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Understanding Access to Preventive Health Screening for Working Women Through the Lens of the Socioecological Model

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Abstract

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Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

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Abstract

Many U.S. working women lack access to routine preventive health screenings due to their 40-hr workweek, problems with transportation, and lack of workplace flexibility as clinic hours often coincide with their work schedules. Research is currently limited on how mobile health clinics (MHC) may enhance access to preventive health screenings for working women. The purpose of this qualitative study was to understand how working women experienced access to preventive health screenings through MHCs. The socioecological model served as the conceptual framework. The study population was working women over 21 years of age who were not homemakers, who worked 30 or more hr outside the home, and who had used MHCs within the last 36 months for preventive health screenings. The data analysis process consisted of using five a priori codes and 30 open codes to assess the interview transcripts. The a priori and open codes were categorized and subcategorized; these facilitated the identification of five themes: (a) MHCs offer informative, fast, and accessible access to care for working women; (b) work hours conflict with access to health care for working women; (c) childcare and transportation reduce barriers to access to care for working women; (d) working women obtain access to preventive health screenings through word of mouth; and (e) MHCs provide working women with access to preventive health screenings. A key conclusion is that MHCs can help to close the health equity gap for working women by providing access to preventive health screenings. This study may effect positive social change by developing policies to improve working women's access to preventive screenings to increase early detection of breast and cervical cancer.

Understanding Access to Preventive Health Screening for Working Women Through the Lens of the Socioecological Model

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Dedication

I dedicate this dissertation to my late mother, Jody Clark. You gave me life and believed in me. As you look down from heaven, I can feel your smile and warmth. I'm proud to say I'm your daughter. This is for you, mom. Without you, none of this would be possible. Thank you for life.

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There are many people whom I have met over the years who have touched my life. Even though I have not mentioned you by name, know that you are in my heart.

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Chapter 1 Introduction to the Study

Many U.S. working women do not obtain preventive health screenings due to barriers including childcare issues, transportation, and clinic hours that often coincide with their 40-hr workweek (Isehunwa et al., 2017). The purpose of this qualitative study was to understand how working women experienced access to preventive health screening through the use of mobile health clinics (MHCs). I used the socioecological model (SEM) as the conceptual framework for the investigation. This study may effect positive social change by developing policies to improve working women's access to preventive screenings to increase early detection of breast and cervical cancer.

Background

In recent decades, the number of women in the U.S. workforce has steadily increased. A working woman is defined in this study as a woman who is gainfully employed and not a homemaker. According to experts, the number of working women in the U.S. workforce has risen seen early days of women being a homemaker (Hannah & Kranzerg, 2021). Research shows that women who work outside the home may face different constraints on their time than men. One issue is access to health care, in particular preventive health screenings (Boom et al., 2018).

Access to preventive health screenings is challenging for many working women. Working women spend a considerable amount of time at work, leaving little time for routine preventive health screenings such as a Pap smear (Isehunwa et al., 2017; Yu et al., 2017). Scheduling appointments for preventive health screening around work hours can be challenging for working women because appointment times may not be

compatible with their work commitments and evening or weekend appointments may not be available for months (Alharbi et al., 2019). Childcare issues, problems with transportation, and out-of-pocket medical costs are other barriers (Isehunwa et al., 2017).

Difficulties in scheduling preventive health screenings may put working women at risk for different health issues. According to the American Cancer Society, obtaining preventive health screenings such as a Pap smear can assist in early cervical cancer detection (Saslow et al., 2012). Early detection offers women a better chance to receive treatment in the early stages of a cervical cancer diagnosis (Saslow et al., 2012), providing women with a 90% survival rate (American Cancer Society, 2021).

MHCs may offer a viable means of enhancing access to preventive health screenings for working women. An MHC is defined as a motor vehicle that travels to communities to deliver a variety of health services (Yu et al., 2017). The clinics are situated close to worksites. MHCs may provide a more convenient means for working women to receive health preventive health screenings such as a Pap smear during working hours. Their existence may address a critical barrier to working women's access to preventive health care services. Research has shown that MHCs can reach sections of the population that are usually difficult to reach (Bertoncello et al., 2020). For example, MHCs provide services to people with chronic diseases to keep them out of the emergency room. This can help to reduce health care costs (Yu et al., 2017). In addition, MHCs can address both medical and social determinants of health in the community (Malone et al., 2020). There is limited research, however, on access for working women to preventive health screenings through an MHC. This study may increase knowledge

that stakeholders can use to ensure access to preventive health screenings for working women. In addition, this study could assist nonprofit leaders in securing grant funding for their organizations or creating government partnerships to increase access to MHCs. Providing these opportunities may increase access to preventive health screenings for working women.

Problem Statement

Many working women lack access to routine preventive health screenings due to their 40-hr workweek, childcare issues, problems with transportation, lack of workplace flexibility, out-of-pocket medical costs, and clinic hours that are the same as their work hours (Isehunwa et al., 2017). Many women in the United States lack adequate health care due to cost and trouble paying medical bills. The lack of access to preventive health screenings such as a mammogram or Pap smear can result in fewer women getting these services (DeRigne et al., 2017). Nonflexible appointments or appointment delays are other reasons for the lack of access to preventive health screenings for working women (Alharbi et al., 2019). Health care leaders, advocates, and other stakeholders use MHCs to increase access to health care in the community (Bouchelle et al., 2017). MHCs can engage women for preventive health screenings, keep health care costs down, and remove geographic barriers because of their portability (Holen et al., 2019). In conducting this qualitative study, I addressed a gap in the literature because there is little research, according to my review of the literature, on working women's access to preventive health screenings through MHCs.

Purpose of the Study

The purpose of this qualitative study was to understand through the lens of SEM, how working women experienced access to preventive health screening.

Research Question

How do working women describe their experiences using MHCs to access preventive health screenings based on the SEM?

Conceptual Framework

I used the SEM to understand how working women experienced access to preventive health screening through the use of MHCs. The SEM model consists of five levels, according to Gombachika et al. (2017). In the first level, the individual characteristics influence behavior. Second-level interpersonal processes provide social identity and role definition. The third level includes rules, policies, and formal and informal structures. The fourth level community establishes norms or values, standards, and social networks. The fifth and final level societal includes cultural context and national policies pertaining to health.

Three researchers, Urie Bronfenbrenner, Kenneth McLeroy, and Daniel Stokols, developed the SEM. Each of these researchers contributed to the SEM in different ways. Bronfenbrenner's (1977) ecological systems theory focuses on the relationship between the individual and the environment. McLeroy's ecological model of health behaviors distinguishes different levels of influence on health behaviors, and Stokols's ecological model of health promotion is a precursor to the SEM (Gombachika et al., 2017). I will further discuss SEM in Chapter 2.

Nature of the Study

I used the basic qualitative approach to understand the experiences of working women access to preventive health screenings on MHCs. The basic qualitative approach is based on the belief that knowledge is constructed by people as they engage in and make meaning of an experience (Merriam &Tisdell, 2015). By using this approach, I was able to gather data to describe the participants' experiences. The resulting knowledge may inform the development of future studies (see Creswell & Poth, 2018).

Definitions

Mobile health clinic (MHC): A motor vehicle that travels to communities so that providers can deliver a variety of health services (Yu et al., 2017).

