

ABCs for Healthy Babies:

A Social Marketing Campaign For Eliminating Racial and
Ethnic Disparities in Birth Outcomes in Southeastern and
Southern Wisconsin

Final Report

Concept and Message Testing:
Milwaukee, Beloit, Racine, Kenosha,
Madison/Dane County

A project of New Concept Self Development Center, Inc.

Lorraine Lathen, M.A.

Jump at the Sun Consultants, LLC
llathen@jumpatthesunllc.com

With the Division of Public Health
Department of Health Services
D!\$\$- - , "March 2009



BACKGROUND

Wisconsin ranks last in African American infant mortality among 34 reporting states and the District of Columbia (NVSS, CDC, August 2007). In 2004, infants born to African American mothers in Wisconsin were 4.3 times more likely to die before their first birthday than infants born to white mothers. More than 90% of African American infant deaths in Wisconsin occurred in Southeastern and Southern Wisconsin with most of these deaths occurring in the cities of Racine, Beloit, Kenosha, Milwaukee, and Madison. Preterm and low birth weight births have been the leading causes of these deaths. Unsafe sleeping environments and sudden infant death syndrome (SIDS) have also contributed to the death toll. In addition, in 2005, according to the Wisconsin Bureau of Health Information and Policy, although very low birth weight infants accounted for only 4.3% of all Medicaid births in the corresponding 5 counties, they accounted for more than 50% of the nearly \$113 million in birth and hospitalization charges during their first year of life.

In an effort to improve birth outcomes in Southeastern and Southern Wisconsin through the application of social marketing, the Wisconsin Department of Health Services (DHS) contracted with New Concept Self Development Center, Inc., (NCSDC) to implement *ABCs for Healthy Babies*. NCSDC further contracted with Lorraine Lathen, Executive Director of Jump at the Sun Consultants, LLC, to serve as the social marketing consultant. Ms. Lathen has approximately 20 years experience designing, implementing, and evaluating health promotion and disease prevention social marketing initiatives in developing countries and in the United States. She served as the principal investigator on the project. The Madison-based advertising agency of Knupp & Watson, Inc., and its Milwaukee-based subcontractor, G Communications, were identified by DHS to provide marketing support to the project.

The goal of *ABCs for Healthy Babies* was to design and implement focus-group research that would lead to the development of a social marketing campaign, influencing the infant mortality epidemic in a way that mobilizes community action. Under this project, 18 focus groups with 138 participants (130 unduplicated) low-income African American women of reproductive age, their families, friends, and community stakeholders were conducted in Milwaukee, Racine, Beloit, Kenosha, and Madison/Dane County.

The purpose of the focus groups was to collect qualitative data on the following topics: perceptions of factors that facilitate healthy birth outcomes and those that are barriers; perceptions of racial disparities; life issues and concerns; father involvement; access to providers and quality of health care; safe sleep; smoking cessation; preterm and low birth weight; and fetal movement. An additional goal of the focus group research was to test the likelihood that proposed messages, promoted through a social marketing campaign, would lead to the adoption of healthier behaviors. Surveys to collect baseline data about knowledge, attitudes, beliefs, and behaviors that support healthy birth outcomes and to assess media habits were also developed.

METHODOLOGY AND RESEARCH TOOLS

From February through June, 2008, 10 concept-testing and 8 message-testing focus groups were conducted. Research and recruitment materials were developed to support this project. During the recruitment phase, a great amount of relationship building and learning from the consumers took place. The social marketing consultant participated in

38 meetings and debriefings with key individuals and agencies, and met with more than 70 community stakeholders.

Participants

The project collaborated with Women, Infant and Children (WIC) programs, city and county health departments, social service agencies, local churches, and community-based organizations to recruit participants for the focus groups. Ideally, we wanted to achieve a focus group size of 7 participants. Of those recruited, 80-100% attended the focus groups (higher than we initially expected) so if 10 or more participants showed up for a focus group we ran 2 smaller groups simultaneously, in order to delve deeper discussions with fewer participants.

Table 1 (A, B, C) and Table 2 (A, B, C) describe the types of groups that were conducted. Participants were low-income African American mothers and fathers of children 0-18 months old or those with a current pregnancy. Focus group participants from the social support networks of our primary audience were grandmothers or friends of African American women who were either pregnant or the parent of a child 0 to 18 months of age.

Materials and Audience Segmentation

Culturally-sensitive focus-group discussion protocols were developed for mothers, fathers, and support networks. The protocols were slightly adjusted as we conducted additional focus groups and wanted to learn more about a particular topic. Early in our research we identified the need to adjust our audience segmentation to include 3 segments rather than 2. Initially we had planned to conduct qualitative research with 2 audience segments, ((1) African American women of reproductive age and (2) their social support networks) but eventually it became clear that we would need to separate the social support segment into 2 segments (fathers and grandmothers); therefore, our total audience increased from 2 segments to 3. All participants signed consent forms, which explained that the information gathered would be used to support the development of a social marketing campaign to raise awareness of disparities in birth outcomes in Wisconsin. Participants gave their permission to be audio taped and/or video taped. The group sessions were 90 minutes long; we audio taped 17 groups, and videotaped 2 groups in Racine. A technical issue resulted in 1 of the fathers' groups not being recorded in Milwaukee; we have relied on our notes for that group and supplemented it with findings from the second father's group that was conducted there. The video group with mothers was also audio-taped. The videotaped group with fathers was not audio-taped.

Incentives

Participants received a \$40 cash stipend for their participation. Child care and refreshments were provided onsite. The focus groups were conducted in social service and/or health agencies that had credibility with the target audience and were easily accessible.

Partners

Milwaukee and Racine

Organizations that helped recruit participants in Milwaukee and Racine included the Milwaukee Birthing Project, the Milwaukee Fatherhood Initiative, the Racine Infant Mortality Coalition, and the Racine/Kenosha Birthing Project. Focus groups were held by New Concept Self Development Center, Inc., at the Martin Luther King Jr. Center in Milwaukee. In Racine, groups were held at Next Generation Now, which allowed us to

use their local number to facilitate a local presence. We oversampled in Milwaukee and Racine, since Milwaukee represents the largest number of African American infant deaths and Racine has the highest African American infant mortality rate among these 5 communities.

