Health norms in pregnancy*

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SUMMARY A study was conducted on a sample of pregnant women. The study had two aims: to develop a method of measuring social expectations (norms) and to find out how far women conform in their behaviour to these norms. The areas of behaviour were smoking, exercise, diet, alcohol, and medication. Pregnancy was found to be appropriate for this study because of the high degree of formalisation that this state enjoys in our society. The methods used for measuring norms in this study are an improvement on earlier methods, but further refinements are needed. The findings show that women generally do conform to the social expectations and that their behaviour is in accordance with three types of norms—that is, general, specific, and transitional. The implications for health education interventions are discussed.

There have been spectacular improvements in the morbidity and mortality of the fetus and the newborn and there is evidence that further improvements depend to a large extent on a better understanding of, and changes in, the behaviour of pregnant women. For example, the dangers from smoking in pregnancy were first reported by Simpson (1957) and Lowe (1959) and subsequently were confirmed by other workers (Frazier *et al.*, 1961; Butler *et al.*, 1972; Schwartz *et al.*, 1972; Andrews and McGarry, 1972; Butler and Goldstein, 1973). Smoking is therefore one area in the behaviour of a pregnant woman that affects fetal morbidity and mortality.

Pregnancy is a highly formalised state in our society and was therefore chosen to study the role of social expectations or norms and the influence of these on subsequent behaviour. The assumption was that norms define the behaviour of a person occupying a certain status or position in society and that consequently changes in behaviour must be preceded by changes in norms if they are to become permanent.

A study was, therefore, carried out to explore what social norms concerning pregnancy exist and to what extent behaviour of pregnant women conforms to the social expectations defined by these norms. To achieve this it was necessary first to develop ways of measuring norms because there were no standard instruments or procedures in this

field of social inquiry. Once a procedure had been established, it required empirical testing; after satisfactory results had been obtained from these tests the method and the instruments were used to explore the relationship between norms and behaviour.

Methods

MEASUREMENT OF NORMS

Although there are many definitions of norms (Homans, 1961; Bierstedt, 1963; Bott, 1971; Broom and Selznick, 1973; Cancian, 1975) and a whole range of classifications and typologies (Linton, 1936; Morris, 1956; Williams, 1960; Gibbs, 1965) most of them agree that there is so far no standard way of measuring norms. In general, definitions agree that norms represent social expectations with some kind of sanctions or repercussions for non-conformity. It would, therefore, seem logical to ask people what they think is expected of them, aggregate their replies, and thus arrive at a 'social norm'. This approach was applied in this study and provided valuable experience. It can be considered as a pilot study for the future developments of more precise ways of measuring norms.

The main problem was to decide when a shared expectation could be considered to be a norm. This question is at the centre of sociology, and represents the difficulty in distinguishing between psychological and sociological data. It goes back to the beginnings of sociology as an independent scientific discipline (Durkheim, 1938) and the debate about 'social facts'.

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THE SAMPLE

The survey population was drawn from 510 women who were booking-in at the Bolton and District General Hospital on 12 consecutive Monday afternoons from June to September 1975. Out of these, 55 immigrants were excluded leaving a total British population of 455 women who were divided into 209 smokers and ex-smokers and 246 non-smokers. Out of the 209 smokers and ex-smokers 68 women who were more than 20 weeks' pregnant were excluded and eight could not be located or refused to be interviewed. This left 133 smokers and ex-smokers who were interviewed. Half of the 246 non-smokers (123) were randomly excluded and 13 could not be located or refused to be interviewed. This left 110 non-smokers who were interviewed. The study therefore comprised 103 smokers, 30 ex-smokers, and 110 non-smokers.

The reasons for excluding certain women were: immigrants were excluded to avoid any social expectations related to pregnancy in cultures other than the one being studied; smokers who were more than 20 weeks' pregnant were excluded because it was considered to be too late for them to change their smoking behaviour with a beneficial effect on the fetus; half of the non-smokers chosen at random were excluded to get comparable numbers with smokers.

The women were interviewed in their homes, the smokers three months after and the non-smokers six months after attendance at the antenatal clinic.

