DADS MATTER: EXAMINING PATERNAL INVOLVEMENT AS A PREDICTIVE FACTOR IN HEALTHY BIRTH OUTCOMES IN AFRICAN AMERICAN FAMILIES

BY
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DISSERTATION
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Abstract

The purpose of this dissertation is to examine the role African American fathers’ play in healthy birth outcomes and explore the role of residential status on paternal involvement. The analyses are based on data from the Fragile Families and Child Well-being Study and focus groups with recent and expectant fathers from the Champaign-Urbana community in the state of Illinois. The overarching research hypothesis guiding this study is that African American involved fathers will increase healthy birth outcomes among their partners because they act as a buffer to maternal stress and unhealthy behaviors that influence adverse birth outcomes. This dissertation includes five chapters. Chapter 1 is the introduction where the research questions are introduced and a discussion of health disparities in African-Americans as well as terms used throughout the subsequent chapters. Chapter 2 is the literature review and introduction to the theoretical framework. This chapter details the existing literature that supports the principles of the theory and hones in on the specific levels utilized for the current study. Chapter 3 is the methods section. It includes three specific aims to better understand the significance of paternal involvement on healthy birth outcomes. The aims include: (1) explore the relationship between neighborhoods, perceptions and involvement (2) explore the role of quality of communication and involvement and (3) explore residential status [resident/non-resident] of African-American men and involvement using both the FFCWS and focus groups. Chapter 4 presents the findings and analysis of the aims. The findings confirm that paternal involvement can be characterized beyond birth certificate status. The findings provide implication for policy formation, interventions and development of prenatal programs that includes a comprehensive paternal component in order to fully characterize paternal involvement. These implications are discussed in Chapter 5 of this dissertation.
Dedicated to my loving grandmother Ms. Louvonzell Ann Thompson

Thanks for watching over me and I will continue to make you smile down on me.
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Chapter 1: Introduction

Statement of the Problem

Among high-income countries, the United States had the highest or near-highest prevalence of infant mortality, heart and lung disease, sexually transmitted infections, adolescent pregnancies, injuries, homicides, and disability (Woolf & Aron, 2013). The United States spends 17% of its gross domestic product (GDP) on health care expenditures, spending more on each individual per capita than most developed nations (CDC 2011). In the United States, infant mortality rates for African-Americans are more than twice that of other racial groups, although there has been an overall decline over the past 50 years (Milligan et al. 2002). The national infant mortality rate indicates that six children die for every 1,000 live births. The National Center for Health Statistics (2006), reported that the infant mortality rate among African-Americans was 2.4 times greater than that of the Whites. Today that rate is almost thrice that of the Whites; it is 13.63 compared to 5.76 (MacDorman & Matthews, 2011). These disparities continue to persist between African Americans and Whites despite the efforts of policy implementation of the Affordable Care Act and the goals of Healthy People 2020. Infant mortality rates are affected by an array of factors such as race, ethnicity, age and health. However, it is important to understand the social, cultural and economic influences that underlay this phenomenon with regards to the persisting disparities of African-Americans versus the Whites.

Place is a major determinant of health, resulting in a variation of health outcomes across populations, which is apparent in the racial residential segregation literature of adverse health and birth outcomes (G. R. Alexander, Wingate, Bader, & Kogan, 2008a; Collins & David, 2009;
Giscombe & Lobel, 2005; Hearst, Oakes, & Johnson, 2008; Paul, Mackley, Locke, Stefano, & Kroelinger, 2009). More specifically, research has associated one’s community or neighborhood as a cultural resource (Mendenhall et al., 2006; Pinderhughes et al., 2007; Leung & Takeuchi, 2011). However, for poverty stricken communities, place has been associated with compromising healthy behaviors and outcomes (Mendenhall et al., 2006; Pinderhughes et al., 2007; Leung & Takeuchi, 2011). Ethnic and racial minority families’ experiences have been found to be very different than their counterparts. In the social historical context, we have seen this enumerated throughout several texts and notable historical events. The socialization processes in ethnic enclaves differ by culture, generation, gender and ethnicity (Moore, 2008; Erdmans, 2002; Kibria, 2003; Patillo, 2008). Other factors to consider are the resiliency of many black families who from a social historical context have experienced institutional racism and discrimination for decades (Grady, 2006). African-Americans have been racially stratified to certain geographical areas and more prominently so in the housing markets as whites reacted negatively to the migration of African-Americans from the South to the North with fear and racism (Grady, 2006). More specifically, racially segregated communities primarily represent the African American community in large urban areas where infant mortality rates continue to exceed those of other ethnic and racial minority groups.

Neighborhood characteristics have been used in research as an indicator for resources (i.e. employment, networks, security, social capital, accessibility, economic mobility) and the ways in which these available resources interact with the racial composition of the community (Leung & Takeuchi, 2011; Mendenhall, Deluca & Duncan, 2006; Morenoff & Lynch, 2004). There is a large range of racial and ethnic differences in health outcomes across many causes of morbidity and mortality (Morenoff & Lynch, 2004). Infant mortality in particular garners wide
attention despite the efforts and advancement in medical technologies, improved screening
efforts, prevention campaigns, clinical care and treatment for other health conditions (Leung
& Takeuchi, 2011) to improve the overall quality of life for the nation. Racial inequities continue
to persist and multilevel research has begun to explore the underlying social, cultural, and
economic reasons that cannot be singularly characterized to the individuals themselves.

The community also serves as a unique space to provide increased support and social
connections necessary for preventative care as a proximal influence on the reduction of infant
mortality in African-American and urban communities and neighborhoods. Community health
approaches for systematic change to impact inequities in health disparities are a collaborative
effort. Research has illustrated that when needs are assessed and decided upon by the
stakeholders in an egalitarian manner, greater health outcomes have resulted (Griffith,
Neighbors, & Johnson, 2009; Richards et al., 2002; Sampson, 2001). More specifically,
preventive services that have incorporated faith based communities, school-based education and
non-profit collaborations with communities and universities for increasing physical activity,
reducing gun violence, reducing risky sexual behaviors, and other health outcomes. Results have
been documented by researchers that community level preventive services and efforts are
effective methods to increase and implement social behavioral changes (Batik, Phelan, Walwick,
Wang, & LoGerfo, 2008; Cowart et al., 2010; Griffith et al., 2009; MacDonald et al., 2011;
Richards et al., 2002; Sterk, Elifson, & Theall, 2007).

Infant mortality is a major concern for large urban areas in the United States because it is
an important indication of population health (Collins & David, 2009; Fiscella, 1996; Gortmaker
& Wise, 1997; Paul et al., 2009; Sims, Sims, & Bruce, 2007). In the United States, there has been
no improvement in reducing infant mortality leading to its significant increase in the last 20
years (Kassebaum et. al, 2014). In large urban areas there are documented disparities and most of the largest U.S. cities have infant mortality rates that exceed the national average (Sims, Sims, and Bruce, 2007). Considerable geographic, racial and ethnic disparities persist in behavioral and health outcomes particularly in preterm birth, low birth weight, and infant mortality, and research is needed to address the factors that maintain this health inequality (Sampson, 2001; Krager and Hogue, 2008; Sims, Sims and Bruce, 2007).

Social position influences an individual’s overall health (Adler, 2009). As with racially and economically segregated neighborhoods, these individuals have great difficulty in obtaining health resources and services. For example, dangers in communities affect parenting styles, mental health, and social mobility and impact the overall social well-being of those who reside in these racially segregated residential areas (Leung & Takeuchi, 2011; Mendenhall, Deluca & Duncan, 2006; Morenoff & Lynch, 2004). Due to their group membership, socio-economic position and environmental limitations, these individuals are then disproportionately burdened with inequities in health care and health disparities (Leung & Takeuchi, 2011).

Until recently, little research has been done to assess the role of fathers’ involvement in the lives of their children. Substantial research depicts father involvement during childhood and adolescence, while failing to explore fathers’ influence on infant health, birth outcomes and prenatal care. Current research has established linkages between paternal involvement and a host of child outcomes, including behavior, learning capacity, and academic achievement (Martin et al., 2007). The issue of fatherhood has been considered an important issue of federal concern for only about 15 years now. In addition to being actively involved in children’s lives, fathers also provide significant resources and emotional support to mothers, which are particularly beneficial
during the prenatal, perinatal and postnatal periods (Martin et al., 2007; Iliyasu, Abubakar, Galadanci, & Aliyu, 2010; Ma, 2008; May, 1982; Bond, 2010).

Paternal involvement in prenatal care has been identified as a factor in the onset of prenatal care and thus reduced risks in infant mortality, and adverse birth outcomes (Alio, Kornosky, Mbah, Marty & Hamisu, 2010; Alio et. al, 2011). However, there is a lack of substantial empirical evidence that supports these claims in the literature. Recent research has illustrated a reemergence in the literature of examination of factors related to paternal involvement, prenatal care, and the impact on birth outcomes (Alio, Kornosky, Mbah, Marty & Hamisu 2010, Alio et.al, 2011; Kramer and Hogue, 2007, Hearst et al., 2008, McAllister and Boyle, 1998). One major limitation of the existing literature is the way that involvement is operationalized as being listed on the birth certificate or not. This crude definition provides little insight into the types of involvement which might be very impactful.

Given recent research findings, there is an urgent need to examine factors related to paternal involvement, prenatal care and the impact on birth outcomes. In addition to promoting infant health, increased involvement of men in their children’s lives is associated with an array of positive outcomes for their children (Jones and Mosher, 2013; Quinn et.al, 2009) including academic success, attitudes, and behavior. Father involvement can have such a positive impact for improving the health of infants and child hence there is a need to determine specific mechanisms that improve infant health between pregnancy and birth. Moreover, the greatest disparities in infant mortality rates are among African-American infants; thus, research is needed to identify the factors for African-American families. Increasing our knowledge and understanding of the factors that contribute or impede paternal involvement during the antenatal and postnatal period may help inform maternal and child health policy decisions. Policies formed
around maternal and child health that effect prenatal and postnatal care should include paternal health as a means to increase healthy birth outcomes in African-American families. Therefore, illuminating which factors are associated with the African American male’s neighborhood, his individual traits, and those characteristics of his partner can serve as a baseline to increase utilization of prenatal care services to frame interventions around healthy African American infants and families.

Theoretical Framework

Several theories have been used to examine the African-American/White disparity in infant mortality, but mostly with respect to maternal health risks leaving out a thorough exploration of paternal indicators. Consider the prominent use both from Alio, Kornosky, Mbah, Marty & Hamisu (2010) adaptation and the original ecological model theory formed by Bronfenbrenner (1999) as key proponents to describe the infant mortality health disparity. The combination of the two has been used to form much of current research on infant mortality health disparities (Alio, Kornosky, Mbah, Marty & Hamisu 2010, Alio et.al, 2011; Kramer and Hogue, 2007, Hearst et al., 2008, McAllister and Boyle, 1998; Iliyasu, Z., Abubakar, I. S., Galadanci, H. S., & Aliyu, M. H, 2010; Ma, 2008; Khanani et. al., 2010). The Socio-Ecological model recognizes the relationships that exist between the individual and the environment. It proposes the following key concepts: (1) that individual behavior affects and is affected by the social environment and (2) that behavior both shapes and is shaped by multiple levels of influence (Glanz, Rimer and Visawanth, 2008). The model focuses on health promotion that health care practitioners and researchers are to acknowledge the many influences on utilization behavior (Sword, 1999; Alio, Kornosky, Mbah, Marty & Hamisu). Although this model is sufficient for this study, the use of Krieger’s (1994, 2011) Eco-social Theory will be considered as the
Theoretical prospective to inform this dissertation study (See figure 1.1 below). The Eco-social Theory builds on the theories of social medicine and theories of social production of disease by incorporating biological explanations, a life-course perspective, and a multilevel perspective over space and time, to describe associations between exposures and disease, with an explicit focus on inequalities in health status among subjugated groups (Kreiger, 2011). Using the Eco-social model to understand the processes which influence healthy birth outcomes, we can then examine the presence or absence of fathers’ influence on healthy birth outcomes and healthy families when controlling for poverty level and individual level characteristics.

**Figure 1.1 Kreiger’s Eco-social Theory diagram**

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**Note:** To explain current and changing population distributions of disease, including health inequalities, and who and what is accountable for the societal patterning of health, it is necessary to consider causal pathways operating at multiple levels and spatiotemporal scales, in historical context and as shaped by the societal power relations, material conditions, and social and biological processes inherent in the political economy and ecology of the populations being analyzed. The embodied consequences of societal and ecological context are what manifest as population distributions of and inequalities in health, disease, and well-being. Source: See references 1,17-21.

**FIGURE 1—A heuristic diagram for guiding ecossocial analyses of disease distribution, population health, and health inequities.**

Figure 1.1 Kreiger’s Eco-social Theory diagram
This Eco-social model like the Socio-Ecological model allows for examination of the multiple layers that are of influence as predictors for healthy birth outcomes at both the individual and neighborhood/community level. The individual factors allow for examination of one’s social position, social contextual factors to identify the biological and personal history that increases or hinders the likelihood of paternal involvement during antenatal and postnatal stages of pregnancy. This model also allows examination of relationships that increase or hinder paternal involvement at the community level which, in this case, is the residential location of both parents [suburban, urban, rural] and finally the societal factors that create the climate in which fathers/partners are encouraged or inhibited in being involved during these stages.

Study Significance

African-Americans experience a disproportionate rate of health disparities, unequal treatment in the housing market, economy, and social mobility (Leung & Takeuchi, 2011; Mendenhall, Deluca & Duncan, 2006; Morenoff & Lynch, 2004). Race is a factor that is salient to the existence of health disparities and imposes additional stress that affects the reproductive health of African-American women, their infants’ health, and their overall family life (Leung & Takeuchi, 2011; Mendenhall, Deluca & Duncan, 2006). Challenges are constant for the African-American population. Race is a salient factor in the health literature and plays an important role in examining health disparity differences. African-Americans have been burdened with various social and economic dispositions due to their race including a variety of health measures that impact economic success, employment, educational attainment, residential neighborhoods, and mortality (Bonham, 1985; Brancati, 1996; Flack et al., 1995; Kvale, Cronk, Glysch, & Aronson, 2000; Penn, Kar, Kramer, Skinner, & Zambrana, 1995; Richards et al., 2002; Singh & Yu, 1995). Examining differences in health disparities is not complete without taking a closer look at the
impact of race on differential health outcomes. This research is a great indication for next steps in healthcare access, utilization and intervention implications for policy formation so as to overcome the health disparity surrounding infant mortality, which national health statistics have indicated as a significant indicator of population health (Gortmaker & Wise, 1997, CDC 2008).

In addition, this study aims to examine the attitudes and beliefs that men may hold in response to their role as fathers during preconception, conception and pregnancy. While the existing literature focuses on outcomes after birth (Khanani et al., 2010; Alio, Kornosky, Mbah, Marty & Hamisu; Dominguez, 2008; Bond, 2012) this study aims to provide a perspective less often explored in this context. If we are able to understand Black men’s perceptions and attitudes and how they are influenced by their partners, social contexts, environments and residential status, we are furthering our knowledge of possible factors associated with healthier birth outcomes in African-American women. Examining factors associated with healthy birth outcomes is warranted, according to the national fatherhood initiative; a non-profit, non-partisan, non-sectarian organization that aims to improve the well-being of children through the promotion of responsible fatherhood (fatherhood.gov).

While few have explored the complex relationship of paternal involvement as it relates to prenatal care (Martin, McNamara, Milot, Halle, & Hair, 2007; May, 1982; Meikle, Orleans, Leff, Shain, & Gibbs, 1995), many of the existing knowledge and research is based on maternal perspectives examining their experiences and social characteristics that influence onset and adherence to prenatal care. The main significance in this study lies in the fact that few existing studies have explored paternal involvement across three types of neighborhood settings (i.e. urban, suburban, and rural) of low-income African-American families and its effects on healthy birth outcomes as operationalized in this context. Additionally, current research operationalizes
paternal/partner involvement as the presence or absence on the birth certificate (Alio, A.P., Kornosky, J.L., Mbah, A.K., Marty, P.J. and Hamisu M. Salihu, 2010; McAllister & Boyle, 1998; Meikle et al., 1995; Melnikow, Alemagno, Rottman, & Zyzanski, 1991; Milligan et al., 2002; Napravnik, Royce, Walter, & Lim, 2000). Therefore, this study is significant in increasing our knowledge and understanding of the paternal perspective and expanding empirical based information.

Although research has indicated some of the impact that fathers have on adolescent development (Hogue & Vasquez, 2002; Sangi-Haghpeykar, Mehta, Posner, & Poindexter, 2005), empirical research on the experiences of fathers has slowly begun to emerge in the literature (Bond & Bond, 2010; Clinton, 1995; Dominguez, Dunkel-Schetter, Glynn, Hobel, & Sandman, 2008). While this body of research is beginning to emerge, these existing studies rely on quantitative measures to identify barriers to paternal involvement. This study aims at providing an in depth perspective in identifying multiple predictors to understand paternal involvement in African-American communities using both quantitative and qualitative analysis methods.

Understanding the roles that fathers are perceived to play in infant health can help determine whether the presence of fathers improves healthy birth outcomes for African-Americans. This is in an effort to see how the presence or absence of partners during the antenatal and perinatal period encourages them to go to prenatal care and other benefits of having a partner during that period. This study examines both individual characteristics and neighborhood factors. At the neighborhood level, we will examine racial isolation as an independent indicator of LBW and preterm births in African-Americans. In addition, the educational level, marital status, employment status, age and race of individuals will be used to inform the specific socio-demographic characteristics needed for analysis. The main focus of this
study will examine the role fathers play in healthy birth outcomes. Both resident and non-resident fathers and their families will be assessed to further examine how cultural differences in parenting relationships may affect birth outcomes in African-Americans in metropolitan urban and suburban areas compared to rural communities, particularly low birth weight (LBW) and preterm births.

Study Purpose

The purpose of this dissertation is to explore the roles that fathers are perceived to play in infant health in order to determine whether the presence of fathers improves birth outcomes for African-Americans. The main objective of this pilot study is to determine whether paternal involvement in the antenatal period (during pregnancy) increases the likelihood of onset of prenatal care and adherence to prenatal care health behaviors as defined by the National Institute for Child Health and Development (NICHD). We focus on African-American families including African-American men who are partners of low-income black women because low-income black women are disproportionately represented in the current statistics as having higher rates of infant mortality (Khanani et. al., 2010; Alio, Kornosky, Mbah, Marty & Hamisu 2010, Alio et. al 2011; Yu, 2008; Elder et. al., 2013). In addition, these mothers are often under high stress due to their socio-economic disposition and environments (McAllister and Boyle, 1998; Leung & Takeuchi, 2011; Mendenhall, Deluca & Duncan, 2006). We include men of varying income levels which provides a wider lens in understanding differences within this racial group and to account for the diversity of the community of the study. The core of this research will explore perceptions and attitudes of fathers as influenced by their partners, social contexts, environments and residential status. Examining these dimensions in African-American women’s romantic partners may provide evidence to support the goal of increasing participation of men in the early stages of
prenatal care and healthy child development before, during and after conception. The study examines responses from African American fathers in the baseline survey of the Fragile Families Child Well-Being Study (1998-2000) from here on out will be abbreviated as the FFWCS and three male only focus groups. The methods section includes three aims that were explored using secondary data analysis and focus groups in a Midwestern city in Illinois. The aims include (1) to explore the relationship between neighborhoods, perceptions and involvement using the FFCWS (2) to explore the role of quality of communication and involvement using the FFCWS and focus groups and (3) to explore residential status [resident/non-resident] of African-American men and involvement using the FFCWS

Several questions will guide my research; however, the overall research question I seek to answer is what role does the presence or absence of fathers/partners across urban and suburban communities play in healthy birth outcomes in African American families?

Additional research questions are defined based on the outlines aims above and explored further in the methods and results of the study.

The long term goal and policy implication in examining these diverse dimensions of influence in partners of African-American women may provide evidence to support the goal of increased participation of men in the early stages of prenatal care and healthy child development before, during and after conception. Additionally, this will provide insight into implications for interventions and policies around paternal and child health. This research naturally leads to an intervention targeting that includes men in prenatal care education and implementation. This may also pose a challenge to policy makers and health workers to create and implement programs that also include a more comprehensive father/partner component.
Chapter 2: Review of the Literature

Health Disparities

Compelling evidence indicates that race and ethnicity correlate with persistent, and often increasing, health disparities among U.S. populations and demands national attention (OMHD, 2010). Health disparity refers to differences in the health status of different groups of people which can be based on a multitude of factors such as race, ethnicity, sex, and geography among others (NIH, 2010). During the early 80s there was a growing awareness that minority populations were experiencing poorer health outcomes in comparison to other groups with African-Americans as a specific group of interest (NIH, 2010). Due to this growing concern, that was attributed to the complex interactions between biology and the environment, a taskforce under the department Health and Human Services was developed to explore these differences in higher rates of disease and illness among African-Americans and other minority groups in the United States in 1985. The landmark report from the taskforce became known as the Heckler report which documented the existence of racial and ethnic health disparities among Blacks and ethnic minority groups within the United States (Heckler, 1985). One of the most significant outcomes of this report was the development of the Office of Minority Health whose mission is to improve the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities (OMHD, 2010). Today, this office is one of the leaders in support in continuing work to eliminate racial and ethnic disparities in health. Coupled with the goals of national initiative Healthy People 2020, health disparities remain largely a concern for minority populations and continue to demand national attention and garner further research.
One of the leading goals of Healthy People 2020 is to recognize the social determinants of health (home, workplace, school, neighborhood, and community) which in part are responsible for the unequal and avoidable differences in health status within and between communities and populations (healthypeople.gov). Health related problems vary systematically by community, often in conjunction with socioeconomic and physical characteristics. Although we would expect to find differences in health outcomes amongst individuals when these differences can be traced to an individual’s race, socioeconomic status (SES), or location, it is important that we begin to examine if this is an irrationally occurring health disparity (Jennings, 2009).

Among the leading health indicators of population health in the United States, reducing the rate of all infant deaths remains a high priority (healthypeople.gov, 2015). More specifically, Infant mortality rates (IMR) have long been a determinant of the health and social condition of a population (Gortmaker & Wise, 1997, OMHD, 2009; Singh & Yu, 1995,) and thus remains at the top of the Healthy People 2020 objectives. Infant mortality is defined as the incidence of death in the first year after birth, expressed as a ratio of every 1,000 live births. (Khanani, Elam, Hearn, Jones, & Maseru, 2010; Singh & Yu, 1995). The U.S. infant mortality rate (IMR) is higher than in most other developed countries. The gap between the U.S. infant mortality rate and the rates for the countries with the lowest infant mortality appears to be widening (Matthews & MacDorman, 2008). The infant mortality rate has dramatically declined in the past decade; however, the largest disparity gap continues to persist between African-Americans and Whites. Although the national rate has dropped to 6.7 per 1,000 live births, African-Americans IMR, 12.63 per 1,000 live births remains almost 3 times that of Whites 5.3 per 1,000 live births (NCHS, 2012). From 1998-2001 over 5.7 million children (n=5,762,037) were born in the
United States and just under 12,000 of those resulted in infant deaths (n=11,897) at a time that IMR were 6.99 per 1000 live births (MacDorman & Matthews, 2008).

