The following documentation has been submitted to ASTHO for the Accreditation Library as a potential example of Health Department documentation that might meet the PHAB Standard and Measure 11.1.4. This document is not intended to be a template, but is a reference as state health agencies develop and select accreditation documentation specific to the health department's activities.

Please note that the inclusion of documentation in this library does not indicate official approval or acceptance by PHAB.

<table>
<thead>
<tr>
<th>Document Title:</th>
<th>Improving Women’s Health Focus Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Date:</td>
<td>September 2015</td>
</tr>
<tr>
<td>Version of Standards and Measures Used:</td>
<td>V 1.5</td>
</tr>
<tr>
<td>Related PHAB Standard and Measure Number</td>
<td></td>
</tr>
<tr>
<td>Domain: 11</td>
<td>Standard: 1</td>
</tr>
<tr>
<td>Short description of how this document meets the Standard and Measure’s requirements:</td>
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This document is a tool used to access methods to improve the health of women in southern Mississippi (District IX). The facilitators were identified and selected in relation to the ethnicities of participants (Caucasian, African American, Vietnamese, and Hispanic). The facilitators were also trained to conduct focus groups in a culturally and linguistically appropriate manner. The moderators asked the group questions about what people could do to maintain their health (page 2), what health needs people neglect (pages 3-4), what obstacles they face in maintaining their health (page 3), where they receive most of their health information (page 4), and what access they have to health insurance and healthcare clinics (page 6). After the data was analyzed and translated, a report was created and disseminated back into the community. Organization scopes of work were modified to including a report depicting findings from the focus group.

<table>
<thead>
<tr>
<th>Submitting Agency:</th>
<th>Mississippi State Department of Health</th>
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<tbody>
<tr>
<td>Staff Contact Name:</td>
<td>Katherine Richardson</td>
</tr>
<tr>
<td>Staff Contact Position:</td>
<td>Accreditation Specialist</td>
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### Route Slip for Internal Review of Contract Employees

<table>
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<tr>
<th>Contract Project Id:</th>
<th>21712</th>
<th>Input Date:</th>
<th>8/11/2015</th>
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<tbody>
<tr>
<td>Contractor Name:</td>
<td>Susan Mayfield-Johnson, PhD, MCHES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contractor Type:</td>
<td>Independent</td>
<td>Contract History:</td>
<td>New</td>
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<tr>
<td>Office:</td>
<td>Health Disparity Elimination</td>
<td>Program:</td>
<td>Health Disparity Elimination</td>
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<tr>
<td>Amount:</td>
<td>$16,500.00</td>
<td>*Amount Varies if blank.</td>
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<tr>
<td>Contact:</td>
<td>Sandra Pryer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start Date:</td>
<td>8/17/2015</td>
<td>End Date:</td>
<td>6/30/2016</td>
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<th>Program Director/Originator</th>
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<th>Date:</th>
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<td>Office Director/District Administrator</td>
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<td>8/2/15</td>
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<tr>
<td>Finance &amp; Accounts</td>
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<tr>
<td>Personnel</td>
<td></td>
<td>Date:</td>
<td>9/4/15</td>
</tr>
</tbody>
</table>
TO: Mitchell Adcock, Chief Administrative Officer
Sharon Nasianceno, Chief Financial Officer

FROM: Tanya Funchess, Director, Office of Health Disparity Elimination

THRU: Evelyn Walker, Director, Health Promotion and Health Equity

RE: Contract Justification for Susan Mayfield Johnson

The purpose of this memo is to provide a justification for the attached contract. Funding for this contract will be provided from two funding sources: $10,000 (GF01 3000012532) will come from GFO1 Infant Mortality Appropriation, and $6,000 (3000005860) will come from Office of Health Disparity Elimination GF01 budget. Dr. Susan Mayfield-Johnson serves as the Evaluator for the Community Research Fellows trainings which is a 16 week program for community organizations. These funds are essential to evaluate the program in an effort to see further funding and to gain knowledge of program effectiveness. She conducts a baseline, midlevel, and end of course evaluation. Additionally, Dr. Johnson will conduct focus groups within Public Health District IX on the new Infant Mortality Project. She will lead 10 focus group sessions.
I. Contractual Agreement

This document and any other attachments, including but not limited to Attachment A, Terms of Contract, and Attachment B, Conflicts of Interest, are made a part of this document and incorporated herein by reference, and constitute a contract for personal or professional services or goods between the Mississippi State Department of Health (hereinafter referred to as the Department) and the Contractor as indicated below. In the space provided herein, provide a description of the purpose of this contract and/or services to be provided:

Susan Mayfield-Johnson, PhD, MCHES will work with MSDH, Office of Health Disparity Elimination on two main activities: 1) Analysis of the Community Fellows' evaluation surveys and post trainings; and 2) Facilitating and analyzing focus groups in District 8 (Covington, Forrest, Green, Jefferson Davis, Lamar, Marion, Perry, and Wayne Counties).

II. Contractor's Required Information

Contractor's Name: Susan Mayfield-Johnson, PhD, MCHES
Contractor's Contact Person(s): Susan Mayfield-Johnson, PhD, MCHES
ID #: 425-25-0361 (SSN or EIN, as shown on attached IRS Form W-9) Program: Office of Health Disparity Elimination
Street: 802 Southeast Circle Telephone #: 601-261-0341
City: Hattiesburg State: MS Zip Code: 39402

III. Contract Supplemental Information (Note: If information below is not applicable, fill blank with "N/A")

Title of Contract or Service Provided: Consultant
Total Contract Amount: $16,500.00 Max. Contract Amount per year: (applicable only if contract is multi-year)
Fee or Retainer: $16,500.00 Fee or Retainer Payment Basis: (per clinic, hour, day, month, quarter, year, etc.)
Beginning Date: August 17, 2015 Ending Date: June 30, 2016
Org.: 0719 Activity: I-302 Project: 66000HD0
Reporting Category: GF01-$6,000; 30000 125979- $10,500.00
Federal Grant: Yes □ No ■ Stimulus Funds: Yes □ No ■
Federal Grant Award #: Federal N/A Aid #: N/A CFDA #:
Occupation: Consultant
Specialty: N/A
Program: Office of Health Disparity Elimination
Total Personnel Services: $15,900.00 Total Travel/Subsistence: $600.00
Max. Hours Authorized per Month: N/A Assigned Travel Base: N/A
Mileage/Meals Authorized:
None: □ Meals: Mileage: Lodging:
Statewide: □ Central Office: ■ District (specify):
Hours (Daily or weekly, i.e., 8:00a-5:00p, 5 days per week):
If in a District(s), list all counties (List in decreasing order for amount of time spent in each county):
N/A

Certification/Licensure (Fill in certificate/license number, date of certification/licensure, and type of certification/licensure, as applicable. If a physician, state whether the contractor is board-certified in area of use by Department, non-board certified, or resident.):
N/A

Contractor's Experience/Degrees Earned (Fill in this blank if Contractor is an individual; use additional sheet if necessary):
N/A

Does Contractor currently receive Mississippi State Retirement System benefits? Yes □ No ■
Will the Contractor be classified as an "Independent Contractor"? Yes ■ No □
ATTACHMENT A: TERMS OF CONTRACT

I. Contracted Services: The Contractor agrees to provide analysis of the Community Fellows' evaluation surveys and post trainings facilitating and analyzing focus groups in District 8 in accordance with the specifications set forth on the preceding page of this contract, titled “Contract Between Department and Contractor” and any other documents as set forth by the Department, and are hereby incorporated into and made a part of this contract. No oral statements of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this contract. If other attachments or exhibits exist which are to be incorporated as part of this contract, the title of each document shall be listed here, as follows (use additional sheets, if necessary):

Attachment B – Conflicts of Interest
Attachment C - Scope of Work

II. Ability to Contract: The Contractor warrants that he/she/it is qualified to provide the services, whether personal or professional, as outlined in this contract. The Contractor agrees to conform to existing policies, rules, and regulations of the Department. The Contractor agrees to maintain throughout the contract period such licensing and/or certification as may be required by law for the provision of services specified herein, if applicable. The Contractor warrants that it is a validly organized business with valid authority to enter into this contract; that it is qualified to do business and in good standing in the State of Mississippi; that entry into and performance under this contract is not restricted or prohibited by any loan, security, financing, contractual or other contract of any kind; and, notwithstanding any other provision of this contract to the contrary, that there are no existing legal proceedings or prospective legal proceedings, either voluntary or otherwise, which may adversely affect its ability to perform its obligations under this contract.

Contractor/Seller represents and warrants that it will ensure its compliance with the Mississippi Employment Protection Act (Senate Bill 2988 from the 2008 Regular Legislative Session) and will register and participate in the status verification system for all newly hired employees. The term “employee” as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, “status verification system” means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. Contractor/Seller agrees to maintain records of such compliance and, upon request of the State, to provide a copy of each such verification to the State. Contractor/Seller further represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration laws of the State of Mississippi. Contractor/Seller understands and agrees that any breach of these warranties may subject Contractor/Seller to the following: (a) termination of this Agreement and ineligibility for any state or public contract in Mississippi for up to three (3) years, with notice of such cancellation/termination being made public, or (b) the loss of any license, permit, certification or other document granted to Contractor/Seller by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year, or (c) both. In the event of such termination/cancellation, Contractor/Seller would also be liable for any additional costs incurred by the State due to contract cancellation or loss of license or permit.

III. This section applies only to a Contractor which serves as a clinical or healthcare provider for the Department, as follows:

A. The Contractor authorizes the Department to accept assignment and receive any amounts payable under Part B of Title XVII and Title XIX of the Social Security Act and/or any monies collected for service rendered by the Contractor under the terms of this contract, including but not limited to private insurance, third-party arrangements, or such other payment or reimbursement mechanisms as may be applicable or available. The Contractor agrees that the Department shall be the payor or financial reimbursement mechanism of last resort when other sources are mandated or are available.

B. The Contractor agrees that no additional charges will be made to patients/clients to whom services are provided under the terms of this contract.

C. The Contractor’s payment records will be submitted to:

D. The Department agrees to assure physician supervision as required by law for the services to be provided under the terms of this contract.
IV. This section applies only to a Contractor who is an individual and presently receives retirement benefits from the Mississippi Public Employees’ Retirement System (PERS), as follows:

A. The Contractor certifies that the forty-five day separation period required by PERS regulations has been met prior to the effective date of this contract.

B. The Contractor is responsible for notifying PERS of re-employment and for submission of required documentation to PERS for review and concurrence of the Contractor’s status as an independent contractor as required by PERS regulations.

C. Contractor’s date of retirement from state service:

V. Financial Records and Audits: The Contractor shall maintain such financial records and other records as may be prescribed by the Department or by applicable Federal and State laws, rules, and regulations. These may be kept according to the Contractor’s usual method of recordkeeping, but must be sufficiently detailed to permit an accurate accounting of contract funds and program activities. The contract and the procurement of goods and services shall be governed by the applicable Mississippi statutes and the applicable provisions of the Mississippi Personal Service Contract Review Board Regulations (copies of which are available for inspection at their offices located at 210 East Capitol Street, Suite 800, Jackson, Mississippi). The Contractor shall retain these records for a period of three (3) years after final payment, or until they are audited by the Department, whichever event occurs first. These records shall be made available during the term of the contract and the subsequent three-year period for examination, transcription, and audit by the Mississippi State Auditor’s Office, its designees, or other authorized bodies.

VI. Records Retention: The Contractor agrees to submit to the Department quarterly program activity reports thirty (30) days subsequent to the closing of each quarter. The Contractor agrees to submit to the Department quarterly fiscal reports thirty (30) days subsequent to the closing of each quarter, or other applicable period as made a part of this contract and agreed to by both parties. The Contractor agrees to permit reasonable program review and evaluation by the Department; to provide access to any pertinent records; arrange meetings with appropriate personnel; permit inspection of the premises; and to cooperate in any other reasonable requests for fiscal and/or program information. Provided the Contractor is given reasonable advance written notice and such inspection is made during normal business hours of the Contractor, the State or any duly authorized representatives shall have unimpeded, immediate access to any of the Contractor’s books, documents, papers, and/or records which are maintained or produced as a result of this contract for the purpose of making audits, examinations, excerpts, and transcriptions. All records related to this contract shall be retained by the Contractor for three (3) years after final payment is made under this contract and all pending matters are closed. However, if any audit, litigation, or other action arising out of or related in any way to this contract is commenced before the end of the three (3) year period, the records shall be retained for one (1) year after all issues arising out of the action are finally resolved or until the end of the three (3) year period, whichever is later.

Where audits are required to be submitted to the Department before funding can be released, the audits must be submitted within the required timeframe and must be acceptable; if a Contractor fails to submit an audit in a timely manner, or if the audit is unacceptable, the Department reserves the right to cancel or suspend the contract at the Department’s discretion.

VII. Reimbursement: The Department agrees to provide reimbursement for the contract period. For contracts that include the use of Federal funds, the Department agrees to provide reimbursement for the contract period in accordance with the requirements set forth in OMB Circular A-87. Such reimbursement will be made upon receipt of the necessary billing listing salaries, Social Security, retirement, and other items provided in this contract, including copies of payroll requisitions and invoice copies for materials, equipment, or supplies. Any final billings shall be submitted to the Department no later than thirty (30) days after the close of the contract. Failure to submit final billings within the stated timeframe for this contract may be grounds for the Department to reject such reimbursements. It is agreed by both parties that the following items will be made only when approved by both parties:

A. reimbursement in excess of the amount budgeted for any item; or

B. reimbursement of items not included in the budget; or

C. the transfer of monies between items within the budget.
VIII. A. It is agreed by both parties that no reimbursement will be made by the Department until this contract has been signed by the appropriate personnel of both parties and until a budget for expenditures pursuant to the contract has been approved by the Department. Therefore, a Contractor may not begin work or report for duty until then. Additionally, it is expressly understood and agreed that the obligation of the Department to proceed under this contract is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide funds, or of the State of Mississippi to appropriate funds, or the discontinuance or material alteration of the program under which funds were provided, or if funds are not otherwise available to the State or the Department, the Department shall have the right, upon ten (10) working days written notice to the Contractor, to terminate this agreement without damage, penalty, cost, or expenses to the State or the Department of any kind whatsoever, pursuant to the termination clause herein. When and if applicable, it is understood that the contract is void and no payment shall be made in the event that the Mississippi Personal Service Contract Review Board does not approve this contract.

B. Pay mode: Payments by state agencies using the Statewide Automated Accounting System (SAAS), or any specific successor system (e.g., MAGIC) shall be made and remittance information provided electronically as directed by the State. These payments shall be deposited into the bank account of the Contractor’s choice. The State, may at its sole discretion, require the Contractor to submit invoices and supporting documentation electronically at any time during the term of this Agreement. Vendor invoices shall be submitted to the Mississippi State Department of Health using the processes and procedures identified by the State. Contractor understands and agrees that the State is exempt from the payment of taxes.