Preventive health screenings: A health examination and test designed to identify and prevent future health problems (Centers for Disease Control and Prevention [CDC], 2021).

Working woman: In this study, a woman who is gainfully employed (outside of the home) and not a homemaker. This definition is consistent with the literature (Harper Collins Publishers, 2001; Lexico Dictionary, n.d.; Merriam-Webster, n.d.).

Assumptions

Creswell (2013) explained that all qualitative research shares philosophical assumptions. These assumptions are as follows: ontological (e.g., multiple realities exist based on different individual experiences), epistemological (e.g., the researcher gets close to participants to understand the truth), axiological (e.g., the reach process involves the potential for bias; as such; the researcher should make their values and bias known and

take steps to mitigate the impact in the study), and methodological (e.g., the research process is inductive and the design, emergent). In this qualitative research study, the primary assumption was that working women use MHCs because they are more accessible for preventive health screenings. Due to their accessibility, working women favor MHCs over traditional brick-and-mortar clinics, I presumed. To confirm this assumption, it was necessary to conduct this research to understand working women's experience of accessing MHCs for preventive health screenings.

Scope and Delimitations

This study was limited to working women who were gainfully employed at least 30 hr per week and not as a homemaker. I selected U.S. working women because they often do not obtain routine preventive health screenings due to barriers (Isechunwa et al., 2017) that include the inability to miss work, limited transportation, and the lack of knowledge to navigate the health care system (Boom et al., 2018). Participants were 21 years old or over because, according to the CDC (2017), women at that age begin to seek preventive health screenings such as Pap smears, which is only required every 3 years. There were no exclusions from the study based on race, ethnicity, geographical locations, and income level.

After reviewing each qualitative research type, I concluded that the basic qualitative approach was the best option for this study. It focuses on the phenomena of each participant's experience (Merrian &Tisdell, 2015). Transferability is the degree to which the results of qualitative research can be transferred to other contexts or settings with other participants (Alexander, 2019). This study may be transferable because there

are limited data on working women who use MHCs for preventive health screenings, according to my review of the literature. The findings and approach of this qualitative study may be pertinent to other researchers seeking to examine MHCs for health care purposes This qualitative study may expand the body of knowledge on working women, MHCs, and preventive health screenings by examining the experience of working women who have used MHCs for preventive health screenings.

Limitations

Conducting a basic qualitative approach can have limitations such as difficulties in interpreting the data and/or developing new theories, the longer time needed to gather data, and the potential for the research to become too structured for the researcher (Creswell, 2013).The potential for bias also exists. My bias entering into this research was the belief that MHCs are the most effective way a working woman can access preventive health screenings. Also, I was biased in believing that working women do not understand the meaning of preventive health screenings and how to obtain these services. In addition, there can be bias during the interview process, which includes body language or not giving participants time to answer a question (Creswell, 2013).

Although I undertook this qualitative study with some bias, I sought to present the results without any personal interpretations. I accomplished this by considering representativeness, scrutinizing potential researcher bias, weighing the evidence, checking the meaning of outliers, following up on surprises in the data, looking for negative evidence, ruling out spurious relations, and checking for rival explanations (see Miles et al., 2014). I conducted the study during the COVID-19 pandemic. Due to the

pandemic, many women skipped preventive health screenings due to the fear of contracting the virus (Akinlotan et al., 2017). Thus, the pool of participants was potentially limited. Interviews were conducted via phone or online, rather than in person.

Significance

This research may provide an opportunity to address a gap in understanding access to preventive health screenings for working women through an MHC. Working women seek access to preventive health screenings that offer availability, affordability, accessibility, and acceptability (Bintabara et al., 2018). Their gaining access to preventive health screenings is necessary to reduce health disparities (DeRigne et al., 2017). The results of this study may reveal practical ways to increase access to preventive health screenings for working women. The study results may also inform future research on preventive health screening for working women.

Summary

The purpose of the qualitative study was to understand access to preventive health screening for working women through MHCs An MHC provides services to people in many ways (Balogun et al., 2018). The main strength of MHCs is their ability to provide suitable and quality health care (Carmack et al., 2017). Preventive health screenings are tests or screenings that are deemed lifesaving (CDC, 2021). Working women face many barriers that can cause them not to obtain preventive health screenings (Kumari et al., 2020). Many working women do not have access to preventive health screenings because of the barriers such as work schedules that are not flexible (Ross et al., 2017). These barriers may result in working women postponing preventive health screenings to a later

date or not getting preventive health screening at all (DeGennaro et al., 2018). In Chapter 2's literature review, I will further discuss working women, preventive health screenings, and MHCs. The literature review furthers understanding of the potential for MHCs to address gaps in working women's health care by providing preventive health screenings.

Chapter 2: Literature Review

Introduction

Many working women are not obtaining preventive health screenings due to multiple barriers (Isehunwa et al., 2017). The purpose of this qualitative study was to understand how working women experience access to preventive health screening through using MHCs guided by the SEM. The articles selected offer background to the understanding of working women and their access to preventive health screenings. Also, the potential that MHCs can enhance access to preventive health screenings for working women. The literature reviewed is broken into sections which consist of working women, access to preventive health screenings, and MHCs. Each section helps break down the research into a more defined body of literature.

Literature Search Strategy

The following library databases were used to obtain scholarly articles for this literature review: ProQuest Health, Medline, PubMed, CINAHL, PsycInfo, SocIndex, ScienceDirect, and Embase. Google Scholar was used to assist in citation chaining for related articles. Keywords used to search included *working women, Pap smears, Papanicolaou, mammograms, mobile health clinics, mobile clinics, mobile hospitals, preventive, screenings, preventive health screenings, shiftwork, women* OR *woman, female, , access to care, access to health care, breast cancer, breast screening, cervical cancer,* and *preventive health care.*

Conceptual Framework

The SEM was used to understand how working women experienced access to preventive health screening using MHCs. SEM was first introduced by Urie Bronfenbrenner (1979) as a conceptual model to understand human development. Later it was looked at as a theory which noted that there were different levels of human development, which he placed people in the center of termed different systems. The first system is the microsystem, it is the closest to the individual containing the people with the strongest influences on them with interactions and relationships (Bronfenbrenner, 1979). The microsystem focuses on demographic characteristics, and the people who shape the individual's knowledge, attitudes, and beliefs. The second is the mesosystem, which looks beyond immediate relationships to interactions such as the workplace, church, and other social activities where the individual is an active participant. The third level is the exosystem where the interactions do not involve the individual as a direct participant but impact them, such as government institutions, their child's class at school, activities of the local school board. The fourth system is the macrosystem and includes societal and religious influences on culture, subculture, and belief systems within and organization and/or society. (Bronfenbrenner, 1979). For example, how health care is delivered in the United States differs from how it is delivered in other countries. The last system is ecological transition, which focuses on normative life transitions such as divorce.

SEM helped guide the qualitative study through the different systems of SEM to understand what individuals or groups experienced. Poux (2017) used the SEM to

examine people's interactions with their community and environment to promote healthy habits in the community. By using the SEM, it helped to identify reasons why public health organizations struggled to promote healthy habits in the community because they did not consider other factors such as behavior (Poux, 2017). The five systems of the SEM helped the researchers to identify a sustainable solution for healthier communities (Poux, 2017). Now public health organizations can promote strategies that increase healthy behaviors in the community.