Beloit

The Beloit African American Infant Mortality Coalition helped to recruit participants, and the focus group was held at the Merrill Community Center. The Merrill Community Center (MCC) was established in 1989 and functions as a social service agency that serves well over 500 children and families each year. Ninety-five percent of their clients live below poverty guidelines in accordance to the federal income standards. Its mission is to strengthen the greater Beloit community by providing programs and resources that build strong families, sustain neighborhoods and celebrate diversity. *ABCs for Healthy Babies* collected qualitative data from low-income women and their families, and brief emailed interviews were conducted with selected community stakeholders.

Kenosha

ABCs for Healthy Babies collaborated with the Professional Women's Network, Job Center of Kenosha, Racine/Kenosha Birthing Project, and WIC program in Kenosha. The Racine/Kenosha Birthing Project is a national project that is being replicated in Racine and Kenosha as an extended family model with each volunteer (a "Sister Friend") responsible for a pregnant woman. It is designed to provide care coordination, support, and advocacy for high risk pregnant women. The project is in its first year of implementation and Next Generation Now serves as its fiscal agent. The Professional Women's Network consists of a group of African American women from Kenosha and Racine who are focused on engaging in community volunteer service activities to improve the well being of women. *ABCs'* community partners were instrumental in providing space to conduct the focus groups and supported recruitment efforts.

Madison/Dane County

ABCs for Healthy Babies collaborated with the Boys & Girls Club of Dane County and the Public Health - Madison and Dane County (PHMDC) Department to conduct focus groups with the target audience. The PHMDC was instrumental in recruitment efforts, providing short-term office space for the social marketing consultant, and offering questions to be integrated into the focus group discussion guide. The Boys & Girls Club of Dane County supported recruitment efforts and provided space to conduct the focus group and offer on site day care.

The focus group was conducted in Dane County. Only 2 of the participants were from the Allied Drive neighborhood, once predominantly African American, but now a more Hispanic neighborhood in Madison. The remaining participants were from other neighborhoods in Fitchburg and Madison, and other municipalities in Dane County.

RESULTS: CONCEPT TESTING

Facilitators of healthy birth outcomes

When asked, "*What is the most important change that needs to occur to help African American women have healthier babies?*," mothers in Milwaukee answered, "*jobs for our men*", and fathers said, "*jobs and attitudes*", including changing their attitudes to become more giving as parents and thinking less about their own desires to ignore the

responsibilities of parenthood and “hang out” with friends. Mothers in Milwaukee and Racine talked about “staying home” as one of the strategies to ensure a healthy and safe pregnancy. They believed that if they stayed indoors, they could avoid harm to their unborn child caused by partying, car accidents, street violence, stress related to interacting with others, and second hand smoke.

In Kenosha, optimism was linked to spirituality and family support. Mothers believed that African American women have the self-efficacy (belief that one can successfully apply new skills and knowledge to effect change) to engage in behaviors to facilitate healthier birth outcomes. They mentioned eating healthy, avoiding fast foods, consistently attending prenatal care visits, attending pregnancy classes, and avoiding smoking, drugs, and alcohol during pregnancy. The focus group participants also mentioned staying positive and avoiding stress as behaviors that pregnant African American women can adopt to help ensure the birth of a healthy child. Ultimately they believed they were responsible for ensuring the health and safety of their unborn child.

In Madison/Dane County, mothers generated a list of factors to make their pregnancy healthy and safe. They listed factors similar to those in other markets, including good nutrition, taking vitamins, reducing stress, avoiding caffeine, not smoking, and drinking a lot of water. Mothers also listed surrounding themselves with positive people and a strong support system, including doctors, grandmothers, social service programs, and the government as entities that could offer support to African American women having healthy babies. Social support programs included WIC, small group discussions like *ABCs for Healthy Babies*, birthing classes, and those for pregnant and parenting teen mothers. Participants believed that churches could pray for mothers who were struggling and provide them spiritual and emotional support and guidance.

Mothers in Beloit believed that financial and emotional support from family and a stable home contributed to having a healthy birth. They also believed that being responsible, not smoking, drinking, fighting or putting themselves in unsafe situations, helped to make their pregnancy safe. Although breastfeeding was not one of the topics included in the discussion guide, when participants were asked, “*What can African American mothers do to increase the possibility of having a healthy baby,*” nutrition, including breastfeeding, was most frequently mentioned, followed by prenatal care. Interest in breastfeeding was high and many of the mothers believed that it provides health benefits to both the infant and the mother.

Barriers to healthy birth outcomes

In every community, mothers, fathers, and grandmothers mentioned stress most often as the barrier that prevents African American women from having healthy babies. In Milwaukee it was the lack of adequate income and joblessness. Fathers couldn’t help reduce stress during and after pregnancy because they are unable to contribute to the financial well being of the mother and infant. Incarceration prevents many of the fathers from being involved in the lives of their children. Mothers in Racine mentioned fighting (physical and verbal abuse) as a source of stress, and pregnancy did not necessarily prevent the fighting. Beloit mothers mentioned an increase in street and interpersonal violence.

Knowledge is high regarding behaviors that can be harmful to an unborn child. In Kenosha and Madison/Dane County, mothers perceived that absent fathers and the lack of a support system contributed to poor birth outcomes. These elements were likely to produce stress and cause pregnant women to engage in unhealthy behaviors such as

smoking. When asked, “*What prevents African American women from having healthy babies?*,” mothers mentioned drinking, smoking, prescription drugs, not exercising, poor nutrition, stress, unhealthy and unhappy pregnant women, and an abusive partner. Participants also mentioned that pride prevents some African American women from seeking the help and support that they need to have a healthy baby. They alluded to a new generation of women who are not on public assistance and whose parents were never on public assistance, but are women who are barely able to make ends meet. With the exception of Madison/Dane County, participants did not mention sexually transmitted diseases (STDs) as a factor that contributes to poor birth outcomes, although when prompted, they knew that STDs can be harmful to their unborn child.

