

High Risk Community—Men's Perceptions of Black Infant Mortality: A Qualitative Inquiry

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Infant mortality has been identified as a key public health concern in the United States. Although infant mortality rates (IMRs) in the United States have declined during the past 10 years, the rates among Blacks are more than two times higher as compared with other racial and ethnic groups. This study used focus groups to explore Black men's awareness and perceptions of the rising IMR in their community. Twenty-five men participated in an initial and follow-up focus group, which revealed that men had limited awareness

of infant mortality, reduced sense of personal responsibility for pregnancy outcomes, and perceptions that stress, the age of the mother, and the health care system were responsible for poor birth outcomes. The role of the community and possible interventions to involve and educate men were also explored.

Keywords: infant mortality; African American; male perspective; community research; qualitative research; Black infant health

Introduction

Infant mortality has been identified as a key public health concern in the United States. Although infant mortality rates (IMRs) in the United States have declined during the past 10 years, the rates among Blacks are more than two times higher as compared with other racial and ethnic groups (Lu & Halfon, 2003; Milligan et al., 2002; Schempff, Branum, Lukacs, & Schoendorf, 2007). As part of *Healthy People 2010*, a national health objective set a target rate of 4.5 infant

deaths per 1,000 live births (Centers for Disease Control and Prevention [CDC], 2005; Lu & Halfon, 2003; Milligan et al., 2002; U.S. Department of Health and Human Services [USDHHS], 2000). Furthermore, the elimination of racial and ethnic disparities was designated as one of the overarching goals for *Healthy People 2010* (CDC, 2005; USDHHS, 2000).

Following the nation's lead with *Healthy People 2010*, the Florida Department of Health (FDOH) developed a report to guide planning and intervention efforts for children and youth, titled *The Health of Florida's Children and Youth: Atlas of Key Status Indicators, Goals, and Objectives for Strategic Planning* (FDOH, 2002). Three key goals were developed to inform the work of policy makers, public health professionals, and service providers to (a) help all children reach their full potential; (b) reduce mortality and morbidity in children and youth; and (c) reduce disparities in health outcomes (FDOH, 2002). Additionally, a leading health indicator was developed to address low birth weight (LBW), birth defects, and infant mortality.

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Although Florida has experienced declines in its IMR, the state rate consistently exceeds the national rate (FDOH, 2002). Furthermore, a racial disparity between the IMR for Black babies and White babies exists at the state level. The national IMR is 6.9 per 1,000 live births (Office of Minority Health and Health Disparities [OMHHD], 2007), whereas the overall IMR in Florida is 7.2 per 1,000 births (Florida Community Health Assessment Resource Tool Set [Florida CHARTS], 2007). At the state level, the IMR for Blacks in Florida is 13.2 per 1,000 live births as compared with 5.5 per 1,000 live births among Whites (Florida CHARTS, 2007). In 2007, the FDOH released data reporting that the Black IMR in Hillsborough County had increased from 16.8 per 1,000 live births to 18.4 per 1,000 live births between the years 2002 and 2006; however, the IMR for Whites in the same county had dropped from 6.9 per 1,000 births to 6.0 per 1,000 births (Florida CHARTS, 2007). The Black IMR in Hillsborough County is 2.5 times higher than the overall IMR for the state of Florida and significantly higher than the national IMR (Florida CHARTS, 2007; OMHHD, 2007).

Studies have demonstrated that Black women are at higher risk than White women to have LBW and very low birth weight (VLBW; Krieger, 2000; Lu & Halfon, 2003; Reichman & Teitler, 2006; Rowley, 2001; Schempf et al., 2007; Yang, Greenland, & Flanders, 2006) births. LBW and VLBW births result in higher IMRs and are associated with more health-related complications (Bailey & Byrom, 2007; Lin, Chen, Chen, Lu, & Li, 2007; Yang et al., 2006). Interestingly, the protective factors for VLBW among white women, such as college education, good health, and access to prenatal care, were not identified to provide the same level of protection for Black women (Rowley, 2001). In fact, comparative analysis of Black and White women who had similar educational levels and socioeconomic status shows that the gaps in IMRs were wider (Rowley, 2001). Moreover, predictive factors for VLBW in White women, such as marital status and educational level, were not predictive for Black women (Rowley, 2001).

New frameworks exploring infant mortality among Black women suggest that a broader perspective be integrated in studies. When examining the disparities in IMRs among Black families, recent studies have begun to link biological issues with psychological issues and social behavior with consideration of cultural, historical, political, and economic factors (Hogan & Ferré, 2001; Rowley, 2001). Furthermore,

studies have begun to examine factors beyond the period of pregnancy to lifestyle and sociocultural issues that may affect the mother's health and, consequently, the infant's health (Lu & Halfon, 2003).

Pregnancy can intensify stressors experienced within many aspects of life, including but not limited to family, partner relationships, children, community, work, housing, and income (Hogan & Ferré, 2001). Furthermore, it has been suggested that psychological and physical stressors experienced by Black women, such as inadequate housing, racism, stigma, discrimination, and occupational hazards, may influence pregnancy outcomes (Hogan & Ferré, 2001; Lu & Halfon, 2003; Rowley, 2001). Therefore, the magnitude of pregnancy-related stressors may be increased among Black women (Hogan & Ferré, 2001). For example, Black women who reported having experienced some form of racial discrimination have been identified to be 3.3 times more likely to have a VLBW infant (Krieger, 2000).

