North Carolina Equity in Birth Outcomes Council

Reducing Inequities in Birth Outcomes in North Carolina: Developing an Actionable Strategic Plan
Community Stakeholder Focus Group Research

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A paper presented to the faculty of The University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the Degree of Master of Public Health in the Department of Maternal and Child Health.
Chapel Hill, N.C.
November 2012

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Acknowledgments

I would like to acknowledge the support and guidance of Dr. Sarah Verbiest, Executive Director of the UNC Center for Maternal and Infant Health, Co-PI of the Academic-Community Partnership to Reduce Disparities in Infant Mortality Project, and my field preceptor. I’d like to acknowledge the key role of the North Carolina Child Fatality Task Force and the Equity in Birth Outcomes Council in this important work.

I would also like to recognize the many women and men who helped to identify groups and contacts in the communities for focus group participation, as well as those who facilitated focus groups, including Rovonda Bradford, Kay Freeman, Amy Hattem, Sharon Johnson, Amy Mullenix, Heather Owens, and Charmaine Purdum.

Finally, I would like to thank the more than 130 North Carolina women and men who participated in the focus groups. Without their candid discussions, this research would not have been possible.
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Introduction

In North Carolina, infant mortality and perinatal related conditions account for over 67% of all child deaths. The infant mortality rate for African American infants (12.6 per 1,000 live births) is more than twice that of Caucasian infants (5.4 per 1,000 live births). African American babies are also disproportionately low birth weight (14% of African American infants were less than 2500 grams in 2011 compared to 7.5% of White infants) and pre-term (17% of African American infants were less than 37 weeks completed gestation compared to 11.2% of White infants).1

The causes of infant mortality are complex and extend beyond the traditional biomedical model to include factors related to family and community systems and social and economic inequalities. ADD MORE.

Public health efforts to close the racial and ethnic gap in birth outcomes have traditionally focused on increasing access to prenatal care, and while the gap has been closing, progress has been slow. In light of this, Lu et al proposed a life course approach to reducing disparities which addresses the needs of African American women for quality healthcare across the lifespan, family and community systems that may influence the health of pregnant women, families, and communities, and the social and economic inequities that underlie health disparities—the 12-Point Plan to Reduce the Inequities in Birth Outcomes (Appendix A).2

This focus group research project was undertaken as a component of the ongoing North Carolina Equity in Birth Outcomes Council’s overarching goal to bring together leaders from different sectors to develop a strategic action plan for the state of North Carolina to eliminate racial and ethnic disparities in birth outcomes. Other components of this work included approximately 18 key informant interviews conducted with leaders in public health, education, and community and economic development across the state, a series of expert presentations, and feedback from the Leadership Team and larger Advisory Council. All of this work has been funded by an Academic-Community Partnership grant (U13) from the National Institutes of Health and Development. The work was approved by the University of North Carolina and Chapel Hill Institutional Review Board and was considered exempt as we didn’t collect personal information about participants in the focus groups.

Quantitative data alone is insufficient to understand the causes behind the racial and ethnic gap in infant mortality and other birth outcomes in our state. In order to obtain a clear picture of the interventions needed to close this gap, it is necessary to understand the

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1 DeClerque JL, Shanahan E, Perry JR. Consensus in Region IV: Women and Infant Health Indicators for Planning and Assessment; Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, September 2012. Accessed October 23, 2012.
stories behind the quantitative data. Starting in August of 2012, we carried out a series of focus groups with the purpose of gathering ideas and opinions of key stakeholders regarding the actions that we should take in North Carolina to address inequities in birth outcomes. The focus groups were exploratory in nature with the hope that they could suggest avenues for further research. Questions were based on the 12-Poing Plan to Reduce Inequities in Birth Outcomes.
Methods and Procedures

We set out with a goal of recruiting and conducting eight focus groups, and between August 9th and September 17th succeeded in conducting ten groups with over 130 participants in five North Carolina counties: Guilford, Robeson, Pitt, Rockingham, and Nash. Figure 1 below illustrates the geographic distribution of the focus groups. Groups consisted largely of local infant mortality coalitions, comprised of representatives from health departments, local agencies, local hospitals, coalition advisors, and some consumer representation.

![Figure 1. Geographic Distribution of Focus Groups](image)

Convenience samples were used for all of the focus groups. The rationale for the focus group selection was to recruit a representative sample of local stakeholders with experience working to address infant mortality, and with geographic distribution across the central and eastern part of North Carolina where infant mortality rates are the highest.

The purpose of the focus group was explained to participants at the beginning of each group. As part of the introduction to the focus groups, Dr. Verbiest delivered a 20-minute presentation to most participants (Appendix B). This presentation consisted of an explanation of inequities in birth outcomes, the life course model, the 12-point plan, and the purpose of the Equity in Birth Outcomes Council.

A facilitator and a note-taker attended each focus group, with the exception of the Young Moms Connect Advisory Council meeting in Rockingham. Facilitators varied depending on the group. In some cases, members of the committees or coalitions themselves facilitated the groups. African American women facilitated at least half of the groups. Every focus group session was audio recorded using a digital recording device after permission to record had been granted by each group. All recordings have been catalogued and stored for more in-depth analysis as needed. With the exception of one group, participants received a $20 gift card to Wal-Mart. Groups lasted approximately one hour.

Facilitators led the focus groups using an interview guide (Appendix C). Facilitators had permission to reorder the questions as they felt fit the flow of the group. They were also
encouraged to allow participants to talk in depth about some topics if they were very engaged and had a lot to say. In the end, some groups were able to cover all of the questions while for other groups only about half were discussed. There were often overlapping themes among the questions and the groups. The key topics covered in the majority of focus groups were:

- General thoughts on implementing 12-Point Plan (strengths and barriers)
- Organizational and/or community interventions that address one or more of the points on the 12-Point Plan
- The reasons for and ways to address racial and ethnic disparities in health-promoting behaviors such as breastfeeding, birth spacing, and preconception health
- Ways for the community at large to better support African American women during adolescence, pregnancy, and postpartum
- Support services and changes needed within the healthcare system
- Access to preventive care for African American women
- Ways to better support and engage young African American men and fathers

Following each group, facilitators, note-takers, and the PI debriefed about the groups, clarifying any areas of confusion. Note-takers edited their notes immediately following the groups, listening to portions of the recordings for clarification if necessary, and then shared those notes with the PI. As part of the note-takers’ write-ups for most of the groups, they included a brief section with personal reflections about the group’s process. Note-takers also identified the demographic information about most groups, including their size, the gender and racial make-up of participants, and the proportion of professionals to consumers.

Upon completion of the ten groups, I compiled the individual notes from each group into a master document, de-identifying them and organizing them by the questions listed in the focus group facilitation guide (Appendix C). In addition, myself and the PI convened a meeting with some of the focus group facilitators as well as other involved parties to review and interpret this data in its entirety, disaggregated by question. We asked the participants of this group to identify common themes in the data, areas for further exploration, specific data needs, and ideas for additional key informants and resources to explore. This report is based primarily on the focus group summaries and the data review session.
Results

The themes below are displayed generally by the 12-Point Plan section they most closely correspond with. The plan includes three overall imperatives: Improving Healthcare for African American Women, Strengthening African American Families and Communities, and Addressing Social and Economic Inequalities. 

1. Improving Healthcare for African American Women
The first section of the 12-point plan includes four imperatives: to provide interconception care to African American women with prior adverse pregnancy outcomes; to increase access to preconception care for African American women; to improve the quality of prenatal care for African American women; and to expand healthcare access across the life course for African American women.