Perceptions of racial disparities

In Milwaukee and Racine, mothers, fathers, and grandmothers held the perception that racial disparities exist in the quality of care that is determined by insurance coverage. Similarly in Beloit, participants believed that “whites” have better insurance than blacks who have Badger Care or Medicaid, and that this influences the disparities in the quality of care.

Examples of disparities in care experienced by some of our focus group participants include the provision of a 3-D colored sonogram for whites versus a black-and-white sonogram for blacks; inducing labor at seven months which caused an infant death rather than allowing the mother-to-be on bed rest and under close supervision of her physician; being forced to endure two pregnancies that both resulted in still births before a medical intervention was applied to prevent a third still birth; and being sent home without treatment when the mother was clearly in medical distress. It is noteworthy that participants never mentioned racism as the cause of disparities in quality of care, but mentioned disparities in the quality of health insurance coverage. There is the attitude that *whites have better coverage so they have healthier babies*. Participants considered class rather than race as a way to explain racial and ethnic disparities in birth outcomes.

There was a heightened level of mistrust of physicians and quality of care expressed in Racine by all participants. This mistrust was related in part to the belief that the quality of health care coverage for blacks is not as good as it is for whites. Mothers and grandmothers in Racine believed that disparities in infant mortality exist because of inadequate resources in the county. Some believed that women had to be pregnant before they could access any form of public assistance. They also held the normative belief that white families typically provide a level of support to their daughters that black families can't, e.g., unlimited financial support.

A person who was an employee in one hospital in Racine-Kenosha area noticed that doctors and nurses have a completely different view of a black single woman, especially on Title 19 (Medicaid), coming in to have a baby. Her feeling was that their views, and sometimes their care is different than that given to a white woman or a white teenager. To the white teen they may say, “*Oh that's such a sad situation but the family is so supportive*”; but if it were a young black woman, comments might be made, e.g., “*She should have known better she probably wasn't doing good any way.*”

In Beloit, some mothers felt they were treated differently at the WIC office from “young white girls who are pregnant”, or from, “older black parents”. Some also believed white women who are involved in relationships with black men experience the same barriers that they do. Others believed since the economy is so bad, all races are experiencing the same barriers that prevent African American women from having healthy babies.

Comments, included, *“a lot of white women that I know were being abused physically”* and, *“all women of all color are treated unfairly.”*

Life issues and concerns

The majority of participants in all communities had concerns and worries over finances, stress, depression, having a healthy baby, and being able to provide for their children. What made participants the happiest were their children. Mothers in Beloit were also proud about completing their GED, being the first home owner in their family, being able to provide for their children, and knowing that their children have a future ahead of them. Some mothers were more worried than others. One had experienced four miscarriages and had only one functioning fallopian tube. Now married and wanting to have children with her husband, she worried about her pregnancy and the health of her unborn child.

After pregnancy, mothers worried about being able to provide stability and keeping their children connected to siblings that no longer lived in the household with them. A few women indicated that they suffered from post-partum depression. Most participants believed that information on depression was not easily available to pregnant women, and that medical care and treatment for post-partum depression was not consistently made available to all women who needed it.

A new concern that was alluded to in Milwaukee and Racine, and quite prominent in Kenosha, was a heightened level of anxiety about giving birth to an African American male child. Participants were concerned about the challenges of successfully raising an African American male child in a society that doesn't value African American males and makes it difficult for them to succeed. They were equally concerned about being judged as “bad” mothers for raising a male child who may be predisposed to engage in deviant behaviors because of race, gender, and poverty.

Participants in Madison/Dane County shared similar concerns expressed by women in our other target markets. However, unlike other markets, many of the participants were concerned about dying during the delivery process. Although none of the participants had personal experience with a family member or friend dying during labor, half of them were concerned about dying.

A common concern that was articulated by most mothers, fathers, and grandmothers across all markets relates to social determinants of health that influence health outcomes, such as, education, income, employment, housing, home ownership, and marital status. Focus group participants repeatedly maintained that not all African American mothers smoke, drink alcohol and use drugs, and that other factors beyond individual health behaviors result in African American women experiencing low birth weight and preterm births. Studies have revealed that where one lives and works can influence health. In many participants' cases, they lived in neighborhoods where fresh produce was not easily accessible; where fast food restaurants, liquor stores, and corner stores were abundant; where tobacco products were marketed to people of all ages; and where violence was pervasive. As mentioned previously, early on in our concept testing, focus groups mothers mentioned fears of leaving their homes, some maintaining that staying indoors was a key factor that made their pregnancy safe. They also spoke of street violence and a shift in normative behaviors that resulted in women engaging in physical altercations with other women during pregnancy. Mothers also indicated co-sleeping with their infants to keep them safe from violence and chaos that may occur in their neighborhoods or even in their homes.

Lack of job security, safe housing, a college education, growing up in poverty, and growing up in a single parent household are all predictors of birth outcomes and often out of the control of low-income mothers. Women often spoke of stress, feeling isolated, and unsupported. It is quite reasonable to believe that stress may take a toll on the health of African American women; it may become chronic and impact birth outcomes.

Father involvement

In all focus groups conducted with mothers and fathers, participants believed that fathers should help reduce the stress experienced by their partner during pregnancy and provide financial support to their families. When asked, “*What can fathers do to help African American women have healthier babies?*,” many participants expressed the following sentiment: “*be there*”. Fathers are more engaged in the pregnancy than we may have thought. Several fathers reported consistent attendance at the prenatal visits with their partners, and using the visit as an opportunity to enlist the support of the provider to reinforce life-style changes that they had been conveying to their partner, such as smoking cessation. The fathers were able to articulate specific adverse outcomes for smoking, e.g., asthma, emphysema, and respiratory problems and they even distinguished secondhand smoke as more potent, due to the fact (they believed) that it is unfiltered when ingested.

Several of the mothers indicated that the fathers were with them through the birth of their child; some believed that fathers just wanted to see the baby and were likely to leave almost immediately after its birth. However, participants believed that there are many factors that prevent African American men from supporting their partners during and after pregnancy, including incarceration and the lack of jobs.