There is a paucity of information regarding the father's influence on pregnancy outcomes, although a few studies have explored the male partner's role within infant mortality. Some studies have reported that increased paternal age is independently and positively associated with LBW and preterm birth, which are strongly linked with infant mortality (Astolfi, De Pasquale, & Zonta, 2006; Reichman & Teitler, 2006; Zhu, Madsen, Vestergaard, Basso, & Olsen, 2005). Advanced paternal age has been associated with sperm abnormalities, preeclampsia, miscarriage, and some birth defects (Astolfi et al., 2006; Reichman & Teitler, 2006).

Some studies have explored the influence of partner violence on pregnancy outcomes. Although the prevalence of partner violence during pregnancy varies, the potential adverse outcomes may have a direct affect through physical or sexual trauma and pregnancy complications or an indirect affect through stress, maternal behaviors, and mental health issues (Coker, Sanderson, & Dong, 2004). Several studies have demonstrated a positive association between partner violence and LBW as well as preterm delivery (Coker et al., 2004; Janssen et al., 2003).

Given the increasing number of nontraditional households, including those with lone mothers or single mothers, some studies have investigated the role of parental status in infant health outcomes. Lone mothers are reported to be at higher risk for adverse pregnancy outcomes, such as LBW (Gaudino, Jenkins, & Rochat, 1999; Pattenden,

Dolk, & Vrijheid, 1999). Consequently, paternal involvement has been identified to be a protective factor against LBW and infant mortality (Gaudino et al., 1999). Lack of paternal involvement is linked with socioeconomic inequalities that may result in absence of or inadequate prenatal care (Gaudino et al., 1999). However, previous studies on the paternal role in pregnancy outcomes have been primarily epidemiological in nature, examining vital statistics and birth registry data (Astolfi et al., 2006; Reichman & Teitler, 2006; Zhu et al., 2005).

The male partner may also affect infant birth weight indirectly through sociocultural issues, including financial and/or emotional support, increased stress, and access to health care (Reichman & Teitler, 2006). One qualitative study (Milligan et al., 2002) identified the role of the infant's father as a primary motivator for women to seek prenatal care. Additionally, the male role could be a barrier to care, if the man did not accept responsibility or provide partner support.

This study sought to examine the role of Black men's perceptions of infant mortality in a high-risk community in the state of Florida. Specifically, the goal was to explore men's perceptions of recent data showing that their community had an IMR higher than the state and national average. This analysis is drawn from a wider study conducted by the authors to explore a community's perception of the Black IMR in their community. This is the first known study to examine the perceptions and beliefs regarding male involvement in adverse pregnancy outcomes among Blacks at the community level.

Methods

The target community for this qualitative study was a county in Florida identified as having a Black IMR that was among the highest in the state. Black men who lived within this county were recruited to participate in community listening/focus groups to explore their perceptions of the recent infant mortality data and their knowledge of community-based programs designed to reduce rates of infant mortality and morbidity. Promotional flyers were placed in community settings, such as nonprofit organizations, churches, parks, and recreation centers. The Institutional Review Board at the University of South Florida approved this study, and each participant signed an informed consent form. Participants

received a \$25 gift card as compensation for their time and refreshments were provided.

The goal was to use a maximum variation sampling strategy to capture and describe the central themes that expand across a variety of social constructs (Patton, 2002). The men were placed in one of three groups based on age and number of children: aged 18 to 25 with no children; aged 26 to 40 with at least one child; and aged 41 and above with or without children.

A second listening group was held 2 months later to validate the responses and conclusions from the original session. Respondent validation is a qualitative technique to increase the validity of results (Barbour, 2001; Silverman, 2003). During this second listening group, participants were shown the results of the original session and asked to comment on their veracity and evaluate the conclusions. Participants from the first listening group were invited to return for this follow-up process; the resulting group comprised 16 men, 8 of whom had attended the first session.

All focus groups, during both the first and second listening sessions, were led by a trained Black male group moderator and assisted by a trained comoderator. The focus groups lasted approximately 1.5 hours and were audiotaped. All focus group sessions were conducted using the same semistructured interview guide containing six questions (Figure 1). A professional transcriptionist transcribed the audiotapes verbatim.

A qualitative interpretive approach was used, merging constant comparison with thematic analysis (Rich & Ginsburg, 1999; Tones & Green, 2004, pp. 178-193). The data were analyzed for key themes using the a priori objectives from the focus group guide. Three trained research assistants and the lead author worked to establish a general code list based on a review of three transcripts. This code list was further refined after a review of each person's initial coding pass. Two further passes of the same transcripts were reviewed, leading to the development of a final code list. An interrater reliability rate of .90 was established (i.e., data were independently coded, and results were compared for agreement) across the four raters (Armstrong, Gosling, Weinman, & Martaeu, 1997). All the remaining transcripts were coded for key themes. In Table 1 we give a summary of key themes from the transcripts, with sample quotes to illuminate the themes. The differences are noted where appropriate, along with majority (most of the people) and minority (a few of the people) responses.

