Summary of Market Research for "Healthy Mothers, Healthy Babies" Campaign

"You shouldn't rest too much because 'se te pega al nino' (the baby sticks to you)," said one woman, who went on to add that labor and delivery would then be longer and harder.

"If you don't breast–feed you can get tumors," another woman remarked. However, one expectant mother said, in a show of strength, "If you want to get what you need for the baby, you won't let anything stop you."

These comments and others, revealing a mix of accurate and inaccurate information, a smattering of folklore, and the respondents' educational levels and attitudes, were recorded during a market survey for the "Healthy Mothers, Healthy Babies" campaign (*1*). Established in 1981, this campaign grew out of a Federal goal to improve U.S. infant and maternal mortality rates. Currently more than 60 government, private, and professional organizations and agencies, working together in a coalition, are conducting a public education campaign aimed at high-risk mothers (*2*).

Although U.S. infant mortality rates have been declining steadily during the last decade, improvement is still needed. In 1982 (provisional data), the U.S. infant mortality rate was 11.3 deaths per 1,000 births. We have good medical care and a high standard of living, but 13 countries have higher infant survival rates than the United States. Our goal for 1990 is fewer than 9 deaths per 1,000 live births. Infants in some demographic groups are at especially high risk. For instance, the mortality rate for black infants remains almost twice as high as for white infants. Furthermore, many children who survive in utero insults, prematurity, low birth weight, or traumatic births suffer some injury. Estimates are that some 250,000 babies are born with birth defects each year in this country.

To a large extent, those seeking to improve infant and maternal mortality rates have relied upon public education to reach high-risk women with information about good health habits and to try to convince them of the importance of seeking early and continued prenatal care. To reach the mothers in danger, educational campaigns have to "speak the right language." Therefore, before initiating the "Healthy Mothers, Healthy Babies" campaign, the Department of Health and Human Services contracted with Juarez and Associates, Inc., of Los Angeles to conduct a market research study (the "market" being the target audience for the campaign) that would provide insights into the best ways to convey the needed health education to the target audience of high-risk mothers. Although the campaign was to be aimed at all women in the childbearing years, the market research was targeted on black and Mexican American women. Goals of the study were to identfy the sources of information of these women, explore the roles of family members, and enumerate the women's health interests and needs. Barriers to health care as well as cultural sensitivities that would assist or impede acceptance of health information were to be identified.

To gather data for the market research study, focus group sessions were held by the researchers with eight groups of black women and seven groups of Mexican American women. (In a focus group session, personal interviews are conducted simultaneously with a small number of people. Unlike indepth interviews, focus groups rely more on group discussion than on a series of directed questions. A major assumption is that people will be willing to discuss personal issues in a setting comprised of others who share a common life situation or problem. The technique produces few numerical data, but it can offer rich insights that will provide direction or definition to a research concept.)

One hundred thirty women from various rural and urban areas participated in the sessions. The areas represented were Los Angeles; Chicago; McAllen, Tex. (in the Rio Grande Valley); and Selma, Ala. All the participants met the following selection criteria: 15 to 22 years old or 23 to 34 years old; black or Mexican American; currently pregnant or planning to be in the next 2 years; had resided in the area for at least 2 years; had never worked in a health-related field; and if Mexican American, spoke only Spanish or spoke Spanish at home in preference to English. All of the women were of low SES (socioeconomic status) as defined by the Department of Labor standards (a maximum annual family income of $10,400 for a household of four). In the course of the market survey, the researchers participated in some 200 hours of conversation with the women in the target audience.

Health care providers, such as nurses, physicians, social workers, and health educators from 29 counties in southern Alabama and 3 counties in Texas were also surveyed. The 163 respondents in the provider group worked mainly with black and Mexican American women of low socioeconomic status; 90 percent worked in a public health setting.