Access to providers and quality of health care

Although access to care is a growing concern among local and state public health officials, participants did not mention access to care or quality of care as factors that prevent African American women from having healthy babies. Most were reluctant to cite providers, physicians, public health, and social service systems as factors that prevent women from having unhealthy babies. In some instances, once they were asked, they spoke at length about the shortcomings of public and social service health systems

Mothers in Kenosha and Beloit did mention that adjustments should be made to the WIC program so that more women and children who are from low-income families can access these services. Several complained that breastfeeding was the one area where they were not given enough information, materials, and guidance. There was confusion around how to access an electric pump through Title 19 (Medicaid) and they stated they often had to find out this information on their own.

Participants were also asked about their preferences for a provider relative to race and gender. For some participants none of these attributes mattered, while others preferred a female doctor over a male doctor or vice versa. In Milwaukee, some women seemed to be more trusting of a female African American physician than non-African American physicians. They held the belief that there is a cultural bond between African American women, and consequently an African American female physician is likely to be more concerned about the health, safety, and well-being of other African American women and their children. Other participants were conflicted on the importance of the race of their physician.

For all participants, it was the quality of the care that mattered most. Madison/Dane County mothers were generally pleased with the quality of care that they received during prenatal visits. Only a few felt that they had not been treated with respect and that their visit was rushed. However, in nearly all focus groups, including those conducted with fathers and grandmothers, participants spoke of a two-tier insurance system that was responsible for inequities in care that resulted in poorer birth outcomes for African American infants.

Safe sleep

Focus group participants in Milwaukee and Racine expressed the cultural belief that *“black folks don’t use cribs.”* This belief seems to relate to income, safety, and nurturing. There is a perception that unlike themselves, other African American women can’t afford cribs, so a lack of income may facilitate co-sleeping among some black mothers. The more dominant view of mothers and fathers was that co-sleeping was seen as part of the nurturing, bonding, and protective experience engaged in by most African American mothers. Co-sleeping was also perceived as convenient, especially if the mother nurses or has experienced a cesarean birth.

In Beloit, participants reported receiving messages from their mothers, grandmothers, and aunts about how to put an infant to sleep. Most of the messages that they received cautioned mothers not to place an infant on its stomach but to place the baby on its side or back. Instructions to place an infant on its side were mentioned more frequently. One participant was very informed on the topic and shared with the group that allowing an infant to sleep on its stomach or side is a concern about increasing the risk of SIDS. She further counseled her peers that babies need a firm sleeping place without pillows and that it’s best not to sleep with your infant. Information collected about the knowledge, attitudes and behaviors relative to co-sleeping is fairly consistent with the other markets. One participant shared an example of a parent rolling over and suffocating her baby. Another participant personally knew of a case where co-sleeping resulted in the death of an infant. Despite this knowledge, none of the participants indicated that they would stop co-sleeping with their children.

In all 5 communities, experiences and culture seem to influence the provision of a safe sleep environment. Convenience, protective factors, and the fear of SIDS were cited most often as the rationale for co-sleeping. Some participants believed that finances (can’t afford a basinet or crib) and drama in the house (fighting with family and friends that live with you) might prevent mothers from consistently providing a safe sleeping environment for their infants.

Almost all of the participants have slept with their infant. Some participants allowed their younger children to sleep with their newborns/infants. Participants indicated that they had received safe sleep messages that counseled mothers to place their newborns on their backs. Participants indicated that they trust doctors and grandmothers to give them the correct information on this topic, however, some questioned the credibility of grandmothers to provide accurate information, despite good intentions. All of the mothers were knowledgeable of the factors that make a crib unsafe such as too many blankets, bumpers, stuffed animals, and toys.

Smoking (tobacco) cessation

In Milwaukee, fathers and mothers alike agreed that smoking is the most important behavior to abandon during and after pregnancy to ensure the birth of a healthy baby.

Contradictions exist with the mothers, as to whether or not they smoke during pregnancy or around their babies. Although mothers often insisted that it's easy to tell someone not to smoke around their baby, they reported smoking during pregnancy and/or after pregnancy. Mothers were also knowledgeable of the harm that smoking could do to the fetus during pregnancy. Stress and boredom were cited as the reason why they smoked. Mothers also expressed frustration in failed attempts to stop smoking that often involved their partner's refusal to stop smoking.

Mothers and fathers both believe that fathers can not influence the smoking behaviors of mothers. Fathers are often unwilling to stop smoking during and after the pregnancy, but will avoid smoking around their partner or infant. Fathers are willing to modify their behaviors for the health of their unborn child relative to smoking and avoiding arguments to reduce stress in their pregnant partner. It is less clear about their willingness to modify their behaviors after the infant is born. Few people are aware of the Wisconsin Quit Line and fewer people are aware of the First Breath Program.

In Racine, unlike the women in Milwaukee, participants all agreed that WIC and their providers are consistent in advising them of the dangers of smoking during and after pregnancy and "nagging" them to stop smoking. Women who smoked were frustrated. They wanted more than pamphlets and "talk" to stop smoking. They wanted a medical technology that they can use during pregnancy that won't be harmful to the fetus. Like Milwaukee, fathers/partners did "nag" their pregnant partners to quit smoking. Unlike Milwaukee, mothers in Racine did not think the smoking behaviors of their partners influenced their smoking behaviors. They also believed that they would not have a problem asking someone not to smoke around them.

The concept of respect and love was perceived as important to preventing people from smoking around a pregnant woman or a newborn. When asked what would help pregnant women quit smoking, all of the responses were related to reducing stress. One participant fantasized a stress free environment, an island where pregnant women could go. *There would be no stress and no worries so there would be no need to even think about smoking a cigarette.*

In Beloit, there seemed to be genuine concern about having a low birth weight or premature birth. Participants were able to connect how their behaviors had placed their child at risk for poor birth outcomes. In some cases, participants altered their behavior to avoid having complications with a future pregnancy and in other cases at least one participant was very frustrated about how information wasn't shared with her about the health risk related to tobacco and marijuana use. She believed that had someone told her the facts she would had gotten the help she needed to quit. This particular participant is the mother of eight and currently pregnant. She believed that she had to educate herself about the effects of tobacco and marijuana on an unborn child. Having done so, she successfully quit smoking cigarettes and marijuana during her current pregnancy.

