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Using Focus Groups to Identify Ways to Reduce Infant Mortality in Kalamazoo

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Abstract

Study goals were to explore maternal perceptions of possible ways to reduce infant mortality in Kalamazoo County, with specific regards to the infant mortality rates of non-Hispanic African American babies versus non-Hispanic Caucasian babies. Two focus groups were conducted of voluntary, anonymous, participants from the YWCA domestic violence shelter and clients of home visiting services provided by the Kalamazoo County Department of Health and Community Services. The focus groups were guided allowing women to voice their opinions about ways to prevent infant mortality in Kalamazoo. Women were also asked to respond to the goals created by a community planning committee to reduce racial disparities within infant mortality. Findings from the focus groups were analyzed to be presented to The Kalamazoo Infant Mortality Community Action Initiative, which is sponsored by the YWCA and aimed at decreasing the racial disparity of infant mortality and increasing positive birth outcomes among at risk women in Kalamazoo. Qualitative data analysis techniques were used to analyze the data. The main themes that emerged encompassed the following: safe sleep, maternal health behavior, healthcare, and stressors.

Introduction

Infant mortality rate refers to the number of infants for which death occurs prior to 12 months in a given year, per 1,000 live births. According to the Central Intelligence Agency (CIA) World Factbook (2016), the United States' (US) average infant mortality rate for 2015 fell just short of 6 at 5.87 out of 1,000 live births; with a slightly higher rate for males (6.37/1,000) than females (5.35/1,000). This places the US in the lower quarter of the world's countries regarding infants making it to their first birthday (CIA, 2016). As to be discussed, infant

mortality can provide insight on how communities support their vulnerable and at risk populations and, on a greater scale, the community. Throughout the US there is evidence of a racial disparity in birth outcomes for minority populations, highlighting, non-Hispanic African-Americans (MacDorman and Mathews, 2011). According to the Kaiser Family Foundation (2016) across the US, African American babies die at roughly two times the rate of Caucasian babies.

Potential risk factors for infant mortality include the following: birth defects, preterm birth (birth before 37 weeks gestation), low birth weight, maternal pregnancy complications, sudden infant death syndrome (SIDS), and injuries (Centers for Disease Control and Prevention, 2016). The risk factors touched on by the CDC (2016) include the top five causes of infant mortality, which accounted for nearly 60% of all 2014 infant deaths in the US.

Many factors may attribute to the racial disparity in infant mortality present throughout the US. Infant mortality can be a key indicator of how a community cares for its' vulnerable populations as well as the population as a whole (Christopher and Simpson, 2014). Christopher and Simpson (2014) go on to explain the World Health Organization's (WHO) approach to interpreting determinants of health such as social and environmental contributions when considering overall well-being. In addition to assessing the whole client, it is important to assess cultural background as well. African-Americans are at higher risk for being or becoming in poverty as well as the relevant risk factors that follow (Christopher and Simpson, 2014). With inadequate finances, ability to acquire necessary and helpful resources is impaired. Those living in poverty are at higher risk for living and working in dangerous environments, eating less nutritious foods, and being under chronic stress which can place both mom and baby at higher risk for adverse pregnancy and birth outcomes.

According to the CDC (2016), being of low socioeconomic status and under ongoing stress increases a mother's chances for smoking while pregnant. Smoking while pregnant can lead to various pregnancy complications ranging from miscarriages and stillbirths to preterm labor and adverse infant and childhood outcomes (Ellingson, 2012). Smoking is a modifiable risk factor for low birth weight which appears to also be directly correlated with low socioeconomic status (Gage, Fang, O'Neill, and DiRienzo, 2013). Further exploring the risks of smoking, whether maternal or simply within the household, the smoke increases an infant's risk for SIDS (CDC, 2016). Salm Ward and Nqui (2015) detail the relationship between co-sleeping, a known risk factor for SIDS, and other factors such as stress (emotional and financial), abuse, financial and educational status, showing connection between the lack of resources and increase in stressors that plague many African American families in the US today. A positive relationship was shown between low socioeconomic status (SES) and education with a mother's likelihood to co-sleep as well as a clear disparity represented between Caucasians and African Americans (Salm Ward and Nqui, 2015). Life stressors that may lead to unsafe maternal behavior can include major changes in housing, relationship, or financial status (MI PRAMS delivery, 2010). Additionally, inadequate finances can lead to decreased options for and participation in healthcare, including prenatal care. Adequate prenatal care consists of regular assessment of the fetus and mother and maternal education (Hernandez-Correa, 2011). The CDC (2016) focuses on the fact that proper prenatal care, including lifestyle (abstaining from nicotine and alcohol) and routine healthcare visits are crucial in maintaining a healthy pregnancy and increasing birth outcomes across all races and ethnicities.