AREAS OF BEHAVIOUR EXAMINED

Two methods were used to identify the areas of behaviour that might affect health in pregnancy. Medical textbooks on antenatal care were examined to determine the general areas of behaviour that require special attention during pregnancy from a medical point of view. This information was supported by informal discussions with doctors. To determine which general areas of behaviour were considered to require care during pregnancy by the 'lay' members of society, unstructured discussions with pregnant women were undertaken supported by a search in the sociological literature for similar information. As a result this study considers five areas of behaviour: smoking, alcohol consumption, diet, exercise, and medication.

SURVEY QUESTIONS

Questions were designed so as to find out the women's behaviour in four different areas: their social and demographic characteristics, past and present smoking behaviour, norms and behaviour in the other areas related to health during pregnancy, and their sources of information about smoking,

diet, exercise, alcohol consumption, and medication.

MEASUREMENT OF NORMS

There were three stages in the measurement of norms. The first determined whether a norm existed, the second evaluated whether there was an association with behaviour, and the third analysed what particular attributes of the norm influenced behaviour.

The existence of a norm was derived by asking women if they were aware of specific expectations. In this way the 'prevalence' of a norm was established. Prevalence was defined, as in epidemiology, as the proportion of the sample population aware at a certain point in time of the existence of a certain social expectation. This was obtained by asking the respondents 'Do you think that it is generally expected by the people you know that a pregnant woman who smokes should modify her smoking behaviour', or similar questions referring to other behavioural patterns during pregnancy.

The relationship between a norm or a woman's perception of a certain expectation and her actual behaviour was defined as 'conformity'. This was derived at a group level by cross-tabulating the two variables in question and applying statistical tests of significance, and at an individual level by comparing a woman's stated expectations and her reported behaviour. There were many different permutations of these two factors.

In cases where the expectations were fully matched by behaviour the women were labelled as conformists. There were two kinds of conformists: positive ones who were aware of an expectation and behaved in that way, and those who were negative and were not aware of any expectations and who did not manifest any specific form of behaviour.

If the norms were not matched by behaviour the women were labelled as deviants. Deviance was positive if the women were not aware of any norms although they did behave in a certain specific way, it was negative if the women in spite of being aware of certain norms did not manifest any specific behaviour.

In certain behavioural areas there were cases where the mismatch between the norm and the behaviour was only partial. These women were defined as variants. They could be positive variants if they did more than they felt was expected and negative variants if they did less.

The different permutations in the relationship between norms and behaviour in the analysis of conformity demanded a further explanation. This was attempted by looking at a number of norm attributes which were jointly supposed to explain the coercive power of a specific norm—that is, to

provide the reason for conformity.

If a norm exists and is part of the objective reality it will exert a pressure on a person to conform by fulfilling its expectations. This coercive power of a norm can be due to certain sanctions or repercussions associated with the act of non-conformity, or to people's perception of such sanctions and repercussions even when they do not exist. The study examines three aspects of a norm that may influence its coercive power: its 'historicity', the 'social support' it receives, and its 'legitimation' in the eyes of the health professions.

The concept of 'historicity' is usually associated with the concept of 'social institutions' (Berger and Luckmann, 1967). Because the origins of various institutions such as family, religion, or law are buried in the past a child accepts them during the process of socialisation as the 'objective reality' into which he or she is born, without questioning or knowing the reasons for their existence. By analogy a norm will manifest 'historicity' if its origins are not known to the people. Historicity thus makes a norm a part of a person's objective reality. In this study, historicity of a norm was assessed by asking the respondents to indicate the source of information about a certain expectation. An expectation was deemed to manifest historicity if the respondents did not mention any specific source and answered that they 'just know' about an expectation. The expectations that showed a degree of historicity were considered to be established as norms and as a part of the objective reality of the respondents.

Another aspect of the coercive power of a norm is the amount of 'social support' that the norm receives. Although 'implicit social support' will be a part of the historicity of a norm, it will also be manifested by the amount of space or time given to it by the mass media. The message transmitted in such a way was defined as implicit social support since it was not directed to any one person specifically. The 'explicit social support' defined as a source of information aimed directly at a woman by her social environment—such as, husband, relatives, or friends—is also considered to be an important aspect of the coercive power of a norm. A norm was considered to have 'social support' if a woman indicated that one of the members of her social environment expressed such an expectation thus acting as a source of information about the expected behaviour.