C. E-Payment: Contractor agrees to accept all payments in United States currency via the State of Mississippi’s electronic payment and remittance vehicle. The agency agrees to make payment in accordance with Mississippi Law on the “Timely Payments for Purchases by Public Bodies” statute, Mississippi Code Annotated §31-7-301, et seq., which generally provides for payment of undisputed amounts by the agency within 45 days of receipt of invoice.

IX. Representation Regarding Contingent Fees and Gratuities: The Contractor represents that it has not retained a person to solicit or secure a contract from the Department upon an agreement or understanding for a commission, percentage, brokerage, or contingency, except as was disclosed in the Contractor’s bid or proposal, if the selection of the Contractor was done through a bidding or proposal process. The Contractor also represents that it has not violated, is not currently violating, or will not violate the prohibition against gratuities as set forth in §7-204 of the Mississippi Personal Service Contract Procurement Regulations (copies of which are available for inspection at their offices located at 210 East Capitol Street, Suite 800, Jackson, Mississippi).

X. Salaries and Fringe Benefits: If the contract provides for the payment of salaries and/or fringe benefits (identified as a line item in the contract’s budget and/or budget narrative), it is understood by both parties that fringe benefits may be spent only for bona fide retirement programs and employee insurance plans. Before any retirement and/or insurance program is initiated or financed with funds received pursuant to this contract, approval must be obtained from the Department. Insurance plans shall be limited to health, life, unemployment, and workers’ compensation. Documentation must be available to the Department of all fringe benefit payments. This clause does not apply where the contract may be used for the payment of salaries and/or fringe benefits, but such were not specifically itemized as budgetary items in the contract.

XI. This section applies only to contracts for which the Contractor shall serve solely on an Independent Contractor basis, as follows:

The Contractor, at all times, shall be regarded as an Independent Contractor and shall at no time act as an agent for the State. Nothing contained herein shall be deemed or construed by the Department, the Contractor, or any third party as creating the relationship of principal and agent, partners, joint ventures, or any similar such relationship between the Department and the Contractor. Neither the method of computation of fees or other charges, nor any other provision contained herein, nor any acts of the Department or the Contractor hereunder, creates or shall be deemed to create a relationship other than the independent relationship of the Department and the Contractor. The Contractor’s personal shall not be deemed in any way, directly or indirectly, expressly or by implications, to be employees of the Department. Neither the Contractor nor its employees, under any circumstances, shall be considered servants or agents of the Department; and the Department shall be at no time legally responsible for any negligence or other wrongdoing by the Contractor, its servants, or agents. The Department shall not withhold from the contract payments to the Contractor any Federal or State unemployment taxes, Federal or State income taxes, Social Security tax, or any other amounts for benefits to the Contractor. Further, the Department shall not provide to the Contractor any insurance coverage or other benefits, including Workers’ Compensation, normally provided by the Department for its employees. Furthermore, none of the work performed under this contract shall be subcontracted without prior approval of the Department. The Department, throughout the life of the contract, shall have the right of reasonable rejection and approval of staff of the Contractor or its Subcontractors assigned to the work by the
Contractor. If the Department reasonably rejects staff of the Contractor or its Subcontractors, the Contractor must provide replacement staff or Subcontractors satisfactory to the Department in a timely manner and at no additional cost to the Department. The day-to-day supervision and control of the Contractor's employees and Subcontractors are the sole responsibility of the Contractor.

XII. This section applies only to contracts that require approval from the Mississippi Personal Service Contract Review Board, as follows:

A. Order to Stop Work: The Department may, by written order to the Contractor at any time and without notice to any surety, require the Contractor to stop all or any part of the work called for by this contract. This order shall be for a specified period not exceeding ninety (90) days after the order is delivered to the Contractor, unless the parties agree to any further period. Any such order shall be identified specifically as a stop work order issued pursuant to this clause. Upon receipt of such an order, the Contractor shall forthwith comply with its terms and take all reasonable steps to minimize the occurrence of costs allocable to the work covered by the order during the period of work stoppage. Before the stop work order expires, or within any further period to which the parties shall have agreed, the Department shall either:

i. cancel the stop work order; or

ii. terminate the work covered by such order as provided in the termination clause of this contract.

B. Cancellation or Expiration of the Order: If a stop work order issued under this clause is canceled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the Contractor shall have the right to resume work. An appropriate adjustment shall be made in the delivery schedule or the contract's price, or both, and the contract shall be modified in writing accordingly, if:

i. the stop work order results in an increase in the time required to, or in the Contractor's cost properly allocable to, the performance of any part of this contract; and

ii. the Contractor asserts a claim for such an adjustment within thirty (30) days after the end of the period of work stoppage provided that, if the Department decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this contract.

C. Termination of Stopped Work: If a stop work order is not canceled and the work covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop work order shall be allowed by adjustment or otherwise.

XIII. The Contractor shall comply with, and all activities under this contract shall be subject to, all applicable Federal, State, and local laws, rules, and regulations, as now exist and as may be amended or modified, including, but not limited to:

A. The Civil Rights Act of 1964, as amended.


C. Title IX of the Educational Amendments of 1972, as amended.

D. The Age Discrimination Act of 1975, as amended.


F. Americans with Disabilities Act of 1990 (ADA), as amended.

G. The Drug-Free Workplace Act of 1988, as amended.

H. Presidential Executive Order No. 12549, Certification Concerning Debarment and Suspension.


XIV. Certification Regarding Lobbying. The undersigned certify, to their best knowledge and belief, that:
A. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

B. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form – LLL, “Disclosure Form to Report Lobbying,” in accordance with its instructions.

C. The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including sub-contracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

D. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by §1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

XV. Equal Opportunity: The Contractor understands that the Department is an equal opportunity employer and therefore maintains a policy that prohibits unlawful discrimination on the basis of race, color, creed, sex, age, national origin, physical or mental disability, or any other consideration made unlawful by Federal, State, or local laws. All such discrimination is unlawful and the Contractor agrees during the term of the contract that it will strictly adhere to this policy in its employment practices and provision of services.

XVI. Confidential Information

A. Definition: “Confidential Information” shall mean:

i. those materials, documents, data, and other information which the Contractor has designated in writing as proprietary and confidential; and

ii. all data and information which the Contractor acquires as a result of its contact with and efforts on behalf of the Department, and any other information designated in writing as confidential by the Department or the State of Mississippi.

Each party to this contract agrees to protect all confidential information provided by one party to the other, to treat all such confidential information as confidential to the extent that confidential treatment is allowed under State and/or Federal law, and, except as otherwise required by law, not to publish or disclose such information to any third party without the other party’s written permission, and to do so by using those methods and procedures normally used to protect the party’s own confidential information. Any liability resulting from the wrongful disclosure of confidential information on the part of the Contractor or its Subcontractors shall rest with the Contractor. Disclosure of any confidential information by the Contractor or its Subcontractors without the express written approval of the Department shall result in the immediate termination of this contract.

B. Disclosure: In the event that either party to this contract receives notice that a third party requests divulgence of confidential or otherwise protected information and/or has served upon it a subpoena or other validly issued administrative or judicial process ordering divulgence of confidential or otherwise protected information, that party shall promptly inform the other party and thereafter respond in conformity with such subpoena to the extent mandated by State law. This section shall survive the termination or completion of this contract. The parties agree that this section is subject to and superseded by Mississippi Code of 1972, Annotated, Section 25-61-1, et. seq. regarding public access to public records.

C. Exceptions: The Contractor and the Department shall not be obligated to treat as confidential and proprietary any information disclosed by the other party (“The Disclosing Party”) which:

i. is rightfully known to the Contractor prior to negotiations leading to this contract, other than information obtained in confidence under prior engagements;
ii. is generally known or easily ascertainable to non-parties of ordinary skill in the business of the Contractor;

iii. is released by the Disclosing Party to any other person, firm, or entity (including governmental agencies or bureaus) without restriction;

iv. is independently developed by the recipient without any reliance on confidential information;

v. is, or later becomes, part of the public domain or may be lawfully obtained by the Department or the Contractor from any non-party; or

vi. is disclosed with the Disclosing Party’s prior written consent.

D. Contractor agrees to comply with the Administrative Simplifications provisions of the Health Insurance Portability and Accountability Act of 1996, including electronic data interchange, code sets, identifiers, security, and privacy provisions, as may be applicable to the services under this contract.

XVII. Non-Discrimination for HIV/AIDS: As a recipient of Federal funds, directly or indirectly through payments from the Department, the Contractor agrees that no person(s) who are otherwise qualified shall be denied employment, funds, education, or care in the program(s) funded in whole or in part by the Department on account of affiliation with Acquired Immune Deficiency Syndrome (AIDS)-related conditions, or on the basis of their infection with the Human Immunodeficiency Virus (HIV). This non-discrimination agreement and policy shall likewise apply to those individuals or groups who may be perceived as having AIDS or the aforementioned AIDS-related conditions, or who are perceived as being infected with HIV.

XVIII. Termination:

A. Termination for Convenience:

i. The Department may, when its interests so require, terminate this contract in whole or in part, for the convenience of the Department. The Department shall give written notice of the termination to the Contractor specifying the part of the contract terminated and when termination becomes effective.

ii. The Contractor shall incur no further obligations in connection with the terminated work and on the date set in the notice of termination the Contractor will stop work to the extent specified. The Contractor shall also terminate outstanding orders and subcontracts and any other orders connected with the terminated work. The Contractor shall settle the liabilities and claims arising out of the termination of subcontracts and orders connected with the terminated work. The Department may direct the Contractor to assign the Contractor’s right, title, and interest under terminated orders or subcontracts to the Department. The Contractor must still complete the work not terminated by the notice of termination and may incur obligations as are necessary to do so.

B. Termination for Default:

i. If the Contractor refuses or fails to perform any of the provisions of this contract with such diligence as will ensure its completion within the time specified in this contract, or any extension thereof otherwise fails to timely satisfy the contract provisions, or commits any other substantial breach of this contract, the Department may notify the Contractor in writing of the delay or nonperformance and if not cured in ten (10) days or any longer time specified in writing by the Department, the Department may terminate the Contractor’s right to proceed with the contract or such part of the contract as to which there has been delay or a failure to properly perform. In the event of termination in whole or in part, the Department may procure similar supplies or services in a manner and upon terms deemed appropriate by the Department. The Contractor shall continue performance of the contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services.

ii. Notwithstanding termination of the contract and subject to any directions from the Department, the Contractor shall take timely, reasonable, and necessary action to protect and preserve property in the possession of the contractor in which the State has an interest.

iii. Payment for completed services delivered and accepted by the Department shall be at the contract price. The Department may withhold from amounts due the Contractor such sums as the Department deems to be necessary to protect the State and the Department against loss because of outstanding liens or claims of former lien holders and to reimburse the Department for the excess costs incurred in procuring similar goods and services.
iv. Except with respect to defaults of Subcontractors, the Contractor shall not be in default by reasons of any failure in performance of this contract in accordance with its terms (including any failure by the Contractor to make progress in the prosecution of the work hereunder which endangers such performance) if the Contractor has notified the Department within fifteen (15) days after the cause of the delay and the failure arises out of cause such as: acts of God; acts of the public enemy; acts of the State and any other governmental entity in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; or freight embargoes. If the failure to perform is caused by the failure of a Subcontractor to perform or to make progress, and if such failure arises out of causes similar to those set forth above, the Contractor shall not be deemed to be in default, unless the services to be furnished by the Subcontractor were reasonably obtainable from other sources in sufficient time to permit the Contractor to meet the contract requirements. Upon request of the Contractor, the Department shall ascertain the facts and extent of such failure, and if such officer determines that any failure to perform was occasioned by any one or more of the excusable causes, and that but for the terms of the excusable cause, the Contractor’s progress and performance would have met the terms of contract, the delivery schedule shall be revised accordingly, subject to the rights of the Department under the clause entitled “Termination for Convenience.” As used in this Paragraph of this clause, the term “Subcontractor” means Subcontractor at any tier.

v. If, after notice of termination of the Contractor’s right to proceed under the provisions of this clause, it is determined for any reason that the contract was not in default under the provisions of this clause, or that the delay was excusable under the provisions of this clause, the rights and obligations of the parties shall, if the contract contains a clause providing for termination for convenience of the Department, be the same as if the notice of termination had been issued pursuant to such clause.

vi. The rights and remedies provided in this clause are in addition to any other rights and remedies provided by law or under this contract.

XIX. Applicable Law: This contract shall be governed by and construed in accordance with the laws of the State of Mississippi, excluding its conflicts of laws provisions, and any litigation with respect thereto shall be brought in the courts of the state. The Contractor shall comply with applicable Federal, State, and local laws and regulations.

XX. Ownership of Documents and Work Papers: The Department shall own all documents, files, reports, work papers, and working documentation, electronic or otherwise, created under this contract, except for the Contractor’s internal administrative and quality assurance files and internal correspondence. The Contractor shall deliver such documents and work papers to the Department upon termination or completion of the contract. The foregoing notwithstanding, the Contractor shall be entitled to retain a set of such work papers for its files. Contractor shall be entitled to use such work papers only after receiving written permission from the Department and subject to any copyright protections. By entering into this contract, the Contractor conveys, sells, assigns, and transfers to the Department all rights, titles, and interest it may now have or hereafter acquire under the antitrust laws of the United States and the State of Mississippi that relate to the particular goods or services purchased or acquired by the Department under this contract.

XXI. Attorneys’ Fees and Expenses: Subject to other terms and conditions of this contract, in the event the Contractor defaults in any obligations under this contract, the Contractor shall pay to the Department all costs and expenses (including, without limitation, investigative fees, court costs, and attorneys’ fees) incurred by the Department in enforcing this contract or otherwise reasonably related thereto. The Contractor agrees that under no circumstances shall the Department or the State of Mississippi be obligated to pay any attorneys’ fees or costs of legal action to the Contractor. This clause shall not apply to any contracts entered into with another state agency, board, or commission.

XXII. Modifications and Changes in Scope of Work: All modifications to the contract must be made in writing and signed by both parties to the contract. The Department may order changes in the work consisting of additions, deletions, or other revisions within the general scope of the contract. No claims may be made by the Contractor that the scope of the contract or of the Contractor’s services has been changed, requiring changes to the amount of compensation to the Contractor or other adjustments to the contract, unless such changes or adjustments have been made by written amendment to the contract signed by the Department and the Contractor. If the Contractor believes that any particular work is not within the scope of the contract, is a material change, or will otherwise require more compensation to the Contractor, the contractor must immediately notify the Department in writing of this belief. If the Department believes that the particular work is within the scope of the contract as written, the Contractor will be ordered to and shall continue with the work as changed and at the cost stated for the work within the scope.