Survey Conclusions

The physician was found to be the most credible source of health information for the women despite the perception expressed by most of them that the physician was often inaccessible and too busy to talk to them. Nurses were cited by both the women and the health care providers as the women's key contacts in the public health clinics. Nurses had less

credibility, however, than either physicians or the women's mothers. The women generally considered their mothers to be good sources of information about personal or subjective matters such as, "Is delivery painful?" Both a literature review and the responses of the health care providers indicated that, for a variety of reasons, including ethnocentricity and some social isolation, the family and a friendship network were dominant influences and an important source of information for the target group. The literature suggests, and the health providers concurred, that family members may reinforce traditional practices and at times conflict with the advice of health professionals.

Community workers, particularly those associated with the federally funded Women, Infants, and Children (WIC) program, were respected as sources of information. Health care providers further credited WIC workers with many referrals for prenatal care.

The public health clinic was the women's prime source of health information. Most women placed the highest value on individual counseling by their physician or nurse. Second in rank were prenatal classes, films or video presentations, and written materials. However, the clinics were seen as having many drawbacks, including unattractive waiting rooms and overworked, often insensitive, staffs. Although the women frequently had long waits in the clinics, this time generally was not used for health education, but wasted. Members of the clinic staff were often considered to lack understanding of cultural as well as economic issues. The women expressed the belief that many times staff members failed to understand the women's limited financial resources and therefore sometimes made recommendations that the women could not afford to follow. The Mexican American women complained that there were too few Spanish-speaking staff members in clinics serving Mexican Americans. Both Mexican American and black respondents expressed the opinion that a better understanding of dietary preferences and traditional patterns, such as deference toward the father in Mexican American families and toward the mother in black homes, would aid clinic staffs in serving pregnant women more effectively.

For effective presentation of health information, pamphlets won out with the women over posters because pamphlets could be taken home and read. Health providers stressed that the pamphlets should be attractive, easy to read and understand, and should be in Spanish for Spanish-speaking groups. To overcome the discomfort some women feel with written material, the health providers suggested that formats with which the women are familiar be used to carry health information, such as the storybook or the comic book or for Spanish Americans, the foto novela (a storybook illustrated with posed photographs).

Many women saw the father of the baby or their current male partner as an important source of encouragement and support. Most women indicated that they might take better care of themselves if urged to do so by the man in their life. Black women, who in particular, were likely to freely express and discuss their emotions, often attributed their failure to follow sound health practices to feelings of loneliness and isolation. In further exploring the role of men in the behavior of pregnant women, the researchers found that, although the recent literature indicates that Mexican American women tend to consult the men in their lives about important decisions and to make such decisions in concert with these men, the idea of a macho society, in which men make decisions for women, may be outdated.

Television was the only mass communications medium found to be highly influential among the women. However, limited Spanish-language programing made television less effective with Mexican Americans than with blacks. Urban black women gained some health information from soap operas as well as from other sorts of television programs. One program, "FYI" with host Hal Linden, was mentioned in almost all discussion groups as being particularly valuable. Public service radio announcements ranked low, as did radio programs in general. The discussions revealed that many teenage Mexican Americans listen to black-oriented radio stations and to other English-language radio stations rather than to those that broadcast in Spanish.

Both the health providers and the women themselves indicated that illustrations and photographs used in educational materials should reflect the ethnicity and the real life situations of the women to be reached. They pointed out that all too many films or booklets on prenatal care depict a white middle-class woman living in a comfortable home with her husband present—an image that is unfamiliar to many of the women in need of such prenatal care campaigns. On the other hand, the women stressed that stereotypes and cliches, such as serapes and mariachis, should be avoided. As for the need for Spanish-language versions of educational materials, although only 36 percent of the Mexican American women spoke Spanish exclusively, almost 90 percent of those from Los Angeles and 66 percent of those from Chicago preferred to speak and read in Spanish, a result that emphasizes the need for Spanish–language versions of pamphlets and films.