While there is a clear racial disparity throughout US regarding infant mortality, there is a significant gap presenting in the Kalamazoo area. According to the Michigan Department of

Health and Human Services (MDHHS) (2014), the most recent data presents the infant mortality rate for Caucasian babies to be just over 2.5/1,000 while the rate for African American babies sits at 11.5/1,000; a rate just over 4.5 times higher or 450%. In regards to ongoing research to specific factors that place families at risk for infant mortality, it is crucial to advocate for the at risk families including vulnerable populations and minorities in the Kalamazoo community. The Kalamazoo Infant Mortality Community Action Initiative, sponsored by the YWCA, is a collaborative community action planning team working towards intervention to prevent infant mortality. It is essential to gain insight into the at risk women of Kalamazoo regarding their perception on infant mortality, healthcare, and contributing factors in order to work towards a solution of the present racial disparity.

Methods

Participants

Participants included 12 women residing at the YWCA domestic violence shelter and clients of home visiting services provided by the Kalamazoo County Department of Health and Community Services. Residents at the YWCA shelter and those involved in home visiting programs provide helpful insight into the infant mortality racial disparity of Kalamazoo as they experience many of the factors including low SES as well as a variety of ongoing stressors. Two focus groups were conducted composed of 6-7 women each. The majority of the women included African American mothers, while there were both biracial and Caucasian mothers included. Additionally, the majority of mothers presented with a high school degree, while some were short or had gone on further to pursue college. The majority of the participants were

unemployed. The goal of the information found through these focus groups is to add information and insight to the ongoing community-wide action plan to reduce infant mortality in Kalamazoo.

Procedure

For YWCA residents, the YWCA staff presented the women the opportunity to participate in the described focus groups during regularly scheduled resident meetings. The YWCA staff used a script provided to them to inform residents of the focus group allowing the women to provide their insight about ways to reduce infant mortality in Kalamazoo. In addition, there were approved posters flyers posted where residents could see them for further information and residents were informed that their participation in this opportunity would in no way affect their services being provided to them. Residents were told that they could sign up at a service desk should they be interested in participating. The participants were required to ask the staff member at the desk for a sign-up sheet which asked for basic information such as how to reach and or locate the resident. Participation remained anonymous through the use of individual sign-up sheets and staff mediation.

A similar process was used to allow women from home visiting program to get involved in the task group and that it would have no reflection on the services that they receive. Through the home-visiting staff the same script and flyer were provided informing women on the option to voice their opinion. These mothers were given appropriate contact information to sign-up, should they choose to participate. The script given to the staff detailed that the goal of the focus groups were to gather perceptions of at-risk mothers from the community on prevention of infant mortality in Kalamazoo.

Data collection

Questions posed during the focus groups asked women about their opinions regarding ways to prevent infant mortality in Kalamazoo (see Appendix). Each focus group began with a review of the voluntary consent, a break for snacks including voluntary exit, introductions, and an explanation of a set of ground rules that included confidentiality as well as a request of verbal agreement by group participants to preserve confidentiality. Then, the group engaged in discussion facilitated by the researchers allowing open-communication. In addition, each mother was provided a \$25 gift card to Meijer for participating.