A large body of research exists on the etiology of adverse birth outcomes (e.g. preterm birth, low birth weight babies, and maternal health status). However, few researchers have examined the effects of the mother’s and father’s residence as a predictor of birth outcomes. In order to extend the literature on predictors of adverse birth outcomes, the relationship of community level risk factors impacting urban-metropolitan and suburban neighborhoods and the influence of living in high poverty areas are needed to review potential influences on the presence or absence of fathers as a predictor in healthy birth outcomes. This will then extend the literature in understanding the persistent black/white disparities in infant health and further inform policy formation on maternal and child health.

African American Health Disparities

A disproportionate rate of African-Americans represent 27 percent of the total population of those who live in poverty in the United States, while only 15 percent of the United States total population lives in poverty (CDC 2010, 2011, 2012). Poverty has been found to be a link to several indicators including adolescent development, crime, educational success, diabetes, and infant mortality among other racial disparities (Hearst, Oakes & Johnson, 2008; Sampson & Morenoff, 1997; Sampson & Sharkey, 2008; Diez-Roux&Mair, 2010; Kreiger, 2012). The complex and multidimensional influence of poverty is the single greatest predictor of adverse birth outcomes (e.g. preterm birth, low-birth weight infants and infant mortality) across racial ethnic groups. The National Center for Health Statistics (2015), reports the African-American infant mortality rate has more than doubled over the past decade between African-Americans and
Whites (2.4). Much of the research in underserved populations has assessed adolescent development, maternal social status, educational attainment, crime and healthcare access and utilization as a means to understanding the cycle of poverty (Sampson & Morenoff, 1997; Hearst et. al, 2008; Holden et. al, 2011; Weathers et. al, 2011; Sims, Sims & Bruce, 2007; Giscombe & Lobel 2005; Collins & Williams 2001; Singh& Yu 1995). Living in poverty is associated with many disadvantages in terms of healthcare, access and utilization of health services and disproportionate rates in the leading health indicators are well documented including cancer, diabetes, heart disease and infant mortality among African-Americans (NCHS, 2015; OMHD, 2010).

Considerable numbers of research studies have sought to understand the etiology of poor black infant survival (Giscombe & Lobel 2005; Collins & Williams 2001; MacDorman, 2011; Singh& Yu 1995) and the persistent disparity between African Americans and Whites. Infant mortality can further be broken down into neonatal morality and postnatal mortality, which account for total infant mortality rates. Research also suggests that economic differences and proximal risk factors do not fully explain the persistent high adverse birth outcomes of African Americans (Hearst et al, 2008). An abundance of literature indicates the decline in infant mortality and other adverse birth outcomes are due to medical and societal advances (Gortmaker & Wise, 1997, Giscombe & Lobel, 2005, Hearst et.al, 2008; Singh & Yu, 1995). Although there has been a dramatic decline, the disparities between African Americans and Whites remain.

There are several indicators of why certain populations are healthier than other populations, such as good genetic heredity, lack of health care, lifestyle, or a combination of these factors (Adler, 2009; Diez-Roux, 2010; Kreiger, 2004). There has been less emphasis acknowledging that of an individuals’ social position or geographic location. There has been a
A growing awareness that health is influenced by one’s social position in society (Robert, 1999; Adler, 2009). Health related problems are strongly associated with social characteristics of communities and neighborhoods (Sampson, 2003; Laraia, Messer, Kaufman, Dolem Cuaghy, O’Campo & Savitz, 2006; Diez-Roux & Mair, 2010). This unequal distribution of disease and mortality across different groups remain an issue in understanding health disparities in society (Adler, 2009; healthypeople.gov).

African-American women in particular deliver infants with adverse pregnancy outcomes, i.e., preterm birth, low birth-weight births, fetal death, pregnancy induced hypertension, and others (Khanani et. al., 2010; Alio, Kornosky, Mbah, Marty & Hamisu, 2010; CDC MMWR, 2008). Explanation for the persistent high rates in poor pregnancy outcomes among African American women has been hard to find (Hearst et. al, 2008, Kramer and Hogue, 2007; MacDorman & Matthews, 2011). Research has documented the increasing magnitude of the racial disparity in birth outcomes among seemingly lower-risk, college graduated, married black and white women. This suggests that there is either a residual confounding by socio-economic status or a negative exposure that counterbalances the protective effects of increasing socio-economic status among African-American women (Hearst et. al, 2008, Kramer and Hogue, 2007).

**African American Health and Neighborhoods**

Current research on neighborhoods and health is shown to be closely connected to work on residential segregation and health (Diez-Roux & Mair, 2010; Kreiger, 2012). A small body of emerging literature exist on the effects of racial residential segregation on African-Americans (Morenoff, 1997; Sampson, 2003; Sampson & Raudenbush, 1997; Leventhal & Brooks-Gunn,
2000) and birth outcomes (Kramer & Hogue, 2008; Hearst, et.al, 2008; Sims, Sims & Bruce, 2007) but, the continued cycle of living in high poverty affects several other aspects related to health. These disparities continue to persist between African-Americans and Whites despite the efforts of policy implementation of the Affordable Care Act, residential mobility programs (e.g. “Moving to Opportunity” or the Geautreaux program) and the goals of the Healthy People 2020.

African-Americans have been racially stratified to certain geographic areas and more prominently so in the housing markets as exemplified by the Geautreaux and Moving to Opportunity studies (Mendenhall, Duncan & Deluca, 2006). Exploring the dynamics of African-Americans in three neighborhood types, rural, urban and suburban, for purposes of this study allows a new perspective on neighborhood level differences. African-Americans although isolated when reviewing the vast majority of census data to high poverty crime stricken areas has not accounted for differences in non-metropolitan areas (Collins & David, 2009; Mendenhall et al., 2006; Pinderhughes et al., 2007; Leung & Takeuchi, 2011). The vast majority of this literature has examined chronic disease related outcomes. Reviews of this literature has also revealed that socioeconomically disadvantaged neighborhoods are generally associated with poor health outcomes including mortality, poor self-reported health, adverse mental health outcomes, and child health outcomes (Deiz-Roux & Mair, 2010).

Associations of both physical and social attributes of neighborhoods have emerged as potentially relevant contexts in affecting the health of individuals (Diez-Roux&Mair, 2010). Particularly, examining this association between neighborhoods to social and race/ethnic health inequalities, show evidence that may contribute to disproportionate rates in chronic disease outcomes. Exploring this relationship has grown dramatically as a study of interest over the past 15 years (Diez-Roux, 2010; Diez-Roux & Mair, 2010; Kreiger, 2012) and continues to grow.
Research in social and behavioral science has established a reasonably consistent set of findings relevant to the community context of health, especially for violence and a number of health outcomes for children (Sampson, Morenoff & Gannon-Rowley, 2002; Sampson, 2003; Diez-Roux & Mair, 2010). This includes neighborhood physical characteristics which studies have generally found that living in deprived neighborhoods is associated with poor health outcomes (Rollings, Wells & Evans, 2015). However, these reviews have not differentiated neighborhood type metropolitan compared to suburban differences but have focused on the physical and social environments of these communities which for this study are purposed with specific interest in infant health outcomes.

As stated previously, place is a major determinant of health, resulting in a variation of health outcomes across populations, which is apparent in the racial residential segregation literature of adverse health and birth outcomes (G. R. Alexander et al., 2008a; Collins & David, 2009; Giscombe & Lobel, 2005; Hearst et al., 2008; Paul et al., 2009). Sampson (2003) and Kreiger (2012) suggest that an improvement in community socioeconomic environment has a causal impact on better health and behavioral outcomes related to violence and neighborhood resilience. This inequality is seen on other health outcomes that cluster at the neighborhood and larger community level, in particular that of cancers, diabetes, heart disease and adverse birth outcomes, more specifically, infant mortality. Varying research illustrates and strongly supports the association between social characteristics of communities and neighborhoods and health disparities (Sampson, 2003; Rollings, Wells & Evans, 2015; Diez-Roux, 2010; Diez-Roux & Mair, 2010; Kreiger, 2012). Lesser known are the differences by types of communities which African-American families reside with majority of the literature focusing on large metropolitan areas (Sampson, 2000, 2003; Collins & David 2009; Collins & Williams 2001; Hearst et al,
Community level predictors of health disparities research have shown consistent evidence of the importance in understanding place and health (Diez-Roux, 2010; Diez-Roux & Mair, 2010; Kreiger, 2012; Mendenhall, Duncan and Deluca, 2006; Sampson, 2003; Rollings, Wells & Evans, 2015) however, rural, urban and suburban boundaries, have not explicitly been reviewed.

Understanding the mechanisms of neighborhood types and communities can help determine whether the presence of fathers improves birth outcomes for African-Americans in racially segregated and/or high poverty communities. The need to understand the complexities of individual level characteristics and neighborhood level factors can provide a more comprehensive approach to understand the direct association between the social context and health. However, for effective interventions and policy to be put in place, further research and theoretical approaches may offer further insight into decreasing the rates of adverse birth outcomes and improving paternal involvement and understanding their role as fathers and community members.

**Healthy Families Healthy Babies**

Increasing healthy birth outcomes are important to strengthening the African-American family and advancing the goals of Healthy People 2020. Questions in this regard have been attempted to be answered by a small body of researchers who discuss themes that currently exist in birth outcomes (i.e. infant mortality, LBW, preterm birth etc.) as well as the impact and assessment of father involvement in prenatal care (Khanani, Elam, Hearn, Jones, & Maseru, 2010; Alio, Kornosky, Mbah, Marty & Hamisu 2010; Jones & Mosher, 2013). However, conversation around healthy birth outcomes in empirical research is minimal in relation to the African-American family. Adverse birth outcomes in African-American infants may affect the
stability of African-American families, the reproductive health of the mother and also affect the perpetuation of the cycle of poverty. Single motherhood appears to be a commonality in the African-American community with men often not in the picture due to diverse social factors at the individual and macro-social level (i.e. neighborhood, economic, poverty etc.) which cause tension in relationships, in turn, complex or adverse birth outcomes due to the additional stress on the physical body (May, 1982; Ma, 2008; Martin et al., 2007). Mounting evidence indicates that a woman who is well supported by her male partner during pregnancies and birth experiences fewer complications during labor and birth and may have an earlier postpartum adjustment. (Iliyasu, Abubakar, Galadanci, & Aliyu, 2010; Martin et al., 2007; May, 1982)

Research also indicates that women whose men/partners participate actively in pregnancy were 1.5 times more likely to receive prenatal care in the first trimester and help in reduction of risky behaviors such as smoking during pregnancy. (Martin et al., 2007) Healthy relationships are necessary to support and increase healthy behaviors that affect healthy birth outcomes. Despite current interest in father involvement in child-bearing, relatively little research has been published and the existing literature poses several problems presenting only data collected in last weeks of pregnancy with little information on early phases of involvement.(May, 1982). Men are important contributors to the lives of unborn children and warrant further exploration in determining predictors of birth outcomes in African-Americans at the individual family level and community/neighborhood contextual level (Bond, 2013; Jones & Mosher, 2013; Ngui, Blair & Cortright, 2009).

Ethnic and racial families’ experiences have been found to be very different than their counterparts in the social historical context as previously mentioned. The socialization processes of ethnic enclaves differ by culture, generation, gender, and ethnicity (Moore, 2008; Erdmans,
2002; Kibria, 2003; Patillo, 2008). Other factors that have been considered include the resiliency of African-American communities in the context of neighborhood violence and crime (Sampson, 2000;2003; Mendenhall et.al. 2006) who from a social historical context have experienced institutional racism and discrimination for decades and continues to persist today (Grady, 2006). Additionally, African-American families in recent years have been largely studied through housing studies and the impact of violence of neighborhood community resiliency (Collins & David, 2009; Giscombe & Lobel, 2005; Hearst, Oakes, & Johnson, 2008; Paul, Mackley, Locke, Stefano, & Kroelinger, 2009; Sampson, Raudenbush, & Earls, 1997), and more recently health outcomes (Woolf & Aron, 2013; Mendenhall et al., 2006; Pinderhughes et al., 2007; Leung& Takeuchi, 2011). However, much of what is known about the African-American family was first detailed in the Moynihan report of 1965. The Moynihan report was an effort to confront the nation to assist in the establishment of a stable Negro family structure,

“...it has to be said that there is a considerable body of evidence to support the conclusion that Negro social structure, in particular the Negro family, battered and harassed by discrimination, injustice, and uprooting, is in the deepest trouble. While many young Negroes are moving ahead to unprecedented levels of achievement, many more are falling further and further behind.”

Chapter I, sec 3. para. 2

It is well known that the family is the basic social unit of American life; it is the basic socializing unit. By and large, adult conduct in society is learned as a child (Moynihan, 1965). He further argues that there is one truly great discontinuity in the family structure in the United States at the present time: that between the white world in general and that of the Negro
American. Due to this harsh reality that was first examined in the early 60s, the need to continue to examine the African-American family is not unfounded and needs continuous exploration from the unborn child or infant to the entire family unit.

The need to explore the family and its relationship to healthy birth outcomes is relevant to increasing our understanding of the African-American family. We understand that healthy relationships begin in the early socialization processes that are influenced by an array of factors including but not limited to family, culture, neighborhoods, and spiritual beliefs (Moore, 2008; Erdmans, 2004; Patillo-McCoy, 2000; Waters, 1994; Rubin, 1990; Carter, 2005). These mechanisms are important to building supportive relationships that in turn may lend itself to social capital and social mobility. However, for African-Americans, these relationships and social networks are often lacking (Carter, 2005; Moore, 2008; Patillo, 2000) within and outside the African-American community due to lack of social and human capital. We can see the need for this has not deterred since the Moynihan publication and it is therefore an important aspect to understanding the health of infants in the perinatal and postnatal stages. This further supports why this study will further examine these complexities as predictors of birth outcomes. And therefore, to expand the literature and understand community level and individual level causal mechanisms of adverse birth outcomes warrants further exploration to enrich research on healthy birth outcomes that is lacking.

**Black Men, Healthy Families and Babies**

The reproductive health of African-American women is an important indicator of familial health and can be attributed to various individual and community level factors that will be considered and explored but at a minimum with a greater emphasis on their male partners. The
contribution of African-American fathers and their role in their families may differ from the experiences of their White counterparts (Jones & Mosher, 2013; Straughen, Cadwell, Young & Misra, 2013). African-American men face many interconnected barriers which are unique to their experience and involvement (Straughen et. al., 2013). Several studies have attempted to examine the potential impact that fathers have on adverse birth outcomes on African-American women. However, the majority of the existing literature examines their potential impact through experiences as reflected by their partners and not men themselves or use of birth records (Alio et. al., 2010; Giscombe & Lobel, 2005; Hearst, Oakes, & Johnson, 2008; McAllister and Boyle, 1998; Straughen et. al, 2013). In thinking about the family as a complete unit, it is noteworthy to understand the characteristics that make each family unique and individuals who make up the unit.

Men and African-American men in particular are important to the structure of the American family. African-American men in contemporary society are important to the well-being of African-American children, family and communities. Fathers in particular are considered not only as the head of households but also as the disciplinary expert, financial support, and decision maker in many homes. However, for African-American men this has not always been the case as documented in reports including the Moynihan (1965) and Heckler (1985) on African-American families and minority health. The absence of men has potential adverse effects on the well-being of communities, families and children, more particularly the role men play on adolescent child development (Clear, 2009; Pettit & Western, 2004; Sampson, Raudenbush, & Earls, 1997; Sampson, Morenoff, & Gannon-Rowley, 2002). The state of the black family was outlined in the Moynihan report in 1965 as earlier stated. The Negro Family: the Case for National Action, detailed a call for action to invest in poor African-American urban
communities, which was and is still throttled by poverty, economic instability and the
deteriorating black family. The call to action identified the issues in the “Negro” family
including unemployment, single-parenthood, increasing divorce rates and dependency on state
funds (Moynihan, 1965) and emphasized the need to invest in stabilizing the structure of the
“Negro” family. However, the African-American family today continues to deteriorate and
related to a variety of social and economic inequities that contribute to health disparities.

Our understanding of the role of the “ideal” African-American father has been illustrated
in media through shows such as the Cosby Show and the Fresh Prince of Bel-Air along with
other movies. However, the ill-reality of the African-American male in rural, urban, and
suburban communities is not depicted the way we are taught to largely believe the Eurocentric
American family is. Therefore, understanding the perspective of fathers from their perspective on
health and healthy birth outcomes provides a lens to examine these cultural differences. In
addition, it is an opportunity to further the literature on the potential relationship between fathers
and healthy birth outcomes in African American families. To date there are few studies that
examined and operationalize paternal involvement beyond the birth certificate. Lamb and
colleagues (1987) were the first existing study that attempted to describe specific characteristics
that explain paternal involvement. They term engagement, responsibility and accessibility as the
main characteristics of the “ideal” father. Engagement is directed at active participation in the
prenatal activities of the mother. Accessibility is defined as being present, physically present,
financially and maintaining a positive relationship with the mother. Finally, responsibility is
embedded in both, but includes the notion that incorporates society’s definition of father as
provider, protector and nurturer (jointcenter.org, 2010).
African-American men are often not found in the home due to an array of social factors and namely that of the criminal justice system. African-American men are incarcerated at six times the rate of their white counterparts (The sentencing project news - racial disparity.; M. Alexander, 2009; Clear, 2009) African-American men and Hispanics account for two-thirds of the prison population, in addition 1 in 5 African-American non-college educated males were in prison in 2004 (Western & Wildeman, 2009) further accounting for the racial disparity in African-American lack of representation in African-American communities. Today, one in three African-American males is under control of the criminal justice system (Mauer, 2013) which has an adverse impact on the African-American family. Research also has indicated the connections of incarceration with low wages, joblessness and unstable families among others (Clear, 2009; Pettit & Western, 2004; Western & Wildeman, 2009).

The role of fathering takes on another dimension for African-American men, fathering is thought to be part of the life course but not necessarily in the same manner their counterparts achieve as marking adulthood. Empirical evidence is needed to support the lived experiences of all fathers. Even fathers that are in the home, we still know very little about their experiences of parenting relationships, community involvement and in relation to the prenatal and postnatal care stages of pregnancy involvement to increase our understanding of healthy birth outcomes. As we examine the African-American family as impacted by the role fathers play in the early stages of infant health, we assess two different aspects, that of the actual community and their residential status. Both resident[in the home] and non-resident[not in the home] fathers and their families will be assessed to further examine how cultural differences in parenting relationships may affect birth outcomes in African Americans compared to other racial and ethnic groups.
African-American families remain in many of the poorest neighborhoods in large urban metropolitan areas ridden with crime, illegal drug trades, unemployment and low educational attainment (Clear, 2009; Hyman, 2004; Pettit & Western, 2004; Sampson et al., 1997; Sampson et al., 2002; Western & Wildeman, 2009). All of these factors play an important role in the stability of the African American family and the role fathers may play or lack thereof. While most studies have used secondary accounts from partners or birth certificate as indicators of involvement, I utilize the Early Childhood Longitudinal Birth Cohort Study (2001-02) survey, which men provide individual accounts of their experiences on numerous topics. Additionally, the use of focus groups takes place to further explicate the potential relationship between healthy birth outcomes and paternal involvement. In furthering our understanding of adverse birth outcomes in African-American families, we must first understand the relationships that exist and how they are formed and maintained as predictors of healthy birth outcomes. The relationship between neighborhood type and residential status is essential to our understanding paternal involvement on healthy birth outcomes.

Theoretical Framework Application – Eco-social Theory

Several theories have been used to explain the relationship of communities or place and health since its emergence in the late 80s and early 90s (Diez-Roux & Mair, 2010; Laraia et. al, 2006) with special attention to the Socio-ecological framework (Bronfenbrenner, 1999) and extensions of it (Alio et.al, 2010; 2011). Research has been able to utilize spatial demography to isolate chronic illnesses and diseases and therefore explaining some of the persistent health disparities on the neighborhood level (Diez-Roux & Mair, 2010; Laraia et. al, 2006; Diez-Roux, 2010). For purposes of this study, the Eco-social theory is used to illustrate the importance of
examining the life-course perspective that may in turn explain differences in healthy birth outcomes among African-American families.

Eco-social theory incorporates biological explanations, a life-course perspective, and a multilevel perspective over space and time, to describe associations between exposures and disease, with an explicit focus on inequalities in health status among subjugated groups (Kreiger, 2012). There are four core constructs to this model which include; embodiment, pathways of embodiment, cumulative interplay of exposure, susceptibility, and resistance across the life-course and accountability and agency (Kreiger, 2004; 2012). The core components are explicitly defined in Appendix E. Embodiment refers to how we incorporate the world around us biologically, the pathways to embodiment refers to concurrent and interactions that involve diverse exposures socially, economically and environmentally. All of the components of this theory are interrelated in some level however; it is not purposeful for uses of this study to examine each specified pathway but to examine specific components to explain the persistent differences in health inequities in healthy birth outcomes.

The Eco-social theory also has three direct purposes that include (a) drawing attention to the combined impact of societal determinants of health, both social and physical, at multiple levels and scales, and in relation to health outcomes spanning from conception to death. The theory is purposeful by (b) encouraging research and researchers to promote understanding of and initiatives to address societal responsibility for social inequalities in health, and it (c) explicitly recognizes that scientific knowledge and hypotheses are socially situated, and that experiences of affected communities are important to scientific exploration and public health research and practice (Krieger, 2004).
This model allows for the examination of multiple interrelated factors that influence health inequalities that are persistent in minority populations. Biological explanations for these differences are explained elsewhere while the focus of this study explicitly focuses on the life-course perspective as it relates to infant health. Eco-social theory considers causal pathways in explaining disease and health inequities as distributed in the population of study. Specifically, this theory allows for analysis of current and changing patterns in population health, disease, and well-being in relation to the multiple levels it examines, biological, ecological, and social organization. This is in an effort to develop epidemiological explanations for persisting and changing distribution across time and space [life course and ecosystems] of health disease, well-being and social inequalities in health. This in turn will assist in the generation of new knowledge useful to promoting social equity in health (Krieger, 2004, 2012).

As with many multiple layers of assessment in models, this model allows for the examination of the individual- father, social context- neighborhood types, race/ethnicity and class- low income African American families and the life-course of all members of the family unit. The focus of fathers will be examined as individuals and within their communities through the use of secondary analysis. Additionally, the use of focus groups furthers the exploration of the levels and pathways that outline the Eco-social theory as a means to understanding the relationship between the absence and presence of father involvement throughout the prenatal and postnatal stages. African-American men are a unique population to study in addition to the African-American family itself. Therefore, the use of this model incorporated into a mixed model design for this dissertation marries the diverse dimensions of the model.

The pathways of embodiment for men may impact that of the child as well as the relationship between the parents. Although true for some, only a few African-American men
reach adulthood through the traditional pathway of the life course. The life course perspective posits that reaching adulthood is a sequence of well-ordered stages that affect the life trajectories after early transitions are completed (Glanz, Rimer, & Viswanath, 2008; Pettit & Western, 2004; Western & Wildeman, 2009). A man is deemed to be a provider, one who has economic stability, a protector, and a participator in society in a positive and responsible manner (Hyman, 2004). This crude definition is then assessed through the focus groups and survey questions that clarify their life-course as it may impact their involvement in the prenatal and postnatal stages of pregnancy.

