COMMUNITY HEALTH EDUCATION:
MATERNAL AND NEWBORN HEALTH

A graduate project submitted in partial satisfaction of the requirements for the degree of Master of Science in

Health Science
School Health Option

by

Margaret Rita-Anne Norris

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The graduate project of Margaret Rita-Anne Norris is approved:

_____________________
She lia Harbet, H.S.D.

_____________________
Mary Parker, R.N., M.S.

_____________________
Waleed Alkhateeb, Dr.P.H.
Chairman of Committee

California State University, Northridge
DEDICATION

To the children of tomorrow's generation that each child is born perfectly beautiful and beautifully perfect.
ACKNOWLEDGEMENTS

At this time I would like to express my sincere gratitude to the following persons who assisted me in my efforts to complete this project.

My Evaluation Committee who were instrumental and supportive in the writing of this project. A special thanks to the March of Dimes Birth Defects Foundation for providing me with the opportunity of designing, implementing and evaluating their first community health education program. To Erwin France, Ph.D. and Janice Kissner for their support, technical assistance and active role in the conducting of this project. To the staff at the Los Angeles March of Dimes, especially Anita Gallegos for her tremendous assistance and guidance in making this program a success and great learning experience.
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ABSTRACT

COMMUNITY HEALTH EDUCATION:
MATERNAL AND NEWBORN HEALTH

by

Margaret Rita-Anne Norris

Master of Science in Health Science

The literature reviewed for this project revealed that the fetal and neonatal morbidity and mortality rates that occur from the twenty-eighth week of gestation until the twenty-eighth day after birth (Perinatal Period) exceeded all other causes of death combined, until the age of sixty-five. Also, 10 to 20 percent of the women who are pregnant are classified into the high risk group and account for over one half of the fetal and neonatal deaths.

The message gained from many of the readings was that women seeking prenatal care, which included basic pregnancy education, had a better pregnancy outcome than women receiving little or no care. It has not been clearly determined if a good pregnancy outcome was related to the woman receiving prenatal care or that she was already living a conscientious pregnancy.

This project, sponsored by Los Angeles County March of Dimes
entailed the development, implementation and evaluation of a community health education program in two Los Angeles communities, identified by the Los Angeles Health System Agency [H.S.A.] as having high infant morbidity and mortality rates and considered high risk. The two communities were East Los Angeles and South Central Los Angeles.

The purpose of this project was to inform community leaders, who had grass root contacts in their community, about the problem of poor pregnancy outcome. Once informed, the participants together discussed solutions to the problem.

The program was conducted for four weeks at two separate sites. The topics covered were:

Session I: An Overview of Poor Pregnancy Outcome
Session II: Conception to Birth--Prenatal Care
Session III: Teenage Pregnancy
Session IV: Role of Community Leaders

The evaluation of the programs revealed:

1. That the participants gained each week a small amount of new and useful information.
2. That the participants could list ways this new information could be dispersed.
3. Four problems the participants identified as areas to be acted upon to improve the outcome of pregnancy.

This program, being a pilot project, will also be a basic plan to build upon for organizing and implementing similar community health education programs in other March of Dimes Birth Defects Foundation's Chapters across the United States.
Chapter 1

INTRODUCTION

A drastic comparison can be made if one looks at the United States perinatal morbidity and mortality rates and the technical advancements in medicine. It seems that the knowledge we have has not been able to adequately insure a healthy baby. This inadequacy is the result of many reasons. Two broad factors lie in those seeking or not seeking care and those providing the care.

This paper will expound on the problem of poor pregnancy outcome and some of the reasons that may be responsible for this tragedy. The actual project will show how one organization attempted to begin taking steps in the improvement of pregnancy outcome, so that every child born may have the right of being born healthy.

Statement of the Problem

Conformable with the facts gleaned from the literature, the suggestions from Los Angeles health professionals and members of the Los Angeles Maternal and Newborn Health Task Force the following problem was delineated: The high risk community is largely uninformed and uninvolved in improving infant morbidity and mortality rates in Los Angeles County.

Purpose of the Project

The primary purpose of the project was to develop, implement and
evaluate a community based health education program in the high risk
community. This program was to inform leaders of the high risk
community about the problem of poor pregnancy outcome and involve them
in identifying local key problems and determining solutions which could
have a positive impact on the morbidity and mortality rates.

A secondary purpose lies with this being a pilot project of the
National Foundation/March of Dimes for the intent of disseminating the
findings to the National Foundation headquarters and other interested
chapters across the nation. Amid these disclosures, other March of
Dimes chapters could begin to develop similar programs in their
communities to improve the outcome of pregnancy.

Limitation of Project

The target populations of the Community Leadership Development
Program was community representatives from East Los Angeles and
South Central Los Angeles, who were concerned about the problem of
poor pregnancy outcome in their own community. This group included
religious, civic, educational, fraternal, women's, business, labor, and
other organizations that were part of the high risk community. Also
attending were the medical or health related professionals who serve
this high risk community.

Of the 115 participants who attended one or more of the sessions,
seventy-eight were health professionals and thirty-seven had little or
no health background. Although the majority had health backgrounds,
many of the participants also belong to non-health community organiz-
ations that could benefit from this type of community based health
education program. The importance of establishing contacts with those health professionals who belong to other community organizations is twofold:

1. They could act as a liason between the March of Dimes and their community organization which would help establish educational programs at the community level.
2. They could serve as faculty for other community health education programs.

Definition of Significant Terms

**Fetal Death:** The death of a product of conception prior to its complete expulsion [stillbirth] irrespective of the duration of the pregnancy (9:G-13).

**High Risk Pregnancy:** Pregnancy with increased overall hazard of perinatal death or disability of the offspring because of complications of maternal disease or abnormality and its treatment (3:11).

**Low Birth Weight:** Any live born infant with a weight at birth of 2,500 grams/5 lbs. 8 oz. or less (13:6).

**Neonatal:** A term applied to newborn infants from the first hour of birth through the first twenty-seven days (9:G-24).

**Perinatal:** The period of time beginning with the twenty-eighth week of gestation and ending the twenty-eighth day after birth (13:18).
**Perinatal Mortality Rate:** The combined fetal (stillborn) and neonatal death rate per one thousand live births. This time period goes up through the twenty-seventh day of life (9:G-26).

**Premature:** A live born infant with a gestational period of less than thirty-seven completed weeks, regardless of birth weight (9:G-28).

**Prenatal Care:** Complete and adequate health supervision of the pregnant woman designed to maintain, protect, and promote the physical and emotional health and well-being of the woman, the newborn infant and the family (3:1-2).
Chapter 2

LITERATURE REVIEW

Maternal health care encompasses a wide spectrum of services and activities, which attempt to respond effectively to the major health needs of the population to be served (3:xvii, abstract). A common goal of modern maternal health care professionals is to maximize the quality of fetal, newborn, and infant life in which every individual conceived is given the greatest opportunity for optimal physical, mental and emotional development.

In attempt to reach this goal, one finds that the stakes are high, for the United States has a higher infant death rate than fifteen other countries (13:8). These stakes are measured by perinatal mortality and etiologically related tragic effects of sublethal perinatal morbidity on the individual, the family and society.

Since the quality of human reproduction with regards to late fetal and neonatal mortality and morbidity is ranked sixteenth among the nations of the world, the team [physician, public health nurse and social worker] working together and sharing new knowledge and approaches will ensure a better outcome of pregnancy (17:3,26).

Infant Mortality and Morbidity Rates

The majority of newborn infants deaths are associated with prematurity and extreme low-birth weight of 2,500 grams/5 lbs. 8 oz. or less (2:9).
Ten to twenty percent of the women in the United States are classified high risk and account for over half of the fetal and neonatal deaths. California statistics show that two thirds of all deaths occur in the first twenty-seven days and that perinatal death exceeds all other causes of death combined, until age sixty-five. One out of ten Americans also will be born to a greater or lesser degree impaired for the remainder of their life (1:2).

Statistics reveal that from 1950 to 1970 perinatal deaths [fetal mortality plus neonatal mortality] have decreased 26 percent and are 20.3 per one thousand live births. This falling mortality rate has been attributed to widespread improvements in patient care, health practices and identification of pregnancies at high risk (1:272).

In the area of fetal mortality [14.2 deaths per one thousand live births], 40 percent are primarily preventable because they are associated with maternal diseases such as diabetes and toxemia, and those resulting from disproportion or malposition. This fetus is usually born at term and weighing over 2,500 grams/5 lbs. 8 oz. (1:272-273).

Another 40 percent of fetal deaths are a result of defects in the placenta or cord. These factors are often silent and undetected until delivery, except when fetal growth is interrupted and discovered. The last 15 percent to 20 percent of fetal deaths are mainly the result of severe defects that are uncorrectable and therefore lead to death of the fetus (1:273).

In regards to neonatal mortality [15.1 deaths per one thousand live births] over 50 percent occur in infants who weigh under 1,500
grams/3 lbs, 3 oz. When neonatal mortality was recorded, it was inversely proportional to the birth weight. Congenital anomalies and respiratory distress syndrome are the most common factors for neonatal death and morbidity (1:273).

This common factor, low birth weight [under 2,500 grams/5 lbs. 8 oz.], found in perinatal mortality and morbidity is a measure of any populations pregnancy health status and a way neonatal mortality and morbidity can be compared (1:274).

The goals that have been established, which ultimately will decrease the infant morbidity and mortality rates are:

1. Reduction of the number of infants born prematurely.
2. Optimum use of physician and nursing skills, particularly in the recognition and management of acute and chronic fetal stress. Expand the regional perinatal centers which are intensive care centers for the high risk fetus and infant so that the best treatment can be available immediately.
3. Reduce the number of low birth weight infants born. This can be accomplished, to some degree, if unwanted pregnancies are prevented, prenatal care early and continuously and the populace is informed and involved concerning poor pregnancy outcome (2:275).

**Identification of High Risk Pregnant Woman**

If the medical care system has as its primary goal "the prevention of human ills of all forms," this prevention must begin at or before the point of conception of new life (17:3).
In attempting to reach this goal the first problem is the identification of the population who is in greatest need of manpower, health care dollars and technological knowledge, but who often is not encountered until the damage is done (17:4). It has been estimated that about two thirds of the high risk population can be detected early in pregnancy, but that this percentage of the high risk population is not seeking such care (17:13).

Reasons for late care and detection often are based on fear and distrust of the physician, modern medicine and hospitalization by the low, socioeconomic individual. Early in life this population performs self diagnosis due to fear of disease and has feelings of fatalism where nothing can be done to prevent or correct the disorder (6:15).

A large percentage of these high risk patients can be found among the socioeconomically deprived women, particularly those from depressed urban areas. These women appear to have a higher percentage of the immature and low birth weight infants.

Some of the factors for these higher percentages are due to extreme youth, grand multiparity, conception out of wedlock, low educational achievement, and inconvenience in obtaining medical care. Because of the high proportion of unwanted pregnancies many high risk patients are disinclined in seeking prenatal care, thus existing or developing complications inimical to normal and complete fetal development are detected too late for correction (2:169).

If a woman comes in for prenatal care, high risk factors have been established to detect if she belongs in this group. The following are factors which identify the woman as high risk.
1. She receives little or no prenatal care.
2. She is under seventeen years or over thirty-five years of age.
3. She suffers from a chronic illness and or contracted an infection during pregnancy.
4. She is either under or overweight.
5. She is taking addictive or therapeutic drugs.
6. She has a minimal education.
7. She is of low-income.
8. She is unwed or without male support. (3:11)

**Teenage Pregnancy**

Teenage pregnancy has been a part of the United States a long time, but not until 1978 did the government become interested in the alarming statistics and cost factors related to this problem. The House of Representatives initiated the "Adolescent Pregnancy Bill" HR 12146 in 1978, which initiated the investigation of the problem. Because of this investigation, money has now been budgeted for numerous pregnant teen services.

One million teenagers became pregnant in 1975 with nearly six hundred thousand ending in live births, two hundred and eighty thousand terminated by induced abortion and the remaining one hundred and twenty thousand resulting in miscarriages or stillborns.

The pregnant teen who completes her pregnancy often suffers severe medical, social, psychological and educational consequences. Some of these problems are as follows.
1. Increase number of low birth weight infants
2. High frequency of developmental disabilities
3. High mortality and morbidity rates
4. Increase in divorce and instability of family
5. Higher unemployment
6. Increase number of welfare recipients
7. Decrease in high school completion

Looking at this tragedy economically, 50 percent or fifty-seven thousand teen mothers give birth to low birth weight infants. The average hospital stay for the infants is thirteen days at six hundred dollars per day, which comes to $163 million (20:3).

Hence the teenager who becomes pregnant has a serious handicap to family fulfillment and solidity, and to the achievement of independence from parental and governmental aid (1:14).

As to why teen become pregnant, one study found many teens knew about contraception, but failed to use it. Reasons for this were:

1. Many teens have not accepted their sexuality or developed the level of cognitive thinking needed to use contraceptives responsibly.
2. Many teens have not visualized the future, but only see the now. Many are also egocentric.
3. Many teens have a fixation at a lower moral reasoning level. (5:26)

Another factor related to teenage pregnancy was that many boys and girls did not realize the increase in complications and birth defected children born to teen mothers (21:8).
Guidelines have been established for comprehensive adolescent pregnancy programs. If the outcome of pregnancy is to be improved many of these activities should be provided, if not already available, as resources permit.

Guideline 1: Adolescents are individuals and should be treated with respect and a nonjudgemental attitude, in an atmosphere of privacy and confidentiality.

Guideline 2: Adolescents must be provided access to sex and family life education, contraceptive advice and treatment, pregnancy testing, abortion, and prenatal/postpartum care without parental consent.

Guideline 3: Adequate financial support should be available so that access to services is not restricted.

Guideline 4: Provisions should be made for the early detection of pregnancy in adolescent women, and information concerning the availability of this service should be emphasized.

Guideline 5: All alternatives for dealing with the pregnancy must be presented as viable solutions.

Guideline 6: An interdisciplinary, comprehensive approach should be utilized in dealing with adolescent pregnancy.

Guideline 7: Where appropriate and possible, services should be offered to the father of the child, and to the adolescents' parents.

Guideline 8: Early and consistent prenatal care should be
available and accessible for those young women continuing their pregnancies to term.