The case for prenatal care has to be made persuasively because many women of lower SES seek medical care only when acutely ill and have difficulty in either perceiving the need or finding the money for regular checkups during pregnancy, which they view as a normal state. Some Mexican American women said that their men were reluctant to have them examined by male physicians, a further impediment to prenatal care. Also, some women are frankly skeptical of the need for prenatal care visits, since they have had previous uneventful pregnancies or have observed women who have suffered no adverse effects from pregnancy despite a lack of prenatal care. For the same reason, some women doubt the necessity of avoiding drinking alcohol or smoking tobacco during pregnancy.

The health care providers found it difficult to assess the information needed by minority women of low SES because these women tend not to ask questions. It was the impression of the health professionals that many of these women lack a basic understanding of the way their bodies work and that this lack prevents them from asking questions. Clinic staff members reported, however, that despite the reticence of Mexican American women in posing

questions, they seemed to listen attentively when the staff discussed various topics with them.

On the whole, the women seemed to understand that the health experts were advising them to stop smoking, limit alcohol consumption, exercise, eat a varied diet, and have regular prenatal visits. Their comments indicated that they knew that breast feeding was being advocated. Nevertheless, most of them reported that they did not follow the recommended health practices and by and large had not changed their behavior in any way during pregnancy. Most of the women apparently believed that improving their diets would benefit the baby, but that ignoring the health advice would harm the mother more than the baby. One woman even observed that being so careful amounted to overprotecting the baby, who would be born into a tough world.

It seemed clear that the women were interested in learning about the changes in their bodies during pregnancy. For instance, they expressed concern and wanted to know whether continued sexual relations would harm the baby. Many had heard that coffee and tea would "make a nervous baby" and were interested in scientific information about such beverages.

Although skepticism played a role in the failure of the women to adopt new health patterns, they also cited financial reasons. The Mexican American women, in particular, reported that traditional diets and family patterns made it difficult to change the way they ate. Black women tended to give other reasons; for instance, they cited the strain of pregnancy as a reason for indulging in smoking, drinking alcohol, or overeating.

The market research demonstrated that a belief in traditional practices can exist parallel to modern ideas without necessarily interfering with the acceptance of these ideas. However, a health educator who understands a group's traditional practice can reinforce an already accepted idea or directly counter a mistaken concept. The admonition for pregnant women "not to rest too much" could be used to support the idea of exercise and still reinforce the idea of adequate sleep. Many Mexican American women, because they do not want to be regarded as backward or not Americanized, reject breast feeding, which they associate with traditional Mexican practices. If breast feeding can be reinforced by showing that it is up to date and scientifically approved, then a woman's familiarity with it in her own culture might be an asset. Knowledge of traditional diets would help dieticians plan food that would be acceptable to the pregnant woman and not require her to make a total change.

The subject of breast feeding elicited many comments. Some women worried about the effect of nursing on the shape of their breasts; others found the idea of revealing a breast in public or the process of nursing in public embarrassing. Still other women stated that you could not both breast feed and bottle-feed a baby. Some, pressured to return quickly to work, indicated that breast feeding was unrealistic. Others expressed fears that if the baby did not nurse during the day, the milk would go bad. And one woman said that pamphlets never tell you how it feels to breast feed. These comments all reinforce the observations of the health educators surveyed that today breast feeding is a learned skill and that therefore pregnant women must be given a lot of information to help them decide to breast feed and to do so successfully.

Free poster offered to agencies serving pregnant women by the "Healthy Mothers" program. Posters and health cards are mailed every other month

Suggestions

- In educational campaigns, the link between the mother's behavior and the baby's health must be made clear.
- The questions that interest the pregnant woman should first be answered before moving on to other topics that need emphasis.
- The public health clinic should be used to disperse prenatal health education, and the time that women spend waiting for appointments should be used for health education.
- Wherever possible, individual counseling should be used to teach pregnant women, reinforced by prenatal education classes, audiovisual materials, or pamphlets.
- A multi-media approach is needed to reach women of lower socioeconomic status.
- The WIC program could serve as a model of how to reach women of lower socioeconomic status.