Also, this theory serves as a means to evaluate the systematic influences of neighborhoods on families, the interplay of accountability and agency, and the quality of communication in the existent/non-existent relationships of men and women throughout this process. Furthering the understanding of the existing pathways through the levels of the ecosystem [area of group, individual and household specifically] across the life-course of the family unit, we may better understand factors associated with healthy birth outcomes in contrast to adverse birth outcomes in African American families.

Since the purpose of this dissertation is to examine the association between resident and non-resident father involvement on healthy birth outcomes in three different communities, use of the dimensions of the Eco-social model will focus on the life-course pathway of the father in relation to the infant and the lower three levels of the societal and ecosystem, area of group, household, and the individual. It is the intent of this research to further enrich the literature of paternal involvement from the father perspective so that we can then inform policy decisions around maternal and child health in focusing on healthy birth outcome efforts.
Chapter 3: Method

This study has two goals. The first is to develop an understanding of attitudes and perceptions of African-American paternal involvement as it relates to antenatal and postnatal stages of pregnancy. The other goal of this research is to use these findings as a guide to developing programs and policies that improve paternal involvement as it reflects healthy birth outcomes in African-American children. This study will contribute to an understanding of the role paternal involvement plays on healthy birth outcomes. Several questions will guide my research. However, the overall research question is as follows: What role does the presence or absence of fathers play in healthy birth outcomes in African-American families?

The methods section includes three aims that were explored using secondary data analysis and focus groups in a single Midwestern city in Illinois. The aims include (1) to explore the relationship between neighborhoods, perceptions and involvement (2) to explore the role of quality of communication and involvement and (3) to explore residential status [resident/non-resident] of African-American men and involvement using both the FFCWS and focus groups. The dataset used had original questions and measures that were recorded to assess the specific objectives of this research study (See Appendix D). The data obtained from the focus groups are based on the moderator guide which was formed based on the literature and the FFCWS. The information is presented below.

Aim I. Explore the relationship between neighborhoods, perceptions and involvement

This section will examine the role of individual income levels from the FFWCS as a proxy of neighborhood wealth status and its impact on African-American father’s perception of the pre and postnatal stages of pregnancy. The variables of interest include father’s individual incomes and their neighborhood type. However, neighborhood type is not explicitly stated in the
survey but the data is representative of large metropolitan areas of 100,000 persons or more, therefore it is assumed that respondents of the survey come from large cities as defined by the data collection methods of the FFWCS. Additionally, the measures used to obtain basic demographic information of focus group participants are also used. Other included measures align with the Eco-social theory to examine differences in involvement levels included, intention to be involved, mothers wanted fathers to be involved, and fathers name on birth certificate.

There three research questions and hypotheses are as follows;

**RQ. I What is the relationship between neighborhood wealth status and African American men’s perceptions of prenatal and postnatal period?**

- **H₀** Men who live in wealthier communities will have positive perceptions of prenatal and postnatal period

**RQ1.1 What is the relationship of neighborhood type [urban and suburban] to perceptions of prenatal and postnatal period?**

- **H₀** Men who reside in rural and suburban communities will have more positive perceptions about the prenatal and postnatal period

- **H₁** There is a relationship with understanding of prenatal and postnatal care

**RQ1.2 What is the relationship of neighborhood type [urban, and suburban] to frequency of participation [none, low, medium, high]**

- **H₀** Participation will vary among all groups; men in rural and urban communities will be similar.

**Aim II. Explore the role of quality of communication and involvement**

The relationship between communication amongst partners and healthy relationships has been explored in previous literature. However, there is limited research on quality of communication as an influence of paternal involvement on pre and postnatal stages of pregnancy specifically in African-American families. Communication is an important aspect to understand the day-to-day duties and improving healthy behaviors throughout theses stages. Measureable variables include discussion of common topics; partners are expected to discuss on a regular basis and frequency of these occurrences. These variables were recorded into one composite variable in which the calculated sum reflects frequency of involvement (See Appendix D).
ascertain differences in the relationship of communication socio-demographic characteristics including education, income and residential status are also variables included that may act as confounding variables to increased quality of communication amongst partners. The research question and hypothesis of this section is;

RQ II.1 How does AA male and infant mother quality of communication impact AA male prenatal care level of involvement?
   H, Males with very good or good communication with their partners will have increased levels of involvement during prenatal and postnatal period

Aim III. Explore residential status [resident/non-resident] of African American men and involvement
   Finally, the role of fathers within the home and outside the home may differ with respect to their understanding of the mother of their child’s experiences, their understanding of their responsibilities and frequency of engagement during the pre and postnatal stages of pregnancy. In this section the role of residential status is explored. The main hypothesis in this section is that men who reside in the home of the mother of their child will have more positive perceptions, higher income and will be more involved.

   RQ III. How does the AA male residential status [resident/non-resident] influence degree of involvement?
   RQ IV. How does the AA male residential status [resident/non-resident] influence perceptions?
   RQ V. What is the relationship of AA male SES on degree of involvement?

Investigative Context

Healthy birth outcomes have been studied in multiple ways including the use of quantitative studies to review national hospital data and statistics (Byrd, Katcher, Peppard, Durkin, & Remington, 2007; Collins & David, 2009; Dominguez et al., 2008; Hauck, Tanabe, & Moon, 2011; Heron et al., 2010). This study will use mixed methods (Tashakkori & Teddlie, 1998, 2003) design to examine the relationship between African-American men and the healthy
birth of their infant. Collecting, analyzing and mixing both quantitative and qualitative data at some stage in the research within a single research study is a procedure designed to help the investigator understand a phenomenon more completely (Creswell, 2002). (Tashakkori & Teddlie, 1998, 2003; Graneheim & Lundman, 2004; Hsieh & Shannon, 2005). Current research on this topic has examined paternal involvement using quantitative measures or qualitative measures (G. R. Alexander, Wingate, Bader, & Kogan, 2008b; Barnes, 2008; Byrd et al., 2007; Centers for Disease Control and Prevention (CDC), 2002b; Giscombe & Lobel, 2005; Hogue & Vasquez, 2002; McAllister & Boyle, 1998; Quinn et al., 2009). However, research has not indicated the breadth of the relationship between paternal involvement and healthy birth outcomes using mixed methods approach. Using this approach the causal inferences made in the current quantitative analysis on paternal involvement can then be enriched with the qualitative inquiry within the same study to support or extend our understanding of the impact that paternal involvement has on healthy birth outcomes.

Research Approach

Study Design

By using quantitative and qualitative inquiry methods to examine paternal involvement as described by men in contrast to their partners, my study will explore the different perceptions about healthy birth outcomes and involvement across the following three communities: urban, suburban, and rural.

As indicated earlier, this research study utilizes a mixed methods approach to collect and analyze data separated into two phases. Phase 1 will consist of quantitative methods using the following national dataset: Fragile Families Child Health and Well Being Study – 1 year follow
up sample of new parents (1998-2000). This data included information from staff-administered questionnaires to resident and non-resident fathers on their involvement as new parents. Phase II utilize qualitative methods consisting of 3 focus groups with 12 African-American men aged 18-44.

The use of text data and numerical data collected sequentially or concurrently can help better understand the research problem. The argument that achieving this integration of numerical and text data collection is purposeful in health research and is supported by the prevalence of triangulation, which is combining two or more sources of data to study the same phenomenon in order to gain a complete understanding of it (Denzin, 1970). Complementarity is also a popular approach which involves achieving complementary results by using the strength of one method to enhance the other (Morgan, 1998).

The core of this research explored perceptions and attitudes of fathers as influenced by ones’ partner, social context, environment, and residential status. There are three forms of data collection that took place and analyzed through Atlas Ti, Qualtrics and SPSS. Demographic data were collected both during the focus group interviews and the self-reported questionnaire.

Included neighborhood level measures will be accessed using individual responses to environmental stressors expressed in suburban and urban participants in Champaign-Urbana, through survey and interview responses. There are two types of communities used in this study Champaign-Urbana [suburban] and 18 large metropolitan cities included in the survey data with a population of 100,000 or more. Each location was chosen based on convenience of the principal investigator’s university and parent studies of the Co-PIs located in each of the areas.
This study is supported under two parent studies of the Co-PIs: Genes Sing the Blues in Chicago Study; a study about African-American Women and stressors as it relates to their neighborhood, wealth, and overall well-being of them and their children. The other study, the Maternal Obstetrics Outcomes Database (MOOD), a depression registry, follows women longitudinally through the prenatal and postnatal periods to examine the impact of maternal mental health on maternal and fetal health outcomes. Each of these studies includes a diverse group of women from various backgrounds and are ongoing. They were used as a resource to identify and recruit men to become participants in the current study. The women acted as initial contact to garner their partners’ attention and participation.

A total of 165 women were contacted and asked to provide information for the father of their most recent child to participate in a 90 min focus group by phone (see Appendix C). All of the women were contacted by phone. Women were also approached in person by research staff at the health district and given a flyer to pass along to potential participants. Men were eligible to participate in 1 of 6 focus groups. Three focus groups were scheduled to be held at a local library or community center that was reachable by public transportation. The target population was identified through the Champaign Urbana Public Health District (CUPHD) MOOD Data Registry study database, the use of snowball sampling methods and convenience sampling. This dissertation will focus solely on the perception of men while women will be reviewed through the parent studies at a later time.

Research Team

The needs of this study are extensive and include strategies, recruitment efforts, and resources from the parent studies. Therefore, the research team was included to ease this process.
and maintain academic and research rigor. The research team was specifically used in the recruitment efforts at CUPHD, obtaining face validity of the focus group moderator guide and during Phase II, the focus group facilitators. The research team consisted of the 3 Co-PIs all members of the university as faculty, staff or student, three African-American college graduates who are men and two additional female research assistants who are part of the parent study investigative teams and familiar with the databases. The African-American college-educated men were used specifically to moderate and recruit African-American males outside of the MOOD Data Registry. These individuals were between the ages of 18 and 30 and used as vehicles to develop rapport and a safe and open environment more promptly than any of the PIs due to their sex. Although they are college educated, they are members of the group of interest. Each has been trained to moderate the focus group sessions and certified to do research with human subjects. Each of these men also has an insight into the locations that are being used for this study and identify with the African-American male culture.

**Phase I**

In this study, the use of national survey data and questionnaires are the measures used to examine the descriptive questions I seek to answer and existing trends of paternal involvement on healthy birth outcomes. Descriptive and categorical questions are also answered by the secondary data contained in the national study, the Fragile Families Child Wellbeing Study (FFWCS), baseline data collection (1998-2001). Descriptive questions include: educational attainment and employment status, relationship to child, race and marital status. Categorical questions include; knowledge about child development, current relationship status with mother of child, parenting practices i.e. how often with child, attitudes about being a father, and most
important things fathers do. The scales used for responses vary using most important to least important, strongly agree to strongly disagree and all of the time to never.

Sample and Recruitment

The Fragile Families Child Well-being is a longitudinal study that includes a nationally representative sample of approximately 5,000 children born in the U.S. between 1998 and 2000. The children participating in the study came from diverse socio-economic and racial/ethnic backgrounds with about three-quarters of these children who were born to unmarried parents. A total of 4700 (3600 non-marital, 1100 marital) births were included in the final sample from 75 hospitals in 20 cities. Interviews included both mothers and fathers with approximately 75 percent of interviews from unwed fathers. The child’s race is identified by the primary caregiver and hospital data. African-Americans represent 69 percent of the total sample population. Resident and non-resident fathers were asked about themselves and their role in children’s lives in several waves of the FFCWS including the birth, 1 year, 3-year, 5 year, 9 year and now data is being collected for the 15 year follow up study. A total of 1870 resident and non-resident African-American fathers were eligible to be included, however in the final analysis participants under 18 were excluded and those who did not include income was excluded with a final population of 1367 African American men 18 and older included. The fathers were interviewed by trained staff who administered surveys. Specifically for this study, baseline survey data was only used as subsequent data collection did not include birth outcomes and this study focuses on prenatal and postnatal care perceptions.

Survey Instrument
The FFCWS is a national longitudinal study that collects data to inform policy makers, parents, caregivers, teachers and childcare providers about the early life experiences of children. Specifically, the first year follow up of staff administered parent survey instruments are used to inform this study. The surveys examine paternal involvement in the first year of life, their experiences and their roles during the prenatal and postnatal period and relationship with mother of child and child’s health. It also addresses three key areas of interest to policy makers and community leaders –non-marital childbearing, welfare reform and the role of fathers. The survey is designed to focus on the early development of the children, their health and wellbeing, care and education during their formative years until age 9.

For purposes of my research, this study only focuses on paternal response and the health of their child and care. Content that were examined was from the baseline study of the FFCWS (1998-2000) new parent staff-Administered Questionnaire. The sections are divided into the following categories; prenatal care, attitudes about being a father, parents’ health, attitudes toward marriage, parenting practices, relationship with mother, involvement as a resident [in-home with child] and non-resident [out-of-home with child], child health and well-being, father’s rights and responsibilities, social support and community resources, background information and experiences.

Data collection and Procedures

Surveys and Qualtrics

Prior to participation in the focus group, participants took a survey that explores basic thoughts and perceptions as informed by the literature to operationalize their perceptions of the meaning of involvement and its effects on a healthy pregnancy and birth. These surveys were
completed by hand and electronically and entered into the Qualtrics data base to be analyzed. Qualtrics is an online survey database tool used to analyze and display survey results to interpret for use to compare transcribed data with survey data in this study. It is password protected and will be available for access to only the research team. Participants had only one time access to the survey electronically or hardcopy at the time of the study participation.

Data Analysis

The Resident and Non-Resident instrument is a self-administered questionnaire that is divided into several sections. The groups of categories in which variables were examined include involvement as resident and non-resident father, attitudes about being a father, information on prenatal/neonatal experiences and social support and community resources through the FFWCS public use data file in which permission for restricted access data was obtained. Variables selected were exported for use in SPSS and were selected on the following criteria; at least 18 years of age, reported categorical income, and father of singleton birth of child participant. These categories align with the proposed questions outlined in the focus group moderator guide (See Appendix A) which the findings are then compared and analyzed to support or extend our understanding of these relationships explored in Phase II of the study.

Statistical analysis of the quantitative data obtained from surveys include descriptive statistics for all the variables, information about missing data, normality, linear relationships, multivariate correlations, multiple regressions and multicollinearity. Descriptive statistics for survey items are summarized in the text and reported in data tables and figures. Chi square F-test analysis and a series of one-way Anovas, multiple regressions and logistic regressions were used to explore the relationships in the categorical and quantitative survey questions. All statistical analysis for quantitative measures of the survey data were conducted using Statistical Package
for Social Sciences software (SPSS), version 23.0 and Qualtrics for basic demographic info of phase II subjects. The specific measures used in the analysis of the survey data are outlined in Appendix D.

**Phase II**

Qualitative inquiry seeks to develop understanding through words, meanings, place and context and often rely on inductive reasoning. Its emphasis is on process and meanings (Graneheim & Lundman, 2004; Hsiu-Fang Hsieh & Shannon, 2005), more specifically focusing on the narrative of the individual and not the summation of data to garner an in-depth understanding. Focus groups in particular were used for purposes of this study to invite a unique perspective on the issue of paternal involvement and healthy birth outcomes.

**Sample and Recruitment**

**Recruitment**

Participants were recruited by research team members and the recruitment took place at the Champaign-Urbana Public Health District (CUPHD) through the parent studies. The perinatal mood database registry is used, this study recruits during a single prenatal visit at CUPHD or Rantoul Public Health Department. Women were given a letter/consent form for participation in future research in which participants are selected from to contact the fathers of their child. The letter explained the purpose of the study and detailed information would be kept confidential. In addition, they were notified of the opportunity of the Dads Matter Study through flyers placed in the health department, phone calls and a number they could call or texted if they were interested in participating to contact the RPI or Co-PIs. The front desk staff gave the Dads Matter flyer to participants and their partners. Participants were also recruited through print
advertising, key community contacts, Facebook, convenience and snowball sampling at community health fairs, barbershops, church events, and others events, with a major emphasis on the Champaign-Urbana community. The flyers included name and contact information for participation in the Dads Matter Study [see Appendix B].

Study Sample

African American Men aged 18 and older who have been identified through the recruitment efforts by study staff, the MOOD Registry [Rantoul and CUPHD] and Genes Sing the Blues [Englewood] studies were contacted through their partners to participate, with specific interest in the fathers. After receiving a recruitment flyer or Facebook post, prospective participants were asked to contact the study by phone, text or email. In the initial point of contact, the RPI and research study team members evaluated whether the prospective participant meets eligibility requirements for the Dads Matter Study (e.g., self-identified as black, minimum of 18 years old, expecting a child or have a child (ren) less than 5 years of age by reviewing the screening form over the phone with the prospective participant. See Appendix C for screening process [Dads only].

Description of Study Participants

African-American men aged 18 years and older were recruited to participate as partners of women from varying income levels including low-income women. A total of 12 men participated in the focus groups. One participant was excluded in the final transcription analysis due to not meeting eligibility criteria n=11. Men were between the ages of 21 and 44 with 58% of the participants between the ages of 25 and 34(n=7). Educational levels varied with only one participant with a high school or equivalent degree while others had some college or a graduate
or professional degree. Income levels also varied with 41.7% (n=5) of men making $75k annually with 16.7% (n=2) making less than $10k and $35-49999 a year. All respondents but one lived with the mother of the expected child or child (ren).

**Survey Instrument**

During this phase, the instrument used to guide the data collection process will be the focus group moderator guide. The guide contains questions that are influenced by the FFCWS survey which is tailored to both resident and non-resident fathers. Items explored coincide with the topics: prenatal and neonatal experiences, knowledge about child development, attitudes about being a father, familial support and resources as it relates to healthy birth outcomes. This guide was also constructed by exploring existing and previously published literature on paternal involvement and healthy birth outcomes, particularly in African-Americans (see Appendix A).

Focus group questions were categorized into three areas, perceptions, resources and challenges, and barriers to involvement. A detailed list of the questions used in the focus groups is outlined in Appendix A. Some of the specific questions that were asked included, “How did you feel when you first learned you were going to be a father? How do you describe your role as a father in a few words? These questions are considered to gain a perspective of the participants. Resources are divided into environmental resources, personal resources, and emotional support. Sample questions include, do you provide financial support? What does that consist of? Is there anyone you can talk to about your [new] role as a father? Finally, several questions explored challenges or barriers to father involvement through the prenatal and postnatal process such as the following: What challenges have you faced with your partner? How have you dealt with them? How do/did you want to be involved during the pregnancy and child birth process? Are there friends and family members that hinder your involvement? Some of the questions evoked
various responses depending on what stage of pregnancy their partner was in during the focus groups.

To ensure credibility or validity of the development of the moderator guides, member checks for interrater-reliability were done. The facilitators were asked to review the guides during their training and provide feedback on what themes or concepts would be evoked by participants so that their interpretations are consistent prior to hosting their focus groups. Revisions and prompts were then made to the guide if warranted. The guide was pilot tested among a group of fathers in a community setting to mirror actual focus groups and provide face validity. These individuals also provided comments, edits and suggestions regarding the facilitation and moderation of focus groups as an expert review panel.

To establish dependability or reliability, an audit trail of research activities, emerging themes, categories, and special effects on data collection and data analysis were kept. An audit trail in this study is a written documentation that provides the sequence of chronological events that took place throughout the entire research process. These included dates and locations of face validity activities, facilitator training, focus group atmosphere specifics and changing themes and categories that arose throughout the process in a tracked document. The researcher’s advisor and/or advisor designee then examined the audit trail and provided special recommendations, if necessary. At the end of each focus group the facilitators and research staff debriefed immediately and discussed themes and how to improve the next set of focus groups. These were critical to ensure that each focus group was ran similarly and that themes that were prominent were not dismissed and increased validity of previous findings.

**Data Collection and Procedures**
Focus Groups

African-American men who met the eligibility criteria were provided with an informed consent to participate in a 90 minute focus group. The focus groups took place in a local community center and library open to the public. Focus groups took place in smaller conference rooms and chairs were placed in a circle to close the conversation to only participants and decrease outside distractions. A 6 foot table included snacks for participants to freely take at their leisure and pens and paper to sign consent forms and jot down thoughts throughout the focus group. At the end of each table we placed an audiotape recorder which was started and stopped by the facilitators. The facilitators sat within the group and the notetaker sat outside the circle keeping time, observation and paid participants at the end of each focus group.

To protect subjects’ confidentiality, all names were purged from the transcripts and survey data. Focus groups were moderated by two trained researchers of the same sex as participants to increase open dialogue among participants and decrease researcher bias. Each focus group consisted of 3-6 individuals from the Champaign-Urbana community. Participants were given informed consent forms that detailed the study purpose and the information we wished to obtain. Specifically, participants were informed about the goal of the focus groups to learn more about the lived experiences and perceptions that men have before during and after their partners’ pregnancy in this suburban community.

A total of 3 focus groups took place which included no more than 6 participants in each. Content analysis was used to examine themes around paternal involvement, social contexts, environment and residential status were explored in-depth in which the perspectives of men are was in question in relation to the tenets of the Ecosocial theory. The main questions examined perceptions, expectations, challenges and barriers to involvement, resources, and neighborhood
characteristics in an effort to understand what contributes or hinders healthy birth outcomes in African-American families. These factors included social and cultural norms in which information from the FFCWS questionnaire doesn’t explicitly examine, however, the use of focus groups allowed for exploration of this content to discern this level of influence similar to Lamb and colleagues (1987) efforts in operationalizing paternal involvement.

A total of 12 men participated in 3 focus groups in the Champaign-Urbana community. Qualitative studies often use purposeful or criterion-based sampling, that is, a sample that has the characteristics relevant to the research question(s) (Patton, 2001). Stratified purposeful sampling was used to focus on particular characteristics of the subgroups of interest in rural, urban and suburban communities since the focus groups were to take place in three different communities. The rule of thumb based on this data collection method is to have a representative sample from each population of study (Patton, 2001). Focus groups typically have 5-10 people in each and since we are studying only men for this portion of the study, two focus group from each site is needed to be representative of the 3 sample sites. With the interest of discussing with only men, smaller groups may be more sufficient to allow participants to be more comfortable and thus the option of more groups. Thus there were three focus groups in which two included 3 African-American men and one included 6 African-American men. At the completion of each of the focus groups each participant received a $15 cash incentive for their time and participation.

Data Analysis

The qualitative phase of this study focused on explaining the results of the statistical test in the quantitative piece and provided the context for thematic areas to further explore the social factors that contribute or hinder paternal involvement during the perinatal, prenatal and postnatal
stages of pregnancy. Data collected through the audio recordings of the interviews were transcribed and coded by research team members and imported into Atlas Ti to summarize and group the entire theme. Atlas Ti is a software used for qualitative data analysis and research software that allows for display and analysis of large textual and audio data.