The following themes emerged relating to improving healthcare for African American women:

1. Barriers to Access: All groups identified a number of barriers low-income African American women face in accessing and utilizing quality healthcare. The most common barriers were competing priorities, inadequate transportation, too few providers leading to long wait times, cost, not trusting providers, and communication challenges with providers. Respondents also frequently mentioned the need to help women to be proactive about their health in spite of these barriers.

   i. Competing Priorities
   The ability to prioritize health over other concerns emerged as a central theme. Some of the most widely cited barriers to accessing healthcare are the multiple competing responsibilities that low-income women face. Those responsibilities cited include taking care of their children, their boyfriends or husbands, and their work and financial responsibilities. The consensus among many groups was that women feel unable to prioritize their health over what they perceive to be more immediate stressors.

   Relevant quotes:
   “It isn’t valued. There are other issues that are more pressing than getting healthcare... getting school supplies for the kids, dealing with housing, etc.”
   “Their boyfriend, having something to eat, life, - that is what is on top of people’s list, not healthcare... They might not see the point in going to a provider – especially if someone else didn’t get care and the baby was fine then why should they go?”
   “When asked why women don’t seek family planning sooner, [one] consumer said that there are more reasons not to do it than to do it. Other stressors.”

   ii. Time
   A related theme, compounding the issue of competing priorities, was the perception that patients often face delays in receiving care, both in the form of scheduling appointments and in long wait times in the waiting room immediately preceding their appointments.
Some groups attributed this to too few providers, particularly providers that accept Medicaid. This reflects additional concerns about what will happen when more women have access to health care – there already aren’t enough providers and appointment times available for the people who have coverage now.

Relevant quotes:
“I know sometimes that a client will need an appointment immediately and [she] cannot get it. She can’t go to an urgent care because she doesn’t have funds.”

“[Another challenge] to [accessing] health care services is the long wait time. First they may call but then can’t get an appointment until three to four months later. They wait a long time for an appointment then wait to see the providers.”

“There are not enough providers. Providers who take Medicaid patients are at their max and can’t take more. This... is going to be even harder when more people have access to health care insurance.”

iii. Healthcare Providers
Many groups pointed out the influence of consumer perceptions about providers on healthcare seeking behavior. A number of groups discussed the social issues and norms around trusting providers, especially among low-income African Americans, due in part to historical trauma. There was a sense among some groups that for some women, health information received from a provider is not valued as highly as health information received from another source, for example, a mother or grandmother.

Relevant quotes:
“Momma might not know best or have the complete information. But the women believe their mothers and don’t have any other information so they might not ask the doctor.”

“There are social issues and norms about why people may not trust providers and what they sat. Some people don’t trust the providers – they might have heard something else and have that information as important.”

“Doctors are biased.”

“The trust factor is missing. Consumers do not trust health care providers.”

Groups also highlighted the communication difficulties between patients and their providers. One participant felt that providers often fail to “meet clients where they are” and should utilize motivational interviewing techniques with their patients. Many perceived communication barriers to be a two-way street: providers are not effective in communicating to low-income patients, but many patients aren’t empowered to communicate their concerns to providers. Many groups felt that helping young women to assertively communicate their questions with their providers should be a top priority.

Relevant quotes:
“Doctors need to be relatable to me.”

“They don’t speak to me.”

“They aren’t listening.”

“Some patients feel intimidated. Providers need to explain better and relate in a way
that the patient can absorb.”

“We need to encourage our young moms to ask questions and to ask why. It is important to help them as they grow and mature by teaching them that you just don’t sign stuff without reading it…how to be assertive in an appropriate and respectful way is an important life lesson. Women need to know it is okay to ask questions about your body.”

“We need to let the women know that they need to ask the doctor questions. People go places and they do not know anymore when they left than when they walked in.”

iv. Transportation

Transportation was a frequently cited barrier to accessing healthcare services, in addition to other non-health services. One group saw this as an area that could be more cost efficient as they noted that many buses are underused in urban areas. For most, the transportation barrier was perceived to be most restrictive for rural residents.

Some groups felt that for many consumers, transportation is a more complicated barrier than simply an inability to physically access it. One participant noted that in her county, a lot of resources and finances have been invested in making transportation easy and accessible, particularly for low-income pregnant women, and that the failure of women to use it to access care is an issue of prioritization more so than access. In general, it seemed to most groups that transportation is largely a factor of prioritization and that it augments other barriers.

Relevant quotes:
“Always and forever transportation.”
“[There are buses] all going in the same direction but all half empty. Combining services could benefit everyone as it could free up transportation money to reach further out into more rural areas.”
“If they really want to get somewhere they can get there – like the mall. What is their priority? But then on the other side of it, they might really care but they don’t have the energy to get through all the red tape.”

v. Cost

Cost was more often cited as a barrier to accessing things like healthy foods or exercise than healthcare, however, many groups cited that challenges Medicaid patients face with reimbursement as a barrier to accessing care. Some groups also mentioned that some consumers perceive the value of accessing medical care to not be worth the cost, particularly when they feel that their appointments aren’t being used effectively, requiring them to come in for repeat appointments. This, compounded with competing priorities and time restrictions, lessened the value of healthcare appointments in the eyes of consumers.

Relevant quotes:
“Medicaid can be slow and insurance copayments aren’t always clear so there is a worry about having to pay up front and maybe not get paid back.”
“Doctors...seem to be most worried about getting their money.” The woman speaking
expressed frustration with all the times she had to keep going back to the doctor, and she didn’t see the value of going so she stopped. “All the different appointments really made life challenging.”

II. Other Healthcare Themes

i. Health Information Sources
Participants reported that many women and men, especially younger generations, receive an overload of health information from many different sources. These often competing messages make it challenging for providers and educators to make their information stand out and requires new approaches to outreach. It also makes it hard for consumers to get the correct information they need. In addition, some participants perceived the growing emphasis on social media to be problematic for particularly low-income, rural women and men who may not have access to these mediums.

Relevant quotes:
“Part of our problem now is an overload of information. Plus we also have to dispel all the incorrect messages that are out there. This makes it a lot harder to help people get it right.”
“[We] need to change the cultural messages...the media is really perpetuating these issues by promoting a certain mentality.”

ii. Bringing services to communities
Some participants suggested ideas for bringing health care services directly to neighborhoods and housing developments through mobile clinics. They also suggested having individuals in these communities be trained to serve as community health advocates who would know the needs of the people in their community and work to make sure they connected with services.

Relevant quotes:
“Social media does not work in all arenas as not all have access. Sometimes you have to go to where the people are; we have to take it to the community...Sometimes you need to go to the people because it may be hard to get the people to come to you...Outreach staff can help in getting the community to trust health workers and build relationships.”
“There are a lot of resources available to the community it is just hard to find them. There needs to be a creative way to get people to come out.”

iii. Mental Health
An additional area of concern for many groups was the underuse of mental health services, particularly for African Americans. Participants mentioned that both the difficulty accessing services and the pervasive stigma within many communities create an environment in which mental health services aren’t sought by those who really need them, and particularly young mothers. Some participants also connected this with substance abuse drug use in communities.
Relevant quotes

“We have a lot of mental illness in the black community. We really need to deal with that.”

“Mental health is a really huge issue. There aren’t many referrals – and it is going down the tubes. There are few alternatives to helping people. Access to services and how you get in changes a lot. And then there is the stigma of getting services.”

“Access to mental health services is important in the context of substance use. Without having behavioral health, including for women experiencing intimate partner violence, it’s hard to really combat substance abuse.”

“Young moms don’t have a clue about how to deal with postpartum depression.”