In Madison/Dane County, during the prescreening period, 9 of the participants indicated that they smoked during and after pregnancy. In the actual focus group, only 7 of the participants admitted smoking during pregnancy and after pregnancy and 1 of them indicated that she had stopped smoking during pregnancy. Six of their partners smoked and 5 of them stopped smoking around their partners once they discovered they were pregnant. There was a mixed level of concern about the impact of tobacco on an unborn and infant child. For the most part, mothers who smoked were willing to take the risk

and maintained the attitude that nothing will happen; their friends smoke and nothing happened to their children or they have smoked in the past and nothing happened to their other children.

Unlike some of the other markets, participants reported consistent exposure to tobacco counseling that involved the five “A” s--ask, advise, assess, arrange, and assist. Participants were **asked** by providers at their first prenatal visit if they smoked. They were then **advised** of the benefits of quitting. There was less clarity on the extent of counseling around the assessment piece. Participants reported that providers did **assess** their willingness to quit, but did not consistently link it to a 30-day time frame. Providers then **assisted** participants who were interested in quitting by giving them information about the Wisconsin Quit Line and or First Breath Program, but did not always assist them in setting a quit date. None of the participants had accessed either of the programs and only a few were familiar with the programs. Participants indicated that providers **arranged** at their follow-up prenatal visits to monitor the status of their smoking. Most participants were aware of the health risk associated with secondhand smoke and believed that it wouldn't be difficult to ask people not to smoke around them while they were pregnant or around their infant child. They did, however, indicate that as the child gets older, it's more difficult to ask people not to smoke.

Preterm and low birth weight

Almost all mothers, fathers, and grandmothers in Milwaukee were able to identify signs of preterm labor. There was confusion around the actual weight of a healthy baby. Some women were perfectly fine with having a premature baby. They complained that they didn't want to have a large baby because of the pain during delivery and the inconvenience of having to carry a large baby for nine months. Others believed that since they had not experienced any health risk with a preterm or low birth weight baby, it was fine to have a baby under 5.5 lbs. It is noteworthy that some of the mothers had infants that are asthmatic and one mother indicated that you might not know if your child has a birth defect until months later. It is only now at six months that she realizes her baby's ears haven't fully developed.

Fathers were quite clear on the health risk related to having a baby too small or too soon. They cited asthma, emphysema, and respiratory problems. They also understood the relationship of smoking to preterm or low birth weight.

In Racine, fathers seemed to be more concerned than mothers about an infant being born too small or too soon. Many of the mothers had experienced preterm births and believed that their children were fine. Some believed that premature babies eventually grow up to be larger than babies that weigh more at birth. Most participants believed that if a baby is born 4 pounds or less we should be concerned about health complications.

Generally all participants in Madison/Dane County were knowledgeable about the signs and concerns relative to preterm labor and low birth weight babies, although one participant was a bit confused on the difference between stillbirth and preterm. Participants listed mental defects and underdeveloped lungs, heart, and brain as possible results of an infant being born premature or underweight. Some participants were suspicious about the relationship between tobacco and low birth weight: *“My friend smoked cigarettes all nine months and she delivered an eight pound baby.”*

Fetal movement

Knowledge on the importance of fetal movement seems to be relatively high among mothers and low among fathers and social support persons. However, some women in Milwaukee have learned from their mothers and trusted adults that in the third trimester it is normal for the fetus not to move as often because it has less space to move. Knowledge on how often the fetus should move was low among all groups.

Most of our pregnant women and new mothers (6 of 8) reported “tracking” the movement of their child but not necessarily writing it down. Monitoring of fetal movement through journaling is perceived as time consuming and something that white women might do more often than black women.

In Racine, knowledge on the importance of fetal movement seems to be relatively high among mothers and low among fathers. However, knowledge on how often the fetus should move was fairly high among mothers in one group and very low among mothers in another group. One group believed the fetus should move at least 10 times every hour rather than every 2 hours. The other group believed that it was fine to go 24 hours and maybe even up to 5 days without experiencing fetal movement.

Many of the women reported taking the initiative to go into the clinic and have the babies’ heartbeat checked if they believed the fetus wasn’t moving enough. Most of our pregnant women and new mothers reported “tracking” the movement of their child, but not necessarily writing it down. During the course of the discussion, it didn’t appear as if these same mothers were consistent in making mental notes of the frequency of fetal movement. Just as with the Milwaukee participants, monitoring of fetal movement through journaling was perceived as too time consuming and something that white women might do more often than black women.

All mothers in Kenosha reported monitoring the movement of the fetus. Although only one participant actually kept a journal of the fetal movement during pregnancy, knowledge on the importance of fetal movement seems to be relatively high among all participants.

In Madison/Dane County, mothers were generally knowledgeable of the importance of fetal movement although only two participants had actually tracked fetal movement. All of the women, except one who is currently very early in her pregnancy, were advised by their providers to track fetal movement and given a book to track the movement.

RESULTS/FINDINGS: MESSAGE TESTING

Messages

The messages were developed based on the extensive concept-testing focus-group research conducted in the same markets with similar audiences. Seventeen print ads and 4 radio spots were tested with the target audience. The overall findings suggest that portions of the 9 print ads and also the radio spots (modeled after spots produced by the First Breath Program, a smoking cessation program of the Wisconsin Women’s Health Foundation), may be developed further for the social marketing campaign. Additional communication materials that may be developed relate to nutrition, breastfeeding, depression, male involvement, and violence reduction.

Messages that were positive and presented the ideal circumstances, such as a family with a father, a healthy baby, a safe, clean, and healthy environment, were favored over “reality-based” messages that focused on negative imagery such as a unhealthy baby, unsafe and unsanitary environments, etc. Mothers and grandmothers were concerned about the potential tone of print and radio ads tested. They believed some of the ads risked being perceived as judgmental, blaming, and depicting African American women in a negative way. They preferred ads that are positive, instructive, and do not stigmatize them as being negligent women who consistently engaged in behaviors that result in poorer birth outcomes for their infants, compared to women of other races. In producing the print ads, it will be important to modify the ads per the focus group participants’ specifications and to focus on the positive rather than the negative. Fear-based ads should be avoided as well as those perceived as judgmental and stereotyping.