Content Analysis

There are numerous methods used to examine text data including ethnography, grounded theory, phenomenological and historical research. However, for purposes of this study content analysis was used for the subjective interpretation of the content of text data collected from the multiple focus groups to systematically code and identify themes and/or patterns. The goal of content analysis is “to provide knowledge and understanding of the phenomenon under study” (Downe-Wamboldt, 1992). This goal is actualized through a systematic process that involves one of the three approaches to qualitative content analysis; conventional, summative, and directed content analysis. Content analysis commonly contains 6-7 steps and the success of content analysis is dependent greatly on the coding process (Krippendorf, 1989; Patton, 2001). The basic process is organizing large text quantities into much smaller content categories (Hsiu-Fang Hsieh & Shannon, 2005). Categories are patterns or themes that are directly expressed in the text and derived from the analysis. The relationships among the categories are then identified and creation of a coding scheme is developed to guide the coding process in analysis (Hsiu-Fang Hsieh & Shannon, 2005; Mayring, 2000). Steps for interpreting content analysis will follow as described for the directed content analysis.

Focusing this study on a directed content analysis provided a context for an in-depth understanding of paternal involvement and its relationship to healthy birth outcomes in African-American families. Creating and adhering to an analytic procedure or coding scheme will
increase trustworthiness or validity of the study (Hsiu-Fang Hsieh & Shannon, 2005; Potter, James W., and Levine-Donnerstein, Deborah, 1999). Content analysis offers a flexible pragmatic method for developing and extending knowledge of the human experience of health and illness (Hsiu-Fang Hsieh & Shannon, 2005). Its use in this study will further enhance its reliability and increase our understanding of the relationships of residency, individual demographics and healthy birth outcomes.

Directed content analysis is guided by a more structured process in which existing theory or research may help focus the research question. The goal here is then to validate or extend conceptually a theoretical framework or theory (Hsiu-Fang Hsieh & Shannon, 2005). Using existing theory or prior research, researchers begin by identifying key concepts and variables as initial coding strategies to expand what may be a phenomenon that is incomplete or would benefit from further description (Potter, James W., and Levine-Donnerstein, Deborah, 1999). The findings from this type of analysis offer supporting and non-supporting evidence for a theory or framework, whereby this theory will guide the discussion of these findings, in this case the Eco-social Theory.

Content analysis employed in small groups is used to differentiate among kinds of verbal interactions, to quantify the contributions made by members, and to conceptualize the role they assume in directing the emergence of social structures that may become explainable in these terms (Krippendorf, 1989). In using the directed content analysis, the researcher uses the existing theory or prior research to develop the initial coding scheme. The process is outlined in Appendix F. Therefore making the main strength of this approach is that the existing theory can be supported and extended.
All focus group recordings were coded and transcribed verbatim. Findings from both the quantitative analysis of the FFCWS questions and the content analysis of the focus groups were examined in relation to the Eco-social theory. This was reviewed to compare findings for both residential (in-home) and non-residential (not in home) fathers. For the purposes of this study, statistical analysis only included fathers whose child is considered born healthy, a healthy birth outcome will be defined as; birth after 37 weeks of gestation, no maternal complications of pregnancy, born without serious birth defects and birth weight 1500≤2500 grams as suggested by the center for disease control;(Amina P. Alio, Alfred K. Mbah, Jennifer L. Kornosky, Deanna Wathington, Phillip J. Marty and Hamisu M. Salihu, 2011; Centers for Disease Control and Prevention (CDC), 2002a; Chang, O'Brien, Nathanson, Mancini, & Witter, 2003; Giscombe & Lobel, 2005; Hauck et al., 2011; Heron et al., 2010)

The researcher thoroughly reviewed the data making notes that were summarized and the relationships among the categories made (Creswell, 2007). The coding process consisted of reading the transcribed data and organizing it into categories that reflected the recurrence of themes and or patterns of contextual factors that are relevant to the research questions posed to inform the rest of the study. This was done by the entire research team at debriefings after each focus group and at a final meeting after all data was collected and transcribed.

The next steps in the process were to code and recode the content of the text data. New codes were added to a master codebook which is the source of the descriptive results from the quantitative data analysis which focuses on attitudes about being a father, parenting practices, relationship with mother, involvement as a resident [in-home with child] and non-resident [out-of-home with child] father, social support and community resources, background information
and prenatal/neonatal experiences. Data is then compared to establish the commonalities for further analyzing to increase the interpretability for the enhancement of our understanding through the complementarity design of the study. The research questions guiding this study seek to investigate African-American men’s perceptions concerning their involvement during the antenatal, prenatal and postnatal stages of their partners’ pregnancy. Once the codes have been identified, themes and categories summarized a balance between interpretation and description will be presented. The interpretation fundamentally represents my understanding of the phenomenon under study theoretically and personally. Therefore, the representation of my findings will provide a “sufficient description to allow the reader to understand the basis for an interpretation, and sufficient interpretation to allow the reader to understand the description” (Patton, 2001, p.503-504).
Chapter 4: Findings

The purpose of this study is to examine the effect of relationships on healthy birth outcomes in African-American families. The results describe what role the presence or absence of fathers and partners across differing communities play in healthy birth outcomes in African-American families, specifically looking at the role of paternal involvement during the antenatal and postnatal stages of pregnancy. There were two primary relationships examined. The first relationship was to examining individual level factors as unique dependent variables related to paternal involvement on healthy birth outcomes. Second, this study explored the impact of neighborhood variable factors on paternal involvement among African-American men with children aged 5 years of age or younger in the state of Illinois. This chapter presents the findings of the study.

Phase I Quantitative Descriptive Statistics FFWCS

The Fragile Families Child Wellbeing Study includes a nationally representative sample of 4700 total live births between 1998 and 2000. There were a total of 3600 non-marital, and 1100 marital births in the study and 69 percent of the sample was African-American. This study group was limited to African-American men only. A total of 1870 resident and non-resident African-American fathers were eligible to be included. Excluded from this study group were participants under 18 years-of-age and African American men who did not include income. The resulting representative sample collected in phase II was n=1367.

Descriptive statistics for phase I of the study are presented in Table 4.1. Individual level data was taken from the 1998-2001 Fragile Families Child Well-being Study and used to create unique dependent variables. The individual level data from 1998-2000 contained missing cases
for some variables of interest (e.g. residential status and income level); therefore, these variables were excluded. The African American men included had varying levels of education with lower educational attainment levels of a high school degree, equivalent or less (42.7%). Most of the men resided with their partners or mother of their child (41.9%) and 95 percent of this sample include men between the ages of 18-44. Income levels varied markedly with reported household earnings between $25,000 and $49,999 represented by 22 percent of participants and another 22 percent represented by incomes ranging between $15,000 and $19,999. Table 4.1 summarizes the descriptive characteristics.

Results Aim I. **Explore the relationship between neighborhoods, perceptions and involvement**

A one-way analysis of variance (ANOVA) was used to answer research question I. The ANOVA test determined if the income levels of the men in the neighborhoods differed on their perceptions and involvement. For this analysis the assumptions were met; the independent variable has several categorical groups, there is no relationship between observations, and no significant outliers. It was determined that there was unequal homogeneity of variances as assessed by Laverne’s Test of Homogeneity of Variance. Since there was a violation in homogeneity of variances a Welch ANOVA was used and results indicated statistically significant differences among the sample means of perception and income level as a proxy for neighborhood wealth status, Welch’s $F(9,1860) = 6.22, p<.001$. Results of the Welch ANOVA are presented in Table 4.2.

The neighborhood wealth status (father’s household income) of participants appears to be related to Dad’s perception, $p<.001$. Additionally, a post hoc test was run to determine individual differences with the groups. The Games-Howell post hoc test was used to test the hypothesis: there exists a direct relationship between income level and Dad’s perception of the prenatal and
postnatal period. Comparisons were then made of the relevant income levels. Table 4.2 displays the results of the post hoc Games-Howell analysis at alpha level of .05. Results of men whose annual household income levels were above $35,000 were significantly different from men with incomes less than $5,000. Men who earned less than $5,000-annually demonstrated fewer positive perceptions about the pregnancy than men who earned $35,000 or more annually. The difference in perception indicates that income positively influences men’s perceptions of the prenatal and postnatal stages of pregnancy.

There was a statistically significant mean difference between neighborhood wealth status (father’s household income) and Dad’s perceptions. Games-Howell post hoc analysis revealed that the Dad’s perception increases based on income differences were only shown in men whose household income is between less than $5,000 k to over $25,000 \( R = 2.31, p = <.001, 95\% CI [.19,1.40] \). Table 4.3 illustrates the Games-Howell post hoc analysis. Those men whose household income level is over $25,000 has .67 less positive score of perceptions of fatherhood than those men who earn less than $5,000 a year, \( p=.018, 95\% CI [.06, 1.28], \) and decreased as annual household income increased from $35,000 k to $75,000, \( R=.75, p =.004, 95\% CI [1.30, 1.40] \).

The analysis also revealed that mean differences in perception was also statistically significant; men whose income is less than $5,000 a year or did not report an annual income were less likely to have scored highly on their perceptions of fatherhood compared to mean whose household income was over $75,000 a year. Income less than $5,000, \( (M=10.573, SD=1.76), p<.001, \) Income less than $75, 000 \( (M=11.347, SD=1.14), p=.004. \) Figure 4.1 summarizes the results of mean comparison of income and Dad’s perceptions.

Results Aim II. **Explore the role of quality of communication and involvement**
RQ. II.
How does AA male and infant mother quality of communication impact AA male prenatal care level of involvement?

The question is considered as communication among partners good or bad may influence specific risks factors such as unhealthy prenatal behaviors, stress and emotional health which research has demonstrated as factors that increase adverse birth outcomes in African American women (Alio,AP. , Kornosky,J.L. , Mbah,A.K. , Marty,P.J. and Hamisu M. Salihu, 2010)Quality of communication was measured using six variables that indicate the frequency of discussing the following topics among partners: (1) money, (2) spending time together, (3) sex, (4) pregnancy, (5) unhealthy habits, and (6) being faithful. A Likert scale of often (1) sometimes (2) never (3) was used. Quality of communication were measured using six variables that indicate the frequency of discussing certain topics amongst partners these include; discuss money, discuss spending time together, discuss sex, discuss pregnancy, discuss unhealthy habits, discuss being faithful on a Likert scale of often(1) sometimes (2) never(3). These six selected variables were computed into a composite variable, which was reverse coded to indicate quality of communication between partners used to analyze this question. A two-way analysis of variance (ANOVA) at an alpha level of .05 was conducted that examined the interaction between the independent variables, age and education level, on the dependent variable, quality of communication, between partners. For this analysis there were three hypotheses. The first hypothesis states that there are differences amongst quality of communication by age (i.e. \( H_0: \mu_{age1} \neq \mu_{age2} \neq \mu_{age3} \neq \mu_{age4} \)). This hypothesis was tested in the first analysis resulting in failure to reject the null hypotheses. Restated, age differences account for quality of communication in partners. The second hypothesis states that there is differences in quality of communication by
education level ($H_a: \mu_{\text{Educlevel1}} \neq \mu_{\text{Educlevel2}} \neq \mu_{\text{Educlevel3}} \neq \mu_{\text{Educlevel4}}$). The third hypothesis states there is no interaction between age and education on the quality of communication among interview participants at baseline using the FFWCS. Table 4.4 illustrates the two-way ANOVA results.

The second hypothesis states that there is a difference in the quality of communication by education. The null hypothesis was accepted and results indicate that education is related to quality of communication. There were statistically significant results, $F(4, 1852) = 4.472$, $p < .001$. Age and education levels were also demonstrated statistically significant results as expected ($p < .05$), which indicates that both age and education influences quality of communication scores of African American men. The third hypothesis stated that there is an interaction between age and education on quality of communication. Analysis of the third hypothesis revealed a failure to reject the null hypothesis. Restated, the interaction of age and education will not show a relationship to quality of communication. There was a statistically significant interaction between the effects of age and education on quality of communication between African American men, $F(3, 1852) = 1.971$, $p = .033$. Results are indicated in Figure 4.2.

In exploring the relationship of quality of communication, we also examined the effects of residential status on quality of communication during the pre and postnatal stages of pregnancy in African American men. Examination of the effects of residential status on quality of communication during the prenatal and postnatal stages of pregnancy in African American men was included when exploring the relationship of quality of communication. The null hypothesis states that there is no relationship between residence of African American men and quality of communication. Chi-square analysis was used to determine if there is a relationship between quality of communication and residential status (resident/non-resident). Residential
status is a variable that can benefit or challenge varying levels of paternal involvement during this time and is thus used as an additional predictor of quality of communication on involvement levels (Teitler, 2001). The assumption of independence and sample size were met before completing analysis. There is at least one observation per respondent in each of the analysis and zero percent of the contingency cells had an expected value of less than five. Quality of communication score and residential status did not yield statistically significant results $X^2=5.189$, $p = .075$. Table 4.5 summarizes the results.

The results indicate that there are no reported differences in greater communication levels with partners who live in the home compared to those less likely to reside in the home of the mother of their child. There was failure to reject the null hypothesis, which stated there are no differences in quality of communication based on African American men residential status. Of the African American men that report fair communication with partner 31.6% live in the home of their partner while 35.6% do not live with the mother of their child, an insignificant difference. A comparison of poor communication with the partner reveals that 67% and 62.1% (resident, non-resident) of African American men not residing with their partner consider their quality of communication to be poor while only 1.8 percent of African American men who reside with their partner consider their communication quality to be good or very good.

While there were observed differences within groups, quality of communication overall was not considered to be very good for majority of African American men in this study, however, poor quality of communication was evident whether or not the mother and father resided in the same home.

Results Aim III. Explore residential status [resident/non-resident] of African American men and involvement
RQ III. How does the AA male residential status [resident/non-resident] influence degree of involvement? H₀ Males who reside with infant mother/partner will be less involved than men who reside outside the home.

Tables 4.6-4.9 present logistic regression models, which demonstrate variation in predictors of involvement for African American fathers. Logistic regression models were performed to investigate the variation in predictors of involvement for resident and non-resident dads. The variables were determined based on the life course exposures of the Ecosocial model (see Figure 1.1). The logistic models were separated by residential status because the variables representative of involvement from the Ecosocial model support the social historical context of the life course span examining the relationship of the father to child in utero into infancy. The variables included the composite variable paternal involvement, SES and residential status with yes as the reference variable. SES demonstrates the likelihood of financial support which is considered of high importance in African American families which shows significance in prior research. The assumptions were met and all variables were mutually exclusive and exhausted. The logistic regression model, chi-square test of independence did not reveal statistical significance overall \( X^2 (3, N=1357) = 4.369, p=.261 \). However, analysis indicated that income significantly impacted involvement \( p<.001 \). There were no other individual level significant predictors as indication of residing with a partner during this process. These results illustrate that fathers residential status is not a confounding variable that hinders or increases paternal involvement for men in the FFWCS baseline study.

RQ. IV How does the AA male residential status [resident/non-resident] influence perceptions? H₀ Men who reside in home will have less positive perceptions about the prenatal and postnatal period
A logistic regression was performed to ascertain the effects of perceptions, partner support, quality of communication and paternal involvement on the likelihood that partners live together during the pre and postnatal stages of pregnancy. The following assumptions were met prior to running the analysis, independence of cases, no significant outliers, no multicollinearity and variables are mutually exclusive and exhausted. The logistic regression model, chi-square test of independence was statistically significant $X^2(4, N=1357) =1470.892, p<.005$. The model explained 28 percent of the variance (Nagelkerke $R^2$) in residential status and correctly classified 60% of cases. Of the predicted variables, all were statistically significant (see Table 4.7).

However, partner support showed greater predictability; if partner support was high there is 1.027 times the likelihood of greater paternal involvement as it relates to the father residing with the partner. Therefore, the null hypothesis that differences in perceptions will be based on if the partner stays in the home is rejected. Table 4.6 illustrates the logistic regression for factors of resident fathers that influence paternal involvement.

A multiple regression analysis was also run to examine the relation of all predictors on paternal involvement the multiple regression equation is defined as $y = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + ... + \beta_p x_p$ for $i=1..n$. The equation used in this analysis is defined as $Y=16.930+.032*x+.008*x+.072*x-.023*x$. Table 4.7 summarizes the binomial logistic regression analysis for residential status, perception, partner support, quality of communication and paternal involvement.

The stepwise multiple regressions revealed that Dad’s perception has relevant explanatory power. The estimated regression model (Paternal involvement=16.930+.072*Dad’s perception) $p=<.001$ CI 95% (17.44, 17.89). All four variables added statistically significantly to the prediction, $p<.05$. The regression model is highly significant $p<.001$ and $F=7.544$. Dad’s
perception was the greatest predictor in examining differences in income on paternal involvement. If Dad’s perception is positively scored the interaction of his score and income, increase the likelihood of greater involvement. The test of significance demonstrates that the intercept and Dad’s perceptions are highly significant (p<.001). Therefore, we show a positive relationship between Dad’s perception and income. As income increases by .002 Dad’s perception also increases by .072. Table 4.8 illustrates the multiple regression analysis of paternal involvement of African American fathers.

RQ V. What is the relationship of African American male SES on frequency of involvement?

H₀ Men with higher SES will be more involved
H₁ Men with low SES will be less involved

A simple regression analysis was used to ascertain the effects of differing income levels on predicting the likelihood that fathers would be more or less involved. The initial hypotheses predicted a linear relationship between SES and paternal involvement. The estimated regression model is that Paternal Involvement=2.98+.002 *Income with an adjusted R² .3% is highly significant with p<.001 and F=4.976. The standard error of the estimate is 813.113. Thus we can show a positive linear relation and we can also deduce that for every level of involvement the income will increase by .002. Therefore the null hypotheses has failed to be rejected as this analysis supports the assertion that men who have higher SES will be more involved as indicated by the positive relationship. Table 4.9 summarizes the results.

Overall, using the FFWCS there is a significant relationship between paternal involvement and socio-economic status. Regression analysis revealed that there is a relationship between SES and paternal involvement. Men whose income was higher had increased levels of involvement being medium or higher and also scoring higher on the composite variable created to examine paternal involvement than men who were of low SES. However, differences were
shown at overall income levels but not individually on involvement using regression analysis. The regression analysis concluded that there is a positive linear relationship between involvement and income when controlling for quality of communication, residential status and education ($p<.05$). All the variables added to the statistical significance but overall test reveal that income was the greatest predictor of paternal involvement ($p<.001$).

**Qualitative Phase II Results Dads Matter**

Research has attempted to explain differences on healthy birth outcomes by examining numerous maternal risk factors such as maternal smoking, drinking, age, income and depression (Alio et.al, 2010; Milligan et. al 2002; Ma, 2008; McAllister & Boyle, 1998), through surveys and interviews of women, while fathers’ names are just shown on the birth certificate without mentioning or showing the impact that fathers have on birth outcomes (Alio et. al. 2010, 2011, 2013; Khanani et. al 2006). However, few studies have examined the role of paternal involvement from the perspective of men in which limited knowledge exists on their lived experiences which in turn influences birth outcomes of their children. In this study, paternal involvement was explored in depth using focus groups to fully understand their influence on healthy birth outcomes. Focus groups were used to examine the following aims: (1) to explore the relationship between perceptions and involvement, (2) to explore the role of challenges and barriers to paternal involvement, and (3) to explore the relationship of resources and support to paternal involvement.

There were three focus groups that included 4-6 African-American men ages 18-44. Each focus group lasted between 60-75min to explore the complex relationship of paternal involvement on healthy birth outcomes. Perceptions of the pre and postnatal stages of pregnancy were examined through a variety of guiding questions (see Appendix A).Men were asked about
their feelings of becoming a father, if it created any stress for them, what they consider to be their role during the process and what does supporting their partner mean in an effort better understand paternal involvement that leads to healthy birth outcomes for their children. Challenges and barriers were examined through questions that asked about experiences of prenatal care visits, communication with partner, familial support and financial or work commitments that influence their involvement. Finally, resources were explored in reference to personal, familial, community or other group affiliations (i.e. church, fraternities etc.). Directed content analysis was used to explore the male perspectives and coded into several themes under the three basic topic areas, perceptions, challenges and barriers and resources. The final thematic areas revealed that culture, support, awareness or lack of awareness; adjustment/adaptation, time, experience and ideals of masculinity were prominent across all focus groups participants. The themes also embody the components of the Ecosocial theory at the individual and community level. The remainder of this chapter details the reported experiences of African-American fathers during the pre and postnatal stages of pregnancy. Table 4.10 further details key illustrations and quotes that highlight men’s perceptions of the pre and postnatal stages, the challenges and barriers they faced in adapting to their role as fathers, the differing support and resources available that may assist them currently and what is expected in the future of fathers.

Results

Aim I. Explore the relationship between perceptions and paternal involvement

Perceptions

The relationship between paternal involvement and perceptions about the pre and postnatal stages as expressed by the lived experiences of African-American men has revealed a diverse response to the notion of paternal involvement. These experiences as discussed with men of a single suburban Midwestern community have provided a new lens in understanding their
roles during this period. Men expressed a variety of emotions and perceptions of fatherhood when learning about becoming a father.

Stress of Becoming a Father

Recurring viewpoints arose when fathers expressed their response to news that they would become a father. Men expressed both emotions about the news and the need to adjust their lifestyles to begin thinking about the caring for somebody else besides their own selves. Men said that they were excited, stressed, doubtful, and scared about the process.

The following excerpts demonstrate examples of stress.

I was very excited and very nervous. I remember the day and I remember the time and I went to the room, closed the door and started crying [laughs]. Just cause I knew it was about to get real, and I knew that I didn’t want all my flaws—I wanted to eliminate as many of my flaws as possible because I didn’t want them to translate into my kids... spiritually, physically, any of that.” (Father #4)

“When I first found out that I was going to be a father I was kind of excited, a little bit nervous, but it was a great experience. I was nervous for the simple fact that I didn’t know how I was going to support my children at first, you know, but—just dealing with the experience over the years has been great; you know what I’m saying. When I first found out, I was—I was happy” (Father #6)

“...after the initial shock it was kinda like well I’m excited but I don’t know, like it might be a little bit, ah I wasn’t quite sure if there, there wasn’t anything that I knew exactly what to do” (Father #8)

So but I was excited man, you know uh, I think I knew before she did because she was just saying certain things and I was like I think, I didn’t say nothing to her though so she came to me, you know, and let me know and I was excited. She wasn’t expecting me to be excited, but I was happy. Ecstatic. (Father #11)

“...And so it was a shock, it was a surprise, it was all those good things, but um, it was good”. (Father #10)

Fear was associated with prior experiences in which pregnancies had not gone to term due to miscarriage or other complication so this news came as a shock.
The following excerpts demonstrate examples of stress expressed as fear.

Well we had three pregnancies, one miscarriage, so the first one was a shock too because it was fresh out of being married and then the—after the miscarriage um it was a shock again because we got pregnant again two weeks after the miscarriage. So we was—every time we was a little shocked, but we were excited um to be parents, but um it wasn’t really anything different, but different experience. So miscarriage, pregnant right away, then we thought we wasn’t able to get pregnant again. (Father #5)

When I found out my girl was pregnant, uh, I don’t know, I was just puzzled, because I didn’t think that would happen to me, because I mean I’m only 23 first of all, and I had stuff to do, and it was a really sensitive situation, and um, how she was acting, I was like um, you know what, if you was gonna be acting like this, then I don’t wanna go through this right now, and stuff like that, but then I came back to my senses and like, I can’t do this to her, to a baby, so I was like, I’m gonna stick it out. (Father #2)

The men expressed that being a father was exciting yet stressful. They also reported fear because of their new parental responsibilities and having to take care of someone they helped to bring into this world. The stress perception was different once the father learned the child’s gender. The following excerpts demonstrate examples of changed stress perceptions once the father learned the child’s gender.