The SEM systems provided depth that can be identified on each level of the model allowing the researcher not to miss important facts about the experienced to understand the phenomenon. In the Khan et. al., (2021), study they looked for barriers that shaped prenatal care experience for women with intellectual or development disabilities. The SEM was used as a framework to describe how health inequity results go beyond individual characteristics and behaviors (Khan et al. 2021). In using each system of SEM, the researchers were able to identify positive and negative experiences that shaped the prenatal care for these women. Those identifying factor created opportunity to understand that intervention was needed to increase disability education for prenatal care providers and use a holistic support networks to better optimize care for with intellectual or development disabilities (Khan et al. 2021). Also, Khan et al. (2021) study found that the SEM was aligned with the social determinants of health framework. Social determinants of health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes (CDC, 2021). Healthy People 2030 uses the five social determinants of health to outline the most needed areas. The

areas are health care access, education access, social and community, economic stability, and building environments (CDC, 2021). My qualitative study also is aligned with SODH that falls under health care access that relies on the SEM.

Literature Review Related to Key Variables and/or Concepts

Demographics of Working Women

There are many definitions of working women. Each one of these sources demonstrated how they define working women, starting with Harper Collins Publisher (2001), a woman who is gainfully employed, a woman who is distinct from a housewife, and a woman who is regularly employed. Merriam-Webster (n.d.) defined a working woman as a woman who works. Lexico Dictionary (n.d.) defined a working-class woman as one who is in paid employment. For the purposes of this study, a working woman was considered a woman who is gainfully employed and not a homemaker. Over time, women's role in the workforce has become more prominent. In the early 20th century, most women in the United States did not work, by 1950, one in three women worked outside the house, and in 1998 three of every five women worked outside the home (Heathfield, 2020). By 2008, 48% of the workforce were women (Heathfield, 2020) and currently, women make up about 57% of the workforce (Kelley, 2020). These statistics demonstrate the shift to women working in roles other than as a homemaker.

Work–Life Balance for Working Women

Trying to maintain a balance between work life and family life can be difficult for a working woman. Women are the support that keeps the family together (DeGennaro et al., 2018). Their role is vital in selecting and maintaining family health care. Working or

not working is not an option for women if families are having an economic hardship which causes no time for a doctor visit or a delayed visit for family health care (DeGennaro et al., 2018). For example, nurses understand the importance of health but with the demand for health care increasing with COVID it became harder to obtain care for themselves and their family (Ross et al., 2017). A woman spends an average of 4 hr a day performing domestic obligations on top of an 8-hr workday, compared to the male partners. Women today are spending extended hours at work (Vasumathi, 2018). They previously were able to devote this time to their family.

Working Women's Access to Preventive Health Screenings

Preventive health screenings can save a woman's life. Obtaining a mammogram or Pap smear can make the difference of having their next birthday, especially since breast and cervical cancer are preventable. For example, although cervical cancer is a highly preventable disease, an estimated 500,000 women are diagnosed with, and 275,000 die from, the cancer each year (Liebermann et al., 2018). A mammogram is an X-ray of the breast that serves as a tool for detecting early signs of breast cancer (CDC, 2021). Preventive health screenings assist women and their health care providers with finding these diseases at the beginning stages.

Women who worked for companies that promoted wellness may receive assistance in preventive health screening. Isehunwa et al., (2017) found that employee wellness programs that encouraged preventive health screenings saw higher rates of participation from women. In addition, women with paid sick leave were more likely to

seek preventive health screenings versus women that did not have paid sick leave (DeRigne et al., 2017).

Barriers to Accessing Preventive Health Screenings

Barriers can prevent women from accessing preventive health screenings which may cause a delay in care. These barriers included the lack of knowledge on how to navigate the health care system, inability to miss work, limited transportation, and alternative childcare (Boom et al., 2018). Poor awareness about the availability of preventive health screening benefits through the Affordable Care Act (ACA) resulted in low access to preventive health screenings (Alharbi et al., 2019). Women reported not knowing that ACA covered preventive health screenings for women without a cost (Boom et al., 2018). Understanding these barriers can provide women with the opportunity for access to preventive health screening.

Strategies to Access Preventive Health Screenings

The patient navigation program assists with obtaining access to preventive health screenings. The patient navigation is a community-based service delivery intervention designed to promote access to timely diagnoses and treatments of cancer and other chronic diseases by eliminating barriers to care (Chor & Haider, 2021). This program can serve as a connection between members of the community and health care employees, linking individuals from low-resource areas to preventive health screening (Chor & Haider, 2021). The combination of early detection and program as the patient navigator helped reduce barriers to preventive health screenings.

Mobile Health Clinics

An MHC is a motor vehicle staffed by physicians, nurses, and community health workers that travels to communities to deliver a wide variety of health services. MHCs can assist with overcoming barriers to access to health care and reduce barriers to health care access that includes transportation and time system complexity (Yu et. al., 2017). MHCs can reach sections of the population that are usually difficult to reach by providing more access to preventive health screening (Bertoncello et al., 2020). MHCs count for an estimated 2,000 MHCs throughout the country (Malone et al., 2020). MHCs can provide services to women for preventive health screenings. MHCs provide important services to patients that could not afford services, do not have access to services, or lack knowledge on to how to obtain services (Balogun et al., 2018). These clinics can provide quick, suitable, and quality health care for working women.

Providing preventive health screenings on an MHC comes with challenges. For example, the Breast Screening Norway project reported financial loss due to bad weather, downtime for maintenance, and unable to control parking to provide space for the MHC (Chen et al., 2016). In addition, the MHCs can interfere with other facilities for services for patients, lack of government funding, and the MHCs are not being utilized by patients (Samouei et al., 2016). MHCs make steps to reduce barriers while reducing challenge so that working women can get access to preventive health screenings. More investigation is needed to explore how MHCs could provide access to preventive health screenings for working women.

Summary and Conclusions

In the literature review, I explored themes of working women, access to preventive health screenings, and MHCs. I also explored how working women's lives are impacted after receiving preventive health screening from an MHC. The chapter also included in-depth information on the SEM, which was the conceptual framework for this qualitative study. The SEM offered a guide to understanding how working women experienced access to preventive health screenings through MHCs. In Chapter 3, I explain the research design, restate the research question, discuss my role as the researcher, and describe the research methodology. Chapter 3 includes a review of the instrumentation, data analysis, trustworthiness, and ethical procedures for this qualitative study.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study was to understand how working women experienced access to preventive health screening through using MHCs guided by the SEM. This study focused on working women who are not homemakers and sought preventive health screenings through MHCs. Chapter 3 provided a summary of the research design, the role of the researcher, methodology, and issues of trustworthiness of the study.

Research Design and Rationale

The research question was as follows: How do working women describe their experiences using MHCs to access preventive health screenings guided by the SEM? I used a basic qualitative approach to understand the experiences of working women's access to preventive health screenings through MHCs guided by the SEM. It provided a deeper insight into individuals beliefs, attitudes, motives, demands, or obstacles to understand their experiences with accessing preventive health screenings (Stuckey, 2013). I conducted this basic qualitative study to explore (a) in how people interpret their experiences and (b) what attributed to their experiences. The overall purpose of basic qualitative approach was understanding how people view their lives and their experiences (Merriam & Tisdell, 2015). The goal for this basic qualitative study was to uncover and interpret the experiences of the phenomenon of utilizing an MHC for preventive health care by working women.