Informed Consent and Anonymity

A waiver of consent was obtained because informed consent would be the only document that could link the participant to the study, and due to the importance that of not maintaining records with names on them that could potentially compromise confidentiality and resident safety. Each participant was provided with a consent form, and the focus group facilitator reviewed the form at the beginning of each focus group. During the consent process, women were notified that if they provide information indicating that their children are being abused or neglected, there would need to be a report made to child protective services. After reviewing the consent form, women were given time to reflect on the form, snack, and ask questions if so desired. This gave women an opportunity to leave if they wished, and they were notified that they may do so. Women were provided with paper copies of the forms; however, their signature was not requested. Women were provided with a copy of the consent form when they signed up for the group so that they could review it prior to attending the group. This allowed the women time to make an informed decision about whether or not they would like to attend and participate. There was also a phone number provided for women to call to ask questions prior to the beginning of the focus group. A demographics form was used to collect information about

women's demographic information, such as age (not date of birth), ethnicity, education and income level, number of children in their care, etc. Women completed all forms anonymously, transcriptions were made anonymous on a secure server, and original recordings were deleted.

Both focus groups occurred at the YWCA, were audio-recorded and later transcribed. The transcriptions were then reviewed by three coders. The transcriptions were broken down to 4-5 sections each. The coders independently reviewed each section and used memoing to note themes and reactions to the transcriptions. The coders then met on three occasions to jointly develop themes from the transcription, summaries of the focus group sessions were created, and themes of the summaries were analyzed through individual evaluation and group discussion.

Results

The key themes that presented throughout the focus groups include: safe sleep, maternal health behavior, healthcare, and stressors. Discussion on safe sleep including confusion as well as conflicting information regarding what is actually safe sleep for an infant which carried over into an evidence of distrust in the healthcare system. In addition, to distrust, feelings of judgement, dismissal of concerns, and receiving inadequate care emerged. It was clear that maternal stressors including financial and emotional play major role in pregnant mother's maternal health behaviors including smoking and lack of maintaining appropriate healthcare as well as overall health during pregnancy.

Theme I: Safe Sleep

Mothers discussed difficulty acquiring consistent information regarding up-to-date safe sleep practices and additionally engaging in what they feel to be safe sleep practices with their children.

Subtheme 1: Mothers reported acquiring conflicting and confusing information on what is actually considered safe sleep practices for their children from various sources including healthcare staff:

“Now they sell these rocker sleepers in the store now, the hospital told me it was fine for the baby to sleep in there but my nurse that comes in said that it’s not okay.” [“But they present it for you to buy as a sleeper”

Further group discussion detailed the anatomy of the infant and why due to the decreased risk for aspiration it is safer to put babies to sleep on their back versus their stomach. This conflicting information across the healthcare system expanding into product packaging causes confusion on what is truly considered safe sleep practices and places vulnerable populations at risk for errors due to lack of adequate information and varying education.

Subtheme 2: In addition to struggling to obtain up-to-date safe sleep practices, mothers report that it is simply easier to co-sleep supported by statements such as:

“I think that’s what is probably really dangerous. It’s that the baby wants to be up and you’re like I really need to sleep.”

“It’s... stressful and then at night you’re like over tired”

Mothers reported being exhausted upon bedtime and it being easier to keep the child in bed with them for various reasons. Reasons for co-sleeping including increased likelihood of both baby and mother to acquire more sleep by allow less interruptions, quicker feedings, and avoidance of relocated the infant once one or both members are comfortable and asleep.

Theme II: Maternal Health Behavior

With emphasis on invulnerability as well as fate, many mothers discussed engaging in risky maternal behaviors such as smoking while pregnant. It was clear that few mothers had adequate knowledge regarding the risks of maternal behaviors on fetal development, and further, increased risk for infant mortality.

Subtheme 1: Mothers reported throughout the discussions a perception of invulnerability to risk with statements such as:

“I’ve got 4 kids, um my first one, I didn’t smoke, his dad smoked, and I know this is bad, I picked up my first cigarette when I was 7 months pregnant with my second child, and they’re healthy, smart, beautiful... they have no complications at all. I smoked with my child and it was fine.”