“I have a] friend who was seeking out mental health services and her doctor recommended that she go out of the county because of the stigma.”

“There is] mental illness, especially in younger moms, who self-medicate with illegal drugs. Mental health is still stigmatized in xxx county. It’s better to say, “My mom has a drug problem than my mom has mental illness.” There is very little money/resources to provide mental health services. Nothing is going to change until we get the word out there about the populations that are affected by mental illness.”
2. Strengthening African American Families and Communities
The second section of the 12-point plan includes four imperatives: to strengthen father involvement in African American families; to enhance systems coordination and integration for family support services; to create reproductive social capital in African American communities; and to invest in community building and urban renewal.2

The following themes emerged relating to strengthening African American families and communities:

I. Community Engagement

   i. Emerging Community Resources
When we asked participants about positive ideas that are happening in their communities, most noticed positive changes related to healthy living (community gardens, green walkways, farmers markets, community centers, etc). Participants also noticed positive changes happening in terms of breastfeeding and baby friendly hospitals. Participants emphasized the importance ensuring that all segments of their communities, and particularly low-income African Americans, benefit from these changes.

   Relevant quotes
   “There are a lot of sidewalks going in, new greenways and a focus on recreational activities which is great for people who want to be healthy. Having these things makes it more likely that people will use it and exercise.”
   “We’re becoming more health conscious in our community. There are more healthy options especially in restaurants...The community gardens are also really nice. It brings people out.”
   “We are becoming more environmentally friendly – recycling and going green.”
   “[In one county], the local farmers market has received permission to accept WIC vouchers. One third of the population is in poverty in this county, so that has a big impact.”
   “More hospitals are going baby friendly and promoting breastfeeding, and keeping mom and baby together from the beginning.”
   “[We are] seeing some more encouragement/support for [breastfeeding]. Agencies are enforcing the joint commission. Some states won’t give Medicaid moms formula unless there is a medical reason.”

   ii. Ensuring Equitable Access to Community Resources
Many participants have noticed that while new community resources are becoming available, they may be difficult for community members to find and may not work effectively together. Participants reported being challenged in reaching out to their target populations in order to help them utilize community resources. While many communities do have community centers and resources, some participants say that it is clear that these services are not being well monitored or regulated and may not be helping the community. The idea of developing Community Advocates was suggested as a way to better connect services to the community and also as a voice of advocacy for the community when services meant to serve them aren’t doing so.
Relevant quotes

“It is time to make sure community centers are actually opened and usable by the community. There is unused community space that people can’t access!”

“There should be a group in the community to be appointed or paid to mediate on behalf of the community with outside groups...like a community advocate group that can broker information on behalf of the community. Then they can share back the information with the community and get them to come out and access what they need. Communities feel like they have no voice. It would be great to have a community health coach – like who can promote healthy living and help drive the change.”

“Moving farmers markets closer to neighborhoods where people have limited access to healthy foods [would help].”

ii. Faith Communities

Most groups identified the faith community, which is expansive throughout the South, as a key partner in the effort to implement the 12-Point Plan. Many participants brought up the significant influence of local pastors on health decisions, especially for low-income African Americans in rural parts of the state. The church’s authority can be significant even for young men and women who do not attend church, as they often have older, influential family members who do.

Participants cited that while churches and faith communities sometimes offer resources and supports that aim to improve health, they can also work against these efforts by sending alienating messages to young parishioners, especially in matters of sexuality and relationships. In this way, churches have been and can be both part of the problem and part of the solution.

For churches that want to engage in their communities in matters of health promotion, working collaboratively with them can present challenges, particularly if they have their own agendas. Many participants suggested unless there is room for faith beliefs to be incorporated in community engagement, churches will be reluctant to become involved.

Relevant quotes

“Local pastors have a strong say – if valuing health and families was preached from the pulpit it would help change messages.”

 “[For those who do not attend church]: somewhere in their family someone goes to church and has heard the message and can share it back with their community.”

 “Working in churches provides opportunities for cross-generational impact.”

 “It is hard to get churches to come together...to reach churches we need to start with establishing relationships.”

 “There need to be more pressures put on churches to give back to the community. They need to outreach beyond their members. Churches should be required to share their space with communities.”

 “It would be helpful for churches to help people learn how to better balance their
money.”
“Could churches help give inspiration...help deal with mental illness?”
“Faith based leaders want to do something but they don't know what to do or how to do it. Agencies could do training and provide resources for these communities. [We] need to also allow faith communities to also include their faith beliefs...Connecting spirituality with information is also important.”
“A lot of churches already have programs going on – so [we] need to piggyback on those programs. As far as teen sexuality, there are some curriculums that incorporate spirituality into those messages. They bring scripture and sexuality and morals together.”
“A lot of pastors use the pulpit as a way to abuse their authority – they can be hurtful to individuals in the church. This can also get some people to start to shut down. It can create divisions in a family if the parents are wooed by the pastor’s message and then the young women and men don't feel that they can really talk to their parents now. So they were damaged by the church.”
“For the faith-based community, they need to stop being judgmental and work with the young women where they are. Then through encouragement help them not get in the same place again.”
“[We] need to find the right church – some churches just aren't going to change. You don't want young moms to suffer more from this bias and prejudice.”
“It would be good if the faith community would have a conversation about how they can reach the young people without judgment about this issue...If a few of the churches could get the ball rolling that would be good. This is a very conservative area.”
“Sometimes things have to speak to the pastors to make it a real experience. For example, my pastor’s daughter got pregnant and then he no longer preached that parents are the best birth control. Remember that pastors are people too, and that you can create leadership among the pastors with each other on this issue.”
“There needs to be time to educate the churches about the programs. The relationship really has to be with the pastor. That is still the key person and the leader of the church. It is important to educate the pastors as well.”

II. Engaging Men and Fathers
Participants had a lot to say on the topic of fatherhood and male engagement in the lives of their children and their children’s mothers. Given that over 72% of African American mothers are single\(^3\) and the way that African American men have been disenfranchised over decades in the South, it seems that this entire topic area needs further exploration. There are many complex issues from lack of cultural competence in schools in working with boys (especially African Americans) to lack of vision for future careers among these young men, the lack of male-friendly healthcare and social services, and issues of lack of male role models/presence in the home.

i. Single Motherhood

Single motherhood was an issue that, while not explicitly brought up by participants, was indirectly explored through many of their insights on inadequate father involvement for many African American families. While the majority of participants' explanations for inadequate father and male involvement were male-centric, some of participants’ speculations focused on the attitudes and perceptions of mothers, including that some women perceive a financial advantage to being single parents. Some participants also brought up a larger theme of mothers isolating themselves not only from their children’s fathers, but also their extended families.

Relevant quotes:
“African American women will truly not get married because of concerns about losing economic benefits.”
“Sometimes there is a lot of stress in the beginning and sometimes women do not know how they feel about the father being involved.”
“[T]here are also mothers who are stupid – they don’t let the fathers help. Even if the men want to help and buy their children things sometimes the mothers reject them. It seems like if the child’s father isn’t with the mother then the women don’t want him to do anything for the child...women need to get smarter about getting help or letting the men do things for their children even if [she] doesn’t want him in [her] life.”
“Women went through a period of time where they had to do everything. We...need to let men step in and help, not just sign on the dotted line and be done.”
“Sometimes the moms don’t want all the dirty laundry aired...There may be issues around shame such as those whose families have cut them off or who have domestic violence. So women are choosing to isolate themselves from their families. It is important to get down to the why.”

ii. Male-friendly Services

Many participants attributed inadequate male involvement to the lack of male-friendly health and social services. Participants mentioned the lack of programs and interventions targeting young men and boys in schools, in social services such as WIC, in health messaging and particularly in prevention messages, and in the health care system including at provider’s offices. A related assertion was the difficulties that single fathers face as a result of this service environment that is unfriendly and untrusting of males.