Media

The media habits and effective media placement channels were also assessed. Findings indicated that radio, television, newspapers, Internet, public bus shelters, and internal and external advertising on public buses are effective ways to reach this audience. The Discovery Health Channel, Birthing Channel, sports programming, health care providers, and churches are effective channels in which to reach low-income women and their families. Milwaukee’s Little Red Book is also a very effective channel. Radio spots similar to those produced by the First Breath Program might be effective with some modifications suggested by participants in the focus groups. If the *ABCs for Healthy Babies* social marketing initiative employs radio as one of its communication strategies, it will be important to deliver a non-judgmental message and raise awareness of existing programs that will support the listener in adopting healthier behaviors. The First Breath secondhand smoke ad was favorable because participants did not perceive it as judgmental. Both of the First Breath ads were appreciated because they connected listeners to actual programs. However, radio was not reported to be an effective way to reach women in Beloit.

Pamphlets and brochures distributed through churches and health care providers are important venues for the dissemination of behavior change messages that support healthier birth outcomes for African Americans. A significant number of participants also report reading the mainstream local newspaper daily. In Beloit, all participants reported reading the newspaper daily, while in Racine 85.8% of grandmothers and 69.3% of mothers read the paper. Approximately 74% of mothers in Kenosha and 60% in Dane County reported reading the paper daily; 42% of mothers in Milwaukee report reading the newspaper daily. The literacy level of participants of the focus group conducted with grandmothers in Milwaukee was too low to assess the reading habits of grandmothers. It is likely that they rarely read the newspaper.

Implications for a social marketing campaign

Our goal as social marketers is not to sell a tangible product, but rather to capture in a creative manner people’s attention and persuade them to adopt, abandon, or maintain a behavior. The intangible products promoted through social marketing involve changing social norms and individual behaviors. Intangible products specific to *ABCs for Healthy Babies* include safe sleeping, smoking cessation, and monitoring fetal movements. The social marketing program must operate in tandem with existing or new evidence-based programs that are culturally relevant and support healthier birth outcomes for African American infants.

A life-course perspective should be embraced as the best practice to model the design and implementation of interventions supporting the health of women and children over their life span. Messaging for a social marketing campaign reflecting the realities and perceptions of the target audience should be developed. In addressing issues of bed-sharing, it will be important to develop messages emphasizing issues of reduced risk and increased safety by not bed-sharing. In terms of tobacco use, it will be important to develop messages that encourage mothers and fathers access to existing quit programs and to enhance the Wisconsin Quit Line and First Breath programs to meet the cultural needs of low-income African American mothers and fathers.

This campaign should avoid cleverness and complicated analogies. Ads that tested best were perceived by participants as clear and to the point. Positive, clear messages reinforcing and empowering individuals to engage in healthy behaviors are likely to be the most effective approach to this campaign. Smoking cessation ads should target couples and their families, rather than just pregnant women in isolation of a support system. Additional ads might focus on nutrition and reducing stress. All of the ads should help to increase self-efficacy and reduce women's feelings of isolation and hopelessness. The ads should be positioned to avoid blaming mothers for poor birth outcomes.

Knowledge is extremely high on most health risks associated with poor birth outcomes; however, awareness needs to be raised about the effects of tobacco on the fetus, and how to access breastfeeding information and services. Support groups, messages, and health promotion initiatives addressing stress, depression, and the psycho-social needs of the target audience should be integrated into an effective social marketing campaign. Additionally, a social marketing campaign can work to make recognition of preterm labor and breastfeeding normative behaviors among African American women of reproductive age.

Only in very specific situations did participants indicate that messages and social marketing efforts might reduce the number of mothers who co-sleep with their infants. These cases involved a parent who had used drugs or been drinking alcohol. Participants believed that if mothers in these particular circumstances were exposed to billboards, radio or television messages, they might not sleep with their infant on that particular night of drug and alcohol use. Results of the research therefore suggest that although it is clear that the safest place for a baby to sleep is in the same room, near his or her caregiver, but separate from the caregiver in a safe crib, a social marketing campaign should consider a risk-reduction educational strategy for mothers who insist on co-sleeping with their children.

In order for the social marketing program to establish and maintain credibility with the target audience, it is imperative that systemic changes occur to address issues of access to and quality of care, and to change perceptions relative to a two-tier system of health care. The social marketers will ask the target audience to adopt, abandon, or maintain a behavior that will support a healthier birth outcome for African American infants. The key is to identify behaviors that are perceived by the target audience as normative (everyone is doing it), fun and easy to adopt (self-efficacy), and beneficial (the benefit outweighs the costs). In sum, the campaign should work to increase the perceived benefits and lower the perceived barriers to adopting the behavior. In order to make the behavior "fun" and easy, programs must be in place to support the target audience in successfully adopting, abandoning, or maintaining behaviors that have been identified through *ABCs for Healthy Babies*.

A synthesis of the findings as they relate directly to the development of a social marketing campaign is provided in Attachment A.

CONCLUSION AND RECOMMENDATIONS

The key to a successful campaign will be to avoid blaming and offending the target audience for poor birth outcomes experienced in Southeastern and Southern Wisconsin. The campaign should also recognize that other factors, social determinants of health and life-course experiences, are in play. Social determinants of health are the economic and social conditions under which people live that impact their health, and life-course experiences involve cumulative stress experienced throughout their lives. Focus group participants repeatedly maintained that not all African American mothers smoke, drink alcohol, and use drugs. They argued that other factors beyond individual health behaviors results in African American women experiencing low birth weight and preterm births. Participants fervently maintained that many of these factors were out of their control; therefore, they should not be blamed for the poor health of their children and grandchildren.

Supportive of their position, decades of research suggests that communities with fewer social resources experience poorer health outcomes than communities that are rich in social resources, such as affordable housing, food sufficiency, safe neighborhoods, quality education, and economic opportunities. Interventions and strategies that augment the social resources in a community have the potential of improving birth outcomes for low-income African American women. Factors such as job security, decreased exposure to chronic stressors, safe and affordable housing, access to higher education, etc., are often outside of the control of low-income women but are predictors of birth outcomes. These factors cannot be separated from the state's ability to improve birth outcomes in Southeastern and Southern Wisconsin. In addition to social marketing activities, a life-course perspective should be embraced as the best practice to model the design and implementation of interventions supporting the health of women and children over their life span.