XXIII. Failure to Deliver: In the event of failure of the Contractor to deliver goods or services in accordance with the contract terms and conditions, the Department, after due written notice, may procure the services from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies that the Department may have.
XXIV. Force Majeure: Each party shall be excused from performance for any period and to the extent that it is prevented from performing any obligation or service, in whole or in part, as a result of causes beyond the reasonable control and without the fault or negligence of such party and/or its Subcontractors. Such acts shall include without limitation acts of God, strikes, lockouts, riots, acts of war, epidemics, governmental regulations superimposed after the fact, fire, earthquakes, floods, or other natural disasters (the “Force Majeure Events”). When such a cause arises, the Contractor shall notify the Department immediately in writing of the cause of its inability to perform, how it affects its performance, and the anticipated duration of the inability to perform. Delays in delivery or in meeting completion dates due to Force Majeure Events shall automatically extend such dates for a period equal to the duration of the delay caused by such events, unless the Department determines it to be in its best interest to terminate the contract.

XXV. Indemnification: To the fullest extent allowed by law, the Contractor shall indemnify, defend, save and hold harmless, protect, and exonerate the State of Mississippi, the Department, members of the Mississippi State Board of Health, and its officers, employees, agents, and representatives from and against all claims, demands, liabilities, suits, actions, damages, losses, and costs of every kind and nature whatsoever, including, without limitation, court costs, investigative fees and expenses, and attorneys’ fees, arising out of or caused by the Contractor and/or its partners, principals, agents, employees and/or Subcontractors in the performance of or failure to perform this contract. In the State of Mississippi’s sole discretion, the Contractor may be allowed to control the defense of any such claim, suit, etc. In the event the Contractor defends said claim or suit, the Contractor shall use legal counsel acceptable to the State of Mississippi and to the Department; the Contractor shall be solely responsible for all costs and/or expenses associated with such defense, and the State of Mississippi and the Department shall be entitled to participate in said defense. The Contractor shall not settle any claim or suit, without the State of Mississippi and the Department’s concurrence, which the State of Mississippi and the Department shall not unreasonably withhold.

XXVI. No Limitation of Liability: Nothing in this Contract shall be interpreted as excluding or limiting any tort liability of the Contractor for harm caused by the intentional or reckless conduct of the Contractor or for the damages incurred through the negligent performance of duties by the Contractor or the delivery of products that are defective due to negligent construction.

XXVII. Recovery of Money: Whenever, under this contract, any sum of money shall be recoverable from or payable by the Contractor to the Department, the same amount may be deducted from any sum due to the Contractor under the contract or under any other contract between the Contractor and the Department. The rights of the Department are in addition and without prejudice to any other right the Department may have to claim the amount of any loss or damage suffered by the Department on account of the acts or omissions of the Contractor.

XXVIII. Severability: If any part of this Contract is declared to be invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision of the contract that can be given effect without the invalid or unenforceable provision and to this end, the provisions hereof are severable. In such event, the parties shall amend the contract as necessary to reflect the original intent of the parties and to bring any invalid or unenforceable provisions in compliance with applicable law.

XXIX. State Property: The Contractor will be responsible for the proper custody and care of any State-owned or State-leased property furnished for the Contractor’s use in connection with the performance of this contract. The Contractor will reimburse the Department for any loss or damage, normal wear and tear excepted.

XXX. Third Party Action Notification: The Contractor shall give the Department prompt notice in writing of any action or suit filed, and prompt notice of any claim made against Contractor by any entity that may result in litigation related in any way to this contract.

XXXI. Unsatisfactory Work: If, at any time during the contract term, the service performed or work done by the Contractor is considered by the Department to create a condition that threatens the health, safety, or welfare of the general public, the Department, its property, or its employees, or for whom the contracted services are to be rendered, the Contractor shall, on being notified by the Department, immediately correct the deficient service or work. In the event the Contractor fails, after notice, to correct the deficient service or work immediately, the Department shall have the right to order the correction of the deficiency by separate contract or with its own resources at the expense of the Contractor.

XXXII. Waiver: No delay or omission by either party to this contract in exercising any right, power, or remedy hereunder or otherwise afforded by contract, at law, or in equity shall constitute an acquiescence therein, impair any other right, power or remedy hereunder or otherwise afforded by any means, or operate as a waiver of such right, power, or remedy. No waiver by either party to this contract shall be valid unless set forth in writing by the party making said waiver. No waiver of or modification to any term or condition of this contract will void, waive, or change any other term or condition. No waiver by one party to this contract of a default by the other party will imply, be construed as, or require waiver of future or other defaults. Failure by the Department at any time to enforce the provisions of the contract shall not be construed as a waiver of any such provisions. Such failure to enforce shall not affect the validity of the contract or any part thereof or the right of the Department to enforce any provision at any time in accordance with its terms.

MSDH Independent Contractor Agreement, Revised 06/13  Page 9  Form #605E
XXXIII. Anti-Assignment/Subcontracting: The Contractor acknowledges that it was selected by the Department to perform the services required hereunder based, in part, upon the Contractor's skills and expertise. The Contractor shall not assign, subcontract, or otherwise transfer this contract in whole or in part without the prior written consent of the Department, which the Department may, in its sole discretion, approve or deny without reason. Any attempted assignment or transfer by the Contractor of its obligations without such consent shall be null and void. No such approval by the Department of any subcontract shall be deemed in any way to provide for the incurrence of any obligation of the Department in addition to the total contractual price agreed upon in this contract. Subcontracts shall be subject to the terms and conditions of this contract and to any conditions of approval that the Department may deem necessary. Subject to the foregoing, this contract shall be binding upon the respective successors and assigns of the parties.

XXXIV. Integrated Agreement/Merger: This contract, including all contract documents, represents the entire and integrated contractual agreement between the parties hereto and supersedes all prior negotiations, representations, or agreements, irrespective of whether they were written or oral. This contract may be altered, amended, or modified only by a written document executed by the Department and the Contractor. The Contractor acknowledges that it has thoroughly read all contract documents and attachments and has had the opportunity to receive competent advice and counsel necessary for it to form a full and complete understanding of all rights and obligations herein. Accordingly, this contract shall not be construed or interpreted in favor or against the State, the Department, or the Contractor on the basis of draftsmanship or preparation.

XXXV. Transparency: This contract, including any accompanying exhibits, attachments, and appendices, is subject to the “Mississippi Public Records Act of 1983,” codified as 79-23-1 of the Mississippi Code Annotated (1972, as amended). In addition, this contract is subject to the provisions of the Mississippi Accountability and Transparency Act of 2008 (MATA), codified as 31-7-13 of the Mississippi Code Annotated (1972, as amended). Unless exempted from disclosure due to a court-issued protective order, this contract is required to be posted on the Department of Finance and Administration’s independent agency contract website for public access. Prior to posting the contract on the website, any information identified by the Contractor as trade secrets, or other proprietary information including confidential vendor information, or any other information which is required confidential by state or federal law or outside the applicable freedom of information statutes will be redacted.

XXXVI. Notices: All notices required or permitted to be given under this contract must be in writing and personally delivered or sent by certified United States mail, postage prepaid, return receipt requested, to the party to whom the notice should be given at the address set forth below. Notice shall be deemed given when actually received or when refused. The parties agree to promptly notify each other in writing of any change of address as shown below:

<table>
<thead>
<tr>
<th>For the Contractor:</th>
<th>Name: Susan Mayfield-Johnson, PhD, MCHES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Title: Consultant</td>
</tr>
<tr>
<td></td>
<td>Organization:</td>
</tr>
<tr>
<td>Street Address:</td>
<td>802 Southeast Circle</td>
</tr>
<tr>
<td>City, State, Zip:</td>
<td>Hattiesburg, MS 39402</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For the Department:</th>
<th>Name: Tanya Funchess, DHA, MPH, MSM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Title: Office Director, Office of Health Disparity Elimination</td>
</tr>
<tr>
<td></td>
<td>Agency: MS State Department of Health</td>
</tr>
<tr>
<td>Street Address:</td>
<td>715 S. Pear Orchard Road, Suite 102</td>
</tr>
<tr>
<td>City, State, Zip:</td>
<td>Ridgeland, MS 39157</td>
</tr>
</tbody>
</table>
TO BE FILLED OUT ONLY FOR 300 LINE ITEM CONTRACTS

CONTRACT JUSTIFICATION

Detailed description of contractual services to be performed including location, program, purpose, and condition or regulatory agency establishing the requirement for contract personnel services (contract services which require regulatory agency action must have concurrence of regulatory agency prior to submission to the State Personnel Director):

Susan Mayfield-Johnson will work with MSDH, Office of Health Disparity Elimination on two main activities: 1) Analysis of the Community Fellows’ evaluation surveys and post trainings; and 2) Facilitating and analyzing focus groups in District 8 (Covington, Forrest, Green, Jefferson Davis, Lamar, Marion, Perry, and Wayne Counties. The quantitative analysis will be developed into a report for OHDE and a detailed analysis of all surveys will be provided to OHDE by January 2016.

Justification of request, including assessment of current personnel resources (i.e. utilization of current position vacancies, temporary increase in workload above capability of current workforce, level of expertise required, position classification not available to agency):

The contract is needed to support the overwhelming workload of the CRFT project.

Qualifications that make this contractor the best suited to perform this task:

Susan Mayfield-Johnson teaches graduate students in the health education emphasis area while serving as the Director of the Center for Sustainable Health Outreach (CSHO); Served as PI/CoPI on projects with a national scope; Trainer and Consultant in CBPR, CHW utilization, and qualitative methods; connecting stakeholder groups across interdisciplinary lines; providing CBOs with technical assistance in qualitative design, implementation, and evaluation; and conducting training workshops.

Justification of modification request (if applicable):

Consequence of contract being disapproved:

If this contract is not approved it will not be possible for OHDE to meet its required goals and objectives for the CRFT training that are the responsibilities of the OHDE.

I have reviewed this contract request and determined that these services are needed and cannot be provided by current staff or through the staffing of a vacant position.

[Signature]
Agency Authorized Signature

[8/24/2015]
Date
Training and Evaluation Subcontract with Mississippi State Department of Health
Office of Health Disparity Elimination

Project Implementation Plan

Upon receipt of contract, Susan Mayfield-Johnson, PhD, MCHES will work with the Mississippi State Department of Health, Office of Health Disparity Elimination on two main activities: 1) Analysis of the Community Fellows’ evaluation surveys to be disseminated at baseline, midpoint, and post trainings; and 2) Facilitating and analyzing focus groups in District 8 (Covington, Forrest, Greene, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne counties, focus group per counties n=8).

CFRT analysis will be conducted with the aid of Danielle Fastring, PhD, Assistant Professor of Biostatistics and Epidemiology, Department of Public Health, The University of Southern Mississippi. Dr. Fastring will serve as a consultant to Dr. Mayfield-Johnson, and bill her for services accordingly. Dr. Mayfield-Johnson will serve as the technical lead, facilitate the analysis, provide the qualitative analysis, and submit findings to the Mississippi State Department of Health. Dr. Fastring will provide the quantitative analysis and assist with the development of the report. Detailed analysis of all surveys will be provided to the Office of Health Disparity Elimination by January 15, 2015.

The question guide and IRB application will be developed and submitted in August 2-15, and all focus groups will be conducted throughout September and October. Analyses and a written report will be submitted by November 30, 2015.

Subcontract Dates
This subcontract period will be for August 1, 2015 – January 31, 2016.

Capability Statements

Susan Mayfield-Johnson, PhD, MCHES is an Assistant Professor at the University of Southern Mississippi where she teaches graduate students in the health education emphasis area. She is also serves as the Director of the Center for Sustainable Health Outreach (CSHO). CSHO has been designated as a best practice CHW model (Rural Assistance Center, 2014) for rural health, and centers on curriculum development, training, and evaluation of CHW models with various health disparate and underserved populations.

She has served as PI for several externally funded projects that have included curriculum development, education and training, program planning, implementation, methods, and evaluation. Mayfield-Johnson has also served as a consultant and trainer in CBPR, CHW utilization, and qualitative methods; connecting stakeholder groups across interdisciplinary lines; providing CBOs with technical assistance in qualitative design, implementation, and evaluation; and conducting training workshops on CBPR models of engagement, CHW capacity, academic-community partnerships, evaluation methods, and utilization of popular education models.

Danielle Fastring, PhD is an Assistant Professor at the University of Southern Mississippi. She teaches graduate and undergraduate students in the areas of epidemiology, biostatistics, communicable and chronic disease, and program evaluation. Dr. Fastring is a former research fellow in the Maternal Child Health Epidemiology Doctoral Training Program sponsored by the Health Resources and Services Administration (HRSA) at Tulane University School of Public Health and Tropical Medicine, She has
received formal training in program planning and evaluation. She served as an evaluator for the ARRA-Funded Clinician Impact and Retention Evaluation Study for the Mississippi Office of Rural Health and Primary Care, and she is currently evaluating the “Color Me Healthy” obesity initiative among HeadStart Centers along the Gulf Coast. Most recently, she and Dr. Mayfield-Johnson served as evaluation consultants for the first Community Research Training Fellows program.

**Budget**

**Consultant Fees: $10,500**

Susan Mayfield-Johnson, PhD, MCHES, will serve as technical lead for the analysis of the Community Fellows’ evaluation surveys and provide qualitative analysis of those evaluations @ $125/hour for 20 hours totaling $2,500. Surveys to be evaluated include baseline, midpoint, and final evaluations. In addition, she will develop the question guide, submit for IRB approval, facilitate, and analyze 8 focus groups in District 8 (Covington, Forrest, Greene, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne counties) @ $125/hour for 36 hours totaling $4,500. Total amount for consultation services of Dr. Mayfield-Johnson is $7,000.

Danielle Fastring, PhD, will provide the quantitative analysis of the Community Fellows’ evaluation surveys and assist with the development of the report to MSDOH @ $125/hour for 20 hours totaling $2,500.

Transcriptionist, TBN, will transcribe all focus groups from recorded audio tapes@ $25/hour for 40 hours totals $1000.

**Travel: $540**

Travel rates are in accordance with the policies and guidelines established by the State of Mississippi, currently @ $0.55. Travel is anticipated for 8 focus group trips in District 8 @ to facilitate focus groups at total 75 miles per trip (total miles = 675). 2 trips to Jackson from Hattiesburg (total miles =380) for development and technical assistance for the focus groups and the CRFT’s evaluation. Total travel = $540.

**Commodities: $5,460**

Stipends of $25/ per person, 20 people anticipated per focus group for 8/focus groups = $4000.