1. State reports show that Black babies die in the first year of life more than four times the rate of White babies. What is your first reaction to this?
2. Many of the babies who die before age 1 are born premature (too small, too soon; premature means before 36 weeks of pregnancy, and a normal pregnancy is between 38-41 weeks. Researchers who study infant health aren't completely sure why more Black babies are born premature than White babies. Why do you think this is?
3. What are good ways to get information about preventing infant deaths and premature birth to mothers (and fathers)?
4. Do you know what the Healthy Start program is? Here is a flyer that describes the program. I will read a description of the program from the flyer.
5. What do people in your community think about "home visits"?

Figure 1. Focus group questions.

Results

A total of 17 male respondents, ranging in age from 19 to 75 years, participated in the first series of listening groups. All respondents had at least some high school education; 35% had a college degree ($n = 6$). The men were divided into three separate groups for the discussion: those aged 18 to 25 with no children (47%, $n = 8$); those aged 26 to 40 with at least one child (24%, $n = 4$); and those aged 41 and older with or without children (29%, $n = 5$). Table 1 provides a summary of the key themes that emerged from the focus groups.

Response to Infant Mortality Data

At the beginning of the focus group session, participants were asked to consider this question: "State reports show that Black babies die in the first year of life more than four times the rate of White babies. What is your first reaction to this?" The majority of respondents were surprised to hear this information. Many remarked it was the first time they had heard this statistic and it shocked and saddened them: "What are they dying from? Do we know?" "Shocking and . . . I'm wondering why is that; I never knew that until today." "The thing that's disappointing as knowing the fact is knowing that people in our community don't know about it."

Some respondents said that the issue of infant mortality is not discussed in the community. "It's not a topic of conversation that you find Black people interested in talking about." "The word is not getting out . . . the information is just not out to people."

Among the men interviewed, there was concern expressed about racial differences regarding the IMR. When one group member suggested that it may be because of stress, the group pondered that idea. In exploring possible stressors, some suggested

that financial burdens as well as barriers to accessing and using the health care system may be the cause of the disparate statistics. "What's the difference between Black babies and White babies? Why Black babies seem to be dying so much more quickly? I mean, is it that the health care isn't adequate or the parents ain't following up with stuff?"

Furthermore, the male participants discussed the lack of personal responsibility, parental concern, education, and resources as possible factors in the disparity in infant mortality.

People ain't doing what they supposed to be doing as far as their children, spending time with them, making sure they making those doctor's appointments. A lot of guys out there, they really could care less about they kids, so even some mothers are like that. Too many people just don't really care.

You know, a lot of parents, you know, they're not responsible. They're not concerned that, I mean, the medication or whatever you mentioned, you know, you can't smoke; you can't drink; you gotta watch what ya eat cause you have another life living inside you. You know, stress is a big factor; stress is.

Some participants also identified stress of the mother as something that could directly and/or indirectly affect the wellness of the infant: "I know a lot of times the babies—babies take on whatever type of emotions that you're feeling. They're trying to put on a persona like everything's going ok because babies can pick it up and sense that." "A lot of single parents . . . They are going through stress because they're living for survival, trying to just provide into the world rather than even thinking about good nutrition, prenatal care."

Suggested Reasons for High Infant Mortality

The next focus group question asked the men to consider the infant mortality data: "Many of the babies who die before age 1 are born premature (too small, too soon; premature means before 36 weeks of pregnancy, and a normal pregnancy is between 38 and 41 weeks). Researchers who study infant health aren't completely sure why more Black babies are born premature than White babies. Why do you think this is?" The respondents listed multiple factors that may be associated with the increasing rates of infant mortality and prematurity, such as financial stressors, lack of education, feeling judged and experiencing

Table 1. Key Findings and Illustrative Quotes From Focus Groups of African American Men