Guideline 9: The nutritional status of the adolescent should be assessed to ensure that appropriate counseling and services are provided.

Guideline 10: Adequate preparation for the hospital and child birth experience should be provided.

Guideline 11: Post pregnancy care should be provided and should emphasize family planning services.

Guideline 12: A program of consistent counseling and health education should be provided to the pregnant adolescent during and after the pregnancy.

Guideline 13: The pregnant adolescent should be encouraged to continue her regular education and should be provided with the appropriate support services needed to do so.

Guideline 14: Special classes in family life education should be provided in various types of settings for all adolescents, especially those pregnant adolescents who continue their pregnancy to term. (3:62-72)

**Prenatal Care**

The National Institute of Child Health and Human Development stated that "approximately 20 percent of all women in the United States who become pregnant have one or more health problems serious enough to complicate pregnancy and place the unborn child in jeopardy" (12:4).
Fewer prenatal care visits has been found to mean more complications (12:i,abstract). One study at Johns Hopkins Hospital, Baltimore, Maryland, found that the prematurity rate for spontaneous single births was 26 percent for mothers receiving no prenatal care, 24 percent for those with one or two visits, and 8 percent for women with three or more prenatal visits. It was pointed out that prenatal care per se may not be responsible for the differences, but rather the living habits between those women obtaining prenatal care and those not (10:8).

Other data found that when prenatal care was not received until the second trimester, a higher percentage of low-birth weight infants were born. Also women nineteen years and younger who had less than twelve years of education and unmarried were more apt to have late prenatal care (12:i,abstract).

Prenatal care is defined as "a planned program of observation, education, and medical management of pregnant women, directed toward making pregnancy and delivery a safe and satisfactory experience" (10:91).

Standards have been established for prenatal care since pregnancy is a "multifactorial dynamic state" (1:6).

1. A careful screening history
2. A general and specific physical examination designed to exclude risk factors
3. Routine laboratory screening
4. Individually indicated maternal laboratory evaluation
5. Careful fetal assessment during the course of pregnancy
6. Specialized studies to ascertain fetal well-being and/or fetal maturity (1:6)

Antenatal visits should follow this following standard:

<table>
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<th>Weeks of Gestation</th>
<th>Frequency of Visits</th>
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<tbody>
<tr>
<td>0 - 32</td>
<td>once every 4 weeks</td>
</tr>
<tr>
<td>32 - 36</td>
<td>once every 2 weeks</td>
</tr>
<tr>
<td>36 - delivery</td>
<td>once every week</td>
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Prenatal care traditionally has been administered by the physician. Today a change is coming about with the utilization of a team. This team is composed of an obstetric nurse, public health nurse, social worker, physician and clinic care to promote maternal and fetal health, especially in the case of high risk, when the family is under stress or when social conditions are poor (1:2).

"Quality prenatal care services should be available, accessible, and acceptable to all pregnant women, and should respect individual differences" (3:3) because when prenatal care is provided positive results are evident.

1. The infant mortality rate has a direct relation to the level of prenatal care a mother receives.
2. The lack of prenatal care is associated with infant prematurity.
3. The more knowledge a woman can gain concerning her pregnancy, labor, delivery as a result of prenatal education, the more favorable her attitude toward her pregnancy will be (9:92).
A consumer movement has recently been established with the purpose being to affect the health care delivery system in responding to real and basic needs of the people (3:143). In 1964 legislation was passed to create neighborhood health services. An essential factor in this legislation was "maximum feasible community participation in the development and organization of services" (3:145). Community groups were established as a result of this bill, whose task with the providers was policy making and management of the health services.

Problems arose in the effectiveness of consumer participation due to two main factors:

1. Consumers should be helped to understand the need for their active concern and involvement in the delivery of health care services and should create a consumer constituency that cannot be ignored.

2. Consumers, in collaboration with providers, should form organizational mechanisms and training programs and maintain the consumer-provider component. (3:145)

Consumers have a role in improving the outcome of pregnancy in their community. Flahault defined their role as:

1. Identify health needs and priorities so consumers have a feeling of conducting their own health fairs. This provides motivation to proceed with further discussion, decisions, and action.

2. Organize community action and select appropriate manpower to
implement the program.
3. When selecting community health workers they need to be approved and supported by the community.
4. Participate in evaluation -- social and technical aspects of the program. (8:150)

As consumers become more involved with their own care, as well as in the decision making process, many solutions will be perceived by the consumer which will meet the needs of the community. Some of those special services developed by the consumer have dealt with:

1. Adolescents and unwed mothers
2. Clinic scheduling so more accessible
3. Legislation on prenatal consent for the treatment of minors has been modified.
4. Self knowledge and instruction for women on their reproductive systems (3:146)

The benefits received from the area of health services that the community consumer has been able to gain for itself has made a positive impact on reducing the infant mortality and morbidity (15:130).

**Education**

Health education is a means by which responsible decision making and voluntary adoption of those practices can promote individual, family and community health.

Usually when health is to be improved cooperative efforts are required by many individuals and groups. People with actual or potential health problems need health education as well as family members,
friends, opinion-leaders, health professionals and others whose advice, examples, and decisions influence health related behavior. An understanding of the actions providers can take to motivate adoption of sound maternal health care should be a first priority of health education.

Another use and concern of health education is "building community support for health programs; mobilizing and developing health resources; assuring the availability, accessibility, and acceptability of essential health services; and helping providers and consumers establish productive partnerships towards those ends" (3:79-80). Finally, the educational process develops skills and understandings useful in future health problem solving through the learning of health content (3:79-80).

The health education has been found to be essential if maternal and newborn health is to be improved. Some of these reasons are:

1. Leads women to seek early and continuous prenatal care.
2. Informing patients that they have rights and that complaints and problems can be reconciled.
3. Educate patients about the responsibilities they alone can assume, i.e., in adopting those behavioral habits which protect and promote health, in seeking care when needed, and in following medical advice.
4. To develope consumer involvement in the planning, delivery and evaluation of health services. (3:80-81)

If the community is to accept health education and its message it must be based upon knowledge of local factors and problems, and
adaptable to the local culture and level of development. The method used is also critical and may include person-to-person communication, mini group discussions, demonstrations, mass media, and women's clubs (22:52).

If health education is to be successful in reducing perinatal problems, it should be offered during childhood and adolescence, not just the prenatal period (22:53).

The areas to include in this early education would be human responsibility, sexual behavior, drug abuse, venereal disease, etc. Here health education is being used as a positive method to reduce the number of unplanned pregnancies (1:280).

Mothers in the high risk category usually are socioeconomically deprived, which includes low educational achievement (2:168). These women it has been found are least likely to seek health education. Therefore special efforts should be directed to reach them (22:53).

A difficulty might arise in the acceptability of health education if the medical practitioners do not cooperate or respect it. Therefore the professional must also be included in the sensitizing to the needs of the community in regards to health education (7:11).
Brief History of National Task Force

In 1958, twenty years after it successfully launched a campaign to wipe out polio, the National Foundation-March of Dimes marshalled its resources to fight another insidious adversary — birth defects.

Birth defects are those abnormal physical and mental conditions that generally surface at some point between conception and postnatal periods. Birth defects can be hereditary or the result of one or a combination of irregular social, economic, or educational environments.

Added to this infamous list of birth defects is the growing concern over low birth weights. Newborns weighing less than 5 lbs. 8 oz. are at greatest risk of exhibiting incidences of disease or death. Statistics indicate that low birth weight is more prevalent among mothers who received little or no prenatal health care.

The absence of appropriate prenatal care is a cause for grave concern across the nation. It establishes an unnecessary high risk factor that could be eliminated with proper understanding and education.

Some other high risk factors affecting low birth weights are the mother's age, the mother's physical condition, drug and alcohol addiction, improper nutrition, environmental and socio-economic conditions.
While the incidence of birth defects (low birth weight included) is a multi-cultural problem, comparative data shows a higher frequency in certain population groups. Examples of these groups are: teenagers; low income populations; socially and educationally dis-advantaged; minorities.

The National Foundation-March of Dimes has evidenced great concern for the quality of reproduction which, in the final analysis, determines the "quality of life" of present and future generations.

The National Foundation is extremely concerned about the persistence of birth defects in the groups mentioned above.

Thus, The National Foundation has assumed leadership in raising the consciousness of the nation to the human and economic costs of birth defects. A far greater challenge is the newer direction being assumed by The National Foundation in improving the outcome of pregnancy. Significant data suggests that undesirable results of high risk pregnancies are, indeed, endemic and so subtle in manifestation as to require a total health model.

Recognizing the leadership role it must play in impacting on the high risk community, the National Foundation-March of Dimes minority group leaders from around the country convened in Los Angeles during the Summer of 1974. These leaders came to discuss the crisis in medical care for high risk women, infants, and children.

As a result of this meeting approximately twenty interdisciplinary professionals formalized a National Task Force on Maternal and Newborn Health. The National Task Force recommended the planning and implementation of several "pilot programs" aimed at improving the
perinatal health care and the outcome of pregnancy in the high risk communities.

Those recommendations were presented to the National Foundation-March of Dimes Board of Trustees which accepted them. Having its mandate clear, the Foundation's National Staff selected Los Angeles, California, Kansas City, Missouri, and Columbus, Ohio as the chapters where the pilot programs would begin. The purpose of these pilot projects was to address the perinatal health needs of ethnic and low-income groups so that all available services and resources were utilized by the high risk population. The project goals can be found on page 25 of this report. The above actions having been taken, the President of the Foundation appointed a National Training Team to provide on-site technical assistance to each city as needed.

In response to the rising Maternal and Newborn Health needs of the high risk community, the National Foundation has issued a new three year plan. In that plan, priority number one is to organize and conduct the annual March of Dimes campaign. The new emphasis of the Foundation is priority number two, which is to organize and conduct community based education and health service programs to improve the outcome of pregnancy in each chapter service area with particular attention to high risk communities.

The National Foundation continues to feel that research is important, but it realizes the need to marry its research efforts to a viable community action program which educates the populace to the problems, and supports community-based action programs aimed at alleviating the problems.
The first of these community-based educational programs was to be attempted in the high risk areas of the three trial cities selected by The National Foundation. Programs to be developed will be used as models for other chapters to build upon.

Brief History of Los Angeles Project

The Los Angeles pilot program encompasses Los Angeles County with a population approaching seven million. Using data supplied by the former Los Angeles Health Systems Agency, and its knowledge of other data on birth defects, the Los Angeles March of Dimes determined which neighborhoods were to be targeted. Based on the factors, South Central and East Los Angeles were chosen. The population of South Central Los Angeles is predominantly Black, and Hispanics are dominate in East Los Angeles. (Appendix B)

In Los Angeles, The Maternal and Newborn Health Task Force received its official inauguration on August 19, 1977. W.R. Russell, Vice President for Chapters of The National Foundation, and members of the National Training Team visited Los Angeles to advance the pilot project concept and to meet key perinatal professionals of Los Angeles County.

Participants in the August 19th meeting were given an explanation of the pilot program concept by Erwin A. France, then Chairman of the National Training Team. Ezra Davidson, Jr., M.D., Chief of the Obstetrics/Gynecology Department at Martin Luther King, Jr., General Hospital, Los Angeles; member of the National Training Team and member of the Los Angeles County March of Dimes Medical Advisory Board gave an
overview of the problems of maternal and newborn health in Los Angeles County. Los Angeles Chapter Chairman, John Haman expressed support for the pilot project and a discussion ensued.

A key suggestion resulting from this meeting was that a local task force be established that would begin to analyze the needs of the community and thereby forge a plan of action for meeting those needs.

Thus, the Los Angeles County Chapter proposed to establish a cadre of key leaders in the perinatal field and the "grass roots" community for the purpose of involving the total community in improving the events surrounding birth. A professional or provider component, formed December, 1977, and a community representative component, formed January, 1978, comprised the Los Angeles Maternal and Newborn Health Task Force. (Appendix C)

The Provider Committee Chairman was Donald Polhemus, M.D., M.P.H. Chief, Los Angeles Regional Office, California Department of Health, Maternal and Child Health Program. The chairpersons of the sub-committees of this Provider Committee were:

**Education/Outreach Committee:** Carolyn Mazur, P.H.N.
Genetic Counseling Program
Department of OB/GYN
Martin Luther King, Jr., General Hospital
Los Angeles, California

**Resources Committee:** Thomas Hamilton, II, M.D., M.P.H.
Assistant Deputy Director of Preventive Public Health
Los Angeles County Health Department
Los Angeles, California

**Legislation/Funding Committee:** Carl Coffelt, M.D., M.P.H.
Chief Maternal Health Program
Los Angeles County Health Department
The Community Representative Committee met for the first time in January, 1978. The Chairperson for this committee was Assemblywoman Maxine Waters of District Forty-eighth in Los Angeles. This committee was organized into the same three subcommittees as their provider counterpart. The following is a list of the Chairpersons for these subcommittees:

Education/Outreach Committee: Eugenia D. Scott
Superintendent-Area 4
Los Angeles Unified School District

Resources Committee: Ronald Brunner
Administrative Assistant
Special Projects
Mt. Zion Missionary Baptist Church

Legislation/Funding Committee: Ilona Bryman
Deputy to Supervisor Schabarum
Los Angeles County

The local steering committee took the leadership for a plan which would identify needs of the community, suggest priorities and pinpoint key grass root leaders.

Besides the identification of grass root leaders, the committee saw the necessity to contact elected and appointed local public officials and inform them about the Maternal and Newborn Health Task Force. The committee argued that collaborative action between the chapter and local officials is essential in helping the community to stamp out birth defects and improve the outcome of pregnancy.

Many ideas developed in the local subcommittees became an integral part of the local chapter and have been implemented through Task Force members, chapter staff and the National Training Team.
A high point of this activity was November, 1978 when members of the National Training Team and the local Task Force met with all five Los Angeles County Supervisors and/or their deputies, the Deputy Mayor of Los Angeles and Los Angeles Unified School District Superintendent to inform them about the local pilot project and to enlist their cooperation.