Relevant quotes:
“We need more male support groups or providers.”
“They don’t have any programs in the county for men. Men are coming to them asking, ‘what about me?’”
“There aren’t many grants for men about taking care of themselves, wearing condoms, etc.”
“What do school systems have for the teen dad? Where is his support or program?”
“I have worked with xx county schools and social workers use women that have
had children and can meet with girls to talk and mentor them about having children. I have never seen a likewise male part of this system.”

“[On WIC]: We should make things more male friendly. We should make it more acceptable for fathers to be involved. We take for granted that mothers will do the work but we should make it more accepting for fathers to join in.”

“As professionals we need to really engage them and help them feel a part. Then they feel they have a choice to be involved. We need men to also see their leadership role in the home/family. This can start in childbirth classes and birth-five childcare to help men and boys know their roles.”

“We should make them [men] feel a part of the process. The man that is even at the appointments they took a step to be there. We should let him be a part of that and not leave him in the lobby or the car.”

“We need to check ourselves on how we are communicating to men in the practices and providers’ offices. Are we making men feel welcome? We need to engage them in the process. Before we invite men we need to be ready for them and understand what we want to do with them.”

“What can happen is we can alienate half of the population by focusing on controversial parts of our message like birth control... We should focus on the things that everyone can agree on.”

“There needs to be a concentration on prevention for guys. It is done so much for girls but not as many programs for men.”

“The trust issue as a single father is hard – he isn’t able to get the same services that are available to single mothers. He has the same issues in wanting to finish his education, pay his bills and take care of his kids. So that isn’t fair. Something has to be done about that.”

**iii. Mentorship for Men**

A number of focus group participants perceived mentorship and mentoring programs, both for boys and men, to be a potentially successful intervention for engaging men and fathers. Some participants spoke to existing mentoring programs in their counties, and others spoke to the need for more programs like them. Participants perceived mentorship to be an effective avenue for instilling positive parenting and family responsibility. Some participants also linked mentorship with employment, by suggesting that mentorship programs be employment or skills based, citing (un)employment as hugely important to a man’s self-esteem.

**Relevant quotes:**

“Some of the black male barrier is in having positive mentors. You are comfortable with people that can relate to you, but there are not many mentors or social workers that are visible. [Perhaps] we can pull professional black men to enter this.”

“There is a huge opportunity around here for mentoring. If every church took one school and provided volunteers to be mentors for that school, we could make a difference.”

“Mentoring is critical to raising boys and instilling that responsibility at a young age.”
With moms and dads working we need to bring in retired men and others who have the time to give. In terms of dads we need to cater more to their machismo and make sure that it is a macho thing to be a father. The media conveys a different image then we want. To be a real man you take care of your children.”

“There is a need for more mentoring programs...[we] need more positive places for men and women to go after school or just hang out spots that are positive, safe and have resources. Need some mentoring so that the cool kids will get involved in certain programs. The lack of jobs is hard – vocational training, internships would be something to put in a 5-year plan – getting businesses involved. For men their job really defines them...it really is who they are. The ability to support their significant other [and] children...can impact their self-esteem. As such, men will find other ways to make themselves feel like a man.”

“[Men need] help with employment-related things: resumes, interviewing skills, vocational skills that lead to temporary jobs with the possibility of a long-term position.”
3. Addressing Social and Economic Inequalities
The third section of the 12-point plan includes four imperatives: to close the education gap; to reduce poverty among African American families; to support working mothers and families; and to undo racism.²

The following themes emerged relating to addressing social and economic inequalities:

I. Breaking the Cycle of Poverty
In addressing the imperative to reduce poverty among African American families, participants spoke about addressing and breaking cycles of poverty. Participants in several groups saw poverty as an intergenerational concern that requires intergenerational interventions. Several groups spoke about the influence of fatalist messages that young people often receive from parents and the older generation of family members regarding their futures. Some participants shared that their clients and sometimes they themselves have received messages from older generations in their families about their likelihood of getting pregnant early in life, for example. Participants also noted that young people who have higher expectations for themselves may experience conflict with other in their families and social circles. Thus, a common theme among the groups was that these messages are often self-fulfilling and lead to generations of poverty and poor health.

Relevant quotes
“[We need to] break the cycle of generational poverty. Some women choose to have children in order to obtain financial support from the government. They don’t have any aspirations to work.”

“[We need] to combat fatalism in communities where children hear from guardians that they have few choices and little control over their futures.”

“We need to train the grandmothers! There is a lot of information that is still being passed down. It is important to educate the grandparents so they are passing down the right information – they have a lot of influence. There is a lot of outdated info that the grandparents have.”

II. The Education System
Participants had a lot to say about pitfalls in North Carolina schools and their influence on later health outcomes. Groups identified several areas in which schools are failing to make an impact, including in sexuality and healthy relationships, reproductive health and life planning, life skills, budgeting, and career options. In general, participants felt that schools are a crucial point of intervention. However, most participants also felt that school systems are both guarded and underfunded, making their compliance a significant challenge. Participants also identified financial literacy training as an essential as part of efforts to address poverty, and something that could be implemented at a young age through schools but is also important for young adults. The general consensus among most groups was that ensuring that students graduate from high school with life skills, especially communication skills, should be a top priority.

Relevant quotes
“We need to begin early in the education process to talk about how to have healthy
families... It would also be good to incorporate life skills at an earlier age in the school curriculum. High school is too late – start it younger at school or after school programs. This would involve some policy and curriculum changes.”

“[Question regarding what the best age is to target to have the biggest impact]: It should be intergenerational. Everyone is involved in the culture.”

“[We are] waiting too long to start working with children around these issues, it should be happening much earlier.”

“It is unlikely that people will drastically change their behavior as adults, [so it is] important to address these issues for school-aged children all the way through high school and college.”

“The school system is still so guarded.”

“We help students plan for their career and not for their family.”

“[We need] education around healthy relationships, early on in life, at school. This is difficult now that schools are cutting so much.”

“[We need to teach] skills about how to interact with professionals – how to interview childcare providers, apply for childcare assistance, talk with professionals – can be transitioned to many other areas in their lives. How to have conversations with adults and seek/receive the information they need is an important skill.”

“The current curriculum in schools for health is very boring.”

“They have health classes but they need to not just follow the book but give much better education about other things – like what to do if they go to the doctor. Schools should educate young women and men on more than just saying this is your body and what it does but going more in depth.”

“The schools have made significant steps through their compliance in supporting the Healthy Youth Act. There is more information being shared by the schools about teen dating violence and bullying, and multiple policies being put into place. There is still push back from parents and the community but they have a good cheerleader in the schools who helps them and a good superintendent who believes in the whole child.”

“In xxx county we have school-based health centers. These centers have full time nurses, social workers; there are nutritionists, and a health education worker. This helped with absenteeism. All the resources are right there... You have lower teen pregnancy rates in these schools and lower adverse outcomes since they have resources there.”

“What about financial literacy training? ... This is something young moms need – how to make a budget ... One person does a forum about how much it costs to have a baby. The economic impact really adds up from that perspective.”

III. Engaging Businesses
Many participants mentioned engaging businesses and workplaces as a way to better support young families and working mothers, and as a way to engage the community at large. Participants emphasized the need for businesses to look internally at ways to better support their own work forces more so than outwardly toward supporting the larger community. They also asserted the need to artfully frame the issue for businesses in a way that incentivizes them to be compliant. Specific themes included co-located day care and
other day care incentives, support for nursing mothers, and general health-promoting efforts.