Role of the Researcher

In this study qualitative study, I was the observer. My role was to observe participants as they answered questions about their experience with MHCs. As the observer, I collected data by looking and listening (Smit & Onwuegbuzie, 2018). I had no personal or professional relationship with any of the participants. I addressed biases by identifying them early. One bias that I identified is how I believe MHCs improve the ability for working women to obtain preventive health screenings. Outlining potential biases enabled critical evaluation of the research findings and conclusions (Smith & Noble, 2014). The reflexive journal assisted me in keeping biases out of the research by making me conscious and aware of potential biases that may come up to keep integrity of this qualitative study (Birt et al., 2016).

I included member checking and peer debriefing. Member checking is a technique for exploring the credibility of the study (Birt et al., 2016). By using member checking in my research study, it helped apply checks and balances to ensure the information presented is accurate and factual based on the participant's experiences. Peer debriefing is the process where a researcher asks a peer to assist in looking over parts of the research which included the methodology or analysis of data (Given, 2008). Peer debriefing helped with the credibility and trustworthiness of the study. Using peer debriefing in my research study provided a tool to offer transparency to keep the findings relevant to the research topic.

Methodology

Participant Selection Logic

The population for this qualitative study were working women who used MHCs for preventive health screenings guided by the SEM. The participants included working women who were not a homemaker, age 21 and over, having used an MHC in the past 36 months. I used purposeful sampling to recruit 13 participants who were working women and used an MHC for preventive health screenings. Purposeful sampling was used in qualitative research to identify and select information related to the phenomenon (Palinkas et al., 2015). The sample size of 12 to 15 was chosen for this qualitative study because it was a big enough sample size to allow for a new understanding of the phenomenon and small enough for analysis (Vasileious et. al., 2018). The purpose of the qualitative study was to identify the phenomena that working women experienced using MHCs for preventive health screenings that answered the research question.

The sample size of 13 participants was a good number to meet saturation. Saturation means that no additional data is being found (Saunders et al., 2018) Also, saturation assisted with criterion to judge when to stop sampling (Hennink & Kaiser, 2019). Saturation assisted me to determine when there was adequate data to understand the phenomenon. The phenomenon was based on the different participants' responses to the interview questions.

Instrumentation

The interview protocol included an interview script with open-ended questions. The development of the interview script was built from the literature. All interview

questions must align with phenomenon that the qualitative study seeks to discover (Roberts, 2020). The pilot study was an important part of the instrument development. The pilot study was a useful tool that addressed the flaws in the interview questions (Majid et al., 2017). Finding flaws in the interview questions early helped strengthen the interview questions and the opportunity to adjust the interview guide. The pilot study was a practical way for the researcher to administer a check and balance to determine if the interview questions achieved data saturation. Also, the first interview provided the opportunity to refine, rephrase, and clarify questions (Brod et al., 2009). The pilot study tested the validity of the interview protocol by ensuring that the instrument of measurement has addressed the concept it sets out to measure by including an adequate representation of the research study (Dikko, 2016). The purpose of the pilot study was to guide the researcher in determining the next steps to approach the research study methods.

Pilot Study

I conducted the pilot study to understand the method or steps to take in the beginning of the research process to identify participants for the study. A pilot study conducted before recruiting participants assists a researcher by (a) clarifying the proper criteria for selecting potential participants and (b) providing insight on how to improve the interview guide (Majid et. al., 2017). After the pilot study is completed, the data is reviewed, and the interview guide is updated as needed (Majid et.al., 2017). For the pilot study, I recruited two participants who met the study criteria. I interviewed them and used the data to determine if the interview questions needed to be changed. This is discussed

further in Chapter 4. When the pilot study was completed, I began recruiting participants to collect data for the main study.

Procedures for Recruitment, Participation, and Data Collection

I recruited participants through posts on social media (Facebook, Twitter, Instagram, and LinkedIn) and Craigslist, as well as a flyer placed at libraries, hospitals, and clinics. Appendix A contains the flyer and Appendix B, the letter I sent to organizations requesting assistance with dissemination of the flyer. Interested individuals emailed me, and I screened them to ensure they meet the inclusion criteria for the study (see Appendix C for the screening survey). If they met the inclusion criteria, I sent the consent form to the participant by email prior to the interview. After the document was signed and returned, the interview was scheduled based on my and the participant's schedules. The interviews were audio recorded and administered through Free Conference Call, a web-based platform. The participant received full disclosure explaining the purpose of the study and how the study was conducted before the interview took place.

Debriefing is an important part of the interview process. Debriefing was used to explain the goals, purpose, and outcomes of the study (McMahon & Winch, 2018) and to ensure the participants that the research study is confidential (Given, 2008). Debriefing was used to reclarify that information participants shared during the interview process was accurately captured and to close out the interview. Member checking was conducted to ensure credibility of the study. After every interview participants were emailed the transcripts and asked to return it within 48 hr of receiving it. Participants were sent a

reminder if the transcript was not received within 48 hr. Ten participants responded to the email that the transcript was correct and that no updates were needed. The other three participants did not return their transcripts.

Participants were offered $10.00 e-gift cards to Walmart as a token of appreciation for the time spent in the interview. When the recruitment process started there was a low response. I reached out to Walden University's Institutional Review Board to request a change to the type of e-gift card to help with the recruitment. Once the e-gift card was changed to a $10.00 Amazon gift card, the recruitment process seemed to move long faster and I was able to recruit more participants for the study.

Data Analysis Plan

Once the interview was administered the next step was to analyze the data collected. According to Merriam and Tisdell (2015) data analysis is the process of making sense out of the data. The process started with reading through interview transcripts. Then the SEM was used to develop a priori codes. The a priori codes were categorized and subcategorized to develop themes that answered the research question. Next, open coding included making notations next to pieces of data that stood out and was potentially relevant to answering the research question (Merriam & Tisdell, 2015). I followed Merriam and Tisdell's six step data analysis process, which was as follows:

1. Reviewed the purpose of the study.
2. Looked at the lens of the epistemological framework (focusing on how people experience a phenomenon) of people life experience based on class, or gender.

3. Coded the data, focused on patterns and insights related to the purpose of the study. Read the dataset and made marks in the margins with the main themes related to the interview using open coding to capture exact wording from the participants.
4. Stepped back from the data to see clearly to recognize patterns.
5. Returned to the data to review the merging data to help identify new themes.
6. The last step I combined codes from open coding into fewer and more comprehensive categories.

A basic qualitative approach was used to focus on how working women used an MHC for preventive health screenings. The information presented their life experiences for the research findings to help to close the gap between established knowledge and individualized knowledge (Charlick et. al., 2016).

Issues of Trustworthiness

In any qualitative research study, it is important to establish trustworthiness. Trustworthiness gives the study direction by examining the (a) credibility, (b) dependability, (c) confirmability, and (d) transferability (Lincoln & Guba, 1985). Credibility is the validity and reliability of the qualitative study (Lincoln & Guba, 1985). I used peer debriefing and member checking to establish credibility. Peer debriefing was the process of the researcher exposing themselves to another a peer who is not involved in the research to probe the researcher's thinking around all or parts of the research process to check the validity of the research (Given, 2008). The chair did the peer debriefing. Member checking or respondent validation was a technique for exploring the

credibility of results of the study (Birt et al., 2016). Member checking assisted the trustworthiness of my study. It was done by results being returned to participants to check for accuracy and resonance with their experiences (Birt et al., 2016).