When the group met with Edmund D. Edelman, Supervisor, third district, he volunteered to submit a motion to the Board supporting the pilot project efforts for improving the outcome of pregnancy. This motion was drawn up by his office, with assistance from chapter staff. The motion directed the appropriate county officials to work with the March of Dimes in defining the scope of the problem and report back to the Supervisors in forty-five days. It was submitted to the Board of Supervisors and passed in January, 1979. (Appendix D)

**Overall Goals of the Project - National**

In the first annual report of the National Training Team, the goals were set forth with guidelines set down by the National Task Force, the pilot programs established overall goals with supporting objectives in planning their projects. The following is an elaboration of those goals and objectives.

Based on the notion that those at highest risk must be involved in solving their own problems, the major goal of the pilot programs is to address the perinatal health needs of the high risk communities in a manner that motivates these communities to utilize services that would greatly improve the outcome of pregnancy.
Services and resources should be made available, should be easily accessible and should be acceptable to the population served. Moreover, they must coordinate, communicate and interface in a manner which fosters optimal service delivery to the consumer. Additionally, every effort should be made to improve cross-cultural communication which is extremely important and necessary for project success.

Several objectives have been set forth to accomplish this goal. These objectives are as follows:

1. "To involve key perinatal health providers, community agencies and institutions, and the high risk target groups in a collaborative effort that results in better educational programs for the prevention of perinatal mortality and morbidity, and improved levels and quality of service.

2. To make a concerted effort in promoting involvement of the high risk communities. The projects aim to organize, inform, and motivate the high risk communities so that they are aware of and demand perinatal health care as a means of reducing health risks. In addition, its intent is to promote the exercise of individual and personal responsibility in guaranteeing the right of every baby to be born healthy.

3. To monitor and suggest appropriate areas for expansion and extension of perinatal health services and resources.

4. To address the non-medical/social as well as medical factors affecting the outcome of pregnancy." (14:4)

The Community Leadership Development Program focused on the National Task Force's goal number two above. Improving the outcome of
pregnancy in the teenager and woman over thirty-five was a primary concern. In Los Angeles the committee developed a basic training program of four sessions for thirty to forty key leaders in the Hispanic community and thirty to forty key leaders in the Black community. The assumption was that those completing this program would then be able to work with the Los Angeles County March of Dimes, and other agencies and community groups where they had influence in carrying out community based programs in their own neighborhoods.
Chapter 4

METHODOLOGY

Project Design

Concept/Rationale

Borne out of years of experience and grappling with the problems, the local Task Force findings agreed with those of the National Task Force and labeled community based educational programs to be a necessity in the Los Angeles high risk area, if improved pregnancy outcome was to be addressed.

The Community Leadership Development Program held in March, 1979 was the first attempt of the local March of Dimes chapter to direct major attention to training neighborhood leaders with their own constituencies in the high risk areas to expand the process of community education and involvement in improving the outcome of pregnancy. The March of Dimes recognizes that the masses/grass roots, can only be reached to the extent that their leaders are knowledgeable about the issue of problem pregnancies and willing to utilize their skills, abilities, and influence in making improved pregnancy outcome a priority among their constituencies.

Description of Approach

The approach was to set up two concurrent four week workshops, one for each target area. Because of the need for group interaction and exchange, the workshops were designed to accommodate no more than
thirty to forty participants per site.

The workshops were scheduled once each week from 7:00 p.m. to 9:30 p.m. As shown below, each group met separately for three sessions and the two groups were combined for the final session.

<table>
<thead>
<tr>
<th>Session</th>
<th>Group A-Black</th>
<th>Group B-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Tuesday, March 6</td>
<td>Thursday, March 8</td>
</tr>
<tr>
<td>II</td>
<td>Tuesday, March 13</td>
<td>Thursday, March 15</td>
</tr>
<tr>
<td>III</td>
<td>Tuesday, March 20</td>
<td>Thursday, March 22</td>
</tr>
<tr>
<td>IV</td>
<td>Combined Group A &amp; B</td>
<td>Thursday, March 29</td>
</tr>
</tbody>
</table>

Group A met at: Hubert H. Humphrey Comprehensive Health Center 5850 South Main Street Los Angeles, CA 90003

Group B met at: Catholic Youth Organization - Brownson House 1508 Brooklyn Avenue Los Angeles, CA 90003

Session IV convened at a central location for both Group A and Group B at: Children's Hospital of Los Angeles 4650 West Sunset Boulevard Los Angeles, CA 90027

For reasons to be discussed later, the faculty was comprised of local and national personalities. Identical faculty served both groups.

**Objective for Each Session**

Specific objectives were established for each session.

**Session I: "Total Overview of Poor Pregnancy Outcome"**

The first objective for Session I was to provide participants with a national overview on the problem of poor pregnancy outcome, defining and explaining its importance and identifying significant relationships between socioeconomic status, race, and pregnancy outcome. The second objective was to place the national description of
the problems in a local context.

Session II: "Conception to Birth - Prenatal Care"

Again there were two main objectives. The first objective was to identify and develop an understanding of the environments of life from conception through birth and infancy and the actions needed to insure good pregnancy outcomes.

The second objective was to show that having a baby be born well is a team effort involving the pregnant woman, the family, and depending on the situation, often many other contributors representing the disciplines of social work, medicine, nursing, and others.

The session focused on the multi-discipline team approach explaining how unmet nutritional, social, emotional and physical needs of the pregnant woman and child must be met.

Session III: "Teenage Pregnancy"

The objective of this session were as follows. First, to develop an understanding of the developmental tasks of adolescence and the special problems for mother and child arising from teen pregnancies.

The second was to present the views of teens themselves.

Session IV: "Role of Community Leaders"

Having identified the fact that the answers lie in trained and informed community leaders, a two-part objective was set for this session. Part one was to bring the leaders of the two different communities together to see that despite ethnic and geographic distinctions, their problems were the same. Part two was to have the two groups begin to prioritize program actions which would emerge as a
program on which they could work together.

Role of Program Presenters

The format used for the seven sessions had varied roles for the faculty members.

A Presider who would be able to relate to the audience was to host or hostess the individual session. For each session a different presiding officer greeted the participants, set the stage, introduced the speakers and closed the session. All of the Presiders were recognized community leaders with a wide sphere of influence. The following is a list of these Presiders:

Session I - March 6  
Juanita Dudley, M.S.W.  
Los Angeles Chapter-March of Dimes  
Executive Board of Directors

March 8  
Jose Duarte, Executive Director  
Community Health Foundation  
Elias Chico Family Health Center

Session II - March 13  
Audrey Quarles  
Zeta Phi Beta Sorority  
Arizona and California State Division

March 15  
Grace Montanez Davis  
Deputy Mayor  
City of Los Angeles

Session III - March 20  
Ronald Brunner, Administrative Assistant for Special Projects  
Mt. Zion Baptist Church

March 22  
Joseph Arciga, Correspondent  
France Press International

Session IV - March 29  
Benjamin Soria, Vice President  
Bilingual Children's Television  
Oakland, California
In planning the sessions, the committee was anxious to insure variety in both program format and presentation style. Thus, for each session the roles of the presenters differed somewhat.

**Session I**

**Main Presenter:** Oakley Saunders, M.D.  
Chairman of National Training Team  
Baltimore, Maryland

The main presenter was to offer a national overview of poor pregnancy outcome. In twenty to thirty minutes, Dr. Saunders was to convey to the audience the following information.

1. Review of the national population characteristics with emphasis on the high risk in the reproduction age groups.
2. Analysis of the Health Service Systems, where greater accountability is necessary, to reduce the disparity in the outcome of pregnancies.
3. Discussion of the need for an effective communication and monitoring system to determine attainment of goals and objectives as established by the community.

All respondents were to discuss local implications of main presenter's data.

**Respondent:** Ezra C. Davidson, Jr., M.D.  
Chief, Department of Obstetrics/Gynecology  
Martin Luther King, Jr., General Hospital  
Los Angeles, California

Dr. Davidson's role was to convey the workings of a county
hospital dealing with a changing population of Black to Hispanic, and
large numbers of high risk pregnant patients. Also to shed light on
the problems facing the administration of such services and to comment
generally on the relevance of the problems as defined nationally in the
Los Angeles setting.

Respondent: Jaime Salazar, Ph.D.
Institute of Applied Research
University of New Mexico

Dr. Salazar also is connected with the University of California
at Los Angeles, so is therefore familiar with the Los Angeles area.
Having worked extensively with the Hispanic population in Los Angeles
Dr. Salazar's role was to discuss the significance of national data
in terms of its relevancy to the Los Angeles and Hispanic populations.

Respondent: David Satcher, M.D., Ph.D.
Dean
Charles R. Drew Postgraduate Medical School
Los Angeles, California

Because of Dr. Satcher's background in Community Health, his
role was to pinpoint some of the Los Angeles high risk community
problems of health, stressing the prevention of disease and promotion
of health by community involvement.

Discussion Leader: Carl Coffelt. M.D., M.P.H.
Chief, Maternal Health Program
Los Angeles County, Department of Health Services

Dr. Coffelt was to facilitate audience participation. The goal
of this discussion was to start the audience thinking about how they
viewed the problem of poor pregnancy outcome in their own communities.
Did they differ from the professionals viewpoint? Could they see
any solutions? What could they do?
Session II  Main Presenter: Effie O. Ellis, M.D.
Co-Director, Quality of Life
Chicago, Illinois

In this session Dr. Ellis was to introduce the topic of
"Conception to Birth - Prenatal Care". She was to discuss the quality
of life concept, the environments of life, and the interdisciplinary
team approach. Her presentation style was to be the case studies
approach using an older teen and a woman over thirty-five years of
age, who were pregnant with complications.

Following Dr. Ellis's presentation the team members, a public
health nurse, a physician, and a social worker were to discuss with
the audience the role they played as members of this team. The
reactors were to discuss how individual disciplines must work together
for maximum results, and the role of family, friends and community
as elements of the team. The following are the interdisciplinary
team:

Maxine Johnson, R.N., M.A.  Director of Nursing
Ambulatory Services at
Children's Hospital, Los Angeles

Antonio Medina, M.D., M.P.H.  Associate Research Physician
and Lecturer, Maternal and Child
Health
University of California, Berkeley

Consuelo Lopez, D.S.W.  Associate Professor of Social
Services
California Poly University,
Pomona

Edith Robinson, M.S.W.  Supervisor, Social Services
Martin Luther King, Jr.,
General Hospital
Los Angeles, CA

Session III  Main Presenter: Effie O. Ellis, M.D.
Dr. Ellis was to outline the developmental tasks of adolescence. This encompassed the physical changes as well as the emotional changes.

**Interviewers:** Carol Smith, C.N.M.
Director of Family Life Education
Martin Luther King, Jr., General Hospital
Los Angeles, CA

Daniel Parker
Assistant Professor
Guidance and Psychological Counseling
Olive-Harvey College
Chicago, Illinois

Ms. Smith and Mr. Parker were to interview three teens seeking to draw out and interpret information from the teens concerning their views and experiences in the area of teen pregnancy.

**Teen Panel**

<table>
<thead>
<tr>
<th>Group A</th>
<th>Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miss Grace Still</td>
<td>Miss Jan Buck</td>
</tr>
<tr>
<td>Mr. Ronel Correia</td>
<td>Mr. Erik Solares</td>
</tr>
<tr>
<td>Miss Anise Godbolt</td>
<td>Miss Ana Magana</td>
</tr>
</tbody>
</table>

These teens resided in the target areas of East Los Angeles and South Central Los Angeles. They were goal oriented teens. They were interviewed and responded to questions from the audience. It was hoped that they would also relate the important factors that helped them decide to be teens wanting to do something positive with their lives.

**Session IV**

Session IV was designed to discuss the "Role of the Community Leaders." This was a joint meeting of the two prior groups. The group was randomly divided into eight mini-groups, each headed by a Leader
and a Reporter.

Prior to the start of Session IV, the Group Leaders and Group Reporters met to be oriented to their roles. Erwin A. France, Ph.D., conducted this session. The training was a simulation of the process to follow. The goal of Session IV was to begin developing a Community Action Plan.

With approximately an hour to work in the mini-groups, the Group Leader was to have his/her group agree upon four priorities for attacking the poor outcome of pregnancy and then list as many solutions as they could for each.

The Group Reporter's role was to organize and present a summary of the group's thoughts to the plenary session which followed.

Main Presenter: Erwin A. France, Ph.D.
Consultant, National Foundation Maternal and Newborn Health Task Force
Chicago, Illinois

Upon hearing the reports of the eight mini-groups, Dr. France was to summarize the total sessions' findings and outline the steps for action.

Evaluation

An Evaluation Committee was established prior to the Community Leadership Development Program. The composition of this committee included Task Force members and program participants. The following is a list of the members of the Evaluation Committee.

Merle Church
Teacher, Teen Mother Program
Glendale Unified School District
Member of California Alliance Concerned with School Age Parents
The project consultant, Dr. Erwin France and the National Project Co-ordinator, Janice Kissner, were technical resource persons to the Evaluation Committee. Two staff members of the Los Angeles March of Dimes chapters, the chapter's Executive and Dr. Oakley Saunders, Chairman of the National Training Team were ex-officio members of the Committee.

With assistance from the technical resource persons and local staff, the role of the Evaluation Committee was:

1. Preparation and approval of a "Participants Evaluation Form" and "Participants Expectation Form" to be administered at each of the sessions.

2. Preparation and approval of an Evaluation Form on the program itself, to be administered at the final session.

3. Analysis and synthesis of the data yielded by these forms, and preparation of a final report in a timely fashion.

4. Participating on site observers for evaluation purposes in each of the sessions.
Two forms were designed and implemented for the Community Leadership Development Program. The "Participants Expectations Form" was distributed as participants arrived for Sessions I, II, and III. It was then collected at the beginning of each program. This form was to provide data on participant characteristics and what they hoped to receive from the session. (Appendix E)

The second form was the "Participant Evaluation Questionnaire" which was to help the committees determine the extent to which the program met the expectations of the participants. Also space was provided for the participants to list any organizations and/or contacts they thought would be able to use this type of program and information. This form was distributed at the end of all sessions. (Appendix F)

The forms were explained to the audience each time by Dr. Erwin France. The evaluation sheets were compiled and analyzed each week by staff of Palmer, France, Green and King, Ltd.

The analysis of the forms was used by the Evaluation Committee, as it met weekly during the month the sessions were being conducted, to discuss how effective the program was in relation to the two audiences, based on this committee work. Adjustments to the individual sessions were make to improve the programs each week.