I wanted a girl so bad, I really did, but I’m having a boy, so I just gotta have a girl. A dad’s got to have a princess. I thank God that I’m having a boy. Boys are just (inaudible) but girls are…the only issue with having a boy, is you were once a boy, so ….Father #2

She told me she thought it was a girl, but as a whole, no I wasn’t stressed. It was my financials, like I said I was, cause at the time my income was just set to take care of the four of us, and then there was gonna be five. I was thinking about that, like how the hell am I going to afford that. (Father #3)

“…found out it was a girl and I really knew I had to change it all, you know, definitely had a bit of work that needed to be changed”(Father #9)

African American fathers also defined what stress meant to them once assuming the responsibility of fatherhood. Many men did not express that the news of becoming a father was very stressful but instead identified where they needed to make individual changes in their lives. Additionally, many fathers reported reaching a point in their lives that the fatherhood event was another milestone shared with their partner after recovering from the initial shock of unplanned
parenthood. Men expressed that fatherhood was more an experience of learning reality and making responsible decisions as it now affected a family of three, not their original relationship. The following excerpts demonstrate examples of fathers who identified the stress of assuming fatherhood and family life.

...well during the nine months, like I said, I was nervous at first, but I had a great support system, so like I said I had my mom and I had a grandmother and stuff like that, so I had people constantly getting in my ear and telling me what I needed to do... But once the baby got here I did kind of get nervous because I had my kids back to back. A year and a day apart so yeah it was kind of hectic, you know what I’m saying? I had to step it up real fast. (Father #6)

I think for me there was some anxiety, it was more so, um, trying, cause we were at a point in transition in career, with school, all those different things that the only anxiety was, you know, I wanted to make sure that I didn’t make a bads, like okay, I’m like okay, up to this point, you know my steps have been, you know, however they’ve been but they haven’t been strategized in regards to children, those type of things because I was so career focused at that time, so it was changing my steps and trying to line things up cause I knew I had a little one coming. So there was a little anxiety there. (Father #10)

I wouldn’t necessarily say that I was stressed on a day-to-day basis, um but I was cognitive. It was a very present thought—it was always like hey, you know... this is real, this is happening, every step, every move I thought about how it would affect my child and my wife”. (Father #4)

Not really stress, um I know how I get—I mean when you find out information—until it actually goes—so you know she’s pregnant... until you actually see that baby it doesn’t hit you, so I’m like okay it’s probably going to be the same and you kinda like—you’re wondering what’s gonna happen, but then when my kid came out, I’m like okay this is real. (Father #5)

Perceptions of stress, quoted above, illustrate how African American men experience their adjustment to the role of fatherhood during their partners’ prenatal and postnatal stages of pregnancy. The selected excerpts also reveal that men view their experiences positively. Men described learning their new fatherhood responsibility was a role they could adapt to over time, although reports of stress remained common.

Role of Fathers

The role of father was defined throughout the focus groups. Men described intangible factors in their fatherhood role. Men uniformly defined their role in the context of their partners’
expectations, social cues and individual character traits, especially personal ideals in masculinity, when they responded to questions of how they would describe their African American fatherly role. Fathers revealed that the role of the father was not limited to supporter and provider. Instead, fatherhood included being a, “servant, protector, mister know-it-all, partner, strength, role model, and gatekeeper. One father described his role as being “amazing.” Men also noted that spirituality and having a “hands on” approach are important to the role of fathers. The following excerpts demonstrate examples of men’s definitions of the fatherhood role, the importance of spirituality and what being “hands-on” means for them.

...um I don’t know if I read this or if I’ve heard it somewhere, but I’m under the mindset that the best thing that you can do for your kids is let them see you respect their mother. (Father #4)

I think in um as few words as possible I would say hands on approach. Like I am constantly just there... like um a typical father won’t constantly be there to change the pampers, to get up, um to feed the bottle. Just these little things you could take, um people might only take—but people just by like well it’s gonna be done by the mother, but I feel like, you know, I have a responsibility too, I helped make the child so I need to help out. And it’s not a guilty feeling, but it’s like I’m proud to be a dad and I wanna at the end of the day say “I helped my kid”. You know? (Father #5)

Men were asked how they perceive their partners’ view of the fatherhood role. The fathers expressed similarities in what was considered important. Many fathers expressed that making their partners “happy” is what they perceived as being most important. Happiness, however, is perceived as changeable; it comes with experience in life as described below.

I believe that it changes. No one ever actually needs the same thing over and over; you know it changes with time, um and with women it changes every day... (Father #6)

I really can’t tell. um I think my wife’s happiness is all that matters to me. She tells me that if the child is satisfied and happy then her joy is kinda full. I try my best to ensure that my wife’s happiness does not subside any one time..... (Father #4)

Happiness is all that she needs from me. Even if I don’t provide financial assistance to her, she says that she can’t trade her joy with money.... (Father #5)
I derive maximum peace from the joy of my wife. I know sometimes I am rude and unfair to her but, um I, I try my best to ensure that her happiness is always available regardless of the kind of stress we are facing.... (Father #3)

Engagement in the fatherhood process included participating in classes offered at the hospital, being emotionally involved, adjusting constantly to change and difficulties due to location, time and transportation. The following excerpts demonstrate examples of men’s descriptions of engagement in the fatherhood role.

I just think that um being there and being engaged in the whole process. My wife, she wanted to go to all of the activities at Carle. I went to about 15 different classes and went to ah everything and so I just said that even though it was stuff, I was like man okay now I’m gonna be up all night studying for this, working on this thing, but just I have to be there. So if it came where I had, like he said just become less self-focused and just say now I really need to concentrate on really being more selfless and participating in whatever was needed to do. Just being there and listening, not being stressed or being like ah I gotta go, I need to go do, but just come and say okay how are you, we need to do this, you need to be comfortable, you the one with the baby, so (laughter) it’s up to me to make sure that you’re comfortable so I, it was just adapting to that role, role that I had really, we were both, you know, we just adults, we married we, yea we could do whatever we want to but now, to kinda have more of that kind of uh planning. (Father #8)

I’ve been to every appointment that my wife has had to this point, with the exception of her breastfeeding class simply because I figured I can’t help with that until she came home and was like, “You should have been there! I was so stressed, and I needed comfort and you’re gonna need to help me breastfeed.” And I was like “I don’t know what you’re talking about” and she was like “yea you have to make sure it’s pointing this way and make sure the baby don’t choke!” So short answer: yes [laughs] you should be at all the appointments. (Father #4)

Experience brings understanding. Experiential understanding was evident in men’s perception of their role in the process of becoming a father. Being a new father or father to a daughter revealed new insights by some men about their expectant role as it how their partners thought. The following excerpts demonstrate examples of men’s descriptions of experiential understanding in the fatherhood role.

...that’s tricky because as a man—I’ve been married almost five years and I know you can’t—you think you know what she wants you to do, but then when you do it it’s probably nine times out of ten the wrong thing. (Father #5)
‘cause I did not understand, like you just said, I did not understand what was going on when she was pregnant with my daughter, that was my first girlfriend. And I, and I wish I had a better understanding of her (inaudible) and balance, cause that would have saved a lot of arguments, and a lot of clashing. That first...was rough, and then nine months, I didn’t realize what was going on with her, I’m like okay why are you so crazy and why are you taking it out on me? (Father #3)

Men expressed a variety of emotions, as demonstrated in the above excerpts, including their thoughts and perceptions about becoming a father and the expectations of their role as fathers. Experiences such as these provide insight into the thought processes of African American fathers and stressors related to their involvement during the pre and postnatal stages.

Defining a Healthy Pregnancy

Men were examined for their fatherhood role from the eyes of their partners. The men were asked how they defined a healthy pregnancy, which may ultimately lead to a healthy birth of their child. Fathers expressed a variety of factors that influenced a healthy pregnancy with a clear understanding that a healthy diet, alleviating stress and support are important to the health of the mother and the child. The following excerpts demonstrate examples of men’s perceptions of their partner’s role and of the experience of pregnancy.

A woman that’s not stressed. Cause stress on a woman, is stress on the baby and you not want that. (Father #7)

I think, uh, carrying the baby to term. I feel like that was going to be important (Father #10)

Um a healthy birth... I would have to piggyback on what #6 said... um full term—at the full term. I think all—for a lack of better terms—all ten digits on the hands and all toes on the feet. (Father #5)

Father’s also conveyed that going to prenatal visits were a regular part of this process and made concerted efforts to attend appointment. They also expressed how this was also a group effort if other relatives attended for any reason. The following excerpts demonstrate examples of men’s perceptions of sharing their partner’s prenatal experience pregnancy.
Me and my girl did it all together. I mean we went to Carle, and just like he said, we booked the next appointment at the next appointment. (Father #6)

Yeah. Me and her every time. I mean, her mom went for the gender ordeal to see what the gender was gonna be, but that’s it. We went to every doctor’s appointment together. (Father #9)

Yeah. It was me and my wife. Her parents live two hours away, mine’s eight hours away so it was just us. (Father #8)

Fathers expressed that a full term pregnancy was an important aspect to having a healthy new child. Men also conveyed that there are other things to consider such as the mood of their partner’s, filtering outside influences to their thought processes reflecting on past births or experiences of others and looking toward the postpartum period as well. The following excerpts demonstrate examples of men’s perceptions of prenatal health during pregnancy.

To me personally, I feel like a healthy pregnancy would be just having those feelings of love and joy, that you know that everyone should feel once you just had a baby into this world. You know, and she’s feeling good about having her newborn baby, and you feeling good about having your family. Then shit that’s a healthy pregnancy then... can’t get no healthier. (Father #6)

When my girl was pregnant I didn’t—no sweets, no chocolates—I’m not really big on that; you know what I’m saying? I don’t really like chocolate and stuff like them, so I’m not big on that, but to elaborate on what #5 was saying with postpartum, you know the brain stuff, we gotta really be on top of that cause a lot of women won’t say stuff, but that postpartum is a big deal, you know it really messes with women after they have those babies and if they’re in a stressful environment, that postpartum gets on them and they get depressed and all types of stuff. (Father #6)

Fathers were very adamant in expressing that their partner’s needs came first and insisting that they put themselves second as it was beneficial to both the mother and the child.

Throughout this time it was a learning experience and with every new day came some challenges but in the end it is for a great term pregnancy and also helped them to come to a better understanding of their role in this process. The following excerpts demonstrate examples of men’s perceptions of their partner’s needs during pregnancy.
I think that the men plays a bigger part in this than I think we believe. Because a woman having a child, going back to your point, us being there eliminates some of that because they just wanna know, am I doing this by myself or are you gonna be here with me? If I have some assurance that I’m not in this fight by myself, I’m not going be the only provider, I’m not gonna be the only one that has to take care of, I don’t feel like this is a race that I gotta run by myself. I think that helps healthy pregnancies because they believe there’s someone else walking beside me to bring this child out into the world and that’s where the man creates a healthy pregnancy. That’s where we can help those medical tests, because we can say I’m with you, you know. Again, we talking about how can I let you know that I’m reliable, you can depend on me. I am gonna be here no matter what, getting up at four o’clock in the morning, that’s healthy and that’s what leads to lack of stress because if you could understand the ones that have issues, if you think about it, it’s because they don’t have the support and they’re fearful of, man should I even keep the baby, I can’t do this by myself, can I, I mean, all those things that’s going through their head. So we play such a huge role as men for the health of pregnancies. (Father #12)

Each father had his own perception about how he felt about healthy pregnancies and his role in the pre and postnatal processes of pregnancy. Father #12 expressed the importance of learning to understand his role. He described that his fatherhood role had influence and described how it helped him improve his partnership with his wife, working together to have a healthy child. Other fathers also expressed similar sentiments about wanting to alleviate stress and being involved in the diet aspect of their partners’ pregnancy. Many reported acting as if they were lay health educators ensuring they have a healthy baby. Perceptions on healthy pregnancy and their involvement varied whether it was their first child or third child. Some fathers felt that a full term birth, prenatal visits, minimal stress and a healthy diet is most important in supporting their partners.

Results Aim II Explore the role of challenges and barriers to paternal involvement

**Challenges and Barriers**

Men were analyzed for challenges and barriers to paternal involvement in the pregnancy. African American fathers also explained if there detected limitations to their involvement in the prenatal and postnatal stages of their partner’s pregnancy. Fathers related a variety of challenges
that existed and some barriers that influenced their involvement during this process. The expectation of being there resonated in all the fathers and being there included physically, emotionally and financially however, work transportation and distance made it difficult at times.

Distance and Work

The following excerpts demonstrate examples of men’s perceptions of their distance and work during pregnancy.

I kinda missed half of it because she lived in Bloomington and I lived here so from there I missed I wanna say, I’d go see her but there wasn’t an everyday basis of me being able to be there. (Father #9)

I would say me going to—it was things that interfered with me going to the doctor’s visits, but not the pregnancy. Like the pregnancy, I was full in, like she wants Sprite? It’s 3am? She gotta get some Sprite. I don’t care if I gotta go in my sleep, that’s what you gotta do. But yes my job did interfere with me going to those doctor’s appointments. (Father #5)

...other than just figuring out a good schedule cause of work and making appointments and changing things around and making sure that I can be where I needed to be when I was supposed to be. Um, I’d say that was the biggest challenge during the pregnancy and even after the baby being born, just making sure that find the time, making time. (Father # 7)

Distance was related to both being able to attend doctor’s appointment and being there for their partner. Distance was also a barrier when it came to meeting the late night cravings of partners. Distance was important for fathers as they expressed that it affected whether they were able to be there. The following excerpt demonstrates an example of the effects of distance during pregnancy.

We didn’t have a car at the time and the grocery store was a mile in each direction. So she woke me up and I was working, I’ll never forget, I stayed far, I work on one side of town and live on the other, and it was a 2 hour bus ride to work every day, and a 2 and a half hour home, and I work 12 to 14 hour shifts, and she woke me up one day, one morning at like 3 in the morning, 2:30 or 3 a.m., I want a strip steak and some mashed potatoes. I got up, walked to the store and got it, cooked it, and by the time I finished cooking it she was back asleep.... (Father #3)

Adapting/Adjustment and Understanding
As expressed earlier, fathers discussed their role as seen through the eyes of others and their partners. The men interviewed reported balance, being able to adapt or adjust and understand what their partner was going through also posed some challenges to their involvement in prenatal and postnatal pregnancy. This was an important piece of the role of being a father. Fatherhood required more attention than other daily responsibilities. The following excerpts demonstrate an example of men adapting to their partner’s pregnancy.

Um, not necessarily, the only thing that threw a wrench in our plans, my plans, the only thing that threw a wrench in the process, like I spoke about in the beginning, was my lack of understanding that I had. This was my first hurrah, I was learning, this was her third hurrah. So yanno, just instead of listening to her I was being stubborn thinking oh I know what this is about, I’ve been around pregnant chicks before, I had never been around a pregnant woman 24/7 before. (Father #3)

you’re balancing that, especially when the baby comes home, waking up at all those times and having to go to work the next day and my wife was a stay at home mom and I just wanted to be there for her so as soon as the baby cries 2 in the morning I need to be up at like 6 so I’m jumping up as well and I’m just so tired. And then I was so glad when she made the decision, you just go to sleep cause she don’t have to work, and you feel, and you have the guilt and that happiness…(Father #8)

I think I got a chance to practice so I had, uh, a lot of my close friends that I went to college with, I got married in a college town, I, you know, met my wife in a college town and my friends didn’t leave, like they didn’t go back to wherever they came from. We all stayed in this area, and so as they began to have kids, I spent time with their kids and, you know, I was around that and then I grew up in a single parent household and my dad sort of modeled, so I knew the operational side of managing kids, but I didn’t know, you know, some of those fatherly type, you know, how to gauge the emotions of my wife and the new baby and stuff like that. (Father #10)

Honestly, to this point I haven’t faced any challenges. Um, just being supportive. She hasn’t asked me to feed her any ridiculous cravings; she hasn’t woke me up in the middle of the night. We had to change sides of the bed because she claimed she has to use the restroom more frequently than I do, but I drink a gallon of water a day so in the beginning I was like, “I’m pretty sure I use it more frequently than you do”, but at one of the classes they had me put on this empty belly and I had to lay down and get up and I was like, “man, this is a little extra couple pounds” so we’re switching sides of the bed. But no, no hurdles for me though. I mean I helped her come up. Overtime, sleep got more difficult so I bought her this dope pregnancy pillow (Father #4)
Men’s capacity to adjust and adapt, understand the role of their involvement and what their partners were going through came with experience. Fathers #10 and #11 explained experience with a friend’s or relatives children did not prepare men for the changes that fatherhood brought.

Differences in culture created greater emphasis on this challenge. Father #10 expressed that cultural barriers affected his capacity to understand his fatherhood role. Integration of culture was a challenge for both prenatal and postnatal pregnancy responsibilities despite having prior experience with a child. The complications associated with different cultures was a process the couple had to overcome. Honoring one’s culture was seen as very important, especially beliefs about family values and mixing of families’ influence on their involvement. The following excerpts demonstrate examples of men adapting to their partner’s cultural differences during pregnancy.

“um so my wife is native, part native and so my family, I got black folks, some native in our family but not like to the extent of her native in her family, um and so she was looking for ways to connect to her tribal culture and therefore and she brought up the idea of co-sleeping and um you know, uh communication elimination, uh where we did cloth diapers, we did all those things that I was like, you know, people buying all these diapers, why we need to clean the diapers ourselves And so it was the integration of culture, which both saved us money and sleep because co-sleeping it was like, it was something I hadn’t, I was like there’s no way in the world, how would we make this, I mean the baby would wake up and I mean it’s right there so, the food source right there...(Father #10)

Family Influences and Challenges

The fathers expressed mixed feelings on the role of family and friends as challenges and barriers. Many expressed that it was something to get used to. However, it was a challenge because the role of family and friends created cultural barriers that highlighted differences in their involvement and rearing children. Fathers were somewhat receptive to family members
participation, especially their elders, but invoked the rules of their home, which was the parenting process was between the father and the mother. Many men thought having family members nearby improved reliability. However, family members nearby was also considered a small challenge. Family member involvement is addressed in detail later in this chapter.

I believe it made the pregnancy a little more difficult and it was her family. You feel me? Like I said, we were young and her family kind of disagreed with the pregnancy so we kinda just jumped out there on faith; you feel me? We were sleeping on floors at first, you know, and then we got our own crib. We just kept working, and working until we got up there....so sometimes the family do play a big part in it, you know, like I said my girlfriend, she was not adopted, but her grandmother took her in, her parents were never there, so when she sees my mom always helping me or my father helping me, you know what I’m saying, it gets under her skin. (Father #6)

The only thing that kinda bothered me was her family. She’s from California, so they just couldn’t experience it, so I just wish, you know talking about distance a little bit, that they could have experienced it. My family, I grew up like 30 minutes from here so it’s a little different but it’s still wasn’t, it wasn’t intimate and they weren’t always around but her family just couldn’t get here. So I think that kinda put more on me to say I am the partner, I am here, I am the supporter because no one else s here. I didn’t have my mother-in-law here, I didn’t have, you know her sister or whatever, nothing, so it was just me. But I wish that could have been a little different for her side of the family so to speak. (Father #12)

Role of Providers

Men demonstrated that they were well aware of prenatal care appointments and participated in the entire pregnancy process. Moreover, men expressed different opinions about how doctors participated in their partner’s pregnancy. Most men understood this process and the birthing plan. The following excerpts demonstrate examples of men participating in their partner’s medical care during pregnancy.

Yea, um, we actually had midwives, yes, and they were very receptive, you know, uh, actually was, you know, when my sister had her first child I was talking to doctors and things like that whether I go to appointments and, you know, I always thought, man, you know, I Don’t wanna be profane but they were just rude, yea, like constant and arrogant and I was like, you know, if that’s what it’s like then, you know, you just wanted to reach over and kinda shake them a little
bit….But you know, we actually did midwives, when me and my wife we had our kids and it was very different. It was an enjoyable experience. (Father#7)

I had a whole totally different experience, um my doctor was cool actually. He was really, really nice, uh he was a gay man and he just was very receptive and he walked us through the whole process, which somethings he coulda left out, I coulda just seen for myself (Laughter) but uh he was great. Honestly, uh the whole was through he was fine, like he came in, his chucks was matching his whole little outfit, he was definitely, he was killing it. He did really good. I like him as a doctor. (Father #9)

Very, and we strategically picked the black doctor just because, you know, that’s really important to us. She’s been helpful. (Father #4)

I guess you could say so. They told us what we needed to know, but we weren’t really keeping a report really—meshing with the doctors like that. (Father #6)

Um, you know, the first birth yea... the second one—like #6 said we didn’t really go to them for answers, we kinda knew what was going on.(Father #5)

Yeah, we had a female and she was phenomenal. Just one thing that was awesome about her is that, one thing I respect about doctors, tell the truth and I know from a liability standpoint you gotta sometime make it extreme, the worst case, that’s just what it is but (inaudible) her personality, she was so upbeat, she was always positive, always energetic. (F: Like always?) Yeah, just very encouraging just with her body language, But she didn’t deliver our child, um and this lady was white, the lady that delivered our child was a black female. I wanted to like buy her a car or something. I mean she was phenomenal, like our daughter wasn’t dropping and so they kinda handle by turn and once she was able to kinda, once she was able to get into the birth canal, you know, my wife obviously started pushing and then this doctor went in and like got her. Like I’m gonna buy you something. Like you helped by baby come out. Like no, come one, she grabbed her and I’m like you’re my hero. (Father #12)

Yeah, we got dropped by our first doctor. Especially if we started talking about non C-section, and I, which we completely understood. So its like we knew what could happen and so they dropped us and then we went to a specific hospital that was sort of, this is what they do and I think they were okay, but the doctor that we were working with, um she took us in and I think she talked a great game but its like as we got closer to birth time, she started saying well okay let’s get a C-section scheduled and we were like, what happened here and so we turned to a midwife because we were kinda caught between.... and then the midwife came and assisted with the childbirth. (Father #10)

Again, fathers expressed both similarities and differences with respect to their perceptions of providers throughout this process. Men expressed some distrust in doctors and depended more on midwives for the safe delivery of their child. Father’s expressed appreciation
for those providers who presented themselves to be helpful. Men stated that having an understanding provider, one that included the father the decisions, was important to their involvement. Providers such as these were not only trusted but their partner similarly trusted. The following excerpt demonstrates an example of provider-father rapport during pregnancy.

_Uh, so, she didn’t wanna listen to me when I’d be telling her ‘calm down it’ll be alright’ no you always calm, I don’t wanna hear that. So having somebody else that she trusted...that helped a lot, but of course...(Father #3)_

**Results Aim III.** Explore the relationship of resources and support to paternal involvement

**Resources and Support**

Paternal involvement includes a myriad of factors and facilitators. African American fathers living in a college town and mixed income community also commented about the availability of community resources. The following excerpts demonstrate examples of father’s concern about the availability of community resources, family and friend resources, and spiritual resources.