Dependability was a factor of unstable and changed within the natural context (Lincoln & Guba, 1985). Reflexive journaling can address the integrity of this qualitative study by keeping written records of information obtained from interviews. (Lincoln & Guba, 1985). Reflexive journal assisted my research study by acting as a check and balance to keep trustworthiness in the study.

Confirmability was the capacity to authenticate the findings, interpretations, and recommendations (Lincoln & Guba, 1985). I established confirmability with an audit trail that provided information. To show credibility and trustworthiness with all the information disclosed. (Lincoln & Guba, 1985). Transferability was the result of qualitative research transferred to other contexts or study's findings (Lincoln & Guba, 1985). In this qualitative study, the content such as working women, MHCs, and preventive health screenings are transferable to another study.

Ethical Procedures

I obtained Institutional Review Board approval (no. 11-07-22-0393260) from Walden University to conduct the study. All participants were asked to fill out a consent form that gave me as the researcher permission to collect and audio record data provided during the study. Also, participants that took part in the interviews were offered a $10.00 e-gift card to Amazon for 1 hr of their time. The e-gift card was a great assistance with getting participants to take part in the interview.

Participants were informed that all information was kept confidential, and they were not required to answer specific questions if they felt uncomfortable with sharing. In addition, participants could withdraw from the study at any time. This did not have any reflection on their participation in any further studies with Walden University. I did not foresee any other ethical considerations that needed to be addressed, and none occurred. I maintained the confidentiality of the collected data, which I shared only with the Walden University Institutional Review Board and my chair. It was not shared with anyone outside the study and data will be kept for 5 years, in accordance with the Walden University policy. The electronic data is password protected and the hard copies are kept in a locked drawer in a home office drawer.

Summary

Chapter 3 provided an overview of how the qualitative study was conducted and how data was collected and analyzed. The issues of trustworthiness and ethical considerations were reviewed. The study sought to understand the experience of working women with accessing preventive health screenings through MHC guided by SEM. In Chapter 4, I will present the data collected and analyzed from the interviews.

Chapter 4: Results

Introduction

The purpose of this qualitative study was to understand how working women experience access to preventive health screenings through MHCs guided by SEM. The study design was a basic qualitative approach with the overall purpose to uncover and interpret phenomena experiences shared by working women. Open-ended questions were used to answer the following research question: How do working women described their experience using MHCs to access preventive health screenings guided by the SEM? Chapter 4 will provide the results which consisted of collected and analyzed data from the interview transcripts. The chapter begins with the pilot study, followed by the data collection process, data analysis steps, issues of trustworthiness, and ethical procedures. Lastly, themes supported participants' quotes that answered the research question.

Pilot Study

Two participants were recruited for the study. One participant from Facebook and another participant was someone I knew, who met the inclusion criteria for the study. Once they met the inclusion criteria, the consent form was sent to the participant by email prior to the interview. After the document was signed and returned, the interview was scheduled based on my and participant's schedules. The interviews were audio recorded and administered through Free Conference Call, which is a web-based platform. The participants received full disclosure explaining the purpose of the study and how the study was conducted before the interview took place.

I interviewed a total of two participants for 60 min each. The interview guide (see Appendix D) was used for the interview. The first participant had a hard time understanding the questions due to a language barrier, though she spoke English and met the inclusion criteria. The second participant spoke fluent English and understood the interview questions. This participant was able to answer the open-ended interview questions and validated the interview guide. None of the questions in the interview guide were changed. After successfully completing the pilot study, I seamlessly transitioned into the official data collection phase, initiating the comprehensive investigation outlined in the study protocol.

Setting

Participants scheduled interview times that were convenient for them. All participants were told to have a private location with no interruptions or distractions to take part in the interviews. I also was in an area with privacy to conduct the interviews without interruptions. It took flexibility to get all the interviews conducted over a 2-month period. The interviews were administered over Free Conference Call which is a web-based platform with audio recording capability for interviews. There were connectivity issues with sound and logging in, causing interview times to be pushed back or rescheduled. The connectivity issues and problems with logging in were the only organizational issues encountered. After completing the pilot study, I begin the official study.

Demographics

Thirteen working women participated in this study. Each participant met the inclusion criteria of being a working woman who worked at least 30 hr per week outside the home, was 21 years of age or older, and used MHCs for preventive health screenings in the last 36 months. I recruited 13 participants over a 6-week period. The recruitment strategy included social media (Facebook, Instagram, Twitter, and LinkedIn), Craigslist, and flyers placed in libraries, hospitals, and clinics. The interviews were audio recorded and administered through the web-based platform Free Conference Call. Interviews were scheduled for 60 min.

Recruitment for the study began on November 15, 2022. Only one person responded to the flyer posted on Facebook. With a low response rate, I applied to the Institutional Review Board for a change of procedure to change the type of gift cards I was offering for taking part in the study. Changing the type of gift cards assisted my recruitment efforts. Recruitment occurred over a 6-week period, ending on November 27, 2022, a period encompassing fall and winter holidays including Thanksgiving and Christmas. The holidays were difficult with low response rates. At the end of December, the recruitment response rate picked up. I was able to conduct interviews with 13 participants over a 2-week period. The average interview was 40 min, the shortest interview was 30 min, and the longest interview was 60 min. The variation was due to some of the participants having more experience to share than other participants.

I encountered other challenges in conducting some interviews. Because of connectivity issues, some participants had to reconnect the call because of a drop

connection or no sound. One participant had to take a 5–7-min pause from the interview due to a problem with her child. I reconnected with participants when the connection was lost from Free Conference Call or held while the participant had to step away from the call briefly. Also, I repeated responses back to the participant. I believe that these actions on my part reinforced the integrity of the study.

Data Analysis

Once the interview was administered the next step was to analyze the data collected. According to Merriam and Tisdell, (2015) data analysis is the process of making sense out of the data. I followed Merriam and Tisdell's six step data analysis process. Once the interviews were complete, I undertook the first step, which was to analyze the data I had collected. The SEM was used to develop a priori codes. Data analysis produced five a priori codes and 30 open codes. The open codes and a priori codes were categorized and subcategorized and developed into themes that answered the research question.

Second, I reviewed the purpose of the study, which was to understand how working women experienced access to preventive health screening through using MHCs guided by the SEM. Third, I looked at the lens of the epistemological framework (focusing on how people experience a phenomenon, my phenomenon was the experience of accessing MHCs for preventive health care) of people's life experience based on class, or gender. My population of study's gender were women, and their class were working at least 30 hr per work outside the home.

The fourth step involved coding the data by using the SEM to develop a priori codes. A priori coding was the first-cycle coding process. Next, I conducted open coding as the second-cycle coding process. I coded the data, focusing on patterns and insights related to the purpose of the study. I read the dataset and made marks in the margins with the main themes related to the interviews using the open coding to capture exact wording from the participants. Fifth, I stepped back from the data to clearly recognize patterns in the coding and grouped them into categories and subcategories. For the sixth and final step, I returned to the data to review the emerging data (categories and subcategories) to help identify new themes (Merriam & Tisdell, 2015). The codes, categories, and themes are shown Table 1. A more comprehensive list can be viewed in Appendix E.