Organizing Process

Process of Program Planning

The planning of this program was conducted by a committee consisting of local and national Task Force members and local chapter staff. Dr. Erwin France served as a technical resource to the
committee. The first planning meeting for the Community Leadership Development Program was held December 12 and 13, 1979 with the following in attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>March of Dimes Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ronald Brunner</td>
<td>Chairman of Resource/Community Representative Committee of the Maternal and Newborn Health Task Force</td>
</tr>
<tr>
<td>Assistant for Special Projects</td>
<td></td>
</tr>
<tr>
<td>Mt. Zion Missionary Baptist Church</td>
<td></td>
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<tr>
<td>Los Angeles, California</td>
<td></td>
</tr>
<tr>
<td>Juanita Dudley, M.S.W.</td>
<td>Member of Executive Board, Los Angeles County Chapter-March of Dimes; Chairperson of the Public Affairs Committee for Los Angeles chapter</td>
</tr>
<tr>
<td>Effie O. Ellis, M.D.</td>
<td>Member of the National Training Team</td>
</tr>
<tr>
<td>Co-Director, Quality of Life</td>
<td></td>
</tr>
<tr>
<td>Erwin A. France, Ph.D.</td>
<td>Consultant, National Foundation</td>
</tr>
<tr>
<td>Anita Gallegos</td>
<td>Assistant Executive Director Program Services Department Los Angeles/March of Dimes</td>
</tr>
<tr>
<td>Maritza Mendizabal</td>
<td>Member of Legislative/Funding Community Representative Committee for Los Angeles Task Force</td>
</tr>
<tr>
<td>Community Relations-Blue Cross</td>
<td></td>
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<tr>
<td>of Southern California</td>
<td></td>
</tr>
<tr>
<td>Margaret Norris</td>
<td>Director of Health Planning Los Angeles/March of Dimes</td>
</tr>
<tr>
<td>Daniel Parker</td>
<td>National Training Team member</td>
</tr>
<tr>
<td>Assistant Professor Guidance &amp; Psychological Counseling</td>
<td></td>
</tr>
<tr>
<td>Jaime Salazar, Ph.D.</td>
<td>Recommended by Dr. Oakley Saunders Chairperson of the National Maternal and Newborn Health Task Force; A consultant on Hispanic contacts;</td>
</tr>
<tr>
<td>Center for Health Services</td>
<td></td>
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<tr>
<td>School of Public Health</td>
<td></td>
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<tr>
<td>University of California,</td>
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<tr>
<td>Los Angeles</td>
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</table>

For introduction of the meeting, Dr. Erwin France highlighted the goals and objectives of the National Foundation and National Training T,
and briefly explained the role of the committee. This role was to plan the first community leaders health education program in the pilot project.

The planning of the Community Leadership Development Program was to be based upon the following goals.

**Major strategy:** Community education and involvement of the high risk population and leaders who work with them.

**Primary strategic goal:** To develop and implement a major training effort for leaders in the high risk community.

**Program Approach:** To set up a basic training program of four sessions for thirty to forty key leaders in the Hispanic and Black Community.

**Target Groups:** Ethnic: Black and Hispanic

After extensive discussion, the message the committee felt should be emphasized was that there is a problem of poor pregnancy outcome, that the consequences are dire and that it is the community's responsibility to help give each child their right to be born healthy.

The committee identified the major tasks to be done, developed a work program and assigned roles.

The local chapter Director of Health Planning, made all the logistical, program and administrative arrangements required to implement the Community Leadership Development Program. Support was provided by Palmer, France, Green & King, Ltd. consultants.
After much discussion, the committee decided upon the following program outline.

SESSION I

Date: March 6 and 8, 1979
7:00 - 9:30 p.m.

Topic: Problem of Poor Pregnancy Outcome

Agenda: A. Welcome
B. Problem Overview
C. Response to Overview
D. Discussion
E. Closing

SESSION II

Date: March 13 and 15, 1979
7:00 - 9:30 p.m.

Topic: Conception to Birth - Prenatal Care

Agenda: A. Case Studies - Interview
B. Discussion with Team Members
C. Questions
D. Closing

SESSION III

Date: March 20 and 22, 1979
7:00 - 9:30 p.m.

Topic: Teen Pregnancy

Agenda: A. Film "Woman-Child"
B. Teens Interview who are Goal Oriented
C. Reaction Summary
D. Discussion
E. Closing

SESSION IV

Date: March 29, 1979

Topic: Role of Community Leaders

Agenda: A. Instructions for Small Groups
B. Small Group Workshops
C. Summary of Workshops
Process of Faculty Selection

The criteria established for selecting the Community Leadership Development Program Faculty was developed by the Planning Committee. Because of the pilot nature of the project, they felt it was important to incorporate into the program as faculty, both members of the local Task Force and some National Task Force personnel. The weight however was to be given to local leadership.

Another important selection was to have faculty who could relate to the audience who had dealt with the high risk community and achieved ethnic balance.

As previously indicated, community leaders from the two target areas were chosen as Presiders because they were familiar with the needs of their community and could smoothly coordinate each session.

Session IV's faculty were Group Leaders and Reporters who were capable of leading small group discussions, familiar with the Maternal and Newborn Health area and able to catalyze the groups. Those selected for these roles were:

1. Members of the local Task Force
2. Community contacts that have previously worked with the local chapter
3. Participants of the Community Leadership Development Program who had attended all three sessions

In reviewing faculty selection several key points should be made. First the planning committee recognized the presence of many qualified professionals in the local community and felt that they should be
maximally involved. It also recognized that the strategic use of national personalities can, and generally does, enhance community acceptance of such a program.

Secondly, each program participant was carefully selected because of his/her background and ability to aid in moving the pilot from training to operation.

Thirdly, the selection of youths for Session III was deliberately aimed at utilizing goal and achievement oriented young people who were not teen parents, with the hope that they could offer insights into how to make more young people goal oriented and at the same time share the views and feelings of their peers.

Process of Recruitment

Recruitment is one of three elements keyed to the success of such a program. The other two are planning/programming and follow-up. The process of recruiting the participants for the Community Leadership Development Program was multi-faceted:

1. Letters were sent to the local Task Force members, soliciting names and addresses of community representatives who might be interested in this program. (Appendix G)

2. Those recommended were to include religious, civic, educational, fraternal, women's, business, labor, youth and other organizations that serve populations at high risk of poor pregnancy outcome, such as the poor and minorities.

3. Personal contacts were another means by which names were requested. Local Chapter staff persons visited various health
clinics, public health nurses and doctors in the community, who were familiar with East and South Central Los Angeles community leaders who might be interested in attending and/or be able to recommend interested community people.

4. With help from the then Director of Community Relations from the National Foundation/March of Dimes headquarters, local organizations and leaders in the Black community were contacted. The names of interested persons received from the various sources numbered over four hundred and all were sent invitations.

5. Personal invitational letters were sent (Appendix H) with the first statement of the letter reading "You have been recommended by [person's name], as an individual concerned about action for health in the underserved community." A more positive response to the letter was expected with this type of personal introduction. Enclosed with each invitation was a brochure giving a description of the program. (Appendix I)

Because there were two groups meeting on separate nights at two locations, one in the Hispanic Community and one in the Black community, two separate brochures were printed. The two brochures were identical except for the location, date and color. Geographic proximity to the site of the program determined which brochure each prospective participant received.

Process of Participant Selection

When asking for recommendations of community leaders to attend these programs, local staff selection was guided by the statement in the

It stated that it was of utmost importance to "organize and train professional and lay leaders of high risk, underserved communities with the objective of improving the quality of health care for mothers and babies in those communities." Within this group the program wanted religious, civic, educational, fraternal, women's, business, labor, youth, and other organizations that serve populations at high risk of poor pregnancy outcome, such as the poor, and minority groups. While it would be discussed in more detail in the evaluation findings, the selection criteria utilized signified a gap in understanding and communications between the National Task Force and local staff. A total of 133 persons responded to the invitation. Seventy for Group A and sixty-three for Group B. Because of the committee's desire to keep the groups small, sixty-seven participants were selected for Group A and fifty-seven for Group B. It was assumed that all of those chosen for the program would not attend.

Those not accepted were placed on a waiting list and this list was predominately health professionals.

Public Relations Plan

The media coverage the Community Leadership Development Program received was very diversified and multicultural. The local chapter's Public Relations Department contacted seventy-six Los Angeles County newspapers-English, with thirteen articles published.

Carmen Ulmer, Public Relations Department of Southern California
Blue Cross, contacted the Spanish newspapers and wrote the Spanish articles, of which six were published. Mrs. Ulmer, a chapter volunteer arranged for Octavio Costa, a feature writer of the largest Spanish newspaper in Los Angeles, La Opinion, to interview local chapter staff twice, concerning the Community Leadership Development Program. Two feature articles from these interviews were printed.

In regards to radio coverage, thirty-five public service announcements were sent out from the local chapter's Public Relations Department. It was impossible to determine how many were actually broadcasted.

The Public Relations Plan also encompassed more personal contacts. Prior to the sessions, local staff persons visited various high risk health centers to discuss the Community Leadership Development Program and how the center might be able to publicize this program to their community. The response was good and many of the participants were recommended by these centers.

The mailing of four hundred invitations by local staff made many community representatives aware of the program.

In addition national staff arranged for filming of the sessions to be used in future public relations and public education programs.

Administration and Management Elements

The Community Leadership Development Program was administered and managed by the local chapter Director of Health Planning. It should be noted however, that such a program requires the full commitment and help from the total staff and must have the full support,
guidance and direction of the Chapter Executive. The job was greater than any one person could do alone and because such programming was integral to the fabric of the chapter, at various points staff at all levels must be involved. Therefore, they must be kept informed of the program's development on a regular bases.

Assisting in major decisions were the local chapter Assistant Executive Director of Program Services, the Director of Community Affairs at the national level of the March of Dimes and the consultant for this program.

Roles of Major Actors

The following identifies the actual roles played by the major actors in this project. Identifying the responsibilities of each one was vital for the program to be conducted in an organized fashion and for other March of Dimes Chapters to have as examples.

Local Chapter Staff

1. Coordinate program
2. Staffs various committees concerning planning
3. Provides clerical support
4. Organizes registration
5. Sets up displays at workshops
6. Arrange for refreshments
7. Implements recruiting strategy
8. Provides budgetary support
9. Handles publicity
10. Secures Board involvement
11. Arranges for volunteers
12. Acts as liaison with the Regional office of the March of Dimes
13. Evaluates program
14. Prepares written reports on the program
15. Handles invitations and confirming correspondence, and thank you correspondence

**Local Task Force**

1. Sets local goals
2. Establishes working committees
3. Formulates planning evaluation system
4. Identifies program participants
5. Serves as faculty, providers, meeting places
6. Interprets local program to the community
7. Follows up on special problems

**National Training Team**

1. Sets broad goals
2. Provides liaison
3. Provides technical assistance
4. Participates in planning
5. Participates in evaluation
6. Serves as faculty
7. Assist in establishing contacts in high risk community
8. Assists in interpreting National Program to community leaders
National Foundation

1. Has financial responsibility
2. Gives technical support
3. Acts as liaison to the community
4. Acts as liaison for the National Office
5. Provides for filming
6. Assists in training of faculty
7. Offers financial support for National Training Team

Consultant

1. Develops overall work program format
2. Advises on program organization
3. Develops forms and questionnaires
4. Develops orientation program and materials for group leaders
5. Develops orientation program and materials for media section, filming
6. Assists in brochure development
7. Acts as liaison between National Training Team and National office staff
8. Develops evaluation forms
9. Prepares evaluation reports, weekly
10. Assists in preparation of final report
11. Acts as technical resource to Planning Committee
12. Recommends operation techniques
13. Reviews and comments on prepared documents
14. Trains group leaders and reporters for the last session
15. Develops Planning Worksheets

**Financial Considerations**

The Los Angeles Community Leadership Development Program, being a pilot project, incurred greater financial expenditures than may be normal for this type of effort. Once a working model is developed, some costs may be reduced significantly. However, this depends on the locality and its resources.

The budget for the Community Leadership Development Program had the following components:

I. Faculty
   A. Honorarium for speakers [where requested]
   B. Transportation and lodging

II. Luncheon-dinner meetings costs
   A. Program planning meetings
   B. Evaluation meetings
   C. Faculty Training meetings

III. Rentals
   A. Sites
   B. Equipment

IV. Refreshments
   A. Food for each session
   B. Paper goods for each session

V. Materials
   A. Notebooks {Material for notebooks}
   B. Brochures
C. Stationery supplies
D. Name tags
E. Certificates

VI. Postage
A. Letters to Task Force Members, locally
B. Letters of invitation
C. Thank you letters to participants and faculty
D. Letters of instruction to faculty for each session
E. Miscellaneous faculty letters

VII. Printing
A. Letters
B. Brochures
C. Notebooks
D. Certificates

VIII. Filming

The National Foundation office and the Los Angeles County March of Dimes shared expenses for the Community Leadership Development Program.
Chapter 5

EVALUATION FINDINGS

Scope

The findings reported in this evaluation arise from a number of sources. Among them are data collected through participant questionnaires, perceptions of local staff, perceptions of national staff, perceptions of the consultant and perceptions of program presenters. The scope of concerns embraces a number of issues including planning, recruitment, facilities, participant expectations, and the structure of the evaluation instrument.

Committee

An important finding is that while an active and viable Evaluation Committee was formed, it was not organized early enough in the process. In the future, the Evaluation Committee must participate in planning and goal setting. The evaluation program was developed after goals, objectives, and program components were already in place. Through the weekly, on site observations and through data summarized by Palmer, France, Green and King, Inc. from the participant questionnaires, the Evaluation Committee exercised substantial influence in generating program changes. The final evaluation report presented here will also be presented to the committee for its review, comments and action.


**Process**

The process through which the Evaluation findings were determined was through verbal conversation, direct observation and the "Participant Expectations Form" and the "Participant Evaluation Questionnaire" completed by the participants at each session.

The Evaluation Committee members observed the audience reactions to the program. They met informally several times throughout the total program with the participants, reviewed and gained information through participant questionnaires. Informal conversations gave the committee members a better insight into the participants' responses.

The evaluation forms, which did not require signatures were completed at each session by the participants and helped the Evaluation Committee perceive what the audience expected and what they actually felt they had received.

