cultures of U.S. ethnic populations, Hahn and Muecke (1987) found that among Mexican-Americans, pregnancy and child rearing were commonly understood within a broad framework of religious and cosmic principles. Prayers and vows are important in the promotion of conception and prevention of illness in pregnancy. Pregnancy and birth are viewed as a natural course and unproblematic,

hence health seeking behaviors may be avoided (perceived as irrelevant) and health services not pursued until harm has actually occurred. Since Hispanics are one of the fastest growing minorities in the U.S. (7.9% of the U.S. population) with the youngest median age (25 years), and conditioned cultural norms do not change rapidly, the effects of acculturation on health behaviors indeed deems attention.

Several researchers have approached the adequacy of maternal care from the standpoint of adequacy of prenatal care. Since one of the main aims of adequate maternal care is continuity, one would suspect that women's perceptions of barriers to prenatal care would be somewhat representative of their perceptions of postpartum care, keeping in mind that infant care and personal/family changes add additional dimensions to be considered in postpartum care.

In 1988 Brown published a comprehensive report on prenatal care for the Institute of Medicine summarizing several studies done from 1982 to 1987. She identified health care system barriers related to financial concerns, inadequate capacity of prenatal care (e.g., limited pool of providers providing care to low income women), cultural and personal factors that limit the use of care, and problems with organization, practices, and the atmosphere of prenatal services themselves as significant obstacles to women. A vital need was seen for linkage of services ( e.g., health education, financial, housing, welfare, and nutrition) and ease of access to the system. Also of great importance was evidence that women's beliefs, knowledge, attitudes, and feelings influence their use of prenatal care, as do behaviors and conditions (e.g., substance abuse and homelessness). To assess this dimension, study results were pooled to reveal the most frequent barriers to care. Among women receiving late or no prenatal care the top ranking barriers were financial

issues, prenatal care being poorly valued, and transportation. Interestingly, obstetricians views were also elicited and virtually all responders agreed on the same barriers as most significant, with female and younger providers being more sensitive to client barriers. Risk factors for late or no prenatal care were assessed via a multi variate analysis of the studies reviewed. Poverty was one of the most important correlates (one-third of all U.S. births are to women with incomes less than 150% of the federal poverty level). Unmarried women were three times more likely to obtain late or no prenatal care (22% of all births in the U.S. in 1985). Also correlated are high parity ( $>2$ ), less than a high school education, tenuous connections to the health care system, negative attitudes toward providers, and geographic location (e.g., inner city and isolated rural areas). Race was not felt to be a significant predictor.

Several classic access barriers that are well recognized in the literature as barriers to health services in general, continue to influence entrance and continuation in prenatal care. The following have been noted in more recent studies: availability of child care, practices and attitudes of providers, language and communication barriers, cultural differences between clients and providers, long clinic waits, physical surroundings, and lack of easily available, widely disseminated information about preventive and prenatal services (Lieber, 1994; Melnikow & Alemagno, 1993; Rhodes, Fischer, Ebert, & Meyers, 1993; Scupholme, Robertson, & Kamons, 1991; St. Clair, Smeriglio, Alexander, Connell, & Neibyl, 1990). In addition, Lieber (1994) and Scupholme et al.(1991) noted substance abuse to be high among women lacking adequate prenatal care, with poor minority substance abusers being most vulnerable. Contrary to Brown's (1988) findings cited earlier, a significant decrease in access to prenatal care was found among Hispanics and

African Americans. Rhodes et al. (1993) and Young, McMahon, Bowman, and Thompson (1989) found poor planning for childbearing and low recognition and planning of pregnancy to be significant personal barriers. In addition, Rhodes et al. (1993) noted high rates of sexual victimization (almost 25%) among those studied. Compared with nonvictims, those victimized scored significantly poorer on every psychological functioning variable on a follow-up analysis. Leatherman, Blackburn, and Davidhizar (1990) also addressed motivation (intent and willingness to seek care) as a significant factor related to less than adequate prenatal care.

In 1993 Bluestein and Rutledge looked at psychosocial factors as determinants of prenatal care use. Their framework was based on the HBM and has several similarities to the studies reviewed previously in relation to prenatal and postpartum care utilization. They suggest that early access to care in pregnancy is likely when perceived susceptibility, severity, and perceived need as well as modifiers and cues to action are high (e.g., when negative life events occur or social support cues from social networks are missing). Delayed or absent care occurs when perceived susceptibility and severity are low (e.g., delayed pregnancy recognition and appointment seeking, limited health knowledge, preoccupation with life stressors, and denial). Perceived need for care may be low in clients lacking social support, self esteem, and those with an external locus of control. Early care may be sought by women who deem the benefits to outweigh the barriers (e.g., belief that prenatal care preserves maternal and fetal health, decreases stress, and provides access to needed services). This may be enhanced even further in individuals with an internal locus of control. Low perceived benefit may result from low income, lack of education, and lack of health knowledge regarding the value of preventive services.

Barriers represent the negative attitudes about pregnancy, maternal care, and health care providers, as well as knowledge deficits. These barriers may be heightened even further in women with associated depression, low self esteem, and lack of supportive social networks. Among women with psychosocial vulnerability, perceived barriers most likely outweigh perceived benefits. Most investigators point to negative attitudes about pregnancy as the most influential barrier (Bluestein & Rutledge, 1993). This study attempts to describe perceived barriers.

In summary, most of the literature identifies the variables of perceived susceptibility and barriers as having the greatest association with maternal care utilization, with barriers being stronger of the two. This association has been well demonstrated in the studies on prenatal care and the few that exist on postpartum care. The major variance is in the difference of approach and data collection methods used. In some of the more recent studies (Leatherman et al., 1990; Lieber, 1994; Toomey, 1982) the tools have the same basic roots of origin, with minor adaptations to fit the population being studied. This study will also follow this basic approach, with minor adaptations to assist in identification of women's explanations for lack of keeping postpartum appointments.

### Research Question

The research question for this study was: What are the reasons (barriers) given by postpartum women for lack of postpartum appointment attendance? It is recognized that the variables of susceptibility, severity, benefits, and readiness to take action are related to women's behaviors in attending postpartum appointments. However, they were not the major focus of this study.