Refreshments for focus group participants, $150/per focus group for 8 groups = $1,200

Supplies (pens, pads, nametags, flipcharts, tapes, etc.) associated with focus group = $260

**Total Project Costs: $16,500**
BACKGROUND AND PURPOSE OF STUDY

• Mississippi currently ranks among the highest in the nation with an overall infant mortality rate of 9.7 per 1,000 live births.

• District IX counties include George, Harrison, Hancock, Jackson, Pearl River, and Stone.

• Infant mortality rate for District IX is 9.3 per 1,000 live births.

• The Healthy People 2020 goal for infant mortality is 6.0 deaths per 1,000 live births before 2020.
FOCUS GROUPS

• Six focus groups
• N=59
• African-American, Caucasian, Spanish, and Vietnamese women
• Eligibility criteria: childbearing aged (18-44 years of age)
• Assess attitudes, perceptions, beliefs, and feelings about women’s health, pregnancy, and infant mortality.
• Separated by race/ethnicity to accommodate for language and culture.
• Discussion on general women’s health, preventative health behaviors and services, barriers to getting preventative health services, health information and advice, relationships with family and friend, pregnancy and reproductive health, and healthy baby messages.

• Developed Moderator’s Guides, consent forms, and demographic survey

• Translated consent forms and demographic survey into Vietnamese and Spanish

• Obtained IRB Approval from USM

• Held focus group training on September for co-facilitators and note takers (Spanish facilitation and Vietnamese facilitation)
  – MSDOH, Office of Health Disparity Elimination staff
  – Mercy Housing, Inc.
  – Boat People SOS
  – Coastal Family Health Clinic Social Worker
RECRUITMENT

• Flyers, social media, and key informant contacts
• Incentives included $25 Walmart gift card and light refreshments.
• Spanish-speaking focus group, child care was also provided at the Moore Center Early Head Start Center by licensed Head Start teachers.
• Jackson County focus groups were held at the Jackson County Civic Action Committee, Inc., in Moss Point, Mississippi on November 4, 2015 with 24 African American and 5 Caucasian participants.

• Harrison County focus groups were held at The University of Southern Mississippi Gulf Coast Campus in Long Beach, Mississippi on October 30, 2015 with 5 African American and 9 Caucasian participants.

• Spanish-speaking women in Jackson, Harrison, and Hancock counties were held at Moore Community House Inc., in Biloxi, Mississippi with 6 women in Spanish.

• Vietnamese women in Jackson, Harrison, and Hancock counties were Biloxi Public Library in Biloxi, Mississippi with 9 women in English.
• Participant completed a consent form and demographic surveys prior to the beginning of the focus group.
• Because the consent form stated that all participation was voluntary, most respondents completed the demographic survey (n=56)
• Focus group discussion
FOCUS GROUPS

- Facilitator and note taker present for the discussion.
- Spanish and Vietnamese focus groups had non-participant observers.
- All focus groups utilized a moderator’s question guide
- Were audiotaped for transcription.
- Personal identifiers removed during the transcription process.
- The Spanish focus group was facilitated in Spanish, transcribed in Spanish, and then translated into English.
- All transcript, field notes, and participatory activities conducted during the focus groups were coded and organized into broad conceptual themes utilizing standard qualitative research procedures.
PARTICIPANTS’ DEMOGRAPHICS

Race of Participants

- African American: 50.00%
- Caucasian: 25.00%
- Hispanic: 8.93%
- Vietnamese: 16.07%

Age of Participants

- 18-23: 32.14%
- 24-28: 14.29%
- 29-33: 26.79%
- 34-38: 10.71%
- 39-44: 12.50%
- 45+: 3.57%
PARTICIPANTS’ DEMOGRAPHICS

Marital Status
- Married: 35.71%
- Living with partner: 14.29%
- Separated or divorced: 12.50%
- Widowed: 1.79%
- Never Married: 35.71%

Education Level of Participants
- 6th-12th Grade: 26.79%
- Completed High School: 19.64%
- Some College: 26.79%
- Completed Community College: 10.71%
- Completed College: 8.93%
- Graduate School: 7.14%
PARTICIPANTS’ DEMOGRAPHICS

Employment Status of Participants

- Unemployed and looking for work: 8.93%
- Full time: 37.50%
- Part time: 10.71%
- More than one job: 1.79%
- Retired: 5.36%
- Homemaker: 25.00%
- Disabled: 5.36%
- Temporarily unemployed: 1.79%
- Unemployed and not looking for work: 0.00%
PARTICIPANTS’ DEMOGRAPHICS

**Yearly Household Income**
- <15k: 20%
- 15k-29,999: 25%
- 29k-34,999: 18%
- 35k-49,999: 12%
- 50k-64,999: 11%
- 65k-79,999: 5%
- 80,000+: 9%

**Health Insurance Status**
- None: 0.00%
- Employer Provided: 28.57%
- Someone Else's Employer Provided: 26.79%
- ACA: 21.43%
- Medicare: 17.86%
- Medicaid: 3.57%

- **Note:** The percentages are approximate and rounded.
### Leading Health Concerns of Participants (n=48)

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Important Health Issue:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>14</td>
<td>29.17%</td>
</tr>
<tr>
<td>Insurance Costs</td>
<td>7</td>
<td>14.58%</td>
</tr>
<tr>
<td>Obesity</td>
<td>7</td>
<td>14.58%</td>
</tr>
<tr>
<td>Prevention/Access to Health Care</td>
<td>7</td>
<td>14.58%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4</td>
<td>8.33%</td>
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<tr>
<td>Health Education</td>
<td>2</td>
<td>4.17%</td>
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<tr>
<td>Mental Health</td>
<td>2</td>
<td>4.17%</td>
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<tr>
<td>Birth Control</td>
<td>1</td>
<td>2.08%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>1</td>
<td>2.08%</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>1</td>
<td>2.08%</td>
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<tr>
<td>High Blood Pressure</td>
<td>1</td>
<td>2.08%</td>
</tr>
<tr>
<td>Infertility</td>
<td>1</td>
<td>2.08%</td>
</tr>
</tbody>
</table>
### PARTICIPANTS’ DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Place Participant Accesses Primary Care (n=56)</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local health clinic</td>
<td>18</td>
<td>32.14%</td>
</tr>
<tr>
<td>Doctor’s office</td>
<td>37</td>
<td>66.07%</td>
</tr>
<tr>
<td>Emergency room</td>
<td>12</td>
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<tr>
<td>Hospital</td>
<td>9</td>
<td>16.07%</td>
</tr>
<tr>
<td>Veteran’s center</td>
<td>4</td>
<td>7.14%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>3.57%</td>
</tr>
</tbody>
</table>
## PARTICIPANTS’ DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Source from which Participant Seeks Health Information (n=56)</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care provider</td>
<td>37</td>
<td>66.07%</td>
</tr>
<tr>
<td>Internet</td>
<td>36</td>
<td>64.29%</td>
</tr>
<tr>
<td>Family</td>
<td>24</td>
<td>42.86%</td>
</tr>
<tr>
<td>Friends</td>
<td>21</td>
<td>37.50%</td>
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<tr>
<td>Magazines</td>
<td>13</td>
<td>23.21%</td>
</tr>
<tr>
<td>Television</td>
<td>11</td>
<td>19.64%</td>
</tr>
<tr>
<td>Library</td>
<td>9</td>
<td>16.07%</td>
</tr>
<tr>
<td>Radio</td>
<td>6</td>
<td>10.71%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.79%</td>
</tr>
</tbody>
</table>
HEALTH AND PREVENTATIVE CARE

• Focused on various dimensions of health.
• Physical health (diet and exercise), but continued discussions concentrated on the social, emotional, mental, and spiritual health needs of women.
• Stress, mental and emotional health
• Acknowledged that regular preventative exams were essential to optimal preventive health, but low on priority list.
• Pap smears, mammograms, dental, vision, and prenatal care were some of the preventative services mentioned. The only exception was vision-related exams and affects daily activities.
BARRIERS TO CARE

• Lack of insurance, money for copays, costs for appointments, costs for medicines
• Inability to get an appointment
• Time spent at the clinic waiting for care
• Transportation
• Fear
• Culture
• Racism/discrimination
• Issues with language/translation services
• Lack of respect. The following are examples from various focus group participants relating issues with lack of insurance, money for copays, or costs for appointments.
HEALTH ADVICE AND INFORMATION

• Technology as the primary source from where they get their health information and advice.
  – The Internet (WebMD)
  – Google, documented as a secondary source.
  – No participant mentioned any governmental agency websites.
  – Social media was also listed a source for several focus group participants

• Compare to answers on survey
HEALTH CARE SERVICES

• Go to federally qualified health center (FQHCs) like Coastal Family Health Clinic
• Urgent care centers,
• Health Department (for gynecologic and obstetrics
• Emergency Room.
• A few had a family care physician
  – , it appeared to be associated with full-time employment and insurance status.
  – A few women noted relationships with their OBY/GYN, and treated the individual as a family care physician.
• 2 respondent sought health care services at the VA Clinic.
HEALTH CARE SERVICES

- Women should go to the doctor to seek preventative care and routine services (like pap smears, physicals, immunizations, mammograms, oral health, and mental health care),
- No agreement on the frequency or the severity of the visit.
- Did not personally practice preventative care.
- Do seek preventative care services for their children
- Compare to demographic survey
HEALTH CARE EXPERIENCES

• Positive experiences
  – Experiencing care and compassion from providers

• Negative experiences
  – Issues of customer service
  – Not being treated courteously
  – Experiencing feelings of inadequate care and compassion from providers
  – Feeling like the doctor or provider was just there for the money
PREGNANCY AND REPRODUCTIVE HEALTH

• Most common answer was full term (9 months) births.
• Prenatal care
• Healthy diet and exercise
• Taking vitamins
• Checkups.
• Refraining from alcohol and smoking
• Reducing stress,
• Breastfeeding Increasing folic acid.
• Factors that contributed to keeping women from getting prenatal care included lack of insurance, transportation, lack of social support, and hassles linked to appointments.
SOURCES OF INFORMATION

- Information on how to care for a baby are often obtained from a woman’s mother, grandmother, aunt, or sister.
- Experience
- Fathers were discussed as a source of information
- WIC department
- Books
- Parenting classes
- Television
- Pediatricians,
- Child’s schools (Head Start centers)
- Internet
- Pregnancy app on smartphone.
Most did not breastfeed
Some cited income as factor
Spanish-speaking women did breastfeed
Environmental influences
Issues associated to breastfeed include having full-time employment, lactation support, a room or environment to support pumping on-the-job, other children and childcare support, and if the individual was breastfed as an infant.
SAFE SLEEP

• Back to sleep
• No blankets
• No pillows
• No stuffed animals
• not sleeping with parent(s).
• Conflicting messages and understanding among participants in some of the focus groups.
INFANT MORTALITY

• 4/6 someone personally that had a child that had died before its first birth.
• All scenarios cited tragedy of the situation and attributed the death to Sudden Infant Death Syndrome (SIDS).
• Reluctant to assess what factors contributed to the death
  – Accidents
  – Issues related to the crib.
• Support and sympathy from the community for the families
• Infant mortality not considered a serious issue in their communities.
PREVENTION OF INFANT MORTALITY

• Consistent with the literature
  – Stop smoking
  – Stop drinking
  – Safe sleep practices
  – Breastfeeding

• More program were needed on infant mortality.
  – Current ones are boring.
  – More educational sessions that include group discussions, personal testimonies, participatory activities, technology, and demonstrations would be desired.
  – A few of the women called the focus group an educational program and stated that more of these types of programs should be conducted.
PREVENTION OF INFANT MORTALITY

• Awareness program that concentrated on how to spend quality time with your children as a means to address infant mortality.
• Media campaigns with billboards
• Social media (Facebook for mature populations, twitter and Instagram for younger populations)
• Television
• Sufficient resources available – focus more on how and where to access these resources.
• Parenting classes
HEALTHY BABY MESSAGES

• Sharing through faith-based organizations, educational institutions like Head Start and day care centers, and through trusted community Spanish speaking individuals (like a promotora).

• African American and Caucasian focus group women recommended billboards, community educational programs, faith-based institutions, higher educational institutions (like USM), television, and social media.

• For the Vietnamese populations, three primary methods (social media, church bulletins, and the Vietnamese channel) are best since the Vietnamese population is a closed community to outsiders.
MENTAL HEALTH

• Culture an issue
  – Not talk about your business with others
  – Take it to the Lord
    • Not praying enough
    • Not a strong enough Christian
IMPLICATIONS AND LESSONS LEARNED

• Access to health care is available but some women do not take advantage of the services.
• Reasons may include knowledge of available services, costs, time away from work, time spent getting care, feelings of disrespect, transportation, and fear.
• Overwhelming desire to be treated with respect and compassion, to not feel rushed, and feel that your insurance type/ability to pay is not related to level of care.
• Most women with negative health care experiences equated it back to a poor bedside manner, poor customer service from staff at the health care facility, and immigration status and discrimination.
• Preventative care was imperative, but they did not practice what they preached.
• Primary barrier to access was related to cost and health insurance status.
IMPLICATIONS AND LESSONS LEARNED

• Health disparities and health equity,
• Different standards of care among women of differing races or ethnicities.
• Social security number is very important to access services (Medicaid) in the state of Mississippi.
• Cultural differences were noted, and feelings of discrimination and racism were provided in personal accounts with various sectors of health and human service agencies.
• Translation is a significant contributor for some racial and ethnic groups as English may be a second language for many legal citizens in Mississippi.
IMPLICATIONS AND LESSONS LEARNED

• Messages are getting to some but some of the mediums for dissemination are not appropriately utilized.
• Increasing technological population
• Recommendations include social marketing campaign
• Educational program should consider rebranding some of the titles to reinforce positive efforts to improve health indicators.
  – The parenting classes signify that mothers are lacking in their parenting skills and need assistance.
  – Some possible suggestions included family resources or family leadership
  – Should focus more on inclusion and active participation of members in the education process.
Susan Mayfield-Johnson
Director, Center for Sustainable Health Outreach
Assistant Professor, Department of Public Health
The University of Southern Mississippi
(601) 266-6266
susan.Johnson@usm.edu
¿Por qué se me ha pedido que participe en este grupo de discusión?

• El propósito de este grupo de discusión es el de aprender sobre las actitudes, creencias y sentimientos acerca de la salud de las mujeres, incluyendo cosas que ellas hacen para mejorar su salud y la salud de sus familias.
• También le vamos a pedir que complete una encuesta demográfica.
• Esta información va a ser utilizada por el Departamento de Salud Pública de The University of Southern Mississippi y la Oficina para la Eliminación de Inequidades de Salud (OHDE por sus siglas en inglés) del Departamento de Salud del Estado de Mississippi, para aprender acerca de la relación entre la salud de las mujeres y el tener un bebé saludable y para mejorar futuras campañas de educación pública.