Each week the majority of participants completed and turned in the evaluation forms.

**Elements**

**Participant Profile and Response**

The participant profile for the Community Leadership Development Program was developed from the "Participants' Expectations Form" and the "Participant Evaluation Questionnaire". Group A and Group B were analyzed separately, which enabled comparisons to be drawn between the two groups.

Of the 115 participants who attended one or more of the sessions,
seventy-eight were health professionals and thirty-seven had little or no health background. Although the majority had health backgrounds, many of the participants also belong to non-health community organizations that could benefit from this type of community based health education program.

The analysis of these evaluation forms was divided into the following five categories for each group:

1. Participants' Profile
2. Participants' Expectations Pre-session I, II and III
3. Participants' Evaluation Post-session I, II and III
4. Participants' Use of the Given Information in Their Community
5. Participants' Suggestions for Future Meetings

Session IV, will be reported separately from the other three sessions. The "Participant Evaluation Questionnaire" was the only form administered at this last session.

Group A: Session I, II and III analysis follows.

1. Participants' Profile

An average of 38 participants attended each of the Group A's first three sessions. In general the profile of the participant was female (75 percent), Black and in the age group of thirty-six to fifty years old, with a background in health related or community organizational fields. Over half of the participants have had previous contact with the March of Dimes.

2. Participants' Expectations Pre-session I, II and III

The participants at all three sessions said they were seeking information on the problems that affect high risk pregnancies, includ-
ing teens. They were also seeking guidance on how to do something about the problems.

At Session III, dealing with the topic of "Teenage Pregnancy" the respondents stated that they were interested in the views and feelings of teens, who have experienced pregnancy, as well as the problems related to teen pregnancy. This is significant since only one teen on the panel, a married female, had been pregnant.

3. Participants' Evaluation Post-session I, II and III

From the "Participant Evaluation Questionnaire" for the first three sessions, those responding had the following to say:

a. Speakers and presenters were rated high
b. Audience participation segment was excellent
c. Most felt they gained new and useful information

Session II was somewhat less favorable in the rating of the speakers and audience participation. The lesser rating of audience participation related to the shortness of time. Again, most indicated that new and helpful information was acquired.

The response from the participants reaction to Session III was one of dissatisfaction with the teenagers selected to discuss teenage pregnancy. They felt the teens were ineffective and did not adequately present the views of most teens. More than half of the respondents said they gained no new useful information at this session.

4. Participants' Use of the Given Information in Their Community

A large percentage of the participants showed an active interest in sharing the knowledge they gained from this program with their community through their job and job related interests. They listed
specific organizations and specific methodologies. For an example of their specific suggestions, see Appendix J.

5. Participants' Suggestions for Future Meetings

For future meetings, the participants urged more small group discussions with a discussion leader offering more specific information on issues and solutions concerning the problem of poor pregnancy outcome. They also requested training in the techniques of communicating this information to the community, especially the teenagers who are affected by high risk pregnancy.

Group B: Session I, II and III analysis follows.

1. Participants' Profile

Thirty-seven was the average number of participants who attended Group B's first three sessions. Their general profile was Hispanic, female [75 percent] with backgrounds in the health field and in the twenty-one to thirty-five age group, which was younger than Group A. Thirty-eight percent had had previous contact with the March of Dimes in the past, which is somewhat lower than Group A.

2. Participants' Expectations Pre-session I, II and III

Despite the fact that Group B was dominated by health professionals, their expectations were very similar to Group A. They desired general information and statistics regarding pregnancy with specific emphasis into the cause and prevention of high risk pregnancy and birth defects. They hoped to understand the problem of poor pregnancy outcome, how to deal with this problem and how to involve the active participation from many areas of the general community. Particular expectations were to gain new information on Hispanic and Native
American teenage pregnancy.

3. Participants' Evaluation Post-session I, II and III

Group B's rating of Session I was similar to Group A's comments. The speakers and presenters were rated high, the audience had a very good opportunity to participate and new and useful information was given.

Session II, the speakers and presenters fell to the mid range of the rating scale, with the audience's ability to participate as good, but not enough. Only half of the participants felt the program met their expectations.

Disappointment expressed by the participants was the fact that they were not receiving new avenues through which they would be able to share their information and ideas. It is interesting to note again that this group was comprised largely of practicing health professionals.

4. Participants' use of the Given Information in Their Community

The participants of Group B showed an interest in developing informative programs on the local community level and better prenatal health care programs. They also would like to share ideas and information with similar health agencies. For an example of how Group B would use this information gained, see Appendix K. It provides an interesting comparison to Group A.

5. Participants' Suggestions for Future Meetings

When asked to recommend suggestions for future meetings, about 50 percent responded. The overall view was for more structure, information, outlines, printed material and resources. In the area of
discussions, the respondents felt it was important to have more time allotted and smaller groups. The group also noted the need to develop more data on health problems among Hispanics.

Group A and Group B Combined: Session IV

1. Participants's Evaluation Post-session IV

The general response about Session IV from the participants was favorable and the following was a summary of their comments.

a. The speakers and presenters were good and well prepared.
b. The audience participation was excellent.
c. Sixty-eight percent of the participants gained new and useful information.

2. Participants' Use of the Given Information in Their Community

The responses stated by the participants on how they might use the information they received upon completing the four sessions of the Community Leadership Development Program was extensive. Many were interested in planning and implementing community education programs in their communities, based on the information they received at these sessions.

Project Implementation

Recruitment. The recruitment efforts were more successful in the Black communities than they were in the Hispanic communities when measured against the National Training Team's expectations. Among the factors facilitating recruitment in the Black community were the availability of technical assistance from the Foundation's National Division of Community Relations, and the degree of prior contact the
local chapter has had with non-health leaders in the Black community. Among factors impeding the recruitment of non-health professionals in the Hispanic community were the absence of a similar catalyst to the Foundation's National Director of Community Relations to assist in the Hispanic community, cultural differences which define the need for specific outreach strategies. The lesser degree of local chapter contact beyond the health professionals in the Hispanic area, the newness of the task to local chapter staff and time constraints also impeded this recruitment.

It should also be noted that where success was experienced in recruitment in the Black community, the age group twenty-one to thirty-five was not reached and must be specifically addressed in the future.

Selection criteria. The relationship between recruitment and selection is clear. Local staff selected those who most nearly met the National Training Team profile from among the universe of those indicating interest. As stated earlier, the waiting list, or those not selected were largely health professionals. In the future, the selection will be improved by more targeted recruitment and better defined recruitment strategies.

Workshops-speakers. The comments received from the audience concerning the speakers was generally favorable. Session III on "Teenage Pregnancy" was the one with which the participants were least pleased.

All of the speakers had excellent backgrounds in the subject areas for which they were responsible. Some were from areas outside of
Los Angeles and known well in their fields.

The contributions of the support faculty, respondents and re­actors, was rated very well by the participants, but in the view of other evaluators it could have been strengthened greatly, had main speakers provided text of their presentations in advance. Also, prior faculty discussions with all program participants attending would have helped.

This was attempted but not uniformly successful.

Workshops-logistics/organization. On the whole, the logistics and organization worked well to support the program.

Of particular note was Session IV held at a central location convenient to both Group A and Group B participants. The response to this session was very good and all participants enjoyed the exchanging of ideas in the small mini group discussions. The mini groups were randomly selected from the main large group. Group A and Group B participants in each of the eight mini groups interacted well together.

While not mentioned elsewhere in the report, a number of additional steps were taken to enhance the training:

1. Because most participants were "working people", a nutritious snack was made available a half hour before each session. This also helped get people there on time and social­ize.

2. Loose leaf notebooks were given to each participant at the first session and additional materials supplied at each sub­sequent session.
3. A display table of literature was set up at the first and last sessions so that participants could add to their libraries.

4. Newsprint, magic markers, and masking tape were provided for each small group discussion at the last session. All of the above worked out well.

Workshop-approach. As stated earlier, the Planning Committee's intent was to provide variety in the approach for each session. This was well received.

Workshop-Content. The vast majority of participants stated they learned new and useful information.

Session I, "Total Overview of Poor Pregnancy Outcome" gave many national statistics on the problem. Presentations from local faculty would have been stronger had they focused more on interpreting the national data in light of local conditions to help the group draw appropriate relationships. The usual tendency of the group to be more interested in local data than seeing the connection with the national picture was evident in this session.

Session II, "Conception to Birth--Prenatal Care" used the members of the Prenatal Health Team to convey their role in prenatal support care and improving the outcome of pregnancy. The content was basic and well understood by both groups.

Session III, "Teenage Pregnancy" again, had excellent content. The verbal presentations were augmented by a National Foundation/March of Dimes film on teen pregnancy entitled Woman-Child. As stated earlier, the content of the teen panelists was lacking in breadth in
that their views were narrow and not representative of the larger teen population.

Workshop-rooms. Both facilities selected to house the Community Leadership Development Program were located in areas easily accessible by the participants attending. Despite the fact that the Hubert Humphrey Center was a new building cheerfully decorated used by Group A, the Brownson House, an older less auspicious facility used by Group B was the better of the two. The room at the Humphrey Center was too large for the group, lighting was poor and thus not conducive to good small group interaction, and tables were not available thus impeding the ability to control the group configuration. Within the limits of the resources available, the best was made of the setting. The major limitations of the facility used by Group B were that it was not air-conditioned, street noise, and though it was not a problem in this instance, it was not easily accessible to the physically handicapped.

The facility used for Session IV, Children's Hospital was excellent in every respect.
Chapter 6

OUTCOME

Community Planning Process

A major outcome of this effort is that there now exists a new cadre of community leaders with constituencies who have a better understanding of the problems and who are committed to collaborating on programs to serve them.

A second outcome is that a new community based planning and programming process has begun. The action options developed in the small groups at Session IV represent only the beginning. Local chapter staff has subsequently refined the small group reports into a draft Community Action Plan which must now go to the cadre for further development and ultimately to the larger community for its input and implementation.

In a real sense, the work of the local chapter and local Task Force is just beginning. The challenge will require new resources, a redirection of existing resources and a further training of chapter staff and Board if the chapter is to maintain the leadership position it has taken.

Impact

The impact of this program thus far must be seen on at least two levels, first, the cadre and second, the Chapter.
The Community Leadership Development Program imparted information that was new and useful to the majority of the participants. The participants showed an active interest in learning more about birth defects and high risk pregnancies and sharing the information they had gained with many community people and organizations they are in contact with. Also the program created among the participants, aspirations to develop informative health education programs and amend existing prenatal health care programs at the local level.

A new group of allies has been formed

Several individuals who attended the Community Leadership Development Program stated their interest in conducting similar education programs in their geographical location. Some of these were the following.

1. Presbyterian Church
   Community Centers
   San Gabriel Valley, California

2. Los Angeles Unified School District
   Teachers of sixth grade
   Central Los Angeles, California

3. Head Start Programs
   Parents Component and Staff Inservice
   East Los Angeles, California

4. Los Angeles Urban Indian Health Center
   Los Angeles, California

5. Health Centers
   Los Angeles County

6. South Whittier Child Development Center
   Inservice for staff
   Whittier, California
Slowness in chapter response can undo all that has been gained thus far. The momentum must be maintained.

Chapter

Impact upon the local chapter may be seen as very positive, but from an organization perspective for each problem it sees, it creates several new ones.

There were many benefits that resulted because of the Community Leadership Development Program. Through media coverage: ethnic radio, television and newspapers, the public became aware of community health education the local chapter was conducting for leaders in the high risk community. This type of publicity broadened the general knowledge the public had about the organization and its goals.

Many of the participants who attended the program were unfamiliar with the organization's goals. This exposure established many new community contacts the local chapter will be able to call upon to help develop and implement community health education programs; to provide leadership for future community maternal and newborn health education programs; and to organize the communities so that they are a safer place for the unborn and newborn.

The local chapter has been able to pioneer this type of programming and begin the development of staff and volunteer skills in this area. On the problem creation side, the local chapter has created new community expectations with respect to its performance, it has in a sense generated a need for change in the way it does business. It has uncovered staff and board weaknesses which, if not corrected, may
set the chapter's growth back, and it has created a new demand for services from already limited resources. The way in which these challenges are transformed into opportunities, will make the difference for the future growth of its basic mission, to improve the outcome of pregnancy and stamp out birth defects.

**Learnings**

In addition to the above, throughout this report many learnings have been revealed. What follows is a summary of some of the key insights gained from the experience and they are largely suggestions to aid other chapters in organizing similar programs. They are not listed in order of priority since each is essential. Community health education programs should:

1. Make formal goals and objectives. List the goals and objectives on materials {brochures} being mailed to the prospective participants of the program. Distribute printed sheets listing the goals and objectives of the individual sessions prior to each meeting and discuss them at the beginning.

2. Establish contacts with lay leaders and those who serve in the high risk community, who have a constituency. The primary approach must be to work through existing leaders in the high risk areas.

3. Allow four to six months prior to the program for identification of community leaders. Adequate lead time is essential.

4. Select faculty who are knowledgeable of the subject matter, sensitive to the audience and able to relate to the audience's
level of familiarity with the subject matter.

5. At each session have local chapter staff and Board members greet arriving participants with warmth and enthusiasm. Greetings from the March of Dimes should be kept short at the beginning of the meetings. Board participation is essential.

6. Have all hand-out materials used for the program designed and printed in a readable and attractive fashion.

7. Provide nutritious refreshments for participants.

8. Award certificates or some form of recognition to participants who have completed the total training program. All participants must receive some recognition. (Appendix L)

9. Assign someone to keep the program on its time schedule and running smoothly.

10. Allow participants to select the program they wish to attend when two or more programs are being conducted on the same topic, at the same time, but at different locations.

11. Arrange for groups to be small and informal and allow participants time to discuss each topic and express their views.

12. Specify the target group for which the program is designed, when establishing goals and objectives.

13. Use personal contact, including volunteers in recruitment. The greatest payoff in recruitment comes in those instances where personal contact was made.

14. Develop specific recruitment strategies to reach the twenty-one to thirty-five year age group in the Black community.

15. Establish and communicate clearly the characteristics of the
target group to all persons involved in the recruitment process and in all printed materials.

16. Develop entirely different recruitment strategy for the Hispanic community in order to overcome cultural barriers to outreach.