Relevant quotes
“Women are still not allowed to take nursing breaks. We need to educate employers as well as women.”
“Companies can apply to be “fit friendly.” They get designated, if they promote health, wellness, and families. This could help businesses to attract better employees, retain employees, etc. Companies look for ways to donate, build their brand in the community.”
“[On the importance of daycare]: It is easy for five people not to show up for a shift if school is closed or someone is sick. It improves employee satisfaction and improves retention and attendance. A lot of this stuff is a ripple effect where you may not see the results immediately but it will take place over time.”
“It helps when you work for a company that is supportive of working and single mothers. If companies could come together and chip in as a group for day care services or such that was somewhat on site it would help if we provided that infrastructure. This would lead to more productivity. If you have all these industries that are so close together they all can benefit.”
“There are a lot of industries in the community and in one part of town there are a lot of businesses in one area. Perhaps they could work together to have a nearby daycare for their collective workers. They could also have a gym and perhaps a health care provider who could be there. Those industries could make a difference for their employees. We could also give businesses incentives to mentor their employees, employees’ children and other children in the community.”
“Businesses, local lawmakers, they don’t totally understand the impact that health has on the economy. It has to be presented as a win-win.”
“We need to recruit and campaign those companies to get them involved. Show how it is good for their bottom line - less turnover, less absenteeism, etc. Show them the potential return on investment. Local stories from people in their company who could benefit from this help might spur them to action – also showing off companies who are doing good things is good for their business.”
“In working with businesses and others it is important to know the numbers – what we could save if the babies weren’t sick – what it costs when you have to ship babies off to higher care services. Make the economic case. For home health and social services this could show how much money we could save if babies were healthy.”

IV. Policymakers
Participants identified policymakers as another group that plays a role in disparities. In the same way that there are communication gaps between patients and health care providers, there are clearly gaps between policymakers and local communities. Engaging poor communities and minority communities in the local political process is important but also challenging given the lack of trust between these groups. Exploring civic engagement and building community voice in the political process are two areas to explore.
Relevant quotes

“Our policymakers blame black women for outcomes and they will say that your face. If policymakers do not believe it they will not let these things happen. They are able to thwart any program at the community level, so what are we to do”

“Policymakers should come to these meetings. It’s not hard to get legislators to come to these meetings, especially before elections.”

“It would be nice if communities could have a chance to sit with someone from the City Council or police department or a health club. We really need more of a personal relationship with these leaders. These leaders need to do better than just send out a complicated piece of paper about issues that are being voted on and that’s it.”

“[Policymakers] made Amendment One look like it was about gay people but it involved a whole lot more. So that felt like a trick. It directly impacted families like theirs who are not gay but are not married or who are single parents.”
Limitations

A significant limited factor in this research was our limited time to conduct each group. Because we used a convenience sample to identify relevant stakeholder groups and conducted our focus groups at the end of already scheduled coalition and committee meetings, we had on average approximately one hour to conduct the introductory presentation, explain the purpose of the groups, and conduct the groups. For this reason not all facilitators were able to ask every question listed in the focus group guide, resulting in some questions being given more time and attention than others.

An additional limitation relating to facilitators was our inability to hire and train one facilitator to conduct every group. Due to time and financial constraints, we elected to use different facilitators for each group, most of whom were members of the coalitions or advisory committees during which the focus groups were held. Despite this, we developed a very detailed facilitation guide with specific instructions and questions for facilitators, which they followed accurately. Additionally, because we conducted focus groups using already established coalitions and committees, we had little control over the size of our groups: we included as participants all group members who attended the initial meeting. This resulted in a few groups that consisted of more participants than would have been ideal for a focus group. Also, there were some groups that consisted of both professionals and consumers (for example, some community advisory committees had consumer representation). In order to honor the confidentiality of focus group participants, we did not keep records of which comments were made by consumers and which were made by professionals.

In reviewing the data, due to the volume of qualitative data we collected and limited funds, we chose not to transcribe any of the data collected. We did not use a formal qualitative data analysis process. Rather, we used the detailed notes taken during each focus group to identify and interpret themes in the data. The Co-PI for the project was involved in all of the sites and most of the focus groups. She carefully reviewed all of the data. We also presented this data to a team of women, some of whom had facilitated a focus group and all of whom have been involved in the work of the North Carolina Equity in Birth Outcomes Council, to review this data so as to mediate our individual biases. Additionally, we have audio recordings of each focus group that can be used for further analysis as needed.

Finally, due to the time restraints mentioned above, we were unable to conduct enough focus groups to achieve an accurate geographic representation of the entire state, but felt that it was important with our limited resources to focus on Central and Eastern North Carolina where disparities in birth outcomes are the largest and where the majority of African Americans live.
Conclusions and Recommendations

I. Questions Regarding Further Exploration
This focus group research highlights a number of areas requiring further exploration and questions requiring further investigation, both through qualitative and quantitative research.

**Understanding the gap**
A key factor that emerged in all of the focus groups was the lack of discussion on specifically addressed the racial and ethnic gap in health outcomes. This is in part due to an error on our part: by failing to clarify to whom participants were referring when they used ambiguous pronouns (they/them) to refer to their populations, we cannot be sure that participants were referring to African Americans. It is possible that some participants were referring to low-income community members and not African Americans specifically. In examining the data more carefully it is also possible that in some cases “they” refers to teenage consumers. Given the lack of clarification, we cannot completely understand participant’s comments. It is also notable that despite our failure to clarify the meaning of the pronouns being used, participants by and large failed to specifically address racial and ethnic disparities in their insights and suggestions, with the exception of content related to engaging men and fathers. Notably, the issue of racism was not apparently or widely discussed. Given the lack of discussion on both racism and the racial gap in health outcomes, it’s important that in future research we explore more carefully why these issues are especially problematic for minority populations.

**Provider attitudes**
A few participants asserted that consumers often feel judged or stereotyped by their healthcare providers and other professionals with whom they interact to obtain health and social services. One group asserted that some women choose not to access certain services because of the frequently unhelpful or rude behavior from the professionals who administer the services:

“Sometimes it comes down to priority and other times it is red tape. And then other times it is the attitudes of people that they have to deal with. With people acting like they’re bothering them – when it really is their job – that makes it hard to ask for help. They know the services are there but they don’t want to have to go through certain people to get what they need.”

Interestingly, we also on occasion heard some comments from health professionals, including healthcare providers, who participated in our focus groups that reflected those judgmental sentiments.

Although teen pregnancies account for only a small percentage of the births in North Carolina each year, participants tended to talk a lot about this population. They felt that teens decided to get pregnant because they didn’t see that they had other options in life. They said that some parents really expected their kids to end up pregnant. For others
having a child was a way to be an adult and have a place in the community. Participants, namely healthcare providers, also mentioned seeing an excess of substance-abusing pregnant mothers in their communities. One participant (a nurse) asserted that Cocaine is a big issue in her county and that in two months she had four patients who gave birth to Cocaine-addicted infants. Another participant (also a nurse) asserted that more than 50% of her pregnant patients are substance abusers during pregnancy.

In light of the volume of discussion on these issues, there is probably is a need for more exploration of both teen pregnancy and drug use among pregnant women as causes of poor birth outcomes, but there is also a need to further explore provider practices and attitudes about their low income, African American patients.