**Community Resources**

_I haven’t heard of anything (Father #2)_

_I agree. I’m looking (inaudible) me and all my group of friends, we all have multiple children, we all have at least four kids each, but I’m the only married one, everybody else is just living with their baby mamas and stuff, or their girlfriends, it’s their girlfriends, I don’t wanna disrespect the ladies. Uh, so, we you know, we talk to each other and stuff, and anything we hear about we throw in the other ones ear, oh you said this, or so and so got this, but as far as like, somebody being out there that’s helping the masses, no there’s nothing like that going on. (Father #3)_

_I’m sure there’s something. There’s a club for everything.(Father #11)_

_The classes offered at Carle... they can really be helpful and they’re free (Father #4)_

_No, I didn’t know of any classes.(Father #6)
I didn’t have any type of resource in the community at all. (Father #9)

**Family and Friend Resources**

I don’t go near my family. In fact, uh. (Father #3)

Honestly, when I went to the hospital for the Lamaze class, no one pointed us in that direction, so it was more of—you know my wife all she has is her mother and all I have is my mom so the tips we can get from ours moms, but to show me how to be a dad I didn’t have anybody to guide me. All male figures in my life are gone. (Father #5)

Well not necessarily classes, but other resources, so it helps that my wife is from Champaign. So her parents are still here, so you know they serve as resources [laughs] in addition to the courses(Father #4)

I mean the community, I would just say my family; you feel me? Just having a great support system and having people that have chosen the way. Can’t get no better than that, you know? Somebody already laid the path for me, all I gotta do is follow it—it’s a blueprint.(Father #6)

... but there was one thing I did, I was curious about was the delivery room. I’m like, hold up, like if I’m gonna be there, definitely gonna be there so I don’t know what to expect. So I thought, I have three brothers and my father and they all have of course have children, my three brothers have children and none of them was in the delivery room. And I’m like, none of ya’ll was in the delivery room? ….So I couldn’t even ask, you know. So that would be the only resource I really wanted to get and I couldn’t even get that. (Father #12)

**Spiritual Resource**

I didn’t even look. And like I said, my situation started off with a word from God. I’m like if He is showing me this vision and its happening, I ain’t gonna need no resources. That was, I’m probably not the best person to ask for that because I felt like He’s guiding me, I don’t need no resources, (Father #12)

I did probably three things. I prayed, I browsed through a few books, and I talked to my dad. That was all, I tried to just kinda recount my child experiences and things that we did as a family and tried to just hopefully build from that and still in that process now.(Father #8)

Um, you know we have church. I’m a faith man, so I guess in my community you know I do talk to the pastors, talk to the deacons, things like that. Do I have someone in my cell phone that I could call 24/7? No, but um I do—they do give you resources, they do sometimes, you know, talk to us about this.(Father #5)

A few of the fathers also relied on the experiences of their biological father as a resource to assist them in their processes as well. These men expressed that this was a great resource and
others expressed that it would have been helpful as well. The following excerpts demonstrate examples of father’s comments about the availability of biological paternal resources.

Father as a resource

Yeah, I talk to my father all the time. He gives me great advice. You know, my dad went to college, he’s a Kappa, he’s always giving me good advice; you know what I mean? So I’ve never had a lack of advice or knowledge; you know what I’m saying? I was always experienced; I was always the head of the groups. I’ve always had a great team to talk to. (Father #6)

My dad is active in my life, always has been. My wife’s father is active in her life, always has been. So I mean I talk to them, I talk to her uncles, I talk to my uncles, I talk to my friends who got kids already, uh yeah... (father #4)

Well, and it wasn’t because my dad was a deadbeat dad, he was just—he passed away, and uh—my father-in-law, he just—he was very ill so he passed away. So we didn’t have those people around us, it wasn’t—you know I have a brother, but you know my older brother just wasn’t the fountain of information [laughs], so I felt like I needed to take responsibility and read up on stuff and take initiative. (Father #5)

Most fathers described that there was little to no resources they could think of and a few mentioned that some existed but they did not access or utilize them. Many men reflected on their spiritual beliefs as a resource, while others also sought support from family and friends.

Future of Fatherhood

Men were asked where they see the future of fatherhood, both in the present and the next generations. Men revealed that fatherhood is changing. The next generation of fathers will question both their culture and ideals of masculinity. Men were concerned that there is no longer an appreciation for the community. Men wanted to be a respected raising a child with their partner, the expecting mother of their child.

“...yea, I think that fatherhood needs to be redefined. So much has changed in the society and there is little or no respect for any man who does not respect or help raise their children....” (Father 5)

“The upcoming generation will most certainly have very funny fathers (laughs). Fathers who will have little to no say in the affairs of their family apart from provision...” (Father 9)
### Results Tables and Figures

Table 4.1

<table>
<thead>
<tr>
<th></th>
<th>n</th>
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</thead>
<tbody>
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<td>HS or Equivalent</td>
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<td>On/Off</td>
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<td><strong>Mean Age ±SD</strong></td>
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<td>7.42</td>
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1 percentage do not add up to 100% because “no answer”, “missing or not in wave” category was excluded
2 percentage do not add up to 100% because the “no answer” and “refuse” categories were excluded
3 percentage do not add up to 100% because “no answer” and “refuse” categories were excluded
Table 4.2

*Welch ANOVA of Dads Perception when Grouped by Neighborhood Wealth Status (household income)*

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*p<.05*, *p<.001** level of significance

![Mean Comparisons of Dads perceptions and neighborhood wealth status (income level)](chart.png)

*Figure 4.1 Mean Comparisons of Dads perceptions and neighborhood wealth status (income level)*
Table 4.3
Games-Howell Post Hoc Analysis for Dads perceptions and neighborhood wealth status

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<th>Income Level</th>
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<th>95% Confidence Interval</th>
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*p < .05, **p < .001
Table 4.4 ANOVA of the relationship between quality of communication, education and age

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<th>Source of Variation</th>
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<th>df</th>
<th>MS</th>
<th>F</th>
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<td>4</td>
<td>379.907</td>
<td>4.472*</td>
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<tr>
<td>Education level</td>
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<td>3</td>
<td>572.532</td>
<td>6.74**</td>
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<tr>
<td>Age x Education level</td>
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<td>10</td>
<td>167.435</td>
<td>1.971*</td>
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<tr>
<td>Error</td>
<td>157321.842</td>
<td>1852</td>
<td>3.627</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>168039.474</td>
<td>1870</td>
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*p<.05  **p<.001

Figure 4.2: Relationship of Education, Age and Quality of Communication
Table 4.5 *Chi Square of Residential Status and Quality of communication*

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<th>Sig.</th>
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<tr>
<td>Quality of Communication</td>
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<td>No N (%)</td>
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<td></td>
</tr>
<tr>
<td>Good</td>
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<td>246 (31.6)</td>
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<tr>
<td>Fair</td>
<td>522 (67.1)</td>
<td>363 (62.1)</td>
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<td></td>
</tr>
<tr>
<td>Poor</td>
<td>507 (27.1)</td>
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<tr>
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*p<.05*

Table 4.6 *Logistic Regression for factors of resident fathers that influence Paternal Involvement FFCWS, 1998-2000 (n=1357)*

<table>
<thead>
<tr>
<th>Variables</th>
<th>e^B (OR)</th>
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<th>Upper</th>
<th>p-value</th>
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<td>Dads Perception</td>
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<td>.882</td>
<td>1.03</td>
<td>.267</td>
</tr>
<tr>
<td>Education</td>
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<td>.851</td>
<td>1.13</td>
<td>.787</td>
</tr>
<tr>
<td>Income</td>
<td>.930**</td>
<td>.899</td>
<td>.963</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Paternal Involvement</td>
<td>1.07</td>
<td>.877</td>
<td>1.34</td>
<td>.471</td>
</tr>
<tr>
<td>Quality of Communication</td>
<td>.823</td>
<td>.667</td>
<td>1.10</td>
<td>.069</td>
</tr>
<tr>
<td>Constant</td>
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<td></td>
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</table>

*p<.05*, p<.001**

Table 4.7 *Summary of binomial logistic regression analysis for residential status, perception, partner support, quality of communication and paternal involvement*

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<th>Predictor</th>
<th>B</th>
<th>SE</th>
<th>e^B (OR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner Support</td>
<td>.027</td>
<td>.006</td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>Perception</td>
<td>-.166</td>
<td>.010</td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>Quality of Communication</td>
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*p<.05*, p<.001**
Table 4.8 Multiple regression analysis of paternal involvement of African American Fathers FFWCS, 1998-2000 (n=1372)

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<tr>
<td>Intercept</td>
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<tr>
<td>Dads Perception</td>
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<tr>
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*p<.05 **p<.01

Table 4.9 Summary of Regression analysis for income and paternal involvement for African American fathers, FFCWS, 1998-2000(n=1372)

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<tr>
<th>Variables</th>
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<td>.667</td>
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<td>.069</td>
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</table>

*p<.05 p<.001**
Table 4.10

Key Findings and Illustrative quotes from African American Men

Becoming a Father

“I was stressed. I had to tell my mom, I had to tell my church, (inaudible) but something just clicked, don’t stress out. Cause I always wanted a kid, yanno, everybody said ‘you’re gonna be a great dad’ cause I work with kids, kids are my passion” (Father #2)

Unbelievable is the word that you used and its interesting because I believe my story is really, people don’t believe it how it happened......So my mind goes, this is unbelievable, I mean it was really God saying okay its time (Father #12)

I probably have to say, um, kinda nervous. I was like, man I better finish school so we could be able to eat and all those good things. So I’d probably say that probably described, I was happy and you know and then but not really, you know, first child, not really knowing what to expect, in I guess anticipation. (Father #7)

“For me it was more so my happiness, you know knowing, turned into anticipation, like okay now I gotta wait nine months, you know (laughs) see, I gotta wait four or five months to find out if it’s gonna be a boy or a girl and then I gotta wait five or four months after that to find, for the baby to actually be here. So it turned into anticipation especially when I found out it was gonna be a boy, I just started going and buying stuff, you know, looking at cribs and strollers and you know we still got six months, almost six months to go and it really just turned into anticipation.” (Father #11)

Adjustment/Adaptation

Mine would have to be change, um, being such a young father, I was only 21, 22 and uh I had to change my whole lifestyle, I mean partying, drugs, drinking, women, I had to change it all. And I knew I had one coming...“ (Father #9)

“I hadn’t even had this vision I’m gonna be this dad, it really wasn’t. I was happy I was married to my wife, and we was just enjoying being together, but I hadn’t even really anticipated that part and I was gonna have to start thinking about those and the roles that it plays. (Father #8)

“Well, I guess I would say happiness turned into anticipation. It was more so, like you know of course you find out you gonna have that initial feeling and once it actually dawns on you that you know you’re about to bring a human life into this world, you know, it’s gonna be the, you know, that anxiety is gonna continue
I was just ready. Wish I had, you know, a little click button, Adam Sandler remote control that fast forwards, hurry up, come on so we can’t get this thing going but I would say that happiness turned into anticipation. It was just a waiting game.” (Father #11)

…..like outside influences, uh, family members, friends. Oh, you need to be laying like this, you need to make sure you got this pillow there and this pillow there and, you know, and trying to have them focused on like, okay this is me and you, this is us, this is our child, you know, let’s, what position do you feel best in, what do you feel best eating. You know, do you feel, is this something that, you know, you like to do, let’s continue to do this, don’t, you know what I mean. So outside of course doctor recommendations and things like that, letting those outside influences actually affect your process with you and your significant other or you and that person you’re having a child with, is, was a big thing for us was trying to have really, not to sound narrow minded, but that tunnel vision, like this is gonna be the end, this is the light at the end of our tunnel. You know, you can’t make your tunnel big enough where you got thirty people in the tunnel going to the same, you know, diving down the same road to the same ending, you know, so trying to just get that tunnel vision and trying to have her focus on what’s best for her and our child at that particular moment, whether that’s how you sleeping…(Father #11)

I believe keeping the situation as low stress as possible is key, as well as—but I mean I do monitor my wife’s diet. Not monitor like you know, “don’t eat this, don’t eat that”, but balance is essential. Hey, have all the pizza you want, but we’re having broccoli tomorrow [laughs], or at least have broccoli for lunch. Don’t eat—don’t have dessert for lunch, and for dinner, and at midnight, and or—I mean I’m fortunate my wife likes fruit so if I gotta pay $13 for a watermelon cause it’s out of season, I’m gonna pay $13 for a watermelon... out of season. (Father #4)

It’s interesting too because in this process we, our emotions have to become reactionary. It’s like they’re the quarterback and we’re the receiver. We ain’t catching nothing unless they throw it. And so what happens is that as the man, we’re feeding off of them. Like if you excited, we gonna be excited cause we ain’t the ones that have to carry it. (Father #12)

Place and Time And um, I think just being around, um you know most of the time I’m working two jobs, um I’m always doing something just to contribute to the family, but then sometimes that’s not what she wants. She wants me there, she wants me,
Table 4.10 (cont.)

um... doing family day, and to me I’m like well I gotta get them money, but to her it’s like “no you do need to go to the zoo with us.” (Father #5)

`Yeah, I drive all the time, I’m there—just put it on my calendar at work like, “I got a doctor’s appointment at this time”... don’t worry about if it’s me—if I’m going to the doctor, or if she going to the doctor, or the baby going to the doctor, it’s on my calendar and we going. And at the appointment we set up the next appointment. (Father #4)

Maternal Support

I really can’t tell. um I think my wife’s happiness is all that matters to me. She tells me that if the child is satisfied and happy then her joy is kinda full. I try my best to ensure that my wife’s happiness does not subside any one time.....” (Father #4)

Happiness is all that she needs from me. Even if I don’t provide financial assistance to her, she says that she can’t trade her joy with money... (Father #5)

I derive maximum peace from the joy of my wife. I know sometimes I am rude and unfair to her but, um I, I try my best to ensure that her happiness is always available regardless of the kind of stress we are facing... (Father #3)

The biggest one is just being understanding, cause like you said, women have to be understandable. There’s no way around it. So that and then then, being a comforter and just making sure, yanno, to get through it, cause it’s for the baby’s sake, and our emotions and how we feel at the end of the day we gotta make sure the baby is safe and healthy...(Father #2)

Um what’s most important to me is... making her happy, and I’m sure that probably just sounds like—of course making her happy, but I went to that dad class that Carle offers and they mentioned that our—they mention that the wife’s endorphins and the baby’s endorphins are connected, so whatever my wife feels, the baby feels. So I try to always do whatever I can to make sure that she’s happy, and to keep her not stressed.(Father #4)

Health of Mother

I think um—I think alleviating stress in the household is very important. Um, I think a healthy pregnancy for the mother is not necessarily—and I’m not a doctor by the way [laughs]—but I think um from viewing my wife it wasn’t more of the weight—she was gaining weight—but it was more of the mental mind frame that she had, how she was feeling. Um I thought some of those things affected the pregnancy a little more than she was even saying. Sometimes I would say you might want to slow down. You know what I’m saying? So that’s
what I view—is um the whole mental—where her mind is at during the pregnancy. (Father #5)

....what’s best for her and our child at that particular moment, whether that’s how you sleeping, whether that’s how many times you’re eating per day or whether that, you know, me being there with you when you feeling sick at 4:00, 3:00 in the morning when you, you know, not feeling well whatever like that. So I think having you, yourself and your significant other focus on what’s best for the three of you, you yourself and the child, is, can, course nothing’s perfect but, you know, that in itself can be, can contribute to a great term or a great pregnancy, however you wanna phrase it. (Father #11)

I can tell you mine didn’t care about me two seconds. All she cared about was herself. Her focus was on her. And in my situation a healthy pregnancy was just keeping her happy and giving her whatever she wanted. Cause mine turned into the biggest brat when she got pregnant both times. The second time I was ready for it. (Father #3)

Health care decisions

uh, nah, I, it was fifty-fifty for everything. I scheduled some of her appointments when she was too tired to do it, and she scheduled some of her own appointments. But one thing I did make clear, I wanted to know about everything ahead of time so I could make myself available. And I think that played a role in the pregnancy, to make her happy, knowing that okay, he’s involved, and that kind of stuff. I helped her plan the baby shower. (Father #3)

It was just mostly, it was me and her and then her mom wanted to go a couple times, uh, but for the most part it was just me and her going to different appointments. (Father #7)

With my first one, no. we switched doctors like four times before we found the right one. Uh, with the second one, we had the, Julian, we had him here, and his doctor, her and she, she hit it off with that doctor right away. Dude was wonderful, cause Julian wound up being an emergency C-section cause the umbilical cord was around his neck twice. And dude, like, he, the doctor did a great job of helping me keep her calm, cause she was flipping out about it, and um, it was kinda crazy cause I’m a real nonchalant, laid-back person and my little man is just like me. So like, the doctor was really helpful with that, he helped me keep her calm,....(Father #3)

Yeah, we had a female and she was phenomenal. Just one thing that was awesome about her is that, one thing I respect about doctors, tell the truth and I
Table 4.10 (cont.)

know from a liability standpoint you gotta sometime make it extreme, the worst case, that’s just what it is but (inaudible) her personality, she was so upbeat, she was always positive, always energetic. (F: Like always?) Yeah, just very encouraging just with her body language, But she didn’t deliver our child, um and this lady was white, the lady that delivered our child was a black female. I wanted to like buy her a car or something. I mean she was phenomenal, like our daughter wasn’t dropping and so they kinda handle by turn and once she was able to kinda, once she was able to get into the birth canal, you know, my wife obviously started pushing and then this doctor went in and like got her. Like I’m gonna buy you something. Like you helped by baby come out. Like no, come one, she grabbed her and I’m like you’re my hero. (Father #12)

Yeah, we got dropped by our first doctor. Especially if we started talking about non C-section, and I, which we completely understood. So its like we knew what could happen and so they dropped us and then we went to a specific hospital that was sort of, this is what they do and I think they were okay, but the doctor that we were working with, um she took us in and I think she talked a great game but its like as we got closer to birth time, she started saying well okay let’s get a C-section scheduled and we were like, what happened here and so we turned to a midwife because we were kinda caught between…. and then the midwife came and assisted with the childbirth. (Father #10)

Support

No. I mean, I have a mother-in-law who’s crazy, but um not really hinder, but she just needs to stay out of my business, that’s it. (Father #5)

...you know, its just people that put their influences over because they raised you; you know what I’m saying? Or they raised your girl, so they feel like they can say what they did, but once she’s in my household that’s out the door. You have nothing else to say, you know, that’s just how it goes. (Father#6)

Experience

Just dealing with attitudes constantly switching. That’s about it though, you know, but that’s expected so hey, hormones(Father #6).

I mean you gotta learn how to duck [laughs] cause, you know, towards that third trimester they start throwing things... fists [laughs]. Their emotions—it’s up and down. Postpartum... that’s the baby one... I know it’s after, but just getting used to her not being pregnant anymore, her getting used to not being pregnant. (Father #5)

“It is very interesting to see the changes that children go through as they grow. You know (laughs) children just cheer you up and you gotta love them. I found it very nice and exposing to me as I watched a buddy’s child grow. However, since I had my own ideas on how to raise a child, the exposure and experience gained
from my buddy was just for the sake of it and nothing more (laughs) .....” (Father 11)

“As much as raising children is somehow similar to most parents, I was adamant to get any experience from anyone. However, my wife made sure that I visit my friends constantly to get some knowhow. She also encouraged me to read some parenting books, and you know, um this did not help. When my child came, I just did my thing and raised my child the best way I knew...” (Father 10)

Resources

Yea I mean I think I know its not a popular place but I believe, I thought planned parenthood had some kind of, uh, its more of an if you’re looking at pregnancy, uh, class, but something specifically geared towards men, um I haven’t seen anything specifically geared towards men, (F: Yeah) like a father group or something like that. The town I used to live in, there was a father’s group but it was men who, um, I think, they weren’t about to give birth, like these were, like it was more like a prayer group for guys and then they might talk about child, childbirth but it wasn’t a specific thing for this. (Father #10)

And I just don’t think its something that you even advertise. Like I don’t even know where to, like I could do a Google search or know what I’m saying something like that but as far as even knowing where to start. Yea, I wouldn’t know what to type into Google. (Laughter) Fatherhood. Childbirth support, 61820. (Father #12)

I didn’t really seek out any resources, it was, uh I don’t know. I mean I feel like I grew up with it, all my nieces and nephews. I feel like I had a know-it-all complex, you know. Of course there’s always gonna be something that you know spins you around, like okay I didn’t know this was gonna happen but I felt like I had enough knowledge from past experiences, of course not with children of my own but past experiences in general that I had a foundation, a mental foundation where I knew, you know, okay, when this happens I need to do this, you know. (Father #11)

Well, I’ve tried some different things here in the community, but nothing that I’ve found uh inclusive. And so that’s just kinda been a deterrent in many ways so if it is and I can’t, most of my colleagues or friends that I have are the ones that I came, that I knew before I got here don’t have kids and the ones that I met when I did get here have either since their in transition and they’ve moved on. So I would say for the most part its just kinda been a learning experience, you know. Either through asking other relatives from time to time or, you know, I’ll ask my sister, but as far as having a resource that I can go to in the community, that I
feel comfortable with, no, I mean I know some, but I don’t, I don’t use them...(Father #7)
Chapter 5: Discussion and Future Implications

Phase I. Fragile Families and Child Well-being Study

The purpose of this study was to examine whether resident and non-resident fathers during the pre and postnatal stages influenced their involvement as a predictor of healthy birth outcomes in African American families. The questions that shaped the focus of this research were:

1. What is the relationship between neighborhood wealth status as measured by individual income on father’s perception of the pre and postnatal stages of pregnancy?
2. What role does communication play in father’s level of involvement?
3. How does SES influence involvement during the pre and postnatal stages?
4. What role does residential status play in paternal involvement?

Kreiger’s (2001) Ecosocial Theory was created and implemented to advance our knowledge in understanding social determinants of health across the lifespan combining biological components and social context to examine health disparities. Different measures of individual and community level variables were operationalized to assess the associations between groups.

The first aim was to examine the relationship between neighborhood wealth status and African American men’s perception of the pre and post stages of pregnancy using the Fragile Families Child Well-being (FFWCS) Study between 1998 and 2000. The FFWCS is a national survey that studies a unique population of men who are considered less learned in reference to exploring healthy birth outcomes in African American families. The FFWCS is a national survey that studies a unique population of men who are considered less studied in reference to exploring healthy birth outcomes in African American families (The Fragile Families and Child Wellbeing Study, 2016. Neighborhood level characteristics were examined by the income level of African
American men based on household. The main findings indicated that increased income levels increased Dad’s perception of the pre and postnatal stages of pregnancy where the largest differences existed between men who lived in communities that made less than $5000 a year in contrast to men of similar communities who made over $25,000 a year ($p<.001$). There were no observed significant mean differences in lower income levels $5000-24999$ about the perception of pre and postnatal stages of pregnancy ($p=.05$). Whereas those who did not report any income level were significantly different across all groups reporting lower mean scores on perception of the pre and postnatal stages of pregnancy. As indicated in the literature review, neighborhoods serve as a resource for a multitude of factors that may contribute to or hinder paternal involvement during the pre and postnatal stages (Sampson, 2001; Kramer and Hogue, 2008; Sims, Sims and Bruce, 2007). Social economic positions influence health disparities. These disparities support the notion that neighborhood and community level predictors are vital determinants to the health of African Americans since it relates to fathers’ position. African American families live in residentially segregated communities in which access to resources are limited and often unknown to community members (Leung & Takeuchi, 2011; Mendenhall, Deluca & Duncan, 2006). These is also consistent with the health seeking behaviors literatures, which suggest that minority men, specifically African American and Latino men, do not seek resources or communicate their needs or often do not know that they are available to them to assist with health information and support (Kim, 2011) in residentially segregated communities.