17. Establish clearly that final responsibility or authority rests with the local chapter. The role of National staff, the National Training Team, and the consultant is to be advisory and supportive.

18. Insure that all speakers understand clearly and precisely what is expected of them and how they fit into the program design.

19. Stress repeatedly the fact that participants must work toward the development of solutions. In programs such as this, the danger is that participants will want to be given answers rather than participate in developing answers.

20. Make final selection of all program presenters. This must be done by the staff in order to assure that they meet all criteria set by the Committee.

21. Make certain not to over promise and underdeliver. This is especially true of the chapters.
Chapter 7

FOLLOW-UP PLAN

Upon the completion of the Community Leadership Development Program, the local chapter designed a plan which dealt with follow-up matters.

A letter was sent to all participants who attended the program, expressing the chapter's appreciation for their time and interest in improving the outcome of pregnancy in their community. A summary of each session was also prepared and sent with the thank you letter. (Appendix M)

At Session IV "Personal Pledge" sheets (Appendix N) were distributed to and completed by the participants of the program. The analysis was compiled by the Los Angeles March of Dimes office and stated the interest and skills the participants possessed, which could be used to develop and implement the Action Plan.

The "Planning Work Sheets", (Appendix O) which were used by the mini groups in Session IV were analyzed to determine a feasible Action Plan the Los Angeles March of Dimes and participants of the Community Leadership Development Program would develop and implement. Next, steps on this Action Plan have been referred to earlier.

Since the Community Leadership Development Program was completed, the Maternal and Newborn Health Task Force has changed status in Los Angeles. There is no longer a Task Force and the project is now the Maternal and Newborn Health Program. A letter went out to all
Task Force members July, 1979 to inform them of this change, with a card to return if they were interested in being involved in community health education programs the local chapter would be conducting. (Appendix P) Over fifty have responded in favor of remaining active in ongoing programs.

Another area required in the follow-up plan is the contacting of the participants who requested similar community health education programs in their geographical area. Each was interviewed to determine the specific type of program desired.

Within the follow-up plan is the preparation of the "Draft Evaluation Report" by the Director of Health Planning. This report is to review the total program, so that other chapters might be able to build upon the experience. The Evaluation Committee is to review, modify, and approve this report upon its completion.
BIBLIOGRAPHY
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APPENDIXES
APPENDIX A

LIST OF NATIONAL TRAINING TEAM MEMBERS OF THE MATERNAL AND NEWBORN HEALTH TASK FORCE
LIST OF NATIONAL TRAINING TEAM MEMBERS OF THE
MATERNAL AND NEWBORN HEALTH TASK FORCE

Mildred C. Bradham, Professor
School of Social Work
Florida State University

Josie Candelaria, Health Planner
New Mexico Health Systems Agency
Albuquerque, New Mexico

Betty J. Carrington, CNM
Administrator, Midwifery Service
Department of Obstetrics and Gynecology
Brookdale Hospital
Cambria Heights, New York

Marjorie A. Costa, MPH, DMA
Assistant to the Administrator for Community Affairs
U.S. Department of Health, Education and Welfare
Rockville, Maryland

Mr. William A. Craig, Jr.
Brooklyn, New York

Ezra C. Davidson, Jr., M.D.
Chairman, Department of Obstetrics and Gynecology
Martin Luther King General Hospital
Los Angeles, California

Effie O. Ellis, M.D.
Co-Director, Quality of Life Center
Chicago, Illinois

Janet Forbush
National Alliance Concerned with School Age Parents
Washington, D.C.

Erwin A. France, Ph.D.
Palmer, France, Green, and King
Chicago, Illinois

Dr. Alyce Gullattee
Professor of Psychiatry
Department of Psychiatry
Howard University Hospital
Washington, D.C.

Harold Hamilton, Publisher
Urban Health
Atlanta, Georgia

Marcia Pinkett Heller
Assistant Director, Instructor
Health Administrator
Columbia University
School of Public Health of the Faculty of Medicine
New York, New York

Bessie King Jackson
Director of Bethune Center for Single Parents
Columbus, Ohio

Theodore Johnson
Middletownship Schools
Cape May Court House, New Jersey
APPENDIX B

NEIGHBORHOOD STATISTICS FOR
SOUTH CENTRAL LOS ANGELES
AND
EAST LOS ANGELES
Target Area: Health Systems Agency Neighborhood # 209
South Central Los Angeles  Population:(1976) 89,395

Geographical Location: City of Los Angeles, statistical areas of Green Meadows, Watts, Willowbrook. Portion of City of Compton. Supervisorial District Number 2--Supervisor Kenneth Hahn.

Health Services: Southeast Health Services region and King/Drew Medical Center.

Ethnic Characteristics

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<td>1. Black</td>
<td>65491</td>
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<td>2. Mexican American</td>
<td>17191</td>
<td>19.23%</td>
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<td>3. Other</td>
<td>6713</td>
<td>7.51%</td>
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Socio-Economic Characteristics

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<td>2718</td>
<td>3.04%</td>
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<td>5. Income below $7,000</td>
<td>57713</td>
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<td>6. Complete College Educ.</td>
<td>1493</td>
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<td>7. Complete High School</td>
<td>29670</td>
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<td>16696</td>
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<td>10. Population under 19 years</td>
<td>3900</td>
<td>39.00%</td>
</tr>
</tbody>
</table>

Maternal & Newborn Statistics in Neighborhood - 1976

<table>
<thead>
<tr>
<th></th>
<th>Live Births</th>
<th>Fetal Deaths</th>
<th>Infant Deaths</th>
<th>Neonatal Deaths</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>28</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>30</td>
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<td>1079</td>
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<td>9</td>
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<td>1132</td>
</tr>
<tr>
<td>Mexican</td>
<td>1007</td>
<td>13</td>
<td>7</td>
<td>10</td>
<td>1037</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
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<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>2124</td>
<td>42</td>
<td>16</td>
<td>27</td>
<td>2209</td>
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Live Births by Ethnicity & Age of Mother - 1976

<table>
<thead>
<tr>
<th></th>
<th>LT-15</th>
<th>15-19</th>
<th>20-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45+</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>0</td>
<td>3</td>
<td>11</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>28</td>
</tr>
<tr>
<td>Black</td>
<td>28</td>
<td>401</td>
<td>351</td>
<td>266</td>
<td>33</td>
<td>0</td>
<td>1079</td>
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<tr>
<td>Mexican</td>
<td>5</td>
<td>192</td>
<td>368</td>
<td>366</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>596</td>
<td>731</td>
<td>652</td>
<td>110</td>
<td>2</td>
<td>2124</td>
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</table>
Continued of South Central Los Angeles Data.

23.8% of Total on AFDC with unemployed parents

Primary Care Physician - ratio per 1,000 population

<table>
<thead>
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<th>General &amp;</th>
<th>Internal Medicine</th>
<th>OB/GYN</th>
<th>Pediatrics</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Med.</td>
<td>8</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Ratio per 1,000 Population

0.13

Target Area: Health Systems Agency Neighborhood # 307
East Los Angeles. Population: (1976) 154,156

Geographical Location: City of Los Angeles, statistical areas of Boyle Heights and City Terrace. Unincorporated county area of East Los Angeles. Supervisoral District Number 3. Supervisor Ed Edleman.

Health Services: Central Health services region and Los Angeles County/U.S.C. Medical Center

**ESTIMATED DEMOGRAPHIC & SOCIO-ECONOMIC CHARACTERISTICS**

<table>
<thead>
<tr>
<th>Ethnic Characteristics</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Black</td>
<td>617</td>
<td>0.40</td>
</tr>
<tr>
<td>2. Mexican American</td>
<td>130755</td>
<td>84.82</td>
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**Socio Economic Characteristics**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>3. Professional Occupation</td>
<td>7554</td>
<td>4.90</td>
</tr>
<tr>
<td>4. Income below $7,000</td>
<td>70912</td>
<td>46.00</td>
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<tr>
<td>5. Complete College Educ.</td>
<td>4563</td>
<td>2.96</td>
</tr>
<tr>
<td>6. Complete High School</td>
<td>41453</td>
<td>26.89</td>
</tr>
<tr>
<td>7. Sub-standard Housing</td>
<td>20089</td>
<td>28.33</td>
</tr>
<tr>
<td>8. Total age 65 &amp; over in poverty</td>
<td>3009</td>
<td>22.30</td>
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**Maternal & Newborn Statistics in Neighborhood - 1976**

<table>
<thead>
<tr>
<th></th>
<th>Live Births</th>
<th>Fetal Deaths</th>
<th>Infant Deaths</th>
<th>Neonatal Deaths</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>79</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>82</td>
</tr>
<tr>
<td>Black</td>
<td>16</td>
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<td>17</td>
</tr>
<tr>
<td>Mexican</td>
<td>4414</td>
<td>44</td>
<td>18</td>
<td>0</td>
<td>4506</td>
</tr>
<tr>
<td>Other</td>
<td>69</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>71</td>
</tr>
<tr>
<td>Total</td>
<td>4578</td>
<td>48</td>
<td>20</td>
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<td>4676</td>
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**Live Births by Ethnicity & Age of Mother - 1976**

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<tr>
<th></th>
<th>LT-15</th>
<th>15-19</th>
<th>20-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45+</th>
<th>TOTAL</th>
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</thead>
<tbody>
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<td>0</td>
<td>14</td>
<td>31</td>
<td>30</td>
<td>4</td>
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<tr>
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<td>0</td>
<td>4</td>
<td>9</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Mexican</td>
<td>10</td>
<td>826</td>
<td>1485</td>
<td>1723</td>
<td>360</td>
<td>9</td>
<td>1,4414</td>
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<tr>
<td>Other</td>
<td>0</td>
<td>6</td>
<td>16</td>
<td>4</td>
<td>5</td>
<td>0</td>
<td>69</td>
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<tr>
<td>Total</td>
<td>10</td>
<td>850</td>
<td>1541</td>
<td>1797</td>
<td>370</td>
<td>9</td>
<td>1,4578</td>
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</table>

26.8% of families on AFDC with unemployed parents.
Continued of East Los Angeles Data

Primary Care Physician - Ratio per 1,000 Population

<table>
<thead>
<tr>
<th>General &amp; Family Med.</th>
<th>Internal Medicine</th>
<th>OB/GYN</th>
<th>Pediatrics</th>
<th>Total</th>
<th>Ratio/1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>9</td>
<td>8</td>
<td>5</td>
<td>82</td>
<td>.53</td>
</tr>
</tbody>
</table>

APPENDIX C

LISTS OF LOS ANGELES TASK FORCE MEMBERS
LOS ANGELES COUNTY CHAPTER MARCH OF DIMES
TASK FORCE MEMBER ON MATERNAL AND NEWBORN HEALTH

ASSEMBLYWOMAN MAXINE WATERS -- Community Representatives Chairperson
48th District

Joseph Arciga
March of Dimes
Board Member

Don Benson
Assistant Administrator
Milestone Center of Educational Therapy

Ronald Brunner
Special Assistant
Mt. Zion Missionary Baptist Church

Ilona Bryman
Deputy
Office of Peter Schabarum
Supervisor of Los Angeles District 1

Samuel Q. Chan, Ph.D.
Children's Hospital of Greater Los Angeles

Merle Church
Legislative Task Force
California Alliance Concerned with School Age Parents

Carl E. Coan, M.S., M.P.H.
Director of Planning
Los Angeles Regional Family Planning Council

Terry Contreras, Administrative Assistant
Child Abuse Program
Pediatric Pavillion
U.S.C. Medical Center

David Crippens, Vice President
Kiset, Channel 28

Juanita Dudley, M.S.W.

Jan Graybill
Member, Health Commission
California State P.T.A.

Seigo Hayashi
Service Coordinator
Asian Rehabilitation Service

Maxene Johnston, R.N., M.A.
Director of Nursing, Ambulatory Services
Children's Hospital of Los Angeles

Genevia H. Landry, R.N.
Coordinator of Nurses
Compton Unified School District

Marilyn Langford, Consultant
Prevention & Community Corrections Branch
State of California
Department of Youth Authority

Jeanne Lindsay
Teacher, Teen Mother Program
ABC Unified School District

Henry Lozano
Administrative Assistant to Congressman Edward Roybal

Dorothy McKissick
San Fernando High School
Community Representatives Committee Members continued.

Maritza Mendizabal
Community Relations
Blue Cross of Southern California

Edna Montgomery, Ph.D.
Assistant Director, Pupil Services
Compton Unified School District

Dennis Nishikawa
Legislative Analyst
Greater Los Angeles Community Action Agency

Marjorie Pearson
Community Liaison Representative for Women
Department of Health Services

Rose Polito
Archdioceses of Los Angeles Health & Hospitals Department

Audrey Quarles
Zeta Phi Beta Sorority

Kate Reiss

Ruth Rich, Ph.D.
Instructional Specialist
Health Education Section
Los Angeles Unified School District

Eugenia D. Scott, Superintendent
Area 4 Administration
Los Angeles Unified School District

Donneta Spink

Carmen Ulmer
Public Relations Department
Blue Cross of Southern California

Christine Ung
c/o Mayor Tom Bradley
City of Los Angeles

Naomi Uyekawa
T.H.E. Clinic for Women

Barbara Vogel
Curriculum Specialist

Aaron Wade, Ph.D.
Superintendent
Compton Unified School District

Lillian Wade, Ph.D.
Compton Unified School District
DONALD POLHEUMS, M.D., M.P.H. -- Health Providers Chairperson
Chief, Los Angeles Regional Office
California Department of Health
Maternal and Child Health

Ricardo Alvarado, Executive Dir.
Southern California Council of
Free Clinics/Family Planning Program

Steve Baranov
PSAF W.I.C. Program

Beverlie Bareis
American Red Cross
Nursing/Health Programs

Geraldine Branch, M.D.
Director, Preventive Health Services
Watts Health Foundation

James Caillouette, M.D.
Member of Los Angeles March of Dimes Medical Advisory Board

John Clark
South East M.I.C. Project

Carl Coffelt, M.D.
Chief, Maternal Health Program
Los Angeles County Department of Health Services

Milton Cohen, Administrator
South Bay Regional Perinatal Proj.