Whereas, social support was considered to be of a more general nature, the attribute of 'legitimation' was considered to be linked directly with the support given to a norm by the health profession. This support was expressed by the health personnel

mentioning an expectation to the pregnant woman during their various interactions and thus the amount of legitimation was derived from the number of women who mentioned the health personnel as a source of information about an expectation.

Results

SOCIAL CHARACTERISTICS OF THE POPULATION

The sample comprised women varying in age from 15 years to over 40 years but most of them (70%) were between 20 and 29 years. For 96 (40%) of the women in the sample this was their first pregnancy. One hundred and thirty-one (54%) of the women had no certificates of educational or vocational qualifications and of the remainder, 49 women had technical qualifications—such as, CSEs or vocational—44 had 'O' levels, and a further 19 had higher qualifications. This distribution of education is comparable with the educational level of women in the country as a whole as taken from the General Household Survey, 1974.

The social class composition of the women in the sample was determined by the Registrar-General's classification of occupations of the women or their husbands, using the woman's own occupation or that of her father if she was not married. The frequency distribution of this classification showed that the sample was composed of 55 women (23%) in social classes I and II, 25 (10%) and 114 (47%) in social class III non-manual and manual respectively, and 45 (18%) in social classes IV and V; (four women were unable to be classified). As with education this social class distribution is very similar to the distribution of the same within the country as a whole, as taken from the Census of Populations (General Household Survey, 1974).

NORMS AND BEHAVIOUR

The findings related to norms are described separately for each of the five behavioural areas investigated and cover the following aspects of the norm-behaviour relationship: the existence of a norm, the pattern of behaviour, the conformity with the norm, and the coercive power of the norm.

SMOKING

Norms

Most of the pregnant women in the sample (79%) were aware of the existence of social expectations (norms) of some sort related to smoking in pregnancy. Of these, 39% thought that a pregnant woman was not expected to smoke at all, whereas 40% thought that they were expected to reduce the number of cigarettes smoked.

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Behaviour

At the time of the survey out of the total sample of 243 women, 140 (58%) did not smoke and 103 (42%) did smoke. The 140 non-smokers comprised 110 (79%) women who had never smoked and 30 (21%) women who had smoked at the beginning of pregnancy but subsequently gave it up and were defined as ex-smokers. Most of the 103 smokers at the time of the survey reported some change in their smoking pattern during pregnancy: 44 (43%) reduced the amount smoked permanently, nine (9%) cut down on their smoking temporarily, eight (8%) stopped and restarted, seven (7%) increased the number of cigarettes smoked, whereas 35 (34%) reported no change.

Conformity

At a group level there was a statistically significant association between the perception of norms and smoking behaviour.

In terms of conformity at individual level a variety of norm-behaviour relationships was found. (See Table 1.)

Table 1 Norm-behaviour relationships: smoking

	No.	%
Conformity		
Positive	88	36
Negative	15	6
Deviance		
Positive	35	14
Negative	27	11
Variance		
Positive	54	22
Negative	24	10

Coercive power

The study showed that the norm related to smoking manifested a relatively low coercive power because only 88 (36%) were positive conformists. In terms of the attributes, the smoking norm showed no historicity at all as all the women were able to name at least one source of information concerning smoking in pregnancy. Correspondingly explicit social support was high with 153 women (63%) naming a friend or neighbour as a source of information. Implicit social support for not smoking in pregnancy was high; 237 women (98%) mentioned the mass media as a source of information. Legitimation of the norm was low compared to social support with only 54 women (22%) mentioning a member of the health profession as a source of information about the dangers of smoking in pregnancy.

DIET

In addition to smoking, diet was considered by some women as being important to the well-being of the unborn child.

Norms

According to the women's reports, dietary measures during pregnancy fell into three categories: eating the 'right' foods, eating for two, and watching weight.

Eating the right foods meant that women believed that attention should be paid to nutrition, making sure that the diet included plenty of meat, fish, eggs, milk, and fresh vegetables. This opinion was expressed by 84 (35%) of women who were aware of such expectations.