### **Definition of Terms**

Conceptual definitions of the variables are as follows:

1. Barriers: perceived costs or obstacles impeding postpartum care (e.g., perception of physical, psychological, social, economic, and other costs)
2. Health motivation: a generalized state of intent and willingness that results in behaviors to improve health, and the extent to which a particular health behavior is believed to be beneficial
3. Health behavior: any health-directed activity undertaken by a person for the purpose of preventing illness or detecting disease at an asymptomatic stage
4. Postpartum appointment keeping: participation in a medical visit with a health care provider within the six week interval after giving birth with the specific intent to assess postpartum health parameters

## **CHAPTER THREE**

### **METHODOLOGY**

#### **Research Design**

A descriptive research design was used to examine women's perceptions of barriers to postpartum appointment keeping. The intent of the study was to identify factors perceived by postpartum women to influence their appointment keeping behaviors.

A possible threat to external validity in this study was sampling effect. Results obtained from the target population may not be generalizable to another population in a different geographical area, or clients receiving care by a different group of medical providers. The sample results may also be skewed by the willingness of the individual participants to participate in data collection procedures.

#### **Sample**

The target population of this research was women who had received prenatal and intrapartum care through a southwestern Michigan midwifery practice. Women who had had at least one prenatal visit and had failed to keep a postpartum appointment by the end of the sixth week after parturition were referred to the study group. Initial referral information included client name, address, telephone number, and information regarding their English speaking abilities. Two individuals were not pursued for participation after initial contact due to their inability to converse fluently in English.



A convenience sampling method was used to obtain participants for the study. A total of 99 names were given to the researcher over a 14 month period of data collection. Of these, only 15 participated in the study. Four declined to participate; no specific reasons were offered. The researcher was unable to locate 72 women for various reasons: including disconnected phone numbers, incorrect phone numbers, relocation without forwarding address, and lack of response to mailed letters of intent and request to participate. In six instances, a phone message was left giving information about the study and agreement to reimburse for return calls followed by mailed letters of intent and request to participate. As mentioned earlier, two did not participate due to language barriers. The overall response rate was 15%, considerably low for this type of study.

### Instrument

The instrument that served as a basis for this study was a reformulated version of one used in a study done by the Ohio State Department of Health (Toomey, 1982). It was originally designed to identify factors related to early entry into prenatal care. The Toomey (1982) survey has been available for a number of years and has been widely used and adapted. In 1990, Leatherman et al. reformulated the survey slightly to study reasons given by postpartum mothers for not receiving adequate prenatal care. References to services not available in the area being studied were omitted. For the current study, Leatherman's 1990 version was adapted to focus on women's perceptions of barriers to postpartum appointment keeping (Appendix A). While no reliability and validity data are available on the Ohio State study, the questionnaires were originally analyzed and reviewed by numerous professionals in three cooperating agencies in effort to obtain content validity for the area of study. Content validity for this study was established by

submitting the instrument to four experts in women's health care. Internal consistency-based reliability was established after completion of the study by calculating Chronbach's coefficient alpha ( $\alpha=.76$ ). Although reliability of this nature is generally considered satisfactory, the sample size was very limited. The data were collected were from a 22 item scale which posed an additional limitation.

For the purposes of this study, the main focus was perceived barriers to obtaining postpartum care. It is recognized that because of the "all-inclusive" nature of reasons for not keeping postpartum appointments, that some of the study items also sampled the HBM dimensions of perceived threat and perceived benefit. In a global sense however, the lack of perceived threat and benefit *are* barriers to care. Perceived threat and perceived benefit are largely functions of a person's knowledge of a condition or situation at hand. Knowledge deficits can present as significant barriers to the probability of appointment keeping.

This study was closely reformulated to address postpartum barriers and the "all-inclusive" nature of the content was preserved to maintain the integrity of the tool and to ease potential future comparison of reasons for lack of maternal care prenatally and postpartum. The content of the tool addresses issue of maternal knowledge, attitudes, and beliefs that contribute to postpartum appointment keeping. It examines perceived barriers (behavioral, psychological, etc.) and other costs or barriers associated with this health behavior.

To meet the needs of this study, the survey consisted of three parts (Appendix B). Part 1 of the survey contained general demographic data, multiple choice questions pertaining to adequacy of prenatal care, pregnancy and birth complications, and general

health status of the mother and child (modifying factors). Part 2 of the survey asked the client to rate the importance of a list of 22 possible barriers to postpartum care on a five point response scale ranging from very important (5) to not important at all or not applicable (1). The total possible score ranged from 22 to 110, with the higher scores representing a greater degree of barrier importance. Part 3 consisted of three open-ended questions allowing the participant to identify other possible barriers that may have influenced their ability to keep their postpartum appointment.

The HBM was the theoretical framework used to interpret the survey findings. The model proposes that an individual's participation in a health behavior is dependent upon their perceptions of susceptibility and severity (threat), potential benefits, barriers, and readiness to take action. Knowledge is a major factor within this concept. The structural variables closely relate to the situational variables in this study.

### Procedure

The data were collected by one researcher utilizing a telephone interview method. This method was chosen to facilitate convenient and time-efficient sampling and minimize threat and time involvement of participants. It was anticipated that the low refusal rate, commonly noted with this method, would further enhance data collection. Potential participants were identified from a rural midwifery practice in Southwestern Michigan. Potential participants were initially contacted by phone and given a scripted explanation of the purpose of the study (Appendix C). If the individual agreed to participate, they were asked basic demographic data to facilitate further data collection and contact. They were then sent an information folder consisting of a sample sheet of questions, a rating scale, an approval note from their CNM providers, a self-addressed stamped envelope, and two

copies of the informed consent containing the researcher's name and telephone number, a telephone appointment date and time for continuation of the interview, and an option to receive a summarized version of the results of the study (Appendix D). Telephone interview dates and times were chosen by the participants and strictly adhered to or rescheduled based on client preference. Actual time involvement for participation in the telephone interview was 15-20 minutes. Since fatigue is common in the postpartum period, participants were queried at least once during the interview to assess their desire to continue to participate. Although not needed, if a participant became fatigued, a second telephone interview would have been arranged at another time chosen by the participant to complete the data collection. In three instances, when participants were contacted at arranged times for survey completion, the contact was rescheduled due to participant preference.