¿Qué tendré que hacer?

• Si usted elige participar, le vamos a pedir que tome parte en una discusión guiada (un grupo de discusión) que durará alrededor de 2 horas. También le pediremos que complete una encuesta demográfica de 2 páginas.
• Le vamos a preguntar acerca de sus creencias y sentimientos así como de los comportamientos de las mujeres relacionados con la salud. Sus ideas y opiniones son importantes, por lo tanto diga lo que tenga en su mente. No hay respuestas correctas o incorrectas para ninguna de las preguntas que le vamos a hacer.
• Hay algunas preguntas que usted puede considerar sensibles. Si alguna pregunta la hace sentir incómoda, usted puede elegir no contestar esas preguntas, en ambos casos, con el grupo de discusión y la encuesta demográfica.
• Este grupo de discusión va a ser grabado en audio, y después la
grabación va a ser transcrita (escrita a máquina) y analizada para describir tendencias, patrones, y temas. Todos los nombres serán cambiados en la transcripción y las grabaciones serán destruidas una vez que la transcripción se haya hecho.

- La encuesta demográfica será ingresada en una base de datos sin ninguna información que la pueda identificar. Todas las encuestas serán destruidas una vez que hayan sido ingresadas en la base de datos.

¿Qué me van a dar por participar en este proyecto? ¿Me van a pagar?
- El proyecto le va a dar una tarjeta de regalo de $25 por su participación en el grupo de discusión y por completar la encuesta.
- Además vamos a proveer refrigerios ligeros durante las discusiones.

¿Tengo que pagar por algo para participar en este grupo de discusión?
- Usted no tendrá que pagar nada por participar en este grupo de discusión.
- El único costo para usted es el tiempo que usted tome para venir al grupo de discusión.

¿Hay riesgo alguno por participar en este grupo de discusión? ¿Puedo dejar de participar en este grupo de discusión cuando yo quiera?
- No esperamos que hayan daños por participar en este grupo de discusión.
- Usted puede dejar de participar en el grupo de discusión en cualquier momento durante este proceso sin ninguna penalidad.

¿Se enterará la gente de que yo participé en el grupo de discusión? (Declaración de confidencialidad)
- Si usted elije participar en este grupo de discusión, por favor
entienda que su participación es voluntaria. Toda la información que usted provea será guardada confidencialmente. La única excepción es si usted expresa la intención de hacerse daño a usted misma o a otras personas.

- Este formulario de consentimiento firmado y con su nombre serán guardados por separado de la información de los grupos de discusión. Usted no necesita darnos su nombre y puede usar un nombre falso si lo desea. Aunque vamos a grabar el audio de los grupos de discusión, usted puede solicitar que paremos la grabación en cualquier momento. Todas las grabaciones van a ser transcritas (escritas a máquina) sin nombre y sin ninguna otra identificación para proteger su confidencialidad.

- La información personal obtenida de las encuestas y los grupos de discusión serán guardados en archivadores con llave en el Departamento de Salud Pública en The University of Southern Mississippi. Solamente el equipo de investigadores podrá ver sus respuestas, y las respuestas serán destructadas una vez que el proyecto termine.

- Solamente información del grupo, sin información personal que la identifique, será presentada en reuniones científicas y publicadas en revistas científicas.

- Si usted quiere un resumen de los resultados de los grupos de discusión, usted puede darnos su nombre e información de contacto en una hoja de papel por separado. Le enviaremos una copia por correo del reporte una vez que el proyecto haya concluido.

¿Qué hago si es que tengo preguntas acerca del grupo de discusión o mi participación?

- Si usted alguna vez tiene preguntas acerca de este estudio, por favor póngase en contacto con la investigadora principal, Susan Mayfield-Johnson, al (601) 266-6266.

- El proyecto y este formulario de consentimiento han sido revisados por el Comité Institucional de Revisión (IRB por sus siglas en
inglés), el cual asegura que los proyectos de investigación que envuelven sujetos humanos siguen las regulaciones federales. Cualquier pregunta o inquietud acerca de los derechos de sujetos de investigación deben ser dirigidas al Director de Investigación y de Programas Patrocinados, The University of Southern Mississippi, 118 College Drive #5147, Hattiesburg, MS 39406, (601) 266-5997.

Si usted está interesado en participar en el proyecto, por favor lea la siguiente declaración muy cuidadosamente. Entonces, si usted aún quiere participar, por favor firme y coloque la fecha en este formulario y devuélvalo a Susan. Usted puede guardar una copia de este formulario, en caso de que tenga cualquier pregunta o inquietud más adelante.

Acuerdo del Participante:

Con mi firma en este formulario de consentimiento, declaro que estoy de acuerdo en participar en este estudio.

_________________________________________________________
Firma del Sujeto de Investigación      Fecha

__________________________________________________________
Firma de la Persona Explicando el Estudio       Fecha
IMPROVING WOMEN’S HEALTH IN DISTRICT IX

A Qualitative Report Prepared for the Mississippi State Department of Health

FEBRUARY 8, 2016
PREPARED BY: THE CENTER FOR SUSTAINABLE HEALTH OUTREACH
Susan Mayfield-Johnson, PhD, MCHES
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Background and Purpose of Study

Infant mortality has been defined as the death of babies less than one year of age. Because certain risk factors (i.e. poverty, access to health care, etc.) directly affect the health of infants, infant mortality has been considered a general measurement indicator for the overall health and well-being of a population. The infant mortality rate is the number of infants who die per 1,000 infants born alive, and is influenced by the health and well-being of women before and during pregnancy, quality of prenatal and delivery care, and the health and care of babies from birth. Reducing infant mortality requires addressing multiple risk factors (infant health and safety, tobacco use during pregnancy, breastfeeding rates, and unsafe sleep environments) before and during pregnancy.

Mississippi currently ranks among the highest in the nation with an overall infant mortality rate of 9.7 per 1,000 live births. In District IX, which includes the Mississippi counties of George, Harrison, Hancock, Jackson, Pearl River, and Stone, the infant mortality rate is 9.3 per 1,000 live births. This is in steep contract to the goals of the nation. The Healthy People 2020 goal for infant mortality is to reduce infant mortality to a rate of 6.0 deaths per 1,000 live births before 2020.

To address the high rates of infant mortality in District IX, the Mississippi State Department of Health, Health Disparity Elimination contracted with the Center for Sustainable Health Outreach at The University of Southern Mississippi to facilitate focus groups across the Mississippi Gulf Coast (Harrison, Hancock, and Jackson Counties) in October and November of 2015. Six focus groups (n=59) with African-American, Caucasian, Spanish, and Vietnamese childbearing aged women, 18-44 years of age, were conducted to assess attitudes, perceptions, beliefs, and feelings about women’s health, pregnancy, and infant mortality. Focus groups were
initially separated by race/ethnicity to accommodate for language and culture. The focus group elicited a discussion on general women’s health, preventative health behaviors and services, barriers to getting preventative health services, health information and advice, relationships with family and friend, pregnancy and reproductive health, and healthy baby messages.

**Research Design and Methodology**

Questions for the focus groups were largely adapted from the Oklahoma State Department of Health (OSDH) Commissioner’s Action Team on the Reduction of Infant Mortality’s (2011) report, “Oklahoma Preconception and Pregnancy Health Focus Groups Summary Report and Recommendations.” Once the facilitators’ guide, demographic survey, and consent forms had been developed, the demographic survey and consent forms were translated into Spanish and Vietnamese for participants in those focus groups. After translation, all materials were then submitted to The University of Southern Mississippi’s Institutional Review Board for approval.

Prior to facilitation of the focus groups, a focus group training was held for potential co-facilitators and notetakers in Gulfport, Mississippi. The day long training consisted of an overview of qualitative methods and focus groups, preparing moderator and notetaker introductions, and practicing facilitation of focus group questions. The training was conducted by Susan Mayfield-Johnson, PhD, MCHES, Assistant Professor of Public Health, and Director, Center for Sustainable Health Outreach. Dr. Mayfield-Johnson has facilitated multiple trainings on various qualitative methods, focus group designs, program planning and evaluation for multiple audiences. She has had formal training on the focus group methodology from Dr. Richard Krueger, as well as health disparities translation from the National Institutes on Minority
Health and Health Disparities. Formative evaluations noted participants’ demonstration of facilitation of focus groups and comfortability with the methodology.

Participants were recruited through flyers, social media, and key informant contacts at various locations across the Mississippi Gulf Coast. Participants were given a $25 gift card as an incentive to attend and participate in the focus groups. Light refreshments were also served. For the Spanish-speaking focus group, child care was also provided at the Moore Center Early Head Start Center by licensed Head Start teachers.

In Jackson County, focus groups were held at the Jackson County Civic Action Committee, Inc., in Moss Point, Mississippi on November 4, 2015 with 24 African American and 5 Caucasian participants. In Harrison County, focus groups were held at The University of Southern Mississippi Gulf Coast Campus in Long Beach, Mississippi on October 30, 2015 with 5 African American and 9 Caucasian participants. Spanish-speaking women in Jackson, Harrison, and Hancock counties were invited to participate in a focus group held at Moore Community House Inc., in Biloxi, Mississippi. Six women participated in the focus group that was conducted in Spanish. Vietnamese women in Jackson, Harrison, and Hancock counties were invited to participate in a focus group held at the Biloxi Public Library in Biloxi, Mississippi. Nine women participated in the focus group.

Each participant completed a consent form (See Appendix A) prior to any focus group discussions. Demographic surveys were also disseminated at the beginning of the focus group. Because the consent form stated that all participation was voluntary, most respondents completed the demographic survey (See Appendix B) noting age, county of residence, income, insurance status, and marital status. A needs assessment question noting highest priority health condition was also included.
Each focus group had a primary facilitator and a notetaker present for the discussion. Dr. Mayfield-Johnson also attended the Spanish and Vietnamese focus groups as a non-participant observer. All focus groups utilized a moderator’s question guide (See Appendix C), and were audiotaped for transcription. All personal identifiers were removed during the transcription process. The Spanish focus group was facilitated in Spanish, transcribed in Spanish, and then translated into English. While the focus group for the Vietnamese population was prepared to be facilitated in Vietnamese, the participants were largely second-generation Vietnamese citizens who were primarily English-speaking due to the age criteria for inclusion. All transcript, field notes, and participatory activities conducted during the focus groups were coded and organized into broad conceptual themes utilizing standard qualitative research procedures (Miles & Huberman, 1994; Strauss & Corbin, 1990).

**Demographic Survey Descriptions**

*Participants*

From the survey, information was gathered about the composition of the focus group participants in terms of age, racial identity, educational level, household income, and insurance status. The majority of the participants were African American (50%) women. Other race/ethnicities listed were Caucasian (25%), Hispanic (9%), and Vietnamese (16%). Almost 13% of the participants were 18-23, 32% were 24-28, 14% were between the ages of 29-33, 27% were 34-38, and 11% were 39-44. Less than 4% of the participants were above the age of 45. Approximately 27% of the women in the focus groups had attended college, and 27% had completed college. Almost 20% had earned a community college degree. Women who were married and never married reported at almost 36%. Women who were living with a partner
(12%), separated or divorced (14%), and widowed (2%) were also included. Although focus group participants employment status was primarily part time (25%) or full-time (37%), total household income reported was less than $15,000 (20%), $15,000 – $29,999 (25%), $30,000 – $35,000 (18%), and $35,000 – $50,000 (9%). Surprisingly, even with the Affordable Care Act, women reported no insurance (29%), employer-based (27%), someone else’s insurance (18%), ACA (4%), and Medicaid (21%). See Table 1 for a complete listing.

<table>
<thead>
<tr>
<th>Table 1: Characteristics of Participants (n=56)</th>
<th>n</th>
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<tr>
<td>Race</td>
<td>n</td>
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<td>Caucasian</td>
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<tr>
<td>Vietnamese</td>
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<tr>
<td>Age</td>
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<tr>
<td>Living with partner</td>
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<td>12.50%</td>
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<tr>
<td>Separated or divorced</td>
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<td>Never Married</td>
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<tr>
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<td>Table 1: Characteristics of Participants (n=56)</td>
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<td>%</td>
</tr>
<tr>
<td>---------------------------------------------</td>
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</tr>
<tr>
<td><strong>County of Residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harrison</td>
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<tr>
<td>Jackson</td>
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<td><strong>Employment Status</strong></td>
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<td>Full time</td>
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<tr>
<td>Homemaker</td>
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<tr>
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<td>Temporarily unemployed</td>
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<td><strong>Yearly Household Income</strong></td>
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<td>&lt;15k</td>
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<td>19.64%</td>
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<tr>
<td>15k-29,999</td>
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<td>25.00%</td>
</tr>
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<td>29k-34,999</td>
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<td>17.86%</td>
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<tr>
<td>35k-49,999</td>
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</tr>
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<td>50k-64,999</td>
<td>7</td>
<td>12.50%</td>
</tr>
<tr>
<td>65k-79,999</td>
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<td>10.71%</td>
</tr>
<tr>
<td>80,000+</td>
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</tr>
<tr>
<td><strong>Health Insurance Status</strong></td>
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<tr>
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<tr>
<td>Employer</td>
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<td>26.79%</td>
</tr>
<tr>
<td>Someone else's employer</td>
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<td>17.86%</td>
</tr>
<tr>
<td>ACA</td>
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<td>3.57%</td>
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<tr>
<td>Medicare</td>
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</tr>
<tr>
<td>Medicaid</td>
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<td>21.43%</td>
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</tbody>
</table>
When asked to list their primary health concern, the top four health concerns were cancer (25%), insurance costs (15%), obesity (15%), and prevention/access to health care (15%). See Table 2 for complete listing.

<table>
<thead>
<tr>
<th>Table 2: Leading Health Concerns of Participants (n=48)</th>
<th>n</th>
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</thead>
<tbody>
<tr>
<td><strong>Most Important Health Issue:</strong></td>
<td></td>
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<tr>
<td>Cancer</td>
<td>14</td>
<td>29.17%</td>
</tr>
<tr>
<td>Insurance Costs</td>
<td>7</td>
<td>14.58%</td>
</tr>
<tr>
<td>Obesity</td>
<td>7</td>
<td>14.58%</td>
</tr>
<tr>
<td>Prevention/Access to Health Care</td>
<td>7</td>
<td>14.58%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4</td>
<td>8.33%</td>
</tr>
<tr>
<td>Health Education</td>
<td>2</td>
<td>4.17%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2</td>
<td>4.17%</td>
</tr>
<tr>
<td>Birth Control</td>
<td>1</td>
<td>2.08%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>1</td>
<td>2.08%</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>1</td>
<td>2.08%</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>1</td>
<td>2.08%</td>
</tr>
<tr>
<td>Infertility</td>
<td>1</td>
<td>2.08%</td>
</tr>
</tbody>
</table>

Summary of Topics and Findings

*Health and Preventative Health*

When asked about health and what makes a woman healthy, most of the participants offered similar answers focused on the various dimensions of health. At first, most of the dialogue focused on matters related to physical health (diet and exercise), but continued discussions led to perspectives that concentrated on the social, emotional, mental, and spiritual health needs of women. The stressful lives that many women lead and the social support from their friends and families were components that were of importance to the respondents. Mental
and emotional health was also strongly discussed as it was a concern for many of the participants.