The need to eat for two because an additional body had to be fed, was something that the women had heard about, but only 16 (7%) of them believed it to be a social norm.

Many of the women were aware of the fact that they might gain excess weight during pregnancy. There were 59 (24%) who expressed their awareness about social expectations concerning the control of weight during pregnancy.

One hundred and twenty-eight women (53%) were aware of the existence of some sort of expectations about special care to be taken with diet during pregnancy.

Behaviour

Seventy-one women (29%) reported taking care to eat the right foods, while 59 (24%) reported taking care to watch how much weight they put on. Only three (1%) said that they took care to eat for two.

Conformity

At group level there was a statistically significant association between the behaviour of the women concerning diet and their expectations. At an individual level the conformity for each aspect of dietary behaviour is given in Table 2.

Table 2 Norm-behaviour relationships: diet

	Eat right foods		Eat for two		Watch weight	
	No.	%	No.	%	No.	%
Conformity						
Positive	55	23	1	0.5	34	14
Negative	143	59	225	92.5	169	70
Deviance						
Positive	16	6	2	1	15	6
Negative	29	12	15	6	25	10

Coercive power

This study showed that we were not dealing with one but several types of behaviour concerning eating habits during pregnancy. Whereas eating for two was less popular, eating the right foods was generally considered to be important. It can be said that those behavioural patterns reflect different

manifestations of a more general norm concerning diet during pregnancy.

Among the various different norms explored in this study, diet scored the lowest in terms of historicity with only 55% of women saying that they 'just knew' what to do as far as their dietary behaviour was concerned. It also scored low on implicit social support with only 21% of the women mentioning mass media as a source of information, and was even lower on explicit social support with only 9% of women mentioning receiving information socially. Compared with the other norms in pregnancy, diet scored highest on legitimization with 24% of the women mentioning health personnel as a source of information.

EXERCISE AND EXERTION

There is, for obvious reasons, an awareness among pregnant women that their state imposes certain restrictions on movements. Because of this, women were asked about exercise during pregnancy. In general, the responses could be divided into two mutually exclusive categories: those who made sure to compensate for the general restrictions in movement by taking special exercises, and those who reduced the amount of movement while performing everyday tasks, thus avoiding unnecessary exertion.

Norms

One hundred and twenty-nine women (53%) were aware that there are certain social expectations concerning exercise during pregnancy. Of these, 92 (38%) thought that a woman was expected to take certain additional forms of exercise, whereas 37 (15%) thought that a pregnant woman was expected to take only very little exercise.

Most women (234 or 96%) expressed awareness of social expectations concerning special caution to control over-exertion during pregnancy which could result from lifting heavy objects, stretching while decorating, etc.

Behaviour

In terms of behaviour, 69 (28%) women actually took forms of extra exercise and 14 (6%) took less. One hundred and sixty (66%) women did not take any special measures concerning exercise.

One hundred and ninety-eight (81%) reported taking special precautions so as not to exert themselves, while the remaining 45 (19%) did not bother about this.

Conformity

At group level there was a statistically significant association between women's awareness of expecta-

Table 3 *Norm-behaviour relationships: exercise/exertion*

	Exercise		Exertion	
	No.	%	No.	%
Conformity				
Positive	66	27	194	80
Negative	103	43	5	2
Deviance				
Positive	11	4	4	2
Negative	63	26	40	16

tions about both exercise and exertion and their actual behaviour. At individual level the various aspects of conformity are presented in Table 3.

Coercive power

The general expectations concerning exercise have been found to cover two different areas of behaviour. Whereas taking special measures about exercise scored relatively low on historicity with only 59% of women mentioning that they 'just knew' that this was the right behaviour, exertion scored very high on historicity with 79% of the women saying that they 'just knew' when asked about the source of their information. Implicit social support was found to be relatively low in both cases with 11% of women mentioning mass media as a source of information about exercise and only 4% reported mass media as a source of information about exertion. Explicit social support was also relatively low with 11% of women mentioning a friend or neighbour as a source of information in both cases. It is interesting to note that only 10% of women mentioned health personnel as a source of information about exertion, compared with 23% in the case of exercise which would indicate that exercise scored relatively higher on legitimization than exertion.