Ezra C. Davidson, Jr., M.D.
Chief, Department of Obstetrics and Gynecology
Martin Luther King, Jr., General Hospital

Hazel Farwell
United American Indian Council

Leonara Flint, R.N.
Training Center
Huntington Memorial Hospital

Virginia Gladney
Nutrition Program Coordinator
Los Angeles County Department of Health Services

Jim Gore, Administrator
Martin Luther King, Jr., General Hospital
Department of Obstetrics and Gynecology

Thomas Hamilton, II, M.D., M.P.H.
Assistant Deputy Director of Preventive Public Health
Los Angeles County Health Dept.

Calvin Hobel, M.D.
Chief, Obstetrics
Harbor General Hospital

Joan E. Hodgman, M.D.
Director of Newborn Services
Women's Hospital
Los Angeles County/U.S.C. Medical Center

Suzanne Holmes
Director of Health Planning
St. Francis Hospital

Bonnie Kellogg, R.N., M.S.
Coordinator Prenatal Diagnosis
LAC/USC Medical Center Genetics Division

Judith Koerner
Community Organization Specialist
San Gabriel Valley Regional Center

Thomas Kring, Executive Director
Los Angeles Regional Family Planning Council
Health Providers Committee Continued.

Beverly C. Lee, R.N.
Community Health Service
Maternal Infant Child Program
Program Specialist
LAC/USC Medical Center

Linda Lowery, R.N.
Hollywood Presbyterian Medical Center
Obstetrics/Gynecology Department

Jack Maidman, M.D.
Martin Luther King, Jr.
General Hospital
Genetics Center

Audrey Mayes
Nursing Consultant
Maternal & Child Health
State of California
Department of Health

Kathy Mittleider, R.N.
Assistant Program Specialist
Bureau of Maternal & Child Health
LAC/USC Medical Center

Marc Moser
Senior Operations Analyst
Department of Medical Economics
Kaiser Foundation - Health Plan

Dominic Muzsnai, M.D.
Chief, OB/GYN Dept.
Olive View Hospital

Charlotte Neumann, M.D.
Associate Researcher/Lecturer of Public Health
and Pediatrics
University of California at Los Angeles
School of Public Health

Victor Pine
Clinic Manager
Alcohol Rehabilitation Center
Hollywood-Wilshire Health Center

Beverly Durden-Pryor
Health Educator
Hubert H. Humphrey Comprehensive Health Care Center

Robert A. Rafael, M.D.
Chief, Medical Services
North Los Angeles County Regional Center

David Rimoin, M.D., Ph.D.
Chief, Division of Medical Genetics
Department of Pediatrics
Harbor General Hospital

Robert Hurd Settlage, M.D., MPH
Maternal, Infant and Child Proj. Director
LAC/USC Medical Center

Lowell E. Sever, Ph.D.
Division of Epidemiology
School of Public Health
University of California at Los Angeles

Bharti Sheth
Los Angeles Health Systems Agency

Julie Simon, Administrator
Perinatal Regionalization Project
LAC/USC Medical Center

Carol Smith, R.N., C.N.M.
Director of Family Health
Martin Luther King, Jr., General Hospital

Patricia Smuland
Maternal Health Program
Los Angeles County Health Dept.

Annabel Teberg, M.D.
San Gabriel Valley Health Services Region

Thomas Thompson
Developmental Disabilities
Health Providers Committee Continued.

Willis Wingart, M.D.
Director
Pediatric Ambulatory Services
LAC/USC Medical Center
APPENDIX D

LOS ANGELES COUNTY BOARD OF SUPERVISORS
MOTION
LOS ANGELES COUNTY BOARD OF SUPERVISORS
MOTION

Author: Supervisor Edmund D. Edelman     Date: January, 1979

According to the National Foundation-March of Dimes, San Francisco has the best statistical record among California counties for healthy pregnancy outcome and prenatal care. The County of Los Angeles is a distant 36th.

One decisive factor that appears to improve infant survival rates, particularly in low-income communities, is early and regular prenatal care.

In response to the identified problems affecting infant mortality rates, the National Foundation-March of Dimes, in collaboration with leading health professionals in the Los Angeles area, has selected Los Angeles County for a pilot program to "plan and carry out a series of demonstration programs of care, as well as education and public affairs, to improve prenatal health services to underserved populations, including high-risk teenagers."

As of this month, the Los Angeles chapter of the March of Dimes is developing programs:

1. To develop and generate community support for increased availability, accessibility, and utilization of comprehensive, high quality maternal and infant care services through educational programs in churches, schools, community organizations, and youth groups.
2. To inform local, state, and federal officials on the importance of prenatal care so they can provide leadership and consider solutions concerning the improvement of all facets of pregnancy outcome.

3. To create an effective line of communication between providers and consumers to improve prenatal health care.

The local chapter of the National Foundation-March of Dimes has requested the Board of Supervisors of Los Angeles County to support the community efforts to improve the quality of reproductive health.

For this reason, I MOVE that the Board of Supervisors recognize that there exists a serious problem of high risk pregnancies and inadequate prenatal health care with poor pregnancy outcome, and that it establish a goal not only to improve greatly Los Angeles County's pregnancy outcome rates but also to reduce the number of low birthweight infants among its target population.

I FURTHER MOVE that the Chief Administrative Office and the Department of Health Services be instructed to meet with the Maternal and Newborn Health Task Force of the National Foundation-March of Dimes and develop a report for the Board within 45 days concerning the implementation of a proposed plan of action regarding this matter.
APPENDIX E

PARTICIPANTS EXPECTATIONS FORM
PARTICIPANTS EXPECTATIONS FORM

1. Session #_______

2. Race & Ethnicity (Check one):  Black ____  White ____  Hispanic ____  Other ____ (Specify)

3. Age: (Check one)
   16-20 ____  21-35 ____  36-50 ____  51-65 ____  over 65 ____

4. Sex: M ____ F ____

5. Circle the number of sessions you have attended  1   2   3

6. Before enrolling in this program have you had any previous contact with the March of Dimes?
   Yes ____  No ____  How ______________________  When ______________________

7. List, in order of importance, the three (3) main things you must want to get out of this session:
   a. __________________________________________________________
   b. __________________________________________________________
   c. __________________________________________________________

8. How did you decide to enroll in this series:
   A friend told me __________
   Through media—Newspaper _____ TV _____ Etc. _____
   For professional reasons ________
   March of Dimes Staff contacted me:  Personally ________
                                       By phone ________
                                       By letter ________
                                       Other ________ Specify
APPENDIX F

PARTICIPANTS EVALUATION QUESTIONNAIRE
1. Session #

2. Race & Ethnicity (check one): Hispanic White Black Other (specify)

3. Sex: M F

4. Age (check one): 16-20 21-35 36-50 51-65 over 65

5. Circle the number of sessions you have attended: 1 2 3

6. Overall, how would you rate the speaker(s)?
   Excellent Very Good Good Fair Poor

7. Do you think the Presenters were:
   Very well prepared Well prepared Not prepared

8. How would you rate your opportunity to participate?
   Excellent Very good Good Fair Poor

9. Did you gain new information? Yes No

10. Did you gain helpful information? Yes No

11. How would you use the information to help in your community?
   a.
   b.
   c.

12. List any organizations or contacts you have where you think the information gathered in this session would be helpful.

13. Did this session meet your expectations? Yes No
   If not, why

14. Any suggestions for future meetings?
APPENDIX G

LETTER REQUESTING NAMES OF COMMUNITY LEADERS
Dear

During the month of March, the Maternal and Newborn Health Task Force will be conducting four Educational sessions on improving the outcome of pregnancy.

In order for this

**LOS ANGELES MATERNAL & NEWBORN HEALTH COMMUNITY LEADERSHIP DEVELOPMENT PROGRAM**

to be a success, we urgently need your assistance in obtaining the names and addresses of those community representatives that you feel might be interested in attending this program. We would like to send invitations to include religious, civic, educational, fraternal, women's, business, labor, youth and other organizations that serve populations at high risk of poor pregnancy outcome, such as the poor and minorities.

By January 25th could you please submit the names on the sheet provided to me, for it would help in our quest for representatives.

Thank you for taking time to help in this matter. Please call me if you have any questions.

Sincerely,

Margaret Norris
Director of Health Planning
Maternal & Newborn Health Task Force
APPENDIX H

INVITATIONAL LETTER TO PROSPECTIVE PARTICIPANTS
February 15, 1979

Name
Address

Dear

You have been recommended by ____________, as an individual concerned about action for health in the underserved community.

We invite you to be a participant, during March in the Los Angeles Maternal & Newborn Health Community Leadership Development Program. The Los Angeles Chapter of the March of Dimes is bringing together local and national experts in the field of Maternal and Child Health to discuss and inform with you the seriousness of high risk pregnancies that can result in dead or damaged babies.

Through this community education effort, the number of birth defected infants can be lowered. We look forward to this opportunity to exchange ideas and information, so that every child born may have the right to a healthy start in life.

The enclosed brochure has the specific details for each session. We ask that you make a firm commitment to attend ALL FOUR (4) informative and challenging sessions. A certificate of completion will be presented at the last session.

Please fill out the attached registration form and send it immediately to the March of Dimes, as participation is limited. Pre-workshop materials will be sent to you. For further information please call me at (213) 956-8565.

Sincerely,

Margaret Norris
Director of Health Planning
APPENDIX I

BROCHURES
COMMUNITY LEADERSHIP DEVELOPMENT PROGRAM
Because Brochure was too large, each panel of brochure will be shown separately. Group A and Group B had different Panel 2 and Panel 3, so they are also included in this section.
WHAT'S THIS ALL ABOUT?

Local and national experts in the field of Maternal and Newborn Health will discuss with the Community leaders their role in the community in regards to improving the outcome of pregnancy. There'll be workshops, lectures, panel discussions, and films for an exciting look at this problem.

WHEN IS IT?

- March 6, 1979, Tuesday — Session I
- March 13, 1979, Tuesday — Session II
- March 20, 1979, Tuesday — Session III
- March 27, 1979, Tuesday — Session IV

It STARTS at 7:00 p.m. ENDS at 9:30 p.m.

WHERE IS IT?

Hubert H. Humphrey Comprehensive Health Services Center
5850 South Main Street — Auditorium
Los Angeles (Corner of Slauson & Main)

HOW CAN I PARTICIPATE?

Just fill out the attached registration form, put a stamp on it and mail it IMMEDIATELY. We'll take care of the rest, including free refreshments for everyone.

I'D LIKE MORE INFORMATION.

Call (213) 663-3985 any weekday between 8:30 a.m. and 5:00 p.m.
Ask for Margaret Norris
WHAT'S THIS ALL ABOUT?
Local and national experts in the field of Maternal and Newborn Health will discuss with the Community leaders their role in the community in regards to improving the outcome of pregnancy. There'll be workshops, lectures, panel discussions, and films for an exciting look at this problem.

WHEN IS IT?
March 8, 1979, Thursday — Session I
March 15, 1979, Thursday — Session II
March 22, 1979, Thursday — Session III
March 29, 1979, Thursday — Session IV

It STARTS at 7:00 p.m. ENDS at 9:30 p.m.

WHERE IS IT?
Catholic Youth Organization-Browson House
1508 Brooklyn Avenue
Los Angeles, California 90033

HOW CAN I PARTICIPATE?
Just fill out the attached registration form, put a stamp on it and mail it IMMEDIATELY. We'll take care of the rest, including free refreshments for everyone.

I'D LIKE MORE INFORMATION.
Call (213) 663-3985 any weekday between 8:30 a.m. and 5:00 p.m.
Ask for Margaret Norris
Panel 3 of Brochure: Group A

PROGRAMS

SESSION I  March 6, 1979

   TOPIC  Total Problem of Poor Pregnancy Outcome
   FORMAT  Overview of Problem Audience Discussion

SESSION II  March 13, 1979

   TOPIC  Conception to Birth Prenatal Care
   FORMAT  Case Studies (teen-older teen-woman over 35) Discussion of the TEAM Approach to Health Care

SESSION III  March 20, 1979

   TOPIC  Teenage Pregnancy
   FORMAT  Film "Woman Child" Interviews with Three Teens on Self Image and Goals

SESSION IV  March 27, 1979

   TOPIC  Role of Community Leaders
   FORMAT  Workshops on Community Action Planning
### PROGRAMS

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<th>SESSION</th>
<th>Date</th>
<th>TOPIC</th>
<th>FORMAT</th>
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<td>I</td>
<td>March 8, 1979</td>
<td>Total Problem of Poor Pregnancy Outcome</td>
<td>Overview of Problem Audience Discussion</td>
</tr>
<tr>
<td>II</td>
<td>March 15, 1979</td>
<td>Conception to Birth Prenatal Care</td>
<td>Case Studies (teen-older teen-woman over 35)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Discussion of the TEAM</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Approach to Health Care</td>
</tr>
<tr>
<td>III</td>
<td>March 22, 1979</td>
<td>Teenage Pregnancy</td>
<td>Film &quot;Woman Child&quot; Interviews with Three Teens on Self Image and Goals</td>
</tr>
<tr>
<td>IV</td>
<td>March 29, 1979</td>
<td>Role of Community Leaders</td>
<td>Workshops on Community Action Planning</td>
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</tbody>
</table>
REGISTRATION

Please reserve a place for me. I am willing to make a commitment to attend the four (4) Program Sessions.