Research conducted under the ABCs for Healthy Babies project indicates that maternal nutrition, breastfeeding, smoking cessation, the provision of safer sleeping environments and stress reduction strategies are appropriate intervention points. These are behaviors perceived by the target audience as beneficial and achievable. Participants believed they have the knowledge, skills, and confidence (self-efficacy) to adopt healthier behaviors in these areas. Reflective of this belief, a social marketing campaign should function to increase the perceived benefits and lower the perceived costs of adopting these behaviors. It is worth noting that relevant to bed-sharing, participants were not optimistic that African American mothers would modify their behavior. Most participants however maintained that after seeing print ads or hearing anti-co-sleeping radio ads, they would continue to co-sleep with their infants to protect them, nurture, and bond with them, and for convenience.

It is worth noting that a social marketing campaign, in and of itself, cannot improve birth outcomes for African American women in Southeastern and Southern Wisconsin. It must operate in parallel with access to quality health care that is culturally sensitive to the needs of the target audience and to social support systems that address the

psychosocial, health literacy, and health education needs of low income, pregnant, and parenting African American mothers and their families. In selecting, modifying, and developing print, radio, and possibly television ads, it will be important for DHS to prioritize those behaviors that they would like to influence. These behaviors should be perceived by the target audience as easy to adopt and likely to yield significant gains in improving birth outcomes among low-income African American women in Southern and Southeastern Wisconsin. Prioritization should reflect local maternal and infant health data, as well as qualitative data collected through *ABCs for Healthy Babies focus groups*.

It has been a challenge to implement this project because of the racial and socio-economic complexities of the issue, time, and budget constraints. Recent data also suggest there may no longer be a racial disparity in infant mortality among African Americans in Dane County, which caused us to rethink our focus group research efforts there. Despite these challenges, the key findings from this project should play an important role in supporting the efforts of the state to improve birth outcomes in Southeastern and Southern Wisconsin.

ATTACHMENT A

General implications

- Persons who have credibility with the target audience are mothers, grandmothers, health care providers, faith leaders, persons of faith, aunts and friends. The campaign should use these types of persons to deliver believable and actionable messages.
- A word-of-mouth campaign may resonate stronger with the primary audience than print media.
- The life course perspective is a viable model to pursue as a best practice for program implementation that should function in tandem with a social marketing campaign.
- Women, especially in Madison/Dane County and Racine, would like to see the campaign promote clear and concise family planning, especially for teens.
- Basic information is less important than providing social support for quality care before, during and after pregnancy.
- The campaign might challenge the belief that staying indoors is safer than leaving home. In some instances the behaviors that the women engage in at home are as or more harmful than leaving home.

Facilitators of healthy birth outcomes

- The campaign should target churches, schools and social service agencies to market the power of collective support for women through participation in women support groups.
- Women are feeling isolated, stressed and possibly clinically depressed. It will be important for the campaign to promote initiatives such as support groups, the Birthing Project™ and pregnancy-centered models that address the psychosocial needs of women before, during and after pregnancy to help reduce stress.
- The positioning of the message should center on sisterhood and support.
- Since women expressed a high level of self-efficacy in modifying their eating habits during pregnancy, a social marketing campaign should promote good nutrition as behaviors to be adopted by expecting mothers.
- It will be important to identify a messaging strategy that conveys credibility and provides “believable” information.
- Good nutrition is an example of behavior that was perceived as achievable and would likely have a significant impact on healthy births. As women achieve success in adopting new behaviors that support good nutrition, the campaign should incrementally promote new behaviors that may be increasingly more difficult to achieve, but are likely to collectively have a greater impact on supporting healthier birth outcomes for African American infants.

Barriers to healthy birth outcomes

- Normative and cultural beliefs prevent some African American women from engaging in behaviors that support healthier birth outcomes and reduce the risk of SIDS. The campaign should position itself in a way that behaviors such as monitoring fetal movement, avoiding drugs, alcohol or tobacco during pregnancy and after pregnancy and consistently providing a safe sleeping environment for newborns becomes normative behaviors among all African American women.

- A social marketing campaign can help to remove cultural barriers that prevent African American mothers from breastfeeding and can help to increase knowledge and information by promoting existing breastfeeding programs and services, and by clarifying the offerings of each program.
- Since knowledge is relatively high regarding behaviors and health risks that prevent women from having healthy babies, less emphasis should be placed on providing the basic facts and more emphasis should be placed on messaging that supports changes in attitudes, behaviors and skills.
- Perhaps the campaign should normalize the behavior of “asking for a helping hand when times get rough” and work to reduce the stigma and stereotyping associated with persons who receive public assistance.
- If the campaign focuses on domestic and street violence as it relates to stress and safety concerns of a pregnant woman or her newborn child, it should identify and promote alternative behaviors to physical and verbal abuse.
- The campaign should promote behaviors that help reduce stress and include messages on the role others can play in reducing a pregnant woman’s stress.
- In addition to conveying prevention messages, interventions should be designed and/or enhanced to specifically address the psycho-social needs of women during pregnancy.
- Relative to STDs, messaging should be positioned in a way that is non-judgmental and provides a safe haven for women to begin to discuss their role in reducing their risk for STDs as well as providing condom use and negotiating skills.
- Messages should be developed specifically for Madison/Dane County to help reduce expecting mothers’ fears of maternal death during delivery.

Racial disparities

- We may need to rethink our focus on race and ethnicity as a strategy for raising awareness of infant mortality disparities in Southeastern and Southern Wisconsin. This message evidently doesn’t resonate with our primary audience, but may resonate with community leaders, funding partners and policymakers. Perhaps the message might have more appeal if the focus is on class rather than race.
- We may consider having an African American physician to serve as the spokesperson for this campaign.

Life issues and concerns

- The campaign may seek to validate worries of African American women during pregnancy and provide them with strategies to address those worries.
- Potentially, the campaign may acknowledge the challenges of raising an African American male child while also providing evidence-based strategies to support adolescent development within the context of gender, race, and class.
- The campaign may involve a positive positioning of mothers and fathers/partners working together to remove “drama” and stress from their lives during and after pregnancy.
- The campaign could convey the concept that when parents shift their focus and attitudes away from themselves and on to their newborns, they experience an indescribable level of joy and pride.