ALCOHOL CONSUMPTION

Pregnancy can affect the amount and the kind of alcohol a woman consumes and it was found that there were different behavioural patterns as a result of a general feeling that drinking in pregnancy was not recommended.

Norms

The expectations about drinking alcohol during pregnancy concerned the amount and the kind of alcohol consumed. One hundred and twenty-three women (51%) were aware of a social expectation to reduce their drinking or to drink only small amounts of alcohol, while 20 women (8%) felt that they were expected to stop drinking alcohol completely. Fifty-five women were aware of a social expectation to exclude spirits during pregnancy.

Seventeen (7%) women believed that there was a beneficial effect in drinking stout during pregnancy.

Altogether a total of 168 (69%) were aware of expectations of some sort relating to alcohol consumption.

Behaviour

In terms of behaviour, 24 (10%) women said that they never drank alcohol and a further 51 (21%) said that they had stopped completely during pregnancy. There were 33 (14%) women who said that they drank only small amounts anyway, and a further 60 (25%) who reported reducing the amount of alcohol drunk.

As far as the type of alcohol was concerned, 70 women (29%) had stopped drinking spirits, while a further 136 women (56%) said that they did not generally drink spirits anyway. Thirty-five women (14%) reported drinking stout during pregnancy.

Conformity

At group level there was a statistically significant association between women's awareness of expectations and their actual behaviour with regard to all types of behaviour concerning alcohol consumption. At individual level the various aspects of conformity are shown in Table 4.

Table 4 Norm-behaviour relationships: alcohol

	Amount drunk		Exclude spirits		Include stout	
	No.	%	No.	%	No.	%
Conformity						
Positive	92	38	51	21	16	6.5
Negative	60	25	35	14	206	85
Deviance						
Positive	40	16	153	63	20	8
Negative	16	6.5	4	2	1	0.5
Variance						
Positive	33	13.5				
Negative	2	1				

Coercive power

There seems to be a general norm about drinking alcohol during pregnancy which the women interpreted in terms of their own drinking behaviour. Some women said that one is expected to stop drinking altogether, others that one should reduce the amount, that one should avoid spirits, or that one should drink stout. Accordingly the women adjusted their behaviour to their perception of the expectations.

In general the norm showed a very high level of historicity with 74% of women reporting that they 'just knew' what they should do about drinking alcohol. It scored much lower on implicit social support with 15% of women mentioning mass media as a source of information: it scored low also on explicit social support with 11% of women

mentioning a friend or neighbour as a source of their information. The norm got practically no support from the health personnel with only 2% of women mentioning them as a source of information thus scoring very low on legitimization. From this one can conclude that the norm concerning alcohol consumption in pregnancy derives its coercive power almost solely from its attribute of historicity.

MEDICATION

There is no doubt that most pregnant women are sensitive to the dangers from medication for the unborn child. This was supported by the findings of this study.

Norms

Expectations about using medications were that either the woman should take more care than usual or that she must take nothing at all without the consent of her doctor.

Only 15 (6%) of the women perceived a lack of social expectations concerning medication. One hundred and eighty-two (75%) thought that a pregnant woman should not take any medicines without first consulting a doctor, and 46 (19%) that some special care should be taken.

Behaviour

In terms of reported behaviour the awareness of dangers from medication was more pronounced. One hundred and ninety (78%) women reported not having taken any medicines at all without consulting the doctor, while 49 (20%) of the women reported taking more than usual care: only four (2%) women did not change their behaviour at all.

Conformity

At group level there was once again a statistically significant association between a woman's awareness of expectations concerning medication during pregnancy and her actual behaviour. The pattern of individual conformity is presented in Table 5.