“I smoke when I’m pregnant and it doesn’t do anything.”

“I feel like I will put a baby on their stomach if there is like nothing in the crib or whatever cause like my niece and nephew slept on their stomach and there’s like nothing wrong with them.”

Despite education about risks regarding infant safe sleep and smoking during pregnancy, mothers believe that they are not vulnerable due to past experiences that have fortunately resulted in positive outcomes when inadvisable maternal behaviors were involved in pregnancy.

Subtheme 2: In addition, mothers seemed to report a resistance of given up smoking, both marijuana and cigarettes during pregnancy with the following statements:

“With my pregnancies... marijuana helped me from throwing up and it gives me an appetite... Sometimes if I don’t smoke or something like that I can be sick like I’m on heroin or something like that, I’m just balled up, can’t move, can’t do nothing.” [“But if I smoke then I’ll be more

active and stuff like that ... I had explained that to my doctor and they had told me tht they hear that from a lot of pregnancy women...”

“It’s the least birth defects, all it do is burn brain cells that regrow, the worst one is alcohol we all know that, marijuana don’t cause birth defects.”

“I mean they tell you oh, please stop, okay I’ll cut back... I’m gonna try to strangle somebody.”

Subtheme 3: Misinformation about the effects of maternal behavior (such as smoking) on child development and possible complications could be contributing to this presence of resistance. The comments following illustrate inaccurate information regarding the most relevant maternal behaviors:

“Marijuana... I used with her, and I didn’t have no type of appetite. The doctor told me it was okay to smoke here and there.”

“I feel that everybody is different and that is one of the unfortunate things. Someone can smoke and have problems and someone can smoke and no problems.”

[“I’ve never had nothing wrong with my kids and they all was off marijuana, I’m sorry, I’m just gonna tell the truth...”

“There haven’t been no studies showing that marijuana has like a bad effect.”

“It’s not about what you put in your body.”

“So if you can smoke the marijuana... why couldn’t you smoke a cigarette? Cigarettes ain’t never caused nothing, I mean what birth defects has it caused? None Anything can put you into

preterm labor.” (Group agreement followed by discussion of other events that may lead to preterm labor such as walking, falling, and stress.)

“I stopped smoking. Smoking the stuff... There’s no way I can eat right now.” (In regards to a doctor commenting on a mother’s weight loss.)

A clear lack of adequate knowledge is present regarding the effects of maternal behavior on the impact of the fetus as well as the child throughout his or her lifespan; especially regarding the topic of smoking while pregnant, both cigarettes and marijuana. Mothers present reports of reaping the immediate benefits of stress and nausea reduction without considering the possible poor health outcomes the habits may have on themselves as well as their baby.

Subtheme 4: Adding to the resistance formed by perceived benefits and lacking education, some mothers report belief that fate is more responsible for birth outcomes than are mothers’ health behaviors:

“I just have to say one thing. I feel that everybody is different and that is one of the unfortunate things. Someone can smoke and have problems and someone can smoke and no problems...”

“The unfortunate thing is, you’re rolling the dice”

“But it’s a tricky and funny thing too, because I mean you can be 100% healthy you know... and have a messed baby”

“It’s just God, if it’s meant to be, it’s meant to be.”

Theme III: Healthcare

Women openly voiced an overall lack of satisfaction with healthcare that they have received. Topics of racism, distrust in the healthcare system, and difficulty receiving and maintaining appropriate prenatal care.

Subtheme 1: Concerns about medications given during pregnancy presented as a hot topic among the mothers. With lots of talk about the anti-nausea effects of smoking marijuana, the negative opinions on prescriptions to resolve this issue were clear:

[“Even the Zofran that they prescribed and stuff, that stuff don’t even work.

“They had a recall on that too” (Regarding Zofran)

“Well they got like different type of pill they try to give you to stop the nausea and stuff like that but then... everybody have different effects with things, like the Zofran, it started making me like constipated and stuff like that and I didn’t like that.”

“Zofran is gross.” [“Zofran don’t help, um, and I get sick on Zofran”

“They had a recall on that, it was giving kids birth defects, there’s a lawsuit going around...”