Participants were instructed to mail one copy of a signed consent form back to the researcher in a self addressed and stamped envelope prior to the prearranged interview session (Appendix E). They were also instructed to have the information folder available by the telephone at the time of the interview. All participants had received the information folder by the time of the arranged contact for survey completion. Five had already marked responses to some of the instrument items, however, all items were still verbally covered in their entirety during the phone contact.

### Human Subjects Protection

The research design exposed participants to less than minimal risk. A human subjects review approval was obtained from GVSU and the midwifery practice prior to data collection (Appendix F). All participant information was numerically coded to

maintain confidentiality. Potential participants were informed that they were under no obligation to participate and that they would receive no direct benefit from participating. They were given an explanation of how the study results may improve the providers practice and be beneficial to nursing research.

## CHAPTER FOUR

### DATA ANALYSIS

An exploratory, descriptive design was used to characterize the sample and describe the existence and frequency of occurrence of perceived barriers to keeping postpartum appointments. The HBM barriers variable was the main focus of the data collection.

#### Sample Characteristics

The data for this study was collected over a 14 month period, between July of 1996 and August of 1997. The sample consisted of 15 postpartum women from 15-34 years of age in a rural midwifery practice in southwestern Michigan. All of the women had missed their 6 week postpartum appointment prior to being contacted for study participation.

The majority of the respondents were white non-Hispanic (67%). Over half (53%) of them were married and 80% were living with their husband or mate. All were living with their children, however one child was hospitalized at the time of survey participation. The majority had between 9 and 12 years of education (87%), with a mean of 11 years ( $SD = 0.99$ ). Two had greater than 12 years education.

Yearly household income for the participants ranged from \$10,000-39,999. Forty percent were working part-time, 13% were actively looking for employment, and 20% were students. Forty percent were not working or actively looking for employment.

All of the women traveled between 4 and 25 miles to receive prenatal care, with a mean distance of 12 miles ( $SD = 5.20$ ). They drove themselves or were driven by family or friends to their appointments. At the time of the survey, two of the women had relocated out of the southwestern Michigan area. Eighty percent of the women who participated had not been evaluated by a medical health care provider since the time of their delivery and 67% had not received any medical or social services support in this period. Twenty percent had participated in a postpartum visit by another health care provider. Five (33%) participants indicated that they had participated in other postpartum services, such as nutrition counseling, social work counseling, public health nursing, family planning, and parenting classes.

Sixty percent of the women entered prenatal care within the first three months of pregnancy, and all had entered by six months. Sixty seven percent were encouraged to enter prenatal care by support persons. The majority were very satisfied with their prenatal care experience (87%). Four had experienced complications during the pregnancy, birth, or since the time of their delivery (27%). Eighty percent judged their prenatal and postpartum health to be good and felt that prenatal care was important or very important. Seventy four percent felt that postpartum care was important or very important. Twelve of the mothers (80%) judged their infant's health to be good since the time of delivery and all judged it to be at least fair. Sixty-seven percent of the women had one or more other children in the home.

### Research Question

The research question for this study was: What are the reasons given by postpartum women for lack of postpartum appointment attendance? This question was

answered by Part 2 of the survey. By assigning a point value to the ordinal ratings of levels of importance, a summative interval barrier score was determined. Twenty two possible barriers were assessed. The range of scores possible was 22-110. A greater numerical score depicts a higher degree of perceived significance of the barrier to postpartum appointment keeping. The resulting range of scores was 26-64, with a mean importance rating of 37.00 (SD = 10.83).

A perceived barrier rating summary was computed using the means to rank the data (Appendix G). Although means are not typically used in this manner with ordinal measurement, they were included to capture the variability of the scores. The top six ratings were chosen to be examined closer, as the existence of barrier ratings sharply declined at that point (Table 1). The most prominent perceived barrier (termed reason on actual questionnaire) was that, the women felt good and saw no need to see the doctor/nurse. This was the only item where a majority (67%) of the respondents rated the given barrier at least moderately important as a reason contributing to their not keeping their postpartum appointment. The next four highest rated barriers were rated moderately important by less than half (33.3-46.7%) of the respondents.



Table 1.

Top Six Highest Rated Perceived Barriers

Barrier Statement	Percent of Respondents					Mean
	Not Imp/ NA (1)	Slightly Imp (2)	Moderately Imp (3)	Imp (4)	Very Imp (5)	
1. I felt good, and did not see the need to see the doctor/nurse.	26.7%	6.7%	33.3%	26.7%	6.7%	2.80
2. I did not think that a postpartum check-up would benefit me or make me healthier.	46.7%	13.3%	13.3%	13.3%	13.3%	2.33
3. I had no problems after my previous deliveries.	46.7%	6.7%	20.0%	20.0%	6.7%	2.33
4. I did not have a babysitter for my children.	46.7%	20.0%	6.7%	13.3%	13.3%	2.27
5. I did not have transportation.	53.3%	6.7%	20.0%	6.7%	13.3%	2.20
6. I did not know how much the appointment would cost.	80.0%	13.3%			6.7%	2.13

Other Findings of Interest

In Part 3 of the survey the participants were given an opportunity to identify other possible barriers that may have influenced their ability to keep their postpartum appointments. Not all of the participants responded to these questions, and most of the responses were general restatements of barriers previously identified in Part 2. However,

two participants noted that they did not keep their appointments largely due to the fact that they had moved away from the area. One person felt that she had difficulty getting a suitable appointment time, as she was only able to attend appointments in the mornings.

Two commented that they would have appreciated an appointment reminder in the mail or a call to their home from the provider. Lastly, three responded that they were experiencing social stressors due to: the illness of a child; being dislocated from their home and living with friends; and family problems.

### Summary

The research question asked what reasons (barriers) women perceived to influence their postpartum appointment keeping behavior. The reasons identified related to the barriers dimension of the HBM, with the highest rated being: they felt good, and did not see a need; they did not think that the check-up would benefit them; they had no problems after previous deliveries; they did not have a babysitter; they did not have transportation; and, they did not know how much the appointment would cost. As expected, these reasons bear close resemblance to the reasons given in previous studies for lack of prenatal and postpartum appointment attendance. The findings of this study support previous research on the HBM and describe perceived barriers to postpartum appointment keeping.