Table 1

A Priori and Open Codes, Categories, and Themes

A priori code	Open code	Category	Theme
Community factors	Access Convenient Necessary Beneficial Informative Quicker Accessible Personal Faster	Access to care	MHCs offer informative, fast, and accessible access to care for working women.
Institutional factors	Schedules Flexible Full-time 40-hr workweek Conflict with hours	Constraints	Work Schedules Impede Working Women's Access to Health Care.
Interpersonal factors	Childcare Babysitter After-school care Transportation	Resources	Childcare and transportation reduce barriers to access to care for working women.
Intrapersonal factors	Mother's experience with health care Sisters' experience with health care Friends' experience with health care	Influence care by others	Working women obtain access preventive health screenings through word of mouth.
Public policies factors	Pap smear Blood pressure Mammogram Yearly physical Blood work	Preventive health screening procedures	MHCs provide working women access to preventive health screening.

Note. MHC = mobile health clinic.

Evidence of trustworthiness

In any qualitative study, it is important to show (a) credibility, (b) dependability, (c) confirmability, and (d) transferability, as explained in Chapter 3. Peer debriefing and member checking were used to establish trustworthiness. For peer debriefing, I met with my chair weekly to explain the data that was collected. Also, participants were able to look back over the interview transcripts once it was available to check accuracy to comply with member checking. The transcripts were emailed to the participants to review at their convenience.

Dependability is a factor of unstable and change within the natural context (Lincoln & Guba 1985). Data were collected across appropriate settings and time, open to all participants that met the criteria. Confirmability is the capacity to authenticate the findings, interpretation, and recommendations (Lincoln & Guba, 1985). As the researcher I was self-aware to remove my personal assumptions, values, and biases from the study. Transferability is the result of qualitative research that can be transferred to other contexts or study findings. The data captured from the study help create themes that were transferable to other studies that pertain to MHCs. These themes can be tested in future studies.

Results

Theme 1: Mobile Health Clinics Offer Informative, Fast, and Accessible Access to Care for Working Women

Participants described their experience with MHCs as more convenient, faster, and easier to get to than a doctor's office. They decided to use this option because it is

accessible without long wait times. Also, participants described MHC staff as being more personable. For example, Participant 03 stated, doctor's offices are "Not convenient for women because our day is always busy." Similarly, Participant 04 stated, "Experience with MHC to be more accessible and easier without the long wait." Participant 13 also stated, "Mobile units are normally quicker in and out." Additionally, Participant 07 felt that MHCs were more personable, stating, "MHCs is very informative and helpful."

Theme 2: Work Schedules Impede Working Women's Access to Health Care

Participants expressed that their work hours made it hard to visit a doctor's office because their operational hours were the same as the participants work schedules. This caused a barrier to access to preventive health screening for working women. For example, Participant 06 stated, "I work about 50 hr per week, it is hard to get an appointment." Similarly, Participant 10 remarked, "I work full-time position at 60 to 70 hr a week and I never can get an appointment." Additionally, Participant 05 stated "I work 40 hr a week and I schedule appointments months in advance.". Each participant demonstrated that working 30 or more hr outside the home made it difficult to visit a doctor's office.

Theme 3: Childcare and Transportation Reduce Barriers to Access to Care for Working Women

Participants explained that having their own transportation made it easier to make it to doctor appointments because they did not have to wait for a ride or public transportation. For example, Participant 11 stated, "I do own my own vehicle, so I can go

to my appointment." Similarly, Participants stated, "I drive myself to my appointment." Participants who had childcare made it easier to keep their doctor appointments. For example, Participant 03 stated, "My goal is to always make all appointments when my kids are in school." Similarly, Participant 07 stated, "Depending on the time of the appointment, I have to arrange after-school care for my children."

Theme 4: Working Women Obtain Access to Preventive Health Screenings Through Word of Mouth

Participants explained that they seek preventive health screens based on someone else's experience. Family members, friends, or coworkers recommended other women to get preventive health screenings. For example, Participant 10 stated, "My sister had breast cancer, that's why I sought preventive health care because of what happened to her. Similarly," Participant 05 stated, "I have a friend who is very health-oriented and has encouraged me and other friends to know their numbers." Additionally, participate 05 viewed older women as trusted source for a health care by stating, "Having older women around, you know and gone through all of this check."

Theme 5: Mobile Health Clinics Provide Working Women With Access to Preventive Health Screenings

During the interviews, participants discussed their understanding of preventive screenings and that MHCs provided access to preventive health screenings. The location was close and provided convenience for a mammogram or Pap smears for working women. They were able to take a lunch break to obtain a preventive health screening. Furthermore, participants explained they would keep up with getting their preventive

health screenings if MHCs were always available. For example, Participant 12 stated, "Someone in my family explained their first visit to MHC and how well it went." Women talked about their first experiencing with MHC and the purpose of a preventive health screening. Additionally, Participant 06 stated that "a Pap smear is required as a part of annual screenings."

Summary

In this chapter, I presented the five themes that emerged from data analysis and that answered the research question. Themes were derived from data collected, analyzed, and coded from transcripts of one-on-one interviews with participants. This study provided data for examining how MHC can offer access to preventive screening for working women. In Chapter 5, I further discuss the study findings, conceptual framework, recommendations, conclusions, and the implications for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Many working women do not obtain preventive routine preventive health screenings due barriers which included their 40-hr workweek, childcare issues lack of transportation, lack of workplace flexibility, out-of-pocket medical costs, and clinic hours that are the same as their work hours (Isehunwa et al., 2017). MHCs were used to increase access to preventive health screening (Bouchelle et al., 2017). and remove geographic restrictions due to its accessibility (Holen et al., 2019). In addition, working women were open to obtaining preventive health screenings through MHC when referred by another woman who had used MHC for preventive health screenings.

This qualitative study addressed a gap in the literature as there is little to no research on working women's accessing preventive health screenings through MHCs. The purpose of this qualitative study was to understand how working women experienced access to preventive health screening through using MHCs guided by the SEM. In this chapter I explain the five themes that emerged from the findings that answered the research question.

Interpretation of the Findings

The Findings in Relation to the Literature

Five key themes emerged from the data analysis and were confirmed by the literature discussed in Chapter 2 and new literature. Theme 1, MHCs offer informative, fast, and accessible access to care for working women. Participants described MHCs as more convenient, faster, and more accessible without long wait times, compared to

traditional clinics. Steingraber et al. (2022) noted that MHCs can reach sections of the population that are usually difficult to reach, making them more accessible. MHCs are effective, increase access, address barriers to transportation, and provide a better patient experience (Trivedi et al., 2022) Also, mobile mammography improved access to breast cancer screening among a large population of women in both urban and rural areas (Trivedi et al., 2022).

Theme 2, work hours conflict with access to health care for working women. Participants noted that most doctor's offices hours are similar to their work schedules, making it difficult for working women to make a preventive health screening appointment. These findings confirm the research that long work hours are risk factors for unmet health care needs (Lee & Rhie, 2021). Long work hours are associated with low health care utilization, such as working women not seeking preventive health screenings (Lee & Rhie, 2021). Participants expressed during the interview that if they had flexible work schedules it would assist in removing a barrier to access preventive health screenings.