Lack of awareness	<p>“It’s not a topic of conversation that you find Black people interested in talking about.”</p> <p>“The word is not getting out . . . the information is just not out to people.”</p>
Lack of personal responsibility	<p>“People ain’t doing what they supposed to be doing as far as their children, spending time with them, making sure they making those doctor’s appointments. A lot of guys out there, they really could care less about they kids, so even some mothers are like that. Too many people just don’t really care.”</p> <p>“You know, a lot of parents, you know, they’re not responsible. They’re not concerned that, I mean, the medication or whatever you mentioned, you know, you can’t smoke; you can’t drink; you gotta watch what ya eat cause you have another life living inside you. You know, stress is a big factor; stress is.”</p>
Maternal stress	<p>“I know a lot of times the babies—babies take on whatever type of emotions that you’re feeling. They’re trying to put on a persona like everything’s going ok because babies can pick it up and sense that”</p> <p>“A lot of single parents . . . they are going through stress because they’re living for survival, trying to just provide into the world rather than even thinking about good nutrition, prenatal care.”</p> <p>“I think man is the problem why those kids are dying because a man can relieve a woman of stress . . . So, I think we should focus on the man’s role in infants dying so we can see the man has not been there for his woman, the man does not hold a job. See, the man causes stress also. The woman is carrying the kid; it’s a problem and the man a problem also. She’s gotta worry about a household to take care of and stress the baby gonna get fat. Old man is a part-time lover—that’s stress enough.”</p> <p>“I know in our focus group that stress was like a big issue, and stress on different levels, so I think it’s interesting that stress was the even denominator of all the other groups as well.”</p>
Lifestyle and behaviors of pregnant women	<p>“I’ve seen pregnant women smoking; I’ve seen pregnant women drinking; I’ve seen pregnant women trying to do everything that they was doing before they was pregnant and it’s like they don’t wanna wake up to realize that they gotta make that sacrifice and stop doing certain things.”</p> <p>“Well, is mama in the clouds shaking her butt while she’s pregnant? I personally, I know women who drink and smoke while they pregnant. They’ll light up a blunt so quick, and oh, I’m pregnant; ah, don’t worry; it won’t hurt the baby, you know, things like that. You got to be responsible for your child.”</p>
Young age of mother	<p>“Some of them get pregnant at 13, 14, 15, and they don’t know they bodies quite well as the older ones do so really they don’t know they pregnant till maybe they’re 7 months already . . . some of them don’t feel it . . . and some of them know they pregnant but they just don’t wanna tell so that’s why they miss out on appointments; they don’t get the prenatal pills . . . that’s why some of those babies come out premature.”</p> <p>“A lot of young Black women that have babies before they’re married, you know, when they young, you know, so they’re not ready to have kids. They just girls, and they dealing with all kinds of stress, all kinds of issues, and they’re blinded because they don’t know cause they did drugs, so they don’t think about Lamaze classes. They thinking about where my baby dad at or this problem and that problem. They’re not thinking about all the things that they should be doing and then the stress that makes them smoke, and you know, drink. It’s like a chain reaction, even if the baby don’t die.</p>
Education and outreach on infant mortality	<p>“Community intervention—things that’s set up in different places within the community where people actually go and talk, have different functions set up.”</p> <p>“I think it should be implemented in the classroom and like, I think the best way to do that is make it more of varieties . . . you teach the kids while they young so when they grow up, you know, they be at least educated on the choices that they make.”</p> <p>“I would look into trying to talk about these things before they get pregnant, so they do understand the importance of the child and whatnot, not when it’s too late, you know, when they already pregnant; their mentality’s already set. I don’t know if it’s being done. . . . So, some proactive measures might need to be looked upon.</p> <p>“It all starts in school, and I think parenting skills play a role in that.”</p> <p>“Somebody droppin’ the ball along the way. I think that schools are responsible also for getting the word out. I think that we oughta hear everything that we can come up with to get that out.”</p>

(continued)

Table 1. (continued)

	<p>“I didn’t see nothin’ about music in that whole thing. I didn’t see anything said about love in that whole session. If you didn’t put more love in the game and didn’t spread to the music, cause we all love music—that was not said. Love and music. And we need some tolerance, need some obedience, need a lot of one-on-ones.”</p> <p>“You know, in our neighborhoods, you know, Black neighborhoods all over the country, these younger people, they gonna click to music ’cause they wanna hear it. I know they go around and have health fairs and stuff in the projects, and they bring music and everything, and that’s what brings the younger people out.”</p> <p>“Yeah, but if you can put the information out there, it has to be on that person to wanna take steps to do what they gotta do, you know.”</p> <p>“You can put all the pamphlets, you can put it on the side of a bus, on a billboard, you know, you can out it in a video game, a comic book, don’t matter; they’re not gonna see it, but you just do the best that you can to make sure people are aware of that but really, it’s on the parents responsibility to follow-up with that. You can do what you can do and that’s the best you can do.”</p>
Finances	<p>“The situation about the men and women, given the financial stress that come up. And raisin’ the kids and having the responsibility and the resources to raise [them] . . . that stuck out.”</p> <p>“To raise the baby now, financially, yes, is very stressful. I mean, there are days you don’t know where the money’s coming from.”</p> <p>“When it’s free, we won’t ask questions... but when we have to pay for that service, we tend to ask more questions... You’ll take care of it cause it’s free but then to pay for that service – you’ll look more into that situation.”</p> <p>“Everything can’t always be fiscally minded. Everything can’t just be like, we’re going to give you something just for your own benefit. See, we also need to find ways to train people to be able to come out and start speaking out, stand up for what they want.”</p>
Fear	<p>“These young people are scared. They’re scared. And that’s why the message isn’t getting across like it really needs to because they’re too afraid to speak up, you know, and that’s also part of being a Black man, a Black adult, you know, where it comes from your parents. They have to also speak up for themselves. Stop letting it just float by and keep doing this.”</p> <p>“I’m born in the South. I’m a Floridian, all my life in Florida. And see, we in the South was passed down; my mama was still scared of the White man. And her grandparents were slaves, you feel me? So, we didn’t have the right to talk, and we still feel uncomfortable talking.”</p> <p>“The reason why people don’t go to the doctor is because half of them are scared—Black or White. Cause they’re afraid of the results they might hear, and they fear they’re a part of that epidemic.”</p>
Health care system	<p>“The thing is that we, as a people, cannot perceive what’s going to happen. We walk in here saying that something bad is gonna happen. We can’t perceive to the point where I come in, I sit down, the doctor’s gonna tell me da-da-da-da, and it’s bad. That’s it. We cannot walk into a doctor’s office—we just can’t do it.”</p> <p>“Sometimes, we can see the big picture, and then, when I go to the White community, their churches on their side of the town, and the boss on the other side. But, in the Black community, when you getting stuck on that little 13” in black and white, and you lookin’ at the big screen and seein’ the big picture, and you see how the White man has manipulated the system, not only for our generation but for the new generation.”</p> <p>“Healthcare system in the South is worse, and Black people don’t get treated right . . . I know the healthcare system is bad. I know they treat people with disrespect, and they give you these looks and everything else like you a second class citizen, and being Black, well all of us are Black, and being Black here in the South, I can’t understand sometimes. That’s why I keep coming back. It’s because our people—our plight is bad, and we have to stand on it, and there’s not a lot of us to come . . . We have to look at it and speak up, and being Black men, we have to be strong. For one, we gotta be strong for our children, our young Black women, young Black mothers.”</p>

prejudice within the health care system, difficulty navigating the health care system, lack of reliable transportation, and the young age of mothers. Most men felt that the process of applying for health care benefits, such as Medicaid, was difficult and may be even more difficult for a young woman. “Go and apply for Medicaid, you gotta go through a act of Congress.”