## CHAPTER 5

### DISCUSSION AND IMPLICATIONS

The research question for this study was: What are the reasons (barriers) given by postpartum women for lack of postpartum appointment attendance? The current research was a continuation and expansion of earlier efforts to identify barriers to postpartum care. This study was undertaken to identify perceived barriers to postpartum health care among women who had not kept their postpartum appointment by the sixth week postdelivery. The main goal was to identify barriers that could be minimized or eliminated in the future to improve postpartum appointment attendance.

#### Relationship to Previous Research

There were similarities to previous research in both the degree of difficulty in obtaining a sample as well as in the findings. It was difficult to locate the women who had missed appointments. By the time of initial contact for participation in the study many of the phone numbers and addresses last known by the health care provider were no longer accurate. In Westheimer's (1970) study involving the use of paraprofessionals to motivate women to return for postpartum appointments 35% of the experimental group and 54% of the control group could not be located.

As in previous studies (Buckley, 1990; Ghilarducci & McCool, 1993; Kogan et al., 1990; Weinman & Smith, 1994; Westheimer et al., 1970), this study identified several perceived barriers to postpartum care, with six of these being rated as clearly most

significant to the participating mothers (Table 1). Of these six, the top three clearly represent a perceived low value attached to postpartum care (e.g., lack of perceived need for care, lack of problems after previous deliveries, and lack of perceived benefit of the appointment). Although stated as barriers, statements one and two also represent low perceived susceptibility. Statement three also represents low perceived benefit. In the most global sense, lack of perceived threat or benefit *are* barriers to care. They function as barriers largely due to the lack of knowledge of many as to the nature of the postpartum visit.

Grunberg and Lord (1990) refer to a lack of knowledge as a biological barrier. In essence, a patient's failure to experience or incorrectly interpret symptoms of underlying disorders results in a message of, simply put, "I feel fine, so I am fine". Variants of this theme include, "I feel fine, so I don't need treatment", or "I feel fine, so I don't have to do anything special to promote or improve health". Adherence or compliance are also reduced when a given behavior has no noticeable positive effects or they are not obvious to the individual, for example, "I've been exercising for weeks, and I don't feel any better; in fact I feel worse". These experiences and the lack of awareness of bodily state, therapeutic effects, or preventive effects can present as barriers to care and need to be addressed and explained to patients. Also important to note, Grunberg and Lord (1990) readily admit that biological barriers exist and are important, yet this area is without experimental evidence and more empirical work is needed. However, their work gives credence to the inclusion of the few items on the survey that also represent perceived threat and benefit as barriers in a global sense.

The fourth through sixth highest rated perceived barriers were more logistical in nature: lack of child care; transportation; and unknown costs. These statements more clearly identify access barriers. These results reveal that postpartum health care continuity efforts need to be aimed at improving educative efforts throughout the perinatal period regarding the importance of the postpartum visit and addressing access to care issues.

Postpartum care has two main purposes: (a) to identify maternal and neonatal complications, and (b) to provide professional assistance during the time when the mother is likely to need support and care. Traditionally, hospital care has focused on the biomedical needs of the mother and infant in the first few days after the delivery. Often, the next maternal-focused contact with the health care system is at or around 4-6 weeks postpartum. This pattern has become less satisfactory as women spend less time in the hospital after delivery.

Several studies have documented the safety, for both the mother and infant, of hospital discharge within less than 48 hours, or even within less than 24 hours, following an uncomplicated vaginal delivery (Rush, Chalmers, & Elkin, 1989; Welt, Cole, Myers, Sholes, & Jelovsek, 1993). Shortened stays necessitate that health care providers be sensitive to potential problems and develop mechanisms to address mother's questions and concerns that arise after discharge, avoiding further barriers to care. With a shortened hospital stay, a home visit or follow-up phone conference by a health care provider such as a nurse within 48 hours of discharge is encouraged (American Academy of Pediatrics [AAP] & American College of Obstetricians and Gynecologists [ACOG], 1997)

The findings of this study were consistent with the findings of previous research to identify perceived barriers to maternal care. Among women receiving late or no prenatal

care, the top rated barriers were financial issues, prenatal care being poorly valued, and transportation. Another similarity to previous studies is in lack of available child care.

### **Relationship to Theoretical Framework**

The theoretical basis of the study was the Health Belief Model, with a primary focus on the barriers dimension as it relates to health beliefs regarding appointment keeping behaviors. The HBM has been used as both an explanatory and intervention tool with a broad spectrum of health-related behaviors, particularly in studies examining compliance with health care recommendations. It is widely used and widely recognized in both medical and psychosocial fields. Since the component of perceived barriers is the single most powerful predictor among the HBM dimension across all studies and behaviors, it was deemed a fitting model to address postpartum appointment keeping barriers (Janz & Becker, 1984). By adequately identifying barriers to care, health care providers can use this data to attempt to not only minimize, but hopefully remove these barriers.

Health care providers can have a unique role in helping mothers and their families to manage changes and overcome barriers in the postpartum period. By understanding the mechanisms of behavior and the inter-related nature of the HBM dimensions as they come into play for patients to perform a health behavior, health care providers can implement programs that address the multifactorial nature of appointment attendance in the perinatal period. Identifying perceived barriers to care is a first step toward facilitating the involvement of patients in their care planning and providing comprehensive services that involve continued anticipatory guidance to families. Once barriers are identified, health care providers can direct efforts to minimize, and ideally remove these barriers.

### Limitations and Recommendations

There are several areas which present possible limitations to this study. The small sample size presents one of the greatest limitations and leads to question about the validity of the results. The data were collected from a small convenience sample (N=15) in a very rural area, therefore, the findings cannot be generalized beyond the sample. It is also of concern that 85% of the target population were not represented. The 15% that were may not be representative of the group as a whole. The inability to locate a large number of potential participants presented as a major problem and disappointment in conducting this research. The interval from time of delivery to data collection may have also influenced the response rate. Referrals were made to the study after the sixth week postpartum, and given time allowance for referral, contact, and recontact for data collection, often several weeks had passed yielding a large number of non-locatable potential participants. Furthermore, patients may have tended to minimize their perception of barriers as not to jeopardize future care with the provider, since a paucity of providers exist in this small rural area. Generalizability of the findings would be facilitated by using a larger random sample drawn from a greater geographical area.