Theme 3, Childcare and transportation reduce barriers to access care for working women. Having their own transportation and access to childcare made it easier for working women to schedule a preventive health screening visit, according to participants. This confirms the findings by Cochran (2022) that inadequate transportation can cause barriers for working women to seek health care. Women without a vehicle were more likely to encounter transportation barriers. The lack of transportation resulted in missed appointments and an increase in emergency visits (Cochran et al., 2022). Transportation

barriers are associated with parking fees, public transportation cost, uber cost, high cost of maintaining a personal vehicle and paying a friend to drive them to the appointment (Cochran et al., 2022). Also, in the literature households with one car were unable to get appointments because of their partner's schedule (Cochran et al., 2022).

The lack of childcare is a significant barrier to accessing preventive health screenings for working women (Alvarez et al., 2022). This research was confirmed by my study. Women often put off or post pone preventive screenings due to not being able to obtain childcare (Alvarez et al., 2022). Not being able to obtain childcare is associated with cost, childcare hours of operation, and lack of getting to childcare center or sitter (Alvarez et al., 2022). Women who struggle to find childcare during their appointment time have brought their children to the appointment rather than skip the appointment but lack privacy during the visit (Boom et al., 2019).

Theme 4, Working women obtain access to preventive health screenings through word of mouth. Participants knew about MHCs through word of mouth. The literature from Palmer, et.al (2022), stated hairstyles spend several hours a week with women and become a trust source for health care referral. This was an emerging theme that helped discover new findings in the research. The participants in the study explained that they were more open to visiting an MHC if they heard about it from another female. Someone else's experiences inspired accessing preventive health care in and MHC for working women.

Theme 5, Working women understand access to preventive health screenings. Participants understood the importance of preventive health screenings and felt MHCs

would help them keep on track. Mobile mammography was used to educate women in urban, rural, and mountain regions in the world about preventive health screenings (Drake et al., 2022). Also, the findings in the literature from (Siseho et al., 2022), contribute to the awareness of preventive health screenings. The participants in the literature who never had a Pap smear was more likely to get Pap smear after gaining knowledge about preventive health screenings.

The Findings in Relation to the Conceptual Model

The first system in the SEM is the microsystem, it is the closest to the individual containing the people with the strongest influences on them (Bronfenbrenner, 1979). The microsystem focuses on demographic characteristics, and the people who shape the individual's knowledge, attitudes, and beliefs. Theme 4, working women obtain access to preventive health screenings through word of mouth, reflects the microsystem. Participants said they heard about MHCs through word of mouth, demonstrating the people with the strongest influence on them. Theme 5, Working women understand access to preventive health screenings, reflects the microsystem. Participants understood the importance of preventive health screenings and felt MHCs would help them keep on track, reflecting their knowledge and beliefs about preventive health care screening.

The second is the mesosystem, which looks beyond immediate relationships to interactions such as the workplace, church, and other social activities where the individual is an active participant (Bronfenbrenner, 1979). Theme 1, MHCs offer informative, fast, and accessible access to care for working women, reflects the mesosystem. The participants described their interaction with the staff at the MHC where

they were an active participant in their health care. Theme 2, Work hours conflict with access to health care for working women, reflected the mesosystem. Participants noted that their work hours were similar to doctor's office hours, making it hard to make an appointment, this shows them as an active participant. Theme 3, Childcare and transportation reduce barriers to access care for working women, also reflected the mesosystem. The participants described the benefits of using childcare, where they were an active participant, which enhanced their access to MHCs. The third, fourth, and fifth systems of the SEM were not represented by the themes found in this study. This is not surprising since the study did not involve organizations where the individual was not a direct participant, a study of belief systems or culture, or ecological transitions.

Limitations of the Study

I explored how working women experienced access to preventive screenings through MHCs based on SEM. There are three identified limitations to the study. First, connectivity issues resulted in the participants and me having to reconnect because of the dropped connection and lack of sound. Second, one participant had to take a 5–7-min pause from the interview due to a problem with her child. I waited patiently until the client returned to the line. After the participant returned to the line, I asked the participant whether she would be okay with continuing the interview or she would like to reschedule; the participant decided to continue the interview. Third, I found it difficult to understand some participants because of their accents. To address this issue, I repeated these participants' answers to confirm that I was correctly interpreting their responses. Also, I

typed some of their responses in the chat feature to double-check that I had accurately captured their perspective.

Recommendations

This study had a small sample size. A qualitative study with a larger sample size is recommended to understand if word-of-mouth influences MHC access. A quantitative study, or mixed methods study on the relationship between word-of-mouth referrals for preventative health screening and MHC access would also be recommended, looking at age, employment status, and other variables. Given the opportunity to present to Congress and the U.S. Department of Health and Human Services concerning the need for guaranteed access for women working over 30 hr or more a week. The enactment of a new preventive health screening policy is merited based on the findings of this study. Employers would initiate the PHSP to include bonus paid workday for preventive health screening appointment. This would not exhaust employee time off allotment (paid time off, sick time, vacation, birthday, and bereavement). This policy would not discriminate again gender identity. In addition, all exempt and nonexempt employees would be eligible. Insurance companies will broaden their in-network options to include preventive health screening at facilities with flexible hours. This policy would ensure that this change in coverage would be available for all employee health plans.

Implications

This study impacts positive social change by demonstrating that an MHC is a key solution to reducing barriers to access to preventive health care for working women. During this study participants stated that an MHC was a more convenient option than a

visit a health care provider in a fixed location. Also, MHCs can expand preventive health screenings geographically which allows more women to be seen more than traditional clinic visit During the study women explained that they were felt more comfortable with asking questions that pertained to their health such as important getting importance getting mammogram to assist in early detection for breast and cervical cancer. Overall, this study demonstrated that MHCs are a key factor in closing the gap in health equity for preventive health care screening for working women.

Conclusion

This study demonstrated that MHCs can be a key factor to improving access to preventive health care for working women. As a working woman myself that work 30 or more hr a week, I appreciate the opportunity to have an alternative way to receive preventive health care. MHCs can provide preventive health screenings that are more convenient with shorter wait times than fixed health care clinics. This study started to identify preventive health care resources for working women that could increase their knowledge about the importance of preventive health screenings. The results of this study could be used to secure grant funding for nonprofit organizations or create government partnerships to increase access to MHCs. Providing these opportunities may increase access to preventive health screenings for working women.

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Appendix A: Recruitment Flyer

VOLUNTEERS NEED FOR A QUALITATIVE RESEARCH STUDY

This research study is being conducted by Charlotte Clark-Rowe, a doctoral student from Walden University. The purpose of this study is to understand how working women experience access to preventive health screening through mobile health clinic (MHC).

Eligibility Criteria

- Females over 21 years of Age
- Working Women not a homemaker and work 30 hours or more a week.
- Received Preventive Health Screening with in the last 36 months through MHC.

Procedures

- Complete a screening questionnaire.
- Participate in an audio-recorded interview that will take about 60-minutes.
- Review summary of the interview for accuracy (takes about 10 – 15 minutes).

Study Risk

Participating in this study could involved the risk of minor discomfort such as sharing sensitive information. Also, participants information will be kept confidential, and they are not required to answer specific questions if they feel uncomfortable with sharing. In addition, they can withdraw from the study at any time.

I will email a $10.00 Bath & Body Works gift card to participants at the completion of the interview.

Individuals interested email me at charlotte.clark-rowe@waldenu.edu.