(Regarding Zofran)

There were evident concerns amongst the mothers about anti-nausea medications including recalls and unpleasant side effects. Mothers made requests for more studies to be done on the medication prior to prescribing them to patients.

Subtheme 2: This negative view of the medications prescribed while hospitalized seemed to carry over into feelings towards appointments and providers as well. Reports of prenatal care appointments being a “waste of money” due to lack of provider involvement and assessment as well as perceptions of judgement from the providers and lack of compassion were voiced:

“I hate when they do those appointments when you come in there, you sit down for a long time and they come in and all they do is listen to the baby heartbeat and then you leave.”

“And then they charge you so much for it.”

“And, every time, ‘oh, you’ve gained a lot of weight. You understand that it is only 32 pounds in the average birth?’ I didn’t want to go anymore, they need to be more positive instead of saying that.”

“... at mine all they say is that I was fat and come to find out I was preeclampsia and gained 100 pounds.”

Subtheme 3: In addition to the mother’s reports of healthcare staff being rude, there was a complaint of lack of attention as well as dismissal of concerns involving one mother in specific who’s provider dismissed her intense pain which was truly presentation of a well-known pregnancy complication:

“No I’m just saying like cause I had a doctor through my first trimester and I was in pain, a lot of pain, and she was just telling me that it was, it was just my uterus or something... Yeah contracting and stretching and I was like no something is really wrong and then I found out that in my second trimester that I had blood in my baby’s placenta and they called it placenta previa or something like that”

“But they try to make it seem like there was nothing wrong with me and I’m like hey.. I’m in pain something’s wrong... And I kept going in and kept going in, and they, “Oh, there’s nothing we can do.”

Subtheme 4: The fact that these mothers feel that they are treated unjustly and do not receive appropriate care ties over into the overall lack of trust in the healthcare system, with a specific example regarding sickle-cell disease:

“Why [are] black people the only people that get sickle-cell?”

“I don’t even want to test mine, I just need to look at mine for the first whole year and watch it, that’s what I do, I don’t agree with the testing, I’m kind of scared to let them test.”

“I’m kind of scared, cause you don’t know if it’s racism you just don’t know.”

“What if there is somebody in the lab that says... I don’t want the population to grow in this race. What if?”

Further discussion included threats of population control regarding sickle-cell and SIDS in African-American baby boys. Mothers express the possibility of hidden racism present within the healthcare system but that they would present zero tolerance if they were to sense it during their care. From there, it is questioned if these infant deaths are due to care given in the home or the hospital. One mother whose infant had died found that the doctor put the wrong diagnosis on the death certificate:

“Until I got the second autopsy that I had to pay for out of pocket and then I found out differently... That’s when we found out it was not SIDS, lungs not developed and collapsed, should have never left the hospital”

Subtheme 5: Throughout the focus groups mothers expressed concerned of exhaustion in the healthcare staff as well as confusion on whether there is presence of racism or providers are simply overworked:

“Didn’t you hear what I said? The doctors be tired. They overworking. They be tired.”

“They tired. If I was tired I wouldn’t be able to think about how to stop something. I mean just think about how, that’s horrible.”

[“I think one of my kids passed due to the fact the doctor was just tired, and he was ready to go. He was really just ready to go and like, ‘okay just come to my office in 2 weeks’.”

“...I’m not saying particularly my case. My doctor was tired.”

“Right, he was tired. He told me he had been up for a week and he was on his way out the door and then they got my call.” [“So he was kind of tired.” [“He was in his care and ready to go home, and had to go back in so.”

Subtheme 6: Aside from race, topics of religious affiliations with the hospital were touched on:

“I like Bronson better than Borgess. Borgess won’t save the baby, they’ll save you before they save the baby.”

“It’s just a religious belief.”

[“See my beliefs are saving the baby before saving me.”

Further discussion on preferences continued briefly comparing the influence of Catholicism on healthcare decisions within a facility as well as preference of mother’s life over baby’s life to be saved first. Concerns about how a hospital religious affiliation would affect the way they and their infant would be treated if there was a medical emergency were the center topic.