The barrier scale brought confusion for some participants. Participants were asked to rate a series of statements as to their degree of importance as a barrier. Some had difficulty with this format and found it easier to restate the essence of the barrier being addressed (e.g., transportation) and then rate the degree of importance (e.g., "How important was transportation as a barrier to keeping my appointment?"). This may have been purely individual preference on the part of some of the participants, but restructuring

the barriers scale and giving an example response, may facilitate the ease of future data collection.

In addition, the study may have been further limited by the overlap of some of the items into other HBM dimensions. The top two rated barriers (perceived need of care and lack of problems after previous deliveries) in essence, more closely align with the perceived susceptibility dimension, while the third highest rated item (lack of perceived benefit) more closely aligns with the perceived benefits dimension. Yet, as discussed earlier, negative assessments of threat, self efficacy, lack of knowledge, and lack of perceived benefit can be construed as barriers in the most global interpretation of the concept. Repetition of the research with the previously mentioned adjustments and an attempt to support construct validity through factor analysis may prove beneficial to more clearly elucidate the items as components of the perceived barriers dimension. Redesigning the study to be prospective in nature would also allow the researcher to follow patients to see who is not keeping their appointments and why.

Possible avenues for future research may be in the area of health education and its correlation with barrier minimization and elimination. Indeed a vast amount of material exists regarding methods of addressing patient education. And, fortunately, patients are becoming more knowledgeable about health care, as it emanates in the media daily. It would be interesting to further research the impact that the method of presentation of health education would have on barrier reduction outcomes. Millar and Millar (1995) emphasize the need to provide health education information with emphasis on addressing the cognitive and affective components of belief systems; minimizing fear-invoking



messages and negative affect often associated with disease-detection beliefs and behaviors. To be most effective, health communications should instill in people the belief that they have the capacity to alter health habits and should instruct them on how to do so.

### Implications for Nursing Practice

While the findings of this study are not generalizable to the population as a whole, a step has been made in the right direction to address perceived barriers to postpartum appointment attendance. By identifying perceived barriers, health care providers can gain valuable insight into the attitudes, beliefs, and stresses presenting patients in the postpartum period. This insight allows a better understanding of why people behave in certain ways with regard to health matters and what affects their decision making process.

Insight into the behaviors of postpartum women can help guide redevelopment of policies and program guidelines to address women's perceived concerns and more openly involve them in their own care. An investment in terms of time spent negotiating programs of care with women might yield substantial dividends by increasing attendance rates in the long term. It is counterproductive to impose health maintenance and preventive care on people who do not want it or see the need for it. Perhaps the most beneficial approach may be to put the onus on the patient. When appropriate, the patient may be encouraged to make their own appointment or at least *participate* in the process. In a large scale review of studies on medical compliance conducted by Sackett and Snow (1979), it was found that compliance is about 50% when the appointment is initiated by the health care provider; rising to roughly 75% when initiated by the patient.

As mentioned earlier, the AAP and ACOG (1997) both agree on a recommendation for follow-up within 48 hours of hospital discharge. A contact at this

time or at least in the first 1-2 weeks may promote continued contact with health care system and may be a more realistic time to approach scheduling or confirm the appropriateness of an already scheduled appointment. By then, the patient has usually settled into familiar surroundings and routine and can participate in a more informed discussion regarding her plan of continued care and express concerns that may have come up regarding her recovery. The health care provider then has an opportunity to reinforce the rationale and need for postpartum follow-up and ongoing health care maintenance and prevention.

Phone contact and shorter scheduling to appointment intervals have been shown to improve attendance at appointments by as much as 31% (McClean, 1984). Such a contact allows the health care provider an opportunity to impart or clarify instructions and review basic medical care (e.g., pain control, importance of rest, care of the perineum, breasts, and bladder, and diet and exercise guidelines) and psychosocial concerns (e.g., adequacy of support systems in the home, sibling adjustment, postpartum mood, resumption of sexual intercourse, contraception, etc.) appropriate to the postpartum period. Health care providers can also assess the need for linkage to additional medical and psychosocial support services (e.g., social worker intervention, mother's support group referrals, etc.) as well as, to offer assistance and sensitive guidance in problem-solving perceived barriers to postpartum appointment keeping.

Despite its limitations, the HBM can prove useful to health care providers as an aid to understanding the role of health-related behaviors. Since nurses have more contact with patients than any other health professional, they are in a key position to be instrumental in influencing patient beliefs. By using such a model as a guide to care, providers can foster

confidence in their patients' abilities to participate in their own care based on a better knowledge of their motives and health beliefs. The HBM is an excellent vehicle for nurses to identify patients with potential risk of noncompliance and those in need of help in following health care recommendations. It is very important to be cognizant of the social context in which patients function. Knowledge of the variables that affect maternal health beliefs can assist nurses to implement educational programs that address the most common beliefs and concerns of women in the perinatal period and plan individualized interventions targeted at addressing individualized situation-specific needs—whether they be economic, situational, or attitudinal.

By using the HBM in practice, nurses have an opportunity to widen the scope of nursing practice to encompass not only prevention of illness, but promotion of health through barrier reduction. It is also recognized that barriers to health care that are a product of interaction with health care professionals or the health care system are most amenable to change. Barriers that are the function of attitudes and beliefs are much more difficult to change.

### Summary

The aim of this study was to explore barriers (reasons) for non-attendance at postpartum appointments. Its purpose was to highlight perceptions of postpartum women regarding postpartum care, in order to reveal attitudes, beliefs, and pragmatic reasons (barriers) that contributed to the problem of non-attendance. The results of the study revealed that a low value attached to postpartum care and logistical barriers posed the greatest impediment to obtaining postpartum care in the population studied. Since health beliefs can often be influenced by health education, it is recommended that health

education efforts be undertaken to not only address patients' health beliefs regarding comprehensive perinatal care (including postpartum care), but provider awareness of the building blocks to health beliefs and subsequent health behaviors.