Table 5 Norm-behaviour relationships: medication

	No.	%
Conformity		
Positive	200	82
Negative	3	1.5
Deviance		
Positive	12	5
Negative	1	0.5
Variance		
Positive	15	6
Negative	12	5

Coercive power

According to the behaviour of women concerning medication during pregnancy there is no doubt that

this norm has a very strong coercive power. Considering the recency of the awareness of the dangers from certain medications (thalidomide 1961) the norm manifests a relatively high degree of historicity with 67% of the women saying that they 'just knew' about the dangers of medication and not mentioning any specific source of information. The norm scored relatively low on explicit social support with only 9% of women reporting a friend or neighbour as a source of information, and relatively low on implicit social support with 16% of the women mentioning mass media. It also scored very low on legitimization with only 13% of women mentioning health personnel as a source of information about the existing dangers from medication.

Discussion

METHODS OF MEASUREMENT

The attempt to measure norms in a specific way in this study can be considered to have been partially successful. Because of this the study should be viewed as an improvement on earlier methods, although further work will be necessary. It was found that a simple approach for establishing people's awareness of certain expectations may be sufficient for the establishment of the existence of a norm in a social group but it cannot fully explain the relationship between a norm and the subsequent behaviour.

For the purpose of preventive medicine in general and the interventions related to behaviour modification (health education) in particular, it was necessary to explore the relationship between norms and behaviour in terms of the coercive power of a norm. The election of certain attributes of a norm in the attempt to explain the reasons for conformity proved partially successful. At the conclusion of the exercise the need was felt to include certain additional attributes in a more precise way such as possible consequences as well as sanctions associated with non-conformity and the utility or gain associated with conformity. In addition to the inclusion of new attributes related to norms, those used will require further refinement of the instruments and of the inferential approach used.

The approach used in this study can be considered to be an improvement on existing methods, as it provided a better insight into the norm-behaviour relationship than could have been achieved otherwise. It provided three types of norms, differentiated according to their coercive power, derived from the intensity and effectiveness manifested by the norm-behaviour relationship. These were:

Specific norms

These were directly related to a certain practice that had clear-cut consequences in the case of non-conformity. Such norms were concerned with medication and exertion during pregnancy, and were characterised by immediate consequences for non-conformity which the women felt had a high probability of occurring and were sufficiently undesirable to be avoided.

General norms

These were related to behavioural patterns in general, and were not specific to a group or a situation. One could say that although they applied to everybody, they became intensified for people in a certain situation or occupying a specific status. Such were the norms of eating the right kinds of food and the consumption of alcohol which applied to everybody in general and women during pregnancy in particular. The indication of the generality of a norm as compared to a specific one can be assessed by looking at the immediate consequences of non-conformity and the relapse-rate after returning to a state of a non-pregnant woman after the delivery. A norm can be classified as 'general' if it manifests a lack of immediate or unavoidable consequences sufficiently undesirable to be avoided.

Transitional norms

These were in the process of changing from being general to acquiring a special meaning associated with a specific status. The norm related to smoking was found to be of such a 'transitional' kind. Although the awareness of health hazards from smoking in general has been known for a while, the specific threat to the unborn child became known only recently. Because of this the implications of smoking have acquired a new meaning for pregnant women. This transition of a norm from being general to becoming specific is characterised by a change in general social values or by new knowledge which gives that norm a new meaning. This process of transition between 'generality' and 'specificity' of a norm can move in either direction as was found by examining the norms related to smoking in pregnancy and to dietary needs of eating for two. The former is rapidly gaining in specificity, whereas the latter is losing its specific meaning and gradually becoming obsolete.

NORMS AND BEHAVIOUR

Once the existence of a norm had been established and the norm classified along the 'general-specific' continuum it was possible to examine the relationship between norms and behaviour of pregnant women in a variety of behavioural areas.

The first step was to establish whether a manifested

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relationship was due to a norm or to another factor. This was tested by dividing the sample population according to certain characteristics and matching the behaviour of these subgroups with their awareness of certain norms. The assumption was that a norm related to pregnancy should affect women equally, no matter what their other characteristics were. The characteristics used were women's age (younger/older), whether it was their first pregnancy, social class (non-manual I, II, IIINM, and manual IIIM, IV, V), and whether they had some higher education. Table 6 shows that in most cases there was a statistically significant association (+) concerning the norm-behaviour relationship according to the specific characteristics of women and the various behavioural areas. In two areas, however, it was not possible to calculate this association because nearly all the women manifested such behaviour (exertion) or because practically none did so (eat for two) and these are marked in the table with '0'. An interesting pattern emerged for smoking during pregnancy which showed a high degree of prevalence (79%), positive conformity (56%), and coercive power (56%) and

yet the statistically significant association between awareness of the expectation and behaviour was found for only certain groups of women. From this one can assume that smoking in pregnancy is a norm in 'transition' and is not yet generally accepted.