Please Print

Name: __________________________________________

Address: ___________________________ City: __________ Zip Code: ______

Phone: _________________________________

PLEASE RETURN IMMEDIATELY. Fill out this form, put a stamp on it and mail it to:

MARCH OF DIMES
2635 Griffith Park Boulevard
Los Angeles, California 90039
FACULTY

Ronald Brunner
Assistant for Special Projects
for Dr. Edward V. Hill

Thomas Canar
Executive Director — Los Angeles
Chapter of the March of Dimes

Carl Coffelt, M.D.
Chief, Maternal Health Program
Los Angeles County
Dept. of Health Services

Grace Montez Davis
Deputy Mayor, City of Los Angeles

Juanita Dudley, M.S.W.
Psychiatric Social Worker

Effie Ellis, M.D.
Co-Director, Quality of Life Center
Chicago, Illinois

Erwin France, Ph. D.
Consultant, National Foundation
Maternal & Newborn Health Task Force
Chicago, Illinois

Janice Kissner
Director of Community Affairs
White Plains, New York

Consuelo Lopez, D.S.W.
Associate Professor of Social Services
Cal Poly, Pomona

Antonio S. Medina,
M.D., M.P.H.
Associate Research Physician & Lecturer
Maternal & Child Health
University of California, Berkeley

Marta Mendizabel
Community Relations
Blue Cross of Southern California

Dan Parker
Consultant, National Foundation
Maternal & Newborn Health Task Force
Chicago, Illinois

Edith Robinson
Medical Social Worker, Supervisor
Martin Luther King, Jr.
General Hospital

Jaime Salazar, Ph. D.
Institute of Applied Research
University of New Mexico
Albuquerque, New Mexico

David Satcher, M.D.
Dean, Charles R. Drew Postgraduate Medical School

Oakley Saunders, M.D.
Chairman of National Task Force for Minorities
Baltimore, Maryland

Eugenia Scott
Superintendent of Area 4
Los Angeles Unified School District

Carol Smith, C.N.M.
Director of Family Life Education
Martin Luther King, Jr.
General Hospital

Benjamin Soria, Vice President
Bilingual Children’s Television
Oakland, California

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Los Angeles Chapter/(213) 663-9385
APPENDIX J

HOW PARTICIPANTS USE INFORMATION IN THEIR COMMUNITY
GROUP A
Table 6: How Participants would use information in their community.

- Personal enhancement, helped to organize thoughts 3
- Give short review of problem 1
- Training session at agency where employed 4
- Staff meeting 1
- Parent education groups 3
- Set up workshops 1
- Involve organization in community awareness 3
- Share with other health center disciplines 3
- Share information with chapter members 1
- Provide information to youth groups 3
- Share with church groups 3
- Girl Scouts 1
- Note resource persons for future use 2
- Parent Teacher meetings 1
- Train teachers 1
- Sorority meetings 1
- Organize community group meetings 2
- Share information with other agencies 1
- Begin outreach programs 3
- Make contact with other health providers 1
- Relay back to AKA groups 1
- Relay written articles 1
- Encourage mothers to get early prenatal care 1
- Use "Stork Nest" (Zeta Phi Beta Sorority & March of Dimes) to encourage other mothers to get early prenatal care 1
- Help set up centers to distribute information 2
- New ideas on services for high risk community 1
- Develop treatment plans for women clients/high risk 1
APPENDIX K

HOW PARTICIPANTS WOULD USE INFORMATION IN THEIR COMMUNITY
GROUP B
PARTICIPANTS EVALUATION QUESTIONNAIRE

GROUP B

Table 6: How Participants would use information in their community.

- Help develop better prenatal programs 1
- Help improve health education outreach to community, especially in foreign languages 2
- Use statistics in planning action program 1
- As a counselor: To take back to agency to develop group 6
- Share with colleagues and other professionals 9
- Counseling teenagers 2
- Help youth counselor prepare information for community meetings 1
- Payment of health services - referrals to health service centers 1
- Give talk to community groups and clubs 7
- Present information to high schools 1
- Information to medical educators in community 1
- Pass information onto other individuals 1
- To be better informed 1
- Share information with students 1
- Generate more community awareness 1
- More information and prepare childbirth education in Spanish 1
- Encourage other women to improve pregnancy care 1
- Genetic counseling 1
- Information about other county agencies 1
- Make list of available services 1
- Distribute information to others 1
- Duplicate and post written information 1
APPENDIX L

CERTIFICATE OF COMPLETION
THIS IS TO CERTIFY THAT

AN INDIVIDUAL CONCERNED ABOUT ACTION FOR IMPROVING THE OUTCOME OF PREGNANCY IN THE HIGH-RISK COMMUNITY HAS COMPLETED THE COMMUNITY LEADERSHIP DEVELOPMENT PROGRAM OF THE LOS ANGELES MATERNAL & NEWBORN HEALTH TASK FORCE AND THE NATIONAL TASK FORCE ON MATERNAL & NEWBORN HEALTH IN THE HIGH-RISK COMMUNITY.

Chairman, Executive Board
Los Angeles Chapter
March of Dimes

Chairman, National Task Force
Maternal & Newborn Health in the High-Risk Community

Executive Director
Los Angeles Chapter
March of Dimes

Date

THE NATIONAL FOUNDATION/MARCH OF DIMES
LOS ANGELES CHAPTER
APPENDIX M

SUMMARY OF SESSIONS
Health care has been announced as a high domestic priority in the United States for the last several years. Despite ever increasing billions of dollars being added to the National Budget significant discrepancies in availability of services continue to exist. A review of the criteria for evaluating the system may lend clues to this anomaly. The effectiveness of the system is frequently evaluated by examining mortality rates – particularly infant or perinatal mortality rates. To be effective as a community health leader, certain concepts regarding the structure and the association of its elements is mandatory. A review of the national population characteristics with particular emphasis on minorities in the reproductive age groups shows significant relationships between socio-economic status, race and outcome of pregnancy. To modify the system so as to reduce the disparity in outcome of pregnancies greater accountability is necessary.

Lastly, an effective communication and monitoring system needs
to be established to determine attainment of goals and objectives as established by the community.

SESSION II "Conception to Birth - Prenatal Care"

Speaker: Effie Ellis, M.D.
Co-Director, Quality of Life Center
Chicago, Illinois

All life has quality; but this quality may be good or bad quality. The quality of life is affected by many different environments: womb, birth, family, school, peers, etc.

The interdisciplinary team approach is important in the quality of life. This team is made up of the physician, the public health nurse and the social worker.

Response: Maxene Johnston, R.N., M.A.
Director of Nursing, Ambulatory Services
Children's Hospital of Los Angeles

For a patient to try to solve a problem, there must be a Trust with the team members. These team members help the patient sort out the information, so hopefully they can make a good decision.

Response: Edith Robinson, Supervisor
Medical Social Worker
Martin Luther King, Jr., General Hospital

Consuelo Lopez, D.S.W.
Assistant Professor
Cal Poly, Pomona

A social worker is mainly there to help families with their crisis and give them the opportunity to talk about their problem and what their new role is.

A social worker can look for the strengths and support systems a patient has that might help in solving the crisis.
Response: Antonio S. Medina, M.D., M.P.H.
Associate Research Physician and Lecturer
Maternal and Child Health
University of California, Berkeley

"Pregnancy is a Family Affair--pregnancy is a privilege."

There is a need to create a system that one can work with and not one that people must sneak around.

Publicity is important and can improve the problem of poor pregnancy outcome, by allowing the community to be aware of the problem.

Audience Discussion: "How do you make contact with the pregnant woman, who is not aware that she needs help?"

1. Health systems need to communicate ideas and ways of reaching common goals.

2. Reach the community people in different ways: store front clinics, parks, and early health education in the schools.

3. Teach self-esteem at an early age.

4. We need "Urgency Care not just "Emergency Care.""
APPENDIX N

PERSONAL PLEDGE SHEETS FOR SESSION IV
NATIONAL FOUNDATION MARCH OF DIMES
LOS ANGELES CHAPTER

TASK FORCE ON MATERNAL & INFANT CARE IN THE HIGH RISK COMMUNITY

PERSONAL PLEDGE

You can count on me to help!

Name

Address

Phone (home number) (work number)

The best time to reach me is

The specific problem I want to work on are:

1.

2.

The special talents I want to put to work are:

1.

2.
APPENDIX O

PLANNING WORK SHEETS FOR SESSION IV
<table>
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<th>Priority Number</th>
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<table>
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<th>PROGRAM ACTION POSSIBILITIES</th>
<th>LEAD ACTION AGENT</th>
<th>TIMING</th>
<th>RESOURCE NEEDS</th>
<th>AVAILABLE</th>
<th>NOT AVAILABLE</th>
<th>UNKNOWN</th>
</tr>
</thead>
</table>


APPENDIX P

LETTER INFORMING OF STATUS CHANGE OF
MATERNAL AND NEWBORN HEALTH TASK FORCE
July 10, 1979

Dear Member:

The Los Angeles County March of Dimes would like to announce two exciting changes that have occurred in June, 1979.

We have moved our business office to a larger facility, due to our tremendous growth these past few years. The new location is at:

1111 South Central Avenue
Glendale, CA 91204
Phone: (213) 956-8565

The other change is the Los Angeles Maternal and Newborn Health Task Force is no longer a pilot project. It is now the Maternal and Newborn Health Program. Starting in September, small community-based educational programs will begin to be conducted. We are attempting to improve the outcome of pregnancy in the high-risk community through education. Our goal is to implement 40 - 50 such programs, using members of the Maternal and Newborn Health Task Force as faculty. If you are interested in being involved in these community-based programs, please return the enclosed card.

Our Public Affairs component of the Task Force has become very active and influential with many local and national maternal and newborn health issues. We hope to be able to call upon you in the future to write your legislator.

Thank you for your valuable support and we look forward to working with you.

Sincerely,

Margaret Norris
Director of Health Planning
APPENDIX Q

CHRONOLOGY
OF
PLANNING
COMMUNITY LEADERSHIP DEVELOPMENT PROGRAM
CHRONOLOGY
OF
PLANNING
COMMUNITY LEADERSHIP DEVELOPMENT PROGRAM

November, 1978

1. Selection of members for the Planning Committee of the Community Leadership Development Program.

2. Developing materials for the Planning Committee meeting.

3. First meeting of the Planning Committee-November 13, 14, 1978.

4. Thank you letters to those attending the Planning Committee Meeting

5. Formalizing the tentative plan the Planning Committee developed for the Community Leadership Development Program.

December, 1978

6. Recruit community leaders who might be interested in the program.

   a. Design letter to be sent to local Task Force members requesting names of community leaders.

   b. Duplicate letter and send it out to approximately 100 local Task Force members.

   c. Make personal appointments to see local high risk community agencies who might be able to supply community leader's names.

   d. Attend a dinner meeting with the Director of Community Activities at the National level and leaders in the Black Women's organizations.

January - February, 1979

7. Faculty recruiting:

   a. Determine faculty roles

   b. Select faculty for roles

   c. Obtain confirmations for each faculty member

   d. Send information to each faculty member on particulars of the program and the role they play in the program.
8. Select location sites for the two group sessions.

9. Make all arrangements, confirmations and requirements for each site.

**February, 1979**

10. Design brochure for Community Leadership Development Program
    a. Arrange for printing of brochure, using different colors for the two sites.

11. Design and have printed the notebooks for the participants.

12. Invitations to prospective participants:
    a. Draft a letter to be sent to all the prospective participants
    b. Have a typing service type personalized invitational letters and envelopes for approximately 500 prospective participants
    c. Determine what persons get which brochure - Group A or B
    d. Sign letters and stuff envelopes with designated brochure and mail

13. Develop list of those attending Group A's program and Group B's program

14. Make arrangements for newspaper and radio advertisements for program
    a. English papers and radio stations
    b. Spanish papers and radio stations

15. Plan budget for program

16. Design and print Certificate of Completion for participants

17. Prepare materials that are to be sent to those participants who have been accepted to program
    a. Letter of acceptance
    b. Detailed program agenda
    c. Registration card
    d. Map on how to get to program location
February, 1979

18. Prepare materials for notebooks
   a. Weekly agendas
   b. Vocabulary lists
   c. Local Task Force members list
   d. Directory of Free Clinics in the Los Angeles County
   e. Statistics on teenage pregnancy in Los Angeles County
   f. Names of the staff in the March of Dimes/Los Angeles Chapter Program Services Department
   g. Application for the Public Affairs activities
   h. Fact sheet on objectives of the National Task Force on Maternal and Newborn Health
   i. Summaries of each session
   j. March of Dimes Fact: 1979, booklet
   k. Pencils and note paper for each participant

19. Assemble 100 notebooks

March, 1979

20. Determine and purchase nutritious refreshments for each session

21. Assign duties to March of Dimes staff who will be assisting at each of the sessions:
   a. Registration
   b. Refreshments setup and cleanup
   c. Literature Display

22. Select people to be on the Evaluation Committee and make arrangements for the meetings.
   a. Review and adapt the "Participants Expectations Form" and "Participant-Evaluation Questionnaire", as designed by Erwin France, Ph.D., consultant.
March, 1979

b. Evaluate each session
c. Draw up an outline for the Evaluation Report of the Community Leadership Development Program

23. Make arrangements for weekly Faculty Training Meetings:
   a. Notification of when and where meetings are to be held to each faculty member
   b. Prepare materials for meeting
   c. Arrange for meeting room, dinner, etc.

24. Conduct each workshop session
   a. Set-up: Refreshments, literature display, registration and room arrangement
   b. Greeting and hospitality of attending participants
   c. Analysis of the evaluation forms--by Erwin France, Ph.D.'s office

25. Have certificates lettered with the names of participants who attended all four sessions.

26. Send out thank you letters each week of the sessions to the faculty who served that week

27. Follow-up to sessions
   a. Design letter of thanks to participants for attending sessions

April, 1979

28. Follow-up to sessions continued
   a. Duplicate letter to participants and mail
   b. Write and duplicate summaries of each session to participants and mail

May, 1979

29. Evaluation meeting with National Foundation on the program
Summer, 1979

30. Design an "Action Plan", which will be sent to the participants for their approval

31. Contact those participants who requested workshops in their areas to determine their needs

32. Write Evaluation Report and send for approval from Evaluation Committee

33. Design, duplicate and mail Announcement letter of Los Angeles March of Dimes change in Maternal and Newborn Health Program status
APPENDIX R

LISTS OF NOTEBOOK MATERIALS
LISTS OF NOTEBOOK MATERIALS

1. Objective of Community Leadership Development Program

2. Agendas for each session, per each site

3. Memorandum from the Los Angeles County March of Dimes, Program services Department to the participants attending the Community Leadership Development Program concerning the local commitment to improving the outcome of pregnancy

4. List of Los Angeles Task Force members

5. History of the Los Angeles Maternal and Newborn Health Task Force

6. Statistics on Los Angeles County Live Births by Ethnicity and Age of Mother--Teenage Pregnancy

7. Medical vocabulary lists of terms to be used in program

8. Lists of Los Angeles County Free Clinics

9. Directory of all those attending the Community Leadership Development Program

10. Sign-up sheet for information of Public Affairs and involvement

11. A salute to the International Year of the Child from the National Foundation March of Dimes


13. YOUNG AND PREGNANT. Published by March of Dimes listing all the Teen Mother Programs for pregnant teens in Los Angeles County

14. Note taking paper