- Messages and interventions should be designed to help pregnant and parenting African American women reduce stress and be connected to resources that will lessen their worries related to survival.

Father involvement

- A parallel campaign could be designed that speaks directly to fathers and empowers them to support their partner during and after pregnancy.
- If developed, a parallel campaign should recognize fathers for the role they play during pregnancy and challenge them to go even further during and after pregnancy.
- Fathers need to be connected to job training, stable employment, and financial planning. The campaign could promote programs that support fathers in maintaining meaningful employment. The appeal or “ask” to fathers might be within the context of “fatherhood” or “being there for your family.”
- The campaign should be complemented by support groups for fathers that provide them with the skills and information to be fully engaged during and after pregnancy. This includes methods that help reduce stress on their partner, increasing partner communication, and increasing the fathers’ ability to provide financially.
- Support groups for couples should be promoted that reinforce campaign messages and builds skills that will support couples staying together and engaging in healthy behaviors to support healthier birth outcomes.
- Rather than singling out that fathers as the culprits of stress, perhaps the campaign should engage fathers and the broader community to help reduce the level of stress experienced by women during pregnancy.

Access to care and quality of care

- The campaign should continue to reinforce the behavior of seeking medical advice and information specific to fetal movement, low birth weight, preterm labor and SIDS. Messaging strategies that make seeking health information from a trusted provider a normative behavior among all African American women is key.
- It is imperative that issues related to access, customer service, patient care and cultural competency be addressed in all markets, especially in Kenosha.
- A social marketing campaign that directs the target audience to fragmented public health and social service systems risks losing credibility with the target audience.
- If the campaign focuses on encouraging women to communicate regularly with their provider, then structural improvements should be put into place that results in improved patient flow and increased quality time with providers. The campaign should avoid promoting the “good visit” (as defined by all participants in all markets) if the quality of care as defined by the target audience is in low supply.
- The image of a “good visit” provides descriptive information that might be used to develop the visuals related to this campaign.

Safe sleep

- Perhaps a personal appeal from a mother who rolled over on her infant may prompt the primary audience to realize this is real and it could happen to them.
- Although it is clear that the safest place for a baby is in the same room, near his or her caregiver, but separate from them, the campaign should consider promoting a risk-reduction educational strategy for mothers who insist on co-bedding with their children.
- The campaign will need to acknowledge prevailing attitudes that *because SIDS hasn't happened to me or to any one I know, the sleeping environment that I provide is safe.* The campaign should also recognize that co-sleeping is perceived by both fathers and mothers as a bonding experience, therefore the campaign will have to offer alternatives to this experience. The message needs to be respectful of culture while promoting safer sleeping environments.

Smoking cessation

- Smoking was linked to stress, recreation and boredom. The social marketing campaign should offer an alternative to smoking that helps reduce boredom and stress, and allows for socializing.
- Since knowledge of the Wisconsin Quit Line was low and few participants were familiar with the First Breath Program, the campaign could be used to promote these programs.
- Since most women believed that they could prevent others from smoking around them when they are pregnant or around their newborn and that this became more difficult as the child gets older, it will be important to include messages around the health risks of secondhand smoke to children of any age.
- Since some mothers stopped during pregnancy, but resumed after pregnancy, the campaign should focus on developing messages that help mothers maintain the behavior of not smoking.
- Develop a tobacco awareness campaign that targets couples with messages that specifically recognize men for not smoking during and after pregnancy around their partner or newborn. It should also challenge couples to go a step further and not to smoke at all.

Preterm labor and low birth weight

- Generally all participants were knowledgeable about signs and concerns relative to preterm labor and low birth weight babies. They were able to list mental defects and underdeveloped lungs, heart and brain as possible results of an infant being born premature or underweight.
- Some participants were suspicious about the relationship between tobacco and low birth weight: "My friend smoked cigarettes all nine months and she delivered an eight pound baby."
- The campaign should reveal contradictions in protective beliefs and actual behaviors. Although parents co-bed with their infants to protect and nurture them, the contradiction is that they may actually harm them by rolling over on them.

Fetal movement

- Since knowledge is high around the importance of monitoring fetal movement, perhaps the campaign could reinforce this behavior as one that all pregnant women should engage in.
- The behavior needs to be marketed in a way that women perceive both easy and beneficial.

Marijuana use

- Similar to Racine, marijuana use before, during and after pregnancy seemed to be common among the target audience in Beloit, Madison and Kenosha.
- Similar to cigarettes, marijuana is used to relieve stress, boredom and for recreational purposes and not believed to be harmful to an unborn child.
- The campaign should correct misinformation about the effects of marijuana on an unborn child.

ATTACHMENT B: DEMOGRAPHICS

Table 1. Concept Testing

A. Mothers segments (6 groups)

City	Total number of participants	Number pregnant	Number smoker	Number completed high school	Age range
Beloit	8	5	3	5	18-29
Kenosha	7	1	3	4	18-30
Madison	10	7	9	7	18-35
Milwaukee	8	4	3	0	19-37
Racine (2 groups)	12	4	7	4	18-26

B. Fathers segment (3 groups)

City	Total number of participants	Number completed high school	Age range
Milwaukee (2 groups)	10	5	18-54
Racine	6	2	18-31

C. Social support group (1 group)

City	Total number of participants	Age range
Milwaukee	8	32-58

Table 2. Message Testing

A. Mothers segment (5 groups)

City	Total number of participants	Number pregnant	Number smoker	Number completed high school	Age range
Beloit	10	5	5	5	18-34
Kenosha	10	3	4	6	18-31
Madison	5	1	1	5	18-27
Milwaukee	7	1	2	3	18-27
Racine	13	3	10	6	20-36

B. Fathers segment (1 group)

City	Total number of participants	Number completed high school	Age range
Milwaukee	7	5	22-54

C. Grandmothers segment (2 groups)

City	Total number of participants	Age range
Milwaukee	10*	34-62
Racine	7	36-77

*One grandfather participated in the Milwaukee focus group