## **APPENDIX A**

### **Permission to Adapt Instrument**

Dec. 22, 1995

Carol Czuk  
200 W. Rocky Weed Rd.  
Stevensville, MI 49127-9422

Dear Carol;

I give you permission to replicate my study entitled "How postpartum women explain their lack of obtaining adequate prenatal care". I am happy to have the study replicated.

I also give you permission to adapt the survey tool, I used, in whatever fashion you would find more helpful. Since I do not know the title of your study, I do not know what this adaptation might look like. I do think it is important that we nurses keep studying rather than haggle over tools.

I also give you permission to include a copy of my original survey in your thesis. It is always good to be quoted in other persons work.

Thank you for agreeing to send me a copy of your study when you are finished. I look forward to hearing from you in the fall of 1996.

Sincerely,

A black rectangular redaction box covering the signature of Julia R. Leatherman.

Julia R. Leatherman

## **APPENDIX B**

### **Postpartum Care Client Survey**

## POSTPARTUM CARE CLIENT SURVEY

## PART I

**DIRECTIONS:** In order to provide better care for patients after the delivery of their baby in the future, I need your help with this survey. I will be reading the questions to you and asking you to choose the response that most closely describes your situation. In some instances you may be asked to fill in a blank in a statement or may be able to give more than one response. I will bring your attention to these questions prior to asking for your response. Your answers will be coded and you will not be identified by name. Your health care provider will not look at your answers.

1. **I am in the age group**
  1. Less than 15 years
  2. 15-17 years
  3. 18-19 years
  4. 20-24 years
  5. 25-34 years
  6. 35 years or older
  
2. **I consider myself**
  1. African American
  2. White/Non-Hispanic
  3. Asian/Pacific
  4. Hispanic
  5. Native American
  6. Other
  
3. **I am currently**
  1. Married
  2. Single
  3. Widowed
  4. Divorced
  5. Separated
  
4. **I live with (choose as many as apply)**
  1. My husband
  2. My mate, not my husband
  3. My parents
  4. Other adult friends or relatives
  5. My children
  6. Other
  
5. **I have completed \_\_\_\_\_ years of school.**  
(Example: Completion of high school = 12 years)



6. **My current employment is (choose as many as apply)**
  1. Full-time job (40 hours or more per week)
  2. Part-time job (less than 40 hours per week)
  3. Unemployed, looking for a job
  4. Unemployed, not actively looking for a job
  5. Student
7. **The yearly income for my household (before taxes) is**
  1. Under \$10,000
  2. \$10,000-19,999
  3. \$20,000-29,999
  4. \$30,000-39,999
  5. \$40,000 or more
8. **How many living children do you have?**
  1. One
  2. Two
  3. Three
  4. Four
  5. Five or more
9. **How far along in your pregnancy were you when you began prenatal care?**
  1. 1-3 months
  2. 4-6 months
  3. 7 months or more
10. **How satisfied were you with the prenatal care you received?**
  1. Not at all satisfied
  2. Slightly satisfied
  3. Moderately satisfied
  4. Satisfied
  5. Very satisfied
11. **Who, if anybody, encouraged you to get prenatal health care?  
(choose as many as apply)**
  1. Baby's father
  2. My parent(s)
  3. Teacher/Counselor
  4. Health care person
  5. No one
  6. Other
12. **Did you experience any complications during your pregnancy, birth, or since your delivery?**
  1. Yes
  2. No

13. **My health during the pregnancy was**
  1. Good
  2. Fair
  3. Poor
14. **My health since the delivery of my baby has been**
  1. Good
  2. Fair
  3. Poor
15. **For women in general, how important do you feel it is for them to receive prenatal care?**
  1. Slightly important
  2. Moderately important
  3. Not sure
  4. Important
  5. Very important
16. **For women in general, how important do you feel it is for them to receive a postpartum (4-6 week) check-up after delivery?**
  1. Slightly important
  2. Moderately important
  3. Not sure
  4. Important
  5. Very important
17. **Who provided your prenatal health cares?**
  1. Obstetrician
  2. Family doctor
  3. Certified Nurse Midwife
18. **Have you participated in a postpartum (4-6 week) exam since your delivery (by anyone)?**
  1. Yes
  2. No
19. **If you answered yes to question number 18, who provided your care?**
  1. Obstetrician
  2. Family doctor
  3. Certified nurse midwife
  4. Family planning clinic
  5. Not applicable
20. **Could you have used help in getting an appointment for a postpartum (4-6 week) check-up?**
  1. Yes
  2. No

21. **How far is it for you to travel to receive a postpartum (4-6 week) check-up?**  
\_\_\_\_\_ miles
22. **How do you usually get to your office visits?**  
1. Walking  
2. Driving  
3. Family/Friend driving  
4. Public transportation
23. **My infant's health since the time of delivery has been**  
1. Good  
2. Fair  
3. Poor
24. **Please indicate which of the following services you have received since your delivery. (choose as many as apply)**  
1. Exam by doctor/nurse  
2. Nutrition counseling  
3. Social work counseling  
4. Public health nursing home visits  
5. Family planning services  
6. Parenting classes

## POSTPARTUM CARE CLIENT SURVEY

## PART 2

**DIRECTIONS:** There are many reasons that women give for not being able to keep their postpartum (4-6 week) appointments. Next, I will read to you some possible reasons that may have applied to your situation. After I read each statement, please give careful consideration to the importance of the reason to you. Using the rating scale provided, I will then ask you to give a number choice that best describes your situation. You will be allowed one choice for each question asked.