The majority of men noted that some women (especially teens) did not change their lifestyle when they discovered they were pregnant. The men’s discussion focused on how much of the responsibility of pregnancy was placed on the role of parents, and mothers in particular. The lifestyle and behaviors of pregnant women was called into question.

I’ve seen pregnant women smoking; I’ve seen pregnant women drinking; I’ve seen pregnant women trying to do everything that they was doing before they was pregnant and it’s like they don’t wanna wake up to realize that they gotta make that sacrifice and stop doing certain things.

Well, is mama in the clubs shaking her butt while she’s pregnant? I personally, I know women who drink and smoke while they pregnant. They’ll light up a blunt so quick, and oh, I’m pregnant; ah, don’t worry; it won’t hurt the baby, you know, things like that. You got to be responsible for your child.

Another issue that arose in the groups was the idea that, in addition to women becoming pregnant at a very early age, these same young women may be unwilling to accept or have difficulty accepting their pregnancies and delay disclosing their conditions to family and friends.

Some of them get pregnant at 13, 14, 15, and they don’t know they bodies quite well as the older ones do so really they don’t know they pregnant till maybe there [sic] 7 months already . . . some of them don’t feel it . . . and some of them know they pregnant but they just don’t wanna tell so that’s why they miss out on appointments; they don’t get the prenatal pills . . . that’s why some of those babies come out premature.

Many men noted that the majority of pregnancies were not planned, and possibly not wanted, and perhaps this led to young women continuing to “drink, smoke, and drug” while pregnant. In addition, they mentioned how women who become mothers at a younger age may experience more difficulties during pregnancy.

A lot of young Black women that have babies before they’re married, you know, when they young, you know, so they’re not ready to have kids. They just girls, and they dealing with all kinds of stress, all kinds of issues, and they’re blinded because they don’t know cause they did drugs, so they don’t think about Lamaze classes. They thinking about where my baby dad at or this problem and that problem. They’re not thinking about all the things that they should be doing and then the stress that makes them smoke, and you know, drink. It’s like a chain reaction, even if the baby don’t die.

Participants also discussed the health disparities that are experienced within the Black community. Given the higher rates of drug use and diseases, women may be in poorer health, which may affect the health of the infant.

If women ever take certain drugs, even prescription drugs, if they smoke, if they have diabetes, you know, certain health issues affect the baby if the mom has it. I think probably we (Blacks) have more drug use, smoking, health issues.

Suggestions for Information Dissemination About Preventing Infant Mortality

Focus group participants were then asked, “What are good ways to get information about preventing infant deaths and premature birth to mothers and fathers?” Most respondents answered that the church was a good way to get information to the community. The men mentioned church bulletin boards, announcements in church, and distributing pamphlets. Some respondents said the media or radio were good ways to get the information out to the community. Community newspapers and magazines were discussed, but one participant said that few people actually read the news. Others suggested recruiting volunteers from the community to act as role models for younger women and to start a new cycle of positive modeling in the community. Getting information out through the clinics was also recommended, but one participant pointed out that this means of recruitment may only help the women who are already seeking medical assistance, which would exclude most young women as they generally are not receiving regular medical care.

The key strategies identified by the male participants were to provide information via cable television channels, like BET, and other community

interventions: "Community intervention—things that's set up in different places within the community where people actually go and talk, have different functions set up."

There was discussion on how the information should be made available. Men felt that information should be made available to women prior to pregnancy, an important component of preconception and interconception care.

I would look into trying to talk about these things before they get pregnant, so they do understand the importance of the child and whatnot, not when it's too late, you know, when they already pregnant; their mentality's already set. I don't know if it's being done. . . . So, some proactive measures might need to be looked upon.

However, some stated that information is not enough to create change in everyone but may be beneficial for some.

Yeah, but if you can put the information out there, it has to be on that person to wanna take steps to do what they gotta do, you know.

You can put all the pamphlets, you can put it on the side of a bus, on a billboard, you know, you can put it in a video game, a comic book, don't matter; they're not gonna see it, but you just do the best that you can to make sure people are aware of that but really, it's on the parents responsibility to follow-up with that. You can do what you can do and that's the best you can do.

Knowledge of Healthy Start Program

Participants were asked if they knew about or had heard of the Healthy Start Program (a federal- and state-based intervention program for women and families who have risk factors during their pregnancy, e.g., aged younger than 18, have chronic disease, or are homeless). Overall, most of the male respondents did not know of Healthy Start and had questions for the moderator on the services provided by the program. Because few knew of the program, some suggestions were made about how to promote awareness of the program, such as working with physicians: "The doctor may not even know what Healthy Start is . . . If he don't, he can't push it."