Appendix B: Request for Organizations to Disseminate Recruitment Flyer

TO WHOM IT MAY CONCERN:

My name is Charlotte Clark-Rowe, a doctoral candidate student at Walden University working on my dissertation research study. The purpose of this qualitative study is to understand how working women experience access to preventive health screenings through mobile health clinics. The study will consist of one-on-one interviews to collect data. The participant criteria for the study (1) females over 21 years old, 2) working women (not a homemaker), 3) received preventive health screenings on MHC within the last 36 months, and 4) willing to take part in about 60-min interview over the phone or Zoom (an audio record).I am requesting permission to post flyers on your website, community board, bulletin board to recruit participants for my research study.

Thank you for your time,

Sincerely,

Charlotte Clark-Rowe

Ph.D. Candidate

Walden University

Appendix C: Screening Survey

Screening Survey

Please complete the following questions:

1. What is your gender? Male_____ Female_____
2. Your Age 21-35_____35-45_____45-55_____
3. Are you currently employed?

   _____Yes, outside the home but not a homemaker

   _____No, I'm a homemaker.
4. Did you receive preventive health screenings within 36 months by MHC?

   _____Yes, please provide date(s)

   _____No,
5. What type of preventive health screening did you receive on MHC?

   _____Breast Cancer Screening

   _____Cervical Cancer Screening

   _____Both Breast & Cervical Screening

   _____Other: _____

Appendix D: Interview Protocol

Hello, my name is Charlotte Clark-Rowe, a doctoral student at Walden University. The purpose of this study is to understand how working women experience access to preventive health screenings on MHC. We will go through several questions, and it may take about 60- minutes.

Before getting started, I want you to be aware of several things. I may quote information that you say but I will not include names or any personal information that will identify you. If there is information you don't want me to quote, please let me know. This interview is completely voluntary; you are free to stop the interview at any time. There will be a transcript of this interview report emailed to you once it is complete. This study will pay a $10.00 email gift card for all individuals that complete the interview. Lastly, this interview will be audio recorded to assist me in not missing any information during our interview.

At this time, do you have any questions for me before we get started? If no, I will start the audio recording now. For the recording state, I agree to be audio recorded for this interview.

Answer each question based on your visit to MHCs.

1. Explain what type of work do you do?

   Probing questions:

   a) Do you work part-time or full-time?

   b) How many hours do you work per week?

   c) Is overtime required?

   d) How long have you been with your present employer?

   e) How flexible is your work schedule?

2. How does an organization promote preventive healthcare?

   Probing questions:

   a) What types of preventive healthcare does your organization provide (e.g., vaccinations, fitness center, urgent care, primary care)?

   b) What type of incentives does your organization offer for preventive health screenings?

3. What type arrangements do you prepare for your preventive health screening appointment?

   Probing questions:

   a) What type of transportation do you need for your appointments?

   b) What type of childcare arrangements do you need prior to your appointment?

   c) Is there any arrangement required at work before scheduling the appointment?

4. What does preventive screening mean to you?

   Probing questions:

   a) What type of services are considered preventive health screenings?

   b) When is a Pap smear required?

   c) When is a mammogram required?

   d) How often do you get a Pap smear?

   e) How often do you get a mammogram?

5. How have other women influenced your decision to seek preventive health screening? Including from an MHC

   a) Describe how women in your family have influenced your seeking preventive health screening? Including from an MHC

   b) Describe how your female friends have influenced your seeing preventive health screening? Including from an MHC

   c) Describe how your female work colleagues have influenced your seeking preventive health screening? Including from an MHC

6. How did you find an MHC for preventive health screening?

   Probing questions:

   a) Explain the MHCs relationship with your insurance (e.g., was the MHC part of your insurance provider?)?

   b) What is the process when you are referred to MHC by a doctor?

   c) How does the referral process work when using your insurance?

   d) Explain the copay process when using your insurance?

Is there anything else you would like to add? If you do not have anything else this concludes the interview. After this interview, if you think of anything else, please do not hesitate to email me at charlotte.clark-ro we@waldenu.edu.

Look for an email from me over the next few weeks with a transcript of today's interview.

Again, thank you for your time.

Appendix E: A Priori and Open Codes, Categories, Subcategories, and Themes

AC	Open Code	Participants	Excerpts	Category	Subcategory	Theme
01 Community Factors	Access Convenient Necessary Beneficial Informative Quicker Accessible Personal Faster	01 02 03 04 05 06 07 09	I feel like was a little bit more personal. I find mobile health clinics could be very necessary and important. …think haven't convenience for women because our day is always so busy. I think a mobile unit would give you faster access and just the ability to be more …convenient. using the mobile health clinic gave you of a more of a variety base. I think it be more beneficial. I think the ease here. We are accessible. …seem very informative and helpful I think these kinds of clinics are imperative	Access to Care	Convenient Personal Faster Quicker	MHC's offer informative, fast, and accessible access to care for working women.

		10 12 13	with helping you know, women keep up with their, you know, their checkup very important women's health to make sure they get their di know mammograms. …mobile units are normally quicker in and out. the mobile unit, I think, would be so nice for us as women because it gives us the convenience of doing it at our time and not being overwhelmed. . mobile unit available could prevent a lot and catch a lot of things earlier.			
02 Institutional Factors	Schedules Flexible Fulltime 40-hr Work Week Conflict with Hours	13 06 01 11 10	Full time between 40 Full time between 40 and 50 hours a week work schedule is very flexible. . It's pretty flexible.	Constraints	Work Schedules Conflict Fulltime	Work hours conflict with access to healthcare for working women.

		05 13 06	part time work per week 30 hours about 50 hours per week makes it hard get appointment full time position. I work 60 to 70hours a week and I never can get an appointment. Full time. I work 40 hours a week. I schedule appointments months in advance.			
03 Interpersonal Factors	Childcare Babysitter After School care Transportation	01 02 03 04 05 07 02	"I drive myself." "I drive myself to my appointments." "Typical a car" "I do own my own vehicle so I can go to the appointment." "I have to drive my own vehicle". Depending on the time of the available appointment, I have to arrange after care after school care for my children.	Resources	Childcare After School Care Transportation	Childcare and transportation reduce barriers to access to care for working women

		03 07 11	My goal is to always make all appointments when my kids are in school.			
04 Intrapersonal Factors	Mother Experience with Healthcare Sisters Experience with Healthcare Friends Experience with Healthcare	12 13 10 13 10 04 08 05	Typically watch my daughter or I try to while she is at school. If they are not in school or daycare when I go and I would have either my mother or my grandmother, or I had to take them with me. I have to get a sitter for my baby for my appointment. I probably have to schedule childcare. My sister had breast cancer, that was why I sought prevent health care because of what happened to her. Having older women around women who		Influence Care by others	Working women obtain access preventive health screenings through word of mouth.

			have already, you know, gone through all of these checkups prior to you know me reaching the age of having to do mammograms.			
05 Public Policies Factors	Pap smear Blood Pressure Mammogram Yearly Physical Blood Work	10 04 08 05 12	"I have a friend whose very heath oriented, and she has encouraged myself and other friends to keep know the numbers and get out screenings." . someone in my family actually have explained to me how well would during "A pap smear require pap smear is a part of the annual screening. …how about a pap smear and	Preventive Health Screening Procedures	Pap smear Mammogram Yearly Physical	MHC's provide working women access to preventive health screening