**Community activists**
A common theme, whether participants were discussing health services, preventive care, or fatherhood engagement was the challenges in finding the best way to reach people. Many participants emphasized the importance of discovering and implementing practices to bring services to communities in a way that fosters the most utilization and consumer satisfaction. Many participants suggested new and innovative ways that they’ve seen services brought to community members and would like to see replicated in other places. Suggestions included community-based events including health fairs to promote health, utilizing community activists, community health advisors, training healthcare providers to be more knowledgeable about community resources that they can then relay to their patients, and utilizing technology. A common suggestion included some variation on the idea of utilizing community activists to relay health messages and connect community members with services. More research should be done around the effectiveness of this strategy.

“We could train health advisors who can get out into the community to talk about the available resources. These people could be lay health people who live in the community who can share this information with people.”

“It would be good to have someone who can help link people in the community to the available resources.”

“In Raleigh they used to have the health bus which went door to door and provided on the spot services...This is good for the elderly or others who need someone to come to them.”

“Incorporating technology. More than likely, folks have smart phones...If they don't have transportation, they still have access to their phone.”

**II. Communities Warranting Further Investigation**
While there was consumer representation in some of the focus groups, the majority of focus group participants were professionals providing health care services or social services to preconception, pregnant, and postpartum women. All groups noted that additional consumer research should be undergone in order to better inform a strategic action plan for North Carolina. Both focus group participants and the data review team suggested that additional qualitative data be collected from the following consumer demographics: young African American women, Latinas, and men.
Consumers
Many focus group participants asserted that obtaining information regarding consumer's health information sources, including where women currently receive their information and what they would like to use as an information source, is an important next step in this research. Participants felt that consumers want to be heard and would be receptive to participation in focus groups.

“Perhaps we could have focus groups with young women getting family planning to hear more about what they want to hear and listen to.”

“Bring these focus groups to the communities that are often and always overlooked and only talk to those that we are trying to help.”

Men
Focus groups and the data review team felt especially strongly about the importance of conducting focus groups with male consumers given the emphasis on fatherhood engagement in the data thus far. Specific areas to explore include the reasons behind the disproportionately high number of single African American mothers and the most important and effective point of engagement for young men and fathers.

“We should hold focus groups with men to learn how to reach them and what they’d like to know.”

Latinas
Finally, some participants felt that Latinas were an important group to consider given that birth outcomes among this group tend to be on par with or better than their Caucasian counterparts. Given that their socioeconomic status tends to be more comparable to African Americans, some participants felt that we could learn a great deal about what protective factors Latina women might be experiencing that African American women are not.

III. Next Steps
It is clear based on the results of these groups that there are two important steps to take in order to meet the purpose of our research. First is the necessity of convening additional focus groups with consumers (including men) of the health and social services that many of these participants administer. Convening consumer groups is essential in order to understand the accuracy of some of the aforementioned assertions made by providers and to expand our understanding of the challenges we’ve heard about so far. Secondly, the dearth of discussion regarding racial inequities in these groups is highly significant, given that our stated purpose was to discuss the reasons for racial and ethnic disparities in birth outcomes. The groups, with the exception of fatherhood engagement and male involved, did not connect the challenges they discussed to race in any explicit way. If the purpose of this research is to understand racial inequities, it will be necessary to adjust the structure and wording of the questions asked in order to elicit feedback from participants regarding specifically how these challenges disproportionately relate to minority populations.
Appendix A. 12-Point Plan to Close the Black-White Gap in Birth Outcomes

Family, Maternal and Child Health Programs Life Course Initiative

A 12-Point Plan to Close the Black-White Gap in Birth Outcomes:
A Life Course Approach

What is the 12-Point Plan?
The goals of the 12-Point Plan to Close the Black-White Gap in Birth Outcomes are to: 1) improve health care services for at-risk populations, including communities of color and low-income families, 2) strengthen families and communities, and 3) address social and economic inequities over the life course.

The 12-Point Plan is different from other approaches to addressing racial disparities in birth outcomes in that it goes beyond prenatal care and the traditional medical model to address family and community systems, and social and economic inequities.

The 12-Point Plan:

Improving Healthcare for African American Women

1. **Provide Interconception Care to Women with Prior Adverse Pregnancy Outcomes.**
   Ideally, all women should receive health care between pregnancies, or interconception care, but this is particularly important for women who have had previous poor pregnancy outcomes. Current research shows that women who have had poor pregnancy outcomes are at risk for having poor outcomes again. Interconception care should include risk assessment, health promotion, medical and psychosocial interventions, and outreach and case management.

2. **Increase Access to Preconception Care for African American Women.**
   The goal of preconception care is to ensure that women are healthy before they get pregnant. Many protective and risk factors that affect birth outcomes are present early in pregnancy or even before women conceive. All women who may get pregnant should receive preconception care, which focuses on a woman’s overall health and includes comprehensive health promotion and disease prevention. These services should be integrated into health care over the course of a woman’s life.

3. **Improve the Quality of Prenatal Care for African American Women.**
   High-quality prenatal care is vital to both the health of the mother and as a foundation for the healthy development of the child’s organs and systems. Though the racial gap in access to prenatal care has been narrowing over time, the gap in quality of prenatal care has not. Research shows that African-American women do not receive the same level of health behavior advice or ancillary health care services during prenatal care as White women.

4. **Expand Healthcare Access over the Life Course for African American Women.**
   Across the lifespan, African-American children and adults are more likely to be uninsured than white children and adults. A lack of access to health care, especially primary care, diminishes opportunities to
provide preventive health education messages and increases the risk of delayed diagnosis and treatment of disease.

**Strengthening African American Families and Communities**

5. **Strengthen Father Involvement in African American Families.**

   In the U.S. today, 49% of poor African-American children live in single-mother families with little or no father involvement. The involvement of fathers in their families can be addressed at the individual, interpersonal, neighborhood and community, and policy levels, across the life course. Fathers need educational, employment, legal, and social services. They also need assistance in improving their relationships with the women in their lives. Community institutions need to take a leadership role in addressing the higher rates of unemployment, violence, and incarceration among African-American men in many communities. Finally, public policies (i.e. Temporary Assistance for Needy Families, Earned Income Tax Credit, and child support) need to be improved to support families that stay together.

6. **Enhance Systems Coordination and Integration for Family Support Services.**

   Currently, services for low-income families are fragmented, requiring parents to visit multiple locations, fill out duplicative paperwork, and arrange for child care and transportation to be able to do all of this. Community-based family resource centers that integrate various sources of funding can provide these families with comprehensive health and social services in “one-stop shopping.”

7. **Create Reproductive Social Capital in African American Communities.**

   Social capital is the level of social connectedness within a community, and research shows that social capital is associated with disparities in health. Reproductive social capital is an extension of this concept, focusing on those aspects of a community’s organization that foster the connectedness of pregnant women to their communities and the promotion of reproductive health within those communities.

8. **Invest in Community Building and Urban Renewal.**

   Socioeconomically disadvantaged neighborhoods, often in urban environments, have been shown to have a negative impact on health outcomes. These neighborhoods are often racially segregated; are more likely to be located near freeways and industries that expose residents to pollution; are more likely to include individuals who engage in violence, and drug and alcohol abuse; have less access to healthy foods and safe exercise; and are underserved by health and social service providers. Men and women who grow up and live in these neighborhoods will accumulate stressors and risk factors throughout their lives that will affect their health and the health of their children. Improvements in these communities will be achieved through economic, political, and infrastructure development.

**Addressing Social and Economic Inequities**

9. **Close the Education Gap.**

   Despite the official desegregation of schools in the United States, substantial disparities in educational opportunities exist, and many low-income children and children of color enter school already behind their white peers in terms of reading and math skills. In addition, these children have less access to
after-school activities and are more likely to have health problems that interfere with learning and school attendance. As an adult, lower educational attainment is linked with lower salaries, greater job and housing insecurity, less access to health care, and poorer health status. Child development educational interventions need to start in early childhood, at as early as six months of age, and need to make preschool available for all children starting at age 3.