The men were asked what they and people in their community thought about home visits, which is a prime component of the Healthy Start, and other interventional programs designed to improve

birth outcomes. Most of the respondents said they personally thought home visits were a good idea but thought that others in their community may object to such visits: "If it has a positive air to it, you know, and if you tell me why you coming to my home, you understand and why you would like to come and talk to me, I don't have no problem." "I think it's okay, but a lot of my neighbors would not think so."

More specifically, most male participants had a positive response to the suggestion of home visits to address the issue of infant mortality.

Put the tools out there; go to people's houses and knock on the door, you know.

I think it's a good thing they come out and talk to the parents and tell them how to take care of they child . . . how to nurture them and all that but now days [*sic*] you got these 13 and 14 year old girls, you know, little girls getting pregnant; they don't know what they doing.

However, there were concerns that some community members may not desire home visits.

A lot of people don't like you coming in their house.

Some people want it and some people don't; some people don't even care about it.

You come to my house, you see how I keep my house and that's badly reflected on me, so I ain't gonna let you in the house.

Instead, some respondents suggested alternate venues for education and outreach rather than the home, such as the school.

I think it should be implemented in the classroom and like, I think the best way to do that is make it more of varieties . . . you teach the kids while they young so when they grow up, you know, they be at least educated on the choices that they make.

Follow-up Results

Two months later, a follow-up listening group session was held with community participants to present the results of the prior focus groups and to validate those responses (i.e., member checking or validation). Of the 16 men who attended the second session, 8 had participated in the first session. For this session, all the participants remained in one

1. Did the information presented seem accurate? Was there anything that “jumped out” at you?
2. After reviewing the specific information presented in each of the slides. Were these responses accurate (e.g., people feeling surprised and saddened about the data presented on the high rates of infant mortality)?
3. How do you feel about the slide stating that stress is a major issue for Black women of childbearing age?
4. What should we as a community do next with this information?

Figure 2. Follow-up focus group questions.

large group and were not subdivided into smaller groups. A focus group guide was also used for this follow-up session (Figure 2).

The participants in the second listening group were asked to comment on a PowerPoint presentation they viewed, which summarized the group comments from the previous focus group. The moderator asked the men if they felt the information presented seemed accurate or if there were anything that “jumped out” at them. One man responded, “I know in our focus group that stress was like a big issue, and stress on different levels, so I think it’s interesting that stress was the even denominator of all the other groups as well.”

The moderator then moved the group on to review the specific information presented in the slides. The group was asked if the responses listed (e.g., people feeling surprised and saddened about the data presented on the high rates of infant mortality) were accurate. The men agreed and had a discussion about the specific geographic areas within the county where the high IMR was most concentrated.

The moderators then asked if the group agreed with the slide that showed that stress was a major issue for Black women of childbearing age. In response, one man stated,

I think man is the problem why those kids are dying because a man can relieve a woman of stress. . . . So, I think we should focus on the man’s role in infants dying so we can see the man has not been there for his woman, the man does not hold a job. See, the man causes stress also. The woman is carrying the kid; it’s a problem and the man is a problem also. She’s gotta worry about a household to take care of and stress the baby gonna get fat.

The financial stressors that come with the added responsibility of having a family, as discussed in the presentation, resonated with many of the participants.

The situation about the men and women, given the financial stress that come up. And raisin’ the kids and having the responsibility and the resources to raise [them] . . . that stuck out.

To raise the baby now, financially, yes, is very stressful. I mean, there are days you don’t know where the money’s coming from.

Although finances affect access to resources, one participant talked about the different attitudes individuals may have regarding free services as compared with low cost services.

When it’s free, we won’t ask questions . . . but when we have to pay for that service, we tend to ask more questions . . . You’ll take care of it cause it’s free but then to pay for that service—you’ll look more into that situation.

Instead of just providing free services or resources, more training may be helpful to community members.

Everything can’t always be fiscally minded. Everything can’t just be like, we’re going to give you something just for your own benefit. See, we also need to find ways to train people to be able to come out and start speaking out, stand up for what they want.

Interestingly, the men’s group talked about a unique form of stress in their lives—fear. This fear was described as a feeling some young people have as a result of the experience of being raised and educated as a Black person in the South. The men revealed:

These young people are scared. They’re scared. And that’s why the message isn’t getting across like it really needs to because they’re too afraid to speak up, you know, and that’s also part of being a Black man, a Black adult, you know, where it comes from your parents. They have to also speak up for themselves. Stop letting it just float by and keep doing this.

I’m born in the South. I’m a Floridian, all my life in Florida. And see, we in the South was passed down; my mama was still scared of the White man. And her grandparents were slaves, you feel me? So, we didn’t have the right to talk, and we still feel uncomfortable talking.

Some of the men thought this fear may affect how people access the health care system.

The reason why people don't go to the doctor is because half of them are scared—Black or White. Cause they're afraid of the results they might hear, and they fear they're a part of that epidemic.

The thing is that we, as a people, cannot perceive what's going to happen. We walk in here saying that something bad is gonna happen. We can't perceive to the point where I come in, I sit down, the doctor's gonna tell me da-da-da-da, and it's bad. That's it. We cannot walk into a doctor's office—we just can't do it.

The men's conversation on fear segued into a discussion of some of the broader structural and societal issues that affect the Black community.