Subtheme 7: Exiting the hospital world and attempting to access resources proved to be equally as frustrating for these at risk women:

["I was frustrated... I might just be like well I quit... I'm not gonna get food stamps... I'm never gonna get a job."]

"Even with a job though in our society. You cannot provide even living in subsidized housing and having a job and not getting food stamps. You're not going to be able to provide for your house, especially with a child on the way."

["It is impossible. I don't care what anybody says.

Mother complaints of excessive requirements for little or "not enough" services through community resources were a hot topic. Mothers reported having too many stressors going on already to be involved in the extra work (paper, volunteer, etc.) required to obtain resources from the community (food stamps, cash assistance, etc.). These concerns are supported below:

"Okay, yes, I do need a job but right now like I'm going through all of this like can I get a break and just like can I go through this program. I mean, like, help me a little bit, like they want you to do too much for like a lot of stuff that's not really helping you too."

"Since I'm so far along I don't have to do any volunteer work, but everybody else would have to do volunteer work... They expect too much for too little."

"I don't get applications. I do everything online, I'm not going to keep going out the house, 9 months pregnant looking for a job."

Uncertainty about what is required to get assistance and various services as well as lack of motivation, time, and or energy come into play when considering the at risk population's ability to become connected to and maintain connection with community resources.

Subtheme 8: Another key social determinant to consider is socio-economic status. Low income women reported receiving poorer medical care as well as transportation issues:

“[At the hospital] they told me like I could get on the bus with my baby” [“They tell me that I am not eligible for a car seat because my car is not working. But you can't leave the hospital without your baby without a car seat... that I could get on the city bus.

“I wasn't eligible for it because my car was not working ... and they like well how'd you expect to leave the hospital? And I'm like I have family, I have support.” [“My cousin was at work when they were getting ready to release me. So I would just get ready for my car seat and they told me, no you can just take the bus.”

The mothers voiced opinions that low income families receive less care and compassion from the healthcare system as well as had an overall distrust for the system.

Subtheme 9: Further into the discussion, gender preferences for providers emerged as a contributing factor to these mothers' feelings towards providers:

“I don't like midwives.” “I had a terrible experience with my midwife, I don't like midwives at all.” [“I just had a terrible experience one time and I just don't like 'em ever sense.

“They are like less caring cause they women, you know with the pain.” “They're like ‘Girl, come on now, we do this for a living.”

“They, just like I said, less caring. I’d take a male doctor to have a baby all day because they are more [caring].”

“They less caring, the women doctors are a little bit less. The men, are so gentle and they coach you”

[“The ones even with no babies, oh they the worst.”

There was an overwhelming perception that midwives and female providers are less caring and gentle than male providers during the time of pregnancy and delivery. While basing decisions off of past experiences may not be the best route to take, it is understandable that a person may have such a crucial impact on these at risk mothers during this vulnerable time.

Subtheme 10: Women reported mixed feelings towards home-visiting healthcare mainly discussing frustration with inadequate follow-up regarding both tangible resources and referrals:

“I know some of the social workers I was working I was working with... for one of my pregnancies and the ladies that come over and be like ‘I’m going to bring you this and I’m going to bring you that.’ And then she never brings it.” [“I don’t know, she might be keeping it for herself or something. So.. Cause she always told me she was going to come and bring it and I never see her. And then when she come back and I remind her...” [“And she’s like oh yeah, I’m going to get it to you. And then you don’t see it.”

“... And then with a lot of the referrals that they say they goin’ give you, you never really receive them.”

“And then when I called she’s like oh you’re not a part of the program anymore...” [“Like when I was a part of the program I was waiting for the referral and you never sent it.”