The next step in the norm-behaviour analysis was to look at the various areas of behaviour and the different attributes of norms studied (Table 7). The percentages indicate the proportion of women in the sample who answered positively to each norm-attribute. It seems that there are two reasons for women to behave in a specific way during pregnancy:

1. When a norm is 'specific' in terms of consequences and manifests a high level of coercive power (exertion/medication);
2. When a norm is 'general' or 'transitional' and manifests a high degree of at least some aspect of coercive power such as historicity (alcohol) or social support (smoking).

IMPLICATIONS FOR HEALTH EDUCATION

Health education can use a variety of methods to

Table 6 Associations between characteristics of population and areas of behaviour

Area of behaviour	Age (years)		Pregnancy		Social Class		Educational qualifications	
	>25	<25	1st	More	Non-manual	Manual	None	Some
Smoking	+	—	—	+	—	—	—	—
Diet								
Right foods	+	+	+	+	+	+	+	+
Eat for two	0	0	0	0	0	0	0	0
Watch weight	+	+	+	+	+	+	+	+
Exercise	+	+	+	+	+	+	+	+
Exertion	0	0	0	0	0	0	0	0
Alcohol								
Amount	+	+	+	+	+	+	+	+
Spirits	+	+	+	+	+	+	+	+
Stout	+	+	+	+	+	+	+	+
Medication	+	+	+	+	+	+	+	+

Table 7 Percentages of women who answered positively to each norm-attribute

Area of behaviour	Prevalence	Positive conformity	Coercive power			
			Historicity	Social support		Legitimation
				Implicit	Explicit	
Smoking (total)	79	36	—	98	63	22
Stop	39					
Cut-down	40					
Diet (total)	53					
Right foods	35	23	55	21	9	24
Eat for two	7	0.5				
Reduce weight	24	14				
Exercise (total)	53	27	59	11	11	23
Increase	38					
Decrease	15					
Exertion	96	80	79	4	11	10
Alcohol (total)	69					
Amount	59	38	74	15	11	2
Spirits	23	21				
Stout	7	6.5				
Medication (total)	94	82	67	9	16	13
Take care	19					
Take nothing	75					

achieve behavioural change. The method selected for a defined health threat to a specific population will depend on the available resources. That is why health education must be system-specific if it is to be effective. In countries where health education is the domain of special agents (Area Health Education Officers) who are responsible for large populations, the method of preference must enable them to be effective on a population scale.

The current study has shown how health education can influence norms:

1. Information related to norms can fulfil two tasks: it can teach people what to do, and avoid the danger of creating a learning situation in a social vacuum by transmitting knowledge together with social expectations;
2. The creation of new norms or changing norms from general into transitional and ultimately into specific norms, will affect people's attitudes to a specific health threat, since attitudes represent internalised social norms at individual level;
3. Specific norms are accompanied by a recognised social status. The creation of specific norms concerning a health threat for a social group will result in the recognition of a corresponding 'at-risk' status with a defined role for that social group;
4. If we consider norms to be shared perceptions about the beliefs or expectations of others, then by changing a status this perception can change rapidly too. The acquisition of a recognised 'at-risk' status should produce a rapid acceptance of new norms accompanied by corresponding behaviour.
5. A social status/role accompanied by specific norms labels people as conformists and deviants with specific sanctions for the latter. The status of deviance is important for the justification of health education interventions on a population scale, which does not provide for a previous agreement by each individual before being exposed to its influence.

The study showed that where specific norms exist for a defined status the appropriate behaviour of the status-occupiers will follow. Thus, the main aim of health education should be to create specific norms if they do not exist, or deal with deviants by teaching them norms if they do exist since people should learn new norms when they acquire a new status.

The study emphasised the responsibility that health education intervention must display when effective methods for population changes become widely applied.

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