Sometimes, we can see the big picture, and then, when I go to the White community, their churches on their side of the town, and the boss on the other side. But, in the Black community, when you getting stuck on that little 13" in black and white, and you lookin' at the big screen and seein' the big picture, and you see how the White man has manipulated the system, not only for our generation but for the new generation.

Healthcare system in the South is worse, and Black people don't get treated right. . . . I know the healthcare system is bad. I know they treat people with disrespect, and they give you these looks and everything else like you a second class citizen, and being Black, well all of us are Black, and being Black here in the South, I can't understand sometimes. That's why I keep coming back. It's because our people—our plight is bad, and we have to stand on it, and there's not a lot of us to come. . . . We have to look at it and speak up, and being Black men, we have to be strong. For one, we gotta be strong for our children, our young Black women, young Black mothers.

All respondents were focused on citing young age of the mother as a major factor in the Black IMR and believed education was the key to reducing those rates: "Young people cause the infant mortality rate in the first place, really has to do with a lot of young ladies, younger people cause I ain't having' no babies."

Consequently, much of the conversation focused on how to organize "workshops" or "education sessions" that young women could attend.

It all starts in school, and I think parenting skills play a role in that.

Somebody droppin' the ball along the way. I think that schools are responsible also for getting the word out. I think that we oughta hear everything that we can come up with in order to get that out.

The men's group also discussed how to deliver health education. Some of the male participants discussed alternative, nontraditional methods for disseminating messages regarding infant mortality to young people, emphasizing the use of music.

I didn't see nothin' about music in that whole thing. I didn't see anything said about love in that whole session. If you didn't put more love in the game and didn't spread to the music, cause we all love music—that was not said. Love and music. And we need some tolerance, need some obedience, need a lot of one-on-ones.

You know, in our neighborhoods, you know, Black neighborhoods all over the country, these younger people, they gonna click to music cause they wanna hear it. I know they go around and have health fairs and stuff in the projects, and they bring music and everything, and that's what brings the younger people out.

The group reviewed the concept of home visits, which was discussed during the first listening groups. Although home visits were viewed positively, the importance of training and preparation for the staff assigned to these tasks was emphasized. Staff should be trained to show respect and "love" for the people in the communities and avoid judgment and prejudice in their actions and demeanor.

In another neighborhood, you gotta adjust to that and deliver your message. You gotta be able to choose the right words—there's times to be ghetto, and there's times to be professional. You should be able to come to a place like this here and make everybody feel comfortable.

You have people coming into their neighborhoods, do the home care or whatever, but they don't know how to speak to these people. And they judge 'em from what is the environment they live in. . . . You know, they come in our neighborhood and lookin' like they have something to say, and they frown on us, and they go in the door and they goin', "Ok, you need to do this, this, this," but it's not loving, and they're not giving like you sayin' about love. And when you don't express those things, young people like they back off.

Young people today, they're not going to say anything because they think they're going to be judged. Now, someone's coming from another neighborhood into your house; the first thing on your mind is "this person is going to judge me." It's not, "Hello, how you doing?" It's, "You're going to judge me."

Additionally, home visit staff should take preparatory actions to ensure that people will feel comfortable during the visits.

I think you should call them up and give them a notice that someone's coming so they can tidy up the house.

If the house dirty, you not coming in the house. She don't care who you is—you could be anyone. If her house ain't nice enough, and you come in the house, that's called respect for her own house. So, I think it would be good to give them a call, a notice that they are coming instead of just poppin' up because that's kinda rude.

Another issue addressed in the men's group was transportation, particularly for people who live in more rural areas.

You know, we got a big problem with transportation. And we got to make the younger women feel comfortable for the doctor to come see them.

Maybe can get some bus passes sent out to them so they can get there.

The conversations ended with a discussion of personal commitment on behalf of the community, getting fathers involved in education and parenting classes, and whether or not such classes are or should be compulsory to attend to receive services.

Discussion

For Black populations, who experience higher rates of infant mortality, the protective factors that have been identified among White women, including educational level, health status, and prenatal care, do not have the same improved outcomes for Black women (Rowley, 2001). Therefore, studies that explore the social and cultural context of infant mortality within the Black community may offer greater insights into how this disparity is experienced. Recent studies have begun to examine the possible associations between

infant health outcomes and psychological, cultural, historical, political, and economic factors (Hogan & Ferré, 2001; Rowley, 2001). However, few studies have explored the role of the male partner in infant mortality. Those studies that address the male partner have investigated the influence of partner violence, paternal involvement, and paternal age on pregnancy and infant health outcomes.

The qualitative data gathered in this study offer insights into male perceptions and beliefs regarding infant mortality. As with all qualitative inquiry, these data are not meant to be generalizable to other communities or similar populations. The data were collected from a limited number of individuals, and randomized sampling was not used. Therefore, the sample was not representative of all Black men, and findings cannot be generalized to the larger population.

To the best of our knowledge, this is the only study that gathered information from men on pregnancy and infant health outcomes; the majority of research has focused on the mother and child. Similar to previous studies, sociocultural issues, including financial barriers, increased stress, and access to healthcare, were identified as possible influences on poor infant health outcomes.