<b>NOT IMPORTANT/ NOT APPLICABLE</b>	<b>SLIGHTLY IMPORTANT</b>	<b>MODERATELY IMPORTANT</b>	<b>IMPORTANT</b>	<b>VERY IMPORTANT</b>
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>

**REASONS**

- |     |   |   |   |   |   |   |
|-----|---|---|---|---|---|---|
| 1.  | I did not have the money to pay for a postpartum check-up .....                                   | 1 | 2 | 3 | 4 | 5 |
| 2.  | I did not have a postpartum check-up scheduled for me when<br>I went home from the hospital ..... | 1 | 2 | 3 | 4 | 5 |
| 3.  | I did not know that a postpartum check-up was recommended .....                                   | 1 | 2 | 3 | 4 | 5 |
| 4.  | I did not know that my doctor/nurse wanted me to come back<br>for a check-up .....                | 1 | 2 | 3 | 4 | 5 |
| 5.  | I did not have transportation .....   | 1 | 2 | 3 | 4 | 5 |
| 6.  | I did not know how much the appointment would cost .....  | 1 | 2 | 3 | 4 | 5 |
| 7.  | I could not come during regular office hours .....  | 1 | 2 | 3 | 4 | 5 |
| 8.  | I did not have a babysitter for my children .....   | 1 | 2 | 3 | 4 | 5 |
| 9.  | I was afraid of finding out that something was wrong .....  | 1 | 2 | 3 | 4 | 5 |
| 10. | I did not feel that a postpartum check-up was necessary .....                                     | 1 | 2 | 3 | 4 | 5 |
| 11. | I have had bad experiences with postpartum check-ups<br>in the past .....                         | 1 | 2 | 3 | 4 | 5 |
| 12. | I had no problems after my previous deliveries .....  | 1 | 2 | 3 | 4 | 5 |
| 13. | I felt good, and did not see the need to see the doctor/nurse .....                               | 1 | 2 | 3 | 4 | 5 |
| 14. | I was afraid of having a medical exam .....   | 1 | 2 | 3 | 4 | 5 |
| 15. | I was afraid someone would take my baby away .....  | 1 | 2 | 3 | 4 | 5 |

ID Number \_\_\_\_\_

NOT IMPORTANT/ NOT APPLICABLE	SLIGHTLY IMPORTANT	MODERATELY IMPORTANT	IMPORTANT	VERY IMPORTANT
1	2	3	4	5

**REASONS**

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- |     |  |   |   |   |   |   |
|-----|--|---|---|---|---|---|
| 16. | I had too many other problems .....  | 1 | 2 | 3 | 4 | 5 |
| 17. | I forgot when my appointment was .....   | 1 | 2 | 3 | 4 | 5 |
| 18. | I have to wait too long in the office/clinic before seeing<br>my doctor/nurse .....                                      | 1 | 2 | 3 | 4 | 5 |
| 19. | I did not feel I was able to make my doctor/nurse understand<br>what I needed when I saw them before the baby came ..... | 1 | 2 | 3 | 4 | 5 |
| 20. | I was not pleased with my overall pregnancy and birth experience .....   | 1 | 2 | 3 | 4 | 5 |
| 21. | I felt the office/clinic did not function smoothly .....   | 1 | 2 | 3 | 4 | 5 |
| 22. | I did not think that a postpartum check-up would benefit<br>me or make me healthier .....                                | 1 | 2 | 3 | 4 | 5 |

POSTPARTUM CARE CLIENT SURVEY

PART 3

**DIRECTIONS:** Following are a few questions that will help further clarify the difficulties that you may have experienced in keeping your postpartum check-up.

1. What reasons, not already mentioned, do you feel influenced your ability to keep your postpartum check-up appointment?

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2. What was the most important reason why you were unable to keep your postpartum check-up appointment?

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3. What one thing would have helped you the most to be able to keep your postpartum check-up appointment?

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## **APPENDIX C**

### **Script for Introduction to Postpartum Care Client Survey**

Hello. My name is Carol Czuk. I am a Women's Health Care Nurse Practitioner and a student at Grand Valley State University. I am doing a study about postpartum appointment keeping. I was given your name by Shoreline Women's Center as a possible participant in this study. I understand that you have not yet completed your postpartum (4-6 week) check with their office. I also understand that there are many reasons women may be unable to keep postpartum appointments. For the purpose of this study, I am interested in your reasons and your input regarding your perceptions of this type of health care in general.

To conduct the study I would like to arrange a time when I can call you back to ask a series of questions regarding your perceptions of postpartum care. I have estimated that the interview will take approximately 15-20 minutes.

If you agree to participate, you will be mailed an information folder consisting of a consent form, sample sheets of questions, a note of approval from Shoreline Women's Center, and information about me and how to contact me. If you like you may fill in the survey prior to my call and write down any questions that arise after we talk. All information collected for the study will be coded, and you will not be identified in any way to Shoreline or in the completed study. A summary of the study results will be made available to you and Shoreline upon completion, most likely, later this year.

You are under no obligation to participate in this study and you will receive no direct benefit from participation. The results of the study are expected to enhance Shoreline's practice and be beneficial to nursing research.

I appreciate your time and patience in listening to this explanation. Do you have any questions about the study or your possible participation in it?

Would you be willing to participate in this study?

Would like some time to think about participating in this study?

Non-participants: Thank you for taking the time to consider participation in the study. I appreciate your openness and understand your reluctance.

Participants: Thanks, I appreciate your time and assistance. Within the next week you will receive the study information I described earlier in the mail. Is \_\_\_\_\_ your correct address?

Please sign one copy of the consent form that is in your folder and return it to me in the mail, using the envelope that will be provided.

I would like to allow at least two weeks for the folder to reach you and for you to return the consent. When would be a convenient time to contact you to conduct the interview? (Discuss possible times/dates when the interview could be completed at her convenience.)



## **APPENDIX D**

### **Script for Telephone Interview**

Hello. My name is Carol Czuk. I spoke with you approximately two weeks ago about participating in a study I am doing about women's perceptions of postpartum health care. I received your consent in the mail and would now like to complete the study, if this is still a convenient time for you.

Do you have the folder handy that I mailed to you?

I would again like to remind you that your responses will be coded and kept completely confidential. You will not be identified by name and Shoreline will not have access to your answers.

Do you have any questions?

We will begin with Part 1 of the survey. I will read each question, then ask you to respond by choosing the appropriate response number that most accurately describes your situation. For the questions with blank spaces, I will ask you to verbally fill in the blank.

Okay. Let's begin. Number 1 (read question and record responses). Repeat for remainder of questions.

Now, let's move on to Part 2 of the survey. Do you feel up to continuing?

In this part of the survey we will look at reasons women commonly give for not being able to keep their postpartum appointments. These may or may not apply to you. I will read each question, then ask for your response, based on the numerical rating scale of importance just above the reasons section of the page. (Read statements and record responses)

Now, let's go on to Part 3 of the survey. Do you still feel up to continuing?