The Eco-social Theory (Figure 1.1) demonstrates the need to examine differences in paternal involvement using a multilevel approach that included examining regional differences and neighborhood and community level influences on perceptions of prenatal and postnatal stages of pregnancy and involvement. The results suggest that using individual income as an
indicator of neighborhood wealth status is a predictor of perceptions about the prenatal and post pregnancy stages in African American men. After examining income level differences, our results indicated that men who made the most money (greater than $75,000) and men who made the least money (less than $5,000) were significant predictors of positive perceptions of the prenatal and postnatal stages. Hence this question has implications for explaining community level differences in perceptions of the prenatal and postnatal stages according to analysis of data in the FFWCS national survey. Income levels are often a predictor of educational attainment and literature, which suggests that women with higher education may also have increased levels of financial stability. Financial stability has been associated with healthy birth outcomes (Din-Dzietham & Hertz-Picciotto, 1998). This association may be correct in men and may partially explain the differences in positive perceptions in those men with higher incomes of the study population.

The second aim sought to explore the relationship of quality of communication on paternal involvement in African American men using data from the FFWCS baseline study (The Fragile Families and Child Wellbeing Study, 2016). Results revealed that quality of communication is impacted greatly by age and education levels. Involvement frequency improved with age as supported by the Eco-social theory (see Figure 1.1) which provides a baseline from which to understand differences in communication and other social context across the lifespan. The Eco-social theory examines the life course perspective and pathways of embodiment to explain the intersection of age and education as predictors of paternal involvement in African American men. The theory further suggests that a cross section of age and education could have adverse effects on exposure to societal concepts which could hinder attainment of education by Africa American men hence affect (Glanz et al., 2008; Pettit &
Western, 2004; Western & Wildeman, 2009). Moreover, the theory asserts that age and experience cannot be detached. Any positive past experience among African American men significantly leads to clearer and better communication with their partners or mother to the unborn child.

A closer examination at education levels and age revealed differences that affected paternal involvement. Cohabitating couples and non-cohabitating couples revealed a variance in communication. The men who had great quality of communication were in steady relationships or married to partners. These findings emphasize the importance of communication and partner support. Quinn (2008) and the Early Childhood Longitudinal Birth Cohort studies have examined specifically the quality of communication between men and their partners on birth outcomes. These studies concluded that quality of communication improved prenatal care utilization which predicts improved healthy birth outcomes in African American families (Lia-Hoagberg et al., 1990). The findings in this study illustrate that communication serves as an important indicator of paternal involvement for African American fathers. Communication between partners is an important aspect that helps fathers to understand their role and that of their partner (Ackerson & Viswanath, 2009; Dutta, 2010; Viswanath & Ackerson, 2011). Healthy communication methods by health care service providers help fathers to understand their roles, and this has had positive outcomes throughout the prenatal process (Viswanathan & Ackerson, 2011).

Most of the predictors used in the multivariate analysis of paternal involvement to explain quality of communication were consistent with other literature such as increasing age (Quinn et al., 2009) and education levels of participants (Ma, 2008; McAllister & Boyle, 1998). The predictors suggest the importance of examining differences in age and education on
communication among African American couples as it may affect paternal involvement during the pre and postnatal stages of pregnancy. These results may also suggest that differences are a possible indication of adverse birth outcomes for African American families. This study looked specifically at the interaction of age and education as well as individually and found that when controlling for other involvement indicators such as socioeconomic status and perceptions, the relationship amongst further socio-demographic measures greatly impacted differences for men.

The third aim of this study was to examine the relationship of income to paternal involvement. Socioeconomic status is attributed to several indicators (i.e. relationship status, education, income and residence) which have been inversely linked to healthy birth outcomes in African Americans. (Alio et.al, 2010; Quinn et.al.,2008). African American families represent the largest population of those who live in poverty and healthy birth outcomes are shown to be related to higher SES status.

Overall as involvement levels increased, the higher the socioeconomic status of the fathers. This pattern persisted significantly across all income levels. There was a demonstrated positive relationship even though some differences existed on residential status. Predictors of paternal involvement were situated in exploring socio-demographic information of fathers as it influences perceptions, involvement and communication between partners. As in past literature, father involvement is indicated as the name on the birth certificate (G. R. Alexander et al., 2008a; Alio,AP. , Kornosky,J.L. , Mbah,A.K. , Marty,P.J. and Hamisu M. Salihu, 2010; Amina P. Alio, Alfred K. Mbah, Jennifer L. Kornosky, Deanna Wathington, Phillip J. Marty and Hamisu M. Salihu, 2011; Balayla, Azoulay, & Abenhaim, 2011; Byrd et al., 2007; Kvale et al., 2000). However, associations between perceptions and involvement are indicative of claims that fathers matter and diverse measures are needed to better explain this association on healthy birth
outcomes. These findings provide measures to be used to inform policy decisions around paternal involvement in maternal and child health as well as informing prenatal care programs.

The final aim in the secondary data analysis of the FFCWS explored the relationship between residential status on paternal involvement. It must be noted that married couples were included in the sample and the marriage effect may have overwhelmingly affected study results. However, among all couples, most of the effects suggest that residential status is not indicative to their involvement. The logistic analysis results suggest that residential status did not make a difference to father’s involvement. However, when included measures of partner support of their involvement and socioeconomic status the model became statistically significant. Additionally, we also included a model that predicted involvement examining the measures of perception of resident and non-resident father. This model explained 28 percent of differences in involvement levels of resident and non-resident father and suggested that fathers are 1.02 times more likely to be involved in the prenatal and postnatal stages of pregnancy with partner support instead of not in the same home. This supports the literature, which suggests paternal support is critical and father involvement has a positive relationship on the overall health of their child (Teitler, 2001).

The analysis of paternal involvement on healthy birth outcomes using the Fragile Families’ Child Well-being Study explains differences in socio-demographic characteristics, neighborhood level indicators, perceptions and quality of communication. These analyses yielded significant statistics which indicates that examining paternal involvement as a predictor of healthy birth outcomes provides implications for explaining differences in resident and non-resident fathers. Past literature purports that fathers name listed on birth certificate is indication of involvement. Also, literature suggests that maternal indicators are pertinent to understanding the disparities that exist in birth outcomes in African American families (Domínguez, 2010).
However, this study further supports the importance of examining paternal involvement as a predictor of healthy birth outcomes. This is also supported by some of the previous literature which identified that all measures of father involvement are associated with healthy birth outcomes (Teitler, 2001; Alio et al., 2013). Additionally, survey data limits our in-depth knowledge into the lived experiences of at-risk populations who disproportionately represent adverse birth outcomes (Giscombe, 2005). Therefore, the remainder of this chapter details experience of fathers during the pre and postnatal stages to enhance our definition and understanding of the impact of paternal involvement on health birth outcomes.

Phase II. Dads Matter Focus Groups

The purposes of this study were to (1) explore the relationship between perceptions and involvement (2) explore the role of challenges and barriers to paternal involvement, and (3) explore the relationship of resources and support to paternal involvement using focus groups to evaluate the role of paternal involvement on healthy birth outcomes in African American families. The questions that shaped the focus of this research are outlined in Appendix A.

Role of Perceptions on Involvement of African American Fathers

African American men viewed their fatherly role as an important aspect to their relationship to their partners and communities. Men conveyed that supporting their partners throughout the entire process included becoming completely selfless in order to satisfy the needs of their role. Men saw themselves as servants, providers, and stress alleviators. Their purpose was to make their partner happy so they would have a healthy child. Perceptions were influenced by age, education, income level, cultural values, previous children and spiritual guidance as it pertained to how they viewed their involvement. Men also perceived that their involvement was indicated through their presence, support and showing understanding to their partners. African
American men’s perceptions of involvement during the prenatal and postnatal stages of pregnancy were presented in ways that included supporting and encouraging their partner for the health of their child, their partner, and their relationship.

African American fathers’ described what they considered to be important during this process based on knowledge of previous experiences and some of what they were taught or even lacked in knowledge in this process. Men believed that being an active father throughout the process included providing financial support, emotional support, and attending prenatal care visits. This characterized their involvement in addition to having their names on the birth certificate as operationalized in prior research (Alio, Kornosky, Mbah, Marty & Hamisu 2010, Khanani, Elam, Hearn, Jones & Maseru, 2008. This is consistent with current literature which describes the role of the “ideal” father (Alio, Lewis, Scarborough , Harris & Fiscella, 2013) and benefits to his presence during these stages. Fathers in this study and previous research ( Alio, Lewis, Scarborough , Harris & Fiscella, 2013; Quinn et al., 2009) believe that men who perceive that their involvement influences the health of their child will more likely perceive their roles to be pertinent to lowering the stress of their partners and creating a healthy environment. Fathers also believed that this has implications for a healthy birth which was the optimal goal of the process.

The role of the father was defined in a variety of ways. Men perceived his role as being the gatekeeper. However, one unique factor that men explained in their perception of the role was that of spirituality which conversely is not explained as a factor in the qualitative literature to increased involvement (Alio, Lewis, Scarborough , Harris & Fiscella, 2013; Quinn et al., 2009), but plays a positive role and a stressor in the infant mortality literature (Barnes, 2008; Dominguez, Dunkel-Schetter, Glynn., Hobel & Sandman, 2010). This finding further supports
the need to further explore this association of men’s religious affiliation as a buffer to decreased stress in partners and increased involvement during the prenatal and postnatal stages of pregnancy.

Additionally, the role that men perceive they play during this time is influenced by an array of social factors including support from their partners and others who are seen as helpers or hinderers during this process. African American fathers revealed that support from family and friends and how they perceive them also influence their ideals of perceptions particularly defining fatherhood. This is also in support of the current and past literature in defining the role of fathers (Alio, Lewis, Scarborough, Harris & Fiscella, 2013; Quinn et al, 2008) which describes the role of involvement as present, accessible, available, willing to learn, and understanding. Moreover, one who is readily there to provide emotional, physical and financial support to the mother of the child. Fathers in this study echoed that same sentiment but included that spiritual guidance was important to this process as well.

Perceptions of Support

All of the African American fathers in this study stated that they wanted to be involved in the birth process. However, many described how perceptions of their role may have been convoluted because they did not have anyone to show them the ropes so it was a self-learning process. African American men described that many of their partners have their moms and other women in their lives to assist them with the transition to parenthood while men relied heavily on friends to gain insight into the perceived roles they are to play during this period. In addition, men were not very receptive to in-laws and focused more on the value of their romantic relationship or relationship with their partner as it pertained to their child and wanting little outside interference. Current literature has reported that being romantically involved with the
mother contributes to her emotional well-being and relieving stress since depression that can occur during the pregnancy (Alio, Lewis, Scarborough, Harris & Fiscella, 2013). Men were well aware of their partner’s emotional well-being being crucial to the health and wellbeing of their child. They noted that it was their place and wanted as little interference as possible. However, some men asserted that having familial support contributed to relieving some of their stress when it was warranted. Research has described the family is seen as an important aspect to the black community in developing ties and social support (Moore, 2006; Patillo 2008) to act as a resource for various social and cultural context. More specifically, in raising a child the old saying goes “it take a village” and many men believed that this was important but to the extent once the child is born and that the early stages were more intimate with the partners.

Fathers who had familial support throughout the process saw it as a positive and some revealed conflicts within their partners because of different upbringing. More specifically, one father found the relationship between him and his partner complicated because his family was so involved. Conversely, her family was not as receptive so this caused additional stress to the relationship. However, all participants believed that the partnership was important and how they perceived the support of each other was pertinent to a healthy pregnancy and reasoned that the mothers’ emotional and physical well-being was optimal to the health of their child.

For African American males, support from friends was an additional factor in their involvement. These fathers were aware that their roles would impact those around them and they then became a resource for others. Participants commented on the fact that many of their friends were also fathers and they needed to build their own support groups because there was nowhere in the community they could go. This was a unanimous decision amongst all fathers that their
perceptions of support from community and other resources were nonexistent and if relationships with friends and families were not strong, this did not hinder their individual involvement.

Perceptions of a Healthy Pregnancy

The primary reason of having a male or partner involved during the pre and postnatal stages was the reduction in maternal stressors and healthy prenatal behaviors. A healthy pregnancy as described by many fathers was, women going full term, being stressed as little as possible, having a healthy diet, and being happy. Participants believed that these facilitated a healthy baby and was the main goal of their being involved. Men explained that this was large in part to their engagement throughout this process and detailed by them being accessible, and physically and emotionally available to the mother of their child. This is comparable to the literature specifically Alio and colleagues (2013) who suggests the benefits of fathers involvement increases healthy maternal behaviors and reduces maternal stress which has implications for a healthy birth and reduces infant mortality in African Americans.

Men were particularly aware that within the early stages of pregnancy and post stages that depression is possible and the women’s emotional well-being influences the health of the baby. Those that were not aware realized the importance of her emotional well-being and knowledge of postpartum as something they should be educated on due to the commonality and pressures of being a mother. However, this knowledge must be pursued. African American fathers described this as something that worried them but their role was to provide a sense of security. They also saw themselves as a buffer to feelings of loneliness in their partners. They perceived themselves as an important factor in the health of the mother and the unborn baby throughout the pregnancy stages.
Challenges and Barriers to Involvement

Being an involved father includes being accessible, engaged, supportive, and maintaining a positive relationship with the mother of the expected child regardless of relationship status and residential status of fathers (Milligan et al., 2002; Quinn, 2008; Alio, Lewis, Scarborough, Harris & Fiscella, 2013; Paisley-Cleveland, 2013). This definition of involvement is nuanced in previous literature that paternal involvement is indicated on the birth certificate (Alio et al., 2010; McAllister & Boyle, 1998; Teitler, 2001; Straughen et al., 2013) to explain differences in healthy birth outcomes. In defining paternal involvement and the interplay of healthy birth outcomes, respondents detail various challenges and barriers to their involvement during the pre and postnatal stages of pregnancy. Some of the factors that influence father’s involvement at these particular stages of pregnancy included location, knowledge, adjustment/adaptation and the provider relationship.

Place and Time

The interplay of location and timing of the pregnancy was seen as an important challenge. Respondents indicated that this influenced their accessibility and engagement throughout these stages of pregnancy. Not being in the same location with the women carrying the child has indication for increasing maternal stress and unhealthy maternal behaviors. Location played a role in father’s ability to attend prenatal visits and become educated on the changes the partner will experience during this process and how he would be able to provide support and act as a buffer to undesirable behaviors when necessary. This finding is consistent with Alio Lewis, Scarborough, Harris & Fiscella (2013) definition of responsibility that suggests men’s involvement as a protective factor that increases healthy maternal behaviors and ease maternal stress. Men found themselves having a sense of guilt in not being able to play that role.
due to distance, work or time. This included not being able to attend classes and prenatal visits and conflicting schedules. However, the relationship with the mother of the child was indicative if this impacted their involvement. Communication amongst partners in this process is pertinent to involvement levels and perceived challenges and barriers. However, this was seen as a temporary challenge and other socio-cultural factors influenced father’s involvement.

Knowledge, Culture and Communication

As highlighted in this study, lack of knowledge and education on prenatal care and pregnancy are consistent with under estimating the influence of the role of fathers and its significance during this period. The dominant messages highlighted in research today zero in on the role of maternal factors in child rearing while not including fathers and continues to perpetuate the idea of the black absent father (Lu et.al 2010). However, knowledge of their role as fathers alludes to increasing healthy birth outcomes of their children in which many men felt they played a responsible part. Lack of knowledge was viewed in the context as being because of the first “hoorah” or time between previous child and now. This understanding of their role is embodied by a multifaceted view which as demonstrated in the Eco-social theory pathways to embodiment and exposure and susceptibility of messages through individuals, communities and culture across the lifespan. In the historical context passed from generation to generation, African American men and African American communities lack human capital (Patillo, 2008; Moore 2008; Sampson 2002; Pinderhuges et. al 2007; Diez-Roux, 2010) but still hold strong ties to their communities and community’s history. For African American men, that history for many individuals does not include a present father and hence their knowledge and understanding of their role comes from the dominant culture.
Culture impacts the attitudes and beliefs of messages surrounding viewpoints of fatherhood and many messages these African American men have seen are negative messages in social media and other media outlets. This creates an atmosphere that promotes irresponsibility and decrease respectability of the role of men during the pre and postnatal stages of pregnancy (Alio, Lewis, Scarborough, Harris & Fiscella, 2013). Furthermore, past messages learned through media have been convoluted, as once seen as role models for the ultimate dad in television and movies have faced controversial legal matters like Bill Cosby and the issue of trust is at stake. Therefore, there are not adequate positive messages received and a reliance on the community is not negotiated nor accessible reinforcing the need to increase substantive education for African American fathers on prenatal care and pregnancy as a means to increase healthy births in African American families. The men in this study assert that their knowledge of their role was being learned throughout the process and that if they had a resource similar to even the focus group they would feel more competent in their roles.

Fathers in this study alluded to their need to have basic knowledge and understanding of their partner in order to be supportive in their roles. As many concluded that they wish they were able to understand the basics of what it means to be around a pregnant woman 24 hours a day and 7 days a week and also how their emotional and physical well-being also matters. In going forward, fathers expressed that the knowledge they obtained will be used and they will continue to look for spiritual guidance as well as relying on friends to support them in the paternal process. Many African American fathers described that groups as these would have been helpful earlier in the process and appreciated this opportunity to learn from one another or share these experiences. This finding supports the need to continue research that explores father’s involvement and what is needed to inform prenatal programs that include a male component and
characterizing paternal involvement during these stages (Alio, Lewis, Scarborough, Harris & Fiscella, 2013; Lu et. al, 2010).

Perceptions of Resources

The roles of providers were viewed as integral to the actual birthing process. There were several conflicts between men and some providers when it came to making final birthing decisions. However men and their partners communicated the role in which they wanted the physician, midwife or nurse to play. Consistent with Alio, Lewis, Scarborough, Harris & Fiscella (2013) terms accessibility and engagement, this included fathers’ activeness in prenatal visits, communication between partners, and fathers’ physical presence in the home. Similar to their study, fathers embraced their role in being assessable to their partners by constantly attending prenatal visits and meeting the needs of their partners at various hours of the night. Fathers however, did believe that providers did their job. However, others were strategic in whom they picked and wanted someone who was culturally aware of their beliefs and understood their values. The interaction between partners during these visits and times is crucial to fathers being involved and may also predict the level of involvement once the child is/was born. When both parents don’t live in the same home or have to travel longer distances to meet for appointments it may impact later paternal involvement and quality of communication among partners (Lu et.al, 2010; Teitler, 2001).

Support from providers was seen as important to father’s understanding the role of prenatal visits and behaviors. However, many fathers did not agree that the provider was an additional resource and therefore, future research may examine the role undervaluing providers by fathers’ impact their role during the pre and postnatal stages of pregnancy. This may in turn
provide implications for research among the patient provider interaction on attitudes about their role in the health of their children.

The support and resources these men illustrated and informed us of the specifics in providing spaces, places, and people that are important to their involvement during the prenatal and postnatal stages of pregnancy in African American men in a suburban community. This study further elucidates the significance of African American men on healthy birth outcomes in African American families. Residential location of fathers further promotes their increased involvement but does not hinder men’s capability in being the “ideal” father throughout these stages. However, the father’s knowledge and understanding decreases if he does not live with the mother of the child. The decrease in knowledge is evident regardless of education or economic levels. These findings also support the multidimensionality of paternal involvement as Lamb and colleagues (1987) described as engagement, accessibility, and responsibility.

The education and promotion of healthy babies and families through men provides a means to directly and indirectly impact the health of African American families and communities while also highlighting the significance of men and partners throughout this process. Additionally, as socio-cultural factors may impact fathers’ involvement during the pre and postnatal stages of pregnancy, these factors and findings of this study should be considered in creating an atmosphere and environment that welcomes fathers and healthy babies.

Future of Fatherhood

The future of fatherhood is seen as both improving and challenging the ideals of masculinity and black masculinity in the African American community. Fatherhood is an important aspect to the life course of African American men which impacts the stability of the
African American family. African American men also face unique interconnected barriers such as socio-economic status, education, marital status, and disadvantaged economic position to name a few (Straughen et al., 2013). These barriers influence their involvement during the prenatal and postnatal stages of pregnancy. However, this does not negate the significance in the presence of fathers to increase healthy birth outcomes. This study found that African American men believe that fatherhood is an important aspect to whom they are as individuals and that the misconceptions illustrated in the media will impact the future of fatherhood. If there are men and role models within the community and technology is used positively to reflect ideals of black culture and masculinity, the African American family will see growth and stability and black masculinity will not be in question. This study also highlights the importance of responsibility, engagement and accessibility as characterized by paternal involvement (Lamb et al., 1987).

Additionally, African American fathers will be viewed in a positive light and research will continue to explore the importance of fathers during the pre and postnatal stages as significant to healthy birth outcomes in African American children. This study provides implications for policy formation and the agenda of the commission on fatherhood and fatherhood initiatives in the African American community. Although this research is limited to a small suburban population in a single Midwestern city in Illinois, the findings from this study support the few studies that have attempted to characterize paternal involvement from the perspective of men during the prenatal and postnatal stages of pregnancy (Lamb et al., 1987, Quinn, 2008; Alio, Lewis, Scarborough, Harris & Fiscella, 2013).

**Integration of FFCWS and Dads Matter**

**Future Research**
While new research is examining community based models to examine the role of paternal involvement on healthy birth outcomes, research is still needed to examine the role of African American fathers. Future research should explore differences in educational levels on paternal involvement using qualitative methods in rural and larger metropolitan areas. Access and utilization differences are also needed to be explored when reviewing developing and existing programs that include men both prenatally and postnatally. Future studies can also explore differences in prenatal services and provider relationships amongst African American men. This study revealed the lack of resources and knowledge of community assets to assist men in their involvement. Although there was a clear understanding of paternal involvement there were still several challenges and barriers identified. Therefore, future research and interventions to increase healthy babies should examine the multiple dimensions of influence that impact individual and familial health across the lifespan of the baby. The future of paternal involvement encompasses examining society’s role, policy, culture, individuals, family and neighborhoods. Future research and interventions should target these factors and will increase father’s involvement and in turn the health of African American babies.