10. **Reduce Poverty among African American Families.**

A number of measures can reduce poverty among families. These include expanding the minimum wage and the Earned Income Tax Credit (EITC), strengthening collective-bargaining, and implementing policies that support full employment and fair wages.

11. **Support Working Mothers and Families.**

The U.S. could provide better support to working African American parents by improving parental leave and child care. The Family and Medical Leave Act (FMLA) of 1993 provides 12 weeks of unpaid parental leave to those working in businesses with 50 or more employees. In contrast, most other industrialized nations provide paid leave from work for mothers and fathers. Part-time employees and employees in small businesses are often not eligible for FMLA benefits. Almost 30% of African-American parents are not covered by the FMLA. Also, the majority of African-American children are in child care while their parents work. Child care can be costly for low-income families, and these families are more likely to receive mediocre or poor quality child care than higher income families. Public policies that expand parental leave and make high-quality, affordable child care available to families are needed to reduce the wear and tear on working mothers.

12. **Undo Racism.**

There is a growing body of research linking racism with disparities in health outcomes. Racism occurs at three main levels: internalized, personally-mediated, and institutional. Institutional racism is the most fundamental level at which change must take place. Currently, there is limited research on the relationships between racism and birth outcomes. Researchers need to develop better measures of racism, study the possible causal pathways between racism and poor birth outcomes, construct intervention studies that address institutional racism, and design longitudinal studies that examine the effects of racism over the life course and across generations. In addition, health care providers should take specific steps to ensure that all patients receive equal treatment, and public health professionals should use the core functions of public health to make racism a leading public health issue.

**Reference:**


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**About the Life Course Initiative**

The mission of the Life Course Initiative is to reduce disparities in birth outcomes and change the health of the next generation in Contra Costa County by achieving health equity, optimizing reproductive potential, and shifting the paradigm of the planning, delivery, and evaluation of maternal, child, and adolescent health services. This 15-year initiative began in 2005. For more information, visit the Life Course Initiative’s website at www.cchealth.org/groups/lifecourse.
Appendix B. Community Stakeholder Focus Group Presentation Slides

**Working Together to Eliminate Inequities in Birth Outcomes in North Carolina**

**NC Equity Council Stakeholder Focus Groups**

*Presented by*
Sarah Verbiest, DrPH, MSW, MPH

*University of North Carolina Center for Maternal and Infant Health*

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**Every day, two babies die in North Carolina**

- A society’s infant mortality rate is considered an important indicator of its health, because infant mortality is associated with socioeconomic status, access to health care, and the health status of women of childbearing age. (Congressional Budget Office, 1992)

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**Infant Mortality: North Carolina**

*Figure 1: NC Resident Infant Mortality Rates, 1980-2009*

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**Acknowledgements**

- **Life Course Founders & Early Adapters:**
  - Dr. Michael Lu, Christine Malin, Mario Drummonds, Cheri Pies, Milt Kotelesnak, Amy Fine, Carol Brady and many others

- **Equity Planning Team:**
  - Amy Mullenix, Shelby Weeks, Judy Ruffin, Belinda Pettiford, Debbie Mason, Elizabeth Hudgins, Monique Bethel

- **Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)**

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**North Carolina ranks in the bottom 10 in the US for infant mortality**

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**About Two-Thirds of NC Child Deaths are Infants**

- Deaths due to perinatal related conditions and birth defects are a major cause of death for children ages 1 to 9 years.

*2008 child fatality data from State Center for Health Statistics*
The Life Course Approach

- Helps explain health and disease patterns across populations and over time.
- Points to broad social, economic and environmental factors and underlying causes of persistent inequalities in health for a range of diseases and across population groups.

Cumulative Pathways

- Stressed
  - Increased cardiac output
  - Increased available glucose
  - Enhanced immune functions
  - Increased learning and memory – neurons grow

- Stressed Out
  - Hypertension & cardiovascular diseases
  - Glucose intolerance & insulin resistance
  - Infection & inflammation
  - Decreased learning and memory – neurons atrophy

Allostasis: Maintain Stability through Change

Risk Factors

- Behaviors or conditions that, on the basis of scientific evidence, are thought to increase vulnerability to a specific condition or behavior
**Protective Factors**

- Behaviors, social influences or policies that, on the basis of scientific evidence, are thought to **reduce** vulnerability to a specific condition

**Critical / Sensitive Periods**

- Periods of time in a life course when the impact of adverse events and exposures is greatest
  - Fetal development
  - Early childhood
  - Adolescence
  - Young adulthood
  - Peri-menopausal period
  - Early years of retirement

**Socio-Ecological Model**

- Public Policy
- Community Relationships between organizations
- Organizational Organizations and social institutions
- Interpersonal Families, friends and social networks
- Individual Knowledge, attitudes and skills

**The Life Course Model**

- The experiences you have each day add up to determine your health throughout your life

**Developing a Strategic Plan**

- Stepping forward to make change happen

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**The Life Course Game**

Life Course Toolbox

[www.citymatch.org](http://www.citymatch.org)

Interactive way to understand key concepts of Life Course framework.
Healthy North Carolina 2020
Maternal and Infant Health Indicators

Objective #1: Reduce Infant Mortality Disparity
- Current death rate of African American babies is 2.45 times that of white babies.
- This rate was 2.75 in 1998. Since this time NC has seen an overall decrease of about 10.9% in the disparity rate.
- By 2020 this rate will be decreased to no more than 1.92 times. This represents NC’s current pace of decline with an additional 10% improvement over pace. Ultimately, disparity of any kind is unacceptable.

Equity in Birth Outcomes Advisory Council

Purpose
- To provide leadership to the development and implementation of an ACTIONABLE strategic plan to reduce inequities in birth outcomes in North Carolina

Resources
- Grant funds from NICHD to support a series of forums with key stakeholder groups and partners. Leadership from the UNC Center for Maternal and Infant Health, Division of Public Health and NC Perinatal Health Committee

Timeline
- Hold forums Summer 2012-Winter 2013
- Finalize plan by Spring/Summer 2013
- Submit grant applications to fund the plan by Winter 2014

A 12-Point Plan to Close the Black-White Gap in Birth Outcomes: A Life Course Approach

- Goes beyond prenatal care and addresses healthcare needs of African American women from preconception to interconception and across the life course
- Goes beyond individual-level interventions and addresses family and community systems
- Goes beyond the medical model and addresses social and economic inequities that underlie much of health disparities.

Improve Healthcare for African American Women

- Provide interconception care to women with prior adverse pregnancy outcomes
- Increase access to preconception care
- Improve the quality of prenatal care
- Expand healthcare access over the life course

Strengthen African American Families and Communities

- Strengthen father involvement in African American families
- Enhance service coordination and systems integration
- Create reproductive social capital in African American communities
- Invest in community building and urban renewal

Address Social and Economic Inequities

- Close the education gap
- Reduce poverty among African American families
- Support working mothers and families
- Undo racism
Appendix C. Community Stakeholder Focus Group Guide

Introduction

Let me begin by thanking you all for being here. Your participation today is voluntary. My name is ______, and I’ll be facilitating our discussion today. Kendall Gurske, Sharita Thomas, and Sarah Verbiest and will be recording our conversation and taking notes. The recording will help us make sure that we have heard what you are saying correctly. We will turn off the recorder at any time if requested. We will not identify your comments with your name in our notes or report. We would, however, like to include your name in our final report as someone who contributed his or her expertise to this important plan. If you would not like us to include your name in the plan please tell me at the end of the meeting.