Most of the groups acknowledged that regular preventative exams were essential to optimal preventive health, but many discussed that they were often placed towards the bottom of their priorities. Attention was directed towards care of their children. For example, a participant in the Jackson County focus group said, “As a woman we have a lot of things going on … especially like our kids. And we tend to put ourselves on the back burner.” Another stated she “puts everything about herself to the back to make sure the child, the husband, the elderly parents or whatever are taken care of before her.” A Vietnamese focus group participant confirmed, “Well, being a mother, you kind of worry about the family first and then you kind of forget about yourself. Ummm… waking up at 5 in the morning, taking the kids to school, going home, making dinner for your family. So, sometimes, you’re always the last person you think about.”

Pap smears, mammograms, dental, vision, and prenatal care were some of the preventative services mentioned by focus group participants that should be included in regular care. However, the majority of the respondents noted that they did not seek these services as recommended unless attention was highlighted to a friend or family member who was experiencing significant problems or had a disease. One person noted,

I feel like the only time we really think about our health is when we start talking to other people … like you hear about something and you’re like, “what about me?” And that’s the only time you think about yourself. When you hear … she’s going through breast cancer … or she’s going through treatment. And you’re like, when’s the last time I got checked, like a pap smear. So, like you say, most of the time we don’t think about ourselves when we’re worried about everyone else. When we hear a horror story about someone close to us, then we worry
about ourselves.

The only exception was vision-related exams. Vision affects daily activities, and is an immediate need that needs to be remedied. Participants noted getting glasses or contacts as needed. There was no discussion of wellness visits or general physicals as preventative care.

*Barriers to Care*

Barriers to care and preventative self-care were numerous for the focus group participants across all of the counties. Those cited included costs (lack of insurance, money for copays, costs for appointments, costs for medicines), inability to get an appointment, time spent at the clinic waiting for care, transportation, and fear. The Vietnamese and Spanish-speaking focus group participants also cited issues with culture, racism/discrimination, issues with language/translation services, and lack of respect. The following are examples from various focus group participants relating issues with lack of insurance, money for copays, or costs for appointments.

The cost…You can’t pay for it. How the heck are you supposed to pay for a doctor’s visit without insurance?

Well, back when I had health insurance I used to get the pap exam but that was it. I didn’t see a regular doctor … Yeah, I just recently left my job that had full benefits and now I don’t have insurance so…

The money it costs to take him to the doctor to get him medicine … for asthma … on top of being pregnant. You know trying to maintain all of that … is a lot … I can barely afford half of my medicine now. And when I don’t have it … it can’t help. It’s a greater risk factor when it comes to being a family … maintaining a family, my health is … I’ll put it by the wayside until I absolutely having to handle me … I make myself separate cause right now I have to put myself in a priority for the kid. But, it’s about time … you can afford a doctor … or this or that and go to a free clinic. And then turn around and go get meds and it costs
you … and you’re low income and it costs like $300 a month… and that’s a preventative. It’s not even a third of the medicine I should be on.

Yes, because XXX clinic… I went there and was told that I can pay one hundred fifty for the appointment today but they’re going to send me an e-mail and I say no man! Better go to another place because it was going to be… four hundred and something…

I haven’t either and I know this is … y’all probably don’t want to hear this … but I need to go. But I don’t have no insurance and $300 … to get somebody to look at your stuff … that’s kind of a lot. But every single time me and my husband do it, I bleed. I’ve Googled it and it says I either have Chlamydia or cervical cancer. And seriously, I don’t have Chlamydia … obviously I don’t have that. So it kind of worries me sometimes, you know? I put it out of my mind and I don’t think about it till after …

A case in point offered a look at the inabilities to get appointment by a respondent. She said,

“The teeth, as it is I been having problems with my teeth for three months, I have gone to the check up for the cleaning and they don’t do anything to one…I went with a tooth ache to the health department…no, no to the XXX Clinic and they couldn’t see me. They gave me an appointment not until November 18. I had to send for a medication to my country for the infection because they couldn’t give an antibiotic.”

Another issue is time spent waiting to receive care for several of the women who participated in the focus groups. Some of the instances noted were,

“Yes because … also in the hospital because I took a lady and poor her, I left her since I think it was around 8 in the morning, and she still wasn’t out and it was 2 in the afternoon. Only because she didn’t know how to speak English. And they told her they would have someone there so I went to my class…and poor lady, there she was sitting waiting and waiting.”
You don’t have the time. If you’re taking off from work, you won’t make the money to even pay for the insurance, so … it’s long. You sit in the office room … the front room for an hour. You go in and wait for the doctor another hour and then you do testing … you can just go home and give her over-the-counter medicine. Really?"

Transportation was an issue that often affects women of underserved populations.

Examples related to transportation included,

I’ve got a lot in my family … in the Head-Start program … that transportation is extremely important. Can’t get to the doctor. And now it’s mostly just the kids that are eligible for Medicaid so … you know, parents are uninsured. And even with that Obamacare, a lot of parents can’t afford that either.

We’re so country here. We don’t have the city buses …

… This transportation. That’s something else I don’t understand about home. It’s so many people without transportation or they ride bikes, yet we don’t have a public transportation system … like a bus. So people could … get to where they need to go. Now, I know there is transportation but you may have to be on Medicaid to get to your doctor’s appointment. So, once again, the great state of MS decided not to expand Medicaid for some reason. You can’t take care of your children. So, how are the children going to be taken care of if the parents aren’t?

I mean when you go to a doctor’s appointment … you usually have to go to the doctor’s appointment. If you don’t have a ride … you’ve got to pull those strings to make everything else happen …

Additionally, fear was also cited as a barrier to care. One participant said, “Sometimes they’re scared of what they might find out …” or “scared of the results.” Another respondent remarked “Some people are just afraid of what they may find out about themselves. They start talking about their family history and they don’t want to have to walk that road … so and so had …”
For women who participated in the Vietnamese and Spanish-Speaking focus groups, there were also other obstacles that prevented access to care. Culture was quoted as a possible specific barriers to care for Vietnamese focus group participants.

It’s just culture … that’s it, basically.

We don’t like to go to the doctor …

We don’t go to doctors … we’re not like how other Americans are like where you have to have your shots, this and that. Even with our parents … coming over here from a different country. They didn’t know anything about it until you get sick and you get to the doctor and there’s routines and steps that you need to take. You can’t just go to the doctor … you have to go to a specialist before you … you know, there’s just steps and requirements that sometimes parents or the older generation doesn’t know. And, for example, like my dad … he doesn’t really. He’s a shrimper on the boat. He gets his checkup here and there but … when he gets sick he goes and gets his checkup. So, he had some pain and by the time he went to get a checkup he was already terminal cancer … lung cancer and had six months to live. But with him, he didn’t know. He was feeling healthy … he works on a boat. He has strength, so he didn’t know until it was too late … that kind of thing.

I don’t go until I’m bleeding.

I remember growing up where, if we get sick, I mean you don’t miss a day of school unless you can’t physically get out of bed. And even then, your parent would just prop you up against the bed and just rub the heck out of you. So, unless it’s a physical symptom … literally like you can’t get out of bed, there’s no reason for you to go to a doctor. You’d have to be … like … dead to go to a doctor.

I was at the club and I cut my hand with a beer bottle and it was dripping blood and then I bumped into her (fellow participant) and she pulled me to the restroom
and nursed it and … my boyfriend was like you need to go to the hospital. I waited … a day and a half … or two … to go. And they almost didn’t take me because within a couple of hours, you know … they can’t stitch it up anymore.

Racism and discrimination are issues often faced by individuals that have come from other countries into the United States or those that come from certain racial and ethnic backgrounds that are not necessarily indigenous to the area.

Yes, I say yes, because in the Health Department of XXX when my child, my second child… no the first one sorry, was little, the interpreter that she mentioned, XXX, caused a huge commotion in the health department. She even told me she was going to get immigration to come get me, since I am Hispanic. She thought I didn’t have papers and that she was going to get immigration to come get me, and she threw my child’s entire record on the floor…

… because she threw the little boy’s record on the floor and she told me that she was going to kick me out because the immigrants come to take the daily bread out of the mouth of American Citizens.

So, let’s say we both go to the ER and she has Blue Cross Blue Shield and I have Medicaid but we both have the same symptoms … she would get all this work up done. She would get like a CT and all this and that and all I would get would be a urine analysis and that’s end … and they give you a prescription and you just go home.

Along with racism, lack of respect can be noted among some participants.

There is a lack of respect when it comes to Latino Patients

They don’t think you know anything. They assume you you’re a different culture and that don’t know things … especially me working at the doctor’s office, the older generation the doctor’s treat you like you’re a kid. And sometimes the older generation, they have … they’re sensitive … I’m your patient … I’m paying for it … you come over here and talk to me respectfully. I’m not stupid …
Finally, issues with translation or translation services were issues. One individual provided this example. “… It was a language barrier. I can’t go to the doctor and say what’s wrong with me. Even if I can convey what’s wrong with me, I don’t know what they’re saying. And then, so, if they don’t have kids or the kids aren’t available … they just sleep it off and hope it goes away.”

Health Information and Advice

Respondents reported the following as sources of health information and advice in the demographic survey.

<table>
<thead>
<tr>
<th>Table 3: Source from which Participant Seeks Health Information (n=56)</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care provider</td>
<td>37</td>
<td>66.07%</td>
</tr>
<tr>
<td>Internet</td>
<td>36</td>
<td>64.29%</td>
</tr>
<tr>
<td>Family</td>
<td>24</td>
<td>42.86%</td>
</tr>
<tr>
<td>Friends</td>
<td>21</td>
<td>37.50%</td>
</tr>
<tr>
<td>Magazines</td>
<td>13</td>
<td>23.21%</td>
</tr>
<tr>
<td>Television</td>
<td>11</td>
<td>19.64%</td>
</tr>
<tr>
<td>Library</td>
<td>9</td>
<td>16.07%</td>
</tr>
<tr>
<td>Radio</td>
<td>6</td>
<td>10.71%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.79%</td>
</tr>
</tbody>
</table>

In the focus group discussions, most of the focus group participants cited technology as the primary source from where they get their health information and advice. The Internet (WebMD) was a primary source with the search engine, Google, documented as a secondary source. No participant mentioned any governmental agency websites, like the Centers for Disease Control and Prevention or the Mississippi Department of Health. Social media was also listed a source for several focus group participants. Once person mentioned, “Social media a lot. I use
Facebook a lot … I’m saying a lot of folks will be like … such and such is sick with a snotty nose and whatever and everybody comments in …”

Other sources of information included television, physicians, family members, and friends, especially if they were a nurse or worked in the health care industry. Interestingly, one person commented, “If it’s a health issue I don’t know about, of course I’m going to go to the doctor. But afterwards, I may just go to WebMD and see about the recent cases … issues along with that.” This remark notes the importance of the Internet to the focus group participants for data and clarification of information.

Most of the participants commented that they do not rely on their boyfriends, spouses, or significant others for information or advice. If there was an issue that was contentious and concerned her child, the mother would make the ultimate decision. Several participants also stated that the boyfriends, spouses, or significant other deferred to their decisions about their children.

**Health Care Services**

On the demographic survey, most of the focus group participants listed that they receive health care at a local health clinic (32%), doctor’s office (66%), and emergency room (21%). See Table 4 for complete listing. In contrast, in focus group discussions, most women reported that they received their health care from either a federally qualified health center (FQHCs) like Coastal Family Health Clinic, Urgent care centers, the Health Department (for gynecologic and obstetrics), and the Emergency Room. While some participants noted they saw a family care physician, it appeared to be associated with full-time employment and insurance status. A few women noted relationships with their OBY/GYN, and treated the individual as a family care
physician. Two respondent noted that they sought health care services at the VA Clinic. Participants agreed that women should go to the doctor to seek preventative care and routine services (like pap smears, physicals, immunizations, mammograms, oral health, and mental health care), however, they did not agree on the frequency or the severity of the visit. They also did not personally practice preventative care. One participant exclaimed, “And I’m saying you need to take care of yourself, but here I am, not doing it.” Overwhelmingly, they did seek preventative care services for their children, and noted time, insurance status, costs, and language/cultural issues for the lack of frequency (noted in previous section) for self-care. Participants sought care “when you’re hurting,” “When it’s really bad …,” or there is “pain.” One respondent said, “People wait until something’s wrong instead of going before … they wait until something is wrong with them.”

<table>
<thead>
<tr>
<th>Table 4: Place Participant Accesses Primary Care (n=56)</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local health clinic</td>
<td>18</td>
<td>32.14%</td>
</tr>
<tr>
<td>Doctor’s office</td>
<td>37</td>
<td>66.07%</td>
</tr>
<tr>
<td>Emergency room</td>
<td>12</td>
<td>21.43%</td>
</tr>
<tr>
<td>Hospital</td>
<td>9</td>
<td>16.07%</td>
</tr>
<tr>
<td>Veteran’s center</td>
<td>4</td>
<td>7.14%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>3.57%</td>
</tr>
</tbody>
</table>

Most respondents agreed they understood what their providers’ instructions were, and if they did not understand, they would ask for clarification. A few would go home and look it up on the internet through WebMD or Google to get more or specific information. Predominantly, most of the women in the focus groups indicated they were comfortable asking questions during their visits.
Positive Health Care Experiences

Personal experiences and experiencing care and compassion from providers contributed to positive encounters focus group participants had with health professionals. The following vignettes illustrate the type of hands-on care and attention these women associated with optimism and not typical routine interactions:

Well, I … uh … when I found out I was pregnant … I think I was like four months … and I … she had become a really good friend no matter what time of day … she was just the kind of doctor that she would give you her phone number … you didn’t get her pager number … she actually gave you her cell phone number. And back when she was first here is when people still had house phones … so, she would give you both her house phone and her cell phone and she didn’t care … she didn’t tell you, “call my office.” She would give you that …

…she’s just a very personable doctor. The first time I met her, she hugged me.