**Strengths and Limitations**

This study has attempted to further characterize the significance of paternal involvement during a crucial period for the partner while child is in-utero. This stage of life is critical to the health and well-being of both the mother and child and supports the theoretical research on health disparities across the life span as posed by the Eco-social theory. By increasing our knowledge on the roles men play during the prenatal and postnatal stages of pregnancy, this study provides implications for measures of paternal involvement that include responsibility, accessibility and engagement but also further expand the definitions first described by Lamb and
colleagues (1987) and Alio, Lewis, Scarborough, Harris & Fiscella (2013). This study is also pertinent to developing programs, policies and initiatives to increase father’s involvement during these stages in African Americans families. The experiences fathers expressed in this study may be similar in other minority fathers and provide guidelines to examine these dynamics in other ethnic and racial groups. There was a variety of experience and knowledge among the fathers. Fathers included new and expectant dads as well as those expecting second and third children which increases the credibility of the information shared amongst African American men.

The intent was to collect data from 3 differing communities to have a representative and diverse sample of fathers. One limitation of this study is that it exclusively examines the experiences of African American men who live in a small suburban college town who are highly educated. However, since African American men are a difficult population to study and reach based on historical misrepresentation and misuse, certain measures were taken to ensure confidentiality and comfort in participation. Although fathers were highly educated and came from similar backgrounds, their experiences reflect the culture of their current community. Therefore, this study lacks some generalizability as the purpose was to examine the experiences of low income African American men and participants had varying income levels. Additionally, ten of the eleven fathers reside with their partners and are in married or long-term relationships which further our understanding of cohabitating couples and don’t fully capture the in-depth experiences of non-resident fathers. Therefore, additional research in examining paternal involvement should look in to the experiences of fathers who are not in the homes.

Researcher Role/Biases

The establishment of trustworthiness of the data process with the researcher bias in the study design will have been identified through the four steps. However, there are other biases
that could have impacted the research study. Being a single African American female creates other biases in this process since the sample population is African American men. This is centered on the researcher and the research team in this context as individuals. My impact on the study was taken into account ensuring that it does not influence the data acquired as well as that of my team of researchers. As an African American single educated female, it is important to consider this impact as it could shape the recruitment process and findings. This holds true for the research team as they were African American educated males in which we all share a similar paradigmatic lens because of our backgrounds. However, the perceived educational differences may create an unequal environment for the participants to divulge personal information that leaves them feeling vulnerable. The particular worldviews and approaches that work best with males interacting with males will not be an issue. However, working with a female as well may not lead to interactions at the same level. Therefore, my role as a researcher was distanced but the concerns of my research team are at hand. The most likely anecdote in the African American community is that fathers are never around or active in their partner’s life during the stages of pregnancy or women not wanting them around creating a resentment or distrust toward African American women.

The establishment of trust needs to be at a certain level in order to ask men to reflect on their experiences and thoughts about their involvement during the various pregnancy stages and birth of child. To accomplish this, I recruited African American men who are trusted already by the community because of their service or previous relationships. The use of African American men to moderate the male focus groups created an atmosphere that was comfortable and helped to eliminate and discomfort that would arise if the researcher were moderating. This will ensure that the data collected is not negatively influenced by the researcher.
Extensive verification procedures, including triangulation of the data sources, peer debriefing, and thick rich descriptions of the focus groups were used to establish the accuracy of the findings and control potential researcher issues. Although these steps toward eliminating bias are not completely relinquished, they helped to decrease the impact of the researcher role in the study findings.

Conclusion

Quantitative and qualitative research both answers the questions posed examining casual relationships and factors to understand paternal involvement’s effects on healthy birth outcomes. However, neither method is sufficient by itself to capture the complexity of paternal involvement in healthy birth outcomes. The rationale for combining both quantitative and qualitative approaches is that the quantitative results will provide a general picture of the research problem using a national survey, while the qualitative data and analysis will refine and explain these statistical results by exploring the participants’ views in more depth (Creswell, 2002; Plano-Clark and Creswell, 2008).

The findings of this study may enhance the body of research which persistently operationalizes involvement as the presence or absence on the birth certificate (Alio, Kornosky, Mbah, Marty, and Hamisu, 2010; Khanani et al., 2010; McAllister & Boyle, 1998). This study is a step forward in combining quantitative and qualitative approaches in one study (Creswell, 2002; Plano-Clark and Creswell, 2008) to better understand the health disparities of African American families. As a qualitative researcher, one of my primary focuses is to capture the authentic life experiences of the people (p. 275). However, the integration of the two connected
the lived experiences with the quantitative findings to produce an understanding of the complex problem being explored.

When we think about men and pregnancy, researchers and health professionals still know very little about how paternal involvement increases healthy birth outcomes. This mixed methods study details the use of quantitative measures of surveys and existing databases to get baseline comparison data. Additionally, the qualitative measures include a directed content analysis that explored the perceptions men have about their involvement during the prenatal, antenatal and postnatal stages of pregnancy. Through the use of these methods, we were able to gain an in-depth understanding of the relationships that has the potential to inform policy around paternal child health.
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Appendix A
Focus Group Moderator Guide

Thank you for agreeing to meet with me. Your presence today is very important and I appreciate the time you’ve taken out of your daily routines to join me. My name is ___________ [interviewer]___________ and I work at the University of Illinois Urbana Champaign.

You are being asked to participate in the African American Families and Healthy Birth Outcomes research study known as the “Dads and Infants Study”. This study will help researchers and clinicians learn about the barriers to paternal involvement throughout the early [prenatal] and final stages of pregnancy [postnatal] for African American men and their expecting partners. This research is being conducted by Drs. Ruby Mendenhall in Sociology, Karen Tabb in Social Work at the University of Illinois at Urbana-Champaign (UIUC) and Kelsie D. Kelly, a graduate student in the Department of Kinesiology and Community Health.

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Illinois. If you decide not to participate, you are free to withdraw at any time without affecting your relationship with UIUC. During the interview I want you to remember that we are interested in your experiences and opinions; there are no right or wrong answers. Your identity will be kept strictly confidential; your name and the names of your family members will not be linked to anything you tell me. While the researchers will ask all participants to respect the privacy of the session they can’t guarantee that one or more members won’t relate ‘who said what’ afterwards. Therefore we ask that what is said during this focus group remains within this group of individuals.

The purpose of our study today is to learn more about the experiences and perceptions that men have before during and after their partners’ pregnancy in rural, urban and suburban communities. What we know so far about father’s participation during pregnancy is:

- Men are to support and provide for their families financially
- Paternal involvement is defined as fathers name on birth certificate
- African American women whose partners are not listed on the birth certificate are two-fold more likely to experience adverse birth outcomes
- African American pregnant women often have partners who are incarcerated

But when we think about men during pregnancy, researchers and health professionals still know very little about how paternal involvement increases healthy birth outcomes. By talking with me today, we hope to learn more information about:
How you perceive your role during the prenatal and postnatal stages of pregnancy
- What challenges/barriers exist to your involvement
- What types of stressors exist in your life that might make it difficult for you to be involved
- What other daily responsibilities exist in your life that you take care of or you’re expected to take are of

So, our time together today will involve me asking you questions about your perception of your role, existing daily responsibilities, and challenges or barriers to them, the ways you manage stress and daily responsibilities, and your thoughts and feelings in relation to your involvement during your partners’ pregnancy while taking care of other daily responsibilities in your life.

I hope you’ll feel comfortable opening up. If at any time I ask you a question and you don’t feel comfortable talking about the topic, feel free to say so.

The interview should last about 90 minutes and we will pay $15.00 in cash for your time and participation. I will be taping the interview with this recorder. I would like to tape the interview to make sure that I have your opinions and experiences recorded accurately. No one outside the research team will be allowed to listen to the tapes, and the tapes will be destroyed at the end of the study.

**CONSENT FORM:**
Before we begin, I need to go over this consent form with you. It gives you more information about the study and a telephone number you can call if you have questions later. I will give you a copy to keep.

**Consent to Participate**

*Men’s perception of involvement on Healthy Birth Outcomes*

We are asking you to take part in a discussion group. This project is part of a research study in the Departments of Kinesiology and Community Health, Social Work, Sociology and African American Studies at UIUC on perceptions of paternal involvement on healthy birth outcomes. The purpose of this group is to research men’s perception of involvement during pregnancy and healthy birth outcomes in African American Families.

This discussion group will be with 6-8 men and will last about two hours. During this time, a male facilitator who leads the group will be asking participants questions related to the topic. We will audiotape the discussion. Later, we will review the tape and write a report and publish a manuscript and submit for conference presentations for our research about what we learned during the group. After we finish reviewing the tape, we will erase it.

We do not expect any harm or discomfort to result from being in the group. Being a part of this group is completely voluntary. The decision to participate, decline, or withdraw from
participation will have no effect on your status at CUPHD, Rantoul Health Department, or future relations with the University of Illinois.

Any information you share with us will be kept confidential. We will use only first names during the discussions. Nothing you say will be linked to your name. You don’t have to answer a question you don’t want to. In appreciation for your time and effort, you will receive $40 cash. Should you decide not to participate, you will still receive the free refreshments.

We will use the information that we obtain to write a report about the group. This report will be read by our research team. We may report the results to other researchers and clinicians. These reports will not contain any information that will identify any of the participants who are in the study.

Your input is important to us. We plan to use what we learn from the group to understand how groups like this are conducted and also to design a project that could benefit the health of African American families and babies.

If you have any questions about the study, either now or later, you may contact the principle investigator Ruby Mendenhall at rubymen@illinois.edu, Co-PI Karen Tabb at ktabb@illinois.edu or 217-300-0200 or the graduate research assistant Kelsie D Kelly at 414-737-3807 and kdkelly2ta@gmail.com. If you have any questions about your rights as a research participant in the study, please contact the University of Illinois Institutional Review Board at 217-333-3670 (collect calls accepted if you identify yourself as a research participant) or via email at irb@illinois.edu.

My Permission

I have read the information about the study provided in this permission form and have been given a copy. I have had the chance to ask questions, and they have been answered to my satisfaction.

Name: ________________________________ Date: ________________________________

Witness: _______________________________

Do you have any questions?

I am going to turn on the tape recorder now, and we will get started [Start recorder]

Perceptions

How did you feel when you first learned you’re going to be a father?

Has this new knowledge [becoming a dad] created worry or stress on your daily life and responsibilities?
If you were to describe your role as a father in just a few words what would it be?

What do you think is most important to support your partner?

What do you think you partner thinks is most important

Do you think your health impacts the health of your unborn child/newborn?

Do you think you should attend prenatal care appointments [doctor’s visit to check on the status of the mother and child each month]

How do you define a healthy pregnancy?

How would you define a healthy birth of your new born?

Resources
Is there anything in your community that helps you involve yourself as a dad to be?

Are there classes for expectant dads that you are aware of?

Do you help/someone helps your partner make their doctors visit regularly?

Do you provide financial support? What does that consist of?

Is there anyone you can talk to about your [new] role as a father?

Are there places in the community you can go to ask for assistance?

Challenges and Barriers to Involvement

Has anything hindered you from being involved throughout the pregnancy process?

Do you fear for the safety of your family?

How do you manage what’s going on if you live or not live with your partner?

Were you in the room during delivery/Do you plan to be in the room during the birth?

Is your name on the birth certificate/will be on the birth certificate?

Do you think the doctors will be helpful to you throughout the process?

What challenges have you faced with your partner? How have you dealt with them?

How do you want to be involved during the pregnancy and child birth process?
Are there friends and family members that hinder your involvement?

**Conclusion**

If you could change one thing about your current involvement what would you do?

What resources would you need?

Would you attend an expectant father support group?

How do you see the future of father involvement during pregnancy? Is getting better?

Thanks so much for sharing with me today. Is there anything you would like to add?

Dads and Infant Study

Fathers Demographic Survey

1. What is your age _____?
2. How many children do you have under the age of 5? ____
3. List age(s) ________________________________
4. Do you live with the mother of your youngest child(ren)?
   1. Yes__
   2. No__
5. Have you ever lived with the mother of your child(ren) under 5?
   1. Yes
   2. No
6. Is your name on the birth certificate [CURRENT fathers only]?
   1. Yes___
   2. No___
   3. Don’t know___
7. Do you want your name on the birth certificate [EXPECTANT fathers only]
   1. Yes ___
   2. No ___
   3. Don’t know ___
8. Now thinking about your relationship with the mother of your youngest child(ren) how would you rate your communication with each other?
   1 Very good
   2 Good
   3 Fair
   4 Poor

9. Please tell me whether you strongly agree(4) agree(3), disagree(2), or strongly disagree(1) with the following:
   1 Being a father is one of the most rewarding experiences a man can have
      4……3…..2….1….1
   2 I want people to know that I have a new child
      …………………………………..4……3…..2…..1….1
   3 Not being part of my child’s life would be one of the worst things………………4……3…..2…..1….1
       that could happen to me

Education and Employment Experience

10. What is the highest grade or year of regular school completed?
    1 8\textsuperscript{th} grade or less
    2 Some high school (Grades 9, 10, 11, & 12)
    3 High School diploma (completed 12\textsuperscript{th} grade)
    4 G.E.D
    5 Some college or 2 year degree
    6 Technical or trade school
    7 Bachelor’s Degree
    8 Graduate or professional school

11. Are you currently employed?
    1 Yes ___
       ____ Full Time ____ Part Time
    2 No

12. Thinking about your income from all sources, what is your total income before taxes in the past 12 months?
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Under $5,000</td>
</tr>
<tr>
<td>2</td>
<td>$5,000-$9,999</td>
</tr>
<tr>
<td>3</td>
<td>$10,000-$14,999</td>
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</tr>
<tr>
<td>8</td>
<td>$50,000-$74,999</td>
</tr>
<tr>
<td>9</td>
<td>Greater than $75,000</td>
</tr>
<tr>
<td>10</td>
<td>Don’t know</td>
</tr>
</tbody>
</table>
Appendix B

Recruitment Fliers

African American Dads Needed!
Focus Group on Dads and Infants

Focus group participants needed for a research study on paternal involvement and healthy birth outcomes in African American Families. Participants will earn $15 and free food for their time.

Contact the Dads and Infant Study
dadsmatteruiuc@gmail.com OR text 773-270-0633

Must be 18+ and child(ren) 5 and under

Sponsored by the University of Illinois Urbana-Champaign in partnership with the Champaign Urbana Public Health District

Focus groups will take place early March
Appendix B cont’d

African American Dads Needed!
Focus Group on Dads and Infants

Focus group participants needed for a research study on paternal involvement and healthy birth outcomes in African American Families. Participants will earn $15 and free food for their time.

Contact the Dads and Infant Study
dadsmatteruiuc@gmail.com OR 773-270-0633

Must be 18 and older to participate

Sponsored by the University of Illinois Urbana-Champaign in partnership with the Champaign Urbana Public Health District
Appendix C
Call Screening Script

Screener:

Thanks for your interest in the DADS and INFANT study, this study is aimed at exploring the experience of men throughout the pre [before] and postnatal [after] stages of pregnancy and how it affects birth outcomes. I am your name from the University of Illinois Urbana Champaign. In order to participate in this study we will ask that you participate in a men’s focus group that will last 60-90min and at the end of it you will be given a $15 dollar gift card as a thank you for your participation. Are you interested in participating?

Caller: NO

Screener: If no, can I take your name and number and give you a call back at a time that is more convenient for you?

Take information and upload in excel doc in the box folder and date and time to call.

Otherwise, thanks for calling and have a great day.

If they agree to participate, continue with the following

Before I register you for the study, I just have a few questions to make sure that you are eligible to participate. This should take no longer than 2-3min. Is that okay with you?

Caller: YES

Screener: Cool/Okay let’s continue

1. Are you 18 years of age or older? Yes- continue; No, thank you for your time however you are not eligible to participate. Thanks for calling and have a good day.
2. Are you a resident of Champaign, Urbana, or Rantoul or Englewood neighborhood Chicago?
   a. If not a resident of either, Screener: Thank you for your time however you are not eligible to participate. Thanks for calling and have a good day.
3. Does/Did your partner [mother of children] receive care from the Champaign-Urbana Public Health District or Rantoul Public Health during anytime of their pregnancy?
   a. If don’t know continue to next question
   b. If they say no then they are not eligible refer back to 2a.
4. How many children do you have?
5. What are their ages?
   a. If any of the children are between 0-5 continue to 6. If not, thank them for their time and tell them they are not eligible to participate.
6. Great, you are eligible to participate in a one-time focus group to be held mid-Feb. the exact date, time and location will be sent to you via text message or email. Can I please have your contact information to schedule you for the focus group?
   a. Take name, number and email if applicable. Ask would they prefer a text message, call or email to confirm date and time of focus group.

Thanks for your time. Focus groups will take place at a determined location on Saturday or Sunday. If those days do not work for you or you have questions please contact us by phone 773-270-0633 or email dadsmatteruiuc@gmail.com.
### Appendix D

**Codebook**

**Fragile Families Child Well-Being Study Codebook**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Question</th>
<th>Response Categories</th>
<th>Recode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Race</td>
<td>What is your Race?</td>
<td>1 White</td>
<td>1= Black</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Black</td>
<td>0= All other races</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 Asian</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 American Indian</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 Other/Not specified</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Highest grade or school completed Fathers baseline education</td>
<td>-9 Not in wave -8 Out of range -7 N/A -6 Skip -5 Not asked -4 Multiple ans -3 Missing -2 Don't know -1 Refuse</td>
<td>1 Less than HS 2 HS or equivalent 3 Some college or Tech 4 College/grad/prof</td>
</tr>
<tr>
<td>Income</td>
<td>Total Earnings in past 12 months</td>
<td>1 Under $5,000 2 $5,000 to $9,999 3 $10,000 to $14,999 4 $15,000 to $19,999 5 $20,000 to $24,999 6 $25,000 to $34,999 7 $35,000 to $49,999 8 $50,000 to $74,999 9 Greater than $75,000 9 -1 REFUSED -2 DON’T KNOW 99DID DID NO REGULAR WORK</td>
<td>Same</td>
</tr>
<tr>
<td>Relationship Status</td>
<td>What is your current relationship status</td>
<td>1 We are romantically involved on a steady basis</td>
<td>1 Steady or Married 2 On and Off</td>
</tr>
<tr>
<td>Paternal Involvement</td>
<td>Fathers do things for their children how important; provide support, show love, finances, protection, teach lessons, serve as authority figure</td>
<td>1 Very Important 2 Somewhat Important 3 Not Important -2 Don’t Know</td>
<td>3 Very Important 2 Somewhat Important 1 Not Important -2 Don’t Know  3 Friends 4 Hardly or never talk</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Dads Perception</td>
<td>Strongly agree or Disagree: father most fulfilling, want people to know have child, not being dad worst</td>
<td>4 Strongly Agree 3 Agree 2 Disagree 1 Strongly Disagree</td>
<td>Same</td>
</tr>
<tr>
<td>Quality of communication</td>
<td>How often disagreements about following: money, sex, being together, unfaithful, pregnancy, unhealthy behaviors (drinking, drugs)</td>
<td>1 often 2 sometimes 3 never</td>
<td>3 often 2 sometimes 1 never Composite sum</td>
</tr>
<tr>
<td>Partner support</td>
<td>How often does your partner, compromise, express affection, criticize, hit or slap, encourage</td>
<td>1 often 2 sometimes 3 never</td>
<td>3 often 2 sometimes 1 never Composite sum</td>
</tr>
<tr>
<td>Residential Status</td>
<td>Live with partner</td>
<td>1 yes 2 no</td>
<td>0 yes 1 no</td>
</tr>
<tr>
<td>Birth Certificate Status</td>
<td>Name on Birth certificate</td>
<td>1 yes 2 no</td>
<td>0 yes 1 no -1 don’t know refuse</td>
</tr>
<tr>
<td>Paternal Age</td>
<td>Constructed Father’s age (years)</td>
<td>-9 Not in wave</td>
<td>-8 Out of range</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------</td>
<td>---------------</td>
<td>----------------</td>
</tr>
</tbody>
</table>

Appendix E
Definitions & Terms

*Infant Mortality* is defined as death prior to first year of life

*Birth Outcomes* are category of measures that describes health at birth that represents the infants’ current health and future morbidity include birth weight, gestation age and maternal risk indicators

*Resident Father* is a father who lives in the same home as the infant/child at time of birth

*Non-resident Father* is a father identified by partner who does not stay in the same home of the infant/child at time of birth

*Preterm Birth* – birth prior to 36 weeks of gestation

*Low Birth Weight (LBW)* is an infant born at less than 2500 grams and it is an indicator used as predictor of infant mortality

*Healthy Birth Outcome* is operationalized as an infant who was born weighing more than 2500 grams, <36 weeks gestation, no extended hospital stay due to complications

*Adverse Birth Outcomes* are potential risks that lead to complications after birth which can ultimately lead to infant mortality, this category of measures are described as low birth weight and preterm birth.

*Embodyment*: referring to how we literally incorporate, biologically, in societal and ecological context, the material and social world in which we live.

*Pathways of embodyment*: via diverse, concurrent, and interacting pathways, involving adverse exposure to social and economic deprivation, exogenous hazards (e.g., toxic substances, pathogens, and hazardous conditions), social trauma (e.g., discrimination and other forms of
mental, physical, and sexual trauma), targeted marketing of harmful commodities (e.g., tobacco, alcohol, other licit and illicit drugs), inadequate or degrading health care; and degradation of ecosystems, including as linked to alienation of Indigenous populations from their lands.

*Cumulative interplay of exposure, susceptibility, and resistance across the life course:* referring to the importance of timing and accumulation of, plus responses to, embodied exposures, involving gene expression, not simply gene frequency.

*Accountability and agency:* both for social disparities in health and research to explain these inequities, causal responsibility for and the power and ability to act
Appendix F

Content Analysis Summative Steps

Data Analysis and Representation, by Research Approaches

<table>
<thead>
<tr>
<th>Content Analysis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare the data</td>
<td>• transform the data into written text</td>
</tr>
<tr>
<td>Define Unit of Analysis</td>
<td>• identify and define units of analysis, unitize messages such as individual themes</td>
</tr>
<tr>
<td>Develop categories and coding scheme</td>
<td>• derived from data, previous studies or theories</td>
</tr>
<tr>
<td></td>
<td>• describe the recording units into categories</td>
</tr>
<tr>
<td></td>
<td>• Develop coding manual if multiple coders</td>
</tr>
<tr>
<td>Test coding scheme</td>
<td>• Test the clarity and consistency of your category definitions by coding a sample of your data</td>
</tr>
<tr>
<td></td>
<td>• Revise if consistency is low</td>
</tr>
<tr>
<td>Code all the text</td>
<td>• consistency has been achieved apply coding to entire corpus of text</td>
</tr>
<tr>
<td>Assess coding consistency</td>
<td>• after coding entire data set, recheck consistency of your coding</td>
</tr>
<tr>
<td>Draw inferences from coded data</td>
<td>• make sense of themes and categories identifies</td>
</tr>
<tr>
<td></td>
<td>• Identify relationship between categories</td>
</tr>
<tr>
<td>Uncover patterns</td>
<td></td>
</tr>
<tr>
<td>Report methods and findings , validation</td>
<td>• report decisions and practices concerning coding process</td>
</tr>
<tr>
<td></td>
<td>• Methods used to establish trustworthiness</td>
</tr>
<tr>
<td></td>
<td>• Description and interpretation</td>
</tr>
</tbody>
</table>

Content Analysis summative steps adaptation from Mayring (2000) and Krippendorf (1989)