Theme IV: Stressors

Stressors were reported throughout the focus groups, with finances being of highest concern in regards to acquiring necessities of daily living as well as appropriate healthcare:

“Even with a job though in our society. You cannot provide even living in subsidized housing and having a job and not getting food stamps. You’re not going to be able to provide for your house, especially with a child on the way”

“I actually have health insurance and I had to fight to the death. I’m talking hours and hours and hours to get Medicaid. I pay thousands of dollars a year that covers nothing.” [“And after fighting and fighting... I almost didn’t bring him to his... hearing testing... ‘cause I have to pay out of pocket.” [“And when I called it’s like a \$300 visit.”

“You don’t want to go in and go to the doctor’s appointments because they’re so expensive.”

“And after fighting and fighting and fighting... I didn’t want to bring him to his hearing testing. It’s different things like that ‘cause I have to pay for it out of pocket... And when I called it’s like a 300 dollar visit.”

Financial struggles including difficulties with insurance, resources and the stress of multiple children add to care the mother must provide as well as resources. Children were also reported to be highly correlated with less sleep:

“I think that it’s just like very stressful having a baby and like the money aspect, obviously, and... just getting things done.”

[“It’s... stressful and then at night you’re like over tired”

["It helps when you got ... [a] big support system and you have people to help you out."

Having children is stressful in a number of ways both financially and including resources. With that being said, unplanned and unwanted pregnancies arise rapidly throughout the nation and considerably in Kalamazoo County. Mothers reported a lack of provision of options (abortion, adoption, paternal custody, etc.) to this population. There were various reports of women unexpectedly getting pregnant while on birth control, including various birth control pills and combinations, Mirena, and ParaGuard. In addition, one report in specific stood out as a pediatric client could not obtain birth control through her provider but was advised to the hospital:

"My sister just had a baby, she's fourteen... she missed her appointment for her birth control... they won't do a birth control through her pediatrics."

In response to a focused question on teen pregnancy:

"Wait a minute, why, what does the teenagers got to do with this..."

"Cause a lot of kids now-a-days are having sex"

"Well, honey no, Kalamazoo has been known for making babies from 15 on up, that's just Kalamazoo."

"Now they starting at 10 and 12." (Regarding having children)

"I don't think they got nothing to do with it."

Further discussion regarding how the mothers' opinions of how teens were uninvolved in the infant mortality issue presenting in Kalamazoo followed, suggesting that allowing teens

access to birth control may give them the perception that it is okay to have sexual relations and that they may lack safe sexual education.

Category V: Recommendations from the Women

Helpful suggestions from the women suggested educating the whole family on risk factors for both mom and baby including safe sleep, SIDS, product information, and resources. A request for more resources (including home visitors and possible “baby shadowers” for the first few months) was made as well as possible equipment such as baby monitors to be provided. Furthering the support for the mothers, suggestions of parenting classes, support, groups, and access to a hotline when in crisis were brought to attention. Seeing as the exhaustion of medical staff was a large concern, the mothers’ idea of resolution is to shorten doctors’ hours and or provide breaks. Lastly, there was suggestion made to educate teens on safe sexual practices even though some mothers felt that they were not involved in the issue of infant mortality.

Discussion

Findings of the study did meet the goal of gaining insight into at risk mothers in Kalamazoo on infant mortality in African Americans. It is clear that lack of education, trust, and continuation of care have occurred throughout the community of Kalamazoo, leaving mothers vulnerable and unsure of where to find optimal care and information; this may lead to lack of proper prenatal care and maternal behaviors (Christopher and Simpson, 2014). It was evident throughout the focus groups that social and environmental determinants of health such as lack of finances and inadequate access to healthcare, evidence-based information, and necessities and resources, play a major role in vulnerable populations receiving appropriate care prior to and during their pregnancies (Christopher and Simpson, 2014). It is clear that some of the women

involved in the groups are presenting a resistance towards cessation of smoking (cigarettes or marijuana while pregnant) due to perceived benefits regardless that evidence supports a direct correlation between smoking and low birth weight (Gage et al., (2013). It was evident that causes of co-sleeping included increased stress and lack of resources. (Salm Ward and Nqui, 2015). Additionally, a relationship for increased risk of unsafe maternal behavior, including smoking was confirmed (MI PRAMS Delivery, 2010). Factors such as being under significant stress, smoking, unsafe infant sleep practices and lack of prenatal care can account for infant deaths. It was evident that women in the community are lacking appropriate education on preventable causes of infant deaths such as safe sleep and appropriate maternal behaviors. In addition, considering the lack of satisfaction of these women regarding the healthcare system including providers and medication, perceived racism, and dismissal of concerns, it is important to consider financial factors and encourage proper prenatal care with an appropriate provider to allow an avenue for education of these mothers (Hernandez-Correa, 2011).