Like … my doctor…I really love Dr. XXXXX. He makes everyone comfortable … you feel like you can open up. He don’t look at me crazy and stuff like that. You know … he treats all his patients the same.

Something did occur to me … this is a very old memory of a positive experience. And I had to like dig way deep for this … But I do remember she was a young doctor … maybe that made a difference, but, ummm … in my early twenties I had a mole, right? And you go have it looked at and so it turned out its benign and everything but it had to be removed … right? And she was a young woman and she was Latina I think. And she was fresh out of medical school practically and she was like … she asked me a question, which I though was really effective that I never heard another doctor ask me. You know how at the end most doctors ask “do you have any questions for me?” And I usually blink because I don’t … it’s a weird way to put you on the spot though it’s a logical thing to ask … do you have any questions for me. But what she asked me was “what do you know about his?” And uh … I was like well … I heard that moles like are sometimes are
skin-cancer related. If you remove it I might scar a little bit … but it depends on the size. And I think I rattled off a few things and based on what I knew she was able to correct me and then steer me in the right place. She said actually this is what’s going to happen. In your case it wouldn’t be skin cancer … In your case is would be this … She started where I was and then she gave me feedback based on that. I thought that was one of the best experiences. But it was a young doctor, it happened years ago, and it hasn’t happened since.

Negative Health Care Experiences

Overwhelmingly, focus group participants described issues of customer service, not being treated courteously, experiencing feelings of inadequate care and compassion from providers, and feeling like the doctor or provider was just there for the money as contributing factors associated with negative health care experiences. Some comments include:

It’s like what we were talking about … if you don’t have health insurance or if you have Medicaid … they’ll treat you different.

Yeah, you’ll go in there and they’ll treat you like trash … And it makes you not want to come back.

It makes you uncomfortable and they’re not going to do what they’d do if you had like … Blue Cross Blue Shield … they’re not going to give you that same treatment and same tests. And they’re going to try to rush you up out of there.

I think … with Medicaid … if you don’t make a certain income and you do need help … they look at it like you want something free … like they don’t want to work. But you don’t know what folks are going through … and like … but I can tell you … you’ve got to treat everybody the same. How you going to say be in healthcare and you want to help people but you not willing to help … or understanding or empathetic … I mean, how are you in this field?
… And if you’re not being listened to. Because sometimes … you know your body. You know what’s wrong … or you know that there’s something that not’s actually right and when you don’t have people who are actually listening to you, you trust yourself …

Other than just the typical waiting forever and seeing the doctor for less than five minutes … it just makes you feel like why bother. Know what I mean? I’m saying … it’s just easier to be a researcher and self-treat. Just … you know, I guess when you go to the doctor you have your hopes up and you just … just make it better. Like you’re a child and they don’t. So why waste my time.

Cause ultimately, it’s a business … they’re making money. The bottom line is for them. We’re not people … we’re money to them. So, it makes sense that they would prioritize us. Because the quicker they take care of you and if you have better insurance, the quicker they get paid. So of course they would take care of those people first versus the people with Medicaid … because that’s government and they take forever to do everything. So …

Reductions in long wait times both for appointments and at the health care facilities, customer service, and cost were the most mentioned aspects that would improve their experiences with health care professionals.

**Pregnancy and Reproductive Health**

While not a specific eligibility requirement to participate in the focus group, almost all the women who participated in the focus groups were either pregnant or were mothers. This is noted from respondents’ introductory statements and discussions about their children in focus group discussions. No questions noted on the demographic survey specifically examined child-bearing status. Perhaps the statement “childbearing aged women, 18-44 years of age” posted on flyers and utilized through key informants was
interpreted to be associated with pregnancy and childbirth. However, when asked to
define a healthy pregnancy and list factors related to healthy pregnancies, the most
common answer was related to full term (9 months) births. Other common elements
were related to prenatal care, healthy diet and exercise, taking vitamins, and checkups.
Other responses subsequently did include refraining from alcohol and smoking, reducing
stress, breastfeeding, and increasing folic acid. Factors that contributed to keeping
women from getting prenatal care included lack of insurance, transportation, lack of
social support, and hassles linked to appointments. One participant shared, “The hassle
of having to go to the doctor … waiting … and only seeing the doctor for like five
minutes … to have him tell you … ok, you’re good. Come back next month.”

**Healthy Baby Messages**

Sources of information on how to care for a baby are often obtained from a woman’s mother,
grandmother, aunt, or sister. The shared experience of having a child seems to qualify an
individual for advice. Also, fathers were discussed as a source of information for many of the
focus group participants. They also listed the WIC department, books, parenting classes,
television, pediatricians, their child’s schools (Head Start centers), and the Internet. One
participant noted a pregnancy app for her smartphone. She said, “My phone app. You know,
this pregnancy phone app … it’s got everything. You check it every day, and it tells you
something …”

Most of the respondents who participated in the focus groups did not breastfeed.
One participant discussed how breastfeeding might be associated with one’s environment
and level affluence.
But the environment I was in … I was living in New Orleans and I was surrounded by like, up-town mothers … they’re the ones with their $500 strollers and their ponytails … and like, you know, running around Audubon Park. And they are very, very insistent on breastfeeding.

However, one participant also noted, “… and some people don’t have money to buy formula or they can’t … or they don’t have the transportation to go get WIC or something … that’s more for lower income … so they breastfeed because …” The exception were women who were in the Spanish-speaking focus group. All of those participants breastfed their children. Some problems experienced by mothers included pain, milk drying up, and troubleshooting how to breastfeed (it’s supposed to be natural). Some issues connected to one’s choice to breastfeed include having full-time employment, lactation support, a room or environment to support pumping on-the-job, other children and childcare support, and if the individual was breastfed as an infant.

Almost all participants could identify infant safe sleep with the “back to sleep.” Others listed laying babies on their back, no blankets, no pillows, no stuffed animals, and not sleeping with parent(s). However, there were conflicting messages and understanding among participants in some of the focus groups. For example, one participant stated, “Babies are smart…they’re not gonna...if they can’t breathe, they're gonna find a way to breathe. They have a brain in their head.” Another mothers asked about a baby choking on spit-up during the night if he or she was placed to sleep on their back.

In four of the six focus groups, respondents knew someone personally that had a child that had died before its first birth. In all scenarios, respondents discussed the tragedy of the situation and attributed the death to Sudden Infant Death Syndrome (SIDS). Focus group
participants were reluctant to assess what factors contributed to the death, but some that were named were accidents and issues related to the crib. She stated,

The crib. What’s the bed made out of … what that crib is made out of. This is one right here … she’s 35. I never used a crib … I’d pull a drawer … one drawer out of my dresser and that’s how … Both my kids … and now the oldest one is 44. That crib don’t do it. It’s the material. It’s the plastic they use. It’s the chemicals, you know … when like you say … you can lay that baby … but if that baby’s got enough stiff in its body to turn inside your womb, that baby can turn itself over. Not from the stomach … lay them flat. That baby can push himself up but it sure can turn himself over.

All reported support and sympathy from the community for the families. However, many focus group participants did not feel that infant mortality was a serious issue in their communities. One person asserted, “Some people … unless it directly affects them … they’re not going to worry about it. If it’s not their child, they’re not … they may feel sorry for you but…”

**Prevention of Infant Mortality**

Respondents itemized many ways to prevent infant mortality that are consistent with the literature. Stop smoking, stop drinking, safe sleep practices, and breastfeeding were some of the most discussed topics. Several of the participants conversed that additional program were needed on infant mortality. However, participants hinted that the current education on infant mortality is didactic and boring. More educational sessions that include group discussions, personal testimonies, participatory activities, technology, and demonstrations would be desired. In fact, a few of the women called the focus group an educational program and stated that more of these types of programs should be conducted.
Another suggestion was to have an awareness program that concentrated on how to spend quality time with your children as a means to address infant mortality. Media campaigns with billboards, social media (Facebook for mature populations, twitter and Instagram for younger populations), and television should be utilized. One person, however, articulated that there are sufficient resources available. She indicated that there should be more of a focus on how and where to access these resources.

I think we just need more advertisement on where and how do we get this education ... I think now, today, people are more concerned and if we knew how to get the information and where, we’d attend more classes. But, you know, lack of knowledge, lack of information.

That’s a good idea. But I think we have to use all of these resources … we’re a technological society. Everybody’s on Twitter … they have little tags. You don’t have to have a whole page for it. Every once in a while … you’re scrolling … you see something that says something about parenting class. People generally stop … I stop to look at it. I actually belong to a parenting group on Facebook and Twitter.

Another area of conversation concentrated on parenting classes. One person noted, “I think it should be mandatory for everybody to take a parenting class when they’ve had a baby. Just cause.” However, some participants acknowledged what one mother said,

But I think that sometimes when you take a parenting class, a lot of people think, “don’t tell me how to raise my child … I know how raise my child.

… It’s like embarrassment … if I go here (parenting class), I’ve got to say I’m not doing something right and I need help.

Like we could have classes. You know how sometimes people are depressed after they have their children … like postpartum… you know, cause some people …
But … and people … you never know. Maybe they need classes or somebody to talk to them … you know, I felt this way too. They maybe they’ll feel like … ok, well, I’m not alone. When you’re motivated … people get … be able to figure out resources … tell them about different medications … so they go and help them.

The primary channels for disseminating information varies. Spanish speaking focus group participants recommended sharing through faith-based organizations, educational institutions like Head Start and day care centers, and through trusted community Spanish speaking individuals (like a promotora). African American and Caucasian focus group women recommended billboards, community educational programs, faith-based institutions, higher educational institutions (like USM), television, and social media. For the Vietnamese populations, three primary methods (social media, church bulletins, and the Vietnamese channel) are best since the Vietnamese population is a closed community to outsiders. One respondent explained,

Well, it just depends. I mean … obviously, with this generation … the best way is Facebook. And that’s because everything is accessible … everything is shared … everything is convenient. You connect to … it’s on your time. You do it whenever you are ready. But for people of an older generation like our parents, aunts and uncles … it depends if you’re Christian-based. Because if you’re Christian-based a weekly bulletin … just get one of those ads out and that’s a message shared. Those old people love those bulletins … they would die without it. I mean, they get angry when we run out. It depends on who you are trying to reach. Now, I don’t know about non-Christians … how you reach them. But I know that the Christian-based … the weekly bulletin at church … that’s your bridge to get the information out.
Oh … the Vietnamese channel. Everything that goes on the Vietnamese channel…

Finally culture and mental health was a topic of dialog for the women in the focus groups. In African American, Vietnamese, and Spanish populations, needing mental health is a taboo. There are many mothers, some who may have postpartum depression, depression, bipolar disorders, anger management issues, victims of violence, etc. that could benefit from a mental health counselor or medication, but culture and embarrassment about the mental health problem keep the mother from seeking treatment and counseling.

Even if we did … it’s not really talked about because of our culture. We keep everything quiet. You know, we’re not going to spread it throughout the whole community … so sometimes you might not know things like that.

Culturally, we’ve been told that depression and all this stuff … all we need to do is take it to the Lord. Culturally, I can’t tell anybody I’m depressed. Because if I’m depressed, I’m weak, and you need to take it to the Lord, and apparently you must not be praying. Get your Bible out and you need to go to church more. But mental illness is a big deal and in our culture we can’t talk about it. So if I am a little mental, I might be on medicine, I can’t tell anybody that.

It’s just the way it is. Because we were taught … most of us were brought up in a Baptist situation where you go to church and you ask God to heal you from whatever you’re going through and it’s supposed to just happen. But what people fail to realize, mental illnesses sometimes it’s not about … you can be spiritual, but sometimes it’s a chemical imbalance. Just point blank. You need some help. I don’t care how much you pray. How much you exercise. How much you … whatever … Something is wrong with you. And it ain’t your fault. You know what I mean. You need to go and seek help and our people don’t understand that

I think mental health … regardless if its women, men, or a child. I think it’s a huge issue … not just only for our culture … I think it’s bigger in our culture.
Our parents didn’t believe in these issues. They figure that either they’re either crazy or they’re not. Period. There’s a reason why they’re crazy … and we know that. Education is the difference … we know there’s a reason they’re like that … a hormonal imbalance …

There is a huge stigma about mental health in the Vietnamese community and that is nationwide … international … big stigma against mental health.

**Implications and Lessons Learned**

Several important themes resonate throughout the six focus group discussions with women along the Mississippi Gulf Coast. While access to health care is available, some women do not take advantage of the services. Reasons may include knowledge of available services, costs, time away from work, time spent getting care, feelings of disrespect, transportation, and fear. There was an overwhelming desire to be treated with respect and compassion, to not feel rushed, and feel that your insurance type/ability to pay is not related to level of care. Most women with negative health care experiences equated it back to a poor bedside manner, poor customer service from staff at the health care facility, and immigration status and discrimination. The women in the focus groups agreed that preventative care was imperative, but they did not practice what they preached. They would seek services and preventative screenings for their children, but delayed in taking personal care of themselves. The primary barrier to access was related to cost and health insurance status.

While there were not specific questions related to health disparities and health equity, there were perceived differences in the standards of care among women of differing races or ethnicities. Having a social security number is very important to access services (Medicaid) in the state of Mississippi. Cultural differences were noted, and feelings of discrimination and racism were provided in personal accounts with various sectors of health and human service
agencies. Translation is a significant contributor for some racial and ethnic groups as English may be a second language for many legal citizens in Mississippi.

Reproductive health messages included prenatal care, vitamins, and less stress when possible. The definition for a healthy pregnancy was unanimously mentioned to be a full-term pregnancy. Breastfeeding was noted to be extremely important in all of the focus groups except among the Vietnamese population. Most were second generation citizens and born here in the United States, and many were bottle fed. As a result of acculturation, they also bottle fed their children. They cited that their children were healthy, had less severe allergies and infections, and “they turned out fine.” Not all Vietnamese participants shared this view and noted environment (occupation and friend group) may have contributed to their decision to breastfeed. Other participants noted that they knew breastfeeding was natural and best for baby, but they did not practice breastfeeding. Time, lack of workplace privacy, and ease and comfort were reasons cited for not breastfeeding. Respondents also noted that Spanish speaking mothers’ breastfed exclusively, but noted it may be due to financial restraints. Others noted that WIC provided formula, and they did not need to breastfeed.

Healthy baby message included the safe sleep practice message on “baby on back,” however, not all participants practiced this measure regularly. A reason for mothers not wanting to put their babies to sleep on their backs is because they fear the babies could choke or suffocate if they burp and spit during sleep. Increasing folic acid consumption was sparingly mentioned, but it was not highly ranked on the scale for healthy baby messages. Many participants did know a child that had passed before his/her first birthday. While this was a sad circumstance, it was viewed as unpreventable or a SIDS related death. It is recommended that communications be developed to address these concerns. Remarkably, no Vietnamese or Spanish focus group
participant noted a child passing before his/her birthday in their community. Familial structure and extended family caretakers were mentioned as a possible resource and reason for this occurrence.