We are working with the UNC Center for Maternal and Infant Health, the NC Child Fatality Task Force and the Equity in Birth Outcomes Council to conduct focus groups with stakeholders around North Carolina. In these meetings we are interested in learning about people’s opinions and ideas about the actions that we should take in North Carolina to address inequities in birth outcomes. We are building a strategic action plan to improve health equity in North Carolina based on the 12 Point Plan to Reduce Inequities in Birth Outcomes. These discussions will help us tailor this plan for our state.

We plan to meet with a total of 8 groups of stakeholders from around the state (20 people per group for a total of 160 people) and to conduct 20 interviews with leaders working in many different fields and sectors in North Carolina. The focus groups will each take 60-90 minutes. We will send you a report with a summary of the results of the focus groups and interviews. If invited, we would be happy to return to your group and share the results with you in person. We will also sponsor up to two people from your group to attend a meeting in the spring of 2013 to finalize the plan.

Discussion Guidelines

As key stakeholders and leaders in your community we value your opinion about the steps that must be taken to improve birth outcomes for African American babies. Let’s set some guidelines for our discussion so that everyone feels comfortable and respected.
[Brainstorm and agree upon 3-5 rules of discussion.]

Comments made during the focus group session should be kept confidential. It is possible that participants may repeat comments outside of the group at some time in the future. We encourage you to be as honest and open as you can, but because this is a group setting we have limitations in being able to protect confidentiality.

We want to be respectful of everyone’s time so I may need to stop discussion on one topic and move us along to the next. If I need to do that, please do not take it personally. We just want to ensure that we cover each topic and that everyone has an opportunity to speak.
Presentation (15-20 minutes)

A set of slides was developed to share information about: a) the problem of infant mortality in NC and the disparities in birth outcomes; b) a framework for addressing this problem (life course model); c) the 12 point plan to reduce disparities in birth outcomes; and d) discussion about the development of a strategic plan. We will provide you with a handout listing additional free resources about the life course model and addressing health inequities.

Discussion (60 minutes)

Now we would like to hear from you. The following questions may be asked:

NOTE TO FACILITATORS:

Please continue to focus the conversation on the “gap” issue. We really want to hear what we can do to increase preventive factors/decrease risk factors for African American and American Indian women.

One technique you might want to use if you are challenged in drilling underneath general issues is the 5 Whys. Just respond to comments with “why” five times – this should prompt people to move from (for example) “these women are using a lot of drugs” to a deeper understanding of why this might be happening.

• We have just reviewed the 12 points of the plan (you have a copy of the 12 points). Is there anything missing? Do you have any comments or thoughts about this plan you’d like to share?

• What are some ideas for change whose time has finally come? Are you seeing any positive changes or movement in your community that we should build on? In the next 5 years? Next year?

• Beginning in August there are new preventive health care services that private insurance plans must cover. In the future there will hopefully be more coverage for health care services. How can we make sure that African American women in your community/ies are able to take advantage of these resources? What barriers exist now that need to be addressed? What do we need to do to make sure these women receive this care first – as a priority?

• How can we increase community support and investment (faith communities, social services, business leaders, schools) in helping young men and women plan for and have healthy families? What is something that could happen in the next 5 years? Next year?
• We know that men are a very important part of a family. What do we need to do in North Carolina to better engage and support young African American men and fathers? What could be done in 5 years? Next year?

• What services/societal changes outside of the health care system are needed to help young women and men achieve optimal health / be as healthy and well as they can? (Probe on education, job training, housing, financial services, etc.)

• What services/changes within the health care system are needed to help young women and men achieve optimal health / be as healthy and well as they can?

• If you had the resources you needed, what program/service/activity would you start offering now to improve the health of African American women and young families?

• There are steps that can be taken to improve birth outcomes and infant health, such as planned pregnancies, making sure young women are healthy before they become pregnant, breastfeeding, putting babies on their back to sleep, and birth spacing. Unfortunately, we continue to see disparities in all of these areas. Whatever we have been doing in the past isn't working very well.

**What should we be doing differently?**
(Probe on things like – is telling people what to do enough? Have we assessed cultural competency among our providers, case managers and others? What role do other factors have on these choices?)

• What forces will work against us as we develop and implement this plan? What should we do to prepare to address these issues?

• What doors / opportunities are open to us now as we move forward with this work? Are there available resources that we should take advantage of?

• In your opinion, what actions must be included in a strategic plan to reduce disparities? [Probe on how those actions might be realistically implemented]

• Are there any other comments, suggestions or questions we have forgotten to ask?

Thank you very much for your time. We sincerely appreciate it.
Appendix D. List of Community Stakeholder Focus Groups

<table>
<thead>
<tr>
<th>Group #</th>
<th>Date</th>
<th>Group (Meeting Location)</th>
<th>Group</th>
<th>Approx. # of Participants</th>
<th>Facilitator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>August 9</td>
<td>Guilford County Health Department in Greensboro, NC</td>
<td>North Carolina Infant Mortality Coalitions Meeting</td>
<td>10-12</td>
<td>Amy Mullenix</td>
</tr>
<tr>
<td>2</td>
<td>August 9</td>
<td>Guilford County Health Department in Greensboro, NC</td>
<td>North Carolina Infant Mortality Coalitions Meeting</td>
<td>10-12</td>
<td>Charmaine Purdum</td>
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<tr>
<td>3</td>
<td>August 13</td>
<td>UNC Pembroke Regional Center in Robeson County, NC</td>
<td>Healthy Start CORPS Infant Mortality Task Force Meeting</td>
<td>10-12</td>
<td>Kay Freeman</td>
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<tr>
<td>4</td>
<td>August 17</td>
<td>Greater First United Baptist Church in High Point, NC</td>
<td>Triad Baby Love Plus</td>
<td>12-15</td>
<td>Sharon Johnson</td>
</tr>
<tr>
<td>5</td>
<td>August 17</td>
<td>Greater First United Baptist Church in High Point, NC</td>
<td>Triad Baby Love Plus</td>
<td>12-15</td>
<td>Heather Owens</td>
</tr>
<tr>
<td>6</td>
<td>August 20</td>
<td>Cooperative Extension Building in Greenville, NC</td>
<td>Pitt Infant Mortality Prevention Advisory Council (PIMPAC)</td>
<td>15-20</td>
<td>Rovonda Bradford</td>
</tr>
<tr>
<td>7</td>
<td>August 20</td>
<td>Cooperative Extension Building in Greenville, NC</td>
<td>Pitt Infant Mortality Prevention Advisory Council (PIMPAC)</td>
<td>15-20</td>
<td>Amy Hattem</td>
</tr>
<tr>
<td>8</td>
<td>August 20</td>
<td>Cooperative Extension Building in Greenville, NC</td>
<td>Pitt Infant Mortality Prevention Advisory Council (PIMPAC)</td>
<td>15-20</td>
<td>Denise ??</td>
</tr>
<tr>
<td>9</td>
<td>August 28</td>
<td>Rockingham Pregnancy Care Center in Eden, NC</td>
<td>Young Moms Connect Advisory Council</td>
<td>15-20</td>
<td>Sarah Verbiest</td>
</tr>
<tr>
<td>10</td>
<td>September 17</td>
<td>Nash County Health Department in Nashville, NC</td>
<td>Young Moms Connect Community Advisory Council</td>
<td>8-10</td>
<td>Rovonda Bradford</td>
</tr>
</tbody>
</table>