The men in this study minimally discussed paternal involvement, which has been found to be a protective factor against LBW and infant mortality (Gaudino et al., 1999). When male responsibility was discussed, all the men repeatedly focused on the financial strain of parenting. This emphasis may be related to the experience of these men and their cohorts with the child support enforcement system. Men often feel that social welfare policies and family interventions are insufficiently supportive of their efforts to be good husbands/partners and fathers (Becerra, Thomas, & Ong, 2001; Smith, Krohn, Chu, & Best, 2005).

The most significant focus in the men's discussion was on the woman and her activities and responsibilities. This may be related to the more complex issue of gender roles and social norms regarding parenting that may exist within the Black community (Hill & Sprague, 1999). Parenting responsibilities fall more heavily on the female parent, which is reflected in data that document an increasing number of lone mothers or single mothers (Gaudino et al., 1999; Pattenden et al., 1999). Given that paternal involvement has been found to increase the mother's likelihood to access prenatal care, decrease financial barriers, and increase emotional support, the minimal recognition of the

paternal role and responsibility among the male respondents is noteworthy.

Some studies have begun to examine lifestyle and sociocultural issues that are traditionally not associated with maternal and infant health because it is outside of the pregnancy time frame (Lu & Halfon, 2003). The results of this study support this broad-based, contextual approach to research. Many of the respondents discussed issues of fear, racism, and prejudice that influence health decision making and practices within Black communities. These issues are not exclusive to the health care system but are also important within the communities themselves. This suggests that a two-pronged approach may be necessary. Changes in health organizational culture, design, operations, management, and outreach, and changes in the health care system comprising many health organizations, including medical training and administrative policies, are required to ensure cultural appropriateness and awareness. Outreach and education within the Black community may also be needed to build trust with and increase accessibility to health care services.

Although Black teens are not the primary demographic who experience infant mortality, the majority of the participants believe poor birth outcomes occur exclusively among the youth of their community. Our findings indicate that community participants associated infant mortality with young age of the mother, low educational status, and limited financial resources. However, infant mortality within the Black community affects women of all ages, educational statuses, and socioeconomic backgrounds. These assumptions influenced the recommendations, perspectives, and ideas shared throughout the focus groups.

Overall, education was identified as the most notable way of addressing the high rates of infant mortality among Blacks. Many of the participants talked about how schools and churches could be vital educational partners on this issue. However, attempts to provide sexual health information within these institutions may result in multiple barriers and setbacks because of the prioritization of abstinence-only education. Participants also suggested more innovative strategies, such as the use of media and music, to educate and inform the community.

The results of this study suggest that social marketing may be an appropriate strategy for promoting positive behaviors to reduce the likelihood of poor infant health outcomes within the Black community. Social marketing is the application of marketing

principles to promote behavior change to benefit society (Andreason, 1989; Kotler, Roberto, & Lee, 2002). Through this approach, barriers and benefits to the proposed behavior are identified and addressed through strategies found to be appropriate and relevant for the target population. Social marketing acts on multiple levels to reduce barriers and highlight benefits to make the proposed behavior more advantageous and desirable.

Conclusions

This study examined the perceptions of Black men regarding the IMR within their community, using focus groups. Results show that there is limited awareness of this health issue, and perceptions of the causes of poor birth outcomes are thought to be related to teen births and unhealthy behaviors practiced by pregnant women. The men participating in this group had limited expectations of the role of fathers in helping produce healthy infants.

The focus groups also highlighted other concerns of men related to daily stress, financial pressures, and a health care system that is difficult to navigate and may be biased against Blacks. The focus groups provided a unique opportunity for men to gather and discuss issues that were on their minds as well as to hear what others in their community thought about current social problems.

The results of this study were presented to community health leaders, combined with an epidemiological assessment of the risk factors associated with Black infant mortality. The future direction of the larger project of reducing infant mortality in this community was discussed and debated. Based on these results and community health leader discussion, more community-based focus groups are planned. The goal of the future focus groups is to continue the dialogue about infant health and the role of the community with a specific focus on protective factors versus risk factors. Future research will examine families and communities with low IMRs to compare differences. Social marketing and the collection of formative research for future intervention strategies will be explored. Ultimately, the goal is to improve resources and systems in the community that encourage and support fathers during pregnancy and parenting, particularly Black fathers, who may feel that their role is limited. Providing opportunities for men to express the pride and joy they feel for their children as well as male peer mentoring to

help men become more engaged fathers should be on the social agenda of communities.

Paul Laurence Dunbar (1872-1906), a son of former slaves and believed to be the first Black poet to reach a wide audience, authored a heart-warming poem titled *Little Brown Baby*. The poem expresses a father's pride for, love toward, and involvement with his child. The desire for involvement and intimacy with one's infant is likely to be inherent in most men, but communities and the health service system may not be structured in ways that are conducive toward men expressing this sentiment.

Little brown baby wif spa'klin' eyes,
Come to yo' pappy an' set on his knee.
What you been doin', suh—makin' san' pies?
Look at dat bib—you's es du'ty ez me.
Look at dat mouf — dat's merlasses, I bet;
Come hyeah, Maria, an' wipe off his han's.
Bees gwine to ketch you an' eat you up yit,
Bein' so sticky an sweet—goodness lan's!

(Paul Laurence Dunbar, available at <http://www.poetryfoundation.org/archive/poem.html?id=173461>)

Acknowledgment

We thank Lo Berry, MA, of Hillsborough Healthy Start for her assistance in coordinating the events and discussing results.

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