Pregnancy and reproductive health messages are getting to some of the participants, but some of the mediums for dissemination are not appropriately utilized. We have an increasing technological population, and recommendations for a social marketing campaign concentrated on healthy pregnancies and reducing infant mortality would prove successful. Educational program should consider rebranding some of the titles to reinforce positive efforts to improve health indicators. The parenting classes signify that mothers are lacking in their parenting skills and need assistance. Some possible suggestions included family resources or family leadership to garner interest and enhance an empowerment model. In addition, educational programs should focus more on inclusion and active participation of members in the education process. Didactic pedagogies are not successful with community members.

Overall, the interactions and discussions with the focus group participants were enlightening, interesting, and fun. Much insight was obtained from each focus group session. Much laughter, sharing, and points of view about women’s health and the various cultures along the Mississippi Gulf Coast were obtained that were not previously unknown. It is the hope of this report on Improving Women’s Health in District IX will serve to guide program development, social media campaigns, and improve outcome measures in infant mortality.
Appendix A

The University of Southern Mississippi
Improving Women’s Health in South Mississippi Focus Group

Why am I being asked to participate in this focus group?
- The purpose of the focus group is to learn about attitudes, beliefs and feelings about women’s health, including things women do to improve their health and the health of their families.
- We will also ask you to complete a demographic survey.
- This information will be used by the Department of Public Health at The University of Southern Mississippi and the Department of Health Disparity Elimination at the Mississippi State Department of Health to learn more about the relationship between women’s health and having a healthy baby and improve future public education campaigns.

What will I be asked to do?
- If you choose to participate, you will be asked to participate in a guided discussion (a focus group) that will take about 2 hours. We will also ask you to complete a 2 page demographic survey.
- We will ask you about your beliefs and feelings about women’s health and behaviors. Your ideas and opinions are important to us, so please just say what’s on your mind. There are no right or wrong answers to any of the questions we are asking.
- Some questions may be considered by you to be sensitive. If any questions make you uncomfortable, you can choose not to answer those questions. This is for both the focus group and the demographic survey.
- This focus group discussion will be audio taped, and then the tape will be transcribed (type the spoken words) and analyzed for trends, patterns, and themes. All names will be changed in the transcription, and all tapes will be destroyed once the transcription has been made.
- The demographic survey will be entered into a database with no identifying information. All surveys will be destroyed once they have been entered into the database.

What will I get out of participating in this project? Will I get paid?
- The project will give you a $25 gift card for participating in the focus group discussion and completing the survey.
- We will also provide light refreshments during the discussions.

Do I have to pay for anything to be involved in the focus group?
- You will not have to pay anything to be involved in focus group.
- The only cost to you is the time you allow to come to the focus group.

Are there any risks involved with participating in the focus group? Can I stop participating in the focus group whenever I want?
- There are no known risks expected as a result of participating in the focus group.
- You can stop participating in the focus group at any time during the process without penalty.

Will people know I participated in the focus group (Confidentiality statement)?
- If you agree to participate in this focus group, please understand that your participation is voluntary. All the information you provide will be kept confidential. The only exception is if you express the intent to harm yourself or others.
- This signed consent form and your name will be kept separate from the focus group information. You do not need to tell us your name, and you may use a fake name if you wish. While we will
audio-tape the focus groups, you may ask to stop the tape recording at any time. All tapes will be transcribed (typed up) without names or other identifying information to protect your confidentiality.

- Personal information obtained from surveys and focus groups will be stored in a locked file cabinet at the Department of Public Health at The University of Southern Mississippi. Only the research team will be able to see your responses, and they will be destroyed once the project is completed. The transcripts of the focus groups with no personal data and the entered data from the survey with no personal identifiers will be shared with the Department of Health Disparity Elimination at the Mississippi State Department of Health.

- Only group information, with no personal identifying information, will be presented at scientific meetings and published in journals.

- If you would like a summary of the findings from the focus groups, you can provide your name and contact information on a separate piece of paper. We will mail you a copy of the report, once the project is completed.

**What if I have questions about this study or my participation?**

- If you ever have any questions about this study, please contact the principal investigator, Susan Mayfield-Johnson, at (601) 266-6266.

- The project and this consent form have been reviewed by the Institutional Review Board, which ensures that research projects involving human subjects follow federal regulations. Any questions or concerns about rights as a research subject should be directed to the Director of Research and Sponsored Programs, The University of Southern Mississippi, 118 College Drive #5147, Hattiesburg, MS 39406, (601) 266-5997.

If you are interested in participating in the project, please read the following statement very carefully. Then, if you would still like to participate, please sign and date this form and return it to Susan. You may keep a copy of this form for yourself, in case you have any questions or concerns at a later date.

**Agreement statement:**

By signing this consent form, I agree to participate in this study.

__________________________  __________________________
Signature of the Research Subject                   Date

__________________________  __________________________
Signature of Person Explaining the Study          Date
Appendix B

Demographic Survey

Instructions: Please circle or write in the space provided the answer to the following questions. All information will be held in strict confidence and will only be reported grouped together with the information from other participants.

1. What is your age?
   a. 18-23 years old
   b. 24-28 years old
   c. 29-33 years old
   d. 34-38 years old
   e. 39-44 years old

2. How would you describe your current living situation?
   a. Married
   b. Living with a partner
   c. Separated or divorced
   d. Widowed
   e. Never been married

3. What county do you live in? _____________________

4. What is the highest level of education that you have attained?
   a. Never attended school
   b. Less than 6th grade
   c. 6th through 12th grade
   d. Completed high school or GED
   e. Some college
   f. Community College Graduate
   g. Completed college
   h. Graduate school

5. Which statement best describes your current working situation? (Circle only one)
   a. Not employed but looking for employment
   b. Working full-time
   c. Working part-time
   d. Working more than one job
   e. Retired
   f. Homemaker
   g. Disabled
   h. Temporarily unemployed
   i. Not employed and not looking for employment

6. How many people live in your household, including yourself? ________
7. Where do you go to get health care services? (Circle all that apply)
   a. Local health clinic
   b. Doctor’s office
   c. Emergency Room
   d. Hospital
   e. Veterans center
   f. Other ________________________________

8. What source(s) do you use to obtain health information? (Circle all that apply)
   a. Magazines
   b. TV
   c. Internet
   d. Library
   e. Radio
   f. Health care provider
   g. Friends
   h. Family
   i. Other, please specify ________________________________

10. What is the total household yearly income for all the people that live at your place?
    a. Less than $15,000
    b. $15,000 to $29,999
    c. $29,000 to $34,999
    d. $35,000 to $49,999
    e. $50,000 to $64,999
    f. $65,000 to $79,999
    g. $80,000 or more

11. Do you have health insurance?
    a. No
    b. Yes, your employer
    c. Yes, someone else’s employer
    d. Yes, ACA
    e. Yes, Medicare (elders and some people with disabilities)
    f. Yes, Medicaid
    g. Other, please specify ________________________________

12. What do you think is the most important women’s health issue facing people in your community today?
    ________________________________________________
Appendix C
Improving Women’s Health in South Mississippi
(90-120 minutes)

Sign-in
• Have each person sign-in and a name on her name tag and name tent.

Introduction, purpose of focus group, and ground rules (5 minutes)
• Let me begin by thanking you all for being here. My name is Susan Mayfield-Johnson (or other person), and I’ll be facilitating our discussion today. My partner, (note taker name) is here with us taking notes and keeping track of the time. We both work for either the Department of Public Health at The University of Southern Mississippi or the Department of Health Elimination at the Mississippi State Department of Health. We are working on an initiative to improve women’s health in South Mississippi. The purpose of the focus group is to learn about attitudes, beliefs and feelings about your health and how you would like to improve the health of women in South Mississippi.

Consent
• We would like for you to sign a consent form. This consent form states that your participation in this discussion is completely voluntary. It also talks about the purpose, the risks, the benefits, and who to contact if you want further information.
  I will go over the consent form now.

Demographic Survey
• Before we begin the discussion, I’d like to ask each of you to complete this demographic survey. I’ll review the survey now.

Introduction to the Focus Group Discussion and Rules
• We are here to learn from you. There are no right or wrong answers-just different points of view and experiences. Please say what is on your mind. You'll notice that we're taping our discussion. That's so we'll be sure to get all of your comments, but let me assure you that your name will not be used in any way. Also, once we've made a transcript of our discussion, the tape will be destroyed. So please feel free to say what's on your mind- both the positive and the negative. Of course, you may decline to answer any question at any time if they make you feel uncomfortable.

• [Establish with the group what the rules of discussion will be for the day – i.e. one at a time talking, cell phones on silent, etc. Brainstorm what these should be and place ground rules on flipchart. Explain the process as well as the roles of the facilitator and note-taker.]

• We want to be respectful of everyone’s time so I may need to stop discussion on one topic and move it to the parking lot. We can continue to discuss that topic at the end of the focus group. I have many topics to cover today, and I want to be sure that we discuss all of them. Does everyone agree that this is ok? Great! Let's begin!

Introduction of Participants (15 – 20 minutes)
• Opening- I’d like to go around the table and get each of you to introduce yourself. Please share something you like about your family, an activity that made you smile, or whatever you’re comfortable sharing. I’ll begin…
Discussion Questions (90 minutes)

1. Health
   • When I say “health or healthy,” what’s the first thing that comes to your mind?
     ➢ Describe what makes a person healthy.
     ➢ Describe what makes a woman healthy.
   • How much importance do you think women generally give to health? How important is your health?
     ➢ Give me an example of something you did that demonstrates the importance (or lack of) of health?

2. Preventative Health Behaviors – List on Flipchart
   • What kinds of things should women do to stay healthy?
     ➢ Probe for more than eat healthy and exercise [at certain times in a woman’s life, doctor’s visits, mammograms, pap’s, vaccinations, etc.]
   • What are some things that you know you should do to take of yourself or to be healthy, but you do not? [refer to flip chart list]
   • What are some of the barriers that keeps you from taking care of yourself?
     ➢ Ask for examples, stories
     ➢ Probe for external factors like access, transportation, lack of health insurance, money, etc.

Transition – To stay healthy, we get advice or learn new information. And we get this advice, suggestions, and information from a variety of sources. Let me ask you about that.

3. Health Information and Advice
   • Where do you get your information on health related subjects?
   • Who do you rely on for advice about your health or your family’s health?
     ➢ Probe for examples and specifics – doctor recommendations, magazines, television, web, news shows, talk shows, family and friends.
   • How do you make decisions about your health?

4. Family, Friends, and Relationships
   • How do your relationships with family members influence your decisions about your health?
     ➢ Probe for husbands/fathers of children/parents/kids, etc.
   • Can you tell me about an instance where you and either your husband, partner, or companion disagreed about how to handle getting health advice or services?
     ➢ Probe about relationships, abuse, domestic violence, etc.,

Transition – We’ve talked about what health means, and where you get your information, so what do you do with all of this information. Where do you go? I’d like to ask you next a few questions about that.

5. Preventative Healthcare Services - List on Flipchart
   • Where do you get your health care?
     ➢ Probe - Make a list on flipchart. Probes: community clinic, doctor’s office, family or friends, work, ER, etc.
   • What kind of health care services do you seek out? List on Flipchart
     ➢ Rank with dots.
   • What are some health care services that you know you should get but often do not? List on Flipchart
     ➢ Rank with dots.
• When do you go to the clinic/doctor?
• What makes you go to the clinic/doctor?
  ➢ Probe – check on well visits, physicals, annual visits
• What things prevent you from going to a doctor?
  ➢ Probe for money, transportation, fear, communication problems, lack of respect from
doctor, nurses, or staff, judgmental attitudes of doctor, nurses, or staff, family members,
domestic violence, etc.
  ➢ Some people say that relationships with health care staff and providers are really
important. Describe a positive experience with a health care professional (like a doctor,
nurse, lab technician, or health advisor).
  ➢ Tell me about a negative experience that stands out in your mind.
  ➢ If you could change something about your experiences with health care professionals,
what would it be?
  ➢ When you go to the doctor/clinic, do you feel comfortable asking questions?
  ➢ How well do you feel the understanding is between you and the doctor and/or nurse with
expectations and treatments?
    ▪ Could you give me an example? Tell me a little more about that.

Transition – We’ve talked quite a bit about general health. Let’s talk about some things that are specific
to women. I’m really interested in the messages we get about our reproductive health.

6. Pregnancy and Reproductive Health
• What is a healthy pregnancy? What does that mean?
• What kinds of things should a woman do before getting pregnant to have a healthy pregnancy?
  Make a list on flipchart.
    ➢ Probe for knowledge of folic acid, stopping smoking, drinking.
• What are some things women should do while pregnant to stay healthy?
• What kinds of things kept you from getting prenatal care as early as you wanted?
  ➢ Probe for external and internal factors, money, transportation, motivation
• For those of you who have had children, what are some things that you wished you had done
differently?

Transition – I know I wish I knew what I know now! It would have really helped during my first
pregnancy. That brings me to our last series of questions. I’m very interested in learning about what
kinds of healthy baby messages you have been exposed to.

7. Healthy Baby Messages
• Where would you get information about how to care for a baby?
• What do you know about breastfeeding?
  ➢ Can someone give me an example of any issues she had with breastfeeding?
• What does the term “infant (baby) safe sleep” mean to you?
• Did you or someone you know have a baby that died before his/her first birthday?
  ➢ What do you think contributed to the baby’s death?
  ➢ How did friends/family/community respond after the baby died?
• What do you think are risk factors for an infant dying before his/her first birthday?
  ➢ Probe for age, nutrition, stress, etc.
• What are community members’ thoughts about infant mortality? What I mean is, do people see it
as a problem?
  ➢ Are they really concerned about it?
  ➢ What are people in your community concerned about?
• What are some ways that you know about to prevent infant mortality?
  ➢ Probe for tobacco cessation, folic acid, safe sleep, etc.,
• What are some things you would like to see in community education messages about infant mortality?
  ➢ How would you like community education messages to be shared?

Transition - Finally, we want to be sure that you have had an opportunity to share your concerns and thoughts about women and health. **What other concerns or issues that we have not discussed would you like to talk about at this time?**

**Closing (5 minutes)**
Thank you very much for sharing your thoughts with us today. The information that you have shared here today is invaluable. It will help us develop better community education campaigns to improve women’s health in South Mississippi.

**Materials Required**
• Flipchart and Easel
• Markers
• Index card and pens
• Colored dots
• Nametags and name tents
• Voice recorders
• Cassette tapes
References