Finally, some women expressed a sense of fatalism, believing that fate is a more predictor of infant outcomes than are the mother's own behaviors. While there are no promises in healthcare and the possibility for both miracles and tragedies exist, it is plausible to consider how some may believe that health is based on fate. With that being said, there are clear links to years of research regarding abstaining from nicotine, following a healthy lifestyle, and obtaining regular healthcare are linked to increased over-all health and well-being for an individual without even considering a second-life being formed inside. Smoking and maternal behaviors are modifiable health behaviors that can influence health outcomes (Ellingson et al., 2012).

Limitations

Limitations of the study include the issue of self-report biases. Bias may have presented regarding participants' willingness to be fully truthful and participate due to fear of judgement. The participants may have experienced mild discomfort in talking about the issue of infant mortality as well as sharing personal information so another self-report bias is present as the potential to distort a memory. Open-ended questions were used throughout the focus group discussions in order to facilitate the most comfortable, engaging atmosphere for the participants as possible. The sample may have presented another limitation regarding both being a sample of convenience and of small size. Due to the women being at high risk for infant mortality, their opinions were undoubtedly relevant to the topic but there is no way to tell if it is representative of all of the families at risk. In addition, due to the small sample size, there was more room present for sampling error and inaccurate representation of the population.

Conclusion

There is an evident racial disparity present in Kalamazoo regarding infant mortality in Caucasian babies versus African-American babies. This lapse in care may be related to any and all determinants of health but seems to focus mainly on social and environmental factors. While some mothers appear informed of risk, it is unclear how educated mothers really are on the severity of risks that come along with inappropriate prenatal care and maternal behaviors. Mothers voiced obvious concern of receiving inadequate treatment when medical treatment was sought due to feelings of perceived racism, judgment, dismissal. While taking this into consideration, it is important to advocate for clients in all areas of the healthcare system to ensure that they are aware of their rights, receiving optimal care for themselves and their families, therefore enhancing the community health and hopefully increasing birth outcomes for this at-risk population.

Appendix

Infant Mortality Initiative Focus Group Interview Questions

Infant mortality, or the infant death rate, is a serious problem in the United States and in our local community, especially among black families. In Kalamazoo, black infants die 3-4 times more often than do white babies. As a community, we are trying to address this issue, and we would like to get input from community members such as yourselves. We would really like to get your ideas and opinions. There are no right or wrong answers.

1. How do you think we can reduce infant mortality in Kalamazoo, especially among black infants?
 - a. How can health care staff (e.g., hospital staff, doctors' offices) help?
 - b. How can social agencies help?
 - c. What other agencies or groups can help?
2. What are some ways that we can better support pregnant women and those who have just given birth?
 - a. How can health care staff (e.g., hospital staff, doctors' offices) help?
 - b. How can social agencies help?
 - c. What other agencies or groups can help?
3. Representatives from several groups in Kalamazoo have been meeting to try to figure out how to reduce rates of infant mortality in Kalamazoo. Some strategies that the group has discussed include (these will also be provided on a board for people to look at):
 - a. Reducing unintended teen pregnancy by making long-acting birth control free and easily available;
 - b. Reducing sexually transmitted diseases among teens;
 - c. Reducing smoking during pregnancy;
 - d. Promoting good prenatal care and safe sleep practices.
 - e. Better coordination of services for women and families;
 - f. Providing health care and other service providers with training in cultural competency/ cultural sensitivity.
4. What are your thoughts or reactions to these strategies? Would you add anything, change anything, or take anything out?

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