—CLARISSA K. WITTENBERG, Office of the Assistant Secretary for Health

References .....

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2. Bratic, E.: Healthy mothers, healthy babies coalition—a joint public-private initiative. Public Health Rep 97: 506-508, November–December 1982.
3. Department of Health and Human Services: Promoting health/preventing disease—objectives for the nation. DHEW (PHS) Publication. U.S. Government Printing Office, Washington, D.C., 1980.

Pediatricians Launch Drive to Cut Childhood Injuries

The American Academy of Pediatrics has launched a nationwide program that will help pediatricians counsel parents on ways to avert childhood injuries and poisonings. The Injury Prevention Program (TIPP) is the first of its kind to be undertaken by a national medical association.

At a news conference during the academy's 1983 spring session in Philadelphia, Surgeon General C. Everett Koop noted that 4 of 10 deaths of preschool children are caused by accidents. He stressed that, by making injury prevention a standard goal of pediatric practice, the TIPP project should prove a major factor in reducing childhood death and disability.

To implement TIPP, the academy has developed and distributed to its members a package of materials they will use to identify families at greatest risk of accidents and to provide systematized prevention counseling. Key elements of the package include information sheets on high-risk injuries and a questionnaire parents will complete to help pediatricians pinpoint hazards about which the parents particularly need counseling.

All parents will be advised to take five specific actions to increase their children's safety:

- Use approved child-passenger safety belts.
- Place smoke detectors in the home.
- Maintain safe hot water temperatures.
- Use window and stairway guards to prevent falls.
- Keep on hand a 1-ounce bottle of Syrup of Ipecac as a poison antidote.

Materials developed for the TIPP program are based on the results of demonstration childhood accident prevention projects funded by the Title V–Maternal and Child Health program in California, Massachusetts, and Virginia. Consultation on the TIPP program was provided by a task force that included representatives of the three projects and was funded by the Health Resources and Services Administration's Division of Maternal and Child Health.

The Secretary's Award for Outstanding Achievement in Community Health Promotion

The Department of Health and Human Services (HHS) is sponsoring an annual competition to recognize significant health promotion efforts by community groups. The award has been established to improve community health status by stimulating greater participation by voluntary and professional associations, other community groups, and public agencies in communitywide health promotion efforts.

Community organizations within States and Territories (including State and local official health agencies) that have implemented a health promotion program targeting 1 or more of the 15 priority areas identified in "Promoting Health/Preventing Disease: Objectives for the Nation" may apply to the participating State or Territorial health agency for consideration for a secretarial award. (As of April 1983, more than 40 State and Territorial agencies had expressed interest in participating.)

By October 1, 1983, each participating State and Territorial Health Officer may submit up to five exemplary projects from his or her State to be considered for a secretarial award. On or about December 1, 1983, the outstanding achievement awards will be announced, and certificates and plaques will be provided to State Health Officers for presentation to the winners in their States.

In 1982 and 1983, special emphasis for the outstanding achievement award has been placed on programs that use a community approach and focus on achievement of the 1990 Objectives for the Nation for:

- enhanced exercise and fitness
- improved nutrition
- reduced alcohol and drug misuse
- smoking cessation
- effective use of preventive services

National Selection Committee

The Department will convene a national committee composed of representatives from voluntary organizations, schools, private business, the health care sector, the health education community, and communications and marketing professionals. The following groups will be among those asked to nominate representatives: National Health Council, National Center for Health Education, National Coalition of Health Education

Organizations, Association of Fitness Directors in Business and Industry, and American Hospital Association. The committee will be chaired by the Director, Centers for Disease Control (CDC), and staffed by the Center for Health Promotion and Education, CDC, with assistance from other HHS agencies with health promotion activities.