For this part of the survey, I will be reading questions to you and requesting your responses. Number 1 (read questions and record responses).

You have now completed the survey. I greatly appreciated your time and assistance with this survey. If you have requested a summary of the findings, it will be mailed to you upon completion of this project, most likely, later this year.

## **APPENDIX E**

### **Informed Consent**

## Informed Consent

This study is being conducted to assess women's perceptions to barriers to obtaining postpartum health care. The information I obtain from you will help Shoreline Women's Center to provide postpartum care that meets the needs of their clients. In addition, it will also provide valuable insights to the field of nursing research and satisfy a course requirement for me at Grand Valley State University.

By signing this consent, you are agreeing that you understand the following:

1. You were selected for participation in this study because you had not completed a postpartum visit with your health care provider by six weeks after the date of your delivery.
2. Your participation in the study involves mailing this consent to me in the envelope provided, and answering questions about your health care during and after your pregnancy. It is estimated that the telephone interview will take 15-20 minutes, and that if this is not convenient for you, the option of another interview will be offered.
3. It is not expected that participation in this study will lead to physical or emotional risk to myself or infant, and it may be helpful to have someone to talk to about my experiences.
4. You can decline to participate in this study at any time. You are under no obligation to participate. Declining to participate will in no way affect your future care at Shoreline Women's Center. You will receive no direct benefit from participation in this study.
5. If any medical problems are identified in the interview, I cannot provide advice. You will be referred to Shoreline Women's Center for any such questions.
6. I have been given an opportunity to ask questions regarding this study, and that these questions have been answered to my satisfaction.
7. The researcher, Carol Czuk, has my permission to review my prenatal record at Shoreline Women's Center.
8. You hereby authorize the researcher to release information obtained in this study to scientific literature. Information given to the researcher will remain private. Your name will not be used in any way.
9. You have been given Carol Czuk's phone number, (616) 429-5569, so that you may contact her at any time if you have questions. You may also contact the Chairman of the Human Subjects Review Committee, Dr. Paul Huizenga, at Grand Valley State University at (616) 895-2472 if you have any further questions.

Please sign below if you have read and understand the statements above, and agree to participate in the study.

\_\_\_\_\_  
Your name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Researcher's name

\_\_\_\_\_  
Date

You may receive a summary of the study results upon completion. Please indicate your choice, yes \_\_\_\_\_ no \_\_\_\_\_. I will be contacting you \_\_\_\_\_ to complete the interview.

## **APPENDIX F**

**Permission from Human Research Committee  
of Grand Valley State University**



1 CAMPUS DRIVE • ALLENDALE MICHIGAN 49401-9403 • 616/895-6611

May 21, 1996

Carol Czuk  
200W. Rockyweed Rd.  
Stevensville, MI 49127-9422

Dear Carol:

The Human Research Review Committee of Grand Valley State University is charged to examine proposals with respect to protection of human subjects. The Committee has considered your proposal, "*Women's Perceptions of Postpartum Appointment Keeping Barriers*", and is satisfied that you have complied with the intent of the regulations published in the Federal Register 46 (16): 8386-8392, January 26, 1981.

Sincerely,

A black rectangular box redacting the signature of Paul Huizenga.

Paul Huizenga, Chair  
Human Research Review Committee

## **APPENDIX G**

### **Perceived Barriers Rating Summary**

### Perceived Barriers Rating Summary

Barrier Statement	Percent of Respondents					Mean
	Not Imp/ NA (1)	Slightly Imp (2)	Moderately Imp (3)	Imp (4)	Very Imp (5)	
1. I felt good, and did not see the need to see the doctor/nurse.	26.7%	6.7%	33.3%	26.7%	6.7%	2.80
2. I did not think that a postpartum check-up would benefit me or make me healthier.	46.7%	13.3%	13.3%	13.3%	13.3%	2.33
3. I had no problems after my previous deliveries.	46.7%	6.7%	20.0%	20.0%	6.7%	2.33
4. I did not have a babysitter for my children.	46.7%	20.0%	6.7%	13.3%	13.3%	2.27
5. I did not have transportation.	53.3%	6.7%	20.0%	6.7%	13.3%	2.20
6. I did not know how much the appointment would cost.	80.0%	13.3%			6.7%	2.13
7. I did not feel that a postpartum check-up was necessary.	66.7%		20.0%	6.7%	6.7%	1.87
8. I did not have the money to pay for a postpartum check-up.	66.7%	13.3%		6.7%	13.3%	1.87
9. I could not come during during regular office hours.	73.3%	6.7%		6.7%	13.3%	1.80
10. I forgot when my appointment was.	66.7%	13.3%		13.3%	6.7%	1.80



Barrier Statement	Percent of Respondents					Mean
	Not Imp/ NA (1)	Slightly Imp (2)	Moderately Imp (3)	Imp (4)	Very Imp (5)	
11. I was afraid of finding out that something was wrong.	73.3%	6.7%	6.7%		13.3%	1.73
12. I had too many other problems.	73.3%		20.0%		6.7%	1.67
13. I have to wait too long in the office/clinic before seeing my doctor/nurse.	80.0%	6.7%	6.7%		6.7%	1.47
14. I did not know that my doctor/nurse wanted me to come back for a check-up.	80.0%	13.3%			6.7%	1.40
15. I did not have a postpartum check-up scheduled for me when I went home from the hospital.	86.7%		6.7%		6.7%	1.40
16. I did not know that a postpartum check-up was recommended.	86.7%	6.7%			6.7%	1.33
17. I felt the office/clinic did not function smoothly.	93.3%				6.7%	1.27
18. I was afraid of having a medical exam.	93.3%			6.7%		1.20

Barrier Statement	<u>Percent of Respondents</u>					Mean
	Not Imp/ NA (1)	Slightly Imp (2)	Moderately Imp (3)	Imp (4)	Very Imp (5)	
19. I was not pleased with my overall pregnancy and birth experience.	93.3%		6.7%			1.13
20. I did not feel I was able to make my doctor/nurse understand what I needed when I saw them before the baby came.	100.0%					1.00
21. I was afraid someone would take my baby away.	100.0%					1.00
22. I have had bad experiences with postpartum check-ups in the past.	100.0%					1.00

## **LIST OF REFERENCES**

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