Involving local community: testing models for communicating surveillance data. From planning to elaborating and evaluating effective communicative tools to specific target groups at local level

Methods

Forty operators from 25 LHUs participated in the six-monthly training: three one day meetings (22 April 2010, 24 June 2010, 11 November 2010) and two rounds of two-monthly activities in the field. A password-protected portal was used for exchanging materials among participants at a distance.

Results

The seven inter-regional Working Groups planned communication, performed and tested materials using surveillance results for specific target groups at a local level. The need for effective approaches to communication was highlighted. Draft materials (leaflets for older women, posters for young people, charts for GPs, papers for policy makers/stakeholders) were tested on selected target groups. The two lay target populations (women, children) evaluated the tools positively, critiquing images, recommending clear and essential messages, clarifying what should be done to improve health. The professional groups suggested editing of text and space for graphs/tables. Materials will be modified accordingly and delivered.

Conclusion

Surveillance systems are valuable tools for advocacy at a local level. Communication is fundamental for knowledge, awareness and empowerment processes in specific target groups, professional and lay. To be effective, materials must be carefully planned and tested.

Risk factors for poor mental health during pregnancy from the born in Bradford cohort: early results from a bi-ethnic sample

Methods

We examined data from White (N=1901) and Pakistani (N=1560) women who completed the GHQ-28 in English. We used univariate and multivariate logistic regression to examine socio-demographic risk factors associated with scoring above the conventional threshold for poor mental health. We conducted a sensitivity analysis on the threshold method by comparing the highest and lowest scoring quintile within each ethnic group.

Results

45% of White and 47% of Pakistani women scored above the threshold. For White women univariate risk factors were not living with a partner, self-reported financial worries and less education. For Pakistani women not being in a relationship and having financial worries were associated with poor mental health. Significant variables remaining in the multivariate models for both groups were financial worries (White OR 2.4, 95% CI 2.0 to 3.0; Pakistani 2.7, 2.1 to 3.5) and not being in a relationship (White 1.4, 1.0 to 2.1; Pakistani 2.6, 1.0 to 6.5). Sensitivity analyses indicated the same significant risk factors with the addition of cohabitation and younger age in the univariate analyses for White women. Pakistani women had worse within-quintile scores than White women (highest quintile difference 5.6 points, t=8.8, p<0.0001).

Conclusion

Prevalence and severity of poor mental health varies by ethnicity but consistency in the associated risk factors underline patterns of social disadvantage in both groups.