Submitting Nominations

All applications should be submitted by the State Health Officer with a letter indicating that the project has been selected as a part of the State's review process. A maximum of five applications may be submitted by each State. All nominations received from the States will be reviewed independently on their merit against all other applications in the United States. States should not rank nominations or assign priority weights.

Health Officers of States and Territories that currently have their own health promotion award program in place are encouraged to use their present review mechanism but should include the information requested in the five segments of the application format.

Applications should be limited to 10 double-spaced typewritten pages. Supplementary materials are welcome but not necessary.

Due Date and Address

Since nominations from the States are due in CDC by October 1, 1983, States are encouraged to establish an application due date no later than September 1, 1983. Send nominations to Secretary's Community Health Promotion Award Committee, Center for Health Promotion and Education, Centers for Disease Control, 1600 Clifton Rd., NE, Atlanta, Ga. 30333, Attn. Martha Hargraves.

Results of New Research to Identify Children at Risk of Mental Health Problems

Programs designed to prevent mental health problems in children need to be based on a complex developmental model in which the child, the family, and society are taken into consideration, said Dr. Arnold Sameroff, a University of Illinois (Chicago) researcher, at a recent meeting sponsored by the Prevention Research Branch of the National Institute of Mental Health. In presenting research findings on possible causes of mental health problems during early childhood, Sameroff stated that no simple answers have emerged from long-term prospective studies of children and their families.

Sameroff and his fellow researchers followed 300 children from birth to age 4 years, some of whom had mentally ill mothers, factoring out characteristics of the child and mother in hopes of identifying specific phenomena predictive of future emotional difficulties that could be addressed by preventive measures. Even before the birth of the children, the investigators tested the mothers on a variety of social, mental, and emotional scales to determine if and how a particular maternal characteristic might affect the emotional well-being of a child.

Test of the newborns showed no single significant correlation with maternal characteristics. However, with the passage of time, the investigators found that each mother's mental health, socioeconomic status (SES), and cognitive style affected her child's development.

To develop a predictive model for the future outcomes of the children, the Illinois investigators examined 11 factors in their sample. These included the severity and chronicity of the mother's mental illness, maternal anxiety, parental perspective, maternal stimulation of child during infancy, the mother's education, occupation of the head of the household, minority status, the presence or absence of a husband in the household, stressful life events, and the size of the family (four or more children were considered a high risk factor).

Sameroff and fellow researchers then applied risk scores for the children. Those exposed to three or fewer risk factors were considered low-risk children and those exposed to six or more were judged high-risk children.

Examination of social-emotional competence measures at 4 years of age indicated that every risk factor —except, "surprisingly," maternal stimulation during infancy—significantly affected the child's outcome. Children with six or more risk factors had many problems. An analysis of risk factors by SES group indicated the same distribution of outcomes in each group. Regardless of SES status, Sameroff said, the odds are 13 to 1 that by age 4 a low-risk child will have superior adaptability and 7 to 1 that a high-risk child will have problems. Further analyzing the 11 factors to see if one had more weight and was pulling the others along, he found that the sum total of factors always predicts outcome. "No one has ever found a single identifiable risk factor for a specific condition, even in studies of medical problems such as heart disease or cancer," he said.

Not all high-risk children have bad outcomes or low-risk children good ones, Sameroff said. "We can predict that a percentage of children in the high-risk and low-risk groups will have problems, but we cannot predict which child it will be."

Discussing children's developmental milestones, Sameroff pointed out that between ages 5 and 8, children begin to stabilize because "they have internalized their world and are less reactive to the environment." Therefore behavior modification as a possible intervention is more effective before children reach that age range, he noted.

Nevertheless, because the child is part of a dynamic system, interventions can be introduced at any and every age. "High-risk children and their families, we have found, need a continuing relationship with the mental health system to enable them to deal with developmental and environmental changes," he concluded.

—MARILYN SARGENT, National Institute of Mental Health